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MAKING WORK SAFER: A QUALITATIVE STUDY TO EXPLORE THE IMPACT OF VIOLENCE ON CLINICAL STAFF IN SCOTTISH EMERGENCY DEPARTMENTS

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INTRODUCTION

Workplace violence defined by the European Commission 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"[1] is a significant problem in many workplaces. According to the World Health Organisation between 8% to 38% of healthcare workers suffer physical violence at some point in their careers.[2] In addition, many others are subject to verbal threats or abuse. This suggests there is a serious problem of violence against healthcare workers worldwide.

There has been investigation into the causes and effects of violence on healthcare workers in many countries but there is a lack of research in Scotland. Emergency Departments (ED) in Scotland are under increasing pressure with rising waiting times, stretched resources and a growing demand for the service, and this has been particularly true during the COVID-19 pandemic.[3] These circumstances can create situations where patients become angry and agitated and, in some cases, aggression may be directed towards staff. In an already high-pressure environment aggressive behaviour can be difficult to manage and can escalate quickly.

ED's are known to be the most stressful and volatile of healthcare environments.[4] The impact of violence towards staff cannot be underestimated. The initial human interactions and environment that a patient experiences when they arrive at the ED can be crucial in preventing or facilitating violence. A study by the 'Design Council' looked into the 'Triggers of violence and aggression in A&E'.[5] They identified nine main triggers:

'clash of people'; 'lack of progression'; 'inhospitable environments'; 'dehumanising environments'; 'intense emotions'; 'unsafe environments'; 'perceived inefficiency'; 'inconsistent responses' and 'staff fatigue'.

Identification of these triggers may allow development of interventions to reduce the frequency of aggressive behaviour.

It is important to recognise the potential impact that violence has on staff with regard to their mental and physical health as well as on their clinical practice. Violence can threaten the relationship of trust between the healthcare professional and their patient,[6] which is crucial for ensuring high quality patient care. It can lower the healthcare worker's belief in their professional competence potentially affecting decision making and leading to errors.[7] Violence can directly impact on a healthcare worker's physical and mental health leading to absence from work, putting strain on an already stretched system. Relationships between staff can also suffer as violence causes staff morale to decline. Ultimately, it can lead to health professionals leaving the NHS. In an environment where teamwork is fundamental to delivering quality care research can help to ensure the impact of violence on staff wellbeing is minimised.

This study is relevant in the context of Scotland's violent reputation. After a period of sustained reduction, violence has risen again recently. In September last year the BBC reported "violent crime in Scotland rises to highest level in seven years".[8] Organisations such as 'Medics against Violence'[9] and 'Scottish Violence Reduction Unit (SVRU)'[10] use a public health approach to tackle violence across Scotland. This project will contribute to the work of these two key organisations.

With the ongoing COVID-19 pandemic this area of work has been brought into sharp focus as numbers of patients attending EDs increase. Restrictions and social distancing mean waiting times can be longer and patients may be kept apart from their relatives or friends. As the pandemic puts increasing pressures on both healthcare systems and individuals' mental health there has been an increase in violence towards staff in Scottish EDs. A social media post by NHS Greater Glasgow and Clyde stated,

> *"Between March and early August, our staff have been subjected to violence and aggression at their place of work almost 2,300 times".*[11]

The aim of this study was to explore the nature of violence against staff in Scottish EDs, the effects that it may have on the staff and further sought to gather their views on how violence against staff can be addressed and prevented.

METHOD

Literature Review

A PubMed search was carried out using the MeSH terms ‘workplace violence’ AND ‘healthcare workers’, this yielded 1588 results, adding AND ‘UK’ reduced this to 48 AND ‘Scotland’ reduced this to 4, of which 2 were in mental health settings. This highlighted the need to explore the impact of violence on staff but also that there was very little research relating to the United Kingdom. A paper from China describes the long-term effects of workplace violence on doctors.[12] Its findings highlight the psychological effects, stress and poor sleep quality that violence can have on healthcare professionals. In Italy, doctors were interviewed about the reciprocal effect of violence on job satisfaction and as suspected they are strongly associated.[13] These two examples confirm the hypothesis that there are significant impacts on healthcare workers and emphasises the research gap in relation to Scotland.

