

## ORIGINAL RESEARCH

# Voices from the bush: remote area nurses prioritise hazards that contribute to violence in their workplace

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## ABSTRACT

**Introduction:** Remote Area Nurses (RANs) in Australia frequently encounter hazards that contribute to violence in the work place. Resources to deal with this problem are limited.

**Methods:** Adopting a risk management approach and using the Delphi method, a panel of expert RANs ( $n=10$ ) from geographically diverse communities across Australia, identified and prioritised hazards that increase the risk of violence to nurses.

**Results:** This descriptive study found that RANs encounter a wide variety of hazards from a variety of sources. Environmental hazards are complicated by living in remote areas and practicing in different locations. Relationships between the nurse and the community can be complex and lack of experience and organisational support may contribute to an increased risk of violence. Hazards prioritised as 'major' or 'extreme' risks included: clinic maintenance and security features, attending to patients at staff residences, RAN inexperience and lack of knowledge about the community, as well as intoxicated clients with mental health issues. A work culture that accepts verbal abuse as 'part of the job' was identified as a significant organisational risk to RANs. A lack of action from management when hazards are identified by clinic staff and insufficient recognition of the risk of violence by employers were also significant hazards.

**Conclusions:** Further consideration of the hazards described in this study following the risk management process, may provide opportunities to reduce the risk of violence towards RANs. Proposed control measures should be developed in consultation with RANs and the remote communities they work in.

**Key words:** Delphi, occupational violence, remote area nursing, risk assessment, safety.



## Introduction

Remote Area Nurses (RANs) work in the most geographically isolated parts of Australia, in predominantly Indigenous communities<sup>1</sup>. These communities are typically the most socially disadvantaged and 'health poor' people in Australia<sup>2-4</sup>. In addition, these communities often experience high levels of violence<sup>5</sup>.

Remote Area Nurses are mostly women<sup>1</sup>, sometimes work alone and are almost universally required to provide after-hours medical assistance<sup>6,7</sup>. Remote Area Nurses are members of small teams, often working with Aboriginal health workers and off-site GPs. They work in Aboriginal communities, mining, farming and tourism communities and off-shore Islands. The scope and variety of locations of practice, creates situations of increased risk of violence unique to remote area nursing<sup>4</sup>. This risk is greatly enhanced by the typically solitary nature of the work and lack of support resources within the community<sup>5</sup>.

Although much has been written about the phenomenon of occupational violence and nursing, literature specific to RANs is scarce. The seminal work by Fisher et al in 1995<sup>8</sup> and follow-up study by Opie et al<sup>9</sup> point to an increase in violence towards RANs over the previous 13 years. Two-thirds of the nurses in the follow-up study reported concern for their personal safety. Violent incidents included verbal aggression and obscene behaviour, property damage, physical violence, sexual harassment/abuse, telephone threats and stalking<sup>6</sup>. Violence is cited as a significant stressor for RANs and is a contributing factor to the frequency of staff turnover in remote areas<sup>5</sup>. Evidence highlights that the retention of experienced RANs provides benefits in terms of patient and community outcomes through continuity of service, and that it is fiscally beneficial to all<sup>10</sup>. Therefore, addressing the issue of violence towards RANs benefits not only the nurses themselves, but also the health of the community.

Australian occupational health and safety legislation states that employers have a responsibility to provide a safe workplace for their employees<sup>11,12</sup>. However, many RANs feel under-prepared to deal with issues of violence and some have felt unsupported by their employer following a violent incident<sup>6</sup>. Understanding how to assess, estimate and evaluate the risk of violence in a variety of settings is vital to safe practice<sup>13</sup>.

A risk management approach which encompasses the overall process of hazard identification, risk assessment, developing control measures, implementation and evaluation, is commonly used as a framework to systematically address the issue of occupational violence<sup>6,14-16</sup>. Determining appropriate measures to manage the risk of violence must begin with the hazards identified by the risk assessment as the highest priority<sup>14</sup>. The role of the four main characters in a violent incident should be explored, namely: environment, nurse, client and organisation<sup>17</sup>. For the purposes of this study: 'environment' refers to the physical practice environment, for example the clinic; 'nurse' refers to the RAN; 'client' could be either the patient or bystander and may be more than one person; and the 'organisation' refers to the external structure within which the nurse is practising and includes the employing organisation and the community.

