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DISCURSIVE PAPER

# Nursing management of emergency department violence—Can we do more?

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## Abstract

**Background:** Emergency departments are the services with the highest risk of violence for nurses. Reports of violence in health care have increased exponentially in the last decade. Front line hospital services are more at risk, and worldwide there are attempts to quantify, manage and prevent episodes of violence, but no consistent solutions have yet been identified.

**Aims:** To stimulate reflection on causal factors of violence against nurses in emergency departments and discuss potential solutions and strategies for aspects that largely remain unresolved.

**Design:** A position paper underpinned by experiences and evidence reported in the literature.

**Methods:** A search of Scopus and CINAHL using the term 'violence' provided information concerning the prevalence of the term 'violence' in contemporary literature and enabled to capture a general overview of contributing factors of violence and current approaches to its management and prevention.

**Conclusions:** However, while risk factors have been identified, there is a tendency to over accentuate the extent of their contribution. The main risk factors present conditions related to or accompanied by mental illness and the impact of overcrowding and long waiting times.

**Relevance to Clinical Practice:** More is needed in terms of implementation of more far-reaching, holistic, practical and effective management solutions to promote nurses' safety and adequately support vulnerable patients.

KEYWORDS
design, emergency department, nurses, risk factors, violence, workplace

## 1 | INTRODUCTION

Violence in health care is a worldwide phenomenon, with professional organisations, health facilities and legislative bodies taking increasing action towards prevention (Brunero et al., 2021). In the international literature, there are various definitions that describe the phenomenon of workplace violence, including that of the National Institute of Occupational Safety and Health (NIOSH), which identifies it as 'any physical assault or attempted assault, threatening behaviour or verbal abuse that occurs in the workplace'. These acts are, in most cases, events with a non-fatal outcome or aggression or attempted aggression, physical (thrusting) and verbal (shouting, insults) (NIOSH, 2002).

Some authors have drawn attention to the fact that hospital violence seems to be a growing concern in health care and of particular interest to nurses (Najafi et al., 2018). Interestingly, one study conducted during the COVID-19 pandemic emergency reported a decrease of the episodes of violence in the ED (Özkan Şat et al., 2021) and observed a decrease of episodes of violence. Whether or not societal or hospital-based violence is on the increase, or whether this is due to growing awareness and intolerance towards it, or is accounted for by increased reporting, is uncertain. However, the literature on this topic is growing exponentially also in terms of violence perpetrated by other staff (Senz et al., 2019) but in this paper, we shall focus on violence perpetrated by patients and accompanying persons in the emergency department.

Therefore, the aim of this paper is to provide a discursive position on the extent and impact of emergency department violence experienced by nurses and to argue about possible solutions and strategies to contain, manage and prevent this phenomenon.

### 1.1 | Background

This growth of interest in violence in health care is reflected in the burgeoning of the literature (Berlanda et al., 2019). Nurses are presented as a vulnerable cohort due to the nature of their work, which brings them into close contact with people in non-ordinary situations that can easily generate tension (Pich et al., 2017). Indeed, almost 20 years ago, Jackson et al. (2002:13) questioned 'who would want to be a nurse?' when the potential for workplace violence is considered. At the same time, internationally there has been voluminous research into the prevalence and typology of these episodes in different contexts to deepen the knowledge of this phenomenon and to implement interventions aimed at addressing it and protecting healthcare professionals.

While violence can pervade across many areas of healthcare practice, violence in the adult emergency department (ED) is often highlighted as being of particular concern (Brunero et al., 2021; Lenaghan et al., 2018; Ryan & Maguire, 2006). Indeed, staff in the ED are more likely to experience violence than in other areas of health care (Sharifi et al., 2020; Zoleo et al., 2020) and many nurses are concerned for their own safety (Sharifi et al., 2020). Along with cafeterias, main lobbies, outpatient clinics and other public areas providing health services, EDs are more commonly faced with the challenge of managing violent episodes (Curbow, 2002). Certainly, our experience has been that ED nurses are frequently victims of violence especially in the ED triage. This experience is supported in the literature as most violent assaults occur in the treatment room (ALBashtawy & Aljezawi, 2016; Al-Maskari et al., 2020) or during triage (Pich et al., 2017). At times, this is physical violence, but in most cases, it is verbal. Most often it seems to be associated with drug or alcohol abusers, or people with organic causes of confusion (Alzheimer's for example) or those who are waiting for hours to be seen. Indeed Ogundipe et al. (2013:758) point out that:

