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'I Feel Disempowered Because I Could Not Do Anything': Clinical Facilitators' Perception of Violence Towards Nursing Students During Clinical Placement

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ABSTRACT

Aims: To explore clinical facilitators' understanding, experiences and perceptions of their role in supporting registered nurse students (RNS) who experience workplace violence (WPV) during clinical placement.

Design: An exploratory, qualitative design.

Methods and Data Source: Data were collected between September and November 2022 using semi-structured interviews of 1-h duration with 11 clinical facilitators working in South Australia. The interviews were transcribed verbatim and analysed using thematic analysis.

Results: Participants reported that WPV is experienced in many forms, including verbal and physical violence towards RNS during clinical placements. Clinical facilitators are not always aware of this experience and have mixed abilities to resolve the damage. Most importantly, clinical facilitators saw themselves as disempowered to provide the support required by RNS after WPV incidents as they perceived themselves as visitors to the facilities.

Conclusion: Findings indicate that a clinical facilitator's scope and ability to support a RNS is often not at a level where real impact and safety can occur. Varying perceptions of what WPV is, what is acceptable, and the authority or influence of a clinical facilitator have all informed this issue and need to be considered in developing strategies to address WPV towards RNS.

Implications for the Nursing Profession: This study highlights that by understanding the causation of WPV and recognising the lack of influence and scope of clinical facilitators to act to support RNS during WPV events, positive industry changes can be instigated to promote student placement experiences and healthcare provision.

Impact: Clinical facilitators felt limited in their role to support RNS experiencing WPV. This research impacts future nursing students, education providers, clinical facilitators and clinical placement providers.

Reporting Method: COREQ guidelines were utilised to report qualitative research.

No Patient or Public Contribution: This paper explores specifically the clinical facilitators' perceptions of WPV.

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1 | Introduction

Globally, the prevalence of workplace violence (WPV) against healthcare workers is high (Dadfar and Lester 2021; Liu et al. 2019). It is estimated that WPV is four times more likely to occur within hospital settings than in any other workplace, and approximately 67% of healthcare workers report having experienced some form of WPV within the last 12 months (Liu et al. 2019), and violence seems to be increasing and occurs daily (Dafny and Beccaria 2020). A recent systematic review included findings from nine countries found that registered nurse students (RNS) experience WPV, including physical, verbal, psychological, sexual violence and racism during clinical placement and highlighted that they are vulnerable to WPV due to their limited experience and skills to manage aggressive behaviour (Dafny et al. 2023). The term RNS has been used throughout this paper to maintain consistency with the findings of the systematic reviews (Dafny et al. 2023; Dafny, Waheed, and Cabilan 2024), and is a synonymous terms with 'undergraduate nursing students' and, 'baccalaureate nursing students' used by other authors (Budden et al. 2017; Birks et al. 2017). Similar findings reported in a recent survey across eight states of Australia reveal that more than half of the RNS had experienced an episode of WPV while providing patients' care during their clinical placements, and that WPV negatively impacted the relationships between students, clinicians and patients (Johnston et al. 2024). The ramifications of WPV on RNS are significant, both mentally and physically, with ongoing stress and anxiety, personal distress, decreased job satisfaction, undermining career confidence and questioning their career choice and can ultimately lead RNS to leave the nursing profession (Dafny et al. 2023; Johnston et al. 2024) and is associated with poorer quality patients' care and health outcomes (ICN 2017).

WPV can be defined as persistent, repeated, negative, and harmful actions that are difficult for the target to defend against effectively (Nielsen and Einarsen 2012). An indication of the pervasive nature of WPV in clinical settings is recognised with recent attempts by the nursing profession to define the experience of WPV specifically for nurses and other healthcare workers, including students. The 2017 International Council of Nurses (ICN) position statement on the prevention and management of WPV defines WPV 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 (ICN 2017). WPV may include physical assault, sexual assault and non-physical violence such as verbal abuse, racism, bullying, hostility, incivility, intimidation or threats (Tee and Valiee 2020; Dafny, Beccaria, and Muller 2021). The ICN position statement does not explicitly include RNS in its definition, however it recognises that RNS have an increased risk of becoming victims of WPV and warns that RNS are more vulnerable to subversive forms of violence and bullying (ICN 2017).

WPV against RNS is widespread (Birks et al. 2017). RNS, defined as students of baccalaureate nursing programs, are reportedly more vulnerable and more commonly exposed to violence from individuals in positions of authority during clinical placements (Birks et al. 2017; Budden et al. 2017). Australian and United Kingdom RNS have indicated other nurses and clinical staff as the main perpetrators of bullying types of violence against them (Birks et al. 2017; Budden et al. 2017). WPV towards RNS is associated with occupational stress and poor retention of students (Budden et al. 2017; Tee, Özçetin, and Russell-Westhead 2016) and inhibits the RNS' learning experience, preventing them from developing appropriate caring behaviours towards patients (Birks et al. 2017). The organisational culture and work environment in which a RNS undertakes their placement is also considered an influencer of WPV, with aspects such as decreased morale, increased staff turnover, and adverse patient outcomes being identified (Crawford et al. 2019). WPV against RNS has ramifications for the quality of patient care (Laschinger and Grau 2012). Globally, nursing shortages are increasing, and retention in the profession is an ongoing discourse while in Australia, nursing shortages, coupled with other challenges such as COVID-19, higher patient numbers, the aging demographic and higher acuity of patients pose a significant concern for the future of the Australian nursing workforce and healthcare system (Mannix 2021). More than ever, the retention of the current and future nursing workforce is critical to ensuring high-quality, equitable healthcare access in the future. Current projections estimate the shortfall of nurses to be 123,000 by 2030 (Mannix 2021).

