Exploring the experiences of workplace stress and support for non-clinical staff, in front line roles in a rural public health services.

And I don't mean to sound like it's all terrible and horrible, I also love my job and I love dealing with people who need someone on the front desk, the sick ones, the broken ones, the young mums, the elderly, that's why most of us do what we do, we love to help people, but it would be nice if occasionally someone helped us too. I.3

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Abbreviations:

HSE	Health and Safety Executive
NCS	Non-Clinical Staff
PHS	Public Health Service

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Abstract

Aim

The aim of this study was to explore the experiences of workplace stress and support for non-clinical staff (NCS) in front line roles in a rural public health service (PHS).

Methods

This is an explanatory sequential mixed methods study commencing with an online questionnaire, prior to 1:1 interviews. Thirty-four participants responded to the online questionnaire and six people participated in the 1:1 interviews.

Results

Non-clinical staff experience stress in the workplace based on a variety of situations including their reported exposure to occupational violence in the form of bullying, verbal and physical aggression, or stress after exposure to a clinical incident. Non-clinical staff also experience high workplace demands, low to medium levels of control and low to high support. The results also found that NCS are resilient, and are likely to access informal supports from peers, clinical colleagues, family and friends. Interestingly, NCS who have two management pathways (i.e. clinical and non-clinical) found accessing higher level supports a complex process. Non- clinical staff would access role specific training including de-escalation training. While, NCS in complex roles with a higher risk of exposure to occupational violence or trauma after a clinical incident would like to attend debriefing and supervision similar to their clinical colleagues.

Conclusions

This study identified that NCS do experience stress in their workplace; high work demands and medium to high levels of control over their work practice; with low to high levels of support. While NCS in clinical teams identified having two management pathways, can at times add to increase levels of demand, lower control with support options being more complex. There are several opportunities to reduce the experience of workplace stress and improve support for NCS in front line roles in rural health services. These include organisational acknowledgement that NCS are exposed to a variety of complex presentations, and review their current support options. For some roles such as community health intake, emergency and mental health services that NCS be provided with role specific knowledge and training regarding their increased risk of exposure to occupational violence, trauma (including death) and adverse outcomes from clinical events. That NCS in particularly complex roles are provided supervision similar to clinical supervision, and that when a team debrief is required, all relevant NCS are invited and supported to participate.

Key Words

Non-clinical staff, workplace stress, workplace violence, public health service

Executive Summary

Context

Public and private health services have long understood that while conducting their daily work activities, clinical staff may be exposed to a variety of incidents that might contribute to their experiences of stress in the workplace. These incidents may include work place violence, bullying and potential trauma after exposure to a critical event. In support of addressing these issues, organisations such as NSW Health have developed a Zero Tolerance Approach to preventing and managing violence that incorporates all staff. Clinical staff currently has access to role specific training, and clinical supervision which acknowledges their exposure to and need for support after stressful incidents in the work place. Limited research has focused on front line NCS who may also be exposed to the same variety of incidents during their work day.

This research acknowledges the limited research into the experiences of NCS staff in PHS, including if they experience stress and what supports are currently available to this cohort. Further, that NCS are often seen as ancillary staff which the research reflects are often not identified as being front line workers and therefore not considered to be as impacted by adverse events as their clinical colleagues. This in and of itself may have impacted on organisational consideration of what supports should be provided or if they were even required. As such this research aimed to explore the experiences of work place stress and support for non-clinical staff in front line roles in a rural public health service.

The Study

This explanatory sequential mixed method designed (Quantitative → Qualitative) research aimed at exploring NCS's workplace stress in context of their exposure to or experience of bullying, work place violence, and trauma after a clinical event. Eligible NCS included:

- Aboriginal health workers,
- Administration workers,
- Health and security assistants,
- Community health intake workers,
- Health information (medical records),
- Patient Transport drivers, and
- Wards men.

Eligible NCS were contacted and invited to participate in the research. Participants completed an online questionnaire developed to explore their workplace experiences of or exposure to workplace violence, bullying and or potential trauma due to exposure to clinical incidences. Further exploration within the questionnaire considered the domains of demand, control and support which considered their generic work roles, but also considered the above mentioned experiences. Participants were then invited to participate in 1:1 interviews to further explore how these experiences impacted on their workplace stress and what support options they access.

The Results

The results of this study indicated that like their clinical colleagues, NCS are exposed to or experience a variety of workplace adverse situations that increase their feelings of stress, but lack the variety of supports available to their clinical colleagues.

The results also indicated that many staff have high demand roles, and some control over their work routines i.e. meal breaks and hours worked. However, this seemed to be in contrast to their feelings of low control over changes to their work responsibilities and who to go to for support about their work roles. That many staff felt that they have inconsistent support after adverse incidents such as the death of a patient, trauma in the

workplace or bullying by staff or public health users. Despite this, participants felt that for the most part, they have positive relationships with peers and nursing staff, and would be interested in participating in a variety of internal formal supports such as training, debriefing and supervision, reducing the reliance on family and friends.

Recommendations

It is recommended that:

1. Organisational acknowledgement that NCS in front line roles are also exposed to or experience complex presentations by public health users.
2. That a review of the current supports offered to NCS occurs in consultation with NCS.
3. That NCS in roles such as emergency department and mental health services be provided at the commencement of their employment, with role specific knowledge and training regarding their increased exposure to occupational violence, trauma (including death) and adverse outcomes from clinical events.
4. That NCS's are provided training (available in their work hours) including but not limited to de-escalation, trauma informed care and self-care.
5. That NCS in emergency departments, mental health services and intake roles are provided supervision similar to clinical supervision.
6. That when a team debrief is required that all relevant NCS are invited and supported to participate.

Introduction

It has been long acknowledged that while undertaking routine aspects of their roles, front line clinical workers in public health service (PHS) may experience stress in the workplace due to experiencing or being exposed to a variety of adverse situations. These situations may include occupational violence including, verbal or physical acts of aggression, or adverse clinical incidents including the injury or death of a patient. Many studies [1,2,14,15,16,17,18,19,20,21,22] have highlighted the need to provide front line staff with a support options including, debriefing (individual or team based), clinical supervision, and training to assist with identifying and de-escalating individuals and situations. What is limited in the research are the experiences of stress and support for NCS including when an adverse workplace situation occurs while they are undertaking their routine work roles.

This report informs those parties involved in the management of NCS as well as training providers and policy makers about the findings of a study to explore the experiences of stress and support for NCS in PHS whose front line roles increase their exposure to adverse workplace situations similar to those of their clinical colleagues.

Literature Review

Non-clinical Staff in Front Lines Roles

Rural communities often have limited community based medical or mental health support options in the private health sector, as such the PHS are regularly overburdened with a variety of complex presentations. [1, 2] Service users of PHS often present when they are in crisis, have experienced a trauma, are distressed or require mental health support. [2] In particular, PHS departments such as the emergency department, the mental health inpatient and community team office and the community health intake line are likely to be the first point of contact for many distressed service users. [2] The first point of contact for service users accessing a PHS are NCS in roles such as administration, wards man, health and safety assistance (HASA's). During a hospital admission or when attending clinical appointments service users may also engage with NCS including Aboriginal Health Workers and patient transport drivers. Phone contact with NCS occurs in community health intake services and when requiring access to their medical record. Trauma informed care, patient centred care, multidisciplinary teams, support and supervision are some of the key concepts that a PHS uses to develop policy and practice, and inform training and supports options for staff. The end focus for all health services is to provide patient centred care to all service users and thereby improve health outcomes.