The purpose of this study was to identify and describe hazards within the RAN workplace from the perspective of experienced RANs. The viewpoint from experienced RANs has not been documented previously, despite the detailed and specialist insight it can provide.

## Methods

This article describes part of the results of a Delphi study that was conducted in the second half of 2010<sup>18</sup>. The aim of the study was to facilitate consensus among expert RANs about the identification and priority of hazards following a risk management approach. Suggestions for addressing these hazards were also identified and will be reported elsewhere. The Delphi method entails several rounds of questionnaires



which progressively refine knowledge and opinion and aims to reach consensus from the participants<sup>19</sup>. This study involved three rounds.

Thirty-two potential panel members were identified by the researcher and a respected academic in the field of Australian remote health practice. Panel nomination was based on extended length of practice as a RAN, geographical representation and active involvement in the RAN community. Elected state representatives of the Council of Remote Area Nurses Australia and health centre managers were also included.

Ten RANs who had been nominated agreed to form the expert panel. A single representative from the states Western Australia, Tasmania, Queensland and South Australia, along with six RANs from the Northern Territory made up the panel. Eight participants were government employees. Eight were female. The average length of time spent working as a RAN was 13.2 years (range 4–25 years) although this increased to 16.7 years (range 4–30 years) when duration of time spent involved in remote health issues, including management and education, were also considered.

Both email and an online survey were the mediums of data collection. This provided low-cost access to the RAN population distributed across Australia's remote regions.

Three rounds were conducted with all questionnaires pilot tested prior to survey. The first and third rounds consisted of open-ended questions and were completed via email. In the first round, the panel was asked to consider two broad questions: 'What is it about Remote Area Nursing that contributes to violent incidents?' and 'What can be done about it?', as a stimulus for generating a list of potential hazards. Content analysis of the data from the open-ended questions facilitated the emergence of themes<sup>20</sup>. A literature search was then conducted based on these themes and some additional items were added for panel consideration. These items were summarised and reduced in consultation with the research team to 125 hazard items.

The hazard items formed the basis of the second round online survey which required the panel to prioritise the hazard items by way of a five-point Likert scale ranging from 'not a hazard' to 'extreme hazard'. Data analysis weighted the Likert scale in an ordinal manner and then calculated the mean for each item. Mean values were calculated as follows: Not a hazard=0; Minor Hazard=1; Moderate Hazard=2; Major Hazard=3; Extreme Hazard=4. The items with the highest mean represented the greatest hazard. Results were then assessed for consensus among the panel with a 70% level of agreement indicating consensus<sup>19</sup>.

The third round sought clarification of several issues identified in the preceding two rounds. This article focuses primarily on the results from rounds one and two. One question, however, asked in round three is directly relevant to this article: 'How is information about community members with a history of violence passed on from one health provider to another?'

Presentation of the data to the panel and provision for comments at each stage of data collection, increased the validity of data analysis and increased the reliability of findings presented<sup>21</sup>. The first author followed a process of 'bracketing' to identify bias that may be present as a result of her previous experience as an RAN<sup>21</sup>.

### *Ethics approval*

Ethics approval was provided by Edith Cowan University, Human Ethics Committee (#5364) and anonymity of panel respondents was maintained throughout the research process<sup>22,23</sup>. All participants gave informed consent.

## Results

### *Round one: open-ended questions*

The panel identified a large number of hazards in the practice of remote area nursing. These items were sorted and



classified according to the characteristics of violence, namely: the environment; the nurse; the client; and the organisation (including community) in which the interaction takes place. Items were further grouped according to similar themes that emerged during the analysis process

## **Round two: online survey**

The highest ranking hazards as identified by the panel in the online survey are shown, as is the percentage of panel members who rated the hazard as 'major' or 'extreme' (Table 1). The 'character' column (Table 1) indicates the hazards position within the sub-categories of nurse, client, environment and organisation.

### **Environment**

Environmental factors such as attending to patients in a RAN's private residence and inadequate security locks in the consulting area were considered the hazards of greatest risk to RANs. These were closely followed by only a single entry/exit, and poor security features of staff housing and inadequate security lighting.

