The Experience of Patient-Related Violence Against Emergency Department Nurses in the United States: A Phenomenological Pilot Study

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Research

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Abstract

Purpose

This study described the experiences, thoughts, perceptions, and feelings of emergency department nurses regarding patient-related violence.

Design and Methods

A descriptive phenomenological research approach was adopted to collect data through unstructured interviews. Three participants were recruited via word of mouth through colleagues from two different states (North East) in the United States. Data were collected from October to November 2018. Colaizzi's phenomenological methodology was adopted to analyze the interview content.

Findings

Seven themes emerged from the analysis of the data: physical violence, take care of patients regardless of their behavior, communication skills, lack of training and educational intervention, contributing factor: long waiting times, expletive forms of verbal abuse and threatening behaviors, and the impact of violent behavior on nurses led to feelings of negative emotions.

Conclusions

Provide training to ED nurses on how to handle violence situations and the employers has to implement policies to make the workplace safe for both nurses and patients. The findings of this study highlight the urgency of taking a realistic approach to preventing workplace violence to organizational leaders.

Introduction

Workplace violence against nurses in emergency departments (EDs) represents a major global problem that has attracted increased attention over the last few years [1]. Workplace violence can be defined as any physical assault, threatening behavior, or verbal abuse that occurs in a work setting [2]. Healthcare workers are 16 times more likely to experience violence than workers in other professions [3]. However, among healthcare workers, nurses are three times more at risk of experiencing violence [3] mostly from patients due to the frequency with which they interact directly with them [4–6].

In the United States, workplace violence increased 23 percent to become the second-most common fatal event in 2016 [7]. Between 2012 and 2015, there was an increase in workplace violence in US hospitals from two events per 100 beds in 2012 to 2.8 events per 100 beds in 2015 [8]. In 2016, hospitals and healthcare facilities invested $1.1 billion in security and training to prevent violence, and $429 million in insurance, staffing, and medical care due to workplace violence against hospital employees [9].

ED nurses more frequently encounter incidents of violence than other departments, ranging from 46% [1, 8] to 82% [10] due to waiting times and delayed treatment [6], patients being under the influence of substances and/or alcohol [11], and the lack of mental health nursing experience and skills of ED nurses [12].

This study aims to describe ED nurses' thoughts, perceptions, and feelings of patient-instigated workplace violence through a descriptive phenomenological qualitative study that follows Husserl's philosophy and to answer the research question 'What is the meaning of workplace violence experienced by ED nurses from their patients?'

Literature Review

Violence can be described as any exertion of physical or verbal force with the intention of abusing or injuring the target. Physical abuse includes pushing, smashing, throwing objects, preventing individuals from leaving the room, pulling, spitting, biting or scratching, striking, or kicking. While verbal abuse includes swearing, threatening behavior, non-serious threats, or sexual intimidation [13]. The purpose of the literature review is to determine and understand the causes of patient-instigated workplace violence in the emergency departments.

Violence in health care was defined "as any incidents where the staff are abused, threatened or assaulted in circumstances relating to their work involving an explicit or implicit challenge to their safety, well-being or health" [14]. This definition includes "any threatening statement or behavior which gives a worker reasonable cause to believe they are at risk" [15]. It also includes a broad type of behaviors [16], from physical assault or direct violence to non-physical forms of violence such as verbal abuse and sexual harassment [17].

Types of Violence

Verbal abuse. Verbal abuse is the most common type of abuse against nurses in healthcare settings. It is three times more likely to occur than physical violence [18]. Verbal abuse is reported to be the most common type of abuse with 82% of nurses [19], and an average of 63.9% of them [5], being subjected to some form of verbal abuse from patients. Of these behaviors, swearing, shouting, or cursing has been identified as the most common [20] and is reported to be the most violent type of verbal aggression [21].

Physical abuse. Physical abuse often co-exists with verbal abuse, suggesting that the latter might act as a warning sign for potential physical abuse [15, 18]. Of these behaviors, "being pushed or hit" identified as the most common type of physical abuse [20], while the use of lethal weapons mostly occurs during the night hours [4].

Risk Factors

The risk factors can be grouped into five categories. They are as follows: substance and alcohol abuse, medical diagnosis and treatment, waiting times, and time of day.

