Nurses and Midwives: Towards a Safer Culture (TASC) Strategy Evaluation

Final Report October 2021

Policy Design and Evaluation Team

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We wish to acknowledge the Traditional Custodians of the ACT, the Ngunnawal People. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Policy Design and
Evaluation Team

Executive Summary

Occupational violence (OV) is a serious issue for health care workers worldwide, with health care consistently rating as one of the most dangerous industries.[1-7]

Nurses and midwives are the largest group of health professionals in Australia.[8] Operating at the front line of service delivery, often under stressful conditions, they are particularly vulnerable to becoming victims of OV, bullying and harassment.

Research from Australia and overseas indicates that the proportion of hospital nurses experiencing one form of violence or another during any given year may be as high as 95 per cent,[9] and of those who experience violence, the majority consider leaving their work.[3,9-12]

Underreporting of incidents is a well-known issue,[13,14] and may occur due to a lack of time or the absence of suitable mechanisms, but also because health care staff self-censor for a variety of reasons.[15]

The international literature also notes the widespread problem of 'organisational silence' or a 'culture of silence' around OV and related issues, including bullying and harassment by clients and around lateral violence within the workforce itself.[15-19]

> The root causes of, and potential solutions to address OV and bullying and harassment in the workplace are a matter of ongoing research and debate.

In order to help address these serious issues the ACT Government launched its ambitious *Nurses and Midwives: Towards A Safer Culture* (TASC) Strategy in late 2018.[20]

The Strategy sought to attack the problem on multiple fronts using 22 Priority Actions – the implicit assumption being that these actions would cumulatively work towards the desired impact of reducing OV, bullying and/or harassment.

Figure ES1 Word cloud based on all TASC project documents

Evaluation methods and limitations

ACT Health Directorate (ACTHD) requested the Policy Design and Evaluation (PDE) team undertake an evaluation of the Strategy in March 2021. A rapid evaluation approach with *process*, *implementation* and *impact* evaluation components was developed, including:

- An internal survey of nurses and midwives (n = 293),
- An external survey to gauge community recognition and attitudes (n = 653),
- Interviews of key stakeholders (n = 15), and
- Literature review and document analysis.

Three issues or facts impinged critically upon the evaluation of the Strategy:

- The Strategy was launched at a time when major organisational change was occurring with the separation of Canberra Health Services (CHS) and a repositioning of the role of the ACT Health Directorate (ACTHD) – *process* issue,
- It entered a 'field of play' that features a range of thematically linked strategies and initiatives – *attribution* and *alignment* issues, and
- Consistent, agreed baseline comparison data and definitions do not currently exist – *measurement* issue.

Key findings

The evaluation finds that the TASC Strategy made an important contribution to maintaining focus on OV – in particular through its coordination efforts, by raising awareness among staff and in the community, by delivering tools, and via its Safewards pilot project.

Figure ES2: Interviewees agreement with statements ('agree' or 'strongly agree')

There are positive signs based on credible indicators that the range of interventions and efforts are collectively generating:

> Significant levels of awareness of OV issues, both in the community and among the health workforce, and
> Improved incident reporting based on RiskMan data.

The 15 key stakeholders interviewed for this evaluation overwhelmingly agreed that the Strategy was filling a gap with regards to OV, and that the Strategy was meeting expectations (see Figure ES2 above).

The external survey also revealed the wider community strongly supports initiatives to address OV against nurses and midwives, and that:

> Nearly 1 in 5 Canberrans have witnessed an incident of violence towards a nurse or midwife,
> 1 in 6 noticed the "Be kind and respectful to our nurses and midwives" media campaign (hereafter referred to as the "Be kind" campaign),
> Almost all Canberrans agree this is a worthwhile campaign and the message should be promoted more widely,
> Close to 70 per cent of survey participants think that the campaign has potential to reduce violence towards nurses and midwives, and
  - 73 per cent also said it made them think differently about OV faced by nurses and midwives, and
  - Around a third also said it made them feel differently, has an impact on them personally, and would make them behave differently in a health care setting.

The internal survey of 293 nurses and midwives in the ACT health sector revealed that the majority of nurses and midwives had heard of the TASC Strategy (57 per cent), rising to 73 per cent who were aware of the "Be kind" campaign which was part of the strategy.

> During interviews, nurses and midwives also stated that they had "felt heard", which is a positive outcome associated with <u>all</u> of the effort that has been put into this area over the last 2-3 years (not just the TASC Strategy).

Forty per cent of respondents to the internal survey also agreed action on OV, bullying and harassment had made a difference to their work environment. The internal survey also yielded some baseline data which gives an insight into the real-life experience of OV, bullying and harassment by nurses and midwives in the ACT:

> 2 out of 3 had experienced some form of OV, bullying or harassment during the last twelve months, and
> Around half considered leaving their job as a result of this during the last year.

These findings are entirely plausible and in line with the results discussed in the literature review. These baseline figures cannot reveal the impacts of the TASC Strategy to date but if

initiatives have an impact, these numbers should change over time and will inform future discussions. At the same time, it is heartening to learn that the majority of respondents said OV is being discussed in their teams, for example at team meetings, and with managers.

Process and implementation evaluation

The interviews, surveys and document analysis convinced the evaluation team that overall, the processes underpinning the delivery of the Strategy were sound, and included:

> A clear need and Vision to ensure processes are well motivated,
> A capable project team and stable implementation for the last two years,
> Appropriate project governance, and
> Good collaboration across the health sector partners (CHS, ACTHD and Calvary).

Two 'Scorecards' were prepared by the evaluation team, one on the basis of the broad Strategy document itself, and another one for the more specific work plan, showing that:

> 15 out of 22 Priority Actions were 'fully' achieved (68 per cent),
> 7 out of 22 Priority Actions were 'partially' achieved (32 per cent), and
> None were 'not achieved'.

A sentiment analysis of interview transcripts found that most of the references to the TASC Strategy provided by the interviewees were predominantly positive (a 2:1 'win' overall).

Analysis of safety perceptions

A regression analysis of factors that were positively or negatively associated with nurses' and midwives' safety perceptions revealed the following statistically significant relationships – the results suggest that survey respondents felt safer at work if they:

> Mainly spoke English at home,
> Were aware of the "Violence Screening Tool Guidelines",
> Were aware of the "Be kind to our nurses or midwives" campaign,
> Have had conversations about OV with their manager, and
> Perceived that their organisation has strong leadership in relation to OV.

These point to potential areas for additional effort (e.g., to support nurses from culturally and linguistically diverse backgrounds). On the other hand, negatively associated with perceptions of safety were, most importantly:

> If workers had experienced non-physical violence on the job, and
> They had experienced violence/bullying emanating from co-workers.

Nurses and midwives, especially those with longer experience on the job, are aware of situations in which they may experience forms of OV from patients and families and may see some of this as unavoidable (e.g., due to the nature of a patient's clinical presentation):

- These findings however reinforce the importance that addressing challenging behaviours from co-workers and managers has in driving perceptions of workplace safety.

Overall, a perception of strong leadership on OV was the most influential determinant of feelings of safety at work, probably due to feeling supported at work when encountering OV.

Gaps, opportunities and recommendations

The four Pillars for the Strategy were based on broad areas for action and implementation. For the next stage, it is recommended that assumptions about the underlying *Theory of Change* be made explicit.

This should help clarify the foundational role that general working conditions and workload management have in driving progress towards a safer culture and safer workplaces, as noted in this report and as supported by the ongoing work on implementing nurse ratios.

Making the *Theory of Change* explicit could also lead to consideration of other potential pillars such as:

- A Pillar with an offender/perpetrator focus,
- A Pillar based on recruitment and promotion strategies and pathways, and
- A Pillar on wider system drivers and engagement, e.g., Domestic Family Violence (DFV) or broader economic drivers.

Opportunities and recommendations to strengthen the Strategy were also identified:

- Additional staff engagement activities are required,
- Clinical leadership needs to be further progressed,
- Ongoing commitment to data collection and analysis processes,
- Increased OV visibility necessitates a long-term commitment to organizational change, and these activities should be continued,
- Civility Index measurement will need to be a focus for the next work program under TASC or another strategic process, and
- Embedding safe design is another long-term strategy and needs to be followed-up regularly to monitor progress.

Next steps should be carefully planned, and any future strategy's remit should be clearly outlined when setting up the governance structure for further work, to avoid issues with overlapping areas of activity or programs.

Finally, and perhaps most importantly, the evaluation team recommends that the impact evaluation baseline (IEB) measures developed for this report be collected again after a suitable period of time has elapsed, noting that culture change takes time – otherwise, there is no way of knowing whether our collective efforts are having the desired impact.

Introduction

Occupational violence (OV), also referred to as workplace violence, is a global problem confronting all health care workers. It is a major focus for organisations involved in the delivery of health services, as they strive to provide for the health and safety of workers within diverse and dynamic workplace environments.

In the provision of public healthcare in the ACT, ACT Health Directorate (ACTHD), Canberra Health Services (CHS), including the University of Canberra Hospital (UCH) and Calvary Public Hospital Bruce (Calvary) are all committed to, and implementing various initiatives and strategies, to improve workplace safety and continued compliance with their legislated responsibility to protect workers and others from harm.

> Under the *Work Health Safety Act 2011* (ACT), all reasonably practicable steps must be taken to protect workers through the elimination or minimisation of risks related to work practices.

In 2016, the Australian Nursing and Midwifery Federation (ANMF) ACT Branch advocated for a broad reaching, in-depth review of workplace safety, including a review of OV and aggression (OVA), challenging occupational behaviours and safe workplace practices to improve the safety of nurses and midwives. In the same year, a commitment to developing the strategy was made in the Parliamentary Agreement for the 9th Legislative Assembly for the Australian Capital Territory.

ACT Health subsequently developed the TASC Strategy to support the fundamental rights of nurses and midwives working in ACT public health services to be safe and protected in their workplaces.

The purpose of the Strategy is to provide a safe and healthy environment for staff and all persons who enter workplaces where ACT public health services are delivered. The Strategy outlines a vision where staff, patients and visitors to ACT public health services are protected from harm and always feel safe.

> This work is led by ACT Health and also encompasses Canberra Health Services (CHS), the University of Canberra Hospital (UCH), and Calvary Public Hospital Bruce.

In late 2017, consultations with nurses and midwives were independently facilitated to inform the development of a discussion paper. Consultation identified the recognition and mitigation of workplace risks, adequate resource allocation, safety benchmarks, workplace design, policy, and education as factors needing to be addressed.

Further consultation was held around the discussion paper, before ACT Health developed this Strategy which outlines recommendations to prevent, reduce and manage the exposure of ACT nurses and midwives to OV and other risks in their working environments.

The TASC Strategy was developed over the course of 2016 and 2017 and published in 2018 with a goal of implementing the relevant Priority Actions by 2022.

The range of Priority Actions cover a number of important issues with regards to OV and other challenging behaviours over four domains:

> *Organisation-Wide:* The development of organisation-wide initiatives to review strengthen governance and workplace risk strategies including identification, minimisation, prevention and reporting of risks with the ultimate goal to promote a workplace culture of respect and staff empowerment;
> *Occupational Violence and Aggression:* Implement a program of activities to develop and implement an OV management plan, including standards, guidelines and education; in addition, further the development of a community, consumer and carer information campaign.
> *Challenging Occupational Behaviours:* This suite of activities was aimed at strengthening bullying and harassment prevention and management guidelines, improve leadership and develop and implement workplace civility measuring and management guidelines;
> *Safe Work Practices:* Embed best practice guidelines in the development of safe work practices, to continue to pursue safe workplace design principles in new builds and redevelopment of workplaces.

Since the TASC Strategy includes an ambitious program of implementation activities, it is important to consider the evidence and theoretical foundations ACT Health has applied to effect change across the ACT Health Public Health system.

Theory of Change

While an extensive literature review was referred in the Discussion Paper document that was released with the Strategy, the TASC Strategy itself did not elaborate a specific *Theory of Change*, which would broadly link the actions to the intended outcomes.

Part of the reasons for this, as the literature review below demonstrates, is that a *multitude* of factors play a role in determining the key outcome of *safety*, with multiple theories and no single 'pathway to safety' agreed in the literature.

> The causes and effects of OV, bullying and harassment are complex and are currently not fully understood – research is underway across a range of relevant subject areas worldwide to understand the types of interventions that might work and why.

As stated in the Executive Summary, the Strategy sought to attack the problem on multiple fronts using 22 Priority Actions – the implicit assumption being that these actions would cumulatively work towards the desired impact of reducing OV, bullying and/or harassment.

At a broad level, one can categorise relevant existing theories around the genesis of violence, aggression and challenging behaviours as shown in Figure 1 below. Possible interventions can also be situated with reference to this framing of the issues.

Figure 1 Levels of change and associated theoretical models

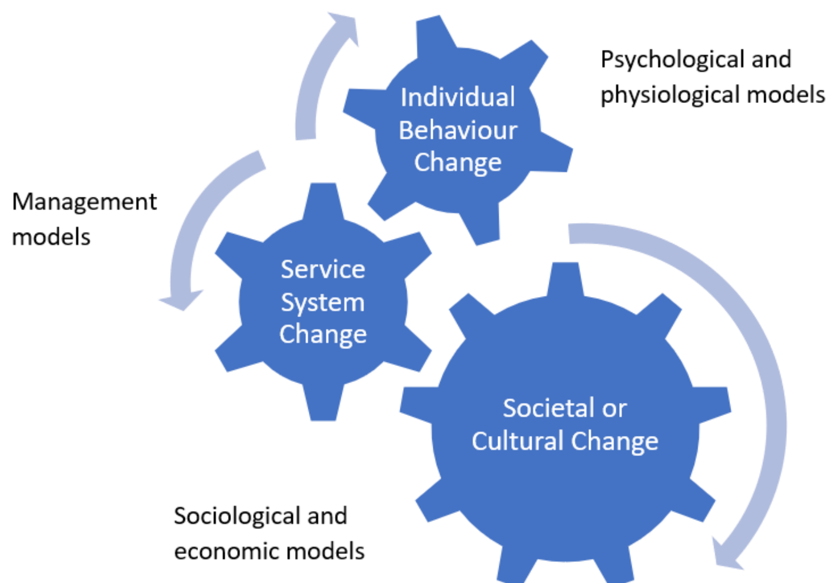
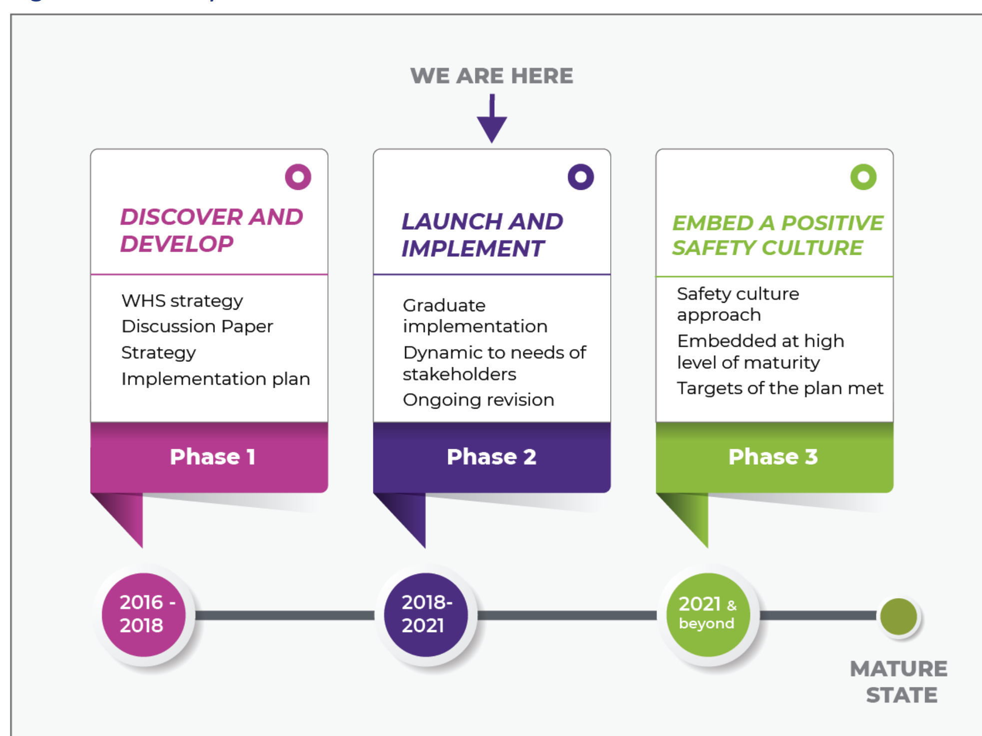


Figure 1 indicates that the levels of change required to drive overall cultural change in any workplace scenario will be interlinked with a range of potential drivers. Unlike material culture (technology, etc.), the literature also suggests that nonmaterial culture (beliefs, norms, and behaviours) can take a long time to change. It is thus appropriate that the TASC Strategy was subtitled 'The First Step', and that its current status is seen as still being in the "launch and implement" phase.

Figure 2 Maturity model – from 'discover' to 'embed'



It is worthwhile examining just one plausible 'chain of causality' and to consider the factors that would determine overall success of an intervention (and, by extension, any strategy that consists of multiple interventions):

1. **Circumstances** (e.g., adequate staffing levels, not a crisis scenario) plus
2. **Identity** (e.g., "I am a nurse" with positive assumptions about role and status) plus
3. **Awareness** (e.g., "I am experiencing occupational violence") plus
4. **Knowledge** (e.g., "I have rights; I can report this") plus
5. **Attitudes** (e.g., "I *should* report this") plus
6. **Skills & Capacity** (having time to report and access to reporting mechanisms) plus
7. **Behaviour** (actual reporting) plus
8. **Managerial Response** (support for victims) plus
9. **Enforcement** (consequences for offenders) plus
10. **Leadership** and **Communication** (everyone must know there is support available and that there are consequences).

This makes clear that changes in links along the chain will not necessarily ensure that broader evidence of a safer culture will emerge – in other words, necessary but not sufficient conditions for broader change.

As an example, awareness may increase, but behaviour stay the same. Similarly, poor enforcement may shape perceptions about how serious an organisation is about change, and this may feed back into nurses' sense of identity and attitudes.

The exercise also reveals that the *sequencing* of interventions may be important, as culture change cannot be achieved through a top-down mandate. Some things need to change first – on the ground – before others can be attained.

Circumstances in particular are foundational. If health professionals are routinely operating under stressed conditions, it is easy to see how a 'toxic' workplace culture can emerge and/or be very difficult to reverse.

- The interviews carried out for this evaluation highlighted that nurses want to be able to spend time providing quality care to their patients; conversely not being able to do so was identified as a key factor that drives low morale and unhappiness on the job.
  - This strongly supports the inclusion of work on staffing ratios as part of the TASC Strategy.

Finally, it is worthwhile noting that possible pathways towards a safer culture include a mixture of *deterrence* and *rewards*.

- Modelling good behaviours at all levels of leadership – within the organisation, the wards and the teams, is important to changing workplace culture, and
- Strategies around recruitment and promotions are critical to putting the right leaders into the right positions.

Literature review

To inform this report, the evaluation team undertook a rapid literature review, yielding the key topics and findings outlined in this section.

While a literature review had previously also been carried out by the TASC project team, this review was largely for the benefit of the evaluation team's understanding of the subject area, and to confirm the evidence base for the TASC Strategy Priority Actions.

The desktop review unearthed the excellent 'Study Report' entitled *Violence in Nursing and Midwifery in NSW* by Dr Jacqui Pich (2019).[21] Some of the discussion in this section follows the structure of Dr Pich's report, of which short, referenced extracts are also included.

A second important source document containing a summary of the early literature is the *State of the Art* paper on workplace violence in the health sector by Cooper and Swanson (2002),[22] passages of which are also cited.

Historical context

The issue of OV has grown in prominence since the late 1980s. As Cooper and Swanson note, there was a "growing realization that violence was becoming a common reality in many workplaces the world over".[22]

This realisation spurred research activity and led to an increase in published guidance at national and occupational levels.[22] Phil Leather, writing in Section 1 of Cooper and Swanson's paper, claimed that:

> *Indeed, in the eyes of many commentators, the issue of occupational violence has risen to the point where, in many countries, it represents a "national epidemic" and "an occupational health problem of significant proportion".*[22,23]

Internationally and nationally, a significant problem impacting at all levels of analysis is the lack of a consistent definition of OV.

- At one end of the spectrum are those who advocate a restricted focus upon actual or attempted physical assault, while at the other are those who define it as any form of behaviour that is intended to harm current or previous co-workers, or their organization.

To fully capture the scope and consequences of workplace violence, a broad rather than a restrictive definition such as the one provided by the World Health Organisation (WHO) is needed:

> *The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.*[24]

A broad definition allows for the full range of circumstances in which a worker might be attacked while in the workplace, while at work or on duty, or in any other circumstances

related to their job. A broad definition also gives due recognition to both psychological as well as physical violence and harm.

> It should be noted that official definitions used in workplace health and safety (WHS) may be narrower than this, with a distinction often made between OV from clients and peer-to-peer bullying and harassment.

Definition of occupational violence

There are many definitions of workplace violence, but one in relation to the nursing sector has been issued by the International Council of Nurses, stating that it includes "all forms of abuse and violence against nursing personnel".[25]

As discussed further below, the relevant academic literature is notable for the variability in definitions of violence and aggression, and the differing methodological approaches used to study the phenomena.

> Few large-scale longitudinal studies have adequately described the scope of OV in the context of nursing practice beyond the speciality of psychiatry. This knowledge gap limits the development of an effective means of reducing OV within the context of Australian nursing practice.[26]

In the ACT Government context, OV is defined as any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed or injured in the course of, or as a direct result of, his or her work.[27]

> This definition is in line with the International Labour Organisation's *Code of Practice on Workplace Violence* and includes personal intimidation, verbal abuse, physical assault, sexual harassment, threatening behaviour, abuse through technology (text, emails, and phone calls), making vexatious complaints, and making derogatory, slanderous or threatening statements to or about another person.[27]

Other research suggests that the health sector is one of the most hazardous workplace settings in most countries, and that nurses are disproportionately affected, especially in settings such emergency wards, aged care and mental health wards.[28]

While there have been suggestions that the frequency of incidents may be on the increase, underreporting and unreliable data renders verification across the health system difficult.[29] When it is reported, patients and their families or carers have been the most common source of OV.[30]

Types of violence

Violence covers several behaviours ranging from verbal threats through to physical violence and sexual assault. Several sections below closely follow the discussion by Pich (2019).[21]

Verbal abuse

Verbal threats have been identified in the literature as the most commonly occurring form of violence, with estimates that up to 100 per cent of nurses affected in some locations.[21,31]

- Swearing is the most frequent form of verbal threat[32] but other forms of verbal abuse include threats of complaints and legal actions, threats of violent actions and questioning professional abilities.[33] These actions do not necessarily have to occur in person; they can also manifest over the phone or on social media as well as both during and outside of working hours.[34]

Hostility

While the relevant literature and evidence-base frequently distinguishes between verbal threats and physical violence, "hostility" is also a form of personal interaction that can constitute OV in cases of glaring at nurses, pacing in proximity or rolling eyes when talking to staff.[33]

Physical violence

As opposed to verbal abuse and hostility, physical violence includes both intentional physical harm and attacks from patients with limited cognitive abilities (e.g. dementia patients).[35] The attacks do not necessarily have to lead to injuries to be classified as physical violence. In most cases, several forms of violence can occur concurrently.[36] This reporting category also includes sexual assault.

Consequences of episodes of violence

Personal consequences

Consequences of OV can be devastating and have psychological, physical and professional consequences for nurses and midwives. Verbal abuse can cause psychological trauma and stress to nurses, even if no physical effects have resulted from the incident.[37]

Patient care consequences

Especially patient-related OV can have impacts on nurse – patient interactions, which are not necessarily related to the same staff member and patient; team members and future patients may be impacted as a result. This may include a modified interaction pattern with patients and feelings of detachment.

Healthcare system costs

The impact of OV in care settings also cost the healthcare system overall in terms of turnover intentions and attrition,[38] personal leave, decreased levels of productivity and worker compensation claims.[39]

Antecedents of patient-driven violence

A review of the literature suggests that there are several "risk factors" that help to understand incidents of OV.

Patient characteristics

Some patient characteristics indicate which patients and families are more likely to commit OV against nursing and midwifery staff. The two most common patient characteristics are a history of violence and clinical presentation.

History of violence

The most predictive risk factor for violent or threatening behaviour is reported to be past violence.[40] This includes any violence the offending person has experienced themselves.[41]

Clinical presentation

While data and reporting can be unreliable, as discussed, frequent antecedents of OV towards nurses include mental-health related incidents, alcohol-related incidents, and drug-related incidents,[42] with these groups increasing the risk to nursing staff by a factor of six.[43]

Risk management strategies

A level of management resistance has been reported in acknowledging that health care workers are at risk of patient-related violence despite the fact that nurses consistently report high expectations of assault as a consequence of their job.[35]

At the same time there is a workplace culture perpetuated by a degree of complacency on the part of staff where violence is viewed as just "part of the job".[44,45] Strategies to prevent and manage violence include the use of security guards, duress alarms, workplace design and access to training.

Training

Minimisation of violence requires early recognition of signs or cues and timely de-escalation.[46] De-escalation has been defined as the reduction of the intensity of a conflict or a potentially violent situation, and researchers have described a "turning point", where nurses can act and contain or prevent violence.[36]

According to the literature the amount and type of training provided to staff varies widely and as a result many staff report that they do not feel that they have the necessary skills to effectively manage episodes of violence.[32] Training is consistently identified as important by nurses,[47] however it is reported to be largely sporadic and fragmented in nature with a lack of consistency between trainers and programs.[48]

While aggression minimisation training is compulsory for those working in high-risk clinical areas like the emergency department, there are large numbers of nurses who have either not completed any training or who have not completed the regular refresher programs required.[49]

Security and Safety measures

The use of visible on-site security services is frequently cited as a measure to aid in the management of episodes of violence; however, their effectiveness is dependent on their ability to respond in a timely fashion.[50] This is also true of personal duress alarms worn by nurses.[51] The presence of security is described as both a preventative strategy, by acting as a deterrent, and a reactive strategy to manage episodes of violence.[47]

Environmental measures

Environmental controls such as restricted access to clinical areas and the use of security screens at triage can reduce the risk of violence from outside the department; however, they do not prevent violence once patients have been admitted into the department.[52]

Restrictive practices such as isolation or seclusion of violent patients or those identified as being at risk of violence have also been identified as an important strategy in their management; however, these are acknowledged to be used only as a last resort as they can also be the precedent to violent behaviour.[47]

Policies and Procedures

The presence of a definitive policy on the management of violent patients may serve to mitigate the risk of violence and aggression.[53] The intent of this policy is to maintain effective risk management strategies and to avoid inappropriate action where violent behaviour is the result of an underlying medical condition.[54] However, it has been argued that zero tolerance is an ineffective response to violence in health settings, one that impinges on the rights of patients and the ability of clinicians to develop a therapeutic relationship due to its inflexible nature.[55]

Australian jurisdictional findings

An online article by Fedele (2020) reinforces the reality of Australian nurses' experience of OV, citing recent cases ranging from verbal aggression through to hitting, biting and even murder.[56] The article also summarises some initiatives led by State branches of the ANMF.

The following sections discuss some of the academic literature which the rapid literature review was able to identify. This does not seek to be comprehensive, but it shines a light on a range of Australian research findings that are relevant to this evaluation.

Victoria

Victoria has been a leader in this field of research and action in Australia.[56] The Safewards program (originally from the UK), which was trialled in the ACT as part of the TASC Strategy, has already been rolled out more widely in Victoria.

Safewards implementation in Victoria commenced in 2016, when the Victorian Managed Insurance Authority committed to a 4-year program to consolidate the implementation of Safewards in partnership with The Office of the Chief Mental Health Nurse.[57]

- A commitment was also made to expand the implementation of Safewards to all public mental health services across Victoria, with further trialling of the Safewards model at emergency departments and acute medical or surgical inpatient units.

Progress may have been driven by the Victorian Auditor-General's 2015 report which found that Victorian healthcare workers continued to face unnecessary – and preventable – levels of risk in regard to OV:

- Despite all the audited agencies implementing changes aimed at preventing and reducing OV, the true extent of the problem in Victorian health services is still unknown,
- Efforts to mitigate risks are incomplete and inconsistent,
- There is also limited evaluation of the effectiveness of controls in reducing and managing OV,
- There have been systemic failures across all audited agencies in relation to collecting, analysing, and reporting quality data for the purposes of continuous improvement,

- WorkSafe rarely used its inspection or enforcement mechanisms to address incidents of OV,
- OV data collected by the Victorian Department of Health and Human Services had not been available to identify sector-wide trends and issues, or to enable health services to compare progress and share better practice.[58]

The 2015 audit report also found that WorkSafe had been slow in identifying OV in the health sector as an area of high risk. The report also noted that Worksafe's education activities and initiatives to support the sector were intermittent rather than systematic.

Prior relevant reviews and inquiries included a Victorian Taskforce on Violence in Nursing (2004).

In addition, a 2011 Victorian Parliamentary Inquiry into Violence and Security Arrangements in Victorian Hospitals and Emergency Departments was undertaken to investigate concerns about increasing violence in emergency departments.

An earlier study by Deans (2004) using a random sample of nurses registered in Division 1 of the Nurses' Board in Victoria suggested failure to receive appropriate organisational support may result in lowering professional nurses' competence levels.[59]

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

An older Victorian study by Cheung et al. (1996) used the Staff Observation Aggression Scale (SOAS) to record 806 incidents of aggression among psychiatric patients in rehabilitation wards.[60]

The authors calculated physical assaults to occur at a rate of 97.6 per 100 patients per year. Notably, of these incidents, 56 per cent were verbal and 44 per cent physical. Surprisingly, less than a quarter of incidents (n =173) were reported via formal incident reports.

- The authors noted that while assaults were commonly found to be directed towards staff members, serious physical injuries were rare.
- Aggressive behaviour was correlated with gender, duration of admission, and time of day.
- Interestingly, staffing levels were not positively associated with aggressive behaviour in this study.[60]

New South Wales

A recent paper by Pich (2020) highlight the high levels of violence that nurses and midwives experience in the workplace across all sectors of employment, geographical regions, and clinical settings in NSW:

> *A cross-sectional design was employed to survey the membership of the New South Wales Nurses and Midwives' Association about their experiences with violence from patients and/or their friends and relatives in their workplace. A total of 3416 participants returned a completed questionnaire and more than three-quarters of had experienced an episode of violence in the preceding six months. Participants working in the public health sector reported significantly more physically violent behaviours than their colleagues in the private sector. No statistically significant difference between the rates of violence (overall) was identified between different geographical areas. Violent behaviours were reported across all clinical settings, with emergency departments, mental health and drug and alcohol settings reporting the highest proportion of episodes.*[61]

In 2017, the NSW Chief Psychiatrist released a report on the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*; in an implementation update from 2019, NSW Health notes that:

> *Macquarie Hospital has been running 'Safewards' in six of its nine units over the last 4 years, which has significantly reduced incidents relating to seclusion and restraint.*[62]

A paper from 2014 explored the reasons why registered nurses resign from rural NSW hospitals, finding that nurses often resigned when their personal values of how nursing should occur came in conflict with organisational values, notably when:

> *…organisational values changed due to rural area health service restructures, centralisation of budgets and resources, cumbersome hierarchies and management structures that inhibited communication and decision making, out-dated and ineffective operating systems, insufficient and inexperienced staff, **bullying**, and a lack of connectedness and shared vision.*[63] [emphasis added]

Hutchinson (2014) reported that around half of nurses and midwives state they had experienced workplace aggression *in the past month*:

> 36% report violence from patients or visitors, and
> 32% report bullying by colleagues.[64]

Another older Australian study that the literature review identified is that Owen et al. (1998), which described the prevalence of violence and aggression in psychiatric units.[65] The prospective study used three assessment tools – the Violence and Aggression Checklist, the Ward Activity Index and the Staff Level Index – to record data in five psychiatric units:

> 1,289 incidents of violence occurred over a seven-month period.
> 58 per cent of these were documented as serious.[65]

Tasmania

A specially designed questionnaire was sent to all nurses registered with the Nursing Board of Tasmania (n=6,326) in November/December 2002, with 2,407 usable questionnaires returned.[66] The response rate was 38 per cent.

