Guidelines on coping with violence in the workplace

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INTRODUCTION

The increasing incidents of abuse and violence in health care settings are interfering with the provision of quality care and jeopardizing the personal dignity and self-value of health personnel. National nurses' associations (NNAs) have identified the risk, documented its negative impact on the professional and personal lives of their members and are implementing strategies to eliminate this major occupational hazard.

The objectives of these guidelines, which complement the ***ICN Position Statement on Abuse and Violence Against Nursing Personnel*** (2006) are:

1. To review the prevalence, incidence and impact of abuse and violence against nursing personnel.
2. To recognise nurses' responses to incidents of violence.
3. To determine the major security factors acting on the workplace.
4. To present strategies that aim to confront and reduce/eliminate violence in the workplace.

DEFINITIONS

For the purpose of these guidelines, key terms are defined as follows:

Abuse	Behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.[1]
Sexual harassment	Any unwanted, unreciprocated and unwelcome behaviour of a sexual nature that is offensive to the person involved, and causes that person to be threatened, humiliated or embarrassed.[2]
Violence	Being destructive towards another person.
*Workplace violence**	Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.[3]

* Adapted from European Commission

VIOLENCE AS AN OCCUPATIONAL HAZARD

Violence in the workplace appears in various forms. Its manifestations include: verbal abuse; physical assault; and homicide.

The prevalence of violence against nursing personnel is of great concern when comparisons are drawn with other professions. Already in 1990, a study in Pennsylvania (USA) found that 36% of the emergency room nurses responding had been physically assaulted at least once during the previous 12 months while only 6% of probation and parole officers surveyed had been physically assaulted during the same period.[4]

More recently in Sweden, reported cases of workplace violence are much higher in the health sector (24%) than in other sectors such as retail trade, the police, education, transport, or banking (4-7%).[5] Once thought to be primarily a problem in industrialised countries, pioneering research undertaken by the Joint ILO/ICN/WHO/PSI Programme on Workplace Violence in the Health Sector documents that this is a worldwide challenge of epidemic proportions. Verbal abuse, bullying and sexual harassment were among the most common forms of violence; the incidents found to be as traumatic as physical assault.[6] Workplace violence is so toxic that nurses increasingly report that it is one reason they abandon active practice. Aiken refers to the increase in violence by patients and their families in health care settings as a type of "ward rage" stimulated by a general sense of frustration and dissatisfaction with the quality of care received. This behaviour compromises the civility of the work environment and contributes to the high rates of nurse burn-out.[7]

While patients and their families tend to be the perpetrators of physical violence in the health sector workplace, colleagues and supervisors are most often

responsible for the unacceptable high rate of psychological violence. More than half of the responding health personnel had experienced at least one incident of physical or psychological violence in the year previous to the Joint Programme study: 76% in Bulgaria; 67% in Australia; 61% in South Africa; 54% in Thailand, and 47% in Brazil. Ambulance staff, nurses and doctors reported suffering the highest offence rates. Recognition of workplace violence as an important generator of post-traumatic stress disorders (PTSD) is an uncontroversial major finding of all the countries surveyed. Between 40%-70% of victims reported significant levels of PTSD symptoms.[8] The correlation between violence and stress is of particular significance in the light of the high levels of stress reported worldwide within health care settings.

Whereas previously incidents of violence occurred in specific departments within the hospital – i.e. emergency rooms and psychiatric wards – this is no longer the case. General patient rooms have replaced psychiatric units as the second most frequent area for assaults. This trend towards increasing general violence is found in all health care settings in rural as well as inner-city and urban areas.

Although it is true that male nurses have been victims of abuse and violence in the workplace, this is a relatively recent phenomenon, less frequent but equally intolerable.

Studies commissioned by the Joint Programme found that psychological violence is widespread everywhere with verbal abuse at the top of the list. In Brazil 39.5% of the respondents had experienced verbal abuse in the last year; 32.2% in Bulgaria; 52% in the health centre complex and 27.4% in the hospital in Portugal; 40.9% in Lebanon and up to 67% in Australia.

