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Emergency Department Nurses' Experiences of Violent Acts in the Workplace

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EMERGENCY DEPARTMENT NURSE'S EXPERENCIES OF VIOLENT ACTS IN THE
WORKPLACE

A Dissertation Presented

by

PAUL STEVEN MACKINNON

Submitted to the Graduate School of the Nursing
University of Massachusetts Worcester in partial fulfillment
of the requirements for the degree of

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Nursing

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This dissertation work would not have been completed if it were not for support, guidance, and strength from my lovely wife Susan. Through the endless times at the computer, missed vacations, and managing our lives, she was always by my side. When times were sad, when a hug was all that was needed, and with the celebration of the joys on projects complete, this is truly her work.

Reserved

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Abstract

EMERGENCY DEPARTMENT NURSE'S EXPERENCIES OF VIOLENT ACTS IN
THE WORKPLACE

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Emergency department nurses are at high risk for violence in the workplace (Keely, 2002; Fernandez et al., 1998; Nachreiner et al., 2005; Mayer et al., 1999). It is estimated that between 52% and 82% of emergency nurses will experience physical violence and 100% of emergency department nurses will experience non-physical violence in their careers. Despite this fact, there are limited studies examining workplace violence among this vulnerable group (Fernandez et al., 1998; Levin et al., 1998). Therefore, the purpose of this qualitative descriptive study was to examine the experiences of emergency department nurses with workplace violence. Levin et al.'s (2003) Ecological Occupational Model (EOHM) was used to guide this study.

Four focus groups were conducted with 27 nurses who represented different types of emergency departments (rural community facility to large urban Level 1 trauma center). Results of the study suggested that the majority of participants (96%) experienced some form of work-related violence and 75% had attended at least one violence education class. The major themes of frustration and powerlessness emerged from the data. Sub themes included professional conflict while caring for violent

patients, personal detachment as an emotional survival mechanisms, and feelings of victimization. Additional factors contributing to workplace violence included: personal attributes of the nurse, the workplace, and the community where the emergency department was located. These study results have potential to guide intervention development aimed at reducing workplace violence in the emergency department setting.

Chapter I

State of the Science

Introduction

Violence is a growing concern in the workplace (Fernandez et al., 1998; Rippon, 2000; McPhaul & Liscomb, 2004). In 2000, the Department of Labor (DOL) reported a workplace assault rate of 2 per 10,000 in the private sector while the rate was 9.3 per 10,000 in nursing and personal care facilities. Also in 2000, the annual prevalence rates for nonfatal violent crimes for all occupations was 12.6 per 1000 workers, compared to the annual rate for physicians at 16.2 per 1000 workers, for nurses at 21.9 per 1000 workers, and mental health professionals at 68.2 per 1000 workers (OSHA, 2004).

Emergency department nurses are at a particularly high risk for violence in the workplace (Keely, 2002; Fernandez et al., 1998; Nachreiner et al., 2005; Mayer et al., 1999). It is estimated that between 52% and 82% of emergency nurses will experience physical violence and 100% of emergency department nurses will experience non-physical violence in their careers (See Table 1).

However, these estimates under-represent the true extent of emergency department violence (Findorff, McGovern & Sinclair, 2005; McGovern, et al., 2000; Gerberich et al., 2004; Rippon, 2000). The underreporting of violent episodes occurs for a variety of reasons, which includes: varied or contrasting definitions of violence (Ferns, 2005; Lau, McGarey & McCutcheon, 2006; McPhaul & Liscomb, 2004; Rippon, 2000), multiple reporting systems (Findorff et al., 2005; OSHA, 2004), and the perception of emergency department nurses that violence is an expectation in the emergency

department setting (Erickson et al., 2000; Levin, Hewitt, & Misner, 1998; May & Grubbs, 2002; Rose, 1997).

Table 1. Prevalence of Physical and Non-Physical Assaults

Type of RN	Method	N	Author	Prevalence of Physical Assault	Prevalence of Non-Physical Assault
ED, ICU, Acute care floor	Descriptive comparative	86	May & Grubs, (2002)	81% in the past year	100% reported verbal abuse
ED	Correlation	55	Erickson & Williams-Evans, (2000)	82% in their career, 56% in past year	
ED	Descriptive correlation	161	Mayer, Smith, & King, (1999)	71.9% in their career, 45% in the past year	95% in the past year
ED STAFF	Descriptive	1209	Mahoney (1991)	65.5% in their career, 36.3% in the past year	97.7% in their career, 89.1% in the past year
ED	Descriptive	36	Rose (1997)	52 % in their career, 33% in the past year	

Despite these writings, there is a limited body of empirical research examining the experiences of emergency department nurses and violence in the workplace (Fernandez et al., 1998; Levin et al., 1998). The purpose of this qualitative descriptive study was to examine the experiences of nurses in the emergency department and their perceptions regarding violence in their work environment. This study used an Ecological Occupational Model (Levin et al., 2003) as a framework to examine the workplace violence experiences of emergency department nurses. This Model suggests that environmental or community, workplace, and personal factors influence workplace violence. It is anticipated that by understanding nurses' experiences, intervention

strategies may be developed to reduce the risk of violence in the emergency department setting.

Definitions of Workplace Violence

Violence in the workplace is an elusive and difficult concept to define (Kraus, 2006; McPhaul & Liscomb, 2004) because there is no uniform definition (Lau et al., 2006; Luck & Usher, 2005; McPhaul & Liscomb, 2004; Rippon, 2000). The lack of a standard definition contributes to the difficulty of interpreting the existing literature on violence in the workplace (Ferns, 2005; Lau et al., 2004; McPhaul & Liscomb, 2004; Rippon, 2000). The existing definitions incorporate the subjectivity of the reviewer, interpersonal interactions, and intimate physical contacts of varying degrees (Arnetz & Arnetz, 2000; Rippon, 2000). For example, definitions of violence in the workplace may be conceptually framed by a criminologist, the individual who experienced the violence, an employer, or by the culture in which the violence exists (Kraus, 2006; McPhaul & Liscomb, 2004).

For the purposes of this research, the World Health Organization's (WHO) definition of workplace violence was used. WHO defines violence in the workplace as: "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" (WHO, 2002). Alternative yet predominant definitions in the literature were eliminated due to conceptual limitations and scope.

The WHO definition was selected for the following reasons:

1. It is complete and congruent with the conceptual framework of this study.

2. It encompasses the domains of environment, workplace, and individual factors.
3. It includes physical and non-physical acts of violence in the workplace.
4. It incorporates implied and overt acts of violence.
5. It includes factors exterior to the immediate workplace environment which may contribute to workplace violence.

As such, the National Institute for Occupational Health and Safety (NIOSH, 2002) and The National Occupational Health and Safety Commissions of Australia (NOHSC, 1999) definitions (See Appendix 1) were eliminated from consideration in this study. The NIOSH definition focuses on violence in the workplace solely in the work environment. It does not include factors exterior to the actual work environment or individual factors which may be contributory to workplace violence. Similarly, the NOHSC definition includes factors implied or specific to the work environment but does not extend outside of the immediate work environment or the community where violence may be precipitated.

Impact of Violence in the Workplace

Financial. Workplace violence has a financial impact on the healthcare system. It is estimated that millions of dollars are lost in workdays, increasing the financial burden to an already stressed health care system (Henry & Ginn, 2002; McGovern et al., 2002). McGovern et al. investigated a sample (N=344) of non-fatal work-related assaults of nurses through the Minnesota Department of Labor and Industry in their workers compensation system. They used a human capital approach to conduct their research and estimated the long-term cost of these injuries was \$5.8 million in 1996 currency.

Similarly, Yassi (1994) performed a retrospective descriptive study (N=242) of healthcare workers who filed reports on physical injuries resulting from workplace violence from April 1, 1991 to March 31, 1993 in a Canadian teaching medical center. The researcher concluded that 80% of the injuries were among the nursing personnel and over 8000 hours were paid in direct workers compensation benefits worth \$76,000 for the dates studied. However, the indirect costs concerning the loss of productivity or the ongoing financial impact of the assault events were not assessed in this study.

Psychological. In addition to the financial impact, violence in the workplace affects the psychological health of the workforce (Fernandez et al., 1998; Gates, Fitzwater, & Succop, 2005; Keely, 2002; Lau et al., 2004; Mayer, Smith, & King, 2002). Low staff morale (Levin et al., 1998), absenteeism (Gerberich et al., 2004), and employment changes are results of violence in the workplace (Finderoff, McGovern & Sinclair, 2005; Gerberich et al., 2004; Nachreiner et al., 2005; Mayer, et al., 1999). However, the literature is still in its infancy. Few studies have investigated the direct effects of workplace violence on the psychological health of the workforce (Gerberich et al., 2004, Levin et al., 1998; May & Grubbs, 2002).

The available literature describes the immediate and long term consequences of workplace violence. For example, between 36% and 86% of the healthcare staff who were physically assaulted had ongoing emotional distress including: anger, frustration, and stress (Finderoff et al., 2005; Gerberich et al., 2004; May & Grubbs, 2002). Of those who were physically assaulted, between 1% and 3 % left their jobs (Finderoff et al., 2005; Gerberich et al., 2004; May & Grubbs, 2002). Similarly, Finderoff et al. (2005) reported comparable results with victims of non-physical violence: 56% of the staff who

experienced non-physical violence reported feelings of anger, while 40% of the staff experienced ongoing stress, and 6% terminated their employment.

Of interest, several investigators (Gerberich et al., 2004; Findorff et al., 2005; Lanza, Zeiss, & Rierdan, 2006) suggested that non-physical acts of violence may represent a greater impact to the long term psychological welfare of healthcare workers. These researchers recommended empirical research be directed towards the investigation of the short and long term sequela of violence and the impact on the workforce.

Violence in the Emergency Department

The emergency department is a dynamic environment, driven by the shifting variables of physical structure, nurses, patients, and the cultural environment (Levin et al., 1998; Rose, 1997). Limited data are available to describe the emergency department as a work environment or the variables associated with violence to emergency department nurses (Levin et al., 1998) because much of the research is based in the general hospital (Catlette, 2005; Gerberich, et al., 2004; Hodgson et al., 2004; Nachreiner et al., 2005; May & Grubbs, 2002; McGovern et al., 2000) and psychiatric settings (Calabro & Baraniuk, 2003; Douglas, Ogloff, & Hart, 2003; Mayer et al., 1999; Whittington, 2002). However, several researchers have performed exploratory studies investigating the components and variables associated with violence in the emergency department setting (Erickson & Williams-Evans, 2000; Fernandez et al., 1999; Luck, Jackson, & Usher, 2007; Levin et al., 1998; Mahoney, 1991; May & Grubbs, 2002). These researchers described environmental, personal, and workplace factors as variables in emergency department workplace violence.

Environmental factors. Environmental or community factors include the geographical location of the workplace, the type of patients presenting to the emergency department for care, the prevalence of substance abuse, access to weapons, and violence in the surrounding community (Levin et al., 1998). These factors may contribute to violence in the emergency department setting (Kowalenko, Walters, Khare, & Compton, 2005; May & Grubbs, 2002; Peek-asa, Cubbin, & Hubbell 2002).

Community demographics may be associated with violent episodes in the emergency department (Kuhn, 1999; Levin et al., 1998; Peek-asa et al., 2002). Hospitals in high crime areas are likely to treat the victims and families of violence. Gang violence, drug abuse, poverty, and the availability of street weapons all increase the likelihood of violent acts against nurses in the emergency department and within the communities they are employed (Keely, 2002; Kowalenko et al., 2005; Mayer et al., 1999; NIOSH, 2002).

Issues affecting the community are drawn into the emergency department due to needs for assistance and treatment of victims (Brewer-Smyth, 2003; Henry & Ginn, 2002; Keely, 2002; Kuhn, 1999). In 2004, Cinat et al. (2004) performed a retrospective review of US Census Bureau data. The researchers compared unemployment rates, trauma epidemiology, and the Federal Bureau of Investigation crime indexes between California's Orange (OC) and Los Angeles counties (LC). They found large correlations between penetrating trauma and unemployment (OC, $r^2 = 0.85$; $p < 0.001$ and LC, $r^2 = 0.88$; $p < 0.001$). They found similar correlations between crime and unemployment (LC, $r^2 = .90$; $p < .001$). However, the researchers were not able to establish any causal relationship between these factors.

There is also evidence suggesting that an increase in domestic and gang violence in areas of low socioeconomic conditions infiltrates the emergency department environment (Kryiacou et al., 1999; Pearlman, Zierler, Gjelsvik, & Verhoek, 2003; Cunningham et al., 2006). In a study of adolescent patients presenting to an urban medical center emergency department ($n = 115$), Cunningham et al. (2006) reported 77% of the adolescents in the emergency department had perpetrated violent acts within the past year. Of these violent acts, 37% were severe (weapons and group fights) and resulted in medical attention to the victim(s).

Also, patients who present to the emergency department arrive in a myriad of physical, psychological, and emotional states. It has been suggested that patients and the conditions under which they present to the emergency department contribute to acts of violence in this setting (Fernandez et al., 2002; Kowalenko et al., 2005; Kuhn, 1999). Perpetrators of workplace violence are often males (Kuhn, 1999; May & Grubbs, 2002), users of intoxicants (Fernandez et al., 2002; Mayer et al., 1999; May & Grubbs, 2002; Zernike & Sharpe, 1998), have a history of violence (Fernandez et al., 2002; Soliman & Reza, 2001), or have a medical condition affecting their cognitive abilities (May & Grubbs, 2002; Soliman & Reza, 2001; Stirling, Higgins, & Cook, 2001).