### **Nurse**

Nursing attributes including lack of common sense, stress and burnout, poorly developed communication skills and inexperience were ranked as the top hazards for RANs. The panel discussed how long it took to be considered an 'experienced' RAN. They agreed that it took on average 4 years to reach this level, although some panel members recognised that experience is gained at different rates. Rigid personal beliefs were identified as evidence of a lack of cultural awareness or cultural safety preparation. As described by one panel member:

*Successful RANs are culturally safe practitioners. They have taken the trouble to see the health service from the community's point of view, learning and understanding the history and the attitudes involved. They also appreciate the*

*power they have by virtue of their position and profession...*  
(Panel member 08)

Tiredness and fatigue, particularly for nurses working in single nurse posts, was seen to:

*...contribute to nurses missing cues, and perhaps being less tolerant which could lead to clients being more aggressive.*  
(Panel member 03)

Inexperience in mental health assessment was also considered to be a significant hazard.

### **Client**

Intoxicated clients and those with a history of violence ranked 4th and 16th, respectively, as likely to contribute to RANs' risk. The dynamic nature of violence was also recognised by a panel member who stated:

*We need to be aware of the reasons people can be violent; intoxication,.. pain, frustration, biochemical derangement etc.* (Panel member 08)

### **Organisation**

Hazards that were perceived to be related to the employing organisation or community included the presence of an alcohol outlet within the community and a work culture that accepts violence as an unavoidable aspect of nursing practice. One panel member stated:

*There are situations tolerated by RANs, perhaps due to isolation or the Indigenous clientele that would never be tolerated in another workforce.* (Panel member 13)

Lack of understanding and action on the part of management in regard to violent incidents were also identified by the panel as significant hazards. Stories were told of hazards being identified to management and safety audits being completed



and then several years later, none of the recommendations had been actioned. One comment highlighted this point:

*In my experience policies around workplace violence do more to protect management than it does to protect staff on the ground.* (Panel member 03)

Responses from the panel pointed to lack of support within the community as a significant area of concern for RANs. Specifically, the panel stated their objection to single nurse posts and communities without a police presence on the grounds of increased risk of violence towards the RANs within those communities. Support within the community extended beyond the police and health service:

*...it is imperative that meaningful relationships are fostered with Aboriginal health workers, traditional healers, community leaders and...specific groups [such as the] women's group.* (Panel member 01)

## Round three – history of violence

Identifying community members with a history of violence was mentioned in the first round. The second round confirmed this history as increasing the risk posed by the client. However, it was not known how this information was passed between health staff, particularly new or relieving staff.

The panel stated that this information was rarely passed on and that there was no standardised way of documenting or handing over information about history of violence to other health professionals. Occasionally, notes were made in the patient's medical file or with an 'alert' sticker. Some health services have computerised records and an alert can be included as part of an individual's file. One panel member suggested having photos or a list of known violent offenders in the staff office to inform new staff members of those in the community with a history of violence.

However, panel members were concerned about labelling clients as violent, as this may adversely affect their care in the future or violate their right to privacy.

## Discussion

Violent incidents in this study were found to be characterised by the interplay of four main characters: the environment, the nurse, the client and the organisation<sup>17</sup>. The character most relevant to that hazard was identified (Table 1).

### Environment

Attending to patients in the RAN's home was seen by most experts as an extremely hazardous situation and providing good security measures at the staff residence was considered a vital aspect of maintaining the personal safety of RANs. This situation, specific to RAN practice, has been identified as an issue of concern previously<sup>6</sup> and there has been at least one serious assault in a RAN's accommodation where the poor level of security provided was implicated<sup>24</sup>.

Issues relating to building design and maintenance were also considered to be significant hazards for RANs. An inability to safely lock the clinic, having a single exit and inadequate external lighting were most commonly ranked as major or extreme hazards. Maximising the safety of a community clinic may include: limiting access to the building after hours by keeping a minimum number of keys in circulation, keeping the building neat and tidy with vegetation cleared well back from access routes, and maintaining bright security lighting to eliminate hiding places and discourage loitering<sup>25</sup>.

Assessment of the work environment either by the nurses themselves, with training and support or an independent assessor should be considered a priority by employers.



