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Stressful Incidents of Physical Violence Against Emergency Nurses

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Abstract

Physical violence against nurses has become an endemic problem affecting nurses in all settings. The purpose of this study was to describe acts of physical violence against emergency nurses perceived as stressful using a qualitative descriptive design with a national sample of emergency nurses. The guiding conceptual model for the study was the Ecological Occupational Health Model of Workplace Assault. Narrative accounts of physical violence were analyzed using a constant comparative analysis method. Key findings included risks related to employee, workplace, and aggressor factors, and descriptions of physical violence. Discussion of the study findings suggests that efforts to prevent violence and promote workplace safety need to focus on designing work environments that allow for the quick egress of employees, establishing and consistently enforcing policies aimed at violence prevention, and maintaining positive working relationships with security officers. While patients with mental health or substance use complaints are deemed most likely to commit physical violence, they are not the only patients to become violent. Risk reduction efforts should target all patients and visitors.

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Physical violence against nurses has become an endemic problem in health care. Researchers have identified that physical violence affects nurses in nearly all work environments and all regions of the world. Patient care settings with reports of physical violence include medical/surgical, obstetrical/gynecological, emergency, psychiatric/behavioral, intensive care, pediatric, and long-term care settings (Gerberich et al., 2005). In addition to the many published studies about the prevalence of violence in the United States (Gacki-Smith et al., 2009; Gates, Gillespie, & Succop, 2011), violence was reported against nurses working in Australia (Cashmore, Indig, Hampton, Hegney, & Jalaludin, 2012), Japan (Fujita et al., 2012), Taiwan (Pai & Lee, 2011), Saudi Arabia (Alqwaiz & Alghanim, 2012), Jordan (AbuAlRub & Al-Asmar, 2011), Egypt (Samir, Mohamed, Moustafa, & Saif, 2012), and Italy (Magnavita & Heponiemi, 2011).

Researchers have identified that physical violence affects nurses in nearly all work environments and all regions of the world.

Consequences of physical violence for the nurse include acute stress, posttraumatic stress symptoms, decreased work productivity, physical injury, and death (Bureau of Labor Statistics, 2012; Gates, Gillespie, & Succop, 2011; Gillespie, Gates, Miller, & Howard, 2010; Janocha & Smith, 2010). While work-related deaths are a rare occurrence in health care, Janocha and Smith (2010) reported that there were still 100 workers fatally injured between 2003 and 2007 in the health care and social assistance sector due to workplace violence. More commonly, nurses will experience a non-fatal injury. Janocha and Smith

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(2010) found that of all non-fatal injuries in the private sector in 2007, approximately 9,953 (59.1%) occurred in the health care and social assistance sector. Specific to emergency nursing, the rate of physical assaults against emergency nurses was 1.8 assaults per nurse per year (Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2013). The purpose of this study was to describe the acts of physical violence against emergency nurses that were perceived as stressful. Such information can benefit nurse leaders and risk managers as they develop primary prevention strategies to prevent distressful, physically violent situations.

Conceptual Framework

The conceptual framework for this study was based on the Ecological Occupational Health Model of Workplace Assault (Levin, Hewitt, Misner, & Reynolds, 2003). Four concepts in this model were applied in this study: personal worker factors; workplace factors; community and environmental factors; and assault situation. Personal worker factors included the demographic characteristics of the worker, nursing experience, and perceived risk for being assaulted (Levin et al., 2003). Workplace factors included the physical design of the emergency department (ED), workplace policies, availability of security officers, and staffing patterns (Levin et al., 2003). Community and environmental factors included the geographical location of the ED and the presence of violence, weapons, and substance use in the community. For this study, community and environmental factors were conceptualized as aggressor factors to study the persons enacting the physical violence against emergency nurses. Aggressor factors included a prior history of violence, patient history of mental health disease or disorder, and the death of a patient (Gillespie et al., 2010). The assault situation included the specific acts of physical violence (Levin et al., 2003).

