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Workplace Violence: Emergency Department versus Medical Surgical nurses

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Workplace Violence: Emergency Department versus Medical Surgical nurses

by

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Abstract

The purpose of this study is to answer the following question: Does a registered nurses department, medical-surgical versus emergency department, change the amount of workplace violence they may experience? To accomplish this, a cross sectional descriptive study using an anonymous web-based Workplace Violence questionnaire survey by Wolters Kluwer Health was used to collect data from nurses working on medical-surgical units and in the emergency department at the facility. The findings indicate more physical violence with more frequent or occasional occurrences in emergency departments. The medical-surgical nurses reported more intimidation or emotional violence and never experience workplace violence.

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Chapter 1

Introduction

Workplace violence can occur in any setting within any profession. Nursing is one of the professions at a higher risk for workplace violence which deals with the public or involved within a community setting. Workplace violence is the "third leading cause of occupational injury fatality in the United States and the second leading cause of death for women at work" (Findorff, McGovern, Wall, Gerberich & Wall, 2004, p. 296). Many individuals believe workplace violence begins with a disagreement or poor interpersonal relations between the worker and the individual involved in the situation. In order to determine the appropriate educational and prevention plans employers must know specific reasons why the individual has been involved in violence. Some states have developed laws regarding workplace violence and disciplinary acts when an incident occurs.

Statement of the Problem

Are some nursing departments within the healthcare environment of a hospital at higher risk or see more violence than other departments?

Purpose

The purpose of this study is to see if emergency departments have more workplace violence than medical surgical areas. Medical surgical areas may not see the higher at risk or critical patients, thus changing the responses by individual nurses, providers, patients, and their families.

Background/Social Significance

According to the United States Department of Labor's Bureau of Labor Statistics (2011), more than eighty percent (80%) of employees reported workplace violence incidents, throughout their career, but less than five percent (5%) of the individuals reported violent injuries and seventeen percent (17%) involved were nurses. Approximately three of four nurses experience workplace violence, but only one of six incidents is officially reported (Lowry, 2010). Healthcare institutions should provide safe workplaces and proper training to avoid workplace violence incidents. Prevention should be a key factor to decrease the amount of violence throughout the community and inside healthcare facilities. The Joint Commission (2008) states "intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments" (Sentinel Event Alert, para. 1). Healthcare organizations must address behavior problems with team members in order to promote safety and ensure quality of work (Joint Commission, 2008).

Definition of terms

Medical-Surgical Nurse. The Medical Surgical Nurses "provides care for primarily adult patients before and after surgical procedures" and "to those who are being treated with pharmaceuticals (medications) to manage illness" (Johnson & Johnson, 2009, medical-surgical nursing, para. 1). The patients are hospitalized for less than 24 hours in the acute care setting.

Emergency Department Nurse. The Emergency Department Nurse **"**cares for patients in the emergency or critical phase of their illness or injury and are adept at discerning life-threatening problems, prioritizing the urgency of care, rapidly and effectively carrying out resuscitative measures and other treatment, acting with a high degree of autonomy and ability to initiate needed measures without outside direction, educating the patient and his family with the information and emotional support needed to preserve themselves as they cope with a new reality" (Emergency Nursing World, 2012, emergency nursing, para. 1).

Nurse. For the purposes of this study, the term 'nurse' refers to a full-time or part-time Registered Nurse. Registered Nurse is defined as "a graduate trained nurse who has been licensed by a state authority after qualifying for registration" (Merriam-Webster Online Dictionary, n.d.).

Workplace violence. Workplace Violence is defined as "a violence or the threat of violence against workers. It can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide" (U.S. Department of Labor Occupational Safety and Health Administration [OSHA] 2011, p.1). Workplace violence occurs while the individual is on duty and divided into the categories of strangers, patients, co-workers, and personal relations (OSHA, 2011).

Conceptual Framework

In a phenomenological study, "the meanings of a lived experiences for several individuals about a concept" (Cottrell & McKenzie, 2005, p. 224) are communicated. Through the phenomenological theory the researcher can capture the richness and perception of each individual nurse's experience regarding their experience with

workplace violence. The phenomenological method for this study will help the researcher gain a deeper understanding of the participant perceptions regarding violence in the workplace. The study sought individuals who have experienced any kind of workplace violence throughout their nursing career and provided assist with understanding the individuals experience in their current setting (Cottrell & McKenzie, 2005). The ultimate benefit of theory in nursing is the improvement in patient care and to avoid injuries in the nurses and patients.

The Adaptation model by Sister Callista Roy is a conceptual nursing model used to provide nurses a different way of thinking about their field and addresses a broad range of concepts. Sister Callista Roy's Adaptation Model hypothesizes human responses to stressors can result in both positive and negative responses (Tomey & Alligood, 2006). The individual and the environment provide three categories of stimuli including focal, residual and contextual. Not all the behavioral and psychological responses to traumatic events are negative. Individuals respond differently to trauma, threats, or actual violence events. Seeking social support and providing appropriate communication to these individuals can provide healthy adaptive responses (Tomey & Alligood, 2006). The conceptual, theoretical, and empirical linkage to research using Roy's model would be the following: violence stimuli, coping strategies, and resulting behaviors (Diagram 1). Roy's theoretical model is particularly well suited to this study as abuse is an external stimulus to which the nurse is exposed. The environment is the unit in which the nurse has to work, and the nurse represents the adaptive system which responds to the external stimulus.

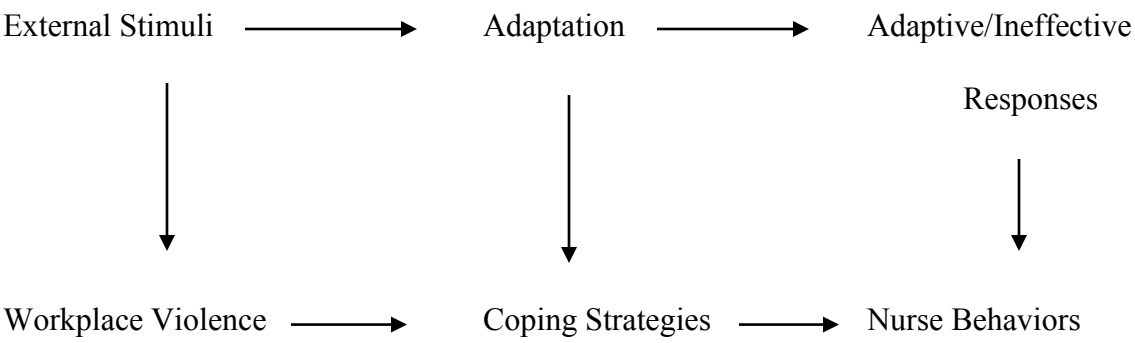

Figure 1 Conceptual – Theoretical Structure of the Study of Workplace Violence

Significance to Nursing

Workplace violence is a major health concern which is starting to receive national attention. Both direct and indirect exposure to violence may result in psychological effects in the future for nurses. If the healthcare worker experiences any kind of violence in any setting, consequences could include a decrease in productivity or even the possibility the nurse will leave the profession.

Theoretical assumptions

Researchers are looking for unbiased answers to questions asked to participants throughout the survey. Workplace violence leads to a decrease in the nurses work performance in the healthcare setting. Emergency department nurses experience more workplace violence than other hospital department nurses. Due to highly stressful workplace of emergency departments, the risk of employee assault is common within all hospitals in all communities. Many individuals believe emergency department nurses have larger number of high risk patients thus are likely to experience a higher number of

workplace violence. Medical-surgical nurses have cooperative and very ill patients in their units.

