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Abstract

There has been an increase in violence and aggression in Emergency Departments (ED) in recent years. Among professional health care workers, nurses are more likely than other staff members to be involved in aggressive incidents with patients or relatives. This research study was undertaken to determine nurses' perceptions of the factors that cause violence and aggression in the ED. Using a qualitative approach, twelve nurses working in an Irish ED were interviewed. Thematic analysis of the interview data revealed that environmental and communication factors contributed to violence and aggression in the ED. Participants perceived waiting times and lack of communication as contributing factors to aggression, and triage was the area in the ED where aggression was most likely to occur. A number of key recommendations arise from the study findings and they all relate to communication. To address the aggression that may arise from waiting times, electronic boards indicating approximate waiting times may be useful. Also, information guides and videotapes on the patient's journey through the ED may be of benefit. Consideration to the appointment of a communication officer in the ED and communication training for ED staff is also recommended.

Introduction

For the purpose of the study, the combined term “violence and aggression” was used to acknowledge the broad spectrum of verbal and non-verbal, physical and non-physical hostility, which may be both intentional and non-intentional, that ED nurses encounter in their workplace.

Violence and aggression is a worldwide phenomenon in EDs (Zampieron et al., 2010; Alameddine et al., 2011; Esmaeilpour et al., 2011; Rafati et al., 2011), and is a leading cause of stress (Healy and Tyrell, 2011) and feelings of powerlessness for ED nurses (Pich et al., 2011).

Background

The literature highlights a number of factors related to aggressive and violent behaviour in the ED, namely, patient factors, environmental factors, and interactional factors.

Patient factors

The age and gender of the aggressive person is considered a major factor associated with violence. Some researchers have found males to be more aggressive than females (Chou et al., 2002), with the highest percentages in the twenty to thirty age range (James et al., 2006). However, it is also reported that the most aggressive patient can be female (Daffern et al., 2003). Furthermore alcohol and substance abuse is strongly related to abusive and violent behaviours (Crilly et al., 2004; Ferns et al., 2005).

Environmental factors

An inadequate number of staff (Gates et al., 2005), excessive waiting times (Crilly et al., 2004; Pich et al., 2011), poor security measures (Landau and Bendalak, 2008)

and overcrowding (Wand and Coulson, 2006), all contribute to violence and aggression.

Waiting times is one of the top three reasons for patients becoming impatient, anxious and aggressive (Gates et al., 2005; Pich et al., 2011). The presence of security in a highly charged department shows authority and has the potential to reduce aggressive and violent outbursts in the ED (Oztunc, 2006). Nurses have also reported that a security presence both day and night helps reduce staff vulnerability (Mayer et al., 1999).

Most aggressive incidents take place during the evening and night, with fewer in the morning; alcohol and substance abuse being associated factors (Mayer et al., 1999; Ferns et al., 2005). Tension and stress can also fuel aggression in departments that are overcrowded, congested and which lack privacy (Van Vonderen, 2008).

Interactional factors

The staff-patient factors most evident in the literature include inexperienced staff (Healy et al., 2002), a lack of communication (MacKay et al., 2005), and the attitude of staff members towards patients/relatives (Jansen et al., 2005). The views of hospital staff and patients on the reasons for aggressive acts tend to differ. Hospital staff believe problems arise because patients and relatives exhibit demanding behaviour and request attention (Murray and Synder, 1991). However, in a study by Ilkiw-Lavalle and Grenyer (2003), patients blamed the lack of communication from staff as the reason for their aggression 36% of the time, where staff only thought communication was the problem 15% of the time.

Nurses are more likely than other health care professionals to be involved in aggressive incidents with patients and relatives in the ED. Much of the research undertaken on this topic is quantitative in nature and examines prevalence and prediction of violence (Rose, 1997; Esmailpour et al., 2011; Alameddine et al., 2011; Talas et al., 2011; Magnavita and Heponiemi, 2012). However, qualitative exploration of this phenomenon is increasing (Pich et al., 2011; Lau et al., 2012).

Aims and objectives of the research

The aim of this qualitative study was to explore nurses' perceptions of the factors that cause violence and aggression in an Irish ED.

