

The Extent, Nature, and Precipitating Factors of Nurse Assault Among Three Groups of Registered Nurses in a Regional Medical Center

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Introduction: This study investigated nurse perceptions of the incidence and nature of verbal and physical assault or abuse by patients and their family members or visitors.

Methods: A survey was given to ED, ICU, and general floor nurses in a 770-bed acute care north Florida medical center.

Results: The response rate was 68.8% (86 out of 125). Large percentages of nurses reported being victims of verbal assault or abuse and physical assault by patients and family members or visitors; 88% reported being verbally assaulted and 74% reported being physically assaulted while at work in the past year. ED nurses reported the highest rates of these incidences, with 100% reporting verbal assault and 82.1% reporting physical assault within the past year. Assaults were most commonly perpetrated by patients with cognitive dysfunction (79.1%), patients with substance abuse (60.5%), and persons who were angry because of the patient's condition (55.8%). Surprising information: the most common causes of assault by family members and visitors were anger related to enforcement of hospital policies (58.1%), anger related to the patient's condition/situation (57%), anger related to long wait times (47.7%), and anger related to the health care system in general (46.5%).

Discussion: Nurses were confused about what legally constitutes "assault" and "abuse"; nurse rights versus patient rights; and policies and procedures for reporting assault or abuse incidences. Our results indicate that nurses are experiencing abusive and assaultive behavior from *family members* and *visitors* just as often as they are from patients, and ED nurses are at higher risk. Nurses perceive a lack of institutional support and an institutional emphasis on patient rights and satisfaction and do not feel safe in the workplace.

During the past decade, the incidence of violence—including the incidence of assaults against health care workers—has increased in US hospitals. This increase in violence is thought to reflect the escalation of violence in our society as a whole. A 1996 report by the Bureau of Labor Statistics reported that in 1994, 38% of nonfatal workplace assaults in the United States occurred in health care settings. Nursing personnel sustained 41% of 20,000 assault-related injuries during this period. Even these statistics do not reflect the true picture; the incidence of assaults is widely accepted as being grossly underestimated because only 29% of all nurse assaults are reported.^{1,2} The terms “nurse assault” and “nurse abuse” have been used interchangeably in the literature, and confusion still remains regarding which terminology to use when describing these incidences.

In 1996, the National Institute of Occupational Safety and Health Report³ noted that health care workers are victims of workplace assault more often than any other worker group, including police officers. Nurses have become the most frequent targets of assault and abuse from patients, family members, visitors, and physicians. In 1991, a large survey of 284 hospitals in the United States and Canada revealed that 25% of all nonfatal assaults and 23% of the 51 homicides of health care workers occurred in emergency departments.

A lack of accurate descriptions of the nature of the assaults and abuse, varied definitions of assault and/or abuse, and underreporting of assaults have been noted to be obstacles to studying the problem of assaults of nurses. We therefore sought to obtain a more accurate picture of the incidence of nurse assault/abuse and the impact of this problem on the physical, mental, and emotional well-being of nurses and institutional health by studying the following questions: (1) What is the nature and extent of nurse assault among 3 different groups of registered nurses (RNs), and do any differences exist between the groups? (2) What are nurses' perceptions of the most common causes of assaults against nurses? (3) Do nurses perceive themselves as being assaulted? (4) Are nurses reporting assaults, and if not, what are their reasons for not reporting? (5) What preventive and intervention measures would nurses support regarding assault of nurses? (6) What are the effects of nurse assault on job satisfaction and personal well-being

of nurses? For the purposes of this study, the definition of nurse assault and/or abuse was “an act of aggression, verbal or physical assaults or threats in the workplace to which the worker is subjected to in the course of employment from patients, patient's family members, physicians, and other allied personnel.”⁴

Methods

This descriptive, comparative study was conducted in a 770-bed acute care North Florida regional medical center to assess the extent, nature, and precipitating factors of nurse assault by patients and visitors or family members among 3 specialty groups of RNs. The convenience sample (n = 125) consisted of all RNs employed in the emergency department, cardiovascular ICU, medical/surgical ICU, intermediate care unit, coronary care unit, general medical/surgical floor, pulmonary specialty floor, diabetes specialty floor, oncology floor, and cardiac progressive floor. Nurses employed in the neurology ICU and neurology floor, pediatric ICU and pediatric floor, operating room, and recovery room were not included in the study because of the increased possibility of inflating the incidence of assault and abuse. Nurses temporarily employed through an agency and traveling nurses also were not included. The cardiovascular care, medical-surgical, intermediate, and coronary care units were grouped together to represent the intensive care group. The floor areas were pooled together to form the floor group, and the emergency department was a group by itself.