Research questions or hypotheses

Does a registered nurses department, medical-surgical versus emergency department, change the amount of workplace violence they may experience?

Chapter II

Introduction

Workplace violence is a serious risk in any occupational workforce setting. Abuse and violence in the healthcare workplace makes the delivery of effective patient care decrease. Violence is a fact of the working life for most nurses. Nursing personnel should be ensured to have the safest work place and be given respectful treatment throughout their shift at the medical facility. According to the National Institute for Occupational Safety and Health [NIOSH], defines workplace violence as "an act of aggression directed toward persons at work or on duty, ranging from offensive or threatening language to homicide" (Gacki-Smith, et al., 2009, p. 340).

In the United States each year approximately 900 deaths and 1.7 million nonfatal assaults occur related to workplace violence (Gacki-Smith, et al., 2009). In 2001, less than 20% of nurses reported feeling safe in their work environment (Gacki-Smith, et al., 2009). Many of the nurses were concerned about inadequate safety measures, personal vulnerability, violence and aggression in their workplace (Gacki-Smith, et al., 2009). The high vulnerability of workplace violence may be related to low staffing levels, inadequate security, long wait times, lack of privacy, anger from patients and families, and many others factors which can influence violent behaviors. Healthcare facilities need to work together to decrease the number of workplace violence in the future. Violence has serious consequences for the employers, employees, and patients thus administration, managers, and employees need to collaborate to develop and implement prevention strategies to reduce and manage the violence.

Emergency department nurses receive the highest incident of physical assaults from patients and visitors than any other nurses (Gates, Gillespie, & Succop, 2011). According to Pich, Hazelton, Sundin, and Kable (2010), 70% of nurses reported experiencing aggression and violence on a weekly basis. According to the Emergency Nurses Association [ENA] (2011), the Emergency department is a high-risk area, and every week between 8% and 13% of emergency nurses in the United States are victims of physical violence (ENA, 2011). According to 60% of nurses, the level of violence in their EDs had increased in the past year (ENA, 2011). One-third of nurses reported emotional abuse, 14% reported threats, and 20% had actual violence and some units had a higher number of abuses up to 65% than others (Roche, Diers, Duffield & Catling-Paull, 2010). Between 60-90% of nurses report both verbal and physical violence due to close contact with patients and their families (Pich, et al., 2010). In 1992, the number of non-fatal workplace assaults were the highest among nurses and increased to four times the number in 2006 (Pich, et al., 2010).

Verbal abuse is the most common form of abuse. More than 82% of nurses report some type of verbal abuse with some of the most common forms being violent aggression, swearing or obscenity (Pich, et al., 2010). Verbal abuse can be a warning sign for physical violence and the most common form is being pushed by a patient or family member. Patients can use objects such as syringes, scissors, stretcher poles, knives or guns in order to show physical abuse to a healthcare worker. The evening shift reported to be the most common time for abuse to occur. According to Pich et al. (2010), 37-40% of nurses reported abuse during the evening 1500-2300 hours which is double the amount reported during the day time hours of 0700-1500 of only 20%. Multiple sources of

literature sites were utilized in order to review the literature available regarding workplace violence.

Literature Review

Violence Areas

Roche, Diers, Duffield and Catling-Paull (2010), conducted a qualitative study to relate nurses' self-rated perceptions of violence on medical-surgical units to the nursing working environment and patient outcomes. The cross sectional data collection surveyed 94 nursing wards in 21 hospitals in two states. The nursing work index revised, environmental complexity scale and a nursing survey were used to obtain data. The study identified one-third of nurses reported emotional abuse, 14% reported threats, and 20% had actual violence. The report showed some units had a higher number of abuses up to 65% than others (Roche et al., 2010). Violence can be associated with unit operations, unanticipated changes, wait times, delayed tasks, and increase in medication errors. A fewer number of reported errors were identified by nurses with a higher skill level or those bachelors degree in nursing. Perceptions of emotional violence not threatening or actual violence is what caused the individual to leave their present position (Roche et al., 2010). Limitations of the study included limiting the study to only seven day collection time and patient adverse outcomes were low during the study period. Also, all the surveyed units were medical surgical ones; the data analyzed did not give a mix of case types by units (Roche et al., 2010). The study determined perceptions of violence in the workplace can affect job satisfaction.

The study by Landau and Bendalak (2008), was conducted to analyze the violence in the twenty-five different emergency departments in Israel. A self-report questionnaire

was provided to various medical personnel with a 78.5% response rate for this qualitative study. The study reported 42% of all physical violence episodes within the hospital setting occur in the emergency department (Landau & Bendalak, 2008). Results through descriptive statistics and general exposure to violence index (GEVI) were used to present the data based on type and frequency of violence during the last year by patients and accompanying persons. Results of violence by patients included verbal attacks (51.1%), Verbal attack on another staff member (42.4%), verbal threats of violence (33%), physical attack on another staff member (23.9%), verbal threats of violence against another staff member (23.7%), vandalism (22.3%), threatening another staff member with sharp object (11.3%), threats with a sharp object (6.1%), threatening another staff member with firearm (5.9%), threats with a firearm (3.9%) (Landau & Bendalak, 2008).

Violence by accompanying persons included verbal attack (55.4%), verbal attack on another staff member (46.8%), verbal threats against another staff member (41.7%), verbal threats of violence (36.8%), physical attack on another staff member (24.7%), physical attack (12.1%), threatening another staff member with a sharp object (9.8%), threats with a sharp object (6.2%), threats with a firearm (5.3%) and threatening another staff member with a firearm (4.8%) (Landau & Bendalak, 2008). The GEVI presented results through regression coefficients, categorical and independent variables, and the significance of each category. The study reported a large contribution of violence through the individual s significant others and a high proportion of multiple victimizations to the nurses by the patients over last year. The study covered multiple hospitals and departments thus providing multivariate analysis. Limitations to the study reported the use of routine activity theory alone is not always the best approach to determining

workplace violence in hospitals, broadening the usage of specific domain models and the study focused mainly on the victim and should have included the offenders and victim to offender interactions (Landau & Bendalak, 2008).

Productivity

The purpose of the study by Gates, Gillespie, and Succop (2011), "was to examine how violence from patients and visitors is related to emergency department nurses' work productivity and symptoms of post-traumatic stress disorder (PTSD) (p.59). A randomized sample of emergency department nurses who were members of the ENA in the United States were participants in the cross-sectional design survey. Of the 3,000 nurses chosen, only 8.8% of the nurses returned the completed Impact of Events Scale-Revised and Healthcare Productivity survey (Gates et al., 2011). The results of the survey showed, "ninety-four percent of nurses experienced at least one posttraumatic stress disorder symptom after a violent event, with 17% having scores high enough to be considered probable for PTSD" (Gates et al., 2011, p. 59). Thirty-seven percent of nurses reported a decrease in performance after a violent event thus having a negative productivity score (Gates et al., 2011). After a violent event, 94% of nurses reported having at least one stress symptom and 22% of participants reported experiencing the stress symptom often (Gates et al., 2011). The survey showed 15% of the nurses had a diagnosis of post-traumatic stress disorder (PTSD) because of experiencing symptoms as distressing emotions, job changes, absenteeism, and difficulty thinking (Gates et al., 2011). Limitations of the study includes no measurement of the severity of the violent event, self-reported data may limit information as the nurses may poorly recall events, and only had an 8% response rate (Gates et al., 2011). The usage of the cross-sectional

study made the survey impossible to identify the relationships between violent events, stress symptoms, and productivity (Gates et al., 2011).

