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The union for nurses and midwives

Queensland Nurses' Union

Inquiry into Workplace Bullying

Submission to the House of Representatives Standing Committee On Education and Employment

June, 2012

Nurses. For you. For life.

because we care
Quality care for older Australians

Introduction

The Queensland Nurses' Union (QNU) thanks the House of Representatives Standing Committee on Education and Employment (the Committee) for providing the opportunity to comment on workplace bullying. Our submission focuses on the terms of reference that consider the prevalence of workplace bullying, the role of workplace cultures in preventing bullying and the adequacy of existing education and support services. These are areas of concern to the QNU and the profession because our members report increasing levels of bullying and harassment from members of the public, other health professionals and nurses[1] themselves.

About the QNU and the Nursing Workforce

Nurses form the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNU - the union for nurses and midwives - is the principal health union in Queensland. The QNU covers all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 48,000 financial members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

The QNU seeks to enhance and enforce industrial protections around specific characteristics of the nursing workforce – it is feminised, part-time and ageing. The national Australian Institute of Health and Welfare 2009 Nursing and Midwifery Labour Force Survey (2011) found that:

- The number of registered and enrolled nurses in the labour force (that is, employed in or looking for work in nursing in Australia) increased by 14.2% between 2005 and 2009, from 254,956 to 291,246.
- Between 2005 and 2009, the number of nurses actually employed in nursing increased by 13.3%, from 244,360 to 276,751.
- The average weekly hours worked by employed nurses and midwives increased slightly from 33.0 hours in 2005 to 33.3 hours in 2009. Over the same period, the proportion of nurses working part time (less than 35 hours per week) declined slightly from 49.8% to 47.7%.

[1] The terms 'nurse' and 'nursing' are inclusive of 'midwife' and 'midwifery'.

- Between 2005 and 2009, the proportion of employed nurses aged 50 years and over increased from 35.8% to 36.3%. The average age of nurses decreased from 45.1 years in 2005 to 44.3 years in 2009.
- Nursing continued to be a female dominated profession, with females comprising 90.4% of employed nurses in 2009 (down slightly from 92.1% in 2005).

Regulatory Framework

In its review of occupational health and safety regulation, the Productivity Commission (2010) noted that there is no nationally accepted definition of psychosocial hazards such as bullying across Australia. In Queensland the *Prevention of Workplace Harassment Code of Practice 2004* (the Code) refers to bullying behaviors as forms of harassment. The Code provides practical advice about ways to prevent or control exposure to the risk of death, injury or illness created by workplace harassment and bullying.

Under the Code:

A person is subjected to 'workplace harassment' if the person is subjected to repeated behaviour, other than behaviour amounting to sexual harassment[2], by a person, including the person's employer or a co-worker or group of co-workers of the person that:

- is unwelcome and unsolicited;
- the person considers to be offensive, intimidating, humiliating or threatening;
- a reasonable person would consider to be offensive, humiliating, intimidating or threatening.

This definition is intended to cover a wide range of behaviours that can have an adverse impact on the workplace health and safety of workers and other persons. Harassing behaviours can range from subtle intimidation to more obvious aggressive tactics and can include:

- abusing a person loudly, usually when others are present;
- repeated threats of dismissal or other severe punishment for no reason;
- constant ridicule and being put down;
- leaving offensive messages on email or the telephone[3];
- sabotaging a person's work, for example, by deliberately withholding or supplying incorrect information, hiding documents or equipment, not passing on messages and getting a person into trouble in other ways;
- maliciously excluding and isolating a person from workplace activities;
- persistent and unjustified criticisms, often about petty, irrelevant or insignificant matters;
- humiliating a person through gestures, sarcasm, criticism and insults, often in front of customers, management or other workers;

[2] See the *Anti-Discrimination Act 1991*, section 119.

[3] This can also include other forms of social media such as Facebook, Twitter etc.

- spreading gossip or false, malicious rumors about a person with an intent to cause the person harm.

There are bound to be occasional differences of opinion, conflicts and problems in working relationships – these are part of working life. However, if the workplace behaviour is repeated, unwelcomed and unsolicited, and offends, intimidates, humiliates or threatens a person, then workplace harassment exists and employees and employers must take action to stop the behaviour (Department of Justice and Attorney General, 2004).

The Productivity Commission (2010) noted that it is possible that prescriptive approaches taken by jurisdictions in relation to risk management, such as the Code, could contribute to higher costs to employers than less formal approaches taken elsewhere. However, any additional costs incurred by employers from a more prescriptive approach need to be balanced by the greater certainty and clarity and the possibility of reduced incidence of hazards such as bullying and harassment in the workplace.

