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THE EXPERIENCES OF REGISTERED NURSES INJURED BY INTERPERSONAL VIOLENCE WHILE ON DUTY IN AN EMERGENCY DEPARTMENT

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for

the degree of Doctor of Philosophy

By

Salena Wright-Brown

May 2017

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Salena Wright-Brown

2017

THE EXPERIENCES OF REGISTERED NURSES INJURED BY INTERPERSONAL VIOLENCE WHILE ON DUTY IN AN EMERGENCY DEPARTMENT

By

Salena Wright-Brown

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ABSTRACT

THE EXPERIENCES OF REGISTERED NURSES INJURED BY INTERPERSONAL VIOLENCE WHILE ON DUTY IN AN EMERGENCY DEPARTMENT

By

Salena Wright-Brown

May 2017

Dissertation supervised by Kathleen Sekula, PhD, PMHCNS, FAAN

Numerous studies and reports site the concerning incidence of work place violence directed toward healthcare workers (Centers for Disease Control and Prevention, 2013; GAO, 2016; Gerberich et al., 2004; U.S. Department of Labor, 2016b). Despite efforts over the past few years to reduce workplace violence in healthcare facilities and specifically in emergency departments, the incidence of violence has not substantially lessened (GAO, 2016). In March, 2016, the Government Accountability Office (GAO) released a report that was prepared by congressional request. The GAO found that workers in in-patient healthcare facilities experienced work-place violence that resulted in lost time from work at a rate at least five times higher than workers in other private sector settings. Exposure to violence can have significant effects, including physical, psychological and emotional injury. Among these injuries are burnout, depression, fear,

posttraumatic stress disorder, decreased job satisfaction and reduced ability to perform their job duties. Some nurses exposed to violence, reported that they considered leaving the nursing profession and/or the emergency department. Although reports exist concerning the physical and mental impacts of violence on the RN, there is little published about the impact violence has on the job satisfaction or on the descriptive experience of the nurse who experienced the violent injury. The intent of this study is to explore the impact that violence has on the job satisfaction of registered nurses working in an emergency departments and to explore their intent to stay in the emergency department practice setting. Additionally, the study describes the experiences of RNs who have been injured by interpersonal violence while working in an emergency department.

DEDICATION

"Live life when you have it. Life is a splendid gift-there is nothing small about it." Florence Nightingale

This work is dedicated to the many nurses with whom I have been blessed to share this gift of life and love in the service of others. Further it is dedicated to those who always expected splendid success, my parents; Walter and Virginia Schrader and my husband, James Leslie Brown. My dedication to my son, Parker and beloved Grandson, Christian. Thanks to June Scarborough and the Discalced Carmelite Nuns who prayed me through many life trials and academic tests (especially statistics) during these years. To all my extended family, friends and colleagues who never doubted….thank you.

ACKNOWLEDGEMENT

I'd like to acknowledge and appreciate the nurses who participated in this study, especially those willing to share their experiences. Additional acknowledgement for the time, wisdom and advice of my Chair, Kathleen Sekula and dedicated committee members, Gordon Gillespie and Rick Zoucha. Thank you for many years of patience!

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Chapter 1 Introduction and Background

There are numerous risks associated with any career in health care, including exposure to illness, injury, or emotional burdens. One of the most startling risks may be that of interpersonal violence directed towards health care workers. Violence directed towards healthcare workers can result in a range of physical injuries or death. Exposure to the violence for the injured staff member also carries the risk of psychological impact that may result in depression or a variety of other symptoms that may be associated with post-traumatic stress reactions (Flannery, 1999; Gillespie, Bresler, Gates, & Succop, 2013). While the incidence is widespread in most health care settings, the risk is heightened in emergency departments (Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013; Cleary, Horsfall, & Hayter, 2014; Gerberich et al., 2004; Hegney, Tuckett, Parker, & Eley, 2010; Institute for Emergency Nursing Research, 2011; Taylor & Rew, 2010; World Health Organization, 2002). There are several factors associated with the increased incidence of violence in the emergency department including the prevalence of weapons carried by patents and others, availability of drugs and money at hospitals, unrestricted movement of the public in clinics and hospitals, long waits in emergency departments, lack of staff training in management of escalating violence, delays in provision of pain medication, and the increased numbers of acute and chronic mentally ill patients discharged without appropriate follow up care or delays in transfer of mental health patients (Gillespie, Gates, & Berry, 2013; OSHA, 2015).

Nurses are frequent targets of interpersonal violence while at work and at least one study found that over 80% of emergency department nurses reported exposure to violence (Ray, 2007). Nurses remain the largest single professional group within the

interdisciplinary health care team. The demand for nurses continues to grow and the supply is not sufficient to meet the current needs (American Association of Colleges of Nursing, 2014). When nurses leave the profession of nursing it adds to the current shortage. Several reasons nurses leave the profession have been identified, including the high incidence of violence in health care settings (Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013). The variety of patients and the unpredictable nature of work in the emergency department can invoke emotional and physical stress on the registered nurse beyond that which might be experienced by registered nurses who work in a more stable, controlled environment. Additional stress may be placed on the registered nurse due to the potential for violence that occurs in emergency departments. Exposure to violence can result in physical and/or psychological trauma. The results can be long lasting and may impact the registered nurses' ability or desire to remain in the emergency department as a practice setting.

There are a number of states with laws that strengthen the penalties for perpetrators if violence occurs in healthcare facilities; however these are not wide spread and are often not fully implemented or enforced (American College of Emergency Physicians, 2016; Bureau of Labor Statistics, 2010; GAO, 2016; U.S. Department of Labor, 2016a). Many professional nursing organizations have policy statements against violence and call for health care environments that protect nurses and other health care workers (American College of Emergency Physicians, 2011, 2016; American Nurses Association, 2015; Emergency Nurses Assocation, 2014). Ongoing efforts related to legislation, education and preventive toolkits have been attempted, but the incidence of workplace violence remains at epidemic proportions and poses a significant risk to the

health and safety of emergency department nurses (OSHA, 2015; World Health Organization, 2002). The Government Accountability Office (GAO) released a report in 2016 prepared by congressional request. The GAO found that workers in in-patient healthcare facilities experienced workplace violence that resulted in lost time at a rate at least five times higher than workers in other settings and called for full implementation of the OSHA guidelines concerning prevention of violence (GAO, 2016).

It is hoped that the findings in this study will provide information that reveals the experiences of nurses who have been exposed to violence so that this data may be used to impact policy and/or legislation that leads to a safer work environment. The goals of this study were to explore how the emergency department registered nurse is affected by personal exposure to violence while on duty, including their self-reported needs satisfaction and their intent to remain in the emergency department as their practice setting. The specific aim is to explore the impact of violence on registered nurses in the emergency department setting. The research questions addressed are: a) What is the relationship between exposure to physical violence and job satisfaction of the registered nurse working in an emergency department? b) What are the lived experiences of registered nurses who have been injured due to interpersonal violence while working in an emergency department?