Perceptions

Judkins-Cohn (2010), conducted a study to "determine nurses' perceptions of the characteristics, sources of, impact of, prevention of, and resolution of verbal abuse" (p.1). The study included 517 direct patient care nurses from five hospitals and approximately ten outpatient clinics within the southeast region of the United States. This descriptive study design was provided to nurses who completed a modified version of the Cox Verbal Abuse Survey and an open-ended question addressing solutions to verbal abuse. The quantitative data findings reported 84.5% of nurses' experienced verbal abuse in their current setting (Judkins-Cohn, 2010). Each different specialty area of nurses reported different percentages of verbal abuse. The highest number of abuse occurred in the medical-surgical unit (36.3%), emergency room (14.6%), operating room (14.2%), intensive care unit (13.4%), mother/baby unit (11.7%) & pediatric nurses (1.9%) (Judkins-Cohn, 2010). The nurses reported four sources of verbal abuse included physicians (74.7%), patients' families (65.1%), patients (63.8%), and fellow nurses (41%) (Judkins-Cohn, 2010). Nurses report different feelings regarding verbal abuse thus 37.5% of them only think about the incident for a few hours, 26.1% of the nurses report the incidents still bother them (Judkins-Cohn, 2010). The survey identified factors which nurses' experienced verbal abuse including 87.4% due to nursing shortage, 79.7% lead to increased errors, 79% due to increased turnover rates, and 52% reported decrease in nurses productivity (Judkins-Cohn, 2010). Through review, Cox Verbal Abuse survey indicated verbal abuse can affect the nurses and her perceptions in the quality of care

provided within the nursing community. The researcher identified several limitations with the survey. The survey initially began with a large sample size but after the surveys were returned there was a low response rate. The data was obtained was based on nurses in the southeast area instead of nationally therefore a question of generalizability may be in question (Judkins-Cohn, 2010).

According to McClellan (2011), the purpose was to determine the relationship between level of perception of threat of workplace violence to environmental and demographic variables. The study was also used to validate the Emergency Department Environmental Comfort Scale [EDECS]. This descriptive qualitative study was completed by presenting a survey to members of the New Jersey Emergency Nurses Association. The results of the EDECS survey reported a mean score of 35.47 regarding escalating levels of fear regarding workplace violence (McClellan, 2011). The mean scored showed a moderate level of fear regarding workplace violence with nurses working in the emergency department. The study showed there is an association between lack of security with the emergency department and higher levels of threat. Nurses reported actually seeing a colleague becoming injured resulted in a higher level of fear than those who actually experienced an assault themselves (McClellan, 2011). Limitations included only 40% of the 1, 086 members returned the survey (McClellan, 2011).

The study regarding workplace violence examined the differences in nurses perceptions between those exposed to the violence and those not exposed. The random cross-sectional, descriptive survey was completed by 39.7% of Queensland Nurses employed in private (15.9%), public (69.5%), or aged care (14.6%) facilities during

October and November 2007 (Hegney, Tuckett, Parker, & Eley, 2010). The 75 question questionnaire was divided into eight sections which included "current employment, working hours, responsibilities outside work perceptions of work and nursing work, nursing work index, about you, and you and nursing work" (Hegney et al., 2010, p. 190). Results of the study showed 49.7% of aged care nurses, 53.4% of public care nurses, and 35.8% of private care nurses experienced workplace violence within the last three months (Hegney et al., 2010). All of the nurses no matter which setting reported patients were the greatest source of violence. In all three facility locations, 80% of nurses reported work stress can influence workplace violence (Hegne, et al., 2010). Only 43% of nurses who experienced previous workplace violence reported their work environment to be safe where 63.2% of those nurses with no previous violence (Hegney et al., 2010). The lowest perception of workplace safety occurred within the public setting. Only 10.3% of experienced violence reported morale to be good related to the 30.2% of those non-experienced violence nurses (Hegney et al., 2010). Staff morale issues were 50% more likely to deteriorate in the experienced violence nurses workplace than 28.6% in the non-experienced workplace violence (Hegney et al., 2010). The study reported no significant different in perceptions of workplace violence regarding sex, age, job level, policy for managing violence, previous violence experience, emotionally challenging job, and lack of teamwork or colleague support (Hegney et al., 2010). Limitations included the studies showing inconsistencies regarding previous similar studies. The study did not provide a clear picture of workplace violence within any nursing workforce. The study only had 39.7% of the large sample to respond to the mailed surveys (Hegney et al., 2010).

The purpose of the study by Gacki-Smith et al. (2009) was to investigate emergency department nurses perceptions and experiences regarding violence from patients and visitors in emergency departments across the United States. Emergency Nurses Associations [ENA] registered nurses in all 50 states were encouraged to participate in the 69 item cross-sectional survey. Only 10.9% of the emergency nurses completed the online survey during the spring of 2007 (Gacki-Smith et al., 2009). Of the 3,465 nurses responding to the survey, 23% were frequent physical violence experience [FPVE] nurses (Gacki-Smith et al., 2009). Pediatric and female nurses were less likely to experience physical violence than those night shift, weekend, and male nurses (Gacki-Smith et al., 2009). Nurses believed barriers to reporting the workplace violence included negative effect on customer service, fear of retaliation from management, show sign of incompetence, lack of support, and attitude of violence comes with the job (Gacki-Smith et al., 2009). Emergency department nurses were less likely to report violent incidents (15.4%) then those working in other areas (28.5%) (Gacki-Smith et al., 2009). Emergency department nurses were also less likely to report verbal abuse (9.78%) than other nurses (21.5%) (Gacki-Smith et al., 2009). Limitations included the use of convenience sampling where all participants were ENA members, self-reported data has a potential increase of being reported inaccurately, and identification of best practices for preventing emergency department workplace violence was not discussed (Gacki-Smith et al., 2009).

According to Chapman, Styles, Perry, and Combs (2010) study, the goal is to examine Taylor's theory of cognitive adaptation to understand perceptions of nurses on how they adapt to workplace violence. The exploratory study for qualitative data

interviewed 35 nurses in a metropolitan hospital in Western Australia through the use of semi-structured open-ended interviews (Chapman et al., 2010). The nurses worked in various departments throughout the hospital including ED, medical, surgical, mental health, pediatric, and maternity. The study gathered that all nurses use cognitive adaptive process to regulate their experiences of workplace violence. The cognitive process of identifying the meaning of the cause of the violence, mastery and self-enhancement was separated into several categories which provided the number of nurses which gave reasons why the violence may occur. The number of nurses interviewed reported illness (14), organization (8), inexperience (7), lack of care (7), refusing care (7), substance abuse (6), and seniority (4) as contributing causes (Chapman et al., 2010). The cognitive process of mastery through physical and psychological control showed assertiveness (11), calling authority (8), diffusing (7), avoidance (6), restraint (5), and perception of blame (4) as ways the nurses adjust to workplace violence (Chapman et al., 2010). The study found three strategies of self-enhancement through comparisons (20), positive view of self (9), and finding benefit (26) as ways in which the nurses used to boost their self-esteem (Chapman et al., 2010). All of the nurses interviewed believed they were able to deal with the workplace violence issues than their colleagues. Limitations to the study showed this was the first study which used Taylor's cognitive adaptation theory to explore workplace violence. The study did not interview nurses who had left the nursing profession because of past experiences with workplace violence and additional longitudinal research should address why workplace violence adjustments is not straight forward but could be repetitive (Chapman et al., 2010).

