Tougher Laws, Too Few Prosecutions? A Mixed Methods Study of Nurses' Experiences Regarding the Reporting of Occupational Violence to the Police

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Research paper

Tougher laws, too few prosecutions? A mixed methods study of nurses' experiences regarding the reporting of occupational violence to the police

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ABSTRACT

Problem: Assaults on nurses by patients are common. To deter occupational violence against nurses, assaults attract penalties of longer imprisonment in many jurisdictions (domestically and internationally). However, the deterrent value of harsher penalties has been questioned when many assaults are underreported.

Aim: To identify the barriers and enablers to the reporting and prosecution of assaults experienced by nurses.

Methods: In this study participants were recruited using a snowballing technique through health workforce emails, social media channels, and professional organisations. The investigator-developed survey prompted for categorical and open-ended responses. Descriptive and qualitative content analyses were used to analyse the study data.

Findings: Of the N = 275 respondents, n = 237 nurses had been assaulted at work. Assaulted nurses were typically female, over 31 years old, had more than five years of nursing experience, and worked in an emergency department. Overwhelmingly, nurses indicated receiving poor support when they wanted to report an assault to the police. Dominant themes (N = 6) identified systemic barriers that hinder criminal reporting, which was found to be a consequence of organisational and policing lapses, and self-limiting nursing culture.

Discussion: This study identified several barriers for nurses to report and prosecute assaultive patients in Australia. The barriers point to a strong imperative for organisations that employ nurses and police to fulfil their responsibilities to enable and support assaulted nurses to prosecute.

Conclusion: The study findings led to important recommendations for organisations and police to support, encourage, and empower nurses to prosecute assaultive patients, and ultimately deter violence.

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Summary of relevance
Problem or Issue
Nurses are vulnerable to physical violence perpetrated by patients.
What is already known
Tougher-sentencing laws exist in certain jurisdictions to protect nurses and deter violence. Assaultive patients can be subject to these laws.
Underreporting questions the value of these laws, but little is known about why nurses do not pursue criminal reporting of assaultive patients.
What this paper adds
Criminal underreporting is a systemic problem.
Criminal underreporting results from lapses of organisations, namely healthcare employers and police, to support and empower nurses to report.
Criminal underreporting is also a product of minimising attitudes held by nurses, particularly regarding experiencing assaults as being 'part of the job'.

1. Background

The magnitude and gravity of patient-perpetrated (classified as type-II violence) occupational violence (OV) against nurses are widely recognised. In this paper, the focus is on physical OV or assault, representing about 20% of OV experienced by nurses (Li, Li, Qiu, & Xiao, 2020). Nurses are commonly grabbed, hit, spat at, kicked, pushed, or punched by patients (Pich & Roche, 2020). Profound impacts of assault include physical injuries, permanent disability, post-traumatic stress disorder, anxiety, and depression. For healthcare services, there are economic losses from sick leave, compensation claims, and replacing sick or injured nurses (Lanctôt & Guay, 2014). Despite the pervasiveness and deleterious impacts of OV, it remains a global problem requiring systemic and other reforms (Aljohani et al., 2021; Liu et al., 2019).

Many nursing organisations have advocated for legislative changes to afford nurses better protection from OV and its harms (Australian College of Nursing, 2021; Canadian Nurses Association, & Canadian Federation of Nurses Unions, 2019; International Council of Nurses, 2017). These appeals are repeated more forcefully when horrific (Dillon, 2019; Robinson & Marchant, 2019; Thompson, 2019) and fatal assaults occur (American Nurses Association, 2022). The term 'assault' is generally defined (e.g., in section 245 of the *Criminal Code Act 1899* (Qld)) as the application of force to another person without their consent — or with their consent if it is obtained by fraud or duress. An assault can also be committed by way of a threat to apply force to another person without consent. Force can also be applied by light, heat, electricity, smell, gas, or any substance that will cause injury or personal discomfort.

