

# **Leading indicators of occupational health and safety: A report on a survey of Australian Nursing and Midwifery Federation (Victorian Branch) members**

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# Executive Summary

## Background and aims

This report presents the results of an **Occupational Health and Safety (OHS) Survey** conducted with the members of the Australian Nursing and Midwifery Federation (ANMF) (Victorian Branch) in April and May 2014 by a Monash University research team. The work is part of a large national research project that is being conducted by Monash University in partnership with the Victorian WorkCover Authority, the Institute for Safety, Compensation and Recovery Research and SafeWork Australia.

Nationally and internationally, industry stakeholders have a keen interest to identify and develop leading indicators of OHS. Concurrently in Australia, regulators are gearing up to include leading indicators in the suite of modern regulatory tools. The **OHS Survey** has emerged in this environment, and offers an invaluable opportunity for industry stakeholders to take a leading and proactive role in the development of future tools and approaches. The participation by the Victorian branch of the ANMF membership in this research is an important contribution to the development of an essential tool for Australian industry.

In 2012, the Monash research team conducted preliminary research that identified and piloted a tool, which was developed in Canada, to measure OHS leading indicators (the 'Organizational Performance Metric or 'OPM').<sup>1</sup> The **OHS Survey**, which is being conducted during 2013-14, is important research that will test the OPM and lead to the development of a practical tool to be used for predictive or benchmarking purposes. Several Australian employers and unions are participating in this research project.

The aim of this report is to present the ANMF with an overview of their members' views and experiences of OHS. The report presents analysis of union members': 1) views of OHS in their workplaces; 2) self-reported OHS incidents; 3) perceptions of psychosocial, physical and physiological risk; and 4) aggression in the workplace.

## Research method

ANMF (Victorian Branch) members were invited to participate in an online **OHS Survey** through April and May 2014. The survey targeted all registered members of the ANMF (Victorian Branch). Overall, 69,927 members had the opportunity to participate in the survey. Responses were received from 4,891 members: 3,273 registered nurses (67 percent), 1,055 enrolled nurses (22 percent), 407 midwives (8 percent) and 156 personal carers (3 percent). This resulted in a 7 percent response rate.

The survey contained several sections where respondents were asked to provide information about their role in their respective workplaces, their experience of OHS incidents in the past 12 months, their perceptions, attitudes and behaviours and other issues related to OHS in their workplaces such as exposure to psychosocial, physical and physiological risk in the

workplace. Respondents were also invited to offer additional comments about OHS at their workplace.

## Major findings

Analyses of the survey results from the ANMF Victorian branch members show that:

- 1) **The OPM is a reliable measure of OHS leading indicators.** A higher score on the OPM indicates that OHS leading indicators are present to a greater extent in the workplace (possible scores range from 8 to 40). The OPM could be used as an initial 'flag' of leading indicators of OHS in a workplace.
- 2) **Workplace scores on OHS leading indicators in the industry are relatively low.** The mean score for the OPM across all respondents was 27.4 (SD = 6.7) and the average score from nurse unit managers within the sample was 30.6 (SD = 5.6). Both of these scores are lower than those from a recent study of managers in Victorian workplaces across different industries where we found the average OPM score was 33.4 (SD = 4.2).

In a break-down of scores into the individual items of the OPM, the item, *those who act safely receive positive recognition*, obtained the lowest average score from respondents in the current sample.

- 3) **The OPM across type of job, workplace and employment status.** Personal carers scored their workplaces slightly lower than all the other groups and enrolled nurses tended to give their workplaces slightly higher scores, on average, compared to all other groups.

Respondents working in mental health, emergency and maternity settings gave lower ratings on the OPM, on average, compared to respondents working in other settings; particularly compared to settings such as disability, rehabilitation and district nursing.

Respondents who were employed full-time tended to give their workplaces higher scores on the OPM compared to respondents who were either part-time or contingent (casual, bank, agency) workers.

- 4) **Self-reported OHS incidents.** Overall, 60 percent of respondents reported that they had experienced an OHS incident in the past year. Personal carers said they were involved in more incidents, on average, and this is particularly evident for near misses; while midwives were involved in fewer incidents of all types, compared to the other groups.
- 5) **Needle stick injuries.** Most respondents reported having access to a safe needle device in the workplace and nearly all reported that they had not had a needle stick injury in the past 12 months. Respondents who had had a needle stick injury and also reported the injury said that their injuries were generally managed well or very well.

- 6) **Leading indicators of OHS are associated with perceived management commitment to OHS.** Respondents who rated their workplaces higher on leading indicators of OHS, as measured by the OPM and safety climate, tended to report that their managers and supervisors:
- prioritised OHS (for staff) at similar levels to patient safety; and
  - were supportive of OHS.
- 7) **Leading indicators of OHS are associated with self-reported employee behaviours.** Respondents who rated their workplaces higher on leading indicators of OHS, as measured by the OPM and safety climate, tended to report that they:
- have greater levels of safety motivation; and
  - behave more safely in the workplace.
- 8) **Relationships between OHS leading indicators and self-reported OHS incidents.** Higher levels of leading indicators (as measured by the OPM and safety climate) were associated with fewer:
- OHS incidents that were reported to management;
  - OHS incidents that were not reported to management; and
  - near misses (i.e., situations that could have caused an injury but did not).
- 9) **Violence and bullying.** Nearly 70 percent of respondents reported they had experienced occupational violence or aggression at least once in the past twelve months. More than 40 percent of respondents reported that they had experienced occupational violence or aggression a few times in the past twelve months, while 23 percent reported experiencing regular episodes of violence or aggression. Respondents reported that the sources of occupational violence and aggression were mostly from patients or relatives of patients; however, some respondents also reported experiencing occupational violence from supervisors, colleagues and subordinates.
- More than half of the respondents reported that they had not experienced bullying in the past 12 months. However, 10 percent of respondents had experienced regular bullying over the past twelve months with a small percentage experiencing bullying on a daily basis. The predominant source of bullying was either from managers/supervisors or colleagues.
- We used two multi-item measures of violence and bullying to examine the relationships between violence and bullying and self-reported OHS incidents. Higher levels of reported violence and bullying were associated with more:
- OHS incidents that were reported to management;
  - OHS incidents that were not reported to management; and
  - near misses (i.e., situations that could have caused an injury but did not).
- Interestingly, the association between violence and reported OHS incidents was stronger than the relationships between violence and OHS incidents that were not reported or near misses. Conversely, the association between bullying and reported

OHS incidents was weaker compared to the relationships between bullying and OHS incidents that were not reported or near misses.

- 10) **Relationships between risk factors and self-reported OHS incidents.** Respondents who had greater psychosocial risk such as burnout and emotional labour (i.e., displaying emotions that are not felt) and physical or physiological risk (role overload, physical demands), tended to report more:

- OHS incidents that were reported to management;
- OHS incidents that were not reported to management; and
- near misses (i.e., situations that could have caused an injury but did not).

Conversely, respondents who had greater workplace psychological safety (i.e., belief that people in this workplace are able to bring up problems and tough issues), tended to report fewer:

- OHS incidents that were reported to management;
- OHS incidents that were not reported to management; and
- near misses (i.e., situations that could have caused an injury but did not).

- 11) **Work engagement, career commitment and intention to leave.** There were few differences between groups on work engagement. Slight differences can be seen for career commitment and intention to leave; midwives reported higher levels of career commitment compared to the other three groups and personal carers reported a greater intention to leave compared to the other three groups.

- 12) **Additional comments about OHS from ANMF members.** Respondents' comments about OHS were grouped into the ten broad categories that represent the leading indicators concept. The predominant concerns shown in respondents' comments were related to:

- Risk management;
- OHS systems; and
- OHS resources.

The majority of comments from respondents were about risk management and more than half of the comments in this category referred to aggression and bullying in the workplace. The remaining comments in this category were about workload, fatigue and mental health.

## Conclusion

Overall, this report provides an analysis of ANMF (Victorian Branch) members' perspectives of occupational health and safety in their workplaces. The analysis demonstrates that the OPM and other measures related to OHS can be used with union members to capture and report on their views and experiences of OHS.

## Introduction

This report presents results of the **Occupational Health and Safety (OHS) Survey** conducted with ANMF members through April and May 2014 by a Monash University research team. The survey is part of a larger research project that is being conducted by Monash University in partnership with the Victorian WorkCover Authority, the Institute for Safety, Compensation and Recovery Research and SafeWork Australia.

Nationally and internationally, industry stakeholders have a keen interest in identifying and developing leading indicators of OHS. Concurrently in Australia, regulators are gearing up to include leading indicators in the suite of modern regulatory tools. The research project has emerged in this environment, and offers an invaluable opportunity for industry to take a leading and proactive role in the development of future tools and approaches.

In 2012, the Monash research team conducted preliminary research that identified and piloted a tool, developed in Canada, to measure OHS leading indicators (the 'Organizational Performance Measure' or 'OPM'). In 2013-14, the Monash team has conducted the **OHS Survey**, important research that will test the OPM and lead to the development of a practical tool to be used for predictive purposes or as a benchmarking tool. The aim of this report is to provide an analysis of ANMF members' perspectives of health and safety in their workplaces.

### What are OHS leading indicators?

OHS encompasses the psychosocial, physical and physiological conditions of an organisation's workforce. Leading indicators of OHS performance can be defined as measures of the positive steps that organisations and individuals take that may prevent an OHS incident from occurring. Baker and colleagues define leading indicators as: "*A metric that attempts to measure some variable that is believed to be an indicator or precursor of future safety performance*".<sup>2</sup> In other words, leading indicators can be said to measure the 'safety potential' of a workplace. Leading indicators are the key to a proactive approach to OHS and the measurement and monitoring of OHS performance. Leading indicators are, by definition, measures of the predictors, or root causes, of OHS performance.<sup>3</sup> Leading indicators can provide effective early warnings, by enabling risks or risk increases to be detected and mitigated, before an OHS incident occurs or a hazardous state is reached. OHS leading indicators may occur at a broad, macro-level (e.g. presence of OHS policy), and/or the more specific level (e.g. number of hazards identified each month). Macro-level indicators may be able to be applied across workplace and industry contexts in order to benchmark and obtain a broad, comparable overview of OHS.

**Table 1: Leading indicators of occupational health and safety**

OHS Leading Indicators	
<i>OHS systems (policies, procedures, practices).</i>	These systems refer to workplace policies, processes and practices designed to control and monitor OHS, and are typically implemented and maintained by managers and in work groups. <sup>4</sup>
<i>Management commitment and leadership</i>	As with any organisational initiative, management commitment is key to OHS. <sup>5,6</sup> This includes managers at all levels, from board and senior executive levels to front-line supervisors. Effective commitment is demonstrated in active engagement in areas such as information gathering about OHS, building trust so all employees view managers as committed to OHS, managers' behaviour demonstrating that they are OHS role models; and managers demonstrating that OHS is a high priority across the organisation.
<i>OHS training, interventions, information, tools and resources</i>	Along with the resourcing of OHS with suitably qualified OHS specialist expertise, the provision of OHS training, information, tools and resources are key leading indicators of OHS performance. <sup>5</sup> This includes preparedness to act and having a response plan in place.
<i>Workplace OHS inspections and audits</i>	A phrase often attributed to management scholar Peter Drucker: is " <i>What gets measured, gets managed.</i> " An important implication of this is that the conduct of an audit or inspection may not in itself be adequate as a leading indicator of OHS performance. Inspections and audits should be designed to provide appropriate and comprehensive information. <sup>7</sup> Appropriate and timely corrective action should be taken to address issues identified in audits or inspections.
<i>Consultation and communication about OHS</i>	This refers to regular, formal and informal communication and consultation about OHS. <sup>8</sup> Employee surveys may be one way of gathering information from employees regarding their perceptions of OHS.
<i>Prioritisation of OHS</i>	The tendency for safety to be traded off against productivity has been discussed at length by OHS academics. <sup>9</sup> Rather than view safety and productivity as competing goals, OHS embedded in the organisation as a high priority alongside efficiency and productivity can be viewed as a leading indicator of OHS performance.
<i>OHS empowerment and employee involvement in decision making</i>	It is widely understood that employee involvement in decision making will lead to 'ownership' of their behaviour and positive outcomes, such as safety behavior. <sup>10</sup> Several researchers have investigated the role of empowerment and engagement in OHS and found that empowerment of workers and supervisors to make decisions with regard to OHS (e.g., to stop work that is unsafe) is a leading indicator of OHS performance. <sup>11</sup>
<i>OHS accountability</i>	A workplace culture that emphasises a sense of shared responsibility and accountability for OHS, by actively applying scrutiny and transparency in reporting, is likely to influence behaviour in the workplace. <sup>3</sup>
<i>Positive feedback and recognition for OHS</i>	It is suggested that high performance on OHS will be reinforced by positive feedback and recognition for past performance. Such recognition should not, however, include rewards that might lead to under-reporting of incidents or injuries. <sup>12</sup>
<i>Risk management</i>	This refers to the integration of risk management with the management of OHS; <sup>13</sup> aspects of risk management include risk assessment, control, inspection and maintenance. <sup>14</sup> Risks may be associated with psychosocial, physical and/or physiological dimensions of OHS.

These may be complemented by more specific and sensitive micro-level indicators that allow for a more fine-grained understanding of OHS performance in a particular work context or organisation. There is recognised value in both macro- and micro-level indicators of OHS performance.

Despite the apparent value of leading indicators, there has been very little development of academic research that focuses on the measurement of leading indicators.<sup>5</sup> This may be at least partly explained by the perceived difficulty of measuring leading indicators.

To summarise the available literature, the major OHS leading indicators encompass the domains that are shown in Table 1 above. This list of the dimensions or domains of leading indicators may not be exhaustive. Further, it is important to recognise that each domain is complex and detailed. Research conducted to date indicates that the OPM shows promise as a simple and practical measure of leading indicators in the Australian context. The OHS Survey is an important step in the validation of the OPM.

### **OHS lagging indicators**

As discussed above, OHS leading indicators can be thought of as precursors to harm, or inputs that provide guidance on how to improve future OHS performance. In contrast, OHS lagging indicators are measures of harm that measure events or outcomes that have already happened;<sup>14</sup> lagging indicators are outputs and provide a measure of past performance.<sup>15</sup>

While lagging indicators are valid measures of past OHS performance, their validity as predictors of future OHS performance is open to debate.<sup>16</sup> Despite their benefits, lagging indicators have limitations or problems, as evidenced in several studies:<sup>5,17</sup>

- by definition, these indicators lag after the OHS event, and therefore do not allow for prevention (at least of the initial event);
- lagging indicators are of limited use in the diagnosis of OHS problems because they typically do not assist with identification of the cause of an OHS event;
- outcomes focused on reportable injuries and illnesses may have very low levels of reporting and therefore low variation. These measures may not be sensitive enough to identify differences in OHS performance between two units;
- a focus on lagging indicators may be counter-productive, as it may not guarantee that workplace hazards and risks are being monitored or controlled; and
- lagging indicators may not occur with enough frequency to be reliable indicators of performance and because they are measured after an event, they are not useful as a preventative measure of OHS.

## **The need for reliable and valid measurement of OHS leading indicators**

A major aim of this research is to see whether the OPM is a reliable and valid measure of leading indicators of OHS in Australian workplaces. To develop a tool that represents 'OHS leading indicators', a necessary criterion is for that measure to have demonstrable validity. This means that the tool as a whole, and each item in it, must have some correspondence to the underlying concept it is supposed to represent, in this case, leading indicators of OHS. When the items meaningfully represent the concept they are said to be measuring then there is evidence of validity.<sup>18</sup> A systematic research process needs to be conducted to demonstrate this validity.

Paying careful attention to the validity of a measure is important because decisions will be made based on the use of such measures; therefore, developing and validating a measure requires rigorous attention to well-established research procedures. Hence, the participation by the members of the ANMF in this research is an invaluable contribution to the development of an important tool for Australian industry.

## **Aims of this report**

This report provides the ANMF with an overview of ANMF respondents' perceptions of OHS. The report presents analysis of: 1) variations in member views of OHS; and 2) the relationship between perceptions of OHS and self-reported OHS incidents. The report contains:

- an evaluation of a new measure of leading indicators of safety (the OPM);
- a summary of OHS outcomes;
- a summary of perceptions of OHS;
- an overview of the relationship between OHS and self-reported OHS outcomes;
- a summary of perceptions of risk in the workplace;
- an overview of the relationship between risk factors and self-reported OHS outcomes;
- a summary of exposure to hazards;
- a summary of perceptions of work engagement, career commitment and intention to leave; and
- an outline of individual comments about OHS.



## Method

### Sample and procedure

Members of the ANMF were invited to participate in an OHS Survey during April and May 2014. The survey was conducted online and targeted all registered members of the ANMF (Victorian Branch). The survey contained several sections where respondents were asked to provide information about their role in their respective workplaces, their experience of OHS incidents in the past 12 months, and their perceptions, attitudes and behaviours and other issues related to OHS, such as exposure to psychosocial, physical and physiological risk in the workplace. Respondents were also invited to offer additional comments about OHS at their workplace.

### Measures

The questionnaire was designed to collect several types of information:

- respondent demographics (e.g., organisational role);
- OHS practices and behaviour (e.g., OPM, safety participation, safety compliance);
- self-reported OHS outcomes (e.g., OHS incidents, near misses, WorkCover claims);
- psychosocial, physical and physiological risk factors in the workplace (e.g., workplace psychological safety, role overload, violence);
- exposure to hazards;
- engagement (e.g., work engagement, career commitment, intention to leave); and
- open-ended comments about OHS.

#### *Demographic measures*

Survey respondents provided details such as their age, gender, organisational role (e.g., unit manager, registered nurse, midwife), employee status (e.g., full-time, part-time), workplace (e.g., hospital, aged care facility), details regarding shifts worked (e.g., morning, afternoon, night shifts, rotating shifts) and number of jobs held.

#### *Measures of OHS and risk*

Perceptions of OHS, as well as risk factors, were examined using several different types of measures. We included both multi-item scales and single item measures to examine perceptions of OHS and risk within the ANMF membership. The following discussion summarises the content of these measures and how they are presented in the report with the summary of multi-item measures in Table 2 and single item measures in Table 3.

The Organizational Performance Metric (OPM) is the primary focus of the broader research project. This measure has been reported to be a reliable eight-item measure of leading indicators of OHS<sup>1</sup>. In this survey we asked respondents to complete the OPM for the

workplace they most often work in rather than for the organisation overall. Respondents were asked to indicate on a five-point scale (from 1 = strongly disagree to 5 = strongly agree), the extent to which they agreed or disagreed with eight statements.

The OPM is designed as a summated rating scale. This means the items can be summed to provide a total score. The score on the OPM indicates the respondent's level of agreement that OHS leading indicators are present in a workplace (possible scores range from 8 to 40).

