Violent behavior and workplace violence in the emergency room-
An integrative review

Maria Rouvinen

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Maria Rouvinen
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ABSTRACT

Workplace violence (WPV) is a global problem, which affects the wellbeing of nurses around the world. The problem has been present for multiple years in emergency rooms and hospitals but still the problem continues. Its impact or the underlying reasons leading to its high prevalence are not widely known.

The research questions in this integrative review were to find out how common workplace violence against nurses in emergency departments is, what are the characteristics or permitting the factors of WPV against nurses and what kind of measures are recommended in the latest research about WPV to limit its appearance.

WPV in emergency rooms is a global problem, affecting the lives of multiple health care professionals, simultaneously causing unnecessary harm and discomfort in the victims and affecting the quality of care provided to patients.

Contributing factors to the appearance of WPV can be related to a cultural aspect of seeing it as a part of the job or a rite of passage for new nurses. The attitude of management in a hospital setting can also allow the appearance of WPV, if necessary steps are not implemented to limit its appearance. Problems were also seen in lack of support given by the management after a violent situation. Violent attacks are underreported. Problems can be seen in poorly designed reporting platforms, which can be hard to use by the staff. Contributing themes, such as the surroundings of the emergency rooms, communication factors and a cultural aspect of permitting WPV were present in the data.

Risk for the appearance of WPV were often related to long waiting times in the ER, non-visible security personnel, open premises of the ED area, lack of visitor policy, poorly designed hospital premises and minimal privacy. Possible solutions to end WPV were related to information given to the patients and relatives about waiting times, education to nurses about communication as well as to the community about when to come to the ED and making the design of the emergency rooms better in hospitals.

Workplace violence means the appearance of physical injuries, but also verbal, aggressive threats towards the health care personnel. WPV is regularly underreported in emergency rooms and hospitals. Better implementation of research and environmental design is needed to end WPV in all its forms.

Keywords: emergency, workplace violence, nurses, integrative literature review
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Workplace violence (WPV) towards nurses is an ongoing global phenomenon. The problem has been present all over the world for several years, spanning from Finland to all around the world. In Finland, violent incidents towards nursing staff has been rising steadily on the span of thirty years. (Beattie, Griffiths, Innes & Morphet 2019, 116; Hoyle, Smith, Mahoney & Kyle 2018, 57; Di Martino 2002, 9; Soisalo 2011, 12-13.) The appearance of workplace violence is usually linked with patients who have mental problems or patients whom are under the influence of alcohol or narcotics (Kaeser, Guerra, Keidar, Lanz, Moses, Kobel & Ricklin 2016, 5). Violence and violent actions can appear everywhere and workplace violence has been on the rise especially in the Nordic countries. Use of narcotics, the heavy use of alcohol and personality problems can lead to lashing out aggressively (Rantaeskola, Hyyti, Kauppila & Koskelainen 2015, 8-10; Piispa & Hulkko 2010, 6). Use of alcohol does not always lead to aggressiveness, but it can lower the threshold for violence in some individuals (Sundell 2014, 126).

According to the World Health Organization WHO (2019), almost 40 percent of healthcare employees have suffered from at least one physical injury in their workplaces during their career. This data does not always include all of the amount of the unnecessary acts of verbal aggression and threats that an employee may experience. Workplace violence is a major risk in the health- and social service area, leading to unnecessary harm and discomfort to the health care personnel (Gates, Gillespie & Succop 2011, 59; Lyly-Yrjänäinen 2018, 94). In Finland, 140 000 violent accident appears on a yearly basis in workplaces, resulting in at least to the loss of two lives (The Centre for Occupational Safety 2009, 3).

Workplace violence can have an impact in the health care area as a whole, because it affects the health care personnel and increases unnecessary costs that could be prevented (Bordignon & Monteiro 2016, 941; Gates et al. 2011, 59). Discussion about violence in the social- and healthcare sector has been present for multiple years. Especially emergency rooms in hospitals are prone to the appearance of violence towards the health care personnel (Soisalo 2011, 12-13; Lau, Magarey & Wiechula 2012, 126; Anttila, Pulkkinen & Kivistö-Rahnasto 2016, 1; Lown & Setnik 2018, 1; Gates et al. 2011, 59). A survey conducted in Finland in 2016 about the work satisfaction of municipality workers, 40 percent of the responders reported of violence towards them in the previous twelve months (Lyly-Yrjänäinen 2018, 94). According to Cheung, Lee and Yip (2017, 987) a violent act is the most likely to be carried out against nurses in the healthcare setting, because doctors can make orders related to patients’ treatments, nurses cannot do this.
Workplace violence can have an effect of the nursing provided, minimizing the appearance of compassionate care. (Gates et al. 2011, 59; Bordignon & Monteiro 2016, 939). In a survey conducted in the United States about WPV in hospitals, revealed that the most common perpetrator of a violent act towards the health care personnel was a white male, aged 26 to 35 and under the influence of alcohol or drugs. (Speroni, Fitch, Dawson, Dugan & Atherton 2014, 218). Even in a primary health care the appearance of verbal violence can be high, but the employees fail to report it forward for lack of trust that problems would be resolved and an appropriate measure would be taken into consideration. (Kremic, Terzic-Supic, Santric-Milicevic & Trajkovic 2016, 16). In 2016, a research was conducted in Tampere, Finland which revealed that open communication, education and hiring a lobby host could decrease the risk for violence in the emergency department. Limiting the visitors in the rooms could be simultaneously beneficial. In the research, they also suggested a phone call to aggressive patients later on, done by the security chief of the hospital. (Anttila et. al 2016, 20-24.)

Workplace violence can have serious consequences to the victim’s overall health and it can even have an impact on the nurse’s life with the appearance of psychological stress and discomfort. Long term sick days can appear due to a traumatic event, which promotes the appearance of reduction in workforce. (Bordignon & Monteiro 2016, 941.) According to Henson (2010, 561) a code of conduct for emergency department patients and visitors could be useful, for the prevention of violent behavior. These rules could be portrayed in posters or signs in the hospital lobby, to remind everyone about the fact that aggressive behavior will not be tolerated in any way in the hospital area. In a study done in Taiwan in 2017, the results stated that the participants in the study saw workplace violence as a part of the job but also having a tremendous affect in their personal and professional lives. The nurses reported that workplace violence leads to lowering the quality of care and allowing them to distance themselves from dangerous life-threatening situations, if a previously violent patient becomes even more ill. The researchers concluded in that the threat of workplace violence and proper implementation of safety procedures has gotten so bad in Taiwan, that multiple nurses are resigning from their posts and already the hospitals suffer from the lack of a professional workforce. (Han et al. 2017,431-433.)

A feeling of constant threat can affect one’s wellbeing at work (Hjelt-Putilin 2005, 8). A ward or an emergency room which is understaffed and pressurized on a regular basis, can be more exposed to the sudden acts of violence perpetrated by the patients towards the health care staff. In these situations, safety is not always secured and can be neglected by accident. Some patients can get stressed from a busy emergency department, when they feel as no one has time for them. Nursing a patient alone increases security threats and makes nurses prone for acts of violent nature. (Sundell 2014, 18; Piispa & Hulkko 2010, 12-13.)
Even patients’ relatives and friends in hospitals can become aggressive when their demands are not met properly in their own opinion (Parantainen & Soini 2011, 11). According to the Occupational Safety and Health Act (738/2002), employers are obligated to secure the safety of all personnel. Nurses have almost the same risk percentage as guards, to encounter violence at work. Working alone increases the risk to encounter violence. Customer and service sector workers are vulnerable, for they are in contact with people daily. (Hjelt-Putilin 2005, 8-9; Sundell 2014, 37; The Centre for Occupational Safety 2016, 7; The Centre for Occupational Safety 2009.)

According to Anttila et al. (2016, 14-15) hospitals have the right to limit the visitation right of relatives to the patient rooms, because it can affect the rooms overall atmosphere. Visitations should last a maximum of fifteen minutes, the patient room with too much people, can be a stressor to some individuals and limiting the visitation right benefits the safe keeping of patient records. Relatives and other visitors usually understand limited visitation rights-policy if they are informed about it properly beforehand. This could be done verbally, but also by putting posters around the hospital could be useful.

3 The emergency room

Municipalities in Finland are ordered by law to organize emergency care to its residents, with the supervision of The Ministry of Health and Social Affairs. Evaluation of the patient’s health must be done at that point urgently. Emergency care includes the evaluation of sudden illnesses, traumas, a sudden decrease of wellbeing related to chronic diseases and a serious decrease in normal condition of a person. (Health Care Act 1326/2010; The Ministry of Health and Social Affairs 2018.) Emergency departments are the busiest area in the hospital, where the attention of the health care personnel must additionally be turned to face worried visitors and relatives (Lala, Sturzu, Picard, Druot, Grama & Bobirnac 2016, 363; Lown & Setnik 2018, 4).

The special feature of emergency rooms is its divergence due to abrupt situations and the importance of teamwork in treating the patient. In particular, the learning process in the treatment of an acute care patient lasts throughout the health personnel’s entire working career. A good workplace culture among nurses and supervisors is best reflected even in the patient’s nursing work positively. Whenever possible adverse factors in the workplace culture are highlighted, they are easier to face and address within the work community transparently. Safety precautions implemented in the workplace would be beneficial to be discussed openly during the day. (Strann, Suominen & Rantanen 9, 2015; Sundell 2014, 24.) Unfortunately, unnecessary work-related stress lowers employees’ wellbeing in the emergency department (Lala et. al 2016, 366-367).
Employers are obligated by law to ensure the safety of employees. This means ensuring the safety of the workplace beforehand, by providing appropriate measures and the possibility for an alarm system if needed. (Occupational Safety and Health Act 738/2002.) Employers can face problems with recruiting if threats and violent incidents are an ongoing problem in their area of operation. (The Centre for Occupational Safety 2009, 4.) Working in the emergency room requires expertise unlike any other place. The health care personnel must be skilled thoroughly in the medical area and have the proper mindset in fast changing conditions (Lala et al. 2016, 363).

The health care personnel are at increased risk to encounter violence and the prevalence of workplace violence is especially high in the emergency department (Speroni et al. 2014, 227; Piispa & Hulkko 2010, 14; Lehestö et al. 2004, 87). The social-, and healthcare sector includes daily contacts with patients and unlike other workplaces such as offices, hospitals and emergency rooms are open spaces compared with them. Cases reported about violence attacks or threats in hospitals has been on a steady rise (Soisalo 2011, 11-14; Hjelt-Putilin 2005, 8.)

3.1 What is violence and aggression?

According to WHO (1996, 5) violence and violent behaviour is the intention to hurt and can almost always lead to an injury. Workplace violence is an act done by a patient or a relative towards the healthcare personnel and it can cause unnecessary fear and discomfort in the victim (Rantaeskola et al. 2015, 7). How an individual face daily disappointments or frustrations are a combination of the situations, traumas, upbringing, previous disappointing encounters with the health sector but also feelings and development until that day. Violence and acting on the emotion of aggression, can be seen as the last resort to some people, to others just an impulse where to act accordingly (The Centre for Occupational Safety 2009, 17; Rantaeskola et al. 2015, 22).

There can be numerous of reasons for aggressive behavior although some patterns can be seen. Aggression can be explained with biology and its combination with the upbringing of a child. Unbalanced levels of cortisol and testosterone can raise aggressiveness. Surroundings matter in childhood. An unstable environment that an individual has encountered, can have long term affects. Some people are more tempered than others. (Rantaeskola et. al. 2015, 9, 17-22; Weizmann-Henelius 1997, 17-18.)

The violent act doesn’t always carry with it the intention to hurt, when something is done or just about to happen. The perpetrator doesn’t always see the irreversible consequences of their acts (WHO 2005, 22). Aggression can be a straight reaction to something, called reactive aggression, or proactive aggression without a spark. Proactive regression is mostly related to
people with a history of personality disorders. The family that the person has grown up in, can prohibit the acts of violence and with it give a silent blessing. It has been shown that an environment, which hasn’t been safe and predisposing the person to a constant feeling of threat, can cause problems in later life. Parents are important to the development of a child and can modify an easier trigger for violent behavior in adulthood. They can simultaneously teach the child how to act when threatened by modifying their behavior towards the child unknowingly in a stressful situation and being aggressive themselves to their offspring. (Soisalo 2011, 28-31; Howell & Miller Graff 2014, 1985; Weizmann-Henelius 1997, 17-18.)

The violent outburst of an aggressive patient can be a coping mechanism, a reaction to the surroundings that they have experienced. Patterns learned in childhood can resurface, or traumas encountered. A pattern usually leads to violence, a feeling of losing control can appear, where the act of violence can seem as the only way out. At this point, the hospital staff in the room are just barriers. This behavior can be sparked by a small non-verbal act, that some people could not even recognize. (Weinzmann-Henelius 1997, 59; Sundell 2014, 13-14; Rantaeskola et. al. 2015, 22-23.) A violent person can be a lone wolf who cannot surrender themselves to the help of other people. Emotions can be dangerous, leading to the loss of control. Patterns for violent behavior can be seen hereditary or caused by influence coming from outside the individual. (Soisalo 2011, 120; Sundell 2014, 14.)

Personality problems, mental illnesses and a substance the abuse can lower the risk for unwanted, aggressive and even hostile behavior. Crowded, small patient rooms can increase some people level of stress and lead to aggressiveness and aggressive behavior. Privacy is not always secured in patient rooms, which can be a stressor to some people. In these situations, it is important to remain professional, in a calm and trustworthy way. (Rantaeskola et al. 2015, 8-9, 89; Sundell 2014, 76.)

