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# At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses

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**Abstract**

**Objective.** Violence is widespread in Australian emergency departments (ED) and most prevalent at triage. The aim of the present study was to identify the causes and common acts of violence in the ED perceived by three distinct groups of nurses.

**Methods.** The Delphi technique is a method for consensus-building. In the present study a three-phase Delphi technique was used to identify and compare what nurse unit managers, triage and non-triage nurses believe is the prevalence and nature of violence and aggression in the ED.

**Results.** Long waiting times, drugs and alcohol all contributed to ED violence. Triage nurses also indicated that ED staff, including security staff and the triage nurses themselves, can contribute to violence. Improved communication at triage and support from management to follow up episodes of violence were suggested as strategies to reduce violence in the ED

**Conclusion.** There is no single solution for the management of ED violence. Needs and strategies vary because people in the waiting room have differing needs to those inside the ED. Participants agreed that the introduction and enforcement of a zero tolerance policy, including support from managers to follow up reports of violence, would reduce violence and improve safety for staff. Education of the public regarding ED processes, and the ED staff in relation to patient needs, may contribute to reducing ED violence.

**What is known about the topic?** Violence is prevalent in Australian healthcare, and particularly in emergency departments (ED). Several organisations and government bodies have made recommendations aimed at reducing the prevalence of violence in healthcare but, to date, these have not been implemented consistently, and violence continues.
**What does this paper add?** This study examined ED violence from the perspective of triage nurses, nurse unit managers and non-triage nurses, and revealed that violence is experienced differently by emergency nurses, depending on their area of work. Triage nurses have identified that they themselves contribute to violence in the ED by their style of communication. Nurse unit managers and non-triage nurses perceive that violence is the result of drugs and alcohol, as well as long waiting times.
**What are the implications for practitioners?** Strategies to reduce violence must address the needs of patients and staff both within the ED and in the waiting room. Such strategies should be multifaceted and include education of ED consumers and staff, as well as support from management to respond to reports of violence.

**Additional keywords:** Delphi technique, triage.

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## Introduction

Maintaining the therapeutic environment of the emergency department (ED) and ensuring a safe workplace are both extraordinary challenges in a society that increasingly tolerates violence and aggression. In healthcare, and particularly in nursing, violence remains prevalent.[1] Australian studies reveal that patient-related violence is experienced by the majority of emergency nurses.[2,3] ED nurses may themselves feel violence and aggression are part of the job. Within the ED, violence is most prevalent at triage. This can cause instability and distress for staff and other patients, making both staff and patients more distracted and defensive, leading to delays in treatment and increased waiting times.[4] ED nurses are at the crossroads: the intersection of caring for a patient with violent and aggressive behaviour and their right to a safe workplace.

Violent incidents are under-reported and this may be due to difficulties with reporting systems; however, researchers have also found that nurses accept this aspect of their workplace conditions for various reasons. Under-reporting of episodes of violence may be as high as 70% according to Kennedy[5] and Gilchrist *et al.*;[2] without this information (i.e. accurate reporting of episodes of violence), it is difficult for any organisation to understand trends in occupational violence or to design intervention programs.[6] Chapman *et al.*[7] reported that, when asked to reflect on the last incident of violence, only 50% of nurses reported it verbally and just 16% filled in an incident form. Reasons for not reporting include that nothing will be achieved, the violence is too frequent and too time consuming to report, the incident is not recognised as serious and because reporting means you will be perceived as not 'tough enough' to work there.[5,8,9] One study revealed that some nursing staff (11%) had resigned from their position due to verbal or physical abuse, and a further 24% had considered resigning for the same reason.[10] The same study found that nurses perceived that speaking with management about their concerns was not an effective way to manage the stress associated with workplace violence.[10] However, if the information was available and well managed, the impact of violence and aggression could be mitigated, and the work environment may remain stable.[4]

