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## Emergency Registered Nurses' Perceptions of Workplace Violence

Margarite Elsey

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Emergency Registered Nurses' Perceptions of Workplace Violence

by

Margarite Elsey

A thesis submitted to the faculty of  
Gardner-Webb University Hunt School of Nursing  
in partial fulfillment of the requirements for the  
Master of Science in Nursing Degree

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2018

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## Abstract

Workplace violence (WPV) is a significant issue in today's healthcare field, especially for nurses in the emergency department. WPV is defined by action of verbal abuse, threats, disruptive behavior, harassment, intimidation and/or physical abuse, or assault (Stene, Larson, Levy, & Dohlman, 2015). Emergency Department (ED) registered nurses (RNs) are in a prime position to experience WPV due to the nature and purpose of the emergency room. To address effectively the problem of WPV against RNs in the ED, it is crucial first to understand how nurses in this setting perceive WPV from patients and/or visitors. In a Level I Trauma Emergency Department in South Carolina, the "Emergency Registered Nurses' Perceptions of Workplace Violence" survey was sent via electronic mail to RNs in the ED. Results from the questionnaire indicated that nurses are exposed to WPV on a regular basis, but often do not have effective tools to prevent a violent incident. Reducing and eliminating WPV are goals worth pursuing to provide successful safety measures for nurses and quality care for patients.

*Keywords:* workplace violence, emergency, nursing perceptions

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# **CHAPTER I**

## **INTRODUCTION**

### **Definition of Terms**

Workplace violence (WPV) is defined by actions of verbal abuse, threats, disruptive behavior, harassment, intimidation and/or physical abuse, or assault (Stene et al., 2015). Registered nurses (RN) in emergency departments (ED) are vulnerable to WPV due to working in a stressful, potentially volatile environment with limited security presence. The atmosphere in the ED can be highly charged and while patients and family members are expecting relief, they experience many emotions, including but not limited to fear, anger, embarrassment, and rage. It is the demands that patient and their visitors expect of the nursing staff that puts RNs at risk for injury or emotional abuse. Patient and visitor attitudes and emotions can range from fear and anxiety to anger and rage. When these emotions are mixed with mental illness, substance abuse, and a high-stress environment - the risk for violence increases.

### **Background**

According to the Emergency Nurses Association (ENA) Emergency Department Violence Surveillance Survey of 2011, 54.5% (n=3568) of RNs nation-wide report having experienced verbal or physical abuse in a seven-day calendar period; the average emergency RN worked 36.9 hours during this seven-day survey (Emergency Nurses Association, 2011). The prevalence of this phenomena is evident with over half of participants of the ENA Surveillance Survey reporting that they experienced some sort of abuse, verbal, or physical. Yet most assaults of verbal and physical abuse are unreported due to the healthcare providers' perception that violence is 'part of the job,' and that

reporting violence will be laborious and inefficient (Stene et al., 2015). It may even be perceived as a weakness on the part of the nurse or as the nurse's inability to handle this aspect of the job and to take control of the situation.

Occasionally violent physical assaults against nursing staff make national headlines. In 2017, two nurses were assaulted and were held at gunpoint by a jail inmate who was receiving treatment at a hospital in Illinois (Trossman, 2018). Also, Elise Wilson, RN, was nearly killed after a patient stabbed her while she was assessing the patient in the ED in Massachusetts (Trossman, 2018). Alex Wubbles, RN, famously made headlines after a bystander recorded a cellphone video of the nurse being unlawfully and violently arrested by a Salt Lake City police officer after she refused the officer to draw blood from an unconscious patient (Trossman, 2018). In 2015, 14 people were physically assaulted by a patient in Charleston, South Carolina, a patient who was attempting to “steal a keycard from staff members to exit the building,” (“S.C. Hospital Patient Assaults 14 Nurses and Staff Members,” 2015). The American Nurses Association (ANA) is promoting a zero-tolerance platform against WPV, along with the ENA, “encouraging nurses to take the pledge and add their names to #EndNurseAbuse,” (Trossman, 2018). The time has come to address this issue and to find an appropriate way to reduce and end this WPV permanently.

In an attempt to understand the true occurrences of WPV in the ED setting, a cross-sectional design survey was issued to ED staff members at a Level I Trauma Center where 147 staff members completed surveys that reflected their perceptions of verbal and physical abuse over the course of six months (Copeland & Henry, 2017). This study was completed in 2017 resulting in 147 respondents indicating 98% (n=147) felt safe at work

whereas 64% (n=147) felt violence at work is ‘part of the job’ (Copeland & Henry, 2017). Clearly these results indicated there was good justification for studying these occurrences and understanding them further so that appropriate actions can be taken to reduce them. It is unacceptable for nurses to feel that violence is to be expected as ‘part of the job.’

As a consequence of the above findings, a 19-question staff survey was developed using the ENA ED Violence Surveillance Study with the purpose of collecting nurses’ and patient care associates’ perceptions of WPV (Stene et al., 2015). Via this survey Stene et al. (2015) reviewed perceptions of safety and violence in the workplace, exposure to violence in the workplace, feelings of preparedness when faced with a violent event and knowledge of how to report violent events. When staff were asked on the survey if WPV is part of the job in the ED, 55.8% (n=154) reported “yes” whereas 44.2% (n=154) reported “no.” This survey was issued again one year later to the same staff with the finding that 24.2% (n=203) did believe WPV is part of the job and 75.8% (n=203) did not believe WPV is part of the job (Stene et al., 2015).