For example, males between 20 and 40 years of age have been responsible for violence in the workplace between 42% and 67 % of the time (Fernandez, et al., 2002; Kuhn, 1999; May & Grubbs, 2002). Furthermore, Mayer, Smith & King (1999) reported a significant correlation existed (*Pearson r not reported; $p < 0.001$*) between violent acts and emergency department nurses' perception that the patient was under the influence of intoxicants. Between 46% and 89% of assaults involved substance abuse or perpetrator

impairment as a factor in those assaults (Gerberich et al., 2004; Kowalenko et al., 2005; Mahoney, 1991; May & Grubbs, 2002). May and Grubbs also found 71% of those patients who perpetrated assaults had some type of cognitive dysfunction (head injury, dementia, or developmental delay). Additionally, Soliman and Reza (2001) investigated risk factors and correlates of violence, committed by patients ($N= 474$) in an adult psychiatric unit in the United Kingdom. The investigators found that violent patients were significantly more likely to have a history of violence ($\chi^2 = 42.4, df = 1, p < 0.001$) and be receiving benzodiazepines ($\chi^2 = 46.7, df = 1, p < 0.001$) as compared to nonviolent patients.

In addition, there are healthcare issues that may increase the incidence of violence in the emergency department. May and Grubbs (2002) found long wait times (38.4%) and general anger directed at the healthcare system (27.9%) as reasons for violent patient behavior. Of interest, these researchers reported that the most common reason stated for assault by patient families was the enforcement of hospital policies (58.1%), anger at the patient's condition (57%), and anger related to the health care system (46.5%).

In summary, the literature supports the importance of the environment or community as a factor contributing to violence in the workplace (Fernandez et al., 1998; Levin et al., 1998; OSHA, 2004; Rankins & Hendy, 1999; Rose, 1997). This includes the geographic location of the emergency department (Cinat et al., 2004; Cunningham, et al., 2006; Pearlman et al., 2003) and the characteristics of patients presenting for care (Mahoney, 1991; May & Grubbs, 2002). Patients present with multiple conditions, sometimes resulting from alcohol, street drugs and illegal weapons use from the surrounding community. Violence may be drawn into the emergency department due its

geographic location or proximity to violence in the surrounding community and the immediacy or availability of care contributing to an increased risk of violence in the emergency department setting.

Personal factors. Environmental factors alone do not fully explain violence in the emergency department. The impact of the emergency department nurse, their perceptions about their environment, and how they interact within their environment are also important factors (Erickson & Evans-Williams, 2000; Lee, 2001; Little, 1999; Mahoney, 1991; May & Grubbs, 2002). Gender, race, age, work location, history, and prior violence may also play a role in workplace violence. The Health Resources and Services Administration (HRSA, 2004) estimates that at the time of the study, there were approximately 2.9 million nurses in the United States (median age = 47 years), of which 94% were female, 81% were white, and 51% had over 20 years of experience. Of these nurses, 117,000 worked in an emergency department setting. The workplace violence literature describes females between the ages of 35 and 55, with ten or more years of experience, as being in the highest risk category for workplace violence (Fernandez et al., 1998; May & Grubbs, 2002; Mayer et al., 1999; Whittington, Shuttleworth & Hill, 1996). Emergency department nurses, therefore, fall into this high risk category.

Prior experiences with violence (e.g., child abuse, domestic violence and / or workplace violence) increase the likelihood that a nurse will encounter violence in the work setting (Lee, 2001; Little, 1999) because past life experiences affect interactions, perceptions, and behaviors when confronted with new violent situations (Erickson & Williams- Evans, 2000; Lee, 2001; Little, 1999). For example, Little (1999) compared the affects of workplace violence, childhood abuse, and education as risk factors for

assault in the work place. From a sample ($N = 65$) of respondents of the New Hampshire Nurses Association, Little (1999) found that a history of child abuse was associated with an increased risk of work place victimization, physical abuse ($r = .33, p < 0.05$), and workplace sexual victimization ($r = .55, p < 0.01$). Additionally, the researcher reported that education had a significant protective effect from both physical ($r = -.29, p < 0.05$) and sexual aggression ($r = -.28, p < 0.05$) in the workplace.

Similarly, Erickson and Williams–Evans (2000) recruited a convenience sample of emergency nurses from two emergency departments ($N = 55$) to explore the frequency of assaults and nurse attitudes regarding workplace violence. Among those who had been assaulted in the previous year, 73% ($n = 31$) believed assault was an expectation of working in the emergency department. Therefore, the researchers suggest that the attitude of the nurses regarding violence in the workplace and their previous experiences with violence affect future behaviors. Erickson and Williams–Evans (2000) theorize nurses may become habituated to assaults and assume the role of a victim. This, in turn makes them more at risk to be assaulted.

Individual perceptions of violence may influence violence in the workplace (Catlette, 2005; Erickson & Williams–Evans, 2000; Landy, 2005; Levin et al., 1998; Luck, Jackson, & Usher, 2007). How nursing staff perceive and interpret the cues of their environment may affect the commission or omission of violent acts (Levin et al., 1998). Several researchers have initiated investigations describing how nurses perceive their work environment and how these factors influence workplace violence (Catlette, 2005; Erickson & Evans, 2000; Levin et al., 1998).

For example, Luck and colleagues (2007) used a mixed method case study design to explore specific observable cues of impending violence in patients, families, and friends in the emergency department environment (Luck et al., 2007). The specific objectives of the study were to:

- Observe the nature of violence towards ED nurses
- Gain insights into the perceptions of ED nurses surrounding violent events
- Gain insights into assessment strategies
- Develop an violence assessment framework for ED nurses

The researchers found five distinct observable elements suggestive of violence in the emergency department. The acronym STAMP was assigned to these elements which included: Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing. The STAMP framework was proposed as a useful way of assessing behaviors that may lead to violent situations. The researchers concluded STAMP offered a practical evidenced based framework for violence in the ED and in early recognition of risk.

Also, Catlette (2005) used a descriptive approach to investigate the perceptions of nurses ($N = 8$) related to workplace violence and safety in two, level-one trauma centers. Vulnerability and inadequate safety measures were two themes expressed by the nurses. This result is similar to the findings of Hislop and Melby (2003), who described nurses' feelings of isolation and powerlessness in a phenomenological investigation with 26 nurses. Hislop and Melby (2003) further found concerns for training, administrative supports, and physical controls of the work environment. These researchers suggested that further investigation was needed to identify factors contributing to violence and the emotional impact of these factors on emergency department nurses.

Additionally, Levin et al. (1998) conducted focus groups to investigate the risks of workplace violence and the perceptions of nurses ($N = 22$) in the emergency department setting. The nurses identified workplace, personal and environmental risk factors. The participants perceived workplace risk factors as poor support from hospital administration, inadequate policies, and lack of security presence. The nurses reported personal risk factors as inadequate training in violence education, limited clinical experience, and the inadequate mechanism of support available after a violent episode occurs. The participants defined environmental risk factors to include specific patient demographics, the community where the hospital resides, and protective physical structures within the hospital.

Common themes emerged from the literature describing the personal factors associated with violence in the emergency department. First, nurses described intense emotional feelings between themselves, the patient, and the patient's families (Catlette, 2005; Hislop & Melby, 2003; Levin et al., 1998; Luck et al., 2007). Second, the research suggested that how the nurse perceived the workplace environment was a significant factor in violent occurrences (Landy, 2005; Levin et al., 1998; Trentworth, 2003). Third, data suggested that there is a relationship between hospital administration, the support structures for issues surrounding workplace violence, and the nurse's perception of a safe work environment (Erickson & Evans, 2000; Levin et al., 1998).

Workplace factors. Several researchers suggested that physical design of the emergency department and the culture of the organization were factors contributing to violence (Duxbury & Whittington, 2004; Gerberich et al., 2004; Levin et al., 1998; Lau et al., 2005; Whittington, 2002). Workplace factors included: the physical architecture of

the emergency department, organizational infrastructure, policies concerning violence, workplace violence education, and staffing levels (Levin et al. 2003).

The physical structure of the emergency department influences the occurrence of violence in the workplace (Fernandez et al, 1998; Levin et al., 1998; OSHA, 2004; Rankins & Hendy, 1999; Rose, 1997). The architectural design of the emergency department, patient access points, and areas where the staff may be isolated are all part of the physical structure. An optimal physical design of an emergency department promotes safety of the staff, patients, and families (OSHA, 2004).

For example, families and patients present to the emergency department in variety of highly emotional states (Erickson & Williams –Evans, 2000; Levin et al., 1998; May & Grubbs, 2002). A physical structure with multiple access points allows an unimpeded flow of visitors, patients, and families, contributing to tensions (Peek-asa et al., 2002; Rankins & Hendey, 1999). Allowing unimpeded access has been implicated in the increased risk for violent acts to occur. Secured access is significant to the protection of victims of gang and domestic violence where the perpetrators of the assault may seek additional harm (Kennedy, 2005; Rose, 1997; Rankins & Hendey, 1999; Peek-asa et al., 2002).

In addition, physical barriers that limit direct access to the nursing staff and the use of visitor passes lower the likelihood that violent acts will occur (Rose, 1997; Mayer et al., 1999). Physical barriers include the use of safety glass in the triage area and the geographic arrangement of the nurse's station (Peek-asa et al., 2002). For example, it has been suggested that the use of safety glass in the triage area may reduce the risk of injury

from gunshot wounds and projectiles from patients (OSHA, 2004; Rose, 1997; Rankins & Hendey, 1999). However, these assertions have not been studied.

Similarly, the use of metal detectors, closed circuit security cameras, visible security, and guard dogs have been suggested to decrease violent episodes in the emergency department (May & Grubbs, 2002; Rose, 1997; Rankins & Hendey, 1999). Rankins and Hendey (1999) performed a retrospective review of security records between 1992 and 1996 in an urban county emergency department to study the effects of implementing security systems on assault rates and weapons confiscation in the emergency department. The authors used frequency distributions and Fishers exact test to compare the proportions of weapon and assaults before and after the security system was implemented. They found that the number of weapons confiscated increased significantly after the implementation of a security program (24 weapons confiscated pre-security and 40 weapons confiscated post-security, $p < 0.001$.); however, there was no significant reduction in assault rates post-implementation (assault rates = 0.3/10,000 before and 0.1/10,000 after, $p = 0.24$). Although the authors site the retrospective nature of their study as a limitation, the results suggest security measures alone will not reduce violence in the emergency department.

How staff perceives the safety culture of the workplace affects the manner in which they approach and respond to acts of violence (Erickson & Williams –Evans, 2000; Levin et al., 1998). These behaviors affect future behavior and shape the organizational culture (Henry & Ginn, 2002). Organizational cultures with defined philosophies on workplace violence, policies and procedures, and a commitment to the elimination of workplace violence may develop a safe work environment, free from

violence and its sequelae (Calabro & Barinuk, 2003; Henry & Ginn, 2002; Peek-asa et al., 2002; Whittington, 2002).

In a multiple linear regression of organizational factors related to safety (job demands, administrative controls, and occupational stress), Calabro & Barinuk (2003) found that nurses' ($n = 138$) perceptions of administrative controls (policies, procedures, and safety inspections) were significant factors influencing safety in a 250-bed psychiatric facility (See Table 2). Similarly, the findings of Levin et al., (1998), suggested that the organization's commitment to issues of workplace violence in the emergency department contributed to the reduction of violence in the workplace.

Table 2. Multiple Linear Regression with Dependent Variable Safety

Variable	Parameter estimate	SE	F	<i>p</i>
Administrative controls	.555	.065	8.600	.001
Job demands	.188	.051	3.704	.001
Occupational stress	.268	.080	3.369	.001

Another workplace factor contributing to violence is the level of staffing. A number of researchers have suggested that staffing levels and shift patterns contribute to violence in the workplace (Henry & Ginn, 2002; Kennedy, 2005; Levin et al., 1998; Whittington et al., 1996). In particular, lower levels of staffing (Kennedy, 2002) and shift patterns in the evening or night are related to higher occurrences of violence (Henry & Ginn, 2002; Mahoney, 1991). Mahoney (1991) found a significant relationship between assaults and threats among nurses who worked night shifts (either 8 or 12 hours) than among those nurses who worked other shifts ($\chi^2 = 14.8$, df (not reported), $p < .01$).

Conversely, Mayer et al., (1999) found that verbal abuse was higher on the day shift ($p < 0.05, < 0.001$)

Some suggested that violence education and training may reduce workplace violence (Arnetz & Arnetz, 2000; Fernandez et al., 2002; Lee, 2001; McPhaul & Liscomb, 2004; OSHA, 2002; Peek-asa et al., 2002; Whittington, 1996). However, study findings have been inconclusive. For example, findings from several studies suggested that nurses who received focused education about workplace violence were less likely to be injured by acts of violence (Arnetz & Arnetz, 2000; Fernandez et al., 2002; Lee, 2001). Fernandez et al. (2002) demonstrated violence prevention education had a short-term protective effect (49 violence episodes at baseline, 19 at three months, and 46 at six months), diminishing within six months. Arnetz and Arnetz (2002) also found that those staff members who were randomly assigned to participate in a violence intervention program from 47 health care sites ($N = 1500$), were significantly more aware of: (1) the risk towards staff (33% vs. 25% control group; $\chi^2 = 10.4$, $df = 3$, $p < 0.05$), (2) how potentially dangerous situations could be avoided (34% vs. 26% control group; $\chi^2 = 5.0$, $df = 1$, $p < 0.05$), and (3) how to deal with aggressive patients (33% vs. 25% control group; $\chi^2 = 10.4$, $df. = 3$, $p < 0.05$).