Ethics Statement

Ethical approval was granted by the University of Glasgow MVLS ethics committee. (Appendix 1) NHS ethical approval was not required.

Subjects and data collection:

This study explored the extent and impact of violence on clinical staff in Scottish EDs using a qualitative approach. Qualitative methodology involves collecting and analysing non-numerical data. It allows collation and analysis of opinions, experiences, beliefs and ideas of research participants towards, in this case, workplace violence. As workplace violence is a complex issue one effective way to address it is by using qualitative research that provides

contextual data and allows theories and outcomes to be discussed and reported. The study further explored potential solutions in terms of both the built environment, team dynamics and the approach to patients.

Data was gathered via telephone interviews in February/March 2021. Interviews were semi-structured, conducted until data saturation was achieved and analysed using thematic analysis.[14]

The participants included doctors and nurses working in Scottish EDs who were invited to take part in the study via an email from their clinical lead or through posters placed in communal coffee areas. Sampling was done purposefully as the participants had to have been working in an ED for a reasonable length of time to take part.

Due to the current COVID-19 restrictions interviews were conducted by telephone at a time to suit the participants. This also allowed inclusion of a range of EDs. Interviews could be carried out in a private room of the participants' choosing which should facilitate more honest and open responses.

Measurement and data analysis

The interviews were semi-structured and based on a topic guide (*Table 1*). Open questions were used where possible to facilitate full and open answers. Interviews lasted between 10-30 minutes and were recorded and professionally transcribed.

The transcribed data was analysed using thematic data. Thematic analysis involves identifying themes in data and analysing how these themes have arisen. It allows connections

to be made between individuals experiences and feelings to understand possible outcomes from the research question.[14] Two individuals (MS and CG) independently reviewed the data for major and sub themes and results were compared to produce the final list. Quotes were selected to illustrate these themes.

RESULTS

The interview sample included 11 staff (8 doctors and 3 nurses) from 7 EDs in the West of Scotland. The participants' job title, workplace and gender are outlined in *Table 2.*

Main theme's

Six main themes were identified. *(Table 3)* The main themes were divided into subthemes providing more contextual information.

Nature of violence experienced

a. Verbal abuse

All participants interviewed had experienced verbal abuse while working in an ED. Many emphasised that verbal abuse was common in this setting.

> *"I honestly couldn't even begin to count the number of times that people have shouted at me, swore at me, threatened me, verbally" (4)*
>
> *"Most often, it's someone calling you names because you're not giving them what they want." (1)*
>
> *"I think it's unfortunately a part of the nature of the environment in which we work, I suppose. So yeah, like numerous occasions, I would say, is probably the answer to that question." (3)*

b. Threat of violence

A few had experienced verbal threats from patients, which had a very negative effect on their wellbeing. One participant described a patient who threatened to harm them outside of the work environment.

> *"So "I'm gonna find out where you live and I'm going to… do you know, I'm going to be waiting outside for you." "I'm going to be waiting outside for you when you've*

finished work, so you just keep… you keep your eyes open." That kind of stuff is much more alarming and frightens me much more than anything else." (6)

c. Physical Violence

Many had also experienced physical violence and explained that this had caused them concern for their own safety and that of other staff and patients in the department.

"I've been spat at, people tried to punch me, I've been clawed at, bitten" (4)

"(he) became very aggressive toward myself, kicking the walls and shouting and swearing… and was actually trying to break into a room with a grieving family… he threw a sharps bin at me" (3)

"it's not nice for all your other patients to be hearing people screaming, shouting, throwing themselves on the floor, throwing stuff at us" (10)

"…the last thing you want is a you know bystander, patient or relative to become the subject of that violence." (3)

d. Sexual Violence or abuse

A few female participants had been victims of sexual violence or abuse. The participants seemed to believe the patients used sexual violence to belittle them.