Also during the initial survey, 40% (n=154) reported they had been instructed on how to report physical or verbal abuse regardless of severity, whereas 47% (n=154) reported they had not been trained on how to report physical and verbal abuse (Stene et al., 2015). The surveyors further explained that in the follow-up survey that there was an increase of participants who reported that they had been trained to report physical and verbal abuse, 76% (n=203). Responses from staff members regarding reasons why they did not report WPV included “‘feeling nothing would happen after incident reported,’ ‘too much work, part of the job, nobody cares,’ ‘we fear retaliation,’ ‘not sure how to report WPV,’” etc. (Stene et al., 2015, p. 117). When given the tools and support, ED

nursing staff can help ensure a zero-tolerance policy of WPV by reporting violent incidents with an appropriate reporting tool. Nursing management and administration should also educate staff on WPV to help support and empower staff. WPV must rise to the level of high importance and visibility if it is to be successfully addressed.

### **Research Problem**

ED RNs are in a prime position to experience WPV due to the nature and purpose of the ED. The situational factors that bring patients to the ED add to the complex interplay of risk factors that can result in violence. In their capacity of being on the frontline with patients, ED RNs often receive the brunt of the patients' expressions of fear, pain, and frustration in the ED experience. Research to explore ED RNs' perceptions of WPV is key to evaluating the extent of WPV occurrences. Additionally, it is also important to recognize and study how the RN's perception of WPV affects his or her quality of care on the perpetrators of the violence and its significance.

### **Research Purpose**

To address effectively the problem of WPV against RNs in the ED, it is crucial first to understand how nurses in this setting perceive WPV from patients and/or visitors. Once a nurse perceives or experiences WPV, how he or she approaches and treats the patient subsequently may impact care quality. For this reason, it is necessary to investigate the sequence of events leading up to and completing a violent patient's visit in the ED. Before providing a solution to WPV, the question of how violence arises and how it is dealt with must be understood.

### **Research Question**

- How do ED RNs perceive WPV from patients and/or visitors?

### Theoretical/Conceptual Framework

Jean Watson's Theory of Human Caring, displayed in Figure 1, is the theoretical framework for this research study. In 1979 Jean Watson published her book *Nursing: Human Science and Caring*, which "emphasizes her theory of transpersonal caring between nurse and patient," (King & Kornusky, 2016). Jean Watson believed that the nurse should connect to the patient from a holistic approach in an attempt to understand the patient's psychological, social, spiritual, physical, and emotional aspects of life (King & Kornusky, 2016). In other words, the nurse should approach the patient as a total person by attending to their mind, body, and spirit. Watson's theory differentiated itself from nursing as a series of tasks to perform to an interaction with the patient by communicating caring availability and caring intentionality (da Silva Borges & Soares dos Santos, 2013). Watson describes a transpersonal caring relationship to be the "nurse's caring consciousness and moral commitment to make an intentional connection with the patient," (Lachman, 2012, p. 112).

In da Silva Borges and Soares dos Santos (2013) article, the authors discussed Jill Taylor's stroke and perceptions of nursing care. Taylor is a neuroanatomist who suffered a stroke in 1996, and she described her emotions and perceptions of healthcare in her book *My Stroke of Insight, A Brain Scientist's Personal Journey* (da Silva Borges & Soares dos Santos, 2013). da Silva Borges and Soares dos Santos pointed out that Taylor's experiences suggested an existence of an energy field in the relationship between patient and nurse, in which the patient can interpret the motivations from the nurses as either favoring or disfavoring for health restoration. Taylor's experience appears to agree with Watson's Transpersonal Caring in that

“this transformative view of caring presupposes understanding that there is an intimate relationship between mind and body, and that consciousness, attention and intentionality influence this relationship,” (da Silva Borges & Soares dos Santos, 2013, p. 609).

In the ED patients are likely to be in a state of unrest at a minimum, and therefore Jean Watson’s Theory of Transpersonal Caring can very well be the best tactic to employ when patients and/or visitors are becoming aggressive. Based on Watson’s Theory of Human Caring Model, two theoretical assumptions are applicable to this research study. The first theoretical assumption is that at RNs from a Level I Trauma ED are more task driven in their patient care rather than attempting to connect to the patient holistically. The second theoretical assumption is that once a patient and/or visitor becomes violent or aggressive toward the RN, the nurse will not attempt to engage more fully with the patient, but instead tends to avoid confrontation.

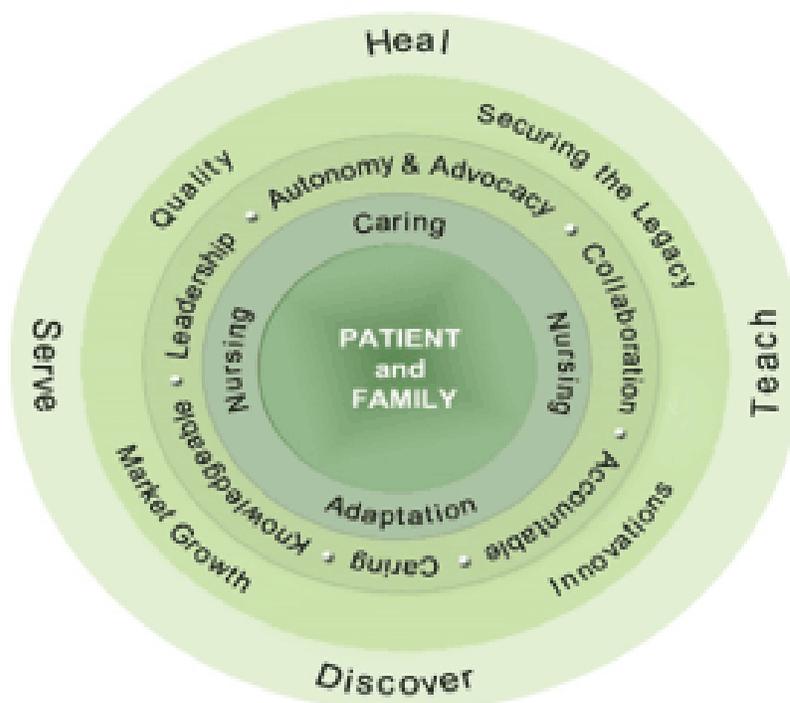


Figure 1. Jean Watson's Theory of Human Caring Model (West et al., 2017, p. 4)

### **Significance to Nursing**

WPV is an important health matter facing ED nurses nation-wide. WPV often goes underreported due to factors including nurses' "fear of retaliation, lack of physical injury, inconvenience, considering exposure to violence as part of job, and fear it will affect customer satisfaction scores" (Emergency Nurses Association [ENA], 2008).