The Design Council, working with three National Health Service (NHS) trusts in the UK observed causes of violence and aggression in the ED and identified six patient and/or perpetrator types:[11] the clinically confused, frustrated, intoxicated, antisocial, distressed and/or frightened and socially isolated. Identifying these types helped staff to sort triggers, challenges and pathways. The Council then set out to communicate with patients, acknowledging their physical or mental pain, managing their expectations of service and making sure they knew the ED system.[11] Each stage of the patient's journey was improved after finding that patients required even the most basic information, so patients knew what to expect while in the ED.[11]

Strategies to address violence and aggression in the ED have been inconsistently implemented in most Australian settings. There is a level of tolerance by community, organisations and governments that those who are violent within an ED should be treated more leniently than those who are violent outside the ED. The Australian Nursing Federation (Victorian Branch) made a submission to a government inquiry into hospital violence and recommended that the Government legislate to provide for sanctions against physical violence directed at health workers.[12]

Zero tolerance policies are one approach to non-acceptance of workplace violence. These policies were introduced in the New South Wales health sector in 2005, and in the UK, where the Prime Minister David Cameron said he would accept nothing less than zero tolerance for those that attack NHS staff.[11] Pich *et al*. note that 'there seems to be an emphasis on the immediate reaction to violent episodes, for example security guards and duress alarms with little attention given to the prevention or long-term management of such episodes'.[13]

The International Council of Nurses (ICN) recognises nurses' vulnerability at work and has produced several documents designed to help nurses cope with, and plan to prevent, violence.[14–16] The Australian College of Nursing also believes that the level of violence in healthcare is unacceptable.[17]

The issues are complex and nurses are at the crossroads; the reality is that despite the strategies and recommendations of the various committees and organisations, violence and aggression remain an undue influence in the ED. The present study explores the factors that continue to influence violence and aggression in the ED from the perspective of triage nurses, nurse unit managers (NUMs) and non-triage nurses.

## Methods

The Delphi technique, used in the present study, is a method for consensus building[18] by using multiple rounds of data collection.[19] The Delphi technique has four main features: (1) the anonymity of participants; (2) iteration with controlled feedback; (3) a statistically informed group response; and (4) the use of experts.[20] For this study, it was felt that nurses employed in EDs across Australia possessed the knowledge and experience necessary to qualify them as experts in the prevalence and nature of violence and aggression in the ED. Participants were members of the College of Emergency Nursing Australasia (CENA), the peak professional body for Australian emergency nurses.

The Delphi technique consists of several survey rounds during which researchers seek consensus about topics that have been identified in the first round of the process, and informed by feedback from each succeeding round of the study.[20] In the present study there were three rounds of surveys. In Round 1, respondents provided free-text answers related to their experience of the categories of people who initiate violence, the most common processes causing violence, the most common acts of violence and their recommendations for strategies to reduce violence in the ED.

The Round 1 responses were independently coded by two members of the research team (JM and DG), consensus was reached between the two researchers and then codes were agreed upon by the whole research team. Responses were then collapsed for each respective group (triage nurses, non-triage nurses, NUMs) into lists of categories of people who cause violence, processes contributing to violence, acts of violence and strategies for change.

In Rounds 2 and 3, the survey asked each group of participants to rank the lists as described above (people, causes, acts and strategies for change). Free-text responses were also invited where any other items could be reported.

Quantitative responses to each round were analysed using median and interquartile ranges (IQR) to collate emerging themes and the results were then returned to the participants for further refinement. This continued until no new topics emerged and consensus was felt to have been achieved.[20]

Ethics approval was sought and obtained from Monash University Human Research and Ethics Committee, and the study had the support of the CENA Board of Directors and Research Committee.