Plain frustration in long queues can lead to aggressiveness if people have been seeking treatment for a long time. Emergency room queues can be slow and it can take time for an individual to finally see the doctor they have longed to see. Small, crowded waiting rooms can increase stress. (Henson 2010, 560.) Shouting and seeking the attention of the nursing staff can be a way to avoid rejection from the employees and by this being properly heard. Intoxicated people and their friends escorting them to the emergency room can cause problems. Patients who are under the influence of a substance, usually pose a risk for a security threat and future problems. If patients think that they are neglected, it can lead to further problems and simultaneously cause aggression (Soisalo 2011, 116-117; Lehestö, Koivunen & Jaakkola 2004, 97-98; Sundell 2014, 84-85.)
3.2 Violent acts

The physical and verbal acts of violence towards hospital staff can include hitting, shuffling, yelling, verbal threats, kicking, spitting, scratching, biting, pulling the victims hair and causing physical injuries. Threats using a gun, or a knife can appear. Reasons for patient’s outburst of aggression are not always clear, but violent situations usually have a pattern relating to the patient to act uncontrollably. Communication plays a key role in setting up the violent scene. Restricting the patient in any way can cause problematic behavior and a sudden outburst of violence from the future perpetrator. (Holmberg 2018; Weizmann-Henelius 1997, 54; Sundell 2014, 14-16; Soisalo 2011, 25.) Professionalism goes a long way in avoiding violence in the workplace. Being a healthcare professional who is strict but equally worth of trust, is something we should all aim for. (Rantaeskola et al. 2015, 49-51.)

A violent attack leads the victim into a crisis, which is an unusual event that a person cannot prepare. Reactions to the ordeals may surface days later and leave memory gaps. Possible variables in the personalities affected by losses and accidents can predict the way a survivor handles what has happened and at what pace. (Pajamäki 2004, 67-69; Thompson 2004, 18-25; The Ministry of Health and Social Affairs 2009, 11-16.) In these circumstances debriefing and talking with a professional is important to lessen the trauma of the ordeal and help the victim start the healing process (Lehestö et al. 2004, 127, 198).

4 Communication

Communication in a room with an aggressive patient is not only about them. All parties bring their own presumptions, ideas and thoughts in to that very situation and how they behave is all about how they communicate with each other. In this situation the staff should not be provoked. Aggression is a reaction to the surrounding circumstances (Weizmann-Henelius 1997, 62-63; Lehestö et al. 2004, 88). The biggest problem in threatening situations lies within the fact that it usually comes as a surprise. A discrepancy in a normal day can feel like overwhelming, if you always expect the same routine with everyone, (Rantaeskola et al. 2015, 51-52). The training of the staff towards violent situations is an important issue in preventing WPV (Adams, Knowles, Irons, Roddy & Ashworth 2017, 14).

According to Rantaeskola et al. (2015, 133) the signs of an attack can be paleness, accelerated breathing, redness in the face or neck and opening and closing of fists. Feelings of fear and racing heartbeat can appear, but the emergency room staff still need to act. Biological changes in the body are normal, but despite those a routine to handle violent situations must be implemented to minimize further threat (Sundell 2014, 18; Lehestö et al. 2004, 132). Safety in threatful situations can increase if proper steps are included. These are keeping a safe distance of 1.5 meters, calling the hospital guard to the room to secure the situation, the possibility to
call for extra help in the area and having a safe work outfit. (The Centre for Occupational Safety 2009, 10.)

With active listening communication skills from the nursing staff, the threatening situation can be controlled. Focusing all the attention calmly on the possible perpetrator can destress the room. Communication is also non-verbal such as small head nods, expression on the face and lifting of eyebrows. Reading these messages needs sensitivity (Soisalo 2011, 134-135). It is still important not to be too straightforward being polite, for it can come as being pompous. Sometimes an employee has to be strict and give out straight commands without going into too much depth in communication. (The Centre for Occupational Safety 2009, 21.)

Communication, seeing the patient as a whole and active listening are multiple layers that need to be acknowledged. If a patient says that he is calm and says this in a violent, aggressive way, the signs of their communication are then mixed. People can adjust the words that come out of their mouth, but they usually cannot hide their bodies non-verbal communication or their tone of a voice in a fit of sudden rage. (Rantaeskola et al. 2015, 86-87.)

Non-verbal and verbal communication can present itself in three different stages, which can be separated. The way a person reacts to a situation with his body is a biological stage, for example sweating and racing of the heart. The emotional stage gives away how a potential aggressive patient will act. How they talk, the movement of the limbs, the expression of the face, stubborn silence, mumbling, looking boldly and aggressively at only one person in the room and walking restlessly in that situation gives hints away. The person they are looking at constantly, will most likely be the person they will attack first. The third and final stage is the way a person talks and which kind of words come out of their mouth. These three stages combine the non-verbal and verbal communication of a person and to confront a person properly at this point, all these stages must be seen, combined and interpreted. (Weizmann-Henetius 1997, 63-64, 115; Hjelt-Putilin 2005, 114-121.)

Careful, calming articulation can make the message of the nursing staff clearer to an aggressive patient. Silence in a situation can be equally beneficial from the health personnel confronting the aggressor, combined with the small signs of politeness. These gestures merge into the willingness to listen and help, but at the same time it can buy precious time to call for more staff to enter the room. Every situation is different, but the basic needs of a human still remain the same. People want to be heard and appreciated. (Hjelt-Putilin 2005, 120-121; The Centre for Occupational Safety 2009, 20.)
4.1 Capabilities of nursing staff and communication

In a threatening situation, it is even more important to confront the aggressor calmly and without any pre-assumptions. The calmer the health care personnel can be before a possible violent situation, the better are the outcomes. The health care personnel can lead the situation towards a non-violent one by making an example of themselves. People are the most likely to follow the example of a person, who does not panic and is in a relaxed mindset. Requests have to be justified towards the patient in these situations, because it allows a violent person to back off, without losing their integrity at the same time (Rantaeskola et. al. 2015, 104-105). Focusing thoroughly to the patient, makes a threatful situation more easily controlled (Soisalo 2011, 134-135).

Every person has their own capabilities confronting and handling a threatening situation and in these circumstances the work community plays a vital role. Support from work colleagues and management are important. Everyone needs a feeling of trust, whatever happens, but it is important for everyone to go through different scenarios of possible threat in their workplaces and acknowledge the different steps that they would do when a situation has emerged. If something seems that it is not right, there could be bigger problems ahead. A violent situation can result in a long-term sick leave due to the trauma that the victim has encountered. (Sundell 2014, 18-19; Hjelt-Putilin 2005, 41, 70-73.)

Violence even without permanent physical damage, can have long term psychological impact on the victim’s life (De Puy, Romain-Glassey, Gut, Pascal, Mangin & Danuser 2015, 213). A patient can come involuntarily to the emergency room and still have an expectation about the course of the treatment. The patient might have had bad experiences related to hospitals before and for this reason cannot cope with the situation normally. In these cases, it is important to sense out the emotions the patient is feeling and adjust our own behaviors as health care workers towards it. (Weinzman-Henelius 1997, 67; Soisalo 2011, 113-115.)

The appearance of work-related stress could be beneficial to be measured in the emergency department regularly (Lala et al. 2016, 366-367). Communication skills are an important aspect in the hospital. Everyone wants to be seen and heard properly and empathetic listening can be a way out of a threatening situation. It is equally important to greet patients properly when they arrive in the room to have a connection with them from the start. (Lau, Magarey & Wiechula 2012, 131.)

4.2 How to prepare for a violent situation

Calmness and the self-confidence of a professional is important. Patients can say very insulting things in order to get on top of the situation and get a reaction of their opposer. (Sundell 2014,
Communication in a threatening situation in a workplace is necessary for it signifies the meaning of the personnel working there and gives every individual working in the unit meaning. With close observation, neutral behavior and calmness can handle a threatening situation better. (Hjelt-Putilin 2005, 26.) The tone of a voice, which is clear and calmly paced, can lead to a feeling of trust and appreciation (The Centre for Occupational Safety 2009, 22).

Non-verbal communication by the nursing staff should additionally be taken account (Soisalo 2011, 134-135). In every case the skills of the nursing staff to see the situation through every angle are important. A person presents themselves in two different levels, non-verbally and verbally. Acting accordingly and keeping an eye on the changes of the aggressors` body language can change the whole outcome. (Hjelt-Putilin 2005, 35.) Unfortunately, some people suffering from personality problems can think that the victim has started the brawl themselves with gestures they thought was contemplating (Sundell 2014, 13-15).

It is important for the employees to acknowledge their professionalism. If they be aggravated by provocation to act, it can be dangerous. Non-verbal, aggressive communication from the possible attacker can give the hints of a coming assault. (Sundell 2014, 75-76.) There could be a link between aggressive behavior and alcohol in some individuals. If a person who doesn’t usually show emotions drinks, it can lower the threshold for aggressive behavior due to the power of the emotions. (Norström & Pape 2010, 1580, 1585.)

Not all people suffering from mental problems are dangerous, but still some individuals can be dangerously delusional and hazardous (Rantaeskola et al. 2015, 72-73, 108). Lack of impulse control can lead to violence in patients whom suffer from mental unstableness. Problems can arise also from personality issues. (Lehestö et al. 2004, 96; Sundell 2014, 13-14.) History of mental problems or substance abuse modifies the normal function of the brain. This lowers the triggering point into an act of violence without a verbal response and leading straight into physical contact. It is vital that when concerned with a patient who is intoxicated, that the nursing staff should never turn their back on them and follow the placement of hands for the risk of a needle, gun or a knife. The patient can experience mood swings in the situation, going from a calm mental state to extreme rage and the back again. In these circumstances, the hospital personnel can be confused. Fear is still something that should not be shown to the patient. (Hjelt-Putilin 2005, 34-37; Rantaeskola et al. 2015, 128-132.) Use of drugs can lead serious problems in some individuals. The use of cannabis can trigger mental issues, leading to first-episode psychosis. (Tosato et al. 2013, 438.)

A psychotic person can suffer from serious mental issues. Paranoia can be so extreme, that it affects one’s behavior and makes it very hard for the health care personnel to reach the patient and limit violent behavior pattern. This increases the risk of violence towards the health care
personnel. In a psychotic episode, the patient can be aggressive due to the symptoms of the disease and see other people as hostiles, who aim to hurt by restricting the patients. It would be beneficial, for the employees to educate themselves about different mental problems and personality disorders. (Rantaeskola et al. 2015, 72-74, 113.) Use of restraining devices can be the only way to control the situation (Henson 2010, 558). Sometimes restraints can unfortunately trigger further violent incidents, so their use and apply must be done in a controlled setting (Yang, Stone, Petrini & Morris 2018, 36). According to Edlinger et al. (2014, 450, 456) patients who have schizophrenia and a history of active psychoactive substance use, can pose a risk for violence.

Basic knowledge of the terms and substances related to the world of narcotic users would be beneficial to be known by the health care personnel (Rantaeskola et al. 2015, 129). People with substance abuse problems do all not act necessarily in the same way, but they can be prone to violence and aggressiveness if their needs are not met in their opinion. Substance use can be the use of alcohol or narcotics. The culture among the users of narcotic substances varies compared with other norms of the society. It changes the personality of a person to seek instant gratification and the ways to fulfill this need can be lying, manipulation, aggression and they aim for their own wellbeing in a stressful situation. This is hard for the hospital staff to comply with due to the resources and the norms of individuals from the daily society. (Lehestö et al. 2004, 150.)

According to Lehestö et al. (2004, 150) and Alho (2015), the reasons for an active narcotic user to come to the emergency room can be traumas or acute infection and most of the time the problems have appeared suddenly. Sometimes they want prescriptions to be renewed and will use any means to get what they want. Users do not always promote the fact that they use narcotics, so they can use a string of different explanations to get the health care personnel on their side. Emergency rooms can be hectic, and some believe that by disturbing the doctors on a busy day, they will eventually get what they are after. Withdrawal symptoms from substances can begin in hours. Substance abusers can carry equipment such as needles, which can be hazardous. (Rantaeskola et al. 2015, 128.) A threatful situation usually begins with a violent act or a verbal threat, which can be seen out of place for some people (Rantaeskola et al. 2015, 131-132).

Active drug users can try to manipulate the health care personnel, by victimizing themselves and using carefully elaborated verbal communication. Moralization in these situations pays no use, or humiliation of the drug user. Drug users can try to have a personal connection with the nurse and finally blame them as the reason why they are in such a bad shape and the nurse does nothing to help or ease their situation in any way (Rantaeskola et al. 2015, 129-130.) In cases of intoxication by drugs, narcotic users do not always want to say what substances they
have taken. This is usually done to avoid the risk of being stigmatized and in a sense losing their face in that situation. This act is still dangerous, for the health care personnel do not know the reason behind the possible sudden decrease of consciousness. The use of mixed substances can be seen as a way to lengthen the feeling of high, but it can be a dangerous act. Narcotics are prohibited by law in Finland, so they are not controlled in any way by the official health care professionals. Use of narcotics can expose a substance abuser to different mental health problems. The reality of the narcotic world can be hard due to their culture of manipulation, lying and avoiding authorities. It can additionally contribute to problems with self-esteem. (Rantaeskola et al. 2015, 128-129; Lehestö et al. 2004, 146, 150-156.)

4.3 Preparedness of staff and leadership

Preparedness in a possible threatening situation can be divided into four different factors called an attitude, activity, initiation and thought. The most important thing in a threatening situation is doing at least something when it is happening, but also being able to build up the character preparing for hazardous situations. To be aware of the environment and threats when an aggressive patient is there makes the room safer for everyone. (Hjelt-Putilin 2005, 57-68.)

According to Sundell (2014, 66, 89-93) and Lehestö et al. (2004, 139), mental, physical capacity and foreshadowing threatening scenarios can help nursing staff to handle those situations better. With mental capacity and healthy self-esteem, risks can be handled when members of the staff are prepared beforehand. Imaginary training gives key elements in avoiding panic when something unusual appears and makes it easier for everyone to react with professionalism.

