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Repeat Violence in the Emergency Department

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REPEAT VIOLENCE IN THE EMERGENCY DEPARTMENT

By

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ABSTRACT

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The purpose of this descriptive study was to conduct a secondary analysis of the data set obtained from the Trauma and Emergency Center Violence Project (Dorsey, 1994). It was noted during the original 6 month study of 33,098 emergency department visits that some patients threatened or carried out real violence on multiple visits.

This study (a) identified the percentage of incidents in the initial sample that were perpetrated by repeat offenders, (b) described the types of violent behaviors, (c) explored the relationship between current substance and psychiatric history and the number of threatened or real violence incidents.

A descriptive research design with a non-probability convenience sample was used. The sample consisted of 32 repeat offenders. The behaviors of the repeat offenders were summarized using frequency counts and percentages. The Cramer's V was the statistic used to describe the significant and moderate correlation between psychiatric history and repeat violence. No correlation between substance abuse and repeat violence was identified.

This thesis is dedicated to my husband Tom for his faithful support of my educational endeavors and to my sons Tom and Michael for their patience with their student mom.

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A special thanks to the staff of the Trauma and Emergency Center at Bronson Methodist Hospital for their participation in the data collection process for this project. Their continued efforts to improve safety in their work environment for peers, visitors and patients is a tribute to their dedication.

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CHAPTER 1

INTRODUCTION

The threat of violence is an increasing concern in modern society and healthcare delivery settings. A recent survey of 418 hospitals in the United States found that in one year 2,118 assaults, 63 rapes, 551 bomb threats, and 72 instances of arson occurred in hospitals (U.S. Department of Health & Human Services, 1988).

Dramatic increases in violent crime in our society are a growing national concern, and incidences of violence in healthcare settings reflect this trend. Society tends to treat violence as an inevitable part of life, not as a preventable problem. Nursing personnel tend to view potential or real violence as a normal reaction to abnormal circumstances. Well known hazards such as exposure to bloodborne pathogens, chemotherapeutic agents, and radiation have been the subject of many occupational health studies over the last decade. By contrast, violence directed toward nursing personnel has only recently been addressed as an occupational health hazard (Lipscomb & Love, 1992).

Violent behavior in patient populations is a problem for all concerned. Violence is a threat to the welfare of the patients themselves, to other patients receiving services, to visitors, and to staff. Violence by patients

directed toward nursing staff may result in injury, lost time, high stress, job dissatisfaction, and subsequent psychological consequences. The price is high; patient violence contributes to increased hospital expense in lost productivity, insurance and medical costs, and monetary losses from litigation.

Nurses are acutely aware that encounters with violence are possible in any healthcare environment. Because of this heightened consciousness, nurses today are less willing than in the past to view violence as an acceptable job hazard. Ensuring personal safety is the foundation of self-care; nurses have been teaching this to patients for years and are now taking it to heart themselves (Worthington, 1993).

Nurses are accustomed to seeing, stabilizing, treating, and caring for victims of violence and their families every working day. They are educated to meet the needs of the patient population as they are physically and emotionally challenged. In addition to ministering to the victims of violence, nurses are more frequently becoming the victims themselves (Alspach, 1993).

Within the hospital setting, the emergency department is the clinical site at highest risk for violence. Because emergency departments are open 24 hours a day and provide unrestricted access to the public, the staff is exposed

constantly to an unscreened and potentially high-risk population for violent behavior (Dubin, Tardiff & Maier, 1992).

In order to define the extent of personnel exposure to potential and real violence in the emergency department, the Trauma and Emergency Center Violence Project (Dorsey, 1994), examined behaviors of patients receiving services in the Trauma and Emergency Center of a 464-bed midwestern hospital over a six month period. The behaviors of patients during 33,098 visits were observed and described related to violence (threatened and real).

Behavior incidents perpetrated by 432 patients ages 14 through 88 years of age were noted during the course of the original study. These ranged from argumentative in nature to out of control violence. The sample was described according to age, gender, the location in the Trauma and Emergency Center where the violence occurred, and if the patient was a current substance abuser and/or had a psychiatric history. Additional security support from coworkers, the hospital security department and the Department of Public Safety was described. The use of both physical and pharmacologic restraint was reported. Fright and/or personal injury incurred by Trauma and Emergency Center personnel, that resulted from the patient's behavior, was described along with the nature of the injuries. The

documentation of the incident in the patient's chart or on an incident report was recounted. The sociodemographic as well as descriptive data was summarized. The Trauma and Emergency Center Violence Project (Dorsey, 1994) confirmed that emergency department staff were frequently exposed to potential and real danger. The results were used to demonstrate the need for additional Trauma and Emergency Center safety measures. Changes in Security Department policies were implemented, electronic locks and door entry pads were installed at the entrances of the department and enhanced video monitoring was implemented during and following the study.

It was discovered during the data collection process that on several occasions violent behaviors were displayed by the same patient during different Trauma and Emergency Center admissions. There was no formal communication mechanism regarding this issue. There was no way of "tagging" charts to indicate a patient with previous and possibly potential behavior problems. A patient could victimize personnel one day and return any number of times to inflict her/his behaviors on an entirely different set of personnel who were unaware of past transgressions.

