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Violence Against Nurses Working in US Emergency Departments

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Objective: The objective of this study was to investigate emergency nurses' experiences and perceptions of violence from patients and visitors in US emergency departments (EDs).
Background: The ED is a particularly vulnerable setting for workplace violence, and because of a lack of standardized measurement and reporting mechanisms for violence in healthcare settings, data are scarce.
Methods: Registered nurse members (n = 3,465) of the Emergency Nurses Association participated in this cross-sectional study by completing a 69-item survey.
Results: Approximately 25% of respondents reported experiencing physical violence more than 20 times in the past 3 years, and almost 20% reported experiencing verbal abuse more than 200 times during the same period. Respondents who experienced frequent physical violence and/or frequent verbal abuse indicated fear of retaliation and lack of support from hospital administration and ED management as barriers to reporting workplace violence.
Conclusion: Violence against ED nurses is highly prevalent. Precipitating factors to violent incidents identified by respondents is consistent with the research literature; however, there is considerable potential to mitigate these factors. Commitment from hospital administrators, ED managers, and hospital security is necessary to facilitate improvement and ensure a safer workplace for ED nurses.

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Workplace violence is a serious occupational risk for the domestic and global workforce,[1,2] accounting for approximately 900 deaths and 1.7 million nonfatal assaults each year in the United States.[3] In 2007, 15% of all work-related fatalities in the United States were due to assaults and violent acts.[4] Workplace violence may be even more common than these statistics indicate because a lack of a uniform definition of workplace violence,[5,6] incident underreporting,[6-9] and absence of mandated regulations for workplace violence prevention[5,9-15] make it difficult to assess the prevalence of workplace violence.[6] The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as an act of aggression directed toward persons at work or on duty, ranging from offensive or threatening language to homicide.[16] Workplace violence is generally defined as any physical assault, emotional or verbal abuse, or threatening, harassing, or coercive behavior in the work setting that causes physical or emotional harm.[5,14,16-19] In recent years, workplace violence has been recognized as a violent crime that requires targeted responses from employers, law enforcement, and the community.[19]

Barriers to Addressing Violence in the Healthcare Setting

Violent incidents in the workplace are often not reported to law enforcement authorities or employers.[3,7-9] Particularly in the healthcare industry, incidents may be underreported because of the absence of institutional reporting policies, the perception that assaults are part of the job, employee

beliefs that reporting will not benefit them, and employee concerns that assaults may be viewed as evidence of poor job performance or worker negligence.[6-9] In a study of nurses in the emergency department (ED), intensive care unit, and general units of a regional medical center, about 50% of the respondents indicated that verbal and physical assaults by patients and family members against nurses were never reported in writing.[8] Many nurses believed that such incidents were part of the job and reporting them would not be helpful. In addition, many felt that empathy for the anger expressed by the patient or family member and lack of evidence of personal physical injury were reasons for not reporting violent incidents.[8]

The Occupational Safety and Health Administration's[9] (OSHA's) *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* includes policy recommendations and practical methods to help prevent and reduce workplace violence. Because the guidelines are voluntary, some healthcare institutions may not have violence prevention programs in place or those that do may not have effective programs. To address the need for consistent and quality programs, nursing and other healthcare professional organizations and unions have asked for federal regulations that require healthcare institutions to provide improved environmental safety.[5,10,12,13,15]

Violence in the ED

In the hospital, violence occurs most frequently in psychiatric wards, EDs, waiting rooms, and geriatric units.[16] Studies have found that 35% to 80% of hospital staff have been physically assaulted at least once during their careers.[20] The high vulnerability to workplace violence in the hospital may be due, in part, to low staffing levels; lack of staff training in recognizing and defusing potentially dangerous patients; lack of violence prevention programs; inadequate security; the perception by criminals that hospitals, clinics, and pharmacies are sources of drugs and money; and possession of weapons by violent hospital patients and visitors.[5,9,12]

The 24-hour accessibility of EDs; the lack of adequately trained, armed, or visible security guards; and a highly stressful environment are some of the reasons why EDs are especially vulnerable to violence.[21-23] The overwhelming majority of perpetrators of ED violence are patients and their family members and visitors.[5,14-17] Patient pain and discomfort, as well as the tension, stress, and anger of patients, family members, and visitors, are often escalated by cramped space, lack of privacy, and long waiting times.[5,8,19,23] The resulting frustration and vulnerability may incite physical and verbal abuse against ED staff.[16,19,22] In addition, verbal abuse and physical assault in the ED can come from disruptive, intoxicated patients who are sometimes accompanied by other intoxicated or disruptive individuals.[7,21]