An item "Everyone has the authority to take charge of OHS e.g., stop work if they consider conditions are unsafe" was also included as an alternative to "Those in charge of OHS have the authority to make the changes they have identified as necessary." This additional item was written to address a higher level of vigilance with respect to OHS in some organisations.

Table 2 below displays the multi-item scales used in this study. For these measures, individual item scores were summed to yield a single total score. When comparisons are drawn between scales that use different numbers of items and response options, the raw total scores are converted to a common metric with scores ranging from 0 to 100.

Table 3 below displays the single item measures of risk in the workplace. Respondent ratings for the 14 exposure to hazards items are presented on a scale from 1 (no risk) to 5 (very high risk). The single item measures of violence and bullying are presented as percentages.

**Table 2: Multi-item measures used in the study**

Measure	Items	Example item
<i>Organisational OHS measures</i>		
OPM <sup>1,19</sup>	8	Everyone at this workplace values ongoing OHS improvement in this workplace
Safety climate <sup>20</sup>	3	Management places a strong emphasis on workplace health and safety
<i>Supervisor OHS measures</i>		
Supervisor support for OHS <sup>21</sup>	3	My supervisor places a strong emphasis on health and safety
Prioritisation of OHS	3	Management applies different standards of health and safety to staff compared to patients
<i>Employee OHS measures</i>		
Safety motivation <sup>20</sup>	3	I feel that it is important to maintain health and safety at all times
Safety compliance <sup>20</sup>	3	I use the correct health and safety procedures for carrying out my job
Safety participation <sup>20</sup>	3	I put in extra effort to improve the health and safety of the workplace
<i>Psychosocial risk factors</i>		
Workplace psychological safety <sup>22</sup>	7	It is difficult to ask other members of this workplace for help
Emotional labour <sup>23</sup>	3	Put on an act in order to deal with patients in an appropriate way
Burnout <sup>24</sup>	7	Is your work emotionally exhausting?
<i>Physical risk factors</i>		
Role overload <sup>25</sup>	5	How often do you have to do more work than you can do well?
Physical demands / Ergonomic issues <sup>26</sup>	8	My job requires lots of physical effort
<i>Violence &amp; bullying</i>		
Violence in the workplace	6	Have you been fearful that someone in your current workplace would physically harm you?
Bullying <sup>27</sup>	6	Been exposed to an unmanageable workload
<i>Engagement</i>		
Work engagement <sup>28</sup>	9	I am enthusiastic about my job
Intention to leave <sup>27</sup>	3	I intend to look for a different field of employment
Career commitment <sup>29</sup>	6	I am proud to be in the nursing profession

**Table 3: Single-item measures used in the study**

Measure	Items
Exposure to hazards	Fourteen single items included risk of exposure to: Fatigue, workplace stress, occupational violence and aggression, workplace bullying Patient handling, other manual handling, noise Needle stick injuries, blood-borne pathogens, other infectious agents Cytotoxic drugs, chemical agents, ionizing radiation (e.g. X-rays), non-ionizing radiation
Violence and aggression	Frequency of occupational violence and aggression Source of occupational violence and aggression Staff support Policies and training to manage violence and aggression
Bullying	Frequency of bullying Source of bullying

#### *Self-reported OHS outcomes*

Respondents were asked to report a number of self-reported OHS outcomes for the past 12 months that they had personally experienced. This did not include OHS incidents reported on behalf of patients or other members of staff. Respondents were also asked about needle stick injuries and Workers Compensation / WorkCover claims submitted.

**Table 4: Self-reported measures of OHS outcomes**

Measure	Items
<i>Incidents</i>	
Reported incidents	How many, if any, occupational health and safety incidents have you experienced yourself (NOT incidents involving patients) for which you completed an incident report form / RiskMan or one was completed on your behalf?
Unreported incidents	How many, if any, occupational health and safety incidents have you experienced yourself (NOT incidents involving patients) <u>that you did not</u> report (or a report was not completed on your behalf)?
Near misses	How many, if any, near misses (situations that could have caused an injury but did not) have you experienced yourself (NOT incidents involving patients)?
Total incidents	Calculated as the sum of the three types of incidents listed above: that were reported to management, incidents that were not reported to management and near misses.
<i>Needle stick injuries</i>	
Needle stick injuries	How many, if any, needle stick or other sharps related injuries (i.e. punctured your skin with a non-sterile needle device or sharp) have you had personally?
<i>Claims</i>	
WorkCover claim for workplace injury	Have you, or has someone else on your behalf, submitted a Workers Compensation / WorkCover claim as a result of a workplace injury or a workplace related illness (NOT including workplace stress or workplace stress-related illness)?
WorkCover claim for workplace stress	Have you, or has someone else on your behalf, submitted a Workers Compensation / WorkCover claim as a result of a workplace stress or a workplace stress-related illness?

## Results

The results are reported as follows:

- a description of the respondents;
- an evaluation of a measure of leading indicators of OHS (the OPM);
- a summary of OHS outcomes;
- perceptions of OHS;
- the relationships between perceptions of OHS and self-reported OHS outcomes;
- perceptions of risk;
- the relationships between risk factors and self-reported OHS outcomes;
- exposure to hazards;
- work engagement, career commitment and intention to leave;
- a comparison of perceptions of OHS and risk across ANMF member groups; and
- individual comments about OHS.

## Description of the sample

Overall, 69,927 members had the opportunity to participate in the survey; responses were received from 4,891 members: 3,273 registered nurses (67 percent), 1,055 enrolled nurses (22 percent), 407 midwives (8 percent) and 156 personal carers (3 percent). This resulted in a 7 percent response rate. Nearly all respondents were female and generally 55 years of age or less with the largest percentage of respondents being in the 46 to 55 years age group. Due to the anonymous nature of the survey, respondents could not directly be compared with non-respondents. Nevertheless, the sample characteristics are highly consistent with national statistics on the nursing and midwifery workforce in Australia.<sup>30</sup>

With regard to work characteristics, most of the sample was employed in more than one job, and had been employed by their current employer for 10 years or less. Most respondents worked part time; only one quarter of respondents were employed in a full-time capacity.

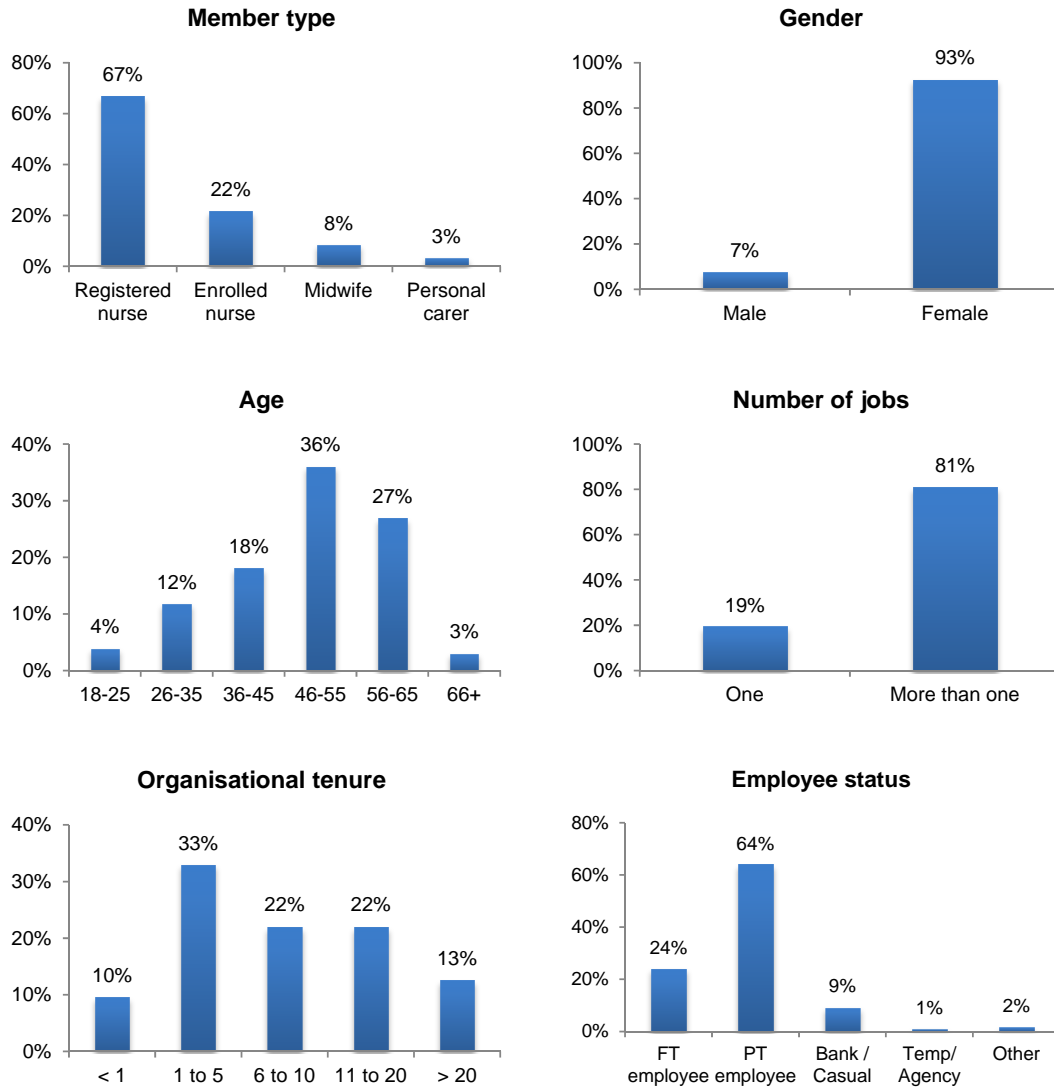
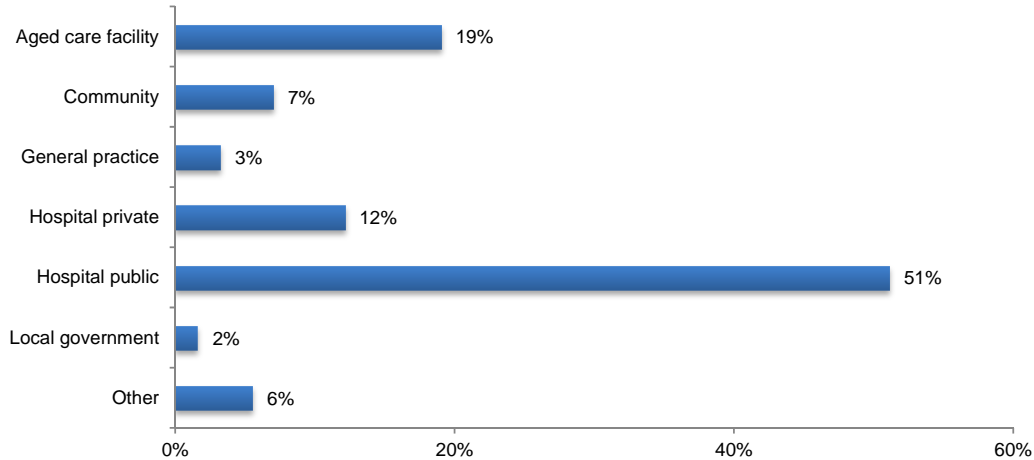


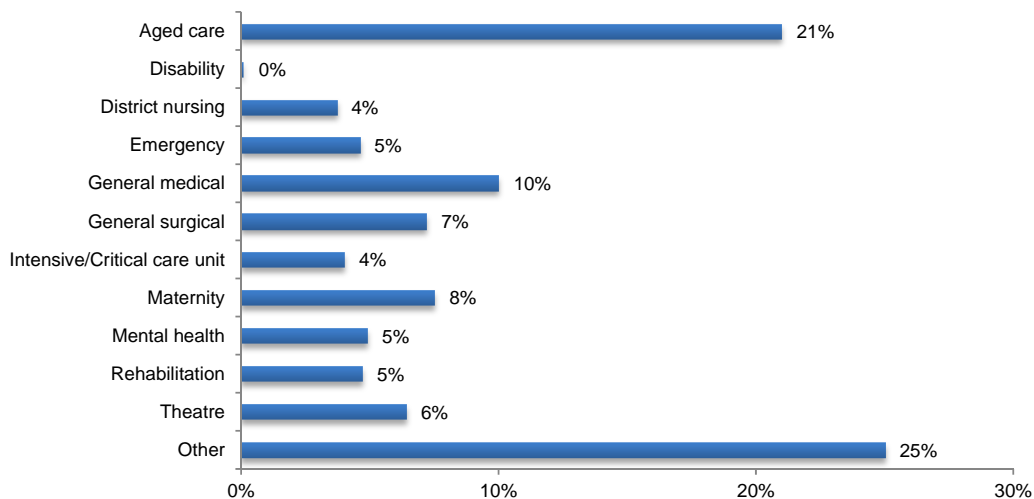
Figure 1: Respondent demographics

Figure 2 below shows that most respondents were employed in public hospitals. Many were also employed in aged care facilities or private hospitals.



**Figure 2: Respondents by organisation type**

Figure 3 displays the workplace units for respondents and most reported being employed in an aged care or general medical workplace. However, a substantial number of respondents reported being employed in 'other' workplaces. Note that there were the six respondents who reported working in a disability unit; however, due to standard rounding practice, the percentage for this group was rounded down from 0.1 percent to 0 percent in this chart.



**Figure 3: Respondents by workplace unit**

Figure 4 below displays the types of shifts worked by respondents. More than half of the respondents in the sample did not work set shifts and a large percentage worked rotating



shifts. Few respondents worked double shifts and those who did work double shifts typically worked one double shift per month.

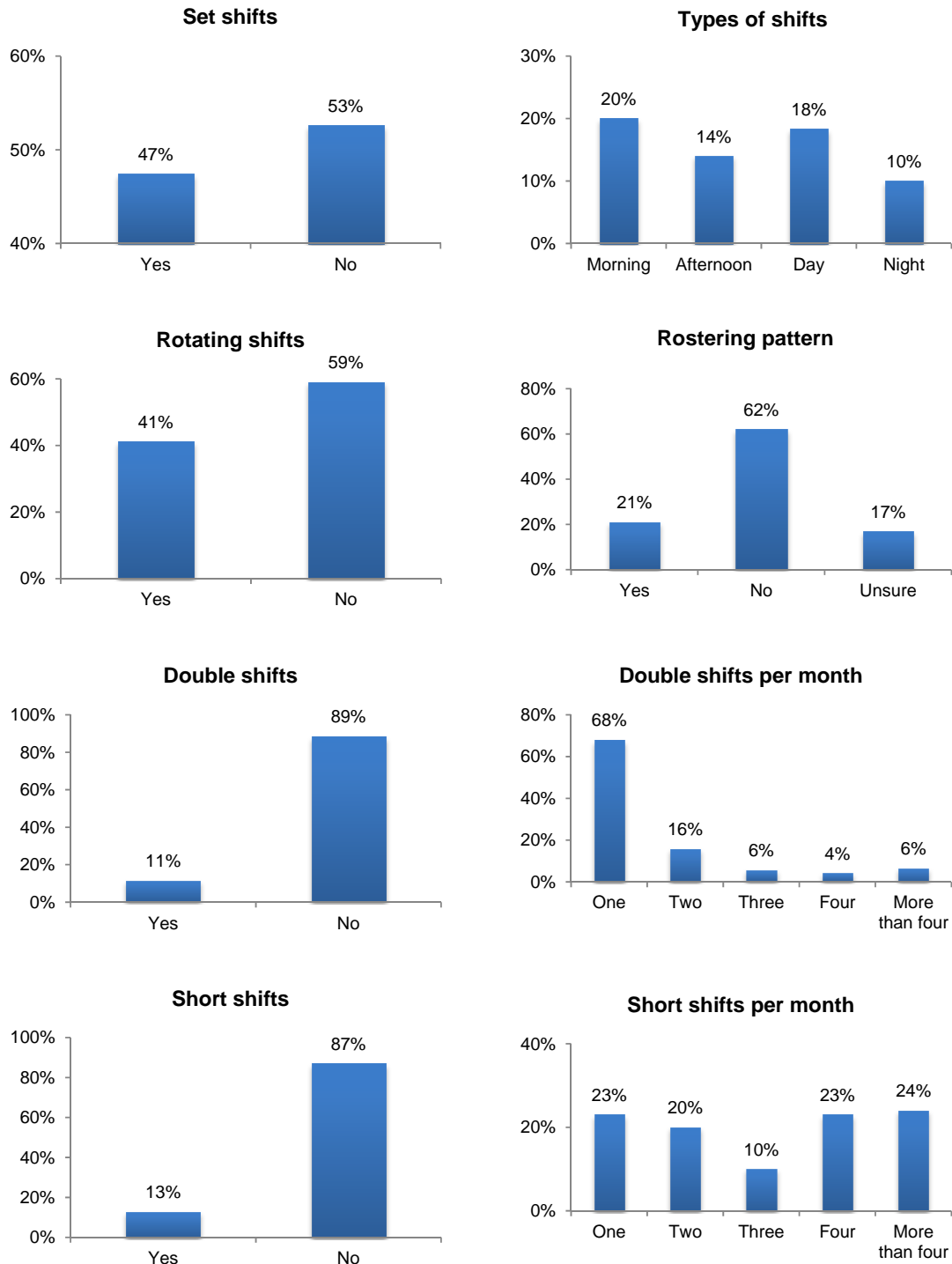
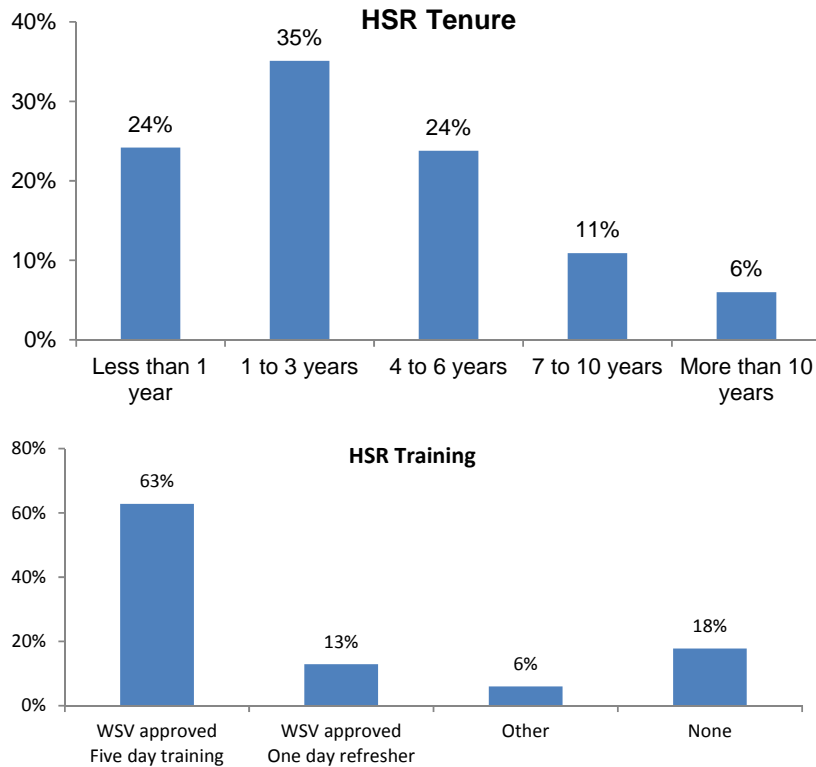


Figure 4: Description of shifts

Seven percent of the sample reported that they worked as health and safety representatives (HSR) in their organisation. Figure 5 below summarises the tenure and training of HSRs. Most respondents who reported working as an HSR had worked as an HSR for three years or less. Most respondents working as an HSR had also completed a Victorian WorkCover Authority training course, nearly 20% had completed no training.