The objective of the program of study is to add to the body of knowledge regarding the impact of violence in the workplace, primarily in emergency departments and to provide opportunity to use that information in ongoing efforts to reduce violence in the workplace. Information about the relationship between exposure to violence and

job satisfaction may lead to increased efforts towards prevention of violence in emergency department settings or to mitigate the effects if violence occurs.

Chapter 2 Literature review

Electronic database searches were conducted that included Elton B. Stephens Company (EBSCO host), Medical Literature Analysis and Retrieval Systems (MEDLINE), Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Journal/Author Name Estimator (JANE). The reference lists in each article was reviewed for possible additions of research study information. The searches were not limited by date, although the preponderance of the published works on violence in emergency departments were mostly published after 2009. Key words and phrases used to search include: nurse(s) job satisfaction, job satisfaction, nurse(s) role satisfaction, violence in health care, emergency department violence, nurses and violence, registered nurses and violence, and interpersonal violence in emergency department(s). The JANE search allows the search by title or abstract, therefore, this site was searched using the title: Experiences of registered nurses injured by interpersonal violence while on duty in an emergency department.

The searches revealed a number of articles and reviews that focused on incidence and types of violence and injuries that result from violence in the emergency department (Bureau of Labor Statistics, 2010; Institute for Emergency Nursing Research, 2011; National Institute for Occupational Safety and Health, 2002). Additionally articles were found that reported factors that increase the risk of violence in the emergency department (Gacki-Smith et al., 2009; Gillespie, Gates, et al., 2013). According to the Occupational

Safety and Health Administration, approximately 70% of all workplace violence occurs in healthcare institutions (OSHA, 2015). The Emergency Nurses Association, Emergency Department Violence Surveillance Study found that 42.5% (n=2,779) of emergency department nurses surveyed reported verbal abuse within the previous 7 days and approximately 12% (n=734) reported physical abuse within the previous 7 days before the survey (Institute for Emergency Nursing Research, 2011). In 2011, the Institute for Emergency Nursing Research published the results of a landmark study concerning violence that occurred specifically in emergency departments. Several studies have addressed the incidence of violence and relay accounts of violence. Two of the most prominent are the World Health Organization Workplace Violence in the Health Sector Study (2002) and the Emergency Department Violence Surveillance Study (2011).

Taylor and Rew (2010) published a systematic review of 16 research articles on workplace violence in the emergency department. They report significant effects of violence on health care workers in the emergency department, including burnout, depression, fear, post-traumatic stress disorder, decreased job satisfaction and reduced ability to perform in the job role. Some participants reported they considered leaving the health care profession. The authors called for continued study and creative solutions to the problems of workplace violence in the emergency department setting. The Framework Guidelines published by the World Health Organization in 2002 also highlighted the negative consequences of violence towards health care workers, including the physical and psychological injuries of the workers as well as the potential for decreased access to health care resources if workers leave the profession due to violence, thus highlighting the serious impact on the current and future nursing workforce.

Searches revealed governmental efforts to address the concerns of violence. In 2002, the World Health Organization published The World Report on Violence and Health and in 2014 published The Global Status Report on Violence Prevention which included an evaluation of the strategies published in the earlier report (World Health Organization, 2002, 2014). The Occupational Safety and Health Administration published guidelines that call for healthcare institutions to implement violence prevention programs (OSHA, 2015; US Department of Labor, 2008). Additionally, the National Institute for Occupational Safety and Health published prevention strategies in 2002 that called for safer hospital designs and prevention strategies. Several sources identify the serious underreporting of violence in healthcare settings, therefore the incidence and risk of violence to healthcare workers, may even be greater than reported (Gillespie, Leming-Lee, Crutcher, & Mattel, 2016 ; National Crime Victim Resource, 2014; OSHA, 2015). However, little was found in the literature that addressed the nurses' job satisfaction after exposure to violence or studies that applied a phenomenological approach to gaining knowledge about the experience of being injured by violence while on duty.

This study is significant because it adds knowledge regarding the impact that violence has on job satisfaction of the emergency department nurse and compares the job satisfaction of those who were injured and those who were not. It is important that this information is assessed and reported to aid in efforts to prevent violence or to mitigate the impact when violence occurs. Further understanding the experiences of those who have been injured may be valuable in efforts to lessen the impact and prevent long term effects which impact the nurses' job satisfaction in the emergency department and the impact on their future physical and mental health.

Chapter 3 Preliminary Studies

A pilot study was completed to determine feasibility for a larger study. A manuscript of this pilot was published in December 2016 (attachment A).

Chapter 4 Design and Methods

This mixed methods 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 registered nurse in an emergency department. The convergent parallel design (also referred to as the convergent design) occurs when the timing of the quantitative and qualitative strands are implemented during the same phase of the research procedure, prioritizes the methods equally, and keeps the strands independent during analysis and then combines the results during the interpretation of both strands (Cresswell & Plano Clark, 2011). The quantitative and qualitative strands were administered concurrently in the study to examine the relationship between exposure to physical violence while on duty and the job satisfaction of the registered nurse in an emergency department.

The participants were registered nurses who were working in an emergency department or who had previously worked in an emergency department. The respondents were asked to complete a survey that addressed satisfaction with their job. The registered nurse's job satisfaction was evaluated using a needs satisfaction questionnaire as a measure of job satisfaction and a questionnaire about the nurse's future professional plans, including the intent to continue in the emergency department 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, 1966). Porter's Need Satisfaction scale was used as the basis for a self-reported scale to reflect job satisfaction. Similar to Maslow's Hierarchy of Needs, the scale addresses need fulfillment in five categories: security, social, esteem, autonomy, and self-actualization (Lester, Hvezda, Sullivan, & Plourde, 1983; Paris & Terhaar, 2010; Porter & Mitchell, 1961). The tool asks respondents to use a Likert scale to rate their responses to questions concerning a characteristic, such as safety, and the ability to make friendships or other aspects that might be associated with their position as an emergency department nurse. 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?

This tool was selected because the questions roughly reflect a hierarchy of needs from the respondents' perception that starts with security/safety and allows the responding nurse to indicate the desired amount of an attribute and how much of that attribute is currently present from the nurse's perspective. 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. 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. Autonomy questions ask about authority, independent thought and action, opportunity to participate in goal setting and in determination of methods and procedure.

Porter and Mitchell (1966) described the manner of determining degrees of dissatisfaction through the determination of the difference between question a. *How much of the characteristic is there now connected to your position?* and question b. *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.