Violence Against Nurses

Nursing has received increasing attention as an occupation at high risk for violent attacks.[2,5,7,9-11,19,22-26] The National Crime Victimization Survey (1993-1999) found that the average annual rate for nonfatal violent crime was 21.9 per 1,000 workers for nurses, compared with only 12.6 per 1,000 workers for all occupations.[3] According to the Bureau of Labor Statistics,[27] in 2004, 46% of nonfatal assaults and violent acts against healthcare practitioners that involved days off work were committed against registered nurses (RNs). Nursing staff are primary targets of violence in the ED.[15,17] In one study, 82% of emergency nurses indicated that they had been physically assaulted at work during the preceding year.[8] The incidence of verbal abuse is increasing as well, and such abuse affects 100% of emergency nurses in some facilities.[6,8,26]

The American Nurses Association found that less than 20% of nurses surveyed in 2001 felt safe in their current work environment.[28] Research has consistently found that nurses are concerned about violence and aggression, inadequate safety measures, and personal vulnerability in the workplace.[7,8,13,26,29] Many nurses simply do not feel safe at work.[8,26,28] A perceived lack of institutional support is a key factor in the dissatisfaction that nurses feel.[8,13] This sense of administrative abandonment may result from inadequate staffing levels, unfulfilled promises to improve environmental safety, ignored concerns, insufficient education and training, and lack of support from peers, physicians, and administrators in the aftermath of an incident.[13] Fair and consistent procedures and a culture of support, not punishment, for victims are critical.[6,19,30]

The Need for Institutional Initiatives

As assaults in the ED continue to be a serious problem, interventions and preventive measures are urgently needed.[2,5,9,12,31] A significant amount of workplace aggression is preventable.[18] Lack of a violence prevention program, for example, is associated with an increased assault risk in hospitals.[5,9] A strong, comprehensive violence prevention program requires an interdisciplinary team approach with clear goals and objectives suitable for the size and complexity of the workplace.[9,10,12,16,19] The OSHA recommends a violence prevention program

that includes management commitment and employee involvement, worksite analysis of existing or potential hazards for workplace violence, measures for violence hazard prevention and control, safety and health training for staff, and record keeping and program evaluation to determine program effectiveness.[5,9,12] The NIOSH also delineates prevention strategies for reducing exposure to violence risk factors in hospitals, including environmental designs to provide a safe workplace, administrative controls to ensure safe staffing patterns and adequate security measures, and training workers to recognize and manage potential assaults.[16]

Study Objective

Because of the lack of standardized measurement and reporting mechanisms for workplace violence in the healthcare industry,[15] data are scarce, necessitating the need for research that explores violence against emergency nurses.[6-8,14,15,17,19,21,22,26,29,32] The Emergency Nurses Association (ENA) was charged by its membership to address violence against ED nurses through advocacy and research. In response, this study was conducted to investigate emergency nurses' experiences and perceptions of ED violence, the types and frequencies of assaults in the ED, and contributing factors to ED violence (See Presentation, Supplemental Digital Content 1, which presents an overview of the study, http://links.lww.com/A1415). To view a PowerPoint presentation given at the ENA 2008 Annual Conference, go to http://www.ena.org/conferences/annual/2008/handouts/339-C.pdf.

Methods

This cross-sectional study was conducted by ENA, a nonprofit association of approximately 31,905 US members at the time the study was conducted. A survey about workplace violence was developed by an ENA work team, evaluated by experts for content validity, and pilot tested on a sample of 15 emergency nurses. The 69-item online survey concerned the respondent's personal experience with physical violence and verbal abuse in the ED, the policies and procedures of the respondent's hospital and ED for addressing workplace violence, and the respondent's beliefs about the precipitating factors of violence and barriers to reporting violence in the ED.

A convenience sampling strategy was used. All ENA members who were RNs working in US EDs at the time of the survey and who had Internet access were eligible to participate in the study. The online survey was developed using Survey Select Expert (version 5.6). The 1-time survey was accessible online during the spring of 2007 for 1 month. Participation was solicited through ENA newsletters, the Web site, and e-mail announcements during the same period. Although ENA could not restrict multiple submissions by the same nurse, the length of the survey may have served as a deterrent. Institutional review board approval for the study was obtained from Chesapeake Research Review, Inc, and designated as exempt.