Tougher-sentencing stances in relation to perpetration of OV, and physical assault more specifically, have been adopted in more recent times in the United Kingdom (Griffith, 2019), and in some jurisdictions in the United States of America (American Nurses Association, 2021) and Australia (Cabilan, 2021). Tougher sentencing pertains to the provision of harsher penalties, such as longer periods of imprisonment for convicted offenders (Bond, Porter, van Felius, & Mulholland, 2019). For example, in Queensland in Australia, under section 340 of the Criminal Code Act 1899 (Qld), serious assault — that includes assault of a health service employee (section 340(3)) — attracts a maximum penalty of 14 years imprisonment, whereas the lesser offence of common assault attracts a maximum penalty of three years imprisonment (section 335). The intention of tougher sentencing applying to health service employees is not only to deter patients from using violence, but also to reflect the vulnerability of health service employees to violence when providing care (State of Queensland, 2020b).

A successful criminal conviction of serious assault cannot be achieved unless a formal process is followed involving several agencies and authorities in the criminal justice system. In Australia, after a serious assault has been perpetrated by a patient in a healthcare setting, it is incumbent on the individual victim (e.g., nurse) to take action, such as reporting the assault to their employer and pursuing filing a complaint with police. Once a complaint has been received, Australian police investigate the facts and the available relevant evidence. If sufficient evidence is found to support a prosecution, the matter will be referred to the Department of Public Prosecutions where further assessment of the likelihood of a conviction on the facts and evidence takes place. If the patient is then charged and the matter proceeds to court, the patient is now an 'accused' and has the right to a fair trial and legal representation as well as the right to silence.

The onus of proof in such matters lies with the prosecution to establish beyond a reasonable doubt that the accused is guilty (e.g., section 13.1 of the Criminal Code Act 1995 (Cth). It is not the responsibility of the accused to establish their innocence. If there is insufficient evidence to establish the guilt of the accused, they will be found not guilty, and no further action is taken (unless the prosecution decides there are grounds to appeal that outcome). If the accused is found guilty, then sentencing occurs. The sentencing process is guided by the relevant legislation in terms of a maximum term of imprisonment.

Systemic underreporting of OV at the organisational level (Arnetz et al., 2015; Hogarth, Beattie, & Morphet, 2016; Partridge & Affleck, 2017; Stene, Larson, Levy, & Dohlman, 2015) is recognised, with recent literature explaining some of the barriers to reporting and providing recommendations to improve incident reporting to employers (Christensen & Wilson, 2022). However, less work has explored the barriers (or enablers) of the reporting and pursuit of incidents of OV as criminal matters (Niu et al., 2019). To fill this knowledge gap, we conducted a study to gain understanding of the extent of underreporting of OV both organisationally, as well as a criminal offence, and in order to determine factors that influence nurses' decisions about reporting OV as a criminal offence. This understanding could be used to influence the development and expansion of support systems for nurses in terms of understanding their legal options and having the capacity to navigate the legal system, to improve the reporting rates of assaults by nurses against patients, to enhance community understanding that assaults on nurses are serious and attract significant penalties, and so ultimately to help deter OV in hospitals and other healthcare settings.

2. Methods

2.1. Study design

A mixed methods design study was conducted involving nurses from a range of healthcare contexts across Australia. The study herein was guided by Good Reporting of A Mixed Methods Study (O'Cathain, Murphy, & Nicholl, 2008).

2.2. Ethics

The study was approved by Metro South Research Ethics (HREC/2021/QMS/76933) on August 25, 2021.

2.3. Recruitment

Participants were registered nurses, enrolled nurses, assistants-in-nursing, and student nurses who self-report being physically assaulted in the workplace by patients or visitors. Nurses were ineligible for the study if they have not directly experienced physical

assault. Physical assault was taken as including the application (or threat of application) of force without a person's consent in the form of punching, biting, slapping, stabbing, spitting, being thrown object/s or weapon/s at, kicking, strangling, sexual assault, or any form of physical attack or threat.

Nurses were recruited using a snowballing technique through health workforce emails (e.g., Metro South Health), social media channels (e.g., The Nurse Break), and professional organisations (e.g., Australian College of Nursing, College of Emergency Nursing Australasia). Invitations were sent twice — initial contact, then a reminder three weeks later. Nurses were sent participant information electronically that linked to an online survey (Supplement 1), with implied consent on completion of the survey.

2.4. Data collection

An anonymous, online survey was specifically created for the study. Face validity was established using a cross-section of purposively sampled nurses (i.e., graduate nurses, experienced nurses — both male and female) who were briefed about the aims and goals of the study and then shown the survey and asked if the survey 'looks like' (face) it measures what it was supposed to measure (experiences of the OV reporting to police and of the legal system). Suggested changes were incorporated in the final version (Supplement 1) that was distributed for six months, from December 2021 to June 30, 2022.

