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Violence and Coping of Emergency Department Nurses

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VIOLENCE AND COPING OF EMERGENCY DEPARTMENT NURSES

SARAH FRASER, RN, BSN
SOUTHERN ADVENTIST UNIVERSITY
SCHOOL OF NURSING

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Chairperson: Date 11/10/06

Committee member: Date 11/10/06

Committee member: Date 11/16/07

Approved by Dean of the School of Nursing:

Barbara James Date 11/10/06
Abstract

The purpose of this research is to gather information about the types of interventions that best help victims of ED violence. Studies demonstrate that there is a definite problem of violence in the Emergency Department (ED). Studies also show there has been an increase in the victimization of ED staff. The problem of violence in the ED is not just a problem within the United States but also found in countries such as Ireland and Australia. There is a need to improve the safety measures of the ED so that staff will feel safe and can perform their jobs efficiently without threat to their person. Further study on the consequences of victimization of ED nurses is needed.

VIOLENCE & COPING OF EMERGENCY DEPARTMENT NURSES

A Thesis Presented for the
Master of Science in Nursing Degree
Southern Adventist University
Collegedale, Tennessee

Sarah Fraser RN, BSN
November 2006
Abstract

The purpose of this research is to gather information about the types of interventions that best help victims of ED violence. Studies demonstrate that there is a definite problem of violence in the Emergency Department (ED). Studies also show there has been an increase in the victimization of ED staff. The problem of violence in the ED is not just a problem within the United States but also found in countries such as Ireland and Australia. There is a need to improve the safety measures of the ED so that staff will feel safe and can perform their jobs efficiently without threat to their person. Further study on the consequences of victimization of ED nurses is needed.
ACKNOWLEDGMENTS

When I decided to pursue more academic knowledge I knew that it would be hard work, but very rewarding. My husband, Michael, has encouraged me during the hard work and cheered when I completed a difficult assignment. Michael, you will never know just how much I appreciate the times you left me alone so that I could work diligently on an assignment or how great your help was with proofreading this thesis and my many other projects. No one said that graduate school would be easy but you have a thirst for knowledge like I do and you made every effort to make sure that I was moving forward in my personal attainment of knowledge. Thank you for your encouragement and your support. I look forward to the time when I can do the same for you in whatever academic setting you choose.

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CHAPTER ONE

Introduction

The memory is still clear as a bell in her mind. The triage nurse told her that he had put a male who was obviously intoxicated into one of the three rooms she was assigned. The man was a bit irritable and it was advised that she should take someone with her when she went in to see the patient. She had received fair warning, but thinking that it was not as bad as the triage nurse thought it was, she went to the room by herself to check on her patient. When she entered the room, her patient demanded to see the doctor and said no [expletive deleted] nurse was going to touch him. She politely replied that the doctor would be in to see him once he was through with the patient he was seeing currently. The man replied that he was hurting badly and that if the doctor did not get in right away that the nurse would also be hurting bad. At that point he started toward her …

This is the story of many nurses who work in the emergency department (ED). This paper examines the prevalence of violence directed at nurses in the ED, and what types of post violence care are most often experienced by nurses who work in the ED.

Violence in ED’s is becoming more prevalent. Nurses need to be more aware of how to cope with violence and to learn ways to deter it when possible. Violence interferes with effective patient care, and can even cause ED nurses to change fields within nursing or to quit nursing all together. This aids the nursing shortage problem, so understanding the violence issue may help in retention of nurses if given a safe healing environment.

Problem Statement

There are many health hazards working as a nurse in the ED. Knowledge of the extent of violence directed toward nurses in the ED would be useful to health care
educators in developing programs that would empower nurses to deal with violence effectively. The question then should be asked “How are nurses being helped after a violent incidence”?

More people then ever before are going to the ED to receive treatment for minor and major ailments. The problem of violent acts directed toward nurses seems to be on the rise, and it has become increasingly important for nurses to realize that this is not normal and that they should have resources to protect themselves. Understanding the problem of violence enables nurses and educators to create programs that empower nurses. These programs can teach nurses how to deal with violence and how to down grade violent situations or eliminate them all together.

**Purpose of Study**

The purpose of this study is to determine what types of interventions would best help RN’s who have been victimized through violent contact with patients and their families. In analyzing this we should be able to develop a post victimization plan of care for the RN’s involved to help them emotionally and physically in an effective manner.

**Research Questions**

What are the most common physical/psychological interventions offered to nurses who have been victimized by patients or family members in violent ways, eg. physical assault or verbal abuse? What physical/psychological interventions are most effective in treating nurses who have been victimized?

**Theoretical Framework**

Myra Levine’s theory is used for the theoretical framework of this paper. The Conservation Model deals with the wholeness, adaptation and conservation of the
individual. The definition used for wholeness is from Erikson "wholeness emphasizes a sound, organic, progressive, mutuality between diversified functions and parts within an entirety, the boundaries of which are open and fluent" (Schaefer et al., 1998, p. 197).