SPSS Windows (version 14) was used for data management and statistical analysis. Because the data had statistically nonnormal distributions, nonparametric statistical methods were used to analyze the data. Nurses whose responses indicated that they had experienced a high frequency of physical violence (>20 times) from patients/visitors in the ED during the past 3 years were classified as frequent-physical-violence-experience (FPVE) nurses. Nurses whose responses indicated that they had experienced a high frequency of verbal abuse (>200 times) from patients/visitors during the past 3 years were classified as frequent-verbal-abuse-experience (FVAE) nurses. The χ^2 test of association and Fisher exact test (when expected frequencies were too small to permit use of the χ^2 test) were used to compare independent groups with respect to percentages. The Kruskal-Wallis and Mann-Whitney *U* tests were used to compare independent groups with respect to noncategorical variables. For all statistical analyses, a .05 significance level was used. No 1-sided tests were done. Data are presented as mean ± SD.

Results

A total of 3,465 (10.9%) emergency nurses completed the survey. This sample of nurses was representative of all 50 states and the District of Columbia. Table 1 describes the characteristics of the respondents and the EDs and facilities at which they worked. The overwhelming majority (87.4%) worked in general EDs, 63.6% worked in a trauma center, 59.7% worked as staff nurses, and 52.1% primarily worked the day shift. The mean ± SD nursing experience was 16.5 ± 10.7 years, emergency nursing experience was 12.1 ± 8.8 years, and experience in the respondent's current ED was 7.6 ± 7.2 years. Most respondents (84.4%) were women.

Some of the most common types of physical violence experienced by more than 50% of respondents were "spit on," "hit," "pushed/shoved," "scratched," and "kicked." In terms of verbal abuse, 70% or more of respondents experienced being "yelled/cursed at," "intimidated," and "harassed with sexual language/innuendo." Sixty-seven percent rated

Table 1. *Characteristics of Emergency Nurses and the Emergency Departments (EDs)/Facilities at Which They Worked*

Characteristic[a]	% (n)
Emergency nurses	
Sex (n = 3,446)	
Female	84.4 (2,910)
Male	15.6 (536)
Age, y (n = 3,451)	
18-24	1.7 (58)
25-34	17.7 (612)
35-44	29.6 (1,022)
45-54	38.2 (1,317)
≥55	12.8 (442)
RN role (n = 3,461)	
Staff nurse	59.7 (2,066)
Charge nurse	16.1 (556)
ED manager	11.0 (379)
Clinical/staff educator	4.9 (169)
Clinical nurse specialist	1.3 (44)
Administrator/director	1.2 (42)
Nurse practitioner	1.0 (33)
Other	5.0 (172)
Shift primarily worked (n = 3,452)	
Day	52.1 (1,798)
Night	25.7 (888)
Evening	13.0 (448)
Rotating	9.2 (318)
Days primarily worked (n = 3,434)	
Weekdays	21.9 (752)
Weekends	7.4 (255)
Both weekdays and weekends	70.7 (2,427)
EDs/facilities	
ED type (n = 3,460)	
General	87.4 (3,025)
Adult only	8.9 (308)
Pediatric only	3.7 (127)
Community population (n = 3,262)	
≤10,000	10.0 (325)
10,001-30,000	16.7 (545)
30,001-100,000	27.1 (884)
100,001-500,000	27.0 (881)
≥500,001	19.2 (627)
Facility type (n = 3,447)	
Nongovernment, not-for-profit	69.5 (2,397)
Investor owned, for-profit	19.1 (657)
State or local government	9.0 (310)
Federal government, military, or Veterans Affairs	2.4 (83)

[a]Sample size fluctuates because of missing data.

their perception of safety at 5 or below on a 10-point scale (1, not at all safe to 10, extremely safe). One-third had considered leaving their ED or emergency nursing because of ED violence.

Frequent Physical Violence Experience

Twenty-three percent (n = 811) of respondents were FPVE nurses. Table 2 describes the factors found to be related to FPVE. As expected, nurses in pediatric EDs were less likely to experience frequent physical violence, whereas nurses who primarily worked the night shift and nurses who worked on weekends were more likely to experience frequent physical violence. Female nurses were less likely than male nurses to indicate that they had experienced frequent physical violence. A reduced risk of experiencing frequent physical violence in the ED was associated with having facility policies for reporting workplace violent incidents, facility responses to such incidents, and hospital and ED administration commitment to eliminating workplace violence against emergency nurses. Nurses who felt that violence from patients/visitors is an unavoidable part of practice were more likely to have experienced frequent ED physical violence.