> Most respondents (63.5 per cent) had experienced some form of aggression (verbal or physical abuse) in the four working weeks immediately prior to the survey.
> Patients/clients or their visitors were identified as the main perpetrators, followed by medical and nursing colleagues.
> Abuse influenced nurses' distress, their desire to stay in nursing, their productivity, and the potential to make errors, yet they were reluctant to make their complaints 'official'.
> As well as reporting high levels of verbal and physical abuse, nurses were distressed because they could not provide the appropriate care to meet patients' needs.
> Few working environments were free of aggression.

Western Australia

In a Western Australian study that documented the prevalence of client-initiated violence in general wards and high dependency settings, O'Connell et al. (2000) showed high levels of client-initiated aggression.[9] In this study, the researchers examined nurse' perceptions of the nature and frequency of aggression. The study involved a sample of nurses working in a metropolitan teaching hospital.

> 95 per cent of 209 nurses who took part in the study had encountered at least several episodes of violence in the last year, many of which were experienced in medical and surgical wards of the hospital.[9]

ACT

A range of search terms were used to interrogate online databases for relevant research or findings specific to the ACT context. These yielded only a small number of studies by authors based in Canberra but with the research projects carried out in other jurisdictions. As a result, no specific research studies relating to the experience of, or action about, OV experienced by nurses and midwives in the ACT were identified.

> While the evaluation team's literature search strategies were by no means exhaustive, this may indicate a knowledge gap that the survey carried out for this evaluation is helping to fill.

The section on Victoria above identified the potential role that Workplace Safety Authorities such as WorkSafe and SafeWork can play to support safety. Another, prior example was a national campaign to assess risk assessments and the effectiveness of controls in 2008-09.

The ACT provides a more recent example of the type of action that Workplace Safety Authorities can take to support workplace safety:

> In 2018, an enforceable undertaking by WorkSafe ACT was accepted by the ACT Education Directorate with a range of actions committed to improving safety.

Scope and objectives of the evaluation

This subject of this report is the TASC Strategy, noting that is sits within a broader context of strategies and initiatives that influence the development of safe work practices for nurses and midwives in the ACT Health sector.

The focus of the evaluation is to assess the contribution of the TASC Strategy in helping foster a strategic, coherent, and coordinated approach to developing and creating awareness of safe work culture for nurses and midwives in the ACT.

Specifically, the objectives of the evaluation are threefold:

> To take stock and review progress made with the implementation of the Strategy, including its main achievements, limitations and lessons learned since its adoption,
> To review the relevance and effectiveness of the Strategy in guiding and facilitating efforts at creating a safe work culture for nurses and midwives, and
> To propose options for enhanced implementation of the Strategy and make recommendations that could be taken into consideration for the preparation of future adjustments.

Information for the evaluation was drawn from various sources including:

> Project documents,
> Literature review,
> Existing focus group data
> Data collected during the course of TASC project delivery, and
> New data collected via survey and interview instruments.

As longer-term data on outcomes specific to the TASC Strategy are not yet available, care must be taken when making inferences about the impact of the strategy on such outcomes.

Where there is robust evidence on specific interventions, for example, based on research from other, similar jurisdictions, then it is reasonable to expect these interventions to have similar impacts in the ACT.

> The Safewards trial is a good example of this, as this particular model of care was developed and refined in the UK, using evidence generated from randomised controlled trials. As discussed in the literature review section of this report, Safewards has also been rolled out and implemented with good results in Victoria and NSW.

Where data on outcomes is not available, as a corollary to that, an examination of process and implementation becomes more important, as good process and good implementation practice will increase the likelihood that the desired outcomes will be achieved.

It is worthwhile briefly reviewing the nature of strategy evaluation and how key evaluation questions (KEQs) were approached for this evaluation.

Strategy evaluation

Some commentators have linked the rise of *strategy* in the 20th century to the rise of private enterprise. Prior to this, the term "strategy" was used rarely, and its use was largely confined to military planning and the so-called 'Great Game' in international affairs, i.e., were about the control of territory and populations.

In 1989, the retired US General Arthur Lykke famously proposed in a paper in the *Military Review* that:

> *Strategy equals ends (objectives toward which one strives) plus ways (courses of action) plus means (instruments by which some end can be achieved).*[67]

The ends-ways-means equation can also be thought of as the why, the what and the how of strategy. A third way in which this is sometimes conceptualised is as vision (aims/why), strategy (ways/what) and tactics (means/how).

The "Why" of the Strategy

In thinking about the aims of the TASC Strategy at a broad level, the PDE Team has considered whether:

- The need for a strategy is evident (e.g., clear problem statement),
- The vision of the strategy is clear and compelling,
- Whether the strategy aligns with the context of OV in Australia and the ACT,
- Whether the strategy is easily understood by stakeholders and the public, and
- How the strategy intersects with other programs of a similar nature.

The "What" of the Strategy

This aspect of evaluation concerns what the Strategy is proposing to implement at a broad level, i.e., the ways to get to the ultimate aim:

- The main tenets or pillars are identified (ideally based on a Theory of Change),
- Whether these are based on evidence of "what works" based on relevant literature,
- Whether the strategy's pillars and associated actions are aligned with the vision promoted by the strategy, and
- Whether other pillars or priority areas could have been identified.

The "How" of the Strategy

This criterion assesses whether:

- Appropriate actions were selected under each of the four pillars of the strategy (actions here may include development of legislative instruments, rollout of pilot projects, guidelines and toolkits, etc.)
- Sequencing of actions and their potential interaction was considered,
- Governance was adequate, and
- The right people were involved (skill sets and capabilities).

These lists are probably not exhaustive and there is a degree of arbitrariness around the selection of criteria such as these. No doubt another evaluation team might apply slightly different sets of criteria and bring different thinking to the task at hand.

Irrespective of these criteria and our individual approach, it is highly likely that any evaluation team would interrogate:

- Whether any outcomes of actions have been ascertained and assessed,
- Whether appropriate indicators and outcomes measures have been designated, and
- Whether enough and appropriate data has been collected to understand these outcomes and indicators.

The PDE Team notes that well-defined, validated baseline measures of the incidence or prevalence of OV, bullying and harassment in the ACT health sector were not available to the evaluation team at the time of writing this report.

The evaluation process has however generated some potential options for measures and indicators that may prove useful for follow-up evaluations.

Strategy and implementation fidelity

The degree to which strategies are performed as intended by the strategy developers is termed the fidelity or integrity of the implementation strategy.[68-70] A strategy for change can only have its theoretical impact if it is performed as intended by its developers.[71]

The degree to which strategies are performed as intended (strategy fidelity) influences how far the strategy has the opportunity to affect outcomes: high fidelity results in more opportunity and poor fidelity in less. Fidelity should therefore be treated as a potential factor influencing the relationship between strategies and their intended effects and should therefore always be measured.[70]

Measuring the relationship between fidelity and effect can help to distinguish between strategies that are inherently faulty (failure of strategy concept or impact theory) and those that are badly delivered (implementation failure).[72]

In other words, evaluation of strategy fidelity can help determine whether a lack of impact derives from a poorly conceptualized strategy or from a failure to consider whether the strategy was delivered at all. The criteria listed below are in line with the methods suggested in the literature:

a) Adherence to the blueprint,
b) Exposure to intervention,
c) Quality of delivery,
d) Participant responsiveness or experiences;
e) Differentiation.[73]

To further guide the review, the following questions and sub-questions were also considered relevant:

- What progress has been made in the implementation of the strategy?
  - What have been the main achievements relating to the implementation of the strategic framework?
  - What progress has been made in implementing actions in the four key areas identified by the strategy?
  - Are there any gaps in the implementation of the strategy?
  - What have been the main challenges/obstacles?
  - What have been the most successful approaches and lessons arising from these initiatives?
- To what extent has the Strategy been effective in fostering a systematic and coherent approach to safer work culture for nurses and midwives?
- Are all the elements of the Strategy (key areas, objectives, proposed activities) still relevant?
  - To what extent are the objectives of the strategic framework still valid?
  - Are the key areas and indicative activities still consistent with the overall strategic goals, objectives and desired changes?

To assess strategy fidelity and effectiveness, the process evaluation 'triangulated' the document analysis with information gleaned from interviews and the survey results from both the public and ACT health sector staff surveys further discussed in the report.

Report structure

As the previous discussion indicates, a broad range of questions were considered as part of the evaluation process, and an approach was developed in discussion with the TASC project team and the TASC Steering Committee.

Conceptually, there is a progression from initial development of the Strategy to implementation, and then to the 'embedding' of culture change and the realisation of impacts (i.e., towards improved safety).

The evaluation team considered how to present the discussion in a way that broadly fits with this progression, but also adheres to standard evaluation terminology. Whilst somewhat arbitrary, this is reflected in the following report structure:

1. Process evaluation: although process is relevant throughout, initial questions relate to whether the Strategy was set up appropriately and the right processes put in place,
2. Implementation evaluation: examining all of the data relevant to implementation, and
3. Impact evaluation: this section explores early findings and potential indicators of impact, which logically and sequentially also leads to the discussion around embedding culture change to safeguard the legacy of the TASC Strategy.

Process evaluation

Process evaluation in the context of a strategy evaluation traditionally focusses more on the "How?" than the "Why?" and "What?". In other words, broadly speaking, it takes the program of activity as pre-determined, but investigates *how* it was delivered.

If an effective process is in place, it can be reasoned that it is more likely that the desired outcomes will be achieved. Process is an essential step in the outcome delivery chain (a necessary but not sufficient condition). Process is also linked to implementation fidelity.

One way to glean some insights into process is through document review and analysis. The PDE Team requested and was provided with a large volume of documents by the TASC Project team. This informed the evaluation team's understanding of the work undertaken.

A summary word cloud of the text in all project documents provided to the evaluation team is shown in Figure 3 below. This provides some reassurance that processes were aligned with the Strategy remit, noting that work, staff, safety and violence are clearly visible.

Figure 3 Word cloud based on all TASC project documents

Safewards also comes through strongly in the word cloud. The TASC project team confirmed that Safewards was indeed a major focus for the team and consequently it is a prominent feature of the process that was undertaken in delivering the Strategy.

Next, the evaluation briefly spotlights the TASC Project team, in terms of selection of the team, its skills, capacity, and related issues.

Project team structure and capabilities

The evaluation team held meetings with the TASC Project Team to understand how the team was established, the structure of the team and the skills and experience represented on the team. In addition, interviews of 15 key stakeholders also yielded relevant insights:

- Key staff members were recruited early in the process,
- The Project Team is a small, highly effective team,
- The team structure is appropriate,
- Team members have appropriate skills and applied experience in nursing and the health sector more broadly,
- A lack of prior experience in project management and more generic government administration skills was noted,
    - Fortunately, key staff were 'self-starters' who quickly learnt on the job.
- The small size of the team implies some 'key person risks' where the loss of staff can have an impact on the performance of the team,
    - To some degree this is unavoidable given funding constraints, but again, fortunately one staff member in particular stayed with the project for most of its duration and ensured continuity of oversight and implementation of actions.

The range and content of the material supplied to the evaluation team indicates that the project team is administratively well set up.

Project plans and progress monitoring activities are in place and meetings are minuted, with agendas and briefing materials provided to Steering Committee members before meetings.

- It was noted that briefing materials were at times extensive, with some impact on Steering Committee members' ability to process all the material provided; however, Committee members stated that they were generally able to review material to their satisfaction.

The evaluation team was also able to observe several Steering Committee meetings, and on this basis was also able to confirm that meetings were chaired well, appropriate time was allocated for discussion of items, and that respectful, constructive debate took place.

The document review and interviews also confirmed that the TASC project team was perceived as highly capable and that it performed the Secretariat function for the Strategy effectively.

Vision

Clarity of vision enables better process – especially where change is involved. This was one of the perceived strengths of the Strategy. As has already been mentioned, the international literature suggests there is a culture of silence around many of the issues raised by the Strategy.

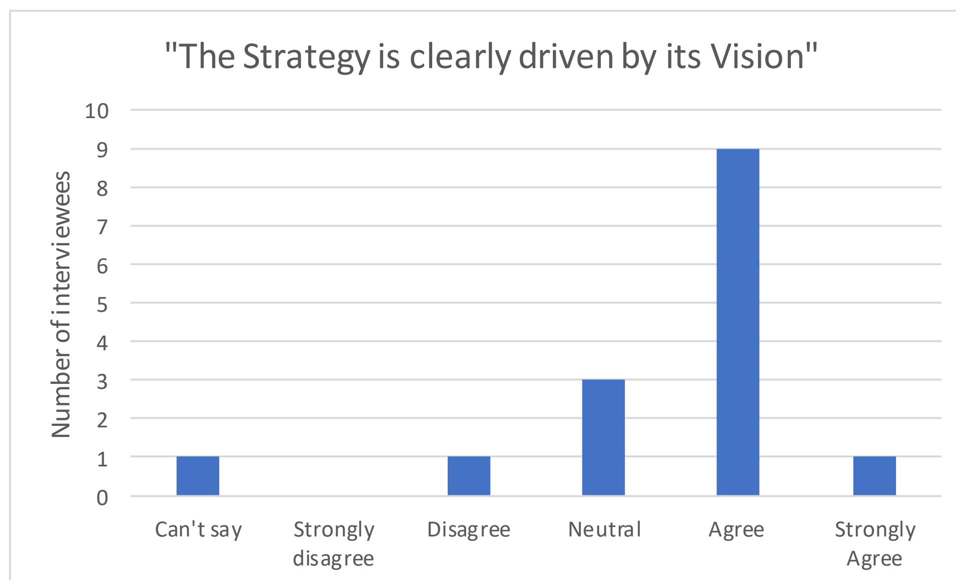
The vision of a safe workplace for nurses and midwives (and for that matter, all staff in the health sector) is easy to grasp and an attractive one. Coupled with effective storytelling (communications campaigns, etc.) this is likely to encourage buy-in and wider support.

Interviewees were asked about the goals of the Strategy ('What do you think are the key aims of the Strategy? Are there any gaps?') and there was some variability in how stakeholders articulated the aims of the Strategy.

This could reflect the fact that the Vision articulated in the Strategy itself contains several layers:

> *ACT Health management and staff work together to ensure that a safe and healthy environment is our priority. We all contribute to a culture where WHS is valued in our decision making and in our day-to-day work and interactions. By providing a healthy and safe environment, staff will perform at their best.*[20]

Figure 4 Stakeholder agreement with statement on strategy vision



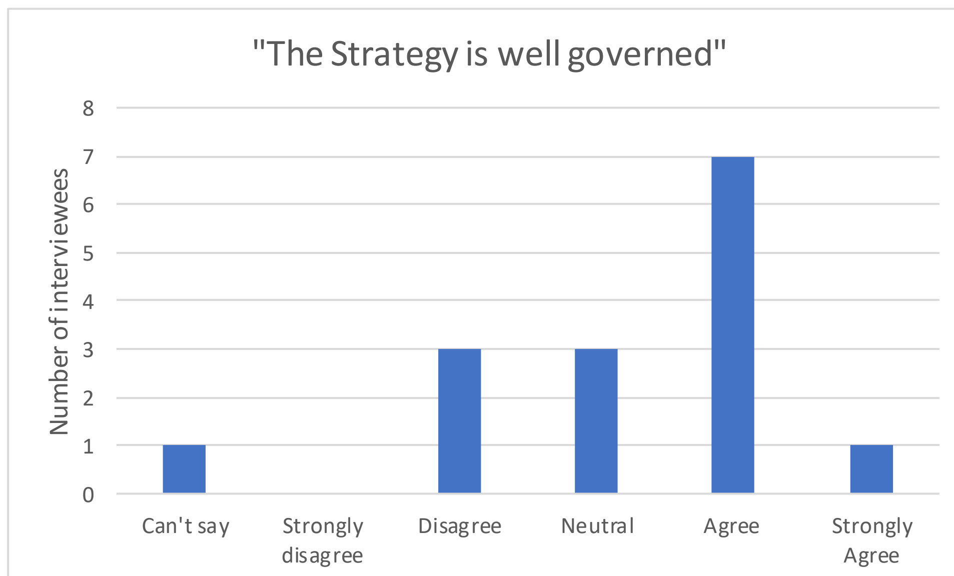
Governance and strategic alignment

Ministerial endorsement of the TASC Strategy set the tone and ensured high level Executive oversight was in place for the Strategy; however, staff turnover at the Executive level meant stewardship of the Strategy took some time to settle.

The document review confirmed that an appropriate governance structure was in place, with an Advisory Committee and a Steering Committee ensuring good representation of areas and providing relevant input into decision making.

Issues around governance were discussed at length in the interviews, and while the majority of interviewees agreed that the Strategy was well governed, a significant minority (one third) were neutral, disagreed or said that they couldn't say (see Figure 5 below).

Figure 5 Stakeholder agreement with statement on strategy governance



The evaluation team sought to understand this in further detail. It concluded that the issue was not inherent to the governance structure but critically influenced by several issues:

> As highlighted in the Executive Summary, the Strategy was launched at a time when major organisational change was occurring with the separation of Canberra Health Services (CHS) and a repositioning of the role of the ACT Health Directorate (ACTHD),

> At the same time, as also noted in the Executive Summary, several other initiatives and strategies that impact on OV, bullying and harassment were underway or about to be launched when the TASC Strategy commenced implementing actions, and

- A third factor impinging on governance which relates to its interaction with policies, initiatives and strategies in other areas was the Strategy's unique targeting of a sub-group of the health workforce.

A result of these issues appears to have been occasional uncertainty how the Strategy sat vis-à-vis other endorsed strategies, which at times impacted on prioritisation of activity and alignment.

> Further work is needed at a strategic level to understand how strategies can be best aligned or re-aligned when overlaps emerge (e.g., work on the broader *Culture Review* implementation, or the WHS strategies developed in CHS).

The interviews and document analysis undertaken for this evaluation indeed confirmed that the Strategy encountered some challenges around its integration and alignment with other strategies, as reflected for example in delays to the initial agreement on work plans.

Role and function of ACT Health

An aspect of the discussion around governance and alignment was the role of ACT Health as stewards of the Strategy (Interview Question 4 'Do you think it matters that the Strategy is administered by ACT Health and in which ways?).

Interviewees agreed that it was an appropriate role for ACT Health Directorate (ACTHD) to administer the Strategy. Interviewees however noted that ACTHD was still 'finding its feet' in its new role which interviewees felt should generally involve broad strategic direction setting, provision of guidelines and some quality control, but not detailed implementation.

Given that the Strategy included very specific action areas, this meant there was an inherent tension and potential for conflict between areas where direction setting from ACTHD became more operational than strategic.

At the same time, interviewees agreed that the project team's personal involvement and hands on work rolling out the Safewards trial was beneficial.

The evaluation team concluded that a good balance was struck during this phase of the Strategy, but that going forward it would be advisable to progressively hand over as much of the day-to-day implementation of projects to the operational areas, as this will not only better reflect the role of ACTHD but also ensure that new practices and changes in culture are embedded across all areas. Future strategies should plan for this transition.

Differentiation from other strategies

Another way of interrogating the question of alignment is to ask whether a strategy is well *differentiated* from other strategies and initiatives. The answer to this depends partly on "how much you know about the sector (and the Strategy)".

The evaluation team investigated differentiation firstly by asking the interviewees directly ('How does the Strategy differ from other OV initiatives in the ACT?') and secondly by testing their level of agreement with the statement that "the Strategy is distinguishable from similar strategies and programs" (see Figure 6 below).

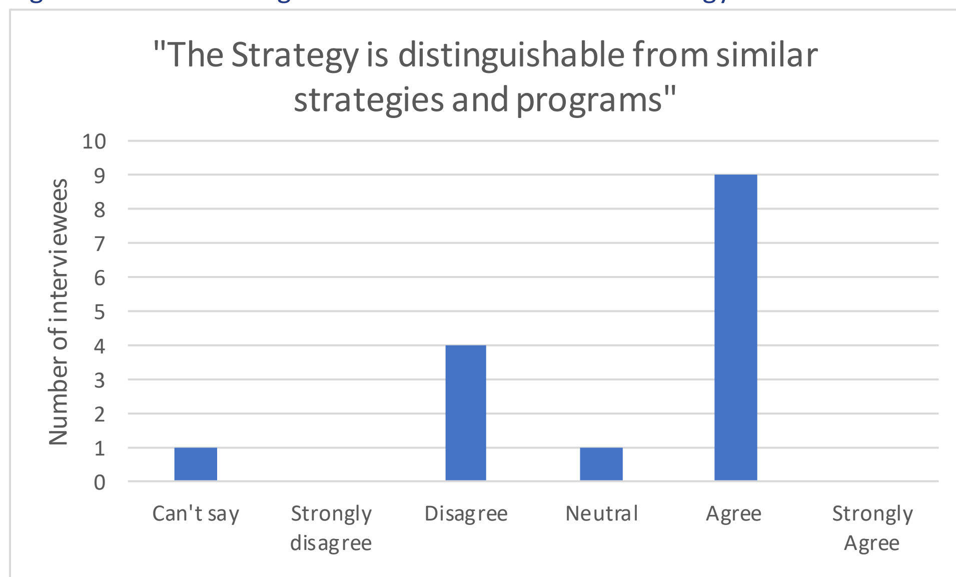
There was a somewhat mixed response to this question. Interestingly, some respondents perceived this to be the *only* Strategy addressing the issue of OV experienced by nurses and midwives in the ACT, giving it clear differentiation. Others disagreed with this view.

While broadly there was agreement that the Strategy was different in the sense that it specifically targeted nurses and midwives, there was also a feeling that some of the Priority Action areas were already covered by other initiatives, which reduced its differentiation.

Some of the Priority Actions under the Strategy were perceived as having stronger differentiation, for example, the Safewards model was accepted as a new approach in the ACT (based on a model that was tested in the UK).

Other contributions such as Guidelines were also highlighted as useful additions to the arsenal of existing tools and guidance materials. While some of these were applicable for a broader range of staff (e.g., Remote Worker Guidelines) they did not replicate anything that had already been developed by another initiatives, thus adding to differentiation.

Figure 6 Stakeholder agreement with statement on strategy differentiation



Leadership and prioritisation

Effective leadership is another essential component of good, effective process. The concept of leadership was tackled in several ways for this evaluation, revealing what might appear to be ‘mixed’ signals, so it is worth unpacking these a little bit.

First, there is no doubt that senior leadership in the organisation was seriously committed to the Strategy – this includes the Chief Nursing and Midwifery Officer, Director and Deputy Director-Generals and of course the Minister.

It was noted by several interviewees that leadership happens at all levels, from individuals in small teams through to ward leaders at the operational level and including leadership in senior administrative positions.

When asked whether the Strategy encouraged leadership to create safe workplaces, 12 of the 15 key stakeholders interviewed for this evaluation agreed that this was the case (see Figure 6 above), indicating fairly strong agreement.

What this means in practice is however open to interpretation. This appears to be reflected in perception ‘on the ground’:

> On the question of whether they thought there is a strong leadership culture in the organisation to support OV prevention programs, over half (53 per cent) of respondents said ‘no’ (see the section of this report on Impact Evaluation Baseline).

Again, the question itself is open to interpretation and different individuals may have very different ideas about what leadership means and what good leadership looks like in practice.

Figure 7 Stakeholder agreement with statement on leadership

The two findings are not necessarily inconsistent – while the Strategy may be encouraging leadership to create safe workplaces, it is also entirely plausible that leadership culture needs to be further strengthened.

This interpretation would appear to be supported by another exercise the evaluation team completed as part of the interviews, namely the forced rankings exercise discussed below.

Forced rankings exercise

As part of the interviews, the evaluation team asked the interviewees to complete a so-called forced rankings exercise.

To make this ranking exercise feasible, the evaluation team in consultation with the TASC project team reduced the 22 Priority Actions to seven broad areas of activity:

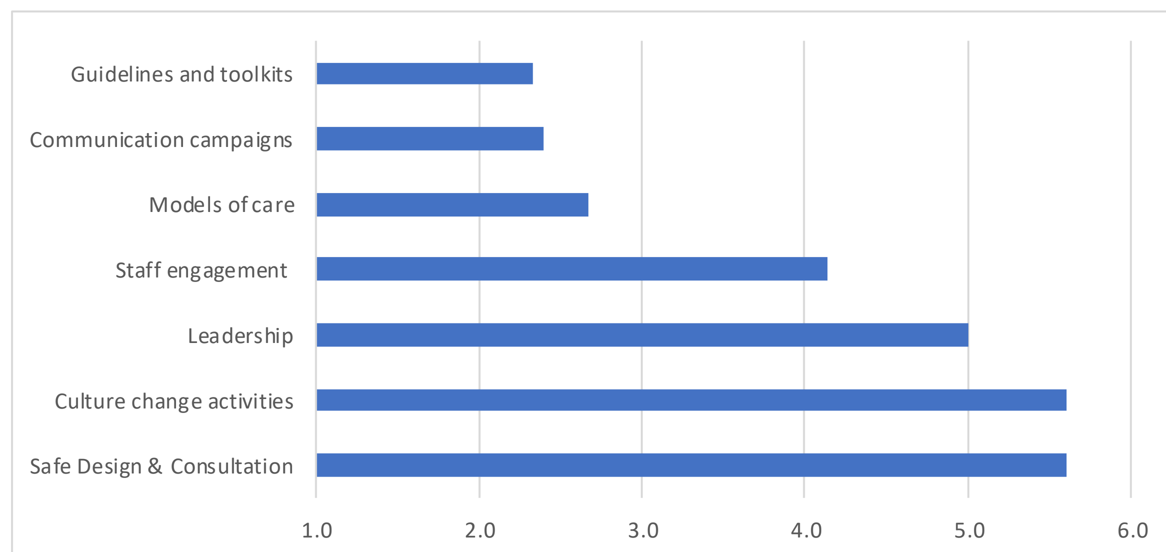
1. Leadership,
2. Guidelines and Toolkits,
3. Staff engagement,
4. Communication campaigns,
5. Safe Design & Consultation,
6. Models of care, and
7. Culture change activities.

Interviewees were asked to rank these seven areas in terms of how they perceived that these had been prioritised in the implementation of the Strategy to date (1 = highest priority to 7 = lowest priority).

If all interviewees had said that they thought the highest priority had to date been given to the development and provision of 'Guidelines and toolkits', for example, the average score for 'Guidelines and toolkits' would have been 1.

As it turns out, guidelines and toolkits did come out on top, alongside communication campaigns and the work on models of care (which included Safewards and also the work on staff ratios). Figure 8 shows these three areas were clearly perceived as having been most prioritised to date.

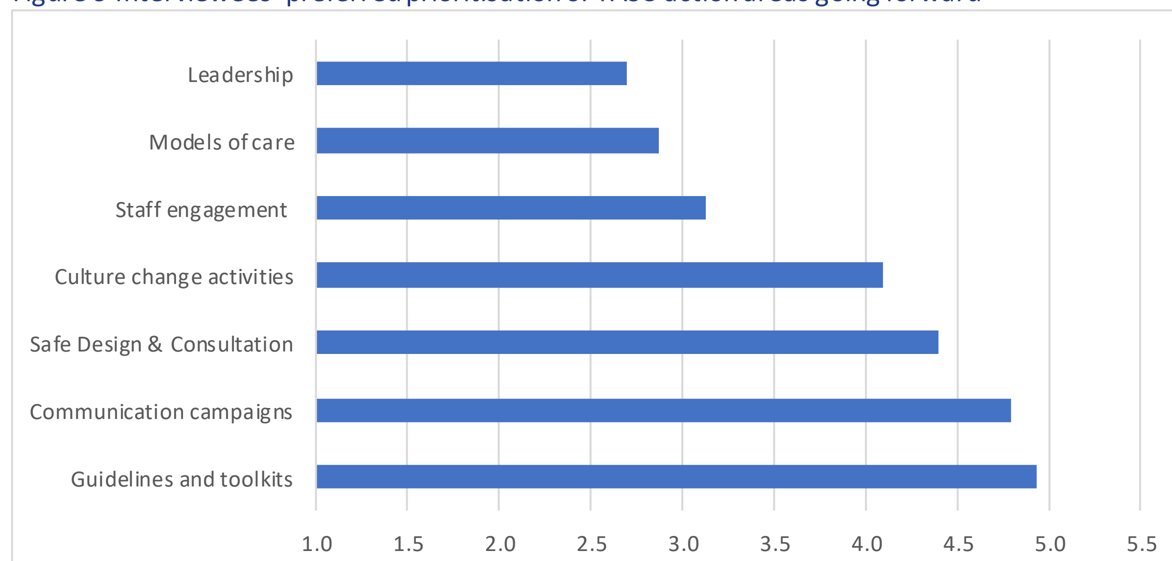
Figure 8 Interviewees' perceived prioritisation of TASC action areas to date



When asked, however, what they would see as the ideal prioritisation going forward, once again using the forced rankings process, the interviewees thought leadership and staff engagement should be top priorities alongside models of care.

In fact, focussing on leadership going forward emerged as the top ranked priority on the basis of the responses provided by the 15 key stakeholders.

Figure 9 Interviewees' preferred prioritisation of TASC action areas going forward



Collaboration

Collaboration is also part of process. Collaboration was evidenced in the documents analysed by the evaluation team, and included working across CHS, ACTHD and Calvary on tools and guidelines, timing and implementation of communications campaigns, and the rollout of the Safewards trial.

Collaboration was effective in those areas where there was no 'grey area' around remit and responsibility. Based on the literature, interviews, and other observations by the evaluation team, where there were perceived overlaps collaboration was slower or more difficult.

The fact that the Strategy targets a sub-group of staff did appear to impact on collaboration in some instances, in particular where it was not always clear how actions under the strategy related to policies and initiatives that, in theory, apply to all staff.

Some minor hurdles around collaborating across Campuses, i.e., with Calvary as a contracted party delivering health services for the ACT Government, were overcome effectively through the initiative of the project team.

Collaboration was facilitated by the project team's prior knowledge of the sector, and their experience in the nursing profession. Where this experience was directly applicable, collaboration appeared to work at its best.