Adaptation is how well an individual adapts to their surroundings. Conservation is the ability of the individual to function even if they are going through challenges.

There are four types of conservation, the first of which is Conservation of Energy, which is a form of conservation dealing with where a person gets energy to continue to function. Conservation of Structural Integrity is how well a person heals from an injury to become whole again. Conservation of Personal Integrity addresses the sense of identity of a person. Conservation of Social Integrity is how well an individual fills the roles of society. Social processes may determine the health of the individual (Schaefer et al., 1998).

Violence directed toward nurses in the ED is a threat to conservation. After every violent incident, how well the individual will heal from that injury is in question. Acts of violence affect all parts of a person. Will a person’s social integrity stay intact when they have experienced something that is outside the norm? How well will a nurse’s personal integrity be kept intact after a violent encounter with a patient? Answers to these questions must be identified.

**Definition of Terms**

The conceptual definitions are as follows for this paper. Violence is defined as unjust or callous use of force or power, as in violating another’s rights, sensibilities, etc (Neufeldt, 1988). Physical assault is defined as any physical contact by a patient that results in the nurse feeling personally threatened (Erickson, 2000). Verbal abuse is
defined as any words or threatening gestures that intimidate hospital staff (Rose, 1997).

Physical/Psychological interventions are defined as anything done for an individual that restores feelings of safety. Victimized nurses are defined as nurses who have feelings of being personally threatened and intimidated, a violation upon the nurse’s rights. Effective interventions is defined as “producing a definite or desired result” (Neufeldt, 1988, p. 432).

The operational definitions are as follows for this paper. Violence is one or a combination of physical assault and verbal abuse. Physical assault is any type of physical contact that the nurse feels threatened by. Verbal abuses are words or gestures that the nurse feels threatened by. Physical/Psychological interventions are what the nurse feels was helpful to them. Victimized nurses are any nurse that feels that they have been victims of violence. Effective interventions are defined as what the nurse feels is helpful to them and are identified through the study questionnaire.

Major Assumptions

It is believed for this paper that all RN’s in the ED setting have experienced some form of violence. It is also assumed that all of these RN’s have some sort of after effect from this violence. No RN is unaffected by the violence directed toward them. It is assumed that nurses will respond openly to questions in the questionnaire and that the questionnaire will capture the true picture of what is being done for nurses after victimization.

Major Limitations

There are several study limitations. The study measures only what the RN who was victimized feels was helpful. The study does not measure the psychological state of
the RN prior to a violent event. This study is a pilot study and will only be done on a small sample size. The study will utilize a questionnaire designed specifically for this research. Reliability and validity of this tool are yet undetermined.

Significance of Proposed Study

Knowledge of the outcomes of interventions for nurses who have been victims of ED violence will allow for better and more appropriate interventions to be put in place for future use post victimization. For nursing staff in the ED to continue to come back to work and be psychologically healthy is important. The health of the nurse may have a direct influence on the patient care that is given.

Summary

Violence in the ED is a significant and constant problem. For nurses to be emotionally and physically taken care of following violence we need to understand what interventions work best under these circumstances. Levin's Conservation Model deals with the wholeness, adaptation and conservation of the individual and this is important in the psychological health of RN's. Violence is not a problem that is going to go away.
CHAPTER TWO

Introduction

Chapter two will cover the purpose of the review of literature and the delimitations of the review. The literature review will show that violence in the ED continues to be a problem. This makes the need for the proposed study relevant.

Purpose of the Review

The purpose of the review of literature is to understand the prevalence of violence in the ED. It is also to help define where more research needs to be done. This review of literature will also show that there is a problem that needs to be addressed in the ED.

Delimitations of the Review

The years covered were initially to be no more than the most recent five years, 2000-2005. Unfortunately, there has been little research done in those years so the ROL was expanded to cover from 1990 to the present.

The research used is primarily from the United States, Ireland and Australia. However, there is research from other countries around the world. ED violence against nurses was the primary topic of research review. This search utilized the CINAHL and EBSCO databases accessed through the McKee Library on the campus of Southern Adventist University.

Key words used for this search were violence, victimization, workplace violence, ED, ER, and nurses. These key words yielded a number of articles that were reviewed. Then articles and research reports were selected that addressed the specific area of violence directed toward nurses in the ED.
Review of Relevant Theoretical Literature

Myra Levine's theory is used for the theoretical framework of this paper. The Conservation Model deals with the wholeness, adaptation and conservation of the individual. Violence directed toward nurses in the ED is a threat to conservation. After every violent incident, how well the individual will heal from that injury is in question. Acts of violence affect all parts of a person.

