Original Article

The Experiences of Registered Nurses Who are Injured by Interpersonal Violence While on Duty in an Emergency Department

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ABSTRACT

A successful career as an emergency department registered nurse (RN) requires the ability to respond quickly to a wide variety of potentially life-threatening illnesses and injuries. The unpredictable nature of this work can evoke emotional and physical stress on the RN beyond that which might be experienced by nurses who work in more stable, controlled, and predictable environments. Emergency healthcare is predicated on unexpected illness or injury leading to unscheduled episodic work. Additional stress is placed on the RN by the potential for violence that occurs in emergency departments. This mixed method pilot study describes the experiences of RNs who have been injured by violence while working in an emergency department. The study included an assessment of the job satisfaction of RNs in the emergency department based on Porter's Need Satisfaction Scale. This scale addresses need fulfillment in five categories: security, social, esteem, autonomy, and self-actualization. The self-actualization subscale measures satisfaction with personal growth, worthwhile accomplishments, and self-fulfillment. During the second strand of the study, phenomenological informed interviews were held with RNs who had been injured while on duty in an emergency department. The findings indicate that the largest reported gaps between the current state and the desired state were found in the area of security and self-actualization. RNs in the emergency department who answered the survey indicated that they desired a safe, secure worksite where they could achieve personal growth, worthwhile accomplishments, and self-fulfillment; but they were not satisfied with their current status in these areas.

KEY WORDS:

emergency department violence; healthcare violence; interpersonal violence; job satisfaction; violence; violence involving nurses

There are numerous risks associated with a career in healthcare. One of the most startling risks is interpersonal violence directed toward healthcare workers. Workplace violence is described as actions that cause physical and psychological injury in the workplace or while on duty (National Crime Victim Resource, 2014). The most frequent perpetrators of this violence toward healthcare workers are patients and their family or friends (Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013). Although the incidence of workplace violence is widespread in all healthcare settings, the risk is heightened in emergency departments (EDs; Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013; Gerberich et al., 2004; Institute for Emergency Nursing Research, 2011; Taylor & Rew, 2011; U.S. Department of Labor, 2015; World Health Organization, 2002). There are several factors that have been associated with the increased risk of violence in the ED. These factors may be assigned to two broad categories: those that can be attributed to the patient and those associated with the context of the ED. These contextual factors include the availability

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of drugs and money at hospitals, unrestricted movement of the public in clinics and hospitals, long waits in EDs, the type of solo work with limited communication, lack of staff training in techniques for managing escalating violence, delays in patient pain management, and delays in the transfer of patients with mental health difficulties to appropriate settings. Additional factors are inherent in patient responses and may include the prevalence of weapons, frustration with long waits for treatment in EDs, and the increasing number of patients experiencing mental health challenges seeking assistance after being discharged from treatment with no follow-up care (Gillespie, Gates, & Berry, 2013; Occupational Safety and Health Administration, 2015).

The variety of patients and the unpredictable nature of this work can evoke emotional and physical stress on the registered nurse (RN) beyond that which might be experienced by nurses who work in a more stable, controlled, and predictable environments. Additional stress is placed on the RN because of the potential for violence that occurs in EDs. Exposure to violence can result in physical and/or psychological trauma. The results can be long lasting and may impact the nurse's ability or desire to remain in the ED as a practice setting. The Emergency Nurses Association Violence Surveillance Study reported that nearly 27% of respondents considered leaving the ED after exposure to violence (Institute for Emergency Nursing Research, 2011).

Violence in healthcare settings has received growing attention over the past years. Many organizations such as the National Institutes of Health, the Occupational Safety and Health Administration, and the Emergency Nurses Association have published toolkits and other resources designed to increase safety related to violence in the workplace. In 2011, the Institute for Emergency Nursing Research published the results of a landmark study concerning violence that occurred specifically in the EDs of healthcare facilities. Several studies have focused on the incidence of violence and have relayed accounts of violence. Two of the most prominent are the World Health Organization's (2002) "Workplace Violence in the Health Sector" and the "Emergency Department Violence Surveillance Study" (Institute for Emergency Nursing Research, 2011). The framework guidelines published by the World Health Organization in 2002 highlighted the negative consequences of violence toward healthcare workers, including the physical and psychological injuries of the workers as well as the potential for decreased access to healthcare resources if workers leave the profession because of violence.