Changes in the model

Changes in the model can undermine a Strategy as they can cloud the understanding of what the chosen pathway, methodologies or pedagogies are. This can require significant recalibration including redirection of effort that undermines effective process.

The interviews included a question on whether the key stakeholders perceived there to have been changes to the model ('Do you think the Strategy has changed over time, in terms or remit or intent? If so, how?').

It was noted that the Australian Nursing and Midwifery Federation (ANMF) played a crucial role in developing the model via its initial efforts – including circulation of a Discussion – Paper and made early changes to the model in consultation with ACT Health.

The interviewees did not perceive there to have been any changes in the model once the work plan was agreed. Interviewees thought that the intent of the Strategy had not changed.

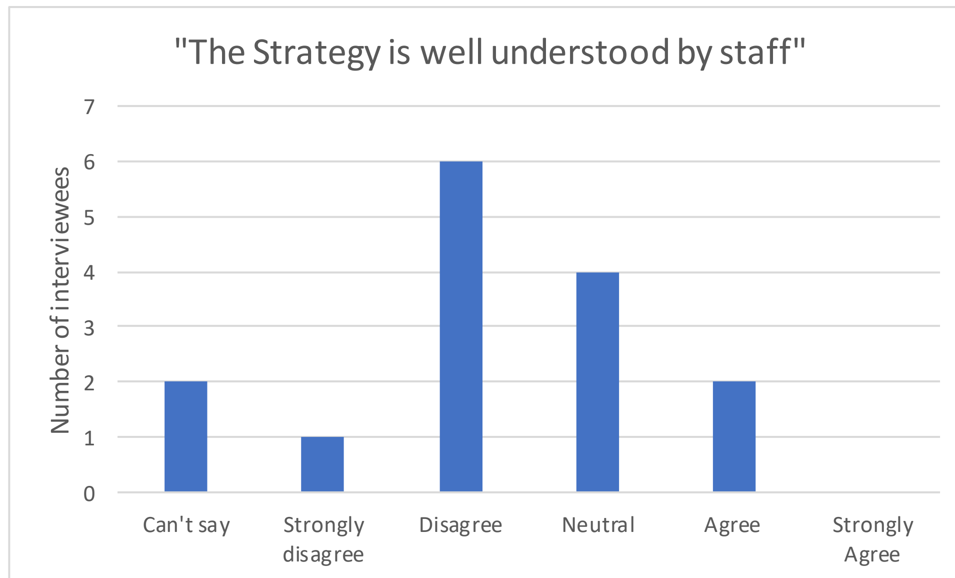
There was perceived to be consistency over the last two years of the Strategy in particular. This stability clearly supported the delivery of the Strategy.

Staff engagement

Overall, the interviewees did consider staff engagement as a more problematic area of the TASC Strategy, with more respondents indicating that they "disagreed", were "neutral" or "can't say" than those who agreed.

While this assessment does not necessarily reflect staff members perceptions of the TASC Strategy (see "Nurses and Midwives" result section), staff engagement can make or break the success of a strategic framework aimed at specific professional groups.

Figure 10 Stakeholder agreement with statement on staff understanding of Strategy



Process evaluation "scorecards"

Having completed the interviews and document analysis, the PDE team assessed the targets laid out in the TASC Strategy document and in the subsequent Implementation Plan. Fidelity of implementation activities to the TASC Strategy is desirable; however, the Strategy clearly had to be "operationalised" in order to facilitate implementation.

Due to the differences in the strategy document and the Implementation Plan, both documents were assessed to establish progress against listed activities or priorities.

In relation to the Strategy document, the PDE Team evaluated whether criteria mentioned under the different Pillars of the Strategy appear to have been achieved:

- For the ten criteria extracted from the original Strategy document, this yielded a result of five fully achieved and five partially achieved (50 per cent).

A second exercise was to examine each of the Priority Actions in the Implementation Plan.

- 15 out of 22 Priority Actions were 'fully' achieved (68%), and
- 7 out of 22 Priority Actions were 'partially' achieved (32%).

Unsurprisingly, a higher proportion of Implementation Plan actions was achieved than Strategy criteria. The Strategy contained broader criteria which makes them harder to "fully" achieve by their very nature. Appendix B contains the detailed "Scorecards".

Implementation evaluation

As outlined above, the approach to the evaluation of the TASC Strategy contains elements related to *process*, to *implementation*, and to *outcomes*.

There is some overlap in the conceptual approaches to process and implementation evaluation, as these are both concerned primarily with the “How?” question of strategy discussed above.

Specific implementation-related questions were considered based on Hulscher et al. (2000):

> What is the nature of the implementation activities as part of the strategy?
> What implementation activities were provided or performed?
> What groups participated in the implementation activities?
> How did the target group experience the strategy for change and the implementation activities that were part of it?
> What problems arose while participating in the strategy and implementing the innovation in daily practice?[74]

Considering these questions, this chapter focusses more specifically on the three sources that could throw light on implementation issues: the stakeholder interviews and the two surveys carried out for the evaluation.

Stakeholder interviews

The previous chapter summarised some of the outcomes of the interviews conducted by the PDE team to support the evaluation. The protocol for these semi-structured interviews is included at Appendix E of this report.

The interviews provided insights into how the process of establishing and implementing the TASC Strategy was perceived by the members of the governing bodies, including Steering Committee and Advisory Committee members.

Interviewees included both ACT Government and non-government employees, to gauge a range of opinions and perceptions about achievements to date and on future priorities.

These interviews took place online, with the interviews recorded and transcribed assisted by transcription software. The transcripts were imported in the qualitative research software NVivo and analysed by carrying out a word frequency analysis based on the transcripts.

Word clouds

Word frequency analyses, as visualised by Word Clouds, allow for quick identification of data patterns from interview responses and focus on the most salient points mentioned by TASC Steering Committee and Advisory Group members.

Figure 11 Word cloud for stakeholder interviews

“Violence”, “care”, “nurses”, “action”, “safety” and “work” were the most mentioned topics. Further topics included “support”, “risk”, “support”, “safe”, “challenging”, “priority”, “workplace”, “nursing” and “public”.

The themes emerging from the word frequency analysis were used to code the interviews by emerging themes, using the “coding” function manually in the first instance and verifying the results by applying the “auto-coding” function subsequently.

Figure 12 below unsurprisingly suggests that issues of “violence”, ”culture” and “health” were mentioned most frequently, together with the notion of “change”, “engagement”, “campaigns”, “measures”, “priority”, “safety”, “services” and “work”.

These themes are in line with the main aim of the TASC strategy and were strongly reiterated by interviewees.

Figure 12 Stakeholder interviews: interview codes

Interview codes

Name	Files	References
actions	8	17
campaigns	6	12
change	9	17
culture	11	36
engagement	6	12
health	12	56
measures	5	13
nursing	7	14
priority	6	12
reporting	6	12
safety	7	17
services	5	18
violence	11	25
work	8	29

Cluster analysis

Cluster analysis confirmed these topics, with "campaigns" and "engagements" closely associated, "work" and "change", "culture" and "health" as well as "violence". Cluster analysis also indicates the importance of aligning "reporting", "actions" and "safety".

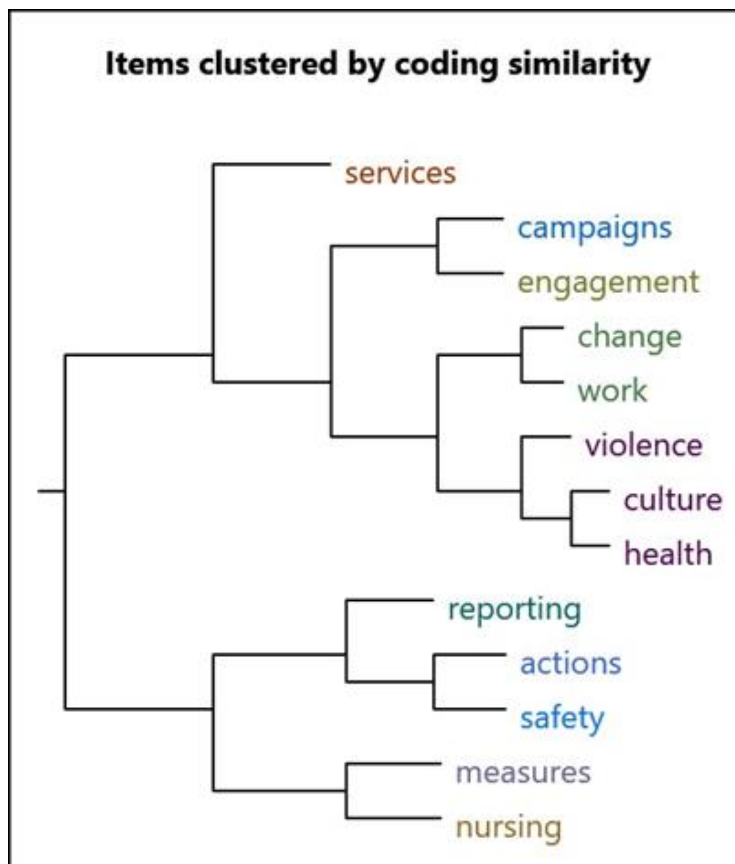
Branching diagrams that visually summarise a cluster analysis are known as dendograms. In these diagrams, similar items are clustered together on the same branch and different items are further apart.

Care must be taken in interpreting dendograms, as they look similar to 'decision trees' but describe something very different. Notably, they do not represent causal or temporal pathways. Dendograms are useful for comparing *pairs* of items.

Word clusters, such as presented in Figure 13, demonstrate in a large body of text (such as project documents, meeting notes, emails etc) issues that are thematically linked and concepts that are frequently mentioned together.

The results of the word cluster facilitate subsequent thematic analysis. Frequently, the large amounts of texts generated over the course of a large project such as TASC are not easily structured – the word cluster presented in Figure 13 allows for further analysis by raising potential associations that have not been raised explicitly before.

Figure 13 Stakeholder interviews: cluster analysis



Some of the opinions expressed on salient topics identified by the word clusters are included in the discussion that follows.

Campaigns and engagement

Most interviewees perceived campaigns and engagement to be a successful activity which have created awareness of OV issues:

> *"That's all right to measure, but I don't know that communication campaigns have had effects in other jurisdictions."*
>
> *"I think we've had success in the promotional poster campaigns about treating staff with respect."*
>
> *"I think staff have seen things like the social media campaign and felt an attention to occupational violence and nurses, midwives' safety."*

Change and work

Another word cluster identified has been linked to "change" and "work/workplace".

Change was linked both to "system change", "leadership change" and "organisational change", with interviewees suggesting that the TASC Strategy has aimed to change the system and culture to create safer workplaces for nurses and midwives.

> *"I think given that, you know, the strategy aims to change some of the work culture so if anything, I guess it tries to promote maybe explicit or implicitly the change of the current sort of system towards a safer work environment for nurses and midwives."*

However, problems with culture change and system change were also widely acknowledged, as long-term culture change largely depends on system readiness:

> *"We probably haven't dealt with in the culture space or because the immaturity of the system."*

Violence, culture and health

The interlinkages of health, violence and culture were also highlighted in the interviews, including both references to consumer-carer violence as well as peer-to-peer violence:

> *"We're working with members of the public in the industry, there's occupational violence risk with sometimes medical professionals may not engage with our staff in a way that shows respect."*

> *"It covers the relationship, the behaviours, workplace behaviours, so improving workplace behaviours."*

Reporting, actions and safety

> *"We need to get people to the point where we know that they are reporting."*

> *"So I think measures of success would actually look like increased reporting and then a downtrend into decreased reporting when we know that that reporting structure is better."*

> *"Well, the safety culture, um, and then in the individual components, I mean, there's so much in each priority action."*

Sentiment analysis

As a final step in the analysis of the stakeholder interviews, a sentiment analysis was carried out.

Sentiment analysis is a research methodology that analyses text – in this case, the interview transcripts – for positive or negative sentiment. This enabled a 'quantification' of TASC stakeholders' opinions and supports inferences about their level of support for the project.

There is some debate in the academic literature about the reliability of automated sentiment analyses, notably their ability to deliver nuanced coding or interpretations for specific sentiments.[75,76] Such detailed interpretation is however not required here.

Importantly, the sentiment analysis revealed that references to the TASC Strategy made by the interviewees were predominantly positive (see Table 1 below).

Table 1 Stakeholder interviews: sentiment analysis

Attitude	Number of text references
Positive (very and moderate)	**495**
Very positive	112
Moderately positive	383
Negative (very and moderate)	**257**
Moderately negative	162
Very negative	95

The results demonstrates that the attitude and perceptions of the TASC Strategy among interviewees were predominantly positive (495 references), albeit moderately positive in the largest part (383) as opposed to very positive (112). Negative perceptions were predominantly "moderately" negative (162), with only 95 very negative references.

Inferences about implementation

When considering the evaluation questions outlined earlier, the analysis of stakeholder interviews presented in this section indicates that:

> Relevant implementation activities were performed,
> Different stakeholder groups across government participated in implementation activities,
> Implementation activities were generally well-aligned with the 'blueprint', and
> Stakeholders' opinions of the strategy and its implementation activities were predominantly positive, although challenges and areas for improvement were also noted.

The Safewards model of care trial was repeatedly cited as a highlight of implementation, as were some of the Guidelines and Tools that were produced under the TASC Strategy.

Areas in which it was perceived that further progress in terms of implementation could be made included:

> Staff awareness of safety issues,
> Reporting, and
> Implementing change in the area of Safe Design & Consultation (e.g., new builds and refurbishments).

These are in line with the conclusions around *prioritisation* discussed in the previous chapter.

Community survey

The analysis now turns to the two surveys carried out for the evaluation, and what they can reveal about the TASC Strategy's implementation.

One of the Priority Actions of the TASC Strategy was to promote public awareness of issues around violence towards nurses and midwives.

> To test for public recognition and better understand Canberrans' knowledge and opinions about nurses and midwives in the ACT, a survey was developed by the evaluation team and approved by the TASC Steering Committee.

> Survey programming and administration to obtain a representative sample of the ACT population was implemented by local market research and survey analysis provider, Pollinate.

> Fieldwork took place at the end of June 2021 and a representative sample of 653 Canberrans aged 18 and over was collected.

The survey included a range of questions relevant to the TASC Strategy, and the responses received throw light on implementation issues but can also 'double up' as baseline statistics for the ACT:

> High recognition of media campaigns points towards effective implementation; however, changes in the level of recognition can be used in future for comparative purposes, if campaigns are run again.

Appendix C provides detailed information on the community survey, such as the demographic profile for respondents, the medical locations visited by respondents, as well as community opinions about forms of violence (verbal, physical, etc.).

Relevant findings

The community survey found that 4 in 5 (78 per cent) of Canberrans believe that violence perpetrated against nurses and midwives is a problem. In addition:

> Over half (55 per cent) of the Canberrans surveyed thought that nurses and midwives experienced violence *regularly* or *very regularly* – the highest among the professions listed in the survey, and notably twice as high as for doctors,

> 1 in 5 (18 per cent) of Canberrans recalled witnessing an incident of violence towards a nurse or midwife ('Have you ever witnessed any incidents of violence towards any nurse or midwife?'), and

> Respondents also overwhelmingly agreed that media campaigns addressing this issue are a worthwhile investment, and that the message should be promoted more widely.

Put together, these findings clearly demonstrate that implementing media campaigns as part of strategies such as the TASC Strategy have strong community support.

While this supports the *relevance* of the implementation activity undertaken, it does not directly address the *effectiveness* of this implementation activity.

In this respect, it is worthwhile noting that the two main media campaigns addressing OV for nurses and midwives included in the community survey were well recognised by Canberrans:

> 1 in 6 had seen the 'Be kind' campaign, and
> 1 in 4 had seen the 'More than' campaign.

Figure 14 'Be kind' and 'More than' campaign posters

While both of these were ACT Government campaigns, the latter was not rolled out under the aegis of the TASC Strategy.

From an implementation perspective, there was potentially some crossover and some unnecessary duplication of effort across the two campaigns; however, it is worth noting the differences in the campaigns:

> 'Be kind' was specific to nurses and midwives while 'More than' included nurses and a range of other health staff, and
> 'Be kind' perhaps somewhat more 'internally' targeted.

While both campaigns were most likely to have been seen either on social media or in hospital settings, the 'More than' campaign was significantly more likely to have been seen at COVID testing sites or Other sites.

> 23 per cent of those who reported having seen the 'More than' campaign had seen it at COVID testing or Other sites, while the same was true for only 13 per cent of those who had seen the 'Be kind' campaign.

Issues around coordinating media campaigns across different arms of the ACT's health system were noted at Steering Committee meetings. It is unclear whether there would have been scope to raise visibility of the 'Be kind' campaign without impacting on the visibility of the 'More than' campaign.

> Given campaign recognition crossover among the public, there was potential doubling up of resources, time and costs by having multiple campaigns promoting a similar message.

In summary, the community survey yielded important evidence around the perception of OV, and the media campaigns which addressed this issue.

> The 'Be kind' campaign was one of the highlights of implementation activity undertaken under the TASC Strategy.

Nurses and midwives survey

The evaluation team committed to collecting perception and opinion data from nurses and midwives currently working in clinical settings, as this reflects on aspects related to implementation.

One of the issues around evaluating the implementation of a broad strategy is that the workforce impacted by the strategy may not be aware of the different components of the strategy.

Questions about the appropriateness, effectiveness or efficiency of implementation therefore tend to be addressed by breaking a strategy down to 'bite size' chunks, for example, examining specific programs or initiatives staff members may be aware of.

Indirect measures such as opinions are often seen as inferior outcomes measures, but in the case of the aims the TASC strategy aspires to, such measures are often the best available indicators.

> Similar to the community survey, the information gleaned through such a survey therefore has a dual purpose: to establish some baselines as well as to better understand implementation and process issues.

Questions were adapted from relevant national and international literature and through an iterative process refined with significant input from the TASC project team and TASC Steering Committee members.

The survey consisted of 30 closed and open-ended questions assessing knowledge of TASC Priority Actions and initiatives as well as experiences with OV, challenging behaviour in the workplace and general perceptions of safety in the workplace.

The questions were compiled and collected in the SurveyMonkey survey software and administered via the ACT Health, Canberra Health Services (CHS) and Calvary Public Hospital communications teams to nursing and midwifery staff members.

In addition, the survey was sent out via the Australian Nursing and Midwifery Federation (ANMF) to their ACT members. The survey was opened on 30 June 2021 and closed on 7 July 2021 after two weeks.

Statistics provided by the Nursing and Midwifery Board of Australia (NMBA) show that on 31 March 2021 there were 875 Enrolled Nurses (EN), 5,973 Registered Nurses (RN), 119 Enrolled and Registered Nurses, 217 Midwives as well as 503 practitioners with both a Nurse and Midwife registration in the ACT.[77] In total, it is estimated there are 7,687 nurses and midwives in the ACT across both the public and private health sectors.

During the two weeks of the survey data collection, 291 responses from nursing and midwifery staff were collected, or around four per cent of *all* nurses and midwives in the ACT. These factors give us confidence that the findings of the survey are reasonably robust and representative of the experience of nurses and midwives across the ACT health sector.

Relevant findings

TASC Strategy awareness

If a strategy is well implemented, then it is reasonable to expect that the strategy and its components are recognised by the affected workforce. Recognition *on its own* does not however necessarily imply that a strategy was well implemented.

Strategy recognition is therefore a sign that implementation *may* have been effective, but this needs to be corroborated by further information, such as may be obtained through interviews or more detailed questions in surveys. In the case of the TASC Strategy:

> More than half of nurses and midwives (57 per cent) had heard of the TASC Strategy in general,

> 72 per cent were aware of the “Be kind and respectful to our nurses and midwives” media campaign, and

> 43 per cent knew about Safewards while only 4 percent (Calvary staff) to 12 per cent (Canberra Hospital staff) had actually worked on a Safewards trial ward.

These high recognition figures suggest that implementation achieved good visibility and potentially also positive reputational effects.

When asked about TASC Strategy priority action items, the largest number of respondents were aware of social media and communications campaigns (58 per cent), the Bullying and Harassment Guidelines (53 per cent), and the Safewards model of care trial (33 per cent).

Next in terms of recognition were three guidelines or tools produced under the TASC Strategy, namely the Dispute/Conflict Resolution Guidelines, the Violence Screening Tool, and the Challenging Behaviour Guideline. Around one third of respondents were aware of these.

> The interviews also confirmed that these were seen as the most useful contributions under the TASC Strategy, suggesting strong implementation success in these areas.

Items with the lowest recognition were the Post Incident Occupational Violence Tool (11 per cent), Lone Worker Guidelines (11 per cent) and Civility Index Measurement (2 per cent).

> The interviews indicated that some of these were seen to be extremely useful contributions, but as they had been rolled out very recently, staff awareness was expected to be low at this stage.

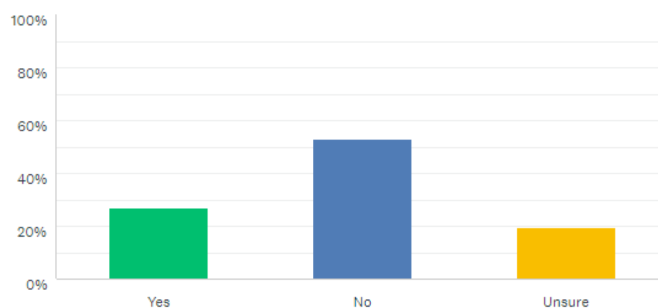
Most of the less recognised TASC action items have already been identified by the TASC project team as priorities for follow up work, which is in line with responses reported in this context. More details on TASC Strategy awareness are included in Appendix D of this report.

Leadership

Figure 15 Perception of Leadership culture in the workplace

Do you think there is a strong leadership culture in your organisation to support occupational violence prevention programs?

Answered: 248   Skipped: 43



ANSWER CHOICES	RESPONSES	
Yes	27.02%	67
No	53.23%	132
Unsure	19.76%	49
TOTAL		248

Note: Internal Survey Question 19

Management engagement with staff

Implementation of TASC Strategy related priorities includes leadership at all levels, and staff engagement. The internal survey of nurses and midwives sheds some light on this through a question on whether or not managers or team leaders had spoken about OV with staff.

It is impossible to disentangle from this whether or not this discussion took place as a result of the TASC Strategy or other initiatives such as OHS strategies that were also implemented at the same time.

> What can be said is that the TASC Strategy, through its focus on OV, would have been a contributory factor.

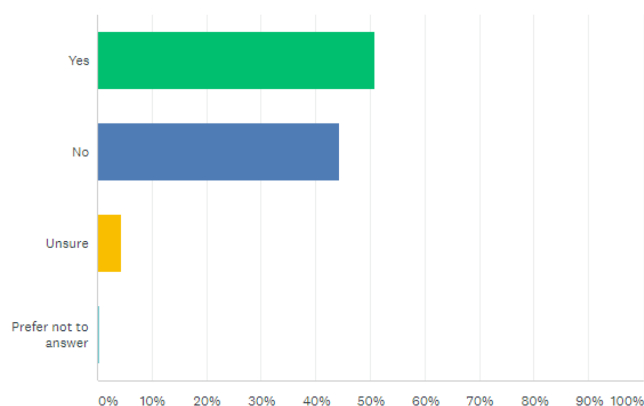
Half of all survey respondents indicated that their manager or team leader had spoken to them about OV over the last 12 months.

> This result indicates that efforts to support leadership, especially at the operational and non-executive managerial level, can be further strengthened in the future.

Figure 16 Speaking about OV with your manager/team leader

Has your manager/team leader spoken to you about occupational violence during the last 12 months?

Answered: 248 Skipped: 43



ANSWER CHOICES	RESPONSES	
Yes	50.81%	126
No	44.35%	110
Unsure	4.44%	11
Prefer not to answer	0.40%	1
TOTAL		248

Note: Internal Survey Question 21

Discussion of OV within teams

In terms of implementing change regarding OV, it is also valuable to understand whether OV is discussed in teams, and in which context OV initiatives may be discussed, if they are discussed at all.

Nearly half of survey respondents who answered this question said that OV was not discussed in their teams – that means, not discussed one on one with managers, or at WHS meetings or other staff meetings.

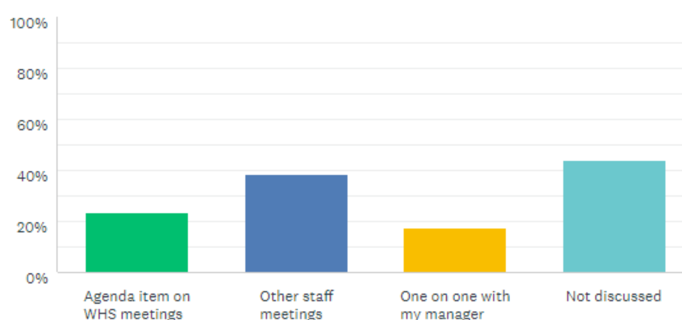
Again, it is impossible to say whether the TASC Strategy had an impact on this proportion – it could be that previously a higher proportion did not discuss it, and so it is entirely feasible that this result is consistent with the implementation having had an impact.

What is clear, however, is that there is further scope for improvement, and next steps may include focussing more on staff engagement about OV through staff meetings or WHS meetings.

Figure 17 OV discussions in teams

How is occupational violence discussed within your team ? (Select all that apply)

Answered: 240 Skipped: 51



ANSWER CHOICES	RESPONSES	
Agenda item on WHS meetings	23.33%	56
Other staff meetings	38.33%	92
One on one with my manager	17.50%	42
Not discussed	44.17%	106
Total Respondents: 240		

Note: Internal Survey Question 20

WHS meeting agendas

Having touched on WHS meetings, it is informative to investigate whether OV is already on WHS agendas or not. This is relevant to the implementation of the TASC Strategy, although once again the strategy alone cannot be credited for OV being included on WHS agendas.

Only 30 per cent of respondents indicated that OV was on the agenda of their local WHS meetings, and 45 per cent of respondents were unsure whether this was the case. This result could indicate a few different scenarios:

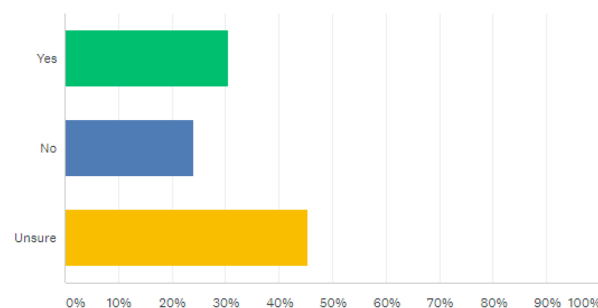
1. OV is not on many WHS agendas,
2. Respondents did not attend those meetings, or
3. Had some definition issues on the term "occupational violence".

As stated earlier, it is impossible to know how much the TASC Strategy was a driver of inclusion of OV on WHS meeting agendas; however, this provides another base line figure that reflects success in implementation and could potentially be monitored going forward.

Figure 18 OV and WHS meeting agendas

Is occupational violence on the agenda of your local Work and Health Safety (WHS) meetings?

Answered: 249 Skipped: 42



ANSWER CHOICES	RESPONSES	
Yes	30.52%	76
No	24.10%	60
Unsure	45.38%	113
TOTAL		249

Note: Internal Survey Question 20

Summary

- Managers talking about OV seems to be important for feelings of workplace safety among nurses and midwives, as a form of acknowledgement,
- Non-physical violence seems to be more related to job turnover intentions. This result, however, indicates further need to analyse the data to reveal contextual factors,
- There is a need to further implement models of care such as “Safewards” that aim to improve staff and patient safety,
- Organisational leadership in relation to occupational violence appears to influence feelings of safety at work,
- Further data analysis is needed to understand environmental factors in which occupational violence, harassment and bullying occurs,
- Occupational violence from patients/carers/families as well as bullying from co-workers influence safety at work and needs to be addressed in conjunction, and
- The data presented are baselines and need to be repeated in due course to determine clear impact on nurses’ feelings of safety at work and turnover intentions.

Impact evaluation

At this stage, due to the data and measurement issues that have already been mentioned, *trends* in outcomes cannot be identified.

In addition, statistically, any influence which the TASC Strategy may have had on intended outcomes cannot be disentangled from other efforts that were underway across the three organisations involved in implementing the Strategy (ACTHD, CHS and Calvary).

From a policy design and evaluation perspective, while it was always intended that the Strategy would be evaluated (as reflected in one of the Priority Actions), upfront investment in evaluation could have helped define key concepts or variables (such as "safety") and laid the groundwork for future evaluation.

- Given that definitions for key concepts including violence, harassment, bullying, and safety vary in the research literature, different stakeholders may have differing views on appropriate definitions, proxies, indicators, and measures.
  - The evaluation team notes this difficulty, and suggests that compromises will have to be made, noting a potential trade-off between what is practicable and what is most robust in theory.

The evaluation team recognises that detailed up front evaluation planning occurs rarely and given the small size of the TASC project team, and the initial urgency around developing work plans, this did understandably mean that evaluation was not a major priority early on.

A second important point to note about impacts is that, as already stated, culture change is often a slow process and it is extremely unlikely that significant measurable change would have occurred over two years (which also included the Covid-impacted period in 2020).

Taken together, this explains why the evaluation can throw limited light on impacts at this stage; however, the development of the surveys for this evaluation, and the data collected, should help to strengthen a later evaluation if that is to occur.

Certainly, the data the evaluation team has collected makes the problem statement very clear – the issue of OV is a real one and is costly to the health sector as it undermines the sustainability of the workforce (OV, bullying and harassment all impact leaving intentions).