**Table 1: Priority hazards as identified by expert panel. Mean values were calculated as follows: Not a hazard=0, Minor Hazard=1, Moderate Hazard=2, Major Hazard=3, Extreme Hazard=4. The items with the highest mean represented the greatest hazard.**

Rank	Hazard	Mean	Agreement %	Character
1	Attending to patients in your own home	3.5	88	Environment
2	Inability to securely lock after-hours consulting area	3.4	80	Environment
3	Lack of common sense of nurse	3.4	90	Nurse
4	Intoxicated (alcohol or illegal drugs) client	3.4	80	Client
5	Alcohol outlet in a community	3.3	80	Organisation
6	Stress and burnout of nurse	3.3	90	Nurse
7	Single entry/exit to the clinic	3.2	70	Environment
8	Poorly developed communication skills	3.2	90	Nurse
9	Inadequate security of staff residences	3.1	80	Environment
10	Inexperience as a RAN (<4 years)	3.1	80	Nurse
11	Underdeveloped instinctive responses ('gut feeling')	3.1	90	Nurse
12	Work culture that tolerates verbal abuse as 'part of the job'	3.1	80	Organisation
13	Inadequate external lighting (particularly over access routes and external utilities)	3.0	70	Environment
14	Rigid personal belief systems of nurse	3.0	80	Nurse
15	Tiredness and fatigue of nurse	3.0	70	Nurse
16	History of violence by client	3.0	80	Client
17	Insufficient experience in assessment of mental health issues	2.9	70	Nurse
18	Lack of management follow up of violent incidents	2.9	70	Organisation
19	Lack of understanding of the risk and effects of violence by management	2.9	70	Organisation

RAN, Remote area nurse.

## Nurse

The panel indicated that inexperience as a RAN was a significant hazard and that experienced RANs were better protected from violence due to their knowledge and respect of the community and its culture. Aspects of experience include: length of service as a RAN, well developed communication skills and 'gut feeling', common sense, clinical confidence and culturally safe practice. It is not known empirically if 'experience' is a protective factor for RANs, or if experienced RANs report less violence.

However, common sense and intuition are considered vital skills in assessing the risk of violence. These skills may reflect attention to the 'markers' of risk such as: general appearance (eg 'rough looking'), sex (male), greater physical size/strength, illicit drug use, age (young), psychiatric illness, predictability and presence of companions<sup>26</sup>. In addition,

expert nurses are considered to have '...mature practical knowledge about what to expect of particular patient populations' (p.153)<sup>27</sup>. This knowledge sparks early recognition when things go awry<sup>27</sup>. Level of experience as an indicator of vulnerability to violence, is pertinent when considered with recent workforce data that shows the most common length of time spent as a RAN was 2 months and the average was 3.2 years<sup>28</sup>. This may, at least in part, be an explanation for the rise in incidence of violence reported by Opie et al<sup>9</sup>. However, it is not known if experienced RANs actually experience less violence. Further research exploring the relationship between RAN experience and incidence of violence could provide guidance for education and recruitment of RANs.

Stress and fatigue appeared to contribute significantly to the risk of violence with 90% of the panel considering the risk as major or extreme. Remote Area Nurses experience high



levels of distress related to a lack of infrastructure and the high acuity of their patients<sup>7</sup>. High staff turnover and inadequate numbers and skill mix of staff in communities is also a significant stressor for RANs<sup>5</sup>. Remote Area Nurses use less sick leave and work 2 days more per week than their metropolitan counterparts because there is no-one to cover for them<sup>1</sup>. Staff who are tired and under pressure may be less likely to recognise behaviours that may be precursors to a violent incident and they may not be able to employ the patience, calmness and communication skills needed to diffuse an aggressive situation<sup>29</sup>. The recruitment of adequately prepared and experienced RANs should be a priority. Retention of RANs using a variety of strategies including personal and professional support appears to be a priority if a reduction in violence is to be realised.

The panel considered RANs with rigid belief system to be at increased risk of violence. This item recognises the different context of nursing practice in remote areas compared with the metropolitan context. City nurses adapting to the very different remote context may experience culture shock<sup>30</sup>. This is exacerbated by living in the community that they work in. Cross-cultural adjustment may cause significant anxiety, confusion and emotional distress and may compromise clinical care and cultural safety<sup>30,31</sup>. 'Cultural safety' is a term used to describe nursing care that maintains a person's cultural integrity and recognises that the nurse's own culture impacts on nursing practice<sup>32</sup>. Culturally safe practice is particularly important in remote areas because the health service provided is generally the only option for residents.