The "Emergency Department Violence Study" was a longitudinal trend study that utilized a cross-sectional survey of 623 nurses in EDs (Institute for Emergency Nursing Research, 2011). Approximately 9% of respondents indicated that they had been exposed to physical violence within the 7 days before the survey. Approximately 54% indicated that they experienced verbal violence within the 7 days before the survey. Reports of the study indicate that the physical violence rarely occurred without the presence of verbal violence. Taylor and Rew (2011) published a systematic review of 16 articles on workplace violence in the ED. They reported significant effects of violence on healthcare workers in the ED, including burnout, depression, fear, posttraumatic stress disorder, decreased job satisfaction, and reduced ability to perform their duties. Some reported that they considered leaving the healthcare profession. The authors have called for a continued study and creative solutions to the problems of workplace violence in the ED setting (Taylor & Rew, 2011). Workplace violence with serious injuries requiring time off from work is four times more common in healthcare settings than in other occupational realms (Occupational Safety and Health Administration, 2015). Although data exist concerning the possible mental and physical impacts of violence, there is little published about the impact violence has on job satisfaction of the RN or about the lived experience of the RN injured by violence while on duty.

The intent of the study described in this article was to further explore the impact of violence in healthcare, specifically in the ED. The specific aim was to explore the impact of violence on job satisfaction of the RN, as measured by the degrees of dissatisfaction gap that are identified using Porter's Needs Satisfaction Scale (Porter & Mitchell, 1961). Further aims were to describe the experiences of RNs who have been injured by violence while working in an ED and to explore their intent to remain working there.

Methods

The study was completed as a pilot study to determine feasibility for a larger study. This mixed method study utilized a convergent parallel design. Both the quantitative and qualitative strands were administered concurrently in the same phase of the study to examine the relationship between exposure to physical violence and job satisfaction of the RN in an ED.

The qualitative strand utilized a phenomenological approach to explore the experiences of RNs injured by violence while on duty in an ED. Phenomenology has been described as an effort to understand the nature or meaning of experiences in life. It allows the reader to gain information about the significance of the lived experience (Munhall & Chenail, 2008). In this study, the experience in question was the episode of violence that led to the nurse's injury and the subsequent actions, thoughts, and emotions of the nurse. The questions asked in the interview were designed to be open-ended and started with a question about the department where the nurse worked. Additional questions were used to continue gaining information about the violent incident and the effect the violence had on the life and work of the RN. The interviewer also used questions to gather information regarding the employer's response after the

violent incident and how the RN viewed that response. Examples of the questions included (a) "Can you tell me about the experience of being injured while on duty?" and (b) "Please tell me more about the time you were injured." The questions continued using an open-ended approach, encouraging dialogue until it was felt that no new information was received.

Human Subject Protection

The institutional review board of the academic institution of the primary researcher approved this study. Personally identifying information was not connected to the written survey tool, and participants in the qualitative survey were given a coded identifier to protect their identity. In addition, any information an interviewee shared that could be identified because of the nature, date, or other public identifier was not included in the final findings. Consent for the study participation was implied through the voluntary completion and return of the tool. For the qualitative interview, a consent form to participate in a research study was reviewed and signed by participants. The consent included discussion of risks and benefits for participation in this study. Reference to the possibility that participation in the study may cause emotional reactions because of memories of the trauma when the injury occurred was also included. Participants were advised to contact their personal provider for care if needed or the ED if symptoms were severe.

Sample

Eligibility for the quantitative survey was limited to RNs who had worked in an ED. The respondents for the survey were recruited at an emergency nurse training conference and through a mailed packet to EDs. Thirty-nine nurses completed the quantitative survey. Highlights of the demographics of the sample are included here. Full results can be seen in Table 1. Results indicate that 31 of the respondents were women and eight (8) were men. Thirty-five (35) of the respondents indicated that they were licensed as RNs, and one was an advanced practice nurse. Respondents were asked about their highest level of education. The Associate Degree was the highest degree for 13 participants. Twenty-five (25) of the respondents indicated that they had more than 10 years of experience as an ED nurse. Fourteen (14) had less than 10 years of experience in emergency nursing.

