A multidisciplinary evaluation of perceptions of workplace violence prevention in the Emergency Department: A qualitative research study.

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Abstract

A multidisciplinary evaluation of perceptions of workplace violence prevention in the Emergency Department: A qualitative research study.

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Aim – The primary aim of this study is to direct future research and guide interventions for the prevention of workplace violence [WPV] in the emergency department [ED] using a multidisciplinary approach and qualitative evidence of perceived facilitators and barriers of WPV.

Background – WPV is a global public health concern that has a significant detrimental impact in healthcare and nursing with physical, psychological, and organizational consequences.

Methods – Qualitative evaluation of 45 multidisciplinary semi-structured individual interviews from two urban hospital-based EDs. Data analysis was conducted applying the consensual qualitative research method.

Results – Four main themes were identified in the interview data that pertain to the perception of WPV prevention. These include work environment, exposure and health, prevention policies and practices, and work resources. These themes expound upon the perception that violence is unavoidable, and that informal training is unable to provide adequate protection. The cumulative effects of WPV and the perceived lack of managerial commitment to prevent the violence affects productivity and job satisfaction.

Conclusions – The work environment of the ED poses unique challenges to preventing WPV. The data suggest hospitals would benefit from increasing management education and commitment toward installing a WPV prevention program, focused on implementing interventions to change WPV prevention culture. Further research is recommended to identify management violence prevention practices and interventions focused on the ED setting.

Implications for Nursing Management – Results of this study strongly suggest that managements' commitment to resource, implement, and evaluate a WPV prevention program is a driving force in altering the culture surrounding WPV, leading to increased staff involvement, safety, reporting, and retention. The perception that management prioritizes safety, health, and well-being are a cultural force multiplier for preventive actions at the employee level. Furthermore, the investment in training managers and high-exposure staff improves outcomes and changes the culture of violence from 'part of the job' to one of 'prevention and safety'.

Key words: Workplace violence, nursing, qualitative research, emergency department, violence prevention

BACKGROUND

Workplace violence [WPV] against healthcare workers is a well-documented international public health concern and a persistent source of occupational stress with physical, psychological, and organizational consequences that many nurses accept as an unfortunate, but inevitable part of their profession (Phillips, 2016). This occupational hazard is defined as acts or threats of violence, ranging from verbal abuse to physical assault, directed toward persons at work or on duty (NIOSH, 2021). Most WPV events are non-fatal acts of physical aggression or verbal abuse, including sexual harassment and bullying, from a patient or visitor toward employees (Spector et al., 2014). Providing healthcare requires close contact to patients with substance abuse, mental illness, and anger, creating a volatile situation with increased risk of WPV (d'Ettorre et al., 2018; Pich et al., 2017; Schnapp et al., 2016). Research shows that one in five healthcare workers are assaulted during routine patient care, and in the US, injuries suffered by nursing assistants and registered nurses [RN] increased in 2018-19 by 250% and 290%, respectively (Li et al., 2020; US Bureau of Labor Statistics, 2020). Furthermore, these rates underestimate the effect of WPV, as they are subject to under-reporting, with 88% of victims filing no formal report (Arnetz et al., 2015).

The emergency department [ED] is known to have high rates of WPV, with 79% of ED nurses reporting a WPV event annually compared to 59% of nurses in other settings (Liu et al., 2019). Studies of ED residents show nearly all (97%) are verbally assaulted, and over half are physically harmed or sexually harassed annually (Schnapp et al., 2016). Patient registration had the least patient interaction, yet over 60% and 20% of these staff reported verbal abuse and physical assaults, respectively, during their employment (Gillespie et al., 2017).

WPV is a leading cause of job dissatisfaction among nurses and contributes to high rates of absenteeism and turnover (Liu et al., 2019). In the US, the annual turnover rate for nurses attributable to WPV is 15% to 36%, a preventable financial burden to the hospital (Copeland & Henry, 2018). When nurses choose to stay despite the WPV events, the emotional trauma is expressed as anxiety, burnout, depression, post-

traumatic stress symptoms, and decreased quality of patient care (Choi & Lee, 2017; Lanctôt & Guay, 2014).