Substance and alcohol abuse. Substance abuse of alcohol and drugs has been reported to be associated with an increased risk of violent behavior by patients [11]. It is reported to be 98% [22] of all violent episodes being attributed in some way to alcohol use.

Medical diagnosis and treatment. There is a relationship between mental illnesses and an increased risk of violence, with sufferers being up to two-to-three times more likely to act violently than the general population [23]. In addition, alcohol and drug abuse in patients with a mental illness increases the possibility for violent behavior [24]. Many emergency nurses lack mental health nursing experience and skills, which has the possibility to trigger potentially violent events [12] because ED nurses classified mental health patients as the most likely to display physical violence [25]. In addition, the environment in ED is noisy, open, crowded and busy, and no privacy for patients with mental health problems and these patients need less noise and privacy to generate an environment in which they feel safe [26]. Matters that are associated with the patients have a very high level of anxiety, tension, and lingering negative impression of bad treatment as well as lack of medical insurance and high hospital bills are common in the ED and these factors can predispose a patient to violent behavior [4, 20, 27, 28].

Waiting times. Many patients holding unrealistically high expectations of the nurses [29], but when these expectations are not met, the consequent anger usually is directed towards the nurses [30]. In addition, patients place the blame of delayed treatment, if so happens, on the nurses [6].

Time of day. Nurses are more vulnerable to patient-related violence in the afternoon shifts (after 4 p.m.) [22, 31]. This was validated when crime statistics on hospital assaults in Australia showed that the most common time for violent events is between 2 p.m. and 9 p.m. [32].

Causes of Under-Reporting

Many studies indicate that violence against nurses goes underreported, e.g., more than 72% of the nurses suffer from violence at their workplace [31]. Emergency departments have been highlighted as locations where violent incidents are likely to be significantly under-reported and the reasons are: a) nurses not satisfied with the way their previous events of violence was handled because some of these cases are not treated with the seriousness they deserve [27], b) the belief that violence is part of the job [16, 33], c) nurses are discouraged from coming forward to report such event because even if they do, there are no policies that will guarantee justice [16, 27], d) insufficient time [25], e) nurses do not report due to the belief that no harm was inflicted on them and they can handle it [33], f) nurses can defend themselves by changing the way they treat that particular patient [5].

Cultural issue. Some countries are male-dominant, which means the culture block women from complaining or questioning a man's acts against them or other issues in the society. Many female nurses do not come forward to report physical abuse against them in the workplace due to the absence of any ability to defend themselves [6]. For example, the male nurse will be more likely to report physical attack than the female nurses and less likely than female nurses to report being verbally abused.

Management Factors

Previous studies reported that nurses feel the absence of assertive legislations, poor management of violent incidents, and lack of resources like insufficient equipment, medical errors, and poor environment contribute significantly to workplace violence [4, 5]. Also, shortage of nursing staff lack of proper communication skills, lack of experience, and lack of quality care could lead to workplace violence as well [4, 27].

Consequences of Violence

Experienced and older nurses are reported to be at less risk of violent behavior than their less experienced colleagues [34]. The majority of nurses who get hurt in physical violent incidences tend to go on leave [4], but some of them also react by saying they cannot make it to work because they are sick [35]. Furthermore, the majority of nurses who are abused physically and verbally think of leaving their profession and believe that their competence has decreased significantly as a result [20].

Workplace violence that is targeted at nurses is a rapidly growing problem that effects nurses throughout the world. There is a severe underreporting of violent occurrences and, due to this, the lack of empirical data supporting this phenomenon are not the only barriers that prevent accurate reporting of violence targeted at nurses. Patients' violent behaviors have deleterious consequences, not only for the nurses but for the patients themselves as they undermine the quality of care that is ultimately delivered to the patient. There is currently a global shortage of qualified nurses [36] and reported instances of workplace violence are negatively correlated with rates of recruitment and retention. Consequently, it is of vital importance that nurses are both encouraged to enter the profession and are provided with a work environment in which they are supported and protected. The provision of such an environment will ultimately increase the quality of care nurses deliver.