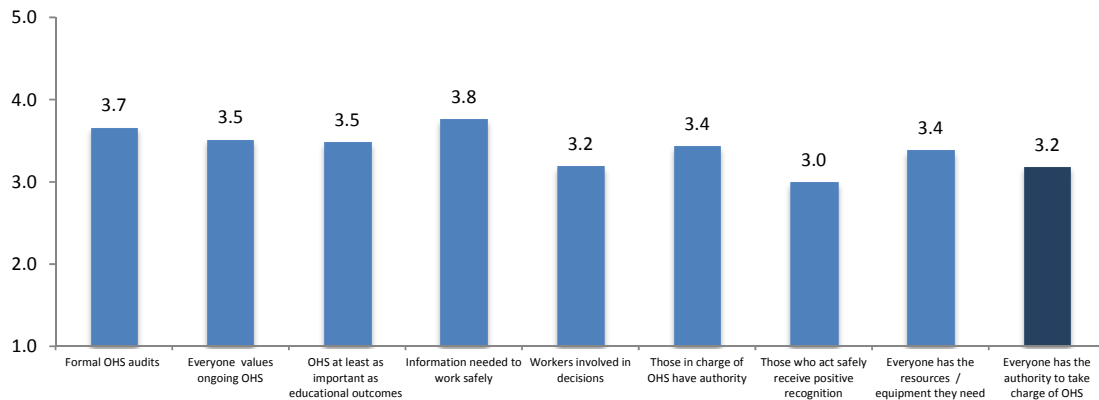
**Figure 5: HSR tenure and training**

## Evaluation of OHS leading indicators

An evaluation of the OPM as a measure of leading indicators of OHS was the primary focus of this report. Scores on the OPM in this study were on average 27.4 ( $SD = 6.7$ ) and the average score from nurse unit managers within the sample was 30.6 ( $SD = 5.6$ ). Both of these scores are lower than those obtained from a recent study of managers in Victorian workplaces across different industries where the average OPM score was 33.4 ( $SD = 4.2$ ).

### Individual OPM items

Figure 6 below displays the average ratings for each of the OPM items. Respondents rated their workplaces using the entire range of response options from strongly disagree (1) through to strongly agree (5) with average scores for each item ranging from 3.0 to 3.8. The item, *those who act safely receive positive recognition*, obtained the lowest average score from respondents in the sample. The item *workers and supervisors have the information they need to work safely* received the highest average score. The additional item (not part of the OPM), *everyone has the authority to take charge of OHS e.g. stop work if they consider conditions are unsafe*, was among the lowest rated items.



**Figure 6: Average scores for items of the OPM**

### OPM scale evaluation

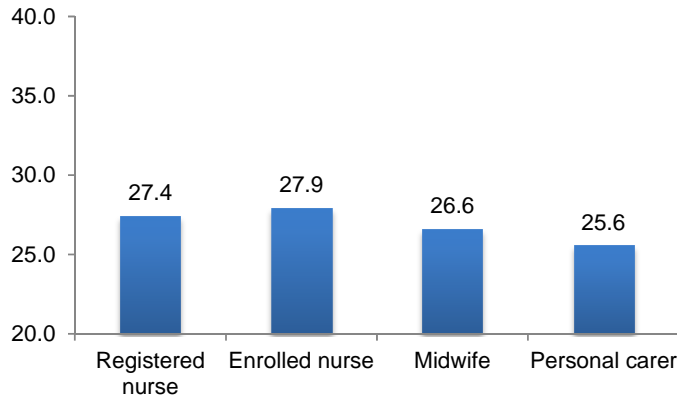
Our analysis revealed that the OPM

- can be summed to a single score;
- has good reliability (Cronbach's  $\alpha = 0.91$ );
- is a valid measure of OHS leading indicators that could be distinguished from other scales that measure employee views of OHS; and
- is valid and reliable when used with the alternative item everyone has the authority to take charge of OHS e.g. stop work if they consider conditions are unsafe.

These results suggest that the OPM could be used as an initial 'flag' of the leading indicators of OHS in a workplace. All subsequent analysis uses the original version of this item.

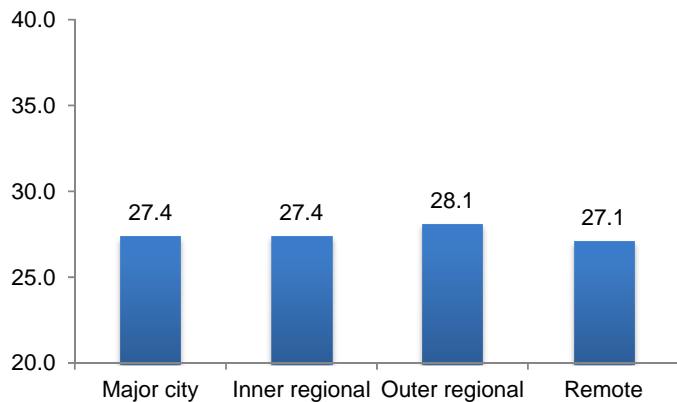
*OPM scores and group comparisons*

As shown in Figure 7 below, there were small differences in how respondents in each ANMF member group rated their workplaces on leading indicators of OHS (as measured by the OPM). Although the differences in OPM scores across member types were small, personal carers and midwives tended to give their workplaces lower scores on the OPM, on average, compared to both registered and enrolled nurses.



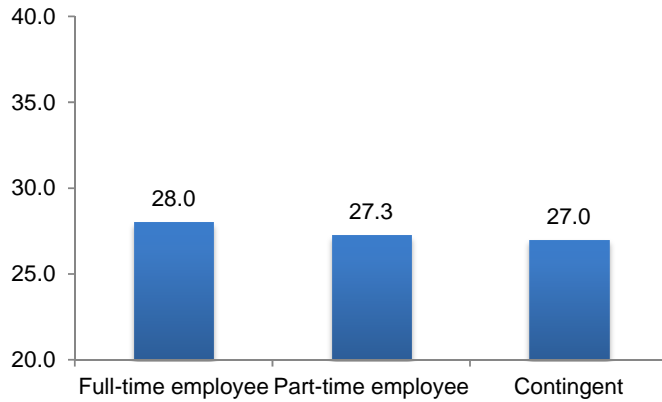
**Figure 7: Average OPM scores across ANMF member groups**

Figure 8 below displays OPM scores by the location of the respondent’s workplace. Based on Australian postcodes provided by respondents, workplaces were coded as: major city; inner regional; outer regional; and remote. Only slight differences in OPM scores can be observed for workplaces across locations. Major city and inner regional workplaces attained equivalent scores on average, while outer regional workplaces were generally scored slightly higher.



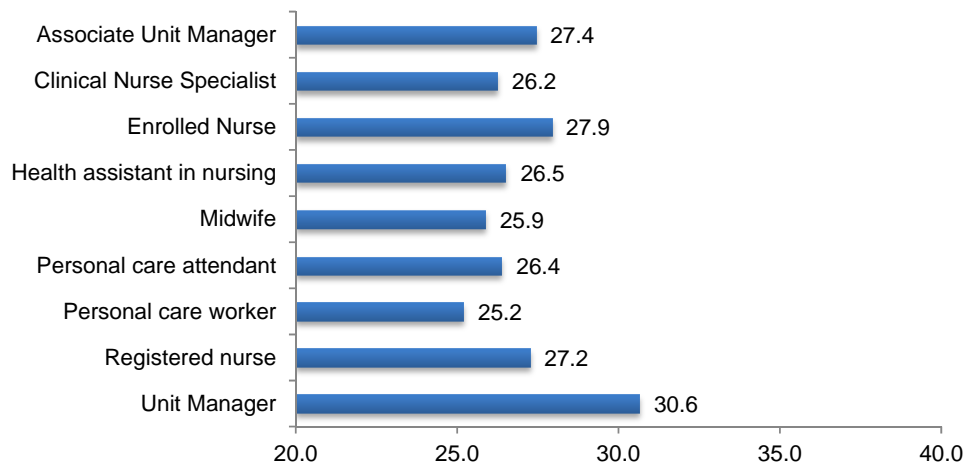
**Figure 8: Average OPM scores by workplace location**

Figure 9 below displays scores on leading indicators of OHS (as measured by the OPM) on the basis of employment status. Only small differences were found between respondents in different employment groups. (Note: contingent includes casual, bank, temporary and agency staff).



**Figure 9: Average OPM scores by employee status**

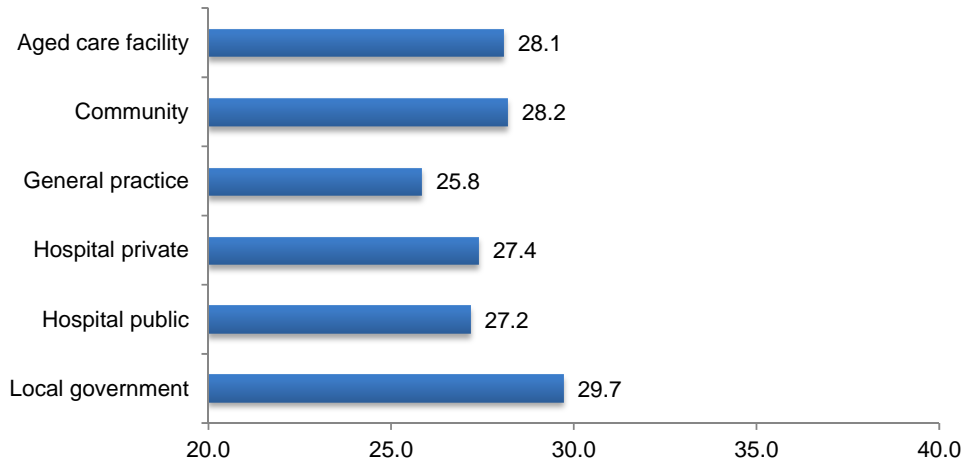
Figure 10 below displays scores on leading indicators of OHS (as measured by the OPM) on the basis of work role. Respondents who were employed as unit managers tended to give their workplaces higher scores on the OPM compared to respondents employed in all other roles. Midwives and personal care workers gave their workplaces lower scores on the OPM compared to respondents in all other roles.



**Figure 10: Comparison of OPM scores by role**

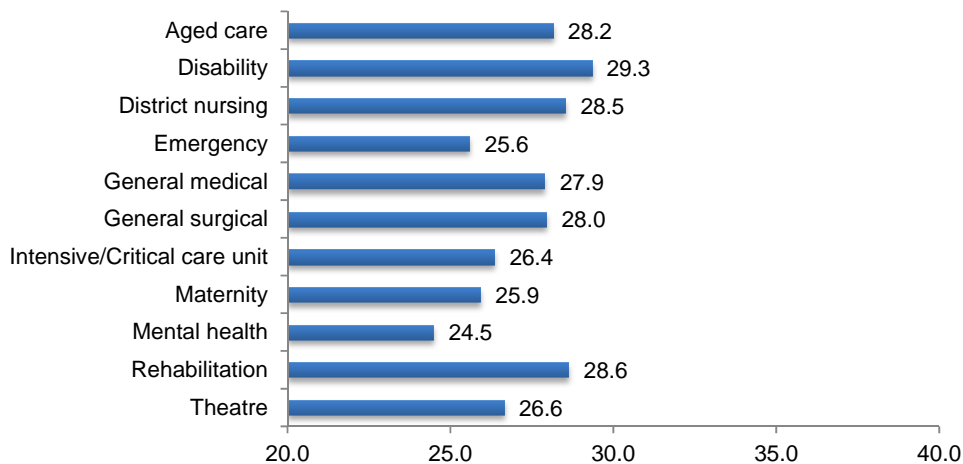
Figure 11 below displays scores on leading indicators of OHS (as measured by the OPM) across different types of organisations where respondents worked. While scores on the OPM were relatively consistent across groups, respondents from local government organisations

tended to give their workplaces higher scores on the OPM and those who reported working in general practice gave their workplaces lower scores, on average, compared to those working in other organisation types.



**Figure 11: Comparison of OPM scores by type of organisation**

Figure 12 below shows the wide variation in scores respondents gave their workplaces on leading indicators of OHS (as measured by the OPM) across different workplace units. Respondents working in mental health, emergency and maternity units gave lower ratings, on average, compared to respondents in other workplaces, particularly units such as disability, rehabilitation and district nursing.

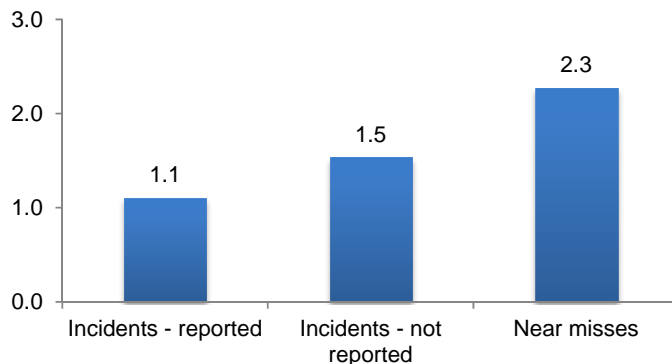


**Figure 12: Comparison of OPM scores by workplace unit**

## OHS outcomes

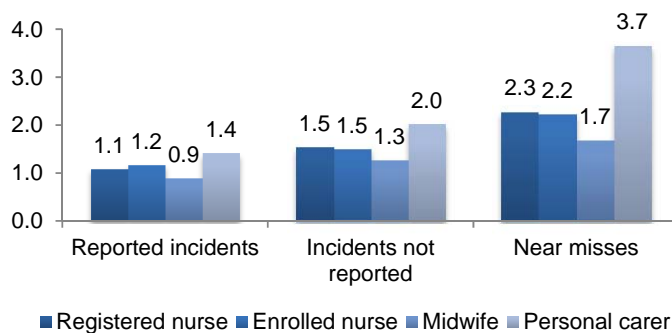
### Self-reported OHS incidents

Sixty percent of respondents reported that they had experienced an OHS incident in the past year. The total number<sup>1</sup> of OHS incidents in the past 12 months ranged from zero to 930 with respondents reporting, on average, 4.9 (SD = 21.8) OHS incidents in the past year. As shown Figure 13 below, the most likely OHS incident to be experienced by respondents was near misses. Three respondents reported an unusually high number of OHS incidents; these respondents indicated that they had experienced 527 incidents, 730 incidents and 930 incidents and they have been excluded from the analysis.



**Figure 13: Average number of OHS incidents in the past year**

This pattern across incident types is consistent across the ANMF member groups with the most common type of incident being near misses in all groups, shown below in Figure 14. Personal carers reported that they were involved in more incidents, on average, and this is particularly evident for near misses; while midwives were involved in fewer incidents of all types, compared to the other groups.



**Figure 14: Average number of OHS incidents by employment type**

<sup>1</sup> "Total incidents" refers to the sum of all OHS incidents: incidents reported to management, incidents not reported to management and near misses.

### *Self-reported days off*

Seventeen percent of respondents reported having days off work that were associated with a workplace OHS incident within the last 12 months. On average, the number of days off work as a result of an OHS injury or illness was 12.3 days (SD = 31.1). The average number of illnesses or injuries these days off work related to was 1.4 (SD = 1.1).

Thirty-two percent of respondents reported having days off work as a result of workplace stress within the past 12 months which is greater than the percentage of respondents taking days off work as a result of a workplace OHS incident. The average number of days off work as a result of exposure to workplace stress was 7.8 days (SD = 21.9). The average number of illnesses or injuries contributing to these days off work related to was 1.4 (SD = 2.1).

### *Self-reported claims*

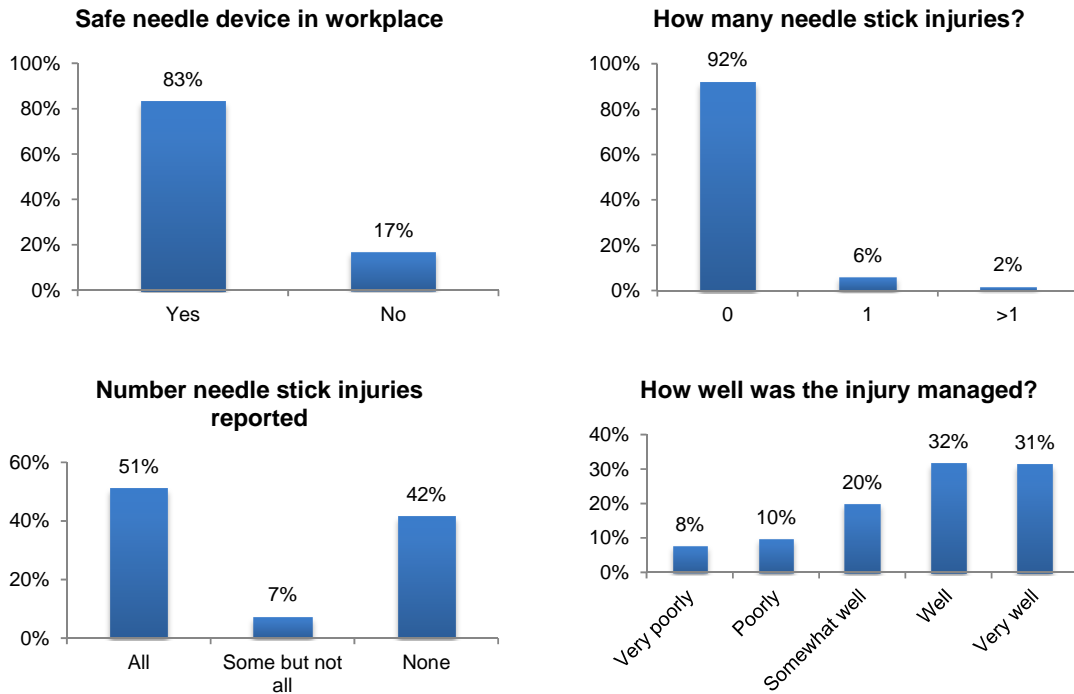
Seven percent of respondents reported that they had made a WorkCover claim for a workplace injury or illness and three percent of respondents reported that they had made a WorkCover claim for workplace stress or a workplace stress-related illness in the past year.