2 | Background

RNS undertake clinical placement as part of their Bachelor of Nursing degree, with a required minimum of 800h in Australia (Australian Nursing and Midwifery Accreditation Council 2019). Clinical placements provide an important link between theory and practise, with students putting theoretical knowledge learnt to practise in a clinical setting (Ford et al. 2016). Clinical placement is also essential for building confidence, professional identity and competence. The experience and support students receive in the learning environment can have a profound impact on their learning and desire to remain in the profession (Minton and Birks 2019; Hakojärvi, Salminen, and Suhonen 2014).

The nursing staff or team in the clinical environment provide day to day support for the RNS learning while on placement. Additionally, each RNS is assigned a specific team member who is their preceptor, who provides the student with the context, activity, and exemplars for practise during each allocated shift. This support is different from the role of the clinical facilitator (CF), who is a registered nurse (RN) who may be employed by the university or hospital and guides RNS throughout their placement, including assessment of learning activities (McAllister, Withyman, and Knight 2018). In Australia, there are two CF models for RNS placements as follows: One, the CF is an RN employed by the education provider and visits the clinical environment to meet with RNS during their placement or two, the CF is an RN employed by the placement venue (usually as an educator or a senior staff member) and nominated to support RNS during their

placement experience (Health Workforce Australia 2010). Either model presents challenges for the CF as one is a visitor to the environment, and the other juggles competing obligations in their employed role within the team and that of RNS facilitation.

The role of the CF (sometimes identified as the clinical supervisor, supervisor or practise assessor) is recognised as a complex role that requires the CF to establish a partnered learning relationship with the RNS. The partnership supports transitioning into the new learning environment and culture, recognising and enabling learning experiences that can then be deconstructed and reconstructed to support understanding of and for learning (Pront, Gillham, and Schuwirth 2016). The role of the CF within the Australian nursing education system may differ from that of facilitators in other countries or settings, and the literature highlights the lack of role clarity and inconsistencies across the globe (Ryan and McAllister 2021). Placements vary in location, focus of care provision, and public or private status. Consequently, RNS placement experiences vary yet depend upon the environment, patient acuity, staffing, workload, and support from the preceptor (facility-based learning partner) and facilitator to promote learning (Brunero and Stein-Parbury 2008). Regardless of the facilitation model, the principal goal of any CF is to optimise RNS learning during the placement experience in preparation for practise as a RN (Pront, Gillham, and Schuwirth 2016). In Australia, a review of CFs working with RNS suggested that students believed their facilitators enabled their learning and supported their successes in placement. However, CF felt unsupported by their education provider in providing the amount of time and support their RNS needed (Ryan and McAllister 2019).

CFs have an important role in advocating, mentoring and protecting RNS during placement (Ryan and McAllister 2019; Budden et al. 2017). However, Budden et al. (2017) report that changes in funding structures and the increasing number of RNS have contributed to Australian universities relying on placement nursing staff to provide facilitation. The issue with this is RNS are then learning under the control of staff who may be torn between their loyalties and commitments to the workplace and the student.

To date, there is no report on the CFs' perspective regarding violence towards RNS or how they support RNS who have experienced WPV during placements. Whilst CFs are positioned to support RNS who have experienced WPV during placement, it is essential to note that they may also be perpetrators of WPV (Budden et al. 2017; Crawford et al. 2019). The importance of training opportunities for RNS, in class and during clinical placements, that provide them with strategies to prevent and mitigate violence against them is a common recommendation in the literature. Crawford et al. (2019) also call for CFs to role model appropriate communication and behaviours and guide RNS to recognise and respond to WPV. Lastly, the literature highlights the importance of collaboration between universities and the clinical environment in fostering a welcoming and positive experience for students (Ryan and McAllister 2019; Budden et al. 2017). The CF is often considered the 'bridge' between these two organisations and arguably may have a powerful influence on advocating and supporting students who experience WPV.

3 | The Study

3.1 | Aims

The study aimed to explore CFs' understanding, experiences and perceptions of their role in supporting RNS who experience WPV during clinical placement.

3.2 | Design and Theoretical Framework

An exploratory, qualitative study design was deemed appropriate to address the research questions. This design utilises a thematic analytical (TA) approach to explore and understand individual and group experiences and interpretations of WPV. Thematic analysis enables researchers to explore participants' experiential meaning through an interpretive process that makes the invisible visible (Polit and Beck 2017). Eleven participants (CFs) were interviewed using a semi-structured interview guide, and the data was analysed using Braun and Clarke's (2019) six step analysis process. The open-ended questions were designed to explore and capture the participants' experiences and perceptions, offering valuable insights to inform the research objectives.

3.3 | Study Setting, Recruitment and Participants

Participants were recruited from an education provider, where they were employed as CFs either on a casual (temporary, contracted) or permanent (ongoing) basis. To protect their confidentiality, the specific location where the CF performed this role cannot be identified. The inclusion criteria specified that participants must be CFs employed in Metropolitan Adelaide, South Australia, either on a casual or permanent basis, who supervise RNS, regardless of their year level. Participants also needed to have worked as CFs within the past 12 months. Exclusion criteria applied to those who had not practised within the last 12 months, those supervising postgraduate nursing students, or facilitators overseeing other qualified health professionals outside of nursing. The education provider administration team emailed all registered CFs, inviting them to participate voluntarily by contacting the research team. Participants were recruited through purposive sampling, with a focus on selecting 'information-rich' individuals to achieve data saturation rather than prioritising the number of participants. The purposive sample size was not a concern, as saturation can be reached with small sample sizes (9–17 interviews) in homogenous study populations with focused objectives (Hennink and Kaiser 2022), as in this study. In qualitative research, the purposive sample size can be as small as a single participant, with sampling continuing only until saturation is reached (Shorten and Moorley 2014). Participants who consented to be interviewed selected their preferred format (either face-to-face or online via Microsoft Teams), along with the date and time. Participants received a $30 voucher for their time.