Reducing and eliminating WPV are goals worth pursuing to provide workplace safety for all healthcare providers and patients, so that patients are able to receive safe and quality care. By investigating and understanding the causes and amount of WPV, nurse management and educators can conceivably improve the situation by implementing training using Jean Watson's Theory of Human Caring.

## **CHAPTER II**

### **RESEARCH BASED EVIDENCE**

ED RNs are vulnerable to WPV because they are working in a potentially volatile environment. In this tense atmosphere of the ED, most patients and visitors have urgent situational circumstances which causes them to experience various emotions. While this notion appears to be anecdotal, the literature on this subject bears out this claim. Several qualitative and quantitative studies and literature reviews have investigated the prevalence and nursing perception of WPV in the ED. These findings provide evidence, statistics, data, and areas that need further exploration concerning this pervasive topic.

#### **Literature Review**

A 2011 study by the ENA distributed a survey nationally to determine whether a violence in the workplace problem existed and if so, to what extent. In order to accomplish this, the ENA researchers used a cross-sectional study to discover the “prevalence and nature of WPV” suffered by the ED nurses during the previous week (p. 9). This design was used to survey this particular population of patients and nurses for a specific time period. Survey Select Expert (version 5.60) was the instrument used for the anonymous survey delivery to a random sample of ED nurses in the ENA membership database, and SPSS Windows (version 18.0) was used for data management and analysis (Emergency Nurses Association, 2011). The study was drawn from a large sample, and many statistics were developed. One area of concern showed a significant amount of verbal abuse, and over 50% of these nurses reported feeling angry after these incidents (Emergency Nurses Association, 2011). Such anger may have overflowed into poor attitudes toward patients and their families, therefore negatively affecting patient care and

nursing morale. About 13% of nurses reported sustaining some kind of physical injury, including minor bruises, scratches, etc. Grabbing, pulling, yelling, and cursing were also common types of aggression towards nurses (Emergency Nurses Association, 2011). Most of the nurses who completed the survey said that they did not file a report after experiencing WPV for different reasons including fear of retaliation from management and because it would be too time-consuming. ED nurses reported that most of the violent incidents occurred during triage, while restraining a patient or while performing an invasive procedure. They stated that patients were the main perpetrators of the violence as opposed to family members or anyone else. Paradoxically, perceptions of higher security ratings and preparedness were associated with lower rates of physical and verbal abuse. When hospital administration and ED management professed zero-tolerance for WPV, again, nurses were less likely to experience WPV (Emergency Nurses Association, 2011).

Investigating WPV in 2017, Copeland and Henry issued a comparably designed survey of ED staff members at a suburban Level I Shock Trauma Center. Out of 147 staff that reported WPV, 52 were RNs. RNs from all specialties were included. The study showed that as high as 88% of respondents experienced some type of WPV in the previous six months: “94.3 % of RNs cited verbal abuse, 52.8% reported being spit on by patients, and 73.6% patient’s threatened to bring a lawsuit on nurses (Copeland & Henry, 2017, p. 72). From their research, it appeared that while reporting WPV incidences had improved to a great degree, so had the phenomenon of WPV altogether. A total of 64% of those surveyed believed violence was to be expected as a ‘part of the job’ (Copeland & Henry, 2017), in other words, that it comes with the territory. When workplace violent

episodes occurred, if they went unreported due to no ultimate harm being done or due to lack of incident reporting training and/or knowledge, there was little support from administration (Copeland & Henry, 2017). With inconsistent evidence of WPV, administrators tended to focus their attention elsewhere.

In 2015, Stene et al. pursued similar questions in their survey which queried RNs and patient care associates (PCAs) regarding the issue of WPV, including their perception of safety, preparation for action, and knowledge of the reporting process at their facility. The survey specifically requested information about the amount of verbal and physical abuse experienced by the ED staff during the Spring 2012. This survey was delivered by Survey Monkey through email to 154 staff members, and only 108 RNs and six PCAs completed the survey (Stene et al., 2015). Prior to the survey, no violent events were reported in 2012 from this 64-bed, Level I Trauma Center with approximately 72,000 patients seen annually by the 150 or so nurses on staff (Stene et al., 2015). The WPV project team identified the reporting process in place as a barrier to getting violent events recorded promptly. Navigating through the software in place at the time was not efficient nor easy to use, typically taking over 10 minute to complete (Stene et al., 2015). Once designing a new tool which took about one-two minutes to complete by staff containing the crucial incident identifiers such as patient name, medical record number, date and incident type, a follow up survey was sent out about a year after the first one. After implementing this quality improvement project, the number of staff who reported consisted of 112 RNs and eight PCAs even as WPV incidents rose by 12% (Stene et al., 2015). The conclusion here pointed to high incidences of WPV being reported successfully in 2013 where 50 reports were filed as a first step toward solving the

problem (Stene et al., 2015). By providing the education and appropriate reporting tools, the staff in the study developed a zero-tolerance atmosphere toward WPV.

