ISSN: 3029-0872

Research Article

Journal of Medical and Clinical Nursing Studies

Nurses' Perceptions of the Factors Which Cause Violence and Ways of Preventions in the Emergency Department: A Qualitative Study

Bayan Najdi[1*] and Asma Imam[2]

[1]*Department of Health Sciences, Faculty of Graduate Studies, Arab American University, Ramallah, Palestinian territory*

[2]*Department of Public Health School, Al-Quds University, Al-Quds, Palestinian Territory*

[*]**Corresponding author**

Bayan Najdi, Department of Health Sciences, Faculty of Graduate Studies, Arab American University, Ramallah, Palestinian territory.

Received: March 09, 2024; **Accepted:** March 19, 2024; **Published:** March 25, 2024

ABSTRACT

Background: Violence has been increasing worldwide. The prevalence of violence in the healthcare sector is continuously rising, and the most vulnerable places for violence is emergency departments due to the critical nature of the workplace environment.

Aims: To explore the factors that contribute to violence experienced by nurses, the impact of workplace violence on nurses, and the preventive methods. understanding these issues could enhance the workplace environment and quality of healthcare.

Method: A qualitative approach was used with purposive sampling of 15 emergency department nurses at hospitals in Palestine who experienced or witnessed workplace violence. Semi-structured, face-to-face individual interviews were conducted to gain in-depth information about nurses' experience in relation to workplace violence at emergency departments. All the interviews were transcribed verbatim for thematic analysis.

Results: Three major themes were found to present the factors that contribute to violence experienced by nurses. These themes are: Knowledge and attitude related-issues, External-related factors and System-related issues.

Four major themes emerged relating to the staff feelings, which are: Feeling overwhelmed, feeling distressed, feeling indignity and feeling helpless and fearful.

Study participants offered some prevention methods to decrease workplace violence, and some suggestions to handle violence.

Conclusion: Numerous factors contribute to the prevalence of workplace violence in emergency departments. Hospital administrations have to ensure the safety of all employees by using suitable precautions. There is an extensive need for psychological support after violent. In addition, universities have to develop communication, violence and stress management-training courses.

Keywords: Emergency Department, Emergency Nurses, Workplace Violence

Introduction

Today, health care personnel face harsher behavior than ever before, all over the world. Of all hospital staff, nurses are most exposed to workplace violence [1]. The World Health Organization defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation [2]." "Violence may be caused by a patient, families, doctors, colleagues, managements, or anyone who makes nurses not comfortable or creates a feeling of inadequacy" [3].

Nurses at the emergency department might face different types of violence, according to Arafeh et al. Workplace violence (WPV) includes threats, verbal or physical abuse, sexual harassment. According to GackSmith et al. Talas et al. physical threats include; pushing, being kicked, slapped, scratched and beaten, objects thrown at or assaulted with a weapon [4-6].

The impact of violence on nurses has a high level of absenteeism, low morale and mental fatigue, which will affect the quality of care and decrease both of patients and nurses' satisfaction [7]. According to Ramacciati et al. violence has a negative impact on nurses which may lead to inadequacy, guilt, excuse, frustration, anxiety, that may last for long times and may progress to post traumatic stress syndrome [8].

Citation: Bayan Najd, Asma Imam. Nurses' Perceptions of the Factors Which Cause Violence and Ways of Preventions in the Emergency Department: A Qualitative Study. J Med Clin Nurs Stud. 2024. 2(2): 1-7. DOI: doi.org/10.61440/JMCNS.2024.v2.44

Nurses who are working in emergency departments (ED) where multiple environmental risk factors exist, such as the critical nature of the wards, long waiting times and had more contact with patients or their relatives [9]. "In Palestine EDs had witnessed an increase in WPV at hospitals, related to chronic political situation resulted from large number of injured people and a large number of people accompanied the victims to EDs, that leads to physical, psychological and verbal violence against health staff" [10].

Most of previous studies about violence at hospitals in Palestine-West Bank as reported by Abu Ali and Kitaneh, are quantitative studies, and according to the researcher's knowledge, there are no qualitative studies about this topic conducted in Palestine, taking in consideration the fact that Palestine is a country in chronic political conflict and economic emergency [10,11].

Methodology

According to the study of Forero et al. who apply the four-dimension criteria (credibility, dependability, confirmability and transferability) to assess rigour of qualitative research in emergency medicine, they conclude that this criterion is effective to achieve trustworthy findings [12].