The purpose of the study by Duxbury and Whittington (2005), was to identify the causes of patient aggression and ways it's managed through staff and patient perceptions. The management of aggression and violence attitude scale and semi-structured interviews was completed by a convenience sample of 82 nurses and 80 patients within three inpatient mental health departments for this quantitative research (Duxbury & Whittington, 2005). The results of the survey identified two key areas: causes of patient aggression and management of the aggression. Nurses believed environmental factors were issues, mental illness was a strong precursor to patient aggression, and staff interaction was not viewed as a problem. Patients did not see mental illness as a factor but issues such as poor communication were factors which contributed to aggression (Duxbury & Whittington, 2005). Both nurses and patients thought there was a need for improvement in how aggression was managed and the use of restraints were necessary for safety reasons. Staff felt the use of medications and seclusion was important while patients saw this usage not significant. Patients felt de-escalation was ineffective and negotiation usage was poor and nurses agreed their ability to use therapeutic communication was not appropriately completed (Duxbury & Whittington, 2005). Limitations included only using inpatient mental health units and not other specialty units where patient aggression may occur. The patients' perceptions and a small sample size address the validity of the study. The use of the new MAVAS instrument could affect the validity and reliability of the study (Duxbury & Whittington, 2005).

Violence Types

The qualitative study by Abualrub and Al-asmar (2011), was to describe workplace violence policies and investigate the complaints, responses, and levels of physical violence to hospital nurses. The convenience sample of 420 Jordanian nurses completed a self-administered questionnaire for this quantitative research design (Abualrub & Al-asmar, 2011). The descriptive, exploratory survey was used to investigate the physical workplace violence with the nurses who were invited by their managers to participate in the survey. The nurses were selected from different shifts and departments throughout the targeted hospitals with a total response rate of 88.4% (Abualrub & Al-asmar, 2011). The survey found 22.5% of the nurses experienced workplace violence within their hospital setting (Abualrub & Al-asmar, 2011). Nurses reported factors related to the violence included patients and families, security, staff, administration, and the public. The results showed 22.5% of nurses had been physically attacked with 15.8% of them with a lethal weapon (Abualrub & Al-asmar, 2011). The survey provided the information showing patients caused the majority of the violent incidents 79% and 43.1% occurred between the 3pm & 11pm shifts (Abualrub & Al-asmar, 2011). The nurses reported 55.8% were injured during the violent incidents with 49.5% of them missing work after the attack (Abualrub & Al-asmar, 2011). In 43.1% of the cases the attackers received no consequences and only 11.4% was reported to the police (Abualrub & Al-asmar, 2011). The nurses felt reporting the incidents as useless (72.6%), felt ashamed in reporting (22.1%), and afraid of negative consequences (6.3%) (Abualrub & Al-asmar, 2011). The nurses reported having disturbing memories or thoughts after the event (28.5%) and 36.8% reported being extremely bothered by the

event (Abualrub & Al-asmar, 2011). The nurses reported 69.2% of their employers did not have specific policies and only 6.2% of the employers had policies in place regarding physical workplace violence (Abualrub & Al-asmar, 2011). Nurses were very dissatisfied with how workplace violence incidents were handled in their facility. Limitations of the study was the small sample size only using four hospitals, only Jordanian nurses were surveyed, and the nurses had to understand the Arabic language. The survey did not address legislations about violence, quality of instituting healthcare polices, and consequences to employee's view of workplace violence and the data could cause bias because the nurses had to recall past experiences (Abualrub & Al-asmar, 2011).

According to Opie et al. (2005), the purpose of their study was to measure how individuals responded to workplace violence twelve months after the occurrence and the amount of PTSD symptoms each participant continued to experience. The study used a structured questionnaire through a cross-sectional design to gather data from 349 nurses working in health centers across Australia with an overall response rate of 34.6% (Opie et al., 2005). This qualitative study showed the most common forms of abuse were "verbal aggression (79.5%), followed by property damage (28.6%), physical violence (28.6%), sexual harassment (22.5%), stalking (4.9%), and sexual abuse/assault (2.6%)" (Opie et al., 2005, p.20). The study identified a correlation between witnessed violence and PTSD symptoms, but found no relationship between sexual abuse/assault and PTSD symptoms (Opie et al., 2005). The study identified nurses working in remote areas felt concerned about violence in the community (86.4%) and 33.2% felt concerned at least once a week (Opie et al., 2005). The nurses showed concern regarding personal safety (66.4%) and at

least once a week (14.3%) (Opie et al., 2005). Limitations of the study are the nurses questioned only worked in remote areas and the study did not include witnessing of incidents to anyone other than patients (Opie et al., 2005).

The study by Newman, Vries, Kanakuze, and Ngendahimana (2011), was to determine the prevalence and contributing factors of workplace violence, describe victim's reactions to the violence, and review workplace violence policies. The qualitative and quantitative collection methods was completed through the usage of six different data collection tools consisting of surveys, interviews using open and closed ended questions, patient focus groups, and risk assessment inventory (Newman et al., 2011). The workers in hospitals, health centers, clinics and public health units in half of Rwanda's administrative districts were randomly selected to participate in the survey. The results of the surveys reported 39% of health workers experienced workplace violence episode in some form over the last year with 27% being verbally abused, 16% bullied, 7% sexually harassed, and 4% physically assaulted (Newman et al., 2011). The open-ended questions provided information about patterns of perpetration and victimization based on gender. When the individuals were asked about bullying, participants reported men (55%) were perpetrators more than women (30%) and male workers were more likely to be victimized by men (69%) than by women (19%) (Newman et al., 2011). Being physically attacked in the workplace proved men (55%) were perpetrators more than women (31%) and female workers were more likely to be victimized by either men (64%) than by women (36%) (Newman et al., 2011). The survey question regarding sexual harassment reported men (55%) were perpetrators more than women (22%) and female workers were more likely to be victimized (75%) than

men (25%) (Newman et al., 2011). Women (55%) were more likely to be verbally abused than men (22%) while both male and female healthcare workers were more likely to be abused by women than by men (Newman et al., 2011). The study also examined how the individuals reacted to experiencing workplace violence. The questions show only 4% of male healthcare workers left a job because of verbal abuse while 10% of female workers left because of bullying and sexual harassment (Newman et al., 2011). The data showed 40% of sexual harassment cases were not reported to anyone and less than 20% of the workers reported the violence to their supervisor (Newman et al., 2011). The men and women healthcare workers (60%) surveyed believed individuals with some type of previous workplace violence perceived treatments they received as unequal (Newman et al., 2011). Limitations included ways to document gender discrimination and had difficulty finding previous research about gender discrimination or violence regarding workplace violence. The researchers sample size consisted of 297 participants but originally planned for a sample size of 450 along with 20% of these individuals being managers and more women were included than men. Bias could be a factor with the retrospective survey being used to identify the respondents' behavior over the past year (Newman et al., 2011).

The study by Khalil (2009), worked to explore the nurses experience with workplace violence in a hospital setting. The ethno-phenomenology study distributed confidential studies to registered nurses in the South African Nursing Council employed in eight public hospitals in the Cape Town area. The qualitative data was used to record responses from the closed and open ended questions from 90 midwives, 202 general, 148 psychiatric, and 31 pediatric nurses (Khalil, 2009). The results of the survey showed

nurses agreed violence is a reality 54% of the time and 13% disagreed the reality is untrue (Khalil, 2009). The nurses reported occur of the each workplace violence being: verbal abuse (45%), discrimination (33%), gossip (30%), bullying (29%), shouting (26%), and physical assault (20%) (Khalil, 2009). Nurses reported the lack of communication, lack of respect among nurses and inadequate anger management training was the three main factors contributing to violence (Khalil, 2009). The study limitations included not finding nurses who had never experienced psychological or covert violence, a few participants elaborated on their opinion with their particular choices, and some participants did not answer all the questions in each section (Khalil, 2009).

