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Review

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

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ABSTRACT

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

1. Introduction

Violence against healthcare workers has been considered a significant problem in the United Kingdom (UK) and worldwide [1,2]. The latest UK statistics demonstrated that there were 70,555 total reported assaults on National Health Service (NHS) staff in the last year [3]. A systematic literature review of patient and visitor violence in general hospitals from multiple countries showed that on average 50 per cent of healthcare staff reported experiencing verbal abuse and 25 per cent had experienced physical abuse [4].

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

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

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

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

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

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

2. Method

2.1. Search strategy

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

The following inclusion criteria were utilised:

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

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

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

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

2.2. Characteristics of included studies

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

2.3. Critical appraisal of papers

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

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

2.4. Analysis and synthesis

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

2.5. Reflexivity

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

3. Results

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

3.1. The inevitability of violence and aggression

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

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

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

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

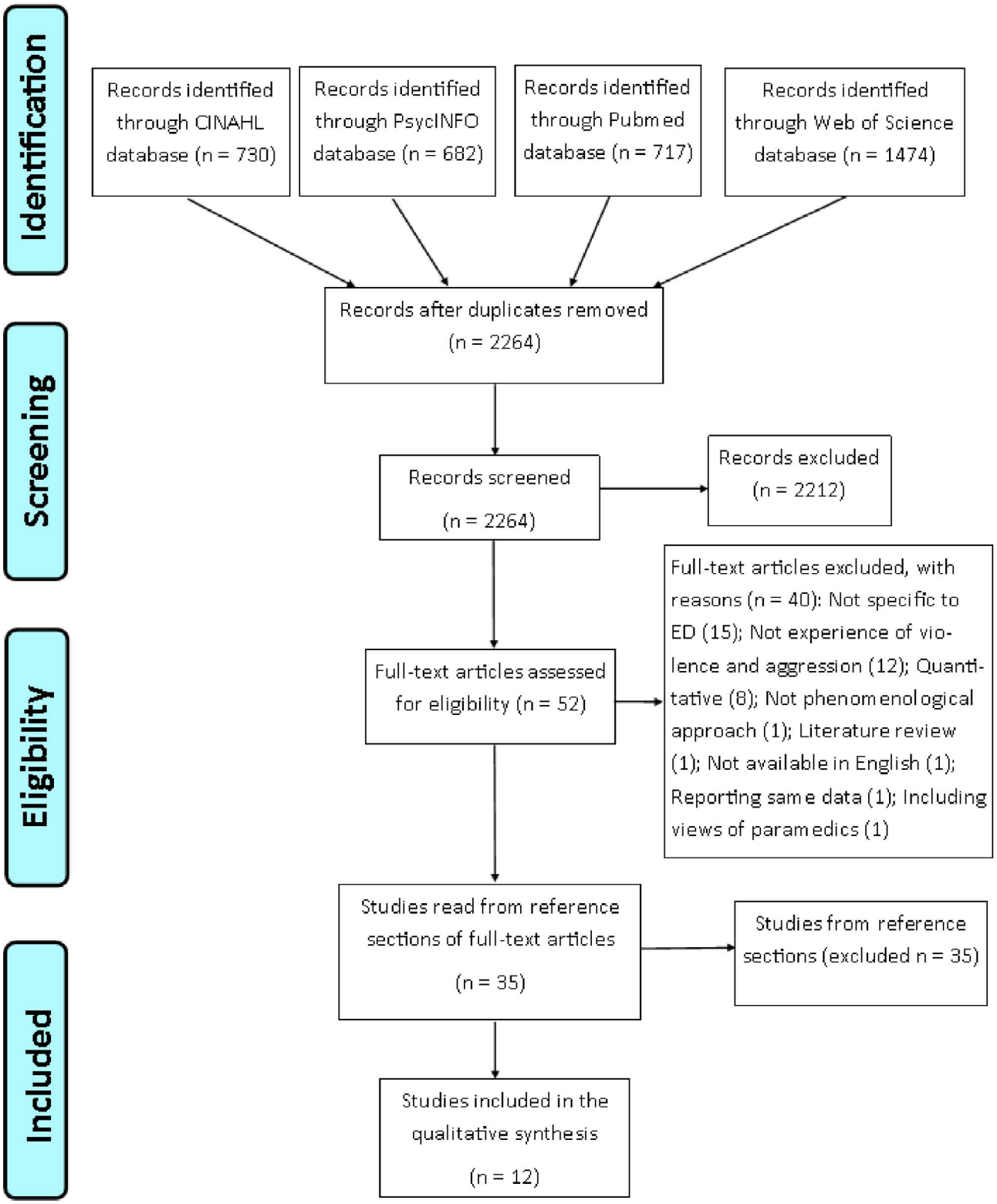

Fig. 1. PRISMA diagram of search strategy.

to see this happen. I finally asked if we were ever going to act on these signs and I was told that basically they were just put up for show [28]

A perceived lack of consequences and response from the organisation and police during incidents and towards the perpetrators of abuse also appeared to demonstrate that violence and aggression was tolerated in the ED: "Most irritating point, that riles me, is that the Trust states that they won't tolerate aggressive behaviour but don't back up the individual" [29]. Inadequate incident reporting procedures also contributed to staff's perceptions that preventing violence and aggression was not an organisational priority "people can swear at us, spit at us, bite at us…try and hurt us and nobody puts an incident report in" [30].