Semi-structured, in-depth face-to-face individual interviews were conducted with a non-probability convenient sample of 15 ED nurses with a minimum of one year of experience in the ED who experienced or witnessed a violent incident within the previous 6 months.

The semi-structured interview guide was developed after reviewing the literature, it was validated by four experts in research, the interviewer was received a proper training about how to conduct a qualitative interview before starting data collection. The instrument was piloted before initiating the study, and it consists of 5 open-ended questions which asked about violent incidence, nurses' feelings after experiencing these incidents, and the factors that cause violence, dealing with violence before, during and after happened, and the reporting system for violence, nurses' recommendations for ways of prevention.

In each hospital, a private, quiet, suitable office was offered by head nurses to conduct the interviews there, no one else present besides the participant and researcher. Each interview time ranged from 30 to 50 minutes. Our assumption was that the targeted group of nurses will be cooperative and truthful in the interviews. The researcher started gathering data through individual interviews from August 2021 to April 2022 at the 5 selected hospitals which are: Palestinian Medical Complex (Ramallah Governmental Hospital) and Beit Jala governmental hospital, Al-Makassed Islamic Charitable hospital, Saint Joseph and Al-Ahli private Hospitals.

Some of the interviews were audio recorded and then transcribed verbatim, for the participants who refused the audio recording, the interviewer handwritten the entire interview on the interview notebook.

After finishing 15 interviews, data collection was ended because no more ideas emerged, and the saturation of data had been reached.

Thematic analysis of the interview data was undertaken using Burnard's framework, Transcripts had large margins and adequate line spacing for later coding and making notes [13]. It was important to becoming familiar with the whole interview using the audio recording and/or transcript in order to start interpretation. After familiarization, and as a method of enhancing rigour, transcripts were collated and distributed to the researchers to facilitate discussion, confirmation, and validation of the themes and subthemes. Multiple meetings were held among the researchers to ensure credibility. The researcher (BN) and three independent experts read the transcript line by line, then applied a paraphrase or code that described the data, at this stage 'open coding' took place, coding anything that might be relevant from as many different perspectives as possible until no additional codes emerged. Codes had been grouped together into three major categories according to the research questions: nurses' perceptions of the factors which cause violence, staff feelings, and ways of prevention in the emergency department. Interpretation of the data was done, and consensus was reached after the discussion on major themes and subthemes. then data was filled out in a special template for each category and quotations were included with the interviewee initials. The coding of the transcripts was done manually by three independent experts and consensus was reached after the discussion on major themes and subthemes. In order to prevent bias, reflexive reviews and discussions among the researcher regarding the transcripts and themes were performed regularly.

Presentation & Discussion of the Results

Characteristics of the Respondents

The table below provides the demographics of the participants.

Table 1: Demographic characteristics of participated nurses

Characteristic		Participating nurses (N=15)
Gender	Male	11
	Female	4
Age	Mean	31 years
	Min	25 years
	Max.	52 years
Educational level	Diploma	1
	Bachelor	11
	higher education	3
Experience in the profession	Mean	8.7 years
	Min	2 years
	Max	27 years

Presentation of Results

Section one: Factors that cause violence in the ED

By using thematic data analysis for the interview questions (From your point of view, what are the factors that caused violence in the emergency department?) thirteen causes of violence emerged (subthemes) in the ED from nurses' perspectives which were grouped into three major themes. Knowledge and attitude related-issues, External-related factors, and System-related issues Figure 1, shows the themes and subthemes of factors that cause violence in ED.

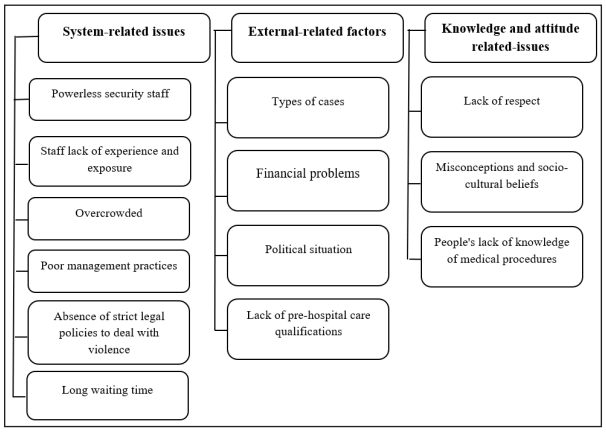

Figure 1: The themes and subthemes of factors that cause violence in ED

The first theme was **system-related issues**
The majority of participants (N=10) talked about the powerlessness of security staff as one of the greatest causes of violence in ED.