The retrospective survey by Magnavita and Heponiemi (2011), compared the exposure of workplace violence between nursing students and registered nurses. The study obtained a 99% survey return from nursing students at three Italian universities along with a 94.2% return from general area hospital (Magnavita & Heponiemi, 2011). The violent incidence form questionnaire identified the effects of violence due to psychological problems, social support, organizational justice, and job strain. The nursing students scored lower on social support and higher on perceived justice, psychological problems & demands, and higher job control than the nurses. Nurses reported (13.4%) at least one physical assault over the last year than nursing students (6.6%), but 42.5% of nurses reported experiencing more threats, sexual or verbal abuse than students who experienced the violence 34.1% (Magnavita & Heponiemi, 2011). Both groups reported female individuals to be perpetrators of sexual harassment (88%) and stalking (82%) where male individuals were perpetrators in other areas of abuse (75%) (Magnavita & Heponiemi, 2011). Nurses reported physical (94%) or verbal violence (71%) occurred

from their patients and patients families while nursing students reported non-physical assaults (76%) and physical violence (41%) occurred from colleagues, teachers, or other staff (Magnavita & Heponiemi, 2011). Nurses reported the result of regression from physical assault was related to fear (21.5%), irritation (30.4%), and the aggression was reported to superiors (51.4%) when nursing students reported fear (38.9%), irritation (27.8%), and the aggression was reported to superiors (35.2%) (Magnavita & Heponiemi, 2011). Nurses reported most of the physical assault occurred from taking care of patients and concerned general clinical issues. Limitations included nurses or students will respond to the survey more biased when they are abused subjects in order to provide information or suggestions, and let of frustration from injury. The survey was completed with a large sample but the study did not include all hospitals and nursing schools (Magnavita & Heponiemi, 2011). The cross sectional, self-reported measures may have lead to an increase of relationship to violence strengths (Magnavita & Heponiemi, 2011).

The study by Yildiz (2007) was completed to determine the frequency of psychological abuse such as bullying in the educational and health sectors in Turkey. The Negative Acts Questionnaire measured qualitative data from the use of closed surveys to obtain exposure to bullying and violence at work. The results of the survey showed 47.1% were exposed to the psychological abuse while 52.9% denied any abuse and no difference was found between male and female participants (Yildiz, 2007). The two most frequent reason of bullying was identified by the education individuals when they were given unreasonable deadlines (45.2%) and ordered to complete tasks below their competence level (42.7%) (Yildiz, 2007). The two most frequent reason of bullying was

identified by the health individuals when their work was excessively monitored (49%), having their opinions ignored (44%), and being given unreasonable deadlines (24%) (Yildiz, 2007). The individuals in both groups reported the effects of the abuse on them as individuals which included feeling infuriated (48.7%), lack of motivation (30.7%), and lack of concentration (28%) (Yildiz, 2007). The individuals reported ways in which they are coping with the abuse including telling friends (48.9%), telling family members (42.1%), doing nothing (27.4%), and reporting to management (18.9%) (Yildiz, 2007). The study found the abusive behaviors were higher in participants with a higher educational level (47%) (Yildiz, 2007). Limitations to the survey included only giving the participants one day to complete the survey and so individuals had to have the surveys translated into the Turkish language. The area does not have a clear law regarding psychological abuse and no legal arrangements regarding the issues which was identified by the study to be a need in order to deal with the violence and assist with productivity of the workers (Yildiz, 2007).

Summary

Workplace violence is a problem which is progressively becoming worse at hospitals. There are multiple articles regarding workplace violence but very few research studies regarding the issue. There is always going to be some degree of violence but making changes to policy and educating staff and administrators hopefully the number will decrease. The majority of literature deals with violence in emergency departments, nursing homes, and psychiatric settings and many do not address the medical-surgical units. The National Health Service [NHS] found 65% of nurses caring for the elderly were more likely to experience violence or aggression incidents than therapists (Roche et

al., 2010). Medical-surgical workplace violence is related to deficiencies in nursing practice and negative patient outcomes such as medication errors, delayed medication administration, and falls (Roche et al., 2010).

Chapter III

Method

A non-experimental quantitative method was used to determine if workplace violence occurs more in the medical-surgical setting or in the emergency department. The workplace violence survey allowed the researcher to obtain statistics and numbers regarding the issue. The researcher was distant from the individuals completing the web-based survey as the researcher will be unable to identify each participant as submission was anonymous.

Setting

The research study was conducted in a 268 bed hospital in the Central Piedmont Region of North Carolina. The hospital provides continuous nursing care 24 hours a day, 7 days a week care to patients. Inpatient services include acute medicine, cardiology, surgery, psychiatry, physical rehabilitation and critical care departments. The hospital has both medical-surgical and emergency departments.

Subjects

A cross sectional descriptive study using an anonymous web-based questionnaire survey was used to collect data from nurses working on medical-surgical units and in the emergency department at the facility.

Sampling

A nonprobablity convience sample of random number of nurses was identified to participate in the survey. After receiving approval from the participating facility, a brief introduction & survey will be emailed to employees by education research council chairperson to the medical-surgical and emergency department unit nurses.

The brief email introduction was given: Hello nurses on the medical/surgical or emergency department units. Dakeita Roakes, a Gardner-Webb University MSN student is requesting you take a survey regarding workplace violence. Your participation is completely voluntary and completion of the survey will serve as your implied consent to participate. Your answers will be anonymous and results of the study may help identify issues regarding workplace violence. Thanks so much for your time.

If the nurse completes the web-based survey, this will give the consent to use data for research purposes. The inclusion criteria will be a registered nurse working in the medical-surgical areas or emergency department at the participating hospital.

Instruments

Permission to use the Workplace Violence Survey 2008 (Hader, 2008) (Appendix A) was given by Wolters Kluwer Health (Appendix B). The survey measures multiple areas related to workplace violence. This researcher worked to minimize the tool questions to give the information to the participants at easier understanding and better clarification.

The modified tool measured the following demographic and descriptive variables and had a total of ten questions. Nurses were asked to answer questions based on the last two years of nursing experience. Demographic variable included in the research were (a) gender, (b) age, (c) years in nursing, and (d) area of clinical nursing practice currently working (Hader, 2008). Descriptive statistics included in the research were (a) which of the following you have witnessed when working with a colleague, (b) check any of the following have you experienced in the work setting, (c) how frequently have these episodes occurred, (d) who's been the victim of workplace violence, (e) who's

demonstrated workplace violence, and (f) check any of the following measures your organization implemented (Hader, 2008).

Procedures

Before implementation, this proposal was reviewed and approved by the Institutional Review Board (IRB) from Gardner-Webb University (Appendix C) and of the participating hospital. The findings provided details of the data collected from the participants. The researcher provided the Institutional Review Boards [IRB] with packet of information which included consent to use tool, site consent, and any consent forms. Providing the board with data allows them to protect the rights and well-being of subjects asked to participate in the study. The researcher also presented the information to the education research council at the participating hospital to obtain approval and taken recommendations to complete the survey.

