Rural Emergency Department Nurses' Experiences with Workplace Violence

Theresa Garren-Grubbs, DNP, RN, CMSRN, CNL[1*]

Lori Hendrickx, EdD, RN, CCRN, CNL[2]

[1]Clinical Assistant Professor, College of Nursing, South Dakota University,

Theresa.Garrengrubbs@sdstate.edu

[2]Professor, College of Nursing, South Dakota University, lori.hendrickx@sdstate.edu

*Correspondence: Theresa Garren-Grubbs

Abstract

Purpose: Workplace violence (WPV) includes acts or threats of physical violence along with harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite. WPV, especially in the emergency department (ED), is often underreported as many nurses consider violence inevitable and a part of the job. There is a perception of a lack of consequences when reporting, and lack of support from organizational administration. Most of the research on WPV has occurred in urban settings and research in rural hospitals is limited. The purpose of this study was to gain an understanding of rural South Dakota ED nurse's experiences with workplace violence.

Sample: Ten registered nurses employed at Critical Access Hospitals across SD participated in the interviews. Years of experience ranged from 2 to 25 years.

Methods: A descriptive, phenomenological approach with snowballing technique was utilized. Interviews were conducted independently with each participant. Participants were asked to respond to five pre-determined questions. Interviews were transcribed verbatim and analyzed for themes.

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Findings: Five themes emerged from the interviews: isolation, reliance on law enforcement, familiarity with patients, preparation, or lack thereof, and chemical influence on patients.

Results: While WPV in EDs has been studied previously, most of these studies have focused on urban settings. The themes emerging from the current study identify challenges of WPV in rural settings. Future studies should explore effective interventions to deter WPV in rural healthcare settings.

Keywords: workplace violence, emergency department, rural

Rural Emergency Department Nurses' Experiences with Workplace Violence

Workplace violence (WPV) is defined as, "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite" (Occupational Safety and Health Administration [OSHA], n.d.-a). Threats, verbal abuse, physical assaults, and homicide are all examples of WPV (OSHA, n.d.-a). According to the United States (U.S.) Bureau of Labor Statistics' most recent data from 2018, those working in the healthcare sector are five times more likely to suffer an injury related to WPV compared to workers overall (U.S. Bureau of Labor Statistics, n.d.). Since 2011, the incidence of WPV has only increased for healthcare workers (U.S. Bureau of Labor Statistics, n.d.). In 2018 alone, nonfatal WPV injuries for healthcare workers comprised 73% of the total injuries and illnesses due to violence (U.S. Bureau of Labor Statistics, n.d.).

In the emergency department (ED), WPV is often underreported as many nurses consider violence inevitable and a part of the job. Furthermore, there is a perception of a lack of consequences when reporting, and lack of support from organization administration (American College of Emergency Physicians [ACEP], 2016; Arnetz et al., 2015; Ashton et al., 2018). The impact of WPV on ED nurses includes reduced work productivity and quality of care for patients,

along with feelings of fear, anxiety, and guilt by the nurse (Ashton et al., 2018). Emergency departments are considered a vulnerable setting; the Emergency Department Violence Surveillance Survey, with data collected from 7,169 ED nurses from May 2009 – January 2011, found that 54.5% of participants experienced physical violence and/or verbal abuse during a seven-day timeframe (Emergency Nurses Association [ENA], 2011). A more recent study, while smaller in scope, found that 70% of ED nurses reported violence such as being hit or kicked while on the job (ENA, n.d.).

Wolf and colleagues (2023) identified challenges to researching the topic of WPV in the ED. Some of the challenges noted include a lack of standardized data collection processes and measures, in conjunction with underreporting of WPV. It has also been recognized that, for many nurses, WPV has been normalized (Brous, 2018). The majority of WPV research has been conducted in urban settings, with limited research and comparisons to rural hospitals (Lukens, 2019). Lukens (2019) identified similarities in types of violence experienced in rural and urban settings, but differences in addressing and preventing WPV, noting that, in urban settings, there is often access to on-site hospital security. In a large surveillance study completed by the ENA Institute of Emergency Nursing Research (ENA, 2010), it was found that physical violence is more prevalent in large urban settings compared to rural settings. However, this study, along with many others does not differentiate between rural and urban emergency departments, making it difficult to discern the unique characteristics and experiences in each setting. The types of physical violence were similar in both settings however, Wax et al. (2019) reported a greater incidence of hospital shootings in urban settings. This study specifically sought to gain an understanding of the rural South Dakota (SD) ED nurses' experiences with WPV.