2.5. Data analysis

Descriptive statistics (frequency and percentage) were used to aggregate quantitative responses. For the free-text data, the qualitative content analysis technique (Hsieh & Shannon, 2005) was used to understand barriers and enablers for nurses in reporting assaults and subsequently navigating the legal system. The primary investigator (CJC) took an advocacy stance in favour of nurses as victims of assault. In this analysis, nurses were not merely viewed as care providers, but viewed as citizens in a community. Patients were treated as autonomous citizens who can be held accountable for assaulting nurses.

The content analysis was a multi-step process. First, all responses were read to gain an overarching understanding of the nature and focus of responses (ChJ). Second, preliminary keywords were identified from the responses and the number of times the keywords appeared or were referred to, were summated, and presented as counts (ChJ and CJC). Third, a conformity process was used to discuss appropriateness of the keywords or reconcile conflicting perspectives between all investigators. Fourth, finalisation of keywords was complete and free-text data were quoted to illustrate contexts in which the keywords appeared.

3. Findings

3.1. Study population characteristics

There were N = 274 responses, and of these, n = 237 (86.5%) were assaulted by patients (n = 227) or visitors (n = 10) while at work (referred to as assaulted nurses herein forward). Assaulted nurses were typically female, over the age of 31 (74.25%), had more than five years of nursing experience (72.15%), and worked in an emergency department (62.71%). Nearly half (44.30%) of the respondents were practicing in the state of Queensland (see Table 1).

Assaults involved being punched, hit, struck, thrown at with objects or body fluids, kicked, grabbed, spat on, threatened, pushed, slapped, strangled, scratched, bitten, or sexually assaulted. Many reported to have experienced more than one form of assault (n = 80, 35.87%).

Of the 237 assaulted nurses, 27% (n = 64) filed a police complaint. Of those complaints, about half (n = 31, 48.44%) led to formal charges. Then of those that were formally charged, 67.74% (n = 21), were referred to court: magistrate or local court (n = 14), district (n = 2), and unsure (n = 5). Two participants were unsure of the charges, but those who responded indicated the following charges: assault (n = 5), common assault (n = 3), assault of a public officer (n = 2), aggravated assault (n = 2), minor assault (n = 1), and assault-occasioning harm (n = 1). Eighteen (85.71%) of these charges were guilty. The penalties varied from fine, suspended sentence, community service, or imprisonment.

Table 1
Study population characteristics (N = 237).

	n	%
Gender		
Female	200	84.39%
Male	35	14.77%
Intersex	1	0.42%
Prefer not to say	1	0.42%
Age group		
20 and below	2	0.84%
21–30	59	24.89%
31–40	74	31.22%
41–50	58	24.47%
51–60	38	16.03%
61–70	6	2.53%
Total years of nursing experience		
0–2	32	13.50%
3–5	34	14.35%
6–10	48	20.25%
11–15	41	17.30%
16+	82	34.60%
Clinical area of practice		
Emergency Department	151	63.71%
General Medicine	25	10.55%
Mental Health	17	7.17%
Aged Care Services	10	4.22%
Intensive Care Unit or Critical Care Unit	8	3.38%
General Surgery	7	2.95%
Primary Care and Community Health	3	1.27%
Perioperative Services	3	1.27%
*Other — combined	13	5.48%
Australian State or Territory of practice		
ACT	4	1.69%
NSW	26	10.97%
NT	10	4.22%
QLD	105	44.30%
SA	17	7.17%
TAS	11	4.64%
VIC	35	14.77%
WA	29	12.24%

3.2. Themes

Generally, nurses' ratings of the support they received from their employers and police were poor (Supplement 2). The ratings were accompanied with narratives, which predominantly detailed nurses' difficulties with the hospital management and police services. There were 326 narrative statements from N = 237 nurses, which generated six themes and sub-themes. Each of these themes are described below with illustrative quotes (Table 2).

3.2.1. Theme 1: nurses were deprived of the opportunity, information, and time to allow for criminal reporting

Following an assault, data indicated three important factors would have enabled nurses to report: opportunity, information, and time. However, nurses' experiences revealed both organisational and police lapses that deprived them of these enablers, consequently hindering reporting of OV as a criminal offence.