Community survey

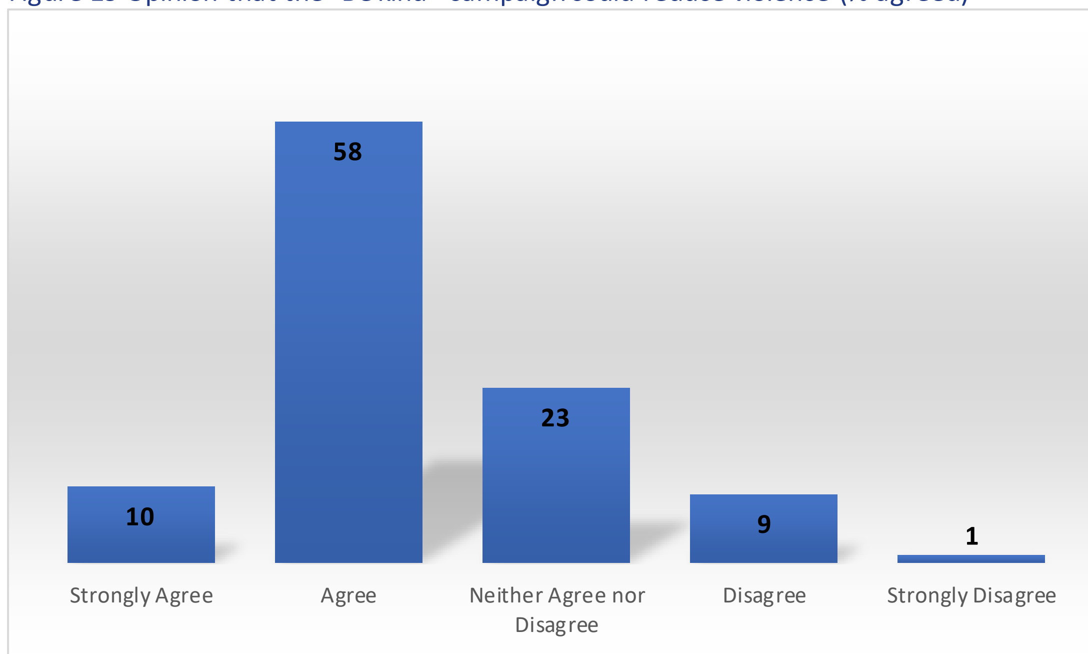
Impact on thoughts, feelings and behaviour

Important findings from the community survey relates to the impact of these campaigns on people's thoughts, feelings, and likely behaviour:

- Perhaps most importantly, over two thirds (68 per cent) of respondents agreed that the 'Be kind' campaign could reduce violence, and in addition:
  - 73 per cent agreed it made them *think* differently about nurses and midwives,
  - 35 per cent agreed it made them *feel* differently, and

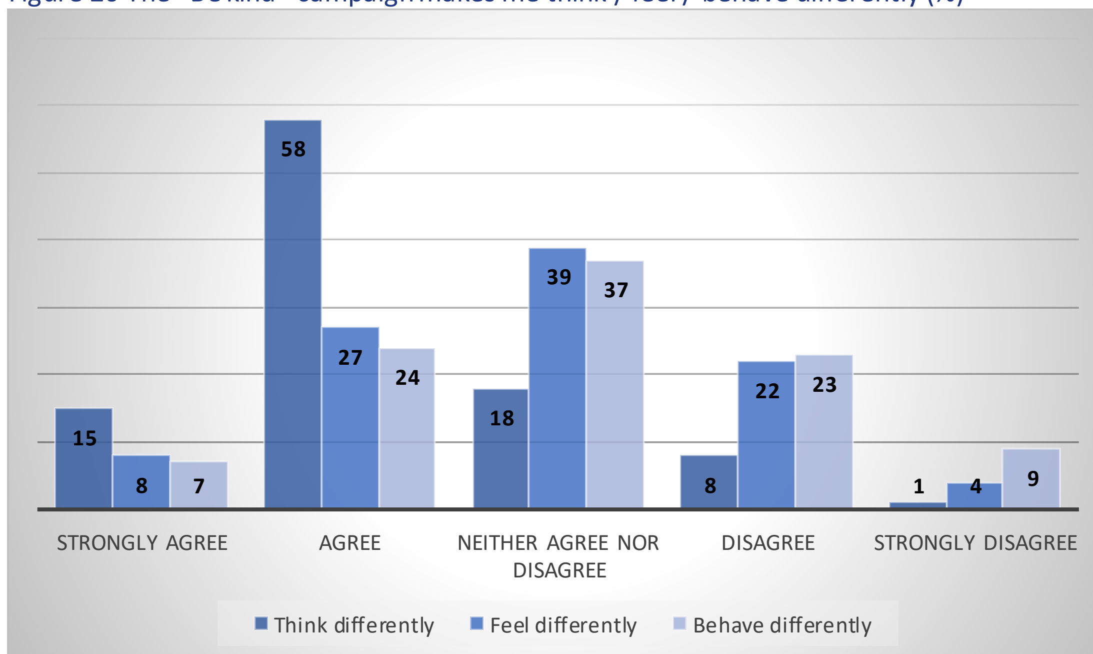
- 31 per cent agreed it made them *behave* differently.

Figure 19 Opinion that the “Be kind” campaign could reduce violence (% agreed)



Note: Community Survey Question C4

Figure 20 The “Be kind” campaign makes me think / feel / behave differently (%)



Note: Community Survey Question C4

These are important findings, indicating that media campaigns could have more significant impacts than might have been assumed. The rollout of the ‘Be kind’ campaign is one of the success stories of the TASC Strategy.

Nurses and midwives survey

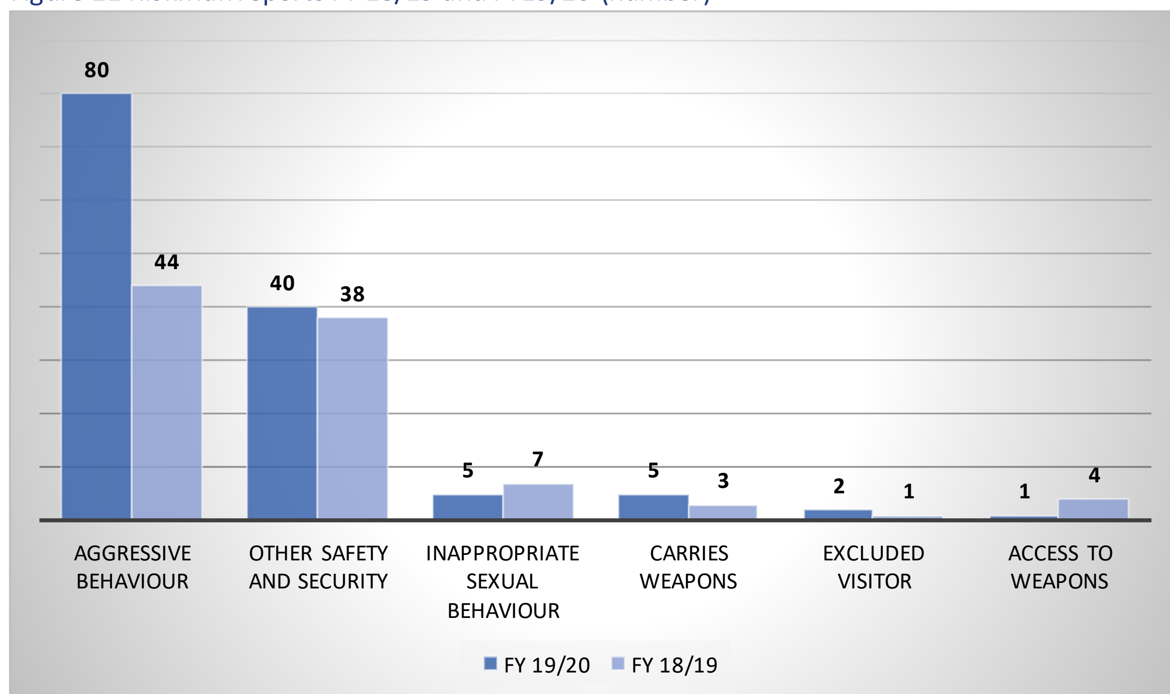
RiskMan reports

A data source that may be used to understand the incidence rates of OV towards nurses and midwives is the ACT Health RiskMan system which is used to report on occurrences of violence from a third party.

Based on the RiskMan data provided for the purpose of this evaluation, "Aggressive Behaviour" and "Other Safety and Security" issues were the most common reporting categories reported on.

Overall, there were 97 reported incidents in the ACT Public Health System in FY 2018/2019 increasing to 133 reported incidents in FY 2019/2020. Only RiskMan data that contained information on OV in public health care settings was included.

Figure 21 RiskMan reports FY 18/19 and FY19/20 (number)



As the literature review revealed, OV tends to be severely underreported, and it is therefore quite possible that the increase in numbers reflects better reporting.

If the finding from the community survey that around one in five Canberran adults have witnessed an incident of violence against a nurse or midwife is taken as a reference point, whichever way those numbers are interpreted, they would very likely represent a significant multiple of the number of incidents reported in the RiskMan system.

This is not a precise measure, of course, as recall is not always reliable, and the length of recall is also unknown (did people recall an event from their childhood or more recently, etc.). It is also possible that *multiple* respondents witnessed the *same* incident(s), which

reduces the number of individual incidents that may have been reportable. On the other hand, when people agreed that they had *ever* witnessed such an incident, this does not preclude them from having witnessed more than one incident in their lifetimes.

Furthermore, RiskMan data on one year is not enough to establish a trend. The context for the information is also not clear in the reporting – while there is a "comment" function, the overall situations entered are rather brief. On balance, there is not enough information to draw any specific conclusions on the basis of these data.

> RiskMan data does not seem particularly well suited to understand the impact of TASC Strategy actions or initiatives on outcomes.

The following sections present visuals from the SurveyMonkey outputs produced for the internal survey of nurses and midwives. These provide descriptive baselines that can be used for future monitoring and evaluation exercises.

Only a selection of highlights is discussed in this chapter; however, the full range of IEBs included in the survey can be reviewed in Appendix D of this report.

Impact of broad action on work environments

Where possible, the evaluation team phrased questions in such a way that they could capture some insights on impact to date, such as the question on whether staff felt that action on OV, bullying and harassment had made a difference to their work environment.

> One in three respondents stated that such action had indeed made a difference with respect to OV,

> One in four stated it had made a difference with respect to bullying and harassment, and

> Around 30 per cent were not sure it had made a difference with respect to either OV or bullying and harassment.

Interpretation of these numbers is difficult. On the positive side, a significant proportion did think that the action made a difference. The fact that a higher proportion agreed that it made a difference for OV than bullying and harassment could reflect:

a) That the public media campaigns (external facing) were particularly successful in reducing aggressive and violent behaviour towards nurses and midwives,
b) That the initiatives addressing challenging behaviours (internal) simply came up against a harder issue (i.e., more entrenched behaviours),
c) The sequencing and recognition of interventions (the media campaigns were rolled out first and had better recognition),
d) Displacement effects (e.g., challenging behaviours from colleagues may be noticed disproportionately more when a reduction in OV from other sources takes place), or
e) A complex combination of the above and other factors (suspected to be the case, but this cannot be ascertained with the data at hand).

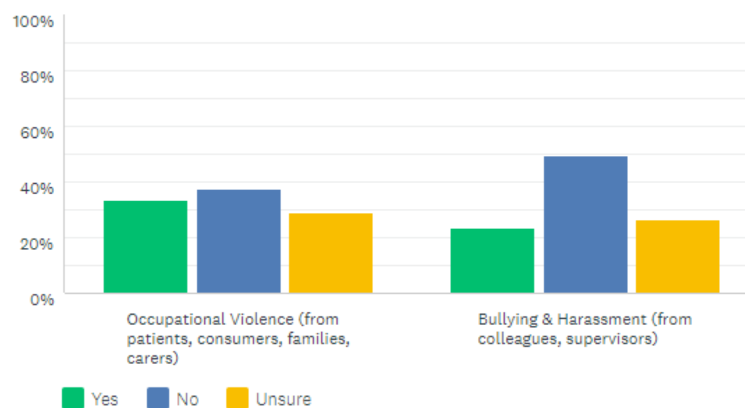
The second point to note is that these data cannot tell us if a *better* outcome could have been achieved or should have been expected. Given that this is the first time the question has been asked in this way, all that can be concluded is that there has been some impact.

Finally, on this question, it is worth reiterating that a *range of efforts* were underway across the organisations, and the proportion of the impact that is attributable to the TASC Strategy initiatives and actions is impossible to ascertain.

Figure 22 Impact of action on OV, Bullying & Harassment on work environments

Do you feel action on Occupational Violence and Bullying & Harassment in your organisation has made a difference to your work environment?

Answered: 243 Skipped: 48



	YES	NO	UNSURE	TOTAL
Occupational Violence (from patients, consumers, families, carers)	33.33% 57	37.43% 64	29.24% 50	171
Bullying & Harassment (from colleagues, supervisors)	23.67% 40	49.70% 84	26.63% 45	169

Note: Internal Survey Question 18

Perceived impact of specific TASC initiatives

In order to address key TASC actions and initiatives more directly, a question was included that asked specifically about eleven prominent TASC-related items as shown in Figure 23. This list was agreed in consultation with the TASC project team and Steering Committee.

Noting that respondents also had a separate option to say they “don’t know about this activity”, the results show that:

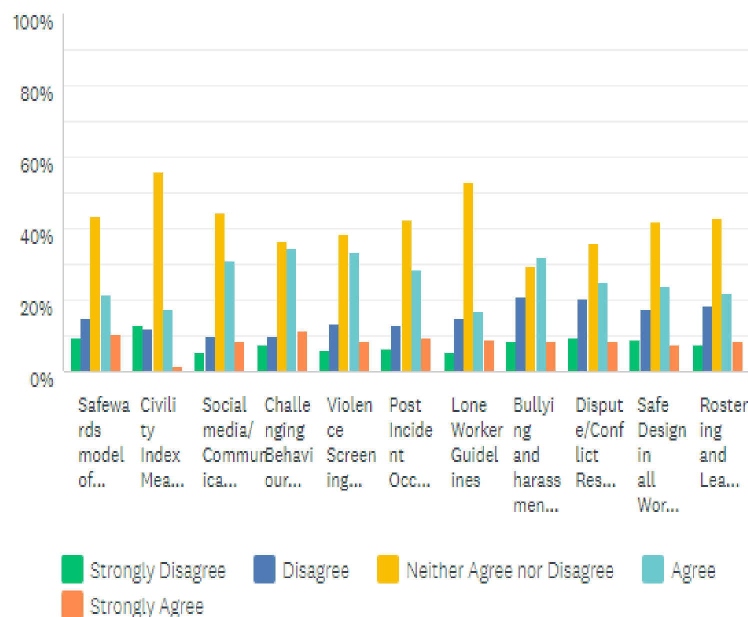
> More respondents agreed that TASC initiatives had made a positive change to their workplace (light blue bars) than those that disagreed (dark blue bars),

> Many respondents felt that they did "neither agree nor disagree" that TASC initiatives had made a positive change to their workplace (see yellow bars).
  - As these respondents did not tick "don't know about this activity", this may be an indication that they lacked the information required to make an informed assessment or had yet to make up their minds about a particular initiative.

Figure 23 Positive change to workplaces attributed to TASC Strategy initiatives

I feel the following have made a positive change to my workplace:

Answered: 248 Skipped: 43



Note: Internal Survey Question 17

The following stand out as being perceived particularly positively, with around 40 per cent of respondents agreeing or strongly agreeing that these had made a positive change to their workplace:

> Challenging Behaviour Guideline,
> Bullying and harassment prevention guidelines, and the
> Violence Screening Tool
  - These Top 3 were closely followed by the Social media / Communications campaigns and the Post Incident OV Toolkit.

The Safewards model of care trials also ranked high, with about 30 per cent of respondents agreeing or strongly agreeing that these trials had a positive impact on their workplace:

> This is somewhat surprising given that only a much smaller proportion had actually worked on Safewards trial wards (12 per cent of respondents at the Canberra Hospital, and 4 per cent of respondents from Calvary), and

- It suggests that the Safewards trials have had positive 'spillover' effects on other areas, possibly by way of signalling or reputation:
  - Staff working in other areas may think of the trial wards as part of their workplace and having heard positive things about the trials could therefore agree to this statement even though they had not themselves worked on a trial ward.

It is not surprising that those actions which were rolled out earlier also scored better – some actions such as the Lone Worker Guidelines have been under development until recently and nurses and midwives may not as yet have had the opportunity use them.

- COVID-19 may also have impacted on some of these more recent actions' recognition factor, as nurses and midwives have been reassigned to other tasks, and

The Civility Index Measurement stands out as the item with low agreement, and the highest proportion strongly disagreeing that it had made a positive impact.

Impact evaluation baselines

Many of the questions put to ACT nurses and midwives in the internal survey carried out for this report have not been asked in this way before, or at least the PDE team did not have access to data on such questions and their responses in the ACT context.

- Data yielded by these questions are effectively impact evaluation baselines (IEBs), with highlights reported here, and additional detail provided in Appendix D for transparency and for future use.

The survey included a small number of questions that were similar to questions that had been previously asked in the ACT Government context. These were included for statistical purposes, e.g., for validation or to test for internal consistency.

Experience of non-physical, physical and sexual violence

An important IEB relates to the experience of violence by nurses and midwives in the ACT health system.

The community survey revealed that a significant proportion of ACT residents witnessed such violence being perpetrated, felt that it is a problem, and thought that such violence happens regularly.

The internal survey provided an opportunity to ask that question directly of nurses and midwives, and their responses indeed confirm the perceptions of the wider community.

While the data in Figure 24 must be interpreted with caution to avoid 'double counting', they show that:

- At least 2 out of 3 have experienced some form of OV, bullying or harassment during the last twelve months.
  - Around 1 in 4 experienced physical violence in the last twelve months, and
  - Approximately 1 in 25 experienced sexual violence and/or assault (four per cent).

As Figure 24 illustrates, most experience of violence appears to be related to patients and their families or carers – both physical and non-physical violence. The numbers for sexual violence and assault are small but are predominantly from patients.

Physical and sexual violence or assault at the hands of co-workers or managers appears to be very rare; however, a substantial number of respondents reported experiencing non-physical violence, bullying and/or harassment from co-workers or managers.

It is extremely difficult, however, to apply evaluative criteria to these data – one could reasonably argue that a single incident of OV is one too many, however as the literature revealed it is a problem that is almost ubiquitous in health care settings worldwide.

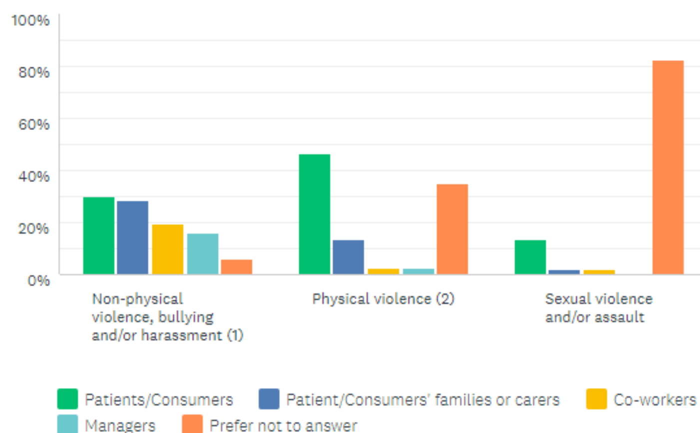
The data do not shed light on *frequency* and also do not allow us to differentiate between different *degrees* or types of non-physical, physical, and sexual violence experienced. More research would be required to develop a nuanced understanding of this.

The evaluation team however sees value in tracking this IEB to check that progress is being made over time.

Figure 24 Experience of Non-physical, Physical and Sexual violence

I have experienced the following during the last 12 months: (Select all that apply)

Answered: 222 Skipped: 69



	PATIENTS/CONSUMERS	PATIENT/CONSUMERS' FAMILIES OR CARERS	CO-WORKERS	MANAGERS	PREFER NOT TO ANSWER	TOTAL RESPONDENTS
Non-physical violence, bullying and/or harassment (1)	30.15% 142	28.45% 134	19.53% 92	15.92% 75	5.94% 28	471
Physical violence (2)	46.43% 52	13.39% 15	2.68% 3	2.68% 3	34.82% 39	112
Sexual violence and/or assault	13.73% 7	1.96% 1	1.96% 1	0.00% 0	82.35% 42	51

Note: Internal Survey Question 22

Staff who considered leaving their position

Another useful statistic to track over time is the proportion of nurses and midwives who consider leaving their positions due to the experience of various forms of violence in the workplace. In the literature this is referred to as 'turnover intentions'.

A question on turnover intentions was included in the survey, and subject to the fact that some nurses and midwives may indeed have experienced several forms of violence (i.e., noting a potential double counting issue):

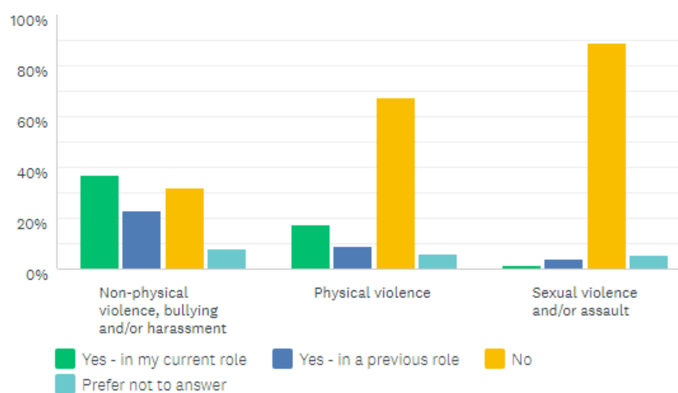
> The data indicate that *around* half of all nurses and midwives considered leaving their position as a result of the experience of workplace violence, bullying and/or harassment during the last year.

Whilst *frequency* and the *degree* of intent are unknown – a 'one-off' consideration or did staff repeatedly consider leaving their position and perhaps even scanned the job market for vacancies – this is another useful IEB.

Figure 25 Turnover intentions

I have considered leaving my position over the last 12 months due to the following :

Answered: 187 Skipped: 104



	YES - IN MY CURRENT ROLE	YES - IN A PREVIOUS ROLE	NO	PREFER NOT TO ANSWER	TOTAL RESPONDENTS
Non-physical violence, bullying and/or harassment	36.92% 79	22.90% 49	32.24% 69	7.94% 17	214
Physical violence	17.35% 17	9.18% 9	67.35% 66	6.12% 6	98
Sexual violence and/or assault	1.37% 1	4.11% 3	89.04% 65	5.48% 4	73

Note: Internal Survey Question 23

Time taken off due to OV and challenging behaviours

Time taken off due to OV, bullying and/or harassment is another useful measure, and if tracked over time could yield insights into the progression of culture change and safety at workplaces in the ACT health system.

The PDE team discussed with the Steering Committee early on in the evaluation project, that a U-shaped progression in reporting and other indicators may be expected to occur over time:

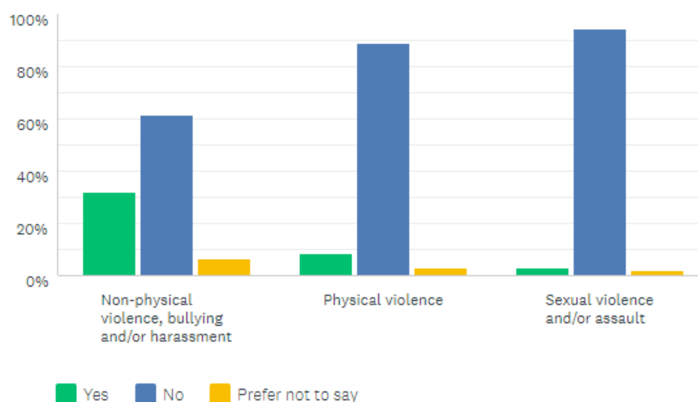
> As awareness around OV increases, reporting should increase given the issue of underreporting, and similarly one may expect that time taken off may increase in the first phase even though the underlying prevalence of OV may be unchanged.

If culture change leads to increased recognition of OV among nurses and midwives, supported by management and leadership, an increase in time take off is indeed foreseeable, and therefore does not necessarily provide a sign of failure.

Figure 26 Time taken off during the last 12 months due to OV and challenging behaviours

Have you taken time off during the last 12 months due to the following :

Answered: 187 Skipped: 104



	YES	NO	PREFER NOT TO SAY	TOTAL RESPONDENTS
Non-physical violence, bullying and/or harassment	31.87% 58	61.54% 112	6.59% 12	182
Physical violence	8.33% 9	88.89% 96	2.78% 3	108
Sexual violence and/or assault	3.16% 3	94.74% 90	2.11% 2	95

Note: Internal Survey Question 24

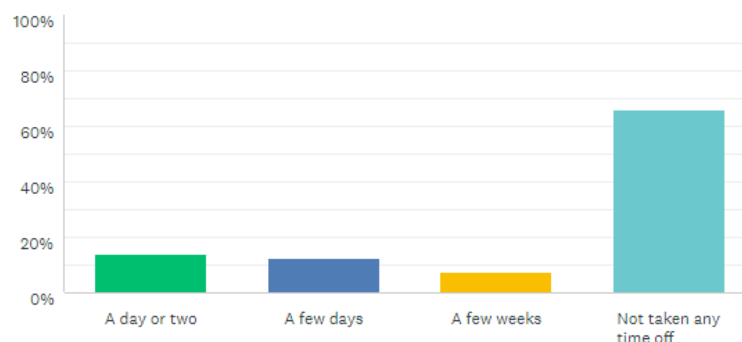
> Figure 26 indicates that up to one-third of nurses and midwives took some time off due to non-physical violence, bullying and/or harassment. Figure 27 also supports this conclusion, with 73 out of 216 respondents taking some time off (34 per cent).

- Although based on smaller numbers, if read in conjunction with the data presented in Figure 24, a significant proportion of those who experienced physical violence, and in particular sexual violence, needed to take time off.
- As Figure 27 shows, the majority of those who took time off, needed to do so for a day or up to a few days; however, 16 out of 216 (7 per cent) took a few weeks off.
  - These figures illustrate not only the impact that violence experienced in the workplace has on nurses and midwives, but also the associated cost imposts including lost productivity to the ACT health system.

Figure 27 Amount of time taken off during the last 12 months due to OV

If you have taken off time, how much time did you take off over the last 12 months due to occupational violence?

Answered: 216 Skipped: 75



ANSWER CHOICES	RESPONSES	
A day or two	13.89%	30
A few days	12.50%	27
A few weeks	7.41%	16
Not taken any time off	66.20%	143
TOTAL		216

Note: Internal Survey Question 25

To shed light on potential changes over time, the internal survey also included a question on whether nurses and midwives had taken more, less or about the same amount of time off compared to the previous year.

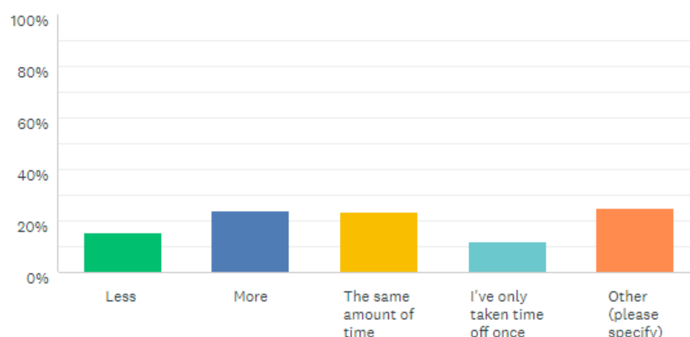
The results depicted in Figure 28 show that the experience has been variable, however more respondents reported taking more time off than less time off. Monitored over time, again, this IEB measure could be used to better understand patterns of impact.

- Additional questions could be included in future surveys; for example, if a correlation between frequency and severity of OV and time taken off could be established, then more or less time taken off could also indicate that frequency or severity are potentially increasing or decreasing. Such inferences cannot be drawn on the basis of the data currently at hand.

Figure 28 Change in the amount of time taken off compared to previous year

If yes, have you taken more, less or about the same time off compared to the previous year?

Answered: 153 Skipped: 138



ANSWER CHOICES	RESPONSES	
Less	15.69%	24
More	24.18%	37
The same amount of time	23.53%	36
I've only taken time off once	11.76%	18

Note: Internal Survey Question 26

Perception of workplace safety

As has been pointed out already, the literature on safety includes a plethora of measures and approaches to interpreting safety in the workplace. This is by no means a settled issue.

There is no doubt that individuals' perceptions can be unreliable; for example, staff may not be aware of the actual number of incidents taking place.

Nonetheless, the PDE team believes that one of the key tests has to be whether staff feel safe or not. This should be supplemented by additional measures, but staff perception is a critical aspect of safety.

> As Figure 29 reveals, 3 in 10 nurses and midwives do not agree that their workplace is a safe place to work. 1 in 10 in fact strongly disagree with this statement.

> Given the statistics discussed in the preceding sections, this should not be surprising.

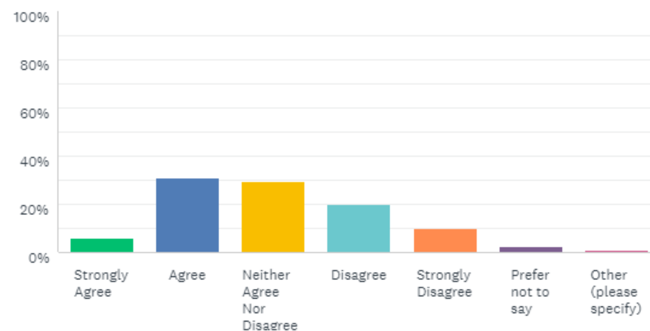
The literature review and interviews indicated that these figures are in line with experience elsewhere. With the ACT Government's commitment to addressing these issues, however, this IEB provides another useful indicator to track over time.

To reiterate, these statistics cannot be used as evaluative criteria to assess the impact of the TASC Strategy to date, except to confirm that there is a need for strategies such as the TASC Strategy given that they address the important issues captured here.

Figure 29 Perception of workplace safety

My workplace is a safe place to work

Answered: 237 Skipped: 54



ANSWER CHOICES		RESPONSES	
Strongly Agree		5.91%	14
Agree		31.22%	74
Neither Agree Nor Disagree		29.54%	70
Disagree		19.83%	47
Strongly Disagree		10.13%	24
Prefer not to say		2.53%	6
Other (please specify)	Responses	0.84%	2
TOTAL			237

Note: Internal Survey Question 30

Factors influencing safe workplace perceptions

To go beyond percentage agreement to survey question statements, the joint influence of different determinants on perceptions of workplace safety was estimated in a statistical methodology called "Ordered probit regression analysis".

Regression analysis is a powerful statistical tool used to aid understanding relationships between multiple factors that play an analytical role:

> The relationship between variables such as education level, experience of OV, perception of leadership, and variables such as perceptions and feelings of safety among nurses and midwives, can be explored using regression analysis.

Regression analysis can identify the effect of one factor while adjusting for other observable differences, for example:

> It can analyse how managerial leadership relates to turnover intentions, after controlling for differences in background characteristics such as education and experience.

As a result, it provides more actionable insights for decision making and policymakers than mere agreement percentages to individual statements in surveys (the latter are often taken out of context).

Usually, an ordered probit model is applied to estimate relationships between a categorical and ordered ("ordinal") variable and a set of assumed determining factors.

In this instance, the question “I feel safe at work” had five levels of agreement respondents could choose from, including “Strongly Agree”, “Agree”, “Neither Agree nor Disagree”, “Disagree” and “Strongly Disagree”.

In this supplemental analysis, determining variables that are assumed to influence perceptions of safety were:

- Source of experienced violence: Patient/Consumer
- Source of experienced violence: Patient family/Patient carer
- Source of experienced violence: Co-worker
- Source of experienced violence: Manager
- Violence type: Physical
- Violence type: Non- Physical
- English as main language at home
- OV on Work, Health and Safety (WHS) Meetings Agenda
- “Towards a Safer Culture" awareness
- Be kind and respectful to our nurses and midwives" campaign awareness
- Safewards model of care awareness
- Manager conversations about OV
- Lone Worker Guidelines knowledge
- Violence Screening Tool Guidelines knowledge
- Post Incident OV Toolkit knowledge
- Challenging Behaviour Guidelines knowledge
- Rostering and Leave Allocation Guidelines knowledge
- Age group
- Professional experience (in years)
- Safe Design in all Workplaces awareness
- Bullying and Harassment Guidelines awareness
- Dispute and Conflict Resolution Guidelines
- Strong Leadership Perception

Not all these factors were found to influence nurses’ and midwives’ safety perceptions, only the factors below could be confirmed in the data analysis process.

