Why you should read this article:

- To recognise the severity of workplace violence towards emergency department (ED) nurses
- To be aware of the findings of exploratory research that examined experiences of ED nurses in Indonesia of workplace violence
- To identify strategies to reduce and prevent workplace violence in the ED

Workplace violence: the experiences of emergency nurses in Indonesia

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Abstract

Background Workplace violence in hospitals is common and underreported. It has adverse effects professionally and personally for victims, and can have a negative effect on the quality of patient care.

Aim To explore Indonesian emergency department (ED) nurses' experiences of workplace violence.

Method This exploratory qualitative study used five sessions of focus group discussion. The participants were recruited from a referral hospital in a regional area of East Java province, Indonesia, using purposive sampling. Thematic analysis was used to analyse the data.

Findings A total of 13 ED nurses participated. Four themes and three sub-themes were identified: (1) Disrupting the rule; (2) Feeling unsafe; (3) Governing the case with the sub-themes mitigating violence, improving reporting flow and receiving follow-up; and (4) Keeping for myself.

Conclusion Managing workplace violence is crucial for the provision of high-quality nursing care in the ED. Hospital management's commitment to zero tolerance of violence is an important statement of support for nurses. Zero tolerance could be shown by improving safety in the ED, simplifying reporting systems and educating and training staff in responding to incidents, and de-escalation techniques.

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Keywords

accident and emergency, emergency care, professional, staff welfare, violence at work, workforce

Background

Violence in the workplace is not new to nursing and is an issue that has occurred for generations (Mitchell et al 2014). Workplace violence is defined as 'incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health' (International Labour Organization et al 2002).

Nurses routinely experience workplace violence more than other healthcare staff (Fasanya and Dada 2015, Pompeii et al 2015, Partridge and Affleck 2017, Ijaz et al 2018, Kadir et al 2019). The emergency department (ED) is most prone to incidents of workplace violence, with emergency nurses

the main victims (Taylor and Rew 2011, Ramacciati et al 2015).

A US study by Pompeii et al (2015) found that 96% of ED nurses had experienced physical assault, 77% had experienced physical threats and 69% had experienced verbal abuse. Other research has found that nurses experience verbal abuse more often than physical violence, most victims are female and few report such incidents (AbuAlRub and Al-Asmar 2014, Abdellah and Salama 2017, Ijaz et al 2018). Patients and their family members are the main perpetrators of workplace violence on nurses (Speroni et al 2014). Research in Indonesia has found that emergency nurses most commonly experience verbal abuse, the main perpetrators being patients' relatives, and victims are not encouraged to report incidents (Nurman 2017, Zahra and Feng 2018, Damopoli et al 2019).

The psychological trauma, distress and stress caused by workplace violence can have a negative effect on nurses' professional performance and the quality of care they provide (Zahra and Feng 2018, Zhao et al 2018, Kholis et al 2019). Workplace violence can result in job dissatisfaction, prevent nurses from thriving at work and make them want to leave their job (Vazia 2016, Jeong and Kim 2018, Zhao et al 2018, Damopoli et al 2019, Kadir et al 2019).

To improve the quality of healthcare services, especially in the ED, nurses' experiences of workplace violence need to be explored. Action by nurses and hospital managements to address this issue is also important.

Literature review

A search was conducted of databases PubMed, CINAHL and Web of Science for articles published in English since 2015. The search terms were 'emergency nurse', 'nurse experience', 'nurse attitude', 'nurse perspective', 'workplace violence' and 'workplace aggression'. Additional articles in Bahasa Indonesia, the official language of Indonesia, were obtained from ProQuest and Google Scholar.

A total of 327 articles were retrieved and, after duplicates were removed, 292 articles remained. Only a few articles focused on the ED setting. There was little literature published in Bahasa Indonesia. Because of the lack of literature relating to workplace violence involving emergency nurses specifically, other relevant articles were included relating to workplace violence involving healthcare staff in hospital settings generally. A total of 57 articles were eventually selected for inclusion in the literature review.