The second part of the study was a phenomenological interview that was conducted with registered nurses who had been injured while on duty in an emergency department to explore their experiences of being injured by violence. 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). The phenomenological approach was guided by Edmund Husserl's work. The experience in question will be 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. 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, 2015). Information in the interview was sought about how the experience of being violently injured while on duty related meaning and impacted perception of the RN. The experience in question during the semi-structured interview was the episode of violence that led to the nurse's injury and on the subsequent actions, thoughts and emotions of the nurse. A semi-structured interview was designed to explore the experience of the nurse related to the episode of violence that led to the nurse's injury and the resulting experience after the injury. The intent is to address the question: What are the experiences of registered nurses injured by violence while on duty in an emergency department?

Setting/Population/Sample

The study population included registered nurses who work or had worked in emergency departments. The demographic portion of the survey tool included questions regarding the educational preparation of the registered nurse, years of experience of the registered nurse and the type of facility where the emergency department was located. A question on the survey asked if the respondent has been injured by violence while on duty in an emergency department. If the answer was 'yes', the respondent was asked the role of the person who caused the injury in the emergency department, i.e.: patient, family, co-worker, visitor, etc. Respondents who indicated they were injured by violence were given the opportunity to participate in a phenomenological interview.

The sample for the quantitative survey tool was registered nurses working or who had worked in emergency departments. The participants in the qualitative interview were RNs who had been injured by violence while on duty in an emergency department and

who voluntarily agreed to be part of the phenomenological interview regarding their experiences.

Data analysis

Data from the questionnaires were entered into IBM SPSS (Version 24). Statistical analyses were completed through the SPSS statistical functions, including frequencies and percentages. Frequency statistics were used to compare those who experienced violence while on duty with those who indicate they had not experienced violence. Degree of dissatisfaction measures were calculated by determining the difference between how much of a characteristic existed and how much the participant thought should exist. The degree of dissatisfaction is represented by a gap number, which is the difference between current state and desired state of a characteristic. Statistical comparisons of the differences in the gap numbers were completed and the results are included in the attached manuscripts.

The interviews for the qualitative strand were transcribed verbatim. The transcripts were read several times to identify patterns or themes. The RN's perception of the event and its meaning was the focus. An approach of inductive coding of data was used to identify themes (Fade & Swift, 2011). During the readings, text was highlighted and lists created identifying common or similar terms, meanings or themes. During multiple readings, the lists were coded and further analyzed with consideration of the subscales in the quantitative survey. Functions of SPSS were also used to aid in the organization and analysis of the qualitative data. Validation of concepts and themes were done with a faculty member who has expertise in qualitative analysis.

Study Limitations

A potential limitation of the study was the lack of information regarding the reliability and validity of the Porter tool. This was not found in the literature nor maintained by the author of the tool, however, the lack was not felt to impact the usefulness of the tool in this study. The characteristics assessed on this tool are determined by the author to be the most appropriate questions in order to explore the research question concerning the impact of violence on job satisfaction. This tool reflects a Maslow's type pyramid of need/satisfaction. The characteristics explored are useful to reflect the registered nurses needs and satisfaction in their role as emergency department nurses. The author evaluated reliability of the tool for this study using Cronbach's alpha. The tool was found to have consistency and the findings are reported in the manuscript.

Protection of Human Subjects

Approval through the Duquesne Institutional Review Board was obtained for both the pilot and full study. Participation in the study was entirely voluntary and participants were not compensated. Completion of the surveys indicated participants consent to participate in the quantitative strand of the study. Participants in the qualitative interview were given a letter or email explaining the survey and potential risk. They read and signed the consent to participate or had the consent read to them and indicated their consent verbally on the recording of the interview. Participants were able to withdraw from the study at any time, however all participants who started the interview, completed the qualitative interview.

Substantial evidence exists that exposure to critical incidents, such as interpersonal violence, can have long-term physical and psychological effects. To address the possibility that discussion of the incident in the qualitative interview might have a psychological impact on the participants of this study or that untreated psychological distress may be identified during the interview process, a psychiatrist was consulted prior to the study to review the proposed process and questions. Additionally, arrangements were made for consultation with a mental health professional if needed during the study. No additional support, or consultation, was needed during the study related to participant distress or symptoms.

Chapter 5 Study Manuscript

The full study was completed in December 2016 and the resulting manuscript of the study is to be submitted to the Journal of Nursing Administration or comparable journal (attachment B).

Summary

The financial, physical, and psychological impact of exposure to interpersonal violence can be great. However, little is known about the specific impact that exposure to interpersonal violence has on registered nurses. This study added information about the concepts and general description associated with the experience of registered nurses who are injured by interpersonal violence while working in an emergency department. Further, this study provided information about the relationship of violence to job satisfaction for registered nurses. It is hoped that this information may further inform

efforts at prevention of violence and mitigation of the effects of violence when it occurs. Emergency department registered nurses 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 indicates an area of dissatisfaction for the emergency department nurses who completed the survey and for those who participated in interviews. Continued efforts to understand the impact of violence on the emergency department registered nurse may encourage corporate and legislative intervention that will better protect the emergency department registered nurse.

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Attachment A

Wright-Brown, S., Sekula, K., Gillespie, G., & Zoucha, R. (2016). The experiences of registered nurses who are injured by interpersonal violence while on duty in an emergency department. *Journal of Forensic Nursing, 12*(4), 8. doi:10.1097/JFN.0000000000000130

Background

There are numerous risks associated with a career in health care. One of the most startling risks is of interpersonal violence directed towards health care 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 towards health care workers are patients, and their family or friends (Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013). While the incidence of workplace violence is widespread in all health care settings, the risk is heightened in Emergency Departments (Bureau of Labor Statistics, 2010; Centers for Disease Control and Prevention, 2013; Gerberich et al., 2004; Institute for Emergency Nursing Research, 2011; Taylor & Rew, 2010; US Department of Labor, 2008; World Health Organization, 2002). There are several factors that have been associated with the increased risk of violence in the emergency department (ED) including; the prevalence of weapons, availability of drugs and money at hospitals, unrestricted movement of the public in clinics and hospitals, long waits in emergency departments, the type of solo work with limited communication, workplace design, delays in the provision of pain medication, lack of staff trainings in management

of escalating violence, delays in transfer of mental health patients, and the increased numbers of mentally ill patients discharged without appropriate follow up care (Gillespie, Gates, et al., 2013; OSHA, 2015). The variety of patients and the unpredictable nature of this work can invoke 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 environment. Additional stress is placed on the RN due to the potential for violence that occurs in emergency departments. 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 health care settings has received growing attention over the past years. Many organizations such as National Institutes of Health, Occupational Safety and Health Administration and the Emergency Nurses Association have published toolkits and other information 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 emergency departments of health care facilities. Several studies have addressed the incidence of violence and relay accounts of violence. Two of the most prominent are the World Health Organization Workplace Violence in the Health Sector (2002) and the Emergency Department Violence Surveillance Study (2011). The Framework Guidelines published by the World Health Organization in 2002 highlighted the negative consequences of violence

towards health care workers, including the physical and psychological injuries of the workers as well as the potential for decreased access to health care resources if workers leave the profession due to violence.

