Received: 29 September 2023 | Revised: 1 March 2024 | Accepted: 22 March 2024

DOI: 10.1111/jan.16189

EMPIRICAL RESEARCH QUANTITATIVE

JAN Leading Global Nursing Research WILEY

Australian nursing students' experiences of workplace violence during clinical placement: A cross-sectional study

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Funding information
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Abstract

Aim: To identify the nature, degree and contributing factors of workplace violence (WPV) incidents experienced by Australian nursing students during clinical placement.

Design: Descriptive cross-sectional study.

Methods: Data were collected from 13 September to 25 November 2022. Eligible participants included all nursing students enrolled in nursing degrees at any Australian university who had completed at least one clinical placement. An adapted version of the WPV in the Health Sector Country Case Study survey was used.

Results: A total of 381 nursing students across eight states of Australia completed the survey. More than half of the students had experienced an episode of WPV; patients were the most frequent perpetrators. Personal factors of patients, staff and students, organizational factors and cultural norms within the workplace supported acts of WPV.

Conclusion: Student nurses (SNs) most often experience violence from patients during direct care. Patient encounters are the core component of clinical placement. Education providers have a responsibility to effectively prepare students to be able to identify escalating situations and manage potentially violent situations. Registered nurses who supervise students during clinical placement require support to balance their clinical role with student supervision.

Implications for The Profession: Experiencing WPV can negatively impact relationships between students, healthcare professionals and care recipients. This results in personal distress, decreased job satisfaction and potentially the decision to leave the nursing profession.

Impact: *What already is known*: SNs are exposed to WPV during clinical placement.

What this paper adds: More than half the SNs in this study experienced violence inclusive of physical, verbal, racial and sexual harassment. Patients were the predominant perpetrators.

Implications for practice/policy: Interventions at individual and systemic levels are required to mitigate WPV.

There was no patient or public contribution to this study.

Reporting Method: This study is reported using the STROBE guidelines.

KEYWORDS
clinical placement, student nurses, trauma informed principles, workplace culture, workplace violence

1 | INTRODUCTION

Globally, workplace violence (WPV) against healthcare workers is a persistent problem (Dafny & Beccaria, 2020). Findings of recent studies have demonstrated nursing staff are experiencing incidents of verbal and physical violence with increasing frequency and as often as daily (Dafny, Champion, et al., 2023). WPV is defined by the International Council of Nurses as involving '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' (International Labour Organization, International Council of Nurses, World Health Organisation, Public Services International, 2002). It is reported that between 30% and 72% of nurses have experienced a form of WPV ranging from non-verbal, verbal and to varied forms of physical violence (International Labour Organization, International Council of Nurses, World Health Organisation, Public Services International, 2002). The effects of WPV can be severe and have detrimental impacts on victims physically, emotionally and psychologically (Dafny et al., 2022; Üzar-Özçetin et al., 2021), with an estimated 17.2% of nurses leaving the profession annually (Dafny et al., 2021, 2022). Despite the dire consequences of WPV, the support provided to nurses following a violent incident has been found to be inadequate (Dafny & Muller, 2021). Experiencing WPV can result in decreased job satisfaction, empathy and trust between healthcare professionals and care recipients (Duan et al., 2019) and contribute to the decision to leave the nursing profession after experiencing episodes of violence. In the face of a global nursing shortage, this could have detrimental effects on the nursing workforce (Karatuna et al., 2020).

2 | BACKGROUND

In Australia, student nurses (SNs) complete a minimum of 800 h of clinical placement hours in a range of clinical settings as part of their nursing course. Specific clinical areas where SNs work, such as emergency departments, long term and mental health facilities have been found to be associated with high incidences of patient-related aggression (Nowrouzi-Kia et al., 2019). Risk factors for violence in these clinical areas include substance abuse, stress, pain, cognitive impairment and alterations in mental state (Hallett et al., 2023). Perpetrators of violence are not limited to patients, families or visitors but include co-workers and other member of the healthcare workforce. The profile of a SN is typically younger, with less work experience in clinical sites and less awareness of the cultural norms in the clinical environment, situating the SN as vulnerable to violence (Dafny, McCloud, Champion, et al., 2023). In a study by Tee et al. (2016) nearly half (42.18%) ($n = 232$) of SNs who had been on clinical placement within the past year had experienced bullying or harassment with 19.6% ($n = 129$) of incidents involving a registered nurse; a much higher proportion than the 4.9% ($n = 32$) of patient perpetrated incidents. Registered nurses (RN) including those in senior roles were perceived to be the common instigators of uncivil behaviour during clinical placement, which ranged from subtle behaviours of ignoring or eye rolling to overt acts of racism (Minton & Birks, 2019). SNs as novice practitioners, must work alongside and report to an RN, relying on them for supervision of tasks and guidance of clinical skill development for the duration of the placement experience. Negative interactions may result in the SN feeling stressed, anxious, devalued and fearful to attend their placement (Minton & Birks, 2019). The cumulative effects of these behaviours influence the student-registered nurse relationship, reinforcing a power differential which negatively impacts learning (Minton & Birks, 2019). The perception of being at the bottom of the pecking order and having no power in the face of aggressive behaviours from patients, visitors or healthcare staff influences their view of the nursing profession (Hallett et al., 2021) and as a result SNs may feel powerless to deal with, or report incidents of violence (Dafny et al., 2021; Dafny, McCloud, Pearson, et al., 2023).