Ethical Considerations

Nurses engage in a variety of ethical dilemmas throughout the course of their careers. The importance for nurses is carefully handle, respect patient and family rights, and maintain facility policies during ethical dilemmas related to workplace violence. Ethical considerations are those in which some religions view violence in a different manner than others. During the study, measures were taken to protect the identity of the subjects and no one was excluded from the study based on gender or race.

Data Collection

Participants voluntarily chose whether they wish to participate in the web-based questionnaire survey and their opinions did not affect their employment. The web-based survey asked the participating nurses age range, gender, ethnicity, and years of nursing

experience. Return of the questionnaire was considered to be the subject's implied voluntary consent to participate in the study. Anonymity was insured by asking the participants to put no identifying information or marks on the questionnaire. In the event, identification could be obtained from demographic information, data was maintained in a locked file and access restricted to the researchers only.

Data Analysis Procedures

Data analysis is the process of providing and interpreting the data obtained from surveys. Responses to the research questions will determine how nurses feel regarding workplace violence in their particular work setting. The data collected was reviewed and grouped together into categories based on the participants' answers and the relationships between the categories. The findings helped staff and management in the emergency department and medical surgical units to identify workplace violence issues. The participants were asked to complete the survey questionnaire within a ten day period and answered questions based on the last two years of nursing experience.

The information was gathered through a computer document program to assist with analysis of data. Following the data collection portion, the researcher transcribed all of the survey answers into table format (see Tables 1-3) to allow for easier comparison of answers, and to aid in the identification of the most popular responses. The results were uploaded at Gardner-Webb University through ProQuest in order for the research findings to be presented to staff.

Chapter IV

Results

After receiving approval from both the IRB from Gardner Webb & participating facility the research began. The workplace violence survey was emailed by the chairperson of the Education Research Council to both medical-surgical and emergency department nurses. The nurses were given a ten day time period to complete the survey. The response to the survey was small compared to the number of surveys emailed out to staff. A total of 27 nurses (*N*= 27) responded to the survey out of approximately 60 medical-surgical and 60 emergency department nurses.

Demographic variable

The following demographic results were obtained from the workplace violence survey at the participating facility (Table 1).

The survey had three (*n*=3) responses from male nurses (11.1%) and twenty-four (*n*=24) female nurses (88.9%). The nurses responding to the survey age groups ranges were the following Less than 25 (*n*=1), age 26-35 (*n*=11), age 36-45 (*n*=8), age 46-55 (*n*=5), age 56-65 (*n*=2), and greater than age 65 (*n*=0). The age group response percentages were as follows: less than 25 (3.7%), age 26-35 (40.7%), age 36-45 (29.6%), age 46-55 (18.5%), age 56-65 (7.4%) and greater than age 65 (0%).

How long have you been a nurse? Less than 5 years (n=8) (29.6%), 6-10 years (n=6) (22.2%), 11-15 years (n=3) (11.1%), 16-20 years (n=3) (11.1%), 21-25 years (n=2) (7.4%), and greater than 25 years (n=5) (18.5%). What's your area of clinical practice? Medical/Surgical (n=12) (46.2%) and Emergency Department (n=14) (53.8%). One of the nurses skipped this question.

Table 1

Demographic Data

	Frequency	Percent
Gender		
Male	3	11.1
Female	24	88.9
Age		
Less than 25	1	3.7
26-35	11	40.7
36-45	8	29.6
46-55	5	18.5
56-65	2	7.4
Greater than 65	0	0
Years as Nurse		
Less than five years	8	29.6
6-10 years	6	22.2
11-15 years	3	11.1
16-20 years	3	11.1
21-25 years	2	7.4
Greater than 25 years	5	18.5
Area of Clinical Practice		
Medical-Surgical	12	46.2
Emergency Department	14	53.8

Descriptive statistics

The following are the results of the descriptive statistics included in the research study with the questions being based on the last two years of nursing experience (Table 2). Check any of the following that you have witnessed when working with a colleague

response to the survey including: increasing belligerence (n=12) (63.2%), apparent obsession with a supervisor or coworker (n=5) (26.3%), ominous or specific threats (n=5) (26.3%), recent acquisition or fascination with weapons (n=3) (15.8%), hypersensitivity to criticism (n=12) (63.2%), preoccupation with violent themes or recently publicized violent events (n=4) (21.1%), and outbursts of anger (n=15) (78.9%). A total of 19 nurses answered the question with eight respondents skipping this question. Check any of the following that you have experienced in the work setting responses included: physical violence (*n*=12) (54.5%), threats of physical violence (*n*=17) (77.3%), harassment (*n*=11) (50%), intimidation (*n*=17) (77.3%), threatening, disruptive behavior (*n*=18) (81.8%), bullying (*n*=9) (40.9%), intentional property damage (*n*=9) (40.9%), and carrying or storing of weapons (*n*=6) (27.3%). A total of 22 nurses answered the question with five respondents skipping this question.

How frequently have these episodes occurred? The responses to this question included never (*n*=4) (14.8%), occasionally (*n*=14) (51.9%), frequently (*n*=9) (33.3%) and always (*n*=0) (0%). Who's been the victim of workplace violence? The responses included yourself (*n*=9) (40.9%), nursing colleague (*n*=8) (36.4%), physician (*n*=3) (13.6%), other healthcare worker (*n*=2) (9.1%), and with patient and visitor (*n*=0). A total of 22 nurses answered the question with five respondents skipping this question. Who's demonstrated workplace violence? Responses included: nursing colleague (*n*=4) (18.2%), physician (*n*=2) (9.1%), other healthcare worker (*n*=1) (4.5%), patient (*n*=19) (86.4%), and visitor (*n*=12) (54.5%). A total of 22 nurses answered the question with five respondents skipping this question.

Table 2

Descriptive Data

	Frequency	Percent
Witnessed working with a colleague		
Increasing belligerence	12	63.2
Apparent obsession with a supervisor/coworker	5	26.3
Ominous or specific threats	5	26.3
Recent acquisition or fascination with weapons	3	15.8
Hypersensitivity to criticism	12	63.2
Preoccupation with violent themes or events	4	21.1
Outbursts of anger	15	78.9
Experienced in work setting		
Physical violence	12	54.5
Threats of physical violence	17	77.3
Harassment	11	50
Intimidation	17	77.3
Threatening, disruptive behavior	18	81.8
Bullying	9	40.9
Intentional property damage	9	40.9
Carrying or storing of weapons	6	27.3
Frequency of episodes		
Never	4	14.8
Occasionally	14	51.9
Frequently	9	33.3
Always	0	0
Victim of workplace violence		
Yourself	9	40.9
Nursing colleague	8	36.4
Physician	3	13.6
Other healthcare worker	2	9.1
Patient	0	0
Visitor	0	0

Demonstrated workplace violence		
Nursing colleague	4	18.2
Physician	2	9.1
Other healthcare worker	1	4.5
Patient	19	86.4
Visitor	12	54.5

The final survey question (Table 3) was for respondents to check any of the following measures that your organization has implemented. The responses were zero tolerance policies and procedures for workplace violence (*n*=15) (57.7%), education/training on harassment and workplace violence, conflict prevention, sexual harassment, workplace security, and a drug-free workplace (*n*=16) (69.2%), conflict management programs (*n*=10) (38.5%), employee assistance programs (*n*=22) (84.6%), preemployment screening (*n*=7) (26.9%), photo identification badges (*n*=22) (84.6%), security guard services (*n*=22) (84.6%), individually coded key cards for access to buildings and grounds (*n*=16) (16.5%), controlled facility access (*n*=8) (30.8%), alternative dispute resolution (*n*=5) (19.2%), threat assessment team (*n*=3) (11.5%), emergency response team (*n*=10) (38.5%), reporting procedures for workplace violence (*n*=16) (61.5%), incident response team (*n*=5) (19.2%), visible security (*n*=17) (65.4%), mock drills (*n*=6) (23.1%), metal detectors (*n*=2) (7.7%), and sign in procedures for visitors (*n*=3) (11.5%). A total of 26 nurses answered the question with one respondent skipping this question.

