ABSTRACT

Workplace violence is increasing across the nation’s Emergency Departments (EDs) and nurses often perceive it as part of their job. Through a quality-improvement project, reporting processes were found to be inconsistent and nurses often did not know what acts constitute violence. As a result, nurses were under-reporting violence in the ED, and as a direct result resources were not recognized or provided. A staff nurse-led workgroup developed an initial survey to assess the perception and occurrence of violence within the ED in nurses and patient care assistants. This workgroup evaluated the survey responses and identified a need for the development of a brief, concise reporting tool and an educational program. A reporting tool was created and education was provided in multiple venues and modalities. A follow-up process and support were given from nursing leadership. A posteducation survey was completed by nurses and patient care assistants to assess their comprehension of acts of workplace violence, and found their perception that workplace violence was part of their job was reduced by half, along with increased knowledge about acts constituting workplace violence, and what is reportable to law enforcement. As a result of the education, the reporting of the violent acts has increased, and staff perceive the ED to be a safer environment. With the appropriate education, reporting tool, and leadership support, ED nurses can create a culture with a zero-tolerance policy for violence within the department, creating a safer environment for staff and patients.

INTRODUCTION

Workplace violence (WPV) is defined as any act or threat of physical violence, harassment, intimidation, or other disruptive behavior that occurs at the work site and may cause physical or emotional harm.\textsuperscript{1,2} Health care professionals are among the workers at highest risk for WPV.\textsuperscript{1,2} According to a 2007 report of the US Bureau of Labor Statistics, WPV occurs more often in health care and social assistance industries than in any other workforce sector, accounting for 60% of all nonfatal assaults.\textsuperscript{1,3} Such events are routinely underreported to health care supervisors and administration because the perception among health care workers is that violence is the norm (ie, an expected part of the job) and because workers fear the response they may receive when reporting these events.\textsuperscript{4-5}

A 2004 study that included 6300 Minnesota registered nurses (RNs) and licensed practical nurses, from a variety of practice settings, identified the rate of physical or nonphysical attacks against nursing staff as 52 per 100 persons per year.\textsuperscript{1} In this study, patients represented the most common source of the violent attacks. The effect of violent behavior and the forms of WPV are substantial in negatively affecting staff morale and compromising health care delivery and efficiency.\textsuperscript{6-8} Nursing staff most often reported WPV-induced anger, frustration, fear, stress, and irritability, with 13% of staff reporting long-term difficulty with these symptoms following an event.\textsuperscript{4} Other long-term problems identified include chronic pain, disability, and flashbacks.\textsuperscript{4}

The Emergency Nurses Association (ENA) recently presented a position statement that identifies WPV as a serious occupational hazard for emergency nurses. Health care organizations have a responsibility to provide a safe environment for employees, as well as for the public.\textsuperscript{1} According to the ENA and the Occupational Safety and Health Administration, WPV can be prevented, or the risk at least minimized, when employers take the necessary precautions. They advocate an interdisciplinary approach to WPV prevention and implementation of a zero-tolerance policy to help achieve the goal of resolving WPV.\textsuperscript{1,2} This effort is aided by the implementation of safety training specific to the emergency setting, expected reporting of violent behavior through an established reporting process, a culture change that supports reporting incidents and, when applicable, reporting to law enforcement without reprisal.\textsuperscript{1} Key to the success of the process is the establishment of a clearly understood and facile system for reporting violent incidents.\textsuperscript{1}

Local Problem and Intended Improvement

Emergency Departments (EDs) are a high-risk area for WPV from patients and visitors directed toward staff members. Factors aiding in this are 24-hour accessibility, a high-stress environment, and lack of visible or trained security staff.\textsuperscript{7} Patients and associated family members or visitors are the most common instigators of violence, for reasons including pain, stress, lack of privacy, and...
long wait times. With fear, anxiety, substance abuse, or mental illness, a volatile environment can be created within the ED.

In this 64-bed level 1 trauma center, there are approximately 72,000 patient visits annually. Of the approximately 150 nurses on staff, no one was reporting the violent events occurring. Before the implementation of this quality-improvement (QI) project in 2012, zero staff incident reports had been filed using the current process. According to the initial survey results, ED staff did not understand what acts constitute WPV or how to report the events, and reported feeling a lack of support from nursing leadership to report the events that did occur.