The Emergency Department Violence study (2011) was a longitudinal trend study that utilized a cross sectional survey of 623 nurses in Emergency Departments (Institute for Emergency Nursing Research, 2011). Approximately 9% of respondents indicated they had been exposed to physical violence within the 7 days prior to the survey. Approximately 54% indicated they experienced verbal violence within the 7 days prior to the survey. Reports of the study indicate that the physical violence rarely occurred without the presence of verbal violence. Taylor and Rew (2010) published a systematic review of 16 articles on workplace violence in the ED. They report significant effects of violence on health care workers in the ED, including burnout, depression, fear, post-traumatic stress disorder, decreased job satisfaction and reduced ability to perform in the job role. Some report they considered leaving the health care profession. The authors call for continued study and creative solutions to the problems of workplace violence in the emergency department setting (Taylor & Rew, 2010). Workplace violence with serious injuries requiring time off from work are four times more common in health care settings than in other industry (OSHA, 2015). There is little published about the impact this violence has on the registered nurse and their intent to stay in health care or in emergency department for employment.

The intent of the study described in this article was to further explore the impact of violence in health care, specifically in the emergency department. 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 is identified using the Porters needs satisfaction scale. Further aim was to describe the experiences of registered nurses who have been injured by violence while working in an emergency department and to explore their intent to remain working in the ED.

Methods

The study was completed as a pilot 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 registered nurse in an emergency department.

The qualitative strand utilized a phenomenological approach to explore the experiences of registered nurses injured by violence while on duty in an emergency department. 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 response after the violent incident and how the RN viewed that response.

Human Subjects Protections

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. Additionally, 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 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. Included was reference to the possibility that participation in the study may cause emotional reactions due to memories of the trauma when the injury occurred. Participants were advised to contact their personal provider for care if needed or the emergency department if symptoms were severe.

Sample

The participants were limited to Registered Nurses who had been injured by violence while working in an emergency department. The respondents for the survey were recruited through a mailed packet to emergency departments and at an emergency nurse training conference. In cases where the totals are less than 39, the respondents did not answer that question. Highlights of the demographics of the sample are included here. Full results can be seen in Table 1. Results indicate thirty-one (31) of the respondents were female and eight (8) were male. Thirty-five (35) of the respondents

indicated they were licensed as Registered Nurses and one was Advanced Practice Nurse. Respondents were asked about their highest level of education. The Associate Degree was the highest degree for thirteen (13) participants. The majority of respondents, twenty-five (25) indicated they had more than ten (10) years of experience as an emergency department nurse. Fourteen (14) had less than ten (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 (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, seventeen (17) indicated they were practicing in a rural setting and twenty-one (21) practiced in an urban setting. The majority of respondents (30) described their practice site as an acute care hospital. Respondents indicated that sixteen (16) of the facilities were considered "community, not for profit". Thirteen (13) were "privately owned, for profit" facilities. Four (4) respondents indicated they worked for a "government owned" facility. Thirteen (13) of the respondents indicated the volume seen daily in their facility was between 50 to 100 patients. Fifteen (15) of respondents stated their emergency department daily volume was between 100 to 200 patients. Five respondents indicated daily volumes less than 50 and three (3) indicated greater than 200 patients per day.

The three respondents for the phenomenology interviews were female registered nurses. Two of the respondents practiced in a rural setting and one in an urban setting. Two remained employed in emergency departments where they had been injured and one had left emergency department nursing.

Instruments

The Registered Nurse's job satisfaction was evaluated using a needs satisfaction questionnaire as a measure of job satisfaction and a questionnaire about the nurse's future professional plans, including the intent to continue in the emergency department as a clinical practice setting. The instruments included a demographic questionnaire and a job satisfaction tool based on Porter's Need Satisfaction scale. The Porter scale was modified from the original version to replace the words "management position" with the words "your position" to better reflect the population of staff nurses in the study who are not specified as being in 'management' or administrative positions. The modification was needed to clarify the use of the tool for emergency department 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' perception that starts with security/safety and includes other concepts. Further it allows the responding nurse to indicate the desired amount of an attribute and how much 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 Need, the scale addresses need fulfillment in five categories: security, social, 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 emergency department. The overall purpose for incorporating this tool is to determine if being subjected to violence while on duty in the

ED impacts job satisfaction and ultimately the conscience decision to remain as 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 position as an emergency department nurse. 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 2 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 3 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 4 questions. Autonomy questions ask about authority, independent thought and action, opportunity to participate in goal setting and in determination of methods and procedure.

While validity and reliability has not been established for this tool, after careful review of tools available to measure needs satisfaction, this tool was determined to most closely evaluate the variables of interest. Porter and Mitchell (Porter & Mitchell, 1966) described the manner of determining degrees of dissatisfaction through the determination of the difference between Question a. *How much of the characteristic is there now connected to your position?* and Question b. *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 nor by the author of the tool

Data Collection

Data for the study were collected over an eight (8) month period. Packets containing an explanation letter, copies of the tools and self-addressed stamped envelopes were mailed to the nurse managers of emergency departments in Arkansas and Oklahoma. The mailing addresses were obtained from a hospital association publication and the packets sent to all hospitals listed. Additionally, 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 were received in the mail via the self-addressed stamped envelope that was included in the packet.

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 experience. The

interview utilized a phenomenological approach asking the participant to describe their experience of being injured by violence while on duty in an emergency department. The interviews were semi-structured, using open ended questions regarding the Registered Nurses work history, type of emergency department where the injury occurred, specifics of the violent occurrence, results of the injury, changes or intent to change their work environment as a result. Questions were designed to lead from cognitive to emotional aspects of the incident when the Registered Nurse was injured. The closing questions were used to address the nurses' satisfaction with the actions following the incident and also with their plans to remain in the emergency department as the practice setting. Qualitative interviews were conducted over a two-week period. Each interview lasted between 1-2 hours and was completed in a single in person interview. The respondent was 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 questionnaire were entered into IBM SPSS (Version 23). Statistical analyses were completed through the SPSS statistical functions. Frequencies and percentages were calculated for demographic and survey questions. Frequency statistics were used to compare those who had experienced violence while on duty with those who indicated 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 should exist. Degree of dissatisfaction is represented by a gap number, which is the difference between current state and 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 it's impact on the person's perception of the world. 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, 2015) Information in the interviews was sought about how the experience of being violently injured while on duty related meaning and impacted perception of the RN. The verbatim transcripts of the qualitative interviews were read several times to identify patterns or themes. The RN's perception of the event and it's meaning was the focus. An approach of inductive coding of data was utilized to create themes (Fade & Swift, 2011). During the readings, the text was highlighted and lists created identifying common or similar terms, meanings or themes. The lists were coded and then further analyzed with consideration of the subscales in the quantitative survey. A member of this author's dissertation committee is a faculty member and has conducted many qualitative research studies that are published in peer reviewed journals. Regular feedback, consultation, and review of the each step in the qualitative analysis was provided.