The following barriers to reporting ED violent incidents were associated with an increased risk of experiencing frequent physical violence in the ED: the perception that reporting ED violent incidents might have a negative effect on customer service scores/reports; ambiguous ED violence reporting policies; fear of retaliation from ED management, hospital administration, nursing staff, or physicians for reporting ED violent incidents; failure of staff to report ED violent incidents; the perception that reporting ED violent incidents was a sign of incompetence or weakness; lack of physical injury to staff; the attitude that violence comes with the job; and lack of support from administration/management. Nurses who felt that there were no barriers to reporting ED violent incidents were much less likely to have experienced frequent ED physical violence (ie, >20 times in the last 3 years) than were other nurses: 15.4% versus 28.5% ($P < .001$).

Nurses also were asked whether 29 factors precipitated workplace violence against RNs in their EDs. The precipitating factors listed in the survey were identified through a review of the research literature and input from emergency nurse content experts. Table 3 lists the most important factors (those specified by >50% of nurses). The factors that can potentially be altered by the ED or facility were: care of psychiatric patients in the ED, crowding/high patient volume, prolonged wait times, misconception by patients or visitors of staff behavior (such as nurses laughing), patients' or visitors' perception that staff is uncaring, holding or boarding patients, shortage of ED RNs, no or poorly enforced visitor policy, and care of patients with dementia or Alzheimer disease in the ED. Nurses in the FPVE group were significantly more likely than those in the non-FPVE group to perceive all but 4 of the 29 factors as precipitators of ED violence.

Frequent Verbal Abuse Experience

Similar results were obtained for verbal abuse. Almost 20% (n = 604) of respondents were FVAE

Table 2. *Factors Related to Experience of Frequent Physical Violence by Emergency Nurses*

Factor[a]	Non-FPVE Nurses, %[b] (n)	FPVE Nurses, %[b] (n)	*P*
Sex (n = 3,043)			<.001
Female	74.8 (1,908)	25.2 (643)	
Male	66.9 (329)	33.1 (163)	
ED type (n = 3,056)			<.001
Pediatric only	90.8 (99)	9.2 (10)	
Adult only or general	72.9 (2,149)	27.1 (798)	
Shift primarily worked (n = 3,050)			.002
Day	76.1 (1,214)	23.9 (382)	
Evening	72.1 (289)	27.9 (112)	
Night	68.7 (540)	31.3 (246)	
Rotating	74.2 (198)	25.8 (69)	
Days primarily worked (n = 3,033)			.001
Weekdays	78.9 (525)	21.1 (140)	
Weekends	72.1 (160)	27.9 (62)	
Both weekdays and weekends	71.9 (1,563)	28.1 (603)	
Facility policy for reporting workplace violent incidents (n = 2,534)			<.001
Present	74.4 (1,602)	25.6 (551)	
Absent	63.8 (243)	36.2 (138)	
No facility response to workplace violent incidents (n = 3,060)			<.001
Yes	63.0 (308)	37.0 (181)	
No	75.5 (1,941)	24.5 (630)	
Hospital administration committed to eliminating workplace violence against emergency nurses (n = 3,043)			<.001
Yes	82.6 (737)	17.4 (155)	
No	69.7 (1,500)	30.3 (651)	
ED management committed to eliminating workplace violence against emergency nurses (n = 3,047)			<.001
Yes	77.9 (1,226)	22.1 (348)	
No	68.8 (1,013)	31.2 (460)	
Feel that violence from patients/visitors is part of practice (n = 3,048)			<.001
Yes	67.8 (1,004)	32.2 (476)	
No	78.8 (1,236)	21.2 (332)	
Barriers to reporting ED violent incidents			
Reporting ED violent incidents might affect customer service scores/reports (n = 3,060)			<.001
Yes	68.2 (763)	31.8 (355)	
No	76.5 (1,486)	23.5 (456)	
Ambiguous ED violence reporting policies (n = 3,060)			<.001
Yes	69.1 (635)	30.9 (284)	
No	75.4 (1,614)	24.6 (527)	
Fear of retaliation from ED management for reporting ED violent incidents (n = 3,060)			<.001
Yes	63.6 (295)	36.4 (169)	
No	75.3 (1,954)	24.7 (642)	
Fear of retaliation from hospital administration for reporting ED violent incidents (n = 3,060)			<.001
Yes	66.5 (468)	33.5 (236)	
No	75.6 (1,781)	24.4 (575)	
Fear of retaliation from nursing staff for reporting ED violent incidents (n = 3,060)			.007
Yes	63.4 (83)	36.6 (48)	
No	74.0 (2,166)	26.0 (763)	
Fear of retaliation from physicians for reporting ED violent incidents (n = 3,060)			.008
Yes	63.8 (88)	36.2 (50)	
No	74.0 (2,161)	26.0 (761)	
No one reports ED violent incidents (n = 3,060)			<.001
Yes	68.2 (503)	31.8 (235)	
No	75.2 (1,746)	24.8 (576)	
Reporting ED violent incidents perceived as a sign of incompetence (n = 3,060)			.002
Yes	68.0 (344)	32.0 (162)	
No	74.6 (1,905)	25.4 (649)	