The project sought answers to these primary questions: do staff perceive violence as part of the job within the ED, and are staff aware of what acts constitute WPV? Other goals were to increase staff awareness of WPV and to develop a simplified process for reporting and evaluating these events within a supportive and nonjudgmental culture of safety with zero tolerance for violence. The project has the intent of improving personal safety and job satisfaction. This effort aligns with initiatives of the ENA and the Occupational Safety and Health Administration. The project also supports the medical center’s commitment to safety, which is considered integral to achieving the inherent goal of medical professionals: to provide safe, quality patient care.

DATA ANALYSIS METHODS

This project was a QI activity, was monitored closely by clinically responsible professionals, and abided by the Health Insurance Portability and Accountability Act and other constraints to protect staff privacy. As a QI project in ordinary operations, this initiative was not classified as research on human participants and did not need institutional review board approval.

This QI project was initiated in the ED at a large academic, level 1 trauma center in the upper Midwest. In spring 2012 a work group comprised of staff nurses and a nurse manager was formed to evaluate the current state of awareness and perception of WPV. This work group used the Emergency Department Assessment Tool provided by the ENA to evaluate the structural and functional status of the ED as it relates to safety and security.

The Survey

A staff survey was then developed on the basis of the ENA’s Emergency Department Violence Surveillance Study. The intent of the survey was to gather data regarding the nursing staff’s exposure to and perception of WPV. The 19-question online survey sought to assess the perceptions of RNs and patient care assistants (PCAs) regarding safety and violence in the workplace, exposure to violence, perceptions of preparedness in the event of violence, and knowledge of when and how to report violent events.

The survey contained questions regarding the amount of verbal and physical abuse staff experience in the ED. It listed examples of physical and verbal violence, asking staff to indicate which examples they believed constituted WPV, whether they personally had experienced the examples described, and whether they would report it to hospital security or law enforcement personnel. The staff were asked whether they thought WPV from patients or visitors was simply “part of the job” in the ED and how they perceived the amount of violence in the ED over the previous year. The staff also were asked whether they had been instructed to report physical or verbal abuse regardless of severity and whether they knew what acts of WPV directed toward health care providers could be prosecuted.

The survey was sent electronically in spring 2012, using the program SurveyMonkey (Palo Alto, CA), to the RNs and PCAs working within the ED before the introduction of interventions related to WPV. Participation was voluntary and was solicited through e-mail announcements before and during the open survey time. The same survey was sent to all RN and PCA staff approximately one year later to evaluate postintervention changes.

The Educational Program

When the initial survey results were compiled, the project team created an educational program for the staff, which was delivered approximately two months later. This education included a review of the initial data captured by the survey, factual representation of what acts constitute WPV, a review of the reporting tool created, and information on how to report violent incidents. The educational program for WPV was presented by the project team members through lecture and PowerPoint (Microsoft, Redmond, WA) presentation at the departmental practice committee meeting and the departmental professional development days. All staff were encouraged to attend these meetings. Staff were paid for their time;
Table 1. Percentage of staff reporting verbal and physical abuse

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Initial survey, %</th>
<th>Follow-up survey, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 times</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>1-10 times</td>
<td>70</td>
<td>79</td>
</tr>
<tr>
<td>&gt;10 times</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Physical abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 times</td>
<td>75</td>
<td>85</td>
</tr>
<tr>
<td>1-10 times</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>&gt;10 times</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2. Respondent answers to the question: “Is WPV part of the job in the Emergency Department?”

<table>
<thead>
<tr>
<th>Response</th>
<th>Initial survey, % (n = 154)</th>
<th>Follow-up survey, % (n = 203)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>55.8</td>
<td>24.2</td>
</tr>
<tr>
<td>No</td>
<td>44.2</td>
<td>75.8</td>
</tr>
</tbody>
</table>

WPV = workplace violence.

The tool identifies the patient name, medical record number, date the incident occurred, and a brief description of the incident, taking approximately 1 to 2 minutes to complete. This mechanism of reporting would permit the staff to complete the report in a timely manner, minimizing disruption to workflow and patient care. For ease of locating what acts constitute WPV and educational reinforcement, specific WPV actions were listed on the back of the reporting form. The form was placed at the charge nurse desk and in the behavioral health area of the ED. The tool was printed on brightly colored paper for ease of identifying the correct form.

However, the meetings were not mandatory. The education was also communicated through personal staff interactions by the project team and via e-mail, which is considered the standard within the institution for distribution of educational material. To facilitate ongoing competency, a question related to WPV was added to the yearly mandated competency examination of the emergency nurses. At the end of the educational program, the expectation of all staff to complete the reporting tool with each event was clearly communicated.