Respondents were also asked about the type and setting of the ED they were working in at the time of the injury (see Table 1). Thirty-seven (37) of the respondents were currently practicing in an ED setting, one was not practicing, and one was practicing in another setting. Of those practicing, 17 indicated that they were practicing in a rural setting, and 21 practiced in an urban setting. Most respondents (30) described their practice site as an acute care hospital. Respondents indicated that 16 of the facilities were considered "community, not for profit." Thirteen (13) were "privately owned, for-profit" facilities. Four (4)

TABLE 1. Demographic of Respondents and Facilities

Gender		
Male	8	20.5%
Female	31	79.5%
Education		
Associate degree in nursing	13	33%
Bachelor of Science in Nursing	9	23%
Bachelor's degree in other field	3	7%
Diploma in nursing	9	23%
Master's degree in nursing	2	5%
Master's degree in another field	1	2.5%
Doctorate in nursing	1	2.5%
Other	1	2.5%
Licensure		
Registered nurse	35	90%
Advanced practice nurse	1	2.5%
Other	1	2.5%
Did not answer	2	5%
Experience as an emergency department nurse (years)		
<10	14	36%
>10	25	64%
Type of care provided by the facility		
Acute care	32	82%
Adults only	6	15.4%
Pediatric	1	2.5%
Type of facility		
Community/not for profit	16	41%
For profit	13	33%
Government owned	4	10%
Did not answer	6	15%
Location of facility		
Rural setting	17	43.5%
Urban setting	21	54%
Did not answer	2	5%
Volume seen in the emergency department per day		
<50	5	13%
50–100	13	33%
100–200	15	38%
>200	3	8%
Did not answer	3	8%

respondents indicated that they worked for a "government-owned" facility. Thirteen (13) of the respondents indicated that the volume seen daily in their facility was between 50 and 100 patients. Fifteen (15) of the respondents stated that their ED daily volume was between 100 and 200 patients. Five respondents indicated daily volumes less than 50, and three indicated greater than 200 patients per day.

Eligibility to take part in the qualitative component of the study was limited to RNs who indicated they had been injured by interpersonal violence while on duty in an ED and who were willing to be interviewed. The three respondents who agreed to be interviewed for this pilot study were female RNs who were injured by violence while working in an ED. Two of the respondents practiced in a rural setting, and one practiced in an urban setting. Two remained employed in the EDs where they had been injured, and one had left ED nursing.

Instruments

RN job satisfaction was evaluated using a needs satisfaction questionnaire as a measure of job satisfaction and a questionnaire regarding the nurse's future professional plans, including the intent to continue in the ED as a clinical practice setting. The instruments included a demographic questionnaire and a job satisfaction tool based on Porter's Need Satisfaction Scale (Porter & Mitchell, 1961). The Porter scale was modified from the original version to replace the words "management position" with the words "your position." The modification was needed to clarify the use of the tool for ED staff nurses not in defined management positions. Porter's Need Satisfaction Scale was used as the basis for a self-reported scale to reflect job satisfaction. This scale was chosen because it reflects a hierarchy of need from the respondents' perceptions that starts with security/safety and includes other concepts. Furthermore, it allows the responding nurses to indicate the desired amount of an attribute and how much of the attribute is currently present from the nurse's perspective. This requires a conscious evaluation of the presence and importance of the attribute by the nurse. Similar to Maslow's Hierarchy of Needs, the scale addresses need fulfillment in five categories: security, social needs, esteem, autonomy, and self-actualization (Porter & Mitchell, 1961). Comparisons of job satisfaction were made between subjects who reported injury by violence and those who reported no exposure to violence while on duty in an ED. The overall purpose for incorporating this tool was to determine if being subjected to violence while on duty in the ED impacts job satisfaction and, ultimately, the conscious decision to remain an ED nurse.

The tool asks respondents to use a Likert scale to rate their responses to questions concerning a characteristic, such as safety, the ability to make friendships, or other aspects that might be associated with their positions as ED nurses. For each question, the respondents were asked to rate the characteristic or aspect in the following categories:

a. How much of the characteristic is there now connected to your position?
b. How much of the characteristic do you think should be connected with your position?
c. How important is this characteristic to you?

