

Nursing students' experiences of violence and aggression

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Nursing students' experiences of violence and aggression: A mixed-methods study

Abstract

Background

Violence and aggression cause significant problems for nursing staff and students working across healthcare.

Objectives

To identify the prevalence of aggression experienced by nursing students whilst on clinical placement in one UK city, and rates and experiences of reporting of aggression.

Design

A convergent mixed method design, with mixing occurring at the objective and inference stages.

Participants

Preregistration nursing students who had completed at least one clinical placement.

Methods

A cross-sectional survey and concurrent focus groups were conducted between May and December 2018. Students completed the 'Students' Experiences of Violence and Aggression Survey' (SEVAS) and were separately invited to participate in focus groups.

Results

There were 129 responses to the survey and 36 students participated in five focus groups. Only about a third of non-physical aggression was reported and around half of the physical aggression and sexual harassment. Very few incidents were reported to the university. Themes from the focus groups encompassed ideas of the ubiquity of violence, that students did not know what they were doing, and issues of racism, bullying, and compassion.

Conclusions

Universities have a responsibility to students; this includes preparing them adequately to manage aggression, and ensuring reporting is easy to do and adequately dealt with. A majority of students who responded to the survey had experienced non-physical aggression in the past year (81%), over half had experienced physical aggression (56%) and more than one in three had experienced sexual harassment (40%).

Introduction

Violence and aggression cause significant problems for nursing staff and students working across healthcare. Studies consistently show that whilst all healthcare staff may experience aggression, nurses are at the highest risk (Pich et al., 2010). For healthcare staff, aggressive behaviour has been linked to increased levels of burnout (de Looff et al., 2019) and absenteeism (Edward et al., 2014), as well as psychological and physical trauma (Lee et al., 2015; Speroni et al., 2014). It is estimated that 2% of staff are lost as a consequence of workplace violence leading to significant costs in recruitment (Ipsos MORI, 2010). Violence causes disruptions to patient care, with nurses losing concentration and working at reduced efficiency (Hassankhani et al., 2018) and functioning at a

heightened level of attentiveness and anxiety (Monks et al., 2013). This paper explores preregistration nursing students' experiences of violence and aggression in one large city in the United Kingdom (UK).

Background

Aggression can take many forms and be perpetrated by different people. Verbal abuse is the type of aggression most commonly experienced by nurses across all healthcare settings (Edward et al., 2014); physical assaults are most prevalent in mental health and older adult settings (Estry-Behar et al., 2008), although emergency department nursing staff also experience high levels (Gates et al., 2011). Patients are most likely to be the perpetrators of aggression, followed by patients' friends and relatives (Campbell et al., 2011). However, bullying, or horizontal aggression, usually comes from peers or colleagues, and often by people who have relative power over the victim (Ariza-Montes et al., 2013). This becomes a significant issue for students who are usually at the bottom of the pecking order.

The extent and experiences of violence and aggression towards student nurses' are less well-documented. The studies that have been conducted show high rates of verbal abuse (Hopkins et al., 2014) and bullying (Liping and Hyunli, 2017), but also physical (Bilgin et al., 2016) and sexual (Tee et al., 2016) aggression. Student nurses appear to experience aggression around the world, e.g. Australia (Hopkins et al., 2014), Egypt (Kassem, 2015), Iran (Rafati et al., 2017), Turkey (Bilgin et al., 2016), UK (Tee et al., 2016) and USA (Smith, 2016). Bullying can leave students feeling angry, anxious, and inadequate, and may cause some to consider leaving the profession (Tee et al., 2016). Furthermore, students may find it more difficult to manage patient verbal rather than physical aggression, affecting their self-esteem (Nau et al., 2007).

Underreporting is an issue in nursing. If incidents are not reported they may not be dealt with and it becomes difficult to identify particular hotspots for aggression. There is some limited evidence that student nurses do not report incidents (Tee et al., 2016), in part because students do not see any outcome to the reporting (Fathi et al., 2018). Understanding the reasons for underreporting will enable solutions to be created that address the specific barriers identified by students.

Given that aggression is experienced by healthcare staff across a range of settings, and by student nurses in various countries, it is reasonable to assume that some nursing students at UK universities also experience aggression whilst in clinical placements. Since 50% of nursing students' time is spent on clinical placement, in the UK at least, this has the potential to negatively impact the student experience.

