

VIOLENCE IN NEW SOUTH WALES EMERGENCY DEPARTMENTS

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ABSTRACT

In 1999 the International Council of Nurses recognised workplace violence as a significant issue in nursing. During the same year the Australian Institute of Criminology reported that health was the most violent industry. This study examined the nature and extent of violence in NSW hospital emergency departments. Emergency nurses experienced violent incidents in their department, in the wards and outside the hospital setting. Every respondent (n=266) experienced some form of violence at least weekly. Ninety-two incidents involved lethal weapons. Ninety-two percent of perpetrators were patients or their relatives, however other staff members were also implicated. Non-reporting of violence is an issue as over 70% of incidents were not referred to authorities. Drugs, alcohol and emergency department waiting times are the most significant predisposing factors. Most emergency nurses are not satisfied with the response of administration to violent incidents within hospitals.

INTRODUCTION

The recent Australian Institute of Criminology report (1999) indicated that the Australian health industry was the workplace most affected by violence and registered nurses as the second highest in reporting violence (Perrone 1999:46). This situation is not isolated to Australia but is pandemic. In a 1999 press release the International Council of Nurses (ICN) recognised the risk and called for zero tolerance.

The emergency nurse may encounter many forms of violence. These include verbal abuse, physical threats, assault and emotional abuse. Many nurses believe that being on the receiving end of this type of violence is *part of the job* (Birkland 1991) however it is clear that this is not acceptable. While most emergency departments have installed security devices and restricted access to the department these actions appear to have had little, if any, impact on the level of violence experienced in the emergency department.

It is believed that nurses who constantly experience some form of inappropriately managed violence may suffer some long-term negative effects (Naismith 2000). The ICN (1999) clearly identify the deterioration of quality care, attrition from nursing and increased health costs as negative consequences of workplace violence. Consequently nurses' perceptions of what constitutes a violent act and what nurses believe to be an appropriate response need to be examined.

LITERATURE REVIEW

Violence in emergency departments (ED) exists worldwide. Violence covers a wide range of behaviours from physical assault to verbal abuse and can occur for a variety of reasons including excessive waiting times, overcrowding and social/cultural behaviours. The definition of violence varies but includes all behaviours that result in physical and/or emotional harm. Perrone (1999) identifies 21 acts that constitute violence. Social psychology researchers have attempted to provide theoretical perspectives on violence. The theory that appears to be relevant in the emergency departments is the frustration-aggression hypothesis (Berkowitz 1990; 1993; 1994). This theory postulates that a situation that becomes frustrating has the potential to result in aggression. In an emergency department this frustration may arise when a patient or their relative does not get the attention they expected or wanted, such as immediate pain relief.

If the patient is under the influence of drugs or alcohol their ability to cope with frustration is altered. Chermack and Taylor (1995) found that alcohol decreased tolerance to frustrating situations. This view is supported by Berkowitz (1990; 1993; 1994) and Wiseman and Taylor (1994). This appears to be corroborated in the nursing literature with alcohol, a factor in a significant number of violent incidences.

Blank and Mascitti-Mazur (1991) identified that 25% of teaching hospitals reported at least one incident of verbal abuse per day and one threat with a weapon per month. This study only included reported incidents. However, there are many incidences that are unreported (ICN 1999). Violent acts are not reported for a number of reasons. Mahoney (1991:284) states '*participants believe that there was insufficient time to complete reports [on violence] and that no real benefit was gained from reporting incidents.*'

Mahoney (1991) indicated that verbal abuse in EDs was a major concern and that some participants believed that their attitude might incite some instances of violence. She found that verbal abuse often included the threat of physical violence, metropolitan areas experience more violence than rural areas, and that men reported greater frequencies of violence than women. This last finding is interesting, as men constituted only 8.5% of the participants in this study. Mahoney also found an apparent correlation between the length of a nurse's shift and the incidence of verbal abuse. She established that verbal abuse increased with the length of the shift although she gave no further explanation regarding this phenomenon. It was also confirmed that illicit drugs and alcohol were implicated in 42.5% of reported incidences.

A factor relating to the non-reporting of violence may be related to the victims blaming themselves for not preventing the incident and others blaming the victim for

allowing it to happen. Lanza and Carifo (1991) identify that society as a whole believes there is a relationship between outcomes and virtue. That is, *good* people will not have bad things happen to them. They argue that if this socialisation is accepted into the workplace then the victim must deserve what has happened and accept that they are to blame. Lanza (1987) concludes that focusing on the victim is dangerous in that the real issues of violence in emergency departments will be ignored.