Safety of all the employees in the patient rooms is important. The removing of all extra furniture, monitors and things that can be used for throwing or as a weapon can be a small but an important safety issue. The nursing staff additionally needs to be able to leave the room easily, without confronting the assailant, this can be reached with properly known exit points. The rooms must be easy to monitor with only one look. (Henson 2010, 558; Lehestö et al. 2004, 106-108.)

A research made in Taiwan in 2014 about workplace violence in the hospitals revealed that big part of the workplace violence was contributed due to the design of the ED, communication to the patients and allowing verbal violence but also seeing it as a non-serious event. Other reasons seen were unstructured organization of health services and lack of proper knowledge about safety measures within the hospital security staff. The research proposed that in the future policies towards violence have to be implemented properly, creating calm environments, providing education and ensuring better organizational structure in health care services. (Lin, Juan & Chu 2014, 14-18.)
The design of a patient room in the emergency department should include interior planning. Proper lighting and surveillance cameras are small but effective ways to make a hospital room safer. (Lenaghan, Cirrincione & Henrich 2018, 11; Henson 2010, 558-559.) A good culture of safety in a workplace can only be secured when everyone understands their importance (Reiman, Pietikäinen & Oedewald 2008, 48). A feeling of compassion from colleagues and employers after a violent incident can better the victims overall feeling when a violence has occurred. Support from the work community is important in any situation. (Zhang et al. 2018, 6-7.) Visitors, who have been acting aggressively in the hospital premises, should not be able to enter a patient room (Henson 2010, 559-560).

4.4 The impact of management

In a research conducted by Johansen (2014) showed that the perception of quality of care is different as experienced by the management and the nurses working in the field. Three themes emerged in the results and those were understaffing in the ER, unrealistic expectations from the organization and lack of understanding about the management towards patient care in the ER.

Communication from the hospital management towards discrepancies in safety and changes in the workplace organization has to be open. The work community should be open to new ideas for development; only by this, the team is committed to their work when the employees experience a feeling of being heard. (The Occupational Health Centre 2016, 5.) According to Schneiner and Weigl (2018, 17) support from nursing colleagues and organization improvements help in minimizing the effects of stress factors in the emergency department. Resilience in an individual towards workplace violence could benefit from active support from colleagues (Hsieh, Hung, Wang, Ma & Chang 2015, 23).

With properly functioning preparedness plans for violence and safety risks, the management can better the employees’ safety and feeling of trust and productivity. Law mandates safety precautions (Soisalo 2011, 48.) It is important to assess threatening situations in the working environment to learn from them and avoid further problems (The Centre for Occupational Safety 2009, 30-31). Safety concerns that the health care staff encounter in their workplace have to be reported forward (Sundell 2014, 78-84). According to Johansen (2014, 17) the management of the hospital must clearly understand the role of the emergency nurse and what it requires.

Crisis through violence is a situation, which turns into a threat, and it can affect a person, or a community and it always poses a risk for bigger problems. A crisis can be divided into three different stages, which are shock, reaction and acceptance. (Hjelt-Putilin 2005, 19-20; The Centre for Occupational Safety 2009, 30.) A simple ongoing threatening situation can affect the victims’ sense of overall security and lead to problems later on. Insomnia, irritation and
heightened physical reactions to normal, daily situations to life outside of work are not uncommon. (The Centre for Occupational Safety 2009, 30-31; The European Commission 2010, 193-195.)

It is important to secure the employees' knowledge and preparedness towards situations that may become stressful. This role falls to the hands of the employee by providing necessary training for the health care personnel. (The Ministry of Health and Social Affairs 2011, 29.) The management can secure the safety of all its employees, by communicating openly to the employees. If the management does not understand the importance of communication, this can become a barrier and slowly making the workers impossible to trust the leadership and safety of the workplace. (Reiman et al. 2008, 56.) The proper, quality treatment of the patient suffers if the main goal is simply patient satisfaction. This can simultaneously limit the feeling of professionalism in nurses and decrease occupational satisfaction in their area of expertise. (Johansen 2015, 17-18.)

5 The research questions of the thesis

The goal of this integrative literature review is to explore the appearance of workplace violence towards the health care personnel working in the emergency room, what are the permitting factors for its appearance and which are the possible means to end its presence according to the latest research.

The objectives of the integrative literature review are to explore:

1. How common is the workplace violence against the health care personnel in emergency room?
2. What are the characteristics or permitting the factors of workplace violence against the health care professionals in the emergency room?
3. What kind of measures are recommended through the latest research about WPV to limit its appearance?

5.1 Integrative literature review

When conducting a literature review, it is important to identify the reason why it is needed. A set of questions must be formed to make it easier to gather the necessary information and see possible contradictions in the gathered information towards the subject. Reviews make thoroughly a review of the subject where it is aimed at. (Suhonen, Axelin & Stolt 2015, 7.) The search for the data is a process, which includes the need for proper documentation and evaluation. Critical thinking is vital when using internet databases. It is very easy to add false data to different web pages without proper knowledge of the subject. (Tähtinen 2007, 11-13.)
According to Whittemore and Knafl (2005, 552) an integrative literature review can be used to gather appropriate and vital data, which can be used to have a comprehensive understanding about problems related to health care. A literature review aims to answer a question, but the conductor of the review must acknowledge why the data is needed, what kind of information will be included and for what purpose is the information gathered for (Suhonen et al. 2015, 7, 13). The aim is to critically analyze literature at hand and point out faults, if there are any (Hirsjärvi, Remes & Sajavaara 2007, 253-254). Integrative literature review makes it easier to have a thorough picture of the research area and questions related to it (Whittemore & Knafl 2005, 552).

Integrative literature review includes five different steps. In the first step, the problem must be addressed and reviewed, by identifying the reason the review is needed. When identifying the problem, it minimizes the appearance of variables and faults in the data, making it easier to find appropriate literature. The first step is the most important phase in the process. It is vital to gather proper and up to date information. (Whittemore & Knafl 2005, 548-550.) The data must be gathered accordingly, always keeping in mind the reason why it is collected and to what purpose (Hirsjärvi et. al 2007, 253-254). See Figure 1 for the stages of an integrative literature review.

![Figure 1: The five stages of integrative literature review applied from Suhonen, Axelin & Stolt (2015) and Whittemore & Knafl (2005).](image)

In the second step the focus of the search is turned to the collection of the literature from different, appropriate sources, with the use of exclusion and inclusion criteria carefully elaborated beforehand. It is important to use accurate search terms, because without it, a great number of results may end up lost in the databases in which the search is conducted in. (Whittemore & Knafl 2005, 548-550.) The same inclusion and exclusion criterion must be used in all the databases. (Lehtiö & Johansson 2015, 53).

The third step assess the quality of the literature. The data evaluation process consists of evaluating the literature gathered at that point, making it easier to point out proper data,
which will be included in the process. The search process can include empirical and theoretical sources, so the sampling can be diverse. (Whittemore & Knafl 2005, 549-550.) When assessing the quality of the literature, precise carefully thought criteria make it easier to exclude irrelevant data, resulting only in relevant literature, beneficial to the review (Lemetti & Ylönén 2015, 77.)

In the fourth step, the collected data is compared with each and other and integration of the literature is formed. The data becomes visualized and different patterns can begin forming. Critical thinking in this step is important, to assess the full scale of the literature gathered. (Whittemore & Knafl 2005, 549-550.) According to Hirsjärvi et al. (2007, 117) making notes is vital in every phase of the review, but simultaneously understanding and seeing different techniques that were used in the data to get to the results.

In the fifth step, the results are presented, making a conclusion of the data that is now gathered, completing all the five stages (Whittemore & Knafl 2005, 549-550). A conceptualization of the research question is formed and ready to be presented (Whittemore & Knafl 2005, 549-550). A review focuses on gathering the necessary information about the subject into one place and makes a conceptualization of the area that it was aimed at (Suhonen et al. 2013, 7).

It is important for the conductor of review to make notes about the subject and evaluate at the same time the result from the research. The gatherer of the articles and research states the findings from the process in the presentation phase. (Hirsjärvi et al. 2007, 117; Whittemore & Knafl 2005, 552.) Literature reviews must include critical thinking and it is important sometimes to rule out literature outside a certain time limit from publication, to secure the validity of the data. An important aspect is to notice, if outside funding was available, distributed and could this fact be affecting the results. If a questionnaire needs to be filled in a research, sometimes people may receive benefits from completing the paper, which may affect the findings. (Kankkunen & Vehviläinen-Julkunen 2013, 91-94.) Literature reviews can take time. For this reason, it is important to identify it as an ongoing process. (Lehtiö & Johansson 2015, 38.)

Conducting a literature review rehearse one’s ability to gather information and evaluate it critically (Hirsjärvi et al. 2007, 252-253). If only one person conducts the literature review, it can unfortunately sometimes affect the results. This can be avoided with credibility and being precise at the reporting phase of the research. (Kankkunen & Vehviläinen-Julkunen 2013, 197.)

The creditability in this thesis was included, by using only peer reviewed information, secured by the carefully documented inclusion and exclusion criteria and precise documentation in the result section.
According to Hirsjärvi et al. (2007, 253) it is vital for the conductor of the literature review to understand the themes and area of the research. Only by this, the preciseness and the documentation be verified. According to Hirsjärvi et al. (2007, 19-20) collected data from different types of researches makes it easier to see a problem from all its sides and simultaneously increase the knowledge base on the subject.

5.2 Collection of data

This integrated literature review was conducted in the spring of 2019. Data was gathered from Finnish database Medic and from three foreign databases. Foreign databases used were ProQuest, ScienceDirect and Ebsco/CINAHL. The review was done also including Finnish articles and this was done by translating the research terms into Finnish in Medic. To secure up to date information, the search was limited including only texts a maximum of ten years of publication, from 2009-2019.

Exclusion criteria for the articles were those, which did not include the research terms, and words, which were not the peer reviewed, articles written in another language than English and Finnish and articles written before 2009. Some articles that were interesting had to be ruled out, because the inclusion criteria in the articles were not met properly and the data did not answer the research questions. See Figure 2 for inclusion and exclusion categories in the research.

Figure 2: Inclusion and exclusion criteria for the integrative literature research
Different search rehearsal terms were performed in the spring of 2019. Inclusion criteria for the articles included workplace violence towards nursing staff in emergency department, limiting the data to include mostly adult patients, English and Finnish literature and articles, published 2009-2019 and having free content. The use of the terms emergency department (ED) and emergency room (ER) were used in the search, because both terms are used when referring to that specific area of care. Both these terms are also used in this thesis. See Figure 3 for more information about the chosen databases.

The final search was performed in the spring of 2019, April-May. Two sessions of literature research with Laurea University of Applied Sciences (LUAS) informatic were held, and one session with an informatic in Terkko Library, Meilahti. The articles found were put under the inclusion and exclusion criterion in different phases. First, the subjects were selected if they were mentioned in the headlines and the abstracts and finally the whole articles. At first, the inclusion-exclusion criterion was limited to five years from publication 2014-2019, but due to minimal results, the inclusion criteria were increased to ten years 2009-2019 to maximize the amount of required data. The use of Medic was problematic, because the use of similar word by word search terms resulted in multiple results. The words were then put into Mesh-terms with the Terkko informatic, resulting in väkival* aggress* uhka* hoitaj* sairaanhoit emergenc* päivyst*. After that, the search terms found 24 articles and researches with the search terms.

The search was done altogether three times in the spring of 2019 and in the first search, the only databases used were Medic, ProQuest and Ebsco/CINAHL but because the search terms brought forth only limited amount of data, Science Direct was also included in the final stage of the integrative research and a final result of articles were reached. Before analyzing the final data, the articles included in the research were read again, which helped to answer the research questions. Due to no external funding in this thesis, free full access was important in all of the chosen four databases. Literature search rehearsals were performed before the final search for the thesis and words used were carefully chosen and added. The emphasis on this literature review was the experiences of nurses working in emergencies although physicians and other health care personnel are mentioned in the data. Their appearance still benefits the findings in this review, because it reveals the magnitude of WPV in emergency rooms.
5.3 Data and methods of the thesis

The process of this thesis started in December 2018 by contemplating different subjects for the thesis. In the end, a big part of the chosen subject was due to courses in Laurea UAS about crisis management. The awakened interest towards the subject was the authors’ own experience in working in the ER and in Saudi-Arabia. Experiences in working abroad and in a Finnish ER offered many viewpoints to the treatment of a critically ill patient, but simultaneously about the importance of communication. The authors’ own grandmother also offered many beneficial points about her own experiences of working in the health care sector.

Regular conversations were done with the authors’ nurse colleagues about the experience of being a nurse and its impact were beneficial and severely crucial during the thesis project. In the planning phase of this project, it was first thought to be done in co-operation with Haartman hospital ER situated in Helsinki, but due to lack of time and resources, this was unfortunately cancelled and other approach to the subject began forming. To fully focus on the thesis project the author worked part-time during spring 2019.

An integrative literature review starts with the planning phase and possible use of various means to gather the necessary information for the final results. The data research phase needs a careful set of words, the possible manual search of literature and making notes. When the needed data is gathered, the results of the search is compared to the actual inclusion and exclusion criterion. The search process is documented as a flow chart. The research questions make it easier to gather necessary information related to the literature reviews theme. (Flinkman & Salanterä 2007, 84, 88; Sulosaari & Kajander-unkuri 2015, 114.)
According to Flinkman and Salanterä (2007, 91-93, 97) the planning of the strategy for the integrative review is important and the data found in the research is beneficial to be put on the table to evaluate the results, methods and nature of the collected literature. With the use of tables, it is easier to process and evaluate the data gathered and compare it with the original research questions. The evaluation of the quality from the literature found needs appraisal and a possible need for two different methods. An important aspect of conducting an integrative literature review is the presentation phase of the results and conclusions according to the literature. The synthesis of the results is beneficial, because it can increase awareness towards the subject. See Figure 4 for the search terms.

