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Current Knowledge and Future Directions Regarding Workplace Violence in Emergency Medicine

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ABSTRACT

In the United States (US), workplace violence (WPV) is a growing problem, especially in the healthcare industry. For all US workers, assaults rank third in terms of occupational injury-related fatalities. The Emergency Departments (EDs) have been especially designated as high-risk environments for WPV among all healthcare settings. With the aim of reducing WPV in EDs, this paper summarises recent epidemiology and research on the topic, provides

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practical steps and resources that ED clinicians and management can use, and identifies topics for further study. There is also a list of resources for WPV prevention. Discussion: Compared to other healthcare settings, ED staff members are far more likely to be physically assaulted. WPV in the ED is a preventable public health issue that requires swift and thorough response, just like other types of violence like elder abuse, child abuse, and domestic violence. A work-site-specific study of their ED can be obtained by ED physicians and ED leadership. They can also use site-specific violence prevention treatments at the individual and institutional levels. Finally, they can advocate for policies and programmes that lower the risk for ED WPV. The victims, patients, departments/institutions, and ED health care staff are all negatively impacted by violence against these professionals. Stakeholders must act quickly to reduce ED WPV by continuous study of efficient Emergency Medicine-specific therapies. To design such interventions, coordination, teamwork, and a proactive commitment are essential.

Keywords: Emergency Medicine; Emergency Department; assault; workplace injuries; workplace violence;

INTRODUCTION

In a study of emergency physicians in Michigan, more than 25% report having experienced physical assault in the previous year (1).

In the previous three years, almost the same percentage of emergency nurses had been physically assaulted at least 20 times (2). Health care professionals experience more workplace assaults than workers in any other sector (3). In comparison to all other jobs, assaults (often committed by one of their patients) caused 7% of the occupational injuries suffered by nursing, psychiatric, and home health aides between 1995 and 2004. Nearly 30% of all workplace assaults occurred in these same occupations over the course of a ten-year period. This was any wide occupational group's highest representation of assaults (4). According to data from the Bureau of Labor and Statistics' Census of Fatal Occupational Injuries, from 1995 to 2004, 154 nursing, psychiatric, and home health aides died as a result of their jobs, accounting for less than 1% of all workplace fatalities during that time. Although automobile collisions accounted for the vast majority of these fatalities, homicide was the second most common reason for fatal occupational injuries. Homicide rates in this category were 36% higher than the overall average for occupational groupings (5).

The American College of Emergency Physicians, American Association of Critical-Care Nurses, Emergency Nurses Association, and American Nurses Association, among other organisations, have lately urged for improved violence prevention programmes in healthcare settings in response (6–9). This article's goal is to analyse the prevalence of workplace violence in emergency departments (EDs), identify risk factors and protective factors, and provide an overview of the most recent initiatives aimed at reducing workplace violence (WPV) in EDs across the country.

METHODS

The following key search terms were used by the authors during their literature review: attacks, workplace injuries, workplace violence prevention, and interventions. Although verbal abuse and threats are a common part of WPV literature, for the purposes of this article, WPV is defined as physical violence (battery) directed towards those who are at work or on duty. Gates et al. characterise this physical aggressiveness as striking with a body part,

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slapping, punching, kicking, biting, pulling hair, striking with an item, throwing an object, spitting, beating, shooting, stabbing, squeezing, and twisting (10). Articles not addressing actual batteries were thus omitted. Only research carried out in the United States were included in the review (US). Although there are instances of violence outside of the emergency department, such as the recent shooting of a surgeon at Johns Hopkins Hospital, the emphasis of this research is the ED.

DISCUSSION

Workplace Violence in the Health Care Sector

Health care professionals are at a greater risk of suffering violence at work because it is frequent in many healthcare settings. 17% of all non-fatal workplace injuries caused by assault and aggressive acts occurred in the education and health care sectors in 2008. (11). although the homicide rate for healthcare professionals is lower than for other occupations, the assault rate for this group peaked in 2007. (12). Patients committed the bulk of attacks in the healthcare sector (59%), although tourists also contributed significantly to the total (4). Due to the massive under-reporting in the medical field brought on by a lack of institutional reporting procedures or the belief that attacks are inevitable in the workplace, the real number of events is significantly greater (13–16). Health care professionals in emergency departments frequently fail to report assaults or battery when no harm was done. In one study, nurses identified hurdles to reporting WPV as fear of reprisal, a lack of support from hospital administration, and poor ED management (2).