Review of Literature

Gerberich et al. (2005) conducted a case-control study with 475 Minnesota nurses who had been physically assaulted at least once in the prior year and 1,425 Minnesota nurses who had not been physically assaulted. Departments with the greatest risk for physical violence when compared to medical/surgical settings were the emergency (fully-adjusted odds ratio: 4.22) and behavioral health departments (fully-adjusted odds ratio: 2.03). Other researchers reported findings consistent with Gerberich et al.'s (2005) finding that physical violence against nurses in the ED is particularly problematic in comparison to other patient care settings (Camerino, Estryn-Behar, Conway, van der Heijden, & Hasselhorn, 2008; Campbell et al., 2011; Fujita et al., 2012). Camerino et al. (2008) conducted a multinational European study measuring physical violence against nurses. The researchers reported that 43.2% (n=660) of emergency nurses were assaulted by patients or visitors on a daily, weekly, or monthly basis.

Nurses share a common response to being the victim of physical violence in the workplace that includes becoming fearful, angry, frustrated, and helpless (Gillespie et al., 2010; Magnavita & Heponiemi, 2011; Samir et al., 2012). Nurses also commonly exhibit signs of posttraumatic stress after physical violence. Signs include consciously avoiding opportunities to talk about the event, having recurrent flashbacks about the event, and having a heightened state of arousal leading to poor sleeping (AbuAlRub & Al-Asmar, 2011; Gates, Gillespie, & Succop, 2011; Gillespie et al., 2010; Pai & Lee, 2011). Gates, Gillespie, and Succop (2011) found that 94% (n=209) of their national cross-sectional sample of emergency nurses had some degree of posttraumatic stress symptomatology. Signs of posttraumatic stress in nurses were also reported by AbuAlRub and Al-Asmar (2011), Gillespie et al. (2010), and Pai and Lee (2011).

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Consequences of physical violence are not limited to adverse psychological signs and symptoms. Being the target of physical violence can impact the ability of nurses to perform optimally. Gates, Gillespie, and Succop (2011) discussed that the posttraumatic stress symptoms caused by physical violence reduces the ability of emergency nurses to cognitively focus on their work in comparison to their ability prior to a violent event. Gillespie et al. (2010) qualitatively explored the effect of workplace violence on nurses in a pediatric ED and found that participants intentionally avoided patients and visitors who were violent, likely in an effort to prevent a recurrent violent act.

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The review of the literature suggests that physical violence can lead to negative psychological health and, for some, a decrease in work productivity. However, it is not clear which acts of violence are deemed as stressful. The findings from this study will help to fill this scientific gap by answering the research question: What are the personal worker, workplace, and aggressor factors, and assault situations, of a distressful physically violent experience in the workplace?

Study Methods

A qualitative descriptive research design was used with a national sample of emergency nurses. The study was approved by the university Institutional Review Board and the Emergency Nurses Association (Des Plaines, IL, U.S.A.).

Population and Sample

The study population was the 30,000 emergency nursing members of the Emergency Nurses Association. A systematic random sample of 3,000 nursing members was drawn from the association membership. Eligibility criteria were (a) providing direct patient care in an emergency setting and (b) a recent experience of physical violence.

Narrative descriptions of physical violence in the workplace were received from 177 study participants for a 5.9% response rate. The mean word count per narrative was 188 words (median 98 words) ranging from 11 to 709 words. The mean age of participants was 43.1 years, ranging from 25 to 65. The study sample was predominantly female (n=149, 85.8%), Caucasian (n=160, 90.9%), bachelor-prepared (n=102, 57.6%), and working day shift hours (n=97, 56.7%). The majority of the violent events depicted in the narrative descriptions occurred in a general ED (n=128, 72.3%) providing care to both adult and pediatric patients. Additional demographic information is provided in Table 1.

Table 1. Participant demographics (N=177).[a]

	N	%
Gender		
Male	23	14.2%
Female	149	85.8%
Race		
Caucasian	160	90.9%
Other	15	9.1%
Educational attainment		
Diploma	10	5.6%
Associate degree	44	24.9%
Bachelor degree	102	57.6%
Master's degree	21	11.9%
Shift worked		
Day shift	97	56.7%
Evening shift	19	11.1%
Night shift	55	32.2%
Emergency department patient population		

Adult patients	43	24.3%
Pediatric patients	6	3.4%
General (adult/pediatric)	128	72.3%
Location of emergency department		
Urban	84	47.5%
Suburban	58	32.8%
Rural	35	19.8%
Patient census of emergency department		
< 25,000	26	14.9%
25,000-49,999	43	24.6%
50,000-74,999	50	28.6%
75,000-99,999	36	20.6%
100,000+	20	11.4%

[a]Sample may not add to n=177 due to missing data for come categories.