In contrast, Hurlbaeus & Link (1997) and Nachreiner et al. (2005) found no significant reduction in workplace violence after training. Nachreiner et al. (2005) conducted a case control study among nurses and found no significant difference between those who had training in workplace violence ($n = 310$) and those who did not ($n = 946$), for the following:

- Success in managing violent patients (OR = 1.38),

- Rate of reporting work-related physical assaults (OR = 1.36),
- Self defense (OR = 1.2),
- Having risk factors for violence (OR = 1.0),
- Knowing how to operate safety alarms (OR = 1.0),
- Rate of reporting work-related harassment (OR = 0.97), and
- Work-related violence policy (OR = 0.91).

Similarly, Lee (2001) explored the effects of violence training on self efficacy in a nursing population of an emergency department ($n = 76$) and their ability to manage aggressive behaviors. Lee (2001) theorized that nurses with higher levels of self-efficacy would be more effective in managing aggressive behaviors. Lee (2001) found staff had higher levels of self efficacy preceding violence training in the study ($t = 2.77$, $df. = 74$, $p < 0.01$) and no other difference with the exception of the management staff ($t = 3.08$, $df. = 69$, $p < 0.01$). It was suggested the management staff had higher levels of self efficacy proceeding violence training and were more effective in managing violent behaviors. Therefore, the benefit of violence education is unclear. Further study needs to be conducted to identify new methods of reducing the risk of violence in the emergency department.

Summary

There are limited data regarding workplace violence among nurses in the emergency department setting. Most of the studies reported to date have been descriptive and used small convenience samples; however, they provide important preliminary information about the importance of the workplace, environment, and personal (nurse-related) factors that influence violence among nurses working in emergency departments.

There are a limited number of studies investigating the experiences of nurses in the emergency department setting (Catlette, 2005; Erickson & Williams- Evans; Hislop & Melby, 2003; Levin et al. 1998; Luck et al., 2007; May & Grubbs, 2002).

For example, Levin et al., (1998) found the environment, workplace, and personal factors contributed to violence in the emergency department. These researchers suggest that how a nurse experiences the cues from the environment, workplace and individually affects the occurrences of violence in the emergency setting. However, there are little data defining how emergency department nurses experience their work environment. Levin et al. (1998) suggested that further investigation of the nurse's experiences of the environment, workplace, and personal factors was needed. Exploration of these areas might establish a foundation for intervention strategies aimed at reducing violence in the emergency department setting.

Similarly, Erickson and Williams-Evans (2000) explored the experiences of violence and nurses in the emergency department. The researchers found a large percentage of nurses expect to be assaulted in their career, were less likely to report these assaults and that these nurses become habituated to violence in the workplace. The researchers found there were additional variables of workplace violence that were not evaluated in their study. The researchers suggest patient demographics, culture, and personal factors (personal history of assault or abuse and prior experiences with workplace violence) contribute to workplace violence in the emergency department.

Also, researchers suggest the nurse-patient experience is significant to violence in the workplace (Levin et al., 1998; Luck et al., 2007, May & Grubbs, 2002). Several researchers found that a patient's cognitive abilities (intoxicated, head injured,

developmentally delayed or dementia), behavioral cues of impending violence, and the nurses interactive experiences with these patients were significant to violence (Luck et al., 2007; May & Grubbs). They suggested that further investigation into the specifics of patient demographics, patient behaviors, and nurse behaviors when confronted with these experiences were needed.

Last, several researchers have investigated nurses and the personal effects of violent experiences in the workplace (Catlette, 2005; Handy, 2005; Hislop & Melby, 2003). These researchers found a variety of emotional themes including: vulnerability, isolation, fear, anger and risk. These researchers suggest that experiences affect or influence violence in the workplace.

Research on violence in the emergency department setting is in its infancy. The purpose of this research was to describe emergency department nurses' experiences of violent acts in the workplace. The resulting data will provide the foundation for developing intervention strategies aimed at keeping emergency department nurses safe from violent occurrences.

Chapter II

Introduction the Problem and Conceptual Framework

Introduction

The Ecological Occupational Health Model (EOHM) (Levin et al., 2003) was used to guide this research. A conceptual model incorporates abstract and related concepts into an organized framework from which the research may be structured and interpreted (Burns & Grove, 2001). This is particularly salient in qualitative inquiry where new ideas, concepts, and relationships emerge from loosely connected themes (Lincoln & Guba, 1985). Few models have been used to study violence in the workplace (McPhaul & Liscomb, 2004).

Of these models, three major frameworks have been used to investigate violence in the workplace: The Haddon Matrix (1972), the National Institute for Occupational Safety and Health/National Occupational Research Agenda (NIOSH/NORA, 2001), and the Broken Window Theory (McPhaul & Liscomb, 2004). The Haddon Matrix is a research framework that was used for several decades to study the epidemiology of injury. Its foundation exists in the public health sector where it uses the domains of host, agent, and disease to explain workplace violence. These domains are investigated through the primary, secondary, tertiary and quaternary influences of injuries associated with violence. The NIOSH/NORA (2001) framework suggests that the work organization influences illness and injury through occupational health services (training, policies, and environmental controls). The intent of the theory was to develop a framework to investigate the influences of job design on occupational injuries and also serve as a foundation for research activities. The Broken Windows Theory is based in criminology.

The framework suggests that tolerating crime creates an environment conducive to more serious crime. In the healthcare setting, lower levels of violence (verbal threats, minor assaults) are tolerated leading to more serious forms of violence (Hesketh et al., 2003).

The Haddon Matrix, the NISOH/NORA Framework, and the Broken Windows Theory were considered and rejected as conceptual frameworks for this study. They were eliminated from consideration due to the limitations in their specificity and completeness relevant to the variables of personal, environmental, and workplace factors evolving out of the workplace violence literature. In this regard, the EOHM was chosen to guide the study of nurse's experiences with violent acts in the emergency department. The EOHM was chosen for the following reasons:

1. The EOHM includes variables (e.g., personal worker factors, workplace factors and community or environmental factors) that have been empirically supported as contributing to workplace violence (See Table3).
2. The EOHM has been used to guide previous workplace violence research, including qualitative (Levin et al., 1998; Levin et al., 2003) and quantitative studies (Levin et al., 2006).
3. The EOHM includes factors that the National Occupational Research Agenda Traumatic Injury Team (1998) identified as key variables in the study of workplace violence.

Thus, the EOHM was an ideal model for guiding qualitative inquiry on nurses' experience with violence in the emergency department setting.

Ecological Occupational Health Model (EOHM) Development

Ecological theory is derived from the early tenants of the biological and social sciences. In his book, *On Origin of the Species*, Darwin (1859) described the interrelationships between organisms and the environment (Salazar & Beaton, 2000). Darwin theorized that organisms evolve and adapt to their environment through natural selection and speciation. These adaptations were influenced by the geography or environment in which the organisms existed (Darwin, 1859).

Table 3. EOHM Factors Demonstrated in the Literature

Author	Methods	Environmental/Community Factors	Workplace Factors	Personal Factors
Levin et al., 1998	Focus Group	X	X	X
May et al., 2002	Questionnaire	X	X	X
Luck et al., 2007	Mixed Method		X	X
Catlette, 2005	Interviews		X	X
Erickson et al., 2000	Questionnaire	X	X	X
Levin et al., 2003	Focus Groups	X	X	X
Fernandez et al., 1998	Questionnaire		X	X
Rankins & Hendey, 1999	Chart Review	X	X	
Mayer, et al., 1999	Questionnaire		X	X
Mahoney, 1994	Questionnaire	X	X	X

These elementary concepts were extended into the social sciences and the application of ecological theory to human issues (Bronfenbrenner, 1977). Bronfenbrenner

(1997) suggested that relationships and interactions should be investigated within the contexts (environment) and complexities of these interactions. He suggested that human interactions were multifaceted and should be studied for their complexities and the contexts in which they occur. This social ecological approach has been widely applied in the contemporary literature to health promotion strategies, mental health, family therapy, and occupational health (Salazar & Beaton, 2000).

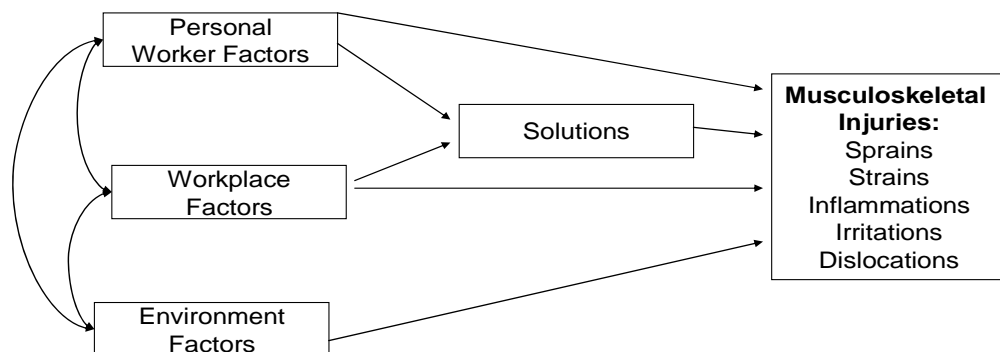
Ecology may be defined as the study of relationships between organisms, their environment, and to one another (Lausten, 2006). Ecological models are multifaceted and are concerned with environmental change. They encompass the physical environment, the participants within the environment, behaviors, and policies which shape healthy choices (Brown, 1999). By the nature of their practice, nurses exhibit multiple ecological interactions throughout the course of their care activities (Lausten, 2006). How nurses interact within their environment influences the outcomes of care while also influencing the practice environment (Lausten, 2006; Levin et al., 1998). Thus, ecological theory is well suited for the investigation of the nursing environment.

In the nursing literature, ecological inquiry closely resembles ethnographic research in which researchers attempt to describe the complexities of the social structures and cultures where they exist (Creswell, 1998). Qualitative inquiry is an ideal methodology to reveal the complexities of nurses as they interact within their work environment. Qualitative methodology provides a framework for the rich descriptions of interactions not evident by casual observation (Miles & Huberman, 1994). Qualitative inquiry allows scientists to immerse themselves within the environment, while providing a structure for data collection, impartiality, and openness to new ideas or concepts as they

emerge from the data (Miles & Huberman, 1994). In this respect, the use of qualitative methodology with the EOHM is complimentary. Qualitative inquiry provides the structure, discipline, and openness to study the complexities of the emergency department environment in which intricate human interactions exist.

An occupational ecological framework was first proposed in the nursing literature by Conrad, Balach, Reichelt, Muran, and Oh (1994) while investigating musculoskeletal work injuries of firefighters. In this study, Conrad and colleagues (1994) conducted focus groups with firefighters (N= 39) to describe the *personal meanings* associated with work-related musculoskeletal injuries and to develop a framework for studying workplace injuries. In addition, Conrad et al. (1994) believed that the framework, which they derived from the qualitative data, could be used in the future to design injury-reducing interventions. Figure 1. illustrates the original model that emerged from Conrad and colleagues' data.

Figure 1. Ecological Model (Conrad et al. 1994).

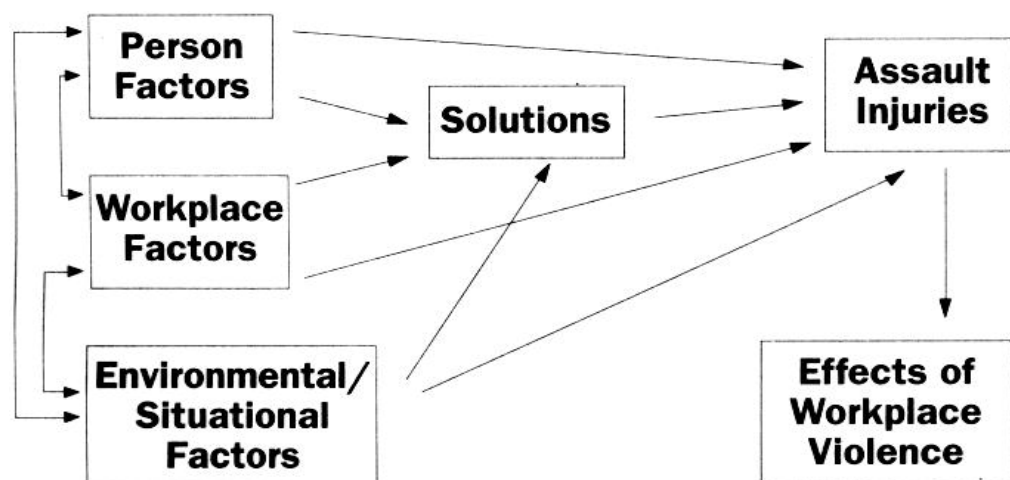


Conrad et al.'s framework (1994) identified personal factors (age, experience, physical fitness), workplace factors (safety training, equipment, job tasks), and environmental or situational factors (unpredictability, emergency situations, structural conditions) that contributed to musculoskeletal injuries among firefighters. In addition, these data identified potential solutions (e.g., skill development, facilities, management support) that helped to prevent musculoskeletal injuries. The researchers further concluded that this ecological model provided a holistic approach that combined both health promotion and hazard reduction through an occupational health framework.

Levin et al. (1998) applied Conrad's ecological approach to the study of nurses and their experiences with violence in the emergency department setting. Levin and colleagues (1998) adapted the model in several ways. First, they replaced the term, "musculoskeletal injuries" with the more general term "injuries." Second, they added the variable "solutions" to indicate prevention efforts or solutions that are put in place to mitigate workplace-related injuries. In this model, the environment has a directional relationship to solutions which does not exist in Conrad's model (1984). Figure 2.