WPV involving SNs has been reported globally with prevalence rates ranging from 12.2% for racism and 58.2% for bullying (Dafny, McCloud, Pearson, et al., 2023; Hallett et al., 2023). A recent qualitative systematic review exploring SNs experience of WPV during clinical practice found SNs experienced all types of violence, from colleagues, nursing staff, teachers, doctors and supervisors (Dafny, McCloud, Pearson, et al., 2023). The types of WPV reported by SNs from nine countries included physical, verbal, psychological and sexual violence and instances of racism (Dafny, McCloud, Pearson, et al., 2023). Research related to WPV specifically in the Australian context is limited and the available studies are also not contemporaneous. In Hopkins et al. (2014) found SNs are exposed to significant levels of WPV, with 60% ($n = 55/97$) of second year and 57% ($n = 32/56$) of third year SNs having experienced non-physical violence in the clinical setting. Around one-third ($n = 33$) of the second year and a quarter ($n = 18$) of third year SNs had been subjected to some form of physical aggression in the clinical environment (Hopkins et al., 2014). These findings were limited by the small sample at a single study site; however, any reports of violence are a concern. In the only other Australian study, bullying and harassment

were the focus (Budden et al., 2017; Courtney-Pratt et al., 2018); therefore not capturing the full spectrum of violence experienced by SNs. These studies were conducted in Australia between 2014 and 2018; a contemporary perspective of WPV is needed to support interventions.

The prevalence of WPV in the healthcare sector continues to rise globally and it is reasonable to assume that SNs will continue to encounter WPV. As SNs are important to the continuum of healthcare delivery as the next workforce generation, and the predicted nursing deficit by 2030, SNs' experience of WPV is important to explore.

3 | THE STUDY

3.1 | Aims

This study aimed to (i) identify the nature and degree of violence experienced by SNs during clinical placement and (ii) to identify the perception of factors contributing to WPV and factors which could reduce WPV during clinical placement.

4 | METHODS

4.1 | Design

This cross-sectional study was conducted between 13 September and 25 November 2022.

4.2 | Setting and sampling

Participation was open to all SNs enrolled in a single or double nursing degree at an Australian university. A single degree was defined as one which concentrated on nursing as the specific area of specialization (nursing); a double degree was defined as a degree which combines the study of nursing with another speciality. Recruitment occurred via Heads of Schools of 37 Australian universities offering nursing programs (either single or double degree). Study documents were attached to an introductory email sent to Head of School, asking for a nominated school liaison person. The nominated staff member was emailed, and it was requested that they distribute study information and links to the survey using internal mechanisms. A follow-up reminder email was sent after 2 weeks. Of the 37 universities, 20 agreed to distribute the survey to SNs.

4.3 | Inclusion criteria

Eligibility criteria included SNs in any year of study who had completed at least one clinical placement.

4.4 | Instrument

This study used the WPV in the Health Sector Country Case Study survey (International Labor Organization, International Council of Nurses, World Health Organization, & Public Services International, 2003) with permission of the authors. The survey (Appendix S1) was piloted by five SNs (excluded from the study) and was modified according to their feedback.

As this study population were only SNs, modifications included removal of items asking about professional group, position and employment sector. Students indicated that questions in Section C: Bullying and Mobbing were repetitive of a previous section and therefore it was removed. The content validity of the survey was then assessed by 10 experts who participated as panel members using the Content Validity Index in terms of relevance and clarity (Grant & Davis, 1997). Criteria for selection of the panel included having (i) minimum education of a master's degree in nursing and (ii) experience in WPV. The updated survey was distributed to five SNs who checked usability and face validity (time needed to complete the questionnaire; their views on clarity of questions and whether the questions are understandable and easy to answer). The final survey comprised a glossary of terms relating to violence, demographic and socio-demographic questions, questions relating to experience of physical violence, psychological violence, racial harassment, sexual harassment and in the concluding section respondents were asked to provide textual responses to three items asking about factors contributing to, and potentially, reduce violence. The survey was uploaded into Qualtrics, and functionality and accuracy were assessed by two academics and the same five SNs (excluded from the survey).

4.5 | Data analysis

Quantitative data were exported from Qualtrics to SPSS version 28 for analysis. Analysis aimed to describe respondents and quantify exposure to violence of various sorts, contexts and perpetrators. Numerical and categorical data were analysed using summary statistics. Textual data were exported to Microsoft Excel and Word for analysis using the framework approach as described by Gale et al. (2013). This approach was selected because it provides a systematic structure enabling development of responses to predetermined research questions while remaining open to responses of SNs not otherwise anticipated, using deductive and inductive logic. The approach is considered particularly useful in applied research where the intent is to describe a phenomenon. Analysis was led by SP, an experienced qualitative researcher and SJ who developed familiarity with data by repeatedly reading and annotating comment. Data addressing each of the three survey items were then coded descriptively to reflect content with multiple coding possible. Codes were reviewed and grouped to create an initial 'thematic' framework for each of item. While full copies were retained for reference, data were then indexed and charted

in the applicable framework, before being progressively reduced. A process of constant comparison was then used to refine the initial framework, collapsing and adding themes to accommodate data. Thus distilled, data related to each item were compared and mapped. Rigour was promoted by maintenance of an audit trail and robust dialogue as authors challenged each other to ground analytic decisions and interpretation in data.

4.6 | Ethical considerations

Ethical approval for the study was granted by the Queensland University of Technology University Human Research Ethics Committee, approval number 5717.

Participation was voluntary; the first question of the survey asked SNs to indicate they had read participant information and consented to participate in the study. Student could refuse to answer any or all the questions. Responses were anonymous. Respondents were offered the opportunity to enter a random draw for one of 20 × AUD $50 vouchers and if they chose to, they were directed to another page separate from the survey responses, where they could leave contact details.