Workplace Stress

Public health service employees in a variety of workplaces deal, with an assortment of unexpected pressures that are often unavoidable due to the modern work environment. Depending on where they are located within the PHS structure, staff members can be exposed (repeatedly for some) to face-to-face or over the phone acts or threats of violence; disclosures of risk of harm to self or others; or details of the service user's experiences of distress. Workplace pressure in isolation, is not necessarily deemed as unhealthy, nor is unexpected pressures in of themselves considered to contribute to an unhealthy work environment. [3, 4] In fact, if the pressure is kept at an acceptable level, and only occurs for a limited time and appropriate resources are made available, workers may even be more alert, motivated, and able to work and learn tasks faster[4]. Resources can be provided by the organisation, but can also include the staff member's personal characteristics, including their pre-employment training, and their ability to recognize and seek appropriate support when dealing with the initial stages of workplace stress. [5,6] However, when the workload related stress becomes unmanageable; excessive or prolonged; and is in the absence of appropriate supports by colleagues and management; and when a worker's role does not provide them the ability to manage their own workload, then workplace stress can occur. [7]

The WHO's (nd) *Occupational Health Stress at the Workplace* describes a healthy work environment is one in which "the pressures on an employee are appropriate in relations to their abilities and resources, to the control they have over their work, and to the support they receive from people who matter to them". [7. p1] While this definition of a safe work environment reflects the generic aspects of a workers role, additional consideration is required to consider a safe work environment in context of the potential for workplace violence which is increasing globally, in a variety of workplaces and across occupational groups. [8] Workplace violence is defined by the WHO as being any physical or psychological "incident where staff are abused, threatened or all 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". [8] This concept of a safe work environment correlates with the idea that a workplace is not simply defined as a place that is 'absent of harmful conditions' but is a workplace abundant of 'health promoting ones'. [7. p1] As such workplace stress can be defined as when the work load and demands do not equal the knowledge, skills and ability of a worker and that this can be compounded by a lack of perceived support by colleagues, management and the systems they work within. [7, 8]

In Australia, work-related stress is the second highest compensable illness or injury after musculoskeletal disorders. [9, 10] The major negative impact of work-stress on an organisation is a reduction of service performance. Identified indicators include reduced productivity and efficiency; lower job satisfaction; morale and cohesion may decline; absenteeism and sickness absence may increase; there may be an increase in staff turnover; accidents and injuries may increase; conflict may increase and the quality of relationships may decline; client satisfaction may be reduced; there may be increased heath care expenditure and workers compensation claims. [5, 6] Identified contributing factors include: work demands; low levels of control; poor support from supervisors and/or co-workers; lack of role clarity; poorly managed relationships; low levels of recognition and reward; poorly managed change and organisational justice. [5,6] Safe Work Australia's 2013 report on workers compensation claims advised that mental stress claims are the most expensive type of claim due to the length of time typically away from work and were predominantly within the sub group Work Pressure claims. [4] The health sector was one of the industries that dominated the Exposure to Traumatic Event sub category, with the majority of workplace hazards identified that resulted in a claim for Mental Stress including exposure to 'workplace or occupational violence' and high levels of work pressure. Conversely, 70% of workers who reported to have experienced work-related stress do not make a compensation report. [4] The same Safe Work Australia report found that the financial burden of work-related stress to the Australian economy was $14.81 billion with the direct cost to employers due to presenteeism (reduced productivity due to being unwell at work) and absenteeism (sick days taken when unwell) being $10.11 billion. [10, 4] These figures do not include the cost of recruiting and re-training the expected high levels of staff turnover due to stress. [10, 4] With such a high number of claims, the impact on the health system and individual organisations is substantial.

Zero Tolerance to Violence

All staff in PHS are at risk of exposure to occupational violence and a variety of broad organisational supports have been put in place to mitigate incidences of this type of workplace violence. This includes NSW Health's *Preventing and Managing Violence in the NSW Health Workplace – A Zero tolerance Approach* which supports that NSW Health employees and public health users have "…the right to work in a safe workplace. Patients and visitors have the right to visit, or receive health care in a therapeutic environment free from risks to their personal safety and from any exposure to violence". [11. p.1] This zero tolerance identifies that no clinical or NCS should at any time be exposed to occupational violence in their workplace, that all staff are to be provided training to ensure they have the skills to "respond promptly, consistently and appropriately" (p1. 2015) to a variety of incidences to reduce escalation or repeated occurrences. NSW Health and Safe Work NSW are committed to reducing physical and psychological workplace injuries and increasing safety for anyone who comes into contact with a PHS. This is evidenced within the *Health Processionals Workforce Plan 2012-2022* [12],

and the Safe Work NSW *Work Health and Safety Roadmap for NSW 2022* [6] a six year strategy with a focus on reducing unnecessary compliance costs and securing safety standards to reduce workplace harm. This *Roadmap* like the Safe Work Victoria [9] framework encourages all stakeholders including peak bodies, associations, community leaders and each employer, and worker to be an active participant in reducing workplace fatalities (by 20%), serious injuries and Illness (30% including mental health) and serious musculoskeletal injuries and illnesses (by 30%). [6] Safe Work NSW [6] have also adopted a shortened seven question version of the Health and Safety Executive's (HSE) longer 35 questions *HSE Management Standards Indicator Tool* [13] to assist in assessing for work related work place stress.

Current research - non-clinical staff in public health services

While there is an abundance of research into the impact of workplace stress for clinical staff in front line health roles, there has been a significant lack of research for their non-clinical colleagues in Australia. [1, 2, 14, 15, 16] The minimal research that has occurred in Australian PHS has primarily focused on administration staff or NCS in mental health services. [1, 2, 14, 15, 16,17,18] In some of the only research conducted within an Australian PHS setting which focusses on non-clinical front line staff, Rohena Duncombe [1, 2] acknowledges limited research focusing on the role of 'receptionists in health services' while undertaking research into the impact on clinical and NCS in intake roles in a rural community health setting. In her findings Duncombe [1, 2] identified that, administration staff are often the first point of contact for both phone in and walk in service users; that consumers may be frustrated by limitations to access services; that they unburden their stress and trauma to administration staff; and that services support a range of service users comprising drug and alcohol, mental health, trauma and complex trauma, including recent assaults, across the lifespan. [1] These factors are often more complicated in rural communities as limited staff numbers increases opportunity for NCS to take referral information, or work with friends, family and colleagues. Further, Duncombe found that there are direct positive implications (i.e. reduction) to Work Health and Safety issues; by ensuring receptionists are resourced, supported in their role, and included in intake system development. [1] That learning approaches such as the situated learning method, often used by NCS, could be supplemented by in internal training options. [1] As such, Duncombe's [1, 2] findings support the development of a PHS framework that acknowledges frontline NCS as first point in intake and service delivery and that there is a benefit to the PHS, their staff and their service users if role specific support and training was provided.

Similar research in the private health sector includes Magin et al studies, which focused on developing a clearer picture of the occupational violence experienced by non-GP staff in private medical practices. [19, 20, 21] Types of violence identified by Magin et al, and which public health staff are also exposed to includes "verbal abuse… assault, threats, property damage, intimidation, manipulation and stalking". [19. p.580] That while occupational violence occurs in a variety of public health roles, front-line health care workers including NCS are at an increased risk of exposure to occupational violence. [20, 21] National and international studies of private sector receptionists suggest that this particular cohort experience workplace violence as a common occurrence and that responses to manage this should be addressed by the whole of the organisation. [20, 22] Ward and McMurray's [22] international based research focused on the emotional management of NCS research and highlighted the vast array of tasks undertaken by 'receptionists' include "…routine tasks such as checking-in, booking appointments, filing, coding and directing. Supplementing these were more complexly 'relational focused'" activities such as "language barriers, psychological, and mental health". [22. p. 1584] Similar to Australian researchers [22] found that little research has occurred for NCS, and that NCS routinely go beyond the basic aspects of their roles. That whilst not stepping into the area of clinician they too were exposed to the emotions of service providers and that NCS develop their own emotional responses including empathy or neutrality and that depending on the service user they were attending to they switched between the two. Ward and McMurray [22]suggest that this juxtaposition of responses

is a characteristic of NCS and allows them to transition smoothly between empathetic or neutral performance modes.

While John Rodwell and his co-authors [14, 15, 16] have contributed to the research of the experiences of NCS in particular administrative staff by considering the impacts of bullying on health care administration staff which identified that "the consequences of bullying included decreases in well-being" [15.p. 337]; aggression towards administrative staff that identified administrative staff as employees who may be perceived as "lower on the organisational hierarchy" [14, p. 889] and this may contribute to their being more vulnerable to workplace violence, bullying and harassment. When Rodwell et al, [16] used demand-control-support model to consider the workplace experiences for NCS they found that when the work demand and control equitable then this will increase the levels of job satisfaction and like other support options that equitable work practices increase job satisfaction even in high demand low control roles. [16] All these papers acknowledge the dearth of research undertaken and identify that previous research often draws comparisons from other fields such as nursing and allied health. That administration staff are often included in broader general staffing demographics such as 'catering and maintenance'. [14] As such, there is a gap in the research that explores a variety of NCS roles in a PHS that considers exposure to or experiences of occupational violence whilst also considering how workplace demands, controls and supports impact on their experiences of stress and what supports are available

Demand Control Support

Non-clinical staff are also at risk of stress due to the limited control they have over their roles including options for managing organisational demands. This can be further compounded in complex work teams where there is an increased requirement for NCS to be flexible with their work tasks and priorities, which can potentially be impacted upon by complex clinical incidents that may be occurring. As such, it is important to understand the impact that workplace demand, control and support have on workplace stress for NCS. The HSE's *Management Standards Indicator Tool*, incorporates the work by Robert Karasek's [23] Job Demand-Control model, which identified a relationship between high demand work levels and low control over task content, as having a direct impact on an individual's health. Furthering this concept, Jeffrey Johnson and Ellen Halls' [24] work identified the conception that supports can potentially modify a stress outcome, and that workplace stress needs to be understood from a place of assessing Demand-Control and (-Support). As such the Job Demand-Control-Support model has endured as one of the most influential models for understanding ad assessing for workplace stress. [25, 26, 16] An example of the utilisation of this approach is the *HSE Management Standards Indicator Tool* [13] a work related stress tool to encourage and assist individuals and organisations to increase their understanding of workplace stress levels. The HSE's website also provide a suite of supportive documents such as *HSE Management Standards Analysis Tool User Manual [27], HSE How to Organise and Run Focus groups [28]*, these are just some of the support that the HSE provide including how to run concurrent reviews to monitor and manage.