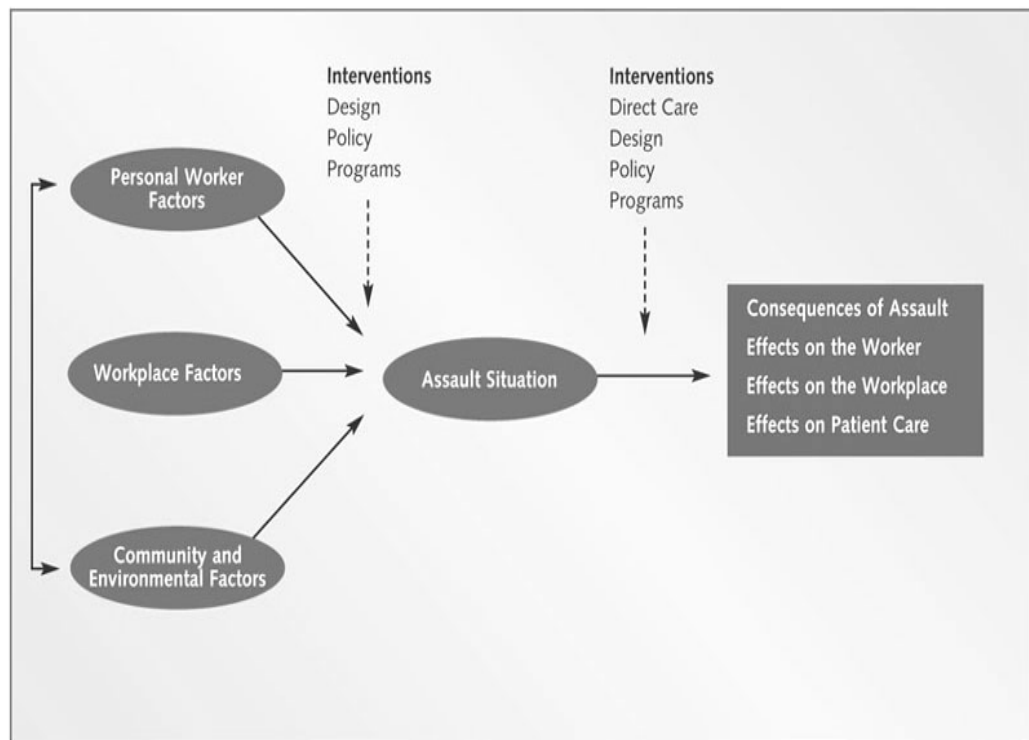
Illustrates the first set of changes to the EOHM.

Figure 2. Ecological Occupational Health Model (Levin et al. 1998)



Levin and colleagues (2003; 2006) further refined the EOHM based on empirical data to include community factors, assault situations, and the consequences of assault (See Figure 3.). Levin et al. (2003) suggested the outcomes of the assault affect the worker, the workplace, and the patients. These outcomes may have both short and long term effects on employees. These effects may be poor worker attitudes, deterioration of work relationships, and inability to provide care for patients.

Figure 3. Ecological Occupational Health Model (Levin et al., 2003)



Levin further suggests that intervention strategies may be deployed prior to and after violent episodes mitigating the outcomes of violent episodes in the work environment. These intervention points replace “solutions” in the original Levin et al. model (1998). Table 4. further outlines the variables in the adapted model and the indicators associated with those variables. This adapted version of the EOHM will be used to guide the proposed study helping to focus interview questions and probes

Table 4. Levin and Colleagues (2003) Adapted EOHM Variables and Proposed Indicators

Model Variable	Indicators
Personal Worker Factors	Demographics of the workforce Individual perceptions or attitudes Prior experiences with violence Personal feelings of vulnerability
Workplace Factors	Workplace violence policies Staffing patterns Job tasks Training Physical design of the work area Presence of security personnel and safety equipment
Community and Environmental Factors	The community where the workplace is located Demographics of the patient population presenting for emergency care Availability or prevalence of weapons, substance abuse and violence in the surrounding community
Assault Situation	The nature and degree of the assault (including physical and verbal assaults) Whether the violent act was reported or not
Consequences of Assault	The short- and long-term effects on the: nurse (physical and emotional), the workplace (lost work time, costs, disability, attrition, change in job performance, morale) and patient care

EOHM-adapted Assumptions

There are several assumptions that undergird the adapted EOHM, these include:

1. The work environment is a complex and interdynamic ecological system.
2. The individual worker, the community (external environment) and the workplace

contribute to the possibility of workplace violent acts.

3. The worker, workplace, and community are interrelated.
4. Both verbal and physical assaults are considered violent acts.
5. Lack of reporting of violent acts hinders prevention efforts.
6. Interventions (e.g. workplace design, policy, training programs, direct care) can be put in place both before and after an assault situation occurs to reduce the consequences of the assault on the worker (in this case the ED nurse), the workplace and on patient care.

Chapter Summary

The emergency department is a complex and dynamic environment. It is composed of multiple internal and external factors affecting the patients and the staff (Fernandez et al., 1998; Keely, 2002; Levin et al., 1998; Rose, 1997). The adapted Ecological Occupational Health Model (Levin et al., 2003) was used to guide the description of nurses' experiences related to violent acts in the emergency department. The framework provided additional insights into violence in the emergency department

The purpose of this qualitative descriptive study was to describe the experiences of nurses in the emergency department regarding violence in their work environment.

The specific aims of this study were to:

1. Describe the personal, workplace and community/environmental experiences of emergency department nurses related to violence in the workplace
2. Describe the short and long-term consequences of workplace violence on emergency department nurses and patient care
3. Explore the personal, workplace and community factors contributing to

an increased risk for violent occurrences

Chapter III

Methods

Introduction

This study used a qualitative descriptive design to explore the experiences of emergency department nurses with acts of violence in the emergency department setting. Nurses who were actively practicing in the emergency department setting were invited to participate in focus group interviews to elicit experiences about acts of workplace violence. The Ecological Occupational Health Model (EOHM) (Levin et al., 2003) was used to guide the study. The EOHM organizes workplace violence into three domains: the workplace, the environment /community, and personal factors

The purpose of this chapter is to describe the methods used for this study. The procedures for data collection, management and data analysis as well as establishing trustworthiness of the results are discussed. Additionally, human subjects' considerations and the study limitations will be identified.

Qualitative Descriptive Methodology and Rationale

Qualitative methodology is indicated when the researcher attempts to investigate broad concepts and connections between phenomena in a natural setting (Miles & Huberman, 1994). Data are in the form of words, which are analyzed into formal structures of interpretation and theory (Burns & Grove, 2001). The data are utilized to formulate meanings, connections, and interpretations within the context of the study setting. These data generate future areas for research and act as a foundation for empirical investigation (Burns & Grove, 2001).

Qualitative inquiry is an ideal methodology to reveal the complexities experienced by nurses as they interact within their work environment. It provides a framework for the rich description of interactions not evident by casual observation (Miles & Huberman, 1994). Qualitative inquiry allows the scientist to immerse himself/herself within the environment while providing a structure for data collection, impartiality, and openness to new ideas or concepts as they emerge from the data (Miles & Huberman, 1994).

Setting

Study participants were recruited from UMass Memorial Health Care (UMMHC). UMMHC is a not-for-profit 1.8 billion dollar health care system serving the residents of Western and Central Massachusetts. It consists of five member hospitals that include full-service emergency departments in each of their clinical sites:

- UMass Memorial Medical Center- University, Memorial, Hahnemann Campuses
- Marlboro Hospital
- Clinton Hospital
- Health Alliance
- Wing Memorial Hospital

The hospitals range in size from a small community-based emergency department (Wing Memorial Hospital) to a large tertiary care, level I trauma center emergency department (UMass Memorial Medical Center-University Campus). (See Table 5).

Table 5. UMMHC Member Hospital Statistics

UMass Facility	City in MA	# of Beds	# of Employees	# of ED visits
UMass Memorial – University Campus	Worcester, MA.	360*	9072*	75,000/year*
UMass Memorial-Memorial Campus	Worcester, MA.	310*	9072*	47,000/year*
Health Alliance Hospital	Leominster, MA.	143	1665	58,602
Marlboro Hospital	Marlboro, MA.	79	649	26,360
Wing Memorial Hospital	Palmer, MA.	52	682	14,065
Clinton Hospital	Clinton, MA.	41	280	13,000

**estimates, the data is reported across all three campuses in aggregate*

Sample

A purposeful sample was recruited to participate in this focus group study. The sample included emergency department nurses from six of the UMMHC system emergency departments. The accessible population included approximately 350 registered nurses working full time, part time and per diem at UMMHC.

The study inclusion criteria were:

1. Emergency Department nurses employed in the UMMHC System at the time of the study
2. Actively practicing emergency department nurses
3. Minimum of 2 years of experience in emergency nursing

The study exclusion criteria were:

1. Agency, traveler, or float nurses
2. Administrative nursing staff
3. New nursing graduates (less than 2 years nursing experience)

Attempts were made to recruit approximately 10 emergency department nurses from each of the six UMMHC emergency departments to participate in focus group discussions. The size of the focus groups allowed for a rich and detailed discussion of the topic.

Attempts were made to recruit emergency department nurses with varied experiences, (e.g. years of experience) and backgrounds (e.g., AS, BS, Diploma, and MS degrees). To date, there are no demographic data profiling emergency nurses (Emergency Nurses Association, personal communication, September, 2007). The demographic data listed in Table 5 were collected on all study participants. (See Table 6).

Recruitment

The Chief Nursing Officer or chief nursing leader at each hospital site was contacted by this investigator to request approval to recruit nurses from their departments. Once approval was received, the investigator met each nurse manager/director to discuss the proposed study.

Table 6. Participant Demographic Data Points

1.	Age in years
2.	Gender
3.	Ethnicity
4.	Number of years as a Registered Nurse
5.	Number of years in emergency nursing

6.	Highest academic degree achieved
7.	Highest nursing degree achieved
8.	Have you ever experienced any type of workplace violence associated with your work in the emergency department (yes/no)? If yes, please describe this experience
9.	Have you ever had formal education in workplace violence management? If yes: How many workplace violence programs have you attended? How many months ago did you attend formal education on workplace violence management? How many total hours have you had workplace violence education?
10.	Have you ever lost work as a result of physical violence in the emergency department? If yes: please indicate how many times this occurred If yes: please indicate approximately how many days you missed from work

Study participants were recruited from each emergency department through postings, fliers, and snowball sampling. Potential participants contacted the investigator directly or by email to discuss the study. The participants signed a UMMS approved written informed consent form before the focus group was initiated.

Focus Groups

Focus groups are used to bring homogeneous groups together to speak about common interactions and are ideal for soliciting feelings, thoughts, and insights about topics of interests (Kruger & Casey, 2000). Focus groups have been used successfully in marketing research and in the service industries. More recently, they have been utilized in nursing research to elicit information and data that cannot be easily captured by

traditional empirical methodologies. Focus groups are iterative, inductive, and naturalistic (Burns & Grove, 2001; Kruger & Casey, 2000).

Focus groups require the use of moderators or facilitators to elicit data. In this study, the moderators consisted of this investigator and a PhD-prepared faculty member from the UMMS Graduate School of Nursing. The roles of the moderators were to lead the group session. This investigator led the focus group sessions. The UMMS faculty member recorded the data, was active in participant in the focus group discussions, and asked clarifying questions.

A total of 4 focus groups were conducted with 6 to 8 participants in each group. The focus group sessions included the moderators and the study participants. An open ended interview guide formed by the EOHM was used to lead the focus group discussion (See Table 7). The focus groups began with introductions and a general discussion of the study. Topics progressed from introductions to more complex discussions surrounding experiences and feelings around workplace violence. The moderators used specific probes to explore the domains of workplace, environment/community, and personal factors contributory to violence in the emergency department setting as defined in the conceptual framework (Levin et al., 2003). The moderators were alert to new ideas that emerge from the discussions and explored these concepts with the group. The interview guide provided sufficient probes and questions to elicit rich discussions and robust data collection.

Table 7. Focus Group Questions and Probes

Conceptual Area	Main Question	Probes
Introduction/opening	Please introduce yourself to the group. When you think about	Can you give examples?

	<p>violence against nurses in the ED, what do you think about?</p>	
Workplace	<p>What things do you think contribute to nurses being assaulted in the workplace?</p> <p>How do the policies and procedures of the hospital affect violence in the emergency department?</p> <p>How does the hospital address issues of violence in the emergency department?</p> <p>Do you think certain things about patients increase the chances a nurse will be assaulted?</p> <p>Do you think anything about families or friends makes the nurse more likely to be assaulted?</p>	<p>Can you give examples?</p> <p>In what manner?</p>
Environmental/Community	<p>How does the work setting contribute to assaults in the emergency department setting?</p> <p>How does the location of the emergency department or surrounding community contribute to assaults in the emergency department setting?</p>	<p>Can you give examples?</p>
Personal	<p>How do you or others respond immediately after being assaulted by patients?</p> <p>Do you think there is anything about a particular nurse that makes him or her more likely to be assaulted?</p>	<p>What happens?</p> <p>If no, why not?</p> <p>If yes, what are those factors?</p> <p>Would you please give</p>

		examples? Does gender play a roll?
Possible strategies	Do you think education about assaults has helped you from being assaulted? If you were putting together a program to help nurses decrease their chances of being assaulted, what should it include? What things need to be put in place (by hospital administration or administrators) to reduce the chances of nurses being assaulted in the emergency department?	If no, why has it not helped? Is so, how has it helped? What has been the most helpful part of the education?
Concluding remarks	Is there anything we missed?	If so, what are they?