5 | RESULTS

A total of 381 SNs completed the survey. Data are reported as available using percentage of respondents completing the item as the denominator. Textual data were provided by 172 respondents to survey items asking SNs to identify: (i) factors contributing to violence and (ii) factors that would reduce violence during their clinical placement.

The results from this study are presented using a joint display approach, where the quantitative and qualitative findings are presented together under common themes. There were three themes identified: (1) proximate factors of violence—personal factors and practice failures; (2) distal factors of violence—organizational factors conducive to violence; and (3) cultural norms which support violence.

5.1 | Theme 1: Proximate factors of violence—Personal factors and practice failures

Proximate factors included those which influenced an individual's present internal state which in turn affected decision processes influencing aggressive and non-aggressive outcomes (Bhattacharjee, 2021). This theme explored the cognitive and behavioural characteristics of patients along with SNs own personal characteristics which situated them in a position of vulnerability in relation to WPV. The very nature of being a SN was perceived to influence certain behaviours of patients and staff. Quantitative data present the rates and experience of violence types and qualitative data extend our understanding of this further by providing what the SNs believed contributed to the occurrence of violence.

TABLE 1 Demographic variables.

Source	Frequency	
	n	%
Gender (*n* = 334)		
Female	297	98.9
Male	34	10.2
Transgender	1	0.3
Prefer not to say	2	0.6
State of university attended (*n* = 335)		
Queensland	30	9
New South Wales	114	34
Australian Capital Territory	28	8.4
Victoria	36	10.7
South Australia	90	26.9
Western Australia	13	3.9
Northern Territory	19	5.7
Tasmania	5	1.5
Program of enrolment (*n* = 335)		
Bachelor of Nursing	316	94.3
Bachelor of Nursing and Midwifery	19	5.7
Year of program (*n* = 335)		
First	45	13.4
Second	131	39.1
Third	149	44.5
Fourth	8	2.4
Fifth	2	0.6
Ethnic group (*n* = 329)		
Minority ethnic group	131	39.8
Majority ethnic group	198	60.2

Table 1 reports the demographic data of the 319 SNs who provided relevant data. Most SNs were female (89%; *n* = 287), 72% were 20–39 years old. Respondents reported studying at universities in all states and territories in Australia. Most were enrolled in a Bachelor of Nursing course (*n* = 316, 94%) and the majority were in their third year of the course (*n* = 146, 46%). One-third (*n* = 107) reported moving to their study location from another country. There were 124 (39%) SNs who identified as being a member of an ethnic minority when on clinical placement.

The most experienced type of violence was verbal abuse, followed by physical and racial and sexual as reported in Table 2. The number of responses for each type of violence is reported as available using percentage of respondents completing the item as the denominator.

The frequency of experience of verbal, racial or sexual abuse in the last 12 months is presented in Table 3.

Students were asked to identify the perpetrator of violence (Table 4). Patients were the most frequent perpetrator of all forms of

violence, followed by staff, relative of patient with the public being perpetrator of one incident.

Most respondents identified various characteristics of individuals as contributing to WPV. Personality, values, attitudes and learned behaviours of patients, their family members, staff and SNs were identified as predisposing individuals to perpetrate, or experience violence. Respondents noted that some patients' personalities were 'naturally aggressive' and/or impatient and that some *took pleasure in attacking others*.

> I think the majority of the problem stems from the patient and their mood/personality. I think just trying to talk to someone and it being misinterpreted is a big cause.

Many respondents associated the attitudes and characteristic ways of behaving that contributed to WPV with patient culture, age and socioeconomic status. A 'general hate for younger generations' harboured by some older people (men particularly), misogyny and feelings of entitlement were all commonly identified. Racial prejudice and stereotyping were identified as contributing to violence perpetrated against SNs whose appearance, or language use, identified them as 'different', that is, not White. Various health conditions were commonly identified as contributing to violence—volitional or unintended, which was not otherwise characteristic of the person. The most identified conditions were associated with alteration in mental state. Specifically, respondents identified, 'delirium', 'mental illness', intoxication by drugs or alcohol and withdrawal syndromes as contributing to violence. 'Cognitive impairment', 'dementia' and 'intellectual disability' were also identified. Less commonly identified were infections of various kinds.

> An example of an elderly man swearing abusive terms to be left alone while he's tired and unwell with a UTI compared to his usual character. I realise this is a quote, but it seems like there is something missing in the quote—did they perceive this to be because the clinician was not their usual carer or was it related to the UTI? Both thoughts in this sentence.

Respondents commonly identified 'student status' as contributing substantially to violence in addition to various personal characteristics of SNs, including race and culture. Apparent lack of confidence, ineffective boundary setting and 'not knowing' how to respond to challenging situations were also identified as contributory to violence experienced by some. Prejudices held by staff, particularly racism and stereotyping were commonly identified as contributing to violence by staff against SNs.

> I find it occurs when a patient or family member are dissatisfied with the healthcare provided or are just unhappy and lash out at the nurses and students where it then escalates to physical violence.

Some respondents attributed violence to patient and family member frustration and distress arising from the (suboptimal) experience of care in the placement setting. Acknowledging that patients were in unfamiliar environments, experienced reduced autonomy and could face multiple barriers to participation in care, respondents identified reduced autonomy and feeling threatened in the caring relationship as proximate causes of violence.

> Cultural/language barriers that causes patients to become agitated and feel as though they are not heard.

Other care-related causes of frustration (and consequent violence) included extended wait times, communication failures and ineffective pain management. Critically, some respondents noted, that it was not

TABLE 2 Type of violence (multiple responses allowed).