This study aimed to identify:

- prevalence of aggression experienced by nursing students whilst on clinical placement in one large UK city,
- their experiences of aggression in clinical placement settings,
- and their rates and experiences of reporting of aggression.

Methods

Design

This study was informed by a critical realist perspective, not intending to identify generalisable laws nor identify the 'lived experience' of participants but rather to develop a deeper level of explanation and understanding (McEvoy and Richards, 2006). To this end, a concurrent mixed methods design (Creswell and Plano Clark, 2018) was used to collect cross-sectional survey and qualitative focus group

data from preregistration nursing students to provide a deep understanding of their experiences of workplace violence during clinical placements. Mixing occurred at the objective and inference stages, with separate data collection and analysis conducted concurrently, see <Figure 1. A critical realist stance was taken during the inferences stage, written within the discussion, by using methodological triangulation to address *completeness*, using the quantitative and qualitative findings to provide a level of richness not afforded by either method alone, and *confirmation*, using the focus group data to explore unanswered questions from the survey data.

<Figure 1 about here>

Setting and sample

The setting for this study was the placement circuit of two neighbouring universities in one UK city. The circuit includes a wide range of adult, mental health and child placements including inpatient settings, primary care and a range of community settings in all fields. The inclusion criteria were preregistration nursing students at one of the two universities, in any year of study and field of practice, who had completed at least one clinical placement. All eligible students were invited to participate in both elements of the study. Invited students were in years 1, 2, and 3, and in Adult, Child and Mental Health fields of practice in both universities, one had Learning Disability field of practice students as well. Data collection was undertaken between May 2018 and December 2018.

Data collection

A survey, the Student Experienced Violence and Aggression Survey (SEVAS), was developed for this study, based on the work of Hopkins et al. (2014) in Australia, and in collaboration with the first author of that study. The survey was given to members of a public engagement in nursing group for comment and was piloted with 10 students; subsequently minor amendments were made. The SEVAS comprises demographic information, followed by questions about non-physical, physical, and sexual aggression. Questions were designed to elicit prevalence, types of aggression experienced, whether it was reported and to whom, and whether time off work was required because of the aggression. Participants were given the web address of the online survey, which took approximately 10 minutes to complete. Consent was implied by the completion of the survey.

In the focus groups, all the participants chose their research names, and the resulting material was anonymised. At least one researcher facilitated group discussions using a series of open-ended questions and structured probes. The focus groups were audio-recorded and the recordings were professionally transcribed. The same set of prompt questions was used for all focus groups. Each focus group lasted approximately an hour. As the focus groups were led by staff from the universities and participants came from both those institutions, participants knew some or all of the facilitators (i.e. lecturer-student).

Data Analysis

Descriptive statistics, percentages, for the prevalence of types of aggression and rates of reporting from the SEVAS were calculated. There were only 19 qualitative responses to questions about whether students felt that their reporting had been dealt with adequately, and so a narrative summary of these responses is given.

The focus groups were recorded, transcribed, and thematically analysed using an Interpretative Phenomenological Analysis (IPA) methodology. The audio recordings were listened to on several occasions which stimulated notes about emergent themes. Subsequently, transcripts were read and greater clarity was formed about the possible themes, and transcripts were phenomenologically coded. Codes were clustered and interpretative themes were generated from the codes and text;

subsequently, these themes were dialectically related to excerpts of the text in a cyclical process. The process of data analysis was as reflective as possible and included interpretation from the researchers upon the emergent themes (Wagstaff et al., 2018).

Ethical considerations

Ethical approval was granted by both university ethics committees for the survey and focus groups separately. Prospective participants were allowed to contact the research team with questions about the research. Survey participants were informed that they had the right to choose not to participate, but that once they had completed the online survey it would not be possible to withdraw as the surveys were anonymous. In case students experienced negative thoughts or feelings following completion of the survey, contact details of student counselling services were provided. Focus group participants were guaranteed confidentiality and anonymity within any future published work. They were informed that they were free to withdraw at any point, even after the focus group had started and that once recording had started they would be free to leave, but that we would be unable to remove their data from the transcript. Following the focus groups, students were offered the option to talk confidentially about issues that they raised.

Results

Participant characteristics

All pre-registration nursing students at the universities, approximately 390 (UoB) and 1530 (BCU) were invited to complete the survey, and 129 surveys were returned, giving an approximate response rate of 7.5%. Participants were predominantly in year three (47%), female (93%), aged 19-24 (65%), and described themselves as white (73%), see <Table 1.