A 27-item, self-report Hospital Assault Survey for Nurses was developed for this study by Deborah D. May, ARNP, MSN. It was a modified version of the Nurse Assault Survey⁵ developed by the Psychiatric Nursing Interest Group of Ontario, Canada, published in 1992. Reliability and validity data could not be obtained for this survey, although it has been distributed to more than 2000 nurses in Canada. The Nurse Assault Survey did not specifically address specialty groups, specific types and frequency of assault or abuse incidences, or separate inquiries regarding assault or abuse incidences perpetrated by patients and family members or visitors. Therefore, questions from the Hospital Assault Survey for Nurses were modified and developed to address the specific nursing specialty groups

and to obtain more specific information regarding the types and extent of assault or abuse occurrences. Additional questions were designed to determine the number of weapons found on patients by nurses, responses of nurses to assault or abuse, responses of management to the reporting of assault or abuse occurrences, and prevention or intervention measures that nurses would support to assist in dealing with assault or abuse. The incidence of assault or abuse perpetrated by physicians was not included in this study in order to focus on patient, family, and visitor occurrences.

A pilot study was conducted prior to the widespread administration of the survey to test the content validity and clarity of questions. Institutional Review Board approval was obtained from the researcher's educational institution and the institution in which the survey was distributed. The survey was distributed by the researcher to the nursing staff in the designated areas on the day, evening, and night shifts during a 2-week period. The survey took approximately 10 minutes to complete, and the participants were asked to complete their survey at their convenience sometime during the course of their shift.

Descriptive statistics were used for the characteristics of the sample population, responses to each question on the survey, interpretation of responses to categorical questions, and to detect significant differences among the variables. Analysis of variance (ANOVA) was used to test for variance within and between groups. The level of significance was set at .05.

Results

Eighty-six of 125 surveys were completed and returned, for a response rate of 68.8%. The majority of respondents were married, white women between the ages of 26 to 30 years and 36 to 50 years. Approximately 45% of the nurses held a bachelor's degree in nursing and had 1 to 5 years' experience in nursing and in their specialty area. Nearly 45% of the nurses worked 12-hour shifts, and 40.7% worked 8-hour shifts. Approximately 49% of the nurses worked more than 50% of the time on the day shift, 33.7% on the evening shift, and 17.4% on the night shift. The ICU, emergency department, and general floor areas were represented by similar numbers of respondents (31.4%, 32.6%, and 36%, respectively).

TABLE 1
Verbal and physical assaults by patients and family members within the past year

	Emergency department (%)	ICU (%)	Floor (%)
Verbal assault	100	85.2	80.6
Physical assault	82.1	77.8	63.3

TABLE 2
Types of assaults by patients experienced at least once in the past year (n = 86)

Type of "assault"	Total (%)	Emergency department (%)	ICU (%)	Floor (%)
Kicked	55.3			
Pinched	58.1			
Spat upon	52.3			
Objects thrown at you	44.7			
"Cursed at"	91.7	96.4	96.3	83.3
"Yelled at"	91.8	96.4	92.6	86.7
Threatened with harm	70.7	85.7	66.7	50

Eighty-eight percent of all respondents indicated that they had been verbally assaulted and 74% reported that they had been physically assaulted while at work. Large percentages of nurses in each of the 3 areas reported significant rates of verbal and physical assault (Table 1). Most perpetrators of assault were male (50.6%). Approximately 6% of the nurses reported being assaulted with a knife and 4.7% with an object; there were no reports of being assaulted with a gun. Thirty-six percent reported no physical harm, 36% reported emotional distress, 26.7% reported bruises or abrasions, 24.4% reported pain, 10.5% reported muscle strain, 3.5% reported broken bones, and 2.3% reported permanent disability. Also of interest is that 41.9% reported that they believed the assault was related to racial tension.

To determine the extent and nature of assaults by patients, nurses were asked to describe the types of assaults and the frequency of these assaults from patients in the past year (Table 2). ANOVA revealed that ED and ICU nurses experienced a significantly higher incidence of being "cursed at" ($P = .04$). Nearly 86% of ED nurses reported being "verbally threatened with harm" by patients within the past year,

TABLE 3
Types of assaults by family members or visitors experienced at least once in the past year (n = 86)

Type of "assault"	Total (%)	Emergency department (%)	ICU (%)	Floor (%)
"Cursed at"	59.3	85.7	48.1	45.2
"Yelled at"	74.4	89.3	81.5	54.8
Threatened with harm	34.9	57.1	25.9	22.6

representing the highest incidence of this type of assault among all groups of nurses in the study ($P = .000$). ICU nurses represented the second highest incidence of this type of assault (66.7%). Fifty percent of floor nurses reported experiencing this type of assault at least once within the past year.