3.4 | Data Collection

Eleven individual interviews were conducted with CFs, between September and November 2022 using a semi-structured interview guide developed by the research team based on a literature review. Per the CF's preference, interviews were in person or

online with Microsoft Teams. The CFs were provided with the participant information sheet outlining the aim of the study and a consent form, including a personalised explanation of the project and the interview process. Written and verbal consent was obtained before the interviews. Participants were assured that they could withdraw their consent at any point during the interview without fear of any repercussions on their employment with the university. The interviews lasted approximately 60 min and were held outside the hospital or the clinical settings to provide a comfortable environment. Interviews were recorded and transcribed verbatim. Recordings were deleted after transcription, and names were changed to ensure anonymity and confidentiality.

An interview proforma of core questions was provided to each interviewer. However, the semi-structured nature meant different issues could be explored within individual interviews. Open-ended questions were utilised to better understand the CFs experiences and perceptions of WPV, for example, 'Have you ever experienced or witnessed WPV while you were on clinical placement with nursing students?' Followed up with 'Would you like to share your experience' *and* 'Can you provide examples?' The open-ended questions encouraged narrative answers and enabled participants to freely express their ideas with the view of extrapolating a rich data set. After the first five interviews, the researchers met to assess whether participants were interpreting the questions consistently. Interviews were conducted until data saturation was achieved.

3.5 | Data Analysis

The interviews were transcribed into Word documents and analysed using Braun and Clarke's (2019) thematic analysis approach. As the data was collected, it was transcribed and thoroughly reviewed, with initial impressions noted. Common ideas were then grouped into codes, which were subsequently organised into preliminary themes. A thematic map was developed with input from all researchers to ensure consensus on the themes. The initial thematic analysis was conducted by two members of the research team, followed by a review and feedback process involving the entire team to ensure accuracy and consistency. Investigator triangulation as described by Polit and Beck (2017) was a significant feature of the analysis process to ensure that bias and idiosyncratic interpretations were avoided. The QSR NVivo 12 (QSR International, 2021) software was used to assist with the initial coding process.

3.6 | Ethical Considerations

REDACTED University's Human Research Ethics Committee (#REDACTED) obtained human ethics approval in 2022 before the study was conducted. Participation was voluntary, with participants able to withdraw at any time without retribution, and informed consent was obtained for participation and dissemination of results. Confidentiality was assured by explaining to participants that their information would be de-identified, not shared outside the research team and recordings deleted once transcribed. De-identified transcribed data would be stored securely on the University R drive for 5 years after the completion of the research project.

Research team members who had worked closely with the CFs were excluded from the interview component of the research, as this was identified as a potential conflict of interest. The mental and emotional health of CFs participating in the interviews was considered, with an explanation at the start that they could stop the interview at any time should they become distressed and a list of support services to contact should they wish further support following the interview was provided.

4 | Results

Eleven RN CF participants ranged in age from 32 to 61 years old, 64% ($n = 7$) of whom were female, as presented in Table 1. The main cultural backgrounds were 54% ($n = 6$) Australian. Among the remaining participants, one did not disclose their cultural background, while the others were international, each representing a different cultural background. Most of the participants, 54% (n = 6), hold an Advanced Diploma, followed by 27% ($n = 3$) with a Master's degree as the highest level of education and had additional training in many specialties, including oncology, cardiac nursing, critical care nursing, emergency nursing, mental health nursing, clinical education, Paediatrics and midwifery. Years of experience as a RN ranged from 5 to 38 years, with an average of 18.5 years of experience as an RN and years of work experience as a CF ranged from 2 to 20 years, with an average of 9.5 years of clinical supervision experience. Most CFs work part-time, 54% ($n = 6$) and on average, work 14.7 h per week and perform as CFs, ranging from 6 to 36 h per week.

The data from the semi-structured interviews elicited four main themes and subsequent subthemes (Table 2). The four main themes are (1) CFs' role and position, (2) CFs' understanding of WPV, (3) Types of WPV and (4) Perpetrators of violence.

4.1 | CFs Role and Position

CFs discussed their role and positions in supporting RNS who experience WPV during clinical placement and agreed they are usually the first point of contact for RNS following a WPV incident. CFs perceived their role as mediators that required communication with clinical staff, RNS and the university and their role required effective communication, nursing skills and being a good educator, as they articulated that good nurses does not mean they are good CFs. Their position included promoting RNS' safety, mental and physical well-being during a WPV incident, which required a supportive approach and open-mindedness. CFs were aware of their limited physical presence in maintaining this mediator position. They recognised that nurses and staff act differently towards RNS when they are present versus when the student advocate is absent. As a result, CFs stated that they usually visit RNS on placements several times weekly and encourage RNS to come to them with their experiences, mainly when the RNS' experienced frustration and disempowerment; however, the CFs felt they could not prevent RNS from being harmed during clinical placement, and it has implications on them.

TABLE 1 | The demographic profile of clinical facilitators.