<Table 1 about here>

Five focus groups were held. There were 36 participants across the groups of whom 32 were female. The three participants of the final focus group (FG5) were all male, older, mental health student nurses, and of African descent. The participants in the other focus groups were all under 30, from a mixture of ethnic backgrounds, and were adult, child, and mental health nurses. One of the institutions offers learning disability nursing but no students from that field participated.

Survey findings

A majority of students who responded to the survey had experienced non-physical aggression in the past year (81%) (<Table 2). Patients were the most likely source of all types of aggression, although patients' visitors were a common source of non-physical aggression. The students who identified the source of non-physical aggression as colleagues experienced shouting, intimidation, and bullying. The types of physical aggression students experienced included punching, kicking, grabbing, having objects thrown, and spitting. Fifteen students had been injured by the physical aggression, and of these two needed time off due to the injury. Students reported frequent sexual comments from patients (n=46), and unwanted sexual looks or gestures (n=28). Twenty students also experienced unwanted deliberate touching, whilst four said they were given unwanted materials of a sexual nature.

<Table 2 about here>

Only about a third of non-physical aggression was reported and around half of the physical aggression and sexual harassment. Most aggression was reported to mentors (non-physical 34 [87%], physical 31 [91%], sexual 25 [93%]), and some via hospital trust reporting systems (non-

physical 7 [18%], physical 10 [29%], sexual 5 [19%]). Only four incidents were reported to the university, and four to clinical and academic liaison staff.

A majority of students felt that their reporting was dealt with appropriately; however, a significant minority did not. Of the nineteen students who responded to this question, nine felt that nothing was done as a result of their report and a further six felt that the behaviour was normalised. This was especially true for incidents of a sexual nature, which appeared to be the norm on some wards, with one student saying that they 'laughed it off' with their mentor. However, one student appeared to find the normalisation of sexually inappropriate behaviour particularly difficult, writing 'Not sure if the problem was me'.

Focus group findings

There were multiple themes from the focus groups, all reflecting the pervasiveness of experiences of violence and aggression on clinical placement: ubiquitous; 'You don't know what you are doing'; 'Deal with it yourself'; racism; bullying; and compassion. Additionally, across all these themes there is a sense that the student nurses were being indoctrinated to the profession, by copying the behaviours of more experienced and accepting that reporting verbal aggression is not what students do.

The following quote cuts across themes of nothing being done in response to a report of racism, being compassionate to patients, acceptance of verbal aggression as part of the nursing indoctrination process, and racism being part of working life. But simultaneously the compassion that the student nurses have towards their patients is also evident:

Pierre (FG5):... So it is an ongoing thing that he is always racist or hostile and inferior to our standards'... It's inevitable, you get used to it so it's one of those things. So, yeah, we don't take offence of it. Go away, we should be compassionate towards them.

Ubiquitous

One theme that was apparent from the analysis of the transcripts was just how ubiquitous violence and aggression was in the students' experiences of clinical placements. All the participants and their friends had seemingly experienced or witnessed violence, aggression, and/or abuse. For example,

Christina (FG2): Quite a few of my friends, as well as myself, have experienced many of the forms of abuse... We've experienced physical abuse, physical harassment, and sexual abuse as well as bullying on placement.

It should, however, be noted in our sample that the physical abuse and harassment was from patients towards the students, but the sexual abuse and the bullying were from staff. It appears that because of the ubiquitous nature of the harassment and abuses, students do not feel that they should report the incidents.

'You don't know what you are doing.'

A theme that was generated from the analysis of the transcripts was the extent to which students are put in situations that they felt were beyond them, but they coped. The students had a perception of the level of support and training that should be offered, whether that be by university or placement, but is lacking.

Fran (FG1): That was me, first day, first placement, I was there for six hours with a confused patient and I didn't know what I was doing... It is scary. Because you don't know what you are doing.

There is a dichotomous point to be made. On the one hand, the students consistently reported that they felt out of their depth and did not know what they were doing, whilst simultaneously surviving and coping. What was also unclear from the participants was whom the students felt should take responsibility for making them feel prepared; their universities, the placement or some other source.

'Deal with it yourself'

One of the aims of this study was to gauge to what extent aggression and violence are reported; students stated that verbal aggression was not reported. Furthermore, it would appear that placement support teams did not encourage students to report verbal aggression. It is viewed by the nursing team as part of the job and the participants quickly learnt this lesson.