Support options

When contemplating support options for NCS some of the possibilities include a combination of mentor or buddy programs, counselling or clinical style supervision either in a group or 1:1 similar to that provided to allied health clinicians and medical staff. [1, 2]In particular, support after a traumatic workplace event, or being exposed to workplace violence or bullying and harassment. [1,2] The benefits of supervision for clinical staff are well documented and supported by NSW Health. Including the production and publication of several documents developed by the Health and Education Institute (HETI) that support the evidence based benefits of supervision to front-line staff including a variety of 'Supervision Superguides' for Allied Health Professional [29]; for Oral Health Professionals [30]; for Nurses and Midwives [31]; and for Doctors. [32] What is absent from these guides is a guide supporting non-clinical front-line staff. A review of the framework around clinical supervision acknowledges the need for clinicians to receive supervision that is reflective of their "different settings, disciplines and career

stages" and that supervisions purpose is to support clinicians "ensure safety and quality of patient care… assist health professionals to reflect on their practice in a confident, safe and supportive environment in the provision of quality care". [29, p. 5-6] The opportunity to obtain support, reflection to manage complex work environments and guidance regarding professionalism, role responsibility and debriefing after traumatic incidence should be a requirement for all front-line staff not only clinicians. Duncombe [1, 2] reports that receptionists would benefit from 'training related to mental illness and communication skills'.[2] Also, that receptionists and services would benefit from inclusion in a collaborative inclusive approach to 'system review and planning'. Implications for practitioners, management and services include developing a framework for 'the receptionist role as first point in intake and service delivery'. The implications (i.e. reduction) to WH&S 'by ensuring receptionists are resourced, supported in their role, and included in intake system development'. [1, 2]

Limited attention in research and service development has focused on the identification of NCS as front-line workers or their experiences of workplace stress and what support options are available. The research that is available identifies a need to provide this cohort of health staff with a formal support framework that addresses their exposure to violence and trauma in the workplace and their increased risk of workplace stress. As such this research aimed to provide a baseline of understanding regarding workplace stress for NCS in a PHS; how they perceive that stress and understand and/or utilise the correlating supports; and if there are any perceived gaps in the support options that are available.

Research Aim and Question

This study aimed to explore the experiences of NCS in a rural PHS including their workplace stress, the implication on their roles and what support options do they currently access or would they access if available. The aim of the study was to gain an understanding of any issues involved in the daily work roles and opportunities for improvement in support options.

The researcher set out to explore if there is workplace stress and supports for non-clinical staff in front line roles in a rural public health services?

A mixed methods study design underpinned by a post positivist theoretical perspective was used. This approach was chosen because of its focus on studying social groups while understanding that society is relatively stable, while also acknowledging the position of the research in the context of the research question, design and interpretation of results. [33, 34]

Ethics Approval

This study was granted ethics approval on the 29th August 2018 by the Greater Western Health Research Ethics Committee 2018/ETH00267. On the 22nd November 2018 Site Specific Assessment approval was authorised 2018/STE00201.

Conflict of Interest - No conflict of interest is declared.

Study design

Through the use of an explanatory sequential mixed methods design (Quantitative →Qualitative) insights into the experiences of workplace stress and support options were gained via completion of an online questionnaire and 1:1 interviews by eligible participants. An Explanatory Sequential Mixed Model design is supported by the concept "that most if not all intervention situations would be dealt with more effectively with a blend of methods from different paradigms" [36. P, 143] and that each data collection informs the next stage of the data collection process. This approach allowed the research to explore not just what NCS experience by why and how

this impacts their workplace stress. Using a post-positivist framework, the questionnaire (Appendix 1) asked participants to provide information regarding general demographic information; their exposure to or experiences of workplace violence; what support options they do or would access; and included a version of the HSE's *Management Standards Indicator Tool* (a 35-item questionnaire on work place stress). Due to the length of the final questionnaire (see Appendix 1) the researcher chose to simplify the process by having all answers as only being never-seldom-sometimes-often-always. This is different to the HSE's version which has strongly disagree-disagree-neutral-agree-strongly agree as the answers for questions 24-35. While it is not anticipated that this will have an impact of the research findings in this report, it does mean that comparisons to similar reports that used an unaltered version of the tool will be limited.

Utilising a descriptive analysis, the results from the questionnaire were reviewed and key themes identified and extrapolated to develop semi structured interviews (Appendix 2). The interviews were then transcribed, coded with main themes identified. Thirty four of the 93 eligible potential participants completed the online questionnaire, of those seven participants agreed to participate in 1:1 interviews. However, unfortunately only six of the seven were interviewed on their experiences of working as NCS in a PHS due to unavoidable scheduling conflicts. However, data saturation was achieved within the analysis of the six transcribed interviews. .

Setting and Participants

The research was conducted within a rural community in southern NSW. This community is serviced by one regional hospital with an onsite community health, community mental health drug and alcohol service, a mental health inpatient unit, one small local hospital, and two stand-alone community health offices. Convenience sampling was used for recruitment for both online questionnaire and the individual interviews. As this was a sequential mixed methods approach eligible participants were initially contacted and invited to participate in an online questionnaire. Emails containing Participation Information Sheets; a link to the online questionnaire; a printable copy of the questionnaire including the location of a secure drop box were sent out. Participants were aware via the Participation Information Sheets that completing and submitting the questionnaire indicated their implied consent. At this time participants were also advised that this was a two staged process and information about the focus groups was also included. Emails were sent to 93 eligible participants whose information was available via local health directories. The generated list covered non-clinical frontline staff employed within a rural public PHS located within a rural community who work directly with service users and who are from the following professions: Aboriginal health workers, Administration workers, Community Health Intake workers, Health Information (medical records), Health and Security Assistants, Patient Transport drivers, Wards-Men. Due to limitations of the study, participants were excluded if they worked in the Health Services sector, if their role did not have direct contact with public health users or if they were not proficient in English.

Participants had eight weeks to complete the questionnaire and to respond to the researcher their interest in attending focus groups. Thirty four participants meeting the inclusion criteria completed the questionnaire – 33 completed the online version and one participant completed the paper-based version and the researcher uploaded these answers to the online version. Participants who indicated their interest in the focus groups was low, with only three responses in total. This had been an anticipated outcome, and the researcher provided an alternative option and sent out a revised email inviting participants to 1:1 interviews, leading to six participants being interviewed. All interviews were held in the same room in the Community Health area of the hospital. All interviews were audio recorded and conducted solely by the researcher. Time constraints contributed to the interview questions not being pilot tested, however they were in line with the questions covered in the questionnaire which was scrutinised by three of the researcher's work colleagues; transcripts being transcribed by an external agency; and participants not having an opportunity to review their individual transcripts.

Data Analysis

A Descriptive Analysis was used to identify repetitions in the questionnaire data. As this is an exploratory study, the goals were to describe and analyse the data to see if patterns emerged. [33] These patterns where then used to inform the semi-structured interviews. The transcripts from the 1:1 interviews were analysed utilising a Framework Method, this method required deeper emersion of the data, by having the audio recordings transcribed verbatim (word for word) to allow for immersion in the data as part of the coding process. As such, while the transcribing of the interviews was outsourced, the researcher spent time in reflection of the interview by reviewing both the audio recordings and the transcripts allowing for a deeper engagement with the data, which is strongly encouraged for novice researchers. [37] Coding of the data from both the questionnaires and the 1:1 interviews was an ongoing process to ensure a holistic understanding of the data was achieved. The data was then reviewed by an experienced mentor who has been supporting this study to ensure that a working analytical framework is achieved. With the analytical framework in place, the last of the transcripts were coded and themes emerged and were discussed with the research program mentors and educators again to ensure that the findings generated reflected the data and not simply the expectations of the researcher. [37]

When analysing the data, and during consideration of how to report the findings, the researcher reflected on NSW Health's Zero Tolerance Approach to violence in the workplace [11] and the WHO's framework for a safe workplace including experiences of workplace stress and violence. [7, 8] The data analysis indicated that of the 34 participants who participated in the questionnaire, not one participant selected the Never answer to all questions asked. This lead to the concept that all staff who selected Seldom, Sometimes, Often and Always as their answer were answering Yes to having experienced at least one or more combined incidents of bullying by peers; bullying by clinical staff; violence or acts of aggression in the workplace by a colleague; violence or aggression in the workplace by public health users; personal harassment in the form of unkind words or behaviours; stress relating to incidental involvement with clinical events. As such the results in the graphs are shown as percentages of all participants who provided a Yes answer in the questionnaire, thereby combining all answers within the scale range Seldom, Sometimes, Often and Always as a single Yes answer. Further, in reporting the results, the quantitative and qualitative data will be combined, with the goal to reflect the integration process undertaken as part of the mixed methods research process and allow the immersion of the information collected from participants.

