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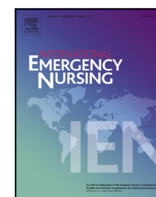

Emergency nurses' perspective of workplace violence in Jordanian hospitals: A national survey

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Background: Emergency departments are considered high-risk areas, where violence against nurses is a serious and prevalent problem. Such violence has negative effects on nurses, and therefore on the quality of care provided.
Aims of the study: To explore the risk factors behind violence, and to specify reasons for the level of low reporting of violence among Jordanian nurses in emergency departments.
Method: A cross-sectional design through conducting a survey in emergency departments in Jordanian hospitals.
Results: The total number of emergency department nurses who participated in the study was 227. Of these, 172 (75%) had experienced some form of violence. Verbal violence was the most reported (63.9%), compared to physical violence (48%). The most reported reasons for violence from the nurses' perspective were waiting time, overcrowding, and patient and family expectations not being met, with frequencies of 54.3%, 53.3%, and 46% respectively. The treatment room was the most common place where the violence occurred. Only 16.6% of the nurses who experienced violence actually reported it. Being accustomed to workplace violence is the most stated reason for not reporting violence to the hospital administration or the authorities.
Conclusion: Violence against emergency department nurses is a significant issue that cannot be ignored. There are multiple reasons. The key point in dealing with the problem is to treat its specific causes.
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1. Introduction

Typically, workplaces are assumed safer for employees than other environments. However, violence and aggression in the workplace is a rising phenomenon. Verbal, physical, and sexual insults are not uncommon (Jackson et al., 2002). Hospital personnel, like any other workers, are susceptible to violent behaviour. According to a recent systematic review, healthcare workers are at greater risk than any other workers (Lanctt and Guay, 2014). Among healthcare personnel, nurses are at a greater risk of violence than other hospital personnel, perhaps because of their direct contact with patients and their families (Mitchell et al., 2014). Also, compared to other healthcare workers, nurses spend the longest time with patients (Angland et al., 2013). Emergency department nurses, in particular, face more violence and aggression than other nurses do (Gerberich et al., 2005). Researchers have shown that this may happen because the first encounter the patient or family has is with emergency nurses, in addition to the critical nature of the situation in the emergency department (Gates et al., 2011).

Centers for Disease Control and Prevention define workplace violence as: "violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty" (Centers for Disease Control and Prevention, 2015). According to the World Health Organization, violence includes "physical assault, homicide, verbal abuse, bullying/mobbing, sexual and racial harassment" (Li et al., 2006). Previous studies have reported that the most common form of abuse experienced by nurses is verbal or emotional, followed by physical abuse (e.g. punching, slapping, beating, kicking), then sexual harassment (Lanctt and Guay, 2014; Pinar and Ucmak, 2011; Roche et al., 2010).

Globally, there has been an increase in violent behaviour against nurses, and emergency department nurses in particular (Angland et al., 2013). The prevalence of verbal violence against emergency department nurses was reported as 91.6% by some studies (Esmaeilpour et al., 2011), while physical violence reached 47% (Pinar and Ucmak, 2011). Even though violence against nurses touched these high numbers, the literature shows that 80% of the affected nurses did not report these incidents. Some of nurses described

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taking compensatory action like sick leave instead (Pinar and Ucmak, 2011), and others reported reasons like fear of retaliation and lack of support from the hospital administration as a barrier to reporting workplace violence (Gacki-Smith et al., 2009). As violence is not reported most of the time, many nurses are suffering in silence.

Researchers have shown that violence against nurses has negative consequences. One study reported that nurses who are victims of violence have higher emotional distress, difficulty thinking, absenteeism, and job changes (Gillespie et al., 2013). The literature also reported that the effects of violence are not restricted to nurses: patient care also is affected. Nurses affected by violence are more likely to withhold care or to provide incomplete care (El Ghaziri et al., 2014; Gates et al., 2011; Magnavita and Heponiemi, 2011). Violence against nurses is not an isolated phenomenon; there are varied and complex contributory factors. Some studies have reported factors relating to nurses' characteristics, such as being under the age of 30, appearing anxious, or having a bachelor degree in nursing (Pai and Lee, 2011). Other studies found hospital- or work-related factors, including: waiting time, lack of communication, lack of leadership, unanticipated change in patient mix, lack of resources, medication error, lack of hospital policy against perpetrators, and working more than 40 hours a week (Angland et al., 2013; El Ghaziri et al., 2014; Roche et al., 2010). In this context, very few studies reported where exactly in the emergency department the violence actually occurred. One qualitative study revealed the triage area as the place where violence was most likely to occur, because it is the place of first encounter between the patient or family and the nurse (Angland et al., 2013).