Nurses were asked the same questions regarding the type and incidence rates of assaults by *family members or visitors*, which yielded similar results with regard to being "cursed at" and "yelled at" (Table 3). Seventy-four percent of the nurses among all groups reported being "yelled at" by family members or visitors at least once within the past year. Approximately 60% reported being "cursed at" at least once in the past year. Thirty-five percent reported being "verbally threatened with harm." One-way ANOVA revealed that ED nurses reported the highest incidence of being "cursed at" ($P = .000$), "yelled at" ($P = .001$), and "verbally threatened with harm" ($P = .03$) by family members or visitors. ICU nurses reported an 81.5% occurrence rate, and floor nurses reported a 54.8% occurrence rate of being "yelled at." ICU nurses and floor nurses reported similar occurrence rates of being "verbally threatened with harm" at 25.9% and 22.6%, respectively.

The most common causes of assault or abuse against nurses by *patients* were reported as cognitive dysfunction (including head injury, dementia, and developmental delay) (79.1%), substance abuse (60.5%), and anger related to the patient's situation or condition (55.8%). Anger related to long wait times and anger at staff members related to enforcement of hospital policies (eg, visiting hours and number of visitors in the room) also were indicated as common causes (38.4%). Anger related to the health care system in general was indicated by 27.9% of the nurses as a common cause of abuse or assault.

The most common causes of assault or abuse by *family members or visitors* were reported to be anger at staff members related to enforcement of hospital policies (58.1%), anger related to the patient's situation/condition (57%), anger related to long wait times (47.7%), and anger related to the health care system in general (46.5%). Substance abuse (22.1%) and cognitive dysfunction (3.5%) were listed as the least common causes of assault or abuse by family members or visitors.

Fifty percent of assault or abuse incidences perpetrated by patients were never reported in writing: "There was no evidence of physical injury" (54.7%), "It's part of the job" (39.5%), "I didn't think it would make any difference" (37.2%), and "I understood the source of their anger and felt sorry for them" (36%). Approximately 48% of the nurses reported that they had never filed any written reports regarding assaults or abuse incidences by family members or visitors. Approximately 38% reported, "I didn't think it would make any difference"; 33.7% reported "It's part of the job"; 33.7% reported, "There was no evidence of physical injury"; and 25.6% reported, "I understood the source of their anger and felt sorry for them."

The most commonly reported measures that nurses would support to prevent future assaults were providing specially trained security staff for high-risk situations (76.7%), training in techniques for reducing aggression (66.3%), self-defense training (64%), use of metal detectors at the ED entrance (62.8%), and specialized security police protection for staff members when violent patients are hospitalized (60.5%).

The most common intervention measures that nurses would support for nurses who have been assaulted in the workplace included immediate medical treatment (72.1%), required reporting of all incidences of physical assaults and threats of physical harm (68.6%), removal, transfer, or discharge of the perpetrator from the department (54.7%), immediate access to individual counseling (52.3%), and immediate permission to leave work for the remainder of the shift (47.7%).

As for the effects of nurse assault or abuse on the individual, 65.2% of the nurses felt some degree of decreased job satisfaction following an occurrence of assault/abuse. Eighty-four nurses (61.9%) indicated that they believed their employer failed to protect nurses from workplace

assaults. Other common effects reported were anger (66.3%), anxiety (53.5%), fear (36%), emotional distress (36%), disbelief (33.7%), powerlessness (23.3%), and reduced confidence on the job (19.8%). Ninety percent of all nurse respondents indicated they were concerned about their safety in the workplace. Interestingly, approximately 41% indicated that their institution had taken no measures to assist them in dealing with workplace violence.

Several incidental findings in this study are worth mentioning. Nearly half of the nurse respondents in this study reported finding a weapon on a patient. Most of the weapons were found on ED patients, followed by floor patients. Approximately 70% of nurses reported witnessing a verbal threat of physical harm to another nurse. According to Florida law, these incidences may very well constitute assault in legal terms. These occurrences involved patients and family members or visitors. Finally, nearly 42% of nurses in this study believed that racial tension was a contributory factor in assaults against nurses. This finding may be related to the geographic area in which this study was conducted, because Florida is a very racially and ethnically diverse state.