## Results

### *Participant sample*

Demographic data showed that the participants in the present study were drawn from all Australian states and territories, with the most being from Victoria ($n = 59$; 36.3%) and New South Wales ($n = 21$; 23.3%), followed by South Australia ($n = 44$; 13.4%) and Queensland ($n = 21$; 12.7%). As indicated in Table 1, the majority of respondents had worked between 6 and 10 years in the ED (Round 1 = 28.6%; Round 2 = 31.3%; Round 3 = 34.7%), and identified themselves as triage nurses (Round 1 $n = 135$ (86%); Round 2 $n = 132$ (83%); Round 3 $n = 130$ (82%)), NUMs (Round 1 = 8%; Round 2 = 11%; Round 3 = 13%) and non-triage nurses (Round 1 = 6%; Round 2 = 6%; Round 3 = 5%).

### *Results from Round 1*

A total of 157 participants answered the Round 1 questions (triage nurses $n = 135$; non-triage nurses $n = 10$; NUMs $n = 12$). Responses from each group (triage nurses, non-triage nurses and NUMs) are reported below.

### *Categories of people causing violence in the ED*

Participants identified people affected by alcohol and drugs, as well as patients with mental health illness, as the most common categories of people causing violence in the ED. Triage nurses also identified that security and ED staff contribute to ED violence (Table 2).

### *ED processes that led to violence*

The overwhelming majority of participants indicated that long waiting times contributed to violence in the ED. When ED systems were not understood by ED consumers, the consumers were more likely to become violent (Table 3).

### *Common acts of violence*

The most common acts of violence experienced by participants were physical assault and verbal abuse (Table 4). Almost one-third of participants reported being spat on. Two triage nurses reported being threatened that they would be assaulted at their place of residence; one reported, 'I have had damage to my garden as a 'punishment' for how I managed' (ID 95).

**Table 1. Participant characteristics**

Unless indicated otherwise, data show the number of participants in each group, with percentages given in parentheses. ED, emergency department

| | Round 1 | Round 2 | Round 3 |
|---|---|---|---|
| *n* | 189 | 160 | 170 |
| Time working in the ED | | | |
| Up to 12 months | 2 (1.1%) | 0 | 1 (0.6%) |
| 1–5 years | 33 (17.5%) | 23 (14.4%) | 20 (11.8%) |
| 6–10 years | 54 (28.6%) | 50 (31.3%) | 59 (34.7%) |
| 11–15 years | 37 (19.6%) | 36 (22.5%) | 36 (21.2%) |
| 16–20 years | 24 (12.7%) | 25 (15.6%) | 22 (12.9%) |
| 21+ years | 39 (20.6%) | 26 (16.3%) | 32 (18.8%) |
| Role in ED | | | |
| Registered nurse | 82 (43.4%) | 64 (40%) | 75 (44.1%) |
| Clinical nurse specialist or consultant | 41 (21.7%) | 36 (22.5%) | 37 (21.8%) |
| Clinical resource nurse | 3 (1.6%) | 2 (1.3%) | 2 (1.2%) |
| Nurse educator | 15 (7.9%) | 11 (6.9%) | 10 (5.9%) |
| Associate nurse unit manager | 15 (7.9%) | 13 (8.1%) | 9 (5.3%) |
| Nurse unit manager | 14 (7.4%) | 16 (10%) | 21 (12.4%) |
| Nurse practitioner or candidate | 16 (8.5%) | 9 (5.6%) | 13 (7.6%) |
| Enrolled nurse | 1 (0.5%) | 9 (5.6%) | 1 (0.6%) |
| Emergency nursing coordinator | 2 (1.0%) | – | 2 (1.2%) |

**Table 2. Round 1 results: categories of people causing violence in the emergency department**

Data show the number of participants in each group, with percentages in parentheses. NUMs, nursing unit managers; ED, emergency department; –, category not reported by this group