Work Place Violence: A Rural Context

In this study, rural was defined using the Office of Rural Health Policy, U.S. Department of Health and Human Services definition which identifies all non-metropolitan counties, as defined by the Office of Management and Budget, as rural (Mueller et al., 2020). Of SD's 66 counties, 64 are considered rural or frontier (Health Resources Services Administration, n.d.). The study focused on nurses practicing in Critical Access Hospitals (CAHs) across SD. To be identified as a CAH by the Centers for Medicare & Medicaid Services (CMS, n.d.), the hospital must be designated by the state as a CAH, be located more than 35 miles from the next hospital, or more than 15 miles when in a mountainous area or only has secondary roads. Other requirements include operating no more than 25 inpatient beds with an average length of stay of 96 hours or less for patients receiving acute inpatient care (CMS, n.d.). Emergency services must be available seven days a week (CMS, n.d.). In SD, of the 66 operating hospitals, 40 are certified as CAHs, representing most of the facilities in the state (South Dakota Department of Health, n.d.). The remaining facilities are located in the urban centers in the state, and were not appropriate for this study.

Methods

Design

A descriptive, narrative approach was used to gain an understanding of rural ED nurses' experience with WPV. Interviews were conducted with 10 nurses working in CAHs across SD. Participants selected either a face-to-face interview where the researcher met with the participant at a site of the participant's choosing, or the interview was conducted using the Zoom platform. Five questions were asked of all participants:

1. Have you personally experienced workplace violence while working in the emergency department?
2. Can you please describe what happened?
3. Was the incident reported to a supervisor or law enforcement?
4. Do you feel you were prepared to deal with this incident?
5. How did the incident affect you?

Following Institutional Review Board approval, email invitations to participate in the study were sent to Directors of Nursing at all thirty-nine CAHs in SD as determined by the SD Department of Health (n.d.). Of note, at the time of this study there were 39 CAHs in SD. An additional facility has received CAH designation since study completion. A snowballing technique was used in which emails were forwarded by the Directors of Nursing to nurses working in the EDs, and those nurses then contacted other nursing colleagues about the study, resulting in ten nurses agreeing to be interviewed. Participation in the study was voluntary and participants could stop the interview at any time. The same researcher conducted all the interviews. A crisis line phone number was available for any participant who felt emotionally stressed by discussing personal incidents of violence in the workplace. The interviews were recorded with the participant's permission and transcribed verbatim. The researchers independently analyzed the transcribed interviews for themes, using word repetition and key-words-in-context techniques (Ryan & Bernard, 2003).

This process involved reading the transcripts multiple times, looking for repetition and frequency of terms or descriptors used by the respondents. Word frequency lists were developed, and the transcripts were reviewed again to search for all instances where the key words were used. In some instances, the key words were categorized into one term. For example, respondents used

the words “drugs” and “alcohol” when describing violent patients. These terms were categorized as “chemical influence on patients.” The most frequently used words across all interviews resulted in the identification of themes. A total of five themes emerged. A third independent reviewer corroborated the findings.

Sample

Ten nurses agreed to participate in the study. Three nurses requested face-to-face interviews and seven requested an interview using Zoom. Face-to-face interviews were conducted at a mutually agreed upon location and the researcher traveled to the participant’s location. To participate in the study, nurses had to be English speaking, licensed as a registered nurse or licensed practical nurse, and currently working in the ED of a CAH.

All participants identified as female, and all were registered nurses. Years of experience working in a CAH ranged from 2 to 25 years, with a mean of 10.2 years. Educational preparation was split evenly, with 50% having a bachelor’s degree and 50% an associate degree. All participants indicated they had experienced WPV while working in the ED. None of the participants indicated they felt emotionally stressed enough during the interview to warrant referral to a mental health professional.

Findings

The five themes that emerged from the data analysis were: a) isolation, b) reliance on law enforcement, c) familiarity with the patient, d) preparation, or lack thereof, and e) chemical influence on patients. Similar to other studies (Budd, 2020; Gillespie & Tamsukhin, 2023; Stene et al., 2015) rural nurses in this study reported verbal abuse, physical abuse and escalation of dangerous behaviors with patients under the influence of drugs or alcohol. Findings unique to rural nurses included the feelings of isolation and familiarity with patients.

Isolation

All participants spoke of feeling isolated in a CAH, particularly at night when there were often only two nurses working in the entire hospital. Most did not have security guards or quick access to law enforcement. Within the hospital, the ED was not always directly connected to the nurse's station so there was isolation within the hospital itself in addition to isolation with limited staff working. This isolation was discussed by all participants, with some adding that this isolation induced anxiety or fear. Participants described the isolation in several ways including:

> Most nights we only have two RNs and an aid on. I feel like I'm a sitting duck just waiting for something to happen. We have a panic button that goes to the police, but we have to get to the button first and we aren't always where that is. The police only have a dispatcher on until 2 am.