Methodology

The study adopted a qualitative descriptive approach and was undertaken in an Irish urban ED which provides care to 62,000 patients per year. The department manages approximately 120-180 patients daily with the highest through-put between 12.00 and 23.00 hours. Emergency departments in Ireland are very busy and although every member of the population has a general practitioner (GP) or access to one, a high percentage bypass the GP service and come straight to an ED, because most believe that the GP will send them to ED anyway. Currently a new service called the "Acute Medical Unit" is in place where the GP may refer directly to, bypassing the ED. This was not in place when this study was undertaken. In addition, staff never present options and tell patients to go elsewhere. The next biggest hospital with the same facilities is approximately 100km/62 miles away. Finally, staff would never tell a patient to present to the private hospital (9km/5 miles) but if the patient enquired the nurse would tell them it is within their right to attend this private hospital.

The study's inclusion criteria were as follows: nurses with a minimum of six months experience in the ED and involvement in a violent or aggressive incident within the previous month. Purposive sampling was employed and all nurses working in the ED who met the study's inclusion criteria were invited to be interviewed. Purposive sampling is sampling those who have enough knowledge and experience of the topic to provide the relevant data (Polit and Beck 2004). Twelve emergency nurses (3 male and 9 female nurses) who met the inclusion criteria agreed to be interviewed.

The majority of nurses interviewed (n = 7) were in the 36-40 age category, and the majority (n = 5) had 7-10 years emergency nursing experience. Ethical approval was obtained from the hospital's ethics review board. The participants were furnished with the informed consent form to review one week prior to their interview. Semi-structured interviews were used to collect the data. Questioning explored the impact of violence and aggression on the participants during their working hours. All interviews were tape-recorded and subsequently transcribed verbatim. Following each interview, participants were offered follow-up support from staff support services if they desired.

Data analysis

Thematic analysis of the interview data was undertaken using Burnard's (1991) framework. Contextual notes were documented regularly in a note book; sometimes these were written following dictation onto the tape-recorded immediately after an interview. Both the contextual and reflective notes were referred to during the analysis phase. An audit trail was established ensuring all the relevant and supporting documentation (reflective notes, memos, and analysis) was available for future scrutiny. As recommended by Burnard (1991), checks for validity included two participants' reviewing their respective transcripts to ensure an accurate reflection of

the interview had been achieved. In addition, an experienced ED nurse with experience of undertaking qualitative research independently coded all of the interview transcripts and identified similar themes.

Seven sub themes were evident in the data and these were further grouped under two main themes; environmental factors and communication factors (Figure 1).

Results

At the start of the interview, each participant was asked to explain what they understood by the term 'violence and aggression'. The participants were able to clearly distinguish between violence and aggression throughout all the interviews.

All the nurses described aggression as a verbal non-physical act sometimes with a threat of violence.

N3: -"Aggression I would define...as where somebody would use language or body language that you could deem to be threatening or that may have a hint of violence behind it without being physically violent."

N2: -"Aggression I suppose...is more verbal rather than an actual physical act, or that you feel in some way threatened that violence may occur towards you."

In contrast, violence was viewed as a physical act where the individual might punch or spit resulting in an injury to the person.

N1: -"Violence I think is when some one strikes out at you, not necessarily with their hand and foot but even if they spit at you. I consider that violent."

N8: -“Violence then would be the actual physical, the physical harm caused be it a hit or punch or throwing of an object.”

During the interviews it became evident that the above definitions were reflected in the encounters of aggressive or violent incidents recalled by participants.

Environmental factors

A variety of environmental factors that cause violence and aggression in the ED were highlighted, including long waiting times, lack of space and overcrowding, triage and security.

All but one participant talked about waiting times being one of the greatest causes of violence and aggression in the ED. The long waiting times mentioned specifically related to patients waiting to see a doctor or to get a bed on a ward. Most participants reported the difficulties they had with this, especially when relatives' families engaged in persistent complaining to staff. A few participants believed that the aggressive nature of patients and relatives was related to their impatience, and a desire for individualised immediate attention.

N5: - *“People want to be seen immediately...they just lose it sometimes when they are told they have to wait.”*

Participants expressed surprise at the lack of understanding on the part of the public regarding the current ED crisis in Irish hospitals. These participants expressed annoyance that the public made no link between what they had heard or seen in the media and what they encountered in the ED.