Results

Of the 39 respondents, fifteen (38.46%) indicated that they had been injured by interpersonal violence while on duty in an Emergency Department. Of those positive responses, 13 (86%) indicated that their injuries were caused by a patient. Two (13%)

indicated a family member or significant other of the patient caused their injury. One indicated that his or her injury was caused by a co-worker and one indicated “other”.

Comparisons were made for each question between those injured by violence while on duty and those who indicated they were not injured. The larger the gap, the greater the difference between the perceived current state and the desired state. In comparison of both groups, the largest gaps between current and desired state was 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 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 (Table 2). The largest gaps between current and desired level 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 current state and desired state in the security/safety questions is larger for those who had not previously been injured by violence in the emergency department. It is also noted that the desired state in both questions related to safety/security were 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 demonstrates that the current state doesn’t 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 desired state for these questions was small with both items at 0.38 or

below, indicating little disparity between the current and desired state in the areas of opportunity to help and opportunity to develop 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 the value of friendship in the non-injured group exceeded what the desired state was (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, scored at 5.67.

The next area addressed in the survey is the subscale for esteem needs. There are three (3) questions addressed in this subscale concerning self-esteem and perceived prestige, from inside and outside of 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 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 the groups felt 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 the opportunity to have a say in 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 was seen in the question concerning goal setting in the not injured group and was 1.68. The other questions in this subscale had lower gaps. The largest differences in the gaps between the two groups was 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 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 (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. (Table 2)

Qualitative Findings

The qualitative interview analysis of three respondents who had experienced violence in the work setting revealed four common themes through the interviews; 1. Emergency Department staff as “family” or “team”, 2. Focus on helping others, 3. Satisfaction in immediate gratification, 4. 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 Emergency Department; ”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.

Lastly, 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 Emergency Department is located. Respondents reported a lack of legal system response as well; none of the persons who injured them was arrested or charged for the violence in the Emergency Department. In one situation, the perpetrator was arrested but for the earlier charge of resisting arrest, not for the injury to the Registered Nurse. 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 occurs".

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 didn't 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 the study might be the small number of participants for the phenomenological interviews. However several authors address the difference between sample size in quantitative and qualitative study. Unlike quantitative study

where generalizability is reliant on sample size, qualitative phenomenological study seeks content and perceived meaning of an experience and that can sometimes be achieved with as few as 2-3 interviews (Englander, 2012; Parse, Coyne, & Smith, 1985). Another limitation of this study might be that none of the participants had experienced severe or debilitating injury. It is likely that the experience and responses of the Registered Nurse might be different based on severity of the injury. Further, facilities seeing greater than 200 per day were minimally represented.

Limitations of the tool include the lack of information regarding the reliability and validity of the tool. While this was not found in the literature nor maintained by the author, 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 in order to explore the research question concerning the impact of violence on job satisfaction. This tool was chosen for that reason.

Discussion

The results of this survey show the same concerning high rate of injury by interpersonal violence for registered nurses working in an emergency department. However it is challenging to make a comparison, because it is difficult to cite an accurate overall rate of injury, as Taylor and Rew reported in a review of literature that there is a lack of accurate statistics related to incidence of workplace violence occurring in emergency department (Taylor & Rew, 2010). Reasons for the inaccuracies include the lack of consistent reporting mechanisms or requirements and the general hesitancy to hold perpetrators accountable in the emergency department 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 actual state and 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 previously 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 emergency department, which may reflect the reliance on the team work when potentially rapid, life-saving work is required. The strong attraction to helping others was also evident in the survey question concerning the opportunity to help others. The sub-scale question concerning the opportunity to help was one of the highest scoring questions on the scale for both the injured and non-injured groups. The qualitative interviews also reflect the Emergency Nurses attraction to knowing what happened to the patient. The nature of episodic care in the emergency department 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 which both groups scored the desired state of these areas as 6.37 or higher on the 7 point scale. This high score seems to indicate that feeling valued and having opportunity for meaningful growth is important to the respondents, but may conflict with the reported lack of support by their corporate offices.

It is recommended that future study include comparisons for those Registered Nurses working in states where enhanced legislative efforts have been established that provide stronger penalties for violence in the emergency department or in Healthcare facilities in general. It would also be informative to include comparisons of Registered Nurses perceived gaps where violence prevention programs have been established in the emergency department.

Emergency department Registered Nurses 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 indicates an area of dissatisfaction for the ED nurses who completed the survey and for those who participated in interviews. Continued efforts to understand the impact of violence on the emergency department RN may encourage corporate and legislative intervention that will better protect the emergency department Registered Nurse.

Conclusions

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 an electronic method of communication with the participants for the quantitative survey tool are among the lessons learned. For forensic nurses this study highlights the impact violence has on nursing colleagues in emergency departments, and provides insights that may be beneficial when responding to violent episodes or when supporting efforts aimed at reduction of violent episodes in the emergency department.

Table 1 (JFN manuscript, published December 2016)

Demographic specifics of respondents and facilities (percentages are rounded)

Gender	Male	8	20.5%
	Female	31	79.5%
Education	Associates Degree in Nursing	13	33 %
	Bachelors of Science in Nursing	9	23 %
	Bachelors in other field	3	7 %
	Diploma in Nursing	9	23 %
	Masters in Nursing	2	5 %
	Masters 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	Less than 10 years	14	36 %
	Greater than 10 years	25	64 %
Type of care provided by Facility	Acute care facility	32	82 %
	Adults only facility	6	15.4%
	Pediatric facility	1	2.5%
Type of Facility	Community/not for profit	16	41 %
	For Profit	13	33 %
	Government owned facility	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 Emergency Department per day	Less than 50	5	13 %
	50-100	13	33 %
	100-200	15	38 %
	Greater than 200	3	8 %
	Did not answer	3	8 %

Table 2 (JFN Manuscript published December 2016)

Quantitative results and gap scores

Question	Injured			Not Injured		
	Current	Desired	Gap	Current	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	1.35	6.68	6.58	0.90

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Attachment B (Manuscript pending submission)

The experiences of emergency department registered nurses injured by violence while on duty: A mixed method study

Introduction

Researchers cite the alarming incidence of workplace violence directed toward healthcare workers (Centers for Disease Control and Prevention, 2013; GAO, 2016; Gerberich et al., 2004; U.S. Department of Labor, 2016b). Healthcare professionals working in emergency departments (ED) are at increased risk for violence, in part due to factors associated with the patient and/or the environment. Factors include the presence of drugs, supplies and money at hospitals, public environments, long waits, delays in effective pain management, and delays appropriately placing patients with mental illness. Isolated environments and limited staff who may lack training in techniques to prevent violence add to the risk of injury (Emergency Nurses Assocation, 2014; Gillespie, Gates, et al., 2013).