The effects of workplace violence on the health system are acute and include loss of staff, cost of sick leave and disruption to patient care. Keep and Gilbert (1992) surveyed 103 nurse managers and demonstrated that the metropolitan departments showed a marginal increase in the number of violent situations compared with rural areas. Metropolitan violence was more likely to be the result of drugs and alcohol or waiting times. In 23% of incidents the victims needed time off work. Naismith (2000) identified that if a critical incident, such as violence, is managed sensitively and supportively the effects on the system can be minimised.

Quite clearly management has a role to play in minimising risk to staff. The results from the Blank and Mascitti-Mazur (1991) study identified failure of management to provide adequate protection for staff as a contributing factor. The authors cite problems such as security guards having responsibilities outside the department, crowded waiting rooms, long waiting times and lack of training as factors that can precipitate violence. These findings are consistent with findings and recommendations in other studies (Cordell and Coughlin 1991; Kinkle 1993; Lee 1994). Kinkle (1993) concludes that security measures can only go so far to protect staff and that the identification of pre-violent behaviours and situations is crucial.

Sweet (1991) describes working in the emergency department as working on the front line of a war zone. Sweet believes that the time taken to deal with violence has not been calculated and, if put in dollar terms, would be a significant amount. She suggests that if someone had the time to do this exercise then management would take action as a cost cutting measure. Glasson (1993) suggests, provocatively, that combat pay for emergency nurses needs to be instigated. On a more serious note Glasson believes that no one can guarantee that violence will not occur, but precautions can minimise the risks.

The American Emergency Nurses' Association in 1991 identified the risks that predispose emergency nurses to violence. These include: '*long waiting times, staff shortages, ED overcrowding, availability of drugs and hostages, easy access to the rest of the hospital through the ED, use of ED for psychiatric and medical clearance of patients with drug and alcohol abuse.*' These risks also exist in the majority of Australian emergency departments.

Rice (1994) believes that the primary role of the ED nurse is to prevent violence by working with management, however this is contentious as the primary role of the ED nurse should be to provide emergency patient care. Training in the prevention and management of violence is recommended by many writers (Glasson 1993; Bjorn 1991). Gunnels (1993) believes that management's treatment of this problem is one which '*will simply disappear if I choose to ignore it.*' She also discusses violence being a norm in the department. These statements should cause concern to any reader. Violence will not disappear and it should not be expected to be a norm in any life situation.

Encinias (1994) identified the risks that exist in rural emergency departments in the US and stated that the problems that arise in rural areas are significantly different to those in metropolitan areas. She identified lack of funding for staff and inappropriate staff responsibilities in the rural area as major problems. Australia experiences similar difficulties as it also has remote areas that have distinctive needs and problems. However, minimal investigations have been conducted which examine the rural and remote areas of Australia.

Due to this lack of current published research in the Australian context, the author believed it timely to examine the nature and response of violence, and chose to do so in NSW. The aims of this study were to:

1. Define violence from the perspective of emergency nurses in New South Wales,
2. Identify the New South Wales emergency nurses' perceptions of violence, and
3. Examine the response of emergency nurses and management to actual violent events.

METHODOLOGY

A descriptive exploratory survey study, as described by Beanland et al (1999), was conducted in New South Wales, Australia. In this study a questionnaire was developed from the analysis of themes and issues identified from semi-structured interviews. Ethics approval was obtained and measures were put in place for debriefing and counselling of participants if required.

RESEARCH DESIGN

Stage 1

PARTICIPANTS

Network sampling was allowed for access to registered nurses from rural, remote and metropolitan emergency

departments. A total of nine nurses were interviewed, three from each region.

PROCEDURE

Seven interviews were conducted in person and two by phone due to geographical distance. The interviews were recorded and analysed for common themes and issues. The focus of the interview was on incidents in the workplace that caused the participants to have concern for their physical and/or emotional safety. The interviews included the following:

- Participants' understanding and definition of violence in the ED;
- personal experience of workplace violence;
- effects on the participant, and;
- role of management.

The themes and issues that formed the basis for the questionnaire included:

- the type of violence experience;
- where the incidents took place;
- use of weapons;
- source of violence;
- response times of police and security staff;
- precipitating factors;
- response of administration, and;
- training to deal with violent situations.

Stage 2

PARTICIPANTS

Members of the NSW Emergency Nurses' Association (n = 650 members).