The Reporting Tool

In an attempt to successfully capture violent events, the WPV project team identified the current reporting process as a barrier: staff are required to navigate through a cumbersome online reporting process, which often requires 15 to 20 minutes to complete. Therefore, during the creation of the informal reporting tool, the WPV project team knew that the tool must be concise, easy to use, and easy to find, in contrast to the current staff incident reporting process. This tool was not intended to replace the current process, which remains the formal reporting process for the institution. The tool provides staff a simplified way to report events in real time, aiding staff and nursing leadership in completing the formal report at a later time, outside of the acute crisis period.

The tool identifies the patient name, medical record number, date the incident occurred, and a brief description of the incident, taking approximately 1 to 2 minutes to complete. This mechanism of reporting would permit the staff to complete the report in a timely fashion, creating the least amount of disruption to workflow and patient care. For ease of locating what acts constitute WPV and educational reinforcement, specific WPV actions were listed on the back of the reporting form. The form was placed at the charge nurse desk and in the behavioral health area of the ED. The tool was printed on brightly colored paper for ease of identifying the correct form.

RESULTS

The initial survey was sent to the entire 154-member nursing care team and was completed by 108 RNs and 6 PCAs, resulting in a 74% response rate. A follow-up survey was sent to 203 nursing staff approximately one year later. Of note, staff size increased by 49 members between the initial and follow-up surveys. The follow-up survey was completed by 112 RNs and 8 PCAs, resulting in a 59% response rate. Table 1 represents a comparison between the initial and follow-up survey results, denoting the percentage of staff who experienced verbal and physical abuse within the preceding month of survey distribution.

On the initial survey, more than half the staff perceived WPV to be part of the job; on the follow-up survey, the number of staff perceiving violence as part of their job was reduced by more than half, as indicated in Table 2. Initial and follow-up staff comments regarding why they feel WPV is part of the job within the ED are included in the Sidebar: Responses to the Question: “Is WPV Part of the Job in the Emergency Department?”

Staff response on how they perceived the amount of violence in the ED during the preceding year is reflected in Figure 1. Although in the follow-up survey fewer staff felt violence had increased, more staff felt violence had remained the same. A small portion of the staff felt violence had decreased in the follow-up survey.

In the initial survey, for the 16 examples of physical violence, approximately 91% of staff respondents indicated that they considered the examples to be WPV. The follow-up survey showed the same results. In the initial survey, for the 8 examples of verbal violence, approximately 75% of staff indicated they considered those examples to be WPV. In a follow-up survey, those results were essentially unchanged. The staff were asked if they had formally reported WPV when they experienced it. Figure 2 depicts an increase in the formal reporting process after intervention.

Examples of physical violence given to the staff in the survey included biting, hair pulling, getting hit/punched/slapped, being hit by a thrown object, and being kicked, pinched, pushed/shoved, scratched, sexually assaulted, shot/shot at, spit on/at, stabbed, and voided on/at by any patient, whether sober, intoxicated by drugs or alcohol, or mentally ill. Examples of verbal violence included in the survey were being harassed with sexual language/innuendo, sworn/cursed at, threatened with physical harm, verbally intimidated, yelled/shouted at, and called names by any patient, whether sober, intoxicated by drugs or alcohol, or mentally ill.

In the initial survey when staff were asked whether they had been instructed to report physical or verbal abuse regardless of severity, 40% of respondents reported “yes,” 47% reported “no,” and 13% reported “sometimes.” On the follow-up survey, 76% reported “yes,” 15% reported “no,” and 9% reported “sometimes.” The responses for why staff did not report WPV in the initial survey are shown in the Sidebar: Initial Survey Responses to the Question: “Why do ED Staff Members Not Report Workplace Violence?” There continued to be a small percentage after intervention who chose not to report WPV.
Workplace Violence in the Emergency Department: Giving Staff the Tools and Support to Report

Survey responses included: “fear,” “too much work,” “nothing ever happens,” “they should be used to it,” “it is an ED area—anything can happen.” These results demonstrate the need for further education.

When staff were asked whether they knew what acts of WPV directed toward health care providers could be prosecuted, on the initial survey, 65% of the staff reported “yes” and 35% reported “no.” On the follow-up survey, 78% of the staff reported “yes” and 22% reported “no.”

**DISCUSSION**

Globally, as noted in the research literature, and locally, as shown by the internal survey completed by the emergency nurses and PCAs, violence is an ongoing problem within the ED. More than half of the staff working in our ED perceives WPV to be part of their job. Of these staff members, 75% were verbally assaulted in the month before the survey, and 25% acknowledged some form of physical abuse during this same time. Knowledge gaps were addressed, as 40% of the ED staff did not know what acts constituted WPV, and more than 67% admitted they had not reported previous acts of violence that occurred within the ED. In the follow-up survey results, more than 77% of the staff knew which acts were considered WPV, and more important, the number of staff who considered those same acts to be part of their job was cut in half. This change in perception is considered the greatest success of this project.