The purpose of this descriptive study was to conduct a secondary analysis of the data set obtained in the Trauma and Emergency Center Violence Project (Dorsey, 1994). This

study examined the number of violent patients who returned on more than one occasion to the Trauma and Emergency Center and the types of violence manifested during the course of the initial study.

This research is important to nursing because the repeat offender is using a behavior pattern that is illness maintaining. Nursing personnel may be taught techniques and educated to redirect the patient's anxiety toward health enhancing behaviors. The interpersonal process may then foster a therapeutic relationship.

Repeat offenders have an increased potential to harm themselves, nursing personnel, other patients, visitors and valuable hospital equipment. It is critical to recognize and assess repeat offenders in order to anticipate and plan for deescalation techniques and violent behaviors. If this information is available to nurses, it can significantly increase awareness of the need for safety precautions.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

Hildegard E. Peplau based her interpersonal theory of nursing primarily on theories of interaction. Her theory was the first conceptualization of nursing to emphasize interpersonal relations between the nurse and the patient and to focus on the analysis of the interpersonal processes central to that interaction (Meleis, 1985). She observed that the crucial elements in nursing situations are the nurse, the patient and what transpires between them (Peplau, 1954). This interactional or interpersonal point of view was in sharp contrast to the prevailing notion that a pathological condition resided within the patient, and the nurse's role was to assist the physician to fix that condition without consideration of the interpersonal elements or the nurse's autonomy. Peplau directed nurses' attention to the need to develop a consciousness, that is a theory, about what the nurse and patient did together. Her theory also provided the knowledge to turn nursing in the direction of autonomous practice during an era when nursing was dominated by medicine (Fitzpatrick & Whall, 1983).

Peplau's theory of nursing provided the theoretical framework for this study. Peplau focused on specific nurse

and patient relationships (1962). She considered the bond between nurse and patient to be the key to the nursing process. The four central concepts in her model are interpersonal process, nurse, patient, and anxiety.

The interpersonal process is a central component of the model and describes the method by which the nurse facilitates useful transformations of the patient's energy or anxiety. The interpersonal focus of Peplau's theory requires that the nurse attend to the interpersonal processes that occur between nurse and client. This is in sharp contrast to many nursing theories that focus on the client as the unit of attention. The emphasis is the interpersonal process and relationships, not the constituent parts (or individuals). Interpersonal processes include the nurse-client relationship, communication, pattern integration, and the implementation of the nursing role (Forchuk, 1993).

The nurse is the instrument of the art of nursing. The nurse's self-presentation and responses to clients reflect a unique blend of ideals, values, integrity, and commitment to the well-being of others. Each nurse is a one-of-a-kind artist in nursing practice (Peplau, 1988). Nursing is an educative instrument, a maturing force, that aims to promote health (Peplau, 1952).

Nursing was conceptualized as the interpersonal

relationship between emergency department personnel and the patient that is necessary to redirect the patient's anxiety toward health maintaining behaviors. The goal of nursing is achieved when emergency department personnel assist the patient to cope with anxiety and move toward health. For the purpose of this study the term "emergency department personnel" included registered nurses, licensed practical nurses, and technicians who staff the Trauma and Emergency Center.

Peplau (1952) defined person as an organism who "strives in its own way to reduce tension generated by needs." Tension results from unmet needs or unaccomplished developmental tasks. For the purpose of this study, Peplau's concept of person was defined as the repeat offender--a patient who has threatened or displayed violent behaviors during more than one visit to the Trauma and Emergency Center.

The nurse and patient clarify the patient's problem(s) and mutual expectations. Goals are explored while deciding on appropriate plans to improve health status. This process is influenced by both the nurse's and the patient's perceptions and preconceived ideas emerging from their individual uniqueness (Belcher & Fish, 1990).

Peplau (1989) describes anxiety as "an energy that emerges in response to a perceived threat." The threat

could range from the physical to the metaphysical. She also characterized the sequence of steps in the development of anxiety as including: holding expectations, expectations not met, discomfort felt, relief behaviors used, and relief behaviors justified. The expectations can include things such as beliefs, needs, goals, wishes, and feelings. The relief behaviors also cover a wide range of possibilities including aggression, withdrawal, compulsive behavior, psychosomatic complaints, delusions and risk-taking behaviors among others (Forchuck, 1993).

People (not just patients) generally develop patterns of relief behaviors that they tend to use over and over again. Some of these patterns are more helpful than others. Anxiety is often a basis for the patient to seek assistance from the nurse. At times, problems created through these relief behaviors bring the patient to seek the services of the nurse. At other times the patient seeks assistance because he or she finds the relief behaviors inadequate in relieving the anxiety (Forchuck, 1993).

Peplau (1989) described how the nurse can assist the patient to channel anxiety productively. First, the patient needs to be aware of and be able to name the anxiety. Then, the patient needs to see the connection between the anxiety and the relief behavior. Finally, the patient formulates and states expectations. This final part of the process

includes an understanding of the connection between held expectations and what actually happened and consideration of factors amenable to control.