Table 1
Characteristics of included studies.

	Country	Aims of study	Stated Methodology	Data collection methods	Participants
Catlette [2005]	USA	To study the phenomenon of workplace violence by interviewing emergency nurses who had experienced violence while on duty	Phenomenology	One-to-one interviews	8 nurses
d'Aubarede et al. [2016]	France	To explore and describe the opthalmology emergency department personnel's experience of acts of violence and anti-social behaviour	Grounded theory, thematic content analysis	Field observations and semi-structured one-to-one interviews	30 staff; 15 nurses, 5 nursing auxilaries, 7 interns, 2 receptionists and 1 senior physician
Hislop & Melby [2003]	UK	To describe and explore accident and emergency nurses' lived experience of violence in the workplace in one major acute hospital	Phenomenology (Giorgi, 1985)	One-to-one interviews	5 nurses
Hyland, Watts & Fry [2016]	Australia	To explore emergency nurses' perceptions of caring for patients displaying challenging behaviour	Thematic analysis	Open-ended survey questions	53 nurses
Knowles, Mason & Moriarty [2013]	UK	To examine staff perceptions and experiences of violent behaviour directed towards them within the emergency department	Thematic framework	Incident reporting, ethnographic observation and staff interviews	16 nurses, healthcare assistants, receptionist or hospital attendant
Lancman, Mângia & Muramoto [2013]	Brazil	To learn about situations of violence at work and their impact on workers in an emergency room	Tranversal, exploratory, descriptive and observational study	Semi structured one-to-one interviews	11 staff from different professional categories including nursing, psychology, security
Luck, Jackson & Usher [2008]	Australia	To explore meanings that emergency department nurses ascribe to acts of violence from patients, their family and friends and what impact these meanings have on how they respond to such acts	Thematic analysis	Participant observation, one-to-one interviews, informal field interviews and researcher journaling	20 nurses
Pich et al. [2011]	Australia	To describe the experiences of a group of triage nurses with patient-related workplace violence during the previous month	Content analysis	Semi structured one-to-one interviews	6 nurses
Pich, Hazelton & Kable [2013]	Australia	To describe the experiences of australian emergency department nurses with episodes of patient-related violence from young adults	Content analysis	Semi structured one-to-one interviews	11 nurses
Ramacciati, Ceccagnoli & Addey [2015]	Italy	To investigate the feelings experienced by nurses following episodes of violence in the workplace	Phenomenology (Colaizzi method)	Focus groups	9 nurses
Tan, Lopez & Cleary [2015]	Singapore	To explore nurses perceptions of managing aggressive patients in an emergency department	Thematic analysis	One-to-one interviews	10 nurses
Wolf, Delao & Perhats [2014]	USA	To better understand the experience of emergency nurses who have been physically assaulted while providing patient care in US emergency departments	Narrative	Narrative accounts	46 nurses

Table 2
Quality appraisal scores.

	Research design	Recruitment strategy	Data collection	Relationship between researcher and participants	Ethical issues	Data analysis	Findings	Value of research	Total
Catlette [2005]	2	3	3	2	3	3	3	2	21
d'Aubarede et al. [2016]	3	2	2	2	2	2	3	1	17
Hislop & Melby [2003]	3	3	2	3	2	2	3	1	19
Hyland, Watts & Fry [2016]	2	2	2	1	2	2	2	2	15
Knowles, Mason & Moriarty [2013]	2	1	2	1	1	2	3	2	14
Lancman, Mângia & Muramoto [2013]	2	1	3	2	2	1	2	1	14
Luck, Jackson & Usher [2008]	3	1	3	2	2	2	3	2	18
Pich et al. [2011]	3	2	1	1	2	2	3	2	16
Pich, Hazelton & Kable [2013]	2	2	2	1	2	2	2	2	15
Ramacciati, Ceccagnoli & Addey [2015]	3	2	2	2	3	3	3	2	20
Tan, Lopez & Cleary [2015]	2	1	2	1	2	2	2	2	14
Wolf, Delao & Perhats [2014]	2	2	2	1	1	2	2	2	14

3.2. Staff judgments about why they face violence and aggression

Staff made judgements about the reasons for violence and aggression which appeared to help them to cope. Violence and aggression was judged depending on patient's capacity to control their behaviour. Where a person's capacity to act in a rational manner was reduced due to a physical health or psychosocial issue, staff tended to absolve patients of blame ("If the patient has dementia that's a bit different than a drunk patient or just a patient angry about waiting time" [19]). Staff were less tolerant towards perpetrators of violence or aggression when their presentation at EDs was regarded as not 'legitimate' "… take a look at yourself, you know you're not really that sick. You're here with a sore toe, there's people dying next door" [19].