Pseudo Names	Age	Gender	Cultural Backgrounds	Education	Special training	Years of experience as a nurse	Years of experience as a clinical facilitator	Employment	Clinical facilitations hours per week
Charlie	57	Preferred not to say	Australian	Advanced diploma	Oncology	30	15	Did not mention	Did not mention
Richard	32	Male	Chinese	Master's degree	Cardiac nursing	5	2	Casual	9
Mark	32	Male	Australian	Master's degree	Did not mention	11	7	Casual	15
Paul	46	Male	Did not mention	Honours, PhD candidate	Did not mention	10	6	Working part time	10
Jane	34	Female	Australian	Bachelor's degree, honours	Paediatrics, midwifery, acute/ surgical	13	5	Did not mention	10
Amelia	53	Female	Australian	Advanced diploma	Critical care nursing	32	15	Part time	6
Emma	33	Female	African	Advanced diploma	Emergency nursing	12	5	Part time	12
Grace	55	Female	Australian	Advanced diploma	Mental health nursing	12	8	Part time	8
Victoria	55	Female	United Kingdom	Advanced diploma	Anaesthesia/ Recovery/Emergency Nursing	30	20	Part time	27
Natalie	Not mentioned	Female	Kenyan	Advanced diploma	Critical care nursing	11	6	Part time	Did not mention
Lucy	61	Female	Australian	Master's Degree	Clinical education	38	16	Casual	36

TABLE 2 | Themes and subthemes identified through thematic analysis.

Themes	Subthemes
Clinical facilitators' role and position	First point of contact
	Impact of WPV on clinical facilitators
	The role of clinical facilitators
	Clinical facilitators treated as visitors
Clinical facilitators understanding of WPV	Prevalence of WPV
	Increasing of WPV
	Part of the job
	Constitution of WPV
Types of WPV	Psychological
	Verbal
	Non-verbal
	Sexual
	Ignored/Excluded
	Power held over another
	Racism/Discrimination
	Attitude
Perpetrators of violence	Violence from everyone
	Patients to anyone
	Violence from visitors
	Nurses to students
	Staff to students
	Doctors to students
	Carers to students
	Nurses to nurses
	Managers to nurses
	Students to students

> Clinical facilitators I think usually is the first point of contact…Course facilitators need to be supportive, needs to be open minded. And also gathering information from all different perspectives, speak to the student, speak to the abuser, speak to the manager if necessary. And provide students directions to find those policies. And give enough support. Help students develop the resilience. Help them identify those selfcare strategies. From the university point of view, of course prepare students for the placement, increase the awareness for workplace violence
>
> (Richard).

> As a facilitator I always say I'm your first point of contact, I'm the person that you should be talking to so that they know to say I know who to go to or who to talk to about what's going on. I've made myself available. I've said "Please if you, if anything like that happens you can call me at any time. Text me, I'll be there to discuss it"
>
> (Emma).

> Well, that's kind of a pretty big role for the facilitators. So, we provide support for the students, whether it be taking them off a shift, just for that shift to make sure they're feeling safe, and then meeting them outside of that workplace venue, having a debrief, allow them to have time off, and then calling them to touch base after to make sure they're feeling supported. And then, worst case scenario, do we need to swap them to a different venue. So, seeing them twice a week, making sure they're feeling supported enough whilst they're on placement. As facilitators, that's part of our role as well, we–before students start, I've usually contacted the ward and let the managers there know, you know, this is their scope of practice, and the skills for that placement, and hopefully the managers have let the staff know… And then they were also, yeah, getting quite kind of verbally inappropriate in their comments and what not as well. So, again, from a facilitator point of view, we can come in and spend the time with the students, but staff act different when we're there versus when we're not there
>
> (Mark).

> Communication, making sure they don't feel alone, so being there for their good and solved the problems on that daily basis, when things arise…you know it really depends on who are facilitators, and unfortunately nursing, we believe that if you are a nurse, you can be facilitator, you can be a tutor. No! We had to go for probably the same amount of practical as the nursing students here, and we've been taught all of this. We had all these interactive workshops, we have all of this things when you really need to deal with difficult students or like in a difficult environment and everything, and you cannot claim if you are a good nurse you are going to be a good educator, not at all, and yeah I mean for being an experienced nurse as well, and again we make a lot of claims or if you are nurse that means you are an effective communicator, not at all
>
> (Paul).

CFs described feeling disempowered by the conditions of their employment, that their role was poorly defined and that they could not support students as needed or as they wanted with the time and authority allocated to them in their role. WPV's impact on CFs who witness violence towards RNS is

destructive and reported through statements such as feeling horrible, frustrated, disempowered, confronting and traumatic.

> I feel horrible, horrible
>
> (Charlie).

> I guess for myself, a bit, a lot of frustration, and also kind of that powerlessness because being a facilitator there's only so much, I can do versus if I was there in a – having worked in like a team leader and manager role, there would be more I could do to step in, whereas being a facilitator and making sure the student is safe
>
> (Mark).

> It's, I feel disempowered because I couldn't do anything at the time to stop that from happening. And it was kind of like a car crash, like you don't want to look but you want to look, and you want to make sure they're okay. So, you feel really helpless and angry at the fact that this student, and all the other nurses have been put in this situation that wasn't, it's not predictable, and there's only a certain amount of management and, that you can do when you wake somebody up
>
> (Amelia).

The CFs shared their concerns regarding the limitations of their roles and employment arrangement. The University-employed CFs were treated as visitors during a placement since they were not always onsite. Those who provided this role across multiple clinical environments had to be abreast of each venue's policies and requirements, often without access to the operating systems as they were not employees.

> As a clinical facilitator again, even though I would say there is a lot to say but again you have a very limited role in a sense because you are not always there. You are precepting them, you are not physically present all the time
>
> (Paul).