The average number of claims submitted (M = 1.5 claims, SD = 1.7) for workplace injury or illness was slightly higher than the number of claims accepted (M = 1.1, SD = 1.2). Similarly, the average number of claims submitted for workplace stress or stress-related illness (M = 1.8 claims, SD = 2.3) was slightly higher than the average number of claims accepted (M = 1.0, SD = 1.1).



*Self-reported needle stick injuries*

Figure 15 below shows that most respondents reported having access to a safe needle device in the workplace and nearly all reported that they had not had a needle stick injury in the past 12 months. Of the 320 respondents (8 percent) who reported having had a needle stick injury, nearly half did not report the injury. The majority of those respondents who said they had reported their injury also reported that their injuries were generally managed *well* or *very well*.

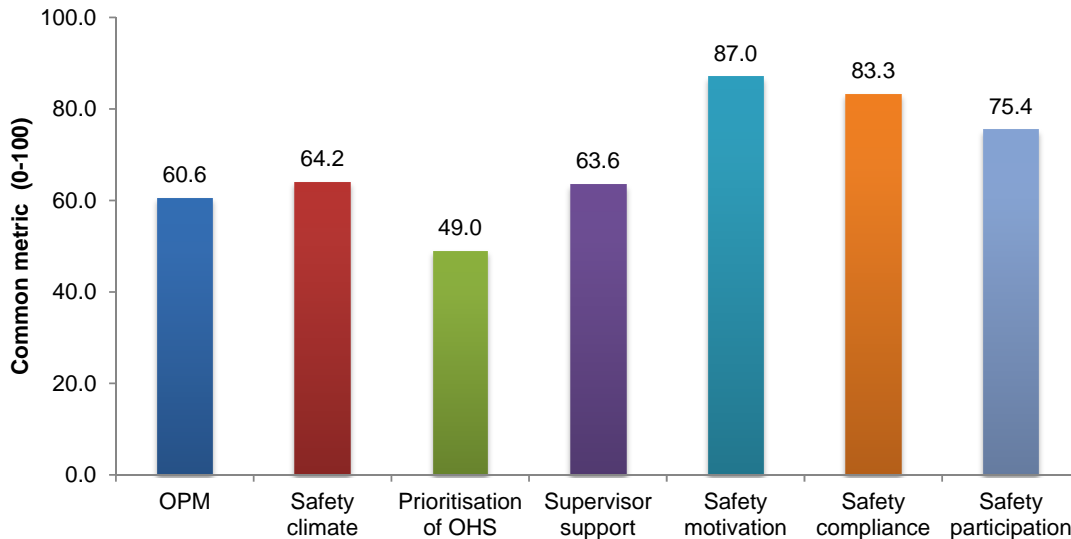


**Figure 15: Needle stick injuries**

## Occupational health and safety

### Comparing perceptual measures of OHS

Figure 16 below compares scores for each OHS measure. For ease of presentation and comparison, scores on these scales have been converted from the raw score to range from 0 to 100 to create a common metric. This enables us to compare scores from scales that have different numbers of items and different numbers of response options. For example, in the chart below, safety motivation scored, on average, 87 out of the maximum possible score of 100. The calculation used to convert the raw scores was sourced from Cohen and colleagues<sup>31</sup>:  $POMP\ score = (observed\ scale\ score - minimum) / (maximum - minimum) \times 100$ . Where minimum refers to the minimum possible score and maximum refers to the maximum possible score.



**Figure 16: Comparison of converted OHS scale scores**

Respondents reported high levels of safety motivation and safety compliance. Measures of leading indicators of safety (OPM, safety climate) were given lower scores, as were respondent scores for the management prioritisation of OHS (prioritisation of OHS, supervisor support for OHS). Generally, areas of safety that respondents have greater control over were rated higher (motivation, compliance, participation) than OHS measures that represent group safety (OPM, safety climate) or management commitment to OHS (prioritisation of OHS, supervisor support for OHS). Respondents gave substantially lower scores for the measure of management prioritisation of OHS compared to all other OHS related measures.

Correlations were conducted to examine the relationships between the perceptual scale scores. **Positive associations** were observed between **all measures** listed below:

- OPM;
- Safety climate;
- Safety motivation;
- Safety compliance;
- Safety participation;
- Prioritisation of OHS; and
- Supervisor support for OHS.

Safety climate can be thought of as another way of measuring OHS leading indicators, so it is not surprising to find a positive association between the OPM and safety climate. Leading indicators (as measured by the OPM and safety climate) were associated with greater levels of: safety motivation, safety behaviour and safety control. Employees who rated their workplace at higher levels on leading indicators of OHS reported that they had higher levels of motivation to behave safely and that they do behave more safely (compliance and participation). Employees who perceived that staff OHS was prioritised as high as patient safety by management, and who perceived greater levels of supervisor support for OHS, also tended to rate their workplaces higher on leading indicators of safety (as measured by the OPM and safety climate) and reported greater levels of safety motivation and behaviour.

#### *Perceptual measures of OHS and self-reported OHS incidents*

Correlations were conducted for the relationship between perceptual OHS measures and total incidents (the sum of reported incidents, incidents not reported and near misses) and separately for these three subtypes of incidents.

**Negative associations** were observed between the number of **total incidents** and:

- OPM;
- Safety climate;
- Safety motivation;
- Safety compliance;
- Prioritisation of OHS; and
- Supervisor support for OHS.

Higher levels of performance on leading indicators (as measured by the OPM and safety climate), higher levels of employee safety motivation and safety compliance and greater levels of management commitment to safety were associated with fewer OHS incidents overall. Respondents who rated their workplaces higher on the OPM and safety climate scales were involved in fewer OHS incidents overall, compared to those who rated their workplaces lower on these scales.

Respondents who reported that management gave the same level of prioritisation to OHS as patient safety tended to be involved in fewer OHS incidents compared to those respondents who perceived that management put lesser emphasis on staff OHS. Similarly, respondents who perceived a higher level of support from their supervisors reported fewer OHS incidents overall.

There were **negative associations** between the number of **reported incidents** and:

- OPM;
- Safety climate;
- Prioritisation of OHS; and
- Supervisor support for OHS.

Higher levels of performance on leading indicators (as measured by the OPM and safety climate) and higher levels of management commitment to OHS were associated with fewer OHS incidents that were reported to management. Respondents who rated their workplaces higher on leading indicators and safety climate were involved in fewer reported OHS incidents compared to those who rated their workplaces lower on these variables.

Respondents who reported that management gave the same level of prioritisation to OHS as patient safety tended to be involved in fewer OHS incidents compared to those respondents who perceived that management put less emphasis on OHS for staff. Similarly, respondents who perceived a higher level of support from their supervisors and those that reported higher levels of safety motivation also tended to experience fewer OHS incidents that they reported to management.

There was a **positive association** between **reported incidents** and:

- Safety participation.

Reporting incidents to management was associated with higher levels of safety participation. The safety participation scale goes beyond compliance with OHS rules and measures the extent to which a proactive approach to OHS is taken with a view to improving OHS in the workplace. Therefore, respondents who tended to promote OHS in the workplace were more likely to report incidents compared to those who had lower scores on the safety participation scale.

There were **negative associations** between the number of **unreported incidents** and:

- OPM;
- Safety climate;
- Safety motivation;
- Safety compliance;
- Prioritisation of OHS; and
- Supervisor support for OHS.

Higher levels of performance on leading indicators (as measured by the OPM and safety climate), higher levels of employee safety motivation, safety compliance and management

commitment to OHS were associated with fewer unreported OHS incidents. Respondents who rated their workplaces higher on the OPM and safety climate were involved in fewer unreported incidents, compared to those who rated their workplaces lower on these constructs. Respondents who reported that management gave the same level of prioritisation to OHS as patient safety tended to be involved in fewer OHS incidents that went unreported, compared to those respondents who perceived that management put less emphasis on staff OHS. Similarly, respondents who perceived a higher level of support from their supervisors and reported higher levels of safety motivation also tended to experience fewer OHS incidents that they did not report to management.

There were **negative associations** between the number of **near misses** and:

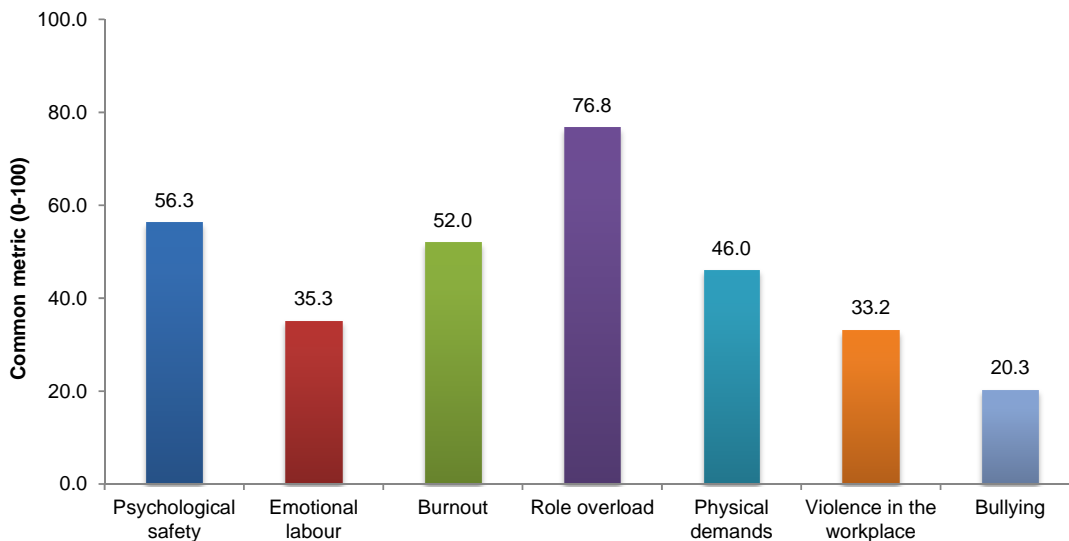
- OPM;
- Safety climate;
- Safety motivation;
- Safety compliance;
- Prioritisation of OHS; and
- Supervisor support for OHS.

Higher levels of performance on leading indicators (as measured by the OPM and safety climate), higher levels of employee safety motivation, safety compliance and supervisor support for OHS were associated with fewer near misses. Respondents who rated their workplaces higher on the OPM were involved in fewer near misses compared to those who rated their workplaces lower on the OPM and safety climate. Respondents who reported that management gave the same level of prioritisation to OHS as patient safety tended to be involved in fewer near misses, compared to those respondents who perceived that management put lesser emphasis on OHS. Similarly, respondents who perceived a higher level of support from their supervisors and reported higher levels of safety motivation also tended to experience fewer near misses.

## Risk factors

### *Comparing measures of risk*

Figure 17 below, compares scores for the measures of risk. For ease of presentation and comparison, raw scores on these scales have been converted to range from 0 to 100 to create a common metric that enables us to compare scores from scales that have different numbers of items and different numbers of response options. For example, in the chart below, role overload scored, on average, 76.8 out of the maximum possible score of 100.



**Figure 17: Comparison of converted risk factor scores**

Respondents reported higher levels of role overload compared to the other measures which were given lower scores. Issues such as psychological safety, burnout and physical demands were given moderate scores by respondents. Emotional labour, violence in the workplace and bullying were given relatively low scores. However, while violence and bullying appear to be less prevalent than issues such as role overload, even these low scores might still indicate unacceptable levels of violence and bullying in the workplace.

### *Relationship between risk factors and self-reported OHS incidents*

Correlations were conducted to examine the relationship between risk factors (e.g., emotional labour, role overload, and bullying) and total incidents (the sum of reported incidents, incidents not reported and near misses) and each of the three subtypes of incidents (reported, not reported, and near miss).

**A negative association** was observed between the number of **total incidents** and:

- Workplace psychological safety.

Respondents who perceived a greater sense of trust and social cohesion in the workplace were involved in fewer OHS incidents overall compared to those who rated their workplaces poorly on this measure.

This pattern was also observed for each individual subtype of incident. Respondents who reported higher levels of workplace psychological safety also tended to be involved in fewer reported OHS incidents, fewer incidents that they did not report to management and fewer near misses.

There were **positive associations** between **total incidents** and:

- Emotional labour;
- Burnout;
- Role overload;
- Physical demands.
- Violence in the workplace; and
- Bullying.

Respondents who reported higher levels of role overload and physical job demands (e.g., physical effort, manually moving objects) tended to report that they were involved in a greater number of OHS incidents overall. Similarly, respondents who reported that they were more likely to engage in emotional labour and experienced higher levels of burnout in their work also tended to report being involved in a greater number of OHS incidents. Respondents who reported that they had been exposed to workplace violence and bullying were more likely to be involved in more OHS incidents overall, compared to respondents who reported not being exposed to violence and bullying.

This pattern of correlations was also observed for each individual subtype of incident: reported incidents, incidents that were not reported and near misses. Respondents who reported higher levels of role overload, more physical demands in the course of their work, higher levels of emotional labour and higher levels of burnout also tended to be involved in more reported OHS incidents, a greater number of OHS incidents that they did not report to management and more near misses.

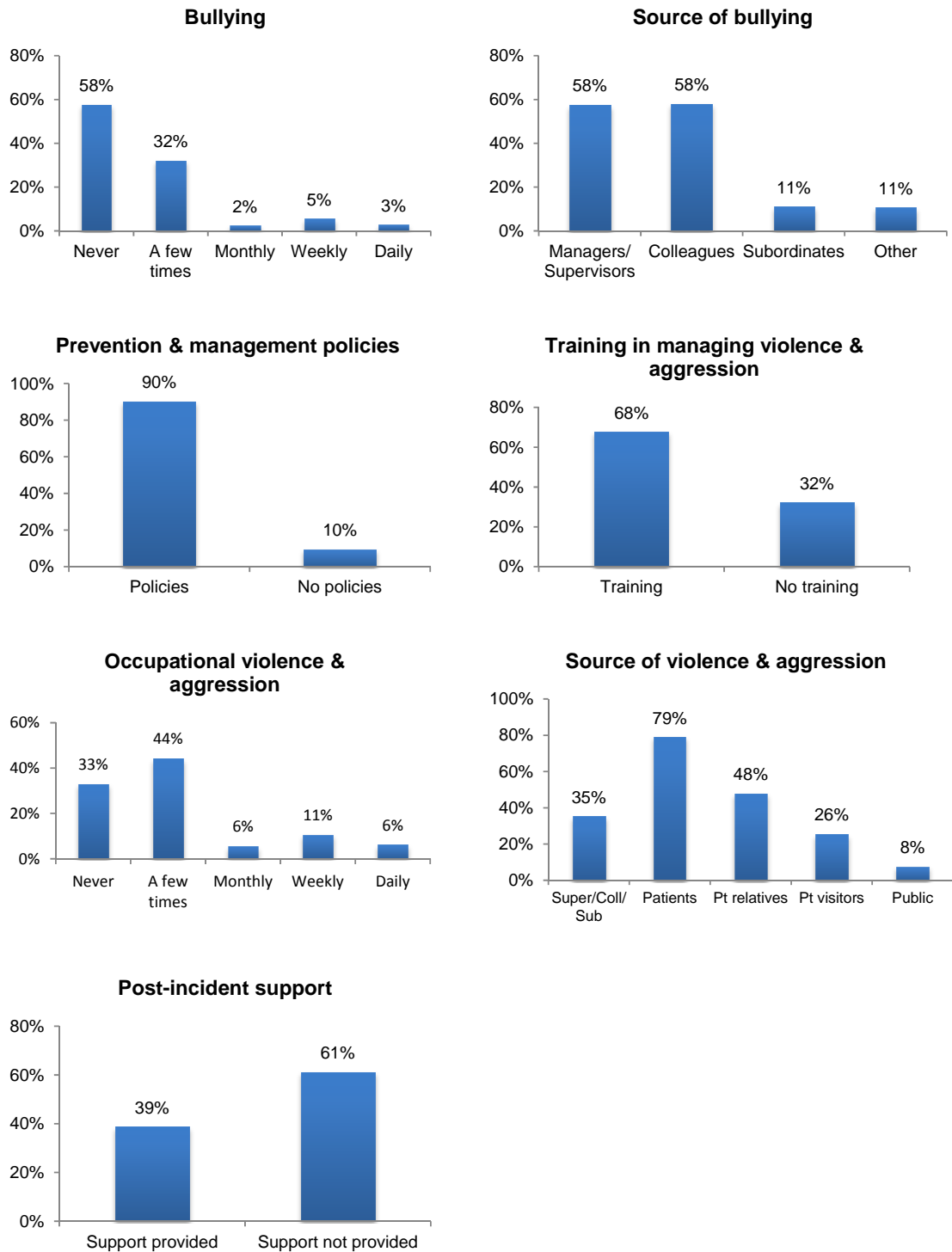
### *Experience of violence and bullying in the workplace*

Most respondents reported that prevention and management policies were in place for the management of occupational violence and aggression in the workplace and 68 percent had received training in this area. Nearly 70 percent of respondents reported they had experienced occupational violence or aggression at least once in the past twelve months. More than 40 percent of respondents reported that they had experienced occupational violence or aggression a few times in the past twelve months, while 23 percent reported that they experienced regular episodes (monthly, weekly or daily) of violence or aggression.

Within the group of respondents who reported experiencing violence and aggression at work (n=3,072), most indicated that occupational violence and aggression came from patients (79 percent) and/or relatives of patients (48 percent); however, a substantial percentage (35 percent) also reported experiencing occupational violence and aggression from supervisors, colleagues and subordinates. It should be noted that it was possible for respondents to indicate more than one source of violence and aggression.

More than 40 percent of the respondents reported that they had experienced at least one episode of bullying in the past 12 months. However, 10 percent of respondents reported experiencing regular bullying (monthly, weekly or daily) with a small percentage reporting bullying on a daily basis. The predominant source of reported bullying was either from managers/supervisors or colleagues with more than half of those respondents who indicated that they had experienced bullying (n=1,850) reporting that they had been bullied by managers/supervisors or colleagues. These results are displayed below in Figure 18. It should be noted that it was possible for respondents to indicate more than one source of bullying.