As note of caution, it is important to understand this this analysis does not suggest *causal influence* between either of these factors but merely indicates potential *association.*

- It does not mean that for instance because physical violence is not found to be a major influence on safety perceptions in this analysis that there is no association either – this result could be a function of model fit and the determinants that were included in this analysis.

The results suggest that survey respondents felt safer at work if they:

> Mainly spoke English at home,
> Were aware of the "Violence Screening Tool Guidelines",
> Were aware of the "Be kind to our nurses or midwives" campaign,
> Have had conversations about OV with their manager, and
> Perceived that their organisation has strong leadership in relation to OV.

Figure 30 Factors influencing nurses' and midwives' safety perception

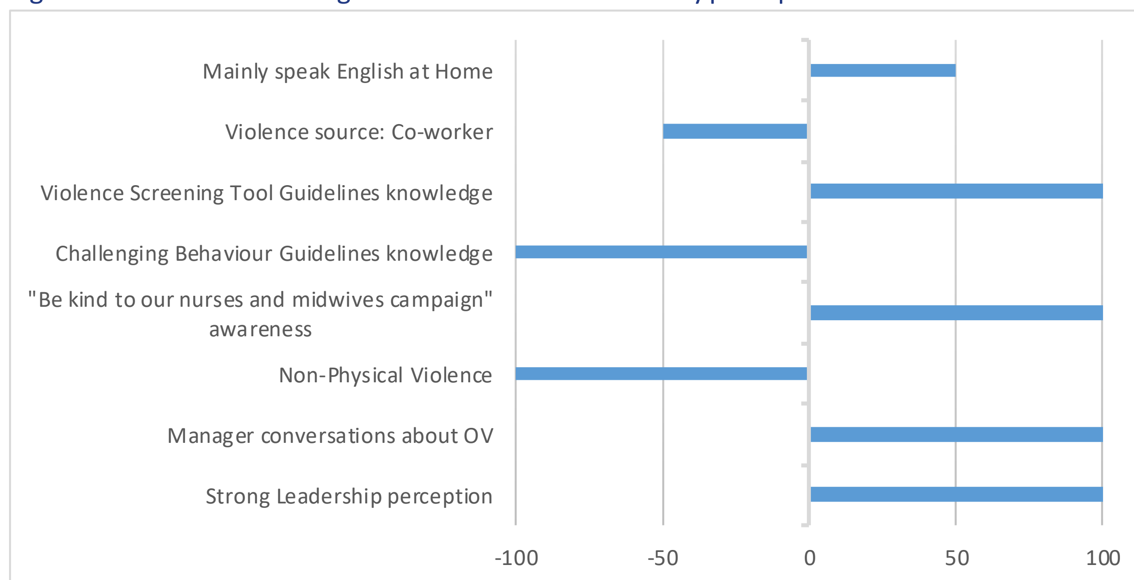


Figure 30 is an approximate representation of the "ordered probit regression" analysis, and graphically depicts whether determinants that have been found to either positively or negatively influence nurses' and midwives' safety perception, and whether this influence is either "strong" or "weak".

> The numbers (-100 to +100) in the graph above do not have a meaning in themselves but are used for illustrative purposes only. The relevant results are presented in Appendix D.

The perception of strong leadership in OV is the most influential determinant of feelings of safety at work, probably due to feeling supported at work when encountering OV.

Similarly, survey respondents feel safer at work when their manager had conversations with them in relation to Occupational Violence (OV).

> The "Be kind to our nurses and midwives" campaign also seems to have a positive safety perception impact for those respondents aware of this initiative. Furthermore, respondents who speak mainly English at home and respondents aware of the "Violence Screening Tool Guidelines" were found to feel safer at work.

In terms of variables with a potential negative association (negative coefficient), the analysis suggests that workers felt less safe at work if:

> They had experienced non-physical violence,
> They had experienced violence/bullying emanating from co-workers, and
> If they had knowledge of the Challenging Behaviour Guidelines.
  - The latter may be a result of a further association, which could not be tested for: perhaps those who experienced non-physical violence from co-workers were much more likely to have read the Challenging Behaviour Guidelines.

As has already been stated, some of these results could be due to more complex statistical issues which are beyond the scope of this report.

> That experience of co-worker bullying may lead to lower levels of safety in the day-to-day nursing and midwifery workplace tasks in general should however not come as a surprise.

Discussion

The tables and graphs presented above and in Appendix D paint the picture of the current experience with OV, bullying and harassment for nearly 300 nurses and midwives in the ACT health system.

There may be a *small* bias in the responses, but the direction of bias is unclear:

> It may be theorised that nurses and midwives working in particularly stressful areas are *more* likely to respond to the survey as this is might represent an "opportunity to air grievances" (and when generalising to the entire cohort, this would lead to an *overestimation* of the problem); or
> Conversely, it may also be theorised that nurses and midwives working in those contexts are actually *less* likely to have free time or to be in the right frame of mind to respond to a survey, for example, for fear of being 'caught' completing a survey (this would lead to *underestimation* of problem).

The direction of this bias, if any such bias exists, is unknown. Statistically, it is *highly unlikely* that the sample consisted only of particularly aggrieved nurses or midwives.

In other words, the evaluation team believes that these data represent the best estimate of the size of the problem in the cohort overall, with key findings being:

> At least 2 out of 3 have experienced some form of OV, bullying or harassment during the last twelve months.
  - Around 1 in 4 experienced physical violence in the last twelve months, and
  - Approximately 1 in 25 experienced sexual violence and/or assault (four per cent).
> Around half considered leaving their job as a result of this during the last year,

> 1 in 3 reported bullying or harassment from co-workers or managers during the last year, and
> A similar proportion did not agree with the statement that "My workplace is a safe place to work"

These findings are entirely plausible and in line with the results discussed in the literature review. These are useful baseline figures that facilitate comparison and better-informed discussion over time. If initiatives are successful, these numbers should decline in future.

At the same time, it is heartening to learn that the majority of respondents said OV is being discussed in their teams, for example at team meetings, and with managers, and that a good proportion of nurses and midwives had heard of many of the actions to address OV, bullying and harassment.

To further advance analysis and to target a better response to nurses' and midwives' safety perceptions, more in-depth analysis such as cross-tabulation of data and more advanced modelling could be used to gain advanced in-depth insight to understand what segment of respondents has specific experiences and may need specific interventions to be reached in the administration of Occupational Violence (OV) and Challenging Behaviour programs.

While significant progress has been made in the implementation of the TASC strategy and main achievements have included building a highly proficient project team, gathering efficient and effective Steering and Advisory Committees, some areas such as leadership and staff engagement, which seem to be crucial for the success of the TASC Strategy, should be advanced further.

Gaps identified in interviews and the nurses and stakeholder survey include the better integration of Occupational Violence (OV) and Challenging Behaviour (i.e. bullying and harassment) initiatives since both seem to interact and influence perceptions of safety at work.

As indicated in the initial chapters, the main challenges and obstacles relate to the set-up of the TASC Strategy, i.e., the initially challenging development of an implementation plan for an such ambitious body of work, and the onset of the COVID-19 crisis.

The administration and implementation of a complex strategic framework requires a team with a substantial full time equivalent (FTE) equivalent, which has not been the case in this project. Additionally, the turnover of some project staff, with only one constant project administration team member present during the TASC implementation period has also led to challenges for project administration and implementation tasks, especially when considering the considerable effort required for successful project outcomes that span three separate organisations and the ACT public health system overall.

With a complex issue such as occupational violence and bullying/harassment prevention, the most visible strategies among the intended recipients have included (as per interview and surveys data):

> "Be kind to our nurses and midwives" media campaign, and the
> "Safewards" Model of Care Trial.

As both programs are public-facing and include members of the public (the social media campaign was targeted at the general public, and the Safewards trial included visible elements that would have been noticed by patients' families), the impact and general awareness may have been higher than ostensibly "inwards" facing programs and initiatives.

The internal survey found that some of the guidelines have not generated high levels of awareness, possibly due to nurses and midwives having less access to governance-relevant documents and organisational policies, but also due to the fact that some of these are new.

The internal staff survey suggests, however, there may still be an influence on nurses' and midwives' safety perceptions. Promotion of guidelines may have provided a benefit to nurses and midwives as an example of organisational support, especially if leadership supports these policies and references them regularly.

The TASC Strategy overall has been effective in addressing systemic issues in relation to safer work culture in the ACT, with more emphasis placed on OV related matters and somewhat fewer initiatives addressing challenging behaviours, despite the clear impact that both have on safe work environments.

While the objectives and the key delivery areas of the Strategy are still valid and consistent with the overall strategic goals, objectives and desired changes, careful consideration needs to be given to which interventions and activities need to be reinforced in the future.

As indicated before, a data-driven approach should be adopted to continue monitoring and evaluating the impact the TASC Strategy may have in the future. This approach will also be valuable to assess whether all the elements of the TASC Strategy, such as key delivery areas, will still be relevant going forward.

Recommendations

As outlined in this report, the evaluation of the TASC Strategy was informed by an initial, rapid literature review, and then undertaken using a 'mixed methods' approach including in-depth discussions with the TASC Project team, a review of project documents, stakeholder interviews, a community survey and an internal staff survey.

The following broad recommendations are based on the evaluation team's interpretation of the evidence that emerged from the interviews and analyses undertaken during the evaluation process, including the surveys, document analyses and the literature review.

The recommendations are expressed primarily in terms of the Priority Action areas in which further work is recommended.

Recommendation 1

- Explore and engage in further **staff engagement** activities. This is a long-term process.

Recommendation 2

- **Clinical leadership** needs to be further progressed. This is also a long-term process.

Recommendation 3

- Ongoing commitment to data collection and analysis to support **evaluation**.

Recommendation 4

> **Increased OV visibility** necessitates a long-term commitment to organizational change, and these activities should be continued.

Recommendation 5

> **Civility Index measurement** should be a focus for the next work program under TASC or another strategic process.

Recommendation 6

> **Embedding safe design** is another long-term strategy and needs to be followed-up regularly to monitor progress.

Recommendation 7

> **"Safewards" models of care** should be considered for a wider implementation in more hospital wards.

Next steps

In addition, the evaluation team recommends that when considering the next stage of work, the underlying Theory of Change be considered and made more explicit in working documents.

There needs to be a common understanding that whichever theory is adopted, it is unlikely to represent the 'sole and single truth' – the practice of isolating one's assumptions is simply intended to allow for more effective evaluation of what works, not to identify shortcomings.

This process should also help in clarifying what success looks like, and which indicators might appropriately capture progress – the Theory of Change should reveal assumptions about the mechanisms by which Priority Actions will lead to expected outcomes.

> Clarity around this will support monitoring, evaluation, and continuous quality improvement.

Accompanying this, the evaluation team suggests that it would be helpful to develop either a Change Management Plan, to refresh the existing TASC Strategy, or to consider the next steps to guide action across the sector going forward.

Whatever form the next stage of this important work takes, strategically it should be clearly linked to a Theory of Change, as already outlined, and key assumptions should be informed by all the relevant stakeholders.

The areas of a refreshed strategy's remit (and/or its Terms of Reference) should also be sharpened when setting up the governance structure for such future work.

> The positioning of a new or refreshed strategy – how it interacts with other, potentially similar strategies, policies, and programs of work, particularly in areas where it overlaps with these other programs – should be clarified.

Appendix A – Document analysis

For the document analysis, two main models of analysis were utilised:

a) Frequency analysis, as visualised by word clouds, and

b) Cluster analysis.

The analyses were carried out based on document-types provided by the project team and included:

> Strategy development documents,
> Implementation planning documents,
> Governance and Committee documents,
> Priority Actions documents, and
> Milestone reports and other reporting documents.

The text frequency and cluster analyses were carried out using the NVIVO software tool, with the documents imported, classified and coded in themes and emerging topics.

Word clouds were generated to identify the most used terms in the analysis, which provides an insight into the importance placed on different activities, concepts, themes or processes. The prominence of these is reflected by the size of the words shown in a word cloud.

The text frequency analyses were run based on “uncoded” data, while the cluster analysis was based on codes to visualise themes and topics emerging from the data documents.

As noted in this report, the branching diagrams that summarise a cluster analysis are known as dendograms, with similar items clustered together more closely, e.g., on the same branch, and more “different” items shown further apart.

As has also been pointed out in the report, dendograms do not represent *causal* or *temporal* pathways, and are most useful as a tool for comparing *pairs* of items.

A brief commentary on each dendogram that was generated for the different document categories is provided in each section below.

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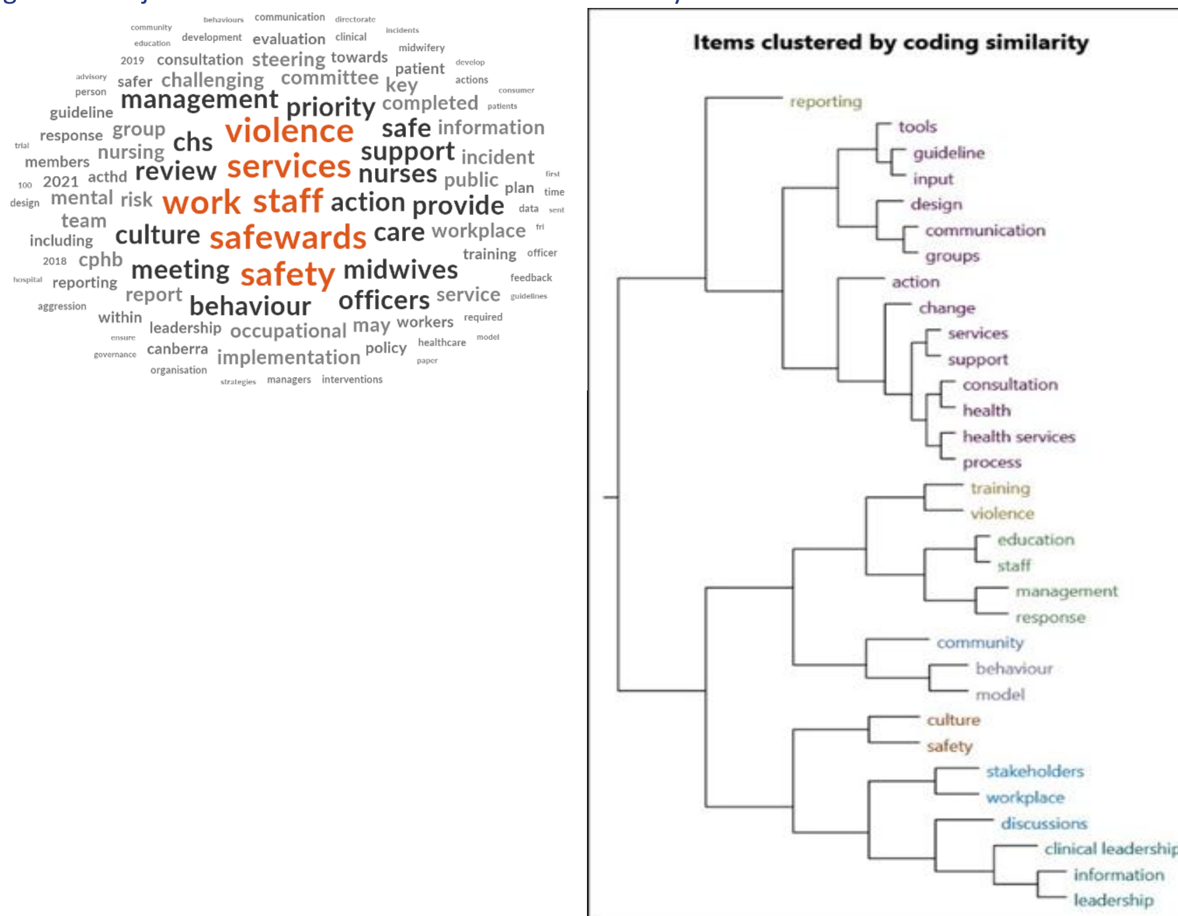
All project documents

When all documents were analysed together the words and themes that were most prominently contained in the background documents emerged as "safety", "services", "staff"," work", and "Safewards" (see Figure 31 below).

In addition, "management", "priority", "behaviour" "culture", "nurses", "midwives", "action", "safe" and "review" are also important themes.

Cluster analysis confirmed topics that occurred in conjunction included "culture" and "safety", "education" and "staff", "behaviour" and "model", "communication" and "groups" (dendogram shown on the right hand side of Figure 31).

Figure 31 Project documents: word cloud and cluster analysis

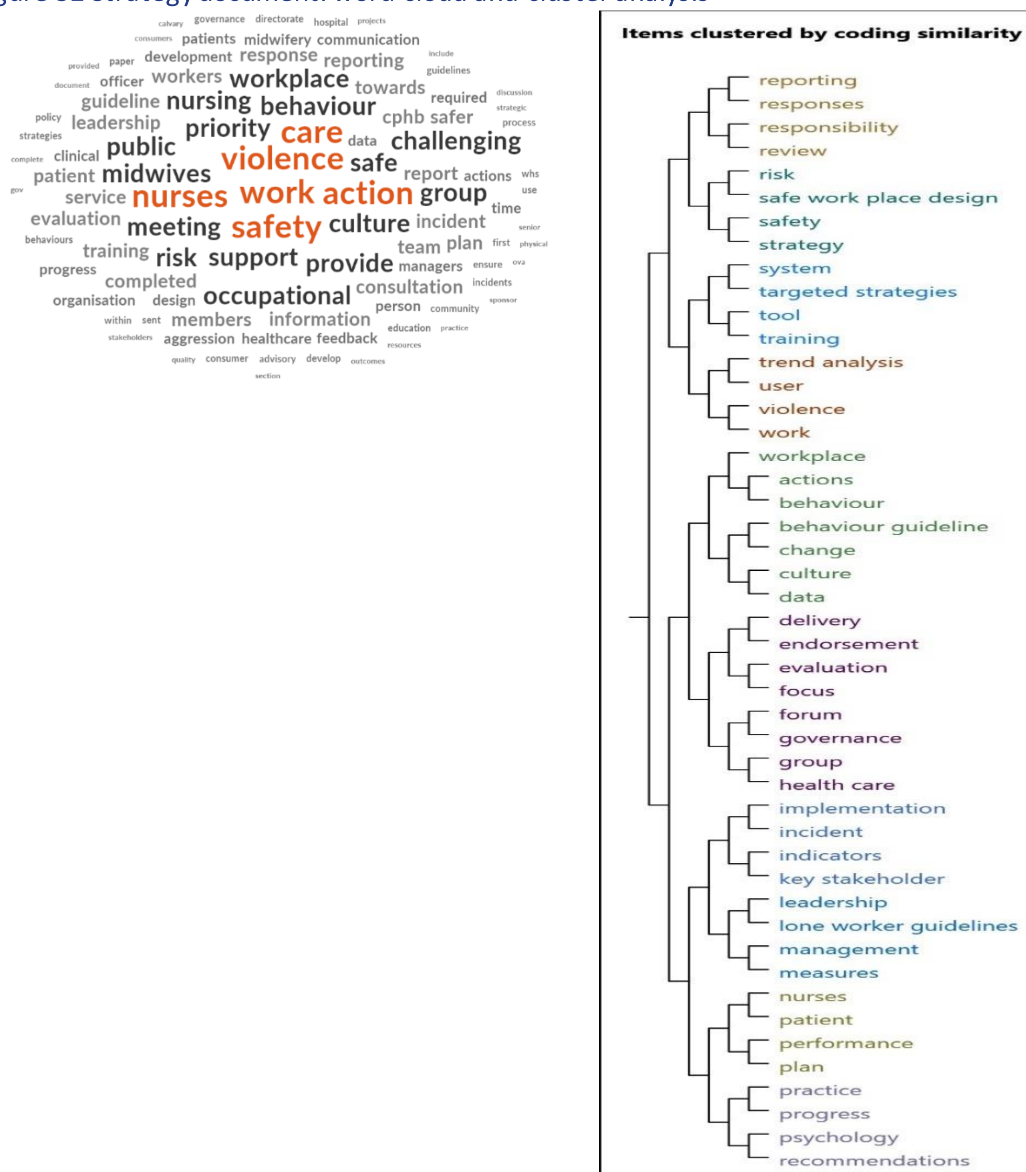


Strategy documents

A separate analysis of the TASC Strategy document uncovers that the most common terms in the text are “violence”, “safety”, “work”, “action”, “nurses”, “care”. Other important themes include “behaviour”, “risk”, “support”, “culture”, “workplace”, and “safe”.

Interestingly, the terms “patient”, “aggression”, “communication”, “leadership” are less predominant in the word frequency analysis presented below. Cluster analysis suggests that themes closely linked in the documents are “practice” and “progress”, “nurses” and “patients”, “management” and “measures”, “delivery” and “endorsement”.

Figure 32 Strategy document: word cloud and cluster analysis

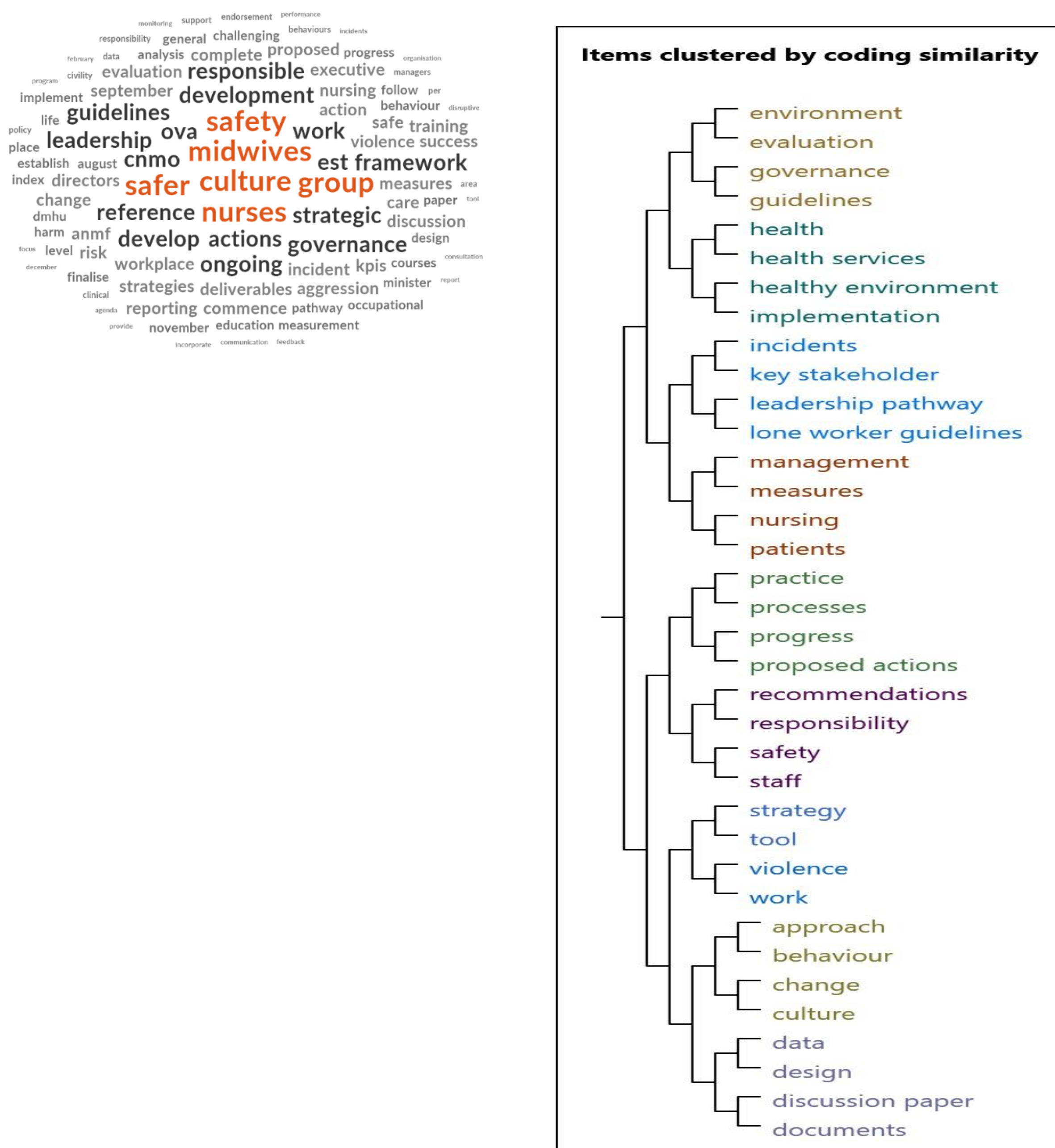


Implementation documents

To compare the TASC strategy document with the TASC implementation document, separate word frequency analyses and cluster analyses were performed.

A separate analysis of the TASC Strategy Implementation plan uncovers that the most common terms in the text are “safety”, “midwives”, “culture”, “safer”, and “nurses”. In line with the TASC Strategy document, words more commonly used in the analysis focus on creating a safer culture for nurses and midwives, with a more pragmatic approach to “action”, “governance”, “leadership” and “guidelines”.

Figure 33 Implementation document: word cloud and cluster analysis

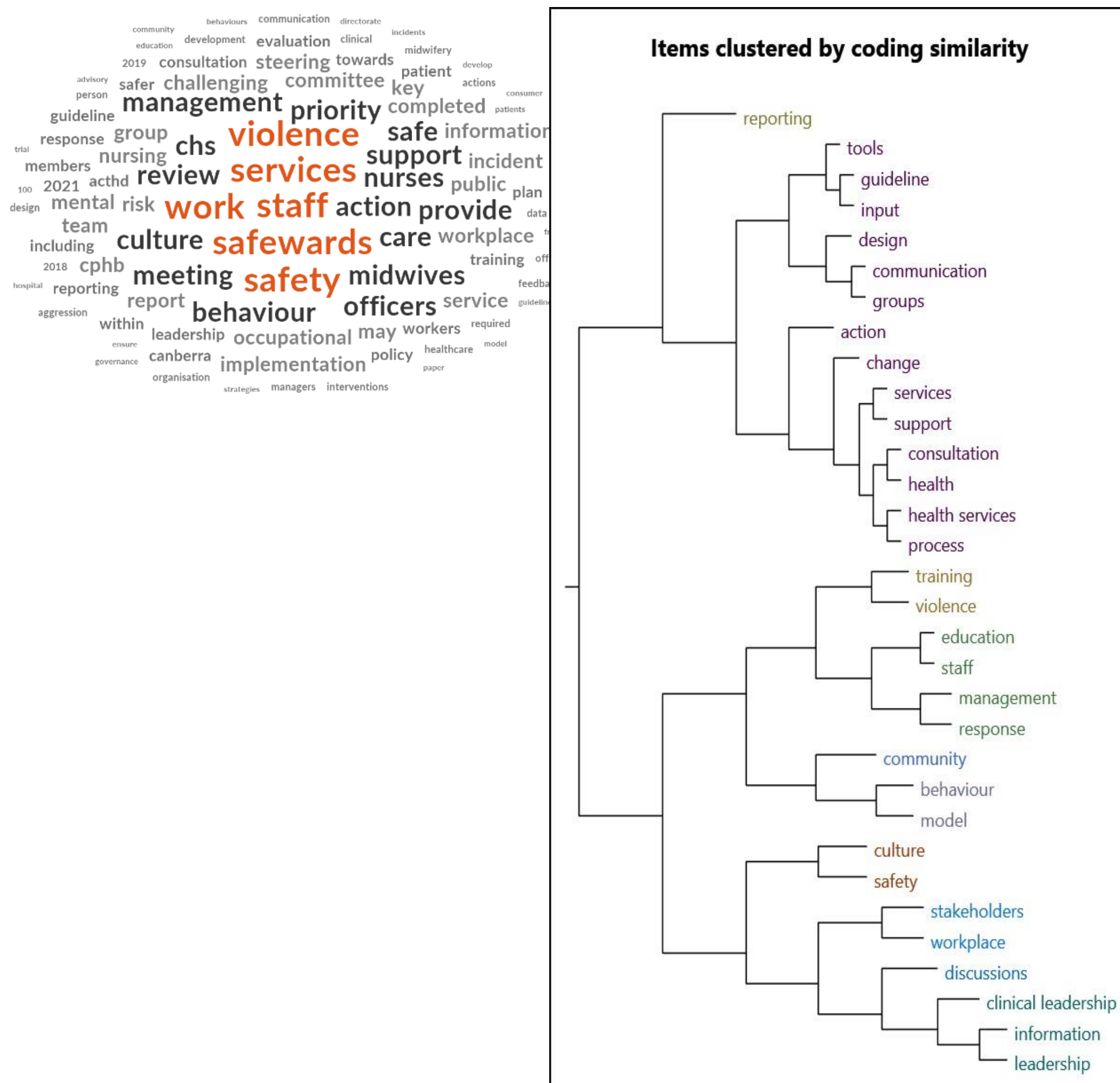


Governance and meeting documents

Documents that related to issues of strategy and project governance focused mainly on “violence” “services”, “work”, “staff”, “safewards”, and “safety”. Secondary topics included “management, “support”, “care”, “action”, “cuture” and “behaviour”.

Both text analysis and cluster analysis had a larger component of management related topics than other categories, such as the Priority Actions discussed below.

Figure 34 Governance and meeting documents: word cloud and cluster analysis



Priority actions documents

Documents that dealt with TASC Priority Actions included fewer management and governance-related topics but focused more “support”, “risk”, “violence”, “behaviour” and “care”.

Cluster analysis confirmed linkage of topics related to “behaviour”, “violence” and “workplace” related issues. These documents were heavily informed by actions to improve safety actions at work.