Workplace Violence in the ED Setting

Among medical facilities, EDs are considered to be particularly high-risk locations for WPV (15,17–20). 78% of doctors reported at least one act of physical or verbal aggressiveness in the previous 12 months, and 21% reported more than one episode, according to a national study of Emergency Medicine residents and attendings who work at EDs with Emergency Medicine residency programmes in the United States (21). More than 50% of emergency medicine residents had been physically pushed or attacked by patients before completing training, according to a 1993 poll. Fear of an assault or being shot was their second-highest concern, behind being pricked by a patient with the human immunodeficiency virus with a needle (22,23). These stories are alarming because emergency room doctors believe that more violence is being threatened. This is corroborated by the Michigan survey's finding that 44% of emergency physicians said that violence in their ED had made them feel less secure than in the past (1).

Evidence suggests that nurses who work in emergency departments are more likely to experience violence and experience physical assaults at higher rates than other nurses (15,18,24). Both emergency room doctors and nurses are susceptible to aggressive outside-the-ED conduct, such as stalking, and violent acts like physical assault (1,15). According to Gates et al. (2006), 67% of nurses, 63% of patient care assistants, and 51% of doctors have experienced physical attack by patients at least once in the preceding six months (10). In a survey conducted in 50 hospital emergency departments in New Jersey, about one-third of nurses reported having been physically abused (13). In a more recent study, 25% of emergency nurses who responded to the survey said they had been physically abused more than 20 times in the previous three years (2)

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Consequences of Workplace Violence

Anecdotally, emergency physicians believe that violence and a generally chaotic environment are "part of the job," and they take some satisfaction in how well they and their staff are able to function in such a setting. However, this attitude may eventually wear down ED staff members. WPV may severely reduce ED staff productivity and job satisfaction in addition to the immediate concern of personal safety, which could result in lost workdays and early burnout. 81% of emergency physicians who recently completed a poll said they periodically worry about WPV; as a result of this worry, 16% of doctors thought about leaving their hospital, and 1% actually did (1). The authors contend that dealing with physical aggressiveness and verbal threats to one's safety adds to the stress already felt by medical professionals who deal with patients who are traumatised by violence and injuries on a daily basis.

WPV may have a greater impact on non-physician workers. According to a poll of 65 US emergency departments, nurses feel the least safe out of all ED personnel (25). The extent to which nurses from emergency departments at Level I trauma hospitals feel insecure and unprotected and fear "anything could happen at any time" is highlighted by focus groups.

(26). ED nurses have stated that WPV causes professional burnout in various studies (8,13,15,25). These strains reflect a working climate that may not be sustainable for many health professionals (27,28).

Why are physical assault rates higher in the ED? Examining the aspects of the ED environment that raise the risk of WPV in comparison to other health care settings is the first step in understanding WPV in the ED setting. First, because ED visits are sudden and unscheduled, and because patient outcomes are unpredictable, patients and their families frequently go through intense stress. In addition to violent patients, emergency room doctors and nurses may also encounter the patient's relatives or family (1,15,29). Additionally, we may be exposed to those who wish to harm the patient, particularly those who engage in domestic or gang violence. Other patient-related factors that nurses perceive as being connected to violence include intrinsic mental health issues, anger related to the patient's situation or condition, frustration with delays or unmet needs, pain, delirium, intoxication, and anger at staff members related to the enforcement of hospital policies (15,24,26).

Patients who were drunk or high accounted for between 27 and 60 percent of the violent incidents. These patient traits are exclusive to the ED environment.

These patients are frequently taken in by the police for public intoxication, even though they frequently don't want to be there. Since they stay in the ED until they are clinically sober, these patients also have quite extensive staff exposure times. These elements, together with the lengthy waits that are frequently required due to crowding, raise tension and agitation levels and frequently result in physical aggressiveness (31–33).