"I've had a sexually motivated derogatory comment towards me" (2)

"urinating all over the cubicle, verbally abusive to be… non-compliant and then resulted in a significant sexual and violent assault on myself." (7)

"I was threatened with a sexual assault once" (8)

e. Violence directed against colleagues

Almost all participants had witnessed both verbal abuse and physical violence directed towards colleagues with many saying they had witnessed violence against a colleague more often than they had experienced it personally.

"the language they used was racist towards a colleague" (5)

"the patient was threatening the life of one of the nurses, their children, one of the doctors, all the Police officers" (4)

"I saw one of my colleagues headbutted" "one literally rugby tackled and pulled her pony tail" (1)

"one of my colleagues was kicked in the stomach… she was pregnant" (10)

f. Non-directed violence

There seemed to be a general acceptance that some level of violent or abusive behaviour was inevitable in the ED environment. Participants described that some patients directed violence indiscriminately towards anyone who got in their way.

"flailing their arms and legs, punching out, kicking. They're not really directing it" (2)

Situations in which violence occurred

a. Patient Interactions

Participants identified direct patient interactions as being the most common situation in which violence occurred.

"direct patient interaction" (4)

"Probably whilst you're trying to assess a patient, so when they get brought in and you're trying to either, you know, do an initial assessment, examine them, work out what's wrong. Or if you're trying to take bloods from them and investigate what's – what's going on with them" (2)

b. In A&E Environment

Others identified situations that didn't involve direct interactions with patients such as general violence or abuse that occurred when patients were dissatisfied or unhappy with their treatment or waiting for long periods of time.

"it feels like to anyone going past" (5)

"delivered as people were leaving, unsatisfied, for whatever reason, with the care they'd received" (1)

Some participants mentioned situations that might predict violence, the most common being where patients were accompanied to the department by Police.

"Some of them were entirely predictable events that you knew this was going to happen because they were being held down by six police officers." (1)

"You can often tell patients who are likely to be violent because frequently they'll, you know, arrive with a police escort, for example" (3)

Triggers

a. Alcohol or Drugs

There was universal acknowledgement that alcohol or drugs were major triggers for most of the violence or abuse experienced or witnessed by participants.

"I don't personally recall an incident that occurred that wasn't fuelled by drugs or alcohol" (2)

"they are nine out of ten times under the influence of some form of intoxicant" (4)

The association with major football games was mentioned by one participant as a factor that tended to exacerbate the issues caused by alcohol in their hospital.

"*…I think that has a very significant impact, and we get a lot more… not just in terms of violence and aggression for us, towards us, but we do also get just in general a lot of more violent presentation, more assaults, more stabbings, more fights, and a lot of these patients because they are already kind of frustrated, riled up, angry, then they do end up being very mouthy, very aggressive, very confrontational with us. And it does kind of spill over into the way they speak to us as well." (10)*

b. Failure to meet expectations

Several participants identified that violence may stem from the failure to meet patient expectations. They perceived that some patients attended hospital with a desired outcome in mind and so if this was not met their disappointment could turn into aggression.

"frequently we have a patient come in that leaves shouting and swearing… because he comes in expecting us to give him his routine medication and that's never going to be met" (1)

c. The ED Environment

A few participants recognised physical features of the ED environment as being potential triggers for violence. One participant specifically said that

"confined areas" (7)

can facilitate violence.

d. Medical issues

Participants recognised that a number of patients became aggressive due to an underlying medical condition and they didn't class this as intentional violence. They understood there was a medical explanation for the behaviour that the patient may not have control over.

"driven by illness" (3)

"a wee old lady that slaps you, pinches the nurses, that doesn't count as violence or aggression, that's muddled" (6)

"… if somebody's an unwell old granny and she decides she wants to slap you because you're touching her, that's very, very different from being an angry, intoxicated young person." (6)

e. Past trauma

The patients' past experience of trauma was mentioned by one participant who seemed to have empathy for this group of patients and an understanding of how they might feel in a stressful situation.