| | Triage nurses ($n = 135$) | Non-triage nurses ($n = 10$) | NUMs ($n = 12$) | Total ($n = 157$) |
|---|---|---|---|---|
| Accompanying person/s: drug or alcohol affected | 74 (54%) | 7 (70%) | 7 (58%) | 88 (56%) |
| Patients alcohol affected | 62 (46%) | 2 (20%) | 5 (42%) | 69 (44%) |
| Patients with mental health issues | 58 (43%) | 3 (30%) | 5 (42%) | 66 (42%) |
| Patients drug affected | 56 (42%) | 3 (30%) | 5 (42%) | 64 (41%) |
| Aggressive or angry behaviour | 14 (10%) | 1 (10%) | 2 (16%) | 17 (11%) |
| Confused patients | 11 (8%) | 1 (10%) | 1 (8%) | 13 (8%) |
| Concerned parents of child | 8 (6%) | 1 (10%) | – | 9 (6%) |
| Security staff | 15 (11%) | – | – | 15 (10%) |
| ED staff (lack of customer service) | 11 (8%) | – | – | 11 (7%) |
| Frustrated or distressed people | 7 (5%) | – | – | 7 (4%) |
| Paramedics | 7 (5%) | – | – | 7 (4%) |
| Patients drug seeking | 4 (3%) | 1 (10%) | – | 5 (3%) |
| Patients in pain | 3 (2%) | – | 1 (8%) | 5 (3%) |
| Nursing staff (horizontal violence) | 2 (1%) | – | – | 2 (1%) |
| Elderly patients | 1 (0.7%) | 1 (10%) | – | 2 (1%) |

**Table 3. Round 1 results: emergency department processes that lead to violence**
Data show the number of participants in each group, with percentages in parentheses. NUMs, nursing unit managers; ED, emergency department; ATS, Australasian Triage Scale; GP, general practitioner; –, process not reported by this group

| | Triage nurses ($n = 135$) | Non-triage nurses ($n = 10$) | NUMs ($n = 12$) | Total ($n = 157$) |
|---|---|---|---|---|
| Long waiting times | 107 (80%) | 7 (70%) | 10 (83%) | 124 (79%) |
| ED systems not understood by ED consumers (e.g. ATS) | 11 (8%) | 2 (20%) | 1 (8%) | 14 (9%) |
| Non-smoking environment | 7 (5%) | – | – | 7 (4%) |
| Insufficient staffing | 4 (3%) | – | 2 (17%) | 6 (4%) |
| Delays in providing analgesia | – | 3 (30%) | 1 (8%) | 4 (2%) |
| Increasing use of ED over the GP | 3 (2%) | – | – | 3 (2%) |
| Lack of a zero tolerance policy | 2 (1.5%) | – | – | 2 (1%) |
| Identified a lack of security | – | – | 1 (8%) | 1 (0.6%) |

**Table 4. Round 1 results: common acts of violence experienced in the previous 12 months**
Data show the number of participants in each group, with percentages in parentheses. NUMs, nursing unit managers; –, act not reported by this group

| | Triage nurses ($n = 135$) | Non-triage nurses ($n = 10$) | NUMs ($n = 12$) | Total ($n = 157$) |
|---|---|---|---|---|
| Physical assault | 106 (79%) | 7 (70%) | 3 (25%) | 116 (74%) |
| Verbal abuse | 100 (75%) | 7 (70%) | 7 (58%) | 114 (72%) |
| Threat of physical violence | 35 (26%) | 3 (30%) | 8 (67%) | 46 (29%) |
| Spitting | 39 (29%) | 3 (30%) | 3 (25%) | 45 (28%) |
| Property damage | 35 (26%) | 2 (20%) | 3 (25%) | 40 (25%) |
| Threat or assault with bodily fluids (e.g. flicking exudate and/or blood from wounds) | 4 (3%) | – | 1 (8%) | 5 (3%) |
| Threat of physical assault to occur outside the workplace | 2 (1.5%) | – | – | 2 (1%) |

### *Strategies to reduce violence in the ED*

Participants suggested a variety of strategies for reducing violence in the ED. These included: increasing the number of security staff; introducing or enforcing a zero tolerance policy; and educating staff in how to identify and manage aggression (Table 5).