Researcher Perspectives

I have a personal experience with workplace violence when I was working as an ED nurse. I can remember when a patient pushed me while I was trying to help him get out of bed. The violence was so unexpected that I immediately left the bedside and talked to the in charge about it which he cannot do anything except saying "Do not worry, you will be fine." I was overwhelmed by my feelings of being hurt. Being angry with the patient at the beginning was easy, but I cannot stress enough how much this event hurt my feelings and it took me weeks to get fully over it. Our role as nurses is to establish a trusting relationship with patients, but when that relationship was broken after an assault we may be left with a fear for our personal safety and thinking of leaving that organization or even the profession because when you enter into a patient's room, you enter with a high sense of confidence to help them, but this type of incident destroyed that confidence that may require long-term support systems that healthcare facilities may not yet have in place.

The Method: General

This study followed Husserl's descriptive phenomenological approach, which is conducive to the examination of a specific phenomenon. The underlying philosophy is predominantly epistemological and seeks to acquire the understanding that corresponds with experiences [37]. Husserl argued that scientists should pay particular attention to subjective information when examining human motivations on the basis that human behavior is guided by an individual's perceived reality [37]. One of his key considerations was understanding precisely what individual humans know and how this can influence outcomes [37]. This research focused on the experience of ED nurses in terms of workplace violence as a specific phenomenon. It examined nurses' perceptions of workplace violence and the meanings nurses associated with the term.

Phenomenology follows some key philosophical traditions. One of these is descriptive, or 'transcendental,' as outlined by Edmund Husserl (1859–1938). The methodology has its origins in the naturalistic paradigm, which assumes reality to be both dynamic and grounded in individual, subjective realities. As such, it is based on the assumption that humans create their own realities. Further, it holds that individual reality can be understood through researcher-participant interactions [37].

Husserl's descriptive phenomenology centers on the belief that humans share consciousness. It holds that every study participant serves as an individual representative for their own world. A key component of descriptive phenomenology is the concept of 'bracketing' which involves researchers suppressing any preconceptions, expertise, experience, and bias in the process of conducting their investigations [37].

Husserl also believed that people typically follow their everyday routines without critically analyzing their own experiences. As such, he holds that it is necessary to take a scientific approach to extract essential elements of an experience shared by a group of people [37]. A key argument within descriptive phenomenology is the idea that some elements of a lived experience were shared by all the individuals who experience it. These are termed either 'universal essences' or 'eidetic structures.' These elements are perceived to represent the very nature of the phenomenon. For any description to become scientific, individuals must share elements of their experiences and commonalities must become apparent, providing a complete portrayal [37].

The 'bracketing' process forms a key component of Husserl's phenomenology-based scientific approach. When adhering to a bracketing approach, researchers remove any preconceptions or biases about a phenomenon while they are studying it [37]. According to Husserl [37], it is particularly important that researchers suppress any personal suppositions during a phenomenological investigation, allowing their studies to focus entirely on the perceptions of the participants and the meaning they attached to their life experiences, including thoughts, emotions, and memories. The descriptive approach seeks to achieve transcendental subjectivity by continually assessing researcher suppositions and bias, protecting the object of the research from any external influence [37]. During this research project, bracketing employed to identify any of the researcher's individual experiences, knowledge, and values that could potentially impact the outcome of the study.

According to Husserl [37], every individual has a self-evident universe of realities that remains both present and unquestioned. For example, these realities could include the notion that the sky is blue and the sun rises every morning. Husserl also holds that an element of our reality is subject to our own interpretation. In particular, he considered the conscious and unconscious psyche of individuals.

Husserl's approach holds that individual thoughts, attitudes, and perceptions are shaped by human experience [37]. He proposed that any negative experiences can be drawn upon in a safer context and subsequently reconsidered and recalled with alternative meaning, thereby allowing them to be viewed in a way that is no longer upsetting [37]. The ability to understand a memory in a manner that no longer causes emotional distress is the key to transcending a negative experience. According to Husserl, a new, more positive version of the experience can then be stored, allowing the individual to recall a memory without any associated negative emotions [37].