RF1P1 said: "We have security personnel, but they are few and their powers less. They can dismantle a conflict, nothing more".

A study conducted by Angland et al. found that when security staff were presented, violence and aggression were reduced [14]. This also was mentioned by other studies [15-16].

Also, the majority of nurses (N=10), mentioned that staff lack of experience and exposure to ED tasks and inadequate and inexperienced staff in dealing with violent behaviors represent the most risk factors of violence in ED. Sometimes nurses who are transferred from other departments to cover for the shortage in ED, is an obstacle in performing effective and comprehensive care. The environment and critical nature of ED completely differs from other departments.

SA1P2 said: "I had someone (nurse) in the emergency room with me, not from the Emergency team, and I did not know how to act frankly. When I asked for help, he came to look at me from behind the curtains and said "OK, what should I do for you!!?"

74% of 81 nurses' participants in a study held in Nigeria by Ogundipe et al. admitted that they did not receive any type of training on how to handle violent incidents, which negatively affected their experience and exposure to these situations [17].

The poor performance of staff leads to aggressive behavior from patients and their companions.

Nurses are the most important asset of the ED. They should be highly qualified to work in the ED.

MO2P3 explained, "There are some nurses who don't know how to insert a cannula for a child. Parents come at us hatefully, "We are not experiment fields, do not train on us"

This result was supported by a study conducted by Roche et al. that reported the presence of higher skilled nurses with a bachelor of science in nursing degrees were associated with fewer reported perceptions of violence at the ward level [18].

Moreover, the inappropriate communication and interaction between patients and the health team is also raises the risk of violence.

RM3P2 said: "Unfortunately, sometimes the medical staff do not have good communication techniques such as: "Wait in line." "There is a patient in line before you." "What can I do?" "I don't have space." "Go complain to the Ministry".

This result is coinciding with a study conducted by Lau et al. showed that patients' and relatives' tolerance towards waiting times varies and focusing on effective communication may be more appropriate than attempts to reduce waiting times[19].

Few nurses in this study complained about their colleagues' lack of professional behavior

SH3P6 said: "Joking too much with patients and companions leads to violent behavior sometimes"

This result is coinciding with the study of Shafran-Tikva et al. which mentioned that 48% of the respondents stated that staff behavior contributed to violent episodes [20].

Most of the participants (N=9) spoke about how crowdedness of patients and companions increase the risk of violence in ED which sometimes induced by a lack of places

SN2P3 said: "It is full of patients. I cannot stop my work for a bit, to find an alternative solution for the patient. Not even two minutes of thinking."
Almost all of the participants agreed that the patient's relatives and escorts perpetrated the violent incidents; in very rare cases, the patients themselves are responsible for the violence, like alcoholic patients and drug abusers.

They also listed the poor management practice as one of the important causes of violence (N=8).

SN2P3 said: "when you know that you have no place for admissions, why not transfer the patient to another hospital. Why should they stay in the emergency department for a day or two?"

MO2P5 said: "In the Emergency Department, in particular, you can't just assign any nurse there. He\she should be qualified".

According to Seow, ED management entails ensuring that the teams work in an environment (people, system and place) where they can deliver the best care to their patients.
In addition [21].

Some of the nurses complained about the absence of strict legal policies to deal with violence (N=6), which enhances the occurrence of violence.

SH3P2 mentioned: "For those who know no punishment, will misbehave"

This result is supported by Roche et al. which stated that lack of hospital policy against perpetrators is considered one of the factors that encourage violence [18].

Some of the participants talked about long waiting time, as one of the important causes of violence in ED (N=6). This result was supported by Crilly et al. who reported that the average waiting time of patients reported to be perpetrators of violence was 66.2 minute [22].

All participants highlighted the impact of **external-related issues** on violence in ED, which was the second theme.

The majority of participants confirmed that there is a relationship between types of cases and violence in ED. For example: (street problems, alcohol or drug abusers, political injuries).

These results coincide with the studies of which consider alcoholic patients, patients in pain and stress, as the highest contributing factors that cause violence in ED [16,23,24].

Some of the participants agreed that the financial situation is directly affecting the aggression of patients and their companion and results in violence, some of the patients don't have health insurance, so they have to pay in order to open an emergency medical file and they have to pay for each required medical test, they get angry on the medical staff and start to assault them, this issue may result from poor economic status in Palestine.

This result was supported by Davey et al. which considered the financial stressors of paying for medical care as one of the factors that cause violence in ED [25].