> We go to lots of different hospitals there are policies set up, but we don't often get access to that system… It's not accessible for us because we don't have had IDs basically when we go into the public sector. The private sector can be a little bit protective as well on what they hand out. And I think it depends on the relationship you have with that venue, if you're only going to be there once in 4 weeks then you've not really built that relationship. I guess with me now where I am actually going, I've built that relationship so I'm sure I probably will be able to get access and get a copy if I need to, but I can't physically go and do it…for me that would be overstepping the professional boundary because I'm not there as an employee, I'm there as a university employee. So, I think that would be overstepping professional boundaries
>
> (Victoria).

4.2 | CFs Understanding of WPV

CFs reported that WPV exists in the health care system, and it has been increasing over time as perceived as 'Part of the job' and even expected within any health industry environment. All CFs agreed that there are different types of violence that RNS can experience during a clinical placement, primarily from patients and nurses. According to CFs, RNS experience mainly verbal violence and rarely physical, sexual violence and bullying, and it depends on the patient's health conditions and the nature of the wards.

> I think workplace violence in nursing exists. Our healthcare system is not perfect. Of course, there is verbal violence, physical violence very rare. Sometimes sexual harassment from patients. It really depends on the healthcare settings, and also the diseases that the patients come with. Certain patients they have cognitive impairment, they are not aware of what they are doing
>
> (Richard).

> a couple of different ways I would find workplace violence, because I work in mental health as well, it means a lot of consumers can also come across as quite violent at times. But for violence, kind of between staff, it would be things like people raising their voice, it could be passive aggressive violence as well, or bullying, but very rarely do we actually see physical violence
>
> (Mark).

> I think it's increasing, the amount of violence, really with the acuities of the patients coming to the hospital and it's been exacerbated obviously by the COVID and the stressors and things as well
>
> (Lucy).

> These days violence is more prevalent in the workplace from patients, from other nurses… it's quite prevalent at the moment, so there's more violence… in the past few years, …, I've had a lot of students actually bring up examples of experiencing violence
>
> (Emma).

> I think students are always going to be exposed to it probably because of the nature of the work, there's always going to be, yeah, patients with behavioural

> issues, they could be drug affected, they could be cognitively impaired–you know?
>
> (Charlie).

> It's the nature of industry which kind of dictates, which replicates the models and patterns of behaviours and those people in power they don't often look at the problem as it's a problem because they treat it as part of their normal environment… but look I have been in the hospital that's my eleventh year and nothing changed
>
> (Paul).

CFs understand and define WPV based on their observations, with most describing WPV as harming another individual intentionally or unintentionally and as anything that comprises people's safety at work. They agreed that violence can come in a variety of forms, such as bullying, harassment, psychological, physical or spiritual harm to another individual.

> The violence in the workplace is anything that comprises the safety of the people at work, or bullying, or harassment yeah towards the staff members really
>
> (Natalie).

> I see violence as anything that is psychologically, physically, spiritually harming to another individual, that another individual actually has intentionally or unintentionally done to somebody
>
> (Amelia).

4.3 | Types of WPV

The violence witnessed by CFs while supporting RNS on clinical placements included physical, psychological, verbal, non-verbal, sexual, ignored/excluded, a power held over another and racism/discrimination. The verbal violence was directed towards RNS from everyone, including patients and their visitors, nurses and other staff members, while the physical violence was less common and mainly from patients. CFs also reported on psychological violence that was targeted towards RNS and was described as emotional violence involving hierarchical violence and emotional burden, such as devaluing the RNS. They expressed that it could be more harmful than physical violence.

> It could be verbal, like family aggression towards staff, towards other patients, from patients or from even staff. So, any sort of verbal, physical aggression or even body language can be a form of violence or threats I would say...body language… it would be like gestures or the way so if people were to gesture rude, sort of rude gestures or the way the person interprets the other person's body language
>
> (Emma).

> I've seen student nurses, probably the last one was about 4 months ago, and they were holding the patient down to try and stop them from getting out of bed, cos this patient was pulling and everything. she was there a good 5 minutes, and clocked a fist to the guts, and just because she went to hold the patient's hand, and the patient hit out
>
> (Amelia).

> I had a student… where the patient was becoming quite aggressive. So, they were spitting on the window, banging on the door, demanding to speak to the student, who was a primary nurse at the time, and it was quite distressing for the student… Across the participants there was agreement that verbal abuse commonly occurred in the health care setting while physical violence was rare: “very rarely do we actually see physical violence”
>
> (Mark).

> I witnessed this type of–type of very, very subtle workplace violence–devaluing the students, disrespect of what they learnt in the school. Quite often, but there is really no obvious verbal workplace violence, or physical violence
>
> (Richard).

Body language or non-verbal violence as a type of WPV was also identified as being commonly witnessed by CFs in the clinical setting, and concerns regarding the inappropriate of sexual violence when staff power imbalances occur or when it is directed at patients. CFs agreed that exclusion is another type of WPV and observed RNS being excluded, pushed out of situations, and ignored, viewing this as WPV. Power held over another was reported as WPV, mainly when people use their status, power, and position to humiliate and intimidate others. Discrimination labelled as racism was presented as a problem in the health sector that CFs witnessed RNSs' experience from clients, doctors, and other staff during their clinical placement.

> So, the way they're standing or the way they look at them or stare at them. Also, things that are not really verbal or where language or where speak is not involved and the other person interprets it as threatening towards them is how I would define body language as a form of violence
>
> (Emma).

> Sexual violence towards nursing students, especially from male patients and staff, was also reportedly observed in the clinical placement by clinical

> facilitators. "Sometimes sexual harassment from patients"
>
> (Richard).