Procedure

Focus group sessions were held in a private room in the facility where the participants are employed. The room was a comfortable temperature with adequate space for moving within the room. Two poster size easels with detachable poster paper were in the room for the documentation of concepts, thoughts and ideas as they emerged from the participants. The UMMS faculty recorded the information shared during the focus group on the poster paper.

Before each focus group the moderators conducted a pre-session. The pre-session included a discussion of the purpose and bracketing of thoughts and feelings to ensure all

of the study logistics had been addressed. The primary investigator's thoughts and feelings were audio recorded to create an audit trail.

The focus groups ranged from 69 minutes to 123 minutes in length. Group sessions were audio taped to ensure accurate and complete capture of the data. The participants were offered breaks throughout the sessions. The focus group participants chose to continue the session without a formal break. Time was allocated at the end of each session to discuss group findings that emerged and to verify an accurate account of the discussions.

Finally, audio taped debriefing sessions with the moderators occurred following each group. The questions posed by Casey (in Krueger, 1998) were used to conduct the debriefing sessions. (See table 8). The research study continued until saturation of concepts and content was achieved. Saturation was achieved when no new concepts or ideas emerged (Creswell, 1998; Krueger, 1998); this occurred after the third focus group session. A fourth focus group session was conducted to assure saturation of the data had been achieved.

Table 8. Debriefing Questions (Krueger, 1998)

1.	What are people saying?
2.	What are people feeling?
3.	What is really important?
4.	What are the themes?
5.	How do the groups compare?
6.	Were there any items needing further exploration?
7.	Which quotes give the essence of the conversations?

8.	What ideas will be especially useful to the project?
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Data Management

Data collection was active and ongoing. Data collection, management and analysis were iterative. The data analysis was accomplished through note-based analysis (Kruger, 1998). Thoughts, ideas, and quotes were recorded on the poster paper by the UMMS faculty during the focus group sessions. Each focus group was designated with a letter A through D. Data written directly on the poster paper and the audio tapes from the debriefing sessions were transcribed into an MS word document. The audio taped sessions were used for clarification of context, content, and intended meanings. The poster papers were collected at the end of the sessions and were under the direct control of this researcher. Data specific to each focus group were designated with the corresponding letter assigned to the focus group. The data were cataloged by date, time, and location.

Each focus group was considered a unit of investigation. The investigator was responsible for data security. Access to the data was restricted to the investigator, the research committee chairperson and the IRB. Written permission to access the data, purpose, and a statement of confidentiality will be required to view the data. The log will be considered discoverable for the audit trail. To date, there have been no requests to access the data.

Data Analysis

Data for analysis included the audiotapes, the notes taken during the focus groups, the debriefing session notes and audiotapes, and field notes taken during the pre-sessions. The investigator used qualitative content analysis (Miles & Huberman, 1994) and a note

based analysis method (Kruger, 1998) to examine the data. Qualitative data analysis is a process by which the investigator reviews data for content, themes, and constructs (Miles & Huberman, 1994). Note based analysis is when comments and written documents are summarized at the end of the focus groups (Kruger, 1998). Data from the focus group were coded into themes. The EOHM framework (workplace, community/environment, and personal factors) was used for initial organizing. Coding of sub themes occurred as new ideas emerged. The investigator was attentive to content, themes, and sub themes that were divergent from the conceptual framework. The investigator reviewed all audiotapes to verify the accurate and complete capture of the data. The investigator returned to audiotape review for clarification and further investigation of ideas as they emerged.

The analysis was progressive, incremental, and iterative. Data were compared in and between the different focus groups. A reflective journal of all coding decisions was maintained throughout the data analysis to address issues of trustworthiness (Creswell, 2003). Descriptive statistics were computed for the demographic data using SPSS version 15.0.

Trustworthiness

Establishing trustworthiness in qualitative research is based upon four components: transferability, dependability, confirmability, and credibility (Lincoln & Guba, 1985). To establish transferability the investigator provided rich and detailed descriptions of the experiences of emergency department nurses with workplace violence. These experiences were tested for consistency with the conceptual model, the matching of participant examples, and review from the dissertation chairperson. Dependability and

confirmability entails the tracking and reporting of the research process. This was accomplished by developing an audit trail, documentation of decision points in the coding process, and frequent communication with the dissertation committee chairperson. Credibility refers to the quality of the research and if it is an accurate representation of the data. Credibility was established by (1) having the investigator conduct the focus groups and immerse himself in the data with the participants, (2) maintaining rigor through the bracketing of thoughts and feelings, and (3) member checks.

Member checks were conducted by having the data results reviewed by three study participants from the total participant group. These participants were chosen due to convenience and representation from a trauma center, an urban and rural emergency department. Request for participation in the member checks were included in the informed consent prior to their participation in the study. Results of the member checks indicated that the themes, subthemes and contributing factors that emerged in the data is an accurate representation of the workplace violence experiences of emergency department nurses.

Reflexivity

Reflexivity is the process by which the researcher continually and consciously examines his or her own internal thoughts as they conduct qualitative inquiry (Dowling, 2006). Reflexivity assumes the researcher brings into an investigation individually preconceptions and thoughts. Reflexivity allows an open acknowledgement of these thoughts and attention to how they may affect decisions or perceptions of study events.

The investigator has over 30 years of health care experience. His early health care experience was in the emergency mental health system in which workplace assaults

were observed. The remainder of the health care experience was in emergency services in both clinical and administrative roles. While practicing in these areas, this investigation has observed assaults and has been a victim of both physical assaults and verbal assaults.

While conducting this study, the investigator remained cognizant of these prior experiences and the impact to the research. He accomplished through the personal journaling (audio taped) of each focus group session including individual thoughts and past experiences. Additionally, frequent conversations and debriefing with the committee chair after each session allowed the researcher to focus on the themes emerging out of the focus group versus personal meaning of violent events.

Protection of Human subjects

The study was reviewed by the University of Massachusetts Medical School's Institutional Review Board (IRB) for approval prior to the initiation of the study. No person was included or excluded based upon gender, or ethnicity. Participants received full disclosure of the study purpose and methods. All participants signed an informed consent form prior to participating in the focus groups. The participants' places of employment were deidentified. Demographic data were reported in the aggregate to protect the anonymity of the individual focus group participants.

There were no anticipated physical risks to the participants. There were the potential risks of psychological distress due to reliving prior violent episodes. The investigator remained alert to any signs of emotional distress among the participants. All focus groups interviews took place in a hospital setting where emergency care and

referral was readily available. None of the participants expressed or demonstrated any signs of psychological distress throughout any of the focus group sessions.

Ethical Considerations

The investigator has over 20 years of clinical and administrative experience in healthcare and the UMMHC system. In this time, he has both formed multiple personal and professional relationships throughout the region. This may influence the participant's willingness or reluctance to disclose sensitive yet significant information regarding violence in the workplace. In this respect, each session was initiated with a personal disclosure of these concerns and the ability of the participants to withdraw from the study.

In addition, sensitive information may be disclosed regarding the unethical treatment of patients or families. The participants were asked to de-identify the specific individuals (e.g. patient, person, family member) and detail the events of the violent occurrence. All participants were given assurances of confidentiality in an effort to ensure rich descriptions of the data.

Chapter Summary

This chapter summarized the design and methods used for this study. Focus groups and qualitative descriptive methods were used. Study participants were recruited from 5 different emergency rooms to represent hospitals ranging in size from a small community-based emergency department to a large level I trauma center. The Ecological Occupational Health Model was used to guide this study. The processes for establishing trustworthiness of the study data were outlined. Results of this study are discussed in the following chapter.

Chapter IV

Results

Introduction

A qualitative descriptive approach was used to describe the experiences of emergency nurses with workplace violence. The results yielded three major themes. The major themes included: frustration, powerlessness, and contributing factors. For the purposes of this research, frustration is defined as: prevention from accomplishing a desire or an outcome. Powerlessness is defined as: a complete lack of control, authority, or status to affect how others will treat or act towards you. Contributing factors include: personal, workplace and environmental factors defined in the Ecological Occupational Health Model for this research project. These major themes are linked with workplace violence due to their contributions to tensions experienced by the nurses.

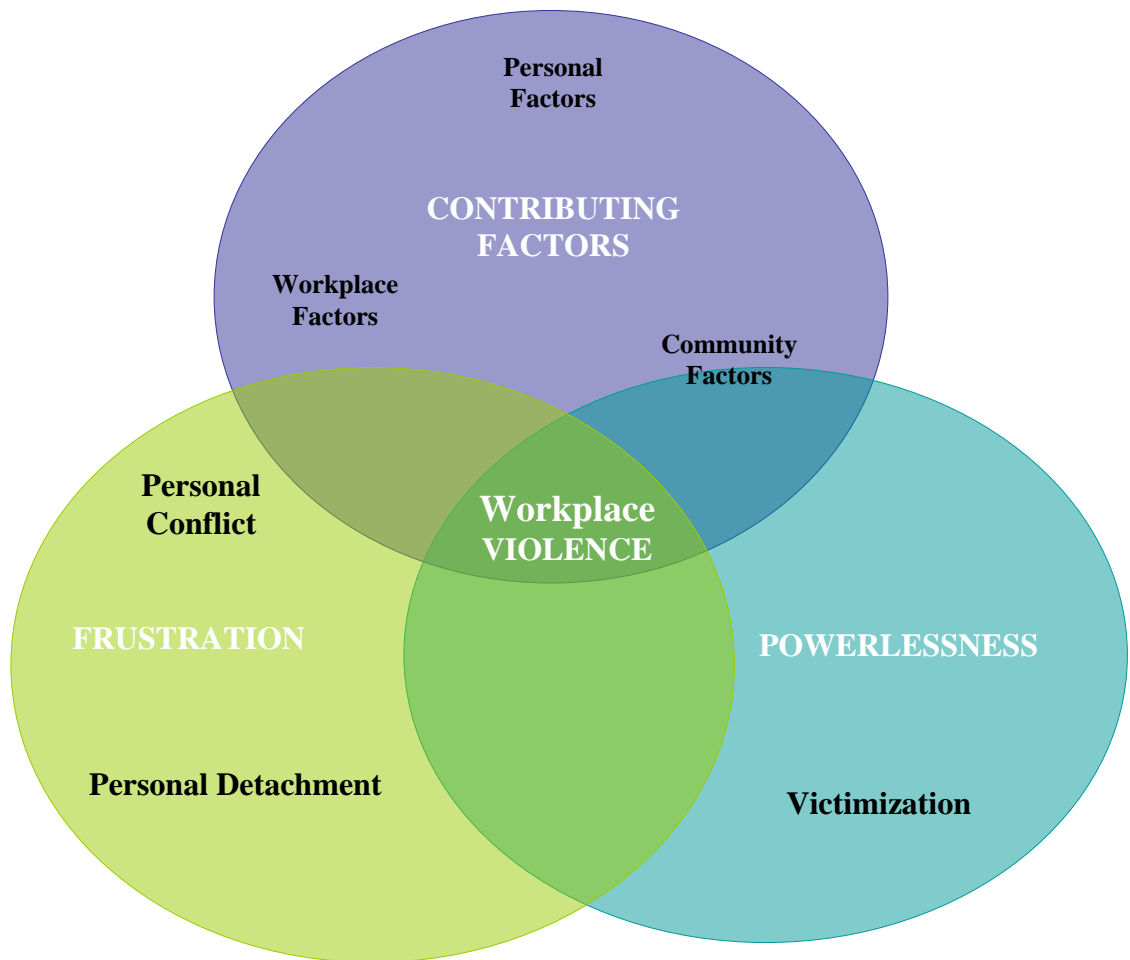
Three behavioral consequences (subthemes) of exposure to these major themes emerged from the focus group data. Professional conflict and personal detachment were behavioral consequences that emerged from the major theme of frustration. Professional conflict is defined as: the actions or circumstances that are divergent from the fundamental principles of nursing practice. Personal detachment is defined as: an emotional and/or physical withdrawal from human interactions. Victimization emerged as a behavioral consequence from the major theme of powerlessness and is defined as: an act or acts that exploits or treat someone unfairly.

Themes and behavioral consequences were linked with workplace violence by the manner in which the research participants experienced violence, addressed violence in the work setting, and altered practice patterns in the emergency department. The major

themes and their behavioral consequences were interconnected in an ecological system (See figure 4). Data supporting the themes, behavioral consequences, and connections will be described in this chapter and organized by the study's specific aims. In addition, the sample demographics will be described.

Figure 4.

Thematic Model: Emergency Department Violence



Focus Group Participants

A total of 27 emergency department nurses were recruited to participate in four focus groups. (See Tables 9 and 10 for a description of the sample). The focus group sessions were conducted between August and September 2008 and each group lasted from 60 – 125 minutes. Nurses were purposefully recruited into segmented groups by emergency department type (See Table 11 for Hospital Demographics).