Other participants described some situations where law enforcement was not available. Many rural counties are large in area with only one deputy on at night, necessitating a long drive to a hospital when law enforcement might be needed. In other situations, law enforcement was called in from home during the night or were difficult to contact. One participant stated:

> The deputies are at home after 2 in the morning and have to be called in. First, there are only 2 of us on so it's difficult to get to a phone if we both have to be with the patient. Second, they (the deputies) don't always want to come in. One time the deputy showed up but didn't know what to do. He was young and new and was like one of my kids. It wasn't helpful.

Reliance on Law Enforcement

Despite some issues with law enforcement, it was clear that the nurses in the study relied heavily on a law enforcement presence with violent patients. In several instances, patients were brought in by law enforcement and stayed with the patients until nurses were comfortable with

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them leaving or the patients were removed from the hospital. Three of the participants indicated that their counties had deputies that rounded routinely on the hospital during the night and had dispatch available all night for rapid response to an ED if needed. The nurses also spoke of good relationships with law enforcement and the willingness of the deputies to stay until the nurses indicated they were no longer needed. One nurse stated:

> We have cameras outside the main door and the doors are locked at night. Someone always knows the patient. If we see a bad one out there, we call the cops right away before we open the door. If patients are brought in by law enforcement, they (law enforcement) stay until we get the patient sedated or they take them to jail. They always ask if it's ok for them to leave before they go. Sometimes the patients listen to a uniform better than a nurse so that helps to have the cops there.

Familiarity with the Patients

Responses commonly included references to knowing the patients. Critical access hospitals are located in small towns where the nurses are familiar with most people who live in or near the hospital jurisdiction. The nurses often tried to rationalize the situation by stating that the patient "wasn't always violent" or that "they weren't really a bad person normally." Nurses also voiced concern because they were familiar with the patient and their families, not wanting to escalate a situation by calling law enforcement on someone she knew. In some cases, the familiarity helped de-escalate a potentially violent situation. One nurse stated:

> I try not to get frustrated because I know we have to care for all people. It's the same people all the time in our town and we know them so it's hard to see them that way. They know me. I can tell them it's me, (name) or Hey it's me, your mom's friend, and they sometimes settle down because they don't want to hurt me, but I'm still careful.

Participants indicated they often would call a family member to help them with a patient. This might include sitting with the patient or talking them down from a potentially volatile situation.

Preparation, or Lack Thereof

Participants were asked whether or not they felt prepared to handle a violent situation and responses were mixed. Several acknowledged the initial training they had in nursing school and others mentioned yearly training provided by the hospital. A concern with the yearly training was that it was online and there was no actual practice in handling a violent patient. Some respondents stated they relied on the more experienced nurses to handle the situation or that they learned the best ways to handle the situation from those nurses with more experience. Most participants voiced a lack of preparation for the violence such as:

> We definitely weren't prepared for how violent he got. He just flipped. One minute he was a little agitated and then boom, just like that. I couldn't react. I'm embarrassed to say I couldn't even find the restraints. I was so scared I just couldn't function.

Other nurses voiced that they felt they had adequate training as a student and that the training was reinforced during their orientation. Participants did feel that they should have more specific training with role playing of actual situations. Others felt that the training should also include the law enforcement agencies in their areas to work out a joint plan for responding to a violent patient.

Chemical Influence on Patients

Every nurse talked about violent patients being under the influence of alcohol or drugs and expecting violent behavior when a patient arrived "drunk or drugged up". Participants stated that patients under the influence resulted in the nurses being more careful and more diligent in watching for cues of violent behavior. The nurses were all more apt to contact law enforcement earlier in an interaction with a patient under the influence than with patients who they did not feel were

impaired, but also made excuses for patients they were familiar with who were not violent under normal circumstances. One participant stated:

> I know these people and they're not bad people when they aren't drinking or using. But we have a lot of drugs, alcohol, and psych issues. If they're on meth, I don't care how nice they are in real life, they can get violent. If they're violent, I want police in the room.

Similar to urban areas, the nurses talked about the difficulty getting mental health care for their patients. Since CAHs do not typically have mental health care on site, patients need to be transferred for acute care and often placement is difficult. This results in violent patients needing to be cared for in facilities lacking expertise and staff who are knowledgeable about caring for patients with complex mental health problems. In several situations, the nurses described keeping patients chemically restrained for long periods of time due to continued concern for violent behavior and not having placement available for more advanced mental health care.

Discussion

While some similarities exist between the literature on WPV and this study, there were differences identified which can be attributed to the rural setting of this study. One recent study performed in a large urban ED identified comments that were racist, sexist, and homophobic as a common example of WPV (Doehring et al., 2023). Verbal abuse was noted in the rural setting but did not specifically focus on these subjects. When addressing violent patients in the ED, those in urban and suburban facilities had a reliance on in-hospital security (Gates et al., 2011) which is not an option in a large number of rural facilities. Instead, nurses in rural facilities reported a heavy reliance on community law enforcement for protection. In rural settings there were concerns about isolation and more familiarity with patients than what is noted in the literature regarding larger facilities.