Type of violent incident	*n* (%)
Physical	84/317 (26.5)
Verbal	201/304 (66.1)
Racial	54/288 (18.8)
Sexual	54/279 (19.4)

TABLE 3 Frequency of violence (multiple responses allowed).

Type of violence/frequency	All the time *n* (%)	Sometimes *n* (%)	It happened once *n* (%)
Verbal ($n=194$)	21 (10.8)	127 (65.5)	46 (23.7)
Racial ($n=46$)	3 (6.5)	30 (65.2)	13 (28.3)
Sexual ($n=51$)	–	20 (39.2)	31 (60.8)

TABLE 4 Perpetrator of violence (multiple responses allowed).

Type of violence/perpetrator	Staff member *n* (%)	Patient *n* (%)	Relative *n* (%)	General public *n* (%)
Physical ($n=81$)	7 (8.6)	74 (91.4)	–	–
Verbal ($n=194$)	51 (26.3)	136 (70.1)	7 (3.6)	–
Racial ($n=46$)	10 (21.7)	32 (69.6)	3 (6.5)	1 (2.2)
Sexual ($n=51$)	3 (5.9)	48 (94.1)	–	–

patient frustration per se, but the approach and behaviour of staff, including failure to identify an escalating situation, which contributed to enacted violence.

> Many issues could be avoided by having staff simply listen or APPEAR to listen to voiced concerns and read body language—rather than take an authoritarian approach.

Further to the identification of conditions affecting mental state as contributing to violence, respondents noted that failure to attend appropriately to health needs and conditions other than that for which the patient was admitted increased risk.

> Patients' mental health/cognitive health not being supported enough during admissions for different presenting diagnosis.

Several respondents identified being under-prepared for placements generally but particularly in relation to WPV. The SNs reported lacking an appreciation of the risks of violence and identified that lack of skills needed to identify and de-escalate potentially volatile situations as contributing to violence. Moreover, they reported feeling unsupported by university facilitators while on placement and therefore lacking the courage to respond effectively to violence and report. Some described facilitators as complicit in the 'culture of tolerance'.

> Even when we escalate to facilitators, at times they are inadequate at advocating for our behalf and hence, we are advised just to 'go through with it' or 'it's always been this way'.

5.2 | Theme 2: Distal factors of violence—Organizational factors conducive to violence

Distal factors are those that contribute to incidents by creating conditions conducive to violence (Bhattacharjee, 2021). These included organizational culture and workforce issues related to universities and health facilities within which placements were completed. This theme explored the organizational or environmental factors contributing to violence including reporting and staff as perpetrators. Many respondents moved beyond the characteristics of individuals, situating violence within a complex context, organizational culture. Within this context various interlinked factors created conditions increasing the risk of and enabling WPV. Respondents identified various work force issues, hierarchical health care structures, professional cultures and tolerance, acceptance and normalization of violence. In this theme, the quantitative data are used to provide information on reporting violent incidents and staff as perpetrators and qualitative data explore this concept further by adding the context of the environment/organization that may impact staff perpetration and reporting of violence.

TABLE 5 Responses to violent incidents (note multiple responses allowed).

Type of violence	Physical *n* = 81		Verbal *n* = 193		Racial *n* = 54		Sexual *n* = 51	
Response	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
No action	15	19	60	31	18	40	16	31
Pretend it never happened	21	26	41	21	8	18	9	18
Told person to stop	46	58	77	40	13	29	30	59
Told family/friend	17	21	36	19	10	22	11	22
Told colleague	33	41	65	34	14	31	19	37
Incident form	16	20	15	8	2	4	6	12
Tried to defend self	14	18	3	2	0	0	5	10
Sought counselling	3	4	6	3	1	2	2	4
Reported to staff member	46	58	99	51	15	33	19	37
Sought help from union	2	3	3	2	1	2	1	2
Pursued prosecution	1	1	2	1	0	0	0	0
Told university	7	9	36	19	4	9	5	10

TABLE 6 Action taken to investigate cause (multiple responses allowed).

	No *n* (%)	Yes *n* (%)	Unsure *n* (%)
Physical (*n* = 77)	58 (75.3)	4 (5.2)	15 (19.5)
Verbal (*n* = 193)	146 (75.6)	11 (5.7)	36 (18.7)
Racial (*n* = 45)	33 (73.3)	3 (6.7)	9 (20)
Sexual (*n* = 51)	43 (84.3)	3 (5.9)	5 (9.8)

The most common responses to physical, verbal and sexual violent incidents were to report to staff members and tell the person to stop. Racial incidents, however, resulted in no action. The range of responses to violent incidents is in Table 5.

Students who reported the incidence of violence identified that the violence was seldom investigated (Table 6) and that few perpetrators experienced consequences (Table 7), which may impact SNs desire to report incidence of violence. These are reported below.

Other factors that may have impacted SNs desire to report the incident included staff as perpetrators and toxic culture of nursing. Respondents commonly described a systemic tolerance of violence, and organizational processes that enabled perpetration of violence by patients and staff.

Health service staff perpetrators included the facilitators responsible for SNs while on placement,

> The most significant event I experienced was from the clinical facilitator. I know of other students who also experienced psychological bullying and

TABLE 7 Consequences (multiple responses allowed).