Peplau (1952) acknowledged that the person lives in an unstable environment. Environment is physiological, psychological and social fluidity that may be illness-maintaining or health promoting (Forchuk, 1993).
The theory focuses on the psychological tasks within the person. This view was appropriate in 1949 when Peplau's first book was written (Belcher & Fish, 1990). The narrow perception of environment is a major limitation of the theory. In this study, environment was conceptualized as the internal psychological state of repeat offenders who visit the Trauma and Emergency Center.

Anxiety was conceptualized as relief behaviors that are described as real or threatened violence during repeat visits to the emergency department. In illness, needs and behavioral characteristics of less mature developmental stages are predominant. Illness is a time of regression and retreat to mobilize energy for use in reducing tension generated by unmet needs and conflicting goals (Reed & Johnson, 1989).

Peplau (1952) defined health as "a word symbol that implies forward movement of personality and other ongoing human processes in the direction of creative, constructive,

productive, personal, and community living" (p. 82). This definition emphasizes that the concept of growth is inherent in health. Peplau believed that assisting the patient to achieve health is the primary goal of nursing activities.

Health was conceptualized as the phenomenon that results when tension due to unmet needs or unaccomplished developmental tasks is relieved and the individual's energy is directed toward promoting personal well-being. Real or threatened violence (destructive behaviors) directed at nursing personnel was conceptualized as illness that is a barrier to achieving health.

Peplau (1989) considered the use of verbal communication to be an essential component of the nurse-patient relationship. Talking about issues and concerns gives the patient an alternative to acting out. Communication includes both verbal communication and non-verbal communication. Verbal communication is expressed through language, while nonverbal communication is expressed through empathic linkages, gestures, postures and patterns (Forchuck, 1993). Verbal communication, or language, is important as a reflection of thought processes. This is obvious on the literal content level; for example, the patient gives information on pain, on current abilities, or on perceptions of problems. However, in addition to the literal content, there are symbolic meanings, patterns, and

underlying assumptions that can be conveyed through the choice of words or phrases (Forchuk, 1993).

The patient who repeatedly threatens or perpetrates violence upon nursing staff is expressing symbolic meaning related to unmet needs. Ineffective coping skills are manifested. These incidents may mask the source of the patient's anxiety and direct the nurse's attention to issues of personal safety for self and others. When this occurs the patient and nurse are not participating in a therapeutic relationship and the patient's behaviors are illness-maintaining.

Each individual has customary patterns of interacting with others. Pattern integrations are the products of the interaction of the patterns of more than one individual. Peplau (1973, 1987) has identified four common pattern integrations: complementary, mutual, antagonistic and mixed. This study described the antagonistic pattern integrations of repeat offenders.

Antagonistic pattern integrations include the combination of different individual patterns that do not fit well together. The combination creates a discomfort or disharmony that can be used as a motivation toward change if properly channeled or a barrier to change when ineffectively channeled. The inherent incongruence of antagonistic pattern integrations is anxiety producing. The resultant

anxiety needs to be harnessed and directed toward health promoting behaviors (Forchuk, 1993).

Theoretical Definition of Terms

The repeat offender is a patient who has presented to the Trauma and Emergency Center on more than one occasion and has threatened or perpetrated violence on nursing personnel. The repeat offender is a patient whose presence in the Trauma and Emergency Center may compromise the safety of the staff members as well as other patients and visitors.

Threatened violence includes verbal and non-verbal cues that demonstrate to the nursing personnel a willingness on the part of the patient to inflict harm and compromise the health of the care-givers. Verbal cues include actual statements, volume of statements and tone of voice. Non-verbal cues include body language, gestures, facial expressions, activity level and brandishing of weapons.

Real violence includes physical harm to nursing personnel perpetrated by the patient during the course of a Trauma and Emergency Center visit. Real violence may include a physical altercation or the use of a weapon.

Literature Review

The majority of nursing research that has explored the types and frequency of threatened or real violence directed toward emergency department staff is retrospective and informal. The information was obtained from incident

reports, as well as from nursing staff and administrative surveys. Feelings about safety and actual incident involvement were described. This researcher was unable to find detailed data that described patients who repeatedly exhibited behavior problems and/or violence tendencies in an emergency department during subsequent visits. There were several studies that led this researcher to seek more indepth information related to the incidence of real or potential repeated violence directed toward nursing personnel.

In an informal telephone survey of nurse managers from seven emergency departments in the greater Philadelphia area (Blank & Mascitti-Mazur, 1991), all respondents indicated that concern for their staff's safety and private property were high on the list of management issues. All of the nurse managers reported that their staff had removed weapons from patients within the past year, including guns with live ammunition, knives, box cutters, blackjacks, piano wire, brass knuckles, razors, hand grenades and drug paraphernalia.

Most of the Philadelphia emergency nurses interviewed at local Emergency Nurses Association meetings (Blank & Mascitti-Mazur, 1991) reported that they usually dispose of the weapon by sending it to security with other patient belongings or by giving it to the police, without ever

documenting its presence in a way that allows tracking or determination of trends. The nurses also were asked what they believed precipitated violent behavior by patients. They cited lengthy waiting times, overcrowded waiting rooms (often poorly lit with limited access to refreshments and restrooms), previous problematic emergency department encounters, patients' perceptions of being ignored by harried staff members, and the lack of appropriate social service resources.