The Researcher

In accordance with a critical realist perspective, the researcher engaged reflexively with her own assumptions. The researcher is a social worker, working in mental health and has extensive experience in mental health incorporating trauma informed work including assessment and counselling in both community and inpatient settings with experience working across the lifespan. As a social worker the researcher also provides support to both clinical and non-clinical across the service after critical incidents. She does not have any formal research experience, and has participated in all aspects of the Health Education and Training Institute's Rural Research Capacity Building Program for novice researchers in rural communities to receive training and to be supported to develop knowledge of research methods, development of the questionnaire and semi-structured interviews, and how to undertake rigorous data analysis. The researcher has also previously been a NCS member in the same PHS that formed the basis of this research. The researcher has both positive and adverse memories of this experience. The researcher is part of the rural community that participants of the research reside in. Most of the participants of both the questionnaire were known to the researcher either through her role as a social worker, her previous role as an administration worker, or through other community networks. The focus of this research topic comes from both personal experiences of working as a NCS member, and a combination of formal meetings and 'hallway' conversations with a variety of staff across both the non-clinical and clinical sectors about what workplace stress and support for NCS looks like and asking the question "are we doing enough"? The

researcher remained aware and reflective during the process of the impact that her personal experiences, views and knowledge may have on the research development, data collection and analysis. To engage in this process of reflexivity, she discussed these issues with her mentor and program support officers in the RRCBP regularly. All participants in the 1:1 interviews indicated that they felt comfortable in their sessions.

Results

An analysis of the 34 completed questionnaires (quantitative data analysis) and then the six 1:1 interviews (qualitative data analysis) revealed that participants experience stress in the work place due to regularly being exposed to or experiencing bullying by peers and clinical staff; occupational violence in the workplace; and stress relating to adverse clinical incidents. Participants assessed their work practice as being high demand, that they have low to medium levels of control and an inconsistent mix of high to low supports. Participants who have two managers (clinical manager and a non-clinical manager) experience a level of ambiguity of which manager to access for support. The majority of participants currently access support via family, friends or peers rather than formal processes available, with future support options of interest appearing to focus on training and supervision. The themes connected and overlapped and captured the experiences of most participants. However, the data analysis across the questionnaire and the interviews suggest that there are variations to the way participants experience these themes.

Participants demographics included 27 females and seven males aged between 26 and 60 years. Due to the low number of participants, all of whom are based in a small rural community and to maintain anonymity for participants, this report will not provide a breakdown of participant numbers from each work role nor will it provide specific details of interview participants. Nevertheless, participants did represent all eligible roles with the majority of participants having worked for the organisation from three to over ten years, with 26 participants having either a TAFE or University qualification. The majority of participants reported no pre or post-employment training specific to their current roles. During the research results section of this report, interview participant's quotes are referenced by an interview number one to six.

Non-clinical Staff in Front Line Roles

A key theme throughout the results was the way participants described their roles as front line workers who contribute daily to the experiences of public health users, when they come into contact with the PHS.

> *It's frontline, so, literally everybody else is behind closed door, whatever comes to the front door come to me in whatever shape or size it happens to at the time, and it's very interesting I think that for both (PHS departments) the frontline is the non-clinician, that's kind of interesting when you think about it. We have so little power to help anybody, and we're completely dependent upon somebody else dealing with a problem, that we're the ones who are on the coal face for, so there just a strange anomaly there. It's like the phones, people who call in. They might be suicidal, they might just be upset… they might be affected by medication. It could be a million things, and we have to use our judgement to keep them on the line, direct them, to find someone, which could be difficult at the best of times. It's a tall order for ($) an hour.* I.3

Participants also reported that they felt there contributions to the team were minimised by clinical staff who they perceive see their role as just about answering the phone or entering data into the computer. That the system itself is not set up to acknowledge and support their roles which incorporate both their generic position descriptions and the complex aspects of working in a clinical environment.

> *I think that's a fundamental part of some of the challenges though of being – I'll say (Non-Clinical Role), in a clinical environment… what we do is seen as a lesser skill… I don't think it's really recognised that our people skills are*

> *everything. it's not hard level, but the handling of the people day in, day out, eight hours a day, the phone's ringing 16 times and you've got 14 people yelling at you… and dealing with their moods and the stress that they have… we don't have that option. If one of us at the front desk loses the plot we'll be fired on the spot…I think there's that in itself is a real strain, it's just never recognised.* I.3

All participants were able to speak of the things they enjoy about their roles including that they have great relationships with many of their colleagues both non-clinical and clinical team members including:

> *I adore my job… we get busy but it's a nice team aspect to work, because everybody has time to get things done* I.1

> *I am very lucky, I found a nice niche, predominantly nice people to work with, mind you… I think you get the most caring, compassionate people in Health, you also get some of the most hard-nosed burnt out* I.3

Participants also identified that some of the complexities of working in a PHS in a rural community where they may have direct contact and obtain information about family, friends and community members and due to often their only being one NCS in a role that they are not always able to redirect this person to another NCS colleague.

> *…it's a small community here. The likelihood of someone being somebody that you know, or – or are even related to is quite high. Um, they don't want you to know that that's what's happened, or that's what they've done. You are in this bubble of I have to do my job and I also don't want to know because then I've got to talk you out of this, and there's no heads up for any of that. There's no discussion for any of that.* I.1

While this is not unique to NCS, participants identified no formal supports or training that is available to assist them in managing this aspect of their work role. The complexities of being an Aboriginal worker in the PHS was also highlighted due to the higher potential for workers to have an overlap between their work and personal roles in the community.

> *Aboriginal workers… it doesn't stop at the door. You know, when they close the door to go home it's not there, it doesn't stop there. People in the community will still come up and talk to you in the street, in the shops and whatever, knock on your door even, and come around and try and do stuff.* I.2

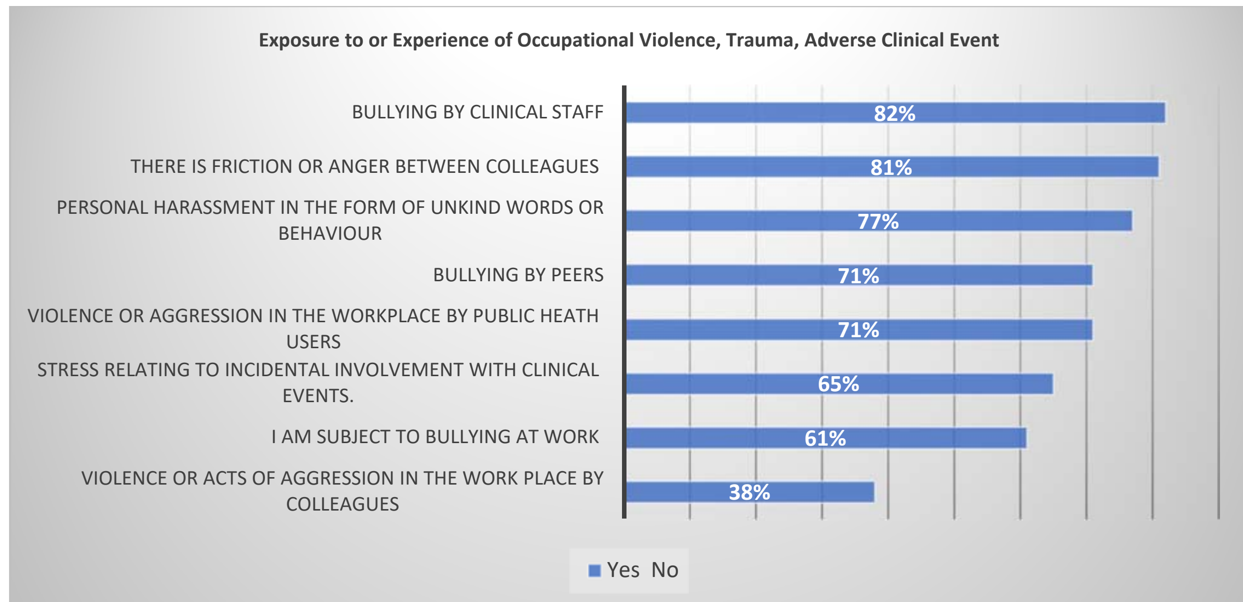
Exposure to or Experience of Violence

Participants reported that they are in front line roles where they often experience public health users who present distressed and can take this out on the first staff member they see.