The second main area of concern is that of bullying and mobbing which had been experienced by 30.9% in Bulgaria, 20.6% in South Africa, 10.7% in Thailand, 23% in the health centre complex and 16.5% in the hospital in Portugal, 22.1% in Lebanon, 10.5% in Australia and 15.2% in Brazil. Until recently the typical profile of violence at work largely featured isolated, major incidents. In more recent years however, attention is also being focused on violence which is perpetrated through repeated behaviour, of a type which by itself may be relatively minor but which cumulatively can become a very serious form of violence. Bullying or mobbing, which have appeared as a new topical issue in developing countries only in the last decade, were virtually unknown to the developing world till then. The results of the country studies have unveiled for the first time the worrying dimension of these two forms of psychological violence in the developing world and in countries in transition.[9]

Sexual harassment, a specific form of abuse, is occurring against nurses at an alarming rate. Surveys document this high prevalence: for example, 64% of the nurses interviewed in India[10], 90% in Israel[11] and 56% in Japan[12]. The figures are similar in highly industrialized countries: 69% for the UK, 48% in Ireland and 76% in the US[13]. It is important that sexual harassment not be seen as isolated occurrences. Experience demonstrates that, in fact, harassment, if not reported, tends to escalate in seriousness over time.

IMMEDIATE RESPONSES TO VIOLENCE

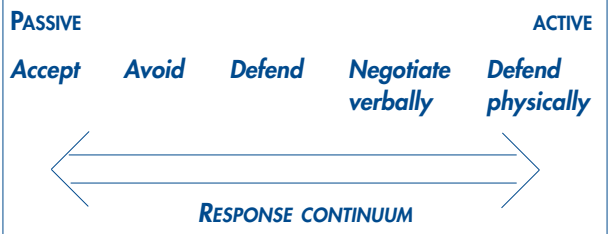
The immediate reaction of nurses, as individuals, will be dictated by:

- personality type;
- learned mechanisms (conscious and unconscious);

- physical environment; and
- societal expectations (cultural and professional).

Immediate responses may range from highly passive to highly active (see Fig. 1). Nurses too often passively accept abuse and violence as «part of the job» – an attitude sometimes unfortunately shared by the general public and leaders in the judicial system. In 1986 a judge, presiding over a case in which two nurses laid charges against the patient who assaulted them, ruled that «consent to work there (a psychiatric hospital) amounted to consent to be assaulted».[14]

Fig. 1. IMMEDIATE RESPONSES TO VIOLENCE



To avoid violence, many nurses ignore abuse, as was the case for some 30% of the nurse respondents to a survey in Canada. Of these nurses, 25 - 35% found this action helpful.[15] However, such action is likely to interfere with the nurse/patient relationship and the consequences must be seriously considered.

In the same survey, verbal defence was used by most respondents and found to be generally helpful in preventing further violence (except for extended/personal care institutions). Interestingly, this study showed that helpfulness from any of the wide mechanisms used depended to a great extent on the category or type of health care setting and patient involved.

Negotiation or conflict resolution was used by the majority of nurses in all health care settings and was found to be most helpful in psychiatry, ambulatory care and community care.

Physical defence was used the least. However, 80% of the nurses having resorted to this response mechanism reported the action as being helpful.

The use of physical intervention is controversial, as it touches on ethical and legal concerns. While the main defence to assault available to staff is said to be self-defence, many nurses are reluctant to use this mechanism and much ambiguity is reported. For example, 70% of surveyed nurses in the Ontario study felt that it was inappropriate for nurses to deal physically with violent behaviour even if they had received self-defence training. Yet over half of these same nurses (56%) supported self-defence training as a strategy for reducing violence in the workplace.[16]

IMPACT OF ABUSE AND VIOLENCE

The impact of physical violence, verbal abuse and sexual harassment is of great concern in view of its prevalence. The consequences of such acts include:

- shock, disbelief, guilt, anger, depression, over whelming fear;
- physical injury;
- increased stress levels;
- physical disorders (e.g. migraine, vomiting);
- loss of self esteem and belief in their professional competence;
- paralysing self-blame;
- feelings of powerlessness and of being exploited;
- sexual disturbances;
- avoidance behaviour that may negatively affect the performance of duties and thereby reduce the quality of care provided;
- negative effect on interpersonal relationships;

- loss of job satisfaction;
- absenteeism;
- loss of staff morale and efficiency;
- increased rate of nurse turnover;
- anxiety of patients, staff and loved ones.

The impact of verbal abuse must not be minimised. The consequences are similar to the effects of physical assault and have serious repercussions on provision of care. Research suggests that a significant percentage of nurses' turnover rate is due to verbal abuse, with many nurses choosing to leave the career as a result. The loss of qualified nurses inevitably intensifies the stress placed on often a short-staffed health unit.

Violence is destructive by nature and has a profoundly negative impact on observers as well as the victims. It has been demonstrated that even close workers who had not witnessed the traumatic event also displayed post-traumatic stress response symptoms.[17]

These incidents leave memorable traces over the long as well as short term. A study showed that 18% (11/61) of nurse victims of physical assaults by patients continued to experience moderate to severe traumatic responses six weeks following the assault. Long-term follow-up highlighted that 16% of those responding after one year (4/25) were still suffering.[18] These findings are confirmed by the country case studies carried out by the ILO/ICN/WHO/PSI Joint Programme. Obviously, violence harms nurses both personally and professionally, altering their lives and the quality of their contributions to health services.

Moreover, violence against nurses also lessens the profession's ability to recruit and retain qualified nurses.

Sick leave and lowered productivity are often side effects of occupational accidents and diseases. "Nurses greatly stressed and vulnerable to injury have a higher absentee

and disability rate than almost any other profession, which disrupts care, makes planning difficult and costs the health care system a great deal of money."[19] Not only does the concern for personal safety dissuade people from entering or remaining in the nursing profession, it also has consequences in terms of temporary absence from the workplace. This tends to increase the workload of colleagues and have a negative impact on the quality of care. Dealing with occupational accidents and diseases is also costly, diverting necessary funds from employing and retaining nurses in sufficient numbers.[20]

FOLLOW-UP RESPONSES

Once violence occurs, treatment of injuries, if required, takes precedence. Whether or not in need of treatment nursing personnel tend to choose among the following responses:

- ***Avoidance*** This may involve avoidance of the problem or avoidance of the perpetrator of violence. Interference with the performance of duties becomes apparent and no resolution to the problem is possible.
- ***Denial*** Frequently traumatic events are suppressed. No resolution of the problem is possible and maladaptive behaviours may appear.
- ***Discussion*** The incident is informally discussed with team members, family and/or friends. One study showed that discussion with team members was used most often and found to be helpful in preventing future occurrences of violence. Discussion with family and/or friends was not found to be helpful in prevention.

- ***Reporting*** Only one fifth of cases are estimated to be officially reported. Most nurses who denounce such incidents feel they are not taken seriously and consider the effort not worthwhile. Employers exert great pressure to withdraw such reports to avoid giving the institution a poor image for future patients, rather than facilitating reporting of all violent incidents with no hidden disincentives or threats of reprisals.

- ***Counselling*** The positive impact of counselling has been confirmed for both the victims of violence and persons indirectly involved in the incident and yet very few services are available or accessible. Debriefing techniques have been developed to specifically deal with the consequences of violence. Combining emotive and psychoeducation techniques appears to facilitate emotional stability. Emotional care must aim to convey acceptance, respect and understanding; reassure and support; encourage ventilation of feelings; provide guidance and ensure adequate follow-up.» Legal counselling is often also advisable to assure that the rights of all those concerned in the case are interpreted correctly should legal action be pursued.