Procedures

A solicitation letter was mailed to potential participants describing the study purpose, study procedures, and human subjects' protections. Enclosed in the mailing were the following instructions provided at the top of a lined data collection sheet:

> Please reflect back over the recent weeks and think about any workplace violent events that you have experienced from patients and their visitors. Reflect specifically over physical assaults (e.g., being spat upon, hit, punched, kicked, bitten, pinched, or shoved) and threats of physical assault (e.g., patients/visitors stating they will hurt you, kill you, come and "get you" or your family).
>
> Now think about a single recent workplace violent event that caused you the most stress. Describe in your own words this workplace violent event. Please include in your description information surrounding the violent event, the perpetrator, and your reaction to the violent event."

After writing their narrative story, participants mailed the hand written data, along with demographic information back to the study team in a pre-addressed, stamped envelope. The narratives were transcribed verbatim into a Word® (Redmond, WA, U.S.A.) document and verified for accuracy by the primary author (GLG). The Word® documents were then imported into NVivo 9® (Burlington, MA, U.S.A.) for qualitative data analysis.

Data Analysis

The transcripts were analyzed using the constant comparative analysis method depicted by Lincoln and Guba (1985). Initially, two investigators (GLG, PB) repeatedly read all of the transcripts, identified important units of information, and preliminarily assigned units of information to categories that were thematically related. The two investigators met and discussed at length categories and representative exemplars depicting the categories. Consensus was reached on a coding schema. The primary author (GLG) then conducted line-by-line coding of the narrative accounts of workplace violence. The coding schema, coded units of information, and summary of the findings were provided to the co-investigators (DG, PB). An audit of the findings was conducted. The coding categories were then structured in relation to the study's conceptual framework and supported with exemplars from the data.

Trustworthiness of the findings was met by using the Lincoln and Guba (1985) criteria of credibility, transferability, dependability, and confirmability. Credibility was enhanced by a prolonged engagement with the data, having two investigators develop the coding schema (investigator triangulation), and analyzing the narratives in relation to one another (data triangulation). Transferability was addressed by providing relevant exemplars that can provide meaning to the readers, allowing readers to draw conclusions between the context of the study findings and a second population. Dependability was met by a data audit performed by an author that did not conduct the data coding. Confirmability was accomplished through investigator triangulation and an audit of the study findings

Findings

Four themes were identified from the data relating to the Ecological Occupational Health Model of Workplace Assault (Levin et al., 2003). The themes were personal worker factors, workplace factors, aggressor factors,

and assault situation. Each theme had several categories.

Personal Worker Factors

Three categories emerged for the theme of personal worker factors: nursing role, nursing experience, and nursing practice. Some participants discussed their specific nursing role when the violence occurred; the majority was providing direct patient care, while others were the charge nurse. Charge nurses were more likely to respond to a volatile situation that became violent (see Table 2). While the majority of the participants did not report their years of emergency nursing experience, a few nurses wrote that they were well experienced and were still the target of physical violence (see Table 2). A variety of nursing practice actions and interventions was reported to describe the actions taken when a patient or visitor became physically violent. Examples of nursing practice were conducting a triage assessment, inserting an intravenous line or indwelling urinary catheter, and administering an intramuscular injection (see Table 2).

Charge nurses were more likely to respond to a volatile situation that became violent

Workplace Factors

There were five categories representing the theme of workplace factors: location of violence, workplace design, security devices and personnel, wait times, and policies. A variety of locations identified where physical violence was enacted by patients or visitors including the ED lobby, triage rooms, patient treatment rooms, and the ED hallways (see Table 2).