3.2.1.1. Opportunity. At the organisational level, the opportunity to report is taken away from the nurse by way of dissuasion or coercion (presumably by organisational leaders):

Table 2
Six themes arising from N = 326 narratives.

Themes (in order of frequency)	N	Additional supporting quotes
1. Nurses were deprived of the opportunity, information, and time to allow for criminal reporting	131	
a. Deprivation of opportunity		"My employer encouraged me not to do so. They also encouraged me not to fill out any sort of incident form." P2 "Reflecting on what colleagues have raised with me. They have felt that it is unfair that if assaulted and wish to proceed with lodging a complaint with Queensland Police Service, they were advised they would be redeployed to another ward." P8
a. Deprivation of information		"I needed the mental health clinicians who reviewed the patient to make a statement as per the police about the patient's mental health status, but they refused and so without that statement I wasn't allowed to press charges, something I really wanted to do." P178
a. Deprivation of time		"I don't want to pursue legal charges outside my work time and I don't have the time at work due to workloads." P42
2. Patient's mental capacity clouded culpability	86	"Not confident that police would take action. Not confident that any legal proceedings would have a helpful outcome because I work in Mental Health and the person's 'state of mind/ diagnosis' would be used as a reason to dismiss the assault/behaviour." -P3 "Previous experience with this person and often police are called and they are removed although no obvious action taken. The reason we are often told was that it's difficult to 'do anything' as they have a large mental health history." P144
3. Violence perpetrated by patients as part of the job is deeply ingrained in the nursing culture	50	"I felt guilty for going to the police as I felt I was wrong for possibly getting her in trouble with the law, and hence took a lot of encouragement from my colleagues to go to the police. I was re-assured by colleagues that if I was to go to the patient's workplace and yell abusive language at them, swing my bag to hit them and shove them, I would be in trouble with the law, so why is it any different when it is done to a health care professional? This made me reflect and realise that as health care professionals, we put up with a lot of abuse." P229
4. Dearth of follow-up and updates from police	24	"I did not hear from the police after the day I made the statement and I fear my complaint was lost to follow up. I would have liked to know the outcome of my complaint. … In the absence of any follow up from the police I don't think the person was charged. I called the police station several times, but I did not receive a call back from the investigating officer." P197
5. Assault did not meet the perceived criteria of seriousness or severity	21	"I didn't think that it was worth reporting it to the police as there was no visible harm done to me." P181
6. Victim (nurse) blaming shifted culpability from patients	14	"I was also blamed and asked what I could have done differently to avoid the situation." — P209 "They [employer] do nothing and ask what could nurses do better to support patient." P176

"I felt like the decision was taken away from me and my management didn't do anything in support of me. I felt alone and unsupported in my decision from management in both departments." P178

Suggestive of coercion, there was underlying fear among assaulted nurses that their job would be compromised if they pursued legal action:

"Hospitals I have worked in wish to preview any statement given to police and have the right to change facts or stop proceeding especially if there are any things which would put the hospital in a negative light. One person I know was reprimanded for giving a police statement about an assault as they had not consulted management first." P206

When assaults were eventually escalated to the police, assaulted nurses were again likely coerced or discouraged not to report:

"I did not pursue charges as pressure from police to drop charges and no further support from my department in doing so." P175

"When [Police] was called - I was told that report and charges wouldn't progress, so it wasn't worth the hassle to pursue." P272

3.2.1.2. Information. Nurses were lacking three important pieces of information to fulfil reporting OV as a criminal offence. First, nurses were unclear what constitutes an assault:

"Make it know[n] that we can fill police reports. I did not realise that a patient throwing objects could be classed as assault." P190

Second, nurses were unaware that they could file police reports against assaultive patients:

"It would be nice to have a liaison police officer come to a staff meeting and explain what is lawful/not lawful, and what a person can be charged for. Or even a resource to refer to about the process of making a complaint and how things work/will work." P3

Third, nurses did not have sufficient evidence to support their police statements:

"According to the policeman my supervisor during the event refused to give evidence to support me and management from the facility would not provide video footage to the police without a subpoena." P7

"They actually advised me that charges were very unlikely to proceed as the video footage was inconclusive, so it was my word against the patient." P89