	None *n* (%)	Warning *n* (%)	Other *n* (%)	Police *n* (%)	Prosecution *n* (%)
Physical (*n* = 77)	60 (77.9)	9 (11.7)	11 (14.3)	1 (1.3)	1 (1.3)
Racial (*n* = 44)	39 (88.6)	5 (11.4)	1 (2.3)	–	–
Sexual (*n* = 51)	44 (86.3)	9 (17.6)	1 (2.0)	1 (2.0)	–

> demeaning behaviour from the facilitator. They are also responsible for the safety of students—if they are the perpetrator the student experiences severe psychological harm and cannot be safe during placement.

Respondents wrote of management and staff 'turning a blind eye' to violence and intentional failure enact policies and procedures designed to reduce and manage violence. Staff and patients perpetrating violence were reported to be 'allowed to get away with it time and time again'.

> Allowing unacceptable behaviour to carry on as if it were normal. It seems this is the way in which the nursing system is, with senior staff feeling they can say and do whatever they please.

> A toxic work culture is the biggest factor that contributes to this, as it normalises unacceptable behaviours in the workplace.

Indeed, respondents reported being actively encouraged to accept violence as 'part of the job', and a sometimes-explicit expectation that SNs put up with violence without complaint. The power differentials and fear of consequences associated with reporting, particularly related to 'passing the placement', reinforced this expectation.

> Lack of protection for students: accepting horrible behaviour out of fear for consequences such as failing placement…out of fear for not being believed or being blamed or having them exaggerate instances to make you look bad so they can fail you.

Workforce issues, specifically understaffing, sub-optimal staff mix and ineffective management, were commonly identified as contributing to violence against SNs. With work demands exceeding capacity, and juggling competing priorities, staff lacked capacity to provide optimal care to patients (potentially contributing to violence from patients), and motivation to attend to SNs' learning needs. Simply, in the words of one respondent 'frustrated nursing staff are taking frustration out on students'.

> Nurses are exhausted, burnt out and overwhelmingly disenchanted with their professional predicament. When student nurses, an additional responsibility for the nurse, are added to their workload repetitively, they often become resentful of this and unwilling to teach. In my experience, this can lead to the nurse, whether they realise it or not, abusing the student nurse. I have been shouted at, abused, ignored, and bullied as a result of this.

The workforce demands of the clinical environment potentially led to a lack of patient information provided by nursing staff to SNs. Subsequently if SNs are not prepared for the required nursing activities or do something dissatisfying for the patient, there is potential for WPV.

> Young students working with elderly men and woman… left alone with these patients in the shower, in the bathroom and bedroom. Lots of these older patients take advantage of that. Students are also commonly told to answer patient buzzers and walk into an environment they have no prior information/warning about.

Respondents commonly referenced hierarchies within the placement context, placing nursing at the bottom of a professional hierarchy and SNs at the bottom of the nursing hierarchy. Many respondents described bullying as common place, reporting that patients and 'staff had no respect for student nurses', and 'being treated like scum by doctors'.

> …nursing is a highly feminised profession…nurses are at the bottom of the organisational chart …nurses are the cleaners, the ones that deal with offensive bodily fluids, the glorified administrative assistants that glue the entire episode of healthcare together.

Violence, particularly verbal abuse, and bullying was further attributed to the 'culture of nursing' in which 'senior staff eat their young'. As a 'free pair of hands', at the bottom of the hierarchy, respondents described SNs as the 'perfect mark to target'.

5.3 | Theme 3: Cultural norms which support violence

Despite the proximate and distal factors that may have contributed to the violence, there is a considerable impact to SNs who experience violence (Table 8). This theme presents the quantitative results from SNs' reporting on the impact the incident of WPV had on them and their qualitative data discussing how to create safer environments for future students completing clinical placement.

TABLE 8 Impact of violence.

How often have you been bothered by	Not at all *n* (%)	A little bit *n* (%)	Moderately *n* (%)	Quite a bit *n* (%)	Extremely *n* (%)
Respondents reporting impact of experiencing physical violence *n* = 78					
Repeated, disturbing memories, thoughts, images of the attack	30 (39)	26 (33)	10 (13)	6 (8)	6 (8)
Avoiding thinking about or talking about the attack of avoiding having feelings related to it	33 (42)	17 (22)	11 (14)	11 (14)	6 (8)
Being 'super alert' or watchful and on guard	9 (12)	23 (30)	18 (23)	14 (18)	14 (18)
Feeling like everything you did was an effort	27 (35)	21 (27)	8 (10)	15 (19)	7 (9)
Respondents reporting racial harassment *n* = 43					
Repeated, disturbing memories, thoughts, images of the attack	11 (24)	18 (40)	8 (18)	5 (11)	3 (7)
Avoiding thinking about or talking about the attack of avoiding having feelings related to it	14 (32)	7 (16)	8 (18)	10 (23)	5 (11)
Being 'super alert' or watchful and on guard	10 (23)	10 (23)	8 (18)	8 (18)	8 (18)
Feeling like everything you did was an effort	13 (30)	9 (21)	5 (11)	12 (28)	4 (9)
Respondents reporting sexual harassment *n* = 51					
Repeated, disturbing memories, thoughts, images of the attack	23 (45)	17 (33)	5 (10)	3 (6)	3 (6)
Avoiding thinking about or talking about the attack of avoiding having feelings related to it	15 (30)	14 (28)	7 (14)	9 (18)	5 (10)
Being 'super alert' or watchful and on guard	13 (25)	12 (24)	10 (19)	8 (16)	8 (16)
Feeling like everything you did was an effort	28 (56)	9 (18)	8 (16)	4 (8)	1 (2)

SNs reported various experiences following the incident of WPV (physical, racial and sexual). As shown in Table 8, some SNs reported experiencing symptoms consistent with post-traumatic stress, to varying extent.