A lack of security on the premises might exacerbate these characteristics, which foster violence, even though the patient mix found in EDs cannot be changed. There aren't many research that detail ED security procedures. Only around a quarter of hospitals had security officers who were continuously assigned to the emergency department, according to a Michigan research. Another 24% of EDs had general hospital security staff who occasionally made rounds in the ED to protect ED staff (1). Lack of metal detectors or alarms, which makes it easier for weapons to enter the hospital, a lack of trained security officers, and a lack

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of metal detectors or alarms have all been noted to contribute to violence in the emergency department, despite the lack of conclusive data on effective security measures (10,26).

Overview of Interventions for Workplace Violence in the ED

Numerous intervention programmes that concentrate on reducing hostility toward ED staff have been developed in response to these alarming figures. These interventions take several different approaches to the WPV issue. 1) Individual medical staff member training; 2) alterations to the ED's physical layout and security; and 3) modifications to local (institutional/state) and federal policy. An overview of these three degrees of violence interventions that might be used in the ED context is intended in the following section.

interventions at the individual level. These interventions centre on teaching medical staff to see warning indications of impending violence, prompt and appropriate reactions to patients and visitors who become increasingly aggressive, handling violence, crisis intervention for WPV victims, and reporting violent acts (34,35). This kind of intervention aims to teach ED medical professionals non-violent conflict resolution techniques and how to recognise building tension and rage.

In order to respond to aggressive or abusive people with firmness and assertiveness while avoiding confrontation, role-playing exercises are frequently used (36). A review of the institution's WPV policies and procedures as well as an introduction to the security system may be included in this staff training. De-escalation strategies and the appropriate use of restraints may also be included in ED-specific training.

There haven't been many studies of these strategies among ED workers. Few individual-level interventions were evaluated for effectiveness at all, and those that were evaluated did not use a rigorous design, according to a recent systematic review of WPV interventions in other health care settings like forensic hospitals, state-supported mental hospitals, long-term care facilities, community homes, and Veterans Administration (VA) hospitals (34). Although such programmes increase knowledge and confidence to deal with violent episodes, they do not always show a decrease in assaults, according to one systematic review of WPV that focused on individual level interventions in health care settings (training and techniques of dealing with combative patients in ED, geriatric or nursing homes, and mental health facilities) (37). Additional study on ED is required to pinpoint crucial, efficient training elements using assaults as an outcome metric.

There haven't been many studies of these strategies among ED workers. A recent study examined WPV therapies in forensic medicine and other health care settings. Few individual-level interventions were assessed for effectiveness at all in hospitals, state-supported mental institutions, long-term care facilities, community homes, and Veterans Administration (VA) hospitals. Those that were reviewed did not employ a rigorous design (34). Although such programmes increase knowledge and confidence to deal with violent episodes, they do not always show a decrease in assaults, according to one systematic review of WPV that focused on individual level interventions in health care settings (training and techniques of dealing with combative patients in ED, geriatric or nursing homes, and mental health facilities) (37). Additional study on ED is required to pinpoint crucial, efficient training elements using assaults as an outcome metric. Security and physical structural modification. Among these measures are changes to the department's physical layout, the addition of security officers, dogs, and tools. Metal detectors, hand screenings of patients arriving by ambulance, and a visible security presence in the emergency department 24 hours a day are just a few of the

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security measures that have been discovered for reducing violent events (22,38–40). In a hospital, conducted electrical weapons have recently been used, with maybe positive outcomes (41).

A common response to threats of serious violence is the use of metal detectors. Several reviews of metal detector use show that the public and staff feel safer if metal detectors are employed, despite the absence of conclusive data to support the claim that metal detectors alone have an impact on violence in the emergency department (42,43). However, the majority of these studies are more than ten years old and might not accurately represent the present-day ED. One study found that installing metal detectors considerably increased the number of weapons seized in an urban emergency department (ED), but it did not show a decline in incidence of deliberate physical assaults against ED employees (44). Other restrictions on metal detectors exist. It is expensive to install these at every door because many hospitals have several points of entry. To monitor and disarm people, trained employees are also required. Alternately, the use of guard dogs in the emergency department has been proposed to show potential as a deterrent to violence in the ED, but further research is required to draw firm conclusions (43,45).