Bullying in Nursing

The nursing work environment involves complex interpersonal relationships within a social and political context. Nurses balance a multitude of tasks and are accountable to many people. Most agree on the hectic nature of nursing practice and the constraints nurses face every day in delivering quality care (Taylor, 2001).

Because nursing is a workforce numerically dominated by women, this type of workforce demographic has specific issues related to its functions and interactions. Gender and socialisation can give some indication of the type of bullying that occurs. Unfortunately, the reality is that nurses' working environments are often fraught with workplace violence or bullying that tends to go unreported. Furthermore, bullying in many organisations filters from the top down and often becomes an acceptable way of managing staff. Not only are there consequences for the individual, but also for the profession as a whole.

Given the central focus of caring in the nursing profession, it is paradoxical that the literature reveals interpersonal conflict and bullying among nurses and midwives as a significant issue facing the profession (McKenna, Smith, Poole, Coverdale, 2003).

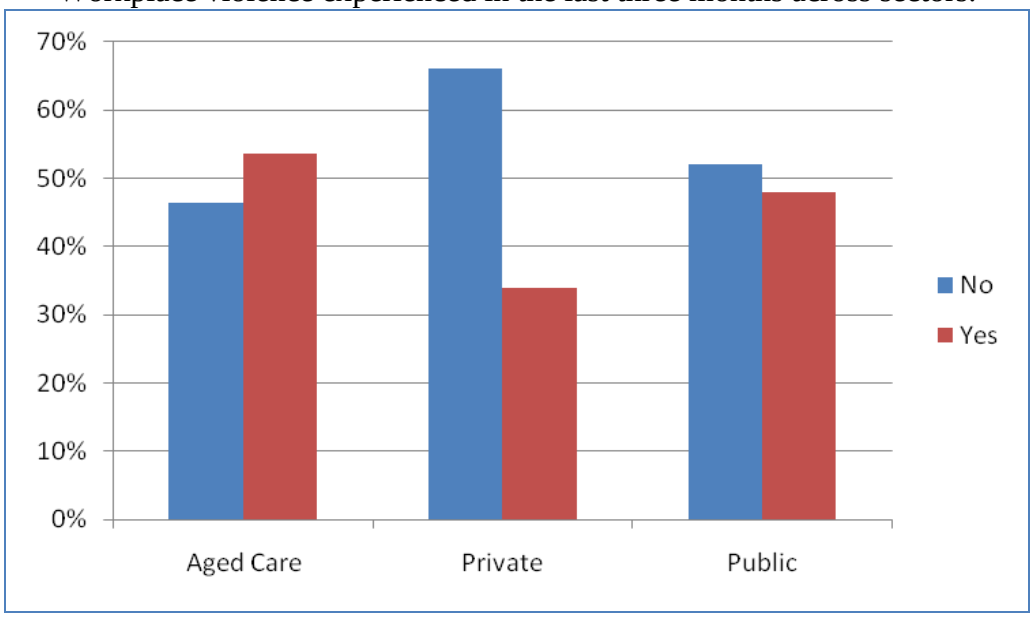
Recent Data

In their longitudinal study of Queensland nurses and midwives, Hegney et al (2011) point to high levels of workplace violence including aggression and/or workplace harassment/bullying with highly significant sector differences.

Prevalence of bullying

Overall almost half of the nurses had experienced workplace violence in the previous three months. Across sectors there were differences with the lowest incidence of violence reported in the Private sector.

Workplace violence experienced in the last three months across sectors.



Workplace violence experienced in the last three months across years.