3.2.1.3. Time. Reporting OV as a criminal offence requires accurate recall and clear and thorough documentation of events. As a result, the collection of sufficient evidence to support an accusation of OV as a criminal offence requires significant time and effort. One nurse estimated that criminal reporting and court time would take "40+ hours over 8 years" (P66). It was clear that nurses would like to fulfil reporting and the associated legal obligations as paid time. However, time was scarce due to their workload, or they were not allowed dedicated time for that task by their employer:

"Protected time off the floor to do this, or time in lieu, or paid 'traumatic leave'. I felt awkward asking for paid leave for my time attending court or submitting my impact statement and original statement. I also had to 'prove' to workforce services I needed MH [mental health] days off, after being punched in the face. That was a joke." P100

3.2.2. Theme 2: patient's mental capacity clouded culpability

Assaulted nurses presumed that patients who have reduced mental capacity rendered criminal reporting of OV incident as futile.

Patients who were intoxicated, have delirium, or mental illness were thought not to be culpable for their actions:

"I also just assumed that the patient was in hospital receiving care and was intoxicated, so you just accept it, at least this is what I have been told" P164

"In the latest incident for example the patient was elderly, acutely, mentally unwell and had underlying medical conditions that meant she lacks the capacity to have intent to hurt - she was reacting instinctively, out of fear and frustration." P107

In some cases, organisational leaders used the mental capacity defence to dissuade reporting:

"Was talked into not doing a report due to the patient being in there for mental health reasons. The patient was not drug affected or psychotic." P70

Nurses' historical interactions with the police on similar incidents can preclude reporting. Below, a nurse narrates that no legal action was taken for a repeat offender with mental illness:

"The patient was well known to police. After lodging a complaint, I received a phone call on a Sunday from an officer informing me that she had recently been to court and determined to be 'permanently unfit for trial' due to mental incapacity. I was informed that I could pursue it but that it would be unlikely to result in any action. The officer recommended I withdraw the complaint. He arranged to visit the patient at home and have a stern word with her. I was happy with this outcome as I wanted the patient to understand that her actions came with consequences, no matter how this occurred. I was grateful that the officer took the time to follow up with me and explain the complex nature of this situation." P79

3.2.3. Theme 3: violence perpetrated by patients as 'part of the job' is deeply ingrained in the nursing culture

Generally, the default attitude of assaulted nurses was that OV was part of their job. It was also suggested that OV has been a longstanding, frequent occurrence in health care, so OV incidents tend to be trivialised:

"Because I tend to special these patients, this is just what I expect every day when I walk into work. When I was kicked, I was trying to help a patient who had soiled herself and had been sitting in it for a while. You get to the point where you begin to question if it was your fault for them assaulting you, and whether if you hadn't done your job at that point, if this incident would have never occurred." P125

This workplace culture perpetuates a norm that assaults by patients are acceptable and inconsequential, and therefore, they are not reportable:

"Because as bad as it is to say this, this sort of treatment from patients happens often and no one reports it. There's this sort of culture that you just move on and get over it. We Riskman [incident reporting platform] things and joke about it and that's about it. Nothing gets done. I also feel like it's insignificant, I have been physically and sexually assaulted a few times over the last year but not reported to police as I feel like I'm wasting time and resources and my claim isn't important enough." P110

Further, the 'part of the job' attitude permeated among organisational leaders, where it resulted in assaults and their detrimental impacts being diminished:

"I was told to return to work as soon as I regained consciousness. I was not assessed or sent to ED to be checked by a doctor. I was told to return to work where I had to look after the same patient because 'there aren't enough staff to replace you, and this is part of nursing. You need to toughen up. There is only 4hours h left of your shift. Then you can go home and sleep it off'." P30

3.2.4. Theme 4: dearth of follow-up and updates from police

Assaulted nurses who eventually reported incidents to the police expressed their frustrations at the lack of communication from police officers after receiving the report:

"Police were good in terms of taking the statement - unfortunately they were not good in keeping me up to date with outcomes - I needed to keep chasing this myself." P50

Being unaware of the outcome of their report, led one nurse to believe that the act of reporting was futile. As illustrated in this quote, a nurse eventually became resigned to the notion that the report did not result in a charge, with the perpetrator therefore avoiding prosecution:

"I did not hear from the police after the day I made the statement and I fear my complaint was lost to follow up. I would have liked to know the outcome of my complaint. … In the absence of any follow up from the police I don't think the person was charged. I called the police station several times, but I did not receive a call back from the investigating officer." P197

3.2.5. Theme 5: assault did not meet the nurses' perceived criteria of seriousness or severity

The narratives of this theme implied that for assaults to warrant legal attention, they would have to cause significant or serious physical injury/ies. Otherwise, assaults were left unreported as suggested by these participants:

"I have never had a serious injury - only bruising or scratching. If I had an injury that caused me severe injury, or impacted my ability to work etc, that would be different." P107

3.2.6. Theme 6: victim (nurse) blaming shifted culpability from patients

Assaulted nurses recalled instances of victim-blaming that essentially shifted the culpability of the assault from the patient to the nurse:

"I was told that it was my fault for not recognising the patient had deteriorated and needed diazepam." — P38

The consequences of victim-blaming on reporting incidents of OV as criminal offences were nuanced from the narratives. Victim-blaming was invalidating, and voided the support required by assaulted nurses to pursue prosecution:

"There was no follow up from the employer except to tell me I should not have gone near the patient on my own - effectively victim blaming, even though my actions were clinically appropriate at the time, and I would do the same again tomorrow." — P27

4. Discussion

In this mixed methods study among nurses in Australia, we found that over 86% of respondents were victims of physical assault perpetrated by patients. Despite that these assaults were punishable by law in all Australian jurisdictions, and subject to tougher sentencing in some cases, the rate of reporting of OV as a criminal offence was low (27%). Study data bring into question the current management of OV through to legal prosecution in healthcare settings. However, it needs to be noted that almost 50% of police reports resulted in formal charges. Then, 68% of charges led to prosecutions, with 86% judged as guilty.

Some study findings overlap with existing understandings of the barriers to reporting verbal or physical OV incidents in health

settings. Similarities include fear of job compromise, OV as a typical part of nursing, a perception of a lack of seriousness or severity of incidents, and victim-blaming (Christensen & Wilson, 2022). Specifically in the context of underreporting OV incidents as criminal matters, our findings concur with studies (Ramacciati, Ceccagnoli, & Addey, 2015; Wolf, Delao, & Perhats, 2014) that previously identified inadequacies in the health and justice systems.

Our findings also suggest that, many times, nurses would have been willing to pursue legal action against patients, but they were discouraged, or were unsupported to report by their employers and the police. Under the *Australian* Work Health and Safety Act 2011 (Cth), employers could be breaching their duties to report notifiable incidents and not engage in discriminatory or coercive conduct when nurses raise work health and safety issues. As for the police service, they could be breaching their Code of Conduct that requires impartiality, fairness, and respect (Australian Federal Police, 2022). These findings shed light on some of the structural factors that influence underreporting of OV in healthcare settings; reinforcing the need for reform in health services, law enforcement, and the criminal justice system so that nurses can be better protected from OV risks.

Further, attitudes and perceptions were observed as, in part, restricting the ability of nurses to pursue legal action. Resonating dominantly among assaulted nurses, and reinforced by organisational management and law enforcement, was the notion that patients who were intoxicated, delirious, or experiencing a mental illness would not satisfy the requirement of a guilty mind (*mens rea*) required for conviction of a criminal offence.

It is understandably challenging to navigate the issues of voluntariness in health services, especially in emergency departments where patients might be admitted involuntarily with such conditions (Tosswill, Cabilan, Learmont, & Taurima, 2023). There are no easy answers to this dilemma, but professional education could be offered relating to the prosecution of patients with reduced mental capacity. It is important to note that voluntary intoxication does not exempt the individual from criminal intent, and every person is to be presumed of sound mind unless proven otherwise (see *Australian* Criminal Code Act 1995 (Cth)).

Another self-limiting attitude that assaulted nurses reported, and perhaps the general nursing population holds, is that the experience of violence from patients is simply 'part of the job'. Care of assaultive patients may have detrimental consequences for a nurse; however, an absence of care could be potentially detrimental to the patient and public, and also to the nurse in terms of their failing to fulfil their work responsibilities and obligations (Dunsford, 2022). With their duty of care to the patient foremost in their thinking, nurses are indoctrinated into a workplace culture that considers patient-perpetrated violence as an anticipated aspect of nursing (Jacob, Van Vuuren, Kinsman, & Spelten, 2022).