Spector, Zhou, and Che (2014) conducted a quantitative literature review of 136 articles covering aggression and violence affecting 151,347 nurses in healthcare settings world-wide. Articles for the literature review were chosen from CINAHL, Medline, and PsychInfo databases (Spector et al., 2014). Five types of violence were recorded: physical, nonphysical, bullying, sexual harassment, and any combination of these. Worldwide about a third of nurses experienced physical violence or even physical injury, two-thirds of nurses were subjected to nonphysical violence such as verbal abuse, and about a quarter of them withstood sexual harassment (Spector et al., 2014). According to the literature review, physical violence and sexual harassment were rated higher in Anglo regions than other regions of the world. Also, nonphysical violence and bullying were rated higher in the Middle East than other regions of the world (Spector et al., 2014). The overarching conclusion confirmed that aggression, conflict, and violence affect about a third of nurses around the world in various ways and in various healthcare settings, although EDs, geriatric, and psychiatric facilities fared the worst in this regard.

Another qualitative study completed in 2013 by Lancman, Mangia and Muramoto, focused on aggression and conflict in EDs conducted over two months in the Fall of 2008. During these two months, 280 ED workers of different job descriptions, in a large city in Brazil, participated in observations and interviews related to WPV cases (Lancman et al., 2013). The information from the interviews contained the situation and context of the violent event as well as vulnerability in the work organization, which contributed to the event. The findings from the study indicated that each professional,

such as security officers and nurses, answered to their own management hierarchy, which caused fragmentation in the workflow process (Lancman et al., 2013). While researcher bias and error could affect the findings more readily in a study of this design type, the sample size observed was larger than before. Such working conditions, by definition, are stressful and anxiety-provoking for all involved. When a spark of anger or pain is added to the equation, it is understandable that violence may erupt and therefore, defusing, or better yet preventing, the violence is paramount.

The research by Blando, O'Hagan, Casteel, Nocera, and Peek-Asa (2013) was gathered via in person interviews with 314 ED nurses and 143 psychiatric nurses. Injury logs were also used as part of the data collection. The sample was very large including randomly selected hospitals in a county in New Jersey and a county in California (Blando et al., 2013). The total sample included 168 EDs and 73 psychiatric units. This mixed method study design used stratified random sampling. The participating nurses differed in their perceptions of safety and WPV (Blando et al., 2013). The research conclusion was that the nurses' perceptions of safety and violence did not correlate well with the actual risk of safety and violence. An example revealed that even though metal detectors were installed and the perception of the staff was that safety had increased, the actual number of violent incidents continued to occur (Blando et al., 2013, p. 492). Nurses in the ED felt more unsafe than psychiatric nurses, 14% versus 4% (Blando et al., 2013). This study found while some security equipment may lull nurses into a perception of safety, these attempts at mitigating violence may actually increase the risk because nurses are less likely to be alert to the possibilities.

An additional qualitative study conducted by Gillespie, Gates, Miller, and Howard (2012) included interviews from 31 healthcare workers in an urban pediatric ED in the Midwest, USA. The researchers viewed all aspects of ED security officers including the need for them, their availability and response, their presence and involvement, their ability to handle situations, the role of restraints and security access to ED (Gillespie et al., 2012, p. 21). The use of security officers was one strategy to address WPV in the healthcare setting. It was imperative that the medical staff and security officers respect each other and work together to provide safe and quality care to all patients. The conclusion was that there is a need for security officers in the ED to respond to escalating or violent events.

One of the earlier studies of WPV took place in 2009 when Gacki-Smith et al. created a cross-sectional study of RNs belonging to the ENA. The respondents were at many different size EDs, including those located in both rural and urban areas. About 25% of those taking the survey revealed they experienced physical violence over 20 times in the past three years, and about 5% less of them noted they experienced verbal abuse more than 200 times during the same period (Gacki-Smith et al., 2009). In addition to reporting these large numbers of exposure to violence, respondents also indicated their reticence to report these incidents was because of fear of retaliation from supervisors or administrators at work. In some cases, a simple lack of support from administrators and supervisors in general led to more silence regarding WPV reporting (Gacki-Smith et al., 2009). Findings such as these showed that mitigating factors to assist staff reporting WPV incidents included support from all levels of administration, management and hospital security were necessary.

### **Summary**

RNs of the EDs were constantly at the patient bedside, which increases the risk for WPV. Research has shown that most ED RNs perceived violence in the ED to be ‘part of the job,’ which resulted in underreporting of violent events. From the research articles discussed, one could conclude that nursing staff underreported violent events that caused no harm, meaning a nurse was more likely to report a physical violent event that caused physical injury rather than sexual harassment or verbal abuse. According to the ENA 2011 Surveillance Study, after a nurse experienced verbal abuse from a patient, the amount of sympathy or empathy the nurse had for the patient decreased due to experiencing emotions ranging from anger to anxiety toward the patient. This ultimately could affect the quality of care the patient received from the victim, the nurse in this case. Even with the initiation of panic buttons, metal detectors, security officers, etc., violence in the ED did not seem to decrease; however, the nursing perception of safety was mollified. It was imperative for hospital administration and ED management to be involved in promoting a zero-tolerance atmosphere in the ED against WPV.