> EDs are high-stress areas where many patients may have conditions consequent on trauma, and they or their relations could have labile emotions that may predispose to violence against caregivers… [and] … nurses bear the brunt of this violence

Emergency nursing associations are increasingly becoming active internationally in terms of encouraging methods of violence prevention, lowering tolerance towards a culture that accepts violence as part of the job and by increasing support and prevention (New Zealand Nurse Organisation, 2016). Indeed, in one area of Australia, ED nurses took to protest about rising levels of ED violence and received community support for this resulting in environmental changes to the ED, such as toughened glass and emergency alarms (Anonymous, 2017).

In the UK, The Royal College of Nursing (RCN) (2017) voiced concern at a reported 28% occurrence of physical violence among

**What does this paper contribute to the wider global clinical community?**

- For many ED nurses, episodes of violence continue to be seen as a normal part of their job, but the increasing frequency of episodes of violence are becoming an unacceptable burden, demanding urgent organizational solutions and ensure that reporting violence is more accessible.
- Some causative factors such as alcohol and drug intoxication appear to be more environmental and societal than individual. Another major cause of ED violence is related to many people with mental health disorders presenting to EDs. Questions must be raised regarding the appropriateness of the ED as the referral point for psychotic episodes.
- Nurse leaders should reflect and collaborate with social services to develop effective interventions to prevent violence episodes and providing safe work environments for their nurses.

**TABLE 1** Violence reporting rates across various countries

| Authors | Country | Violence reporting rate (%) |
|---|---|---|
| Ryan and Maguire (2006) | Ireland | 3.0 |
| Richardson et al. (2018) | New Zealand | 12.0 |
| Sills et al. (2020) | Australia | 14.0 |
| Al-Maskari et al. (2020) | Oman | 18.0 |
| Afshari Saleh et al. (2020) | Iran | 35.0 |
| Wright-Brown et al. (2016) | USA | 38.0 |
| Song et al. (2020) | China | 45.5 |
| ALBashtawy and Aljezawi (2016) | Jordan | 48.0 |
| Ogundipe et al. (2013) | Nigeria | 87.0 |
| Pich et al. (2017) | Australia | 87.0 |
| Ramacciati et al. (2019) | Italy | 91.5 |

6,000 nurses surveyed. They welcomed the Assaults on Emergency Workers (Offences) Bill 2017–19, a Private Member's Bill that introduced the new offence of assaulting an emergency worker and new sentencing guidelines. The RCN outlined their support for the Bill and suggested more far-reaching measures to protect healthcare staff from violence and aggression (RCN, 2017). Similarly, the Royal College of Emergency Medicine (2019) has expressed its concern about the rising violence against those working in the NHS and especially those working in ED.

### 1.2 | Design

A position paper.

## 2 | METHODS

A search of Scopus and CINAHL using the term 'violence' was conducted and yielded broad information on the prevalence of the term 'violence' in contemporary literature and a general overview of violence in the emergency department, contributing factors and current approaches to its management.

Scopus revealed that references to the term 'violence' have steadily increased in the Journal of Advanced Nursing (JAN) ($n = 489$), and almost one-third of these references belong to the last ten years ($n = 154$). Similarly, references to violence in the Journal of Nursing Management (JNM) in the last five years ($n = 112$) are more than double the number of those published in the previous 23 years ($n = 55$).

The results yielded through our search of the CINAHL database revealed similar trends. Both JNM and JAN have published an increasing percentage of articles on violence in the last decade 2010–2020; 61% and 38%, respectively. Nurses are presented as a vulnerable cohort due to the intrinsic nature of their work in close contact with people in non-ordinary situations that can rapidly precipitate into episodes of violence (Pich et al., 2017).