> Having a student in a room with a male nurse, we had our nurse unit manager, who's gone now, but he used to take the students in his room and teach them. And I'm sure nothing happened, there were never any complaints, but to me, that seems inappropriate to have a young vulnerable nurse behind closed doors in the position of power, so I think that's, you know, that's inappropriate.... it's kind of like bullying by exclusion, and whether that comes under that banner of workplace violence... So, they'll be a group of people that are talking at the end of the bed, and the student nurse will be left out, you know won't even be asked anything
>
> (Amelia).

> It can be as a group as well where you have issues with clicking; when you know a group of staff members, they exercise this you know uneven attitude and humiliating attitude towards a staff member, and of course as a result of workplace violence we have someone who is suffering
>
> (Paul).

> Even outside of nursing students, you see it a lot with doctors. That will turn up onto a ward and say, is there anyone here who speaks English I can talk to... I've seen that happen multiple times... So, racism's definitely a problem. I've heard definitely from nursing students that they experience that as students in the workplace. They go out and why are you even here? Why are you're not studying in your own country? How are you going to be any good? And, and that's from co-workers as workplace violence, but then they also have to cope with that from clients as well... Expressions of attitudes towards students, your – or even when it's comparing different universities. You're one of the ones from X Uni so you're no good compared to the ones from Y Uni. Or you're much better than the ones from there, because which is such a, an absurd generalisation... it's belittling to the students for absolutely no reason
>
> (Charlie).

4.4 | Perpetrators of Violence

According to the CFs, RNS experienced violence in the clinical placement, and the perpetrators included patients, visitors, nurses, other staff members, doctors and carers. Horizontal violence was reported from managers towards nurses, nurses towards nurses and RNS towards other RNS. CFs witnessed such WPV with clear identification that RNS were the recipients of violence from everyone during clinical placements. Patients were reported to act with verbal violence towards anyone, which included RNS and nurses. Other clinical staff, such as doctors and carers, were also seen as misbehaving towards RNS, which was perceived to result from increased workplace pressures. Doctors are observed to treat RNS poorly, can be rude, treat students inappropriately and sometimes blame students in healthcare settings.

> Yeah, everyone, everyone is a potential risk.... Experience violence in the workplace while they're doing their clinical placement from patients, visitors, nurses, and other Allied Health professionals–Medical doctors..."When they're (nursing students) being treated poorly more obviously by doctors or more senior staff that's going to be less common, but nastier..... The–it's only very, very recently that some have been convinced to stop throwing things. Not at nurses but just generally in the theatre. Yeah, it still happens, still happens"
>
> (Charlie).

> Students have shared experiences of what they've seen as inappropriate behaviour from staff. The way that staff talk to students, I guess, in a really demeaning derogative way... Visitors, such as the patient's family members and friends, were found to be demanding and violent toward nursing students. I would say probably more so visitors maybe not understanding what's happening or not having good communication between staff and visitors about what's happening with their family or friend
>
> (Jane).

> I think towards nursing students meaning that actually come from nurses. from nurse supervisors, because I think most of the patients, they do understand nursing students lack clinical experience, they are learning. And they wouldn't really blame nursing students. Well sometimes they may specifically tell the nurses–okay I would like to have a nurse looking after me instead of nursing students looking after me, because I'm a bit stressed or something like this. But rarely they actually blame ... abuse nursing students. Most of those come from our nursing colleagues when students make mistake, or when students are not up to their standard, and they leave terrible comments on their feedback form without any constructive feedback, and making students feel distressed
>
> (Richard).

> I think a lot of the junior doctors I've seen can be quite kind of verbally abrupt with students, as well, especially there's I guess that powerplay there, and yeah, I've seen a lot of doctors be quite inappropriate with the students in terms of just kind of what they're asking them to do and just how they're speaking, communicating to each other as well.
>
> (Mark)

Horizontal violence was another type of WPV that the CFs mentioned. Horizontal violence was described and witnessed by CFs as violence between co-workers, such as nurses to nurses and managers to nurses. The main witnessed horizontal violence by CFs was when RNSs experienced violence from other RNSs during placements, and it was mainly verbal violence, gossiping or ignorance of other RNSs.

> Usually, stuff happening between co-workers. The most common violence would be from other nurses, but it's going to be a lot of those low-level comments and attitudes
>
> (Charlie).

> If someone is dominating you cannot change them overnight and of their position in particular, and what really frustrates me in a sense when it comes to the hierarchical violence or horizontal violence we call it, it's organisation wraps it up so nicely and I mean these abusers they have been in the system for so long, and you can't get rid of them
>
> (Paul).

> I've had multiple cases where I've had to do some, a little bit of conflict resolution between students. I've had cases where I've had students come behind other students back and just went off and said really negative things about them. And I've had other issues where there's been bullying between students
>
> (Amelia).

5 | Discussion

The aim of this research was to explore the participants, CFs, perceptions of their role in supporting RNS who experience WPV during clinical placement. The participants described feeling disempowered by the conditions of their employment, that their role was poorly defined and that they were unable to support RNS as needed with the time and authority allocated to them in their role. The participants agreed that their students were experiencing WPV while on placement however, the participants in this investigation did not provide a common definitive understanding of what WPV was. All agreed that WPV experiences encompassed a wide range of violent behaviours committed against RNS, including verbal and physical violence, bullying, and, to a lesser extent, sexual harassment. Racism was mentioned briefly as an extension of verbal violence.