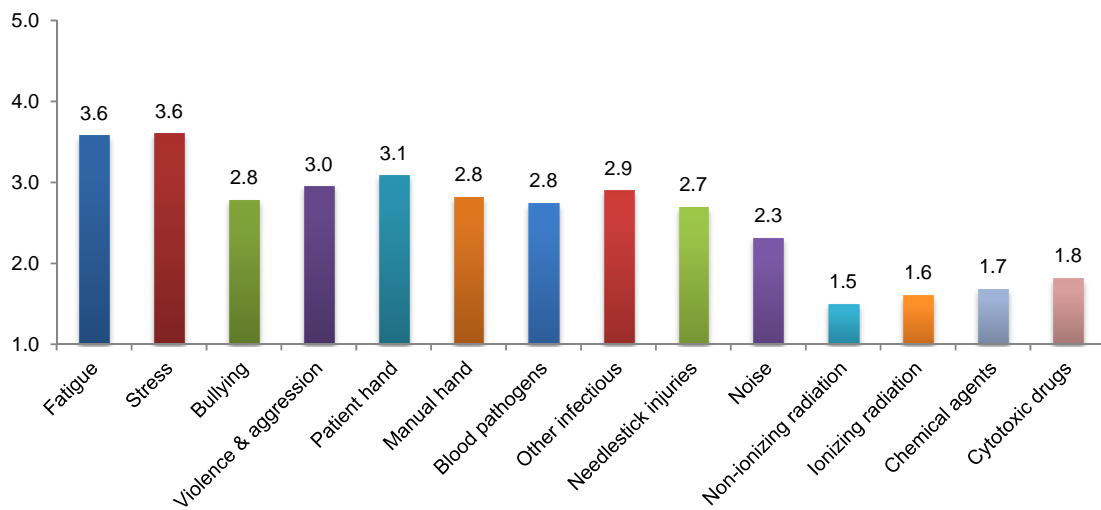
**Figure 18: Violence and bullying in the workplace<sup>2</sup>**

<sup>2</sup> Note, that for sources of violence/aggression and bullying, figures do not add to 100% because respondents were asked to indicate all sources.

## Hazards

Respondents were asked to estimate the level of perceived risk from a set of single item measures representing health and safety hazards in their workplace. Figure 19 below shows three distinct clusters of risk. First, fatigue and workplace stress; second, a cluster of risk factors pertaining to bullying, violence, patient and manual handling, needle stick injuries and infectious agents; and third, a cluster of risks pertaining to radiation and chemical agents.

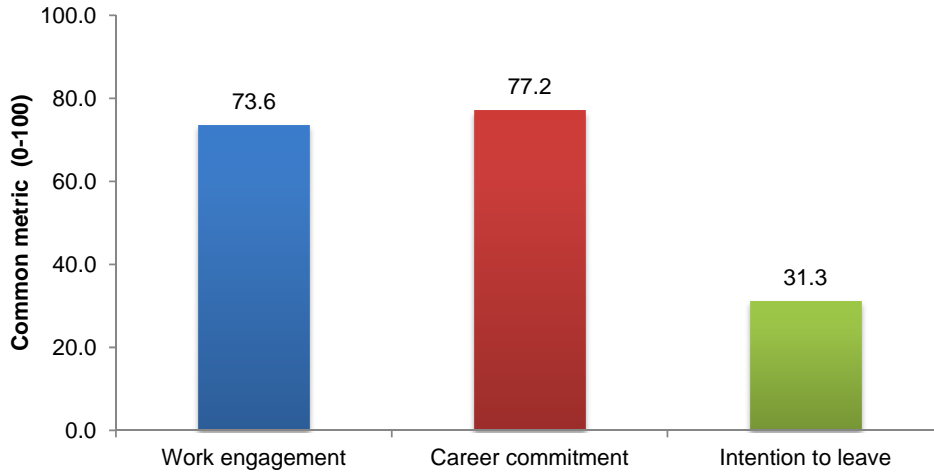
Respondents perceived higher levels of risk from fatigue and workplace stress compared to all other issues. However, the pattern of risk probably represents the number of respondents exposed to these specific risks rather than the magnitude of the risk to any specific individual.



**Figure 19: Exposure to hazards**

**Work engagement, career commitment and intention to leave**

Figure 20 below displays the relationship between employment type and work engagement, career commitment and intention to leave. For ease of presentation and comparison, raw scores on these scales have been converted to range from 0 to 100 to create a common metric and enable us to compare scores from scales that have different numbers of items and different numbers of response options. For example, in the chart below, career commitment scored, on average, 77.2 out of the maximum possible score of 100.



**Figure 20: Work engagement, career commitment and intention to leave**

The chart above shows that in general, respondents report higher levels of work engagement and career commitment and relatively low intention to leave.

### Comparing perceptions of OHS and risk across ANMF member groups

This section compares each ANMF member type (registered nurses, enrolled nurses, midwives and personal carers) on their perceptions of OHS, risk factors and their engagement in the workplace. The scores displayed in the charts below are total scores for each measure (the sum of individual item scores) and have not been converted to a common metric so the range from minimum to maximum possible scores will vary across each measure. The purpose of these charts is to show similarities and differences across ANMF member types for each multi-item measure.

#### Measures of OHS

The OPM and safety climate address perceptions of OHS with regard to the workplace overall, rather than individual characteristics such as safety behaviour or motivation. Figure 21 below indicates that personal carers had slightly less positive perceptions of OHS compared to the other three groups.

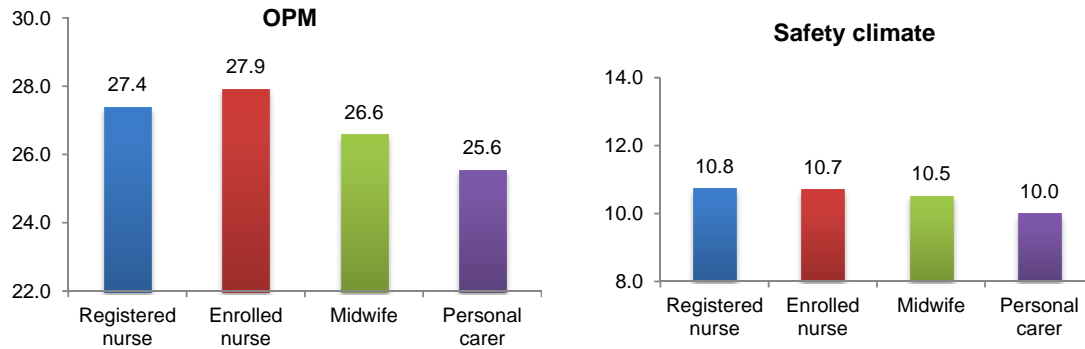


Figure 21: OHS measures of the workplace overall

Figure 22 below displays respondent views of their management/supervisor. Only small differences can be observed with midwives and personal carers rating management’s prioritisation of OHS or their supervisor’s support for OHS slightly lower than registered or enrolled nurses.

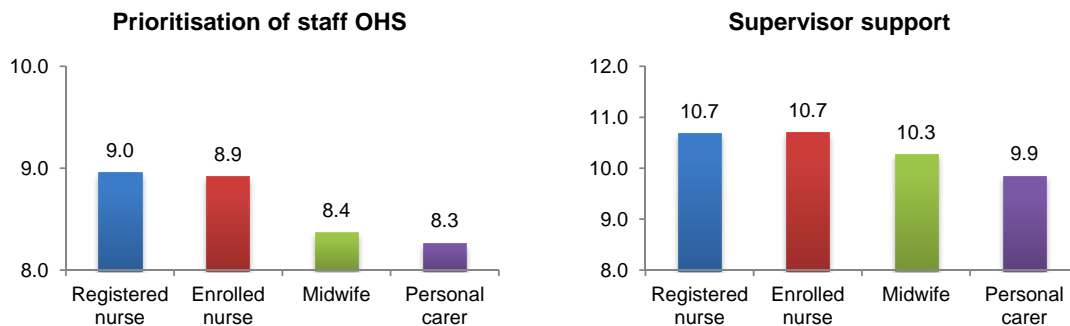
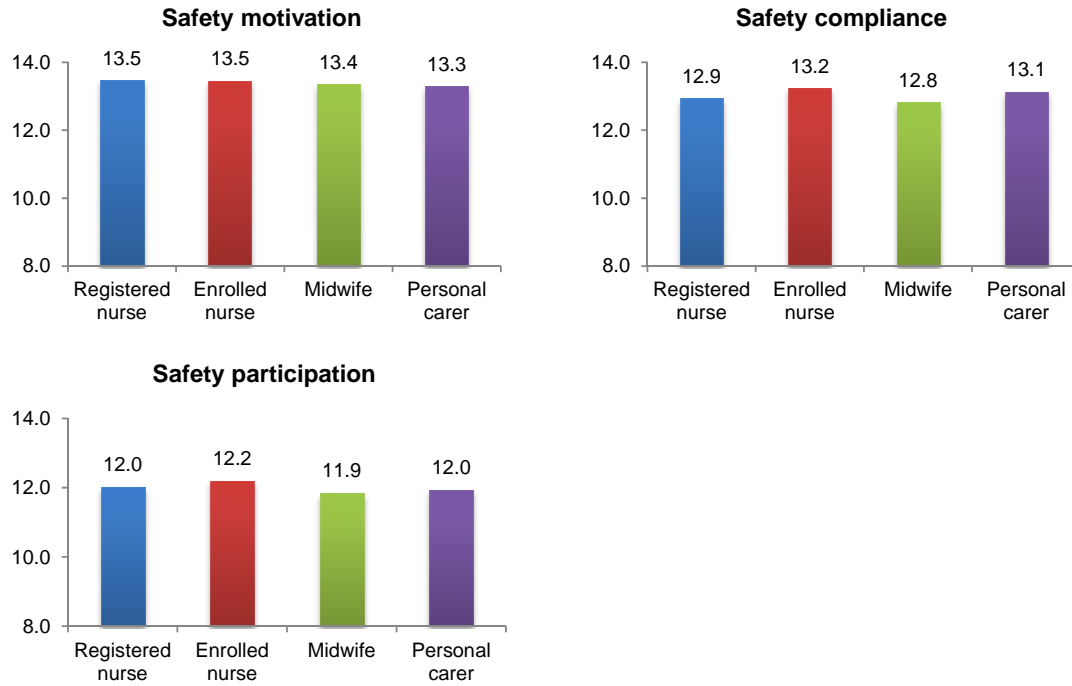


Figure 22: OHS measures of management/supervisor support for OHS

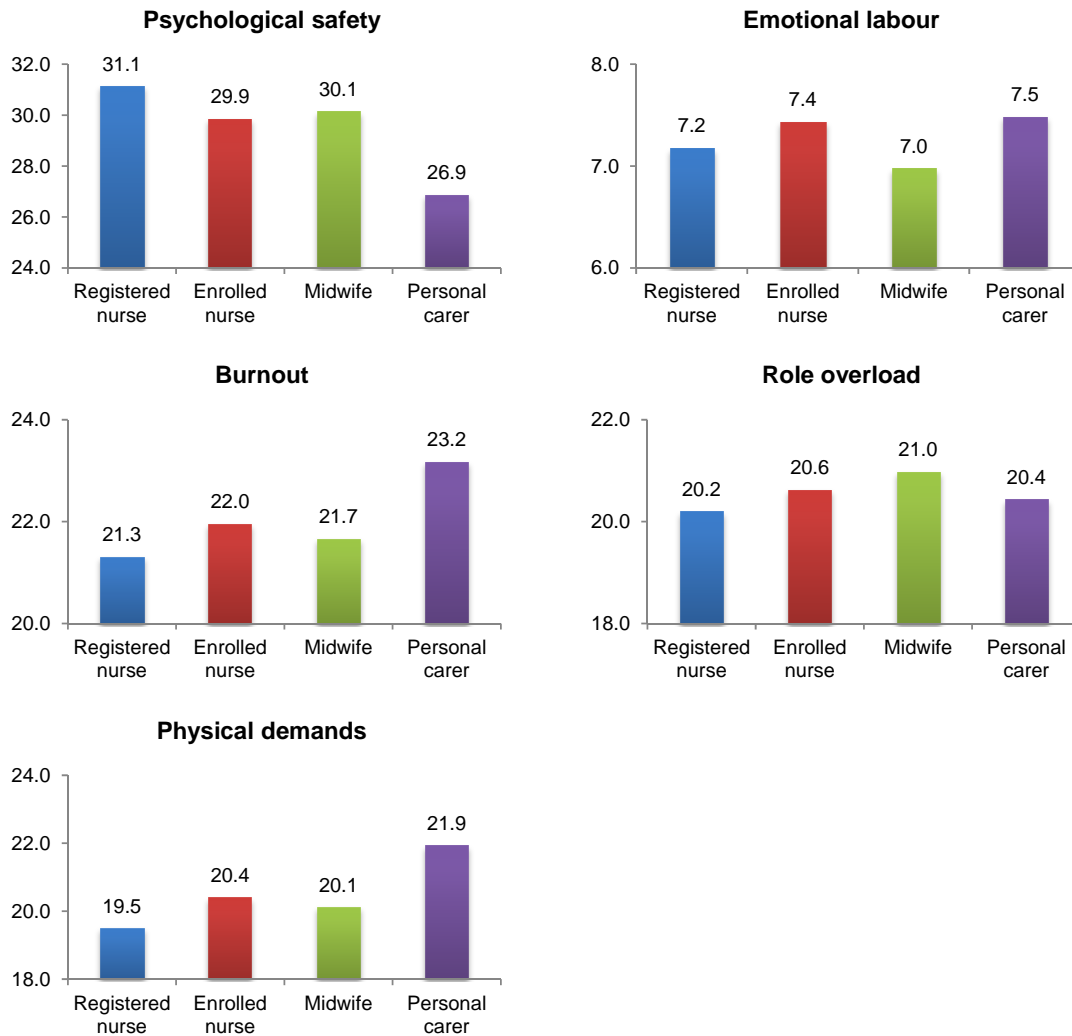
Figure 23 below displays respondent views of their own safety motivation and behaviour (compliance, participation). Scores on these measures were roughly equivalent across the four member types.



**Figure 23: OHS measures for individuals**

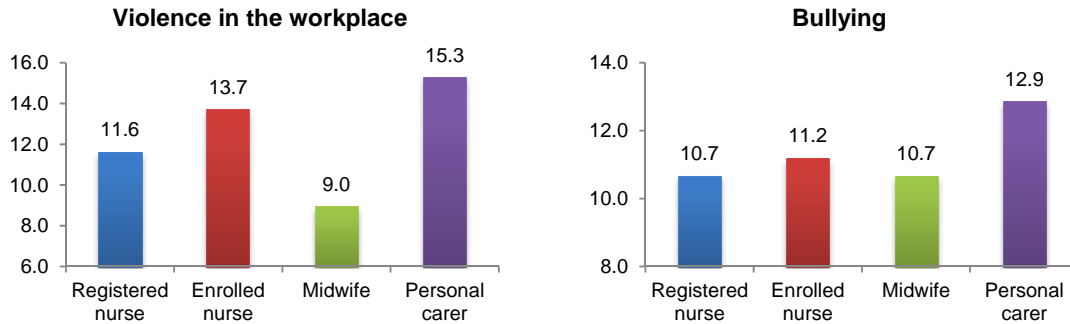
*Risk factors*

Some variation in scores between ANMF member groups can be seen across the risk factors; however, these differences are generally small. With the exception of role overload, personal carers score higher on average across measures of risk (emotional labour, burnout, physical demands) and lower on psychological safety compared to the other three groups.



**Figure 24: Risk factors across groups**

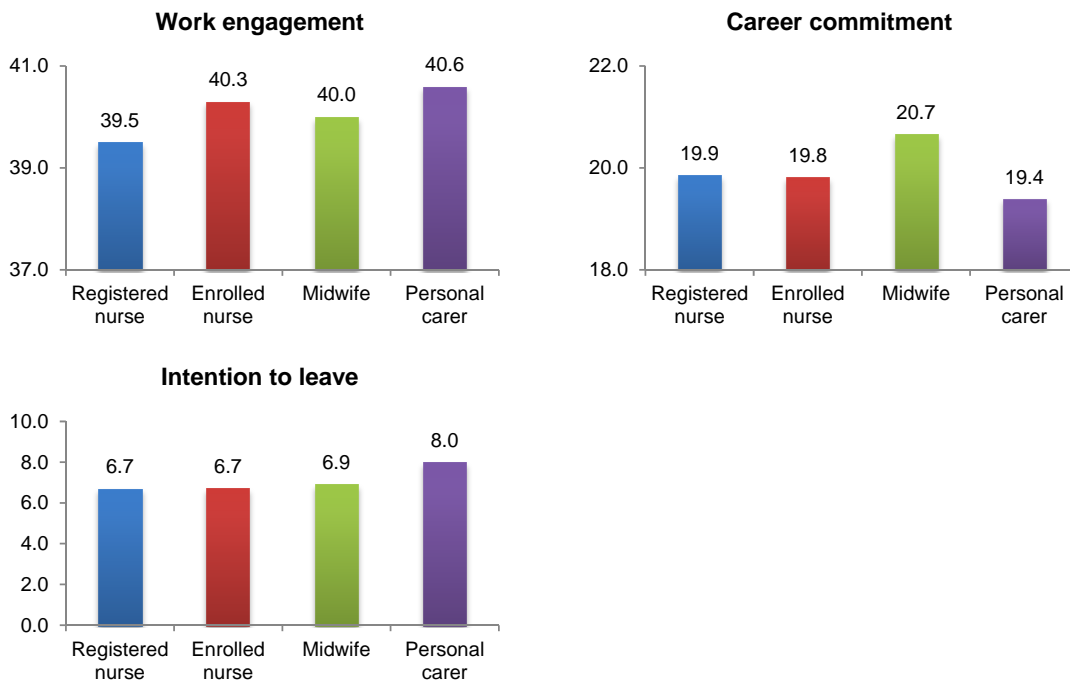
Figure 25 below displays average scores on multi-item measures of violence and bullying across ANMF member groups. Personal carers report higher levels of both violence and bullying, on average, compared to the other three ANMF member groups. Midwives tend to report lower levels for violence.



**Figure 25: Violence and bullying across groups**

*Work engagement, career commitment and intention to leave*

Very small variations in scores can be seen across ANMF member groups for scores on measures of career commitment, intention to leave and work engagement. While personal carers report higher levels of intention to leave and lower levels of career commitment, the differences are small.



**Figure 26: Work engagement, career commitment and intention to leave across groups**

## Summary of outcomes by member type

This section summarises the survey by ANMF member type separately for each group: registered nurses, enrolled nurses, midwives and personal carers. We summarise:

- OHS incidents;
- Perceptions of OHS;
- Perceptions of risk and aggression; and
- Other risk factors.

Note that the data in each chart in this section are presented on a different metric:

- OHS incidents have been presented as average scores for each incident type: reported incidents, unreported incidents and near misses;
- Other risk factors are single item measures that were rated on a scale of 1 (no risk) to 5 (very high risk); and
- Scores for perceptions of OHS, risk factors, violence and bullying as well as work engagement were transformed from the raw scores to a common metric ranging from 0 to 100.