N12:-*“people would amaze you, they read it on the papers, they hear it on Galway Bay FM [local radio station] practically every day but they just don’t relate to it when it comes to themselves.”*

A few participants believed that the design of the ED with its limited space often caused patients and/or relatives to become aggressive. The participants described the ED as ‘hectic’ and about half the size it should be for the number of attendances each day. The difficulty in providing care in corridors with no space or privacy, results in patients and relatives becoming so frustrated that they become aggressive towards any member of staff in the vicinity.

N8:- *“The doctors were on their morning round and started to examine the patient on the corridor. Then, her daughter lost the plot [an unexpected and sudden display of aggression] [because her relative was on the corridor] and started hurling abuse at both the doctors and myself.”*

The majority of participants spoke of how the corridors were so full of people that they could smell the rising tension and knew, because of the heat, noise and confined space that people were going to become aggressive.

N10:-*“There were so many patients on the corridor the heat and noise was cruel...you just knew someone was about to fly off the handle...next thing this guy is in my face hurling abuse and everyone looking and waiting to join in”*

Participants suggested that improved security measures might help reduce aggressive and violent incidents. They described how just the mere presence of security acted as a deterrent and reduced incidents of violence or aggression.

N6: *“it was our two oldest and more experienced security guards who can calm down any one...they nearly have a sixth sense for these situations.”*

The majority of participants believed that a lot of violence and aggression could be prevented if the security were more easily accessible to staff. As security was based at the ED entrance and not in the ED itself, some participants reported that the time delay in responding to phone calls was slow.

N11: *“The boys do a great job but they have their office and unless they are called they tend to sit out there....It took three phone calls to security before they bothered to turn up”*

The presence of a panic button throughout the department especially in triage with a direct line to the local police station gave participants some comfort. Some participants also suggested that all staff, not just triage staff, should be issued with personal alarms.

Triage was identified as the area with the greatest risk of violence and aggression by all participants.

N2; *“I have to say that triage is the worst place to work when it comes to abuse...it's never ending out there.”*

The majority of the participants blamed the size and layout of triage as a key factor which influenced violence and aggression. At times, triage was used by the waiting public as an enquiry office because there was no other method of communication for patients and relatives to make enquires. Participants reported that these constant interruptions to triage made it difficult to assess patients and maintain patient privacy.

N10: *“triage is too small and claustrophobic at times, we are the only ones accessible to the barrage from the waiting room.”*

Communication factors

All participants highlighted the importance of being honest and truthful when communicating with patients and their relative(s). Participants believed that communication is a significant aspect of their role which, if done appropriately may alleviate much violence and aggression.

N1: *“look...it’s basically about the way we talk to them.....you know if everybody communicated properly with patients and relatives we wouldn’t have half the problems we do.”*

Some participants also believed that much of the communication-related aggression emanated from unresolved professional difficulties. More than half the participants made reference to problems with doctors imparting the wrong information to patients/relatives and nurses consequently having to take remedial action to manage the error.

N5: *“the doctor said to them...patient x is for admission we’ll organise a bed [The doctor never communicated this to the nurses]. The patient was happy, hours later they became irate when no bed surfaced.”*

Poor communication was often seen among nurses themselves. They suggested that important and relevant information in relation to the care of the patient was sometimes forgotten or viewed as irrelevant by others.

N9: *“Our communication is pretty bad sometimes even among ourselves.”*

Lack of time and staff resources also contributed to poor communication.

N9: *“how many times you walk past somebody and you had meant to say something to them...you’re just too busy and the next thing you know that person is in giving out to somebody else”*

Although interpersonal communication is affected by issues such as resources and poor communication practices, participants also talked about stress as a significant contributor to the manifestation of unhealthy attitudes towards violence and aggression in ED. Participants felt that, when under stress, they often gave off negative attitudes towards patients and/or relatives and, in particular, towards patients who they believed should not be in the ED.

N9: *“A lot of the times you might be stressed, you might aggravate the situation because you haven’t got the time or the interest to deal with certain patients that shouldn’t be here anyway.”*

A few participants said that as the end of their shift approached it was extremely difficult for them to deal with people, and without any provocation they grew increasingly intolerant of patients and relatives. A few participants also highlighted that they believed in advance that certain patients/relatives would inevitably create problems in the ED.