While the panel identified shortcomings of the nurse as 'hazards' it is important to note that lack of preparation and support, combined with high job demands are organisational hazards and outside the control of the individual nurse. Remote Area Nurses who experience violence in the workplace must always be seen as victims of a traumatic event<sup>6</sup>.

## **Client**

The panel agreed that intoxication with alcohol, petrol sniffing and to a lesser extent marijuana were the most

significant risk factors to consider during a violence risk assessment. Mental illness was identified by the panel as a significant hazard with the qualifier that intoxication and non-compliance with a treatment regime further increased the risk. The effects of alcohol, drug abuse and mental illness on the risk of violence posed by a client is well established in the literature<sup>29,33</sup>.

Clients with a history of violence were identified by the panel as a significant hazard that increased the risk of violence; however, the panel only showed moderate support for documenting clients with a history of violence even though this is highly significant in terms of risk assessment<sup>33,34</sup>. Further investigation with the aim of creating a process of identifying community members who may pose additional risk due to a history of violence, and also upholds a client's right to privacy, is warranted.

## **Organisation**

The organisation within which RANs work was considered in this study to include both the employer and the broader community context. Communities with an alcohol outlet were considered to be higher risk communities, as were single nurse posts and communities without access to immediate police back up.

A work culture that tolerates verbal abuse was identified as a significant organisational hazard. Under-reporting of violent incidents, a lack of understanding from management, as well as dishonesty about the risk and effects of violence were seen to contribute to this culture. A culture of acceptance that verbal abuse is 'part of the job' contributes to the risk of violence in that it encourages the 'context of silence' that surrounds violence in the remote area nursing workplace<sup>6</sup>. Adopting an attitude that verbal aggression does not affect the RAN personally, may appear to be protective for some RANs but it may also discourage reporting and discussion among RANs about the effects of verbal aggression, because doing so may be seen as 'weak'. Under-reporting of violent incidents was recognised as a hazard by the panel and well documented in the literature<sup>6,35,36</sup>. Lack of action from management when



hazards are identified and lack of evidence of a commitment to violence prevention initiatives were seen as organisational hazards. One of the reasons cited for the under-reporting of violent incidents is the belief that 'nothing will be done about it anyway'<sup>35</sup>. Organisations may be considered to be contributing to the incidence of violence by reinforcing the context of silence.

Analysis of organisational policies and procedures related to aggression management and reporting, along with education programs and resources aimed to assist management in changing organisational culture, may counter the context of silence that currently exists.

## Limitations

Bias may have been present in the selection of the panel for this Delphi study, and the generalisability of results was limited due to the descriptive nature of the study, and the fact that the majority of participants resided in the Northern Territory.

Prioritising hazards according to a risk management process involves more than just identifying the most extreme hazards. The likelihood and consequences of a hazard occurring must also be considered when allocating resources or implementing control measures<sup>14</sup>. Further research is required in order to identify control measures and priorities for resource allocation in each workplace.

## Conclusion

This study sought to document the opinions of a panel of expert RANs in order to identify and describe hazards that contribute to an increased risk of violence in their workplace. Documentation and analysis of the knowledge and insights of RANs in regard to this phenomenon has not previously been conducted and, as a result, this study adds to understanding the phenomenon of violence towards RANs.

The working environment presents risks to RANs as some consultations occur outside of the clinic environment and building design and security features are vital considerations for RAN safety. Experience as a RAN appears to be an important factor in the incidence of violence as is the level of stress and fatigue experienced by RANs. Remote Area Nurses appear to be concerned about the increased risk of violence when consulting with intoxicated clients, particularly those with mental health issues or a history of violence. Organisational responsibility includes managing the risk of violence through establishing a process of reporting and action where hazards are identified. Challenging a culture of acceptance of violence within the workplace is an important role for the organisation.

Identifying hazards is the first step in a risk management process. Further research is needed to identify measures that may reduce the risk of violence towards RANs. Implementation of strategies to reduce stress and improve retention of RANs may deliver reductions in the level of violence experienced in the RAN workplace.

Further research that considers the impact of violence on victims and the costs incurred by organisations is warranted. Assessments of employers policies, responses and compliance with occupational health and safety legislation may provide evidence to encourage the urgent action that is required to halt the unacceptable burden of violence carried by RANs.

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