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The relationship between workplace violence, perceptions of safety, and Professional Quality of Life among emergency department staff members in a Level 1 Trauma Centre

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ABSTRACT

Background: Emergency department staff members are frequently exposed to workplace violence which may have physical, psychological, and workforce related consequences. The purpose of this study was to examine the relationships between exposure to workplace violence, tolerance to violence, expectations of violence, perceptions of workplace safety, and Professional Quality of Life (compassion satisfaction – CS, burnout – BO, secondary traumatic stress – STS) among emergency department staff members.

Methods: A cross-sectional design was used to survey all emergency department staff members from a suburban Level 1 Trauma Centre in the western United States.

Results: All three dimensions of Professional Quality of Life were associated with exposure to non-physical patient violence including: general threats (CS $p = .012$, BO $p = .001$, STS $p = .035$), name calling (CS $p = .041$, BO $p = .021$, STS $p = .018$), and threats of lawsuit (CS $p = .001$, BO $p = .001$, STS $p = .02$). Tolerance to violence was associated with BO ($p = .004$) and CS ($p = .001$); perception of safety was associated with BO ($p = .018$).

Conclusion: Exposure to non-physical workplace violence can significantly impact staff members' compassion satisfaction, burnout and secondary traumatic stress. Greater attention should be paid to the effect of non-physical workplace violence. Additionally, addressing tolerance to violence and perceptions of safety in the workplace may impact Professional Quality of Life.

1. Introduction

Workplace violence in healthcare settings is a significant problem, particularly in environments such as emergency departments [1–4] and it is well established that patients are overwhelmingly the perpetrators of this violence [1,3,5,6]. In addition to the prevalence of workplace violence, the effects of exposure to workplace violence have also been investigated. Results of the Emergency Nurses Association (ENA) Violence Surveillance Survey indicate that the most common physical injuries sustained as a result of workplace violence are bruises/contusions and abrasions, primarily to the arms or hands [1]. Fortunately, most nurses who are victims of workplace violence do not require treatment for physical injuries [6].

Short and long-term psychological effects of exposure to workplace violence have also been identified. These psychological effects are primarily associated with exposure to non-physical forms of workplace violence such as threats and harassment [1,3,6]. Anger, anxiety, and frustration are among the most commonly reported feelings nurses experience after exposure to workplace violence [1,6]. In addition to these immediate responses, 94% of emergency nurses who experienced workplace violence exhibited symptoms of post-traumatic stress; intrusion and avoidance were the two most common symptom clusters in one sample of emergency nurses [7]. In a Swedish study, trauma nurses reported feeling anxious, insecure and scared of being recognized by violent patients in public [8]. Furthermore, in a multidisciplinary study of Italian healthcare workers, physical health was significantly negatively associated with physical workplace violence [3]; and a Chinese study found that exposure to workplace violence in the previous year was a significant predictor of both physical and mental components of Quality of Life among nurses and doctors [9].

Not only may exposure to workplace violence have physical and/or psychological sequelae, it can also impact workforce issues including retention and productivity. With respect to retention, in a large study of the consequences of exposure to workplace violence, 6% of nurses who

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participated identified it as a reason for leaving a job [6]; in a separate study of emergency physicians, 1% of participants cited workplace violence as a reason for leaving a job [2]. While the majority of emergency nurses have not considered leaving their departments as a result of workplace violence [1], some have reported a desire to work in environments with lower risks of exposure to violence [1,8].

A Spanish multidisciplinary study of healthcare workers found exposure to workplace violence to be significantly correlated with burnout; in this study burnout was conceptualized as emotional exhaustion, depersonalization, and work inefficacy [10]. The acute stress associated with exposure to workplace violence also significantly affects the cognitive and workload demands of emergency department staff members. In particular, acute stress has been found to significantly negatively impact emergency department staff members' ability to handle/manage their workload and concentrate/keep their mind on work [11]. Among emergency nurses in particular, post-traumatic stress symptoms were significantly negatively associated with support and communication demands such as providing emotional support and being empathetic [7].

Exposure to workplace violence is particularly prevalent among some healthcare workers and this exposure is clearly not without consequence. As illustrated, there may be personal and professional consequences. This study builds on that existing knowledge and examines the relationship between exposure to workplace violence and another theoretical concept: Professional Quality of Life.