5.4 Assessing the quality of the data

Evaluation of the data found is important in every step of the integrative review. Conclusions cannot be made, unless information is not precise and related to the theme and questions of the integrative review. Exclusion criteria towards the found data are beneficial, to rule out data which are not answering the research questions. (Flinkman & Salanterä 2007, 93.) The data gathered was the peer reviewed and given funding was reported on some of the articles. The data collected can sometimes be affected from the researchers own bias subject, which can affect the results (Russell 2005, 12). In this integrative review, a big emphasis was put on the reporting phase, to narrow down any potential problems or bias. The reliability of a research means that the research could be performed again with the same results. (Hirsjärvi et
According to Russell (2005, 12-13) conducting an integrative literature view is beneficial, because it also allows the researcher to see gaps in the collected data and the possible need for further research on the subject. Integrative literature reviews can offer the possibility for new research questions and point out problems from the current findings. Evaluation of the research from the previous literature is equally important and the appraisal of the found results. Suggestions for further investigation on the subject could benefit from provocation, to raise the interest towards the subject for future researchers (Torraco 2005, 364).

The reliability and validity of the data gathered was carefully considered to be exact due to the global phenomena of WPV, although the data included also narrative element of being subjected to violence at work. The articles collected for this study had multiple variations and different research methods for the original data that was gathered. This project was beneficial, because it was possible to see different ways of conducting a research and collect data. The quality of the studies was assessed by using CASP-checklist and STROBE. (CASP 2018; STROBE 2009).

This integrative review aimed to find out how common is the workplace violence against nurses in emergency room, what are the characteristics or permitting the factors of workplace violence against nurses in emergency department and what kind of measures nurses in emergency room implement managing violent incidents. The data showed that WPV is a global problem. As Morphet et al. (2014, 200) stated, everyone should be able to work in a safe environment.

The literature included in the table was evaluated by using two different methods. The Critical Appraisal Skills programme, the cross-sectional studies were analyzed using STROBE, with a checklist of 22 different parts. The word STROBE (2009) comes from the words STrenghtening the Reporting of OBservational studies in Epidemiology. The limitations of the STROBE-checklist and CASP were that only one author reviewed it. Most of the studies in this integrative literature review had good results after the use of the checklists, which benefits the validity of this integrative literature review. See Appendix 3. CASP (2018) is a checklist, which was originally developed as an educational pedagogic tool. The found qualitative data was appraised through CASP. See Appendix 4.

The evaluation of the qualitative studies revealed that they had commonly moderate evaluations score. In many of them, there was visible lack of data related to possible bias towards the subject and minimal reporting of funding. If the question mentioned in the CASP-checklist was not properly discussed in the article, this naturally limited the points for the study and for the final score. Only two of the articles had a score of six out ten points. The
observational studies that were assessed through the STROBE statement (STROBE 2018), revealed numerous of differences in the collected quality of data, which ultimately lowered the total points of the articles collected. All of the chosen articles were still included in the final integrative literature review.

6 Results

The first stage of the research had 152 potential articles. The removal of duplicates left 144 articles for the next stage. After the titles and abstracts were read, this left 71 articles for the next step, where 35 of them were taken into closer examination. The final stage revealed 22 potential references. The chosen articles were from Australia, China, Egypt, Finland, Iran, Ireland, Italy, Jordan, Jordania, England, New Zealand, Nigeria, Republic of Korea, Saudi Arabia and USA. This was beneficial, because it helped to see the problem of WPV globally and the impact it has.

The research was not limited neither to Europe nor the Nordic countries. Eight duplicates were removed from the data, to secure the accuracy of the results found. The search was limited to peer reviewed, full access articles, with the publication a maximum of ten years. Science Direct did not approve the mark *, so when conducting the research, the full words of “emergency AND nurses AND workplace violence AND prevalence” were used. In all of the other search databases, the words used were “emergency AND nurs* AND workplace violence AND prevalen*”. The methods of the studies were not limited in the search terms, to assess the whole data related to the research. See Figure 5 for the data chart of the collected studies.
Records identified through database searching.
Potential references (n=152)
Cinahl/Ebsco (n=16)
Medic (n=24)
Proquest (n=68)
Science Direct (n=44)

Potential references found (n=144)

Removal of duplicates (n=8)

Potential references found (n=144)

Title/abstract screened, removed (n=75)

Potential references found (n=71)

Full text screened, removed (n=35)

Potential references found (n=36)

Full text assessed, removed (n=14)

References found for the search (n=22)
Correlational studies (n=1)
Cross-sectional (n=12)
Qualitative (n=9)

Figure 5: Data chart for the integrative literature review
6.1 Type of WPV against the health care staff in emergency rooms

Nurses working in the ED are at greater risk being subjected to verbal threats and physical acts, than any other profession in the ED (Gillespie, Bunnany, Byczkowski & Fisher 2017, 82). Workplace violence (WPV) affects the wellbeing, performance and overall satisfaction of nurses and healthcare professionals all around the world (Darawad, Al-Hussami, Saleh, Mustafa & Odeh 2015; Gillespie 2017; Morphet, Griffiths, Plummer, Innes, Fairhall & Beattie 2014; Richardson, Grainger, Ardagh & Morrison 2018; Albashtawy & Aljezavi 2016; Knowles, Mason & Moriarty 2013). The appearance of WPV in EDs can be linked to weekends, especially Saturdays and evening or night shifts (Richardson et al. 2018, 53; Ogundipe, Etonyeaku, Adigun, Ojo, Aladesanmi, Taiwo, & Obimakinde 2012, 759; Huttunen, Joronen & Rantanen 2018; Darawad et al. 2015, 13).

According to Knowles et al. (2013, 926-927) and Angland, Dowling and Casey (2014, 134) the acts of workplace violence can be verbal threats but also direct physical attacks towards the health care personnel working in the hospital. In a research conducted by Huttunen et al. (2018) in a Finnish University hospital, the collected security officers` reports revealed that security personnel were called to secure a threatening situation in the ED almost five hundred times that year. In most cases, the assailant was the patient. A patient in the emergency room can have anything from mild flu, to a life-threatening illness and everything in between (Darawad et al. 2015, 9).

Suicidal tendencies can also be a prevalent factor for the appearance of violent behavior (Hyland et al. 2016). Forty-six participants in the study included in Wolf, Delao and Perhats (2014) research revealed that some of the participants, who reported on being subjected to WPV, mitigated the overall experience. Others saw the whole concept as life altering and still having effect on their personal and professional lives. According to Morphet (2014, 194), Gillespie et al. (2013, 1) and Wolf et al. 2014, 308 the treatment of patients who are under the influence of alcohol or narcotics or having problems with mental health benefits to the appearance of WPV.

In 2015 a cross sectional survey was done in three emergency departments, situated in Riyadh, Saudi-Arabia. It revealed that eighty-nine percent of 121 nurse participants had experienced some kind of violence in their workplace during the previous 12 months. The most common perpetrator was the patient or their families. Verbal threats were aimed toward gender and educational levels of the nurses. In fifty-nine percent of the cases, the nurses did not report the incident forward, mostly because they thought that nothing would happen to the perpetrators and reporting would pay no use. The acts of violence were non-physical but also physical. Everyone in the staff should know operating models for different threats, risks and attacks. (Alyaemni & Alhudaithi 2016, 35-37.)
Sometimes health care professionals can think that a violent act needs to be a physical gesture or an act of physical violence to make a verbal threat real and more acceptable to be reported forward (Angland et al. 2014, 136). Preparedness is important in avoiding violent situations towards nursing staff. The impact of workplace violence in the emergency setting does not limit only to nurses because also other health care personnel can suffer from it. (Gillespie et al. 2017, 79, 85.) Workplace violence is underreported and the culture of accepting violence as a part of the job benefits its appearance. For this to change, the management of the hospital and the whole community has to be harnessed to end its root causes and identify the professionalism of nurses in and stop seeing them simply as barriers to receive treatment in the ED. (Morphet et al 2014, 194-195, 200).

Occasionally, patients are escorted to the ED by relatives. Half of the WPV cases reported in Jordania happened in the evening and half of them were perpetrated by the patients. Relatives and friends of the patient contributed to half of the attacks of WPV towards the health care personnel in the survey. (Darawad et. al 2015, 11.) In China, the most common workplace for the violence to occur was the emergency room and the most common perpetrator of violence was the patient’s male relatives, aged 31-50 years. (Shi et al. 2017, 7-8.) The relatives escorting the patient to the ER can have expectations towards the care of their family members. Understandably, a sudden illness of a relative can be a stressful situation, leading to the variety of emotions. (Abdellah & Salama 2017, 3.)

High-risk patients can be seen those individuals brought in by the police, having suicidal tendencies or a history of violent behaviour or who are under the influence of a substance (Wolf et el. 2014, 308). Cases of WPV can happen anywhere in the ED, but the most common places are the patient rooms and the triage (Albashtawy & Aljezavi 2016, 63; Angland et al. 2014, 137; Richardson et al. 2018, 53). The triage is especially vulnerable to violence because there is only one nurse with the patient and admitting them to the emergency but also possibly limiting their admission (Ramacciati, Ceccagnoli & Addey 2015, 276-277).

According to Richardson, Grainger, Ardagh and Morrison (2018, 50) workplace violence incidents are usually under-reported by the health care personnel. Difficulties may also arise from the fact that the program made for reporting WPV is too hard to use. Some participants in the studies reported that they feel that violence is a part of the job. (Knowles et al. 2013, 927-928; Albashtawy & Aljezavi 2016, 63; Wolf et al. 2014, 307-308.) Problems can also arise from the attitudes of hospital management and how much they understand about the skills needed in the ED as a nurse and the threats related to the job (Ramacciati et al. 2015, 276-277). In a study conducted by Hyland et al. (2015, 147) the typical assault took place 109 minutes after the patients’ arrival to the ED.
Problems towards reporting WPV can be related to the fact that reporting programs are too hard to use (Hogarth, Beattie & Morphet 2015, 77-78.) Ramacciati et al. 2015, 277) emphasized the fact that verbal violence is so prevalent in the triage area in the ED, that nurses may think that it simply inevitable.

In Nigeria almost, sixteen percent of eighty-one nurses included in a research about WPV reported on being subjected to violence with the use of a weapon and seventy-four percent admitted that they did not receive any type of training on how to handle violent incidents, which made the situations even more hard to control and recognize (Ogundipe et al. 2012, 759). One respondent in a research conducted by Knowles et al. (2013, 928) reported that verbal threats are hard to decipher when they happen if they are not directed straight to an individual level. According to Richardson et al. (2018, 53) verbal threats can be aggressive swearing and shouting, individual threats and inappropriate sexual verbalization.

6.2 Characteristics and permitting factors for WPV against nurses

The most common ways of WPV in the ED are physical assaults, verbal abuse but also threats with the intention to hurt. When wait times are minimized, the risk for WPV can be lessened (Gillespie et al. 2017, 80-83, 85.) Characteristic of physical and verbal abuse can be kicking, spitting, scratching, the use of a knife or a gun, verbal threat, grappling and holding, pushing, shuffling, hitting, punching, verbal threat of perpetrating a violent act, being spat on, the twisting of the arm or hand, assault with other bodily fluids or with hospital equipment against staff. Naturally verbal threats were combined with the acts of physical harm in the researches and threats and assaults with bodily fluids. (Morphet et. al 2014; Wolf et. al. 2014; Hyland, Watts & Fry 2016, 147; Angland et. al 2014.)

Reasons for WPV can also be seen in the shortage of health care personnel and health concern about patients who suffer from dementia or Alzheimer’s disease. Other reasons can be substance abuse of a patient, badly informed visitor policies, poor communication skills, psychiatric patients and drug-seeking behavior of a patient, heavy workload, the attitude of management and a rite of passage for ER nurses to become professionals in their workplace. (Darawad et al. 2015, 11, 13; Richardson et al. 2018, 54-54.) Nightshifts and weekends can rise up the risk for the appearance of WPV (Hyland et al. 2016, 146-147; Alyaemni & Alduhaithi 2016, 36).

Recurring themes in the data collected which benefitted the appearance of workplace violence were environmental, communicational and cultural factors. Violence is a part of the job that is something that you had to get used to phrase was multiple times mentioned. (Knowles et al. 2013; Angland et al. 2014; Wolf et. al. 2014; Gillespie et al. 2017; Albashtawy & Aljezavi 2016; Morphet et al. 2014.) A recurring theme in the results was related to verbal and non-verbal
output, surroundings in the ED and culture of acceptance in the nursing profession. A patient suffering from dementia or Alzheimer's disease can also be aggressive (Darawad et al. 2015, 9).

6.2.1 Communication factors

Communication factors can be seen to be problematic to the patients and to other co-workers and this is mostly related to limited time, staff resources and big communities, which cannot give specialized individual care, unlike small rural EDs. The unpredictable nature of EDs makes it hard for anyone to mitigate the effects of personal frustration. EDs could also benefit from certain core groups, which are formed to take care of the frequent visitors of the hospital (Angland et al. 2014, 134-137; Darawad, et al. 2014, 13; Gillespie et al. 2017, 84; Hyland et al. 2015, 146-147.) Problems with communication was seen as a big problem, in both interpersonal relationships and attitudes to patients or relatives (Angland et al. 2014).

Overcrowding, waiting and expectations towards the health care services were a recurring theme in the data collected, but problems with communication and substance abuse of patients were also seen (Albashtawy & Aljezavi 2016, 64; Gillespie et al. 2017, 197; Wolf et al. 2014, 306-308; Angland et al. 2014, 135-138; Darawad et al. 2014, 9-10, 13; Ogundipe et al. 2012, 758). Concerns also surfaced about communication with doctors. If nurses are not informed about the patients’ treatment in the ER and what is planned for them next, patients can become frustrated, aggressive and lash out towards nurses. (Angland et al. 2014, 136.)