Review of Relevant Research Studies

Mahoney (1991) completed a descriptive study of ED nurse victimization. Participants were 1209 nurses who worked 20 hours or more in the ED from 124 participating hospitals from all over the state of Pennsylvania. A survey was used to gather information from the respondents. The first part of the survey allowed individuals to “report the number, nature, type, and severity of the victimizations that they had experienced” (Mahoney, 1991, p. 186). During their careers, 97.7% of the respondents had experienced some sort of violence. Verbal abuse was the most frequently occurring type of abuse. The most frequent times for abuse were the eight hour and twelve hour night shifts (Mahoney, 1991).

Nurses (52.4%) felt that their job performance was affected adversely as a result of the victimization. “…nurses (14.4%) had considered requesting a transfer to another area, away from the emergency department, as a result of victimization. Two hundred twelve (17.5%) nurses said that they had considered quitting nursing altogether as the result of a victimization experience” (Mahoney, 1991, p. 287). The perpetrator variable that was the greatest (46.3%) was that of alcohol intoxication (Mahoney, 1991).
The section of the survey that focused on emotional responses showed that the “most predominant emotional reaction to victimization was anger, followed by anxiousness, helplessness, loss of control, and increased irritability” (Mahoney, 1991, p. 289). Biophysiologic responses were also analyzed and body tension, headache, difficulty falling asleep, and body soreness where hit were all problems experienced. The social evaluation was that victims often felt fear and changes in the relationship with those with whom they worked.

This study makes a valuable contribution to literature on ED violence. The large sample size (n=1209) and variety of facilities make it possible to generalize the findings to a wider area. The study also, wisely, addressed many different aspects of violence and victimization.

Erickson & Williams-Evans (2000) studied patient assaults toward ED nurses and what attitudes they had with regard to violence in the ED (Erickson & Williams-Evans, 2000). The descriptive research design consisted of a convenience sample of nurses from two EDs in the mid-south region, that were working at least 20 hours a week or more. The survey questionnaire used was the “Attitudes Toward Patient Physical Assault that was developed by Poster and Ryan” (Erickson & Williams-Evans, 2000, p. 211). A consent form was signed before the survey was distributed to Registered Nurses (RN) who wished to participate. The consent and the survey were collected separately with no identification on the survey so that the RNs remained anonymous. The instructions on how to fill out the survey were given by the principle investigator so that everyone would do it the same way.
Fifty-five RNs were willing to participate in the study from the two ED’s. The EDs that were chosen had an all RN staff making the sample “homogenous with regard to profession” (Erickson & Williams-Evans, 2000, p. 211). Thirty RNs worked at least 20 hours a week in ED (A) and 26 RNs worked at least 20 hours a week in ED (B). Of this number 55 completed surveys and returned them. This response rate was 98%.

“Emergency department (A) is located within a medium-sized, suburban, tertiary hospital location approximately 15 miles from a large mid-south city. Emergency department (A) provides emergency care for clients of all ages and with varied complaints. Emergency department (B) has a level I trauma designation and is located within a large, urban teaching institution. Emergency department (B) provides care exclusively for adolescent and adult trauma patients” (Erickson & Williams-Evans, 2000, p. 211).

The survey that was used had 31 items. The survey was broken down into four main categories: “(1) Safety concerns, (2) patient responsibility for behaviour, (3) staff performance, and (4) legal/ethical concerns” (Erickson & Williams-Evans, 2000, p. 211).

“Eighty-two percent of nurses surveyed had been physically assaulted by patients during their career. Fifty-six percent had been assaulted within the preceding year. Twenty-nine percent of these assaults were unreported. The majority of nurses (50.9%) had experienced one to three assaults during their career; however, 10.9% had experienced more than 15 assaults during their careers” (Erickson & Williams-Evans, 2000, p. 212).

The next study reviewed was one that was done in Ireland by Rose (1997). The purpose of this study was to see if there was an increase in violence directed toward nurses and attendants in an Accident and Emergency (A&E) Department. Descriptive
statistics were used in this study. A survey was used to determine several factors: “(1) what proportion of staff had experienced physical or verbal violence while on duty in the hospital, (2) the frequency of such attacks, (3) whether the violence was officially reported and sick leave taken, (4) whether age and experience changed attitudes to violence, or the reporting of it, and (5) the level of staff training, if any, in dealing with violence” (Rose, 1997, p. 214).

A questionnaire was used that dealt with all the above-mentioned areas. Confidentiality was offered to the participants. There were 36 nurses on staff, 27 of whom responded to the survey; there were 13 attendants on staff and 9 of them responded. “Attendants are patient care assistants (all men), with handling and lifting duties” (Rose, 1997, p. 216).

The hospital that was used for this survey was in Dublin, the capital of Ireland. The hospital is located close to main roads and highways, which brings in a wide range of patients and their injuries. The A&E also does psychiatric evaluations before patients are transported to other facilities.