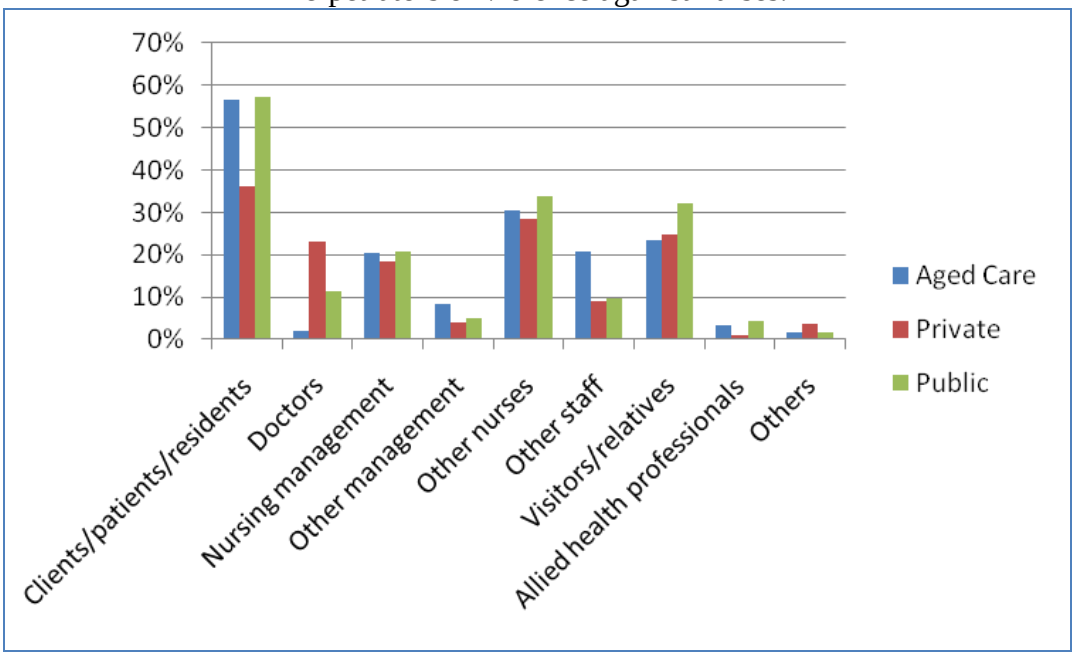
Abused at workplace in last 3 months?		Year of survey				Total
		2001	2004	2007	2010	
No	Count	821	613	538	723	2695
	% within Year	58.3%	47.9%	54.4%	54.8%	53.9%
Yes	Count	587	668	451	596	2302
	% within Year	41.7%	52.1%	45.6%	45.2%	46.1%
Total	Count	1408	1281	989	1319	4997
	% within Year	100.0%	100.0%	100.0%	100.0%	100.0%

Perpetrators of bullying

Nurses who had experienced violence or aggression identified the following perpetrators and prevalence of violence and aggression.[4] Clients/patients/residents were the highest source of workplace violence followed by violence by other nurses. There were significant sector effects in the perpetrators of violence. Client violence was lowest in the Private sector where violence by doctors was high. In Aged Care virtually no violence by doctors was reported but violence by other staff was highest. In the Public sector visitors were more likely to be the source of violence.

[4] Respondents could indicate more than one source of violence.

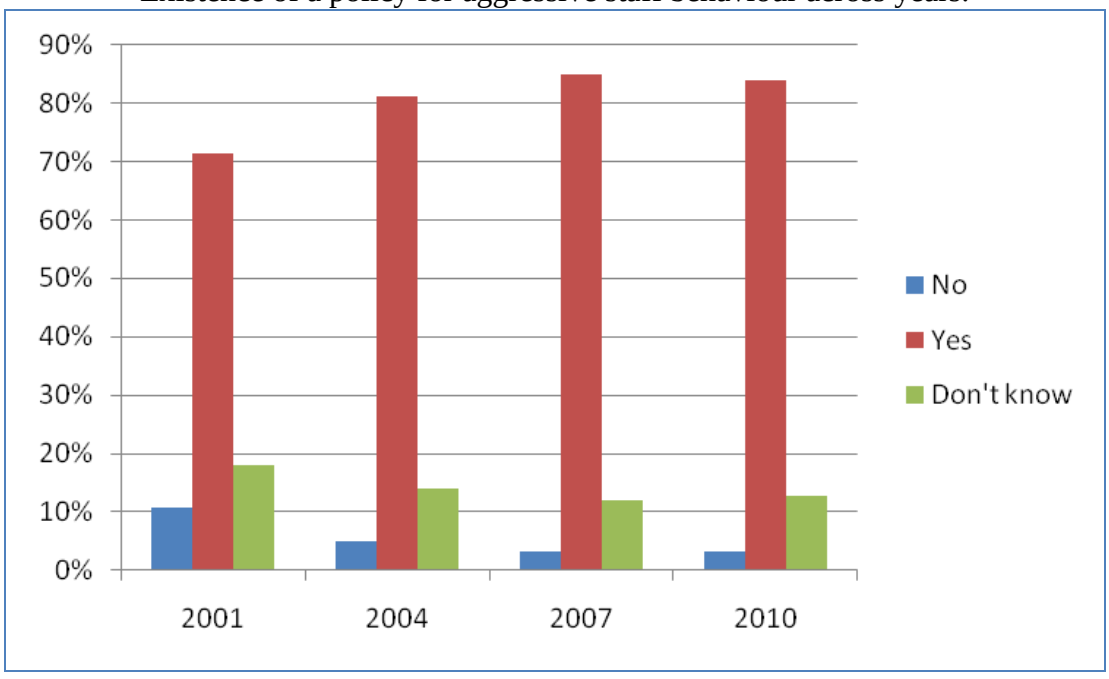
Perpetrators of violence against nurses.