A few participants mentioned that the political situation in the country lead to violence. Unfortunately, the medical staff is harmed, especially if there are wounded patients in the ED after clashes happened with the occupation soldiers.

This result was explained by Abu Ali he mentioned that Palestinian face many hardships in their daily lives which leads to a different rate of victims, which will increase frustration aggression process [10]. In addition, this result was supported by the Palestine Red Crescent Society [26].

A few of the participants identified the lack of pre-hospital care qualifications of emergency medical services staff (EMS), paramedics and referring physicians as causes of violence.

The participants said that most EMS employees are first aiders, their qualifications are very weak, also they do not have effective communication with the patients and most of times they do not coordinate with the emergency departments before referring patients to them.

RF1P4 mentioned: "The ambulance staff does not coordinate with us when they respond to the patients. If they inform us about the traffic accident with four severely injured patients, we would told them that we have no vacancy; no CT scan; no thoracic surgeon on call."

The result was supported by Baig et al. study finding in which the representatives of law enforcement agencies mentioned poor quality of ambulance services and low competency of health care providers as a cause of violence [27].

The majority of participants talked about **people's' knowledge and attitude related-issues**, they mentioned peoples' lack of respect as another cause of violence.

RF1P3 said: "The patient told me "Move one of the patients, I want to sit in his place!"

This result was supported by Brophy et al. who found that lack of respect for healthcare staff is a social risk factor of violence [28].

Also, most of the respondents spoke about misconceptions and socio-cultural beliefs

MM1P3 stated: "The prevailing culture, is that East Jerusalem provides less care for the patients than the Jews" Albashtawy & Aljezavi, mentioned that the expectation of health care services can be a promoting factor of workplace violence [29].

Some of the respondents mentioned that the lack of people's knowledge of medical procedures leads to misunderstanding and then violence.

MO2P2 stated: "Most people think that when they come to the emergency department this means "I am a high-risk patient, you need to see me now."

This result supported by Fallahi-Khoshknab et al. they found that a lack of people's knowledge of medical staff tasks was the most common contributing factor to physical violence [30]. Moreover, according to Howerton Child & Sussman the patients may feel frustrated because they are coming to ED and they do not understand the triage process, and the expected time to be seen by a physician [31].

Section Two: Staff Feelings

By using thematic analysis, four major themes for the interviews emerged relating to the staff feelings. Figure 2. Shows the four themes and sub-themes of staff feelings.

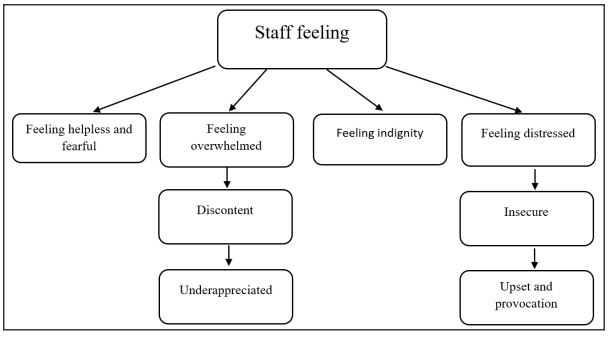

Figure 2: Themes and sub-themes related to staff feelings

The first theme was **feeling helpless and fearful**

Fear of personal targeting, fear of bearing the consequences, fear of losing a job and livelihood, SA1P8 noted "I was new, and afraid of losing the contract since we're still in the training period"

The second theme was **feeling overwhelmed,** with two subthemes:

Feeling discontent, JM2P1 said: "why is there no one to protect me; why do people think that I get my salary just because they have health insurance. I get very upset, look at the other units,

they are exposed to violence much less than in the Emergency Department".

Feeling underappreciated, MM1P1stated: "You feel your knowledge is worthless, I mean, there is no appreciation. As if they are saying. Just treat the patient and finish your work!!"

The third theme was **feeling indignity**, JS3P1 mentioned: "I felt as if I were a very vile thing, with no value at all. It was a feeling of injustice".

The fourth theme was **feeling distressed** with two subthemes: Feeling insecure, HR3P4 stated: "It was a sad feeling. I lost hope. The thing we were not expecting was present"

Feeling upset and provocation, MS3P4 said: "Sometimes, seriously, I go home and cry from the emergency department! I am tired. All of us are mentally strained".

According to Ramacciati et al. feeling of injustice, fear and stress may lead to frustration, anxiety, sadness, low self-esteem, and anger that may last for long times and may progress to post-traumatic stress syndrome [8].