### 2.1 | Extent of violence in the emergency department

Defining the exact nature and prevalence of violence has always been problematic. As early as 2002, Krug et al. reported the difficulty in getting an accurate measure of the scale of the phenomenon due to incident reporting not always being completed, even in health services that supported reporting (Ryan & Maguire, 2006). As more recent studies show, little has changed and there is still a perception of under-reporting by nurses (Ayasreh & Hayajneh, 2021; Dafny & Beccaria, 2020; Hogarth et al., 2016; Sills et al., 2020; Stene et al., 2015) especially when there are no perceived injuries (Dafny & Beccaria, 2020) and because nurses think that reporting incidents of violence would not change anything (Alsharari et al., 2021; Kvas & Seliak, 2014). Violence is experienced by all grades of staff in the ED (Nikathil et al., 2017) although it is believed to be a more common experience for nurses, perhaps because they spend more time with patients and are usually more visible in the ED (Ogundipe et al., 2013). It is also believed that nurses are more vulnerable as a predominantly female group (Dafny & Beccaria, 2020; Ladika, 2018).

Reported incident rates of physical violence towards ED nurses vary dramatically and a recent literature review showed that the reporting rates still tend to be low (Ayasreh & Hayajneh, 2021). Reports can be as low as Ryan and Maguire's (2006) report of 3% in an Irish ED up to an estimated 91.5% in Italy (Ramacciati et al., 2019) (see Table 1). A recent review confirmed that this disparity and difference in percentages is common across the literature (Nikathil et al., 2017), although it must be noted that some of the studies where higher rates were observed included to small local samples (Ogundipe et al., 2013; Wright-Brown et al., 2016). However, it is believed that there is an increasingly upward trend, with a frequency of episodes of violence above 50% (Edward et al., 2014).

Back in 2006, a survey ($n = 80$) examined ED nurses' views on violence and reported this as ranging from threatening aggression to severe physical violence; in one month, the occurrence of both was estimated at 54% and 3%, respectively (Ryan & Maguire, 2006).

In this study, minor acts of violence were reported much more frequently (23%) than major ones (2.8%). Violence towards nurses was mostly inflicted by patients rather than accompanying adults, but often there are multiple perpetrators (i.e. both patients and their accompaniment). In other studies, the patient is described as the major perpetrator (Wright-Brown et al., 2016) and interviews with nurses indicate that it is the patient who is more likely to be physically violent, whereas accompanying persons are more likely to be verbally aggressive (Dafny & Beccaria, 2020). Although a recent study in Oman revealed that both patients and accompaniment equally exhibited violence towards nurses (Al-Maskari et al., 2020), and in Nigeria, accompanying persons are reported to be more likely to offend (Ogundipe et al., 2013). Interestingly, violence during ED cardiopulmonary resuscitation (CPR) is an emerging phenomenon, where accompanying adults are the source of violence (Margavi et al., 2020).

Physical violence in the ED is of particular concern given its psychological effects and risk of injury (Najafi et al., 2018). However, the WHO points out that defining violence only in relation to its outcome as injurious 'limits the understanding of the full impact of violence on individuals, communities, and society at large' (Krug et al., 2002:5). Physical violence, regardless of the outcome, is a cause of great stress for nurses (Afshari Saleh et al., 2020; Zhang et al., 2021). A recent meta-synthesis for example emphasised the long-lasting effects on nurses within two emerging themes: 'invisible wounds and painful memories' and 'post-violence repercussions' (Al-Qadi, 2020:4). Similarly, Hassankhani et al.'s (2019) interviews with ED nurses in Iran revealed a long-lasting impact, including effects on the perception of their professional role, confidence and mental health issues.