To sum up, violence against nurses, especially those who work in emergency departments, is a prevalent problem, with verbal violence being most frequently reported. In developing countries, including Jordan, a few studies have been conducted in this area. They observed that the incidence of violence against nurses ranged from 22.5% to 91.6%, with verbal violence being the most frequent. Only a very small proportion of this violence was reported (Abualrub and Al-Asmar, 2011; Esmaeilpour et al., 2011; Oweis and Mousa Diabat, 2005). For this reason, this study aims to explore the risk factors behind violence, to specify reasons for the low level of reporting the violence.

2. Research questions

This study intended to answer the following research questions: "What are the contributing factors that lead to violence against nurses in the emergency department?" and "Do specific areas in the emergency department have higher incidence of violence?"

3. Methods

3.1. Design

Current work employed a cross-sectional design through conducting a survey in Jordanian hospital emergency departments. The study took place over a three month period from September 2014 to November 2014.

3.2. Sampling and setting

Jordan (where this study took place) has twelve provinces. In order to represent all the provinces in this study, one hospital was randomly selected from each, resulting in eight government hospitals and four private ones. The total number of nurses working in the emergency departments of the selected hospitals was 417. Of these, 227 nurses agreed to participate and completed the study procedures, a response rate of 54.4%. According to G power software (version: 3.1.9.2) a sample of 102 nurses was required to achieve a statistical power of 0.8, with a medium effect size (0.15), based on $\alpha = 0.05$ as the level of significance.

3.3. Data collection procedure

The team for data collection consisted of the 12 head nurses of the emergency departments in the selected hospitals. In order to minimize recall bias, participating nurses were asked to report violent incidences over the last six months only. Moreover, the data collection team was given full details by the principal investigator about the nature and procedure of the study, in order to give instruction and information to the participating staff. Nurses included in the study had to agree to participate, be employed fulltime in the selected hospital, and have worked in the emergency department for at least the past six months.

The data collection sheet was distributed throughout the week and collected at the end of the week. The data collection team was also responsible for checking the returned sheets for completeness, and for answering any questions from the participants. In order to insure no coercion to participate in the study and keeping the identity of the participating nurses anonymous, nurses were offered a closed secure box in their changing rooms so they can put the returned sheets in, not handing them directly to the head nurse.

3.4. Data collection sheet

In order to answer the research question, a data collection form based on previous literature was devised (Angland et al., 2014; Magnavita and Heponiemi, 2011; Roche et al., 2010; Spector et al., 2014). It consisted of three parts, containing 11 questions. The first part (six questions) covered the participants' demographic and professional characteristics. The second part (two questions) comprised questions about the context of violent incidents (type and frequency). The third part comprised three open-ended-questions: first, the reasons for unreported incidents of violence; second, factors that contributed to workplace violence from the nurses' perspective; and third, the locations within the emergency department where the violent event occurred. The sheet took approximately 10 minutes for each participant to complete. Before the data collection sheet was used in the actual study, it had been revised and modified by a panel of experts in the field. The panel consisted of two occupational health doctors, 2 head nurses in the emergency departments, and 2 psychologists. All of whom were asked to appraise the initial data sheet, write down their amendments, and then a meeting with the research team was held in order to discuss all the proposed amendments and reach a consensus regarding all the items in the data collection sheet. It was then piloted on 20 emergency nurses and modified accordingly; nurses who participated in the pilot were excluded from the actual study.

3.5. Ethical considerations

Before the study took place, ethical approval was granted from both the author's home university Ethical Committee and the participating hospitals' ethical committees. Participation in the study was voluntary. Respondents were assured of the confidentiality of their responses, that their participation (or decision not to participate) would place no legal burden of any penalties or job termination on them, and that the information they provided would be used for research purposes only. Informed consent was obtained from all participants before the data collection sheet was completed.

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