Table 9

Sample Age, Years in Nursing, Years as ED Nurse, Time since Workplace Violence Education and Number of Workplace Violence Classes (*N* = 27)

Demographics	Mean	Median	SD	Range	Missing
Age	44.6	43.0	10.37	27-65	1
Years in Nursing	17.52	14.0	11.70	1 – 37	0
Years in ED Nursing	12.00	8.0	10.25	1 – 31	0
Number of Workplace Violence Classes Attended	1.26	1.0	0.99	0 – 3	8
Time since Workplace Violence Education (<i>months</i>)	27.79	24.4	35.50	24-144	8

Table 10

Sample Gender, Race, Presence of Workplace Violence, Lost Work Due to Violence

Variable	N	%
Gender		
Female	23	85.2
Male	4	14.8
Race		
White	27	100
Presence of Workplace Violence		
Yes	25	92.6
No	1	3.7
Missing	1	3.7
Lost Work Due to Violence		
No	20	74.0
Yes	2	7.4
Missing	5	18.5

Table 11

Hospital Demographics

Focus Group	Hospital Classification	Number of Hospital Beds	Number of ED Beds	Yearly ED Volume
Group 1	Community tertiary care Facility, urban setting	380	28	48,000/year
Group 2	Community hospital, urban setting	79	13	26,300/year
Group 3	Community hospital rural setting	41	7	13,000/year
Group 4	Level 1 Trauma, tertiary care, urban setting	357	56	78,000/year

To preserve anonymity, the sample is described in the aggregate; instead of within individual groups. The median age of the participants was 43.0 years (range = 27 – 65). The majority of participants were female (85%). All participants were Caucasian. The median years of practice as a registered nurse was 14 years (range = 1 - 37) and in emergency nursing was 8 years (range = 1 - 31). More than half of the participants had a baccalaureate degree ($n = 14$, 51.9%).

The majority ($n = 25$, 96%) of participants experienced some form of violence in the emergency department setting. These experiences ranged from verbal abuse to

physical assault. Of participants who did not report violence in the work setting ($n = 2$), one did not respond to the demographic questionnaire. Both participants actively participated in the discussions. Only two participants admitted missing work as a result of violence in the emergency department (lost work days, range 1-7 days). These nurses reported minor musculoskeletal injuries requiring rest and immobilization. A total of 75% ($n = 18$) of the participants attended some type of violence education class. Of the participants who took part in violence education classes, 31.6 percent ($n = 6$) did not have a class within the past twenty four months and for some participants (21.1%; $n = 4$) it had been over 48 months since their last class. Several participants ($n = 2$) commented that it had been “years” since their last violence education class.

Participants’ Definition of Workplace Violence

Each focus group session was initiated with the participants being encouraged to define violence in the emergency department. Responses included descriptions of both physical and non-physical violence. Some participants defined physical violence as “strikes and hitting” or “physical contact with intent to harm.” Others defined violence as “threats of physical harm” and “intimidation.” Several participants included both the physical and non physical acts of violence in their definitions such as “Someone that is flailing, someone that is spitting, someone that attacks, someone that is in your face, verbal and physical assaults.”

Others defined violence from an individual context: “violence is personally defined.” One participant reported “a person’s history defines how they look at violence.” One female participant described a personal history of domestic violence that influenced the manner in which she experienced violence in the workplace: “I have a history of

personal domestic violence, when a patient yells at me, I live that.” Similarly, a participant described violence as “very personal, where you grew up. Some people carry guns around.” The participants went on to describe how their personal history with violence defined how they experienced, reacted, and related to violence in the workplace.

Results that address aims 1 (*describe the personal, workplace and community/environmental experiences of emergency department nurses related to violence in the workplace*) and 2 (*describe the short and long-term consequences of workplace violence on emergency department nurses and patient care*) will be presented together according to the major themes and behavioral consequences that emerged from these data.

Frustration

Frustration was a major theme throughout the focus group sessions. Participants experienced frustration from personal (feelings of anger and hostility), workplace (insufficient resources, boarding of patients), and/or community/environmental (unrealistic expectations from patients, and societal changes) factors, all which increased the likelihood of workplace violence in the emergency department. The focus group participants linked frustration with an increase in violence: “They [patients and families] get frustrated which leads to loss of control.” The participants also asserted that frustration increased individual nurse’s feelings of anger and hostility. As frustration increased, nurse’s anger and hostilities increased with patients, families, and their fellow emergency department nurses: “frustration, which leads to their anger, which leads to their loss of control.” The participants described violence occurring as tension increased

for both nurses and patients “they are frustrated and so are we” and “frustration, anger, resentment that I can’t provide the care I want.”

All the participants expressed frustration with insufficient resources to care for their patients. Participants cited overcrowding in the emergency department, the lack of beds to treat patients, patient flow, and inadequate staffing as examples of insufficient workplace resources. For example, one participant stated: “the patients are already sick and in pain and [nurses] must overcome the numbers [of patients] are the challenges. Few are fine, but 30 [patients], increases anger and frustration on nurses and the patients both.” Several participants across the groups commented that the emergency departments are “boarding” multiple patients (awaiting admission over two hours) waiting for inpatients beds. The participants indicated that the process of boarding patients results in an increased workload and does not allow the emergency department nurses to care for “emergency patients” and this increases their frustration. One focus group participant described this best:

Our emergency department is filled up with admissions, they take up a lot of time and slows the whole process down, you can’t move the patients out, therefore half of our emergency department is filled up with admissions, we are seeing less emergency department patients, they wait 6 to 10 hours to see a doctor, they get frustrated and they get angry. This leads to more frustration, not for just the patient but for the staff.

The focus group participants expressed concern regarding unrealistic expectations from patients because of a lack of knowledge regarding the emergency care system. The groups reported patients are unfamiliar with the processes within the emergency

department resulting in increased frustration leading to overt hostility: “need signs that say this is how it is in an emergency room - that is why they get mean and angry [lack of understanding].” Expectations begin in the triage area and extend into the clinical treatment areas: “the patients are upset prior to coming to the ED - they are sick and something is wrong with them” and “people are sick and have expectations - they want immediate help, I can’t move that fast.” All of the focus groups mentioned that patients want immediate gratification of their needs such as “they want it.” One participant stated: “people [the patient] get very angry, my problem is severe and why are you making me wait” and “people want immediate help.” If these needs are not met, patients and families become increasingly frustrated leading to anger and violence. Several participants commented they received “death threats” from gang members using hand signals intimating a gun. Another participant described, the mother of a child threatening the nurse: “If he dies [so will you].” The expectation of immediate gratification was experienced across all of the focus groups and emergency departments.

Across all groups, the participants commented that our society has changed and society wants immediate gratification and service delivery. The public has higher service expectations of healthcare in a “broken” health care system: “we have become a society of instant gratification and people use the emergency room not for emergencies but for primary care.” Additionally, “there is a lack of primary care, they [primary care physicians] send patients to the emergency room for the treatment of minor illnesses or when their primary care office is over scheduled [when it is not an emergency].” Several participants stated that the emergency department is an easy access point for all care needs. These care needs can be emergencies, primary care, or social issues.

One female participant stated: “they feel as though the ED nurse is a public servant.” Each of the focus groups offered a “McDonalds,” “BK” (Burger King) or a “Marriott” metaphor to describe the public’s “entitlement” and “demand” for immediate care. The immediacy of care transcends the patient’s clinical needs to an expectation of service regardless of the degree of injury, illness or healthcare need.

Study participants cited frustration with the community due to an increase in substance abuse, gang activity, and limited resources for the mentally ill. For example, one participant stated: “as the economy falls apart, people turn to alcohol and drugs.” All groups commented on the increase of patients with substance abuse problems and the difficulties that ensue when caring for their complex needs. One female participant mentioned: “it’s getting worse...lot more drugs in town and most have alcohol, already fired up when they come in, [and they are] seeking treatment for mental illness.”

Also, the participants spoke of increased gang activities in their communities. One participant from the Level I trauma Center stated: “gangs are coming into the ED.” Participants described the challenges of caring for gang members and the violence that they represent: “these people are violent outside, we draw these people in.” One male participant stated: “there is an undercurrent of violence, you may have someone stabbed and five people walk in and they may all be carrying [weapons] and coming in to finish the job.”

Feelings of frustration are particularly acute with the lack of resources for the mentally ill. Across all groups, the participants commented on the complexity of caring for the mentally ill patient. Each of the groups told anecdotal stories of mentally ill patients being held in the emergency department for days due to the lack of resources in

the community and the inability to provide appropriate clinical care. One participant stated: “everyone is frustrated due to the lack of resources and the system that is inadequate...even the patient.” One female participant described a clinical occurrence of a young psychotic male who “stayed in the emergency department for 4 to 5 days, nobody would take him [psychiatric care facilities], he could not even get a shower, you thought about him for days.”.

Short term consequences: Personal conflict

A short term consequence of workplace violence is professional conflict (a behavioral consequence of frustration). According to the study participants, this professional conflict emerged from the basic nursing values of advocacy (speaking on a patient's behalf), justice (universal fairness), and beneficence (to do good). The principles of advocacy, justice and beneficence are in conflict when either the nurse can not care for a patient in a timely fashion or the nurse has negative emotions or actions while caring for the patient. For example, a female participant “felt rotten and began to be angry with the patient” when she was describing her care of a severely ill mental health patient. The nurse went on to describe how she felt angry with the patient because he would not follow instructions and was violent. She recognized the patient was sick and expressed an internal conflict: “I knew he was sick.” However, she could not provide both clinical and emotional care for the patient. This was in conflict with her basic nursing values of advocacy, justice, and beneficence.

This conflict was further exemplified by a female participant who was caring for a patient with suspected substance abuse: “I felt angry that I was being taken advantage of” when describing the care of a patient seeking narcotics. The nurse clinically understood

the medical and behavioral symptoms of addictive behavior. However, the conflict arises when the nurse became angry with the behaviors of the patient contrary to the values of advocacy and beneficence.

Fundamental conflicts arise when nurses act in a way that is not congruent with the basic values of nursing practice. An example of this is when participants' experienced anger or intolerance toward their patients who were violent, intoxicated or were "repeaters" (patients who chronically present to the emergency department). The nurses described that they are taught to be patient advocates. Therefore, the emotions of anger, resentment, and or intolerance by the nurses are inconsistent with values of patient advocacy, justice, and beneficence resulting in professional conflict. One female participant stated: "Patient advocacy is so ingrained in us, always advocating." This is in contrast to: "we get less sympathetic especially for the alcoholic or drug addict, we get negatively opinionated and develop biases."

These conflicts become increasing salient as nurses are exposed to violence over a longer period of time. When discussing the exposure of violence over years of practice, one male participant reported: "you get jaded after a while." Another female participant responded: "we get deconditioned to it all." All participant groups reported changes in their practice and approach to their care as a result of long term exposure to violence in the workplace. These long term consequences will be described in the following section.

Long term consequence: Personal detachment

One of the most compelling long term consequences of exposure to violence in the emergency department was the issue of personal detachment (a behavioral consequence of frustration). All of the focus groups described a personal "hardening"

from practice in the emergency department setting. This was further described as “you have to disconnect yourself a bit” and “we loose track that they [the patient] have a mother and father” when describing this process of detachment. One participant described the interaction with patients as “cynical...not feeling anything.” When this was further explored, the groups commented; “you have to hold yourself back after awhile” and “after 20 years, you sometimes just don’t care.” More directly, one female participant spoke to the manner in which she felt as though she provides excellent clinical care. However, she separated the emotional aspect of that care: “my care has not changed but my emotional attachment has...not as willing or interested.” One participant described this detachment as a “self defense mechanism to self persevere in the job” and “for me personally, it makes me less tolerant especially when it is a person under arrest or sympathetic to the alcoholic or drug addict.”

The participants described detachment as a catalyst for violence. For example, one male participant reported that patients sense this detachment as lack of caring or empathy: “you can escalate a patient right from the beginning, you can give the opinion of a non-caring person, and that escalates them because they have other big problems in the world, you present that picture to them that you don’t care before they even open their mouth.”

Powerlessness

Powerlessness was the second major theme that emerged from the focus group sessions. The participants spoke about issues of control over their practice, their workplace, and their environment. The sense of powerlessness was expressed overtly as

“frustration and powerlessness” and “I feel powerless.” The feelings of powerlessness were also expressed more subtly as “you just accept it” or “I can’t do anymore.”

As the feelings of powerlessness increased so did individual perceptions that they had little control over their work and their environment. The participants associated feelings of powerlessness with violence because they were unable to change or intercede within their environment. One participant stated: “we learn about patient rights but don’t have our rights” and “nurses do not have power, both police and nurses are exposed to violence but they [police] can do something about it.”

Long Term Consequence: Victimization

Feelings of victimization were a behavioral consequence (of powerlessness) throughout the focus group discussions. Across all groups, the participants described victim behavior of the staff due to long term exposure to violence. The participants expressed feeling victimized by the hospital administration and the legal system. The participants described the “hospital administration” as having minimal acceptance or support for nurses after being assaulted and a legal system which was inconsistent in their treatment of assaulted nurses.

For example, the participants across the groups described episodes in which the nurse was assaulted and the hospital failed to respond on the nurse’s behalf. One female nurse reported: “if a nurse gets hurt, she gets reamed out [by administration] for she [the nurse’s actions] should not have been there in the first place.” Also, one participant described a severe assault of a nurse in the emergency department. The administration was reported to have responded: “it doesn’t matter” and “they [hospital administration] never asked how she was, just told her to fill out the papers-blamed the nurse.”

In addition, the participants described victimization by “society” and the “legal system.” The participants spoke to an inequity of the nursing role compared to other professions when assaulted: “compare nurses to other workers; it would not happen [physical violence] and would be considered assault.” For example, one participant made the analogy that if someone assaulted you while “waiting for the bus” the person would be arrested. However, if the person assaults an emergency department nurse in the course of their duties, there is little action.

The focus group participants related that it is an expectation that nurses in the emergency department will be assaulted and it “is part of the job” and “we as nurses still feel it is okay to be punched.” The participants expressed these expectations in terms of normalizing violence. One female participant reported: “society sees that as part of our job, as hospital workers, that it is part of you job; if you choose to work in this type of environment then you need to expect to be assaulted.” The normalization of violence in the emergency department by administration, society, and nurses themselves results in a lack of corrective actions and is a major barrier in reducing the risk of workplace violence. And in effect, this vicious cycle (violence in workplace, lack of support by administration, professional conflict, and disengagement) mirrors the experience of the disenfranchised living in poor unsafe violent communities.