Table 2. Continued

Factor[a]	Non-FPVE Nurses, %[b] (n)	FPVE Nurses, %[b] (n)	*P*
Reporting ED violent incidents perceived as a sign of weakness (n = 3,060)			.037
Yes	70.2 (428)	29.8 (182)	
No	74.3 (1,821)	25.7 (629)	
Lack of physical injury to staff (n = 3,060)			.040
Yes	71.5 (894)	28.5 (356)	
No	74.9 (1,355)	25.1 (455)	
Attitude that violence comes with the job (n = 3,059)			<.001
Yes	64.8 (608)	35.2 (330)	
No	77.3 (1,640)	22.7 (481)	
Lack of support from administration/management (n = 3,060)			.003
Yes	63.6 (105)	36.4 (60)	
No	74.1 (2,144)	25.9 (751)	

Abbreviations: ED, emergency department; FPVE, frequent physical violence experience.
[a]Sample size fluctuates because of χ^2 analyses and missing data.
[b]Row percentages.

nurses. Factors related to FVAE are shown in Table 4. Nurses were more likely to experience frequent verbal abuse if they worked in general or adult-only EDs, primarily worked the night shift, or worked on weekends. Female nurses were slightly less likely than male nurses to indicate that they had experienced frequent verbal abuse. Facility policies for reporting workplace violent incidents, facility responses to such incidents, and hospital and ED administration commitment to eliminating workplace violence against emergency nurses were all associated with a reduced risk of experiencing frequent verbal abuse. Barriers to reporting ED violent incidents were often associated with an increased risk of experiencing frequent verbal abuse. Nurses who felt that there were no barriers to reporting ED violent incidents were much less likely to have experienced frequent ED verbal abuse (ie, >200 times in the last 3 years) than were other nurses: 9.78% versus 21.5% ($P < .001$).

Strategies and Interventions

The effectiveness of strategies such as security, environmental controls, and violence prevention education/training cannot be determined from cross-sectional data of this type because such strategies are often initiated in EDs after violence becomes a problem. This confounding can make it appear as if such strategies increase ED violence. For example, nurses who indicated that their hospital had no security personnel were significantly less likely to have experienced frequent physical violence ($P = .002$) or frequent verbal abuse ($P = .007$) than were other nurses. However,

Table 3. FPVE and Non-FPVE Nurses' View of Factors Related to ED Violence

Factor	Perceived as Precipitator of ED Violence, % (n)			*P*
	Total Sample	FPVE Group	Non-FPVE Group	
Patients/visitors under influence of alcohol	90.2 (3,126)	94.7 (768)	90.0 (2,023)	<.001
Drug-seeking behavior	90.2 (3,124)	94.0 (762)	89.4 (2,010)	<.001
Patients/visitors under influence of illicit drugs	88.4 (3,063)	94.3 (765)	87.7 (1,972)	<.001
Care of psychiatric patients in ED	88.2 (3,055)	91.9 (745)	86.7 (1,950)	<.001
Crowding/high patient volume	87.0 (3,015)	91.1 (739)	86.5 (1,945)	.001
Prolonged wait times	83.5 (2,892)	86.3 (700)	84.0 (1,890)	NS
Misconception by patients/visitors of staff behavior	66.1 (2,289)	69.7 (565)	65.9 (1,481)	.048
Patients/visitors' perception that staff is uncaring	65.6 (2,272)	71.8 (582)	64.6 (1,452)	<.001
Holding/boarding patients	59.1 (2,048)	68.3 (554)	56.3 (1,267)	<.001
Shortage of ED RNs	58.6 (2,031)	66.2 (537)	55.8 (1,256)	<.001
No/poorly enforced visitor policy	56.2 (1,949)	69.1 (560)	52.9 (1,189)	<.001
Care of patients with dementia/Alzheimer disease in ED	54.6 (1,893)	59.1 (479)	53.8 (1,209)	.009