Workplace violence in the ED

Workplace violence occurs in every healthcare setting. The ED, psychiatric units, acute care settings and admission areas have a higher risk of workplace violence, with more incidents in the ED (Taylor and Rew 2011, Copeland and Henry 2017). In the US, the Emergency Nurses Association (2008) identified environment, patient and staffing factors as reasons why EDs are prone to workplace violence, for example overcrowded waiting rooms, direct working with potentially volatile people, transporting patients, inadequate security, understaffing, and lack of staff education and training.

Violent incidents in the ED are underreported because nurses accept violence as part of their normal working day and designated reporting systems are perceived as challenging and time consuming to use (Hogarth et al 2016, Elsey 2018).

To prevent and address workplace violence in the ED, hospital management and healthcare staff need to collaborate in identifying the hazards, analysing worksites, mitigation and training, and enhancing reporting systems (Gillespie et al 2017). Management's commitment to prevent and address workplace violence needs to be recognised by healthcare staff to engender trust and a feeling of safety.

Aim

To explore Indonesian ED nurses' experiences of workplace violence.

The research questions were:

1. How do ED nurses manage workplace violence?
2. What do ED nurses who are subjected to workplace violence expect from hospital managements?
3. How is workplace violence expected to be handled by hospitals?
4. How have hospitals handled workplace violence so far?

Method

Design

An exploratory qualitative approach (Holloway and Galvin 2017) was adopted. The data collected from exploratory studies either contribute to the development of theory or explain phenomena from the perspective of the participants (Brink 1998).

Participants

Purposive sampling was used to select participants. This involved the researcher identifying and contacting nurses who worked in the ED, had experienced or been witnesses to workplace violence, and were

Implications for practice

- Staff and patient safety are fundamental in the ED
- Staff require education and training in responding to incidents of workplace violence and de-escalation techniques
- Robust reporting and follow-up systems are required for incidents of workplace violence and staff should be supported to use them
- Hospital management must commit to a zero tolerance approach to workplace violence
- Appropriate interventions need to be developed to prevent and mitigate the incidence of workplace violence in healthcare settings

willing to participate in the study. Qualitative research samples are more likely to be purposive than random (Kuzel 1999) and this approach is based on the principle of taking opportunities to obtain rich data (Holloway and Galvin 2017).

Setting

Participants were recruited from one referral hospital in a region of East Java province, Indonesia.

Data collection and analysis

The lead researchers (AHK and RPP) conducted focus group discussions with the participants between June and August 2019. The focus groups each lasted between 80 and 90 minutes and were video- and audio-recorded. The audio files were transferred to a computer and transcribed. The researchers made field notes during the focus groups that included the date, time, arrangement and atmosphere of the room, the physical position of participants in relation to the researchers, descriptions of the participants, and social interactions and responses that occurred during the discussions, such as body language and facial expressions (Creswell and Poth 2016). Five sessions of focus group discussions were held to achieve data saturation.

To analyse the data, thematic analysis was used (Flick 2018). Two researchers independently reviewed the transcripts from each focus group session. Meaningful statements relevant to participants' experiences and feelings were extracted and coded, and similar codes were classified into themes. Important themes were then organised into theme groups. The transcripts were re-examined to ensure that the themes matched the participant's original meaning and participants were asked to confirm whether this classification reflected the meaning of their statements. Throughout the study, rigour was crucial to ensure the credibility, trustworthiness and reliability of the findings (Zhang and Wildemuth 2009, Anney 2014, Holloway and Galvin 2017).

Ethical considerations

This study received ethical approval from the hospital where it was conducted. Anonymity, consent and coding systems were used in the data analysis to maintain the privacy and confidentiality of participants. Participants were able to withdraw from the study at any time.

Findings

A total of 13 participants took part in the study. Table 1 details some characteristics of the participants.