Results related to the third specific aim (*explore the personal, workplace and community factors contributing to an increased risk for violent occurrences*) will be discussed next.

Contributing Factors

Throughout the focus group discussions, the participants discussed factors that contributed to an overall theme of increased risk for violent occurrences in the emergency department. These factors included: personal, workplace, and community variables effecting violence in the workplace. Personal factors included: the individual nurse's personality, experiences and history of violence exposure. Workplace factors included: workplace violence education, policies and procedures surrounding violence in the workplace, the physical design of the emergency department, and police or security presence. Community factors included: the community where the emergency department exists and the demographics of the patient populations presenting for care. The following sections will explore these factors as experienced by the emergency department nurses.

Personal factors.

The participants described that the “attitude” or “personality” of the nurse working in the emergency department influenced the likelihood of workplace violence. One of the female participants reported: “the personality you bring to work” influences how you interact with the patients and the attributes the nurse expresses in the workplace: “I bring things to the table.” One female participant reported she has to mentally prepare herself by reviewing her day at home so she will not let her non-work life influence her decisions or actions with patients. Several participants spoke to “having to leave it at home” and “if you bottle in your problems, it does [effect work].”

The participants also expressed how personal experiences with violence influenced the way they reacted to patients. One female participant revealed a prior personal history of domestic violence. She reported a reliving of these personal

experiences when confronted with a violent patient in her work setting. For example, she reported that when a patient “yells at me, I relive the experiences. It would bounce off of someone else, I would be in tears.” Another female participant spoke about living on the west coast of the United States in an area where gun violence was prevalent in the emergency department setting. This participant stated: “I had a gun put in my face” and as a result of this experience, treats all patients as potentially violent. She continued this conversation by stating: “they are ax murderers until proven otherwise.”

Life experiences can result in either positive or negative patient interactions. One nurse reported: “how you handle things in your real life comes to work with you” and “It’s your personality.” Another participant reported: “every nurse brings their own style. Sometimes you will see a nurse go in and the patient is agitated, the nurse is really soothing, and the patient calms down. Then you will see a different nurse go in with the same patient with a different attitude [sternness] and the patient escalates.”

Similarly, the long term exposure of nurses to violence affects the manner in which patients are approached by nurses. Many participants reported a “hardening” of their personalities and approach to patients due to the chronic exposure to violence. One nurse described an evolution of her practice from “caring” to an emotional isolation from her patients. Ultimately, the long term exposure to violence may contribute to its proliferation.

One focus group suggested that the power balance between patients and nurses may contribute to violence. One female participant described this as an “alpha versus alpha” phenomenon. She discussed that some nurses feel the need to assert themselves in a dominant position as the care provider. As a reaction, the patients may escalate to the

point of violence. The nurse reported this to be particularly true with patients that are intoxicated or families that are demanding. More directly, the participant reported: “I am in charge here” when describing the behavior of a nurse exhibiting dominant behavior with a patient. Three out of four focus groups reported that they witnessed emergency department nurses use aggressive behavior or comments that agitated violence in patients or family members. One group reported they saw nurses being verbally abusive to patients: “the nurse would not start it, but would egg it on [violence], I have seen it quite a lot.” Participants from different groups reported: “I have seen nurses cause violence” and “[nurses] will yell back at patients.” All groups reported that the actions of nurses directly influenced the likelihood of violence. The behaviors of nurses can be seen as aggressive, detached, and domineering, all resulting in an increased risk for violent occurrences.

Workplace Factors

The focus groups reported several workplace factors that increased the risk for violent acts. These factors included the (1) lack of staff education surrounding workplace violence, (2) physical design of the emergency department, (3) lack of adequate policies and procedures related to workplace violence, and (4) lack of a trained security or police force. The focus group participants reported that a combination of these factors increased the potential risk of workplace violence. Each of these factors will be described in the following section.

All of the focus groups reported that nurses who have not had workplace violence education are more at risk for violence than those who have had this focused type of education. The participants suggested that nurses who were ineffective in “dealing” with

violent patients were poorly trained. For example, one participant stated: “by lack of education in confronting people and dealing with the belligerent person, we avoid the situation [with the violent patient], the patient will pick up on that and pick on you.” In essence, lack of workplace violence education allows the behavior to escalate. The participants from all groups discussed the need for education on how to approach, de-escalate, and physically intervene with those patients who are violent.

The participants discussed the manner in which nurses approach patients affects patient behavior. As the preceding paragraphs indicate, the participants’ reported that the nurse’s approach “sets the tone” for the interaction. If the nurse is aggressive or asserts herself/himself in a position of authority or control, the patient may react with aggressive behavior. The participants could not agree on a “correct approach” and mentioned that the variability of patients presenting to the emergency department precludes one approach versus another: “every situation is different, not every technique works every time.”

All focus groups reported that de-escalation techniques were important skills to master to reduce workplace violence. One female participant reported: “violence de-escalation techniques help, I definitely use them in my practice.” The participants reiterated the goal of de-escalation was to prevent the patient from committing violent acts. For example, one female participant reported: “I think recognition of violence before it escalates [is important] that would be the ideal situation, in hopes of talking to that person, de-escalating the situation before it becomes a full blow out.”

Nonverbal aspects of approaching patients were also discussed. For example, all groups mentioned that nurses need to know how to enter a patient’s room: “you need to

know how to read the rooms before you enter it” and “you need to understand the body language [of the patient].” One female participant reported: “you need to teach staff not to get caught in a room.” Not getting caught in the room includes an assessment of the patient volatility, by evaluating the patient’s body language and the nurse’s actions to reduce their volatility. The participants reported that not interpreting signs of impending violence increased the risk of violent events and reduced the opportunity for preventative intervention. The participants spoke of the need for physical intervention training for nurses in the emergency department because: “de-escalation techniques are not always effective.” The focus group participants asserted that emergency department “nurses need to learn self defense” and “we need physical training.” The participants reported that physical training should consist of a wide variety of activities. The physical training suggestions ranged from “karate moves” to techniques to remove the staff nurses from “choke holds, hair pulls, and the implementation of physical restraints.”

Little consensus was reached among the focus group participants about the length of individual training or ongoing education required to be effective in reducing violence risk. Several participants suggested that this type of education should be incorporated into the basic orientation of emergency nurses. For example, one female participant reported: “if you are a new grad or new, you won’t recognize the signs these people are giving you [you will get hurt].” Others recommended ongoing training from “twice a year” to yearly as part of “annual competencies.” The participants recommended that training be interactive with both verbal and physical interventions: “unless you use it, you will lose it, need repetition more than once a year” and “the more you hear it, the more

you remember it.” The groups suggested “role playing” with patients of all ages and groups including: children, the mentally ill, and substance abuse patients.

When discussing the requirements of ongoing education, the focus group participants expressed the needs for more policies and procedures specific to violence in the emergency department. Across the groups, the participants described the absence of policies or ineffective policies contributing to an increased risk of violence in the emergency department. For example, one participant described being employed in a different emergency department where there were: “policies that screened everyone [for weapons] and the hospital took it very serious.” She related that there were policies in her current emergency department; however, few participants knew or enforced them.

Consistently, the focus groups participants acknowledged the presence of some workplace violence policies. Few participants recalled the content of these policies: “I can’t say I know [the content], I imagined there is something.” Of the policies they did recall, the participants considered them ineffective: “they don’t make a difference; it has to be a cultural change.” One participant reported that of the policies that existed, the staff are “inconsistent in adhering to them” and this makes the policies ineffective due to non-compliance.

The participants expressed that policies and procedures could be effective at reducing risk. They reported that all staff would have to be consistent in the application of the policies and that the hospital administration would have to be consistent in enforcing the policies: “they are important” and “everyone needs to enforce them, including the doctors.” The participants suggested specific policies and protocols for “screening patients,” the treatment of violent patients with “medication management,”

“practice guidelines,” and “critical stress debriefings.” The focus groups inferred these actions would be beneficial in reducing violent episodes. For example, one participant commented that “consistency of care is important.” The participants concluded that hospitals should have clearly defined policies for the effective treatment of violent patients.

The focus groups reported that the physical design of the emergency department contributed to an increased risk of violent occurrences. The facilities design contributes to overcrowding, uncontrolled access points, unsafe room design and areas isolating the nurse from the rest of the emergency department. For example, the participants from smaller emergency departments considered themselves at increased risk for violent occurrences due to their small size. The participants reported that the small size presents challenges with unpredicted high volumes, patient overcapacity, and the lack of “specialty rooms” for violent patients. They have too many unpredictable patients in a confined area and are unable to escape from the area should a patient become violent. They also mentioned that due to their small size, they have no safe harbor to lock the patient or themselves in should they need to evade a violent patient.

Conversely, the focus group in the largest emergency department reported the large size of the emergency department contributed to increase risk violence. The large size of this facility isolated staff from one another, placing staff at risk if someone were to act out violently: “actually, I think the physical plan of this department is probably worse than the old department [6400 sqft vs. 2400 sqft] in terms of being able to help each other, if something happens, you can be very isolated.” The vast size of the area precludes quick communication with their colleagues should violence erupt.

Several of the participants identified that their emergency department had multiple access points for patients, families and visitors. The lack of control over these access points, creates an increased risk for the nurses because they can not control their environment: “anyone can walk in.” This is especially true when the patient has a history of violence (e.g., gang members) where anyone could access the hospital to inflict additional injury. One female participant related a story of a patient who was in the custody of the police. The patient was able to “get word” to the community that she [the prisoner] was in the emergency department. When the nurse revisited the patient, the visitor had gained access to the patient: “thank God it was not the head of the Mob calling his buddies to come and get them” and “if five guys came in and recognized the patient, they could have jumped him.”

In addition, the participants spoke to the design of the treatment rooms as contributing to an increased risk for violent acts. The participants stated that treatment rooms with one access and entrance point make it easier for nurses to be trapped. Several participants reported treatment rooms without windows on the doors. When the doors are closed the staff would have no way to assess if the patient or the nurse was in trouble.

Also, the staff reported not having enough “safe” rooms for violent patients. Safe rooms were described as room where violent patients could be isolated. These rooms are free of movable objects such as chairs, tables and small medical equipment. Often these rooms include “store front barriers” which may be pulled down to cover medical equipment and unsafe items. Two of the focus groups worked in emergency departments that had these specialty rooms. However, due to high volume these rooms are often used as traditional treatments spaces for non-violent patients. Therefore, they are not always

readily available. And if the room is already occupied with a violent patient, additional patients with violent tendencies would have to go into a traditional treatment room “stripped” of injurious items.

All of the focus group participants reported the lack of police or security presence was a factor that increased the risk for violence. Participants unanimously concurred that police or security presence was required to reduce the risks of violent acts in the emergency departments: “we have a luxury here of having police at our disposal, it helps enormously” and “police make a big difference, their presence is very important.”

The participants were less clear on the type of police presence needed. The two focus groups from smaller emergency departments reported the presence of an unarmed security force was sufficient. However, the participants offered a recommendation that the security force needed to be educated in violence de-escalation techniques in order to be effective.

Conversely, the focus group from the largest emergency department was adamant that uniformed and armed police was imperative: “absolutely armed, deadly force armed.” This group described several situations involving patients with weapons in the emergency department. In several of these cases, the participants reported the police “drew their guns on patients” to prevent injury to the nursing staff.

Community factors

The participants reported community factors (i.e., the community where the workplace is located, the demographics of the patient population and the availability of weapons in the community) increased the risk for violent events in the emergency department. Each of these factors will be discussed below.

The focus group participants reported the location of the community affects the risk for violence. For example, one emergency department is located in a small community that was supported by a factory economy. The factories have closed; resulting in a depressed economy in the area. The depression of the economy has led to an increase in drug and alcohol use and therefore an increase in patients presenting to the emergency department who are under the influence of intoxicants and violent.

Another group reported their emergency department is located in an area close to a large entertainment facility. The staff reported that after sporting events, they receive patients who are intoxicated and acting out. One female participant reported “they are in walking distance, they come over from doing something stupid and we have to deal with them.” She further reported there are many colleges in the area: “we get lots of college students who come in drunk; we have to put up with their nonsense until they sober up.” Either the economic conditions of the community or the proximity to sporting facilities, the complexion of the community may directly and indirectly affect the likelihood of violence presenting to the emergency department.

Summary

The major themes of frustration, powerlessness, and contributing factors permeated the focus group discussions. Frustrations were expressed outwardly as anger and hostility due to unmet expectations of (1) nurses caring for patients, (2) patients and families’ expectation for immediate care, and (3) an imperfect healthcare system with limited resources. The participants tied these frustrations to workplace violence due to escalating hostilities as the patients’ and nurses’ needs were unmet. As frustrations

increased, so did feelings of powerlessness and the need to adapt practice or change their work environment.

Out of frustration, short and long term consequences of workplace violence were described during the focus groups. A short term consequence of workplace violence is professional conflict. The nurses expressed a professional conflict between caring for violent patients and the principles of advocacy, justice and beneficence. Long-term behavioral consequences of violence were a personal detachment from patients and nurses feeling victimized. The participants described individual detachment as a catalyst to violence due the patient perception of non-caring. The nurses further described feelings of victimization by hospital administration and society for not effectively addressing the issues surrounding workplace violence.

The participants also described factors that increased the risk for violent occurrences in the emergency department. These factors included the personal, workplace, and community variables. The participants suggested that focused education and emotional preparation for staff, improved physical design of the emergency department and attention to the community composition affecting violence were needed. In concert or individually, these variables affect the likelihood of violence to occur. The participants suggested focused and tangible interventions in personal, workplace and community areas were needed to decrease violence. These results and implications for practice, policy and research will be explored in the subsequent chapter.