Husserl's philosophy was chosen for this study on the basis that humans can bracket personal experiences and preconceptions attached to a specific phenomenon, concentrating entirely on its essence in order to understand it. Within this study, the researcher had to bracket his own personal experiences of workplace violence as a means of focusing, instead, on the essence of the experience, free of any bias.

Methods

This study was guided by Husserl descriptive phenomenological study design in which the researcher seeks to describe a particular phenomenon and remain as faithful to the meaning of it under study as possible. The study design helped the researcher to gain a better understanding of the human condition [37].

Colaizzi's method of data analysis. The study analysis was guided by Colaizzi's [38] method of data analysis. This method is appropriate for use with descriptive phenomenological studies. Once the interviews were completed, verbatim transcriptions were checked for accuracy. The steps were employed and confirmed by the researcher as follow:

Making sense or acquiring a feeling for the protocols. Each transcript was read and re-read in order to get a sense of feeling about the meaning of the whole content. Review each transcript was also accomplished through listening to the audiotapes recording while checking the written transcription simultaneously.

Extracting significant statements. I searched each participant transcript for significant statements that pertained to the phenomena of workplace violence. These statements were highlighted on printouts of each transcript and each statement was given a number then these statements were written on index cards coded based on their significant statement, page, and line numbers.

Formulating meanings. Meanings were formulated from significant statements and manually coded for each participant transcript.

Organizing the clusters of themes. Formulated meanings were then sorted and coded into categories, clusters of themes, and themes. This was accomplished using a manual coding of index cards. Clusters of themes that reflected a particular experience were then merged to create central themes.

Integration of results and exhaustive description. At this point of step five in which the findings of the study were integrated into an exhaustive description of workplace violence.

Validation. Validation of findings was discussed with research participants to compare the researcher's descriptive results with their experiences. Participant feedback was discussed through email contact, which Colaizzi calls it the fundamental structure.

Bracketing

The process of bracketing involves recognition and acknowledgment of previous knowledge and preconceptions obtained through personal experiences and/or literature reviews with the phenomenon of workplace violence, as well as, biases that arose during interviews that might influence data analysis or interpretation [37]. Every effort was made to ensure I did not influence the content of the interview, so results would reflect participants' actual experiences. My bracketing included thoughts, ideas, and impressions from personal experiences with workplace violence that may have interfered with data collection and analysis.

Before the interviews started, I realized that I had started to think about what I knew so far about the concept of workplace violence. In my mind, I went through a list and wrote down my thoughts and ideas. I feel this has been helpful in setting those thoughts and ideas aside. When reviewing the literature, I purposefully avoided some of the results or findings sections related to workplace violence, knowing that I wanted to keep my mind clear and my perspective fresh when conducting my interviews.

The Method: Applied

This study was designed with the purpose of examining the lived experiences of nurses who have been verbally or physically assaulted by patients in the emergency department (ED).

Research Question

What is the meaning of workplace violence experienced by ED nurses from their patients?

Sample

This study was limited to examining the perspective of three ED nurses who have experienced physical assault, threatening behavior, and verbal abuse from their patients based on the guidelines of this pilot study. As shown in Table 1, an average age was 46.7 years and all participants were female, Caucasian, and received training on how to deal with patients who might become violent. One participant received 6–

8 hours of treatment after a physical assault from a patient and missed 48 hours of work then once she returned back to work, she did so with restricted duties due to a shoulder injury from the physical assault.

Table 1. Participant Demographic Information

Participant	Age	Gender	Race	Marital status	Highest educational degree	Experience as RN (average 22)	Experience as ED nurse (average 15.5)
1	54	Female	Caucasian	Married	Master's	33	24.5
2	42	Female	Caucasian	Divorced	Master's	19	10
3	44	Female	Caucasian	Divorced	Associate	14	12

Note. RN = Registered Nurse, ED = Emergency Department.

Inclusion criteria. All the United States ED registered nurses who have experienced violence from a patient while working in the ED was invited to participate in the study.

Method for Data Collection

Unstructured, face-to-face and over the phone interviews were conducted using descriptive statements for each participant asking, 'please tell me about your experiences of workplace violence from your patients, describing situations in which you experienced this, and sharing all the thoughts, perceptions, and feelings you can recall until you have no more to say about the situation.' Participants was encouraged to talk freely and to tell stories using their own words.