One author identified that few staff acknowledged their role in precipitating violence and aggression, with many being unaware of signs of increasing aggression 'Cues or precursors to violence were often missed or ignored in nurses' narrative accounts' [28]. This sometimes led to violence being seen as an injustice, bringing about strong feelings of anger and rage "I want to scream and say how dare you" [31]. It was also harder for staff to understand why they had been subjected to violence and aggression when they were trying to help "…how could you do that? Tell me why. I did everything I could, even more than I was supposed to, and you turned violent. Why?" [27].

3.3. Managing in isolation

Narratives portrayed staff managing very challenging circumstances in isolation and in whatever way they could. A sense of abandonment underlay accounts where a physical absence of support staff and managers on the wards meant that staff 'often felt totally alone in a difficult and dangerous situation' [31]. Staff also described feeling uncared for by management "nobody cared at all, not even the head nurse. You feel abandoned" [27]. Without the perceived support of management, staff appeared to attempt any possible method of reducing violence and aggression "you need to …just be nice to them, do whatever you need to do" [32].

Within the accounts there was significant variety in how staff coped with violence and aggression. Cultural narratives, such as taking a 'stoic' stance to aggression appeared to influence staff in the Singapore study, and in one UK study 'every member of staff spoke of their commitment to working in the ED despite the aggressive incidents' [29]. However, on occasion, staff appeared to struggle to cope with violence and aggression, with some being unable to maintain their professionalism [33], and other staff appearing to minimise or attempt to forget episodes "You have to forget or you won't cope" [33]. Informal debriefing with colleagues was also used to cope with incidents which brought a sense of belonging "Outside the department no one seems to understand what it's really like but your colleagues do" [31].

3.4. Wounded heroes

Experiencing violence and aggression appeared to have significant consequences for staff including physical injury and reducing well-being and willingness to do their job. Staff described feeling upset, powerless and frustrated. Many staff discussed feeling fearful of violent patients returning to the ED "I'm always worried whether the person will come back" [26]. The experience of violence and aggression also appeared to have an effect on the ability or willingness of staff to do their job, which was exacerbated by physical injury "I ended up tearing cartilage in my left knee, ended up having surgery" [28]. Consequentially, violent incidents made some staff reluctant to work in the ED "…leaving you a little hesitant to work in triage" [34].

Other staff reported psychological 'pain' described as "wounds" or 'wounded professionalism' related to particularly difficult incidents [33]. One staff member eloquently shared the long-term impact of violence and aggression:

> A female patient…came into be treated. For some reason this triggered a post traumatic reaction for me. I instantly became very shaky, nauseated, and started crying…I then went to counseling for a couple of months, I think. My biggest hurdle…was [that I felt], and still do, feel like a victim, rather than getting to be in the 'superman' role [28]

This illustrates how difficult staff found simultaneously taking on the roles of hero and victim when caring for patients in the ED. Despite being victimised, staff who were not able to prevent violence and aggression experienced feelings of 'inadequacy and guilt' [27]. These accounts imply that staff's sense of self-worth was dependent on their ability to care and 'rescue' patients.

4. Discussion

The aim of this review was to synthesise studies exploring ED staff experiences of violence and aggression.

The first concept 'The inevitability of violence and aggression' illustrated how staff often resigned themselves to the experience of

violence and aggression due to the high frequency of violent incidents and a perceived lack of preventative and reactive measures being in place. Previous research has found that a lack of measures such as robust reporting procedures are seen as a sign of an organisation deprioritising effective management of violence and aggression [35]. Our findings are consistent with previous research showing normalisation of violence and aggression against staff in the ED [12]. Seligman's theory of 'learned helplessness' [36] suggests that when people have no perceived control over a negative situation, they give up trying to change the situation. This is thought to lead to depression, which would damage staff well-being in the long-term. Visible signs of the organisation prioritising dealing with violence and aggression might help prevent staff becoming helpless towards violent incidents.