> *"But the vast majority are actually people that ……have had a lot of difficulties, and have been kind of conditioned in general by their traumatic experiences, to be distrustful. And when they do come to A&E, they don't really know how to deal with the whole situation, and they do lash out. So when it's those patients, you know, I don't tend to take it personally"* (10)

Impact of Violence on the ED team

a. Wellbeing of individuals

Violence in the ED had a significant impact on the wellbeing of the participants in this study. Experiencing violence made many participants feel frustrated, angry and disrespected by their patients.

Many felt upset in the immediate aftermath of their experiences.

> *"I was indignant. I was angry that this was what had happened to me in my workplace" (6)*
>
> *"(I) feel a bit angry, a bit upset, a bit frustrated" (1)*
>
> *"I was like really upset, I had a cry for about three hours afterwards" (11)*

A few participants felt fearful after their experiences. It was common theme that verbal abuse and threatening language seemed to frighten individuals significantly.

> *"the guy who threatened me that I ended up essentially getting somebody to come and pick me up from the front door… he scared me much more… there was a threat, which is much more frightening in my experience than the reality of it" (6)*
>
> *"makes other staff feel vulnerable too… it did kind of put the fear into people" (7)*

b. Longer term impact and coping strategies

The long-term effects of experiencing violence in the ED varied between participants. Some felt that they managed to compartmentalise the incidents and move on while others suffered lasting effects.

"I tend to be able to compartmentalise them and move on" (1)

"lasting anxiety from it" (2)

"I would use the word 'scared'. I feel a lot more vulnerable now when I do have that kind of patient" (7)

Most participants seemed to expect to have to deal with some form of aggression when working in the ED.

"it's unfortunately a part of the nature of the environment in which we work" (3)

"you've just got to do it again… you cannot do my job and not be able to let it go" (4)

"unfortunately we do expect to get it" (8)

"it definitely feels like we've been desensitised to it" (10)

"To be honest, I've done A&E for twenty years, so I'm kinda… I'm kinda used to it, and I know you probably shouldn't get used to it, but… I kinda am. I don't know that it particularly bothers me." (9)

Physical pain and the anxiety of contracting a blood borne virus was mentioned by one participant.

"you've got dirty great scratches down your arm, then they're sore" "you've got to go through the whole rigmarole of was their saliva bloody at all, what sort of risk is the source patient… you know blood borne virus etc…" (4)

c. Staff morale

All participants felt that staff morale was affected when violent incidents occurred. Many commented on how violence increased the stress levels in the ED. Several participants spoke

of a lowering of the mood of staff in the department creating an unpleasant atmosphere and impacting on cognitive functioning.

"it contributes to the general sense of feeling unappreciated" (1)

"it does affect team's morale and certainly affects the atmosphere and the ability to run the department effectively" (3)

"everyone's processing power has dropped, and when everyone's processing power has dropped, then everything becomes harder, and therefore morale drops" (4)

On a more positive note, some mentioned the support they received from and how the shared experience they had seemed to be useful in helping them cope.

"I think our department are actually quite good at kind of banding together and supporting each other…. So I think people tend to stick together and just, in a way, sort of try and laugh it off a bit so that it doesn't affect the rest of your shift." (2)

d. Impact of violence on patient care

All participants acknowledged that some aspect of patient care was affected during or after violent incidents in the ED. Many found that it was more challenging to manage a violent patient.

"makes it really difficult to manage the patient" (2)

Others mentioned curtailing or reducing the care they were able to provide under those circumstances

"*And then I guess on an individual patient basis, if you're going into a room where you know that someone is potentially being violent or aggressive, or you've got the feeling that they might be, that you're not necessarily going to spend as much time with them, or ask sort of probing questions that may be appropriate to their patient care, because you're not wanting to … trigger anything that may make them angry or violent towards you. Which may then impact on their care, because you're not…*

you're not asking the questions you need to ask to find out what the correct diagnosis or treatment might be for them" (5)

It was commonly acknowledged that subsequent patient interactions may be affected.