The findings of this survey revealed that 60% of the nurses and attendants had been physically assaulted at least once during their careers. It also was found that 40% of these individuals had been assaulted in the last 12 months. Nurses were not assaulted as frequently as attendants, 52% and 88% respectively. The majority (91%) stated that they were concerned that they would have violence directed at them. Nurses and attendants were required to record and report all incidents of violence. This however was not the case of what happened. “…63% of all incidents and 29% of physical assaults were unreported” (Rose, 1997, p. 217). Nurses who had been working for 10 years or more,
were more likely to report verbal abuse, reporting it 71% of the time. Nurses that had been working in the field for less than 10 years reported verbal abuse only 20% of the time.

An interesting note in this study was that the respondents felt that the judicial system did not support them in the way they felt they needed. They further stated that if these assaults had been directed toward a private citizen, they would be taken more seriously. It was reported that some managers were supportive, but others were not; however, colleagues were always very supportive (Rose, 1997).

The training that these nurses received appeared to be inadequate. “…slightly more than one fifth of the staff had received training in dealing with violent or abusive patients” (Rose, 1997, p. 217). This training ranged from one hour of lecture to comprehensive preparation of those who were qualified as psychiatric nurses.

The researcher stated that there was not much literature available and that this was the first study of this kind to be done in Ireland. The author also talked about the changes in the A&E since the time of the survey. Currently, staff is encouraged to report all incidents of violence. The staff had also been given training in “techniques for breaking away from physical assaults” (Rose, 1997, p. 319). A security officer is now present in the A&E at all times. The most important change that came about was that all staff receive a personal alarm that can be activated by pushing a button or pulling a string and the noise can be heard throughout the A&E.

A research study conducted by Lyneham (2000) in New South Wales, Australia, was used to determine the type and amount of violence that took place in New South Wales (NSW) emergency departments. The design of this study was a qualitative
descriptive exploratory survey, conducted through semi-structured interviews. These interviews were then analyzed to determine if there was a common theme. There was also provision made by the researcher for those participants who needed debriefing or counseling to receive it.

This research was done in two parts. Stage one used interviews with participants. “Network sampling was allowed for access to registered nurses from rural, remote and metropolitan emergency departments. A total of nine nurses were interviewed, three from each region” (Lyneham, 2000, p. 10). Stage two of this survey involved 650 nurses who were members of the NSW Emergency Nurses’ Association. The NSW Emergency Nurses’ Association took the responsibility of labeling the survey envelope, which contained the survey, so that anonymity could be maintained. Data were analyzed using univariant methods.

Of the 650 surveys distributed, only 266 respondents were obtained from all three regions: metro, rural, and remote. Violence was prevalent; all respondents had experienced some form of violence during their work as an ED nurse. “Fifty eight percent of respondents experienced verbal abuse, 56% encountered abuse on the phone, 14% faced physical intimidation or assault, and 29% received threats, at least weekly” (Lyneham, 2000, p. 11). A table described the kinds of weapons that were used in violent ED incidents; knives being the most prevalent. The most common source of the violence was either from the patient or a family member. The causes of violence were determined to come from “three main factors, alcohol, drugs and waiting times” (Lyneham, 2000, p. 12). Twenty percent of violence is not reported, and 54% is rarely reported. Fifty-two percent of respondents said that they received no support following violence directed at
them. Twenty-eight percent of respondents had not received any training in dealing with violence (Lyneham, 2000).

The researchers summarized the study with recommendations for making EDs a safer working environment. Suggestions included training and education, dedicated police phone line, security staff on site at all times, metal detectors as needed, adequate staffing, legal support to the staff and video cameras (Lyneham, 2000).

Mayer, Smith and King (1999) studied the factors associated with victimization. The purpose of their study was: "(1) to identify the incidence of personnel victimization in selected Central Florida emergency departments, and (2) to examine the relationship of these incidents to victims reports of three factors: characteristics of the patient/perpetrator, characteristics of the personnel victimized, and characteristics of the ED environment" (Mayer, Smith, & King, 1999, p. 361).

Data were collected from a 37-item mail-in survey, Mahoney's Emergency Department Victimization Questionnaire (EDVQ). A demographics form was also used. "Chi square with Spearman's rank correlation coefficient (rho) and frequencies were used to describe incidence and Pearson's product moment correlation was used to analyze its relationship to the three factors studied..." (Mayer, Smith, & King, 1999, p. 362). ED personnel who worked more then 20 hours per week and were involved in direct patient care and worked in one of 19 hospitals in the tri county area of Central Florida were involved in this study. Of the 19 hospitals that were eligible, only 18 chose to participate. The hospitals were located in rural, urban and suburban areas. Two hundred twenty six ED personal chose to participate from the 600 member staff (Mayer, Smith, & King, 1999).
Of the respondents 92.6% had more than one year of ED experience. A total of 94.3% respondents had a diploma or other degree. Only 28.8% reported that they had never received any course work or education on violence and 29.9% reported no continuing education regarding violence. The type of violence reported most was physical assault at 71.9% in the career of ED personnel. The number of physical assaults experienced by personnel in the last year was 41.5%. “In reporting which of their experiences was most serious, physical assault was named most frequently (44.7%), followed by threat or intimidation (21.7%), verbal abuse (18.18), [and] damage to reputation (1.8%)” (Mayer, Smith & King, 1999, p. 363). Eighteen percent of respondents reported threat or harassment outside of the hospital. The majority of respondents said that there was under reporting of the incidents (Mayer, Smith, & King, 1999).