Further, it appears that nurses are willing to deprioritise their own safety to fulfil their duty of care, even when patients are assaultive (Beattie, Innes, Griffiths, & Morphet, 2020). Notably, in the care of patients who are "not in control of what they are doing due to illness" (i.e., dementia, psychosis) (Beattie et al., 2020, p.E19). However, this 'part of the job' attitude should not be used to dismiss nurses' experiences of OV, nor excuse indifference or complacency towards OV (Christensen & Wilson, 2022; Edward, Ousey, Warelow, & Lui, 2014; Wolf, Delao, & Perhats, 2014). Rather, it should be used to recognise the risks nurses are prepared to take to provide quality patient care. With this knowledge, organisations that employ nurses need to fulfil their responsibility to provide nurses with resources and means to safely care for assaultive patients. This includes opportunity, information, and time needed to pursue prosecution of assaultive patients when nurses experience OV.

Assaulted nurses in this study also reported that reporting and prosecution of assaultive patients are unnecessary because they perceived their injuries to be insignificant or not severe enough to warrant reporting or prosecution. This perception appears to stem from knowledge gaps that could be remedied with disseminating more accurate information (such as through social media or poster campaigns).

The final barrier to reporting of OV by nurses identified in this study was victim-blaming, which is unfortunately a recurring theme in the profession (Christensen & Wilson, 2022). Study data identified apportioning blame to assaulted nurses as silencing, and as being used to rid health organisations of the appropriate responsibility to support nurses. Both the health and legal systems must therefore be aware of the issue of victim-blaming and work to raise awareness to address it.

5. Recommendations

The study findings suggest that underreporting of OV by nurses in the criminal justice system is systemic and results from an interplay of organisational and cultural factors. The study recommendations include the need for organisations, health services, and law enforcement to have accessible information regarding what constitutes assault and appropriate pathways to pursue complaints when an assault is committed. Organisations should also enable nurses to take paid leave to fulfil the requirements of reporting OV as a crime and the duties required for prosecution.

Cultural factors identified in the study were associated with nurses' attitudes. Educational and awareness-raising approaches could be developed to challenge these attitudes and encourage a shift to accepting that the perpetration of OV against nurses is wrong. Although education is not the ultimate answer, it is a starting point that can work to empower nurses to make decisions about the unacceptability and criminality of assault. Further, recognising the weight nurses place on their duty of care to patients, organisational policies could help delineate the boundaries or limits of the duty of care (i.e., Behaviour Contracts, Not Welcome Notices) (Forster, Petty, Schleiger, & Walters, 2005).

6. Limitations

The study findings need to be viewed in the context of several limitations. First, recruitment method may exclude those who sporadically monitor their emails or social media accounts and nurses who do not have professional memberships. Second, place of work during the study may not necessarily reflect where the incident occurred. Third, participants may have recollected and described their experiences from different incidents. However, what the data highlight would be the consistent lack of support offered to assaulted nurses. Fourth, was that assaulted nurses established belief that it was just 'part of the job', and perceived insignificance of the assault, might be less inclined to participate. The final limitation would be the external validity of this study as it depicted the Australian setting.

7. Conclusion

There are several barriers for nurses in reporting OV to the criminal justice system in Australia, which included organisational, policing, and nursing cultural factors. Each of these factors needs to be addressed to rectify the underuse of the criminal justice system in holding assaultive patients to account. Support, encouragement, and empowerment of nurses are essential to prosecute assaultive patients, and ultimately deter OV.

CRediT authorship contribution statement

C.J. Cabilan: Conceptualization, Methodology, Data curation, Validation, Analysis, Writing – original draft, Writing – review & editing, Project administration, Funding acquisition. **Chantelle Judge:** Data curation, Validation, Analysis, Writing – original draft. **Rachael Field:** Writing – original draft, Writing – review & editing.

Rob Eley: Conceptualization, Methodology, Writing – review & editing. **Amy N.B. Johnston:** Conceptualization, Methodology, Writing – review & editing, Funding acquisition.

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Ethical statement

The study was approved by Metro South Research Ethics (HREC/2021/QMS/76933) on August 25, 2021.

Conflict of interest

The authors have no conflicts of interest to declare.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.colegn.2023.08.003.

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