While risk factors and exposures are well-researched, less attention has been focused on resources for violence prevention and safety (Timmins et al., 2022). Violence prevention culture, training, and management/team support have been identified as key resources for mitigating the harmful effects of stressors such as WPV (Bakker & Demerouti, 2017; Yu et al., 2019). Violence prevention culture refers to employee shared perceptions of organizational policies, practices, and prioritization by the hospital to prevent and address violence from all sources. Halbesleben (2006) found that managerial commitment and vocalized support for WPV prevention was protective against negative effects of WPV. Conversely, Cannavó et al. (2019) showed that a lack of managerial support became a barrier to formally reporting WPV, displaying the pivotal role management has in violence prevention culture.

The current study explores the ED work environment, exposure to WPV, impacts on staff wellbeing, and preventive resources. Specifically, the study was guided by the following questions: *What is the work environment for emergency department healthcare workers exposed to WPV? What are the effects of violence on ED staff health? What can hospitals do to prevent WPV?*

Methods:

The research team conducted an exploratory study on WPV prevention in the ED. Two urban acute-care hospitals, located in the Pacific Northwest, United States, volunteered to participate.

Participants and Procedures

The sampling frame (n = 45) was designed to include multiple perspectives on the topic of WPV prevention, spanning from management to frontline healthcare workers, within the ED (Table 1). Nearly

half of the participants were RNs at 48.9%. To provide confidentiality, data are reported as aggregated participant information.

Participants were recruited by email and flyers placed in common areas. Semi-structured interviews covering topics surrounding WPV were recorded in a private office during working hours, lasting 60-90 minutes and completed in 2019. Participants received a five-dollar gift card for their contribution. The Washington State Institutional Review Board approved research documents and procedures and the hospital system approved the research governance.

Analytic Strategies

A consensual qualitative research (CQR) committee approach guided all analysis steps (Hill et al., 1997, 2005). The de-identified interview recordings were transcribed by a transcription service. These transcriptions were coded by the research team using an open coding approach with qualitative software (NVivo 12 Pro, 2018). Throughout the analysis process, the team developed and maintained a codebook and journal to provide an analysis audit trail. During the analysis, researchers held discussions to gain consensus concerning inductive coding and thematic structure. Themes were summarized by the research team and verified to establish confirmability and enhance the trustworthiness of the thematic findings (Miles & Huberman, 1994).

Findings

To address the research questions, we present selected themes portraying the current state of WPV in the ED, from healthcare worker and management perspectives. Four main themes were identified: work environment, exposure and health, prevention policies and practices, and work resources.

1. Work environment refers to the environmental factors impacting WPV, and related stresses. This theme is supported by two sub-themes: community and hospital.

2. Exposure and health refers directly to how WPV event exposures impact the physical and psychosocial well-being of participants. This theme is supported by two sub-themes: violent events and effects of violence.
3. Prevention policies and practices refers to application of all WPV written policies within the institutions, WPV prevention practices, training, and reporting. This theme is supported by four sub-themes: prevention strategies, policy and regulations, training, and reporting practices.
4. Work resources refers to the structure, assets, and culture that support ED staff in completing work safely, maintaining high work performance, and sustaining personal wellbeing. This theme is supported by two sub-themes: violence prevention culture and team/management support.

Work Environment

Study participants often mentioned how the hospital and outside community organizations, such as the police and mental health services, influence WPV in the ED and the stress caused by it. Respondents agreed that the hospital's physical environment was perceived as a facilitator for WPV. Participants noted the crowded and loud ED conditions interfered with de-escalation attempts, especially with full ED rooms forcing psychiatric patient care and holding into the hallways. Staff described frequent co-worker turnover and absenteeism fueled by the exhaustion of frequent patient verbal assault. This left remaining staff feeling overwhelmed and trapped under threat of patient escalation to assault.

> *"…it's not if, it's when something is going to happen, and so you're always trying to be on guard." -Manager*

Some respondents expressed concern about how many psychiatric patients were brought to the ED by police for care. Participants noted an increased duration of stay, sometimes weeks, for patients requiring psychiatric evaluation and with that an increased violence risk to staff.

> *"*[psychiatric patients] *don't belong here for hours on end because that's when it becomes not safe"* -RN

Staff and managers described a lack of support from local community mental health resources as a failure of the system.

> *"What I see is a lot of patients getting left in the EDs for* [multiple] *days… leaving staff vulnerable ... I think it's an injustice to the patient* [and] *the staff."* -Charge Nurse [CN]

The perception of law-enforcement was varied, being helpful during some events or callous and disinterested in others. Staff conveyed that their concerns of verbal assault were not above the threshold of importance to the police officers.