The two factors that seem to have the most influence on the perpetrator which caused them to be violent were alcohol and street drugs. The respondents felt that their patients’ medical condition, the medical reason for which they had come to the hospital, had only a mild influence on violent behavior. Another point of interest is that “women were significantly more likely to avoid identification in the ED area through practices such as turning their name tag over (P=.044; n=217), despite a trend of using only first names on name tags” (Mayer, Smith, & King, 1999, p. 363). Fifty-seven percent of respondents were dissatisfied or extremely dissatisfied with current security.

A case study by Crotty and Crotty (1996) addressed the use of cocaine and how a person may react when under the influence. The authors reviewed how cocaine is produced and used. There was no indication as to where this study was carried out; it was
a case study of one person in one emergency department of unknown location, which was a limitation. It did, however, provide valuable information.

This case study used one example of a cocaine induced psychotic episode. The article related the signs and symptoms that the client experienced. It then detailed management of the patient and reactions from the medications used in the treatment.

The conclusions the authors made were that there are seven different ways to improve ED security. "Providing adequate and qualified personnel, installing metal detectors to keep weapons outside the ED, enclosing nurses' stations with protective materials like bullet-proof glass; providing and requiring all personnel to wear picture identification; controlling access to facilities; installing panic or emergency buttons to alert specially trained security teams of violent or potentially violent situations; and positioning security in the ED 24 hours per day" (Crotty & Crotty, 1996, p. 17).

Summary

There is a common theme that is seen in Emergency Departments around the world: violence. Violence is not limited to US emergency departments only. Regardless of the extent of the problem there is a definite need for change. There is a need for better reporting and better protection. None of these articles dealt with the retention of nursing staff given violence in the workplace or how safety measures altered retention rate. Tolerance for this issue is not an option and patient, family and the public must be educated that violence is not acceptable behavior.
CHAPTER THREE

Introduction

This chapter will explain the research design and the population to be studied. The instrumentation and plan for data analysis will be explained. Also included will be the identified limitations of this study.

Research Design

The study utilizes a descriptive survey design. This methodology was best suited for this study because it provided a picture of what happens naturally in a given situation, ER violence against nurses. The goal was to identify the most and least helpful forms of post ER violence care for the nurses. The limitations of this design are that inference to larger groups is limited. The design also limits data obtained as compared to qualitative design; a survey obtains less data, data that are more specific and scripted but may miss important elements of what nurses who have been victimized need and want.

Population, Sample, and Sampling Criteria

The population of interest was ED nurses. From this group, a sample of ten individuals was selected. A pilot study of ten participants obtained as a convenience sample was conducted.

The RN’s involved in this study work a minimum of 20 hours per week in an ED. They also had to have been working in an ED for a minimum of one year prior to participating in this study. They were willing to participate and give informed consent. The nurses also had to be victims of ED violence at least once during their career.
Setting

This research was done at more than one of the local hospitals, in the Chattanooga, Tennessee area. The nursing staffs of the ED’s of these hospitals were utilized.

The strength of doing this at local hospitals in Chattanooga was that it was easy access for the researcher. There was also a giving back to the local area by doing the research in Chattanooga where the researcher is currently living. This research was done locally with plans to move to a national level with later research.

Weaknesses of this setting were that most hospitals in the local area are small. There was a small sample size compared to a large city hospital. The research can not be generalized to ED’s outside the Chattanooga area.

Ethical Considerations

Protection of subjects’ rights encompasses an anonymous survey with biographical data collected separately. These two sets of information were stored separately as well. There was also no information given to the employer as to who participated and who did not.

The consent form for participation was signed and no one was forced to participate. All data collected will be stored for five to seven years in a locked cabinet at the home of the researcher after graduation.

Approval for this research was obtained from the Internal Review Board (IRB) at Southern Adventist University. No data were collected without approval.
Instrumentation

The informed consent included the introduction of research activities, description of risks and discomforts, description of benefits, disclosure of alternatives, assurance of anonymity and confidentiality. Also included was an offer to answer questions, a non-coercive disclaimer and an option to withdraw if desired.

The instrument used in this study was questionnaires that included twelve questions to determine what methods offered to nurses were the most helpful after they were victims of ED violence. The scoring for this questionnaire was on a one to four scale, one not helpful to four very helpful. The questionnaire was designed for this study and therefore there were no data to show reliability and validity.