Interview lengths ranged from 14 to 26 minutes and all of them were conducted by the researcher. At the end of each interview, the researcher handed a demographic form (Appendix B) to the participant to fill out, then reminded them about the need for a second contact via email to discuss the study findings and to make sure that the study findings reflect their own experiences. Interviews were captured via digital audio recording with consent of the participants, and interviews were transcribed via automated audio transcription then for accuracy, the researcher review each transcript by listening to the audiotapes recordings while checking the written transcription simultaneously.

Setting. The interviews were conducted at a time and location convenient to the researcher and participants, suggesting that the location should, for instance, be quiet and easy to find. The importance of the interview location and time were for the participant to feel safe, provide privacy, and be uninterrupted. Participants could choose from several options for their participation, including a reserved study/meeting room at the university, their home, or over the phone. Each option offered ended up being used by one participant, so one participant chose a reserved study/meeting room at the university, the second chose her home, and the third participant chose over the phone. Two digital audio recorders were used simultaneously for data collection as a means of preventing data loss post interview.

Gaining access. The sampling technique to recruit the participants was via word of mouth through colleagues after study approval was received. Colleagues were asked to discuss the research study with friends and contacts who met the inclusion criteria.

Human subjects. Research for this study did not occur until approval was received from Institutional Review Board (IRB) and study consent was explained prior to the interview with ample time allowed the participant to ask questions or clarify concerns before signing the consent. At the beginning of each interview, participants were reminded that participation was entirely voluntary, and they were free to withdraw from the study any time.

All the data kept confidential and the results reported without revealing the identifying information. Only the researcher has access to the computer data file and monitor the data collection process to ensure confidentiality throughout the project. In addition, the researcher listened to audiotapes with a headphone to reduce the risk of others' overhearing conversations, then the recordings were erased after being transcribed and verified for accuracy. All materials related to the study kept in the locked cabinet at the University of Connecticut for three years before being destroyed.

Measures to Ensure Trustworthiness

Based on Lincoln and Guba [39]: There are quality criteria that have to be achieved to ensure the accuracy and comprehensiveness of the data collected.

Credibility. In order to achieve credibility, the interviewer who is also the researcher of this study asked the participants to provide feedback regarding emerging themes, in an attempt to validate the accuracy of findings. Study findings were sent through e-mail. Two participants replied via e-mail and confirmed that the findings were congruent with their experiences so, as a result, no changes were made.

Dependability. A transcription of all interview recordings was read several times and confirmed by the researcher.

Transferability. The transferability was not met due to the restriction of a pilot study, offering a small sample size and limited generalizability. Strategies that would increase the transferability of the current study include adequate data collection by increasing sample size and seeking saturation. Additionally, increasing the diversity of the participants' experience would greatly enhance the transferability of future study findings.

Data Analysis Results And Findings

A total of 71 significant statements are revealed in this study. Seven themes emerged from the formulated meanings of the data analysis: (a) physical violence, (b) take care of patients regardless of their behavior, (c) communication skills, (d) lack of training and educational intervention, (e) contributing factor: long waiting times, (f) expletive forms of verbal abuse and threatening behaviors, and (g) the

impact of violent behavior on nurses led to feelings of negative emotions. For some examples of significant statements and the significant statement's formulated meaning, see Table 2.

The incidents of violent episodes reported by participants are at an average of one per day. One participant noted, "I cannot even tell you how many every day at work it happens" (participant 3), while another reported, "we always had one a day" (participant 1). All participants reported both verbal and physical abuse: "I could remember being down to the end of the stretcher" (participant 2).

Theme 1: Physical Violence

The types of physical violence experienced included being strangled, kicked, spat on, squeezed, pushed, and hit by patients: "he ended up taking my stethoscope and trying to strangle me" (participant 1), "I had gotten kicked in the belly…and she spit in my face" (participant 2), "he punched me in the stomach…and he squeezed my finger" (participant 3). In one instance, a patient used the valium syringe as a weapon of violence: "A patient tried to grab the valium syringe I was holding and administer it intracardiac" (participant 1). In the most serious case, a knife was pulled out by a patient for not getting the medication he wanted: "A patient did not get the medication he wants it, so he pulled out a knife" (participant 3).