Discussion

Findings from this study are consistent with previous research regarding verbal and physical assault or abuse against nurses.⁶⁻⁸ The causes of assault by *patients* found in this study were also consistent with previous research,⁸⁻¹¹ specifically, cognitive dysfunction resulting from dementia, substance abuse withdrawal, and acute delirium. Our findings regarding assault and abuse occurrences from family members or visitors, however, are unique in that little has been reported. Our results indicate that significant numbers of nurses are being assaulted or abused by family members and visitors, as well as by patients themselves. In this study, the most common causes were related to anger regarding enforcement of hospital policies, the patient's situation/condition, long wait times, and anger toward the health care system in general. Whereas many nurses overlook assaults by patients who are cognitively impaired or undergoing withdrawal from legal and illegal substances, it seems that assaults from family members/visitors who are angry or intoxicated are also being tolerated by nurses and medical institutions and are not being reported to law enforcement

or the medical institution. Although the rights of patients are important, the rights of nurses to be protected from assault and abuse in the workplace should have equal consideration and respect. Comments written in the margins of the surveys by the respondents indicated a common theme—that nurses' rights are being compromised and/or neglected to ensure patient/customer satisfaction. In other words, institutional emphasis and public perception on customer satisfaction and patients' rights may be compromising nurses' rights to be protected from workplace violence.

Findings from this study regarding reasons for not reporting incidences of assault are consistent with previous research.¹² Nurses do not seem to believe it is necessary to report assault or abuse if there is no evidence of *physical* injury, as if proof of assault is needed to justify reporting the incident. In addition, many nurses believed that reporting the incident was extremely time consuming and would not result in any action by hospital managers. Findings related to the effects of assault or abuse on job satisfaction are also consistent with previous research in this area.^{9,13} The perceived lack of support from managers probably contributes to low report rates, decreased job satisfaction, and acceptance that assaults are "part of the job."

The effects of nurse assault or abuse on the nurse as an individual found in this study were, again, consistent with previous research.^{6,7,9,13-16} Anger, fear, emotional distress, powerlessness, and reduced confidence on the job reported by the nurses in this study and previous studies can significantly affect the nurse's ability to function and cope. "Calling in sick," medication errors, further conflicts with patients and family members and visitors, conflicts with co-workers, and decreased job satisfaction are some of the possible outcomes of these effects of nurse assault on the individual nurse.

Nurses who participated in this study supported the following preventive and intervention measures:

1. Specially trained security personnel for high-risk and high-traffic areas
2. Staff training in aggression reduction techniques and self-defense
3. Use of metal detectors
4. Flagging charts of patients who have exhibited violent behavior during past admissions
5. Improved alarm systems/panic buttons in several easily accessible locations

Previous studies have not provided such a detailed list of prevention and intervention measures. It is apparent that the nurses who participated in this study believed that much more needs to be done to protect them against workplace violence.

Limitations

A convenience sample of nurses in one individual hospital limits the ability to generalize the results to the entire nursing population. Minority and male respondents were underrepresented. The night shift nurses said that they were "too understaffed and busy" to fill out the questionnaire on time, and thus they also were underrepresented in this study, possibly underrepresenting the actual incidence of assault or abuse. More input from the night shift is needed because it is a shift with fewer available resources.

Implications for practice and education

Considering the large percentage of nurses who reported being assaulted in the workplace, it is important for nurses to be educated at the undergraduate level about assault and abuse, including state definitions of assault, techniques for self-defense, and aggression diffusion training. Hospital administrators and managers must provide clear policies and procedures regarding assault and abuse against hospital employees. Incident reports should be considered mandatory for any incidences of abusive or assaultive behavior, regardless of whether there is evidence of physical injury. More attention to the emotional and cumulative effects of assault and abuse on the individual nurse is needed. Emergency employee assistance programs can be developed to provide immediate assistance to employees following an assault or abuse incident. Security officers might try to prevent, rather than respond to, assaults. Many nurses reported feeling as though they were responsible for enforcing the policies of the hospital, which results in tension and anger between the family members, visitors, and patients and the nurse. Thirty-six percent of nurses reported ineffective restricted access to patient care areas, which can result in nurses feeling vulnerable and powerless to control traffic and provide patient privacy.

The use of metal detectors in medical facilities has shown that there has been little resistance from the public

regarding the use of these devices, and significant numbers of weapons have been removed from persons upon entry through emergency departments.¹⁷⁻²⁰

Recommendations for future research

A larger sample from more than one institution and with more ethnic and gender diversity is needed to provide a more accurate picture of the incidence and nature of assault and abuse by patients and family members and visitors. More research is needed to determine if assault and abuse awareness education, self-defense training, aggression reduction training, and improved security measures reduce the incidence of assault and abuse and/or improve the emotional well-being and job satisfaction of nurses.

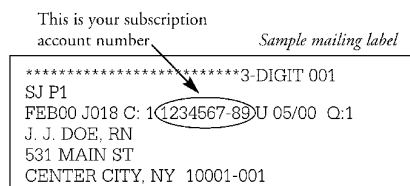
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