Hilda (FG1): I think in mental health it's working standard, it's weird if you go a shift without somebody swearing at you or there's some sort of threat, it's just sort of taken as normal... You sort of learn to deal with it, it's just part of your role, I don't know, you kind of accept it.

Even when students did report incidents, there was a feeling that nothing would be done.

Hilda (FG1): No, I've had to report a few things and nothing's ever been followed up... I know there are a couple of things that haven't been followed up that should have been.

This is exemplified by one student who joined the focus group because of an incident that had happened on placement, and that she had not spoken to anyone about. It had been causing her distress, but she had not found an outlet for her distress. None of the focus group participants reported satisfactory or meaningful outcomes following the reporting of an incident.

Racism

No matter what the ethnic background of the participant they were all aware of the racism that was part of the working lives of nurses:

Fran (FG1): ...you hear like some particularly much, much older patients and they can be quite offensive to people's race... a lot of international members of staff at the hospital and the way they speak to some of them is absolutely disgusting... they sort of almost imply they are not doing as good a job but they are doing exactly the same job like it makes no difference.

The racism experienced directly by the students was verbal, though they had been told of violence towards staff that had a racial undercurrent. Similarly, all the racism that was reported by the participants was from patients to staff, there were no reports of racism by other members of staff. Pamela (FG4) exemplified the seriousness of racist abuse experienced by black student nurses, when she witnessed a patient shouting 'black offensive language' at a porter who later warned the student that the patient 'doesn't seem to like the likes of us so be careful'.

Bullying

Amongst the verbal aggression that the participants reported from their placements, it was clear that bullying happens. Jane (FG4) described what happened when she asked the ward manager to explain the ward off duty to her:

Jane (FG4): ...she [ward manager] dragged me away... she was like, 'Instead of spying on me and doing, instead of spying on me and criticising what I do, you can go and do what you're paid to learn for' and she was, I was only there for four weeks cause then she horrible every other day.

The majority of the bullying seemed to be from qualified staff to students, but there was other bullying too.

The participants had witnessed nurses bullying each other, and doctors bullying nurses. One participant described a lecturer she knew coming onto the ward as a patient, being publically verbally aggressive towards (including having her removed from the course) and reducing the student to tears. Within the same city, there are students from different universities sharing the placement circuit, and the participants reported that there was verbal aggression from students from one university to students from another which were not viewed as competitiveness between universities but as bullying.

Compassion

Despite the challenging behaviour from patients, the participants were compassionate towards their patients and separated the illness related behaviour from the person. A common theme that ran through the focus groups was that the patient was always right, with mental illness, including dementia, was seen as an excuse for aggression or violence. The compassion and genuine warmth towards the patients, despite their behaviour, is evident.

Georgia (FG1): *I know when you got scratched in your first ever placement, do you remember?* [Hilda: yeah, that was fun] *and that was the dementia lady, the first-ever placement and you were like, what?! She was scratched to pieces by this lady that had dementia.* Hilda: *She was really lovely though!!* [they laugh].

There also seems to be a personal/professional divide, i.e. because they are at work their professionalism determines that they should excuse the behaviour. Age was also deemed to be a reason to excuse behaviour, in the sense that behaviour that would not be acceptable from a younger person was excused when the person was older. Although none of the students openly expressed why they demonstrated this nuanced compassionate behaviour, it may well be because of the compassionate ideals that lead them to the profession, coupled with modelling the behaviour of their more experienced colleagues.

Discussion

The majority of student nurses in our study experienced violence and aggression on clinical placements, and whilst they often didn't report it, they appear resilient to the potentially negative impacts. On the one hand, it is worrying that students appear to be going into clinical areas feeling woefully underprepared yet, simultaneously, the students cope. They have the resilience, they have the skills.

Most students in our study had experienced verbal aggression and one in three had been harassed sexually. . These are in the range of prevalence rates identified by similar recent studies within Anglo region countries (Australia, Canada, New Zealand, United Kingdom, United States of America) (Globe Project, 2020). The prevalence of non-physical violence is 28% to 99% (Hopkins et al., 2014; Tee et al., 2016), whilst for sexual aggression it is 9% to 42% (Budden et al., 2017; Tee et al., 2016). It is likely that the wide range is partly due to definitions of aggression, which vary between studies, and that the reality is somewhere in the middle. The noticeable difference was in the prevalence of

physical violence which ranges from 8% to 42% in recent Anglo region studies (Clarke et al., 2012; O'Connell et al., 2017) compared with over half of participants in the current study. It may be that the placement circuit from this study is particularly dangerous, it could be that participation was more likely for students who had experienced physical aggression or again it could be related to definitions of physical aggression, which were purposefully broad in this study.