Table 1. Characteristics of the participants (*n*=13)

Participant	Age (years)	Education	Gender	Work experience (years)	Position
1	35	Bachelor of Nursing	Male	15	Nurse team leader
2	40	Bachelor of Nursing	Male	20	Nurse team leader
3	39	Diploma of Nursing	Female	19	Nurse team leader
4	35	Diploma of Nursing	Female	14	Nurse team leader
5	44	Bachelor of Nursing	Male	24	Nurse team leader
6	36	Diploma of Nursing	Female	16	Nurse
7	34	Diploma of Nursing	Male	13	Nurse
8	28	Diploma of Nursing	Female	8	Nurse
9	38	Diploma of Nursing	Male	18	Nurse
10	29	Bachelor of Nursing	Female	6	Nurse
11	47	Bachelor of Nursing	Male	27	Head nurse
12	46	Master of Health Science	Male	25	Director of education and training
13	52	Master of Health Science	Male	35	Director of nursing

Four main themes and three sub-themes emerged from the thematic analysis:

1. Disrupting the rule.
2. Feeling unsafe.
3. Governing the case:
   - Mitigating violence.
   - Improving reporting flow.
   - Receiving follow-up.
4. Keeping for myself.

Disrupting the rule

Disrupting' hospital policy could trigger workplace violence. For example, the 'entrusted' patient is common in Indonesian culture. It refers to patients who have connections with officials at the hospital, patients who have an important social status for the hospital or patients who are high-profile politicians. However, management do not always notify staff of entrusted patients and use codes to refer to entrusted patients. Dealing with entrusted patients was therefore risky for participants because not all nurses knew which patients were entrusted and which were 'ordinary':

'The hospital has a different policy about… "entrusted patient", sometimes we don't know that the patient is under hospital special policy, and we just treat them as same as the other because no information before, this what causes the violence in ED.' (Participant 2)

'Some of [government] officials and others labelled "entrusted patient". Well, they really need to be prioritised, but then the family of those officials also want to be prioritised.' (Participant 11)

Families want their unwell loved ones to be seen quickly, but families' lack of understanding of the triage system also has the potential to cause workplace violence:

'Sometimes the family member did not understand the triage system, they want the ill family member being immediately treated in the ED.' (Participant 3)

'In the ED within 6 hours the patient must have been distributed [admitted to a ward, intensive care unit or operating room], sometimes up to 24 hours the patient has not been distributed, this is what causes conflict. The prolonged time… causes conflicts, the political conditions also affect it.' (Participant 13)

Feeling unsafe

Participants thought safety was an issue in the ED. Patients and/or their accompanying family members sometimes adopted protective measures, such as overseeing or even following nurses. Participants reported feeling intimidated by these behaviours. The security officers were the first port of call for security-related matters and the smooth running of the ED. Participants identified their importance and sought their support:

'We want to work comfortably and safe.' (Participant 7)

'We are special in the ED, the security is special, as the security of the banks, so they should always be on stand-by.' (Participant 5)

'We have the security officers at ED, but sometimes [they] need to patrol around the hospital and leave ED.' (Participant 9)

'Security is… in the initial screening for patients entering the ED including providing explanations from security-related services and others.' (Participant 13)

Governing the case

Participants thought that the commitment to zero tolerance of workplace violence would show how the hospital management was governing the case, that is, what process it adopted starting with mitigation.

Mitigating violence

Emergency situations often result in pressure for patient escorts – family members, friends or colleagues – and can have the potential for violence, whether physical, verbal or psychological. Understanding and responding to patient complaints in the ED is complex. Nurses need to be able to mitigate violence, but to do so they require appropriate training in 'customer service' style complaint handling and de-escalation techniques. Participants reported the need to be able to respond appropriately through education and training for the benefit of patients and themselves:

'This psychological training briefing was experienced by me in the ER, so for violence, I was equipped first, we were trained to be customer care.' (Participant 13)

'We need education training to manage our emotion experiencing the verbal abuse or other abuse.' (Participant 1)

'Do you think there is training on how to handle customer complaints or anger? … I think this training is the most important to educate nurses, because we cannot predict the WPV [workplace violence].' (Participant 9)