The other subscales include questions that address social needs, esteem needs, autonomy, and self-actualization. The subscales for security/safety and social needs include two questions. Security/safety questions specifically address feelings of security and feelings of safety. The social needs questions ask about the opportunity to help others and the opportunity to develop close friendships. The subscales for esteem needs and self-actualizations include three questions for each subscale. Esteem needs are addressed through questions about feelings of self-esteem and two questions about prestige of the position. The self-actualization subscale addresses opportunities for personal growth, self-fulfillment, and worthwhile accomplishment. The subscale for autonomy needs has four questions. Autonomy questions ask about authority, independent thought and action, opportunity to participate in goal setting, and the determination of methods and procedure (Porter & Mitchell, 1961).

Although validity and reliability have not been established for this tool, after a careful review of the tools available to measure a hierarchy of job satisfaction, this tool was determined to have face validity and most closely evaluate the variables of interest. Porter and Mitchell (1967) described the manner of determining degrees of dissatisfaction through the determination of the difference between the questions "How much of the characteristic is there now connected to your position?" and "How much of the characteristic do you think should be connected with your position?" The larger the difference between the two questions, the greater the degree of dissatisfaction. Information about the reliability and validity of the tool was not available in the literature or by the author of the tool. Plans are in place to evaluate the reliability for future use of the tool.

Data Collection

Data for the study were collected over an 8-month period. Packets containing an explanation letter, copies of the tools, and self-addressed stamped envelopes were mailed to the nurse managers of EDs in Arkansas and Oklahoma. The mailing addresses were obtained from a hospital association publication, and the packets were sent to all hospitals listed. In addition, the investigator attended a state Emergency Nurses Association meeting and made packets available there. Emergency nurses from three states were present at the meeting. Ten completed surveys were returned at the time, and the remainder of the surveys were received in the mail via the self-addressed stamped envelopes that were included in the packets.

Participants who returned the quantitative surveys and who indicated that they had been injured by violence while working in an ED were also asked if they would be willing to participate in an interview with the researcher to discuss their individual experiences. The researcher utilized a phenomenological approach to the individual interviews and began by asking the participants to describe their experiences of being injured by violence while on duty in an ED. A semistructured interview schedule was utilized, including open-ended questions regarding the RNs' work history, type of ED where the injury occurred, specifics of the injury occurrence, results of the injury, and changes or intent to change their work environment as a result. Questions were designed to lead from the cognitive to emotional aspects of the incident when the RN was injured. The closing questions were used to address the nurses' satisfaction with the actions after the incident and also with their plans to remain in the ED as the practice setting. The interviews were conducted in person over a 2-week period. Each interview lasted between 1 and 2 hours and was completed during a single interview. Interviewees were offered a choice of settings close to their location for ease of travel. The interviews were recorded and later transcribed verbatim.

Analysis

Data from the quantitative questionnaires were entered into IBM SPSS (Version 23). Statistical analyses were completed through the SPSS statistical functions. Frequencies and percentages were calculated for the demographic and survey questions. Frequency statistics were used to compare those who had experienced violence while on duty with those who indicated that they had not. Degree of dissatisfaction was calculated by determining the difference between how much of a characteristic existed and how much the participant thought it should exist. Degree of dissatisfaction is represented by a gap number, which is the difference between the current state and the desired state.

The phenomenological approach utilized was guided by Edmund Husserl's work as the experience in question was explored as a singular event and the effect on the RN is treated as a conscious result (Smith, 2013). Edmund Husserl was one of the early philosophers to focus on phenomenology (Dowling, 2007; Smith, 2013). In his methods, he used the idea of the "lived experience" and its impact on the person's perception of the world while noting that the researchers must "bracket" their beliefs, thoughts, and experiences to provide for a pure analysis (Rank, 2015; Smith, 2013). He further wrote that the meaning of an object or act is what constitutes the importance or impact of that object or act (Dowling, 2007; Rank, 2015; Sawicki, n.d.). The purpose of the interviews was to seek our information regarding the lived experience of being violently injured while on duty and the importance or impact it had on the RN. The verbatim transcripts of the qualitative interviews were read several times, and key words or concepts were identified during these readings. The text was highlighted, and lists were created from the commonly used similar terms and phrases. Concepts for each respondent were identified from the lists, and later, the concepts across respondents were analyzed to detect possible themes (Fade & Swift, 2011). The concepts and themes were further analyzed with consideration of the subscales in the quantitative survey to identify congruent data within the two methods of the study. Regular feedback, consultation, and review of each step in the qualitative analysis were provided among the authors. In addition, a separate analysis of the transcript was completed by one of the authors as a way of validating the qualitative analysis.