Theme 2: Take Care of Patients Regardless of their Behavior

Two participants reported that in their hearts they try to heal and care for patients regardless of the situation: "I think we set ourselves up for injury because in our heart we are trying to heal and care" (participant 1), while others keep caring for the patients even if they get violent: "I was worried about him…and It does not stop us from caring for the patients even they get violent we still continue to care for them" (participant 3).

Theme 3: Communication Skills

The patients' attitudes toward nurses amount to abusive communication, which can potentially lead to violence: "The communication that some patients decide to talk with is usually very abusive communication" (participant 1), and the same participant thought the way of talking is a useful strategy for preventing patient aggression: "I always try to soften my voice and not try to meet their voice style and how loud they are to help de-escalate it" (participant 1).

Theme 4: Lack of Training and Educational Intervention

One participant had recognized that emergency department nurses are not well trained for such violent situations: "I think that emergency nurses really need to be trained on how to take care of violent situations" (participant 1). The same participant recommended a self-defense training as part of the requirements of becoming an emergency nurse: "I am talking they need self-defense. I think that should be part of the standard role of an emergency department nurse" (participant 1).

Theme 5: Contributing Factor: Long Waiting Times

Long waiting times were cited by one participant as being the major precipitating factor with regards to episodes of patient-related violence: “patients are frustrated with the long waits in the emergency department and I believe that adds to more of the possibility of violence within the emergency department” (participant 1). This was considered to be directly related to increased patient volumes and the lack of available beds in the emergency department.

Theme 6: Expletive Forms of Verbal Abuse and Threatening Behaviors

Swearing emerged as the most common type of verbal abuse, reported by three participants: “we used to be called names and sworn at” (participant 3), and “I have been called probably every name in the book” (participant 2). This was followed by threatening behavior reported by two participants, which included threats to the personal safety of the nurse: “I am breaking your house” (participant 3). Other common types of verbal abuse included using a loud voice or shouting, as well as making unjustifiable demands: “yelled something at me” (participant 2).

Themes 7: The Impact of Violent Behavior on Nurses Led to Feelings of Negative Emotions

All emotions used to describe the personal impact of patient-related violence were negative and participants expressed feelings of sadness, confusion, and surprise: “That is kind of the gamut of the feelings of going from being very new, very beginning, and being confused and surprised…and I felt sad that I expect to come to work and be assaulted” (participant 2). Participants also spoke of being prepared to safeguard their safety and the patient’s as well: “I am trying to make sure I have security in bedside, so everyone is safe including the patient” (participant 3).

One participant preferred the idea of having to endure a physical attack to that of a patient spitting in her face: “I would rather have gotten into a physical altercation with her than spitting in my face” (participant 2). The same participant said her anger increased more with the patient who spat in her face when compared to a patient kicking her in the stomach: “I remember comparing the anger of the guy that kicked me in the stomach to the anger that I had with the one she spit in my face, spitting was a hundredfold more” (participant 2). The same participant did not seem to care about being verbally assaulted when compared to being physically abused: “sticks and stones may break my bones, but words will never hurt me” (participant 3).

The participants were expecting violence to happen every day they are at work: “I felt over time you almost get jaded to it and you really come to expect it at a certain point” (participant 2), and another “It happens every day that we go to work” (participant 3). This means that the high frequency of violence within the emergency department has brought their minds to the point where they perceive violence as being a part of their daily job and one that is not going to go away: “It is here, it is not going away…and I felt that it just seems to be acceptable to abuse the emergency nurses” (participant 1).

Discussion

Participants reported that they had experienced both physical and verbal abuse on a regular basis, including, in some cases, the use of a weapon. These findings are consistent with the findings examined in the review of existing literature. This behavior has become so commonplace that it has become accepted as a standard occupational hazard of working in an emergency department. For example, a study that was conducted by ALBashtawy [33] in Jordan revealed that the instance of violence that ED nurses most frequently experienced was verbal abuse (63.9%), which occurred five times more frequently than alternative instances of physical abuse (11.9%). All the participants in the current study reported having experienced verbal abuse. This finding is in line with the existing literature, which estimated that as many as 95% of ED nurses experience this form of abuse at some point in their careers [40].