## **CHAPTER III**

### **METHODOLOGY**

WPV in the ED has remained a growing concern. In this age of instant and pervasive violence, attacks against nurses have been magnified and organizations such as the Emergency Nurses Association (ENA) have created tools and supported current research regarding WPV in the ED. Some factors that contributed to WPV in the ED were stress, pain, long wait times, fear, anxiety, substance abuse, and mental illness (Stene et al., 2015). The purpose of this research study was to evaluate emergency RNs' perception of WPV and its potential effect on care quality. According to Stene et al.'s survey (WPV in the ED: giving Staff the Tools and Support to Report Survey, 2015), "health care leads all other sectors in the incidence of nonfatal workplace assaults." To pursue further knowledge in this area, a qualitative survey used in the Stene et al.'s (2015) article that stemmed from the ENA WPV Toolkit, was employed to investigate ED nursing perceptions of WPV.

#### **Implementation**

A qualitative study was conducted to research the perception and awareness of WPV in the ED, and how it could affect quality patient care. In a Level I Trauma ED with the capacity of approximately 80 beds, this survey tool was provided to all current RNs. Permission to use the survey was obtained from the instrument's developers, then amended and subsequently approved. Participants were given an approximate two-week time period to respond to the survey.

### **Study Design**

A descriptive design will be used for this study. The survey reflected many aspects of nursing perception of WPV that was discovered in prior research. The “Emergency Registered Nurses’ Perceptions of WPV” survey contained 18 questions, consisting of multiple choice options and fill-in comments. After the survey was opened to the subjects for a two-week period, data was collected and statistically analyzed using the IBM Statistical Package (Version 24) for the Social Sciences (SPSS) software program.

### **Setting**

Nurses responded to the “Emergency RNs’ Perceptions of WPV survey in an online setting through the SurveyMonkey website. Nursing staff were able to answer survey questions from any location during the two-week time period. Each participant was allowed to complete the survey once. Utilizing SurveyMonkey assured confidentiality and anonymity of the individual participants’ responses.

### **Sample**

Participants were RNs from the main hospital ED’s location of a Level I Trauma Center. Sample included participants of all job statuses such as full-time, part-time, and per diem. One hundred and fifty-six subjects were contacted via work electronic mail. Reminder electronic mail requests were sent to 156 nurses on the eighth day if there had been no response by that time. A non-probability sampling method was chosen of the convenient sample type.

### **Protection of Human Subjects**

Permission to use Stene et al.'s (2015) survey was granted via electronic mail. The Stene et al. (2015) survey was developed from the ENA Violence Toolkit survey. Furthermore, the current research survey used here was additionally amended to incorporate the theoretical approach to this study as well as questions related to nurses' perceptions of quality care after WPV events. The subjects of this study were informed that there were no risks or rewards due to them from completing this survey. The initial portion of the survey included language of informed consent detailing the purpose, risks, benefits, and voluntary completion of the survey via electronic mail. To protect participant demographic information, it was separated from participant responses to the survey, so that subjects were not identifiable individually.

### **Instrument**

The research instrument used was a survey tool entitled "Emergency RNs' Perceptions of WPV" questionnaire. The survey consisted of 18 questions ranging from multiple option answers, Likert scale choices and fill-in comments. The original survey tool was created by Stene et al. (2015). It contained 18 questions designed to elicit perceptions of RNs and patient care assistants concerning WPV. It was subsequently amended further to reflect interests of the study at hand. The survey tool ultimately consisted of questions given only to ED RNs relating to perceptions of WPV, whether verbal or physical; actual experiences of WPV, whether verbal or physical, levels of safety perceived, training and process of reporting incidents. Additional amendments were made to this survey tool by the current researcher to evaluate the effect WPV had on care quality. Participants were given questions related to amount of time spent avoiding

patient and/or patient's families after a perceived violent event, whether physical or verbal.

### **Data Collection**

The data used from the research study were answers from the "Emergency RNs' Perceptions of WPV" questionnaire. RNs from a Level I Trauma Center main ED were the sources of the data. Subjects were contacted, using their work electronic mail, detailing the reason for the research study and the hyperlink to the survey attached to the message. The e-mail message also contained a letter of informed consent for the subject to sign. Once the participants completed the survey, data was collected and stored in SurveyMonkey website. The researcher gathered the data from SurveyMonkey website for further analysis.

### **Data Analysis**

The researcher collected data from the website SurveyMonkey, which was the website tool the survey was distributed through via a hyperlink in electronic mail. The researcher entered data into IBM SPSS (Version 24) software program to evaluate statistical analysis. The theoretical assumption of this data analysis was that RNs were more likely to avoid patients and/or patient's family after experiencing a violent event, whether verbal or physical. Also, theorized was that nurses perceive violence at work to be expected in their profession.

### **Summary**

A descriptive research design was used to study RNs' perception, knowledge, and opinions of WPV. A non-probability sampling method was chosen of the convenient sample type in a Level I Trauma Center main ED. Subjects were contacted via electronic

mail and given a hyperlink to a letter of consent and the hyperlink to the “Emergency RNs’ Perceptions of WPV” questionnaire located on SurveyMonkey. Participants’ responses were collected as data for statistical analysis using the IBM SPSS (Version 24) software program. The participant’s rights and privacy were maintained during this research. Also, no identifying information was gathered during this research.

## **CHAPTER IV**

### **RESULTS**

As the prevalence of WPV toward ED RNs increases, it is important to understand the RNs' perceptions of WPV in order to work towards an intervention to help prevent WPV in the future as well as maintain a high quality of care when WPV does occur. In a Level I Trauma Emergency Center in South Carolina, ED RNs were given the "Emergency RNs' Perceptions of WPV" survey. Major findings from the survey results demonstrate how WPV is perceived by ED RNs in a South Carolina Level I Trauma ED.