Faust and Rhee (1993) described the incidence of battery of emergency department medical staff by patients or visitors at a university-affiliated Level I trauma/emergency center over a six month period. The hospital, located in a major metropolitan area, had an annual emergency department census of approximately 64,000. All staff members who had been punched, kicked, grabbed, pushed, or spat upon by a patient or visitor while on duty in the emergency department completed a questionnaire after the incident.

During the study period, there were 19 instances of violence against staff by patients. Staff members were punched six times, kicked seven times, grabbed three times, pushed once, and spat upon twice. Blows usually were sustained on the face or head (n = 7) or on the extremities (n = 7). Hospital incident reports were completed in only four cases. None of the injuries was serious enough to

require emergency department staff treatment or disability leave. The assailant was usually male (n = 15) and usually on a psychiatric or substance abuse detainment (n = 15) (Faust & Rhee, 1993).

Faust and Rhee (1993) studied the incidence of physical violence because it represents a clear act and demonstrates violent intent against a staff member. It is important to note that the study underestimates the overall risk to emergency department staff because verbal threats and missed blows were not reported. Of great concern is that in many settings, weapons appear to be readily available to patients and visitors.

The Faust and Rhee study (1993) suggested that instances of physical violence in an urban university hospital emergency department are usually not serious and that these acts are committed by patients who have a history of psychiatric and/or substance abuse. The study was consistent with previous reports suggesting a reporting rate of only a fraction of the true incidence.

The California Emergency Nurses Association (ENA) conducted an informal survey of violence in California emergency departments following the April 15, 1990 shooting deaths of an emergency department nurse and a emergency medical technician student (Keep & Glibert, 1991). A physician and a visitor were also injured when a disturbed

family member walked into the department and opened fire.

Discussions among emergency nurses across California demonstrated that such assaults or injuries sustained at the hands of patients or patients' families were not isolated events (Keep & Glibert, 1991). As a result of these discussions, California ENA's Government Affairs Committee decided to conduct a survey to determine the following: (a) the magnitude of violence against emergency nurses, (b) current practices in effect to deal with aggressive or violent behavior, and (c) current security practices within institutions. Members of the Government Affairs Committee agreed that if a problem was found, the California ENA would draft and sponsor legislation to curb violence against emergency department staff.

Nurse managers in five California metropolitan areas were informally surveyed (Keep & Glibert, 1991). Committee members living in each metropolitan area contacted local emergency departments or made use of a hospital facilities directory. Because most violence reported occurs in urban areas, urban hospitals were primarily targeted and were therefore heavily represented in the data. Nurse managers (N=103) were surveyed about their emergency departments. Respondents were from inner-city (10%), urban (60%), and rural (30%) hospitals. Seventy percent of respondents were from private hospitals and 30% were from public hospitals.

Thirty-five percent of the respondents indicated that there was a predominance of drug and gang activity within the area served by their facility. The authors believed that nurse managers downplayed the magnitude of violence. Some managers may have feared negative public relations consequences.

Several interesting observations were made about the California ENA data (Keep & Glibert, 1991). First, it was surprising to find that a clear majority of emergency departments did not have gang and drug activity in the area served by the hospital and yet still experienced considerable violence in their emergency department. It may be a myth that violence occurs primarily in areas where gangs and drugs flourish. Second, although most incidents were threats--verbal and physical (without a weapon)--actual acts of violence were occurring. Most violence was directed at staff members, resulting in mostly minor injuries. Severe injuries were noted in several instances.

A startling finding in the Glibert and Keep (1991) study was that more than one-half of all California emergency departments surveyed reported incidents that involved weapons brought into the department by patients or visitors. The most common weapons were knives and loaded guns. Interestingly, even when violent or aggressive patients were recognized, few were searched. More incidents

of hospital emergency department violence have been reported since the survey was conducted in late 1990. These include gang shoot-outs in the emergency department, attacks against personnel, and display or use of weapons in the emergency department. The California General Assembly Congress has drafted a bill that is being introduced to reduce emergency department violence and better prepare emergency department personnel to combat violent acts.

Data on the extent of exposure of emergency department personnel to potential and real violence was collected during the Trauma and Emergency Center Violence Project (Dorsey, 1994). The six month study also described intervention(s) used to secure protection for the patient, emergency department personnel, and others in the Trauma and Emergency Center in the face of danger. Interventions included use of security support personnel and physical and pharmacologic restraint.

During the Trauma and Emergency Center Violence project (Dorsey, 1994), there were 33,098 patient visits to one emergency department. Problems ranging from verbal abuse to threatened or real physical violence were exhibited by 358 (1.3%) of the patients. Only deliberate verbal and physical abuse were reported, based upon the judgement of the emergency department personnel. Frightened young children who were incapable of perpetrating injury and those who were

suffering from diagnosed dementia and head injury were not included in the study. Four emergency department personnel reported injuries due to patient violence during the study. None of the injuries required medical intervention. Under reporting was noted to be a limitation of this study.