Results

Of the 39 respondents, 15 (38.46%) indicated that they had been injured by interpersonal violence while on duty in an ED. Of those positive responses, 13 (86%) indicated that their injuries were caused by a patient. Two (13%) indicated that a family member or significant other of the patient caused their injury.

Comparisons were made for each question between those injured by violence while on duty and those who indicated that they were not injured. The larger the gap, the greater the difference between the perceived current state and the desired state. When comparing both groups, the largest gaps between the current and desired states were found in the questions addressing security and safety. The mean response of those injured by violence for the current state of feelings of security was 4.36. The desired level mean response for this group was 6.57, with a gap of 2.21. Those indicating that they had not been injured by violence had a current security mean of 3.84, with a desired mean of 6.68 and a gap of 2.84 (see Table 2). The largest gaps between the current and desired levels in all questions were seen in these two questions. The next largest gap was 1.68 and was in the area of goal setting.

The gap between the current state and the desired state in the security/safety questions is larger for those who had not been injured by violence in the ED. It is also noted that the desired state in both questions related to safety/security was scored high on the 1–7 scale, with the lowest average at 6.57 and ranging as high as 6.71. The high scores for the desired state indicate that safety/security is a high priority to respondents and the gap number indicates that the current state does not meet the desired state.

The subscale for social needs included two questions addressing the opportunity to help others and the opportunity to develop friendships at work. The gap between the current state and the desired state for these questions was small, with both items at 0.38 or below, indicating little disparity between the current and desired states in the areas of opportunity to help and opportunity to develop

TABLE 2. Current State and Desired State Gap

	Injured			Not injured		
Question	Current state	Desired	Gap	Current state	Desired	Gap
Security	4.36	6.57	2.21	3.84	6.68	2.84
Safety	4.14	6.71	2.57	4.06	6.67	2.61
Opportunity to help	6.29	6.67	0.38	6.45	6.60	0.15
Opportunity to develop friendships	5.67	5.93	0.26	6.10	5.95	−0.15
Self-esteem	5.60	6.27	0.67	5.75	6.45	0.70
Prestige inside the facility	4.27	5.67	1.4	4.85	5.65	0.80
Prestige outside the facility	5.00	5.69	0.69	5.21	5.58	0.37
Authority	5.00	5.77	0.77	4.84	5.53	0.69
Independent thought/action	5.08	6.08	1.00	5.58	6.32	0.74
Goal setting	5.23	5.92	0.69	4.53	6.21	1.68
Methods/procedures	4.87	6.20	1.33	4.70	6.05	1.35
Personal growth	5.00	6.53	1.53	5.32	6.45	1.13
Self-fulfillment	5.27	6.47	1.20	5.40	6.37	0.97
Worthwhile accomplishment	5.24	6.64	1.40	6.68	6.58	−0.10

friendships. Of note in the question concerning the opportunity to develop friendships, the group who had not been injured on duty had a negative gap of –0.15, indicating that the value of friendship in the noninjured group exceeded what the desired state was (see Table 2). Most of the current state responses for the social needs questions scored above 6 on the scale, except the opportunity to develop friendships in the injured group, which scored at 5.67.

The next area addressed in the survey is the subscale for esteem needs. There are three questions addressed in this subscale concerning self-esteem and perceived prestige, from inside and outside the facility. In this subscale, the biggest gap was noted in the prestige conferred on the emergency nurse position by those outside the facility. The gap was 1.4 for those who indicated that they were injured by violence. The rest of the gap results were less than 1.4 in this subscale and can be seen in Table 2. It would appear that both groups felt that the desired state for self-esteem was important, as both scored it above 6.27 on the 1–7 scale. The questions concerning the desired state for prestige were scored between 5.58 and 5.69, indicating that prestige was less important to both groups than self-esteem.