- ***Prosecution*** Although nurses are not legally required to tolerate abusive behaviour, prosecuting offenders

is rare. When a patient initiates violence, prosecution is often considered to be unprofessional and unethical. Nurses often blame themselves for being unable to cope with aggressive behaviour and feel ill-prepared to defend their competence and legal rights in court. However, prosecution may be considered part of the nurse's healing process as well as a means to file compensation claims. Yet, prosecution is not viable in all cases; for example, psychotic patients are not considered responsible for their actions.

According to the ILO/ICN/WHO/PSI Joint Programme, reporting is an essential precondition for an effective response. In many cases, reporting procedures are lacking, proper investigation does not follow, the perpetrator is not persecuted and the victim feels dissatisfied of the way the incident has been handled. These weak response structures and missing victim support are leading to significant underreporting: victims of workplace violence do not report the incident because they think it would be useless, they feel humiliated or fear negative consequences.

In the majority of cases no specific policy on workplace violence is in operation. The limited development of workplace policies, as stressed in the country reports, is a major impediment to effectively dealing with workplace violence.[21]

SECURITY IN THE WORKPLACE

Employers must provide – and employees have the right to expect – a safe work environment. Security in the health workplace depends on the following factors,

each of which must be thoroughly investigated and appropriate measures taken to attain the highest level of safety.

Social Structure

Traditionally, many cultures have covertly accepted physical violence, sexual harassment or verbal abuse against women. Complaints lodged by female nurses have frequently been minimised, ridiculed or considered useless in the light of «human nature». Violence directed toward male nurses appears to be less frequent but is in no way more tolerable. The pressures on female and male victims to remain silent are great and underreporting has hampered the development of effective strategies to eliminate or at least reduce violence in the workplace. Respect of an individual's right to personal dignity and privacy must be integrated in the social norms and behaviour codes.

Legal Context

As mentioned above, the fact of being employed in the health sector is seen as consent to be assaulted within the judicial system. Legislation must thus be introduced that will support all individuals' (including health care workers') right to a safe work environment.

Specific legislation dealing with security questions would mean that measures could be imposed on employers, mechanisms put in place to monitor their implementation and disciplinary steps taken in cases of non-compliance. Legislation can, for example, demand that hospitals perform a safety assessment, analyse the incidents of violence seen, develop a plan to correct the problems identified, impose specific educational requirements for certain high-risk or responsible employees and discipline any persons interfering with the reporting of any act of assault or violence. Legislation can also increase the penalties for assaults (verbal or physical) against health care workers.

Clinical Issues

Research has not yet provided a reliable tool to predict the potential for violence. Studies however support the theory that health care workers are at greatest risk of future assaults with the small percentage of patients who have a history of violent behaviour and who are, in fact, responsible for the majority of assaults. Interestingly, a history of violent behaviour within the past several **hours** was a strong predictor of assaults in the emergency department.

By flagging charts of patients with a history of assaultive or disruptive behaviour assaults against staff was reduced by 91% in one study,[22] highlighting the importance of taking a complete patient history.

The most useful criteria in indicating a potential for immediate violence have been changes in the patient's autonomic nervous system. Sweating, flushed face, changes in the size of the pupils of the eye, muscle tension are some of the subtle cues used by nurses. Other warning signals include a loud tone of voice, a clenched fist, a tightened jaw and pacing in the hallway. Nurses must learn to assess from a distance and to trust their instincts.

The majority of injuries from surveyed violent incidents have been sustained while containing patient violence, underlining the need for more appropriate containment techniques and/or staffing levels. Furthermore, the workplace should develop protocols and procedures with regard to chemical and medical restraint as well as seclusion, taking into account the therapeutic justification as well as the rights of the health care worker and the patient.

Organisational Climate

An organisation's formal policies and management attitudes greatly influence the climate in the workplace.

The degree to which an individual's safety and dignity are considered important will greatly influence security within the work environment.

