International Emergency Nursing xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

Review

A qualitative meta-synthesis of emergency department staff experiences of violence and aggression

Rebecca Angharad Ashton[a], Lucy Morris[b], Ian Smith[a,*]

[a] Furness College, Lancaster University, Lancaster LA1 4YG, UK
[b] Merseycare NHS Foundation Trust, Whalley, Lancashire BB7 9PE, UK

ARTICLE INFO

Keywords:
Workplace violence
Aggression
Emergency services
Emergency department
Health personnel
Qualitative studies

ABSTRACT

Introduction: Patient and visitor violence or aggression against healthcare workers in the Emergency Department (ED) is a significant issue worldwide. This review synthesises existing qualitative studies exploring the first-hand experiences of staff working in the ED to provide insight into preventing this issue.
Method: A meta-ethnographic approach was used to review papers.
Results: Four concepts were identified: 'The inevitability of violence and aggression'; 'Staff judgments about why they face violence and aggression'; 'Managing in isolation'; and 'Wounded heroes'.
Discussion: Staff resigned themselves to the inevitability of violence and aggression, doing this due to a perceived lack of support from the organisation. Staff made judgements about the reasons for violent incidents which impacted on how they coped and subsequently tolerated the aggressor. Staff often felt isolated when managing violence and aggression. Key recommendations included: Staff training in understanding violence and aggression and clinical supervision.
Conclusion: Violence and aggression in the ED can often be an overwhelming yet inevitable experience for staff. A strong organisational commitment to reducing violence and aggression is imperative.

1. Introduction

Violence against healthcare workers has been considered a significant problem in the United Kingdom (UK) and worldwide [1,2]. The latest UK statistics demonstrated that there were 1,343,464 total reported assaults on National Health Service (NHS) staff in the last year [3]. A systematic literature review of patient and visitor violence in general hospitals from multiple countries showed that on average 50 per cent of healthcare staff reported experiencing verbal abuse and 25 per cent had experienced physical abuse [4].

Violence and aggression against staff has been documented as a significant problem in EDs specifically [5]. In one study conducted in Australia, 70 per cent of nurses working in two EDs reported that they had experienced violence in the previous five months [6]. One recent review of studies across 18 countries showed significant discrepancy between staff reports of the incidence of both verbal (21–82 per cent) and physical aggression (13–79 per cent) in the ED [7]. This suggests that rates of verbal and physical aggression in the ED vary greatly internationally.

Research has highlighted the significant consequences of patient and visitor violence against staff. Experiencing violence and aggression can lead to staff responses including anger, fear or anxiety, post-traumatic stress 'symptoms', guilt, self-blame and shame [8]. Direct physical injury is also a common consequence of assaults on staff [4]. Violence and aggression against ED nurses reduces work productivity and quality of patient care [9], which in turn increases the costs to the organisation [10], and possible recrtuiment problems [11].

Nurses are subjected to verbal and physical abuse so frequently in some EDs that it has now arguably become an accepted part of the job [12]. The normalisation of violence in the workplace impacts on incident reporting. Chronic under-reporting of violent incidents in EDs has been well-documented both in Australia and worldwide, with reasons for under-reporting including: a lack of policy and procedure; feeling discouraged to report by management; a lack of follow-up [13]; fear of being negatively judged; fear of vendetta, and lack of reporting systems [7]. Pich et al. [12] have argued that the normalisation of patient and visitor violence can become embedded within organisational culture which inhibits the implementation of effective preventative strategies.

In the UK, preventative strategies have been environmentally focussed, such as alarms, security presence or metal detectors. Another strategy adopted in several countries is the zero tolerance policy, which

* Corresponding author.
E-mail address: i.smith@lancaster.ac.uk (I. Smith).

https://doi.org/10.1016/j.ienj.2017.12.004
Received 2 October 2017; Received in revised form 22 November 2017; Accepted 20 December 2017

stipulate that specific actions or behaviours will not be accepted; however, the effectiveness of this approach is questionable [14]. In fact, few studies exist which assess the effectiveness of any interventions aimed at reducing violence in EDs [15], with reviews being inconclusive due to design issues, difficulty defining violence and a paucity of papers [16].

There are also few studies examining first-hand experiences of healthcare staff dealing with violence and aggression in the ED, despite such accounts having the potential to suggest novel ways of preventing violence. Existing quantitative reviews in this area have focused on simply describing the phenomenon [5], whereas qualitative methodologies can be useful in exploring perspectives [17]. However, there are no known qualitative reviews exploring the experience of violence and aggression in staff working in the ED. Synthesising studies across countries and contexts can offer greater understanding about the common factors which influence the experience of violence and aggression in the ED. The aim of this review is therefore, to synthesise qualitative studies exploring staff experiences of violence and aggression in EDs.

