Occupational Disappointment: Why Did I Even Become a Nurse?

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Contribution to Emergency Practice:

- This research is new, as—to the researchers' knowledge—very little research using grounded-theory methodology has been done about verbal workplace violence (VWPV) in emergency departments in the United States.
- Although the emergency nursing society is well aware of the problem of workplace violence, this study illuminates some new and interesting themes that will contribute information to the practice of emergency nursing. These themes include occupational disappointment and specific personality types that can prevent or de-escalate workplace violence.
- Translation of this article's findings to emergency nursing practice includes discussing occupational disappointment with both new and seasoned nurses. Protective and causative factors should be identified internally and addressed as needed.
- Identifying specific personality types among staff members might be useful in protecting nurses from the deleterious effects of VWPV.
- Emergency departments need consistently to evaluate and re-evaluate mandatory violence prevention courses that are provided by hospitals and that ensure nurses are being provided "real time" tools for proper management of VWPV.

Abstract

Introduction: The aim of this study was to identify patterns of feelings and behavior of ED RNs who have experienced verbal workplace violence.

Methods: Twenty-eight registered nurses from across the state of California were recruited. Data were collected, using in-depth interviews, and were recorded. The tapes were transcribed and analyzed using Glaserian grounded-theory methodology.

Results: The main experiences of participants included occupational disappointment, peer support, lack of preparation by mandatory violence prevention classes, and unrealistic patient expectations.

Discussion: These findings can help staff, managers, and future educators of ED RNs examine feelings, mitigate the profound and pervasive effects of VWPV, and improve patient care.

Key Words: Workplace violence; Emergency nursing; Grounded theory; Occupational disappointment

Workplace violence of all types in the emergency department is a current focus of literature and development of policies and procedures. Numerous regulatory and professional agencies have placed workplace violence (WPV) on research agendas and group statements, including The Joint Commission (TJC), the American College of Emergency Physicians, the American Nurses Association, the Emergency Nurses Association (ENA), The Occupational Safety and Health Administration, and the National Institute for Occupational Safety and Health. The Occupational Safety and Health Administration defines WPV as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide."[1]

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Background

Those working in the health care profession are expected to help people; therefore, it is counterintuitive that health care workers are more likely to be attacked than police officers or

prison guards[2] and that health care workers account for 48% of all nonfatal injuries from workplace assaults.[1] The estimated incidence of physical WPV (PWPV) ranged from 42% to 72% in a 6- to 12-month period in various studies.[3] Other studies have reported a staggering statistic that 99% of ED RNs have experienced verbal WPV (VWPV) within a 3-month period.[3–7] These estimates are generally considered to be on the low side, as the majority of WPV remains grossly underreported.[3]

The effects of WPV are far reaching and produce a heavy financial and emotional burden. Days off work, workers' compensation claims, staff turnover, and other various medical and legal expenses are estimated to cost billions annually.[7–9] The emotional burden of violence of both types (physical and verbal) can lead to negative effects for both the ED RN and, subsequently, the patient care they render.[10–12] Decreased or negative coping skills may lead to substance abuse, increased absenteeism, stress, anxiety, and intent to leave.[13]

The emergency department is at highest risk for WPV of any type, owing to its ease of access by the public, 24-hour availability, perceived chaos, acute nature of patients' physical complaints, and high levels of stress by those who visit emergency departments for their health care needs. Also, the degree to which emergency departments see acutely intoxicated and psychotic patients also increases the levels and types of WPV.[3,14–16]

The efficacy of policies, procedures, and programs to mitigate all types of WPV prevention programs has not been well-established. Implementing a "Zero Tolerance" policy has been recommended by the ENA and TJC, but whether or not these policies are effective in reducing violence is unknown at this time.[3,17] Mandatory classes that ED staff may take to provide tools to de-escalate violent situations have also not been validated.[18,19] The majority of these de-escalation courses were designed for other settings, such as correctional facilities, and then modified to apply to the health care or ED settings. Whether or not this is adequate in providing ED staff with the tools they need to effectively deal with WPV situations is not well- documented.[13,20]

There has been limited literature that explores the experience of VWPV by itself, without the link to PWPV for the ED RN. Major themes from all VWPV studies include a sense that WPV is just "part of the job," reporting the incidents does not modify or influence future outcomes, and a feeling that the incidents will somehow be blamed on the RN.[21] Swearing, obscenity, and the threats of legal action have been the most consistently reported types of VWPV.[6,22–24] Not only does VWPV affect the RN, it also affects patient care. The Joint Commission[17] issued a sentinel event alert, acknowledging that disruptive and intimidating behaviors can lead to medical errors and poor patient care. It can also lead to increased turnover, which also contributes to decreased patient care, as that adds to organizational costs and less experienced nurses.

The other important reason to address and manage VWPV effectively can be illuminated using concepts borrowed from Kelling and Coles Broken Windows theory.[25] When lower levels of violence or crime are tolerated, it signals an underlying acceptance of higher levels of violence, including violent crime. In the criminal justice literature, these disorderly conditions augment fear and lead to more verbal and physical incivilities. If a patient is verbally assaultive to the ED RN in triage, and nothing is done about effectively de-escalating the situation, that patient—or those who viewed the "successful" abuse of the ED RN—may continue to act out and either continue to verbally assault the nurse or move on to physical assault.

Methods

The aim of this study was to explore the experience of VWPV directed at ED RNs from patients or family members. A grounded-theory methodology[26,27] was chosen to explore the experiences of individual participants and to produce a conceptual understanding of the data.

DESIGN

Using grounded-theory methods, we studied ED RNs who had experienced VWPV, to explore experiences and feelings regarding VWPV from patients and their visitors. Grounded theory focuses on the identification, description, and explanation of various interactional processes among individuals and within groups that experience a given social context.[28]

PARTICIPANTS

Participants were recruited through advertising in local hospitals and social networking sites. Snowball sampling then quickly filled the remaining necessary participants until saturation was achieved. The final participant total was 28. The university's Institutional Review board approved this study, and the study was funded by a university-based grant. The participants gave informed consent and were aware that they could drop out of the study at any time and that their responses would be confidential and coded for anonymity. Names that appear in the discussion are fictitious and randomly assigned by the researchers.

DATA COLLECTION

A total of 28 nonstructured, in-depth interviews were conducted with participants between June 2014 and June