Exposure and Health

When asked about the nature of WPV, the unpredictable behavior of patients was identified as the primary cause, especially those with substance abuse or behavioral health concerns. When these events occurred, the immediate reaction by staff was perceived as robust, with many staff coming to the area to assist as needed. The high variety of circumstances surrounding WPV events make the response difficult to rehearse, leading to disorganized takedowns and restraint application. Having muscle memory, earned through training or frequent use, was felt to be the only prevention in the immediate time of a violent event.

> *"I don't get paid to be abused… we are abused like no other place, no other workforce. We get tons of abuse and it needs to stop"* -RN

The stated types of WPV sustained in the name of patient care included: verbal assault, spitting, weaponizing urine or blood, shoving, biting, scratching, choking, punching, and kicking a pregnant person in the abdomen. The effects of verbal abuse in the ED were perceived as a constant and unavoidable reality.

"*I cried, and it wasn't because they were physically violent… they were just so dang mean."* -RN

Participants acknowledged that providing care or actively preventing elopement involved close contact with patients and high risk for WPV exposure.

"You just act, and not always with [your] safety in mind. It's safety of the patient" -CN

Physical and psychological damage from violence exposure was a common topic within the interviews and included effects such as inability to relax, insomnia, burnout, anxiety, and frustration mentioned across participants at both hospitals. The effects of witnessing WPV are not limited to the person that is assaulted. As one CN said "[it's] *very traumatic for the people watching."*

"A part of my soul has been sucked out because of this job… It's taken a lot of my compassion away." -RN

The frequency of WPV from the same patient is a compounding factor as mentioned by an RN, *"to see the same* [violent] *person* [frequently]. *Some people after a while, you just don't really have that much compassion anymore."* This loss of compassion or hardening is a known component of burnout syndrome.

Prevention Policies and Practices

A violence prevention program typically consists of policies, formal training, prevention strategies, and reporting practices, including data analysis of incidents with reports that inform future program improvements. When talking about mandatory WPV prevention policy, while many participants knew of a policy, almost none knew its contents or function. On the contrary, many participants stated that current restraint policies and rights of an employee to safety complicated the response to WPV events.

"I don't think we have any sort of specific violence policy." -Manager

"The general feeling among nurses is that the rights of everybody else supersede ours" -RN

Most participants agreed that current training for WPV prevention was non-functional, although after a significant event a renewed focus on this lack of training emerged.

> *"Historically there has been no safety training."* -Manager

> *"A lot of our people get kicked during* [restraint application]*, we get zero training"* -CN

The EDs response to violence was reported as reactionary and reliant on coaching, rather than prevention. A preceptor assigned to new employees facilitated informal training during the workday, leading to inconsistency rather than standardized training practices. Many skills are expected to be learned through experiencing WPV and reacting to it.

> *"Only through experience, I've learned what not to do and what to do and I try and pass that along to some of our newer staff."* -RN

All participants agreed that there is a need for formal hands-on training for de-escalation and safe response techniques.

> *"*[during patient restraint]*, there is a potential for harm here for the patient and for us. We need to do this every time… do it well. And… practice it."* -RN

Regarding WPV prevention strategies there was a significant divergence between management and staff participants. Managers prioritized personal responsibility for situational awareness, while non-managers recognized the importance of situational awareness learned with experience. Staff described skilled de-escalation and standardized communication of historic patient risk factors as highly valuable preventive strategies. However, some staff remarks indicated that there was no solution for WPV, that it was a part of the job, a mindset that may act as a barrier to situational awareness and culture change.

> *"It is part of the job. I look at it as that's kind of my role, to manage this. And nobody wants to manage it every time with restraining and isolating them, but in reality, it is what it is."* -CN

"You're never going to make the ED 100% safe. You're dealing with the public in a volatile situation." -CN

WPV incident reporting elicited strong agreement that many events are never reported in a surveillance platform, although they will often be reported verbally to a CN or written in the nurses' note. There was inconsistency among participants on what is considered a formal report, between the patient chart, security log, reporting computer system, police report, or a combination of the above. Unanimously, participants stated there is no reporting of any kind for non-physical WPV within the ED.