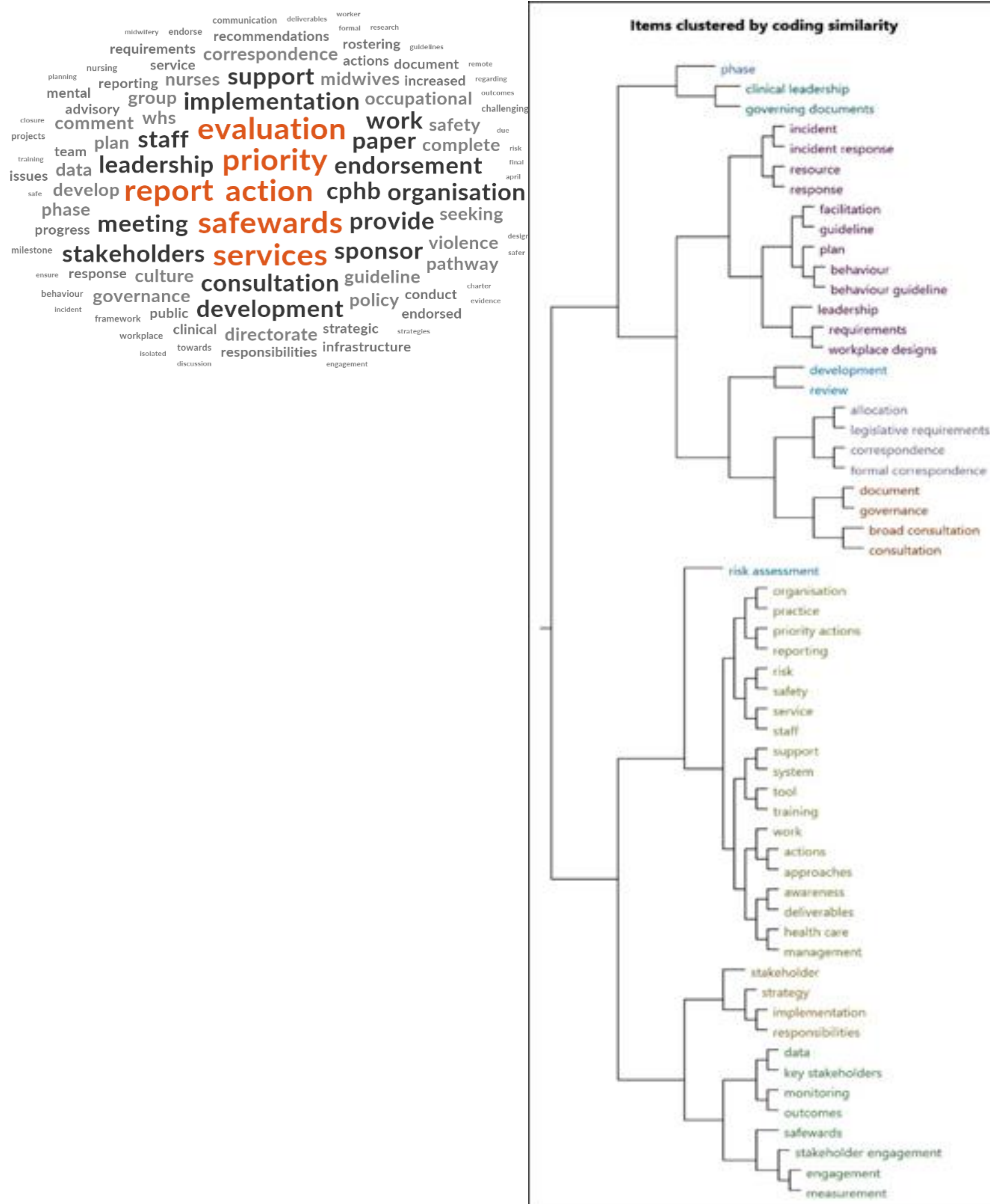
Figure 35 Priority actions documents: word cloud and cluster analysis

Milestones and reports

The project team also compiled a range of “Milestone reports”, which were focused on the project achievements and served important reporting functions.

Notably, “evaluation”, “services”, “Safewards”, “support”, “leadership”, “implementation” and “endorsement”.

Figure 36 Milestones documents: word cloud and cluster analysis



Appendix B – Scorecards

Table 2 Strategy document recommendations

Criterion	Pillar	Assessment
Review and strengthen governance	Organisation-Wide	Fully achieved
Review and strengthen workplace risk strategies, including identification, minimisation, prevention and reporting of risks	Organisation-Wide	Partially achieved
Promote a workplace culture of respect and staff empowerment	Organisation- Wide	Partially achieved
Develop and implement an Occupational Violence and Aggression management plan, including standards, guidelines and education	Occupational Violence and Aggression	Fully achieved
Develop a community, consumer and carer information campaign	Occupational Violence and Aggression	Fully achieved
Improve leadership	Challenging Occupational Behaviours	Fully achieved
Strengthen bullying and harassment prevention and management guidelines	Challenging Occupational Behaviours	Achieved
Develop and implement workplace civility measuring and management guidelines	Challenging Occupational Behaviours	Partially achieved
Embed best practice guidelines in the development of safe work practices	Safe Work Practices	Partially achieved
Continue to pursue safe workplace design principles in new builds and redevelopment of workplaces	Safe Work Practices	Partially achieved

Table 3 Strategy documents: Priority Actions scorecard

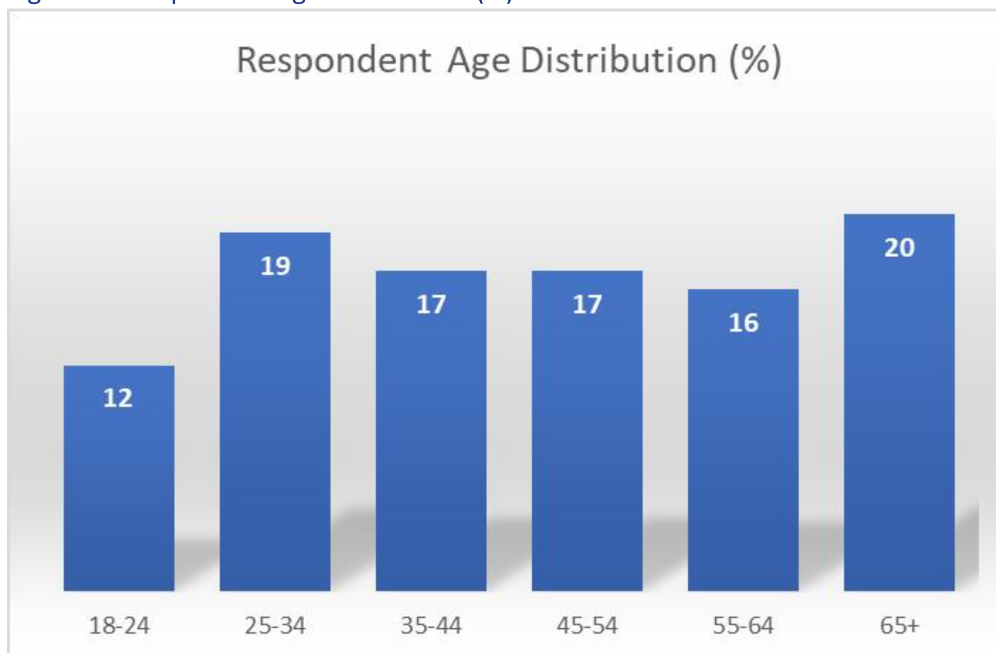
Priority Action	Assessment
Establish governance for the Strategy	Fully achieved
Review and strengthen project governance	Fully achieved
Implementation of WHS Strategic Plan	Fully achieved
Staff engagement	Partially achieved
Clinical leadership	Partially achieved
Ongoing review of strategy actions to ensure legislative requirements are considered and maintained	Fully achieved
Evaluation of the Strategy	Partially achieved
Development and implementation of Disruptive Behaviour Guideline, including Violence Screening Tool, Disruptive Behaviour Algorithm, Post incident Evaluation Tool	Fully achieved
Implementation of Safewards model	Fully achieved
Increased OVA visibility across organisation	Partially achieved
Target strategies to prevent OVA	Fully achieved
Post OVA Follow-up	Fully achieved
Development of Lone Worker guidelines	Fully achieved
Community awareness communication strategy	Fully achieved
Civility index measurement	Partially achieved
Using the results of the Civility Index measurement, develop targeted strategies to improve outcomes	Partially achieved
Review of bullying and harassment prevention and management guidelines	Fully achieved
Review of dispute / conflict resolution guidelines / pathway to provide greater focus on alternative management and early intervention	Fully achieved
Research and develop a Ratio Framework	Fully achieved
Following the work of the Ratios Framework MOU, research, develop and implement an appropriate workload management system	Fully achieved
Review and strengthen rostering and leave allocation guidelines to support work/life balance and minimise fatigue	Fully achieved
Embed safe design in all workplace designs	Partially achieved

Appendix C – Community survey detailed results

Demographic respondent profile

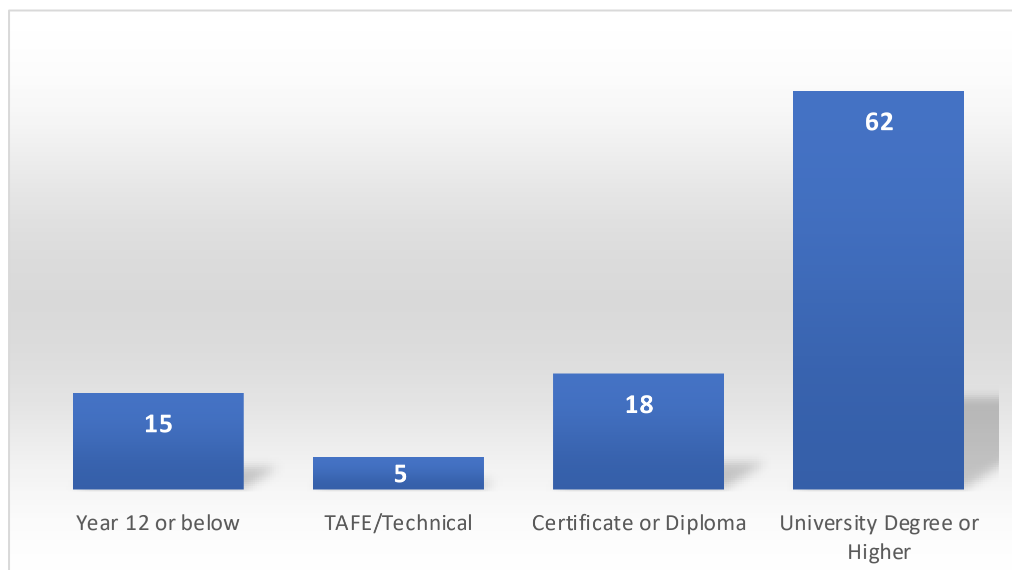
Females and Males are both equally represented in the respondent sample (50 per cent each). Age group respondents are broadly aligned with the ACT overall population distribution.

Figure 37 Respondent Age Distribution (%)



Note: Community Survey Question 2

Figure 38 Respondent Education Level (%)



Note: Community Survey Question G1

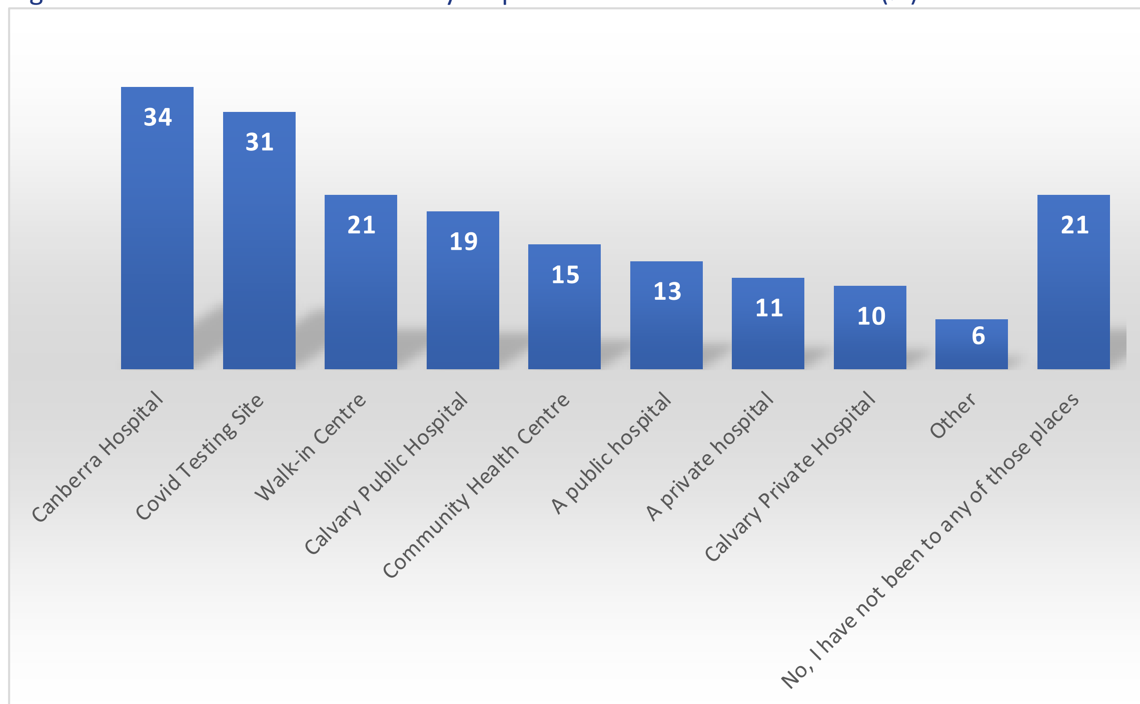
The majority of respondents had a university degree or higher, which is in line with higher education levels in the ACT, on average, when compared to other jurisdictions.

Medical locations visited by respondents

More than 30 per cent of respondents had visited Canberra Hospital in the last 6 months, even though the answer does not allow for more information on in what capacity (i.e. patient/consumer, family member or carer, visitor etc).

In addition, 19 per cent of respondents also indicated having visited Calvary Public Hospital. Unsurprisingly, many respondents had also been at Covid-19 testing centres (31 per cent) and Walk-in Centres (21 per cent).

Figure 39 Medical locations visited by respondents in the last six months (%)



Note: Community Survey Question B1

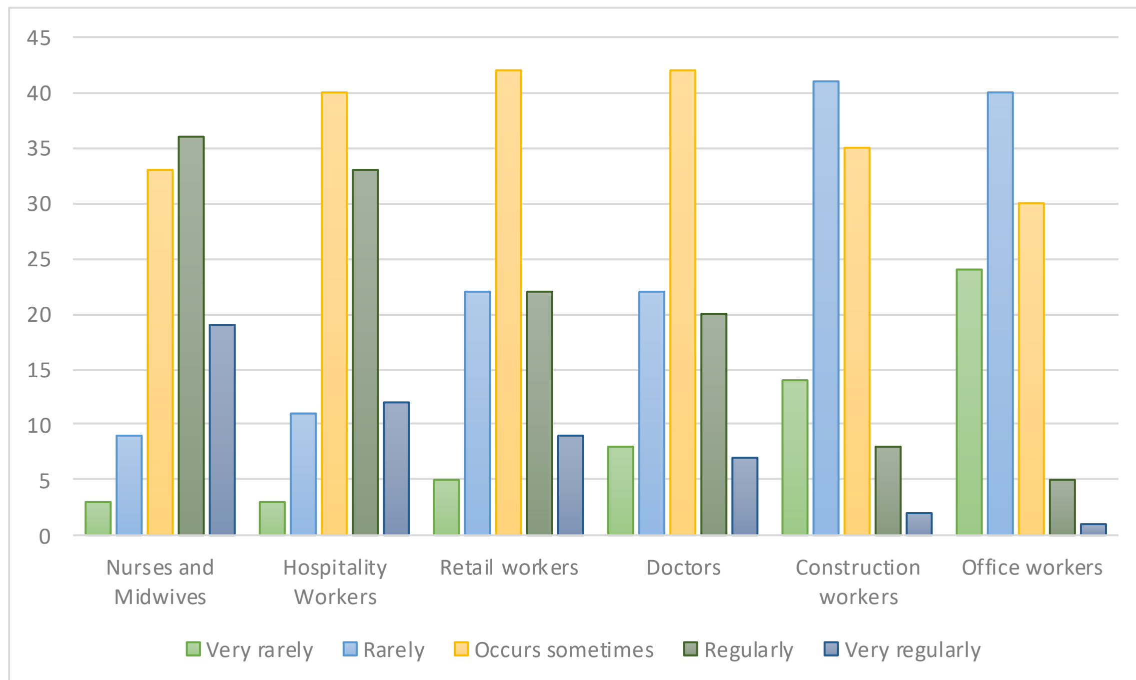
Perceptions of violence against nurses and midwives

Nurses and midwives are the professional group which members of the community believe to be most frequently exposed to violence, almost double the rate of another medical professional group, doctors.

When members of the public witnessed violence against nurses and midwives, it was most frequently perpetrated by a patient/consumer, followed by patient/consumer family members or carers.

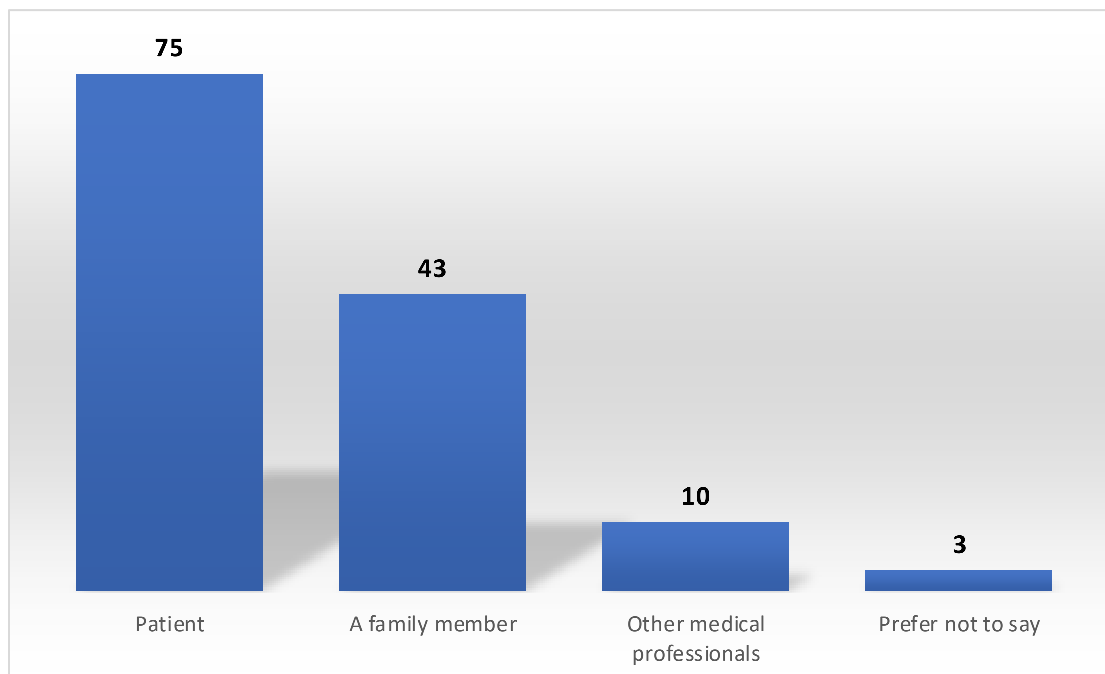
Interestingly, episodes of violent behaviour towards nurses and midwives was reported by survey respondents more frequently in private hospital settings (33 per cent) than public hospital environments (27 per cent). This could be due to higher expectations or feelings of entitlement among private healthcare consumers.

Figure 40 How often do you think incidents of violence occur? (% agreed, by profession)



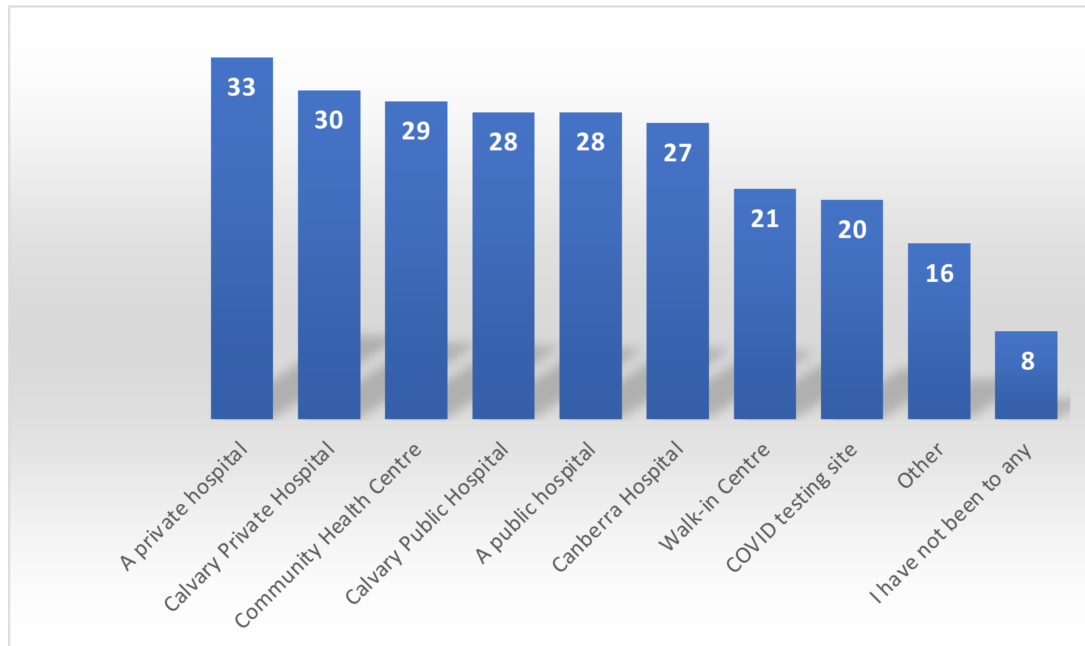
Note: Community Survey Question B2

Figure 41 If witnessed violence, it was perpetrated by ... (%)



Note: Community Survey Question B6

Figure 42 Location where violence towards nurses and midwives was witnessed (%)



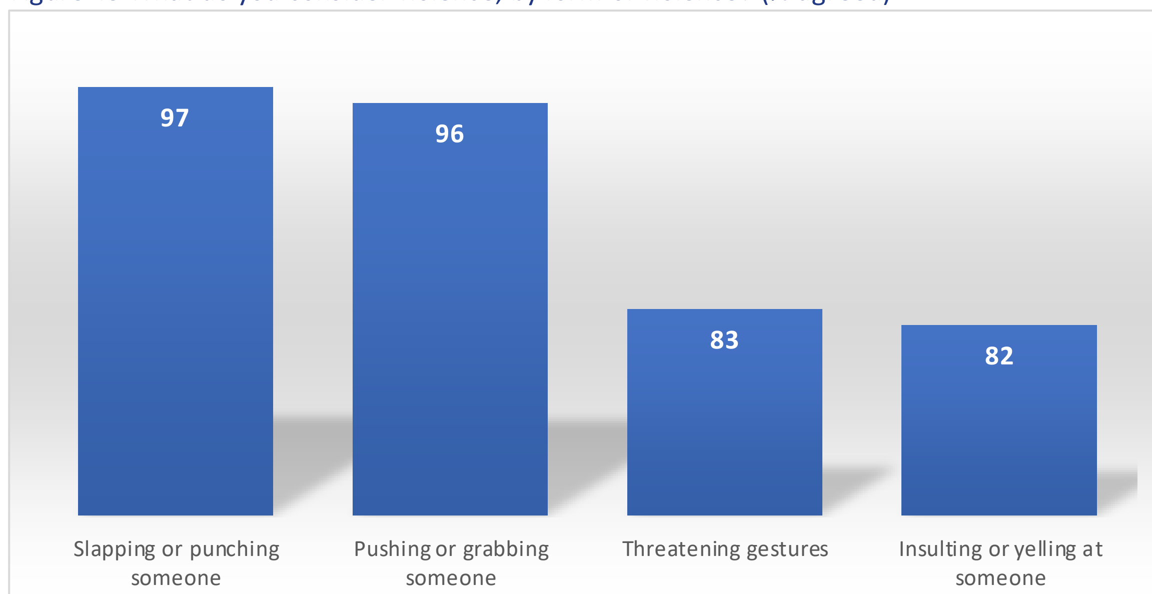
Note: Community Survey Question B6

Opinions about forms of violence

More than 60 per cent of survey respondents considered physical abuse to be a problem in the ACT, with over 70 per cent thinking that verbal abuse is a problem.

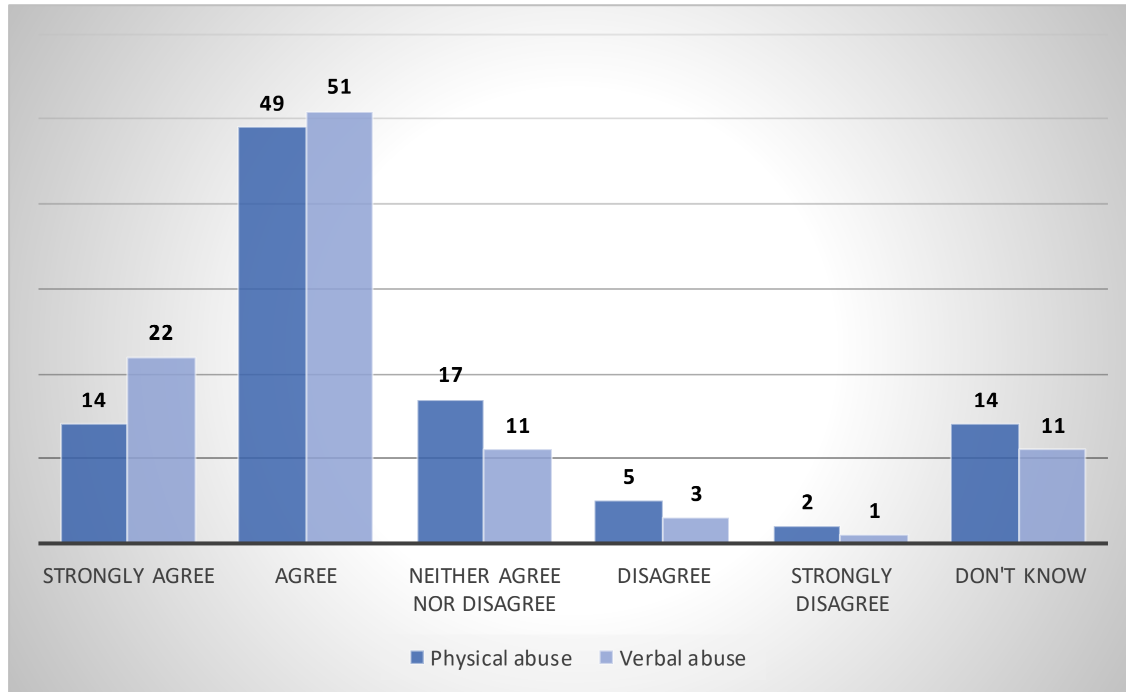
While insulting or yelling is considered a form of violence (82 per cent), close to 100 per cent of respondents define slapping or punching someone as well as pushing or grabbing as violence.

Figure 43 What do you consider violence, by form of violence? (% agreed)



Note: Community Survey Question B3

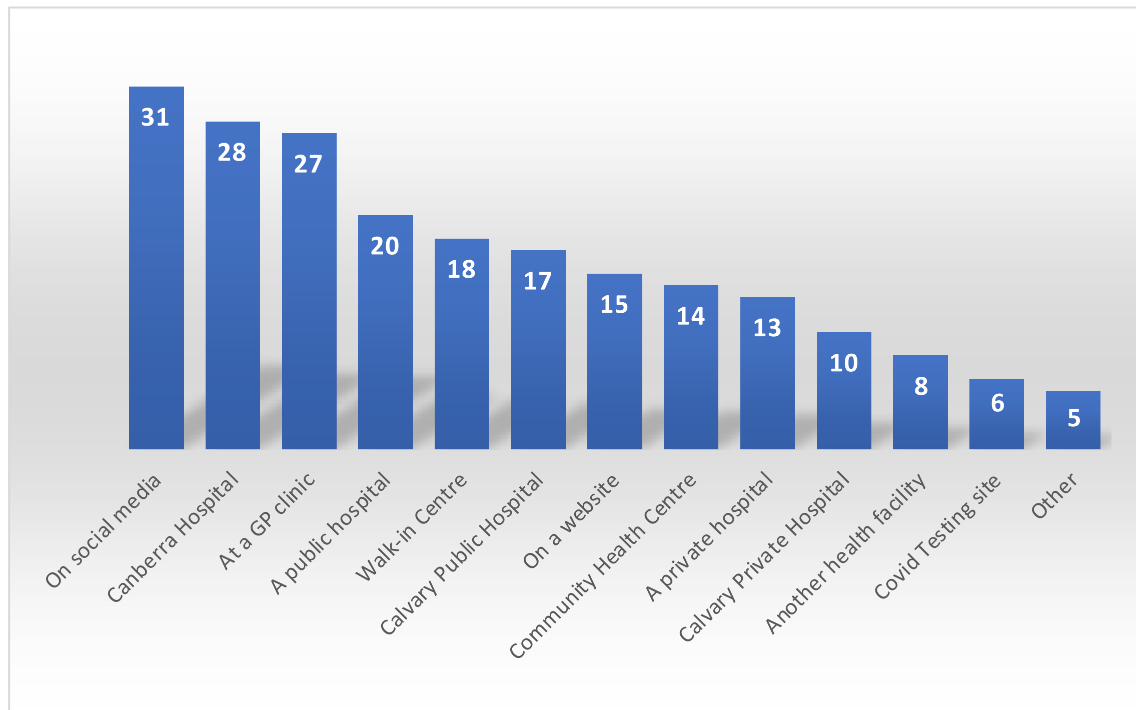
Figure 44 Violence against nurses and midwives is a problem in the ACT (% agreed)



Note: Community Survey Question B4

"Be kind towards our nurses and midwives" campaign awareness

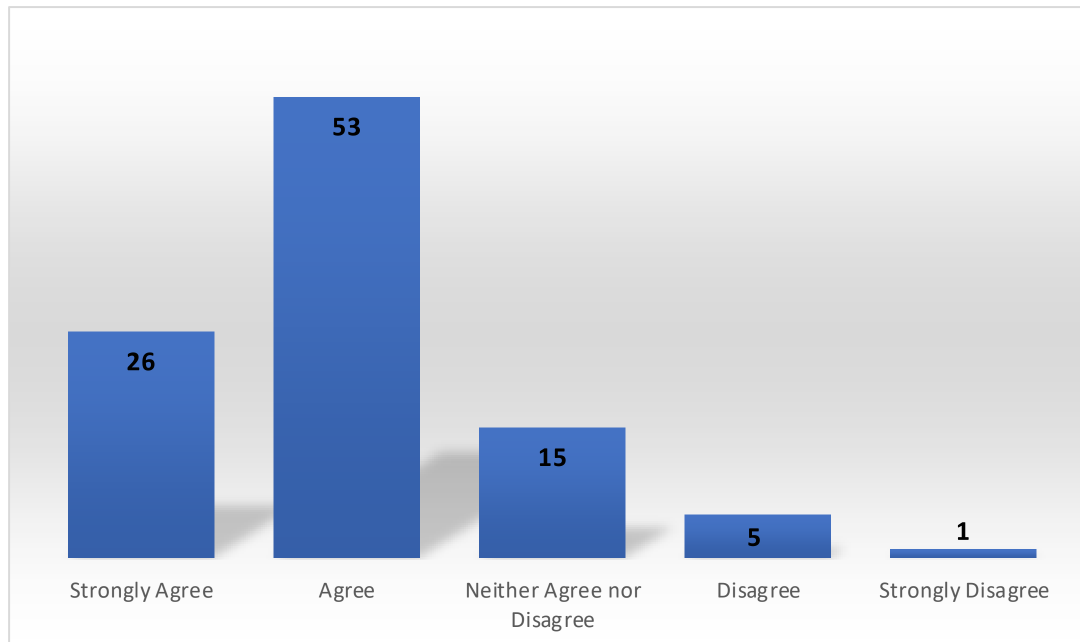
Figure 45 "Be kind" campaign seen at these locations (%)



Note: Community Survey Question C1

Respondents report having seen the TASC Strategy flagship campaign "Be kind to our nurses and midwives" most frequently on social media (31 per cent), in Canberra Hospital (28 per cent) and at a GP clinic (27 per cent).

Figure 46 Is the "Be kind" campaign a worthwhile investment? (%)



Note: Community Survey Question C4

Close to 80 per cent of respondents report that the "Be kind" media campaign is a worthwhile investment and close to 70 per cent of survey participants think that the campaign has potential to reduce violence towards nurses and midwives.