PROCEDURE

The NSW Emergency Nurses' Association permitted access to their membership and agreed to label the survey package to ensure anonymity. The package contained the questionnaire, an introductory letter and reply paid envelope. An SPSS data file was developed and the responses to the survey were entered and analysed using univariate methods.

RESULTS

Table 1 describes the distribution of the sample. The responses (n=266) representing 11.9% of the total number of ED nurses in NSW (A.I.H.W. 1999).

As indicated in table 2 there are still 3% of emergency departments without any security devices. However, as presented in table 3, it can be seen that in the remaining departments the devices usually worked.

Table 1: Number of responses as per department location

	Frequency	Percent
Metro	180	68
Rural	65	25
Remote	21	8
Total	266	100

Table 2: Types of security devices per region

	Metro %	Rural %	Remote %	Totals %
No security devices installed	3	2	0	3
Closed circuit TV	40	59	43	45
Doors	78	77	52	76
Personal alarms	54	77	81	61
Fixed duress alarm	23	8	5	18
Other security devices	11	19	0	12

Table 3: Working order of security devices

	Metro %	Rural %	Remote %	Total %
Never	2.2	2	5	2
Sometimes	6	14	5	8
Often	15	15	5	14
Usually	77	69	86	76

Tables 4 and 5 indicate the types and frequency of violence experienced by emergency nurses. All respondents experienced some type of violence in the department and 42% also experienced violence from outside the department. In metropolitan area hospitals outside the department, violence and aggression mainly came from other areas in the hospital or on the way home. In the remote area there have been incidents in the nurse's home as this is where handover may occur.

Fifty eight per cent of respondents experienced verbal abuse, 56% encountered abuse on the phone, 14% faced physical intimidation or assault, and 29% received threats, **at least weekly**. Outside the department these figures were 26%, 16%, 6%, and 13% respectively. The effect of such violence is reflected in Table 6 where only 4.5% (12 respondents) reported that they do not feel fearful at work. Fifty-one (51) respondents feel fearful most of the time.

Table 4: Types and frequency of violence directed at emergency nurses in the department

Type of Violence	Frequency	Metro %	Rural %	Remote %	TOTAL %
Verbal abuse	Never	0	0	0	0
	Less than 6/year	15	14	38	15
	Once a month	23	38	38	28
	Weekly	41	28	19	36
	Daily	24	20	5	22
Verbal abuse by phone	Never	4	3	0	3
	Less than 6/year	34	34	71	37
	Once a month	22	29	14	23
	Weekly	27	22	14	25
	Daily	13	12	0	31
Physical intimidation / assault	Never	8	8	43	11
	Less than 6/year	55	65	52	57
	Once a month	19	17	5	17
	Weekly	23	6	0	10
	Daily	4	5	0	4
Threats	Never	2	0	10	2
	Less than 6/year	34	35	14	37
	Once a month	32	37	14	32
	Weekly	20	22	10	20
	Daily	12	6	0	9

Table 5: Types and frequency of violence directed at emergency nurses outside the department

Type of Violence	Frequency	Metro %	Rural %	Remote %	TOTAL %
Verbal abuse	Never	0	0	0	0
	Less than 6/year	12	14	38	15
	Once a month	23	38	38	28
	Weekly	41	28	19	36
	Daily	24	20	5	22
Verbal abuse by phone	Never	4	3	0	3
	Less than 6/year	34	34	71	37
	Once a month	22	29	14	23
	Weekly	27	22	14	25
	Daily	13	12	0	12
Physical intimidation / assault	Never	8	8	43	11
	Less than 6/year	55	65	52	57
	Once a month	19	17	5	17
	Weekly	13	6	0	10
	Daily	4	5	0	4
Threats	Never	2	0	10	2
	Less than 6/year	34	35	67	37
	Once a month	32	37	14	32
	Weekly	20	22	10	20
	Daily	12	6	0	9

Table 6: Emergency nurses' level of fear at work

	Metro %	Rural %	Remote %	Total %
Never	6	3	0	4.5
Sometimes	77	74	86	77
Often	16	22	14	17
Usually	2	2	0	2

Given that 20% of incidents involved physical intimidation or assault the reality of physical harm is indisputable. Table 7 reflects not only the type of weapons used but also the frequency of their use. There were 92 actual incidents with weapons that had the potential to cause immediate loss of life (guns and knives).

Patients and their relatives/friends are the most common source of violence against nurses (both 92%) - see table 8. Nurses and other hospital staff including medical staff and nursing administration were also identified as perpetrators.