Table 3

Descriptive Data-Question 10

	Frequency	Percent
Implemented measures at organization		
Zero tolerance policies and procedures	15	57.7
Education/training	18	69.2
Conflict management programs	10	38.5
Employee assistance programs	22	84.6
Preemployment screening	7	26.9
Photo identification badges	22	84.6
Security guard services	22	84.6
Individually coded key cards for access	16	61.5
Controlled facility access	8	30.8
Alternative dispute resolution	5	19.2
Threat assessment team	3	11.5
Emergency response team	10	38.5
Reporting procedures	16	61.5
Incident response team	5	19.2
Visible security	17	65.4
Mock drills	6	23.1
Metal detectors	2	7.7
Sign in procedures for visitors	3	11.5

Chapter V

Discussion

Interpretation of Findings

The results of the survey showed workplace violence does occur in the hospital setting. The survey had three male nurses respond thus male nurses may view workplace violence differently than female nurses. Many nurses in the healthcare setting are females but the number of males entering into this workforce have increased over the past several years up to 13% and the hope is to have 20% male nurses by 2020 (American Assembly of Men in Nursing [AAMN], 2011). The AAMN believes nursing is not a gender based profession but a nursing profession (2011). Approx seventy-four percent of the nurses responding to the survey were less than 45 years of age with the largest number between 25-35 years (40.7%). Younger nurses are more vulnerable to workplace violence than those in the older age bracket as these nurses have less experience in life. The highest response came from nurses with less than five years of experience (29.6%) and the lowest response from nurses with 21-25 years of experience (7.4%).

The number of responses from each department was almost even to each other with medical-surgical nurses (46.2%) and emergency department (53.8%). Only a total of 20% of medical-surgical and 23% of emergency department nurses responded to the survey. One respondent did not answer this question and unsure of the reason why the selection was not chosen. The respondent may have felt they did not work in either area, could have changed departments, or survey answered by someone who is not a nurse since the email did not go out to just nurses but to all staff within each department.

The descriptive responses were based on the last two years of nursing experience. Nurses responding to the survey reported the event witnessed when working with a colleague the most was outbursts of anger (78.9%) followed by increasing belligerence (63.2%) and hypersensitivity to criticism (63.2%). Most of the responses were from emergency department nurses as the eight who skipped answering this question were mostly medical-surgical nurses. The majority of the emergency department nurses reported the top two responses of outbursts of anger and increasing belligerence. Of the medical-surgical nurses who answered the question, most reported outbursts of anger while the majority gave no response. The most significant experiences in the work setting included threatening, disruptive behavior (81.8%), threats of physical violence (77.3%), intimidation (77.3%), physical violence (54.5%), and harassment (50%). A large number of the staff responding to the survey has experienced workplace violence. All of the emergency department nurses who responded reported the experiences of threatening, disruptive behavior, threats of physical violence, and intimidation while the medical-surgical nurses identified intimidation occurred more. All five of the nurses who skipped responding to answering the question were medical surgical nurses.

The respondents to the survey reported the workplace violence episodes occurred occasionally (51.9%), frequently (33.3%), and never (14.8%). Many of the nurses who skipped questions in the survey were those who had never experienced workplace violence in the healthcare setting. The nurses who never experienced violence were medical-surgical nurses. Nurses reported themselves as being a victim of workplace violence (40.9%), their nursing colleagues (36.4%), and physicians (13.6%). The nurses felt patients and visitors were not victims of workplace violence.

Nurses reported those who demonstrated workplace violence were patients (86.4%), visitors (54.5%), and nursing colleague (18.2%). Of the nurses responding, employee assistance programs, photo identification badges, and security guard services were implemented 84.6%, followed by education/training (69.2%), and visible security (65.4%). The lowest measure implemented at the organization was metal detectors (7.7%), sign in procedures for visitors (11.5%), and threat assessment team (11.5%). There are no noted metal detectors at the research facility thus wondering if the respondent honestly read the question, could have possibly been a travel nurse who had the detector at a previous facility, or answered due to worked at facility throughout years of experience at facility.

Limitations of the study

There are several limitations to the survey. The first limitation is the low number of respondents completing the survey. The survey had a total number of 27 respondents when approximately a total number of nurses (N=120) on the two different units could have participated. The survey results may not be accurate and give a full understanding of everyone true opinion of current nursing practice due to the lower response rate. Many nurses have experienced workplace violence but do not or afraid to report them to management thus making the true violence numbers skewed. The researcher may have a lower response rate because of staff not having time to check emails, respond to survey questions because of the staffing shortage and workloads on their individual units. The second limitation is the researcher only used one healthcare facility and two nursing departments. Obtaining more opinions in a larger healthcare facility and more departments would give a more accurate response to workplace violence.

The third limitation could be a large flaw as nurse respondents may not be honest regarding their responses to the survey, some may have just selected all the responses and several of the respondents skipped the important data questions. Honesty is important in making sure data collection is correct and when an individual does not tell the exact truth the data can be skewed. The researcher would like to know if the reasoning behind skipping the questions was because the events have never occurred over the past two years or just did not want to answer the question honestly. The fourth limitation could be researcher bias. Staff may not want to respond to a survey from someone who has left the facility or received an email from the research council chairperson who they do not recognize their name therefore deem as not important.

Implications for Nursing

Individuals respond differently to trauma, threats, or actual violence events. The ultimate benefit of theory in nursing is the improvement in patient care and to avoid injuries in the nurses and patients (Tomey & Alligood, 2006). The Adaptation model by Sister Callista Roy is a conceptual nursing model used to provide nurses a different way of thinking about their field and addresses a broad range of concepts (Tomey & Alligood, 2006). After completing the survey, hopefully bedside nurses and administrative staff will start to visualize what is actually happening in the hospital setting regarding workplace violence. Providing patients, visitors, nurses, physicians and other healthcare workers with a safe working environment will assist with decreasing the growing concern for workplace violence within the healthcare environment.

Implications for Further Research

Future recommendations should include education not only to nursing staff but to the general public. Over 80 percent of all assaults on registered nurses are not reported and few states offer legal action when the assault occurs (American Association of Critical Care Nurses [AACN], 2011). Violence in the workplace not only makes for hostile working environments, but can make employees have increased stress and staff turnover, and a low morale (AACN, 2011). Further nursing studies regarding workplace violence needs to continue in the future. Researchers need to exam multiple healthcare facilities and multiple nursing departments, follow up to see if recommendations in changes within a facility and state as being implemented, and examine federal workplace violence standard regulations.

Emergency department nurses reported having higher risk for physical workplace violence where medical surgical nurses have more emotional violence. In order to decrease the amount of violence which has been on the rise over the last several years, nurses need to be aware of proper policies in regards to the workplace violence episodes which may occur while employed. Healthcare workers should notify congressman or senators through email or telephone to tell them real-life healthcare violence stories in order to achieve disciplinary action for violence injuries per patients and families. We should strongly urge politicians to pass a bill in North Carolina to safeguard nurses and healthcare providers who experience workplace violence.