Verbal threats towards the nursing staff can be a precursor to a physical attack (Gillespie et al. 2017, 83). Verbal threats can also have a big impact on the nurse's occupational satisfaction causing unnecessary stress and discomfort. Constant demanding way of communication towards nurses, can make them think that they are incompetent in their work and start to question their professionalism. (Howerton Child & Sussman 2017, 548-549.) Multiple participants in one study reported that there is that one co-worker in the ED, who could always handle any kind of situation, but this is not something that cannot be taught (Howerton Child & Sussman 2017). WPV can lead to problems with concentration at work and cause unnecessary discomfort and isolation in the social lives of nurses (Hassankhani, Parizad, Gacki-Smith, Rahmani & Mohammedi 2017, 23).

Constant verbal abuse towards nurses in the ED lowers the quality of communication from them to patients, relatives and colleagues. This also causes the feelings of fear, frustration and has severe impacts on their private lives. (Hassankhani et al. 2017, 23.) According to Hyland et al. (2016, 146) verbal abuse and physical acts are can be hard to control in the ED, but the most challenging act of WPV can be being spat at. A personal verbal threat towards a nurse can have a long-term impact towards their own feeling of security off-duty (Hassankhani et al. 2017, 22).
6.2.2 Surroundings of the ER

Environmental themes are long waiting times, small ED premises, substance abuse and the appearance of psychiatric patients (Wolf et al. 2014, 305-309). Constant verbal abuse and minimal support from management can benefit the appearance of occupational disappointment among nurses (Howerton Child & Sussman 2017, 545). To some nurses, ED can be seen as a terrifying place to work in, if the hospital security personnel are not present in the premises of the ED continuously (Hyland et al. 2016, 146-147).

Patients with a history of mental problems can become aggressive and a verbal threat of violence is the most likely precursor of leading into a physical attack later on (Gillespie et al. 2017, 85). Improper safety precautions can be seen as a risk for WPV in the EDs (Ogundipe et al. 2012, 758). Physical violence can lead to chronic pain and other health problems (Wolf et al. 2014, 308). One participant in a survey conducted by Angland et al. (2014, 136-137) reported that on a busy day, you can sense the tension rising in the corridors of the ED due to lack of personal space. Open access to patients and their escorts in the ED, minimal spaces, triage, waiting, lack of security and overcrowding of the ED can be seen as promoting themes for WPV. Triage is a pressure point because they are the first contact of health care professionals when a patient comes to the ER and they do not understand the importance of patient evaluation (Angland et al. 2014, 134-137; Hyland et al. 2016, 146-147; Darawad, et al. 2015, 13; Gillespie et al. 2017, 84; Howerton Child 2017, 549). It could be beneficial to acknowledge possible aggressive patients in the ER, due to their previous course of treatment in the health care sector and act accordingly when they come to the hospital (Wolf et al. 2014, 308).

6.2.3 A culture of acceptance

A culture of permitting WPV and seeing it as a part of the job can promote its appearance in the health care sector (Richardson et al. 2018, 54-54). Employees can see that reporting incidents to the necessary personnel is not needed, if a threat has not been turned into a physical act resulting in an injury (Richardson et al. 2018, 54-55).

Reporting violent incidents can take time and it can also be seen as a barrier, due to the volatile and versatile environment of EDs (Hogarth et al. 2015, 79). One participant in Knowles et al. study reported that violence is also something that you can expect to happen (Knowles et al. 2013, 927). To some nurses WPV is more acceptable during the weekends, but not on a Monday (Knowles et al. 2013, 927).

Problems can also arise from the fact that sometimes nurses think that a violent situation needs a physical injury to justify the report that will be put forward. A verbal threat is not a big act of violence, unlike a situation leading to a physical injury. A verbal threat is often seen as something that you can just ignore because its prevalence is so high in emergency care. (Hogarth et al. 2015, 77.) Seventy-five percent of the participants reported about being
subjected to a violent incident during their career in a research conducted by Albashtawy & Aljezavi (2016, 61). Violence in the ED is not usually reported to the management, because it is thought to be a part of the job or no proper harm was done. The presence of verbal abuse in the EDs is higher than it is actually reported forward. (Partridge & Affleck 2017, 144; Hyland, Watts & Fry 2016, 145.)

The cultural aspect of a permitting WPV was a recurrent theme and violence was often stated as a part of the job (Abdellah & Salama 2017; Albashtawy and Aljezavi 2016; Knowles et al. 2013; Angland et al. 2014; Shi et al. 2017, 7). A concern can also rise, that WPV reports about incidents of an only certain kind have to be filed forward. If there is no physical injury, no harm was actually done. A no blame-policy can also be seen, if a patient is really sick or suffering from memory problems and with that aspect, they cannot be accounted for their action and take blame. (Richardson et al. 2018, 55.)

6.3 Solutions to end WPV

Recommendations against workplace violence in the data were related to information, environment and education. Suggestions about the distribution of information given to the patients or relatives in a timely manner about the course of the treatment were given, propositions about hiring a lobby host to the ED and informing the public about the occurrence of WPV in the hospitals. (Gillespie et al. 2017; Angland et al. 2014; Wolf et al. 2014 & Morphet et al. 2014). Proper strategies towards WPV work the best with the support of the whole ED staff (Gillespie, Gates, Kowalenko, Bresler & Succop 2014, 590).

In one study, a critique towards security personnel was present, because a few participants thought that not all security staff are interested in their work. Factors, which were seen to cause WPV in the ED, were organized under two themes related to environmental factors and communication factors. The participants reported of the possibility for communication training would be beneficial to minimizing violent incidents towards nursing staff. A remark was also made that electronic screens, which shows the approximated waiting time, would relieve some of the stress in the area of the hospital. (Angland et al. 2014.)

One study stated that WPV is a problem which can be solved only with the help of management level to limit its effect. Management of verbal threats also needs properly functioning strategies. The expertise of the health care personnel working in the field must be included in the planning phase. Future research must be done towards WPV and the staffs’ perceptions recognizing possible aggressive patients. (Gillespie et al. 2017, 85).

According to Ogundipe et al. (2012, 760) certain attributes in a person such as availability, respectfulness, support and responsiveness can mitigate the appearance of WPV. Communication training for staff, electronic boards for estimated waiting times and hiring a
communication officer to work in the hospital lobby could be beneficial. Many participants in the study reported that their attitude against the patients sometimes promoted aggressive behaviour, because in their opinion the patients did not need ER services although coming to the hospital. The nurses in the research also stated that they thought that the public did not see their professionalism and this led to different types of barriers, such as defensive approaches to patients, their relatives and avoiding straight eye contact. (Angland et al. 2014, 138.) A strict visitor policy could benefit in making the ED atmospheres calmer (Darawad et al. 2015, 12).

Professionalism of the nursing staff could be respected more in the community to minimize the appearance of WPV. The appearance of demanding relatives and patients in the ED can promote feelings of being undervalued as a professional, causing the health care staff acting stricter towards patients, potentially at the same time causing more incidents of WPV for lack of proper communication. (Shi et al. 2017, 8; Angland et al. 2014, 138.)

Visible security guards in the premises of the hospital can minimize the threat to WPV and increase security and feeling of safety (Morphet et al. 2014, 198; Hyland et al. 2016, 146; Howerton Child 2017, 549). Open access and no implementation of a strict entrance codes in EDs can promote the appearance of WPV, where patients can come to the patient rooms and go as they see fit (Hyland et al. 2016, 146).

6.3.1 Environment

Suggestions to control the appearance of workplace violence were about visible and active security staff in the ED, the streaming of ED process, management support, giving personal security alarms to everyone, open communication with authorities, bettering the patients admission protocols, separating the areas for the treatment of known easily agitated patients, improving the design of the EDs, improving communication, the increase of resources in the community to treat patients whom suffer from mental health issues, known penalties for WPV against hospital staff and improved health services against the hazards of substance abuse and alcohol. Legislation about zero tolerance to WPV was also mentioned as a possible powerful way to end its appearance. (Angland et al. 2014, 136; Morphet et al. 2014, 197-198, 200.)

Open access to the ED promotes the appearance of disruptive behavior (Hyland et al. 2016, 146). Functional programs for ending WPV in hospitals needs the full support of the organizational level (Gillespie et al. 2014, 591). Hiring a lobby host working full time with expertise towards mental health problems could be beneficial. This leaves room for the nursing professionals to take care of other patients and distribute the resources more accordingly. (Gillespie et al. 2017, 85.) Nurses from Morphets’ (2014) research suggested visible, professional security guards in the ED, zero tolerance-policy for WPV, education towards aggression and violence incidents, the streaming of ED processes for the patients and increase
of medical staff in the workforce (Morphet et al. 2014, 198.) The better treatment of psychiatric patients could lessen the weight of unnecessary verbal abuse, which can see as a promoting factor for WPV (Gillespie et al. 2017, 85.)

In Shi et al. (2017, 8) research, the authors called out for zero tolerance policy for WPV and increase in professionalism and pride among health care workers. They also suggested that management in the hospitals would engage in a more proactive attitude against WPV, so that the employees think that they have the support of the hospitals in cases of being subjected to violence. The health care staff needs the support of the management towards concerns about WPV, this was a recurring theme in the data collected. (Morphet et al. 2014, 199; Wolf et al. 2014, 308-309; Gillespie et al. 2017, 85; Ogundipe et al. 2012, 761.)

The reasons and causes leading to WPV needs to be addressed in its root causes and diminishing its appearance, not only by enforcing strict laws, which can take time to be, implemented (Wolf et al. 2014, 309). According to Partridge and Affleck (2017, 144), the presence of security guards in the ED cannot be underestimated, preventing threatening situations. The most common victim to fall for the acts of workplace violence was a nurse with limited or little nursing experience. Older nurses, with a larger background on working at the ED, were not subjected to violence that much. Working in the private sector, was also helping to limit the appearance of violent acts. (Darawad et al. 2015).

6.3.2 Education

Morphet et al. (2014, 198-199) suggested that when preventing WPV in an emergency, education could be a solution. Education given to nurses about the management of aggressive patients could be beneficial, but also for the patients and relatives about ED. Promoting especially the fact when to come to the ER and when to use other health services. Sometimes the health care staff’s communication skills and attitude towards patients can contribute to aggression but also de-escalate its appearance (Ramacciati et al. 2015, 278; Howerton Child & Sussman 2017, 548-549).

People coming to the ER do not necessarily understand that patients are organized under different categories in triage in the hospital lobby, as in how fast they doctor should come in and see them. This can frustrate the patients. (Howerton Child & Sussman 2017, 549.) According to Morphet et al. (2014, 200) the best way to diminish the appearance of WPV is to address the issue with the community and educate them about it. Education against WPV should be adjusted to meet the needs of ED nurses, due to its versatile atmosphere, compared with other service areas of the hospital (Howerton Child & Sussman 2017, 551).

According to Hassankhani et al. (2018, 24) the empowerment of nurses could be beneficial and the implementation of a psychological counselling and support after WPV could be studied
more. Policy makers and the hospital management should be active in implementing proper strategies towards WPV. Workplace violence is a stressor, which has to be taken seriously, to secure the safety of health care personnel around the world and seek out different intervention methods (Gates et al. 2011, 59; Alyaemni & Alhudaithi 2006, 39). Effective WPV control must include proper and thoroughly planning, research and understanding the fact that verbal aggression and threats will most likely lead also to an act of violent nature towards the health care staff. By any means, its appearance cannot be mitigated in the hospital area and it must be taken seriously. (Gillespie et al. 2017, 45.) WPV has hidden costs, which are not widely known (Ramacciati et al. 2015, 274).

Being subjected to WPV can cause the nurse to apply for sick leave. It can simultaneously have an effect of the quality of care and increase costs of health care (Darawad et al. 2015, 11; Wolf et al. 2014, 308; Hassankhani et al. 2017, 24). Reasons leading to violence in the hospital should be researched more thoroughly and different plans of its appearance diminished (Huttunen et al. 2018). A big problem was seen in Abdullah & Salamas (2017) study about reporting the violent incidents. The researchers call out for better understanding about the problem by doing more research towards the subject and they concurred that not all cases of violent attacks are reported forward in the hospital due to unknown reasons. Education about how to control WPV is important (Hyland et al. 2016, 147). According to Park et al. (2017, 539, 543-544) a development tool for increasing hardiness could be beneficial to nurses. Hardiness training could simultaneously minimize the appearance of work-related stress when encountering violent situations in the emergency department. A better understanding about times that are the most common for the acts of violence towards the ED personnel could be beneficial in distributing enough workforce (Hyland et al. 2016, 147).

According to Gillespie et al. (2017, 85) WPV cannot be tackled unless nurses whom interact with patients and visitors are included in the strategies and planning phases. There needs to be a clearer understanding about the factors that increase the appearance of WPV in the hospital, because violence can have long term effects on the professionals working there (Wolf et al. 2014, 309). More studies would be beneficial to be made with the theme of evaluating circumstances leading to WPV. Only by this can the subject be addressed, allowing the health care staff identify potential violent patients and hostile, harming environments which allow the culture of acceptance towards WPV, continue. (Wolf et al. 2014, 309.)

WPV can also have an impact on the other patients in the ED, such as unnecessary fear (Richardson et al. 2018, 53). According to Gillespie et al. (2017) WPV is a problem, which needs to be seen at the management level to mitigate its effect. Management of verbal threats also needs properly functioning strategies. The expertise of the health care personnel working in the field must be included in the planning phase. Future research must be done towards WPV and the staffs’ perceptions recognizing possible aggressive patients. Although substance abuse
and the psychological problems of patients are a prevalent factor for WPV, other groups and their actions needs to be taken into consideration in future research (Gillespie, Gates & Berry 2013). The environment and surroundings of the ED can promote the risk for aggressiveness and this can only be avoided by proper strategy planning and security precautions. (Darawad et al. 2015, 13.) See Appendix 1 for acts of WPV, permitting factors for WPV and suggestions to end WPV according to the results of this integrative literature review.