According to Hassankhani et al., nurses are suffering from workplace violence consequences; they have mental and physical health risks, threats to professional and social integrity. For example, they suffered from depression, lack of motivation and feeling hopelessness and isolated, feeling of unpleasant emotions like insecurity, sadness, fear, frustration [32].

Section Three: Ways of Prevention

The interviewed participants were asked to indicate or to talk about the preventive strategies that might decrease violence against nurses in ED. These strategies are the followings:

1. Enhance the security system, the importance of security personnel presence around the clock inside the emergency building and increasing the number of security personnel to cover the hospital demands. Also, in hiring process for security personnel hospital managers should take in their consideration to choose those people who are qualified and interested in their work.
2. The importance of activating (code white) which refers to emergency response for a violent person, by creating a special button easy to access in different places in the ED.
3. Applying proper nursing orientation and rotation programs in hospitals, adapting the number of medical staff members to the demand of ED, hiring qualified nurses with effective communication skills, and improving the triage system.
4. Enhance the communication process, this includes the communication between pre-hospital care, the ED medical staff, and the hospital medical staff themselves and between the medical staff and patients and their companions. The participants pointed out several important points in this regard, including: demonstrating the ability to face violence by being assertive, trying to control their anger, using body language effectively, talking respectfully, and not arguing with the perpetrators or to react by the same action.
5. Do some modifications to the hospital structure by allocating a safety room for the staff and a special entrance for the ambulance and a triage room, expanding the hospital to accommodate more cases.
6. Customer service training, most of the participants agreed with conducting courses in effective communication and how to deal with violence by the Continuous Education Committee in the hospital or including the violence report process in the orientation program for the new employees.
7. Create a clear policy for violence by the hospital administrators, include it in the orientation program, and generalize it to all of the employees, also to activate the role of the quality and safety committees in studying and analyzing the incident report in order to find solutions to the problems.
8. Regulate the entrance of companion to ED, some of the participants in the study indicated that most of the violent incidents are caused by the companions not by the patients themselves, and the presence of a large number of companions inside the ED without existing of clear instructions which limit their numbers, will leads to overcrowding and chaos.
9. Clients' education, study participants emphasized the importance of raising public awareness, and suggested several methods that could be used, for example: in the waiting room, using a TV screen to display a simple clear video with audio instructions or using large awareness posters or small flyers to display written instructions about the most misunderstood issues in an ED, for example the triage system, or to direct patients with non-urgent cases to visit the out clinics instead of ED. They also emphasized the importance of having a strong role in the media-television and radio, social media, and the Internet, in order to confirm the importance of respecting medical staff and to clarify the laws and consequences of violence on perpetrators.
10. Decrease waiting time, it includes shortening the periods of registering, receiving patients to ED, admission to in-patient departments, discharge or transfer processes, also shortening the response time of the ED or consultant physicians.
11. Building trust relationship between hospital managers and employees, by making the employees feel safe, and acting professionally in analyzing and addressing problems of violence incident report, in order to encourage employees to report violence, some of the participants talked about the necessity of having females in the administrative structure of the institution, because of cultural issues, sometimes female nurses refrain from reporting the incidence of violence, if they do not find another female employee at the administrative level to discuss the incident with her and talk without restrictions, also some participants suggested that there should be an official lawyer in the institution to defend the legal rights of employees.

Conclusion

The results showed that numerous factors can contribute to the prevalence of workplace violence, these factors are classified into three major themes: Knowledge and attitude related-issues, External-related factors and System-related issues. Four major themes emerged relating to the staff feelings, which are: Feeling overwhelmed, feeling distressed, feeling indignity and feeling helpless and fearful. There is an extensive need for psychological support after violent incidents by hospital managers, society and the legal system.

Moreover, some suggestions were noticed by the participants in order to handle violence.

Ethical Considerations and Permission

Declaration: the experimental protocols were approved by the research ethics committee: the faculty of graduate studies at the Arab American University of Palestine, No: 028\2021. All methods were performed in accordance with the relevant guidelines and regulations. Participants were encouraged to share their experiences of WPV (without the use of personal identifiers) to ensure privacy and confidentially. Prior to the interview, the research purpose, methodology, voluntary participation, and dissemination of research findings were explained to all participants during the consent process, all participants signed on informed consent before they entered the interviews. All the participants had the right to withdraw from the study at any time without disclosure of the personal identifiers

The participants were informed that the audio recording data will be converted to written sentences within one month after the interview and will be deleted immediately after that. The written data was stored without names or any identifications to ensure confidentiality only the code number for each interview was assigned. Data was stored on a personal locked computer. My study might a stressful event for some participants. I planned to refer them to a social worker, in order to ensure that they will be okay after the personal interview, but no one of the participants complained of stress during the interviews.