Abbreviations: ED, emergency department; FPVE, frequent physical violence experience; NS, not statistically significant.

Table 4. *Factors Related to Experience of Frequent Verbal Abuse by Emergency Nurses*

Factor[a]	Non-FVAE Nurses, %[b] (n)	FVAE Nurses, %[b] (n)	*P*
Sex (n = 3,048)			.045
Female	80.9 (2,065)	19.1 (488)	
Male	77.0 (381)	23.0 (114)	
ED type (n = 3,060)			.034
Pediatric only	88.2 (97)	11.8 (13)	
Adult only or general	80.0 (2,360)	20.0 (590)	
Shift primarily worked (n = 3,055)			.001
Day	82.8 (1,317)	17.2 (274)	
Evening	77.5 (306)	22.5 (89)	
Night	76.1 (606)	23.9 (190)	
Rotating	81.7 (223)	18.3 (50)	
Days primarily worked (n = 3,039)			.012
Weekdays	83.8 (560)	16.2 (108)	
Weekends	76.0 (174)	24.0 (55)	
Both weekdays and weekends	79.5 (1,795)	20.5 (440)	
Facility policy for reporting workplace violent incidents (n = 2,536)			<.001
Present	81.7 (1,767)	18.3 (395)	
Absent	71.9 (269)	28.1 (105)	
No facility response to workplace violent incidents (n = 3,064)			<.001
Yes	71.5 (353)	28.5 (141)	
No	82.0 (2,107)	18.0 (463)	
Hospital administration committed to eliminating workplace violence against emergency nurses (n = 3,047)			<.001
Yes	88.5 (799)	11.5 (104)	
No	76.8 (1,647)	23.2 (497)	
ED management committed to eliminating workplace violence against emergency nurses (n = 3,052)			<.001
Yes	84.0 (1,325)	16.0 (253)	
No	76.2 (1,123)	23.8 (351)	
Barriers to reporting violent incidents			
Reporting ED violent incidents might affect customer service scores/reports (n = 3,064)			<.001
Yes	75.0 (834)	25.0 (278)	
No	83.3 (1,626)	16.7 (326)	
Ambiguous ED violence reporting policies (n = 3,064)			<.001
Yes	76.1 (687)	23.9 (216)	
No	82.0 (1,773)	18.0 (388)	
Fear of retaliation from ED management for reporting ED violent incidents (n = 3,064)			<.001
Yes	72.7 (335)	27.3 (126)	
No	81.6 (2,125)	18.4 (478)	
Fear of retaliation from hospital administration for reporting ED violent incidents (n = 3,064)			<.001
Yes	74.6 (523)	25.4 (178)	
No	82.0 (1,937)	18.0 (426)	
Inconvenient/do not want to deal with it (n = 3,064)			.001
Yes	77.2 (873)	22.8 (258)	
No	82.1 (1,587)	17.9 (346)	
No one reports ED violent incidents (n = 3,064)			<.001
Yes	75.0 (548)	25.0 (183)	
No	82.0 (1,912)	18.0 (421)	
Reporting ED violent incidents perceived as a sign of incompetence (n = 3,064)			<.001
Yes	74.6 (379)	25.4 (129)	
No	81.4 (2,081)	18.6 (475)	
Reporting ED violent incidents perceived as a sign of weakness (n = 3,064)			<.001
Yes	74.0 (444)	26.0 (156)	
No	81.8 (2,016)	18.2 (448)	
Lack of physical injury to staff (n = 3,064)			<.001
Yes	76.6 (951)	23.4 (290)	
No	82.8 (1,509)	17.2 (314)	
Attitude that violence comes with the job (n = 3,063)			<.001
Yes	73.6 (680)	26.4 (244)	
No	83.2 (1,779)	16.8 (360)	

Table 4. Continued

Factor[a]	Non-FVAE Nurses, % [b] (n)	FVAE Nurses, % [b] (n)	*P*
Lack of support from administration/management (n = 3,064)			<.001
Yes	65.4 (106)	34.6 (56)	
No	81.1 (2,354)	18.9 (548)	

Abbreviations: ED, emergency department; FVAE, frequent verbal abuse experience.
[a]Sample size fluctuates because of χ^2 analyses and missing data.
[b]Row percentages.

as evidenced by nurses' comments in the survey, having inadequate security personnel to effectively mitigate violence was a major concern.