The instances of physical abuse that were described by the participants, which included being hit or kicked by patients, were in alignment with those described in the literature, in which pushing was identified as the most common type of physical abuse ED nurses experienced [20]. Similarly, the experiences of participants who had been subject to some form of physical violence involving a weapon were consistent with an Australian study of ED nurses that found that the weapon nurses most commonly encountered in the workplace were knives followed by weapons of opportunity, including hospital equipment such as syringes [16].

The instances of verbal abuse encompassing both threatening and non-threatening language are cited as being the most common form of abuse nurses experience [20]. The current study found that swearing is the most frequent form of verbal abuse that nurses are subjected to and that this occasionally precedes further threatening behaviors. Another study of nurses in Australia found that over 62% of survey participants had been subjected to being sworn at by patients, with 50% having been threatened [19]. Alarmingly, this research found that 66.7% of the participants had been sworn at, while 66.7% indicated that they had experienced threats. This data suggests that these behaviors may be becoming even more commonplace within the emergency department.

One ED nurse in the current study cited long waiting times as being a major cause of workplace violence from patients. Another study that was conducted on a similar topic suggested that over 50% of all instances of violence reported involved patients who had protracted waiting times exceeding the recommended level [6, 41]. All the participants in this study claimed that they perceive workplace violence to be a standard element of their jobs and that they expect to be exposed to some form of abuse from their patients each day that they work. The existing literature indicates that this is true of more than 50% of the staff that work in emergency departments [42].

The existing training and educational interventions to prevent violence against ED nurses are inadequate to address this growing problem. The current study found that a lack of necessary communication and self-defense training to be the most frequently perceived barriers to effectively preventing workplace abuse. In support of this theory, another study by Gillespie, Gates, Miller, and Howard [43] concluded that the implementation of self-defense programs represents an effective method of reducing the occurrence of violence against nurses.

Nursing Implications

Because this study is a pilot study, further research with larger and more diverse sample populations is necessary. This would allow for a more all-encompassing view of the incidence of this phenomenon and, subsequently, generate more insights that can facilitate and inform the development of remedies. Further studies would allow a more in-depth exploration of the findings of the current study that ED nurses continued to provide care to a patient after an incident of workplace violence occurred because they feel it is their place to care for all patients and are concerned about the health status of these patients, regardless of any abuse they are subjected to. There is a tendency in this situation for interactions between nurses and patients to become less person-centered and more task-oriented. This, perhaps, may represent a form of self-preservation strategy that the nurses employ as they continue their duties.

Strengths And Limitations

Strengths

Phenomenology was chosen as a methodology to answer the research question for this study as the descriptive phenomenological method has the potential to clarify phenomena that are difficult to define [44].

Limitations

A potential limitation of the study was the small sample size provided by three ED nurses, with no study sample diversity having been recruited meaning that data saturation was not achieved.

Conclusion

Violence is a reality that nurses working in the emergency department are forced to face every time they go into work. Whether the cause of increased instances of violence toward nurses is unique to the health care system or mirrors a similar trend across society as a whole is the topic of much debate. Factors that are inherent in the health care system, such as long waiting times, are often cited as contributing factors to this trend. Irrespective, there appears to be a distinct lack of commitment on the part of employers to acknowledge the magnitude of this problem and adopt preventative strategies by which a safer working environment can be created for nurses. A gap has emerged between the formation and passage of policies that aim to train staff on how to handle violence and the implementation of these policies within individual facilities. There appears to be a greater emphasis on reacting to ongoing violent episodes than on preventing or managing these episodes in the long-term. The findings of this study highlight the urgency of taking a realistic approach to preventing workplace violence to organizational leaders. However, further research is needed for these results to be more generalizable.

Declarations

Ethics Approval and Consent to Participate

Informed consent was obtained from all individual participants included in the study.

University of Connecticut Institutional Review Board protocol number: H07-190

Consent for Publication

Not applicable.

Availability of Data and Materials

The dataset used and/or analyzed during the current study will not be shared due to individual participants privacy/identity could be compromised.

Competing Interests

The author declare that he has no competing interests.

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Author Information

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