Workplace design was seen as a major factor that could promote the safety of the worker or increase the risk of being victimized

Workplace design was seen as a major factor that could promote the safety of the worker or increase the risk of being victimized (see Table 2). One participant wrote, "... the area in triage did not allow for an 'out,'" leaving the worker trapped in a room with a violent patient. The workplace design contributed to the safety of one participant who was in the ED lobby/triage area when she saw a patient brandishing a weapon. She wrote, "I ran to the back. We were able to lock down the ED. He never made it to the back." Workplace design was interrelated to security devices and personnel as described by this participant: "Our facility has no 'surveillance' or rooms where you can see in. It is very uncomfortable to walk in a room and not know what to expect." Workplace design and security devices were only implemented in one ED after a severe act of physical violence. The participant wrote that the event "... led to the remodel of the main ED doors to a more formal locked down door system, a new ID [identification] badge system for the visitors, and increased security."

Wait time was an additional characteristic deemed to provoke physical violence from patients and visitors. Participants wrote that patients who believed they were not taken to a treatment area, seen by a physician, or received their pain medication fast enough were more prone to becoming violent. In addition, the nurses had difficulty transferring some mental health patients to an inpatient behavioral health unit (see Table 2).

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The enforcement of policies or lack of policies were identified as additional contributors to physical violence. Physical violence occurred when enforcing the visitor policy restricting access to a deceased child because, ". . . the body was considered a crime scene," the facility lacked a universal weapons screening policy (see Table 2), and limited security officer effectiveness by not permitting them to carry firearms. Non-enforcement of policies was also identified as a perceived risk for further violence (see Table 2).

Aggressor Factors

Factors depicting patients and visitors as aggressors were related to a patient's chief complaint or situational context. Categories related to chief complaint were mental health crises, substance use, and patients in pain. Patients that became physically violent were commonly described as having a mental health disease or disorder (n=68, 38.4%) concomitant with substance use (n=58, 32.8%; see Table 2). For example, one nurse wrote that a violent patient was an "18 year old with a history of bipolar and polysubstance abuse with positive alcohol and depression with suicidal ideation." Another nurse wrote, "Adult male 40's – presented under the influence of cocaine, opiates, and alcohol. Patient was depressed and suicidal." Examples of patients in pain that became violent were patients with legitimate injuries, non-trauma related pain (e.g., abdomen, chest), and

narcotic-seeking behaviors (see Table 2).

Pronouncement of or pending death of a patient was identified as a stressor that led some visitors to ultimately become physically violent.

Categories related to a situational context were patients in police custody, history of violence, frequent user of the ED, and patient death. Two situations most prone to escalating to physical violence identified by participants included a patient being in the custody of police (n=18, 10.2%; see Table 2) and a patient with a history of violence (n=17, 9.6%; e.g., the victim or aggressor of violence). Victims of violence were perceived as increasing the chance of further violence in the ED (see Table 2). Frequent users of the ED (patients that came recurrently to the ED and were well known to the nurses) could escalate to physical violence when their perceived needs were not met (see Table 2). Pronouncement of or pending death of a patient was identified as a stressor that led some visitors to ultimately become physically violent (see Table 2). For example, one nurse reported that he "... had a father and mother of an infant in full arrest that threatened staff," including himself.

Assault Situation

Three categories of the assault situation were reported: physical assaults, verbal threats of physical violence, and intimidation. Physical assaults (n=131, 74%) included patients' biting, choking, grabbing, kicking, pinching, pulling hair, punching, scratching, shoving, slapping, spitting, throwing objects or body fluids, and brandishing a weapon such as a firearm, knife, or sharp object (see Table 2). In one example, the nurse penned, "This young man was escalating in our waiting room. I heard glass crashing. He had picked up furniture and thrown it around, also crashing-in a glass enclosure around the triage desk." Verbal threats of physical violence (n=59, 33.3%) were also perceived as disturbing to the participants. Aggressors told the nurses that they would be back later to cause physical pain or kill the nurses (see Table 2). Intimidation (n=21, 11.9%) was displayed by both patients and visitors. Intimidation was displayed when visitors pushed their way through closed doors and windows to gain access to triage or the patient treatment area. Aggressors also encroached upon the personal space of nurses while simultaneously yelling or shaking their fists at the nurses (see Table 2).