Respondents identified various measures that could be taken by universities, health facilities or both institutions, to reduce WPV on clinical placement. The various measures were described as contributing to and reflecting the fundamental cultural shift required to mitigate risk and reduce violence.

> Culture of tolerance of violence needs to be replaced by culture that enables all to speak up and address inappropriate behaviour.

Many respondents identified enactment by universities and health facilities of policies and practices designed to mitigate risk and manage WPV as a necessary but not sufficient measure. Both institutions, respondents wrote, needed to publicize policies and related procedures, and provide education to staff, SNs and patients so they understand behavioural expectations and have knowledge and skills needed to respond effectively to violence.

> Educating staff and students how to manage violence in a clinical setting without feeling like there would be consequences.

Respondents advocated for 'accountability' and 'real consequences' for perpetrators of violence and timely provision of appropriate support to those subject to WPV. Universities and hospitals were considered both responsible for education and preparing SNs for dealing with violence in clinical placement. Respondents commonly identified 'proper preparation' for placement, generally and for specific settings, as critical to reducing violence. Proper preparation extended beyond the clinical skills to be practiced; preparation necessarily encompassed being equipped with an appropriate understanding of the nature and causes of WPV, and development of the interpersonal skills and self-efficacy needed to maintain professional boundaries and effectively respond directly to volatile situations and after an incident.

> University clinical practice units should take proactive steps to prevent abuse and violence against students on clinical placements. They should educate their students on what abuse, bullying and violence looks like, how to respond and report. They should build into their financial/contractual agreements with hospitals a penalty for violations including a non-payment of placement fees on a per-student basis if that student experiences violence, bullying or abuse while on placement.

Respondents commonly identified addressing workforce issues as essential to improvement of safety. To enhance staff capacity to provide appropriate care, and reduce stress levels seen to contribute to WPV, respondents advocated for appropriate staff mix, staffing ratios and qualification levels. Before hosting SNs, respondents wrote, organizations should ensure that staff were trained and willing to engage with and educate SNs (as other than free labour). To minimize exposure to risky situations, the university and organization should agree the supervision requirements and roles/duties appropriate to student educational stage. Such agreements should be founded in recognition of the

need for SNs to learn 'on the job' and respect for their novice status. As one respondent wrote a culture of respect would create a virtuous cycle:

> Staff showing respect to students in front of other staff. Staff showing respect to students in front of patients and family. Staff seeing bad behaviour from other staff towards students and advocating on behalf of the student. Staff not telling students to accept bad behaviour when they see it.

Several respondents identified a comprehensive orientation to the placement setting and patient cohort as important to reducing violence. The orientation should encompass the physical environment, behavioural expectations, staff roles and responsibilities and any risk mitigation strategies adopted in the setting. Key to mitigating the risk of WPV from patients were improvement in the timeliness and quality of care and effective management of expectations. Respondents identified various practical interventions that could contribute to this. They proposed that patients be managed in an environment appropriate to their condition with allocation supported by routine patient screening for risk of violence, using a structured screening tool. Where risk was identified management plans should be developed and shared with all stakeholders, and SNs should not be allowed to work alone with patients identified as at risk for potential violence.

> Students not being allowed to care for aggressive/inappropriate patients on their own without direct supervision. Nurses ensuring to give proper handover to students so that they know which patients to be aware of in terms of violent/sexual behaviour.

6 | DISCUSSION

Although there is difficulty performing direct comparisons with other WPV studies due to the inconsistencies in definitions of violence, the results of this study are consistent with those of other Australian and international studies with a focus on the SN. In this study, more than half (66%) ($n=201$) of the SNs had experienced verbal violence and more than a quarter physical violence ($n=84$, 26.5%) during clinical placement. In the most recent previous Australian study, which surveyed SNs and their experience of WPV, half the SNs (50.1%, $n=446$) reported experiences of harassment during clinical placement and 9% had experienced physical abuse (Hopkins et al., 2014), whereas our findings are higher. It is possible that the difference is in part due to difference in definitions relating to physical violence between studies. In a recent study in the United Kingdom, 55.8% (72) had experienced acts of physical aggression (Hallett et al., 2021).

The number of clinical hours completed in the United Kingdom is 2300 (Hallett et al., 2021), much greater than the 800 h required in Australia with the greater duration of clinical placement allowing more opportunity for WPV to occur, possibly accounting for the variation in findings. No level of violence is acceptable, as any level or degree of violence can negatively impact SNs' physical and psychological wellbeing, as well as affect their desire to remain in the workforce and question their career choice (Budden et al., 2017; Hallett et al., 2021).

In this study, nearly one in five SNs (19%, $n=54$) reported they experienced sexual harassment. This is considerably higher than the number of SNs who reported sexual harassment (11.6%, $n=96$) in the most recent previous Australian study (Budden et al., 2017). Nursing by nature requires close body care and the sexualisation of nurses increases SNs' vulnerability to sexual harassment, possibly accounting for the reported increase in sexual harassment incidents (Smith et al., 2023). The international '#MeToo' movement which gained international traction in 2017 may have contributed to increased understanding that such behaviour is unacceptable and influenced reporting rates of unwanted sexual behaviours in this study (Smith et al., 2023). Although we pose that reporting of sexual harassment has increased, reporting incidents overall was poor. We interpreted the response of 'completing an incident form' as formally reporting an incident, with results showing that the reporting rate was lowest at 4% for racially motivated violence and ranged to only 20% for physical violence. As reported in the literature, despite nurses understanding the importance of reporting incidents of WPV, only serious violent incidents tend to be reported as violence is viewed as just part of the job (Dafny & Muller, 2021). Organizational barriers such as a lack of time and resources, heavy workloads, reporting systems which are not user friendly and a lack of follow-up or belief that nothing would change also impede reporting and devalue any violent incident (Dafny & Muller, 2021; Karatuna et al., 2020). Underreporting presents an underestimation of the true extent of the problem, and without the knowledge of the full spectrum of events to which SNs are exposed, there is a perception of less of a need for preventative measures against WPV (Arnetz et al., 2015).