> *I can pretty much guarantee that a shift that I work, I'll experience some sort of verbal violence, and I suppose you go home or you walk away from it thinking they're hurt, they're scared… you're dealing with people's lives here. It's – there's going to be that sort of thing. So person to person I can forgive someone for behaving the way that they do in those scenarios. Um, I don't however think that it's okay that people walk into those scenarios totally un-knowing that that's what they're going to experience.* I.1

Participants reported that they are aware that at times their role may require them to work with public health users who may present distraught including being verbally aggressive due to a variety of reasons and at times those patients may have limited capacity to manage their safety in that moment. Non- clinical staff also report that they often experience verbal aggression by their clinical colleagues when they too are distressed in the work place. Participants report a workplace cultural expectation that NCS should be tolerant of this type behaviour in others whether it is a public health user or their clinical colleagues. This reportedly leads to strained relationships within the teams which is reflected in the data from the questionnaire which indicated that of the 34 participants, 85% reported strained work relationships, similarly high reports were made for exposure to or

experience of bullying by peers (71%); bullying and/or acts of violence or aggression by clinical staff (bullying 82%, acts of aggression 38%); violence or aggression in the workplace by public health users (71%); personal harassment in the form of unkind words or behaviours (77%); stress relating to incidental involvement with clinical events (65%).



Graph 1: Results are shown as Yes answers only to highlight the high level of exposure to or experience of occupational violence, bullying and stress due to clinical events as reported by NCS.

Being exposed to or experiencing the distress of public health users is not limited to face to face contact. One participant reported multiple experiences of having to manage and redirect calls from suicidal patients to mental health triage or has had to call an ambulance to attend the location of the patient.

Participants were able to acknowledge that part of their role is to assist distressed public health users, but that this does not reflected in the training or acknowledgement of skills required to conduct their general work roles. Many participants reported they had no pre or post training or role specific information to support working in complex areas, in particular those where NCS may be exposed to particularly distressing situations including significant injuries or the death of patients.

> *it was more that, more recently that I've discovered that I'm introducing and training staff myself now, and one of the girls that I trained recently said that she wasn't aware she would see – see death or see, ah, patients being resuscitated or that she'd have to talk to family members who have just lost – lost somebody, and it got me thinking sort of well, yeah, there's actually no conversation to say that that's what you'll see in emergency.* I.1

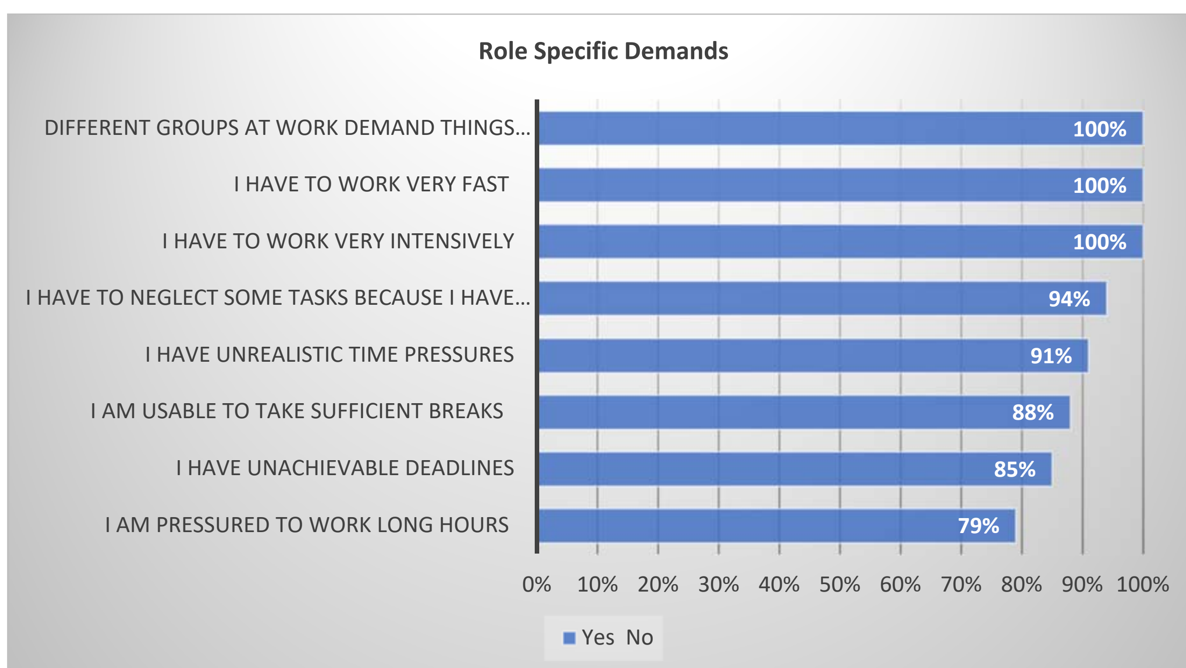
While complex patient work was spoken of throughout the majority of interviews so was bullying and what participants described as inappropriate communication by clinical colleagues and peers, which has already been reported as featuring significantly in the questionnaire results. Participants reported that clinical staff can be verbally aggressive in both times when they are involved in a complex critical incident (which responders reported a higher tolerance for) or just when they are going about their general roles.

> *Like, you'll walk in and say good morning to someone, and they'll just snap at you or grunt at you or something. And I find that really hard. Yeah, I find that kind of behaviour really hard to cope with 'cause I, I don't know, you say hello to someone, no matter how you're feeling, there's always time to say hello to someone. If someone asks*

you how you're going, even if you're not, you know, you can say, "I'm good, thanks." Or, "I'm not too bad." I find it happens, yeah, some days it's like you're walking on tender hooks. You don't want to approach that person and you don't want to approach that person 'cause you're scared 'cause you're going to get your head bitten off. I.6

Workplace Demand Control Support

Experiences of demand, control and support overlapped their roles as well as the results. The theme demand was about the level of workplace pressure that participants felt in their daily work roles when undertaking their general duties. As already mentioned NCS feel undervalued and overstretched in their work role, therefore when looking at these results, it can be seen that of the 34 Participants the majority identified that they feel pressured during their work day to complete their work. Participants perceived that there can often be a lack of understanding of the complexity of their roles and teams in which they work, and that this can come from other NCS, clinical staff and management. Those in roles which are more likely to be impacted by a clinical incident (i.e. emergency and mental health departments) found this particularly distressful as they are often required to work with multiple competing demands with what they perceive as little support to address this issue. Key result which indicate a high work demand included 100% of participant feeling that different groups demand different things, that they are given unachievable deadlines to complete tasks (85%) combined with unrealistic time pressures (91%).



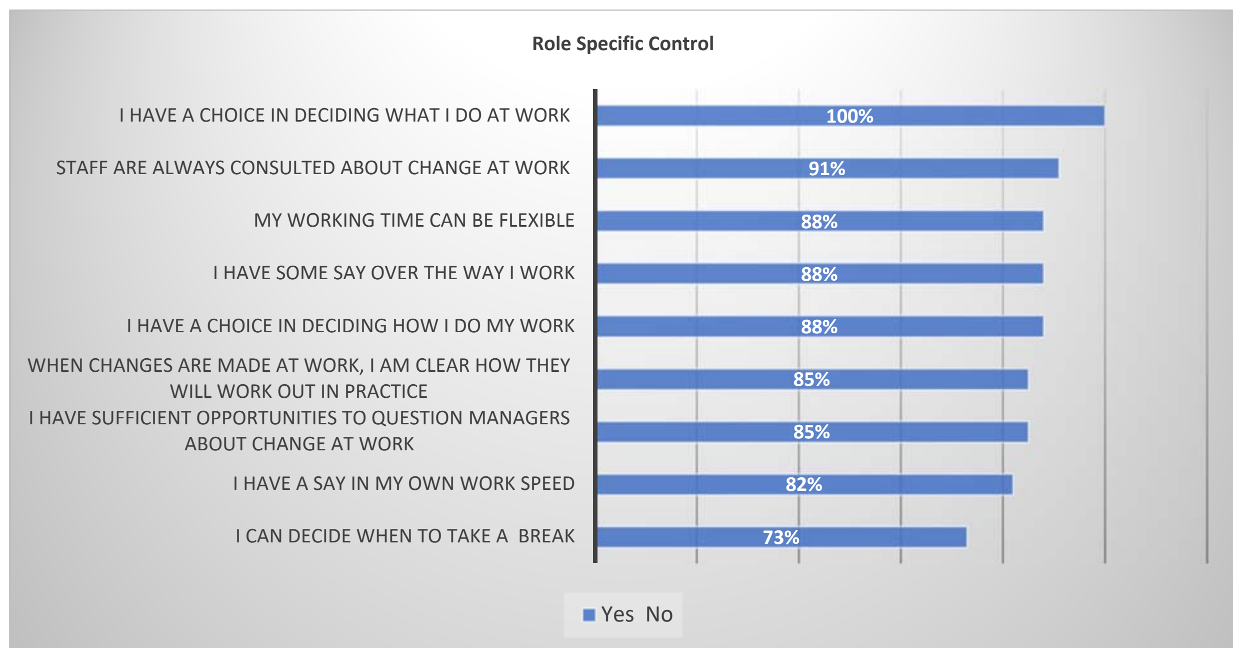
Graph 2: Results are shown as Yes answers only to highlight the high level of work place demand as reported by NCS.