The fourth subscale has four questions that address autonomy needs. The questions address items that reflect the nurse's involvement in strategy and decision making within the work setting. The questions specifically ask about authority associated with the position, ability for independent thought and action, opportunity to participate in goal setting, and opportunity to have a say in the methods and procedures in the work setting. The current state in the autonomy questions scored from (a low) 4.53 to 5.58. The largest gap of 1.68 was seen in the question concerning goal setting in the noninjured group. The other questions in this subscale had lower gaps. The largest differences in the gaps between the two groups were in the question regarding the ability to set goals. The group who had been injured by violence had a gap of 0.69 between the current state and the desired state, compared with the gap for those not injured of 1.68 for the goal setting question. Several questions in this subscale averaged above 6.00 for the desired state, including the opportunity for independent thought and action and the opportunity to influence the methods and procedures in the work setting (see Table 2).

The last subscale addressed questions related to self-actualization and included three questions related to personal growth, self-fulfillment, and worthwhile accomplishment. The largest gap (1.53) was seen in the question related to personal growth. Of note, all questions in the self-actualization subscale averaged higher than any other subscales, except for safety/security questions. The self-actualization questions for both groups had averages above 6.37 for the desired state. The current state for both groups on all questions in this subscale scored between 5.00 and 5.68. The gaps were all greater than 0.90 and ranged as high as 1.53 on the personal growth question in the group that had been injured by violence (see Table 2).

Qualitative Findings

The qualitative analysis of the three interviews with respondents who had experienced violence in the work setting revealed four common themes through the interviews: (a) ED staff as “family” or “team”; (b) focus on helping others;

(c) satisfaction in immediate gratification; and (d) disappointment with the corporate response. The respondents made reference to their co-workers as having close relationships and taking responsibility for each other. This was evidenced through statements such as "We kind of take care of each other," "we are family," and "great team to work with." Respondents reflected statements indicating a connection and some level of reliance on their colleagues. This was also reflected in other statements indicating that they were concerned about their co-workers during the violent episode. One respondent described talking to a man with a gun, "so we could get the clerks out of their enclosure because they were basically sitting ducks." Another described staying in the room with a violent patient so her colleagues would not get hit like she had.

The second theme concerned their ability to help others. All indicated satisfaction with their role as a nurse who could help others, as evidenced by statements such as "You know there was a patient—somebody who needed help and I never thought about it. I just went there" and "bottom line, I love what I do…the different people and the different things."

The third theme detected in the interviews expanded on the nurse's ability to help others and to know the outcome of the episodic care they provided. The theme is described as "satisfaction in immediate gratification." Respondents made reference to enjoying the part of emergency nursing where an episode of care has an end point. One respondent described it as getting one of three "envelopes" when you come in the ED—"you go home, you go to God, or you go to the hospital." Another respondent stated, "…they get better, go home, get admitted, transferred or die. But I know the ending before my shift ends." Respondents spoke positively about knowing the outcome of the care provided. All indicated that it was a strong attraction for the work in emergency care.

Finally, the respondents all expressed a level of dissatisfaction with the corporate response to violence in their facility. The corporate response refers to the response by the administration of the facility where the ED is located. Respondents reported a lack of legal system response as well; none of the persons who injured them were arrested or charged for the violence in the ED. In one situation, the perpetrator was arrested but for the earlier charge of resisting arrest, not for the injury to the RN. Respondents described their experience as "still a lack of prosecution…it's just easier for them to stay out of it," "police wouldn't do anything that night," and "that was the first phone call we got…don't talk to reporters." One respondent summed it up by saying, "they have policies against violence but nothing happened when the violence occurred."

Two of the respondents indicated a degree of guilt or blaming self for "getting hurt." One questioned her own actions and why she did not respond or remove herself from the danger sooner. Another questioned why she did not just leave the area where she was but followed that statement with "but that goes against everything that we are trained to do."

Limitations

One of the limitations of this pilot study is the small number of participants for both the quantitative and qualitative strands. Because the survey tools were distributed partially via mail delivery, it was not possible to determine response rates for the survey, as it was not known how many reached the target population. Thirty-nine responses, although low, was deemed sufficient to inform the feasibility of a larger study. Only three interviews were conducted during the qualitative strand. Several authors address the difference between sample size in quantitative and qualitative studies. Unlike a quantitative study where generalizability is reliant on sample size, the purpose of a qualitative phenomenological study is to seek content and perceived meaning of an experience, which can sometimes be achieved with as few as two to three interviews (Englander, 2012; Parse, Coyne, & Smith, 1985). None of the participants in the qualitative phase had experienced a severe or debilitating injury, which may be seen as an additional limitation. The experiences and responses of the RNs might have been different based on the severity of their injuries. Finally, facilities seeing greater than 200 patients per day were minimally represented.