The results of this study indicate patients were the most frequent perpetrators in all categories reported by SNs in this study, like the findings of Hallet's recent study which identified the patient as the most common instigator of acts of racism, physical violence and harassment (Hallett et al., 2021). The textual comments frequently identified RN as perpetrators of WPV, aligning with a synthesis of findings in a recent systematic review of WPV which found that all included studies ($n=18$) identified nursing staff as the main perpetrators of WPV. In Meissner (1986) coined the phrase 'nurses eating their young' to describe toxic personal interactions between junior and senior nurses. Some 30 years later, there is still an ingrained culture of disrespect between SNS and experienced staff, with staff across all levels of hierarchy have been found to be responsible for incidents of WPV and have inappropriately used their position of power (Birks et al., 2017; Meissner, 1986). Despite there being a professional requirement to mentor the future nursing workforce, elements of the mentoring role have been the cause of incidents of WPV (Hallett et al., 2021) with similar findings in this study. There are inherent

challenges in providing education in environments designed for clinical service rather than education and SNs perceived staff to be frustrated with the dual role of clinician and student supervisor, causing stress, prompting uncivil behaviours and creating what SNs described as a toxic environment. The feeling of being unwelcome in the clinical area has resulted in SNs reporting anxiety and stress long-term emotional distress, loss of confidence, reduction in learning opportunities and even causing them to question their career choice leading to attrition (Dafny, McCloud, Pearson, et al., 2023). Creation of an environment where the supervisor role is valued and supported, and SNs are welcome is an immediate area of need. Having a dedicated student supervisor to be the bridge between academic and healthcare settings and to provide adequate support for SNs and the staff who work with SNs daily may be of use (Birks et al., 2017). Part of this role could also encompass advocating for SNs, ensuring incidents are reported without fear and ensuring follow-up support is provided, therefore mitigating the impact of WPV (Birks et al., 2017).

The proportion of respondents reporting racial harassment (18.8%, $n=54$) in this study was similar to a previous Australian study which reported 18.6% (Budden et al., 2017). In this study, it was perceived a SNs' ethnicity, particularly not being White, contributed to WPV. This is consistent with other studies where verbal racial abuse was instigated by not only patients (Hallett et al., 2023; Tee et al., 2016), but also staff, who made comments intended to humiliate SNs (Hallett et al., 2021; Meissner, 1986; Minton & Birks, 2019) enabling the culture of WPV to thrive. Alarmingly, the most common action after an episode of racial violence was to take no action and this poses the question as to whether this is accepted as 'part of the job' and as reported previously supports the normalization of incidents of violence (Dafny & Muller, 2021). In nursing education, the development of nurses to deliver culturally safe care (Nursing and Midwifery Board of Australia, 2018) is promoted, yet there appears to be little dialogue or emphasis about experiences of acts of racism directed towards nurses. Patient to nurse racism has a reciprocal effect on patients as it hinders the nurses' efforts to meet patient needs, leading to a reduction in quality of care and a cyclic pattern of abuse continues (Vaismoradi et al., 2022). Racism towards nurses also causes emotional trauma and job-related stress, leading to job turnover (Vaismoradi et al., 2022). There is the high percentage of foreign-born nurses working in Australia (38% in 2016) and the forecasted shortage of 123,000 nurses by 2030 (World Health Organization, n.d.) indicates that overseas recruitment will continue and therefore ignoring racist comments to staff cannot be ignored (Safari et al., 2022).

WPV experienced by SNs is not a result of individual factors but rather an interconnection of student, patient and organizational factors (Hallett et al., 2023) and SNs written responses were reflective of this. In this study, SNs demonstrated some insight into patient personal characteristics of patients which they perceived to precede violent behaviours. Patient care occurred in a clinical environment characterized by staff shortages, inappropriate skill mixes of staff while balancing an often-unwanted role of student supervision causing acts of aggression. The working environment was comprised of a combination of factors known to contribute to the inability to meet patient's immediate needs, also known cause of aggression, therefore creating a perfect storm (Hallett et al., 2023). Previous studies have highlighted that preparation to work in the clinical environment requires SNs to be equipped with a comprehensive understanding that the cause of challenging behaviours may be combination of intrinsic and extrinsic factors (Dafny, McCloud, Champion, et al., 2023; Hallett et al., 2023).

There is emerging evidence that education providers should prepare for clinical practice using trauma informed care principles which may be useful and alternate lens to view why WPV may occur and how to avoid WPV (Hannah Kamsky, 2019). A trauma informed approach to the delivery of healthcare acknowledges the prevalence of toxic stress and trauma in healthcare consumers. Fleishman and colleagues suggest simple strategies in applying a trauma informed lens to practice by asking three simple questions—'do my actions and words cultivate a sense of safety; am I and others showing respect; do my actions and words build trust?' People accessing healthcare may inherently have past interpersonal trauma, potentially affecting mental and physical well-being (Hannah Kamsky, 2019). Clinical environments often present as stressful situations to these individuals, threatening their sense of safety, resulting in reactivity and aggression to healthcare providers, such as SN who may be their closest point of contact.