7 Discussion

The objectives of the integrative literature review were to explore:

1. How common is the workplace violence against the health care personnel in emergency room?
2. What are the characteristics or permitting the factors of workplace violence against the health care professionals in the emergency room?
3. What kind of measures are recommended through the latest research about WPV to limit its appearance?

1. Workplace violence is a global problem, which affects the health care area as a whole. It can lead to occupational disappointment, health problems and social isolation among nurses. Workplace violence does not only limit the quality of care, it has an impact on the overall wellbeing of health care personnel. Workplace violence is a problem, which has numerous of consequences to the health care area and may succumb to financial losses.

There were multiple incidents of WPV performed against nurses in EDs present in the data found. Workplace violence is a problem all around the world and it is important to acknowledge its meaning to the health care personnel, their feeling of safety and their occupational satisfaction, which can lead to disappointment. WPV is a violent act, aggressive verbal threats or a combination of both. Verbal threats are not necessarily reported forward, because they can be misinterpreted in not causing enough harm.

2. The reporting of WPV incident is low. Due to the cultural problem of seeing violence as a part of the job or a rite, you must go through in becoming a dignified member of the staff can lead to hazardous consequences. A verbal threat is also WPV and it must be seen as so and reported forward. The proper implementation of working and easily used tools for the reporting of WPV could be developed to reach and see the whole impact and threat of WPV in ERs. The whole scale of WPV cannot be seen if not all the verbal threats, insults, physical attacks and injuries are documented.
Constant, inappropriate verbal threats in the workplace can lead to serious impacts on a person’s feeling of safety at work, lead to unnecessary discomfort outside of work and decrease the quality of care provided to patients.

Problems with small patients’ rooms, poor visitors’ policy and unlimited access to the hospital was a prevalent factor for violence. Free visitor policy and open access ED were also seen as cause for further problems. Security personnel in the ED can minimize aggressive and threatening behavior with their presence. Personal alarm systems are beneficial, when distributed to everyone working in the ED, to secure safe working environments. Communicational issues and problems were visible in the data. The frustration and stress of nurses, patients and relatives can lead to unnecessary misunderstanding. The architectural designs of the EDs could benefit from better views on safe working surroundings.

3. Information could be beneficial to be distributed to the patients and relatives more accordingly. The impact of education could be researched more towards nurses in handling aggressive patients. Guidelines and recommendations for patients coming to the ER could be more accurate, simultaneously benefitting the patients’ needs. Nurses working in the ER could be more involved in the planning phases between WPV strategies and simultaneously give out new solutions. The findings in this integrated literature review also showed serious problems with the management and attitudes of health care personnel about reporting WPV forward.

Distribution of different types of solutions, such as communication training and giving accurate information to the patients and their visitors could be an important aspect. The reasons for not reporting violence forward is a big issue in concerns about WPV. According to the results of this integrative literature review, more emphasis could be put into the design of ERs, to make it more easily controlled and safer for all the individuals in the premises. The professionalism aspect of nurses working in hospitals could benefit from occupational pride. Constant verbal abuse, unacceptable threats and physical violence limits the appearance of a stable, well-timed care in the ED. The hospital administration and management should be more aware of the circumstances, versatile environments and constant staffing challenges in the ER. Frustration towards management was visible in many of the articles.

A risk or a threat to encounter workplace violence can make it harder for the healthcare employees to concentrate at work. An interesting remark about safety was also present in the articles included in the study, because safety personnel are not implemented everywhere. Many of the ERs did not have proper visitation policies.
7.1 Strengths and limitations

The found data was limited to peer reviewed articles. Possible strengths and limitations in this integrative review are related to the fact that all of the articles chosen were included in the data and no area of a method used was done to limit the original words for the search phase. Limitations in this study are simultaneously related to the fact that the data included focus groups and open-ended questionnaires, which had the narrative accounts of lived WPV experiences and feelings. These experiences make the data vivid, possibly even bias. In many of the studies, the inclusion for participating in the research was being subjected to WPV in the previous months or at some point during their career. Different results could have been accomplished by focusing on the surveys and researches to the patients and relatives visiting the emergency departments to see their views on the subject or only to randomly selected health care personnel working in the emergency room.

The research words used in this integrative review were carefully selected, but possibly, with different search terms, the results could have been different. Different results of data for the review could have been reached with the use of other databases, with the increase of years from publication. This integrative literature a reviews goal was to have a synthesis of current literature related to the subject, which is beneficial in having an up-to-date view on the selected subject. The author reports on no previous experience in conducting a literature review.

7.2 Ethical considerations

Conducting a research, which involves all aspects of critical thinking, can be the problematic and use of internet as a research base makes it even more challenging (Tähtinen 2007, 12-13). According to Hirsjärvi et al. (2007, 23, 27) ethics in the world of scientific writing means more than just an individual view of what is right, because of this it is even more important for the results to be evaluated in the science world.

The chosen method and strategies guide the search process. (Hirsjärvi et al. 2007, 179). One person made this integrative literature review so naturally it limited the accordance of the results. To avoid this, the thesis was written with notes, active criticism towards to the data found and ethical consideration in every step in the writing process. Inclusion and exclusion criteria were an important aspect in the research phase, because it helped to limit the findings and focus on the main subject. The years of publication was limited to ten years, to verify the validity of the data found and limited to peer reviewed articles. Although the problem of WPV has been prevalent for many years, multiple studies have been conducted during these previous years. Critical consideration has to be implemented into all the data found (Hirsjärvi et al. 2007, 184). The author reports of no funding received during this process. The results were assessed by reading the articles in this integrative review and putting the necessary information
visible about the publications that were selected, including the year of publication, methods that were used and data findings related to the subject. The data collected was evaluated through CASP (2009) and STROBE (2018). See Appendix 3 and Appendix 4.

Because only one author performed this integrative literature review, the approval of another writer of the data gathered was not possible. To avoid this, careful consideration was put into the reporting phase of this integrative literature review. Another author in this integrative review could have simultaneously have been beneficial for pointing out information that could have been missed. Problems can arise when assessing data gathered from focus groups, where pressure peer can be present (Hirsjärvi et al. 2007, 201-202).

8 Conclusion

Numerous factors can contribute to the prevalence of WPV. Frustration of patients, substance abuse, problems with mental health, communication issues, the attitudes of health care staff, expectations of patients towards their treatment and lack of information. According to the studies included in this integrative review, the role of basic communication plays a big role and the value of professionalism. Nursing staff could be included in the planning phase of finding new solutions.

The safety of all employees in beneficial to be ensured in the hospital and this can only be achieved with suitable precautions, properly functioning alarm systems and training of the staff. For these things to work, the staff needs the support of the employer, management, their work community and a normal feeling of self-esteem.

The seriousness of WPV cannot be controlled if the reports do not show what is happening in the ER environment, its magnitude and the effects of it are hidden. The resources in the hospital are always limited, so other methods of intervention could be beneficial. Further research on the subject of WPV could be done to see the impact of nurses when planning interventions and new solutions for the appearance and mitigation of WPV around the world. The role of communication and experience is something that could be included in further studies. The need for research was mentioned multiple times in the data that was collected and more knowledge could be beneficial to acquire to reach a safe work environment for nurses all around the world.
References

Printed sources


Electronic sources


Knowles, E., Mason, S. M., & Moriarty, F. 2013. 'I'm going to learn how to run quick': Exploring violence directed towards staff in the emergency department. Emergency Medicine Journal. 30 (11), 926-931. DOI:10.1136/emermed-2012-201329


Australasian Emergency Nursing Journal, 20(3). 139-145. https://doi.org/10.1016/j.aenj.2017.05.001


Appendix 1: Acts of WPV, permitting factors for WPV, suggestions to end WPV.

<table>
<thead>
<tr>
<th>WPV as acts towards the health care personnel</th>
<th>Physical harm</th>
<th>Verbal threats</th>
<th>Verbal threats and physical harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>• kicking</td>
<td>• Verbal threat with an intention to hurt / warning of intent to injure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• spitting</td>
<td>• insulting behavior, related to the nurses education, appearance or skills.</td>
<td></td>
<td></td>
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<tr>
<td>• scratching</td>
<td>• threat to assault with bodily fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the use of a knife or a gun</td>
<td>• threat of physical assault outside of the workplace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• hitting</td>
<td>• verbal threat of being armed with a gun or a knife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• shoving</td>
<td>• verbal intimidation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• twisting of arm/leg/hand</td>
<td>• Verbal threat combined with physical harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• assault with bodily fluids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• attack with hospital equipment against staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• grabbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• physical intimidation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pushing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pinching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• pills spat in face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• harm with sharp or hard object</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• assault with bodily fluids</td>
<td></td>
<td></td>
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<tr>
<td>Permitting factors for WPV</td>
<td>Communication</td>
<td>Environment</td>
<td>Culture</td>
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<td>---------------------------</td>
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</tr>
<tr>
<td>• attitudes of patients/relatives</td>
<td>• busy ED.</td>
<td>• accepting culture for WPV in the ED and in the hospital</td>
<td></td>
</tr>
<tr>
<td>• communication with doctors failing</td>
<td>• crowded lobbies/confined space</td>
<td>• authorities’ attitudes towards nurses reporting the incidents</td>
<td></td>
</tr>
<tr>
<td>• communication with management failing</td>
<td>• demanding relatives that heat and smells in the ED.</td>
<td>• authorities not taking cases of WPV seriously because it takes too much resources.</td>
<td></td>
</tr>
<tr>
<td>• frustration of health care personnel about the use of their own professionalism</td>
<td>• lack of resources to treat the patients</td>
<td>• empathy for patients whom are sick and do not understand what they are doing</td>
<td></td>
</tr>
<tr>
<td>• frustration of patients and relatives</td>
<td>• no privacy</td>
<td>• fear of losing good reputation as a workplace</td>
<td></td>
</tr>
<tr>
<td>• relatives and patients attitudes towards nurses</td>
<td>• overcrowded EDs</td>
<td>• institutional culture allowing WPV.</td>
<td></td>
</tr>
<tr>
<td>• stress causes miscommunication from the nurse to the patients, relatives and colleagues.</td>
<td>• patient does not need urgent care but still comes to the ER.</td>
<td>• mitigating the effects of WPV to the health care staff by the management.</td>
<td></td>
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<tr>
<td>• substance abuse of patients</td>
<td>• problems with security</td>
<td>• no physical harm means no harm done</td>
<td></td>
</tr>
<tr>
<td>• attitude of nurses against “regular visitors”</td>
<td>• security alarms not available for everyone</td>
<td>• peer pressure from colleagues for not reporting WPV incidents forward</td>
<td></td>
</tr>
<tr>
<td>• triage nurses interrupted all the time for enquiries about estimated times for evaluation.</td>
<td>• small patient rooms or/and triage-area too small</td>
<td>• proper law against WPV not implemented.</td>
<td></td>
</tr>
<tr>
<td>• patients do not understand triage in the hospital</td>
<td>• the security office not in the ED area.</td>
<td>• reputation of hospital jeopardized if WPV incident are reported forward</td>
<td></td>
</tr>
<tr>
<td>• patient or family expectations towards health care services and/or course of treatment</td>
<td>• urban area EDs more crowded than others</td>
<td>• rite of passage for new nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• understaffing</td>
<td>• under-reporting of incidents</td>
<td></td>
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<tr>
<td></td>
<td>• non-smoking environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestions to control WPV.</td>
<td>Information</td>
<td>Education</td>
<td>Environment</td>
</tr>
<tr>
<td>----------------------------</td>
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</tbody>
</table>
|                            | • information given to the patients/relatives in a timely manner about the course of the treatment.  
|                            | • hiring a lobby host to the ED.  
|                            | • inform the public about the occurrence of WPV in the hospitals. | • communication education to nurses about the management of aggressive patients  
|                            |                                              | • education for the patients/relatives about ED.  
|                            |                                              | • a small info recording about the treatment path of the patient in the ED to the lobby.  
|                            |                                              | • education to the patients when to come to the ER and when to use other services. |
|                            |                                              | • better communication with the authorities and improved communication from triage to the patient room and back.  
|                            |                                              | • better patient’s admission protocols  
|                            |                                              | • calming the ED lobby atmosphere  
|                            |                                              | • health care management assessing the problem better  
|                            |                                              | • Implementing zero tolerance for WPV in the ED.  
|                            |                                              | • Improved security measures  
|                            |                                              | • Improvement of health services related to substance abuse/alcohol  
|                            |                                              | • Increase resources in the community to treat patients whom suffer from mental health issues.  
|                            |                                              | • minimum tolerance of verbal abuse in the ED.  
|                            |                                              | • penalties for WPV against hospital staff.  
|                            |                                              | • personal security alarms for everyone |
### Appendix 2: Reference-table of articles