Of concern within our findings is that ED nurses often view violence as an inevitable part of their daily job and are reluctant to report incidents, a fact echoed in many international studies (Dafny & Beccaria, 2020; Hogarth et al., 2016; Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2018; Ramacciati, Ceccagnoli, Addey, & Rasero, 2018; Stene et al., 2015). Indeed, two recent meta-syntheses revealed the inevitability of violence as a major emerging theme (Al-Qadi, 2020:4; Ashton et al., 2018). In fact, themes from Hogarth et al.'s (2016) interviews with ED nurses revealed that they did not perceive a physical assault as violent unless they received an injury. They also noted a reluctance among healthcare management to fully address the issue (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2018; Ramacciati, Ceccagnoli, Addey, & Rasero, 2018) a fact reported throughout the literature (Doby, 2015). Interestingly, in the USA, there are clear obligations on EDs as employers to support staff through the provision of training, security and protection, and assault in ED can lead to prosecution although the ultimate management of this by the authorities is deemed lenient (AHC MEDIA., 2019a). Although staff are really encouraged to report and act in this regard (AHC MEDIA, 2019b), there is evidence internationally of under-reporting (Richardson et al., 2018). Organisational barriers to reporting may occur for cultural reasons (whether or not it is encouraged or supported) and can be related to the approach of the reporting method (Hogarth et al., 2016).

## 2.2 | Reasons for violence in the emergency department

While drugs and alcohol are often blamed for ED violence in the literature (Ramacciati et al., 2017) these do not always appear to be the major influencing factor (Al-Maskari et al., 2020; Ramacciati, Ceccagnoli, Addey, & Rasero, 2018; Zoleo et al., 2020). Indeed, a recent examination of risk revealed that those deemed at greater risk of violence were patients with mental health disorders (Brunero et al., 2021). For example, Connor et al. (2020) found that most (57%) of the violent episodes reported in the ED were mental health related, whereas very few cases (2%) were related to drugs or alcohol. A recent meta-analysis confirmed that mental health issues are the most frequently reported reason for violence against ED staff, followed closely by drug and alcohol-related incidents (Nikathil et al., 2017). Conversely, in one large Australian study, ED nurses reported alcohol intoxication as the major influencing factor in violent episodes (87%), followed by mental health issues (77%) and drug intoxication (76%) (Pich et al., 2017). In Australia, restricting the hours for alcohol sales appears, anecdotally at least, to have contributed to a reduction in ED violence in Sydney (Anonymous, 2018), and a recent review appears to implicate drug and alcohol as one of the main predictive factors for ED violence (Kleissl-Muir et al., 2018). Interestingly, a Delphi study about Australian ED nurses' perspectives of ED violence revealed a consensus that long waiting times, drugs and alcohol all contributed to ED violence (Morphet et al., 2014).

However, certainly while patients exhibiting mental health disorders, drugs or alcohol are creating risk, and increasingly awareness is developing in relation to ED environment characteristics and how these can contribute or compound the issue. In a recent large national study including more than 15,000 EDs across 600 healthcare facilities in Italy, for example four major themes were identified: the nurses' perception of physical and verbal aggression, precipitating factors, consequences and solutions (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2018). These were further conceptualised and mapped onto a global model for understanding violence in the ED, which gave equal weight to the importance of environmental and organisational factors alongside nurses' individual characteristics (that could become triggers) and patient considerations. It is interesting that rather than viewing violence as patient perpetrated, a more holistic approach to its understanding was taken (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2018). The fact that nurses' characteristics may contribute to the occurrence of violence is also interesting. Delphi studies support this finding (Morphet et al., 2014). Similarly, in Ogundipe et al.'s (2013), Nigerian study nurses were of the belief that ED violence is reduced when nurses adopt the following behaviours: availability (85%), respectfulness (85%), support (53%) and responsiveness (68%). Indeed, in the same study, the main perceived reasons for violence (highest mean score) were environmental ED overcrowding, long waiting times and 'frustration of patients', and inadequate security system (Ogundipe et al., 2013:760). Ramacciati et al., 2017 also found that long ED waiting times, for both patients and accompanying persons (related to 56% of the reported violent episodes), combined with crowded EDs followed closely as the second main causative factor (56%). Violence is

also triggered by the perception that no obvious person is 'in charge' and this accounted for a large proportion of the violent episodes (42%) in Ramacciati et al.'s (2017) study.