Introductions of SN and their role in every patient interaction may assist patients to understand the plan of care and empower them to be actively engaged in their own care (Hannah Kamsky, 2019). Using non-threatening body positioning helps conveys trust and a sense of value. Past trauma has often been associated with surprises and may have been unpredictable. Touch, even when appropriate and necessary for providing care, can easily activate a fight, flight or freeze response (Beattie et al., 2019).

Understanding and applying a trauma informed approach to care can assist in building strong patient staff therapeutic relationships, potentially reducing WPV perpetrated by patients (Beattie et al., 2019; Hannah Kamsky, 2019). It must be acknowledged that the COVID-19 pandemic and related stressors of fear for personal safety, isolation, prolonged experiences of stressful working conditions also put healthcare staff at risk for trauma responses (Hannah Kamsky, 2019). The impact of COVID-19 has resulted in burnout and stress, known contributing factors to an increased number of WPV incidents (Beattie et al., 2019; Hannah Kamsky, 2019). Trauma informed care considers healthcare providers own history of trauma, acknowledged that this may affect how staff respond to WPV perpetrated against them (Hannah Kamsky, 2019; Safari et al., 2022). Healthcare organizations which have a workplace culture underpinned by trauma informed care may help build a culture where employees understand what happens to clients that causes them to instigate violence against healthcare providers and implement systems and strategies to respond to such threat. This may positively contribute to an environment conducive to clinical and professional learning.

6.1 | Strengths and limitations

The COVID-19 pandemic caused a surge in research activity and a rise in survey-based studies due to the restrictions posed on data collection methods. A relatively small percentage of SNs enrolled in nursing course responded to this survey which was conducted in the immediate post COVID-19 period and therefore survey fatigue may have influenced the response rate in this study. The analysis of free text responses however allowed integration of survey data from a relatively large number of SNs to be combined with the richer textual data therefore enhancing our understanding of the phenomenon. Self-reported measures can be influenced by factors such as recall bias and social desirability. The effects of WPV are long lasting and SNs who had experienced WPV may have not felt comfortable recalling their experiences. It is possible that the title of the survey attracted only those who felt they had an experience to report, therefore biasing the sample. The generalisability of this study is limited by the sample size and that this study was only undertaken in Australia. This study used a cross sectional design which does not allow for causality to be established and the small sample size limited exploration of relationships between variables.

6.2 | Recommendations for future research

SNs are the workforce of the future in Australia and internationally. The important findings of this study are worthy of exploration to ascertain the extent of WPV among international student cohorts. Implementing interventions based on theoretical frameworks such as trauma informed care will extend the knowledge of and inform practice for prevention of WPV. Further research should address this study's identified limitations and seek to extend the findings of this study. The free text responses received in this study were significant and the use of interviews would provide greater exploration of SN experiences. The proportion of males in this sample was too small to permit any exploration of this variable, but further research may explore gender and frequency of WPV by SNs. Further work should aim to identify and evaluate strategies such as those informed by trauma informed care to prevent WPV incidents and the reduction of impact of WPV when it occurs.

6.3 | Implications for policy and practice

The findings from our study have implications for education providers and healthcare organizations. SNs are vulnerable in the clinical environment and need an advocate to support them in the instance of incidents of WPV. Education providers can prepare SNs to understand and apply provide trauma informed principles of care in the clinical environment to mitigate risk of WPV. Healthcare organizations can also benefit from using these principles and recognizing and addressing the impact on self and others working in a stressful environment.

7 | CONCLUSIONS

There is a connection between a positive and supportive clinical learning environment and a desire for SNs to continue in the nursing progression. There is an unacceptable proportion of SNs experiencing WPV from a range of sources during clinical placement and strategies to mitigate WPV must therefore address these sources. SNs will continue to care for a range of patients, and therefore must be equipped with an understanding of types of violence and the triggers and instigators of WPV which may occur in their role as caregiver. It is evident that SNs need significant support during clinical placement, and this usually lies with RN working with SNs. This additional burden potentially causing hostile interactions between nurses and SNs may be lessened by RN feeling supported in their role as student supervisor. Education providers can provide information needed on what is expected from them as supervisors and provide strategies to support and facilitate student learning. Healthcare organizations, who are relying on SNs to be next generation of workforce, could also take a role in supporting the RNs who play such a key role in SN supervision.

AUTHOR CONTRIBUTIONS

Project conceptualisation: SJ and AF. SJ and SP led data analysis and initial manuscript draft. RJ, data integration. Contribution to manuscript revisions, subsequent reviews and editing: HD, JP, RJ, SP, AF and JD. All authors approved submitted version of the manuscript.

FUNDING INFORMATION

This project was funded by a Queensland University of Technology Seeding Grant and Australian College of Nursing Myrtle Ivy Quicke Founders Scholarship.

ACKNOWLEDGEMENT

Open access publishing facilitated by Queensland University of Technology, as part of the Wiley - Queensland University of Technology agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

This study was funded by grants awarded to the lead researcher. This funding was used to provide financial support for research assistance in data collection, analysis and interpretation of data. No financial assistance was provided to any other members of the research team during this project.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16189.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

This study was approved by Queensland University of Technology Human Research Ethics Committee #5717. The statistics expert on the author team was Susan Patterson.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Johnston, S., Fox, A., Patterson, S., Jones, R., Dafny, H., Pich, J., & Duff, J. (2024). Australian nursing students' experiences of workplace violence during clinical placement: A cross-sectional study. *Journal of Advanced Nursing*, *80*, 4933–4945. https://doi.org/10.1111/jan.16189