<table>
<thead>
<tr>
<th>Reference and country.</th>
<th>Purpose and aim of the study</th>
<th>Data and methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdellah &amp; Salama. 2017. “Prevalence and risk factors of workplace violence against health care workers in emergency department in Ismailia, Egypt.”</td>
<td>The research was carried out the Suez Canal University to determine the prevalence, types, sources and risk factors of workplace violence in the ED.</td>
<td>The data was collected through a cross-sectional study. One-hundred-thirty-four questionnaires were included, with the response rate of ninety-four-point-four percent. Participants in the study were health care professionals, such as nurses, secretaries, physicians and housekeepers. Sixty-seven (n=67) nurses answered the questionnaire and were included in the data. The original questionnaire was first translated to Arabic and then back to English with the answers.</td>
<td>The nurse participants in the questionnaire, reported a rate of thirteen-point-four percent to being subjected to physical violence. The rate for verbal violence was sixty-five-point-seven percent. The most common time for the appearance of violence, was in the evening and night. The most common reason for violence as reported by the participants was waiting time in the ED, overcrowding and unrealistic expectations of the patients or their family towards treatment. In Ismailia, Egypt the appearance of WPV was clear, but still the reports about the acts were not put forward. In over seventy percent of the cases in both physical and verbal attacks, the participants saw that situation could have been prevented. A big problem was seen in reporting the violent incidents and the researchers call out for better understanding of the problem by doing more research towards the subject and they concurred that not all cases of violent attacks are reported forward in the hospital due to an unknown reason.</td>
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<tr>
<td>Albashtawy &amp; Aljezavi. 2016. Jordania “Emergency nurses’ perspective of workplace violence in</td>
<td>The aim of the research was to explore the risk factors for workplace violence toward nurses and find</td>
<td>A cross sectional design survey, which was conducted in Jordanian hospital emergencies. Participants two-hundred-twenty-seven nurses, the survey consisted of three</td>
<td>The research which was conducted for a three-month period in Jordan, seventy-five percent of the participants, reported of being subjected to workplace violence during the previous six months, but only sixteen percent reported the incident forward. This amount included verbal and physical violence in the ED.</td>
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<tr>
<td>Study Title</td>
<td>Methods</td>
<td>Findings</td>
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<td>Jordanian hospitals: A national survey.</td>
<td>reasons for underreporting of WPV, included altogether eleven questions. Eighty-two participants were male, one-hundred-forty-five were female.</td>
<td>In Jordania the problem with workplace violence is underreported due to multiple factor as stated by the researchers in the paper. Reasons leading to WPV were related to long lines for the doctor’s evaluation, the patients and their family’s unrealistic expectations towards treatment and overcrowding of the ED.</td>
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<tr>
<td>Alyaemni &amp; Alhudaithi. 2016. Saudi-Arabia.</td>
<td>A cross-sectional research. The goal of the research was to explore workplace violence and its forms and consequences in three EDs, situated in Riyadh, Saudi Arabia. The study was done by questionnaires. Participation was voluntary. The research was advertised and the survey sample was N = 121. The survey was conducted in a three-month period. The questionnaire had a total of 23 questions. Results were analyzed by SPSS-program.</td>
<td>The occurrence of violence was very common and perpetrated by the patients and their relatives in the hospital EDs. Satisfaction with management varied in the management of violence incidents. Violence was verbal threats, but also physical violence. Open ended questions in the survey revealed that nurses suggested an impartial counselor, stricter code of conduct for visitors and a security code in the ED to use when a patient becomes violent. The quality of care increases when proper guidelines and strategies are implemented to decrease the appearance of WPV. Communities could benefit from understanding the professionalism of nurses.</td>
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<tr>
<td>Angland, Dowling &amp; Casey. 2014. Ireland.</td>
<td>The aim of this study was to find out emergency department nurses’ views of the reasons, which led to WPV. A qualitative study. Interviews were conducted to twelve nurses working in the emergency department in Ireland. Participant were recruited from the same ED. Interviews were recorded. Three participants male and nine participants</td>
<td>The results from the interviews were arranged under different sub categories that the nurses reported which caused violence and aggression. Four of them were related to environmental factors and three to communication. The participants reported that in the ER setting there is not much time to encounter every single patient individually and it often leads to misunderstanding. WPV was often reported by some as a part of the job. Results also showed that a problem was the environment in the ER area, which can be overcrowded and noisy. Long waiting queues also contributed</td>
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women, with minimum of six months of work experience.

<p>| Darawad et al. 2015. Jordania. “Violence Against Nurses in Emergency Departments in Jordan: Nurses’ Perspective.” | A cross-sectional study. The aim of the study was to research the amount WPV that emergency nurses are subjected to and possible promotive factors to it in their workplace. The data was collected from one-hundred-seventy-four ED nurses, working in Jordania in different emergencies, both in private and public sector. The research was carried out through a four-part questionnaire. | The majority of the participants in the survey, reported that they had experienced violence at their work, including physical and verbal abuse. The minimum amount of work experience for the participants was three months in the ED. Most of the participants in the study felt that there would be no need to press charges if a patient or a relative would become violent. According to the nurses, the most common causes for workplace violence in the ED subjected towards them were too many people in in the ED and the massive workload that they had to take care of. Verbal violence was the most common type of WPV. The research revealed that one-hundred-and-seventy-four participants reported a rate of ninety-one-point-four percent of being subjected to workplace violence in the previous five years. Verbal violence rate was reported ninety-five-point-three and physical at twenty-three-point-three percent. Thirty percent of nurses from the questionnaire took sick leaves after WPV incidents. Jordanian EDs lack of professional security personnel and they have no authority in the premises. |
| Gillespie, Gates &amp; Berry. 2013. USA. “Stressful Incidents of Physical Violence Against Emergency Nurses”. | The aim of the research was to describe acts of physical violence against 177 study participants were randomly selected from a sample size of 3000 nurses working in EDs. The participants were all members of the | The results stated that WPV in the ED is a widely spread problem and it should be faced with different types of solutions, starting from the design of the ED. Security precautions and a straight line of communication to the security personnel could be beneficial. People with mental health or substance |</p>
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Country</th>
<th>Title</th>
<th>Participants</th>
<th>Methodology</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Gillespie et al.</td>
<td>2014</td>
<td>USA</td>
<td>“Implementation of a Comprehensive Intervention to Reduce Physical Assaults and Threats in the Emergency Department.”</td>
<td>Emergency nurses.</td>
<td>An intervention study was conducted with 3 intervention and 3 comparison EDs to see if intervention-training model was beneficial. The study had altogether 209 participants and the data were collected through three surveys that the participants had to fill. One of the surveys was to be filled whenever a violent incident occurred. The participants were nurses but also other professionals working in the ED. The survey was to be filled 9 months before and 9 months after the intervention.</td>
<td>Abuse are most likely to pose a risk for WPV but other patterns of violent and aggressive behaviour were also seen in other groups. Although the hospitals were involved in the survey, data was still missing about WPV in the official reporting system, although their appearance was reported in the survey. Debriefing was not usually done, although WPV incident had occurred. The researchers conclude that a more thorough approach towards WPV could be implemented. A conclusion was made in the data, that WPV can only be dealt with properly if everyone in the hospital is determined to diminish its effect.</td>
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<tr>
<td>Gillespie et al.</td>
<td>2017</td>
<td>USA</td>
<td>“Worker, workplace, and community/environmental risk factors for workplace violence in emergency departments.”</td>
<td>280 (n=280) employees from six emergency departments in the Midwest United States participated. Participants were non-physician, such as working in the registration, patient care and nursing.</td>
<td>A cross-sectional research about factors which permitted the appearance of WPV.</td>
<td>The study revealed that almost all of the nurse respondents to the research reported of being subjected to WPV during their career. These acts were verbal threats but also direct physical contact. A possible re-adjustment of nursing patterns in the ED may be beneficial in avoiding violence and for example using a mental health expert to take care of challenging patients who have psychiatric symptoms. Patients who are regularly using the ER services, could benefit a core team assigned to their cases whenever they seek for help.</td>
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<tr>
<td>Study</td>
<td>Country</td>
<td>Title</td>
<td>Methodology</td>
<td>Findings</td>
<td>Recommendations</td>
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<tr>
<td>Hassankhani et al. 2018. Iran.</td>
<td>“The consequences of violence against nurses working in the emergency department: A qualitative study”.</td>
<td>A qualitative study made with semi-structured interview about the impact of WPV towards ER nurses. Sample size was sixteen nurses, working in five different hospitals EDs in Iran. Semi-structured interviews were held February to December 2015. Collection of participants by purposive sampling.</td>
<td>Four themes emerged in the data under a theme of nurses who suffer. Those sub themes were related to mental and physical health risks but also to threats towards professional and social integrity. Mental and physical health risks as reported were anxiety, lack of sleep, physical and chronic injuries from WPV and depression. Professional and social integrity problems as reported were loss of interest towards work, poor communication, problems within the nurses social lives and problems with the quality of care provided. WPV can have serious health impacts as reported by the nursing personnel. Healthcare managers should be more active in actions towards WPV and understand its impact.</td>
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<td>Hogarth, Beattie &amp; Morphet. 2016. Australia.</td>
<td>“Nurses’ attitudes towards the reporting of violence in the emergency department”.</td>
<td>The research was done to seek out problems which affect the reporting of violent incidents forward in the ED. Two focus groups were held, participants in the research were nurses working in ER. Focus group 1 had 8 participants, focus group 2 had 7 participants. The groups were held two weeks apart in September 2013. Altogether 15 nurses (n=15) was included. Inclusion criteria was working in an ED and willing to participate.</td>
<td>The respondents felt that violence is a part of the job, a permitting culture was present. Participants had also mixed feelings when to report if a WPV incident had not caused any physical injury to the victim. Other problems seen were limited procedures and policies towards WPV, not being encouraged enough to report and problems using the WPV reporting system. A mitigating issue was also seen if a patient was too ill to understand a violent act that he/she had committed. Reporting procedure of WPV with the official platform took too much time and it was seen as a big problem. The reason to report was also related to the fact that the incident resulted to a real physical injury. The reporting was also done using various sets of other reporting programs and not with the program designed for its use.</td>
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<td>Howerton Child &amp; Sussman. 2017. USA.</td>
<td>The aim of the study was to identify patterns of feelings and behavior of nurses.</td>
<td>Twenty-eight nurses were recruited from California through advertisements, internet platforms and they were interviewed.</td>
<td>The findings of the study stated that occupational disappointment was a major theme in the interviews, due to the challenging nature of the profession. The feeling was strongly linked to the appearance of verbal workplace violence in the ED.</td>
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<td>Reference</td>
<td>Study Title</td>
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<tr>
<td>Hyland, Watts &amp; Fry. 2016. Australia.</td>
<td>“Rates of workplace aggression in the emergency department and nurses’ perceptions of this challenging behaviour: A multimethod study”</td>
<td>A multi-method study.</td>
<td>The aim of the research was to identify patterns and characteristics of challenging behavior in the ER and explore nurses views about the treatment of those patients. The study was conducted in two phases at two hospitals. In phase 1, a review of 12 months was held. In phase 2 a survey was implemented towards the ER nurses perceptions about the treatment of challenging patients. Inclusion criteria for the staff, one year working in the ED (n=53).</td>
<td>The results showed that all participant in the study were victims of verbal abuse in the previous 12 months. and it was a frequent form of WPV. The appearance of WPV was high in the ERs towards the nurses. Physical and verbal abuse was reported in the survey multiple times. The most common shifts for WPV as reported were evening and nightshifts. Themes emerged from the study included need for security in the ER, limitations to open access and the imbalance in understaffing. Multiple participants reported that caring for a patient, who had been acting previously challenging, was hard. A suggestion was made that the formulation of an aggressive response team could be beneficial.</td>
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<td>Huttunen, Joronen &amp; Rantanen. 2018. Finland.</td>
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<td>The aim of the research conducted in a University hospital ED was to assess violent</td>
<td>The data was collected from the security providers incident records, in 2015. Altogether four-hundred-eighty-seven incidents</td>
<td>The inclusion criteria were fulfilled, when a nurse’s safety was compromised due to verbal or physical abuse. The areas of the ED included specialized health care, communal health care and the hospitals general facilities. The security officers reported incident rate of sixty-two procent (n=304) of verbal abuse and thirty-eight procent (n=183) of physical assaults in the ED</td>
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“A register-based study on violence endangering nursing staff’s occupational safety in the emergency room”.

incidents as an occupational risk, the places in the ED that they happened and the prevalence of the phenomena. were reported by the security staff about WPV against nurses and the results were analyzed under different categories due to the place and time that the act occurred.

in which they were called into secure the scene. In ninety-eight procent (n=468) of the reported incidents the perpetrator was a patient. The relatives of the patients only played a small role in the results.

The reports that the security officers filed, revealed an incident rate for verbal abuse sixty-two percent (n=304) and physical assault rate of and thirty-eight procent (n=183).

The most common shifts in which a violent physical act was perpetrated was the evening or night shift and in the area of the specialized health care. In the communal health area, the most prevalent act was verbal abuse. The report also included violence towards the security staff after they were called to the scene. WPV aimed to the nursing staff was listed to the reports, if it was physical or verbal. The reports also included a threatening approach done by the patients towards the health care staff as an act of direct physical injury.

Forty-eight procent (n=89) of the cases required the use of force by the security officers and in nineteen procent (n=58) of the cases the situation was resolved with the mere presence of a security officer. In only fifty-six cases (n=56), the use of restraints was needed.


“I’m going to learn how to run quick’: Exploring violence directed towards staff in the emergency department”.

A qualitative study, which examined ED staff experiences and perceptions towards violence and violent behavior directed towards them. Semi structured interviews were held and close observation in the selected four EDs’ were performed for three days each. Reports about incidents written about WPV were included.

Sixteen (n=16) members of staff were recruited in the interviews with twelve (n=12) of them. Data was collected through incident reporting, ethnographic observation and staff interviews. The impact of WPV were seen in three levels which were workforce, patient level and departmental.

Many employees in the ED reported that WPV and a risk for it was a part of the job. The observer in the ethnographic studies, made a remark that to the outside people, not coming from a health care sector, the appearance of possible patients whom are aggressive may seem disturbing. The departmental level the WPV effects is that when a violent incident happens, the workforce of the ED in bonded to the aggressive patient and takes away time from the other patients.
having nursing background. Two healthcare (n=2) assistants were in the data. No doctors were included in the interviews. Minimum work experience 18 months.

Conclusions in the survey stated that more research must be done to thoroughly assess the risk for WPV to be able to see it properly.