Limitations related to Porter's Need Satisfaction of the tool include the lack of information regarding the reliability and validity of the tool. Although this was not found in the literature and maintained by the authors, it was not felt to impact the usefulness of the tool in this feasibility study. The questions asked on this tool were determined to be the most appropriate questions to explore the research question concerning the impact of violence on job satisfaction. Despite the lack of reliability and validity data, this tool was chosen because it most closely aligns with the hierarchy of concepts related to job satisfaction. It is the intent of the primary researcher to evaluate the reliability and validity of the instrument during future testing.

Discussion

The results of this survey show the same concerning high rate of injury by interpersonal violence for RNs working in an ED. However, it is challenging to make a comparison because it is difficult to cite an accurate overall rate of injury. As Taylor and Rew (2011) reported in a review of literature, there is a lack of accurate statistics related to the incidence of workplace violence occurring in the ED. Reasons for the inaccuracies include the lack of consistent reporting mechanisms or requirements and the general hesitancy to hold perpetrators accountable in the ED setting.

Porter's Needs Satisfaction tool loosely mimics the pyramid of needs actualization found in Maslow's Hierarchy of

Needs. As with Maslow's hierarchy, the most significant and important responses for the respondents in this pilot study were in the area of safety/security. The gap between the actual state and the desired state for the safety/security subscale was larger in the group that had not been injured by violence. A possible reason for this disparity may be that those who had been injured by violence either had personally developed enhanced safety procedures or had a facility response after the injury that increased their sense of safety/security. The next highest subscale overall for the desired state was in the subscale of self-actualization. Beyond safety and security, respondents desired work that offers opportunity for personal growth, self-fulfilling work, and worthwhile accomplishment.

The qualitative interviews revealed a strong connection to colleagues in the ED, which may reflect the reliance on the teamwork when potentially rapid, lifesaving work is required. The strong attraction to helping others was also evident in the survey question concerning the opportunity to help others. The subscale question concerning the opportunity to help was one of the highest scoring questions on the scale for both the injured and noninjured groups. The qualitative interviews also reflect the emergency nurses' desire to know what happened to the patient. The nature of episodic care in the ED generally lends itself to resolution during the episode. The respondents described resolution not in terms of "cure" but in terms of addressing the immediate care and disposition of the patient to home, hospitalization, or the morgue. The respondents expressed disappointment with the corporate response, and two of the respondents expressed statements of blaming themselves for actions. The self-actualization subscale addressed questions of worthwhile accomplishment, self-fulfillment, and personal growth for which both groups scored the desired state as 6.37 or higher on the 7-point scale. This high score seems to indicate that feeling valued and having an opportunity for meaningful growth are important to the respondents but may conflict with the reported lack of support by their corporate offices.

It is recommended that future studies include comparisons for those RNs working in states where enhanced legislative efforts have been established that provide stronger penalties for violence in the ED or in healthcare facilities in general. It would also be informative to include comparisons of RNs' perceived gaps where violence prevention programs have been established in the ED.

ED RNs are highly trained and may literally provide lifesaving intervention for patients. However, they work in volatile situations where violence frequently occurs. Both components of this study reveal that nurses desire a safe secure worksite where they can achieve self-actualization as measured by personal growth, worthwhile accomplishments, and self-fulfillment. The gaps noted between the current state and the desired state in the self-actualization subscale indicate an area of dissatisfaction for the ED nurses who completed the survey and for those who participated in the interviews. Continued efforts to understand the impact of violence on the ED RN may encourage corporate and legislative intervention that will better protect the ED RN.

Conclusion

The outcomes of this feasibility study lead one to conclude that it is reasonable to conduct a larger study. Offering an incentive, as a way of increasing participation, and using only an electronic method of communication with participants for completion of the survey are among the lessons learned. For forensic nurses, this study highlights the impact violence has on nursing colleagues in EDs and provides insights that may be beneficial when responding to violent episodes or when supporting efforts aimed at the reduction of violent episodes in the ED.

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