Plan for Data Collection

Once the IRB of Southern Adventist University agreed to allow the research then the researcher obtained a convenience sample of ten nurses as previously described. The questionnaire was explained to them and informed consent was obtained.

The only one collecting data was the primary researcher for this paper. The data were collected in a four week time period after the IRB had agreed to the research proposed (Appendix A). Data compilation and review were done in the two weeks after the data collection was complete.

Data were managed using computer software for this purpose. All files and information were locked so that only the researcher had access. Biographical info and survey info were separated. All data will be shredded and all electronic data will be deleted upon the seven year anniversary of completion of research.
Plan for Data Analysis

Analysis of central tendency and measures of dispersion were completed on the data. Analyses included gender, years of ED experience, shifts worked and hospital status. Analysis was also done for the research questions. Descriptive statistics were used to explain the research questions.

Identification of Limitations

A limitation of this study was that the operational and conceptual definitions are not clearly defined by the theory used in the framework of this study. Another limitation was that a small sample size was used and therefore generalization to a wider group is not possible. The instruments used in this study were not tested for reliability and validity.

Discussion of Communication of Findings

Findings were written up in a report using narrative, graphs and tables. This report was presented to faculty and student at Southern Adventist University. Findings will be presented at meetings and in journals specific to ED nurses if possible.
Chapter four will describe the demographics of the individuals involved in the study. It will also talk about the performance and reliability of the instruments and describe the findings for each research question. This chapter will summarize the data collected.

Sample Demographics

A total of eight surveys were returned that were complete and useable from a total of 16 distributed. The ages of the participants ranged from 25 to 59, with a mean of 41.8 years of age. There were six female and two male participants. A range of 4 to 45 years of nursing experience was reported, with a mean of 16.74 years of nursing experience. Of this number, the consecutive years worked in the ED ranged from 1 to 35 years, with a mean of 13 years. The average number of hours worked was 33.24, with a range of 20 to 40 hours per week. Five participants had AS degrees and three participants had BS degrees. There was an even distribution of types of hospital that these RN's worked at with four urban and four suburban. The shifts represented by those sampled included day shift, (four RN's), night shift (one RN), and variable shifts (three RN's). One participant worked in a level-two trauma center and seven worked in a level-three center. The number of ED beds ranged from 8 to 30, with a mean of 14.6 ED beds. During a work shift the RN's were assigned to a minimum of three rooms and a maximum of five rooms, with a mean of 3.87 rooms. These ED's saw all types of patients with no particular specialty.
Performance and Reliability of Instruments

The reliability of the instrument was determined using Cronbach’s alpha. The overall reliability of the tool was 0.665. The reliability of the “Helpfulness questions” was 0.787 and the reliability of the “Anticipated helpfulness questions” was 0.780.

Description of Findings

A number of physical/psychological interventions were offered to nurses who had been victimized by patients or family members of patients. Common interventions included: manager support, 87.5% (N=7); peer support, 87.5% (N=7); colleague support, 87.5% (N=7); physical exam and treatment, 75% (N=6); and police report, 50% (N=4).

Physical/psychological interventions the RN’s thought to be most and least helpful after they had been victimized were evaluated in this study. The survey also attempted to determine which additional interventions these RN’s felt would be beneficial for them to receive.

Six participants received a physical exam and treatment after a violent event. Of these, 16.7% (N=1) felt it was “not helpful”, 16.7% (N=1) felt it was “helpful”, and 66.7% (N=4) felt it was “very helpful”. Two participants did not receive a physical exam and treatment, of these, 50% (N=1) felt it would have been “not helpful”, and 50% (N=1) felt it would have been “very helpful”.

Four participants had a police report filed. Of these, 50% (N=2) felt it was “minimally helpful”, 25% (N=1) felt it was “helpful”, and 25% (N=1) felt it was “very helpful”. Four participants did not file a police report. Of these, 25% (N=1) said that it was “not applicable”, 25% (N=1) felt it would have been “not helpful”, and 50% (N=2) felt it would have been “very helpful”.

Seven participants received manager support following a violent event. Of these, 28.6% (N=2) felt it was “minimally helpful”, 14.3% (N=1) felt it was “helpful”, and 57.1% (N=4) felt it was “very helpful”. One participant did not receive manager support and this participant felt that it would have been “helpful”.

Three participants received time off from work following a violent event. Of these, 33.3% (N=1) felt it was “minimally helpful”, and 66.7% (N=2) felt it was “very helpful”. Five participants did not receive time off. Of these, 40% (N=2) said that it was “not applicable”, 20% (N=1) felt it would have been “not helpful”, 20% (N=1) felt it would have been “helpful”, and 20% (N=1) felt it would have been “very helpful”.