## *Results from Round 2*

A total of 132 participants completed the Round 2 survey (triage nurses $n = 109$; non-triage nurses $n = 8$; NUMs $n = 15$). The items that were identified as most significant to participants in Round 2 were included in the Round 3 survey (see Table 6 for final results). In the free-text responses, seven triage nurses (6%) identified that police were a cause of violence in the ED and, as a result, the option 'Police' was added to the final list for ranking by triage nurse participants in Round 3.

## *Results from Round 3*

A total of 158 participants completed the Round 3 survey (triage nurses $n = 130$; non-triage nurses $n = 8$; NUMs $n = 20$).

### *Categories of people causing violence in ED*

All groups identified aggressive and/or angry people, alcohol- and drug-affected patients and accompanying people as being the most significant categories of people causing violence in the ED. In contrast, only triage nurses identified drug-seeking patients and police as being sources of violence (Table 6).

### *ED processes that led to violence*

Several processes were identified as causes of violence in the ED. There was consensus among the participant groups that long ED waiting times and ED systems not being understood by ED consumers (e.g. the Australasian Triage Scale) were significant issues. Other process causes of violence included ED overcrowding and insufficient staffing (Table 6).

### *Significant acts of violence*

The most significant acts of violence experienced by all groups in the previous 12 months were verbal abuse and threat of, or actual, physical assault (Table 6).

### *Strategies to reduce violence in the ED*

All groups of respondents recommended introducing and enforcing a zero tolerance policy against violence in the ED. In addition, participants indicated that support from management to follow through and enforce that policy, ensuring assaults are actually reported to police, would reduce violence in the ED (Table 6).

In the free-text responses, triage nurse participants identified items that had not been listed in either Rounds 1 or 2 and may be significant to triage nurses. 'Poor communication' was identified by eight triage nurses as contributing to violence in the ED; this included 'a lack of information provided by care providers to patients and family about the processes in ED' (ID 30). In addition, compassion fatigue was reported by seven triage

**Table 5. Round 1 results: strategies to reduce violence in the emergency department**

Data show the number of participants in each group, with percentages in parentheses. NUMs, nursing unit managers; ED, emergency department; ATS, Australasian Triage Scale; GP, general practitioner; CCTV, closed-circuit television; –, strategy not reported by this group

| | Triage nurses ($n = 133$) | Non-triage nurses ($n = 10$) | NUMs ($n = 12$) | Total ($n = 155$) |
|---|---|---|---|---|
| Appropriately trained and visible security staff in the ED 24 h per day | 57 (43%) | 6 (60%) | 6 (50%) | 69 (45%) |
| Introduction of a zero tolerance policy | 46 (35%) | 7 (70%) | 4 (33%) | 57 (37%) |
| Education of staff in relation to the recognition and management of aggression and/or violence | 43 (32%) | 6 (60%) | 5 (42%) | 54 (35%) |
| Streamline ED processes to reduce time spent in the waiting room (e.g. streaming) | 38 (29%) | – | 1 (8%) | 39 (25%) |
| Increase the numbers of nursing and medical staff to expedite care | 38 (29%) | – | – | 38 (25%) |
| Education of ED consumers regarding ED processes (e.g. ATS) | 21 (16%) | 6 (60%) | 4 (33%) | 31 (20%) |
| Increase access to health services in the community (e.g. GPs, mental health services) | 19 (14%) | 2 (20%) | 4 (33%) | 25 (16%) |
| Separate secure areas for agitated and/or violent people | 19 (14%) | 2 (20%) | 4 (33%) | 25 (16%) |
| Improve communication between triage and people in the waiting room regarding processes (e.g. expected length of wait) | 21 (16%) | – | – | 21 (14%) |
| Educate the public regarding the incidence of violence towards health professionals in the ED | 21 (16%) | – | – | 21 (14%) |
| Improved patient admissions processes to facilitate rapid transfer to wards | 19 (14%) | 2 (20%) | – | 21 (14%) |
| Education of the public regarding when and why to use the ED | 17 (13%) | – | 3 (25%) | 20 (13%) |
| Streamline ED specialist referrals | 15 (11%) | 1 (10%) | 3 (25%) | 19 (12%) |
| Improved security features within ED (e.g. locked doors, CCTV cameras, security screens to detect weapons) | 11 (8%) | – | 1 (8%) | 12 (8%) |
| Penalties for violence against staff | 8 (14%) | – | 1 (8%) | 9 (6%) |
| Support from management to 'follow through' (e.g. to ensure policies are adhered to, such as reporting violent episodes to the police) | 7 (5%) | 1 (10%) | 2 (17%) | 10 (6%) |
| Improved community services to reduce drug- and alcohol-related presentations (e.g. people brought in by police to sober up) | 7 (5%) | 2 (20%) | – | 9 (6%) |
| Improved communication between hospital and police | 4 (3%) | – | 3 (25%) | 7 (5%) |
| Personal duress alarms | 5 (38%) | – | 1 (8%) | 6 (4%) |