Mirrors, alarm systems, panic buttons, sufficient lighting and visibility, hallway surveillance, physical barriers between employees and the general public, and the removal of isolation rooms are some other often used modifications to the ED's architectural structure (43,46). A TV monitor at initial registration to warn the registrant and reassure the worker, as well as limiting access to the ED, have all been suggested as methods to reduce violence, albeit there are no concrete numbers to back this up (39). The ideal connection between the institutional security system and local law enforcement agencies, as well as the best practises for ED-specific security measures, both require more study.

Policy-level interventions. At the institutional, municipal, state, and federal levels, this category covers work practises, policies, and initiatives that support a safe workplace (47). The American College of Emergency Physicians and the Emergency Nurses Association agree that violence in EDs is a serious problem, and they both urge clinical care providers and health organisations in general to take action to prevent and lower the risks of WPV (9,48). To increase the safety of ED staff and patients, leaders in emergency medicine and healthcare must continue to advocate in this manner.

Interventions and Approaches to Decrease WPV

Given the lack of research in this area to date, the Occupational Safety and Health Administration (OSHA) guidelines and other resources for WPV prevention programmes, such as Henson's "Situational crime prevention in EDs," describe a number of components that can also be used as a template for initial steps to address WPV in the ED (54–57). In order to lower ED WPV, ED leaders must first secure management and institutional commitment.

Management commitment: Administration support and staff participation are required for a workplace violence prevention programme (59). The company must promote the idea that violence and aggressiveness are unacceptable, that it values the safety and well-being of its employees, and that it will not tolerate violence and will take appropriate action against offenders (60). One difficulty is that people in positions of decision-making are rarely trained on employee security and safety. The patient is the main focus of most safety programmes, not the worker. The majority of administrators have backgrounds in medicine or nursing.

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Administrators are concerned about how the public may react when safety measures like metal detectors are implemented (22).

The company needs to do a work-site-specific analysis that evaluates the risk factors for violence in the hospital's department and community hospital in question. The number of psychiatric patients or patients with substance use disorders treated annually in the ED; the patient population of victims of violence with a potential for in-unit retaliation (such as gang violence); an assessment of staffing ratios; and the prevalence of handguns and weapons in the community or carried into the ED by patients are the main risk factors for violence in the ED (61). Risk elements that are a result of the hospital's environmental design, such as dimly illuminated hallways, rooms, and other areas like parking lots, should also be taken into account (19). Third, put site-specific interventions into place to lessen WPV in the particular ED.

After the work-site analysis is complete, a site-specific intervention may be created. Despite the complexity of WPV, there are obvious steps that may be taken to increase the safety of ED personnel (62). Gates et al. created an action plan that leadership can use to begin developing interventions that may reduce violence in the ED using an action research plan, which included gathering the best available evidence and input from all stakeholders (ED workers, managers, security, and patients). (62). A summary of starting actions and prospective interventions that might be made to improve worker safety as well as a list of resources to help with the process, however they are not an exhaustive list.

LIMITATIONS

Inherently hampered by recollection bias, several of the studies are based on survey data that was gathered retrospectively. It is challenging to extrapolate the outcomes from the majority of research describing the WPVor an intervention because they were carried out at solitary sites. Additionally, a lot of the studies are small or have methodological issues that make it challenging to generalise the findings or suggestions. Following an integrative literature evaluation of measures to lessen violence towards ED nurses, Anderson et al. reached a similar finding (63).

CONCLUSION

WPV has become a serious issue that jeopardises the safety, self-worth, productivity, interpersonal connections, and general health of ED staff. Large, well-designed studies that support any intervention intended to stop ED WPV are scarce. All that is left are the rules and advice provided by organisations like the Occupational Safety and Health Administration. The idea that violence in emergency departments is "part of the job" needs to be abandoned by the field of emergency medicine. The field of emergency medicine needs to progress toward developing evidence-based regulations and interventions that safeguard staff, give each employee a safe working environment, and enable staff to offer the greatest care to patients while still being happy in their jobs. The issue of WPV needs to be addressed more urgently by stakeholders in the field of emergency medicine through ongoing research on efficient interventions unique to emergency medicine, coordination, cooperation, and active commitment, as well as legislation, in order to promote an effective and safe ED work environment.

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