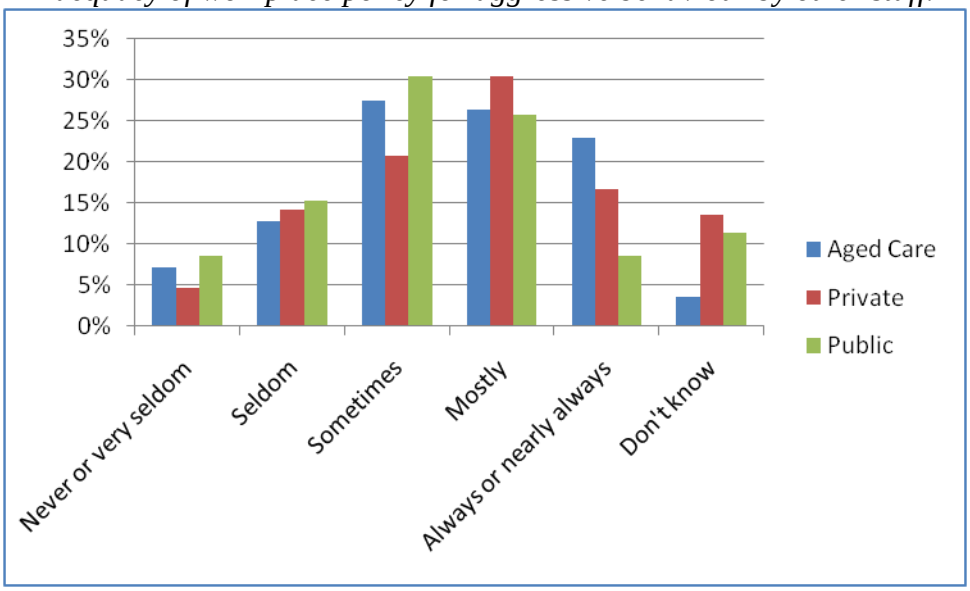
Existence and Adequacy of workplace bullying policies

Among the nurses who knew that there was a policy there were differences among sectors in whether they thought this policy was adequate. The main effect was that in the Public sector the proportion who indicated *mostly*, *always or nearly always* was lower than in the Aged care and Private sectors.

Existence of a policy for aggressive staff behaviour across years.



Adequacy of workplace policy for aggressive behaviour by other staff.



Types of bullying behaviour

Nurse-to-nurse hostility may take many forms: criticising, sabotaging, undermining, infighting blaming, scapegoating and bickering. Further, many nurses report that intrastaff aggression is more upsetting to deal with than patient assault or the aggression that they sometimes experience from colleagues from other disciplines (Farrell 1997, 1999).

Various perspectives explain the reasons for the prevalence of bullying in nursing. One explanation given by Spring and Stern (1997) suggests that nurses enter their profession after being educated as care givers. They take on the role of carer and advocate for their patients whose needs always have priority. As a result, nurses' needs are often not acknowledged. Because of their daily exposure to human illness and tragedy, nurses may become outer-focused. Spring and Stern believe that this can desensitise nurses to the effects that these daily experiences have on them. A sense of powerlessness turns into oppressed personal behaviour that is turned against colleagues. This combines with an hierarchical power structure in which the young and less experienced become the targets of bullying. Nurses themselves may maintain the status quo through denial, minimisation and ritualisation and thereby overlook the effects of bullying and abuse.

Lewis (2006) contends that bullying in nursing is essentially 'learned behaviour' within the workplace rather than any predominantly psychological deficit within individuals. While individual personality may undoubtedly play a role, in many cases, bullies learn to manipulate the workplace context and play the power game to their advantage. For example, newly employed nurses may observe and embrace the bullying behaviours of other nurses just to fit in, thus contributing to the continuation of bullying behaviour. Organisations can socialise workers into a culture that reinforces this type of behaviour as normal and hence it

goes under reported. These are complex dynamics that become problematic to deal with because often managers who have been the targets of bullying are not infrequently accused of it themselves. Added to this are the pressures of intense workloads and informal organisational alliances that can enable bullies to control work teams using emotional and psychological abuse.