The endorsement from ED leadership to report WPV incidents, both internally via the WPV reporting tool as well as to law enforcement, was a crucial step in the process. A challenging aspect during project implementation was found to be staff concern regarding staff and patient confidentiality when reporting to law enforcement and the legal process. Support from ED leadership and education was found to be the most helpful in alleviating these concerns. The ED leadership team receives all WPV incident reports and follows up individually with each employee involved in WPV to ensure his or her well-being, provide support to the person reporting in an effort to change unit culture, and establish a follow-through with the institutional reporting process when applicable. Each staff member who reports a WPV incident receives leadership support, and therefore the behavior of continued reporting is reinforced.

After the reporting tool was created and implemented, and ED leadership began following through with each incident report, the ED staff perceived a decrease of violence within the ED during the year between the initial survey and follow-up survey. After the ED staff were given the education, support, and tool to report these incidences, the ED staff began reporting those violent incidents that occurred within the ED. Before the implementation of this project, no staff incident reports related to WPV were filed in 2012, even though staff indicated on the initial survey that WPV was present. The number of WPV reports filed after project implementation was promising as more than 50 reports were filed in 2013.

Three of the reports filed to law enforcement by nursing staff were published in local news sources, including the local newspaper and local television news channel. These articles highlighted the charges filed, ranging from misdemeanor assault charges to felonies, and the circumstances of the charges. Slapping, kicking, spitting at, biting, and verbally threatening to kill a nurse and his children were examples
shared in the news reports. Although once identified as a barrier to reporting, the publication of these violent events was accepted with positive reactions from staff in the hopes of increasing awareness to the public that violence in the ED would not be tolerated.

The emergency nurses and PCAs collectively acknowledged violence was not to be tolerated in the ED and violence was no longer part of their job. Assessing knowledge gaps, providing education, creating a brief reporting tool, and acquiring the support of the ED leadership were imperative to move this sensitive issue into the forefront for the safety of staff and patients alike.

Limitations
This project does have notable limitations. The initial survey was sent to all staff working in the ED. The follow-up survey was also sent to all staff members working in the ED approximately one year later. Whether the staff had participated in the initial survey as well was not assessed; neither were staff turnover rates because they were not considered a deterrent in participating in the follow-up survey. The educational program was not ongoing; therefore, the 49 new staff members hired within that year may not have had the same level of education-awareness as those who participated in the initial survey.

The project was performed at only one location, which limited the sample size and possibly narrowed the viewpoints that could have been addressed if studying multiple EDs. The data were collected through a convenience sample of ED staff, and participation was elective. The return rates for the survey were encouraging, nearing 70%; however, the sample size continued to be relatively small at 114 and 120 responses to the pre- and post-surveys. These limitations may have hindered the project, we acknowledge, and the results may not be generalizable to other EDs nationally.

CONCLUSION
Violence in the ED has been traditionally tolerated as part of the job. When given the tools and support to report these violent incidents, staff realized a decreased tolerance for the violence. By means of assessment of the current state, thorough education, and a concise reporting tool, the project team has empowered their peers to identify the issues and patterns within the patient population and to commit to an environment structured around zero tolerance and holding patients accountable for their behavior. With these tools in place, the reporting of violent incidents increased, with some incidents leading to criminal prosecution as supported by Minnesota statute 609.2231. This statute indicates that persons who inflict bodily harm on a health care provider within a hospital ED are guilty of a felony and could be imprisoned or made to pay a substantial fine, or both. The accumulation of these events is leading toward a zero-tolerance culture for WPV within the ED. Violence within our ED is no longer tolerated as part of the job.

Initial Survey Responses to the Question: “Why Do ED Staff Members Not Report Workplace Violence?”

- Feel nothing happens
- Too much work, part of the job, people are afraid
- Part of the job, nobody cares
- We think it’s part of the job, intimidated to do so
- We fear retaliation, feel it’s part of the job
- Takes too much time, too busy, happens too much
- I didn’t know we were supposed to until recently
- Not sure of how to do it
- Fear of not being supported by leadership
- You slowly get used to dealing with it
- Daily occurrence; the sheer number of reports would keep us from patient care
- Management does not care, and security does not encourage the reporting

ED = Emergency Department

References

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