Summary of Literature Review

It is the belief of the managers who participated in these studies that emergency department nurses often are exposed to patient behaviors that place them at risk for emotional and/or physical harm. However, the data was not widely reported and, therefore, that belief was not substantiated. No studies were found that reported the ages of the patients who were violent toward healthcare providers. References were made to substance abuse and psychiatric illness in only two of the studies that were reviewed. One study reported on violent behaviors perpetrated only by those who were substance abusers or in psychiatric crisis. The literature did suggest that there is insufficient knowledge related to the number and types of threats, as well as real violence. Under reporting is one of the major deficits that prevents an accurate description of this problem.

The study of violence directed toward emergency department nursing personnel is limited and predominantly informal. Few of the studies are scientifically based.

Much of the research is retrospective in nature and, therefore, subject to incorrect recall.

No studies were found that described the violent patient who returned repeatedly to the emergency department. Secondary analysis of the Trauma and Emergency Center Violence Project (Dorsey, 1994) data set provided information about those patients.

Research Questions

The four research questions were: (a) What percentage of incidents in the initial sample were caused by repeat offenders? (b) What types of violent behaviors were exhibited by the repeat offenders? (c) What is the relationship between present substance abuse and the number of incidents of threatened or real violence by repeat offenders? (d) What is the relationship between history of psychiatric illness and the number of incidents of threatened or real violence by repeat offenders?

CHAPTER 3

METHODOLOGY

Research Design

The Trauma and Emergency Center is an area where patients exhibit a wide variety of physical and emotional reactions due to psychological, chemical, and organic causes. Unfortunately, some of those reactions result in threatened or real violence directed at the nursing personnel who are attempting to alleviate the patient's physical and/or emotional problems. The risk of harm to nursing personnel increases when a previously violent patient returns to the Trauma and Emergency Center--especially if information about that violence is not communicated to subsequent emergency department staff members. The purpose of this descriptive study was to conduct a secondary analysis of the Trauma and Emergency Center Violence Project (Dorsey, 1994). The behaviors of repeat offenders were described and sociodemographic data were examined.

Setting

The Trauma and Emergency Center Violence Project (Dorsey, 1994) was conducted at the Trauma and Emergency Center of an urban 464-bed southwestern Michigan hospital. The hospital has been designated a Level I Trauma Center by

the American College of Surgeons. The Trauma and Emergency Center is composed of three distinct areas: Triage, Main Department, and Express Care. All patients entering the hospital for emergency services are assessed upon arrival by the triage nurse. The patient care is then delivered in the fast track Express Care or in the main department. There are 29 beds in the Trauma and Emergency Center with capacity augmented, as needed, by hallway beds.

The Trauma and Emergency Center Violence Project sample (Dorsey, 1994) included data on all Trauma and Emergency Center patients and visitors over a six month period. The time span included 3 months of typically peak census and 3 months of expected moderate census time. All instances of threatened or actual violence were observed and described by emergency department personnel. The actual monthly census varies somewhat from year to year.

Sample and Procedure

Data from the Trauma and Emergency Center Violence Project (Dorsey, 1994) were used to discover if violence was perpetrated by the same patients on different occasions. The initial sample consisted of all Trauma and Emergency Center patients, as well as visitors, who threatened violence or displayed violent behavior during a six month period (N = 432). A subsample of repeat offenders was drawn from the initial data set of all patients who threatened or

displayed violent behaviors toward Trauma and Emergency Center nursing personnel.

Each patient who enters the study hospital is assigned a permanent identification number. The existing Trauma and Emergency Center data set was reviewed for repeat hospital assigned patient numbers thereby identifying the subset of repeat offenders in the patient population. There is no mechanism in place to screen repeat violence perpetrated by visitors.

The subsample was identified and the original data collection forms were retrieved and reviewed. The types and frequencies of the behavior problems as well as sociodemographic factors were analyzed.

Instrument

The instrument used to collect data (Appendix) for the Trauma and Emergency Department Violence Project (Dorsey, 1994) combined a behavior assessment tool designed by Green (1989) and additional sociodemographic information. It provided for the description of patient and visitor behaviors and consequences. The data collection form was divided into four parts. The first part documented sociodemographic background including hospital assigned patient number, name, age and sex from the addressograph stamp. The name was then obliterated from the form with heavy blank ink. The date and time, area in which the

behaviors occurred, evidence of current substance abuse and/or past history of psychiatric disorder were also recorded. The color of the form was pink for data collected in the Express Care and yellow for data collected in the main department.

The second part of the form, Green's (1989) staging criteria behaviors, described five levels of behavior. "Argumentative behavior, threat perceived or implied" is the least serious of the stages. The patient is angry but there is no perception that the patient is unable to control his/her anger. This stage is demonstrated when the patient states, "Let me out of here." or "Don't you dare touch me." The next stage is "Verbally threatening behavior to self, persons, or property." In this stage, the patient is planning violence against a health care provider. Such statements as, "I'm going to get you for this." or "I'm going to kill you." may be heard. Physically threatening behavior is the subsequent stage. When behavior has deteriorated to this level, the patient makes gestures that may lead to harm of self, persons or property. This behavior is noted when the patient raises his arm and shakes his fist at a care provider who is attempting a clinical intervention. "Assaultive behavior towards self, persons, or property" is demonstrated when the patient makes attempts to incur physical harm but is unsuccessful. This would

include incidents such as when the patient tries to throw an object at a care provider or tries to bite or spit. "Out of control or violent behavior to self, persons, or property" is the most dangerous of the staging behaviors. It is at this level that the patient acts upon threats and incurs physical harm to self, others or property. An example of this behavior is a suicide attempt or punching the care provider.