Table 2. Categories and Representative Exemplars for the Narrative Accounts of Physical Violence.[a]

Thematic Category	Exemplars
Personal worker factors	
Nursing role	*[As the] day charge that day, went to room to assist with pediatric TV – on the way around a corner, [there was a] patient becoming more and more agitated and vocal, pacing in room. So I come up to room, he grabs security guard off of chair – has him in head lock and proceeds to beat his head against wall and door frame and then throwing him across hall into a wall. Patient then stands in middle of hall yelling – I grab his arm (again adrenaline rush) and make him go into room.*
Nursing experience	*We are a pretty seasoned group.*
	I have been in nursing 20+ years.
Nursing practice	*She was angry regarding a Foley catheter insertion. During the procedure she grabbed my forearm and pinched me really hard.*
Workplace factors	
Location of violence	*The mother became irate that they were being sent to the waiting room . . .*
Workplace design	*. . . forced access through a minimally secured door to gain access.*
Security devices and personnel	*In our ER we have no security.*
Wait times	*The patient was yelling obscenities all evening and afternoon. The psych/behavioral unit could not come down to take the patient.*
Policies	*It wasn't common practice to search all psych patients unless the complaint was suicidal or homicidal.*
	We did not go on lockdown even when the patient was discharged.

Aggressor factors	
Mental health patient	*One recent event was that of a psychiatric patient who truly was confused and psychotic.*
Substance use	*We had an 18 year old male that had been experimenting occasionally with marijuana. He had gone to a party and was intoxicated and unresponsive.*
Patients in pain	*Unhappy discharged emergency care center patient threatened to bring gun to get what he needed for pain.*
Patient in police custody	*. . . escaped convict who was intoxicated led police on high speed chase before being brought into the ER for evaluation after getting cut up by a fence when he tried to run.*
History of violence	*A male who appeared under the influence of drugs forced access through a minimally secured door to gain access to an ex-girlfriend and son who he had just stabbed in the face with a large pocket knife. The ex-girlfriend was screaming about a protection order and his involvement in the stabbing of his infant son.*
Frequent user of the ED	*A frequent flyer [frequent user of the ED] female patient with many psychosomatic complaints and illnesses, who utilized the ED whenever she needed attention or experienced anger at her spouse, was checking in for another repeat visit.*
Patient death	*The event happened when we received a 58 year old male DOA [dead on arrival], victim of a robbery upon entering his dry cleaning store. The patient suffered cardiac arrest. When the family arrived, the RN and the MD brought them to the 'quiet room' to break the news. The son reacted so violently.*
Assault situation	
Physical assaults	*While in isolation (10x10 foot room with door that has large glass window), he became increasingly agitated and verbally abusive toward his primary nurses. His agitation escalated to the point of ripping out the call light system out of the wall in his room, ripping the curtains in half, breaking the plexi-glass-face of a wall mounted sphygmomanometer and then proceeding to use, plexi-glass pieces to threaten staff.*
Verbal threats of physical violence	*She looked at me in a way that frightened me and stated, 'I never forget a face, and if it kills me, I'm gonna hunt you down and make you pay for treating me like an animal. You and your family will pay. Remember I know where to find you!'*
	He was walking off, stating he would just get a gun, return, and just shoot everyone on duty. As I was attempting to follow after him, I heard him state that he would just wait outside in the parking lot or in the street to catch staff going off duty and shoot them.
Intimidation	*. . . very threatening tone and posture . . .*
	. . . threatening gestures with fists . . .

[a]ED/ER = emergency department

Discussion

The Ecological Occupational Health Model of Workplace Assault (Levin et al., 2003) provided an adequate framework for studying workplace violence in emergency nurses. The following discussion of the findings is presented in relation to personal worker, workplace, and aggressor factors, and the assault situation.

Personal Worker Factors

Several participants in our study reported being physically assaulted during the

commission of their nursing practice (e.g., starting an intravenous line, inserting an indwelling urinary catheter, triage assessment). An essential protective strategy to prevent being assaulted is maintaining a safe distance from a potential aggressor (Zuzelo, Curran, & Zeserman, 2012). However, nursing practice as depicted by our participants requires close contact with patients. This close contact increases the likelihood an emergency nurse will become the victim of physical violence, especially if the signs of violence are absent or missed (Fujita et al., 2012). Gillespie et al. (2010) reported that participants in their sample of workers in a pediatric ED were most surprised when physical violence ensued during routine patient care. The surprise of physical violence during nursing practice may explain why some acts of violence in our study were depicted as the most distressful recent event of violence.