There was a shared concern among participants in this cohort that the prevalence of violence against nurses was increasing and becoming more severe and that RNS were captured within this. The increase in WPV was attributed to violent behaviour being tolerated or perceived as just part of the job and, therefore, not being taken seriously by the health sector or by nurses. Similarly, Dafny and Beccaria (2020) and Warshawski (2021) found that the incidence and severity of WPV were increasing, and violence in nursing was routinely accepted as a part of their job. Globally research identifies verbal and psychological violence in clinical spaces, often perpetuated by clinical staff in positions of authority, is viewed as 'historically entrenched' and stems from the hierarchical nature of the nursing profession and an ongoing culture of bullying (Birks et al. 2017; Tee, Özçetin, and Russell-Westhead 2016). Evidence suggests that the rates of bullying in nursing have not improved in recent years (Crawford et al. 2019; Warshawski 2021).

The types of WPV participants witnessed during RNS placements varied, ranging from covert bullying and lost learning opportunities to physical, verbal, sexual and racial violence. Perpetrators of the episodes witnessed were patients, family members, clinical staff, and predominately nursing staff, this is supported by recent research conducted (Solorzano Martinez and De Oliveira 2021) who concur there is a variety of perpetrators of violence to RNS, including patients, patients' families and hospital staff such as doctors and nurses. During the interviews, CFs reflected on years of experience and ratified the extant literature that describes the WPV experiences of their students. All CFs could recall examples of WPV against RNS they had seen, although it was unclear in some quotes if the CF reflected on an event they personally attended or events that RNS described to them. It was apparent from the interviews that CFs believed RNS when they reported WPV against them while on placement. This perspective is supported by a recent qualitative systematic review investigating RNS' experiences of WPV during clinical placement. Dafny et al. (2023) identified physical, verbal, psychological, sexual and racial violence as the primary forms of WPV, with verbal and psychological violence being the most commonly reported.

From an Australian perspective, Hutchinson et al. (2010) attempted to catalogue the behaviours that constituted bullying in the Australian nursing workplace. Bullying behaviours here were thought to include personal attacks, such as isolation and degradation, erosion of professional competence and reputation, and attacks through work roles and tasks, wherein work is made more difficult or opportunities for work are blocked. These forms of bullying were prevalent in the voices of participants in this study.

All clinical staff, including doctors, managers and other students, have been identified in the wider literature as potential perpetrators of WPV against RNS, although nurses and carers remain the primary perpetrators of hierarchical WPV. This was expressed as bullying or unfair treatment. References to nurses 'eating their young' described a common, long-running phenomena where RNS and graduates face hostility from more

experienced nurses (Meissner 1986). The term, coined in 1986, remains in the extant literature around WPV against RNS, highlighting that these damaging behaviours continue to permeate healthcare settings (Gillespie et al. 2017).

The participants also noted verbal and physical violence perpetrated by patients and their visitors; however, this was broadly dismissed as part of the role of nursing, despite explicit policies protecting staff and students from these behaviours. Such behaviour was rationalised through the condition of the patient and the stress or confusion experienced by family members as contributing to the violent behaviour. This perspective was commonly found in the literature, mainly when patients are identified as the source of WPV with rationales such as considered part of the job, walking away rather than any penalty for patients, they (patients) do not mean to be violent, and RNSs themselves also support this justification (Warshawski 2021). The systematic review by Dafny et al. (2023) concurs with this finding. While RNS included in the review studies were distressed by the WPV committed by patients and their families, they were more tolerant of the behaviour and accepted the situation as immutable to the nursing role (Dafny et al. 2023). This pattern of behaviours then formulates a culture of acceptance, where in violence is tolerated by all nurses, and goes unreported and unmanaged (Dafny et al. 2023; Warshawski 2021). In the present study, a solution proposed by the participants was to remove RNS from the patients rather than address the patient or visitor behaviours. The strategy of removing staff from potential violent situations is considered an effective way to protect staff, but removing the staff member is not always practical, and nursing staff would also like to see improvements in policy enforcement and action against perpetrators of violence (Dafny, Beccaria, and Muller 2021; Al-Qadi 2021).

The Dafny et al. (2023) review also highlighted the potential for CFs to be perpetrators of violence against RNS by abusing their authority as assessors to punish those perceived to be troublemakers. While CFs as perpetrators of violence was not a theme identified in this study, there was recognition that violence can come from any staff member associated with RNS on placement, implying there is a possibility of CFs being perpetrators. Australian research indicates that bullying and harassment from CF may be experienced. In 2017, a cross-sectional study estimated a quarter of RNS in their cohort identified CFs as perpetrators of WPV during placement (Budden et al. 2017), although it was unclear of the facilitation model and if the CF was employed by the education provider or placement venue. Managers in placement venues can empower nurses through education, improving communication and adaptive skills (Wang et al. 2023; Dafny and Muller 2021). Most nurses (97%) agreed that all hospital services should empower nurses with education and training to address WPV (Dafny, Beccaria, and Muller 2021) and report WPV immediately, following which staff felt empowered to return to their duties (Dafny et al. 2022). Several studies have called for universities to act to address WPV against RNS by implementing policies to identify and address WPV incidents and prepare students to act should they encounter violence issues on clinical placement (Budden et al. 2017).

CFs, as witnesses of violence, have not been widely discussed or reported upon regarding WPV against RNS. Instead, the experiences of other staff and students as witnesses of WPV are more commonly reported. Limited studies focus on CFs and include Lim et al. (2023), where CFs, through interviews, explored the facilitation role of supporting international RNS in Australia. The CFs recognised the struggles of international RNS, including difficulties with bullying and discrimination, and worked hard to improve RNS' learning experiences during clinical placements (Lim et al. 2023). Other qualitative research involving CFs in Australia has not explored their experience of witnessing violence against RNS. Instead, the narrative pertains to the CFs feeling alone and unsupported in their roles while recognising their position, enabling them to be agents of change (Ryan and McAllister 2019).