The third part of the data collection form described any additional security support provided by Trauma and Emergency Center staff, Security Department, Department of Public Safety, and use of physical and/or pharmacologic restraint. It provided nursing personnel the opportunity to record fright and personal injury. If a nurse was injured, a description of the injury was included. The final part of the instrument indicated the documentation source: (a) patient chart, (b) incident report or (c) report of concern (Appendix).

The data collection form was pilot tested for one month prior to the onset of the Trauma and Emergency Center Project (Dorsey, 1994). This gave nursing personnel time to become familiar with the form and give input regarding possible changes.

Content validity was addressed in the design of the data collection form. Green's (1989) behavior staging

criteria were reviewed by Trauma and Emergency Center Administrative and Education staff to assess if the criteria were representative of all levels of patient behavior. An additional stage, "Client(s) controlled and exhibits no adverse behavior" was added to the form at the request of the reviewers.

Inter-rater reliability was established by the administration of several tests designed to measure nursing personnel knowledge of patient and visitor behaviors as outlined on the data collection form. The tests were developed by the researcher. Testing of nursing personnel followed inservice training before the initial Trauma and Emergency Center Project (Dorsey, 1994) began, 1 month following implementation and again at 4 months. The test provided brief behavior scenarios for which nursing personnel selected the categories of behaviors on the data collection form. Answers from nursing personnel were compared with the correct answers provided by the investigator. This testing demonstrated 85% to 90% interrater reliability.

Human Subject Risk

Patients treated at the study hospital gave their permission for use of the information obtained during the original study when they signed the admission consent form. Patient consent was not required for the current study

because it was a secondary analysis of existing data.

The confidentiality of the study participants was protected by the removal of names from the data collection forms. This ensured that individual identities would not be linked to the information that was provided and will never be publicly divulged. The data collection forms were shredded after the secondary data analysis was completed.

Chapter 4

DATA ANALYSIS

A secondary analysis of a subset of data from the Trauma and Emergency Department Violence Project (Dorsey, 1994) was conducted for this descriptive study (Table 1). The original study described 432 behavior incidents which occurred during 33,098 total emergency department patient visits. Behavior problems were a factor in 1.3% of patient visits to the Trauma and Emergency Center during the original study. Of those 432 behavior incidents, 83 were caused by 32 repeat offenders or patients who returned to the emergency department between two and eight times.

Table 1

Population Description Original Study and Secondary Analysis

	Total ER visits n = 33,098	Violent incidents n = 432	Violent incidences by repeat offenders n = 83
Mean age	52 years	36.5 years	43.38
Sex:			
Male	n = 18,535 (56%)	n = 220 (51%)	n = 44 (53%)
Female	n = 14,563 (44%)	n = 212 (49%)	n = 39 (47%)

The first research question in this study asked the percentage of incidents in the initial sample that were perpetrated by repeat offenders. The total number of repeat offender incidents in the subsample were totalled (n = 83) and divided by the total number of originally documented behavior problems (n = 432). The percentage of incidents in the initial sample that were caused by repeat offenders was 19%. Repeat offenses made up 1% of the original emergency department visits screened in the Trauma and Emergency Department Violence Project (Dorsey, 1994).

The total number of repeat offender behavior incidents (n = 83) were generated by 32 individual patients. The population of repeat offenders consisted of 47% females (n = 15) whose ages ranged from 19 years to 79 years and 53% males (n = 17) whose ages ranged from 27 years to 88 years. The mean age of the female repeat offenders was 40.5 years. The mean age of the male repeat offenders was 46.2 years.

The second research question asked the types of violent behaviors exhibited by the repeat offenders. The behaviors were summarized for repeat offenders as a whole using frequency counts and percentages. Of the 83 repeat offender incidents, 56% (n = 46) were argumentative in nature. These were most often verbal disagreement about the provider-developed plan of care and/or the expected treatment outcome. Forty-eight percent (n = 22) of the incidents were

perpetrated by females and 52% (n = 24) by males. Verbally threatening behaviors were noted related to 17% (n = 14) of the incidents. This category represented a threat of physical harm to the caregiver related to the patient's perception of loss of control over treatment modalities and anticipated results. Of these incidents, 71% (n = 10) were caused by male patients and 29% (n = 4) by females. Physically threatening behaviors occurred in 8% (n = 7) of the incidents. Caregivers were jeopardized by kicking, spitting and grabbing and they were threatened with objects in the patients' hands. These threats of physical violence did not actually touch the caregiver but the intent to do so was clearly understood. The perpetrators were male in 71% (n = 5) of the cases. Repeat offenders displayed assaultive behavior in 8% (n = 7) of the incidents. Males were assaultive in 86% (n = 6) of the cases. Out of control violent behavior incidents were reported in 11% (n = 9) of the cases involving 78% (n = 7) males and 22% (n = 2) females. These incidents resulted in physical contact with the caregiver and caused physical harm. Some of the physically violent behaviors demonstrated by repeat offenders were scratching, biting, punching, arm twisting and kicking. Table 2 depicts the summary of threatened or actual violent behaviors reported by health care professionals who delivered care to repeat offenders .