"[Verbal threats] *don't get reported… We've had people that were more destructive with their mouths than any physical attack."* -ED Tech

Despite the reporting requirement, the complicated process and lack of enforcement from management make this a low priority for ED staff's time.

"[Filing a report is] *supposed to be mandatory but nobody makes people do it."* -RN

Work resources

The perception of violence prevention culture among both hospitals' staff and management respondents included a sense of complacency, unclear definition for violence, lack of empathy for psychiatric patients, improper de-escalation techniques that increased hostility, and early use of restraints. Participants stated that some of this was due to lack of training in prevention or lack of confidence in "talking down" a volatile patient.

"A lot of staff think that if you show enough force, and you sound mean enough, they're not going to [be violent]*... But sometimes all you're doing is baiting them."* -RN

There were some divergent responses on management's role in a recent change process to create a WPV prevention culture. Respondents acknowledged a new "zero tolerance" policy on WPV and encouragement to formally report WPV assaults to the police.

> *"And it's changed now. It's like, of course, you would turn in a report, you were assaulted."* -RN

These steps to improve WPV prevention culture led to culture-clash interactions with the community and other services. As one RN stated, it had been frustrating that there was not a clear message of expectations "*from the leadership down… [of] how things are done."* being broadcast to the public including the police and ambulance services, who were perceived as barriers to safety, for example, being casual about preventing weapons from entering the building.

> *"*[after a patient arrived with a gun] *the* [ambulance] *crew…were like 'Well, if he wanted to bring it, he didn't feel like it was going to be a problem.'"* -RN

The participants were generally in agreement that their high team support was of great value and contributed to team identity and unity around patient escalation and violence.

> *"*[we aren't] *supportive in every aspect of the job, but for workplace violence it doesn't matter if you get along with that person or not, we're going to help each other out."* -RN

When speaking about the chronic effects of WPV, manager participants mentioned their commitment to culture change and emotional support to staff venting their frustrations. This was supported as an emerging WPV prevention culture shift from a WPV prevention champion working at the hospital system level with executives and a risk manager to survey ED staff and evaluate WPV event data. Still, there were contrasting negative statements about this support with one CN stating "*the co-workers are really your support system. It's not administration at all.",* that reflected a culture in transition.

Violence prevention culture includes formal debriefing, a practice for learning and problem solving. Participants agreed this was reserved only for the most severe incidents (shootings, major injury). Most participants were unaware of the benefits of Critical Incident Stress Debriefing, instead relying on brief check-ins by senior staff or peers. Friendly referrals to hospital assistance programs made during these informal coaching sessions were rarely acted on.

> *"It is just so difficult to get a group of people together after an incident like that if we're busy"* -CN

> *"I guess, yeah, informally we go out to breakfast sometimes and I guess that would be our informal debriefing, yeah.* [If] *it was a rough night, we go out to breakfast."* -CN

In our analysis, we found strong emotional support at the team level and management taking the first steps toward strengthening violence prevention culture. However, as one manager acknowledged there was increasing violence and much further to go, *"We just don't know what to do really."*

Discussion

Our study explored the ED work environment, exposure to WPV, impacts on staff wellbeing, and preventive resources. Our contribution lies in a systems approach and multi-disciplinary findings from staff and manager perspectives at two hospital EDs at a point of change in efforts to prevent violence. Additionally, we provide direction for practice and future research.

The first theme regarding work environment in EDs aligned with prior research descriptions of chaotic stressful environments, patient volatility, especially those with substance abuse or behavioral health concerns, and increasing staff WPV exposure with recent management focus on prevention strategies (Gacki-Smith et al., 2009; Liu et al., 2019). This theme highlights individual and organizational consequences of violence and corroborates prior research on physical and psychological harm from direct experience or witnessing violence (Liu et al., 2019). Awareness among managers of the costs to staff or the organization varied greatly and points to an urgent need for management, as called for in research, to take due responsibility to protect staff and patients from harm (Cannavò et al., 2019).

The theme, prevention policies and practices, showed insufficient manager and staff knowledge of policy, lack of training, under-reporting WPV events, and failure to monitor data on physical and nonphysical violence exposure. Research has documented the importance of policy, where physical assault decreased with a zero tolerance policy and policies addressing prohibited violent behaviors (Nachreiner et al., 2005). The data revealed reporting practices were weakened by unacknowledged suffering from WPV and time constraints, thereby lost to formal reporting mechanisms for WPV. Moreover, a high tolerance for violence may increase barriers for acting at multiple target points.