Chapter V

Discussion

Workplace violence involving emergency department nurses is a poorly understood phenomenon (Fernandez et al., 1998; Keely, 2002; Mayer et al., 1999). It is estimated that up to 100% of emergency nurses will experience some form of violence in the workplace during their careers (Erickson & Williams-Evans, 2000; May & Grubbs, 2002). However, accurate estimates of violent acts against emergency department nurses are difficult to determine (Findorff, McGovern & Sinclair, 2005; McGovern, et al., 2000; Gerberich et al., 2004; Rippon, 2000) and few studies have examined the experiences of emergency department nurses with workplace violence (Fernandez et al., 1998; Levin et al., 1998). Results of this study add to this literature by describing the experience of ED nurses with workplace violence.

In this sample, 96% of the nurses had experienced workplace violence. The gender, age, and ethnic distribution of the participants were similar to the existing literature on workplace violence in the emergency department (mostly white, middle-aged females) (Fernandez et al., 1998; May & Grubbs, 2002; Mayer et al., 1999; Whittington, Shuttleworth & Hill, 1996). The participant's personal definitions of workplace violence were consistent with those found in the literature (Kraus, 2006; McPhaul & Liscomb, 2004) including the World Health Organization definition (WHO, 2002). For example, participants suggested that workplace violence involved verbal assaults, physical acts and interactions outside of the workplace. The WHO definition also includes factors outside the immediate workplace environment.

The theme of frustration was a major study finding. Frustration has been reported in other studies of healthcare workers (Finderoff et al., 2005), general staff nurses (Gerberich et al., 2004) and nurses working in the emergency department environment (Hislop & Melby, 2003; Levin et al. 1998; May and Grubbs, 2002). For example, Findorff et al. (2005) reported 41% ($n = 56$) of healthcare workers in their study (nurse, physician and counselors) experienced frustration as a consequence of workplace violence. Gerberich et al. (2004) reported that 46% ($n = 301$) of general staff nurses experience frustration as a consequence of workplace violence. In a qualitative study, Hislop and Melby (2003) reported that all of the emergency department nurses ($n = 5$) had expressed feelings of frustration regarding workplace violence. It is important to note however, that these researchers reported frustration and anger as consequences of violent acts, while the present study found that patient and family frustration was a precursor or catalyst to violence acts; an also increase nurses tensions in these difficult situations.

The participants' linked workplace violence with community economics. This linkage has also been mentioned in previous studies (Cunningham et al., 2006; Kryiacou et al., 1999; Kuhn, 1999; Levin et al., 1998; Peek-asa et al., 2002; Pearlman, Zierler, Gjelsvik, & Verhoek, 2003). Kryiacou et al. (1999) investigated the relationship between socioeconomic community factors and the incidence of gang related homicide. These researchers concluded that gang related homicide is associated with lower economic conditions and unemployment. As expressed by the participants of this research, the violence associated with these same conditions, increases the likelihood of victims presenting for care and the potential for gang related retaliation in the emergency

department. Also, Cunningham et al. (2006) suggested that over 77% ($n = 115$) of youth presenting to an urban emergency department had perpetrated some form of violent acts in the past year. These researchers suggest the violence associated with these activities is normative to the economic and social aspects of the community. As with Kryiacou et al. (1999) the violence associate with the economic conditions of the community spills over into the emergency department as these victims and assailants seek treatment. In addition, Levin et al., (1998), reported the emergency department nurses viewed workplace violence in the emergency department as stemming from the economic conditions of the community where they worked.

This finding is especially important in contemporary society. The participants reported an increase in local crime and substance abuse as a response to a deteriorating economy. As the economy of the United States continues to be unstable, poverty, substance abuse, and violence will most likely increase. In addition, with a failing economy and a reduction of services to the community, the emergency department is placed in an untenable position of a safety net for marginalized populations. All of these factors increase the volatility of the emergency department environment and likewise will potentially increase the risk of violence to emergency department nurses in the future. The short and long term impact on the nursing staff is increasingly important as violence in the emergency department escalates.

One of the short-term behavioral consequences of workplace violence was professional conflict. The participants described ethical and professional conflict between the moral duty to care and the difficulty they experienced when trying to care for patients and families who were excessively demanding, intoxicated, or mentally ill. The

principles of advocacy, justice, and beneficence (American Nurses Association, 2001) were constantly challenged because of an imbalance of resources (excessive patient loads, lack of clinical competence for critically ill patients, lack of clinical monitoring equipment) to care for a complex patient population.

Hislop & Melby (2003), Levin and colleagues (1998) as well as May & Grubbs (2002) found that emergency department nurses developed feelings of resentment and negativity towards their patients. For example, Hislop & Melby, (2003) found that emergency department nurses were irate that they [emergency department nurses] were in a caring position and would be the targets of verbal and physical abuse. Similarly, Levin et al. (1998) reported that emergency department nurses: “vividly expressed their smoldering anger over their assault experiences.” However, none of these studies discussed these feelings in terms of the conflict between professional nursing principles and managing the day to day work environment of the emergency department.

One of the most striking long term consequences found in this study was the process of personal detachment experienced by ED nurses. This finding is similar to Levin et al.’s (1998) report that emergency department nurses withdrew from patients or became callous to their needs. However, the present study described this detachment as an emotional survival mechanism to cope with the multiple stressors associated with their environment.

The fact that detachment was viewed as a protective mechanism is disheartening in that it may also contribute to violent acts. Further research needs to exist with strategies that may de-escalate this type of patient detachment. Perhaps cognitive

behavioral intervention for emergency department nurses considered bitter, to identify or minimize these types of maladaptive protective behaviors.

An additional long term consequence of workplace violence found in this study was victimization. Victimization has been reported in the literature as a consequence of workplace violence. For example, Erickson & Williams- Evans (2000), reported 73 % ($n=55$) of the emergency department nurses expected to be assaulted in their career and accept workplace violence as “part of the job”. They suggested that the nurses in the emergency department assume a victimized role through chronic exposure to violence and “habituation”. Levin et al (1998) found similar finding in which nurses expressed feelings of retaliation and lack of support by hospital administration after verbal abuse by physicians. However, the literature is limited in describing the victimization of emergency department nurses as a long term consequence of workplace violence such as how it was described in the present study.

Study results indicated that the personal life experiences of the emergency department nurses influenced the workplace and how patient care was delivered. These findings have been reported elsewhere (Erickson & Williams- Evans, 2000; Lee, 2001; Little, 1999). For example, Little (1999) suggested that staff nurses and certified nurses aids (CNA) who had a history of prior childhood abuse were at an increased risk for abuse in the workplace and this behavior was consistent with a revictimization phenomenon. Better screening of emergency department nurses personal past experiences with violence could alleviate, de-escalate violence, or provide opportunities for intervention in the workplace. In addition, as recommended by the study participants, an essential element to reduce risk from violent acts is continuing education on causes and

strategies to prevent workplace violence. This education should include: didactics, behavioral indicators of impending violence, physical training, and role play with multiple patient populations. (Arnetz & Arnetz, 2000; Fernandez et al., 2002; Lee, 2001; Luck et al., 2007; McPhaul & Liscomb, 2004; OSHA, 2002; Peek-asa et al., 2002; Whittington, 1996).

The question is how often this type of education is required. For example, Fernandez et al. (2002) investigated the effects of education in emergency department staffs (nurse, physician, and support staff) to reduce violence over time at baseline, three months and six month intervals after workplace violence education. These findings suggest a reduction in the effectiveness of workplace violence education at both the three and six month data points. Further investigation into the type of curriculum, the timing of the classes and the effectiveness of these types of education is clearly warranted (Nachreiner et al., 2005).

The participants reported the overall design of the emergency department, access or egress points, and the availability of security was factors in workplace violence. These findings are supported by other studies that outline the importance of the physical design, (OSHA, 2004) access points (Rankins & Hendey, 1999; Rose, 1997), and security presence (Levin et al., 1998; May & Grubbs, 2002) as important strategies to reduce workplace violence.

Finally, institutional support for a culture of staff safety emerged as an important issue for all four focus groups. Organizational leadership in the reduction of workplace violence is also suggested in the literature (Catlette, 2005; Calabro & Barinuk, 2003; Henry & Ginn, 2002; Levin et al., 1998; Peek-Asa et al., 2002; Whittington, 2002). For

example, Catlette (2005) suggest careful listening to nurses concerns and suggestions so changes can be made to enhance safety in their environment. Hislop and Melby (2003) suggested increased feedback after violent episodes to the staff from the management and the development of colleague support systems. Similarly, Levin et al. (1998) suggest the importance of administrators being proactive in considering the safety of the staffs as important as that of the patients.

Study Limitations

Limitations of this study include the single geographical region in which the study was conducted and recruitment within one large not-for-profit health care system. In addition, the study sample was voluntary. The sample, therefore, could reflect a self-selected group of nurses with a strong interest in workplace violence. Also, the sample consisted of mostly middle age, Caucasian women. All of these factors limit the generalizability of the study findings.

Finally, the investigator previously worked in one of the hospitals for approximately 20 years and held a leadership position in two of the Emergency department sites investigated. Many of the participants were known to the investigator and it is unknown if this relationship biased the participants responses in any way. We attempted to reduce this source of bias by having a PhD-prepared nurse co-lead the focus group with these participants and participate in all of the focus groups to evaluate any possible bias in responses.

Implications

Implications of this study include recommendations for practice (including administration) policy and research (see Table 12). For nursing practice, these results

suggest that a workplace cultural shift is needed; where violence is not considered a normal expectation of ED work. To accomplish this hospital administration needs to establish a culture of support. A culture of support includes declaring and adhering to a commitment of “zero tolerance” to violence in the workplace. Hospital administration needs to provide the resources to enhance the safety of the physical environment, adequate resources to care for patients, provide a security presence, immediate support for victims, and ongoing emotional support for all staffs who work in the turbulent environment of the emergency department.

All emergency department nurses need to be educated in workplace violence. This education should include: personal, environmental, and organizational risks factors for Table 12.

Implications to Practice, Policy, Research

Practice	Policy	Research
<ol style="list-style-type: none"> 1. Workplace violence education 2. Hospital resources 3. Administrative commitment 4. Physical structure enhancements 5. Security presence 6. Emotional support 	<ol style="list-style-type: none"> 1. Community resources 2. Enhanced primary care system 3. Resources for mental illness, substance abuse, poverty 	<ol style="list-style-type: none"> 1. Risk factors 2. Safety designs 3. Education

workplace violence. Workplace violence education needs to encompass those factors that predispose the nurses to violence, how to recognize impending violence and how to diffuse violence should it occur.

Also, results of this study suggest the need for policy changes. Some of these changes focus on easing the burden on emergency departments by increasing access to primary care services including urgent care within primary care practices. To accomplish these nurses need to have a well developed understanding of community resources for their patients and how to access these resources. Nurses need to advocate for their patients with emotional support, education, and guidance to the resources most appropriate to the patients needs. In doing so, patient will be provided with the appropriate community resources precluding their need for emergency department visits in non-emergency situations.

Similarly, nurses and hospital administrators need to become politically active at the local, state and national levels. Nurses and hospital administrators need to advocate for the community resources that are absent which forces patients to seek services in the emergency department. As health care dollars shrink, it is imperative this advocacy occur in the state and national arenas which includes; increases in services for the mental ill, substance abuse, and for the marginalized patient populations who seek primary care through the emergency department. It is critical the healthcare system shift from treating the sequela of an inadequate primary care system and resolving the underlying causes.

Research implications include further investigation of the risk factors associated with violence in the workplace, optimum physical designs of the emergency department and workplace violence education. To accomplish this, research of risk factors needs to include additional investigations of the personal, environmental and workplace factors that predispose emergency department's nurses to workplace violence. Second, this research suggests the need to investigate optimal physical designs of the emergency

department to enhance patient flow. This may be accomplished by working directly with emergency nurses and personnel to investigate access and egress, room design, patient flow processes, and safety systems designed to reduce violence. Last, this study is clear that education on workplace violence is needed. All of the study participants expressed the need for workplace violence education. This needs to occur with a collaboration of educators and experts in the field where outcome measures of effectiveness can be demonstrated can be demonstrated

Conclusions

Emergency nurses are in the highest risk category for workplace violence and injury. It is estimated that 100% of emergency department nurses will experience some form of workplace violence in their career. Frustration and powerlessness are important factors that influence the violence experience among these nurses. Conflicts arise with the basic ethical tenants of nursing practice when nurses care for violent patients in an environment of unpredictability and insufficient resources. Experiences of victimization leveled by hospital administration and the legal system further challenge the emergency department nurses as they carry on their daily activities. Personal detachment seen as an emotional survival mechanism only adds to the volatility of the emergency department environment and the patients to which they are entrusted. The individuality of the nurse, the characteristics of the workplace and community encompassing the emergency department are all factors in workplace violence. Despite these factors, little is know about the experiences of emergency department nurses and workplace violence. It is through this research, the experiences of emergency nurses are further exposed and strategies at the reduction of workplace violence may be achieved.

Appendix 1 Definitions of Workplace Violence

1. The National Institute for Occupational Health and Safety (NIOSH, 2002) defines workplace violence as “violent acts (including physical assaults and threats of assault) directed towards persons at work or on duty”.
2. The National Occupational Health and Safety Commissions of Australia (NOHSC, 1999) defines workplace violence as “the attempted or actual exercise by a person of any forces as to cause injury to a worker, including any threatening statement or behavior which give the worker a reasonable cause to believe he or she is at work”

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