"in the back of your mind sort of another element of staff safety or your anger or your frustration… that's going to impact things on the next patient" (5)

"you might have gone from someone who tried to punch you, spat at you… and then you're going to someone who has just been raped and it is impossible to give them the compassion that you would give them if you'd not just had the experience you had with the patient prior" (4)

"other patients end up maybe missing out on attention and care" (10)

"unfortunately there will be patients that are maybe sitting there, you know, not causing any bother, not asking for anything, but do maybe need a lot of care, and you're not able to provide it to them because…. your kind of attention is taken away. So rather than affecting your care with the violent and aggressive patient, it affects your care for everyone else." (10)

Potential strategies to prevent violence

Participants made many wide-ranging suggestions for the prevention of violence.

a. System alerts

Multiple participants felt that the computer warning system for alerting staff to potentially violent patients could be improved. One participant emphasised that patients should *"get an alert on them" (7)* for any form of aggressive or violent behaviour but that many staff would be reluctant to put an alert on a patient's record.

"its making sure that any alerts you've got on the system there are correct and it's not just 'Violent patient'. It's about what mitigating things should we do?... this guy's

only violent towards men, so shouldn't be seen by men?... it's about making sure we inform staff as well so they can minimise their risk" (1)

b. Security

A visible security or police presence was a common theme that participants felt would reduce the incidence of violence. Staff also felt that it might reduce the time they had to spend de-escalating violent situations:

"(security/police presence) frees up staff… which means then the department runs better, less people are being directly exposed to violence and aggression, and therefore are less affected by it and you have a slight morale boost of being able to actually look after your patients" (4)

However, one participant felt that increasing police presence would not be beneficial.

"But not police in the department, nothing like that, because I think that it changes it from a therapeutic environment to something very confrontational before you even start" (6)

c. A Zero Tolerance Policy

Participants had differing views towards the Zero-Tolerance approach in UK hospitals.

"there's a risk of having a zero-tolerance approach to this, that you would miss, you know, potentially serious underlying reasons why someone is, you know, behaving in that manner." (3)

"I think that's the main way for turning it round, is to say, there is a Zero Tolerance Policy for violence and aggression" (6)

d. Patient Education

It was commonly felt that the public needed more education on what an ED can do for them. As violence maybe triggered by unmet patient expectations it is important to inform patients of what they can realistically expect from an ED, both in terms of waiting times and the

treatment that can be provided. There was a general acknowledgement that the triage system used in the ED may not be clear to patients.

"we need to think about the information we're giving patients and that needs to start with their first interaction" (1)

"clear information about sort of waiting times… expectation of what we can actually manage in the department" (5)

"You've got a shared waiting room with perhaps a lack of understanding about triage and priorities. So someone doesn't realise why they're having to wait and why someone just appeared to walk in" (1)

e. Staff Training

Participants thought it would be beneficial if staff received more effective training on how to deal with violence. It was felt that staff should also be aware of what may trigger violence so that they can be alert and responsive around triggering behaviour.

"we also have to remain professionally vigilant… and understand the root cause of these actions" "take a step back and work out why… people would act like that" (3)

"have an awareness of how to de-escalate those particular situations, you know, from a personal point of view" (3)

f. Improvements to the physical environment

Some participants felt that improvements to the physical environment of the ED might prevent some violence or improve staff safety by, for example reducing lone working.

"ensuring that actually we have enough seats for people to sit in. Ensuring the area is kept clean, and that we have information boards that tell people what to expect… we need to start managing expectations" (1)

"having departments where there are kind of locked doors into departments that people can't just walk in… patients coming in, if you're feeling frustrated about not

being able to leave, can beat their fists against the door, rather than against a member of staff trying to restrain them back into the department" (5)

"having rooms with two doors on them, so you're not ever stuck behind a door" (9)

"…. layouts of departments, you're not having … staff in areas of the departments where they are… where they are kind of lone workers, or in areas where they… where they can't to see or call for help if… if they're in situations" (5)

Response to violence when it occurs

a. Reporting Violent incidents

Multiple participants mentioned that reporting incidents took too much effort, therefore, many incidents were unreported.