Improving reporting flow

Improving the reporting flow or standard procedure for reporting workplace violence was also important. Cases of violence in the workplace are usually underreported. However, if incidents are not reported to management at the most senior level the issue cannot be addressed in the long term:

'We have a standard for reporting the case, but mostly the case stops only in head nurse, the management did not know, then the problem did not solve.' (Participant 12)

'As a head nurse, the usual report for the case is in the morning meeting, but if the cases happened in the night, they have duty manager to help solve the problems. I usually tend to solve the problems in my department first then I can report to the management.' (Participant 11)

'Actually, we have team leader, head nurse, duty manager at night, to handle the case, and after that, we can report it to the management.' (Participant 5)

Receiving follow-up

When cases of workplace violence were reported to management, participants said they did not always receive follow-up reports on how the case was addressed:

'Physical, verbal abuse from patients or their families has made into written reports and we report to management, so it is usually followed up by management, but it is not always the reporters are given feedback.' (Participant 11)

'After I reported, by verbal or written, I did not know how this case end, either from hospital or perpetrator not any sign of good news.' (Participant 3)

Participants needed to know the policy on reporting incidents of workplace violence, that reports would be followed up promptly by management and that they would receive follow-up reports on how incidents had been addressed. If these actions were not taken, not only was participants' psychological safety at risk, but also potentially the quality of care provided, because staff felt unsafe in the workplace:

'The impact is enormous if it is not immediately followed up.' (Participant 12)

'We need policies regarding acts of violence then follow up on the handling of acts of it.' (Participant 13)

Keeping for myself

Participants' approaches to coping with workplace violence varied, for example newly qualified nurses were perceived as responding by crying:

'New nurse usually crying.' (Participant 10)

As might be expected, experienced nurses were more able to handle incidents:

'When I was a novice nurse, I tremble, you know shock response, but now I try to let it pass.' (Participant 7)

Other participants reported remaining calm and smiling at patients because they expected violence as part of working in the ED:

'I don't pay attention to their abuse, I just smiling in front of them, it usually happens, WPV is usual… working in ED.' (Participant 6)

Some participants were motivated professionally to work in the ED, and identified its financial benefits:

'We have a big motivational intention, and ED staff nurse has more income than in other wards.' (Participant 11)

Anxiety because of workplace violence was addressed through spiritual belief or self-coping methods. Strategies to cope with stress were found through either internal (self) or external (the immediate environment) means:

'We absorb our emotions by ourselves.' (Participant 3)

'I am praying when I have any problems in life including WPV. Only when I am praying to God, I found peace.' (Participant 5)

'Self-coping, whereas if we know, there are two kinds of coping, internal and external, if the internal is weak, this external usually has to strengthen.' (Participant 13)

Participants also identified finding support through colleagues:

'At the handover from night shift to the morning, whatever the problem is accommodated there, including confiding.' (Participant 6)

Discussion

The findings of this study indicate that participants had common experiences of workplace violence: unclear or withheld information on the status of entrusted patients, patients and their families not understanding hospital triage processes, feeling unsafe at work and the drawbacks of reporting systems. The prevention and management of workplace violence was also a concern. They had different responses to violent incidents, which reflected their professional experience and personal coping strategies.

Participants identified vague information and hospital policy regarding entrusted patients as a potential trigger for workplace violence. Family involvement is important in Indonesia, especially when a family member is hospitalised. However, when families did not understand the triage system they directed their frustration at nurses. Patients attending the ED are often critically ill, in pain and may wait for many hours until they are seen by a clinician or receive medication. These factors increase patients' and relatives' stress levels and feelings of anger and frustration, which may result in violent incidents (Abdellah and Salama 2017).

Participants emphasised that working in a safe environment was a must. Previous research has found that EDs are prone to workplace violence and there is a need for sufficient trained security officers (Copeland and Henry 2017, Zahra and Feng 2018). Strategies and solutions are available to prevent and minimise workplace violence and improve safety (Taylor and Rew 2011). In Indonesia, security officers must patrol the ED and other areas of the hospital. Some of the violence occurs when the security officers are not present. In an Australian study by Partridge and Affleck (2017), staff who thought that security officers responded to violent incidents promptly and were a visible presence in the ED were more likely to feel safe.