Table 7: Incidents involving weapons used

	Metro	Rural	Remote	Total
Gun	11	4	2	17
Knife	51	23	1	75
Hospital equipment	12	8	0	20
I.V. equipment inc poles	3	4	1	8
Syringe	7	2	0	9
Furniture	13	3	0	16
Other weapon	17	12	0	29

Table 8: Perpetrators of violence in emergency departments

Perpetrators	Metro %	Rural %	Remote %	Total %
Patient	93	91	90	92
Relatives	92	91	90	92
Nurses	21	26	10	21
Medical staff	23	35	29	26
Administration	16	32	29	21

Table 9 reports that in the metropolitan area 53% of calls to hospital security staff are answered within five minutes. At times it is necessary to seek the assistance of the police who have the authority for detention and arrest. Table 10 reflects the response time when their assistance has been requested in the ED.

There are three main factors, alcohol, drugs and waiting times which are implicated in the majority of incidents reported by ED nurses as outlined in table 11.

Table 12 demonstrates that 14% of violent incidents are usually reported however there remains a significant 20% that are never reported.

Table 9: Response times of hospital security staff

	Metro %	Rural %	Remote %
No security staff	2.3	16.9	33
< 1 minute	17	6	0
2-5 minutes	53	23	19
6-10 minutes	21	23	29
> 10 minutes	7	3	19

Table 11: Precipitating factors in violent incidents

	Metro %	Rural %	Remote %	Total %
Alcohol	84	94	95	88
Drugs	79	83	62	79
Emergency department staff	26	22	5	23
Waiting time	89	85	48	85
Socioeconomic factors	64	57	62	62
Psychiatric	7	9	5	8
Other	8	11	19	10

Table 10: Response times of police

	Metro %	Rural %	Remote %
< 1 minute	0	0	0
2-5 minutes	17	12	19
6-10 minutes	41	32	29
11-30 minutes	36	40	33
> 30 minutes	7	15	29

Table 12: Percentage of incidents reported in writing

Incidents Reported	Metro %	Rural %	Remote %	Total %
Never	22	14	19	20
Rarely	57	54	33	54
Sometimes	4	11	14	7
Mostly	4	6	10	5
Usually	12	15	24	14

The respondents were asked to answer the next four questions in relation to their most serious violent incident experienced. Only 26% respondents were satisfied with the response of administration and 52% were dissatisfied, 20% did not even report the incident as indicated in table 12. There was also a positive correlation between satisfaction with administration's responses and incidents reported in writing, $r = 0.4$, with a significance level of 0.01. However the level of dissatisfaction in the rural areas is significantly higher and correspondingly the level of satisfaction is lower.

A significant 52% of all respondents reported that they never received any support following their most significant violent incident. Only 18% received support in less than an hour (table 14). Many respondents commented that the support did not come from administration but from colleagues.

The last three questions in the survey tool related to institutional support. There were 22% of departments that did not have a policy on violence and 22% of respondents who did not know if a policy existed (table 15).

The adequacy of current policies to cope with a violent situation was recorded from the respondents' personal experiences. No information was collected regarding the duration, initial development, or focus of such policies. The policy was deemed as adequate in 24% of incidents (table 16).

The metropolitan and remote areas appear to support staff training in dealing with violence as 42% and 45% of emergency nursing staff had training at the institution's expense, whereas only 19% of rural areas were offered paid training. A further 28% have never been offered training (table 17).

Table 13: Satisfaction with administration's response by area

	Metro %	Rural %	Remote %	Total	Total %
Not applicable	38	9	6	53	20
Very satisfied	8	3	2	13	5
Mostly satisfied	39	11	5	55	21
A little dissatisfied	39	18	4	61	23
Very dissatisfied	50	24	4	78	29

Table 14: Time taken to be offered support for most significant incident

	Frequency	Percent
Never	137	52
< 1 hour	48	18
< 12 hours	27	10
< 24 hours	19	7
> 24 hours	20	8
Not applicable	1	4

Table 15: Policy on violence in emergency department

	Metro %	Rural %	Remote %	Total %
None	19	29	24	22
Don't know	23	17	29	22
Yes	58	54	48	56

Table 16: Adequacy of current policies on violence

	Metro %	Rural %	Remote %	Total %
Never	7	5	5	6
Sometimes	36	43	33	38
Often	11	2	5	8
Usually	16	14	24	16
Not applicable	30	37	33	32

Table 17: Training

	Metro % N=185	Rural % N=68	Remote % N=22	Total % N=275
Never offered	26	34	23	28
Offered at my expense	12	19	18	15
Offered work covered cost	42	29	45	39
Offered but did not go	5	1	9	4
Offered but no time off	14	16	5	14

DISCUSSION

The despondency felt by emergency nurses was evident in the initial interviews and the comments on the final questionnaire. There was a general feeling of helplessness and hopelessness. One respondent summed up this feeling by stating:

'One has to ask: Who cares about the safety of ED nurses? Will your survey achieve anything or just more paper to be filed.' (Respondent No 87).