A major difference between the urban and rural settings was the type of physical violence. More shootings and stabbings are reported in urban settings. A content analysis study showed that of 88 shootings occurring in hospitals over a 5-year period, the ED was the most frequent site (n=27, 30.3%). Of those shootings, 86 (97.7%) were in urban hospital settings (Wax et al., 2019). None of the respondents in our study mentioned any violence involving guns or knives.

The ENA and other professional organizations are raising awareness about WPV and dedicating time and money to the development of policies and programs that address the issue (Adams et al., 2023). Collaborative programs with law enforcement agencies are gaining support and are crucial in isolated rural areas where support for nurses is limited. It is well documented that ED nurses are under-reporting incidents of WPV to law enforcement (Adams et al., 2023; Howard & Robinson, 2023; Lukens, 2019). Nurses also have resigned themselves to thinking that nothing will be done about the WPV and accept that WPV is an expected part of the ED nurse's role (Adams et al., 2023; Howard & Robinson, 2023). Participants in this study expressed similar frustrations and voiced opinions about administration not responding to concerns when they were reported. Changing this type of thinking is imperative if reporting of WPV is to become more routinely accepted.

Reporting tools have been developed that encourage nurses to call attention to WPV (OSHA, n.d.-b, Stene et al., 2015). Each ED should develop and implement some type of violence reporting process. Additionally, nurses should be aware of how to report a violent incident to law enforcement. Participants in this study stated they did not report incidents of WPV to law enforcement formally because "they were already here," assuming that just by virtue of law enforcement being present in the ED the incident was now reported.

Adams et al. (2023) developed guidelines from law enforcement to use when filing a report. These guidelines include getting identifying information such as a license plate, providing a detailed account of the incident with pictures of injuries or items that may have been damaged, listing witnesses, and providing security footage if available. Law enforcement personnel should also be reminded that charges should be filed (Adams et al., 2023).

Effect on Participants

Experiencing WPV may have lasting effects on nurses. For the participants in this study, fear, feeling unprepared to handle a violent patient, and expressing a desire to leave the work setting were all voiced. Several options for providing support could be implemented. While larger facilities may be able to implement behavioral emergency response teams (Bruccoli, 2023), CAHs most likely will not have the staff available to initiate such measures. For rural nurses in this study, the use of debriefing with more experienced nurses was mentioned as an effective way in dealing with the aftereffects of experiencing WPV. Rural facilities need to implement security measures such as locked doors, cameras, ways to rapidly contact law enforcement and ensuring that nurses are not left alone in an isolated area of the hospital. Rural nurses should carry portable phones at all times so that access to a phone is not an issue. There should be good lighting and two exits from the ED. When a patient with a known history of violence is admitted to the ED, appropriate signage can be placed outside the door to alert staff as they enter the room (Hanley, 2022). Facilities should also have a method in place for nurses to call for help such as a “white code” indicating a violent patient situation (Öztaş et al., 2023).

Much of the literature addresses what nurses are experiencing and how to respond to WPV but prevention or preparation for violent patients is also key. Risk assessment tools are plentiful and should be implemented in all ED settings (Cabilan et al., 2023; Quinn & Koopmen, 2023;

Sammut et al., 2023). Participants in this study mentioned looking at a camera and recognizing a potentially violent patient because of familiarity with the patient. While this may be one effective way to prepare for a violent patient in rural facilities, more sophisticated methods of risk assessment would potentially identify key behaviors prior to a patient becoming violent, especially with the increase in number of patients with mental health disorders seen in the ED.

Education and ongoing training need to be implemented to ensure that rural nurses feel more prepared to handle a violent patient. As participants in this study indicated, the training needs to include a practice component and should involve law enforcement or any other personnel that might respond to an incident of WPV. Participants indicated they learned how to handle WPV from other, more experienced nurses which is consistent with findings that older nurses with more experience were more able to remain calm and manage stress in WPV situations (Öztaş et al., 2023).

Conclusion

This study identified challenges of WPV which highlight the unique nature of rural healthcare while also confirming some concepts of WPV in urban settings. While patients with similar diagnoses may be seen in rural and urban settings, the support staff available to manage WPV situations (i.e., security guards, response teams) is vastly different in the two settings. Nurses in the ED should be able to work in an environment where WPV is not part of the job. Further research is needed to determine best practices for WPV prevention and interventions in rural healthcare.

Conflicts of Interest

These authors declare no conflicts of interest.

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