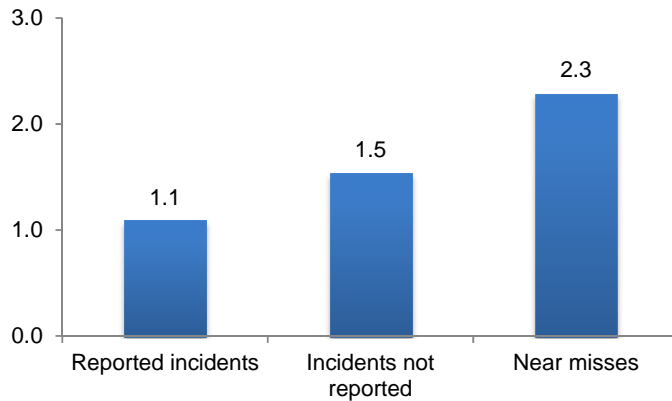
The creation of a common metric enables us to compare scores from scales that have different numbers of items and response options. For example, in the perceptions of safety chart in the registered nurses summary, safety motivation scored, on average, 87 out of the maximum possible score of 100.



*Registered nurses*

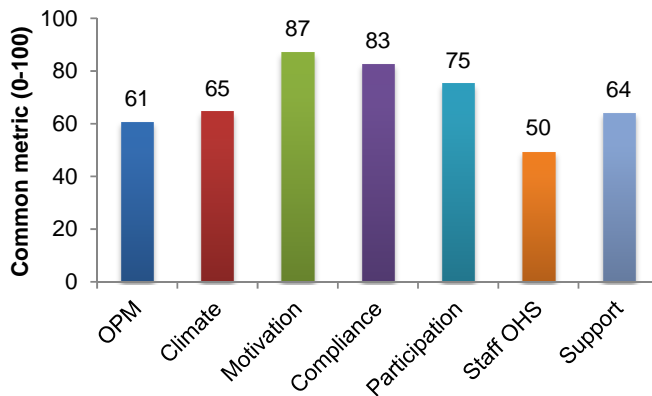
Sixty-seven percent (3,273) of respondents reported working as registered nurses.

The number of near misses was higher than both reported and unreported OHS incidents. OHS incidents that were not reported to management also exceeded the number of OHS incidents that were reported to management.



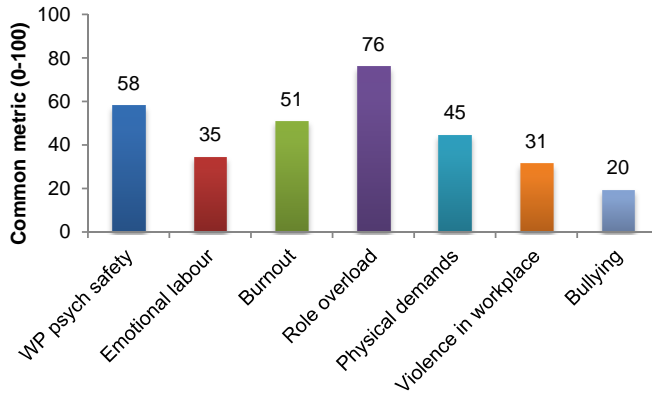
**Figure 27: OHS incidents for registered nurses**

A comparison of transformed scores on the perceptual measures of OHS show that registered nurses rated their safety motivation, compliance and participation substantially higher than they rated other group level variables such as the OPM and safety climate. While scores for supervisor support for OHS were moderate, scores for the management prioritisation of OHS compared to patient safety were low.



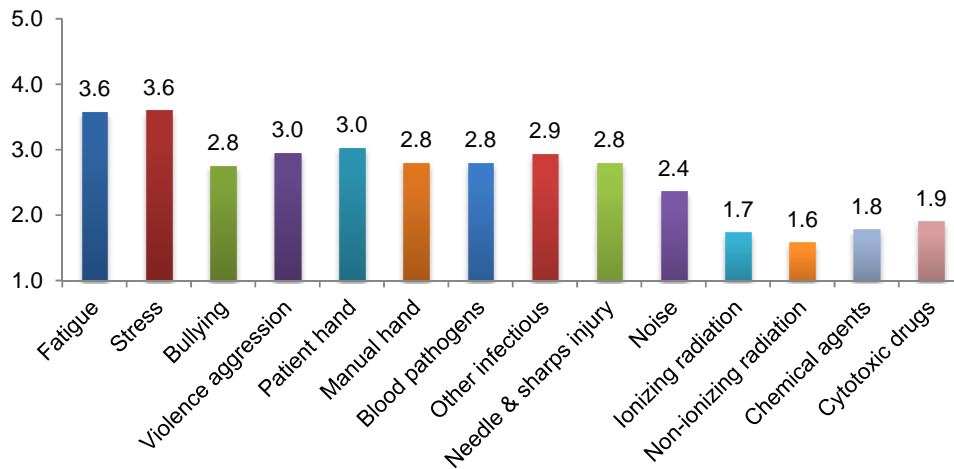
**Figure 28: Perceptions of OHS among registered nurses**

Respondents in this group rated role overload at higher levels than other issues including physical demands, burnout and emotional labour. While violence and bullying were reported by registered nurses, these issues appear to be less common for this group compared to other workplace concerns.



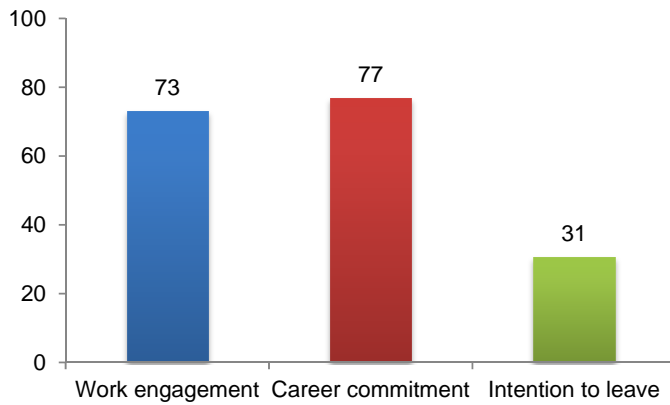
**Figure 29: Perceptions of risk and aggression among registered nurses**

When asked to rate the level of risk for specific OHS hazards in the workplace, respondents in this group rated issues such as fatigue and workplace stress as the most likely risk factors, ahead of other risk factors such as violence and bullying. Similarly, physical factors such as risk from infectious agents, patient and other manual handling issues also received lower ratings compared to fatigue and workplace stress.



**Figure 30: Other risk factors for registered nurses**

In this group, substantially higher levels of work engagement and career commitment are reported compared to intention to leave.

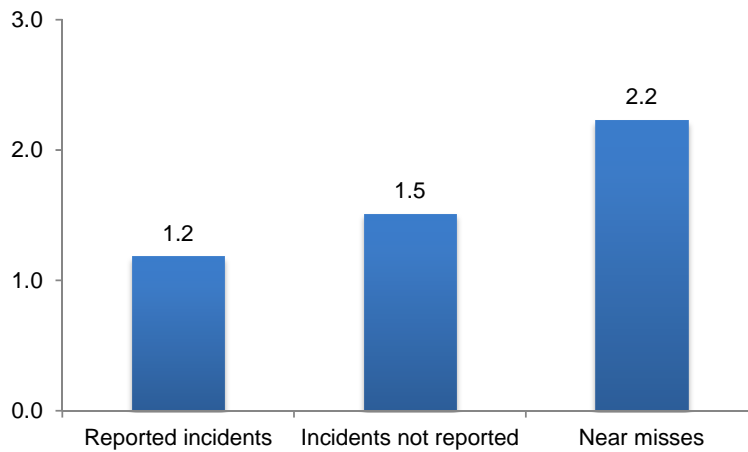


**Figure 31: Work engagement, career commitment & intention to leave: registered nurses**

*Enrolled nurses*

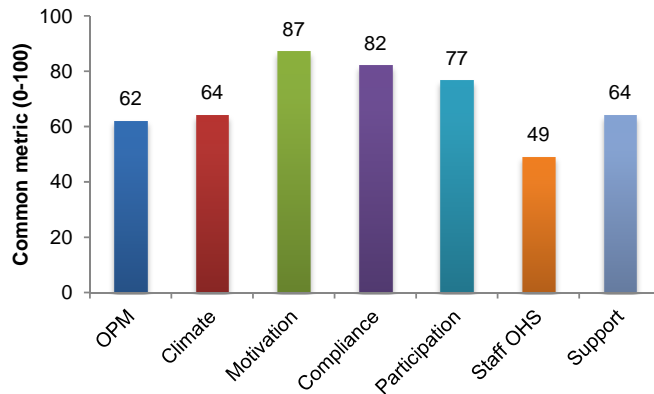
There were 1,055 (22%) respondents who reported working as enrolled nurses.

The number of near misses was higher than both reported and unreported OHS incidents. OHS incidents that were not reported to management also exceeded the number of OHS incidents that were reported to management.



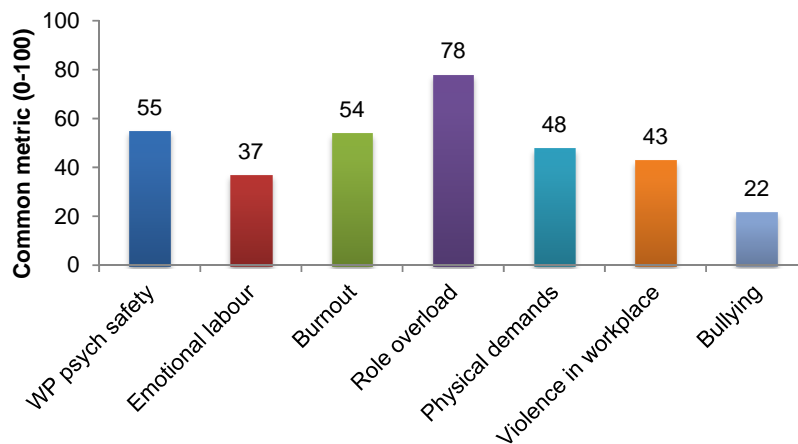
**Figure 32: OHS incidents for enrolled nurses**

A comparison of converted scores on the perceptual measures of OHS show that enrolled nurses rated their safety motivation, compliance and participation substantially higher than they rated other group level variables such as the OPM and safety climate or management support for OHS. While scores for supervisor support for OHS were moderate, scores for the management prioritisation of OHS compared to patient safety were relatively low.



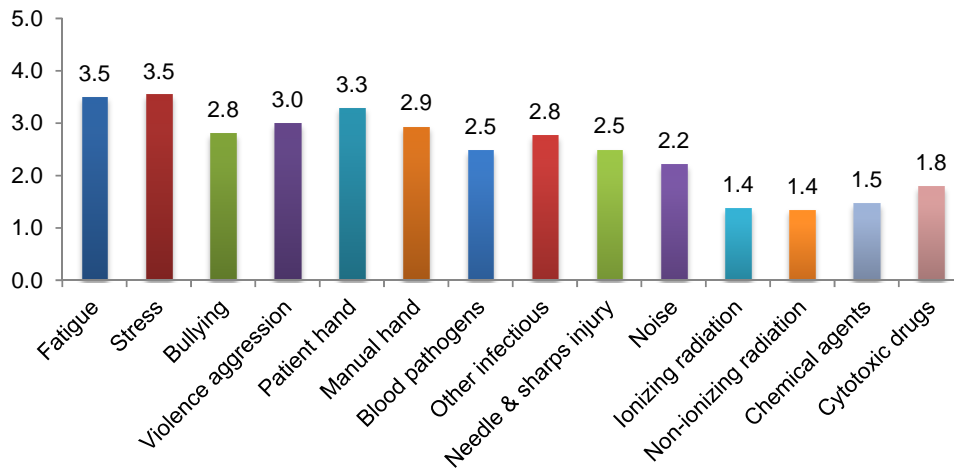
**Figure 33: Perceptions of OHS among enrolled nurses**

Respondents in this group rated role overload at higher levels than other issues including, burnout and emotional labour.



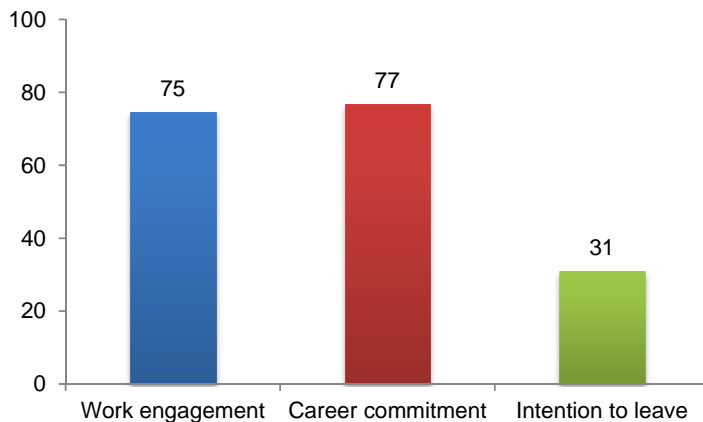
**Figure 34: Perceptions of risk and aggression among enrolled nurses**

When asked to rate the level of risk for specific OHS hazards in the workplace, respondents in this group rated issues such as fatigue, workplace stress and patient handling as the most likely risk factors. While these risks were rated higher than other risk factors such as violence, bullying and manual handling, these later issues were still rated relatively highly. Physical factors such as risk from infectious agents received lower ratings, particularly compared to fatigue and workplace stress.



**Figure 35: Other risk factors for enrolled nurses**

In this group, substantially higher levels of work engagement and career commitment are reported compared to intention to leave.

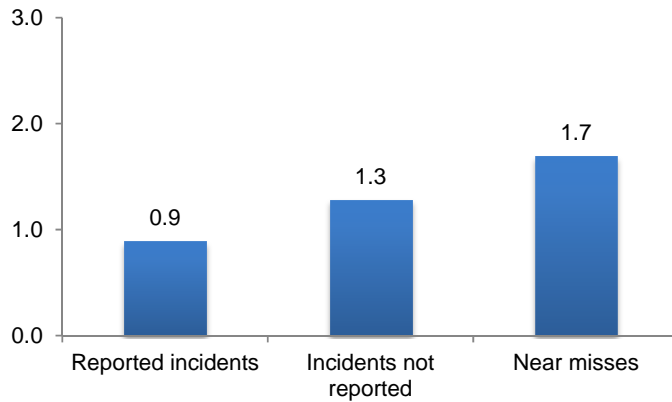


**Figure 36: Work engagement, career commitment & intention to leave: enrolled nurses**

*Midwives*

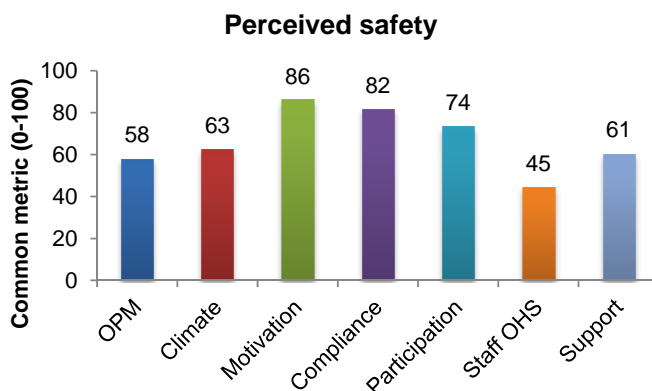
There were 407 (8%) ANMF members who participated in the survey and reported working as midwives.

The number of near misses reported by respondents was higher than both reported and unreported OHS incidents. OHS incidents that were not reported to management exceeded the number of OHS incidents that were reported to management.



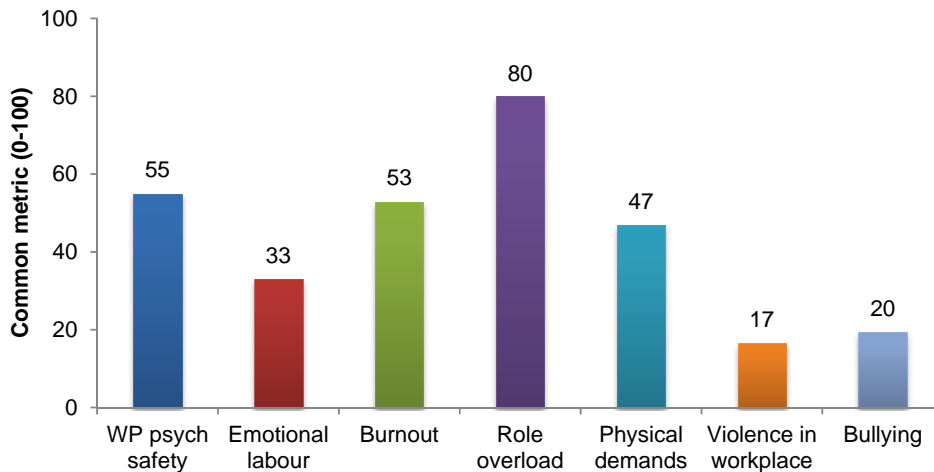
**Figure 37: OHS incidents for midwives**

A comparison of transformed scores on the perceptual measures of OHS showed that midwives rated their safety motivation, compliance and participation substantially higher than they rated other variables such as the OPM and safety climate. While scores for supervisor support for OHS were moderate, scores for the management prioritisation of OHS compared to patient safety were low.



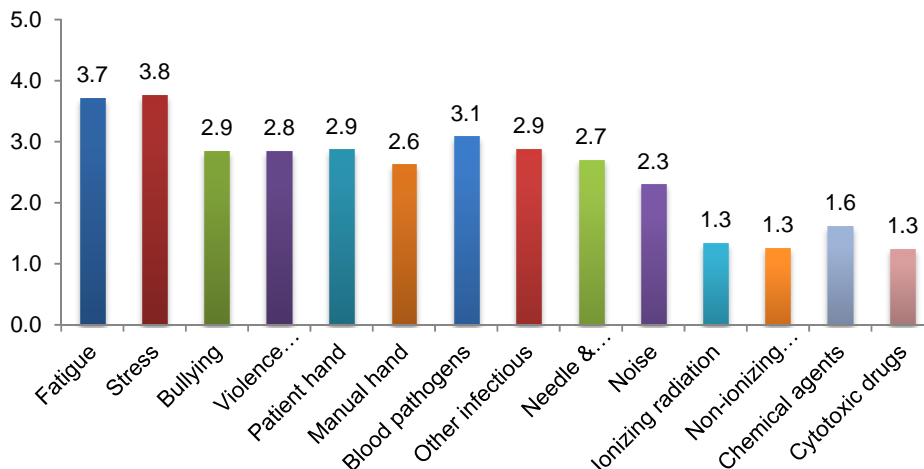
**Figure 38: Perceptions of OHS among midwives**

Respondents in this group rated role overload at higher levels than other issues including physical demands, burnout and emotional labour. While violence and bullying were reported by midwives, these issues appear to be much less likely for this group compared to enrolled nurses or personal carers.