Appendix D – Nurses and midwives survey detailed results

Demographic respondent profile

The TASC survey respondent profile, in terms of its age group distribution, was strikingly similar to that of the ACT nursing and midwifery profession as a whole – based on data published by the Nursing and Midwifery Board (NMBA) of Australia.

Perhaps the only deviation in the surveyed group was in the youngest age bracket, which may be explained by the fact that student nurses were on holiday when the TASC survey went live. The evaluation team is considering a follow up of student nurses at a later stage, as the issue of OV experienced by student nurses is also considered important.

Table 4 Age group comparison: NMBA and TASC staff survey

Age group	NMBA cohort	TASC survey response
18-24	6.3 per cent	2.4 per cent
25-34	25.9 per cent	23.4 per cent
35-44	21.5 per cent	22.3 per cent
45-54	21 per cent	27.5 per cent
55-64	21.3 per cent	21.6 per cent
65+	5 per cent	2.75 per cent

As the results of the survey shown in the figures below demonstrate, more than 80 per cent respondents work as a nurse with 10 per cent working as a midwife. The remainder of respondents may have a nursing or midwifery education but could be working in administrative roles. Only 8 respondents were either not working in the ACT Health system or in a different profession.

In addition, respondents speak predominantly English at home (83 per cent) and only 3 per cent have an Aboriginal or Torres Strait Islander background.

These figures, and the others captured in the figures presented in this Appendix, are descriptive baselines that can inform future analyses.

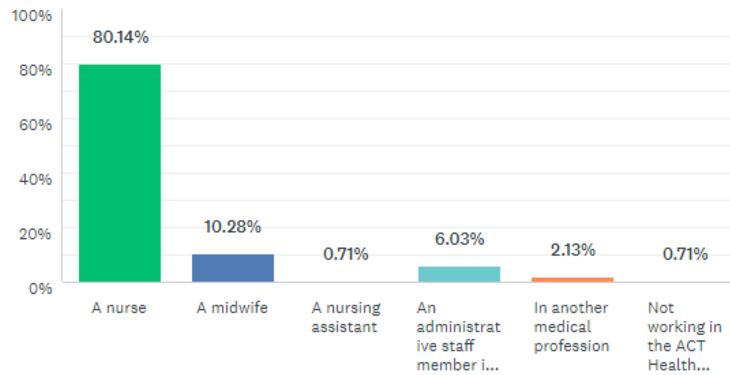
The evaluation team has raised this with the TASC project team, as it would be a missed opportunity if the data collected and presented here were not to be utilised for further analyses in future.

A recommendation around this has also been included in the Executive Summary.

Figure 47 Respondent professional group affiliation

Are you working as:

Answered: 282 Skipped: 9



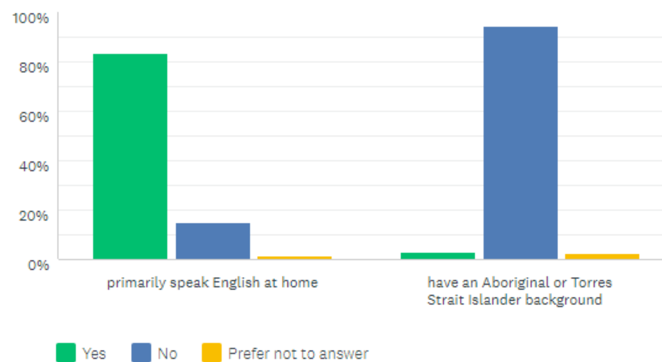
ANSWER CHOICES	RESPONSES	
A nurse	80.14%	226
A midwife	10.28%	29
A nursing assistant	0.71%	2
An administrative staff member in the ACT Health System	6.03%	17
In another medical profession	2.13%	6
Not working in the ACT Health system	0.71%	2
TOTAL		282

Note: Internal Survey Question 1

Figure 48 Language spoken at home and ATSI status

Do you:

Answered: 288 Skipped: 3



	YES	NO	PREFER NOT TO ANSWER	TOTAL
primarily speak English at home	83.33% 240	14.93% 43	1.74% 5	288
have an Aboriginal or Torres Strait Islander background	2.88% 7	94.65% 230	2.47% 6	243

Note: Internal Survey Question 3

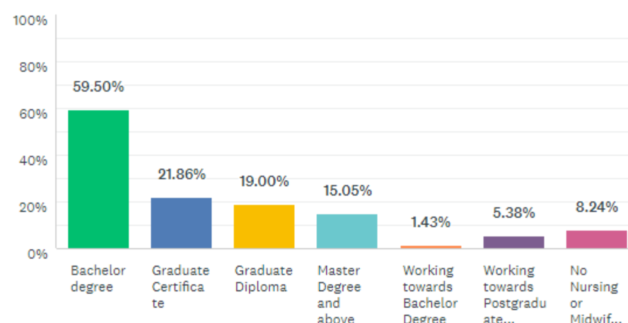
About 60 per cent of respondents have completed a Bachelor's degree and another 19 per cent a Graduate Diploma, 21 per cent of respondents completed Graduate certificate, 15 per cent of respondents completed a Master's Degree and above, and a further 1.43 per cent are working towards a Bachelor's degree or a Postgraduate degree (5.38 per cent). Multiple answers were possible for respondents with several completed education programs.

While 60 per cent of respondents selecting "Bachelor's degree" seems to be a low percentage given that nursing and midwifery are degree-based programs, it appears that some respondents may have misunderstood the question to select only their highest level of educational achievement.

Figure 49 Nursing and midwifery education level

What nursing or midwifery educational programs have you attended or completed? (Select all that apply)

Answered: 279 Skipped: 12



ANSWER CHOICES	RESPONSES	
Bachelor degree	59.50%	166
Graduate Certificate	21.86%	61
Graduate Diploma	19.00%	53
Master Degree and above	15.05%	42
Working towards Bachelor Degree	1.43%	4
Working towards Postgraduate Degree	5.38%	15
No Nursing or Midwifery Degree	8.24%	23
Total Respondents: 279		

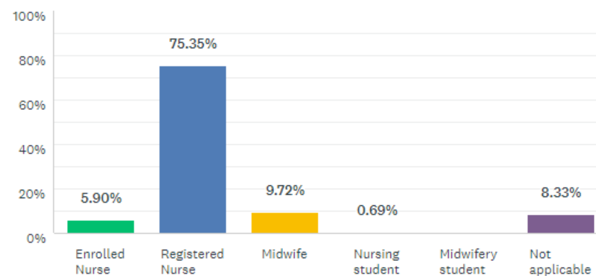
Note: Internal Survey Question 4

The largest proportion of survey respondents are Registered Nurses (RN) (75 per cent), with another 10 per cent Midwives, and 6 per cent of Enrolled Nurses (EN). More than 90 per cent of respondents have a General Registration status with the Nursing and Midwifery Board of Australia (NMBA).

Figure 50 Nursing and midwifery registration status

What is your professional status in Nursing or Midwifery?

Answered: 288 Skipped: 3



ANSWER CHOICES	RESPONSES	
Enrolled Nurse	5.90%	17
Registered Nurse	75.35%	217
Midwife	9.72%	28
Nursing student	0.69%	2
Midwifery student	0.00%	0
Not applicable	8.33%	24
TOTAL		288

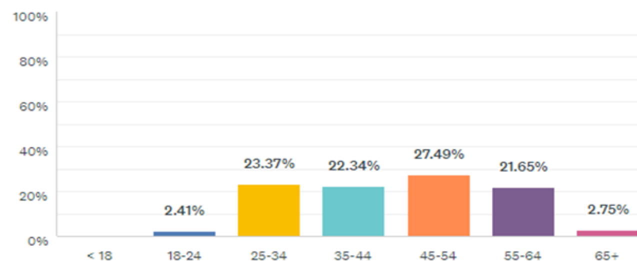
Note: Internal Survey Question 5

Nurses and Midwives age distribution overall follows the expected distribution, with nurses in the 18-24 age cohort slightly underrepresented in the present survey.

Figure 51 Nursing and midwifery age group distribution

What is your age?

Answered: 291 Skipped: 0



ANSWER CHOICES	RESPONSES	
< 18	0.00%	0
18-24	2.41%	7
25-34	23.37%	68
35-44	22.34%	65
45-54	27.49%	80
55-64	21.65%	63
65+	2.75%	8
TOTAL		291

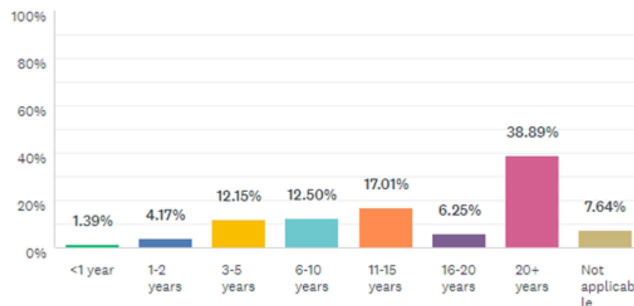
Note: Internal Survey Question 7

Respondents in the present respondent cohort are very experienced on average, with 60 per cent reporting a professional experience of 10 years or more.

Figure 52 Nursing and midwifery professional experience

How many years have you worked as a nurse or midwife?

Answered: 288 Skipped: 3



ANSWER CHOICES	RESPONSES	
<1 year	1.39%	4
1-2 years	4.17%	12
3-5 years	12.15%	35
6-10 years	12.50%	36
11-15 years	17.01%	49
16-20 years	6.25%	18
20+ years	38.89%	112
Not applicable	7.64%	22
TOTAL		288

Note: Internal Survey Question 8

TASC Strategy awareness

More than 57 per cent of respondents have heard of the TASC Strategy, with another 72 per cent reported awareness of the associated "Be kind and respectful to our nurses and midwives" media campaign, which is a remarkable result. In addition, 43 per cent of respondents reported awareness of the "Safewards" Model of Care trialled at Calvary Public Hospital and Canberra Hospital Wards.

Figure 53 Awareness of TASC Strategy, "Be kind" campaign and Safewards

	YES	NO	UNSURE	TOTAL
Towards a Safer Culture Strategy	57.30% 153	31.46% 84	11.24% 30	267
"Be Kind and Respectful to our Nurses and Midwives" Campaign	72.66% 194	22.10% 59	5.24% 14	267
Safewards	43.08% 112	51.15% 133	5.77% 15	260

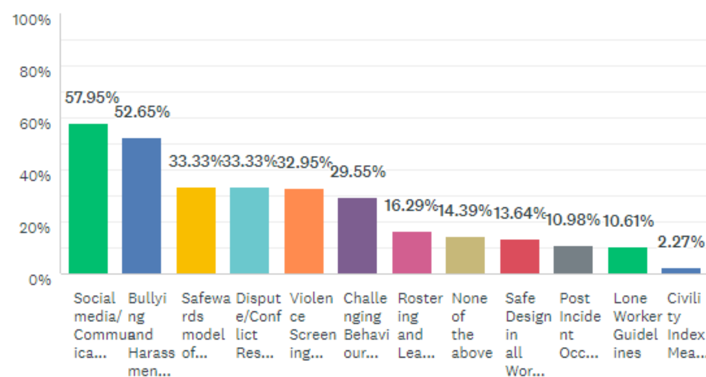
Note: Internal Survey Question 9

Within the TASC Strategy Priority Action items, the largest number of respondents again were aware of the social media and communications campaigns (58 per cent) as well as Bullying and Harassment Guidelines (53 per cent). The lowest recognition had the Post Incident Occupational Violence Tool (11 per cent), Lone Worker Guidelines (11 per cent) and Civility Index Measurement (2 per cent). Most of these less recognised TASC action items have been identified by the project team as priorities to be completed in the future, which is in line with responses reported in this context.

Figure 54 Awareness of TASC Strategy Priority Actions

I am aware of the following initiatives:

Answered: 264 Skipped: 27



ANSWER CHOICES	RESPONSES	
Social media/Communications campaigns (e.g. Be kind and respectful to our nurses and midwives)	57.95%	153
Bullying and Harassment Prevention Guidelines	52.65%	139
Safewards model of care trials	33.33%	88
Dispute/Conflict Resolution guidelines	33.33%	88
Violence Screening Tool	32.95%	87
Challenging Behaviour Guideline	29.55%	78
Rostering and Leave Allocation Guidelines and Discussion Paper	16.29%	43
None of the above	14.39%	38
Safe Design in all Workplaces	13.64%	36
Post Incident Occupational Violence Toolkit	10.98%	29
Lone Worker Guidelines	10.61%	28
Civility Index Measurement	2.27%	6
Total Respondents: 264		

Note: Internal Survey Question 10

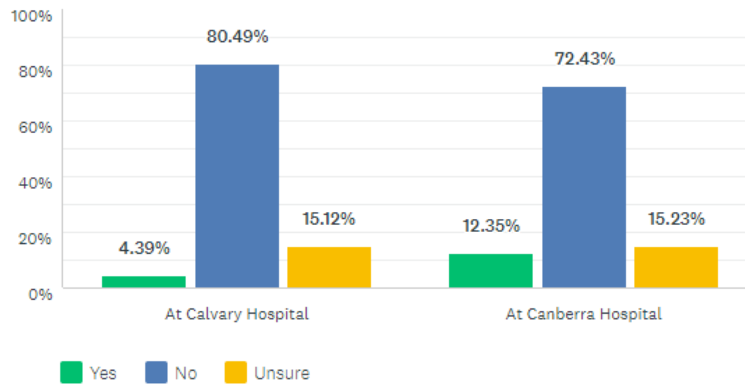
Staff who worked on *Safewards* trial wards

Despite Safewards recognition among a larger cohort of respondents, only 4 per cent (at Calvary Public Hospital) and 12 per cent (at Canberra Hospital of survey respondents) have worked on a Safewards ward. While these numbers seem low, the program is still in its pilot phase, so a larger recognition beyond the Safewards nurses is encouraging. A separate evaluation report is currently being prepared by the PDE team to better understand the trial's implementation in the ACT.

Figure 55 Safewards experience

Have you worked on a "Safewards" Ward?

Answered: 267 Skipped: 24



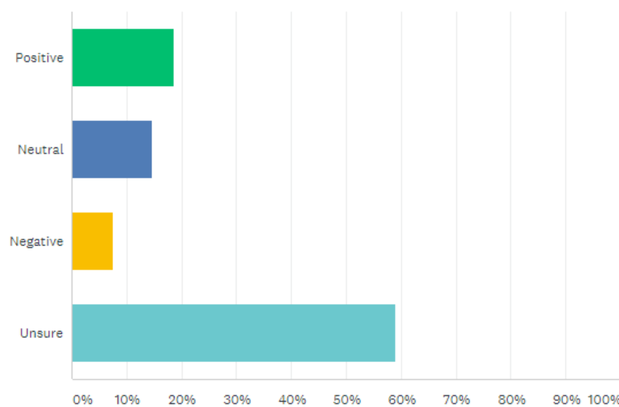
	YES	NO	UNSURE	TOTAL
At Calvary Hospital	4.39% 9	80.49% 165	15.12% 31	205
At Canberra Hospital	12.35% 30	72.43% 176	15.23% 37	243

Note: Internal Survey Question 11

Figure 56 Safewards perceptions

How do you believe staff in your ward/division perceived Safewards?

Answered: 267 Skipped: 24



ANSWER CHOICES	RESPONSES	
Positive	18.71%	32
Neutral	14.62%	25
Negative	7.60%	13
Unsure	59.06%	101
TOTAL		171

Note: Internal Survey Question 14

Definition of Workplace Safety

The last question in the nurses and midwives survey was in an open-ended format, probing respondents to provide a definition of what they perceive to be a safe workplace.

Figure 57 Open-ended workplace safety question: word cloud

The text frequency analysis revealed that nurses and midwives feeling of safety centres around patients, support (or lack thereof), team support, managerial behaviour, and colleagues to mediate situations in which aggression, violence and bullying may occur.

Grievances

> *"Lack of security, violence isn't taken seriously by the organisation. Clinical staff on the floor don't get adequate training on OV"*

> *"Patients/ family members feel like the nurses are their maids and others do not respect us as human beings."*

Safe workplaces

> *"Culture of zero tolerance to violence"*

> *"Safe when colleagues support each other and when consumers are polite and respectful. unsafe when patients are aggressive and no plan for this in place. Unfortunately, it is unavoidable at times"*

> *"Physical barriers - locked doors, duress buttons Good work relationships with immediate colleagues"*

> *"Smaller hospital, supportive management"*

"A secure workplace not accessible by members of public unless escorted. Somewhere when you are verbally attacked by a patient you can be supported by your colleagues and managers. The support of managers would be nice".

Unsafe workplaces

"Patients can be unhappy about being in hospital and don't have good coping or interpersonal skills. Drug withdrawal is also a problem for some."

"As an emergency department, patients/families are in a heightened state of stress, and more likely to display aggression. It doesn't make it ok, but I don't think we're ever going to get to a time where it doesn't happen at all."

"Unpredictable consumers with multiple complex medical problems Poor communication between staff and consumers/family members".

"Unsafe for to high workload Patient's expectations not being delivered"

"Behaviours (belittling, gaslighting, lack of transparency and honesty, unfair practices etc) by managers are just as harmful as bullying and harassment".

Additional graphs and figures

Figure 58 Age group and workplace safety perception

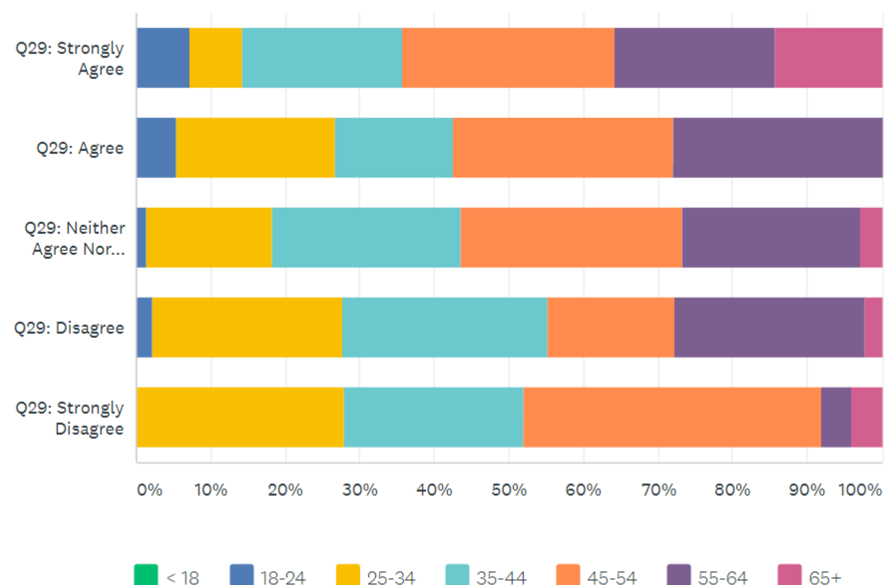


Figure 59 Work experience and workplace safety perception

How many years have you worked as a nurse or midwife?

Answered: 230 Skipped: 2

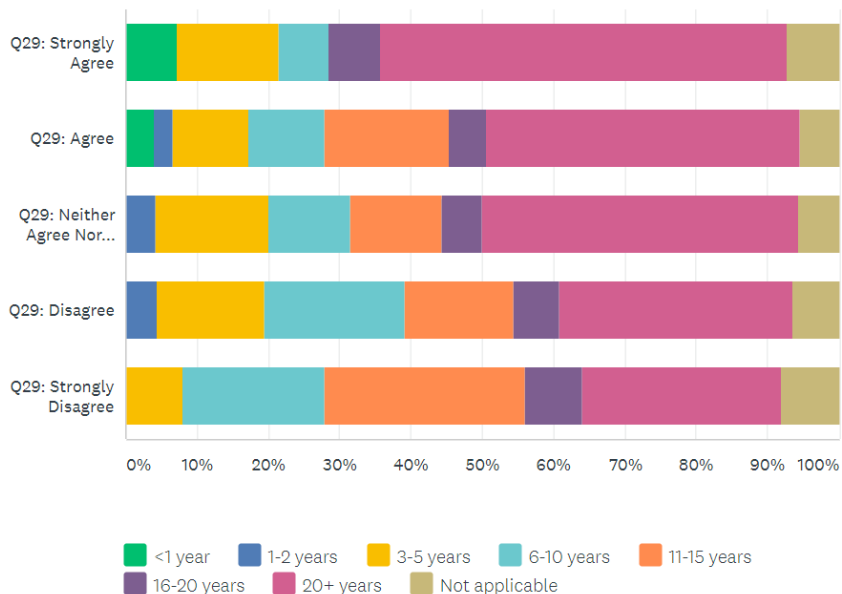


Figure 60 OV prevention program awareness (TASC Strategy)

I have heard of the following ACT-based programs that address occupational violence

Answered: 232 Skipped: 0

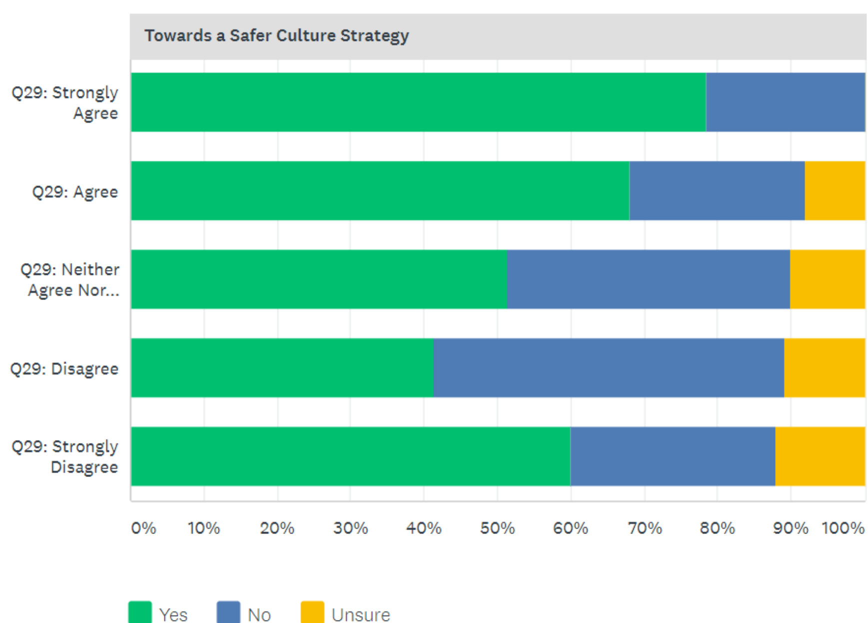


Figure 61 OV prevention program awareness (TASC media campaign)

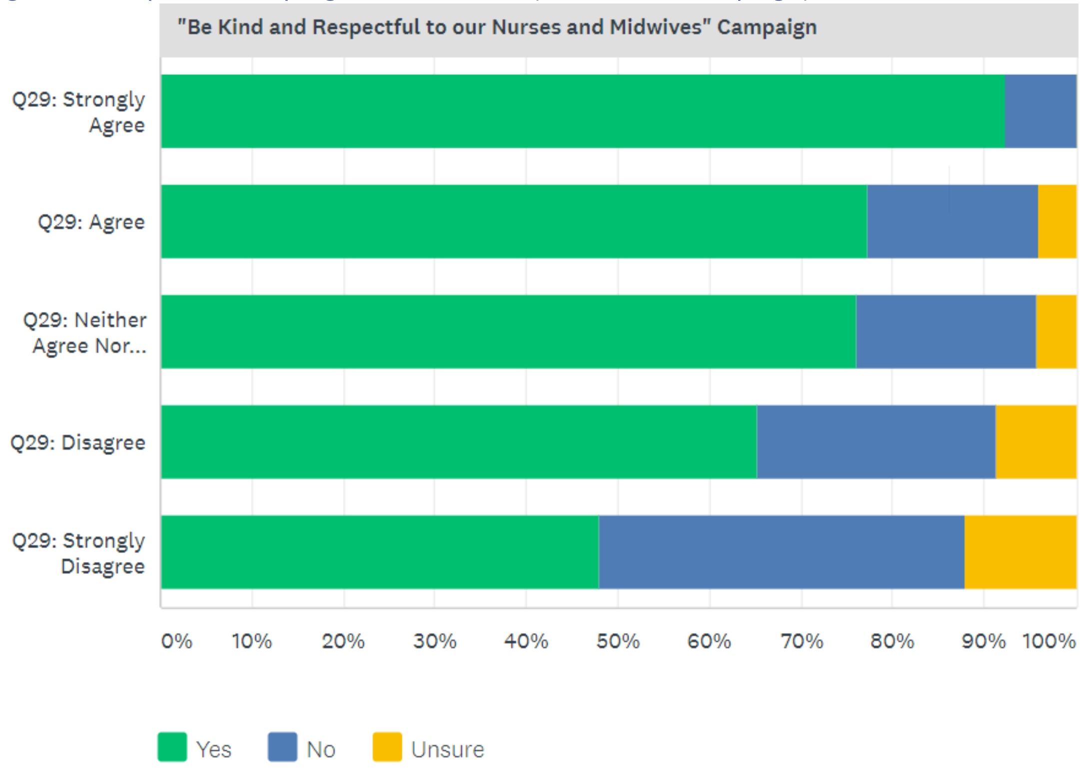


Figure 62 OV manager conversations and workplace safety perception

Has your manager/team leader spoken to you about occupational violence during the last 12 months?