The experience of NSW emergency nurses is similar to those described by Mahoney (1991), Keep and Gilbert (1992) and Sweet (1991). The reality is that in a decade not much has changed and ED nurses still experience verbal abuse, threats and assaults. The comments by respondents also highlight difficulties not previously noted in the literature. Some respondents commented that the design of their department affords little protection and no escape routes. Nurses are often unable to remove themselves from a situation and many respondents commented on the escalation of violence.

Keep and Gilbert (1992) briefly commented on the security of facilities in their research but did not comment on the implementation of security procedures. Respondents in this NSW study were more concerned with the inappropriate implementation of policy that subsequently decreased the level of protection it was supposed to afford. Many respondents felt that security doors reduced the risk of violence from the outside but did not prevent violence once the patient and the relatives/friends are admitted to the inner sanctum of the department. Other security equipment was reported as being useful when situations occurred, but the time taken to repair broken equipment was an issue. If security equipment malfunctioned on weekends it was often not repaired until the next week and even then only if the

appropriate service person was available. In the rural and remote areas the time taken to repair broken equipment was often longer than in the metropolitan areas. The performance of equipment was often commented on by respondents:

'Took us years to get doors locked, even then the main hospitals closed but not locked. ...Main doors not locked as engineer worried that motors will be burnt out if people force them open when locked.' (Respondent 151).

and

'Personal duress pagers - response located at ED desk - hence we are expected to answer our own duress page !!!' (Respondent 52).

The use of weapons in ED is increasing with 92 incidents involving either a gun or a knife in this study. This is disturbing considering the Australian Federal gun laws in place which severely restrict gun ownership and the NSW State knife laws which prohibit the carrying of knife blades, razor blades or any other blade. It appears that anything that is not tied down has the potential to become a weapon in ED. Some respondents commented on the ready availability of hospital equipment such as syringes, needles etc, which can become weapons. In the emergency department it would be inappropriate to lock down essential equipment, for such equipment must be readily available for use.

The next significant precipitating factor contributing to violence in the ED is socioeconomic factors and in this section many respondents also addressed cultural factors. Respondents felt let down by the legal system leading to despondency and cynicism. As one respondent stated:

'Following an aggravated verbal abuse and intimidation and threats by a relative he was charged. The matter was dismissed by the magistrate saying that it was OK for this person to demonstrate his feelings according to his cultural way !!! What chance do we stand !!!' (Respondent 227).

The perpetrators of violence may include all the people an emergency nurse comes into contact with during a work shift, with patients and their relatives/friends constituting the greatest problem. This finding is consistent with previous studies. Respondents also commented on the impact of deinstitutionalisation, which has increased the number of psychiatric patients presenting to the emergency department. While these patients are mostly distressed and not violent or aggressive, there are times when an acutely psychotic, aggressive person arrives in the department. In such instances interacting with the patient is not the only problem but also the lack of a suitable room in which to assess them adds to the difficulty.

It was also reported that nurses outside the department can also be a source of verbal abuse and aggression. Respondents felt these nurses appear not to understand the nature of emergency work and have unrealistic expectations of the nurses in the department. Over 20% of ED nurses surveyed identified tension as an issue leading to aggressive behaviour with verbal abuse and threats by medical staff and nursing administration. This was more of a problem in rural areas than metropolitan areas. As one respondent wrote:

'ban aggressive nursing supervisors' (Respondent 35).

The precipitating factors of waiting times, alcohol and drugs are consistent with issues identified in previous research. Waiting times include the initial wait to see medical staff, waiting to have tests done, waiting for senior medical staff, waiting for results, and waiting for a bed to be available. A number of respondents commented on the public's lack of understanding of the triage categories and that clients did not accept that others required more immediate attention.

There was an acknowledgment that there are often situations where the emergency nurse's behaviour creates or exacerbates a volatile situation.

'nurses need to learn don't meet aggression with aggression' (Respondent 116).

One respondent noted that a vicious cycle exists.