The study clearly shows a need for increased training on WPV prevention to protect staff and patients. In-person hands-on multidisciplinary training in prevention and response to violence scaled to the ED is supported in research (Gillespie et al., 2012). Management statements of not knowing what to do or how to prevent WPV present an opportunity for education in the creation and supervision of a WPV prevention program. Increased targeted training would be recommended for WPV prevention culture change.

Work resources is a theme with strong agreement on the abundance of support during the immediate danger phase of a WPV event. The perception of management prioritizing a safe workplace was reported as lacking, through unenforced policies, lack of feedback, and minimal actions to decrease risks. A large US study found that WPV prevention is dependent on commitment from hospital administrators and ED managers (Gacki-Smith et al., 2009). Addressing the perception that management doesn't prioritize the safety of their employees is critical to altering the WPV prevention culture.

Practical Implications

The creation of a WPV prevention program is recommended for altering the WPV prevention culture. Management has a key role in developing and implementing a violence prevention committee. The committee of staff and management can implement violence prevention, response, and monitoring policies. Furthermore, the committee can be an outlet for data, updates, and open communication top-

down and horizontally (Arnetz et al., 2015). This committee can also be empowered to oversee annual training, clarify roles in WPV response, and plan scaled response training events (Gillespie et al., 2012).

The costs of WPV are not just limited to the nearly $100,000 worker's compensation claims for each injury (Speroni et al., 2014). The costs are also found in burnout and decreased staff productivity. As seen in the interviews, loss of compassion negatively impacts reactions during stressful situations and significantly increases staff turnover, per the NSI survey (2022) averaging three months and $46,000 per nurse to recruit. Manager commitment to prioritize WPV prevention is not just one of staff and patient safety, but for organizational reputational and financial health as well.

Strengths, Limitations, and Future Research

The strengths of qualitative research methods employed for the current study include discovery in new or understudied areas of research. We applied a systems approach to understanding WPV incidents in the current work conditions for ED staff with multidisciplinary and organization cross-level interview data. Qualitative research sets a foundation for further hypothesis testing and corroboration of qualitative findings in future quantitative survey research in ED settings. Future quantitative research with a larger, representative sample should build on the current research findings.

Sample size adequacy and thematic saturation are often concerns as they are with the current study. We conducted interviews as a formative research phase. Because WPV is a difficult topic and ED work is demanding, we may have missed staff and managers who experienced burnout and lacked the energy to participate. Finally, due to the sensitivity of the topic, some healthcare workers may have been reluctant to participate, fearing hospital retaliation. We also acknowledge the possibility that some participants may have been the most dedicated and engaged employees or the most dissatisfied.

Participants who contributed to this research had much to say on the topic of WPV. The interview findings underscore the need for continued research on solutions that guide violence prevention culture and improved adherence to preventive policies in the ED setting. Future research topics should also

include examination of management team violence prevention practices and organizational barriers such as resource constraints, competing priorities for management, and manager burnout in overburdened healthcare systems. Additionally, evidence-based ED-targeted preventive interventions such as patient agitation management that will protect staff and patient safety are a focus for future research.

Conclusion

The findings of this study suggest that interventions for ED WPV should address management education and commitment to providing resources for WPV prevention. These resources include funding a violence prevention program with the necessary evidence-based intervention components for staff to work safely with agitated patients.

We hope our study from a systems perspective, and novel insights of hospital EDs transitioning to a WPV prevention program, will stimulate ED leaders to work with interdisciplinary hospital managers to evaluate current WPV concerns in their EDs. We hope they are inspired to overcome the many challenges and take steps to implement ED-targeted interventions with the participation and support of their ED teams. And finally, we hope leaders commit to and sustain the strengthened violence prevention culture created in this endeavor.

Implications for Nursing Management

Results of this study strongly suggest that management commitment to resource, implement, and evaluate a WPV prevention program is a driving force in altering the culture surrounding WPV, leading to increased staff involvement, safety, reporting, and retention. The perception that management prioritizes safety, health, and well-being are a cultural force multiplier for preventive actions at the employee level. Furthermore, the investment in training managers and high-exposure staff improves outcomes and changes the culture of violence from ‘part of the job’ to one of ‘prevention and safety’.

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