Despite efforts over the past years to reduce workplace violence in healthcare facilities, the incidence of violence has not lessened substantially (GAO, 2016). In March, 2016, the Government Accountability Office (GAO) released a report prepared by Congressional request. The GAO found that workers at in-patient healthcare facilities experienced workplace violence that resulted in lost time from work at a rate five times higher than workers in other settings. Using data from three federal datasets; Department of Labor (DOL), Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH), GAO points out that OSHA provided guidelines for prevention of workplace violence and specific guidelines for

health care settings. Facilities are not required to implement these guidelines even though the Occupational Safety and Health Act states all workers should be free from hazards that may lead to death or physical harm (OSHA, 2004). There are no federal laws that mandate hospitals institute workplace violence programs (Campbell, 2016; GAO, 2016). There are state legislative efforts to strengthen penalties for violence against healthcare workers and to require prevention programs, however these are not well implemented, nor enforced (GAO, 2016; OSHA, 2004).

The full extent of the problem is not known due to underreporting and lack of standardization of reporting. However, it is evident that the risk of violence towards nurses in EDs is high. The World Health Organization's (2002) "Workplace Violence in the Health Sector", Emergency Nurses Association's Emergency Department Violence Surveillance Study and more recent GAO report on Workplace Safety and Health all identify risk of violence towards nurses and specifically those in the ED (GAO, 2016; Institute for Emergency Nursing Research, 2011; World Health Organization, 2002).

Exposure to violence can have significant effects, including physical, psychological and emotional injury. Among these injuries are burnout, depression, fear, posttraumatic stress disorder, decreased job satisfaction, and reduced ability to perform job duties (Gillespie, Bresler, et al., 2013). Some nurses exposed to violence reported they considered leaving the nursing profession (Campbell, 2016; Wright-Brown, Sekula, Gillespie, & Zoucha, 2016). Although reports exist concerning the physical and mental impacts of violence on the RN, little is published about the impact violence has on job satisfaction or on the descriptive experience of the nurse who experienced the violent injury. The study described in this article builds on the work done by the author in a pilot

study reported in 2016 (Wright-Brown et al., 2016). The intent of this study is to further explore the impact violence has on job satisfaction of registered nurses working in EDs and to explore the intent to stay in the ED setting. Additionally, the study describes experiences of RNs injured by interpersonal workplace violence while working in an ED.

Methods

This mixed method study was completed using a convergent parallel design. Quantitative and qualitative strands were administered concurrently. The quantitative strand was administered as an online survey via Survey Monkey to measure ED registered nurses' responses to demographic and job satisfaction questions. An introductory email with the survey link was sent to contacts at EDs and professional organizations. Additional permission was obtained to have the survey recognized through the Emergency Nurses Association. The introductory email encouraged respondents to forward the link to others as appropriate thus obtaining a snowball sample.

The quantitative strand utilized a job satisfaction scale based on Porters Needs Satisfaction Scale (Porter & Mitchell, 1961). Respondents were asked if they had been injured by interpersonal violence while on duty in an ED, who committed the violence, and if in the nurses' opinion, the injury was intentional. Respondents who indicated they had been injured by violence also were asked if they would be willing to participate in a qualitative interview regarding their experience. If willing, they were asked to provide a contact telephone number or email. Respondents were provided with the researcher's contact information. Of the 141 responses to the survey, 73 (51.8%) indicated they had been injured by violence while working in an ED. Forty-eight (34%)

indicated they were willing to participate in an interview, however only 25 included contact information or contacted the researcher. An individual email was sent to those who provided their contact information thanking them for their potential participation and asking to arrange an interview time. Three RNs responded to initial contact and interview times were scheduled. For those who did not respond to the initial email, a second email was sent which resulted in three additional interviews. For those who did not respond to the first two emails, a third email was sent. Three respondents had included a phone number and contacts were attempted for those by phone. Interviews were held as soon as possible after contact. Efforts to contact potential participants were stopped when saturation of data had been achieved.

The qualitative strand of the study was guided by the phenomenological approach of Edmund Husserl. The experience in question was explored as a singular event and the effect on the RN is treated as a conscious result (Smith, 2013). Husserl wrote of the idea of the "lived experience" and its impact on perception of the world while noting that researchers must assume a *phenomenological attitude*; researchers "bracket" their everyday knowledge to take a fresh look at the data (Rank, 2015; Smith, 2013). The purpose of qualitative interviews in this study was to explore the impact of an act of violence on the life and career of the RN who experienced it.

Twelve RNs were interviewed during the qualitative phase of the study (three from the original pilot). Interviews were conducted in person or by phone, recorded, and transcribed after the call. Respondents were asked about the ED where the injury occurred and about the experience. The questions were open-ended and intended to continue gathering data about the incident and the affect the violence had personally and

professionally on the RN. Questions used included: (a) Can you tell me more about the incident? (b) What else can you remember? (c) What happened next? and (d) Please tell me more about that. The questions continued until no further new information was obtained.

Human Subjects Protections

Study approval was granted by Duquesne University Institutional Review Board. Consent for the quantitative phase was implied by completion of survey tool and consent was obtained either in written form or recorded verbally for the qualitative interview.

Sample

The sample for the quantitative phase included 141 RNs who work or had previously worked in an ED and voluntarily completed the survey. Seventy-three (51.8%) of the respondents had been injured by violence while working in an ED. The majority (n=67) indicated that the injury was caused by a patient. Three stated family or friends of a patient caused their injury, two were injured by co-workers, and one by someone trying to hurt the patient. A summary of the demographic responses about the nurse are presented in table 3. Demographic responses about the type of facility are presented in table 4.

Eligibility for the qualitative interview was limited to RNs injured by violence while working in ED and who consented to be interviewed. A total of 12 qualitative interviews were analyzed (nine from the current (larger) study and 3 from the pilot study). Ten participants were female and 2 were male. One respondent was retired and

one was currently working in an administrative role. The remainder were employed in EDs. While specific questions were not asked about years of experience during the qualitative interview, nine respondents referred to the duration of their ED careers. The range of experience as ED nurse was 15-40 years. All had been injured by violence at least once (three mentioned multiple occurences) while working in an ED. Two participants mentioned additional situations where they were present in the ED when a perpetrator entered with a gun. In both cases the gun was fired, but without injury to staff (table 5).