Interestingly, Angland et al. (2014) interviewed 12 ED nurses to explore their perceptions about what triggered ED violence and their responses overwhelmingly pointed to environmental issues. Long waiting times, overcrowding and poor communication were highlighted as the main causes. The long waiting times mentioned, specifically related to patients waiting to see a doctor or to get a bed on a ward.

> A few participants believed that the aggressive nature of patients and relatives was related to their impatience, and a desire for individualised immediate attention. N5: "People want to be seen immediately… they just lose it some- times when they are told they have to wait." (Angland et al., 2014:137).

> A few participants believed that the design of the ED with its limited space often caused patients and/or relatives to become aggressive. The participants described the ED as "hectic" and about half the size it should be for the number of attendances each day. (Angland et al., 2014:137).

Environmental design of EDs was also addressed by Gilliani and Azad (2016). This review identified various environmental design interventions that could contribute to reducing violence in the ED. The author developed a 13-item checklist for use in ED to guide design and ensuring that there is a focus on items such as security presence, personal alarms, security cameras, entry and exit controls, lighting, noise control, communication mechanisms and seclusion areas (Gilliani & Azad, 2016).

Overall, a number of organisational, societal and community factors influence the interaction between healthcare workers and patients (Curbow, 2002:39). Organisational factors include long ED waiting times (Curbow, 2002); however, in the literature, little attention is paid to environmental prevention or queue management. Lau et al.'s, (2012a, 2012b) ethnographic study involving both nurses and patients revealed one of three main cultural factors in ED violence as 'requests and demands'. Similarly, Pich et al. (2017) revealed that the three highest risk nursing activities for patient-related violence were initial assessment in triage, communicating with patients and managing patients' reactions to delays (Pich et al., 2017). Najafi et al. (2018) also found that nurses believed that not meeting the expectations of patients or their families often precipitates into violent episodes.

## 2.3 | Approaches to the management of emergency department violence

The management of ED violence is a very complex issue. Efrat-Treister et al. (2019) examined how psychological approaches to managing ED waiting times and queues could reduce violence. They found that ED overcrowding resulted in increased violent episodes, but these were reduced if the patients perceived that their waiting time was short. Interestingly, ED violence prevention programmes while successful, focus mostly on identifying at-risk patients and encouraging prompt reporting (Gillespie et al., 2013), rather than exploring how to appropriately support individuals with mental health disorders or effectively handle queues in the ED. In addition to risk management and security measures, much could be done to improve environmental aspects of ED. This includes the use and implementation of queue management theory, improving the aesthetics of waiting environments (Health Innovation Network, 2019) and providing quiet, private and less stressful environments for patients with mental health issues (Bracken-Scally et al., 2019; D'Ettorre et al., 2018).

Given the emergence of the potential impact of people with mental health issues presenting to the ED (both on themselves and others), and the somewhat drastic measures available to deal with these aspects of their illness, it is worth considering whether mental health professionals should be permanent members of the ED team. Interestingly, a recently adopted improvement introduced into Advanced Nurse Practitioner (ANP) training in the Republic of Ireland included the adoption of a more generalist model of education (DOHC, 2019). This includes for example advanced physical assessment for mental health nurses but does not require ANPs (for example in ED) to have additional mental health training (DOHC, 2019).

Approaches to the management of physical ED violence include security presence, sedation and restraint (Mitra et al., 2018). Although Ramacciati, Ceccagnoli, Addey, Lumini, et al. (2018), Ramacciati, Ceccagnoli, Addey, and Rasero (2018):25) called for 'suitable environments with adequate structural measures', this largely amounted to official security measures such as police presence and security cameras (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2018; Ramacciati, Ceccagnoli, Addey, & Rasero, 2018:25, Ramacciati & Giusti, 2020). Even tasers have been suggested for use in the ED in the USA (Lefton, 2014) although concerns have been raised about their safety and appropriateness (O'Brien, 2014).