Several participants identified an inability to take regular breaks, and the efforts and stress involved in accessing a day off due to the pressure of not being provided coverage for that time and having to almost do double the work on the day prior to a day off to ensure that their department ran smoothly.

You, feel empathy for the patients, they've come in, they're sick, they're worried about their child… but we are human you know, you can be having the most busiest day where you have not had time to – you feel like you haven't even had time to breathe. And then you can get a patient that is just so rude, and you can just go – you can snap at them, just like that, and that's wrong…. you know, we should be able to go, whatever, but in saying all of that, the lack of support, if we could have our breaks, for a start, that would help [sighs]. I.4

Participants felt they do have some control over being informed when there are changes, and believe they are consulted when the change is made. However, some participants felt that post change consultation about the implementation process is more likely to occur, rather than their being opportunities to be part of the pre-change consultation process prior to the change occurring.

> *So without any consultation or collaboration with admin, that process has now changed that the people come in, the nurses will put them on the system generally, and there's no proper process been put in place, because sometimes the nurses will put them on and then send them – and triage them and send them to us to do the cleansing of the data, you know, their personal details.* I.4

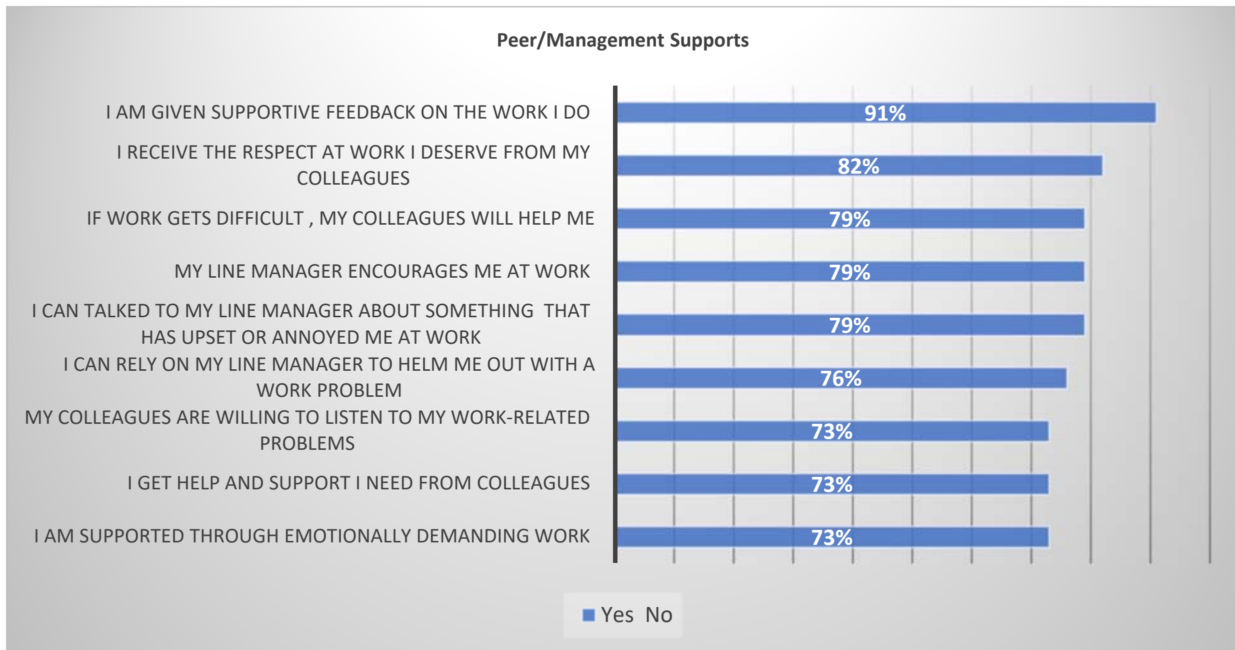


Graph 3: Results are shown as Yes answers only to highlight the level of control as reported by NCS.

Participants were very open to discussing supports they could access. For some participants just the act of having colleagues and the organisation acknowledging the array of communication and people skills they bring to their roles as front line workers would be supportive. For the majority of participants they identified the following to be options they would use including having someone to debrief with; having role specific discussions about exposure to distressing situations as part of orientation; having training opportunities such as de-escalation; having clearer guidelines about support from management.

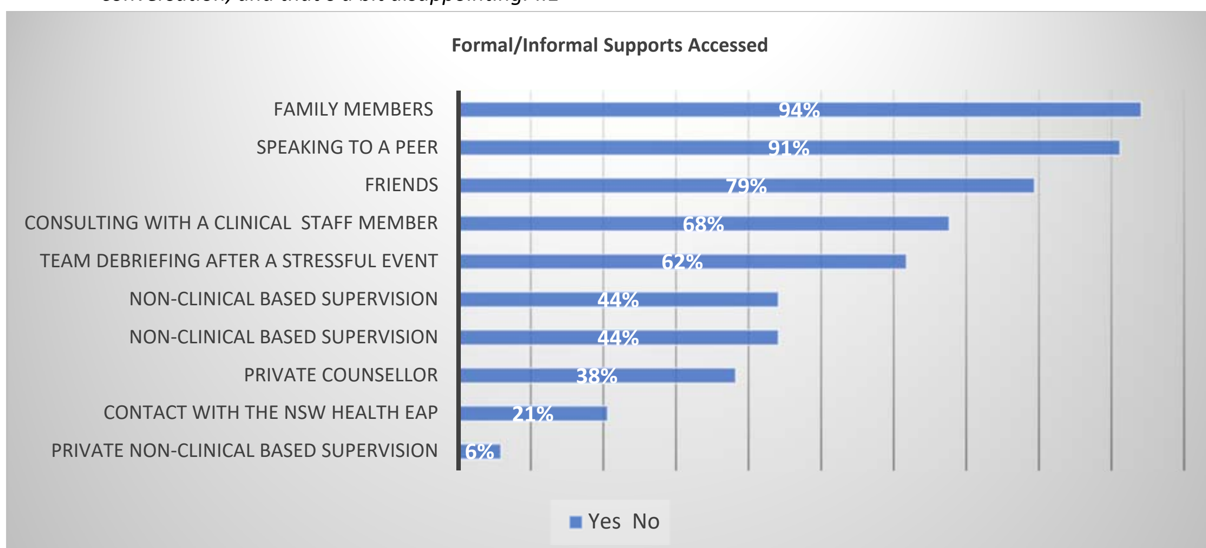
Participants reported inconsistent low to high levels of support from some sections of their teams in particular peers and nursing staff. However these same supportive cohorts, also rated highly for contributing to exposure to or experiences of bullying and aggression in the work place. Participants also raised that support after a critical incident may be limited or only made available to clinical staff. Also for some participants who have a two management stream (i.e. clinical and non-clinical) there is some ambiguity about which manager to access for support in context of demands on their work role or after an adverse incident in their clinical team.

> *I'm also working under two managers (Non-Clinical), plus the two managers (Clinical) up where I am which sometimes can be a bit – a bit hard because, you know, I've got my role up there, but then they want me doing something, and sometimes that can kind of clash*. I.6



Graph 4: Results are shown as Yes answers only to highlight the peer or management supports as reported by NCS.