Three participants received workman’s compensation following a violent event. Of these, 33.3% (N=1) felt it was “not helpful”, 33.3% (N=1) felt it was “helpful”, and 33.3% (N=1) felt it was “very helpful”. Five participants did not receive workman’s compensation. Of these, 60% (N=3) said that it was “not applicable”, 20% (N=1) felt it would have been “not helpful”, and 20% (N=1) felt it would have been “very helpful”.

Two participants received job reassignment inside the ED following a violent event. Of these, 50% (N=1) felt it was “helpful”, and 50% (N=1) felt it was “very helpful”. Six participants did not receive job reassignment inside the ED. Of these, 16.7% (N=1) said that it was “not applicable”, 16.7% (N=1) felt it would have been “not helpful”, 16.7% (N=1) felt it would have been “minimally helpful”, and 50% (N=6) felt it would have been “very helpful”.

None of the eight participants received job reassignment outside the ED following a violent event. Of these, 25% (N=2) said that it was “not applicable”, 25% (N=2) felt it
would have been “not helpful”, 12.5% (N=1) felt it would have been “minimally helpful”, and 37.5% (N=3) felt it would have been “very helpful”.

Seven participants received peer support following a violent event. Of these, 14.3% (N=1) felt it was “minimally helpful”, 28.6% (N=2) felt it was “helpful”, and 57.1% (N=4) felt it was “very helpful”. One participant did not receive peer support and felt that it would have been “minimally helpful”.

One participant received support group assistance following a violent event and this participant felt it was “very helpful”. Eight participants did not receive support group assistance. Of these, 25% (N=2) said that it was “not applicable”, 12.5% (N=1) felt it would have been “not helpful”, 25% (N=2) felt it would have been “minimally helpful”, 12.5% (N=1) felt it would have been “helpful”, and 25% (N=2) felt it would have been “very helpful”.

One participant received professional counseling following a violent event, and this participant felt it was “helpful”. Seven participants did not receive professional counseling, of these 14.3% (N=1) said that it was “not applicable”, 28.6% (N=2) felt it would have been “not helpful”, 28.6% (N=2) felt it would have been “minimally helpful”, 14.3% (N=1) felt it would have been “helpful”, and 14.3% (N=1) felt it would have been “very helpful”.

One participant received debriefing time following a violent event and this participant felt it was “very helpful”. Seven participants did not receive debriefing time. Of these, 14.3% (N=1) said that it was “not applicable”, 14.3% (N=1) felt it would have been “not helpful”, 28.6% (N=2) felt it would have been “helpful”, and 42.9% (N=3) felt it would have been “very helpful”.
Seven participants received colleague support following a violent event. Of these, 14.3% (N=1) felt it was “minimally helpful”, 14.3% (N=1) felt it was “helpful”, and 71.4% (N=5) felt it was “very helpful”. One participant did not receive colleague support and felt that it would have been “minimally helpful”.

Summary

Eight surveys were complete and usable. Reliability for this survey tool was good. The completed surveys had varying responses to the questions with no one dominant theme for significantly good or bad responses following a violent event. There appear to be trends in the data that will be discussed in the next chapter.
CHAPTER FIVE

Introduction

Chapter five will discuss the research findings, the conclusions that can be drawn from these findings, and their relevance for nursing. Recommendations for additional research will be made as well.

Discussion and Conclusions

The sample size and untested tool make this study most appropriate as a pilot study. While the sample size was small, the data are of interest. The actions that the victims of ED violence thought were of greatest benefit to them were: physical exam, manager support, job reassignment inside ED, peer support, and colleague support. This indicates that persons around the victims have the biggest impact on how the victim copes with the violence.

At the beginning of this study, it was thought that nurses needed better support after a violent incident occurred in an ED. The results of this study show that there are still nurses who do not receive needed or wanted support following a violent event. The data suggest that victims of ED violence view police reports, job reassignment within the ED, and debriefing time as potentially valuable.

Based on the study findings, the interventions that seemed to matter the least for the victims of ED violence were: time off, worker’s comp, job reassignment outside ED, and professional counseling. There would be no point in ED’s putting time and money into these fields due to the lack of evidence that these areas are helpful to nurses who have been victimized.
Significance of Findings

As was demonstrated in the literature review violence at some point is significant in ED nurse's lives. The Pennsylvania study showed that greater than 97% of ED nurses had experienced verbal abuse violence and greater than 93% had experienced threats of violence. Only slightly smaller (65%), experienced a physical assault in the ED. What can be done to help them once they have become victims of violence?

The results of this study suggest that nurses do not use or want to use professional sources to deal with the aftermath of a violent incident. This is in direct contrast to a study published in the Emergency Medicine Journal that stated “preventative measures, such as increased availability of formal psychological support, should be considered...to protect the long term emotional wellbeing of their staff” (Crabbe, 2004, p.568).

Given that nurses who have been victimized seem to need the support of those around them, it would be beneficial to the EDs to have an education system set up. This would educate managers on the needs of victims and educate the staff on how they can best help the victims of violence. Nurses care for patients as well as each other and giving them tools to better help victims of violence would create a healthier staff to continue to do a great job in caring for their patients.