nurses as contributing to violence. Examples of compassion fatigue include a 'lack of tolerance or empathy from staff towards patients and their family' (ID 3) and 'staff attitudes and the way people are managed definitely affects the incidence of violence' (ID 49).

Interestingly, although previous rounds had revealed that accompanying people contributed to violence if they were drug or alcohol affected, in this final round 16 participants (triage nurses $n = 14$; non-triage nurses $n = 1$; NUMs $n = 1$) identified that accompanying people who were not drug or alcohol affected contributed to violence in the ED.

## Discussion

The aim of the present study was to examine violence in the ED and compare the perspectives of emergency nurses who perform different roles within the ED. One of the notable variations in the perceived cause of violence between the groups of participants was the identification of security staff. NUMs and non-triage nurses identified a lack of security staff as contributing to violence in the ED. Security staff are reported to be essential in managing episodes of violence in healthcare.[21–23] Almost half of all respondents identified that appropriately trained security staff, who were visible in the ED 24 h a day, was the key strategy to reducing ED violence, a finding that is supported by other studies.[22–24]

In Round 1 of the study, triage nurses also acknowledged the contribution security staff make in reducing ED violence. However, by Round 3 this group no longer identified security staff as reducing violence in the ED; instead, some triage nurses ($n = 15$; 11%) reported that security staff actually contributed to episodes of ED violence. This highlights a stark contrast in the participants' perception of security staff. Within the ED, security staff are seen as a 'protector' from violence, whereas at triage they are perceived as 'aggressors' of violence. This suggests the behaviour and needs of staff and ED consumers varies inside the ED compared with the triage area and waiting room. Although seemingly incongruous, these contradictory perceptions of security staff are also evident in the literature.[25]

An interesting finding was that elderly patients were not perceived to be a source of violence. This is in contrast with findings in the literature that indicate that healthcare workers in aged care settings experience high levels of violence.[26] One theory that may explain this is the way nurses perceive violence.[27,28] Often, an action is only perceived as violent if it is intentional and deliberate.[29] As such, participants may rationalise or excuse the violent behaviour of elderly or confused patients, because they were not perceived to be intentionally aggressive.

**Table 6. Round 3 results: final ranking of the most significant people, causes and acts of violence in the emergency department, and strategies for change**
Data show median values, with the interquartile range in parentheses. ED, emergency department; NUMs, nursing unit managers; ATS, Australasian Triage Scale; GP, general practitioner; i.v., intravenous; –, from Round 2 results, this item was not identified by this group and was therefore not an option in the Round 3 survey