The findings showed that staff appeared to make judgments about the causes of violence and aggression, which were based on the perpetrator's perceived capacity and intention. These judgments affected how staff coped with violence and aggression, and the extent to which they tolerated the perpetrator. The idea that nurses rationalise violence and aggression to cope with it has been documented elsewhere [12,37]. Weiner [38] postulated that peoples' causal attributions about whether behaviour is under the personal control of an individual affects their emotional responses to the behaviour. Markham and Trower [39] found that staff perceived that clients with a diagnosis of Borderline Personality Disorder were more in control of their behaviour than clients with depression or schizophrenia, which meant staff were less sympathetic towards the former group. This suggests that when challenging behaviour is perceived to be within a person's control, this has a negative impact on staff's sympathy and likelihood of helping. However, it is unclear precisely how staff in the current review responded differently based on their appraisals of violence and aggression which could be explored further in future research.

Very few staff acknowledged any role they may have played in the occurrence of violence and aggression, however research has suggested that ED staff's verbal and non-verbal communication may contribute to violence [40]. Additionally, emotionally depleted staff have been shown to be less tolerant of aggressive behaviour [41]. This suggests that staff may inadvertently trigger violence and aggression due to being unaware of their own role in violent interactions, which has implications for providing staff with greater understanding of their role in difficult incidents with patients.

The 'managing in isolation' concept suggested that staff often felt isolated when managing violence and aggression in the ED, which appeared to impact on their coping strategies. This concept could be understood in terms of attachment theory, which suggests that children's experiences with primary attachment figures form an internal working model for future relationships [42]. Ainsworth, Blehar, Waters and Wall [43] proposed that attachment styles depend on whether the child learnt that the caregiver was available, responsive or helpful when called upon. It has been posited that organisational leader-follower relationships may be influenced by attachment styles [44]. Within this review, it appeared that staff wanted support from management during violent incidents however they perceived that help was not available, which could be experienced as an ambivalent attachment style to frontline staff [43]. Research has shown that attachment styles can have an impact on how staff cope in response to work-related stress [45], which could offer an explanation for how the absence of management impacted on staff's coping strategies.

The final concept 'wounded heroes' demonstrated the significant impact that violence and aggression can have on staff's emotional and physical well-being and on their willingness to do their job. Previous research has shown that staff experienced a range of emotional responses to violence and aggression including anger, fear, guilt, self-blame and shame [8,46]. Our findings suggest that staff found it difficult to be a 'hero' if they were a 'victim', as staff's sense of self-worth was based on rescuing patients. This notion is consistent with Bowlby's [47] 'compulsive care-giving' attachment style whereby the person has learnt that the attachment bond is dependent on them giving care rather than receiving it. Some healthcare professionals have been considered to be vulnerable to being 'compulsive caregivers', and this pattern of relating to clients has been considered to contribute to burnout [48]. This style of attachment may also explain why staff can find it difficult to be in the 'victim' role as this places them in the position of needing care. This is a novel finding which may expand our conceptual understanding about staff's experiences of violence and aggression.

4.1. Recommendations for clinical practice

The findings showed that staff appeared to passively accept violence and aggression, often when preventative and reactive strategies were inconsistently enforced. One literature review suggested that zero tolerance policies are "largely impractical for clinicians in the ED" [14]. Victorian Health Services in Australia have published specific guidance around managing violence and aggression in acute care settings [49]. This document suggests that a standardised organisational response to violence and aggression is necessary through the use of a coding system, where different coloured codes refer to different levels of violent threat. As part of this response, five core principles for staff training were recommended, for instance tailoring training to staff groups.

The findings suggested that staff may be drawn into patterns of 'compulsive caregiving', which in psychological therapy is referred to as countertransference. Supervision can be an effective way of understanding and exploring countertransference [50], and has been shown to be beneficial for nurses through providing peer support and stress relief, promoting professional accountability and knowledge development [51].

4.2. Limitations and future research

The results of this review are inevitably reflective of the authors' own preconceptions and experiences, which may have differed had more authors been involved in the meta-synthesis. One particular strength of this review was the inclusion of papers from several different countries which potentially offers an international viewpoint of violence and aggression in the ED.

The precise mechanisms by which staff responded when they negatively appraised violence and aggression remain unclear. Future research should explore staff perceptions of their responses and behaviour following violent incidents. This could be achieved by conducting a mixed-methods study, through the use of questionnaires asking staff about their attributions, emotional response and helping behaviours alongside observation of ED staff after incidents.

5. Conclusions

This review provides an international perspective on frontline staff experiences of violence and aggression in the ED. A significant finding was that staff appraisals of the causes of violence and aggression affected how they coped and responded to patients which has implications for further escalation of violent incidents in the ED. Staff also struggled to be in the 'victim' role when caring for violent patients, which could negatively impact on them seeking care from staff and the wider organisation. A strong organisational commitment to reducing violence and aggression is needed through a focus on staff training and clinical supervision.

Conflict of interest

None.

Ethical statement

Not applicable.

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Appendices. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.ienj.2017.12.004.

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