Recommendations

Several recommendations may be made based on this pilot study. First, the research tool should be refined. The survey tool (Appendix A) did not need to have the “N/A” option available. This option seemed to confuse participants. The survey appeared to be confusing to some participants because all columns were used. Instead it would have been clearer to state “if yes, then how much was it helpful and if no, then how much
do you think it would have been helpful if received”. The wording needs to be changed from “peer support” to “family support” because “Colleague support” and “peer support” seemed to address the same group. Family support needs to be recognized as a possible support system for these nurses.

The survey tool possibly needs better directions and should be reformatted for better clarity. A much larger sample size is needed. This study also could yield a wealth of knowledge using a qualitative design. There were questions that could have been left open ended with space to write answers that would have given a greater understanding about what resources RN’s use after they have experienced violence.

Summary

There does not seem to be a clear cut answer about what nurses need once they have experienced a violent incident. This study has shown that there are areas that are very helpful to nurses and areas that have not been. There is a growing trend of violence in the ED’s. Nurses who have been victims of violent events need to be cared for effectively. For effective care of those who have been victims of violence there is a need to use resources at hand, time, staff and money, to put in place a program that nurses think will help them the most. Additional research to further understand these areas will be helpful.
References


APPENDIX A: CONSENT LETTERS AND FORMS

1. Southern Adventist University Institutional Review Board approval letter

2. Biographical data sheet

3. Survey

4. Informed consent
June 6, 2006

Ms. Sarah Fraser
PO Box 1023
Collegedale, TN 37315

Dear Ms. Fraser,

The Human Participants in Research Subcommittee has approved your research application entitled "Violence and Coping in the ED Nurse". It is the understanding of the committee that you will be collecting data from nurses who have worked in ED for at least one year and have had at least one violent interaction with a patient or patient’s family members.

It is our understanding that your dissertation research is being conducted through the School of Nursing, and information will be collected in the form of a survey. All participation in your research must be voluntary and data kept in a secure location. All data is to be kept in a secure location and the study is expected to be concluded by August 30, 2006.

Sincerely yours,

Linda Ann Foster, Ph.D., Chair, Human Participants in Research Subcommittee
Professor, Biology Department
Southern Adventist University
BIOGRAPHICAL DATA SHEET

NURSE:

Name

Age

Male / Female

Number of years worked as RN

Degree: AS / BS

Number of consecutive years in ED

Average hours worked per week

Shift: Day / Night / Evening

HOSPITAL:

Location: (Urban, Metro, etc.)

Status: (Level I Trauma, etc.)

Number of beds in ED:

Average number of rooms per nurse:

Type of pt’s ED sees (pediatrics, trauma, etc.)
Below are listed specific interventions for nurses who have been victims of violence at work.

Please circle:
1) whether or not you received these services,
2) how helpful each service was if received
3) how helpful you think this service would have been if you did not receive it.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Received</th>
<th>Helpfulness</th>
<th>Anticipated Helpfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes / No</td>
<td>1 Not Helpful 2 Minimally Helpful 3 Helpful 4 Very Helpful</td>
<td>1 Not Helpful 2 Minimally Helpful 3 Helpful 4 Very Helpful N/A</td>
</tr>
<tr>
<td>1. Physical exam and treatment</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>2. Police report</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>3. Managerial support</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>4. Time off</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>5. Workman's Comp</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>6. Job reassignment inside ED</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>7. Job reassignment outside of ED</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>8. Peer support</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>9. Support group</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>10. Professional counseling</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>11. Debriefing time</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
<tr>
<td>12. Colleague support</td>
<td>Y / N</td>
<td>1 / 2 / 3 / 4</td>
<td>1 / 2 / 3 / 4 / NA</td>
</tr>
</tbody>
</table>
INFORMED CONSENT

Introduction:
This study is being done to help determine the best help that can be given to a nurse after being victimized so these methods can be implemented more often. You will be filling out a survey that will take 10min of your time.

Description of Risks and Discomforts
1. Remembering violent situations can be emotionally painful.

Description of benefits
Your participation will generate knowledge for use in future studies that will help determine what are the best resources that can be made available to nurses who have experienced victimization.

Disclosure of alternatives
You may choose not to participate

Assurance of anonymity and confidentiality
You will be filling out a biographical information sheet that will be kept at all times separate of your survey. There will be no identifying marks that will allow for your survey to be attached to your biographical information. Your identity will remain anonymous in all presentations, reports and publications of this study.

Answer questions
If you have any questions that I may answer please feel free to ask. You may contact me by mail at PO Box 1023, Collegedale, TN 37315 or by phone at 423-503-6801.

Non-coercive disclaimer
Participation is voluntary and refusal to participate will involve no penalty or loss of benefits to which you are entitled.

Signature ___________________________ Date ____________