Table 2

Behaviors Perpetrated by Repeat Offenders

	Percent of total	Male	Female
Argumentative	56% (n = 46)	52%	48%
Verbally threatening	17% (n = 14)	71%	29%
Physically threatening	8% (n = 7)	71%	29%
Assaultive	8% (n = 7)	86%	14%
Out of control violence	11% (n = 9)	78%	22%

The third research question explored the relationship between current substance abuse and the number of incidents of threatened or real violence by repeat offenders. Substance abuse (alcohol or illicit drug intoxication) was indicated in 11% (n = 9) of the behavior problem incidents perpetrated by repeat offenders (Table 3).

Table 3

Repeat/Non-Repeat Offenders in Relation to Substance Abuse

	Repeat offenders	Single offenders
Substance abuse	11% (n = 9)	14% (n = 49)
No substance abuse	88% (n = 74)	86% (n = 300)

The relationship between a history of psychiatric illness and the number of incidenets of threatened or real violence by repeat offenders was examined by the fourth research question. Table 4 demonstrates that psychiatric

illness was noted in 6% (n = 5) of the occurences.

Table 4

Repeat/Non-Repeat Offenders in Relationship to Psychiatric Illness

	Repeat offenders	Single offenders
Psychiatric illness	6% (n = 5)	2% (n = 7)
No psychiatric illness	94% (n = 27)	98% (n = 342)

In this study the independent variables were dichotomous. The history of substance abuse was treated as a dichotomous variable as was the history of psychiatric illness. The number of violent incidents were limited and, therefore, the use of parametric statistics was inappropriate. The 32 repeat offenders were compared to 32 single offenders who were randomly selected by the computer. The statistic used was the Cramer's Phi (Table 5).

Table 5

Comparison of Repeat and Single Offenders to History of Mental Illness or Substance Abuse (n = 64*)

History	Phi	Significance
Psychiatric illness	.31	.04
Substance abuse	.19	.12

* 32 single offenders were selected at random.

Chapter 5

DISCUSSION AND IMPLICATIONS

Findings and Conclusions

The Trauma and Emergency Department Violence Project (Dorsey, 1994) described 2.5 daily incidents of threatened or real violence incurred upon emergency department nursing personnel during the 6 month study period. Nearly one in five of these incidents was caused by a repeat offender. The incidences ranged from argumentative behaviors to real physical violence. Male repeat offenders were more likely to become physically threatening and assaultive than the female population. There was not a significant correlation to documented substance abuse in the group of repeat offenders. There was a significant and moderate correlation to psychiatric history (phi=.31, p=.04).

Relationship of Findings to the Conceptual Framework

According to the research findings, repeat offenders played an important role in the incidences of danger to which emergency department nursing personnel are commonly exposed. Peplau's key concepts provide a framework for nursing personnel to identify and understand a patient's anxiety as it relates to unmet needs. The importance of interpersonal communications is stressed.

The anxiety that leads to poor coping mechanisms and antagonistic relationships is often at the root of violent

behaviors. Patients who repeatedly threaten or perpetrate violence may be using these events to direct attention away from the real health care issue. The behavior prevents the formation of a therapeutic relationship between the nurse and the patient and is therefore illness maintaining.

If the nurse is able to form a relationship with the patient, the patient's anxiety may be redirected toward health promoting behaviors. Anxiety that manifests itself as violent behaviors may result as a part of a patients' usual coping pattern, in response to perceived or real animosity on the part of the caregiver, disatisfaction with care or for a myriad of other reasons. It is not only very important that the nurse recognize the cause(s) of violent behaviors, but be able to employ defusing techniques that can allow open and honest communication to take place. Peplau's conceptual framework provides guidance in achieving that interpersonal process. Once communication is established, through communication, the door to health is opened and possibly the reoccurance of violent behaviors will be averted.

Relationship of Findings to Previous Research

There are few scientifically based studies related to violence in the emergency department. There are no studies that examined the behaviors of repeat offenders. This research will add to the body of knowledge related to the

broader issue of emergency department violence and specifically to the behaviors of repeat offenders.

Limitations and Recommendations

In studies in which the data are collected by means of observation, selection bias may occur. The researchers preconceptions may unconsciously bias the objective collection of data. Despite the educative and testing processes prior to and throughout the Trauma and Emergency Center Violence Project (Dorsey, 1994) the nursing personnel's interpretation of behaviors may have been influenced by personal or outside factors. The patient behaviors were observed and recorded by 84 different emergency department personnel. In some cases the patients' behaviors may have been influenced by the characteristics or behaviors of the emergency department personnel who were caring for them.