N8: *“When a patient is under the influence of alcohol, you can nearly expect that they are going to kick off [become aggressive].”*

In contrast, the majority of participants stated that they felt less threatened by those who were drunk. They believed that there was more of a threat from sober people in the ED.

N12: *“I’d like to allay the myth that it’s always drugs and substance abuse that causes aggression... That’s actually far from the truth....this guy wasn’t drunk.....he knew what he was saying and he was just trying to be as insulting as possible without actually being physical”.*

The findings also identified that many of the above attitudes were borne out of fear and vulnerability. Participants relayed their frequent feelings of fear at work. They used the following terms frequently when interviewed: “insulted”, “soul- destroying”, “shouted at me”, “afraid”, “invading my space”, “threatened and cornered”. Participants made reference to occasions when they felt trapped and vulnerable, and dreaded the hours ahead as they anticipated a constant bombardment of complaints and abuse in triage.

N3: *“it’s so small [triage] and only one exit, and if someone attacks you, you have nowhere to run.”*

Some participants blamed themselves for feeling fearful and vulnerable. These participants believed that they tolerated large amounts of abuse from patients and relatives because it was believed to be part of the job. They discussed the feeling of being trapped and cornered in the ED.

N5: *“You know it just felt so threatening, we all have our comfort zone that surrounds us and when somebody comes very close and especially with the loudness of the voice, it just made me very uncomfortable and wonder, God...I took a step back.”*

The participants described shifts where there was nothing but constant abuse and aggression towards staff. A number of the more experienced participants stated that

they frequently were the subjects of prolonged aggression and found themselves in a position of having to plead with the aggressor to stop the abuse. Another participant stated that patients often engaged in insulting remarks towards one nurse while being pleasant to another nurse, leaving the insulted participant feeling soul destroyed.

N1: *“why don’t you just shut up now and go do your job because this nurse is taking care of us...I had no response to that, he was telling me to shut up and do my job, I was doing my job...it was soul destroying.”*

Discussion

The reality of increasing violence and aggression in the ED is clearly reflected in the extensive volume of published literature on this topic (Ferns et al., 2005; Hahn et al., 2012; Lau et al., 2012). In this study, aggression was viewed by participants as a verbal act rather than a physical act, while violence was defined as a physical act resulting in injuring a person but not necessarily with force. The participants’ views reflect those of Rippon (2000) who concludes that violence is reserved for those acts of aggression that are particularly intense and more heinous, infamous or reprehensible.

The majority of the participants in this study believed that waiting times was the highest causative factor of violence and aggression. The unpredictable and chaotic nature of the ED makes it difficult to eliminate frustration encountered often arising from the inevitable waiting time. Most participants associated inadequate staff resources with long delays. Participants also relayed that aggression occurred a number of hours after the patient presented to the ED. This is in contrast to some literature where it is reported that violent and aggressive incidents occur within the

first hour of presentation (Crilly et al., 2004). This discrepancy could possibly be due to the frustration that arises from the long waiting times which may lead to aggression.

Several participants spoke about their frustration when trying to deliver patient care in overcrowded corridors, with noise and smells contributing to aggression. As violence and aggression intensifies in busy, noisy, overcrowded departments, nurses increasingly rely on security staff to maintain control. It was generally agreed that, when security were present violence and aggression was reduced, a view also reported elsewhere (Gilchrist et al., 2011; Gillespie et al., 2012). Participants however, had mixed feelings towards security staff. While speaking fondly of their good working relationship and how safe they felt in the presence of security staff, they also identified that security were not always present when urgently required. ED staff need a clear understanding of the roles and responsibilities of security in the ED and communication between staff and security needs to take place before a violent incident develops (Gillespie et al., 2012).

Triage was identified by participants as the primary area for violent and aggressive acts toward ED staff. Triage is first port of call for patient assessment and thus provides patients and their relatives with an opportunity to take their frustrations and aggression out on the first person they meet. This finding is consistent with that reported by others (Crilly et al., 2004; Lau et al., 2012).