An essential protective strategy to prevent being assaulted is maintaining a safe distance from a potential aggressor

Workplace Factors

One of the participants in our study commented that the design of the patient room (e.g., no windows) coupled with a lack of security devices (e.g., closed caption cameras in the patient room) caused her to feel at risk when entering a patient's room. The design of the workplace and use of security devices have been shown to impact the risk for workplace violence (Peek-Asa et al., 2009). When physical violence occurs, it may be warranted for the emergency nurse to leave the immediate area for personal safety. An effective workplace design is required for the safe egress by staff away from the violent patient or visitor until help can respond (Peek-Asa & Jenkins, 2003).

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Several participants in our study related the importance of a physically secure work environment (e.g., "locked down" ED, security officers limiting access). AbuAlRub and Al-Asmar (2011); Peek-Asa and Jenkins (2003); and Gillespie et al. (2010) discussed the importance of having a secured work environment where access to the patient treatment area is managed. However, as was related in our study, access is not always controlled. Violent patients and visitors were able to gain entry to the treatment area, leaving emergency nurses feeling insecure and fearful that a physical assault would occur. Gillespie et al. (2010) described a similar finding in their study; patients' and visitors' ability to access the patient treatment area was a threat to the safety of ED workers.

Policies and procedures are vital for workplace safety from physical violence. One specific policy mentioned in this study was a visitor restriction policy; however, the participant believed that enforcement of this policy led to physical violence. It is possible that the physical violence was partially accounted for by the lack of consistently enforcing the visitor policy at all times. Gillespie, Gates, Miller, and Howard (2012) described that security officers inconsistently enforced the visitor policy in the pediatric ED where their study was conducted. This led to too many visitors in the ED treatment area. It is important that policies are developed with a focus on violence prevention (AbuAlRub & Al-Asmar, 2011; Gacki-Smith et al., 2009); however, policies need to be uniformly enforced at all times by all employees (AbuAlRub & Al-Asmar, 2011; Gates, Ross, & McQueen, 2006).

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Security officers can play a pivotal role in the security of the ED and safety of ED personnel. While some researchers have depicted a degree of dissatisfaction by ED workers for the effectiveness of security officers (Gates et al., 2006; Gillespie et al., 2012), the participants in our study overwhelmingly wrote about the positive presence, support, and actions taken by security officers to keep them safe. Peek-Asa and Jenkins (2003) posited that workplace safety requires an effective relationship with security officers which generally reflected the narrative accounts in our study. Gillespie et al. (2012) discussed that while not all ED workers appreciated the effectiveness of security officers, the ED workers ". . . overall valued and respected the security officers with whom they worked" (p. 24). Reasons for this dichotomy may be the limitations placed on security officers as noted in our study by hospital policies and procedures (e.g., not being allowed to carry a firearm, not being permitted to assist with the application of physical restraints, over reliance on police officers).

Aggressor Factors

Several commonly held beliefs were supported by our findings. Consistent with workplace violence literature (Chapman, Perry, Styles, & Combs, 2009; Gacki-Smith et al., 2009; Gates et al., 2006; Gunasekara et al., 2011), emergency nurses in our study perceived that patients most likely to commit physical violence had a mental health disease or disorder or were under the influence of drugs or alcohol. Several reasons account for

why these two groups of patients may be more violent than general ED patients. First, patients may have been brought to the ED against their will for a psychiatric examination. Second, some patients may be informed that they will be involuntarily admitted to a behavioral health unit and then become violent as an expression of dissatisfaction or in an attempt to leave the ED (Gillespie et al., 2010). Third, multiple patients that became violent were in police custody, including one patient that disarmed the police officer in an effort to escape and potentially shoot the police officer and ED workers during his escape attempt. Fourth, nurses are less tolerant of patients that become violent when they are under the influence of alcohol (Luck, Jackson, & Usher, 2008). This intolerance may start as soon as intoxicated patients arrive to the ED. If the patient perceives this intolerance, the perception may actually lead to the ultimate escalation to physical violence. Fifth, patients under the influence of drugs or alcohol may have lower inhibitions and a greater desire to satisfy their personal needs at the expense of others becoming physically injured or intimidated.