Emergency department personnel were responsible for the collection and recording of the original research data. Another limitation of this study was that some of the data collection forms were incomplete. Every form contained the behavior displayed by the patient, however, every form did not record present substance abuse or psychiatric history.

The findings of this research study are from a small sample (repeat offenders: n = 32), therefore the findings generated by one institution cannot be generalized beyond

the present sample. Random sampling of institutions would generate a larger sample of violent and repeat offenders and would facilitate generalizibility.

An additional limitation of this and the original study was the lack of complete documentation on the data collection forms and in the patient record. There was probable under-reporting of alcohol and illicit drug intoxication, based on anecdotal comments made by nursing personnel during the study period. Laboratory testing for the presence of drugs and/or alcohol was not required for this study, however, these tests were done on all patients who admitted drug or alcohol use and all patients whose physical assessment suggested this type of impairment. Some substance abuse may have gone unrecognized.

Absence of hospital required incident reports was also noted. Administrators must ensure that they foster an environment that encourages the reporting of all violent incidents and provides supportive and competent follow-up care to nursing personnel.

Lack of patient satisfaction with care delivery may have contributed to poor coping behaviors by some of the repeat offenders. Argumentative behaviors may have been an appropriate response to unmet needs or may have been a reaction to hostility on the part of the care provider.

A further limitation was that there were 12

documentation forms in the original study that were not stamped with patient identification number, age and sex (hospital stamper). It was impossible to determine if these patients were among those who were repeat offenders.

Implications for Nursing

Perceptions of what constitutes threatened or real violence are based on a person's experience, education, and awareness. Additionally, nurses may view violent behaviors or threats as normal responses to abnormal circumstances.

Based on the findings of this study, the emergency department patient triage process should include screening for potentially violent behaviors. This researcher believes that the appropriateness of the admission should be carefully evaluated including previous acts of potential and real violence. Rapid admission into a private room is recommended for the high risk patient. As a means of forewarning nursing personnel, this researcher maintains that the charts of patients who have a history of violence should be flagged. Special consideration related to patient confidentiality is necessary.

Nursing staff development programs for the emergency department nursing personnel should include extensive training, including techniques for violence de-escalation using both verbal skills and physical restraint. It is vital that educational programs increase awareness and

assist nurses to address personal and situational variables that are present in cases of threatened or real patient violence.

The emergency department is a high risk setting related to violence. Nurse administrators should be cognizant of the special safety needs of the nursing personnel who staff the area. Staffing patterns should ensure adequate response to escalating situations. Along with improved staffing is the need for consistent and adequate shift-to-shift report and appropriate orientation of new and float staff.

It is important to note that the focus of this study was to describe characteristics of patients who displayed violent behaviors on more than one admission to the emergency department. Violence directed toward emergency department nursing personnel has not been adequately studied. Efforts are needed to further define the risk of violence as well as identify and test preventative measures to reduce future violent acts.

Violent incidents are severely under-reported. Most studies emphasize data that is gathered from formal hospital incident reports or from retrospective patient profiles. Environmental factors associated with violence have not been thoroughly studied.

The adequacy of existing hospital security, employee training, policies and procedures for preventing violence

has rarely been studied. When examined, it suggests that it is sorely inadequate, particularly in emergency settings. Identified risk factors for violence include staffing patterns, novice staff, time of day, and containment activities. Further study is needed into all of these areas. The emotional impact of violent behaviors on nursing personnel in health care settings should also be examined. Continued research in this area will contribute to the existing body of nursing knowledge and facilitate safety for nurses and their patients.

Appendix

Appendix

Addressograph

Emergency Department Client Behaviors
(Client population is defined as patients
seeking treatment and/or visitors of those patients.)

Date: _____ Time: _____

____Patient ____onset Triage area ____Evidence Current Substance Abuse
____Visitor ____onset Clinical area ____Psychiatric History

Behaviors

1. ___ Client(s) controlled & exhibit no adverse behavior.

2. ___ Argumentative behavior, threat perceived or implied.
Example: Client states, "Let me out of here this minute. Don't you touch me."

3. ___ Verbally threatening behavior to self, persons, or property.
Example: Client states, "I'm going to get you for this. Get away from me or I'll kill you."

4. ___ Physically threatening behavior to self, persons, or property.
Example: Client raises arm and shakes fist as RN attempts clinical interventions. Client tries to grab sharp instruments.

5. ___ Assaultive behavior towards self, persons, or property.
Example: Client attempts to throw chair. Client pulls IV out of arm and throws it to floor. Client attempts to bite or spit on staff.

6. ___ Out of control or violent behavior to self, persons, or property.
Example: Client kicking, hitting, biting staff or shouting uncontrollably; client attempting suicide; client smashing, breaking, or destroying hospital property.

Additional security support provided by:
____ ED staff ____ Security Dept. ____ Department of Public Safety
____ Physical Restraint ____ Pharmacologic Restraint

Client behavior frightened (caused anxiety) ED staff: ____ Yes ____ No

Client behavior caused personal injury to ED staff: ____ Yes ____ No

If above answer is "yes" please describe the nature of the injury.

Incident documented:
____ Client Chart ____ Incident Report ____ Report of Concern

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