"the feeling amongst staff is that the effort it would go to report it, record it, have all the staff members give statements and go to court is not really worth the effort and support from the rest of the legal system on that basis" (5)

Another participant regarded reporting incidents as a crucial way to prevent violence in the ED:

"I think there has to be a proper crackdown on it, and I think when people misbehave we have to consistently report it… it feels like a waste of time, but until that kind of stuff is being addressed all the time, I don't think the public realise that it happens" (6)

b. Staff Support

One participant felt that staff support would be beneficial

"had staff support after these incidents" (2) and thought that *"it would be a good idea to have a sort of structured debrief" (2).*

c. Help with De-escalation

Individuals praised the Navigator programme and the ability of Navigators to de-escalate violence.

> *"a very useful resource, when they're on, you know, on the shop floor, if you like, for de-escalating situations" (3).*
>
> *"they come and speak to patients, and a lot of the time they are very good at de-escalating situations as well, because they are, you know, an outside influence that is not really, you know, a nursing influence or a police influence, or a doctor's influence" (10)*

DISCUSSION

This qualitative study examined the nature of violence experienced by the participants, all of whom were doctors or nurses who worked in EDs in the West of Scotland. All 11 participants interviewed had experienced some form of violence directed towards them at work. A systematic review by Liu et al[15] studied the prevalence of workplace violence in multiple countries and found that 61.9% of healthcare workers had experienced some form of violence. A meta-analysis by Li et al[16] found the prevalence to be 19.33%, these studies and others[2] demonstrate that worldwide violence against healthcare workers is common and constitutes a significant problem. Other studies[15,17], conclude that ED staff face the highest rate of violence within the healthcare professions and the results of this study reinforce that it is a common experience for staff working in this setting. Multiple studies, including this study, found that verbal abuse was the most common form of violence against healthcare workers.[15,18,19,20,21,22] Physical, sexual violence and threatening behaviour were also common among the participants in this study.

Multiple factors can trigger violence in healthcare settings.[5,20,21] This study found that a significant trigger for violence was alcohol or drugs reported by almost all participants. This was also seen in studies by Kumari et al[23], D'Ettorre et al[24] and Vardy et al.[25] Failure to meet patient expectations was also thought to cause anti-social behaviour and this study adds to the existing evidence[22,26] to support this theory. In the ED tensions can run high, waiting times are long and patients may not understand the triage process. The atmosphere within the ED does not always constitute a calming or therapeutic environment for patients which may lead to confusion and agitation.[26,27] Multiple social factors, including previous experience of trauma can also precipitate violence and these are covered in the wider literature[26,27,28], however, these were only mentioned by one of the participants in this study. The wider

causes include personal, societal and organisational factors. This can include, history of violent victimisation, emotional distress, involvement in gangs and low levels of community engagement.[28] Nelson[17] proposed that the prevention of violence should begin at the reception desk. Training staff to recognise these wider triggers of violence and helping them to become trauma informed could help reduce the incidence of violence in the ED.

The impact of violence on patient care was evident from analysis and is known from literature.[20,29] It was common that participants felt they were consciously more reserved towards the violent patient and possibly not as thorough with their care. Interestingly, subsequent patient interactions were also affected. Some participants felt that they were more reserved when interacting with patients after being a victim of violence. This could be a subconscious effect of being a victim of abuse. Many were concerned about the effect on other patients in the department as time and human recourses are used to control a violent patient, diverting attention away from other unwell patients. Studies from Palestine[30] confirm the negative effect violence has on patient care and a study in India suggests it has a negative impact on decision making by the healthcare professional.[22] Many participants felt that staff morale was affected by violence in the ED indicating that the impact of violence goes far beyond the individual victim. Low mood, increased stress and reduced cognitive functioning were some of the effects mentioned by participants.