| | Triage nurses ($n = 130$) | NUMs ($n = 20$) | ED nurses ($n = 8$) |
|---|---|---|---|
| Categories of people as the most common sources of violence in ED | | | |
| Patients: alcohol affected | 2.00 (1.00) | 2.00 (2.00) | 2.00 (1.50) |
| Patients: drug affected | 2.00 (1.00) | 2.50 (1.00) | 1.50 (2.75) |
| Aggressive and/or angry and/or bad behaviours | 2.00 (3.00) | 3.00 (3.00) | 3.00 (1.75) |
| Accompanying person/s (relatives and friends): alcohol affected | 4.00 (2.00) | 4.00 (1.00) | 4.00 (1.75) |
| Patients: drug seeking | 5.00 (1.00) | – | – |
| Police | 6.00 (1.00) | – | – |
| Patients with mental health issues | – | 4.00 (3.00) | 4.50 (1.00) |
| Processes as causes of violence in ED | | | |
| Long ED waiting times | 2.00 (2.00) | 2.00 (0.75) | 1.50 (1.75) |
| ED systems not understood by ED consumers (e.g. ATS) | 2.00 (2.00) | 2.00 (2.75) | 3.00 (2.75) |
| ED overcrowding | 3.00 (2.00) | – | 3.50 (2.75) |
| Increasing use of ED rather than GP | 3.00 (3.00) | – | – |
| Delays in admission from ED to the ward | 4.00 (2.00) | – | 4.50 (1.75) |
| Lack of security | – | 3.00 (2.75) | – |
| Insufficient staffing | – | 3.00 (2.00) | – |
| Delays in providing analgesia to people in pain | – | 4.00 (1.75) | 3.00 (1.75) |
| Most common acts of violence in ED | | | |
| Verbal abuse (e.g. swearing, threat of litigation) | 1.00 (0.00) | 1.00 (0.00) | 1.50 (1.75) |
| Threat of physical violence | 2.00 (1.00) | 2.00 (1.00) | 3.50 (2.75) |
| Spitting | 3.50 (1.00) | – | 4.00 (3.00) |
| Physical assault or physical harm (e.g. punching, kicking, biting) | 4.00 (1.00) | 4.00 (1.00) | 3.00 (2.75) |
| Physical assault with hospital equipment and/or furniture (e.g. i.v. poles, chairs) | 4.00 (2.00) | – | – |
| Property damage | – | 3.00 (0.00) | 3.50 (1.75) |
| Threat or assault with bodily fluids (e.g. flicking exudate and/or blood from wounds) | – | 5.00 (0.00) | – |
| Strategies for change to reduce violence in ED | | | |
| Improve communication between triage and people in the waiting room regarding processes | 2.00 (3.00) | – | – |
| Support from management to 'follow through' (e.g. ensure assaults are reported to the police) | 3.00 (2.00) | 3.00 (2.00) | 3.00 (1.75) |
| Introduction and enforcement of zero tolerance policy | 3.00 (3.00) | 2.50 (2.00) | 2.00 (2.00) |
| Penalties for violence against staff | 3.00 (3.00) | – | 4.00 (2.50) |
| Educate the public regarding the incidence of violence towards health professional in ED | 3.00 (3.00) | – | – |
| Education of staff regarding recognition and management of aggression and/or violence | – | 3.00 (3.00) | – |
| Appropriately trained and visible security staff in the ED 24 h a day, 7 days a week | – | 3.00 (3.75) | 2.50 (3.00) |
| Streamline ED processes to reduce time spent in the waiting room (e.g. streaming) | – | 4.00 (1.75) | 4.00 (3.25) |

Long waiting times were reported by each group as the most common ED process contributing to violence. The authors of one study suggest that the triage system may not be well understood (a belief supported by the present study) and that consumers' perceptions of a 'long wait' may vary from those of the ED staff.[30] However, one cannot attribute a misconception of the waiting period as being the cause of violence when the ED staff themselves believe consumers are waiting too long.

A small percentage of participants reported threats of assault at their place of residence. This act forms a personal attack and, as such, needs to be investigated and taken seriously by management and the police. In keeping with this, an interesting finding was that participants in each group, including NUMs, indicated that support from 'management' to follow up violent incidents, including reporting the incident to police, was an important strategy in the reduction of ED violence.