Smythe (1984) suggests that the very practice of nursing care may account for conflict within nursing. Much of a nurse's work centres around rules and task/time imperatives. The patient's day is typically constructed within a linear time framework where nurses provide care according to task/time schedules. A nurse does not normally finish a shift until they have completed all assigned tasks. The time/task notion is a powerful imperative. Street (1992) notes that inexperienced nurses rapidly learn to structure their workload in terms of time-based lists of tasks in their heads. Conformity to task/time schedules within a continuous shift environment attests to a highly developed structural efficiency model of nursing that allows limited scope for individual autonomy. Hence the work practices, hierarchical structures and cultural norms can facilitate environments where conflict and bullying can occur.

In the first of a three-stage sequential, mixed-method study of bullying in the Australian nursing workforce, Hutchinson et. al. (2010) developed a typology of three predominant bullying behaviours. These included:

- Personal attack - where isolation, intimidation and degradation were used to attack the identity and self-concept of nurses;
- Erosion of professional competence and reputation - where damage to professional identity and limiting career opportunities occurred; and
- Attack through work roles and tasks - where obstructing work or making work difficult, including denial of due process and economic sanctions, were used by bullies against targets.

Gauging the effects

Clearly workplace bullying can have a major impact on morale. Hutchinson et al (2006) documented workplace bullying as lasting from six months to seven years and reported that nurses who are the targets of bullying frequently find themselves labelled as stupid or less capable. These nurses then become the focus of attention while the bully goes unnoticed. Salin (2003) observed that large organisations with formalised, lengthy decision-making processes make excellent shelters for bullies to hide or go unrecognised. Meanwhile, the victim and others may suffer isolation, fear and/or stress-related illnesses.

The first year of practice is an important confidence-building phase for nurses, yet many new graduates may be exposed to bullying that can impact negatively on the induction process. McKenna et al (2003) found that many new graduates were likely to have experienced horizontal violence and that the behaviour was prevalent across all clinical settings. Most of

the behaviour experienced was subtle and covert in nature, although direct verbal statements which were rude, abusive, humiliating or involved unjust criticism were also common.

Nurses feel at a loss when it comes to controlling the bullying behaviour of other nurses. These feelings of helplessness may lead to an increase in absenteeism, stress leave and resignations, all of which contribute to the nursing shortage and cost to the health care system (Rocker, 2008).

Promoting positive workplaces

Findings in the literature consistently underscore the priority for effective prevention programs, adequate reporting mechanisms and support services. Yet although these measures have been in place for some time in most areas in Queensland, there has been little change to the incidence of bullying.

Nurses themselves have an important role to play in preventing and correcting bullying and harassment. The problem of nurse-to-nurse bullying has gained considerable attention as health care providers struggle to recruit and retain nursing staff. As role models and creators of the work group culture, nurse leaders also have a key responsibility to implement workplace policies and programs to address bullying behaviours.

For nurses, workplace harassment and bullying are both industrial and professional matters. This type of conduct is regulated within a legislative context that requires employers to take action to prevent and address it occurring. It is also a professional matter because it calls into question ethical standards and self-regulation within the profession. Clearly, the prevalence of bullying calls for action by employers, the public, nurse managers and nurses themselves.

As a union, the QNU promotes a comprehensive education and awareness program to support greater reporting and prevention of workplace bullying. Queensland has the regulatory framework to enable these outcomes, but it does not appear to provide a sufficient enabler or deterrent. Ultimately, it comes down to whether an individual will make a complaint in the knowledge that they may experience retribution or further harassment as a consequence.

Recommendation

The challenge is to change entrenched cultures and attitudes that enable bullying in all its forms to continue. This requires an education program that promotes positive workplace cultures and provides employers with the apparatus to deal with both the perpetrator and the victim. Employers must adopt a zero tolerance to bullying and harassment through awareness programs that address all those with whom workers come in contact during the working day. For nurses this includes members of the public, other health professionals and nurses themselves. The prevention of bullying is also a community responsibility and a primary health care imperative given the estimated annual cost to the economy (Productivity

Commission, 2010)[5]. If Australians want the benefit of a world class health system, then they must treat nurses, midwives, doctors and other health carers with the respect they deserve.

The QNU recommends:

- increased community and organisational awareness of the effects of bullying through wider education and support programs and an emphasis on positive workplace cultures;
- allocation of funding across the health sector for a targeted education campaign and support programs;
- addressing the inappropriate distribution of power within the health system that exposes nurses to bullying behaviours.

[5] Using international studies as a guide, the Productivity Commission estimated of the annual cost of workplace bullying to employers and the economy in Australia ranged from $6 billion to $36 billion (in 2000).

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