The study also identifies communication as a contributing factor. Poor interpersonal communication was the focus in all participants' interviews. All participants spoke about communication or the lack of it as a causative factor of violence and aggression. Many of the patients and relatives whom the participants spoke about

received no communication from any healthcare professional in the intervening period between triage and the eruption of violence and aggression. Nurses are allowed to give specific/approximate waiting times; however there can be as many as three nurses in triage and they would not specifically know of another patient with the same condition therefore would not know the approximate waiting time.

Nevertheless, nurses give approximate waiting times in respect to different areas within the ED. So they would enquire to the nature of the condition and relate the time delay according to this. However, while all study participants acknowledged that their lack of communication was a contributing factor none identified the importance of education and developing better communication strategies as a method to alleviate the problem of miscommunication. This finding may be because they believe that the only factor that can improve the problem of violence and aggression in the ED is to improve resources. However, good communication strategies and the early establishment of an empathetic rapport with patients is central to avoiding violence in the ED department (Lau et al., 2012). Moreover, communication skills training such as ACT-SMART (Attitude and Communication Techniques for Scripps Mercy Aggression Reduction Training) is reported to improve nurses' confidence in managing aggression in the ED (Cahill, 2008). Electronic boards indicating approximate waiting times can also be useful, but they are only accurate if triage nurses or clerks are available to update the system (Lau et al., 2012). Moreover, patients and relatives' tolerance towards waiting times varies and focusing on effective communication may be more appropriate than attempts to reduce waiting times (Lau et al., 2012).

An information guide on the patient's journey through the ED may be of benefit. Some limited evidence suggests that an information leaflet describing the working

and geography of the ED can improve patients' understanding of why they have to wait (Nelson et al., 1997; Kington and Short, 2010). An informational videotape for patients in waiting areas of the ED also has been shown to reduce anxiety (Corbett et al., 2000).

The appointment of a communication officer in the ED is also useful. Meek and Torsello (2006) report that the presence of a dedicated communication officer in the ED enhances communication and patients and relatives' perceptions of the care given. Communication workshops for staff may also be of use. Education and training in the management of aggression is a useful intervention in the acute hospital setting (Kynoch et al., 2011). However, the training should focus on communication skills specific to the care context with an emphasis on patient centeredness (Hahn et al., 2012).

Most study participants indicated that they occasionally exhibited a negative manner toward certain patients and relatives because they believed these patients were not ill enough to attend the ED, and this sometimes incited aggressive responses. This view is upheld by Erickson and Williams-Evans (2000) who state that if nurses communicate negatively as a result of previous experiences, they may themselves be the instigator of much of the aggression that ensues. Likewise Lau et al., (2012) state that nurses' judgemental behaviour toward certain patients contributes to violence in the ED (Lau et al., 2012). Hislop and Melby (2003) also highlight that nurses can be intolerant of drunk, psychiatric and drug abusing patients specifically, because they viewed them as inappropriate attendees. However, the study participants did not highlight alcohol, substance abuse or psychiatric patients as inappropriate attendees but merely a fact of daily ED business.

Participants also relayed feelings of being undervalued as professionals and believed that the public really were not aware of what their job entailed. Participants also revealed that they sometimes raised barriers (i.e. defensive body language & no eye contact) towards patients and relatives as a type of defense mechanism to protect them. This led to the development of a more aggressive, authoritarian or sarcastic stance toward patients, again potentially inciting aggressive incidents.

Some of the study participants made particular reference to articulate and well dressed individuals being the most aggressive and displaying little courtesy to staff. This is an interesting finding and not reported elsewhere. However, although only four participants specifically spoke of these as aggressors, most of all these incidents involved relatives rather than patients. This finding concurs with the findings of others who report that patients' relatives and friends are the most common cause of violence and aggression in EDs (Adib et al., 2002; Ergün and Karadakovan, 2005; Esmailpour et al., 2011).

Conclusions

This study determined nurse' perceptions of the factors that cause violence and aggression in the ED. Whilst acknowledging that this qualitative study's sample size is small, the findings contribute further to our understanding of this important issue. The findings reveal that environmental and communication factors contributed to violence and aggression in the ED. Participants perceived waiting times and lack of communication as contributing factors to aggression, and triage was the area in the ED where aggression was most likely to occur.

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