Management's traditional «paternalistic» attitude towards nursing personnel has made many nurses' feel dependent and helpless and thus guilt-ridden when unable to cope with violent incidents – encouraging the process of punishing the victim. Contrarily, management must send a strong, consistent message of zero tolerance towards abuse, sexual harassment and violence in the workplace. Supported by clear written policies and procedures – including confidential grievance machinery – this attitude must be integrated in the behaviour code of all employees.

A positive organisational climate includes the following aspects:

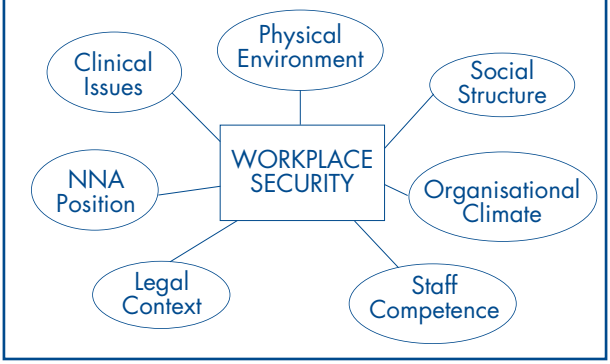
- Management ensures that staff are aware of their rights, legal requirements and responsibilities.
- Acknowledgement is made that violence will not to be tolerated.
- Development of security policies are multidisciplinary in their approach (administrative, nursing, medical, security, ancillary and house staff).
- Decisions regarding violent patient admission and discharge are made jointly by the physician and the nurse.
- Security factors are regularly investigated to identify hazards and develop strategies to reduce them.
- Continuing education programmes are developed on containing occupational hazards including violence and sufficient work time is allocated for attendance (see also *Staff Competence p. 19*).
- Staffing levels are determined to assure security of employees, as short and temporary staffing

have been associated with increased incidents of violence in health units.

- The quality of care and competence of staff are maintained at optimal levels.
- Accountability for unskilled workers is reasonably allocated to professional staff.
- The health team skill mix meets patients' needs.
- Staff is allowed to introduce safe work protocols and organise their work accordingly.
- Professional staff is given some flexibility so that rules and policies are not interpreted by patients as intolerable constraints.
- Funds are allocated for the implementation and maintenance of security measures (i.e. security personnel, adequate lighting, alarms, telephones, guarded parking).
- Support structures (e.g. medical services, confidential grievance machinery, counselling services with debriefing teams comprising mental health professionals) are easily accessible to workers.
- The responsibility and accountability for management of pre- and post-aggressive incident strategies are clearly outlined.
- Transportation policies take into account security risks for personnel.
- The movement and management of patients through various health units/services are rationalised and clear to those involved. For example, long waits in emergency rooms and the inability to obtain needed services or explanations have been cited as contributing to violence.
- High-risk activities and locations are identified and dealt with specifically (i.e. on-site storage of narcotics, cash-handling functions).

- Policies specific to field workers have been developed to deal with particular risks: e.g. regular reporting to base, visits in pairs to high-risk areas, police support for certain assignments, written protocols on when to stay or leave a high-risk situation.

Fig. 2. **SECURITY: DECIDING FACTORS**



Physical Environment

All measures must be taken to reduce the physical environment aspects that accentuate stress and trigger violence. While these approaches have previously focused on hospitals and health centres, they can be applied to other health care settings as well. Examples of such measures include:

- Provide safe access to and from the workplace.
- Minimise multiple public access to hospital buildings, including staff living quarters.
- Facilitate visitors' transit route from one main visitors' entrance.
- Place security services at main entrance, near visitors' transit route and emergency departments.
- Place staff parking areas within close range of workplace.

- Provide adequate and effective lighting.
- Facilitate appropriate routing of patients.
- Provide spacious and quiet reception areas, with sufficient space for personnel.
- Provide public toilets.
- Choose the colours that do not encourage aggression.
- Allow observation of reception areas by staff.
- Reduce boredom by providing activities (e.g. reading materials, television).
- Choose furniture, fixtures and fittings that cannot be used as weapons. Pens, stethoscopes, cords and chairs can become dangerous in incidents of violence.
- Climate control.
- Install duress alarm systems at appropriate locations.
- Separate treatment rooms from public areas.
- Provide appropriate communication equipment for staff.
- Screen incomers through metal detectors.