2. Method

2.1. Search strategy

A systematic search across four databases (CINAHL, PsycINFO, Pubmed and Web of Science) was conducted. Four concepts were utilised: 'staff'; 'violence and aggression'; 'accident and emergency'; and 'qualitative'. Where available for each database, a free text search and a search using subject terms or Medical Subject Headings (MeSH) was conducted independently and the results combined. See Appendix 1-A for detail of the final search strategy.

The following inclusion criteria were utilised:

- Papers written or available in English
- Studies using phenomenological qualitative approaches (either solely or as part of a mixed-methods design)
- Studies reporting on patient or visitor violence or aggression
- Studies exploring experiences of any staff member (medical and clerical) working in the ED or triage

In this review, violence or aggression was defined as "a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is behaviourally or verbally expressed, physical harm is sustained or the intention is clear." [2]. The definition of ED used was "a health care setting in which patients may receive accident and emergency services and initial, stabilising treatment for medical, surgical and/or mental health care" [5].

Papers were excluded if the study: used non-phenomenological qualitative approaches; explored any experiences that were not related to violence and aggression; explored views of anyone who did not work in the department unless the paper reported data for department staff separately; focused on aggression that was sexual, stalking or not related to physical or verbal assault.

Initially 3603 papers were identified. Once duplicates were removed, titles and abstracts of the papers were reviewed. This resulted in 52 papers which were reviewed in full against the inclusion criteria. A further 40 papers were excluded including one paper by Luck, Jackson and Usher [18] due to reporting the same data as Luck, Jackson and Usher [19]. A hand search of reference sections of the full papers was also completed, however this resulted in no additional papers being identified. A total of 12 papers met the inclusion criteria and were included in the meta-synthesis. See Fig. 1 for a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram of the process [20].

2.2. Characteristics of included studies

All included papers (see Table 1) reported data from hospital EDs. All of the studies interviewed registered nurses, with three studies also interviewing other staff in the department.

2.3. Critical appraisal of papers

It has been argued that study quality can impact on the overall meta-synthesis, with better quality papers contributing more to the results [21]. However, a low score on an appraisal tool may be more indicative of reporting quality, which can be influenced by word limits rather than the actual research procedure [21]. In our review, quality appraisal was used to understand the strengths and weaknesses of the studies to minimise potential bias rather than as a tool for exclusion.

The Critical Appraisal Skills Programme (CASP) [22] measures quality of papers across ten domains that are considered vital in qualitative research. All 12 papers were assessed with the CASP [22] using the three-point rating system developed by Duggleby et al. [23]. See Table 2 for a summary of scores for each paper.

2.4. Analysis and synthesis

Noblit and Hare's guidance for synthesizing qualitative literature [24] was followed to complete the meta-synthesis, alongside a worked example adapted for health research [25]. See Appendix 1-B for details of the analysis process.

2.5. Reflexivity

The authors are clinical psychologists with no prior experience of working within an ED. It is necessary to acknowledge that the findings represent the authors' own interpretation of the studies and for this reason, an audit trail was kept to ensure transparency of synthesis and interpretation.

3. Results

Four core concepts emerged from this meta-synthesis: 'The inevitability of violence and aggression', 'Staff judgments about why they face violence and aggression', 'Managing in isolation' and 'Wounded heroes'.

3.1. The inevitability of violence and aggression

Narratives conveyed a sense that staff had resigned themselves to the inevitability of violence and aggression in the ED due to the frequency of incidents and a lack of perceived preventative measures and consequences from the organisation.

Violence and aggression was experienced as a regular occurrence in the ED, with one author explicitly noting that 'The idea of violence … was recurrent and consistent in most interviews' [26]. This led to staff's 'resignation to violence' where violence and aggression was experienced as inevitable, such as one participant's view was that "…it seems like an inevitable part of the situation…" [27].

When employers' preventative and reactive strategies (such as security presence, panic alarms and zero tolerance policies) were perceived as not being consistently implemented, then this also appeared to exacerbate the feeling that violence and aggression should be tolerated by staff:

> [The signs stated] 'we won't tolerate violence, acting out, threats or cursing.' The sign also stated that if you acted in any of these ways, you were going to be escorted out by security and police. I have yet