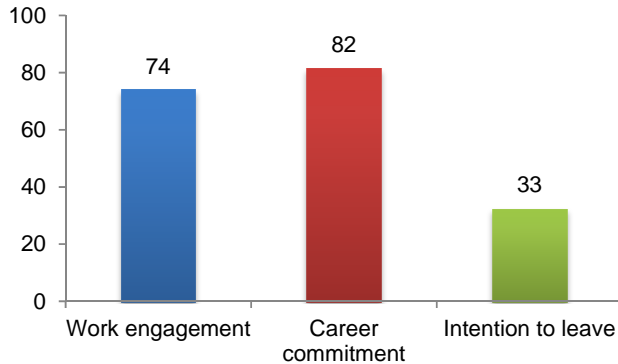
**Figure 39: Perceptions of risk and aggression among midwives**

When asked to rate the level of risk for specific OHS hazards in the workplace, respondents in this group rated issues such as fatigue, workplace stress and blood pathogens as the most likely risk factors, ahead of other risk factors such as violence and bullying. Similarly, physical factors such as risk from infectious agents, patient and other manual handling issues also received lower ratings compared to fatigue and workplace stress.



**Figure 40: Other risk factors for midwives**

In this group, substantially higher levels of work engagement and career commitment are reported compared to intention to leave.

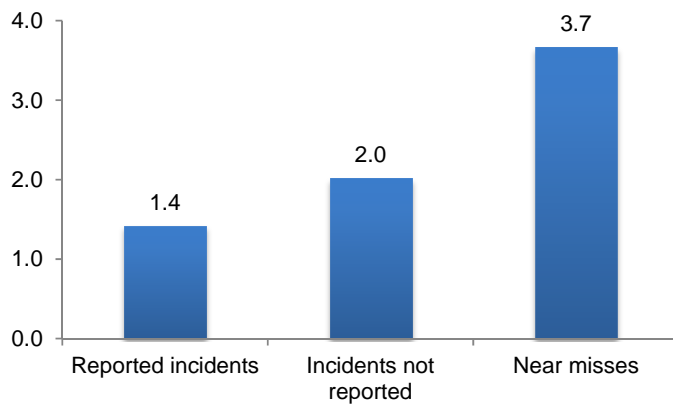


**Figure 41: Work engagement, career commitment & intention to leave: midwives**

*Personal carers*

There were 156 (3%) survey respondents who were personal carers.

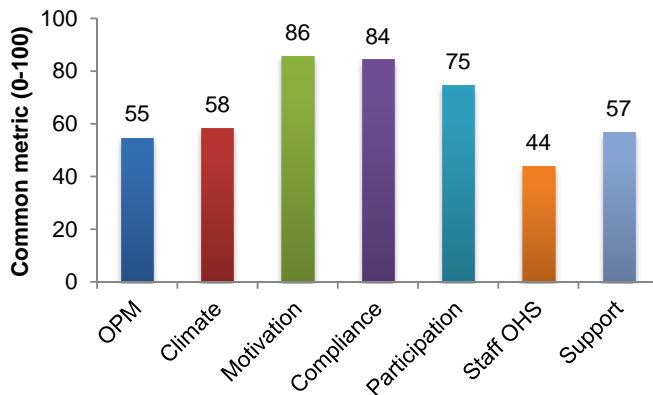
The number of near misses was higher than both reported and unreported OHS incidents. OHS incidents that were not reported to management also exceeded the number of OHS incidents that were reported to management.



**Figure 42: OHS incidents for personal carers**

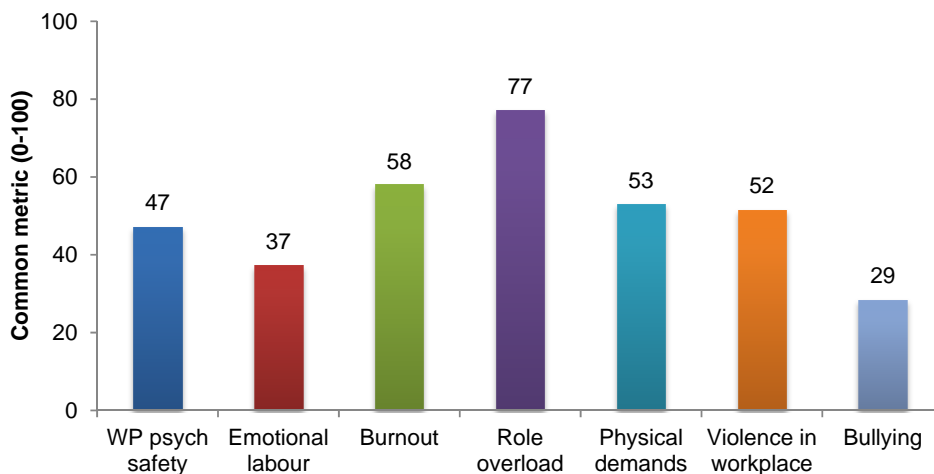


A comparison of transformed scores on the perceptual measures of OHS showed that personal carers rated their safety motivation, compliance and participation substantially higher than the ratings of other group level variables such as the OPM and safety climate or management support for OHS. Scores for supervisor support for OHS and the management prioritisation of OHS compared to patient safety were low. Scores on these two scales were lower in this group compared to midwives, registered and enrolled nurses.



**Figure 43: Perceptions of OHS among personal carers**

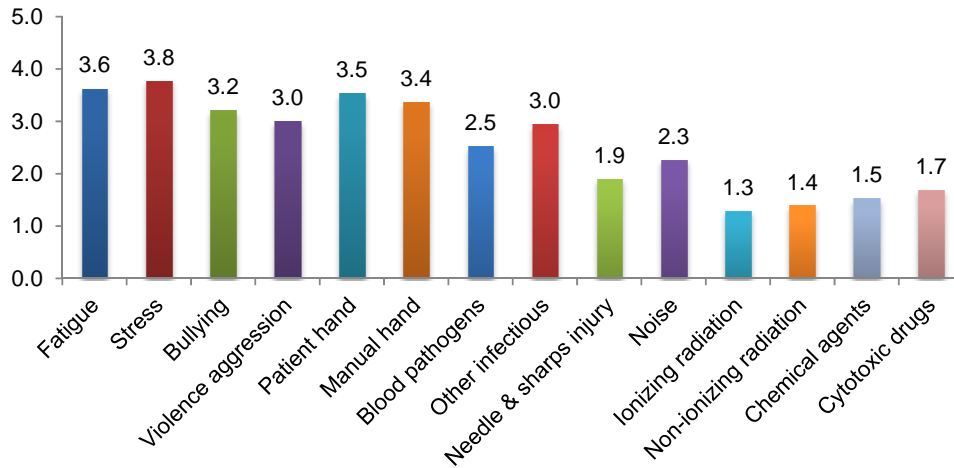
Respondents in this group rated role overload at higher levels than other issues including, burnout and surface acting emotional labour. Issues such as physical demands, violence and bullying were reported at higher levels in this group compared to midwives, registered and enrolled nurses.



**Figure 44: Perceptions of risk and aggression among personal carers**

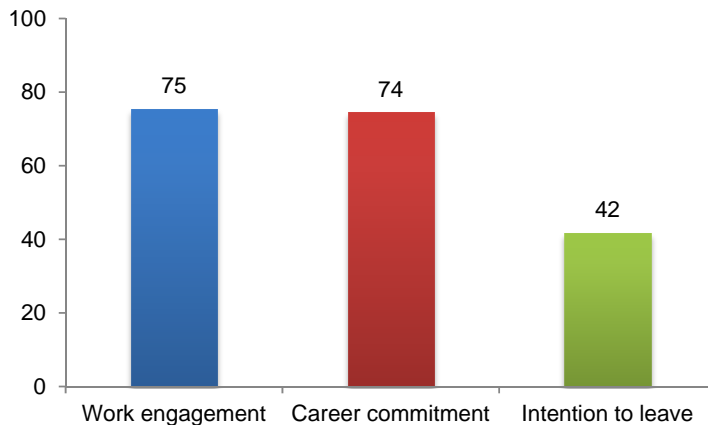
When asked to rate the level of risk for specific OHS hazards in the workplace, respondents in this group rated issues such as fatigue, workplace stress and patient handling as the most likely risk factors. While these risks were rated higher than other risk factors such as violence, bullying and manual handling, these later issues were still rated relatively highly.

Physical factors such as risk from infectious agents received lower ratings particularly compared to fatigue and workplace stress.



**Figure 45: Other risk factors for personal carers**

In this group, substantially higher levels of work engagement and career commitment are reported compared to intention to leave.

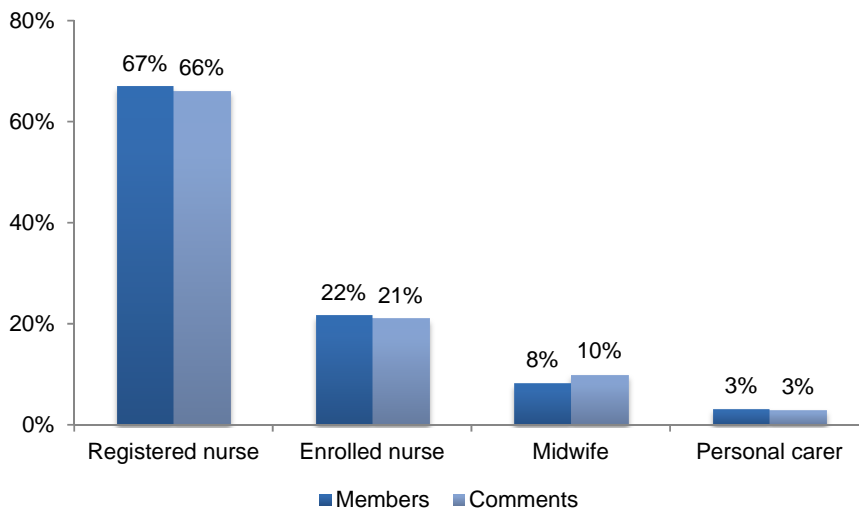


**Figure 46: Work engagement, career commitment & intention to leave: personal carers**

### Comments about OHS from ANMF members

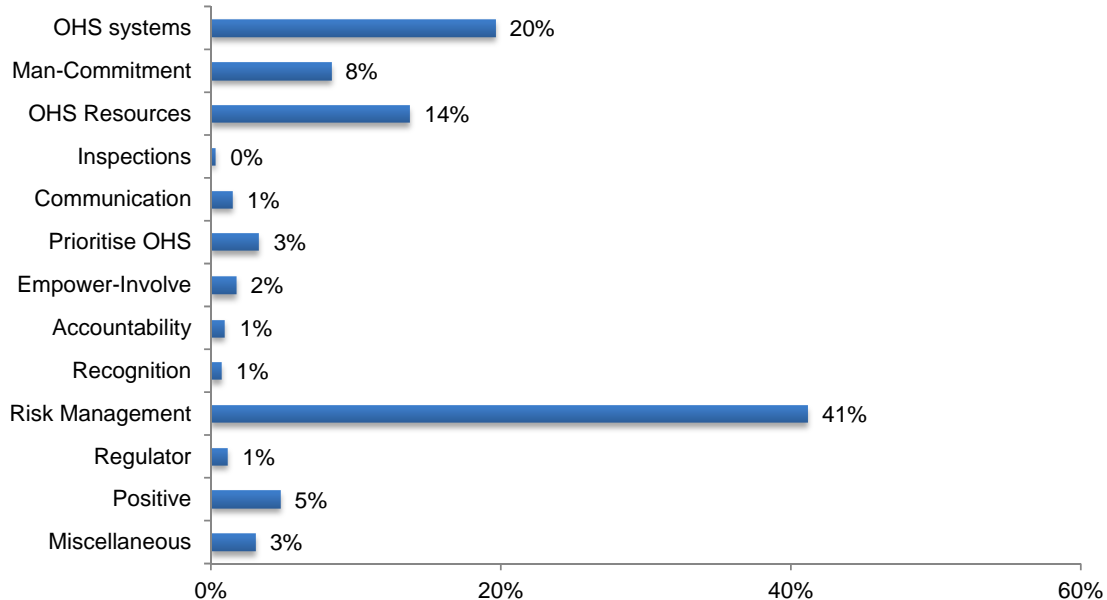
Respondents were given the opportunity to add comments about OHS at their workplace with an open-ended question. Respondents were asked to *“please enter any comments about health and safety at your workplace, or health and safety issues facing nurses at work, that you consider important and that the questionnaire did not cover.”*

Respondents often addressed multiple issues and therefore each issue raised was categorised separately. In total, 1,463 respondents (30 percent) answered this open-ended question and generated 1,705 comments. Respondents from all four groups contributed comments about OHS at their workplaces. As shown in Figure 47 below, most comments came from registered nurses, but percentage of comments from each group was consistent with the percentage of participants responding to the survey from each of the member groups.



**Figure 47: Distribution of comments by occupation**

The comments were summarised into 10 categories which were mapped to the 10 elements of leading indicators of OHS identified earlier (see Table 1). In addition to these categories, the remaining comments were categorised into comments about the regulator, positive comments about OHS in the workforce and miscellaneous comments. The distribution of comments across these categories is displayed in Figure 48 below. As shown in the figure, the areas of most concern to respondents were risk management, OHS systems and OHS resources. Less than 1 percent of the comments related to workplace audits and inspections.



**Figure 48: Distribution of comments regarding OHS from ANMF members**

The majority of comments from respondents could be grouped into the category of risk management and encompassed psychosocial, physical and physiological risks. More than half of the comments in this category referred to aggression and bullying in the workplace; other areas of concern were workload, fatigue and mental health.

Examples of verbatim comments in the **Risk Management** category include:

*I often feel ambivalent to work and nursing. I feel that my concerns are either not understood, not addressed or trivialized. It then becomes easier to not say anything, just work your hours, look after things during that time and then go home, and hopefully not think or dream about issues on days off.*

*The majority of nurses are over worked, not supported or recognised enough which in turn can result in work place stress, nurses need more mental health days to assist them and more annual leave.*

*Organisation has good bullying & code of conduct policies, but if you complain, HR will punish you. People who make these complaints are moved out of their area, not the person who has been doing the bullying.*

*I work as part of a team that looks after people with dementia, delirium, are drug or alcohol affected. This exposes team members to an above average level of potential violence/abuse. Team members are frequently hit or punched, sometimes kicked or scratched and bitten by affected patients. We often have to duck thrown objects or body fluids/solids. Do they pay me enough? No!!!*

*Physical violence towards nurses in the workplace occurs far too often. There are no real consequences to patients or their family members for such acts of aggression. Management needs to take their duty of care toward staff to provide a safe workplace just as seriously as their duty of care to patients.*

*In my experience this never happens. I frequently feel fearful for my personal safety at work and this would be the major reason I would consider leaving the nursing profession. I think this clearly reflects management's priorities.*

*I do feel that in regards to violence or aggression from patients towards staff, that the facility does not provide any training to deal with these episodes, or support/counselling for staff that have experienced it.*

*Lack of security, community assumption that hospitals are a prosecution free zone and that they don't have to abide by the social norms that are expected in other areas of society.*

*Biggest stress comes from actions of management, trauma of having immediate manager terminated instantly and threatened by management not to discuss, unable to voice concerns for fear of retribution, bullying and harassment officer is the person bullying so therefore cannot complain. If you complain too often about systemic or difficult to fix problems you are likely to be bullied from above, but the bigger problem is from poorly performing colleagues and subordinates, the poorer their work practices the better they are at bullying.*

*The aggression and violence that nurses have to put up with is disgusting and is slowly becoming the norm. I feel there is much needed awareness and resources in this area and I'm disappointed that management doesn't do more to combat the negative behaviour displayed by patients and relatives.*

*Escorts into high risk areas for community nurses/assessment clinicians that are deemed unsafe by police and ambulance personnel.*

*Occupational violence in the emergency department is a regular occurrence which could be improved with an increased security presence. Currently only one security person for the whole hospital after business hours.*

*All nurses expected to work late shift finishing at 2230 then early shift starting at 0700 the next day, up to twice per week if required. Often nurses on this roster state they've had little sleep between shifts.*

*Night duty is a huge OHS issue for many nurses on rotating rosters. Many can't sleep properly due to the change of routine thus exposing them to fatigue errors at work and driving home. Many nurses use drugs to facilitate sleep.*

*The most common concerns voiced by myself and my co-workers are poor and inflexible rostering practices e.g. frequently rostered to work for 8-10 days in a row. Frequent changes of shift (short shifts) and inadequate days off between day shifts and night-duty.*

*Unreasonable workloads and ever increasing paperwork and administration. Expectations to take on extra work e.g. portfolios without any kind of remuneration. Being expected to participate in in-house training, which if falls on a day off, accepting that you won't be paid for it.*

*The workload for ENs is increasing all the time. No time to spend with residents, increased paperwork, working short staffed, no thanks for the work we do.*

*I find the most frustrating thing is not having the time to assess patients on admission, and time or resources to do a "good job".*

*Nursing is always a physical strain to the body. The way we move patients these days appears to have shifted the injuries from the back to the shoulders and I don't know how you can stop this risk other than setting up individual kinetic assessments and training to staff to make them as physically strong and aware of their body capabilities as possible. I think this should be the duty of care to employees by the employers. I am sure it could be set up as a staff health program somehow?*

Comments regarding OHS systems included: the impact of non-OHS policies and practices on OHS system compliance, the reactive nature of OHS systems and gaps in reporting and training processes.