#### **Sample Characteristics**

The "Emergency RNs' Perceptions of WPV" survey was sent to 156 RNs in a South Carolina Level I Trauma Emergency Center via electronic mail that contained a hyperlink to SurveyMonkey. The final sample size, after the survey was open for a two-week period in July 2018, was  $n=33$  RNs. By the end of the first week, 22 RNs had completed the survey. The primary investigator sent out a reminder electronic mail message about survey completion and its importance. Following this reminder, an additional 11 RNs responded by the end of the second week. When reviewing the data for analysis it was noted that not all respondents completed all questions. There were 123 non-responses and no withdrawals or losses. The only sample for this study came from the population of EN RNs from a Level I Trauma Emergency Center and to ensure complete anonymity no demographic or job status information was collected.

#### **Major Findings**

The "Emergency RNs' Perceptions of WPV" survey consisted of 18 questions, with multiple choice options and fill-in comments. Participants were not required to

answer all questions within the survey. If a participant did not feel comfortable answering a particular question within the survey, the question could be skipped. The first question within the survey was the participants' agreement to proceed by giving their consensual participation to do the survey.

The first 10 questions within the survey determined how safe the participants feel in each area of the ED at the Level I Trauma ED. These areas are pre-determined by hospital administration based on anticipated patient acuity and resources required to stabilize patients. These areas listed from lowest acuity to highest acuity are as follows: Fast Track, Intermediate Care, Women's Center, Chest Pain, Major Care I, and Major Care II. The other areas which are not solely based on acuity include: Triage Pivot, Triage Assessment Rooms, and Behavioral Health.

According to the data found in Table 1, 60.36% of participants rated Fast Track to be the safest area, at a rating of eight or above, within the ED. The data shows that five participants out of n=33 felt very safe in Fast Track and rated the area with a "feeling very safe 10." A notable calculation showed that 36.36% (four) of participants felt the least safe in the Women's Center, with a rating of three or below. The Women's Center is considered the geriatric-psychiatric holding unit and a case management hold unit. Women's Center is staffed with one RN and one emergency services technician (EST) during all hours of the day. The Women's Center can hold up to seven patients at a time with one RN. When comparing Triage Pivot and Triage Assessment areas, participants found the Triage Pivot to be more vulnerable than Triage Assessment areas.

Table 1

*Area Ratings: Nurse Safety Ratings based on Emergency Department Areas*

	1 Not At All										10 Feel
	NA*	Safe	2	3	4	5	6	7	8	9	Very Safe
ED Overall	0.00%	0.00%	3.03%	6.06%	6.06%	18.18%	24.24%	18.18%	21.21%	0.00%	3.03%
	(0)	(0)	(1)	(2)	(2)	(6)	(8)	(6)	(7)	(0)	(1)
Triage Pivot	0.00%	3.03%	9.09%	6.06%	24.24%	9.09%	18.18%	9.09%	9.09%	3.03%	9.09%
	(0)	(1)	(3)	(2)	(8)	(3)	(6)	(3)	(3)	(1)	(3)
Triage	0.00%	3.03%	12.12%	15.15%	9.09%	15.15%	12.12%	3.03%	18.18%	3.03%	9.09%
Assessment	(0)	(1)	(4)	(5)	(3)	(5)	(4)	(1)	(6)	(1)	(3)
Major Care I	0.00%	0.00%	0.00%	6.06%	9.09%	9.09%	18.18%	15.15%	27.27%	6.06%	9.09%
	(0)	(0)	(0)	(2)	(3)	(3)	(6)	(5)	(9)	(2)	(3)
Major Care II	0.00%	0.00%	0.00%	6.06%	9.09%	9.09%	18.18%	15.15%	27.27%	6.06%	9.09%
	(0)	(0)	(0)	(2)	(3)	(3)	(6)	(5)	(9)	(2)	(3)
Chest Pain	0.00%	0.00%	3.03%	6.06%	12.12%	12.12%	18.18%	12.12%	24.24%	3.03%	9.09%
	(0)	(0)	(1)	(2)	(4)	(4)	(6)	(4)	(8)	(1)	(3)
Behavioral	6.06%	6.06%	9.09%	9.09%	15.15%	12.12%	15.15%	15.15%	3.03%	9.09%	0.00%
Health Unit	(2)	(2)	(3)	(3)	(5)	(4)	(5)	(5)	(1)	(3)	(0)
Women's Center	0.00%	12.12%	6.06%	18.18%	18.18%	9.09%	18.18%	12.12%	3.03%	0.00%	3.03%
	(0)	(4)	(2)	(6)	(6)	(3)	(6)	(4)	(1)	(0)	(1)
Intermediate	0.00%	0.00%	3.03%	0.00%	6.06%	18.18%	6.06%	24.24%	24.24%	12.12%	6.06%
Care	(0)	(0)	(1)	(0)	(2)	(6)	(2)	(8)	(8)	(4)	(2)
Fast Track	0.00%	3.03%	0.00%	0.00%	9.09%	12.12%	18.18%	9.09%	21.21%	12.12%	15.15%
	(0)	(1)	(0)	(0)	(3)	(4)	(6)	(3)	(7)	(4)	(5)

*Note.* NA not answered.

The survey also included four questions measuring how many times RNs experienced physical and/or verbal abuse or assault from a patient or patient family member/visitor in the last six months. In Table 2, more than half of the participants (63.64%, 21) experienced verbal abuse or assault from a patient one to five times over the last six months. Seven (21.21%) participants reported experiencing verbal abuse or assault from a patient more than 10 times in the last six months. When participants were asked how many times they experienced physical abuse or assault from a patient over the last six months, 18 (54.55%) participants reported experiencing physical abuse one to five times in this time period.