The impact violence has on the healthcare provider has been investigated in previous studies. It has been shown that exposure to workplace violence causes psychological stress, anxiety, PTSD, burnout and loss of self-esteem.[19,20,22] This study also confirms the negative effect it can have on staff wellbeing. A heightened awareness around disorderly patients and lasting fear was reported. Many felt frustrated and angry after being subjected to abuse. The long-

term impacts of violence on healthcare staff generally are known to include absence from work, avoidance of social interaction and poor sleep quality.[19,22] There were mixed results from this study regarding the long-term impact. Many felt incidents did not have a long-term impact while some felt a lasting sense of fear and anxiety. A particularly concerning theme arising from the interviews was the idea that many healthcare professionals accepted some experience of violence as part of their job and the setting within which they worked. This was not a new finding, other studies have reported that doctors believe violence is "part of their job".[20,29] If staff, particularly those in senior positions, accept that violence from patients in the ED is inevitable, they risk this becoming an attitude prevalent among the more junior members of their team. This may result in an overall tacit acceptance of a level of violence in that setting which in turn may reduce the likelihood and motivation to report violence or find solutions.

Many participants in this study felt that system alerts marking patients as a risk of becoming violent could be improved. Staff need to be encouraged to put an alert on patients for verbal abuse and threatening behaviour as well as physical violence. The alert system could work to reinforce the zero-tolerance policy towards violence. The UK has had a zero-tolerance policy towards violence against NHS workers since 1999[31] and in some countries patients can be refused access to the ED if they have a significant violent history against healthcare workers. In contrast, a systematic review[32] found no evidence to support this tactic and highlighted that it could threaten one of the foundations of the NHS- ensuring universal healthcare.

Many participants felt that more effort should go into educating patients on what to expect in the ED and this would help target a trigger for violence, that of unmet expectations. The Design Council[5] proposed offering patients a comprehensive package of information about

the department, waiting times and treatment processes in order to empower them and reduce anxiety levels. It includes information throughout a department such as on-site environmental signage, patient leaflets, digital platforms and touch screen applications.[5] Implementing this idea into NHS ED's would be hugely beneficial for reducing violence. A study into reducing violence in ED's in Palestine highlighted hospital management's role in reducing violence by decreasing waiting times through better use of resources.[30] Managers can also help to ensure staff safety by providing a greater security presence in ED's. Increasing security and police presence was mentioned by many participants as they felt their presence deterred violence and helped free-up staff allowing them to continue delivering care. Their thoughts are backed up by additional evidence.[29]

In this study, providing training to staff on how to deal with violent patients was mentioned. Benefits of ED training programmes have been found in multiple studies.[29,30,33] In addition to training, staff must also receive support after being a victim of violence. Many will receive social support from relatives and friends, however, support from their workplace is crucial to prevent the psychological and work-related impacts which follow violence.[33] When violence occurs de-escalation strategies can be useful. The Navigator programme was mentioned by several participants as a peer support service that, alongside its main role in provision of support for patients, can be effective in de-escalating violence in the ED.[34] Increasing the funding and reach of this programme, which is currently only operational in Scotland, would help to reduce violence in ED's across the UK.

Ideally, all incidents of violence should be reported so that the extent of the problem is clear to managers and senior clinical staff. Currently a large number of incidents go unreported. According to a systematic literature review 39% of articles reported that victims did not

report their abuse.[22] Studies have suggested multiple reasons for this, with one study suggesting that victims do not believe any outcome will come from reporting.[30] This highlights the necessity for hospital managers to follow up reports of violence and ensure victims see results. A study in India agreed with the data gathered by this study in that many participants feel the effort and time it takes to report incidents is not worth for the lack of outcome that they see.[22] Performing a root cause analysis on all reports of violence should gather more data on the triggers of violence to allow continuous improvement of prevention schemes used in hospitals to target violence.

Limitations

Although a call for participants was issued to EDs across Scotland all of the participants who responded worked in the West of Scotland. The data gathered showed violence to be a significant issue for these individuals and reached data saturation with the same themes recurring in successive interviews. It also reflects the situation which many healthcare workers face worldwide. However, as the participants were limited to one area of Scotland it may not be representative of every ED in Scotland or the wider UK. The West of Scotland has traditionally had a violent reputation and, although overall violence has decreased significantly in recent years,[35] the experiences that these participants faced may overestimate the extent of the problem. The sample also included more doctors than nurses. Previous literature[16,17,27] has found that nurses encounter more violence in their careers than doctors so this may conversely result in an underestimation of the problem. Interestingly, the levels of violence experienced by nurses in this study did seem to be more significant and included sexual assaults. This study could also potentially have participant bias. Although the participants were not selected by the researcher, people who have experienced violence in the workplace may be more likely to put themselves forward for an interview on this topic.