Staff Competence

Inadequate training has been identified as a contributing factor to the prevalence of assaults and, in fact, three studies have shown that training in management of assaultive behaviour can reduce injury from assault.

Attitudes are important in dealing with violence. The nurses' tendency to blame themselves for such incidents must be eliminated. Nurses must openly recognise that violence and harassment are intolerable in the workplace and no longer accept such incidents. An attitude of zero tolerance is essential if sound policies are to be developed and conscientiously implemented. A comprehensive educational programme would, therefore, include:

- Level of risk based upon historical data.
- Legal and ethical rights and responsibilities of workers and management.
- Employer's policy and procedures related to aggressive patients (i.e. prevention, management and follow-up).
- Medical/psychiatric/social causes of aggressive behaviour.
- Triggers that provoke violence in the health care setting.
- The assault cycle.
- Recognition of impending violence.
- Techniques to interrupt escalating violent behaviour.
- Techniques of conflict resolution.
- Communication skills, including assertiveness training and debriefing skills.
- Techniques of medical and physical restraint.
- Post-incident management and analysis.

More detailed information on effective strategies to reduce workplace violence in the health sector is provided in the Framework Guidelines for Addressing Workplace Violence in the Health Sector (see www.icn.ch/sewworkplace.htm#Framework). An accompanying training manual is also available free of charge at www.icn.ch/SEW_training_manual.pdf.

National Nurses Association Position

National nurses' associations (NNAs) must address their members' concerns and promote policies that will ensure the attainment of nurses' professional and personal goals and permit them to practise their profession in a safe work environment. The formal and informal positions taken by the NNA and its leadership will have a major impact on attitudes adopted by nurses,

colleagues, employers, legislators and the general public.

The NNA through its various programmes can provide:

- A position statement on abuse and violence against nursing personnel (see www.icn.ch/psviolence00.htm).
- Raise awareness of the issues involved: nursing community, health sector personnel, authorities, public, etc.
- Guidelines on Coping with Violence in the Workplace (www.icn.ch/guide_violence.pdf).
- Immediate as well as follow-up individualised accompaniment or support on-site and during the various reporting/compensation claim procedures.
- Public education on violence prevention.
- Assistance in creating a supportive nursing culture that does not perpetuate the tendency for nurses to blame themselves for incidents of violence.
- Consultation on nursing curricula to foster positive nursing images and respect for nurses' rights to dignity and personal safety.
- Continuing education programmes on violence and its management.
- Bibliographies on the subject of violence.
- Counselling services for members who are victims of violence (emotional, physical, legal).
- Counselling services for members who display violent behaviour (emotional, physical, legal).
- Statistical and anecdotal support for development of sound policies against violence.
- Lobbying/networking support for policies against violence.

- Safeguarding nurses' rights to a safe work environment.
- Assisting in development of work methods that provide quality care, maintain adequate staffing levels and promote safe patterns of behaviour.

CONFRONTING VIOLENCE

Supported by the research previously mentioned, various points can be highlighted:

- Violence in society is an increasing problem.
- Health personnel in general and nursing personnel in particular are victims of abuse and violence in the workplace.
- Nurses have responded in various ways to incidents of violence and with varying degrees of success.
- Violence is highly destructive and has a negative impact not only on the professional and personal lives of nurses but also on the quality of care provided.

Once violence in the workplace is identified as a nurses' concern and a professional issue, NNAs need to develop appropriate strategies to eliminate, or at least reduce, such incidents. The following steps are recommended as an approach to be used to confront the mounting abuse and violence experienced by nursing personnel in their work environment.

1. Identify Risk Behaviours and Environmental Triggers

The identified risk factors associated with violent behaviour are:

- history of assaultive or violent behaviour; diagnosis of dementia;

- intoxication from drugs or alcohol;
- characteristics of the environment or the treatment itself.