'Staff become 'stale' and are inappropriate in behaviour. They ooze dissatisfaction, see all patients as gomers [get out of my emergency room] and this negative attitude appears to be 'copied' by new {usually young and inexperienced} staff.' (Respondent 132).

This may be the result of stresses that arise from the work situation. However, it also may be a reflection of approaching burnout or lack of suitability for emergency work.

When a violent or potentially violent situation occurs it is a reasonable expectation that appropriate help for staff be available in a timely fashion. This issue is not addressed in the literature and requires further investigation. A few departments have security staff on site at various peak times such as between 2100 and 0500 hours. In many rural and remote areas the male cleaner may double up as security staff. This practice is questionable. Many respondents commented on the inadequate training, behaviour and actions of security staff. One example cited by respondents involved security staff calling the department and asking if they really needed help.

The police response to violent incidents in EDs varied dramatically. In rural and remote areas the police may be on patrol, on another call or physically distant from the

hospital. Response times in these areas can be over 30 minutes with cutbacks and closure of police stations compounding this problem.

The results of non-reporting of violent incidents in EDs are consistent with the ICN findings and also current American and Australian studies in other areas of nursing practice (Araujo and Sofield 1999; Duraiappah 2000). ED nurses are not reporting violence as they believe nothing will be done or they perceive violence as part of the job. Compounding this issue is that the response of administration to violent incidents appears to be less than satisfactory. Lack of appropriate support and feedback increases the negative impact on the nurse; this is consistent with the findings of Lanza and Carifo (1991).

A number of respondents commented that administration were punitive when reports of violence were submitted and blamed the staff for causing the situation. This is inappropriate and blaming the victim further traumatises them.

'Administrators: tend to take sides with non staff assailants. Staff usually blamed for the incidents [and] provide little or no support.' (Respondent 74).

'No admin acknowledgement of violent incidents in ED despite multiple incident reports.' (Respondent 52).

'Following an assault management did not follow up or offer support - appeared to be because no hospital property was damaged. My injuries not important despite success in prosecuting perpetrator.' (Respondent 44).

RECOMMENDATIONS

The following recommendations are suggestions from the respondents and from the data collected during the study.

- A larger study needs to be conducted that includes all emergency nurses in order to fully determine and assess the extent of violence.
- A study on violence that includes all working nurses needs to be completed to assess the extent of violence in all areas of nursing practice.
- Education of non-ED staff regarding the function, role and responsibilities of the emergency nurse and the department may reduce some tensions between staff.
- Education and training for administration regarding appropriate responses to violence is essential.
- Each hospital should have a dedicated telephone line to the local police for use in emergencies.
- Consideration should be given to the appointment of permanent emergency security staff which should reduce the number of violent incidents.

- In high-risk areas metal detectors should be in use to locate potential weapons.
- The development of shift incident reports where a nurse can quickly record the occurrence of certain types of incidents would encourage reporting. The simple form could be at the triage desk and in the main area and forwarded to administration at the end of each shift. This would be valuable to provide trends and patterns so that appropriate staffing can occur. However, a separate form for a serious incident would still be required.
- The development of appropriate policies which include controlling the violent situation, actions to be taken once a situation arises, support available and the process to be followed.
- Hospitals and government policies should focus on reduction of waiting times, and the development of policies to deal with the situation when waiting times reach a critical point.
- Funds should be available for training at times when emergency department staff are not part of the shift complement.
- Hospital should provide adequate staffing numbers including, nursing, medical officers, support and security staff.
- Legal support should be available for nurses to take action against perpetrators.
- Recording video cameras should be installed in EDs to be used as evidence if necessary.

CONCLUSION

This study has shown that there need to be major changes in attitudes and practises from both administrators and emergency nurses.

Emergency nurses need to take responsibility and document all violent incidents. Hospital policies need to clearly document the process of dealing with a complaint including what will happen to a complaint report and the provision of feedback to the staff member involved.

The study showed a lack of institutional support for training to deal with violent situations. Many respondents acknowledged the need for such training but felt that there were insurmountable obstacles. For example, training is often only offered during the day and is therefore not suitable for permanent night staff, the long distances required travelling to training especially in rural and remote areas, and the uncertainty of ED patient load all contribute to a potential lack of attendance.

Violence in nursing is a reality and it will not disappear if the issues are not addressed. The effects of workplace violence are significant and costly. Further research is required to examine the issues of non-reporting, security and precipitating factors so that there can be a concerted effort to find real solutions and protect emergency nurses from harm.

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