Risk assessment measures and tools are widely reported across the literature (Cabilan & Johnston, 2019; Connor et al., 2020) and are a key component of education in the field of ED violence prevention (Gillespie et al., 2013). However, relevant training and approach of security/police, staff training and spotting high-risk patients are not widely available internationally (Ogundipe et al., 2013). Most studies revealed limited staff training (Ogundipe et al., 2013). Senz et al. (2019:897) suggest the use of a 'routine risk assessment' tool to detect situations in the ED that could potentially precipitate into episodes of violence not only among patients but also to prevent sources of horizontal or occupational violence perpetrated by other staff. Focusing solely on the patient behaviours, the tool examines confusion, irritability, boisterousness, physical and verbal threats, and damage to objects (Senz et al., 2019). Sharifi et al. (2020) provided education and tested the effect of a similar risk assessment checklist, encouraging ED nurses to assess patients across these latter categories during triage.

However, nurses report reluctance to use risk assessment tools because of the perceived effect on patients. These tools frequently

focus on presence of weapons and history of violence, and for this reason in one study nurses considered them to be provocative (Daniel et al., 2015). At the same time, early diagnosis of the threat and intervention (e.g. sedation, restraint or seclusion) does appear to prevent the need for more serious interventions, such as more serious restraint (e.g. 'take down') when situations escalate (Kelley, 2014:61).

Education in the field of violence prevention is highly recommended for all ED nurses although focused on risk assessment, early intervention and security measures (Martindell, 2012). Indeed Sharifi et al., 2020 found that episodes of violence reduced significantly after ED nurses ($n = 37$) received education that focused on early risk assessment. Interestingly, the Italian Ministry of Health issued a Recommendation to prevent acts of violence against health workers and has been described as a valid tool for the management of violence against health workers (La Torre et al., 2017). A special effort is required when implementing a workplace interior design that is effective in minimising stressful conditions in waiting rooms, which have turned out to be the most frequent site of assaults (D'Ettorre et al., 2018). Nursing management has a key role in this (Özkan Şat et al., 2021). In the absence of solid evidence on the effectiveness of single interventions adopted so far, Ramacciati, Ceccagnoli, Addey, Lumini, et al. (2018), through a narrative review of literature, suggest a set of 24 theoretical frameworks on violence against healthcare workers, which could be used to build actions to mitigate this phenomenon.

## 3 | CONCLUSION

There are increasing literature and awareness worldwide on episodes of workplace violence against nurses, especially in the ED.

For some ED nurses, this is still seen as part of the job due to the unpredictability and acuity of emergency cases (Ayaresh & Hayajneh, 2021), while many others, in line with the more modern multifaceted conception violence, also consider verbal aggression as an unacceptable form of violence (Dafni & Beccaria, 2020; Hogarth et al., 2016). The increasing frequency of episodes of violence is becoming an unacceptable burden, demanding urgent organisational solutions (Dafni & Beccaria, 2020). Organisations must be vigilant in ensuring that support and reporting violence are more accessible and streamlined. While all forms of violence in the workplace are a challenge, physical violence, and its potential for severe harm, is a cause for concern within the ED in terms of physical, psychological and social outcomes.

Both Curbow (2002) and Ramacciati, Ceccagnoli, Addey, Lumini, et al. (2018) models point to a multiplicity of factors that impact upon the potential for ED violence, and much of the qualitative work with ED nurses supports the fact that also nurses' approach and attitude can influence events. However, some causative factors such as alcohol and drug intoxication appear to be more environmental and societal than individual (Anonymous, 2018).

There are also other major ED violence-related issues that have far-reaching consequences and implications, such as the high proportion of people with mental health disorders presenting to EDs. Questions must be raised regarding the appropriateness of the ED as the referral point for psychotic episodes, and whether or not a mental health professional ought to be part of the regular ED team to deal with this patient cohort. In addition, a separate, less hospital-like and more comfortable room, where such patients could have peace away from other waiting patients, might be useful.

The mainstream continues to be about managing and containing violence rather than prevention. This paper could serve as a starting point from which nurse leaders could reflect and collaborate with social services to develop effective interventions to prevent ED violence episodes and providing a safe work environment for nurses.

## 4 | RELEVANCE TO CLINICAL PRACTICE

More is needed in terms of implementation of more far-reaching, holistic, practical and effective management solutions to promote nurses' safety and adequately support vulnerable patients.


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