1.1. Theoretical framework

The terms vicarious trauma, secondary traumatic stress and compassion fatigue are often used interchangeably. Historically, the term vicarious trauma refers to cognitive changes experienced by clinicians working with trauma victims. These changes include perceptions of safety, trust and spirituality resulting from repeated exposure to and treatment of trauma victims [12]. The concept of secondary traumatic stress, on the other hand, refers to the PTSD-like symptoms that can develop in those who know about and want to help people who are traumatized or suffering. These symptoms may extend beyond cognition to include irritability, avoidance, hypervigilance, insomnia, and nightmares [12]. Finally, compassion fatigue is a term used more broadly to describe the overall experience of emotional fatigue that can occur among those who repeatedly use empathy to treat individuals who are suffering. Experiencing this emotional fatigue, while stressful, may or may not co-occur with a secondary traumatic stress reaction [12].

This study used the Professional Quality of Life model [13], illustrated in Fig. 1, to examine the concepts of compassion fatigue and compassion satisfaction in relation to exposure to workplace violence among emergency department staff members. In this model, Professional Quality of Life (ProQOL) is described as how one feels with respect to his/her work as a helper, and incorporates both positive and negative aspects of that work. Professional Quality of Life is a complex phenomenon as it considers characteristics of the work environment, individual personal characteristics, and individual exposure to primary and secondary trauma in the workplace. In this model, the positive aspect of helping work is referred to as compassion satisfaction. It is described as the pleasure derived from being able to do one's work. The negative aspect of helping work, compassion fatigue, has two elements: secondary traumatic stress and burnout. Secondary traumatic stress is defined as work-related, secondary exposure to people who have experienced extremely stressful or traumatic events. Negative effects of secondary traumatic stress can include fear, difficulty sleeping, intrusive thoughts, and avoidance. Burnout is described as feelings of hopelessness/feeling as though one's efforts do not matter and difficulty dealing with work or effectively doing one's job. These feelings can be associated with a non-supportive work environment or a high workload. Effects of burnout can include exhaustion, frustration, anger or depression [13].

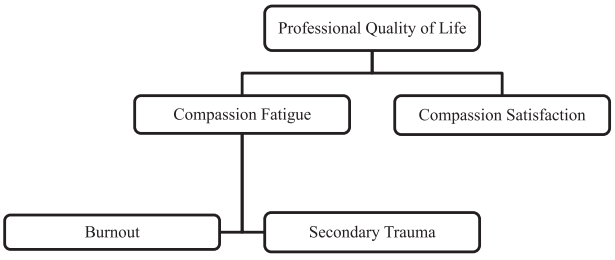

Fig. 1. The Professional Quality of Life model.

In addition to being exposed to violence in the workplace, emergency department workers can understandably experience secondary traumatic stress and burnout. In one study there were no significant differences in burnout or compassion fatigue among emergency nurses when compared to nurses in other departments [14], however, when compared to ICU nurses, emergency department nurses had significantly lower compassion satisfaction [15]. While an early study of emergency nurses found that 33% of the participants met diagnostic criteria for secondary traumatic stress [16], a more recent exploration of these concepts among emergency nurses revealed low to average levels of compassion fatigue and burnout and average to high levels of compassion satisfaction [17].

1.2. Purpose

There is no research available specifically investigating the relationship between exposure to workplace violence and Professional Quality of Life among emergency department staff members in the United States. A better understanding of how these phenomena are related may offer insight into whether or not creating safer work environments might decrease compassion fatigue and/or burnout and increase compassion satisfaction. Therefore, the purpose of this study was to examine the relationships between exposure to workplace violence, tolerance to violence, perceptions of workplace safety, compassion satisfaction and compassion fatigue among emergency department staff members in a suburban Level 1Trauma Centre.

2. Methods

A cross-sectional design was used to survey all full and part time emergency department staff members (n = 235) in a 224 bed suburban Level 1 Trauma Centre, in the western United States, that sees an average of 132 patients each day, or 48,000 patients annually. Approximately 12% of patients seen in the ED are trauma patients; last year 2570 trauma patients were admitted to the hospital, 95% of these due to blunt trauma. Once Institutional Review Board approval was obtained, all emergency department staff members were sent an email to their organizational email account describing the study and inviting them to participate. A link to an anonymous, online survey was included in the message; completion of the voluntary survey implied consent to participate in the study.

The survey included demographic questions, questions regarding perceived tolerance to violence relative to coworkers (higher, about the same, or lower), perceived safety at work (yes/no), perception of violence as an expected part of the job (yes/no), and exposure to the following from patients, family members or visitors within the past six months: verbal abuse, name calling, physical violence, threats, sexual innuendo, sexual groping, grabbing, spitting, or threats of lawsuit. The Professional Quality of Life: Compassion Satisfaction and Fatigue v. 5 tool [13] was used with permission. This 30-item instrument uses a 6 point Likert scale (0 = never to 5 = very often) and consists of three subscales designed to measure the three dimensions of Professional Quality of Life (ProQOL): Secondary Trauma (STS), Burnout (BO), and