We found that most aggression was perpetrated by patients. Patients, followed by their friends and relatives, are also most likely to be the perpetrators of aggression towards nurses (Spector et al., 2014). For many of the students in this study, there appeared to be a culture of acceptance, particularly for verbal and often sexual aggression, and especially in mental health services. However, it could be argued that by not responding to, let alone reporting aggression, that this culture is part of the nurse indoctrination process; presumably when the students are qualified they will perpetuate this acceptance. This appears to be an issue for nursing globally; nurses have become so desensitised to violence that it is now an expected and accepted 'occupational hazards' of the job (Pich and Roche, 2020).

The negative effects that aggression can have both psychologically and physically for staff and patients suggest that training should focus on preventing all types of aggression. It is a requirement that all frontline staff working in mental health have training in the prevention and management of violence and aggression (PMVA), and this is mandated in UK guidelines (Ridley and Leitch, 2019). However, whether students consistently receive such training, particularly in non-mental health settings, is unclear. Training pre-registration nursing students in PMVA likely has a positive effect on their confidence. Online training (Brann and Hartley, 2017) and simulation (Martinez, 2017) have demonstrated increased knowledge and confidence for students managing workplace violence. De-escalation is an important element of violence prevention (Hallett and Dickens, 2017), and teaching students de-escalation skills seems to create a demonstrable improvement in the skills students exhibit (Nau et al., 2010). It is possible that the universities attended by the students in this study provide a good foundation in PMVA training, and that this is the reason for the resilience demonstrated. However, aside from the participants in focus group 5, we did not have information about whether the students were or had worked previously in healthcare settings nor about any external training they may have participated in.

Training may help students to manage workplace violence, and potentially the negative after-effects, when it comes from patients but when it comes from colleagues it may be more difficult to manage and have a greater impact. A significant minority of survey participants experienced verbal aggression from colleagues, and students in most of the focus groups reported bullying. However, in FG5 where they were all male, older, mental health nurses, and of African descent, they did not report any bullying. Bullying in nursing is widespread and well-documented (Wilson, 2016), and there is much evidence for the idea that nurses 'eat their young', i.e. that newly qualified nurses experience bullying at greater rates than their more experienced counterparts (Kang and Lee, 2016a). Improving student resilience is one way that universities can help to prepare students (Sidhu and Park, 2018), but this will address the symptom rather than the root cause. Clinical settings that are supportive and that have strong leadership tend to have lower levels of bullying (Kang and Lee, 2016b). Organisational change may be required to change the culture of bullying that occurs in some settings at least. Universities can respond by proactively teaching leadership, to create the leaders of the future.

In line with previous research, a majority of incidents appear to go unreported, and of those that are reported, a significant minority were not dealt with adequately. What is more concerning is that almost none of the incidents were reported to the university. Students may not always know the

outcome of an incident they report to a clinical setting; they are there for a relatively short time and may leave before the outcome is known. However, if universities are aware of incidents and utilise the people who provide the bridge between clinical and academic settings, then students are more likely to find out what has happened in response to their report. Furthermore, if universities are unaware of incidents that could have long-term impacts on students, they are not able to provide the necessary support.

Strengths and limitations

Few studies have used mixed methods to explore nursing students' experiences of aggression in clinical settings; this methodology allowed integration of survey data from a relatively large number of students to be combined with the richer data provided by the focus groups, thus enhancing our understanding of the phenomenon. Methodological triangulation increases the credibility of the findings. However, there are several limitations. All the students were training in a single UK city, and whilst there are high levels of diversity within the city and students experience a wide range of placement settings, the findings may not be reflective of all students' experiences. Furthermore, only a small proportion of the total student population participated. There is a risk that we could have over-estimated the prevalence as people who have experienced aggression may have been more likely to participate.

Conclusion

Nursing students, as with nurses, appear to experience a variety of aggression from various sources during clinical placements. Further research into the long term outcomes and effects would be useful, for example, does aggression affect students' rates of attrition, does it affect where students choose to work once registered? Furthermore, issues around reporting need to be addressed in both clinical and academic settings. Universities have a responsibility to students; this includes preparing them adequately to manage aggression and ensuring reporting is easy to do and adequately dealt with.

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