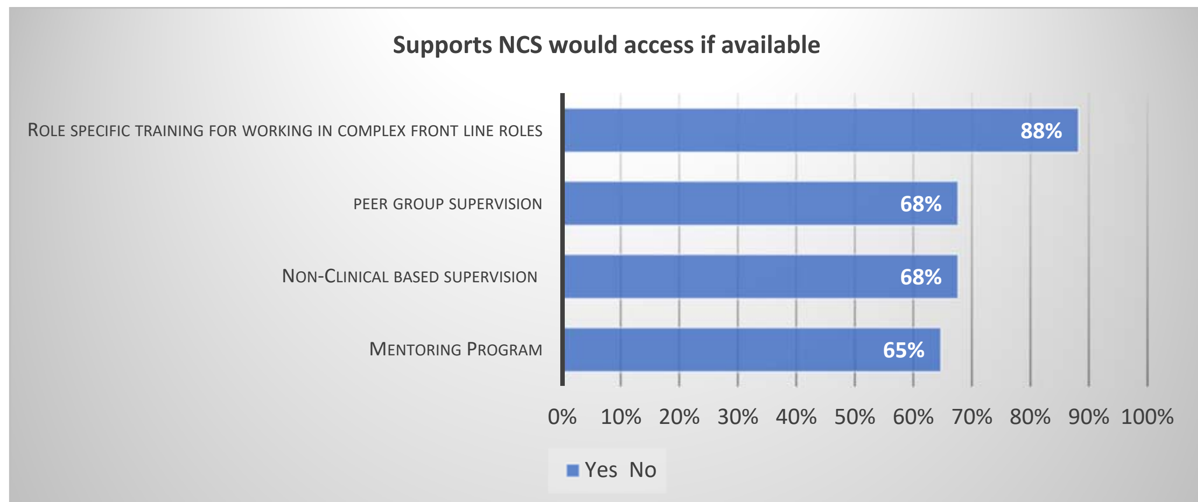
I know that when the nurses or doctors, the other staff that work in (Department), experience, death or trauma or that sort of thing… that they do have, total care and support for those sorts of incidences. There was an incident… and it was very traumatic for everybody in the room…) immediately (afterwards) a big debrief. Everybody was in the room together and then there was like a – a conversation at the end of it saying if you still need to talk to somebody, which is the best sentence I've ever heard, come see me, and it was directly solely at clinical staff and I think that is a bit more of a cross the board sort of result. So why not [crying] include us or include the cleaners who have been there and who have had to – to deal with it afterwards. It would be nice if it was across the board. So that's in a perfect world. Support would be that conversation happening with everybody who was in that room, not just the staff that are trained to deal with it I'm sure that there's nobody who actually has total control over what it is they see [crying] and they don't walk away feeling fine, but I have a lot more confident that they are followed up on and that they're checked on and that they're asked; whereas we're not. We don't even get the conversation, and that's a bit disappointing. I.1



Graph 5: Results are shown as Yes answers only to highlight the supports that NCS staff access as reported by NCS.

Participants reported that there are no formal supports in place that they regularly access that they believe meets their needs as NCS.

Ah, support for staff, especially when you newly start out. When I started working …I was thrown a bit in the deep end which I, looking back on, think I handled pretty okay. Um, there was no mention that I'd watch, ah – I'd watch infants die or people be actively resuscitated, and there's very little support for staff [crying] when that sort of thing started and it was distressing… but as I said, the nursing staff, fantastic and they will go out of their way to support you in those sorts of scenarios. They ask if you're okay. I.1



Graph 6: Results are shown as Yes answers only to highlight the supports that NCS would access if available to NCS.

Graphs five and six represent the types of supports that NCS are currently accessing and what they would access if available. According to these results the majority of NCS seek support from family (94%), friends (79%) and peers (91%), while accessing more formal supports such as private or health based provisions is occurring at very low levels including the Employee Assistance Program (EAP in the above graph) at 21% and supervision at its highest is 44%. This indicates that the majority of NCS are seeking information rather than formal supports. Some participants stated that they had limited understanding or unhelpful responses to some of the work place supports available. However, all participants were interested in developing more work based helpful supports including education and supervision similar to that of their clinical colleagues, while those with limited information about accessing the Employee Assistance Program indicated they would consider this in the future.

> *Um, if there was some sort of – I don't know if it necessarily needs to be something that's constantly followed up on, like every single week or – or anything like that, but maybe just like an introduction. This is – this is what you'll experience and then every now and then, um, check in to see how people are doing, a – a phone call, that sort of thing, which I sort of would have thought would come with management, but it doesn't. So I – I sort of think that maybe there needs to be a – a conversation where that's brought up and addressed.* I.1

Discussion

This research looked to explore and develop a baseline understanding of workplace stress as experienced by non-clinical front line staff in a PHS, and identify any role specific support options in their workplace. The results clearly identify that non-clinical front line staff experience stress due to a variety of workplace incidents including that they are likely to being exposed to or experience of violence in their workplace by public health users,

bullying and acts of aggression by peers, and exposure to traumatic events including injury or death. Despite these often challenging work environments, NCS enjoy their work and value their contribution to the experiences of public health users who attend a PHS.

The results also indicated that NCS can empathise with unwell and distressed public health users due to the personal distress they may be facing which brought them into contact with the PHS. This empathy can also extend to their clinical colleagues, but when this behaviour becomes significantly distressing or repetitive NCS can struggle to identify correct management pathways for support increasing their levels of stress. [23, 24]
The NCS that participated in this research were clear about their roles as front line workers, but that aspect of their work was not clearly identified in their position descriptions. Nor was it acknowledged by some members of their teams either colleagues or management, and this is similar to the current research. [1, 2, 14, 15, 1620, 21, 22]
When commencing their roles in particular those in more complex departments such as emergency, community intake and mental health NCS would benefit from their orientation including discussions about the types of presentations and situations that may impact their whole team including them, and how to access supports. Like other research on this topic, NCS also believe that they and the organisation would benefit from providing them with role specific training. [1,2] This could include opportunities to develop skills in de-escalation which would be a fundamental part of their role and would assist in their ability to not only manage but reduce aggressive incidents from increasing.

This exposure can be compounded by staff who work in rural communities as there is often less opportunity to distance one-self from the clients experience when they are a member of your small community. [1, 2] Participants reported that their levels of work place demand is high, their ability to have control over their work routine is medium to high, and that their supports were low to high. These findings are consistent with other similar findings that indicate that as staff members who are considered to be on the lower rung of an organisational ladder that NCS are at risk of having high demand, low control roles with supports that are inconsistent with their needs. [1, 2, 16, 23, 24] While NCS did report a variety of supports they could access, many reported that this as being inconsistent, for NCS with two managers they found that it was sometimes difficult to seek the correct support from the right manager.

However, NCS staff in a NSW PHS are guided by the Zero Tolerance policy [11] which upholds that no NSW Health staff member is to be affected by violence in their workplace. As such, with this policy in mind, there are opportunities to address some of the above inequalities in the supports currently available to NCS to reduce the impact of workplace stress on this cohort. For instance, supervision frameworks [29, 30, 31, 32] currently utilized and supported by NSW Health could be easily adjusted to include NCS. These frameworks provide clinical staff members with the opportunity to obtain support, reflect on complex work environments and seek guidance regarding professionalism, role responsibility and debriefing after traumatic incidence. While all current supervision guides are geared towards clinical staff a review of these frameworks would allow for the addition of NCS. This recommendation is consistent with previous research findings that also suggest that NCS require ongoing regular support and that supervision should be a requirement for all front-line staff in complex work environments not only clinicians.

Strengths and Limitations
This study contributes to the limited research about the experiences of NCS in PHS and the implications this has on their experiences of workplace stress and support.

One limitation of this study was the small sample size. All participants in the 1:1 interviews were female which is representative of the number of women employed in non-clinical roles in a PHS. Further, it is unknown if the

response rates were impacted upon by sending out the initial emails prior to the Christmas period, which is a time that participants may have been on annual leave and not accessing their emails.

The researcher was known to most participants who responded to the online questionnaire and all participants who agreed to the 1:1 interviews and this may be perceived as both a strength and limitation. It is possible that this impacted on those who agreed, or declined to participate in the 1:1 interviews. Additionally, it may have allowed changes to the responses participants had to the interview questions. The researcher, however made it clear to those that did participate that their involvement was voluntary and that there were no right or wrong answers that the interview questions and that the goal of the interviews was to capture their individual experiences.

Conclusion

In conclusion, this study demonstrates that in a rural area the experiences of stress and workplace support for NCS in front line roles in PHS is similar to that of their clinical colleagues. That they too are likely to be exposed to or experience of bullying, occupational violence, and trauma after an adverse clinical event. To support clinical staff, many PHS have developed a variety of training and support options that recognize the importance of keeping updated with clinical skills, training to provide clinicians with abilities to respond effectively to potential exposure to violence in their workplaces and supports in the form of team debriefing, and individual clinical supervision.