Answered: 231 Skipped: 1

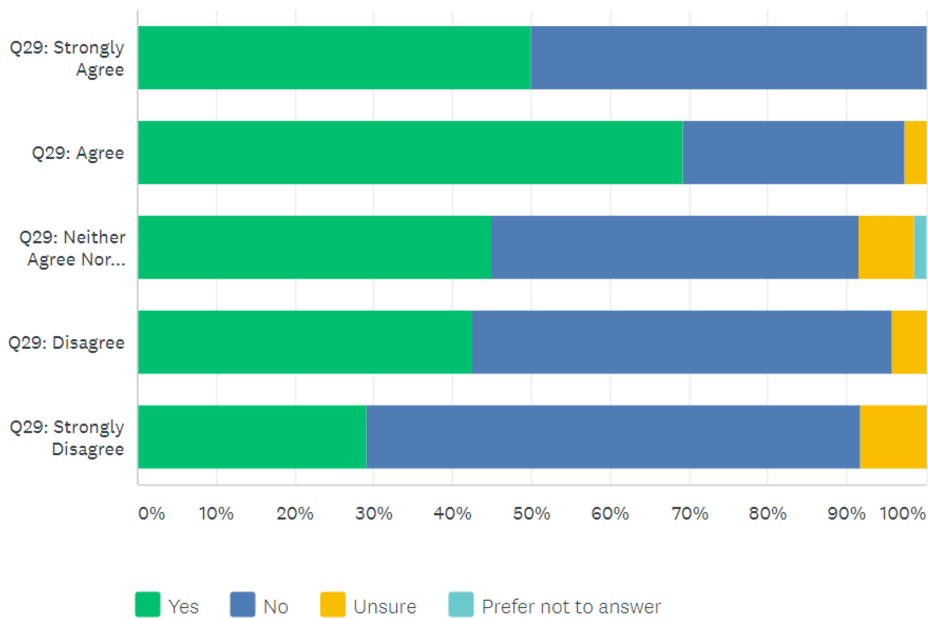


Figure 63 TASC initiatives awareness and workplace safety perception

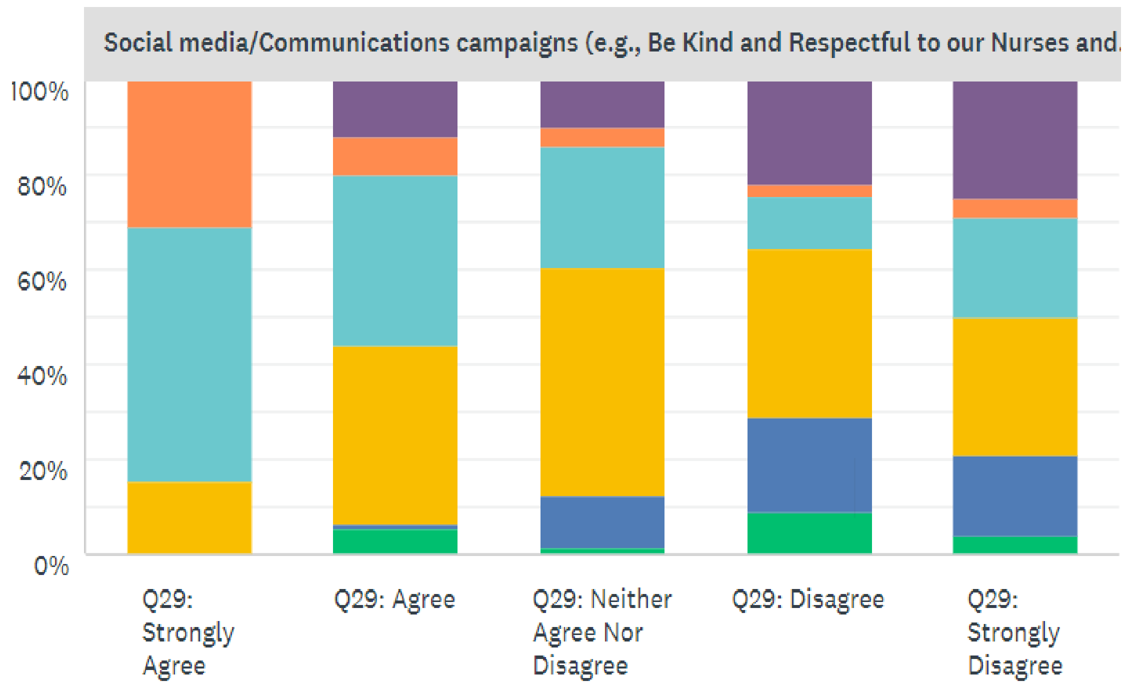


Figure 64 TASC initiatives awareness and workplace safety perception

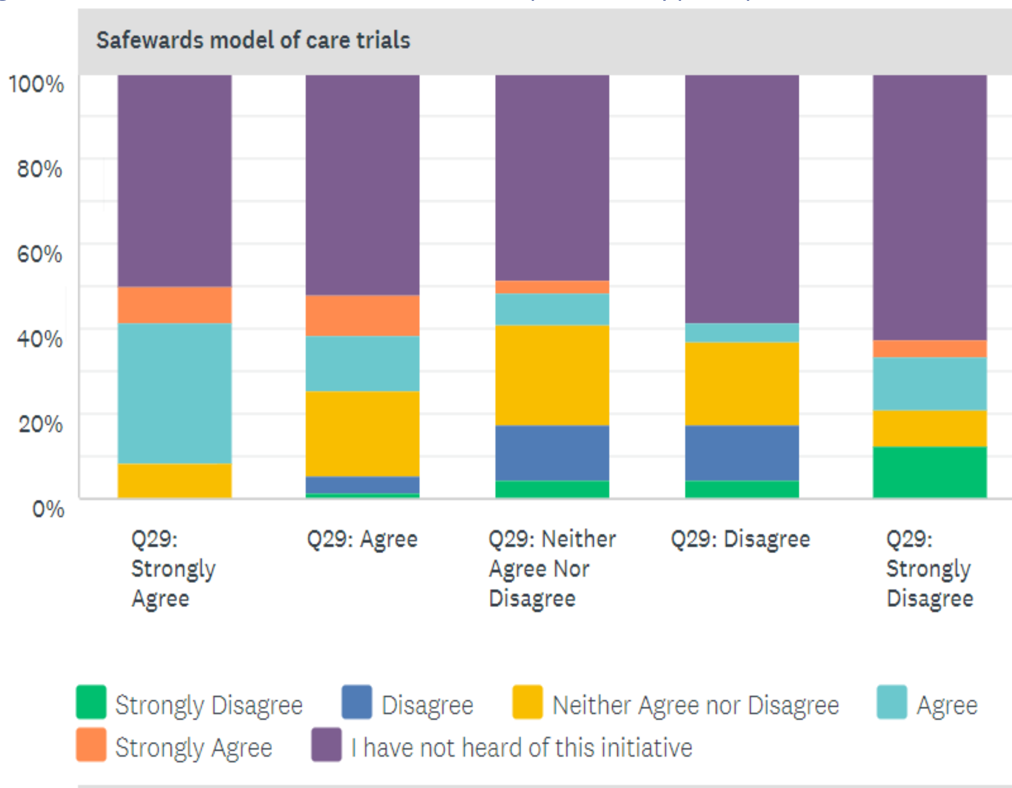


Figure 65 TASC initiatives awareness and workplace safety perception

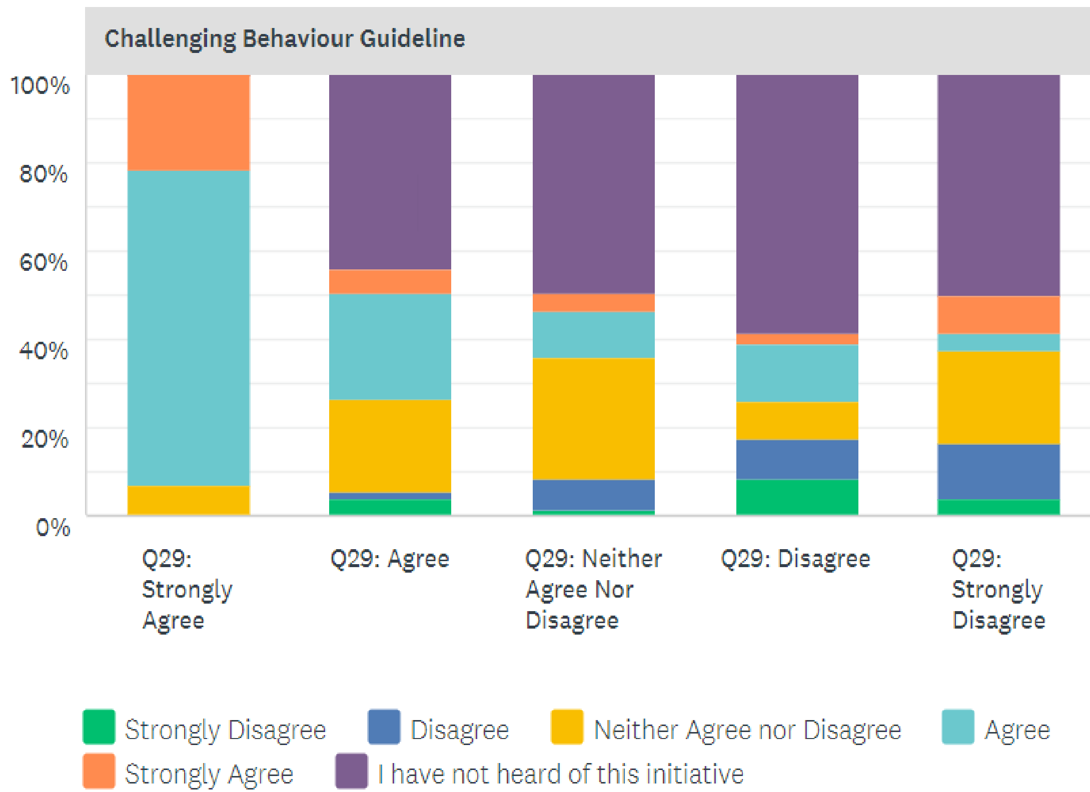


Figure 66 TASC initiatives awareness and workplace safety perception

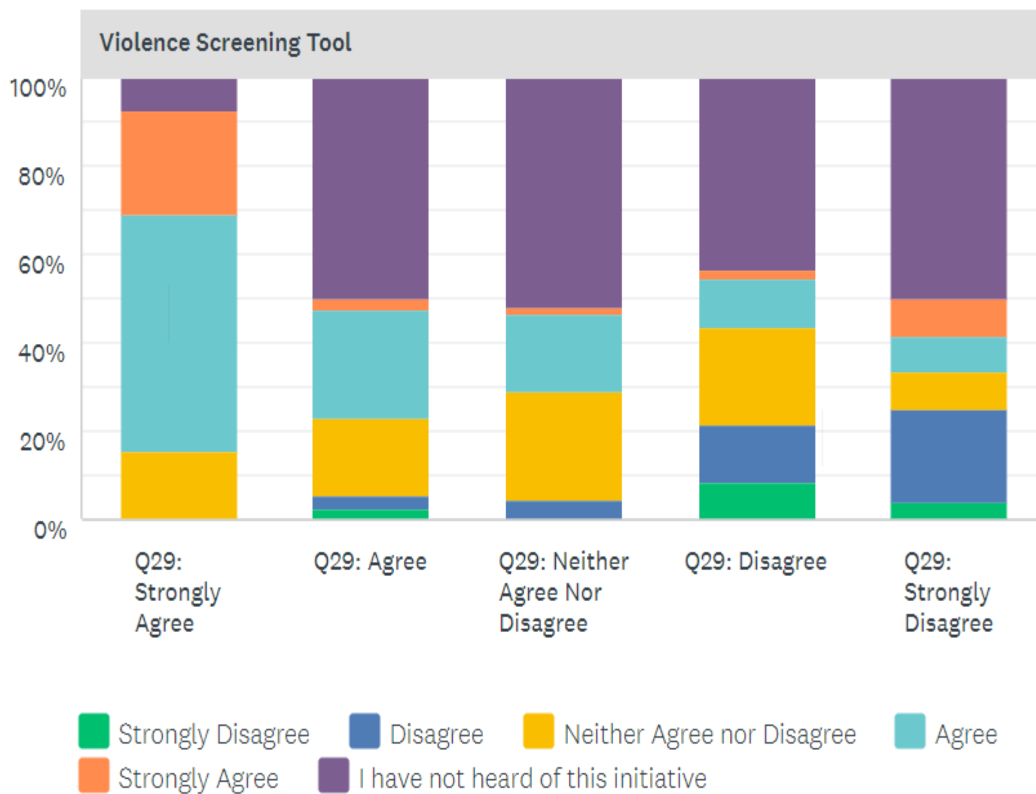


Figure 67 TASC initiatives awareness and workplace safety perception

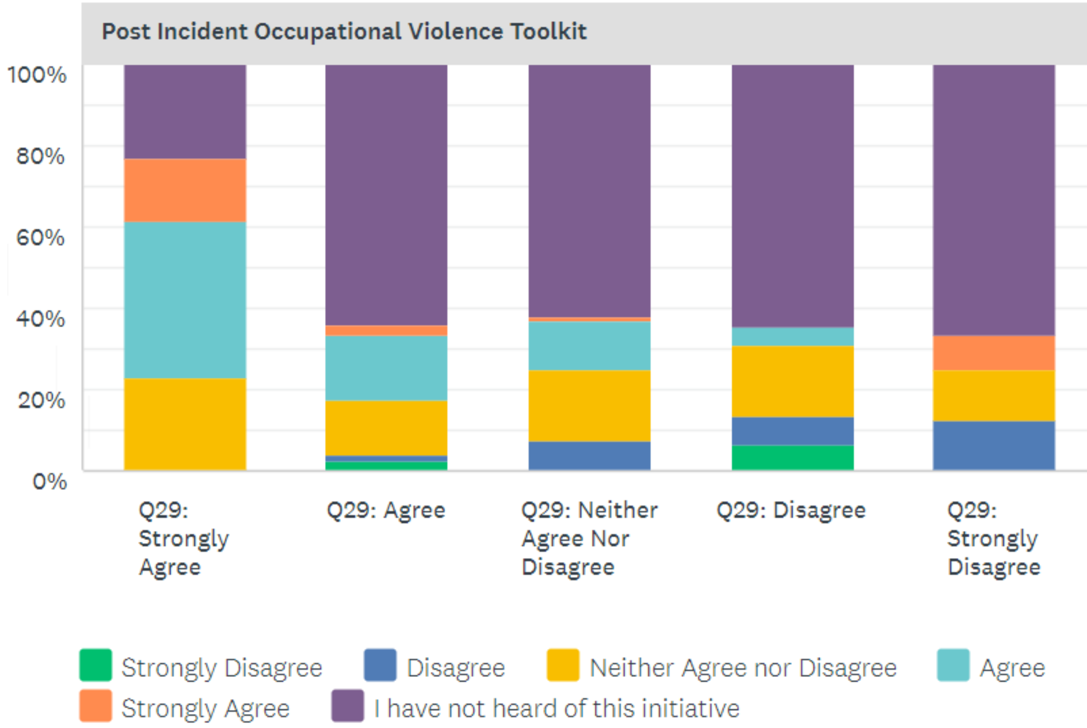


Figure 68 TASC initiatives awareness and workplace safety perception

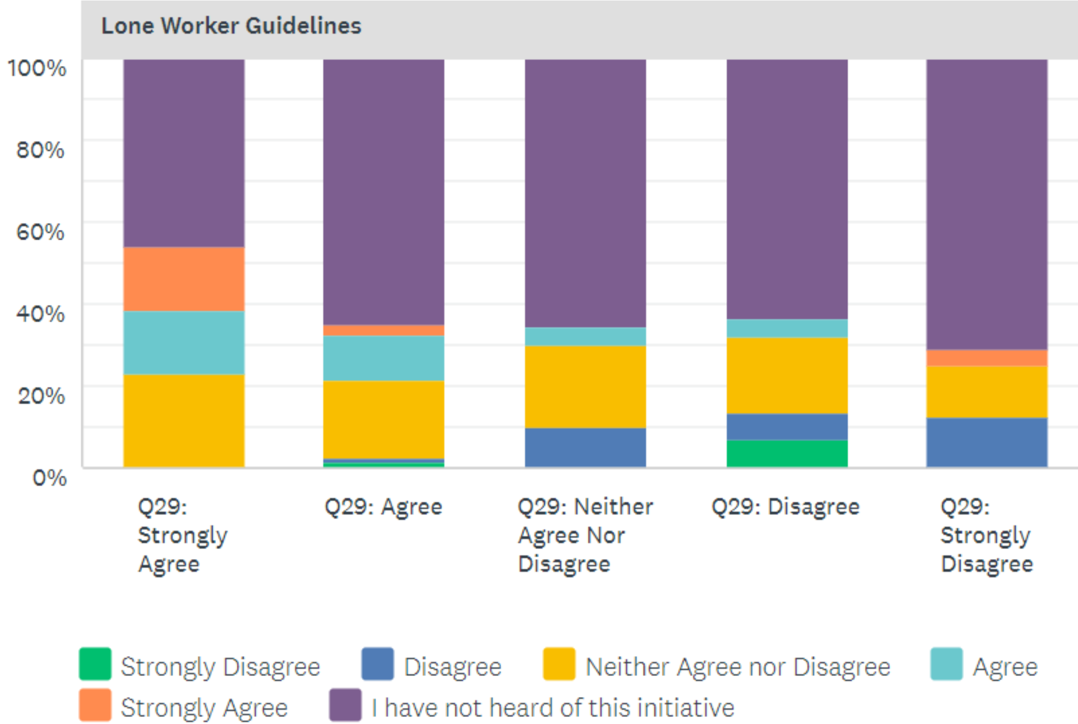


Figure 69 TASC initiatives awareness and workplace safety perception

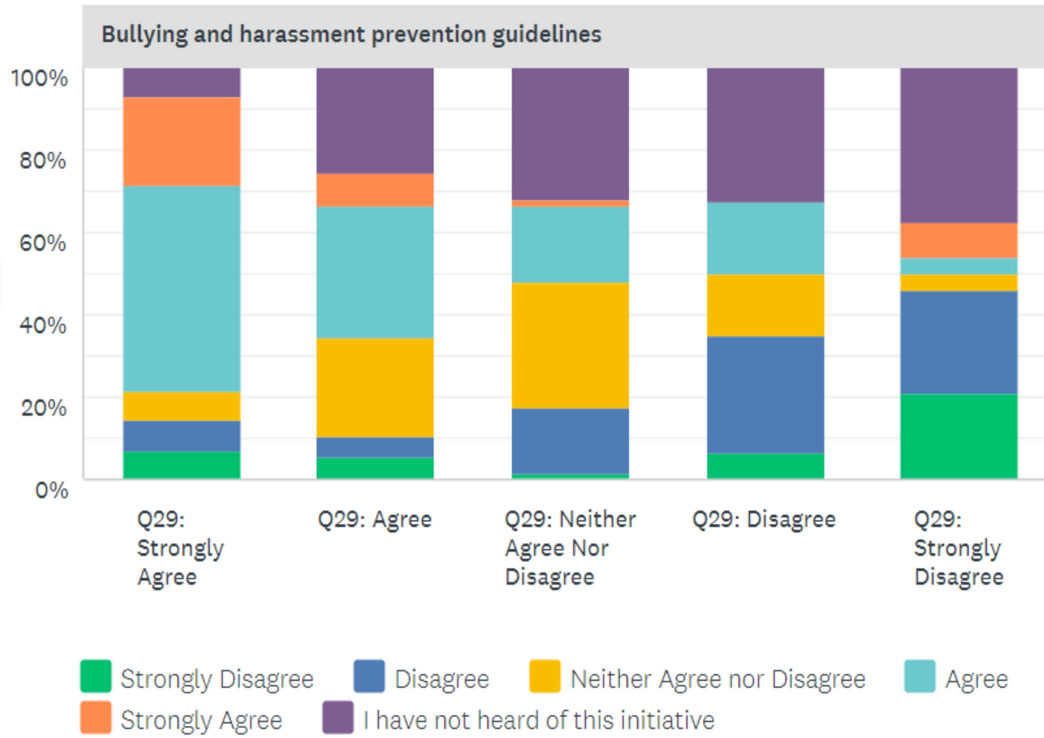


Figure 70 TASC initiatives awareness and workplace safety perception

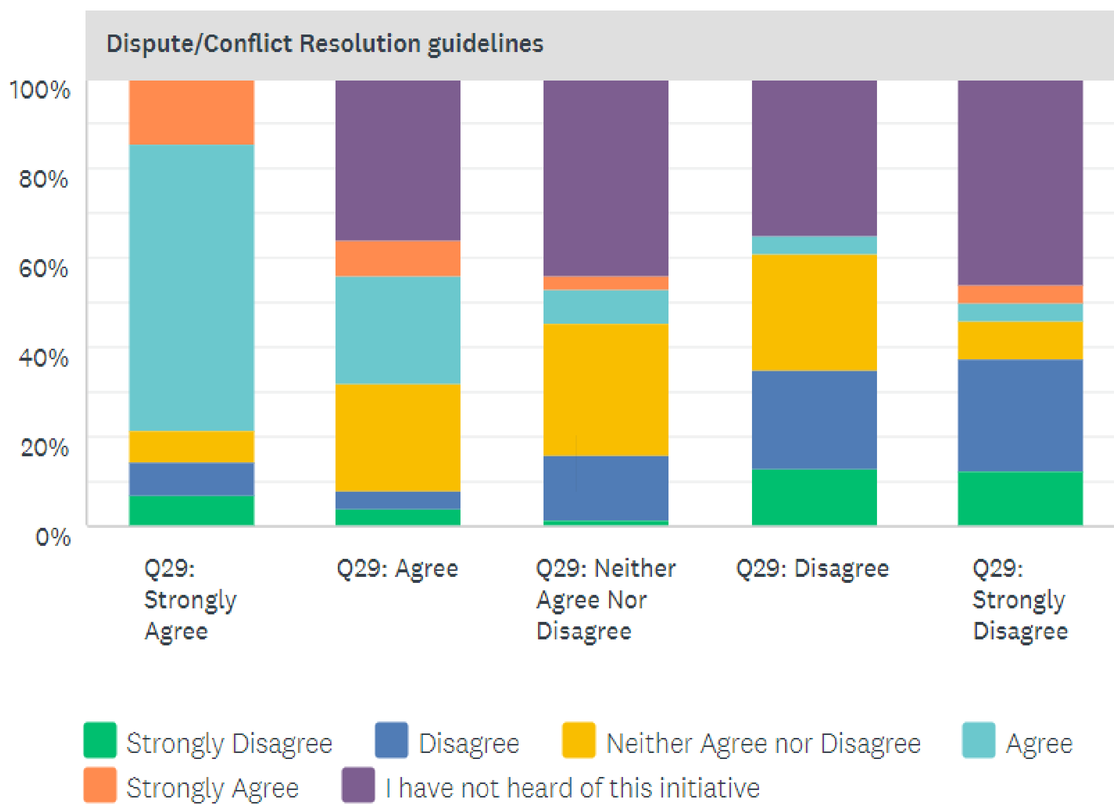


Figure 71 TASC initiatives awareness and workplace safety perception

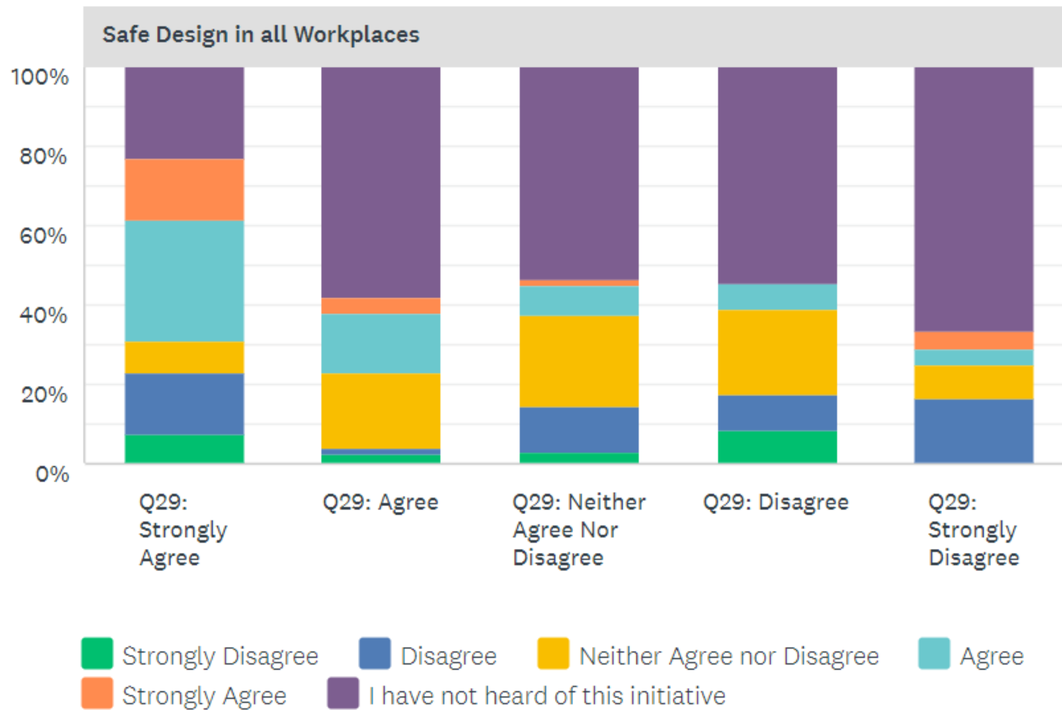


Figure 72 Strong leadership culture and workplace safety perception

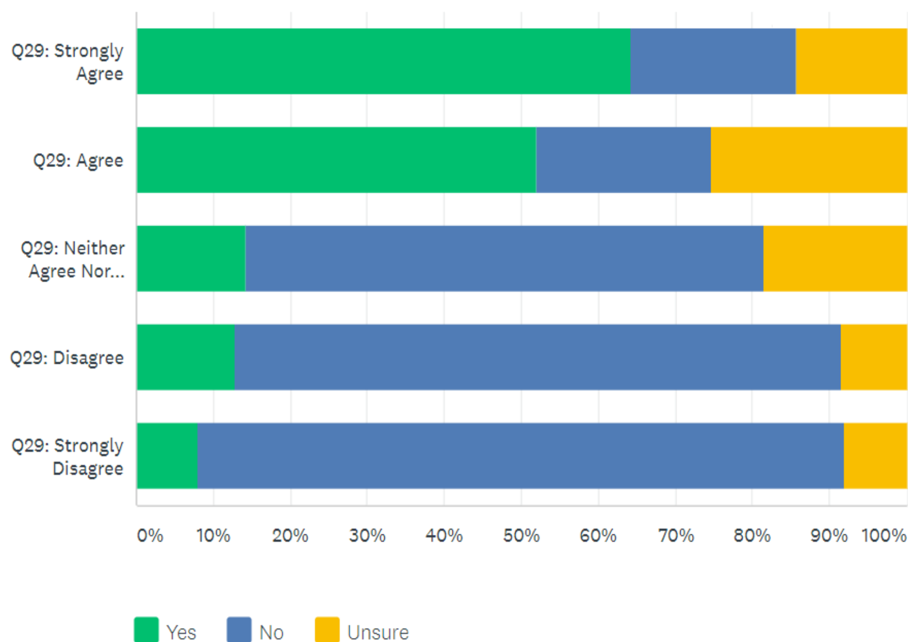


Figure 73 Strong leadership culture and workplace safety perception

Is occupational violence on the agenda of your local Work and Hea
Safety (WHS) meetings?

Answered: 232 Skipped: 0

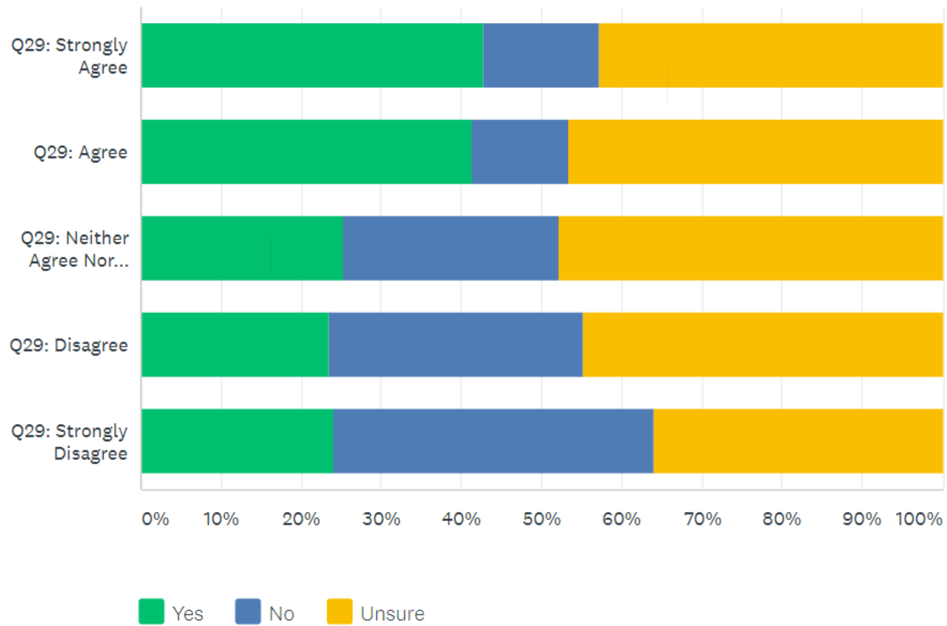
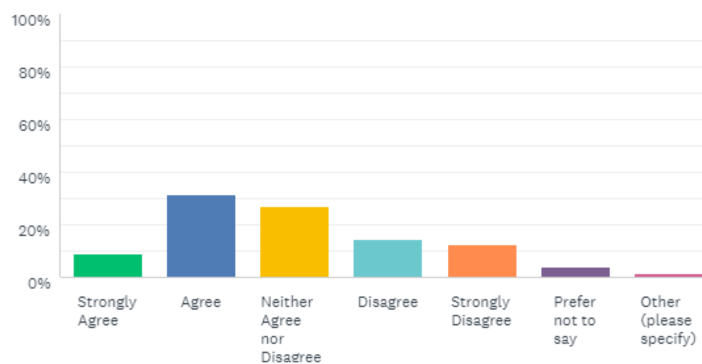


Figure 74 Organisation is a great place to work

My organisation is a great place to work:

Answered: 238 Skipped: 53



ANSWER CHOICES		RESPONSES	
Strongly Agree		8.82%	21
Agree		31.51%	75
Neither Agree nor Disagree		26.89%	64
Disagree		14.29%	34
Strongly Disagree		12.61%	30
Prefer not to say		4.20%	10
Other (please specify)	Responses	1.68%	4
TOTAL			238

Note: Internal Survey Question 29

Ordered logistic regression results

Table 5 Detailed results of the ordered logistic regression

Safe workplace perception	Coefficient	Standard Error	z	P > |z|	95% Confidence Interval	
Violence source: Manager	-0.108	0.247	-0.44	0.661	-0.593	0.376
Violence source: Co-worker	-0.375	0.222	-1.69	0.092	-0.81	0.061
Violence source: Patient family	-0.132	0.279	-0.47	0.636	-0.679	0.415
Violence source: Patient	-0.348	0.295	-1.18	0.238	-0.927	0.23
Violence type: Physical	0.164	0.334	0.49	0.624	-0.491	0.819
Violence type: Non-Physical	-0.672	0.232	-2.89	0.004	-1.127	-0.216
Primarily speak English at home	0.427	0.258	1.65	0.098	-0.079	0.933
Occupational Violence on WHS agenda	-0.026	0.12	-0.21	0.83	-0.261	0.21
"Towards a Safer Culture" awareness	0.148	0.16	0.92	0.355	-0.166	0.463
"Be kind and respectful ..." campaign awareness	0.618	0.227	-2.72	0.007	-1.064	-0.173
Safewards model of care awareness	-0.258	0.184	-1.4	0.161	-0.619	0.103
Manager conversations about OV	0.498	0.194	-2.57	0.01	-0.878	-0.119
Lone Worker Guidelines knowledge	0.056	0.119	0.47	0.635	-0.177	0.29
Violence Screening Tool Guidelines knowledge	0.25	0.092	2.73	0.006	0.07	0.429
Post Incident OV Toolkit knowledge	-0.116	0.12	-0.97	0.332	-0.351	0.119
Challenging Behaviour Guidelines knowledge	-0.213	0.09	-2.36	0.018	-0.39	-0.036
Rostering and Leave Guidelines knowledge	-0.08	0.08	-1	0.318	-0.236	0.077
Age group	0.218	0.124	1.76	0.078	-0.024	0.461
Professional experience (in years)	-0.056	0.075	-0.75	0.451	-0.202	0.09
Safe Design in all Workplaces awareness	0.063	0.093	0.67	0.504	-0.121	0.246
Bullying and Harassment Guidelines awareness	0.077	0.084	0.93	0.355	-0.087	0.241
Dispute and Conflict Resolution Guidelines	0.089	0.086	1.03	0.305	-0.081	0.258
Strong Leadership perception	1.073	0.243	4.41	0.000	0.596	1.55

Note: the variables highlighted in yellow were discussed in the report (see Figure 30 on page 55).

Appendix E – Interview protocol with questions

The protocol below includes the questions that were asked in the semi-structured interviews. Interviews were recorded with participants permission.

Question 12 was only put to interviewees who had professional experience working as a nurse or midwife or had worked in a setting (e.g., hospital) where they were directly interacting with nurses and midwives.

Table 6 Protocol for semi-structured interviews

Running order of interview	
Preliminaries	
Acknowledgement of Country	
Project background & aims - *As indicated in the invitation, the purpose of this project is to perform an evaluation of the "Towards a Safer culture" Strategy. The aim of this evaluation is to review development, implementation and outcomes of the TASC strategy and to inform future actions in the area of safe workplaces for nurses and midwives.*	
Consent to record the interview - *Do you consent to us recording the interview and using your de-identified data for project reporting?*	
Privacy, data and ethics - *To reiterate, data collected will be retained in line with the ACT Territory Records Act 2002, will be stored safely and personal data will be de-identified. If we would like to quote a statement you made in the interview we will seek your permission first, and we are guided by the Territory Privacy Principles and the National Statement on Ethical Conduct in Human Research.*	
Structure of interview (1. Open Response Questions, 2. Rubric grading, 3. Ranking of Priority Areas)	
Section 1. Open response questions (approx. 30 minutes)	
Question 1	Please outline your involvement with the “Towards a Safer Culture” Strategy
The next few questions are about the status and objectives of the TASC strategy	
Question 2	Please describe the current status of the Strategy (e.g. Implementation), if known.
Question 3	Do you think the Strategy has changed over time, in terms or remit or intent? If so, how?
Question 4	Do you think it matters that the Strategy is administered by ACT Health and in which ways?
Question 5	What do you think are the key aims of the Strategy? Are there any gaps?
The following sections deal with the outcomes and impacts of the TASC strategy (impacts are a bit further downstream or longer term):	
Question 6	In which areas has the Strategy been successful from your point of view to date? In which ways has it not?
Question 7	What do you think are key measures of success to assess the Strategy?
Question 8	How does the Strategy differ from other OV initiatives in the ACT?
The next few questions are about the impacts of the TASC strategy:	
Question 9	What do you think has been the impact of the Strategy for nurses and midwives to date?

Question 10	How do you think the Strategy has influenced members of the general public in their behaviour towards nurses and midwives?
Question 11	In which ways has the Strategy influenced culture change (if any)?
Question 12	Have you been impacted by Occupational Violence? If so, how did it impact you?
Question 13	Anything else that you would like to comment on in relation to the Strategy?

Section 2. Rubric	
Please indicate your level of agreement with the following 11 statements:	
[Options: Can't say / Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree]	
The Strategy is ...	
Statement 1	*... well implemented*
Statement 2	*... well governed*
Statement 3	*... well understood by staff*
Statement 4	*... filling a gap with regards to occupational violence*
Statement 5	*... encouraging leadership to create safe workplaces*
Statement 6	*... clearly driven by its Vision*
Statement 7	*... distinguishable from similar strategies and programs*
Statement 8	*... well supported by stakeholders*
Statement 9	*... achieving its intended outcomes*
Statement 10	*... "on track", i.e. meeting expectations*
Statement 11	**Overall, the strategy has been a success**

Section 3. Ranking exercise	
We would like you to assess the following priority areas and their implementation in terms of their importance now and in the future:	
(1= Most important, 7= Least important)	
Area 1	Leadership (clinical and strategic)
Area 2	Guidelines and toolkits (e.g. Staff rights to a safe workplace factsheet)
Area 3	Staff engagement
Area 4	Communication campaigns (e.g. be kind to our nurses and midwives)
Area 5	Safe Design & Consultation (e.g. new builds and refurbishments)
Area 6	Models of care (e.g., Safewards, Ratios)
Area 7	Culture change activities (e.g., systemic; peer to peer relationships)
Thank you for participating in this interview.	

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Policy Design and Evaluation Team

Nurses and Midwives: Towards A Safer Culture (TASC) Strategy Evaluation – Final Report September 2021