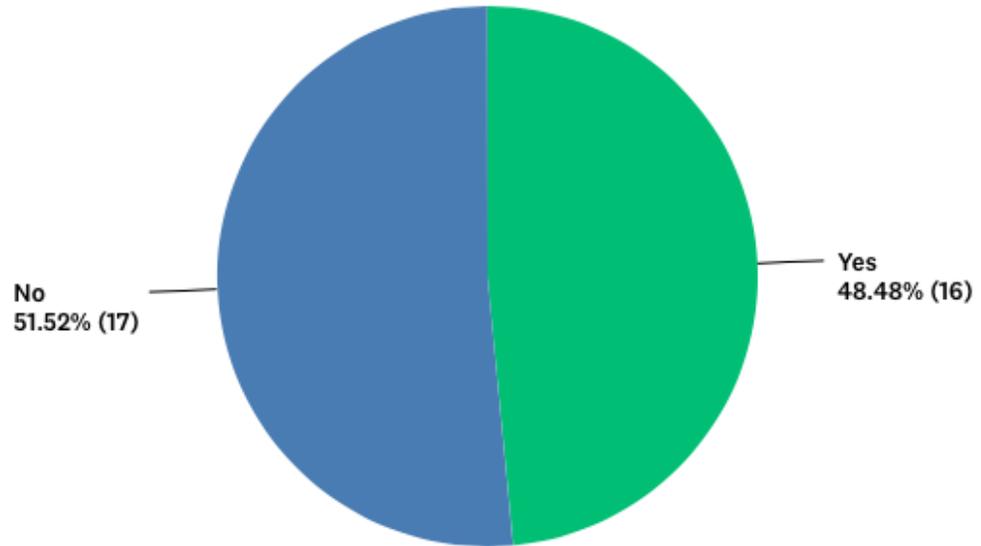
Participants were also asked the same question regarding verbal and physical abuse related to the patient's family members and/or visitors. According to the data found in Table 2, 18 (54.55%) participants reported experiencing verbal abuse from a patient's family member and/or visitor. Thirty participants (90.91%) reported not experiencing physical abuse from a patient's family member and/or visitor in the last six months. However, three participants reported experiencing a physical assault from a patient's family member and/or visitor one to five times in this time frame. These results were based on a six-month period, therefore each respondent averaged one incident each of physical and verbal abuse in one month period.

Table 2

*Measurement of Frequency of Verbal and Physical Abuse toward Emergency Registered Nurses in last six months*

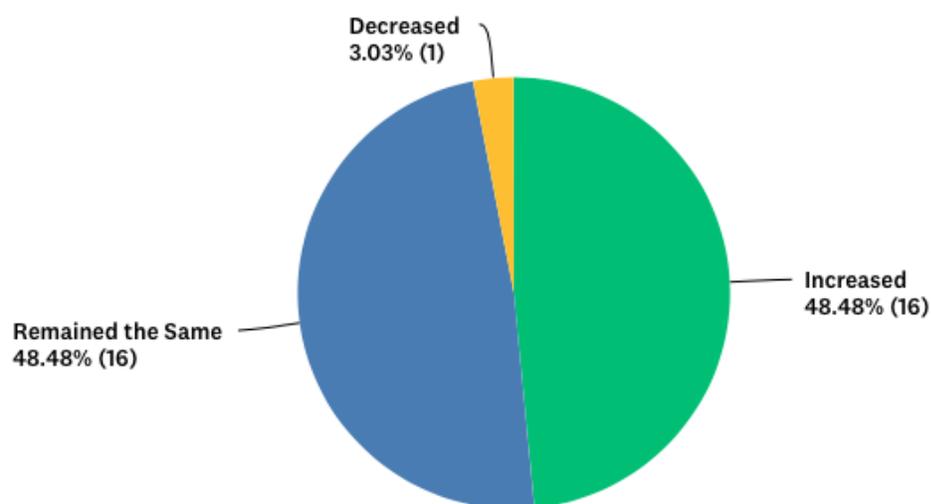
	0 Times	1 - 5 Times	6 - 10 Times	> 10 Times
How many times in the last 6 months have you experienced verbal abuse/verbal assault from a patient?	3.03% (1)	63.64% (21)	12.12% (4)	21.21% (7)
How many times in the last 6 months have you experienced verbal abuse/verbal assault from a patient's family?	24.24% (8)	54.55% (18)	9.09% (3)	12.12% (4)
How many times in the last 6 months have you experienced physical abuse/ physical assault from a patient?	45.45% (15)	54.55% (18)	0.00% (0)	0.00% (0)
How many times in the last 6 months have you experienced physical abuse/ physical assault from a patient's family?	90.91% (30)	9.09% (3)	0.00% (0)	0.00% (0)

As evident from the pie chart in Figure 2, when emergency RNs were asked whether they thought WPV was ‘part of the job,’ approximately half of the participants (51.52%, 17) said ‘no’ whereas the other portion of participants said ‘yes’ (48.48%, 16). If these responses are truly reflective and can be extrapolated to a larger group of nurses, almost half of nurses are accepting some type of violent incident, whether verbal or physical, on a fairly regular basis, such as monthly. Should care providers, such as nurses, assume that it is acceptable to expect violent incidences while caring for a patient? This needs further study and analysis with a larger sample to understand if this data is reliable.



*Figure 2.* 'Part of the Job' Pie Chart

Figure 3 illustrates the participants' responses to the question whether they believe WPV has increased, remained the same, or decreased in the last year. As evidence from the chart, 48.48% (16) of participants reported that violence increased over the last year. Whereas 3.03% (one) of participants reported that violence decreased over the last year. Interestingly, 48.48% (16) of participants' stated that WPV remains the same in this particular ED. One of the noticeable results indicated that many participants believe WPV is increasing within the ED, even though 66.67% (22) of participants reported feeling safe within the ED, rating the overall ED on safety from six to 10. This fact appears to be a paradox.