Recommendations

The findings from this research indicate that NCS are generally resilient and able to work in high demand low-medium level of control positions. However an opportunity to address support options for this cohort is required. As such the following recommendations are made based on participant feedback and current supports provided to their clinical colleagues.

1. Organisational acknowledgement that NCS are also exposed to or experience complex presentations by public health users and that a review of the current supports offered is required.
2. That NCS in roles such as emergency departments and mental health community or inpatient settings need to be provided with role specific knowledge and training regarding the potential for the increased exposure to violence, trauma (including death), and adverse outcomes from clinical situations.
3. That NCS's support options need to be reviewed with consideration of adding training (which is available in their working hours) for de-escalation, trauma informed care (including communication). Further, that NCS in particular departments (i.e. emergency or mental health departments) are able to access supervision similar to that provided to their clinical colleagues.
4. That NCS are considered when there is an adverse event within the hospital (i.e. a Code Black) and that they are routinely invited to participate in any team debriefing and or supports provided.

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Appendix 1: Microsoft Word version of the Questionnaire

Title: **Work related stress for non-clinical frontline staff in a rural NSW public health setting: What is the impact and what support options are available?**

This questionnaire is designed to capture the opinions of non-clinical front line staff throughout public health settings located within the Bega Valley Shire. This survey will be used to find out about your experiences and opinions and there are no right or wrong answers. All information collected in this survey is non-identifiable. This survey will take about 15 minutes to complete.

This questionnaire contains two sections, the first section is intended to gather general information about your experience of training related to your role and any role specific support that is available within your work place. The second section uses the Health and Safety Executive (HSE) workplace stress tool.

At the end of the questionnaire you will find a copy of the Participation Information Sheet for the Focus Groups. Please review this information and if you are want to register to participate or ask any additional questions, contact the researcher Tracy Bolton via tracy.bolton@health.nsw.gov.au

Section 1: General Information

It is important that your responses reflect your work in the last six months. Please read each question and for each option please select one box only or state for other.

Gender:

☐ Male ☐ Female ☐ Do not identify ☐ Other

Age

☐ 18 -25yrs ☐ 26-30yrs ☐ 31-40yrs ☐ 41-50yrs ☐ 51-60yrs ☐ over 60yrs

Do you identify as:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither

Main language spoken at home: ____________________________

Education/Training
What is your highest level of training?

☐ Year 10

☐ Year 12

☐ Other

____

☐ Tafe qualification

☐ University qualification

How long have you worked for SNSWLHD

☐ Less than 12months

☐ 1-2yrs

☐ 3-5yrs

☐ 6-10yrs

☐ More than 10yrs

Please write in the free text boxes below:

What is your current main role within SNSWLHD and which department do you work in? Please include if you work in other dept.'s and how often.

Prior to commencing with SNSWLHD, did you have any pre-employment role specific training and what was it?

Since commencing with SNSWLHD what post-employment, role specific training have you had? Please indicate if this has been paid for by your workplace, yourself or other.

Please read each question and for each option please select one box only.

In your main role, how often do you interact with public health users via the following methods?

Email	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
Phone	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
Face to face	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
Other (please specify) ________________________________	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5

During your time employed by SNSWLHD how many times have you experienced or been exposed to:

Bullying by peers	Never	Seldom	Sometimes	Often	Always

Bullying by clinical staff	Never	Seldom	Sometimes	Often	Always
Violence or acts of aggression in the work place by colleagues	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Violence or aggression in the workplace by public heath users	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Personal harassment in the form of unkind words or behaviour	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Stress relating to incidental involvement with clinical events.	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Other (please specify)	Never	Seldom	Sometimes	Often	Always

During your time employed by SNWLHD, how often have you not been able to attend work because of:

Bullying by peers	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Bullying by clinical staff	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Violence or acts of aggression in the work place by colleagues	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Violence or aggression in the workplace by public heath users	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Personal harassment in the form of unkind words or behaviour	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Stress relating to incidental involvement with clinical events.	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Other (please specify) ______________________	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

During your time employed by SNWLHD, how often have you attended work, despite not wanting to attend work because of:

Bullying by peers	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Bullying by clinical staff	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Violence or acts of aggression in the work place by colleagues	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Violence or aggression in the workplace by public heath users	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Personal harassment in the form of unkind words or behaviour	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Stress relating to incidental involvement with clinical events.	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Other (please specify) ________________________	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

During your time employed by SNWLHD, which work place support options do you access:

Speaking to a peer	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Consulting with a clinical staff member	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Non-clinical based supervision	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Team debriefing after a stressful event	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Contact with the NSW Health Employee Assistance Program (EAP)	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

Other (please specify) ______________________________	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

During your time employed by SNWLHD, which other (including those outside of work) support options do you access:

Private counsellor	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Private non-clinical based supervision	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Family members	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Friends	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Other (please specify) ______________________________	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

As an SNWLHD employee, of the supports listed below what support options would you access in the workplace if they were available:

Mentoring program	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Non-clinical based supervision	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Peer group supervision	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Role specific training for working in complex front line roles	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5
Other (please specify) ______________________________	Never ◘1	Seldom ◘2	Sometimes ◘3	Often ◘4	Always ◘5

Section 2: ***HSE Management Standards Indicator Tool.***

Instructions: It is recognised that working conditions affect worker well-being. Your responses to the questions below will help determine your experience of your working conditions. It is important that your responses reflect your work in the last six months.

Please read each question and for each option please select one box only.

1	I am clear what is expected of me at work	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
2	I can decide when to take a break	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
3	Different groups at work demand things from me that are hard to combine	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
4	I know how to go about getting my job done	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
5	I am subject to personal harassment in the form of unkind words or behaviour	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
6	I have unachievable deadlines	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
7	If work gets difficult, my colleagues will help me	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
8	I am given supportive feedback on the work I do	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
9	I have to work very intensively	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
10	I have a say in my own work speed	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
11	I am clear what my duties and responsibilities are	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5

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12	I have to neglect some tasks because I have too much to do	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
13	I am clear about the goals and objectives for my department	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
14	There is friction or anger between colleagues	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
15	I have a choice in deciding how I do my work	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
16	I am unable to take sufficient breaks	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
17	I understand how my work fits into the overall aim of the organisation	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
18	I am pressured to work long hours	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
19	I have a choice in deciding what I do at work	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
20	I have to work very fast	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
21	I am subject to bullying at work	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
22	I have unrealistic time pressures	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
23	I can rely on my line manager to help me out with a work problem	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5
24	I get help and support I need from colleagues	Never ☐1	Seldom ☐2	Sometimes ☐3	Often ☐4	Always ☐5

25	I have some say over the way I work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
26	I have sufficient opportunities to question managers about change at work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
27	I receive the respect at work I deserve from my colleagues	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
28	Staff are always consulted about change at work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
29	I can talk to my line manager about something that has upset or annoyed me about work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
30	My working time can be flexible	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
31	My colleagues are willing to listen to my work-related problems	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
32	When changes are made at work, I am clear how they will work out in practice	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
33	I am supported through emotionally demanding work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
34	Relationships at work are strained	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5
35	My line manager encourages me at work	Never ◻1	Seldom ◻2	Sometimes ◻3	Often ◻4	Always ◻5

Thank you for taking the time to complete this questionnaire. If participating in this questionnaire has brought up topics or memories that you find distressing you are encouraged to contact **EAP** on **1300360364** for confidential support.

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Appendix 2: Semi-Structured Questions for 1:1 Interviews

Interview No:

Introduction.

1. *When I refer to your work I will just refer to them as your role and your department is that ok.*
2. *General results have identified a few themes and it would be great to have a chat with you about these today.*
3. *I will start recording when you are ready.*
4. *Thanks for letting me interview you.* ***Everything confidential unless illegal or risk to self or others. Recording will be transcribed and transcription will be de-identified. Recording will be erased.***

Questions.

Are there any comments you would like to make about your work place?
Are there any concerns about your work place you would like to mention?
Are there any positive aspects about your work place you would like to mention?

Have you experienced violence in your work place.	Physical
	Verbal
	Sexual
	Emottional
	Bullying
	Unkind words
	Other
Exposure to violence in you work place including working with P/H users or staff who have experienced	Physical
	Verbal
	Sexual
	Emottional
	Bullying
	Unkind words
	Other
Stress after critical incident	
Supports do you access generally or after an incident	peer
	clinical staff
	supervison
	team debreifing
	EAP
	Other
	Unable to attend work re above
	Attended work despite above
	What support or training would you like to see in your workplace

Thank you for sharing your story with me. Do you have any final comments or questions?