<table>
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<tr>
<th>Study</th>
<th>Description</th>
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<tr>
<td>Morphet et al. 2014. Australia</td>
<td>“At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses”. This qualitative research aimed to explore the causes for workplace violence and its occurrence in the ED. The research was done with the The Delphi technique. It was used for consensus-building and made in three phases. The participants in the study were triage nurses, nursing managers but also regular staff nurses. The sample size was N = 157 in the first part. N = 132 in the second section. N = 158 in the third part. Substance abuse and long waiting in the emergency department queues were the most common traits leading to workplace violence. Compassion fatigue was seen as a problem by seven nurses from the triage. The biggest pressure point was the triage, where the patients register to wait for the doctor’s evaluation. Almost all of the nurse participants in the survey called out for enforcing a zero-tolerance policy. The problem of workplace violence was also seen as a provocation by the employees themselves due to communication issues. According to the results, many different reasons accumulate to the appearance of violence.</td>
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<tr>
<td>Ogundipe et al. 2013. Nigeria</td>
<td>“Violence in the emergency department: A multicentre survey of nurses’ perceptions in Nigeria”. A questionnaire-based survey was performed to nurses working in six hospitals. Eighty-one (n=81) nurses were interviewed in the study. Most of the respondents were female. The respondents were aged 25-57 years. The survey was conducted. The most common perpetrator of a violent act was a male visitor in the ED. 15.8% of the participants reported of being subjected to a threat using a gun in the previous year. The most common time for WPV to appear was evening and the survey stated that all of the hospitals lacked even basic WPV training. The research conducted in Nigeria reported that sixty-five percent of eighty-one male and female respondents had been subjected to WPV.</td>
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| **Park et al. 2017. Republic of Korea.**  
**“Hardiness Mediates Stress and Impact Level in ED Nurses Who Experienced a Violent Event.”** | **within two months, October-November 2009** | The participants felt that availability, respect, support and responsiveness could help in minimizing the appearance of WPV. Reasons for WPV as reported were substance abuse, the use of alcohol, lack of proper security and waiting time. | **Reasons for WPV as reported were substance abuse, the use of alcohol, lack of proper security and waiting time.** |
| | **This secondary analysis study researched the possible mediating effect of hardiness, between impact and stress level of nurses working in the ED.** | A visual analog scale was used to examine the impact of WPV. The participant rate was 321 (n=321) in the study and they were selected from a previously performed research about assault response. | **Personal attributes, such as hardiness can mitigate the effect of WPV in the emergency setting in nurses.** |
| | **A visual analog scale was used to examine the impact of WPV.** | **Verbal violence was reported by the participants in the ER multiple times.** |  |
| | **The sample size was 330 (n=330) ED staff working in four public hospitals working in the metropolitan health service are in Queensland, Australia.** | **ED nurses’ level of stress can rise after a WPV incident and its level can become lower if an attribution of hardiness is involved within them.** |
| **Partridge & Affleck. 2017. Australia.**  
**“Verbal abuse and physical assault in the emergency department: Rates of violence, perceptions of safety, and attitudes towards security.”** | The aim of the research was to explore the rates of WPV in the ED by the workers, their view of safety and possible attitudes towards security staff and reporting of WPV. | The mere presence of security guards benefitted the feeling of security in the ED. Nurses were the most common victims of WPV in the hospitals and the reporting of WPV was highest among them. Official reporting was not performed in all of the WPV cases. | **The mere presence of security guards benefitted the feeling of security in the ED. Nurses were the most common victims of WPV in the hospitals and the reporting of WPV was highest among them. Official reporting was not performed in all of the WPV cases.** |
| | **A phenomenological approach was selected, a purposive sample of nine (n=9) nurses were included in the study done in a focus group meeting.** | **Almost 90% of the participants reported of being subjected to verbal WPV in the prior six months. 53 procent of nurses reported of being subjected to physical assaults in the ED in the previous six months.** |  |
| | **The research findings stated that the nurses felt WPV as something that could not be avoided in the ER setting.** | **Possible resilience factor was found in the results towards acts of WPV among the ED workers.** |
| **Ramacciati, Ceccagnoli & Addey. 2015. Italy.**  
**“Violence against nurses in the triage area: An Italian qualitative study”** | A qualitative study, done with focus groups to investigate the feeling of nurses, after WPV had occurred. | The research findings stated that the nurses felt WPV as something that could not be avoided in the ER setting. | **The impact of WPV was seen through feelings of inadequacy as nurses, by not being able to prevent WPV. Nurses felt that they also triggered the violent acts themselves. The respondents brought forth feeling of being left alone in the aftermath of a violent act.** |
The nurses were selected from 7 different EDs in Tuscany situated in Italy. The gender of the participants played a key role in the emotional response to WPV. Acts of WPV had serious impact on the nurse’s wellbeing working in the ER. Some of the nurses thought that WPV in emergencies is unavoidable.

“ Violence and aggression in the emergency department is under-reported and under-appreciated”.

The purpose of the study was to find out reporting levels of WPV and study the attitudes of staff on violence and reporting the incidents forward. The study was done as one-month qualitative audit in a New Zealand ED. The results showed that reporting WPV in the ED was not done regularly. The ED admitted 7896 patients during the audit month.

Reporting violent incidents in the ER were not done regularly. WPV was verbal, but also physical and the most common place for violent acts was the monitor/resuscitation room. WPV can only be tackled with a proper reporting program, to see the full impact of the violence happening in the ED.

"A cross-sectional study on the prevalence and associated risk factors for workplace violence against Chinese nurses”.

A cross sectional questionnaire was performed. Stratified random sampling was done in December 2014 to January 2016, to explore the characteristics of WPV and to seek out possible risk factors for its prevalence. Forty-four tertiary hospitals and ninety county level hospitals were included in the study. 21 360 questionnaires were distributed, and 15 970 participants were included in the research. The prevalence of workplace violence in all the respondents included was sixty-five-point-eight percent. The research revealed that out of 15 970 respondents working in hospitals and emergency departments, over half reported of being subjected to WPV through verbal and physical abuse.

Violence was most common in the emergency ward and in the pediatric department. The nurses work experience, age of 30 years or less, the workplace and direct contact with the patients increased the risk for WPV. High risk for WPV was also linked to working in rural areas of the country, which was possibly related to the cultural standards of the area. Age is commonly respected in China, so this could also explain why younger nurses experience WPV more often as explained in the research.

A change of cultural atmosphere was recommended, so that nurses’ professionalism should be respected throughout the medical area.
**Wolf, Delao & Perhats. 2014. USA.**

“Nothing changes, nobody cares: understanding the experience of emergency nurses physically or verbally assaulted while providing care”.

| The aim of the study was to collect descriptive data about workplace violence and its impact towards ED nurses in America. | A qualitative descriptive exploratory design. Forty-six written narratives were submitted by email, which described the violent incident they had succumbed to in the ED. Eight participants were men, thirty-seven women and one nurse who did not report gender. | The results were categorized under themes of environmental, personal and cue recognition. Environmental themes included culture of acceptance towards violence. The participants brought forth a deep concern, that although physical injuries were reported to authorities, they officials were unwilling to press charges because it would end up in nothing and waste resources. Personal themes included reports of injuries, denial of the impact of the violent acts, transferring to another workplace but also accepting the violence as a part of the job. Cue recognition talked about the impact of violence in a setting which was acted upon without provocation. Concerns was also brought forth about high-risk patients, whom were not properly identified dangerous and their behavior was not restricted or controlled by the health care staff. |
### Appendix 3: Evaluation of observational studies applied from STROBE statement.

| Name of author/authors | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | Score |
| ALbashtawy & Aljezavi  | + | + | + | + | + | +/- | + | + | + | +/- | +/- | + | + | +/- | - | + | + | + | +/- | + | + | 19/22 |
| Abdellah & Salama 2017 | + | + | + | +/- | +/- | +/- | - | + | + | +/- | +/- | +/- | +/- | +/- | + | - | - | - | +/- | - | 12.5/22 |
| Alyaemni & Alhudaithi 2016 | + | + | + | + | +/- | +/- | +/- | + | + | +/- | +/- | +/+ | + | +/- | + | + | + | +/- | +/- | +/- | + | 17.5/22 |
| Darawad et al. 2015     | + | + | + | +/- | +/- | +/- | + | + | + | +/- | + | + | + | +/- | +/- | + | + | + | + | + | + | 19/22 |
| Gillespie et al. 2014   | + | + | + | + | +/- | + | + | + | +/- | +/- | +/- | +/- | +/- | +/- | + | + | +/- | + | + | +/- | + | 18.5/22 |
| Gillespie et al. 2017   | + | + | + | + | +/- | +/- | + | + | + | +/- | + | + | + | +/- | +/- | + | + | + | + | + | + | 19.5/22 |
| Huttunen et al. 2017    | + | + | + | + | +/- | + | + | + | + | + | + | x | + | +/- | x | + | + | + | + | + | - | 18/22 |
| Name of author/authors | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | Score |
|------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|     |
| Hyland et al. 2016.    | +  | +  | +  | +  | +  | +  | -  | +  | +  | +  | +/-| +  | +/-| +  | +/-| +  | +  | +  | +  | +  | +  | 19,5/22 |
| Park et al. 2017       | +  | +  | +  | +  | +/-| +/-| +  | +  | +  | +  | +/-| +  | +/-| +  | +/-| +  | +  | +  | +/-| +  | +  | +  | 18,5/22 |
| Partridge & Affleck. 2017 | +  | +  | +  | +  | +/-| +  | +/-| +  | +/-| +  | +/-| +  | +/-| +  | +/-| +  | +  | +/-| +  | +/-| +  | +  | 18/22  |
| Richardson. 2018.      | +  | +  | +  | +  | +/-| +/-| -  | +  | -  | +  | +/-| +  | +/-| -  | +  | +/-| +  | +  | +/-| +  | +  | +  | 16,5/22 |
| Shi et al. 2017.       | +  | +  | +  | +/-| +  | +  | +  | +  | +  | +  | +  | +  | +/-| +  | +/-| +  | +/-| +  | +/-| +  | +  | +  | 19,5/22 |
| Ogundipe et al. 2012   | +  | +  | +  | +  | +/-| +/-| +/-| +  | -  | +  | +/-| +/-| +  | +/-| +/-| +  | +  | -  | +  | +  | x  | +  | 13,5/22 |

Questions included in the Strobe-checklist:

+ discussed in the study.
+/- no throughral discussion
- no discussion present.
x not applicable
**STROBE-checklist.**

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<td>Is the study's design visible and does the abstract provide information</td>
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<td>What is the scientific background of the study</td>
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<td>3.</td>
<td>Objectives mentioned</td>
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<td>4.</td>
<td>Main elements of the study design discussed</td>
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<td>5.</td>
<td>Is the data collection explained</td>
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<td>6.</td>
<td>Eligibility criteria of the study participants discussed</td>
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<td>7.</td>
<td>Outcome, potential confounders and modifiers discussed</td>
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<td>8.</td>
<td>Potential variables carefully discussed</td>
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<td>Was there any bias in the study</td>
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<td>How was the study size selected</td>
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<td>How was the quantitative data reported</td>
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<td>12.</td>
<td>Was discussion about statistical methods</td>
</tr>
<tr>
<td>13.</td>
<td>Number of participants excluded and included</td>
</tr>
<tr>
<td>14.</td>
<td>Demographical variables are mentioned and discussed, study size discussed</td>
</tr>
<tr>
<td>15.</td>
<td>Summary of data reported</td>
</tr>
<tr>
<td>16.</td>
<td>Unadjusted findings in the study reported</td>
</tr>
<tr>
<td>17.</td>
<td>Was there any other analysis done</td>
</tr>
<tr>
<td>18.</td>
<td>What are the findings of the study compared to</td>
</tr>
<tr>
<td>19.</td>
<td>Were there any limitations in the study, point of bias</td>
</tr>
<tr>
<td>20.</td>
<td>Did the study findings answer the original research question</td>
</tr>
<tr>
<td>21.</td>
<td>Can the findings be used</td>
</tr>
<tr>
<td>22.</td>
<td>Was funding mentioned in the study and was it discussed</td>
</tr>
</tbody>
</table>
Appendix 4: Evaluation of qualitative studies and their score applied from CASP-checklist.

<table>
<thead>
<tr>
<th>Name of author/authors</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angland et al. 2013</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>8,5/10</td>
</tr>
<tr>
<td>Gillespie et al. 2013</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>6/10</td>
</tr>
<tr>
<td>Hassankhani et al. 2018</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>9/10</td>
</tr>
<tr>
<td>Hogarth et al. 2016</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>8/10</td>
</tr>
<tr>
<td>Howerton Child &amp; Sussman. 2017</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>9,5/10</td>
</tr>
<tr>
<td>Knowles et al. 2013</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>9,5/10</td>
</tr>
<tr>
<td>Morphet et al. 2014</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>8/10</td>
</tr>
<tr>
<td>Ramacciati et al. 2016</td>
<td>+</td>
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<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>7,5/10</td>
</tr>
<tr>
<td>Wolf et al. 2014</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+/-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>6,5/10</td>
</tr>
</tbody>
</table>

Questions included in the CASP:

+ discussed in the study.
+/- no thorough discussion
- no discussion present.
Quality assessment applied from CASP-checklist questions:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aims of the research stated</td>
</tr>
<tr>
<td>2</td>
<td>Can the qualitative method be applied</td>
</tr>
<tr>
<td>3</td>
<td>Did the research design address the aims of the research</td>
</tr>
<tr>
<td>4</td>
<td>Was the recruitment strategy explained</td>
</tr>
<tr>
<td>5</td>
<td>Did the collection of the data address the original research question</td>
</tr>
<tr>
<td>6</td>
<td>Did the researcher critically examine their own role</td>
</tr>
<tr>
<td>7</td>
<td>Did the study address ethical issues</td>
</tr>
<tr>
<td>8</td>
<td>Was the data analyzed and with methods</td>
</tr>
<tr>
<td>9</td>
<td>Are the findings stated in the study</td>
</tr>
<tr>
<td>10</td>
<td>Is the study valuable</td>
</tr>
</tbody>
</table>