*Figure 3.* Emergency Center Nurses' Perceptions of Frequency of WPV over the Last Year

### Summary

Study findings are in agreement with the seriousness and frequency of WPV for ED RNs. As evidenced by the data above, many nurses 66.67% (22) of RNs that participated in this study felt that their ED was a safe place to work. Whereas, 48.48% (16) of participants felt that WPV had increased over the last year. It would be interesting to see how these same participants answer this survey again in the winter months, which are considered busier (higher census) for this particular ED. The data above also recognizes the participants' of this study's perceptions of WPV not being 'part of the job.' However, 48.48% (16) of participants believe WPV is considered 'part of the job.' It would be interesting to see the rationale for this belief that WPV is a 'part of the job' when caring for others in the ED.

## CHAPTER V

### DISCUSSION

This survey was amended from the original survey tool that was created by Stene et al. for their (2015) article *Workplace Violence in the Emergency Department: Giving Staff the tools and Support to Report*, which was amended from the ENA's (2008) Violence Toolkit. The fact that this study's survey is an amendment of the ENA's survey shows that WPV is an issue nationally. WPV is relevant and serious, therefore the 'root' of ED WPV must be understood so that it can be managed effectively. At the end of the "Emergency RNs' Perceptions of WPV" survey, the primary investigator asked questions for future scholarship such as asking participants what types of violence are they most prepared for? Also, there were four questions where the researcher investigated how soon the RN returned to the patient's room after a violent event. These results varied and could be more reliable with a larger sample. Therefore, in a healthcare environment where providing high quality patient care is the ultimate goal, ED RNs will need to be educated and have a clear understanding of methods and techniques for defusing violent or difficult patients before the situation escalates in order to provide the best possible care.

#### **Implication of Findings**

Responses provided insight to the microcosm of WPV in a Level I Trauma Emergency Center in South Carolina. Implications of these findings reverberate in the larger society where violence is a growing problem. Nevertheless, in the specialized area in emergency services, RNs deserve to be treated with respect and civility. When this is not the case, the situation must be investigated, resolved, and learned from. Some options

for dealing with this WPV issue that could be evaluated are increasing security personnel, monitoring the metal-detector, installing panic buttons, etc.

### **Application to Conceptual/Theoretical Framework**

This research study was a qualitative study that reviewed and analyzed how ED RNs perceive WPV. No intervention was applied to this study due to time constraints. Watson's Theory of Human Caring Model is applicable to this study (West et al., 2017). One theoretical assumption is that at RNs from a Level I Trauma ED are more task driven in their patient care rather than attempting to connect to the patient holistically. Another theoretical assumption is that once a patient and/or visitor becomes violent or aggressive toward the RN, the nurse will not attempt to engage more fully with the patient, but instead tends to avoid confrontation. In future studies, it would be interesting to implement the Theory of Human Caring Model as a tool to assess how RNs de-escalate a violent situation or even prevent a violent outcome.

### **Limitations**

Limitations of this study were definitely affected by the short response time-frame as well as reliance on nurses to find time during their work day to answer a survey on WPV. The time frame of this study was a two-week period during the middle of July 2018. One can assume that more than the typical number of nurses were on vacation or leave during this time. The summer is considered the slowest season of the ED schedule since there are not as many people with influenza or other infections related to people being confined to closer areas during the winter months. Also, the survey was voluntary, which means the investigator could not compel all possible participants to participate.

Furthermore, there was a question that could not allow for multiple answers when it was designed for such in the “Emergency RNs’ Perceptions of WPV” survey. This question was worded to assess how participants perceived and if they had ever experienced types of verbal and physical assaults. Some of the types of assaults listed include: bitten, slapped, cursed at, sexual harassment, etc. A few participants informed the primary investigator by electronic mail that they could not select multiple answers regarding if they experienced the action, would report the action to ED security, would report the action to law enforcement, or if they considered the action to be WPV. They had to make a choice of which one appeared to be most appropriate rather than being able to select all that applied in their own situation.

### **Implications for Nursing**

Understanding and dealing successfully with WPV for RNs in the ED is crucial to the caring profession and healthcare as a whole. Emergency RNs are on the front-lines of patient care; violence should not be expected nor tolerated. The solution should not be retroactive; the solution has to be to prevent violence from occurring in the first place. Also, quality patient care could be effected due to violent confrontations between patient and nurse. It would be ideal to promote a zero-tolerance policy in which patients would be held accountable for their actions. However, this is not the case in the Level I Trauma ED that as used for this study. Therefore, the solution is to prevent WPV from occurring so that the nurse can provide the most optimal level of patient care.

### **Recommendations**

Recommendations that could further the study of this topic would be to increase the sample participation within this study to several EDs nationally. Compelling 100%

respondent compliance would provide a more reliable sample due to the increase in size. A tactical change would include editing the survey on SurveyMonkey to allow the choosing of multiple answers on appropriate questions. A suggestion comment box could be added in the future for respondents to provide other questions or concerns in addition to inputs and ideas related to WPV in the ED. It would also be recommended to increase the time available to complete the study to increase the rate of response or complete in person interviews to gain a better understanding of the RNs' perceptions of WPV.

### **Conclusion**

Research findings from the "Emergency RNs' Perceptions of WPV" survey found that almost half of the ED RNs who participated have accepted WPV and tolerates it as 'part of the job.' The area of the ED causing the most angst for ED RNs is the overflow area for psychiatric and case management patients. It is logical that the unlocked geriatric-psychiatric (Women's Center) area generates the highest perception of violence towards nursing staff since instability and unpredictability are commonly expected with the patient population assigned to this area. Future research should investigate ways to prevent WPV and also the effects that WPV has on patient care.

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