Instruments

Instruments used included demographic questions, job satisfaction questionnaire, and question about respondents' intent to remain in ED as a practice setting. The job satisfaction tool is based on Porter's Need Satisfaction Scale (Porter & Mitchell, 1961). The Porter scale was modified to replace words such as "management position" with "your position". This modification was needed to clarify the tool was being used with nurses not in positions described as "management". Porter's Need Satisfaction Scale was chosen because it reflects needs from the respondents perspective that are hierarchical starting with security/safety and includes attributes ending with self-actualization (Porter & Mitchell, 1966). The instrument asks three questions for each characteristic utilizing a Likert scale to rate responses. The questions are: 1. How much of the characteristic is there now connected to your position? 2. How much of the characteristic do you think should be connected with your position? 3. How important is this characteristic to you? This allows the nurse to indicate how much of a characteristic is currently present and to

consciously evaluate how important that characteristic is to them. Porter and Mitchell described the determining degrees of dissatisfaction through calculation of the difference between the amount of characteristic now and how much the respondent thinks should be connected to their position (Porter & Mitchell, 1966). The differences between these two scores indicate degree of satisfaction or dissatisfaction, also referred to as 'gap' score (Porter & Mitchell, 1961, 1966). The larger the difference between present state and desired state, the larger the degree of dissatisfaction or gap.

There are five categories assessed: security, social needs, esteem, autonomy, and self-actualization (Porter & Mitchell, 1961). The security questions include assessment of security and safety. Social needs are addressed through questions about opportunity to help others and develop close friendships. Esteem needs and self-actualization scales include three subscales. Esteem needs are evaluated through questions about feelings of self-esteem and two scales regarding prestige associated with the position. The self-actualization subscale addresses personal growth, self-fulfillment, and worthwhile accomplishments. Four attributes are included in the autonomy subscale; authority, independent thought/action, opportunity to participate in goal setting, and determination of methods and procedure (Porter & Mitchell, 1961).

The Porter tool was chosen because of interest in the hierarchy of need satisfaction and this tool most closely accomplished that intent. Although validity and reliability had not previously been reported for this tool, after careful review of tools to measure a hierarchy of job satisfaction, this tool was determined to have face validity and most closely evaluated variables of interest. Assessment of reliability showed a Cronbach's alpha at .887 for the 42 items that included three questions for all 14

characteristics. For this study the degree of dissatisfaction was calculated based on the difference between the current state and the desired state. Therefore, a reliability assessment of the two questions utilized to reach the gap or degree of dissatisfaction revealed a Cronbach's alpha of .884 for the 28 items.

Analysis

IBM SPSS Statistics, version 24 was utilized for data analysis. Frequencies and percentages were calculated for demographic and survey questions. Degree of dissatisfaction was calculated by determining difference between how much of an attribute existed currently and how much a participant thought should exist. Degree of dissatisfaction is represented by gap number, the difference between current state and desired state. Comparisons of gap scores included those who had been injured by violence and those who had not.

Qualitative interviews were recorded and transcribed verbatim. Utilizing the method guided by the work of Edmund Husserl and described by Amadeo Gorgio an initial read through was done of each transcript. During subsequent readings, words and phrases were highlighted, underlined or marked to identify meaning units. These units then were analyzed across transcripts to identify common concepts. The concepts were used to reveal themes. SPSS was used to organize lists to assist in identifying concepts and themes (Fade & Swift, 2011; Giorgi, 2006). Analyses of data continued until no new themes were identified and data saturation occurred. The concepts and themes were further analyzed with consideration of subscales in Porter's Need Satisfaction Survey to identify congruent data within the two strands of the study. Regular consultation and

review of each step were provided among the authors. Rigor of the qualitative analysis was addressed through review, discussion, and cross-validation with a second author in the study creating investigator triangulation.

Results

The survey asked respondents to score current state of an attribute or characteristic on a 1-7 Likert scale. The lowest scores for current state were in security, safety, and prestige inside the organization. Prestige inside the organization for the group who was injured by violence was the lowest overall score (3.74). The degrees of difference/gap score was calculated for each question. The gap scores of those who reported injury by violence were compared to scores of those who reported they had not been injured. The higher the score, the greater the dissatisfaction with the current state of that attribute. The largest degrees of dissatisfaction were in security and safety. This was true for both injured group and those who were not injured. The gaps ranged between 2.48 and 2.60 for these attributes. Conversely the smallest gap (0.23) between current state and desired state was found for the injured group in the opportunity to develop friendships (Table 6).

There were 18 concepts identified during the qualitative analysis: helping coworkers, helping others, co-workers as family, nothing is going to change, high risk area, violence worsening, surprise/disbelief as first reaction, police failed to act, legislation failure, administration failed to act, avoid media/bad publicity, failure to report, accepted as unsafe, nature of ED care, protect others, gut reaction, satisfaction knowing clinical outcomes, and no consequences for perpetrator. The concepts revealed

the following four major themes; 1) safety/security status; 2) dissatisfaction with responses: administrative and law enforcement; 3) helping others; and; 4) surprise/disbelief. Eleven of the twelve RNs interviewed indicated that the ED was not safe or secure as a workplace. The majority indicated this was a worsening, but expected part of the job. Statements included: "ER is progressively getting more violent"; "nothing is ever going to change this", and; "ER is just a high-risk place to practice". One of the respondents indicated happiness with the way administration responded after being injured, however the majority of respondents (n=11) were displeased with the response or lack of response from managers and administration. One stated, "this was administrative failure", another stated "administration instructed us not to do anything, it was bad for customer relations". This aligns with the low score on prestige within the organization as rated during the quantitative strand. All respondents indicated displeasure with some aspect of law enforcement response to their injury. One stated no call/report was made to law enforcement; another stated the police tried to talk her out of making a report. A summons was issued in one case, but the perpetrator had left the state and still has not been served the summons. All respondents mentioned some aspect of helping others during their interviews. One described her workplace as "we are all family and here to help each other." Three described getting satisfaction from the job because they could help other people. One described not understanding why someone would hit her when she was "only there to help". This corresponds with high scores on desired state of "opportunity to help" in the quantitative strand (>6.52). Nine respondents indicated their first reaction was surprise, using the terms "surprise" or "disbelief". One stated, "I just couldn't believe it happened".

The themes from the full study when compared to the pilot study were similar with the exception of the theme of satisfaction in immediate gratification. The additional interviews from the full study helped to clarify the themes, and themes from both studies complemented each other (Wright-Brown et al., 2016).