Despite this, any level of violence in the ED is unacceptable so considering the strong testimonies gathered and the level of agreement among participants it would seem the issue is significant.

Future Work

It is important that the impact that violence has on healthcare workers continues to be evaluated because of both the impact on staff but also on patient care. With a health system which is continuously under pressure, it is essential to ensure a safe working environment and staff wellbeing must be protected to ensure the human resources we need are available for delivering healthcare in the UK. Prevention of violence is key to ensuring improvements in healthcare within the ED and so this must be a focus of future policy making, hospital design and medical training.

CONCLUSION

In conclusion, this study shows that workplace violence continues to be an issue for healthcare workers in the West of Scotland. The results give an in depth understanding of the impacts of violence on staff and patient care. In addition, some valuable ideas for preventing future violence have been brought to attention. The powerful testimonies presented in this study highlight that more time and investment is needed in preventing violence in order to protect healthcare staff across the UK.

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Question 1)

a) Have you ever experienced violence directed at you from patients while working?
    a. Was this verbal or physical violence?
    b. Tell me a bit more about this experience?
    c. In what situation did this occur?

Question 2)

a) Have you ever witnessed violence directed towards a colleague?
    a. Was this verbal or physical violence?
    b. Tell me more about what you observed?
    c. In what situation did this occur?

Question 3)

a) Based on your experiences from Questions 1) and 2) how did these situations make you feel?
b) How did it affect your well-being?
c) How did it affect the staff moral in the department?
d) How did it affect your practice / patient care?
e) How did it affect you outwith your work environment?

Question 4)

a) What do you think are the triggers that can lead to verbal and physical violence within the Emergency Department?

Question 5)

a) What measures do you think could be adopted to assist and prevent verbal and physical violence within the Emergency Department?

Table 1. Topic guide for semi-structured interviews

PARTICIPANT	JOB TITLE	GENDER	HOSPITAL
1	CONSULTANT	FEMALE	A
2	CLINICAL DEVELOPMENT FELLOW (CDF)	FEMALE	B
3	CONSULTANT	MALE	C
4	REGISTRAR	FEMALE	F & G
5	CONSULTANT	MALE	D
6	SPECIALITY DOCTOR	FEMALE	B
7	BANK NURSE	FEMALE	MULTIPLE
8	SPECIALITY DOCTOR	FEMALE	E
9	CONSULTANT	FEMALE	D
10	STAFF NURSE	FEMALE	E
11	CHARGE NURSE	FEMALE	E

Table 2: Participant Demographics

MAIN THEMES	SUB-THEMES
Nature of violence experienced	Verbal violence Physical violence Sexual violence Threat of violence Witnessing violence Non-directed violence / violence not considered abuse
Situation	Interactions with patients In emergency department environment
Triggers	Alcohol & Drugs Patient expectations Environment Medical cause
Impact on healthcare worker	Frustration Fear Patient care Staff morale Physical impact Long term impact Acceptance / expectation with the job
Prevention strategies	Warming system improvement Education to public Security/ police presence Staff training Zero tolerance policy Environment improvements

Response to violence when it occurs	Staff support Debrief Navigator programme Easier reporting system

Table 3: Main themes and sub-themes identified during thematic analysis of the transcripts

APPENDIX

1. Ethical approval was granted by the University of Glasgow ethics committee prior to the start of collecting data for the study and the key guidance parameters for the study included:
    - All participants took part on a voluntary basis with no incentives and after giving informed consent;
    - The volunteers were aware that they could withdraw at any point form the study without any repercussions;
    - The emails of the staff were provided by the head of their respective emergency departments;
    - An information sheet and consent form was sent to the participants along with the email to organise time and date for their interview;
    - Data for this study was to be gathered through telephone interviews; and,
    - All names and personal data are anonymised throughout the paper.