Participants discussed being able to respond appropriately to patient complaints through education and training for their own and patients' benefit. Previous research has found that nurses are aware that they themselves can trigger conflict with patients (Ramacciati et al 2015, Rees et al 2015, Zahra and Feng 2018). Training and education for healthcare workers is needed on understanding violence, its source, perpetrators and how to avoid violence (Baydin and Erenler 2014, Shahzad and Malik 2014, Wolf et al 2014, Ramacciati et al 2015). In addition, 'customer service' style training on patient management is important. In a study that aimed to review and analyse major known national guidelines and strategies for the prevention and management of workplace violence in the UK, Australia, Sweden and the US, training as a preventive measure was recommended and found to be provided by more than 90% of UK NHS trusts (Wiskow 2003). The training provided in the trusts comprised assessment of danger and the taking of precautions, interaction with aggressive people, understanding of violence and aggression at work, reporting and investigation of incidents, counselling and other follow-up action (Wiskow 2003).

Improving the procedure for reporting workplace violence was also important, and it was identified that management needed to know about incidents if a long-term solution was to be found. When participants reported workplace violence to management they needed to receive follow-up. Hospital managements must commit to protect healthcare staff from workplace violence (Zhao et al 2018). The reporting system is a crucial aspect of managing workplace violence (Shahzad and Malik 2014, Speroni et al 2014, Ramacciati et al 2015, Zahra and Feng 2018). Workplace violence in the ED is underreported because of a lack of organisational policy and the categorisation of violence as a criminal act (Lenaghan et al 2018). Nurses' response to violence varies, but mostly they do not report it (Shahzad and Malik 2014, Pompeii et al 2015, Ramacciati et al 2015, Kholis et al 2019). Nurses identify individual and group cases of workplace violence being unrecognised and unaddressed.

If violence occurs it is consistently accompanied by a lack of administrative support and judicial mitigation and assistance (Wolf et al 2014). In work by Lenaghan et al (2018), several sources reported that hospital leaders accused nurses of inadequate work performance and negligence, with the suggestion that nurses were therefore somehow to blame if they experienced workplace violence.

Participants' responses to dealing with workplace violence differed depending on their professional experience and coping strategies. Some were motivated professionally to work in the ED. Participants accepted violence as part of the high-stress ED environment. Others identified that ED staff were compensated in their salaries. Many tried to solve issues on their own. Lenaghan et al (2018) found that newly qualified nurses did not know what to do about workplace violence and were afraid of being judged not to be doing their job well. Participants identified the role of spiritual belief in coping with workplace violence. Faribors et al (2010) observed that religion and spirituality enabled nurses to achieve self-actualisation – the realisation of one's full potential – and well-being. Colleagues represented another coping mechanism for participants. Research has found that peer support can improve nurses' resilience (Stene et al 2015, Hsieh et al 2016).

Limitations

Indonesia has thousands of recognised ethnic groups with their own cultures. This exploratory study was conducted with ED nurses in one referral hospital in a region of East Java province and therefore its findings cannot be applied to other ED nurses in different areas of Indonesia.

Conclusion

This exploratory study indicated that participants had common experiences of workplace violence: unclear or withheld information on the status of entrusted patients, patients and their families not understanding

hospital triage processes, feeling unsafe at work and the drawbacks of reporting systems. The prevention and management of workplace violence for personal and professional reasons, including its effect on nursing care, was also a common concern. Participants had different responses to violent incidents, which reflected their professional experience and personal coping strategies.

Management's commitment to zero tolerance of violence can be shown through ensuring the hospital's policy is understood, safety is increased, reporting and follow-up systems are robust, and healthcare staff are educated and trained in responding to incidents and de-escalation techniques. ED nurses must recognise that accepting workplace violence is not part of their job.

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