Lack of a 'zero tolerance' policy was identified by triage nurses as contributing to violence, and all three respondent groups identified that the introduction and enforcement of a zero tolerance policy would reduce ED violence. A zero tolerance policy identifies actions and behaviours that will not be tolerated within the ED and manages behaviours appropriately (e.g. having the patient removed from the department).[31]

To ensure a zero tolerance policy works, it must be appropriately resourced and consistently applied, and a culture of reporting violence must be supported by management. However, even with these resources and supports in place, management of a zero tolerance policy in the ED is not straightforward. As described previously, a zero tolerance policy was introduced in NSW in 2005. Yet an examination of responses revealed that NSW participants in the present study ranked the introduction or enforcement of a zero tolerance policy as the most important strategy to reduce violence in ED (median 2, IQR 1), suggesting that the current zero tolerance policy in that state was not consistently enforced. One reason for this may relate to the nurses' understanding of their duty of care to patients. For example, if a person with a head injury initiates violence, a zero tolerance policy would result in that patient being asked

to leave the department, potentially resulting in patient harm.[24,32,33]

In light of these challenges, it has been suggested that rather than a single 'one size fits all' zero tolerance policy, EDs should consider implementing proactive policies that encourage a safe environment, free from violence, and encourage a culture of reporting.[24] Such policies should take into account underlying health concerns and be aimed at the early recognition and prevention of violence.[24]

### *Recommendations*

The most important element to the successful management of violence in EDs is education, aimed at both staff and consumers.[24]

#### *Education of the public*

Participants suggested that public awareness programs addressing the appropriate use of, and behaviour in, EDs could encompass examples of recent workplace violence, which may act as a deterrent. Education strategies have been shown to work in the UK, wherein a focused education program ensured that ED consumers were provided with information about their journey and what to expect next.[11]

#### *Education of staff*

Triage nurse participants reported that ED staff themselves contributed to violence, through poor verbal and non-verbal communication and compassion fatigue, showing a lack of empathy towards patients. Overall attitude, including tone, negativity and confronting and questioning patients' validity for presenting to the ED, for example, can initiate or exacerbate acts of violence.[1,34] Education for ED staff should focus on effective verbal and non-verbal communication, as well as recognition of potential for violence, and de-escalation strategies including negotiation skills.[24,31] Education should also promote a culture of workplace safety, in which reporting workplace violence is encouraged and feedback provided.

### *Limitations*

This study was keen to identify the perspectives of the three groups of nurses working in the ED. The results in Round 1 highlighted the differing views of the triage nurses compared with the other two groups. However, by the third round these differences were diminished, subsumed in the Delphi technique's consensus approach. Further exploration of triage nurses' views may provide important insight given this is the location where the greatest incidence of violence occurs.

## Conclusion

The present study contributes to the body of knowledge on occupational violence in the ED by undertaking an investigation using the Delphi technique and identifying and comparing the perceptions of triage nurses, non-triage nurses and NUMs on violence in the ED. This study has identified some important findings.

People affected by drugs and alcohol were reported by all groups as the most common source of violence in the ED. Triage nurses further identified that security staff, and the way triage nurses communicate, can contribute to ED violence. This finding did not arise from the NUMs or non-triage nurses, suggesting that ED staff, or patient needs, are different in the waiting room than they are within the ED.

All employees have a right to a safe workplace. Participants agreed that the introduction and enforcement of a zero tolerance policy, including support from managers to follow up reports of violence, would reduce violence and improve staff safety. The enforcement of a policy of zero tolerance must be legislatively supported to deter violence against healthcare workers. Education of the public and the ED staff would further develop an antiviolence culture, and positively influence society's tolerance of violence.

Many of the solutions to ED violence suggested by participants in this study are not new ideas. Education of staff and consumers has been shown to work in the UK, wherein some consumers are recognised as too distressed or unwell to be considered accountable for their behaviour. Staff have been taught how to improve communication with these consumers, and this has been shown to reduce ED violence. By comparison, those who are deemed 'antisocial' are held responsible for their actions, with the application of the zero tolerance policy.[11] A workplace that provides focused solutions may allow ED staff to look after themselves and their patients in a more therapeutic environment.

## Competing interests

The authors declare that no conflicts of interest exist.

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