Examples of comments in the **OHS Systems** category include:

*The supervisor and Clinical Co-ordinator are included in the ratio of staff to residents, however these two employees do not work on the floor, instead they remain in the reception and office during the day, but on paper it appears like we have the correct ratio of staff to residents.*

*The system is only concerned with recording information so when it goes wrong they can investigate easier. They need to do this because they also know they are pushing nurses to the point they cannot get it right all the time. They have implemented so much paperwork and tasks that are not part of the role that nurses are doing mandatory training on their own time.*

*In the last twelve months our shift hours have been shortened to start 30 mins later. This unit often hold in-services in the first half hour of the shift and this leaves us missing out on unit updates and education that are vital to improving work knowledge and performance. I have raised this issue with a superior but received no feedback. As casual staff we don't receive education allowance, hence this in-house education is essential for improving our professional development.*

*Despite OHS procedures, it is still hard to dress, move, transfer larger size residents, especially if they have dementia, are non-ambulant and are often very resistive. Even smaller size residents who are not ambulant and are resistant are physically demanding at times.*

*Continually working short staffed. No ratios of PCW/EN on a shift.*

*It is my opinion that the greatest threat to health and safety in my workplace, is from the lack of replacement staff available to fill in for staff on sick leave. This means we are almost always providing health care in an environment that is extremely time pressured, and stressful.*

*You do not mention supposed self-rostering where we put down the shifts we would like the management impose the roster making changes. This can lead to shifts such as a late shift early shift night shift then another early. Terrible rostering. No policy known of in organisation to stop this happening.*

*A huge push in the organisation of safety first but the emphasis is on patient safety. KPIs to be met include no falls, no pressure ulcers, no medication errors. Patient centred care is ok but there needs to be time and opportunity to do things properly.*

*Hospitals only confront health & safety issues after they have occurred. Nurses still keep quiet after over 30 years in the profession. I still see the same things happening to a younger generation, now we also have to cope with endless paperwork, computer work and layers of useless management.*

*Hospital routines are not always in accordance with ANMF policies and regulations which is putting staff and patients at risk e.g. not working to ratio, inadequate equipment to complete tasks, no meal breaks, using precious time for non-nursing duties etc.*

*I work a lot of unpaid overtime as adequate administration time is not given, despite requests. Many extra duties are given but not the time to do them in.*

*I have no contract, I have no set shifts, management has said they don't do contracts, I have been punished for taking sick leave and my hours cut back. I have no security.*

*Incident reports are not easily available – have to ask for one, and then wait for it to be provided.*

*It is not obvious who our OHS officer is.*

*Incident reports are often not reported due to a time issue and staff are reluctant to stay back in their own time to fill these out, I see this often.*

*The hospital I work at has started admitting drug and alcohol dependent patients with in the last twelve months. No extra training or safety provisions have been offered to staff members other than a written notice on the wall stating "violence and aggression will not be tolerated in this work place". Fortunately no incidences have occurred but if they were to, staff are untrained as to how to deal with it other than hoping someone else can call a police no. before the situation would get out of hand*

*I have worked with a colleague who was put through a gruelling process over incidents that management never discussed with her. Management has failed to set up any legal OHS processes and insisted on a designated HSR. I am in the process of establishing a legitimate system, and have put my own hand up. I anticipate needing the help of both my ANF rep and a WorkSafe rep.*

*If an incident occurs there have been instances where management and staff blame staff (the victim) for the occurrence rather than the perpetrator. Poor management happens after an incident as rights are not explained surrounding staff rights to pursue with Work Safe, contact a union, next step or take legal action. If going through a workplace incident OHS, and the organisation worked for, make it really difficult for the victim to work through the process making a person feel more victimised and helpless.*

Comments regarding OHS resources (tools, interventions, training and information) were predominantly focused on the availability of, and ease of access to, appropriate equipment. Training and education in OHS and relationships with OHS representatives were also areas of concern.

Examples of comments in the **OHS Resources** category include:

*Consideration for staff health and safety is generally poor in the private healthcare system. This is due not only to the absence of nurse-patient ratios, but also the lack of properly-functioning equipment. In my current workplace, there is no provision of a sharps disposal container within each patient's room.*

*Frequently, the OHS risks are related to equipment not being available or suitable.*

*You follow the processes and risk assessments etc. but always told will have to wait for equipment, no money in budget for that, so why bother doing all these assessments etc. if employers just say that!?*

*Don't have bariatric equipment to hand. Find we get a lot of over 130kg patients that do not fit in the normal beds well. So it becomes dangerous for us and them when we try to turn or manoeuvre in and around be, sometimes impossible.*

*Frustration of computers that do not work as they should when trying to complete documentation. Practices that increase the risk of frustration e.g. installing new computers on Friday afternoon, when there is no support on a weekend for correcting glitches.*

*Not enough equipment for all of the staff, having to share and wait for equipment to carry out our jobs in a timely manner, and at times safe manner.*

*Stores are always a problem. We run out of gloves, chemo gloves. Have **requested protective eye goggles for months and wide top sharps disposal units for huber and gripper needle disposal!!!! Still do not have them.***

*I don't even know if we have a person allocated to OHS or not.*

*Storerooms in hospitals are often unsafe, being overcrowded with equipment. Finding what you want is often under heavy or awkward to handle equipment.*

*The lack of room in the public system is a huge issue. Nowhere to place the equipment away so you don't fall over it.*

*The supply of consumable equipment such as slide sheets, and regular emptying of bedside sharps containers can affect one's safety and are sometimes not attended to.*

*Broken beds have been asked to be used when large numbers of patients are in the hospital and not enough working beds are in circulation. The **maintenance engineer also works across more than one hospital site** meaning that emergent maintenance cannot always be fixed in time. Patient nurse call buzzers are often faulty constantly saying that buzzer is out of the wall which is inaccurate or very easily become loose.*

*We have equipment to perform our work in accordance with OHS, however the equipment doesn't always work effectively.*

*An added stress in the workplace is lack of equipment, wasting much time looking for a particular piece of equipment. Sick of hearing about lack of budget!*



Comments regarding management commitment to safety included: a lack of support and follow up from management in response to safety concerns; and a suggestion that attention to minimum legal requirements was enough for some managers.

Examples of comments in the **Management Commitment** category include:

*It is a workplace with a very "top-down" management structure, where staff aren't taken seriously when they raise concerns, equipment isn't adequate to do our job, and staff feel tired and overworked.*

*We are more so affected by upper middle management who always put down our efforts and believe "other nurses" could do a better job... no matter what we have achieved for them.*

*Lack of feedback from managers/supervisors, whether positive or otherwise, can be as harmful and distressing as receiving complaints about your performance. The only time feedback is given to my team, is when something has happened or someone has done something wrong or outside procedure, and the whole team is scorned for it. When a formal request to management is made for feedback on individual performance, it is either not given or is exceedingly unhelpful.*

*Lack of support from management regarding safety of staff. At times the manager refuses to replace staff which means we work short which increases the safety concern.*

*OHS policy at work looks great on paper but in reality it is something different. Time and time again the same things are brought up in audits and meetings and management mumbles about changes but nothing ever happens.*

*I find it a constant time consuming and draining task to gain support for OHS issues from management.*

*I find that the more outspoken you are, the more you are penalised by managers. I also find certain managers do not have the people skills to discuss issues with staff.*

*Management doesn't care or treat their staff well, it's all about statistics and money making.*

*Management has no interest in the welfare of their staff and only provide what they are legally required to do.*

*Management only pays lip service to OHS, to do the minimum to comply with regulations.*

*Management seems to spend more time completing the required paperwork related to Occupational Health and Safety and insufficient time, energy and money is spent on actually making appropriate change.*

*My workplace has a culture that does not appear to value nursing staff and patients. The culture is set by the management staff who are lazy and disengaged from their roles and responsibilities. The responsibility is always put back onto the field staff.*

*There is appointment of managers, by senior managers on basis other than competence. There is an "us and them" culture which leads to division, infighting and wears (all) people down. Takes energy away from the already difficult business at hand and prevents the hospital from working at optimum.*

Comments from respondents about the prioritisation of OHS address the concern that management prioritises financial matters over OHS.

Examples of comments in the **OHS Priority** category include:

*Cost saving seems to override any care factor for nurses' well-being.*

*OHS safety for nurses is usually budget related, not enough funds to replace old but usable equipment, even if not as safe as possible.*

*While Senior Management (a large public hospital network) has all the correct policies, actual implementation at the local unit level is dependent on the dollar cost. Most staff are indifferent and have been conditioned to accept taking OHS risks with mental health residents as just part of the job.*

*Bariatric care, regardless of how management says it is following OHS guidelines, still does not provide the number of staff required to prevent pulling, pushing and mere physical exertion required to attend to their daily requirements of care. It boils down to the cost factor involved.*

*Employers, especially in the private sector, tend to prioritise money saving instead of staff safety: not replacing staff who are calling sick, and letting the remaining staff manage the care of so many patients. This practice is totally not safe for the patients nor for the workers.*

*Funding cuts have impacted on the nurse patient ratio. This is a risk factor for all OHS problems.*

*I feel that health and safety is compromised by the pressure on reducing funding and increasing productivity.*

*Management at my workplace does not consider OHS a priority. Management seems to be more concerned with revenue raising by having nurses and care staff and administration work with unreasonable workloads, without having the adequate or best possible mix of staff to resident ratios or providing support when needed to help manage the workloads.*

Most comments in the OHS empowerment and employee involvement category focused on the difficulty in speaking up about OHS concerns and the lack of employee involvement in decision making related to workplace changes.

Examples of comments in the **OHS Empowerment and Employee Involvement** category include:

*It is important for nurses to feel there is a confidential person to turn to when there are grievances without fear of retribution. I feel too many nurses remain silent when issues arise for fear of consequences. They want to be part of a solution but don't know how to go about it.*

*Ongoing culture of poor morale and staff therefore hesitant to speak up about issues.*

*Some health and safety measures are now so over the top they are making everyday tasks too difficult to perform. Very little common sense seems to go into the decision making process (not made by nurses working on the floor).*

*I find it frustrating wanting to improve the living/health conditions of aged care residents but feel it is not my place or I am not listened to so there must be something wrong with my approach to the bureaucracy of management.*

*Effective management should pass on information to employees in a transparent, honest and timely manner. People thrive when they work in a climate in which their needs are considered and where they have a voice in decisions that affect them. They become invested in their place of employment and are motivated, creative, accountable, productive and fulfilled. The current management is not transparent in their actions or decisions.*

*Health and safety only seems to be a thing once a year. Posters are displayed but there is no involvement with the staff. Very broad and not specific to any tasks that we perform.*

*Management is making many changes at the moment with very little consultation and expertise in change management and the whole workforce is extremely stressed and feel they have nowhere to turn for support and advice.*

Comments in the leading indicators categories of communication, recognition and OHS accountability covered issues such as the difficulty in communicating with management and other employees about OHS concerns, the lack of recognition and feedback and the importance of having everyone engaged in OHS. Several comments were made about accreditation.

Examples of comments in the **Inspections, Communication, Recognition and OHS Accountability** categories include:

*Sometimes due to poor communication we are unable to organise the appropriate resources/staff for new admissions.*

*I have heard that "debriefing" is no longer seen as a positive experience. I disagree, I don't believe we have enough discussion/debriefing.*

*I believe greater effort should be placed on creating a positive culture of communication, respect and encouragement rather than identification and reporting. Reporting should however be seen as positive process change rather than just one of initiating punitive measures.*

*I find there is a lack of education in general practice – and also a lack of communication about safe clinical waste disposal and who is in charge of disposals etc.*

*The organisation I work for has a high turnover of staff. Most staff are not satisfied with the working conditions, the pay is poor, the hours are poor and most workers do not feel valued, are not recognised for their effort and even clients have noticed this.*

*Feedback and team morale – in my workplace little positive feedback is ever given to staff and little is done to boost team morale. I consider individual esteem and team morale important aspects of health and wellbeing in the workplace.*

*As a manager it is difficult to engage with staff who do not want to engage and participate in their own health and safety. You place strategies in place that they ignore, you try to engage them as a group one on one or a few on one to seek their ideas to reduce their exposure to manual handling risks and they do not want any part of it.*

*Big issue is that my colleagues are apathetic to H&S.*

*Health and safety is everyone's concern at work.*

*I am HSR and try to bring things into the ward but it's like banging your head on a wall. Staff have been doing thing the same way so long they hate change.*

*It's about time that accreditation visits were surprise visits, so management don't run around making things look good/quick fix.*

*The issues seem to get acknowledged and solutions promised just prior to accreditation but after accreditation there appears to be no money or big delays in receiving items or equipment unless we are constantly following up the promised items.*

Comments in this category address concerns about inspection and regulatory bodies and the impact on OHS in their workplaces.

Examples of comments in the **Regulator** category include:

*Previous place of employment had very poor health and safety standards. Issues raised with WorkSafe who supported the employer and his lies.*

*Worse than being injured or assaulted at work is dealing with the whole process of WorkCover and the amount of money you lose for the privilege of being injured at work whilst doing your job. ANMF needs to do more to support injured workers.*

*The WorkCover process as well leaves a lot to be desired when you are made to feel guilty and/or a liar about your witnessed and traumatic incident.*

Finally, there were a number of positive comments from respondents who view OHS policies and practices at their workplace to be supportive and effective, with good processes in place.

Examples of comments in the **Positive** category include:

*At my employment, I am regularly informed of any changes that are being implemented. We also have a large OHS board in our staff/handover room which all employees have access to. We also have 2 reps that we can easily approach as well as management.*

*Health and safety is considered as a high priority by my employer and I have been encouraged by my employer to mentor other staff members in matters of OHS.*

*When it comes to the residents, the facility will do anything to help with the safety of our residents, if it is to help manage them better. Staff only have to ask and we get lifting machines, slide sheets, standing machines.*

*I am very fortunate in my current position. We have awesome management and work conditions (providing Mental Health clinical services, based in GP practices). Much safer and more enjoyable than my previous years in the Public Hospital system.*

*I coordinate OHS on site and trained HSRs are fully involved with six monthly (soon to be three monthly) workplace inspections and annual ergonomic inspections. We have quarterly OHS meetings and comprehensive minutes are taken and displayed on our official OHS board as well as other mandated information relating to OHS. We scored 97% in a recent annual OHS audit conducted by OHS consultant.*

*I have been on Return to Work schedule since an incident at work last year. Everyone involved have been very helpful and understanding. This has made my journey back to my set roster fairly stress free.*

*My public employer has well developed OHS policies. I find management supportive.*

## Summary and conclusion

This report has presented the key findings from the survey of ANMF (Victorian Branch) members. Responses were received from 4,891 members (an overall response rate of 7 percent): 3,273 registered nurses (67 percent), 1,055 enrolled nurses (22 percent), 407 midwives (8 percent) and 156 personal carers (3 percent).

The primary objective of this study was to evaluate the OPM for use as a simple, preliminary measure of OHS leading indicators and to determine whether the OPM can be used in the Australian nursing and midwifery workforce. Consistent with earlier studies, the results indicate that the OPM is a reliable and valid measure of OHS leading indicators and that it might be of use as an initial 'flag' or measure of OHS potential in a workplace. We tested the validity of the OPM by evaluating its relationship with other measures of OHS. There were strong associations between the OPM and a measure of safety climate, as well as measures that represent management commitment to safety (prioritisation of OHS, supervisor support for OHS). While scores on the OPM were associated with employee behaviours (motivation, compliance, participation), these associations were weaker than the associations between the OPM and measures of safety climate and management support for staff OHS. This pattern of correlations indicates that the OPM is a valid measure of leading indicators of OHS rather than other aspects of safety – that is, it represents OHS at the organisational level rather than at the level of individual employee behaviours.

An assessment of self-reported OHS outcomes showed that 2,998 ANMF respondents (60 percent) had experienced an OHS incident. For those who reported they had been involved in an OHS incident, they indicated that they had experienced an average of 4.9 OHS incidents in the past twelve months. The predominant OHS incident disclosed by respondents tended to be near misses, followed by incidents that were not reported to management. OHS incidents that were reported to management were the least likely to occur on average. This outcome is consistent with the studies conducted in other industries as part of this research project. The OHS incidents that respondents disclosed were more likely to be near misses, followed by OHS incidents that did not get reported to management.

Respondents were asked to complete a series of measures that addressed OHS at multiple levels: organisation (OPM, safety climate), management/supervisor (prioritisation of OHS, supervisor support) and employee (safety motivation, compliance, participation). An examination of the responses to these measures indicated that respondents tended to rate their own levels of safety motivation, safety compliance and safety participation higher than OHS at the organisational or supervisor level. This is also consistent with the results from the other studies conducted as part of this research project: respondents tend to report that they perform well in areas of OHS where they have more personal choice or autonomy. That is, they are motivated to act safely and they behave safely (compliance and participation).

In contrast, the OPM, safety climate, prioritisation of OHS and supervisor support for OHS measures refer to domains that are beyond the control of individual workers, and these are the domains that respondents rated lower compared to areas of OHS where they have more choice or autonomy.

With regard to risk factors, on average, respondents tended to rate their levels of role overload as being high and associated measures such as burnout and physical demands as moderately high while emotional labour was given low ratings. Scores on the workplace violence and bullying measures indicated that these issues are present among ANMF members but not to the same extent as role overload or other physical demands. Violence and bullying were reported by respondents in all employee groups, although enrolled nurses and personal carers reported higher levels of both occupational violence and bullying compared to registered nurses and midwives.

Our investigation of the relationships between the multi-item measures used in this study and self-reported OHS incidents over the past 12 months revealed an association between most of these measures and the total number of self-reported OHS incidents disclosed by respondents. The OPM, safety climate and measures of management support for OHS (prioritisation of OHS, supervisor support for OHS) were more strongly associated with the number of self-reported incidents, compared to the measures that focused on employee behaviour (e.g., safety participation) or risk (e.g., burnout, role overload). Interestingly, safety participation was only related to reported incidents and not to near misses or to incidents that were not reported to management. This suggests that respondents who were more proactive in their approach to OHS were also more transparent in their reporting of OHS concerns.

The OPM showed variations across employee subgroups within the sample. Specific group comparisons were: employee type (i.e., registered nurse, enrolled nurse, midwife, personal carer); organisation type (e.g., hospital), workplace unit (e.g., mental health, general practice), employee status (full-time, part-time, contingent), role (e.g., unit manager, registered nurse). While comparisons revealed some consistency in OPM scores across these subgroups, there were some groups of respondents who generally gave lower ratings to their workplaces. For example, personal carers and midwives tended to give lower scores to their workplaces compared to registered and enrolled nurses. Respondents who reported working in emergency or mental health workplaces tended to give their workplaces the lowest ratings on the OPM compared to all other workplaces. Those in disability and rehabilitation tended to give their workplaces higher ratings compared to all other groups.

In terms of work engagement, career commitment and intention to leave, there were few differences between groups on work engagement. Larger differences were reported for career commitment and intention to leave with midwives displaying higher levels of career commitment compared to the other three groups and personal carers displaying a greater intention to leave compared to the other three groups.

In the final section of the questionnaire, 1,463 respondents (30 percent) answered an open-ended question, generating 1,705 comments about OHS. Respondents from all four groups contributed comments about OHS at their workplace. Most comments came from registered nurses, but this was consistent with the percentage of participants responding from each employment group. Respondents' comments about OHS were organised into the ten broad categories that represent the leading indicators concept. The predominant concerns shown in respondents' comments were related to risk management, OHS systems and OHS resources.

Overall, this report provides an analysis of ANMF (Victorian Branch) members' perspectives of OHS in their workplaces. The analysis demonstrates that the OPM and other measures related to OHS can be used with union members to capture and report on their views and experiences of OHS.



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