Limitations

As is true for most studies based on self-report, this study is limited by the potential inaccuracy of self-reported data. No self-report study can conclusively identify factors related to ED violence. Because a convenience sampling method was used and all respondents were ENA members, the generalizability of the study is limited. Despite these limitations, the results indicate the extent and severity of workplace violence experienced by emergency nurses and the substantial barriers that remain to preventing, mitigating, and reporting ED violence. Opportunities to address these barriers exist. Further research is needed to identify best practices for preventing and mitigating ED violence.

Discussion

As the first national study of emergency nurses' experiences and perceptions of workplace violence, this study provides significant contributions to our understanding of ED violence. As evident from the survey findings, workplace violence is highly prevalent among the ED nurses in our study, highlighting the seriousness of the issue. Findings from this study are consistent with the research literature involving nurses in other disciplines and emergency nurses internationally. Our findings further support the research literature in that nurses indicated not feeling safe in the workplace, a perception that violence is an unavoidable aspect of the job, barriers to reporting violence, a desire for improved security measures, and a lack of administrative commitment to addressing ED violence.

The results of this study have important implications for strategies to reduce ED violence. Innovative approaches are needed to modify factors that emergency nurses believe are precipitators of ED violence, such as care of psychiatric patients in the ED, crowding, long wait times, misconceptions of staff behavior, perceptions of staff as uncaring, holding/boarding patients, shortage of nurses, and lack of an enforced visitor policy. These are well-known ED problems, and the solutions are difficult, hence the need for innovation. In addition, there is a need to change hospital administration's and emergency nurses' perceptions and attitudes that violence is acceptable and "comes with the job." Reducing ED violence will require solving many of the larger problems that afflict EDs, some of which originate outside the ED at the hospital or community level.

As indicated by the nurses in this study, a strong administrative commitment is imperative to reducing ED violence and eliminating barriers to reporting incidents of violence. Staff and ED managers need to know that senior administrators are aware of the violence issue and support efforts to prevent and mitigate violence. Nurse executives must be proactive in taking steps to make the workplace safe. Establishing a culture of acceptance for reporting violent incidents is a positive step toward creating a safer work environment. Procedures for reporting violent incidents should be clear and consistent, and ED staff should have access to medical care and follow-up counseling if needed. Another essential strategy to addressing ED violence is convening an interdisciplinary task force to identify vulnerabilities in the ED and develop a plan for preventing, mitigating, responding to, and reporting violence. This task force should include the chief operating officer, chief nurse executive, ED medical director, ED manager/director, security personnel, risk management personnel, local police, and most importantly, ED nurses.

Findings from the study were inconclusive regarding the effectiveness of education and training on violence prevention; however, many hospitals provide violence prevention education for ED staff.

Education should include practical and relevant skills for managing assaultive behavior in the ED. For example, education for ED managers and staff should include learning how to be aware of one's surroundings and identify patients and visitors who may be disposed toward violent behavior.

Conclusion

The recommendations outlined here involve facility and department level change for improving workplace safety. This study is one important step toward identifying ways to mitigate and respond to ED violence. Additional research to further this cause should focus on the effectiveness of education in preparing nurses to deescalate a potentially violent situation, the usefulness of various security measures and environmental controls, best practices for reducing ED violence, and longitudinal trending of ED violence incidence and prevalence rates.

More importantly, federal and state laws to protect ED nurses from violence are needed to address this issue. Whereas some states have made assault of a nurse a felony, other states do not have such stringent laws in place to adequately protect nurses. Unfortunately, legislation such as this is often passed only after a tragic incident against a nurse takes place. To make this a legislative priority, leaders of nursing organizations need to use their government affairs departments to heighten legislators' awareness. Without legislative action at the state and federal level and innovative strategies at the hospital and department level, there can be no realistic hope of significantly decreasing ED violence.

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