Common across all interviews was the notion that they were the RNS advocate and a point of contact that provided support and information for students during placements. These elements were viewed as central to their role and participants encouraged RNS to come to them with their experiences, mainly when the RNS' experienced frustration and disempowerment; however, they felt they could not prevent RNS from being harmed (Dafny, Waheed, and Snaith 2024). Participants of this investigation were employed by an education provider on casual short-term contracts or as full-time or part-time permanent staff members. This is typical in countries where universities increasingly rely on sessional teaching staff for nursing supervision within undergraduate nursing programs, providing facilitators with job insecurity and poor working conditions (Halcomb et al. 2010). Ryan and McAllister (2021) found in their investigation of Australian facilitators that professional development is not available to all facilitators, linking this to the part time nature of the role, and unclear expectations. For staff not on permanent contracts the availability of this professional development is likely significantly limited. Limitations in their capacity to act on RNS complaints could be attributed to the conditions of their employment, as it positions CFs outside the venue employee model (Needham, McMurray, and Shaban 2016), limiting their formal preparation and continuity (Ryan and McAllister 2021). Participants needed assistance from the manager or staff to access the reporting mechanisms for WPV, which may present a barrier. In this study, participants were aware of their limited physical presence in maintaining this liaison role. Open communication channels between the CF and RNS were considered essential to support student wellbeing; therefore, participants aimed to be onsite and available to students as much as possible. The limitations of this employment arrangement have been noted in other Australian studies (Needham, McMurray, and Shaban 2016). Challenges faced by CFs employed by an education provider include limited notice and time to prepare for the role, especially if there are casual employees, along with isolation and autonomy of the role with limited support/mentorship (Andrews and Ford 2013; Needham, McMurray, and Shaban 2016). The employment arrangements of the CFs may dictate their perspectives and opportunities to act through access to supportive resources when managing WPV experienced by RNS.

6 | Strengths and Limitations of the Research

The study aimed to explore CFs' understanding, experiences, and perceptions of their role in supporting RNS who encounter

WPV during clinical placements. The eleven participants varied in age, years of experience, and education levels. However, the generalisability of the findings is limited, as all CF were employed by limited South Australian universities. Given that the institutional context may influence their experiences, we recommend replicating this study across different institutions.

To our knowledge, up to the time of submission, there have been no qualitative study from CFs perceptions published on this topic, and this research will be the first to provide a quality pooled evidence from a CFs point of view. We cannot report if the CFs worked for the university or the hospital, as this could potentially identify them. Therefore, it cannot be argued with certainty that CFs may have been disempowered in their specific role or link findings to research with other CFs, specifically in a hospital or university setting. A professional dilemma exists for CFs situated in the hospital or employed by the clinical environment as RNS or the university may ask them to make a report against a colleague. Whereas a CF employed by the university or education provider is required to approach the reporting of WPV as someone coming from the outside, has no control over access to reporting mechanisms, and has minimal influence in that workplace. Most CFs work in both places; however, working with colleagues and students in multiple locations creates a position in the system that will dictate/limit their capacity to act.

7 | Recommendations for Future Research

Since this study has a limited number of participants and from one educational institution, it is recommended to replicate this across as many institutions as possible to ensure that the findings are robust and transferable regardless of the clinical or educational environment. Greater clarity is needed around the role of CFs and the impact of current employment processes for CFs that may be impinging on their capacity to provide support and protection to RNS on placement. What is evident is that universities and clinical settings need to develop and implement policies and procedures to combat WPV towards RNS, and further research is needed to examine the effectiveness of these policies in addressing WPV towards RNS.

8 | Conclusion

This study examined CFs perceptions of WPV towards RNS during clinical placements and their identification of perpetrators in these incidents. The findings provide valuable insights into how CFs define WPV, recognise its various forms, and identify those responsible for violent acts. CFs revealed that they perceive themselves as mediators between clinical facilities and universities when WPV incidents occur, often serving as the primary point of contact for RNS. However, despite this critical role, many felt powerless, citing a lack of authority or resources to effectively support students in the aftermath of such events.

Addressing WPV against RNS is vital, not only for safeguarding the well-being of students but also for ensuring the retention of future nurses—a key factor in combating the global nursing shortage. Effective strategies must be developed to both reduce the occurrence of WPV and mitigate its impact on students. Given their unique position, CFs are instrumental in bridging the gap between universities and clinical environments, and their role should be integral to the development and implementation of these strategies.

9 | Relevance to Clinical Practice

- WPV has significant implications for patient care and satisfaction, staff wellbeing and career longevity.
- WPV takes various forms, some more subtle than others, but its impact is especially severe on vulnerable groups like RNS.
- RNS are often disproportionately exposed to WPV, making it critical to understand the role of CFs in addressing these issues.
- Recognising CFs′ ability to influence change helps identify specific actions and roles necessary to create a safer, healthier learning environment for RNS.
- There is an urgent need to shift how WPV is perceived and managed.
- Addressing the root cause of WPV rather than removing RNS from the situation, is key to a sustainable solution.
- Without systemic changes in WPV management, the global nursing shortage will worsen as fewer people choose to enter or remain in the profession.
- Prioritising strategies that protect RNS and foster environments conducive to learning and professional growth is essential for the future of nursing.

10 | Implications of the Findings for Policy and Practice

The 'nurses eat their young' mantra still lives because of the harmful relationships between RNS and staff during clinical placements. CFs have limited authority within the workplace and cannot always provide a safe and conducive workplace experience to promote RNS learning outcomes. WPV is a global phenomenon that has long-reaching impacts on the nursing profession, the healthcare industry and the health outcomes of anyone cared for within this system. Therefore, WPV must be addressed quickly to improve care outcomes.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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