Nurses in our study indicated that they wished they had known that a patient had a history of being physically violent. This knowledge would have led them to interact differently with the patient prior to being physically assaulted. Peek-Asa et al. (2007) and Zuzelo et al. (2012) wrote that the ED needs to have procedures for communicating to colleagues that a patient is at risk for being physically violent. Gates, Gillespie, Smith, et al. (2011) concluded that there needs to be a mechanism to flag previously violent patients as an alert for when the patient returns to the ED in the future. Another important strategy is to assess every ED patient and visitor upon arrival for the risk of becoming violent. Chapman et al. (2009) created the STAMPEDAR assessment tool to determine patients and visitors at risk for violent behaviors. The acronym STAMPEDAR stands for staring, tone and volume of voice, assertiveness, mumbling, pacing, emotions, disease process, anxiety, and resources. While the tool cannot predict who will or will not become physically violent, STAMPEDAR does serve as an essential tool to focus emergency nurses on behavioral precursors to violence (e.g., staring, tone and volume of voice, assertiveness, emotions, disease process).

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Assault Situation

The assault situations in our study were characterized as physical assaults, physical threats, and intimidation. These types of physical violence were similar to those found by other researchers studying workplace violence. Zuzelo et al. (2012) provided a list of types of physical assaults experienced by their sample of nurses working on behavioral health units that mimicked our list including throwing objects and body fluids, kicking, biting, and punching. As previously stated, a large portion of the distressful patients enacting violence in our study was committed by patients with mental health diseases or disorders or under the influence of drugs or alcohol. One reason for why the violence received by these two groups of patients was identified as the most distressful may be the uncertainty involved in the outcome of the assault situation. Participants may have been more likely to question themselves, asking "What if—?" in terms of what would have happened if the aggressor had not been stopped. As noted in Table 2, the outcome for one victim was death. The participants in our study may not have believed that physical violence from patients would result in an inability to work or death.

Eleven nurses in our study identified the use of a weapon by a patient or visitor during the commission of physical violence. AbuAlRub and Al-Asmar (2011) reported that 15.8% (n=15) of the acts of physical violence in their study included the use of a weapon. The number of weapons identified in our study (n=11, 6.2%) was fewer, but still enough to note. As the concern for weapons increases in the ED, some nurses posit that a metal detector would increase their safety from being assaulted by a firearm or knife. Rankins and Hendey (1999) reported in their classic study that even after the implementation of a weapons screening process, 17 weapons were still found on patients in the patient treatment area. While a weapons screening program is an essential strategy to reducing potential harm from weapons, the program may also lead to a false sense of security. Nurses could become more confrontational believing that the patient or visitor could not have a weapon, when in fact he or she may. Even with a weapons screening program, attention needs to be paid on preventing escalation to physical violence.

While a weapons screening program is an essential strategy to reducing potential harm from weapons, the program may also lead to a false sense of security.

Limitations

The study is potentially limited by selection bias. Study respondents self-selected to participate. Efforts were made to reduce selection bias by using a systematic random sample. The key source of data was qualitative, self-written narratives detailing an account of physical workplace violence. This source of data leads to a

potential for bias because not all narratives fully depicted an event of physical violence, leading to an inability to use the data to analyze for all factors related to physical violence. The study sample was also largely homogeneous (female, Caucasian, and bachelor-prepared). While qualitative data are not intended to be generalizable, the homogeneity of the sample may further limit the transferability of the findings to clinical sites that are more demographically diverse.

Conclusion

...risk reduction efforts should target all patients and visitors, and not be restrictive to any sub-population.

Physical violence in the ED remains a problem for emergency nurses during the routine performance of nursing practice. Efforts to prevent violence and promote workplace safety need to focus on work designs allowing for the quick egress of employees away from violent patients and visitors; establish and consistently enforce policies aimed at preventing workplace violence, and maintain positive working relationships with security officers. While patients with mental health or substance use complaints were deemed as the most stressful encounters of physical violence, they are not the only patients acting out violently that lead to nursing stress. Therefore, risk reduction efforts should target all patients and visitors, and not be restrictive to any sub-population. Future research needs to quantitatively measure the frequency and severity of consequences and effects to the worker, workplace, and patient care for those physically violent events deemed as most distressful.

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