Full information on these risk factors must be disseminated to all persons likely to be involved in incidents of violence and those responsible for staff at risk.

2. Take preventive measures to reduce/eliminate risk factors

Once the risk factors are identified, strategies to reduce/eliminate them from the work environment must be developed, adopted and implemented. While the exact role of the NNA will depend on the parties directly concerned, the association must above all be the advocate for nurses and defend their right to a safe workplace. Negotiating the introduction and maintenance of appropriate safe work methods, security measures and confidential grievance machinery in the work environment is a basic response to nurses' concerns with regard to violence.

NNAs must meet with officials of the pertinent employing groups and national health and other organizations to voice nurses' concerns and seek their assistance in providing an atmosphere that does not tolerate disrespectful behaviour towards nurses and other healthcare workers.

3. Apply incident management mechanisms if and when violence occurs

To help members when involved in incidents of violence, the NNA must ensure that they are aware of the issues and competent in violence management techniques through courses in their basic training and continuing education programmes.

4. Guarantee access of all involved to effective support structures

While the employer is responsible for effective support structures to staff victims of violence, the NNA can act as a pressure group to introduce or revise such services at the workplace. If no services are available, the NNA must develop mechanisms within its own infrastructure to address members' needs, including one-to-one supportive interventions immediately after the incident of violence. As interviews are often traumatic, accompaniment throughout the reporting procedures (e.g. health unit, police) is necessary. The shock of the incident is often progressively felt over the following days.

If NNA resources permit, a lawyer can be employed to give helpful orientation and legal support. If this is not possible, the association can build cooperative ties with voluntary women's groups dedicated to dealing with these issues (e.g. rape centres), lawyers' professional associations or law schools that provide the services of final-year students.

If a nurse is the perpetrator of a violent act, the association must provide counselling and support services of a different nature.

5. Keep reliable records

Statistical support for the identification of risk factors, analysis of trends, development of effective preventive strategies and evaluation of these measures is of major importance. The NNA may choose to initiate such studies, cooperate with other groups, verify the data collected and/or participate in the analysis and policy development.

6. Evaluate violent incidents and their management

The nurses involved – as well as the association and the employer – need to evaluate the management of violence and aggressive behaviour. Determining the continued applicability of policies and procedures is crucial to maintaining the relevance of current practice.

7. Develop appropriate recommendations on the basis of findings

Once the continued relevance and applicability of policies and procedures are determined, revisions and their justification must then be presented to all likely to be involved in incidents of violence, so that they can be integrated in behaviour codes.

SEXUAL HARASSMENT

Sexual harassment is considered to be a type of abuse or violence. It is now widely recognised that rape, the extreme form of sexual harassment, is motivated by a search for power and not sexual attraction. Most of the management techniques recommended for dealing with violence therefore apply for the management of sexual harassment.

Physical and emotional responses to sexual harassment and violence are very similar and both tend to embarrass and punish the victim when complaints are registered. Fear for the loss of employment is also experienced in both cases.

A clear definition of sexual harassment is needed as part of a prevention programme. And confidential grievance machinery is all the more necessary for processing these complaints. Educational programmes must be provided so that all staff members understand the policies, investigative procedures and disciplinary steps.

ICN's POSITION

The International Council of Nurses condemns all forms of abuse and violence against nursing personnel, including sexual harassment. Such incidents are considered to be violations of nurses' rights to personal dignity and integrity. Furthermore, violence in the health workplace threatens the delivery of effective patient services. If quality care is to be provided, nursing personnel must be ensured a safe work environment and respectful treatment.

Particular attention has been placed on the elimination of abuse and violence against nursing personnel, as they represent a category of workers considered most at risk. It must be stressed, however, that the International Council of Nurses strongly condemns such acts perpetrated against **any** category of health personnel, employed person or private citizen. (See www.icn.ch/psviolence00.htm).

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