Discussion:

This survey continues to highlight the risk associated with working as a nurse in the ED setting. It brings attention to the lack of effective solutions and validates the widespread assertion that the risk of violence is ‘part of the job’ (Jacobson, 2014). RNs in the survey indicated they believed the administration of their facility did not value or hold the safety of ED nurses as important. Further, they were dissatisfied with the administrative response when violence occurred. This seems to be re-enforced by the recent findings of the GAO indicating the lack of full implementation of violence prevention programs. Eight states have instituted requirements for workplace violence programs in healthcare facilities (GAO, 2016; Jacobson, 2014). If the recommendations from GAO 2016 report to Congress are followed, then OSHA will take a stronger role in assuring that healthcare employers address prevention and address workplace violence. The need for employers and administrators to take strong actions is further emphasized by the findings which showed a strong dissatisfaction with the administrative response to violence. Likewise, respondents reflected dissatisfaction and resistance from law enforcement to bring charges and follow through when violent injury occurred, despite legislation in 35 states to strengthen the penalties to felony for assaulting healthcare staff (GAO, 2016).

Full implementation of the environmental safe design practices, utilizing OSHAs (2015) five core elements; demonstrating management commitment and employee participation, completing worksite analysis and hazard identification, implementing hazard prevention and control, ongoing safety and health training, and accurate recordkeeping and program evaluation would enhance the safety in EDs. It may also have a positive impact on ED RN's satisfaction with the perception of prestige within the organization (OSHA, 2015).

Emergency Department RNs train repeatedly for response to emergency situations such as when a patient needs cardio-pulmonary resuscitation (Koller, L., 2016, Georgina, M., et al., 2015). A training program that incorporates the same rigor for assessment of risk factors for violence and immediate safety protocols when those factors are detected might better prepare the ED RN to respond instinctively. This practiced and immediate response should lead to prevention or mitigation of the impact in response to the violence.

Conclusion

Results of this study indicate there is a gap between the current state and desired state of significant attributes for ED nurses, including safety/security and prestige. Healthcare administrators should be aware of the OSHA guidelines regarding workplace safety and appropriate strategies for prevention and response to workplace violence, including assuring management's commitment to an effective program. Management's commitment can be publicized through strong policies assigning accountability for prevention and response actions if violence occurs. Employees should be involved in

efforts to increase safety and security in the workplace. Further violence prevention programs should include ongoing analysis and response through prevention and/or mitigation of risk factors. OSHA's guidelines include recommendations for staff training and for strengthening of the program if indicated. Efforts to eliminate violence in the workplace should include implementation of the OSHA guidelines (OSHA, 2015).

Healthcare administrators are responsible to provide a safe work environment as required by OSHA and other regulatory agencies (GAO, 2016). The current level of acceptance of violence in the ED must change so that all involved address prevention as primary goal and appropriate administrative and legal response when prevention has failed. Further study regarding the experiences of RNs injured by violence may lead to improved response when violence occurs and ultimately enhance processes to prevent violence in the ED.

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Table 3 (Manuscript pending submission)

Demographic specifics for QUANTITATIVE (percentages are rounded)

Gender	Male	30	21%
	Female	111	79%
	Registered Nurse	128	92%
Licensure	APN/APRN	10	7%
	Other	1	1%
	Associates Degree	26	19%
Education	Diploma	14	10%
	Bachelors in Nursing	57	40%
	Bachelors in associated field	9	6%
	Masters degree in Nursing	20	14%
	Masters in associated field	8	6%
	DNP	2	1.4%
	PhD in nursing	2	1.4%
	PhD in associated field	1	1%
	Other	1	1%
	0-1 years	7	5%
	2-3 years	6	4.5%
Practice Duration as a nurse	4-5 years	12	9%
	6-10 years	21	15%
	11 years or more	91	64%
	Did not answer	4	3%
	0-1 years	6	4%
Practice duration as ED nurse	2-3 years	13	9%
	4-5 years	13	9%
	6-10 years	27	19%
	11 years or more	80	56%
	Did not answer	1	1%
	Single	13	9%
	Married	72	51%
Marital Status	Divorced	12	8.5%
	Widowed	3	2%
	Prefer not to answer	2	1.5%
	Did not answer	39	28%

Table 4

Facility Demographics for QUANTITATIVE (percentages are rounded)

Practice setting	Emergency Department	131	93%
	Not currently practicing as a nurse	3	2%
	Other setting (but previous ED)	7	5%
Facility patient type	Acute care children/adults	102	725
	Acute care adult only	29	21%
	Pediatric hospital	3	2%
	Other specialty hospital	3	2%
	Did not answer	4	3%
Hospital Description	Community based not for profit	89	63%
	Privately owned for profit	30	21%
	Government facility	13	10%
	Other	4	3%
	Did not answer	5	4%
Average ED volume	0-10 patients	2	1.5%
	11-20 patients	2	1.5%
	21-30 patients	8	6%
	31-40 patients	3	2%
	41-50 patients	5	4%
	51-100 patients	28	20%
	101-200 patients	66	47%
	201 or more patients	20	14%
	Did not answer	6	4%
Magnet facility	Yes	22	16%
	No, but seeking Magnet	29	21%
	No	83	59%
	Did not answer	6	4%

Table 5

Demographic Specifics for QUALITATIVE INTERVIEW (percentages are rounded)

Gender	Male	2	17%
	Female	10	83%
	Patient	9	75%
Perpetrators	Friends of patient	2	17%
	Gang members	1	8%
	Alcohol	1	8%
Contributing condition/substance	Drugs	1	8%
	Mental illness	8	67%
	Drugs and mental illness	1	8%
	Alcohol and drugs	1	8%
	Yes	5	42%
Lost time from work	No	7	58%
Experience (9/12 reporting)	Range 15-40 years		

Table 6

Quantitative Results and Gap Scores

Subscale	Injured			Not Injured		
	Current State	**Desired**	**Gap**	**Current State**	**Desired**	**Gap**
Security	3.81	6.36	2.55	3.88	6.48	2.6
Safety	3.97	6.45	2.48	4.08	6.60	2.52
Opportunity to help	5.98	6.53	0.55	6.10	6.62	0.52
Opportunity to develop friendships	5.02	5.25	0.23	5.29	5.60	0.31
Self-Esteem	5.34	5.95	0.61	5.49	6.25	0.76
Prestige inside the facility	3.74	5.59	1.85	4.48	5.53	1.05
Prestige outside the facility	4.73	5.43	0.70	4.82	5.37	0.55
Authority	4.09	4.91	0.82	4.37	4.98	0.61
Independent thought/action	5.00	5.89	0.89	5.24	6.20	0.96
Goal Setting	4.34	5.84	1.5	4.53	5.94	1.41
Methods/Procedures	4.39	5.97	1.58	4.44	5.83	1.39
Personal Growth	4.31	6.29	1.98	4.80	6.25	1.45
Self-Fulfillment	4.82	6.16	1.34	5.22	6.33	1.11
Worthwhile accomplishment	4.61	6.14	1.53	5.10	6.26	1.16

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