Employers cannot guarantee to employees that they will work in a violence free setting. Employee and employers must learn how to recognize violent situations, alert supervisors about safety concerns and report occurring violence incidents immediately

(OSHA, 2011). Every nurse and every employer are responsible to take measures to address and prevent violence in the workplace (AACN, 2011). Workplace violence will continue to occur in the healthcare industry but hopefully through research and education measures can be taken to decrease or stabilize the number of future incidents. No nurse or healthcare provider should be injured while rendering care to another.

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Appendix A

Subject survey

Revised Workplace survey

Placed into Survey Monkey http://www.surveymonkey.com/s/DSXBSHD

1- What is your gender?

Male Female

2- What's your age?

Less than 25 26-35

36-45 46-55

56-65 Greater than 65

3- How long have you been a nurse?

Less than 5 years 6-10 years

11-15 years 16-20 years

21-25 years Greater than 25 years

4- What's your area of clinical practice?

Medical/Surgical

Emergency Department

PLEASE ANSWER THE FOLLOWING QUESTIONS BASED ON THE LAST 2 YEARS OF NURSING EXPERIENCE.

5-Check any of the following that you have witnessed when working with a colleague

Increasing belligerence	Apparent obsession with a supervisor or coworker
Ominous or specific threats	Recent acquisition or fascination with weapons
Hypersensitivity to criticism	Outbursts of anger
Preoccupation with violent themes or recently publicized violent events	

6- Check any of the following that you have experienced in the work setting.

Physical violence	Threats of physical violence
Harassment	Intimidation
Threatening, disruptive behavior	Bullying
Intentional property damage	Carrying or storing of weapons

7-How frequently have these episodes occurred?

Never	Occasionally
Frequently	Always

8-Who's been the victim of workplace violence?

Yourself	Nursing colleague
Physician	Other healthcare worker
Patient	Visitor

9-Who's demonstrated workplace violence?

Nursing colleague Physician

Other healthcare worker Patient

Visitor

10- Check any of the following measures that your organization has implemented.

Zero tolerance policies and procedures for workplace violence

Education/training on harassment and workplace violence, conflict prevention, sexual harassment, workplace security, and a drug-free workplace

Conflict management programs Employee assistance programs

Preemployment screening Photo identification badges

Security guard services Controlled facility access

Individually coded key cards for access to buildings and grounds

Alternative dispute resolution Threat assessment team

Emergency response team Incident response team

Reporting procedures for workplace violence Visible security

Mock drills Metal detectors

Sign in procedures for visitors

Appendix B

Permission to Conduct Research

Workplace Violence Survey 2008

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Jun 25, 2012

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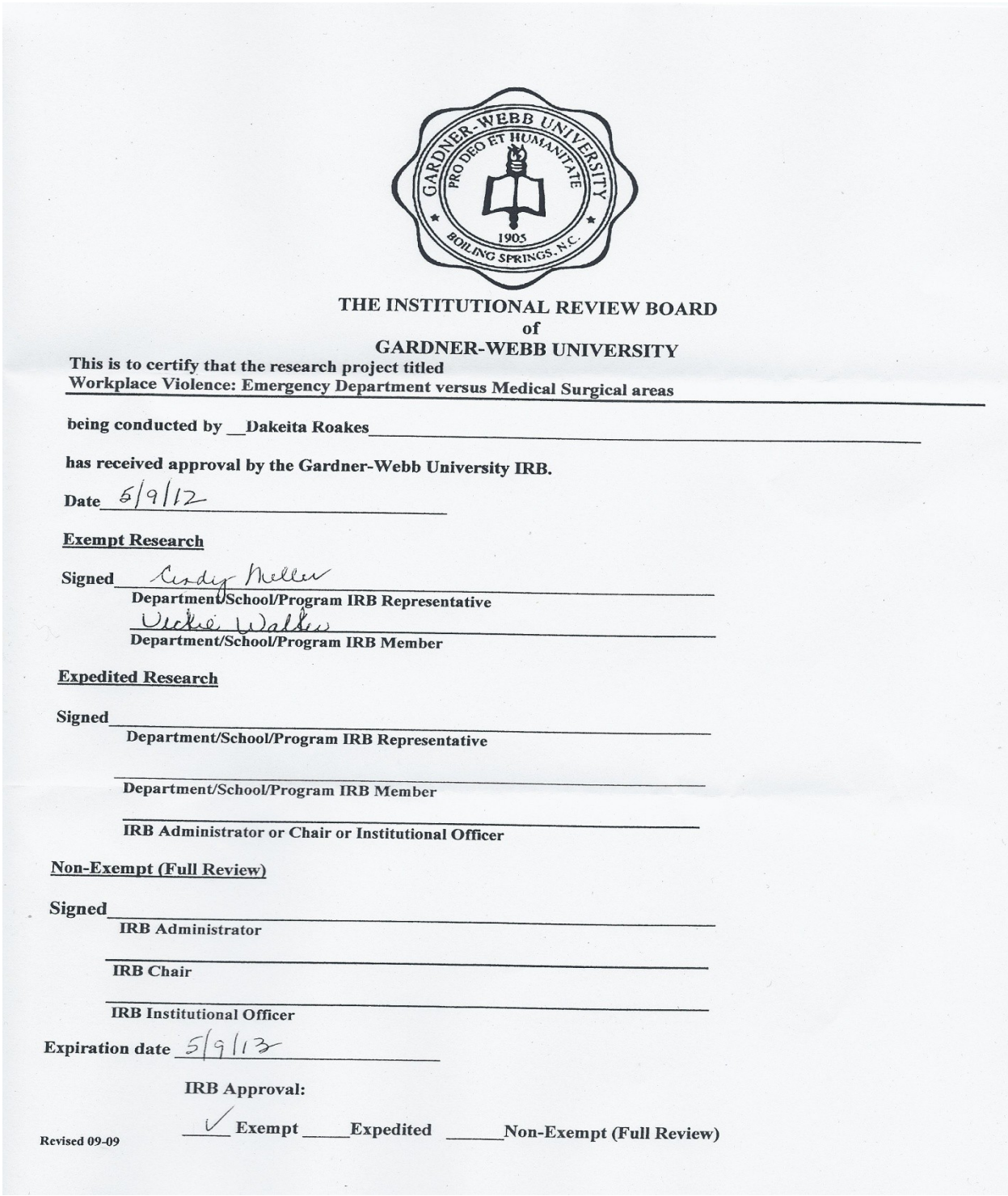
Appendix C

Permission to Conduct Research

Gardner-Webb University



THE INSTITUTIONAL REVIEW BOARD
of
GARDNER-WEBB UNIVERSITY

This is to certify that the research project titled
Workplace Violence: Emergency Department versus Medical Surgical areas

being conducted by Dakeita Roakes

has received approval by the Gardner-Webb University IRB.

Date 5/9/12

Exempt Research

Signed Cindy Miller
Department/School/Program IRB Representative
Vickie Walton
Department/School/Program IRB Member

Expedited Research

Signed
Department/School/Program IRB Representative
Department/School/Program IRB Member
IRB Administrator or Chair or Institutional Officer

Non-Exempt (Full Review)

Signed
IRB Administrator
IRB Chair
IRB Institutional Officer

Expiration date 5/9/13

IRB Approval:

✓ Exempt ____Expedited ____Non-Exempt (Full Review)

Revised 09-09