Consent for the Publication: not applicable

Acknowledgements: To the participating health care organizations for facilitating this study and the staff for their open and frank participation to this study. To Dr. Imad Abu Khader the Assistant Dean for Health Affairs and Head of Science Department at Arab American University, Palestinian Territories, and Dr. Maha Nahal Assistant Professor at College of Health Professions at the Faculty of Nursing, Al-Quds University, Palestinian Territories, for their evaluation of the tool (the interview guide was clear, understandable, and give sufficient data), and for their contribution in data analysis of the pilot study.

Competing Interests: There is no potential conflict of interest with respect to the research authorship or publication of this article.

Funding: I declare that no funding or financial support was received for the data collection nor the analysis or interpretation of results.

Authors' contributions

BN - Design, data collection, analysis, interpretation and draft and revision of the article.

AI - Design, analysis, interpretation and draft and revision of the article.

All authors have approved the version to be published and have participated sufficiently in the work to take public responsibility and accountability for appropriate portions of the content.

References

1. Bernardes MLG, Karino ME, Martins JT, Okubo CVC, Galdino MJQ, et al. Workplace violence among nursing professionals. Rev Bras Med Trab. 2021. 18: 250-257.
2. World report on violence and health: summary. World Health Organization posts P23. 2002. http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf
3. Hajaj A. Violence against Nurses in the Workplace, Middle East Journal of Nursing. 2014. 7: 20-26.
4. Arafa A, Shehata A, Youssef M, Senosy S. Violence against healthcare workers during the COVID-19 pandemic: a cross-sectional study from Egypt. Arch Environ Occup Health. 2022. 77: 621-627.
5. Gacki-Smith J, Juarez AM, Boyett L, Homeyer C, Robinson L, et al. Violence against nurses working in US emergency departments. J Nurs Adm. 2009. 39: 340-349.
6. Talas MS, Kocaöz S, Akgüç S. A survey of violence against staff working in the emergency department in ankara, Turkey. Asian Nurs Res. 2011. 5: 197-203.
7. Chen WC, Huang CJ, Hwang JS, Chen CC. The relationship of health-related quality of life to workplace physical violence against nurses by psychiatric patients. Qual Life Res. 2010. 19: 1155-1161.
8. Ramacciati N, Ceccagnoli A, Addey B. Violence against nurses in the triage area: An Italian qualitative study. Int Emerg Nurs. 2015.23: 274-280.
9. Aljohani B, Burkholder J, Tran QK, Chen C, Beisenova K, et al. Workplace violence in the emergency department: a systematic review and meta-analysis. Public Health. 2021. 196:186-197.
10. Abu Ali N. Violence against health professionals in Palestinian Hospitals: Prevalence, sources, Responses and Prevention. Bethlehem University Journal. 2012. 31: 26-43.
11. Kitaneh M, Hamdan M. Workplace violence against physicians and nurses in Palestinian public hospitals: a cross-sectional study. BMC Health Serv Res. 2012. 12: 469.
12. Forero R, Nahidi S, De Costa J, Mohsin M, Fitzgerald G, et al. Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. BMC Health Serv Res. 2018. 18: 120.
13. Burnard Ph. A method of analysing interview transcripts in qualitative research, Nurse Education. 1991. 11: 461-466,
14. Angland S, Dowling M, Casey D. Nurses' perceptions of the factors which cause violence and aggression in the emergency department: a qualitative study. Int Emerg Nurs. 2014. 22: 134-139.
15. Gillespie G L, Pekar B, Byczkowski TL, Fisher BS. 2017 Worker, workplace, and community/environmental risk factors for workplace violence in emergency departments. Archives of environmental & occupational health. 2017. 72: 79-86.
16. Stene J, Chaboyer W, Creedy D. Workplace Violence in the Emergency Department: giving staff the tools and support to report, The Permanente Journal. 2015. 19: 113- 117.
17. Ogundipe KO, Etonyeaku AC, Adigun I, Ojo EO, Aladesanmi T, et al. Violence in the emergency department: a multicentre survey of nurses' perceptions in Nigeria. Emerg Med J. 2013. 30: 758-762.
18. Roche M, Diers D, Duffield C, Catling-Paull C. Violence toward nurses, the work environment, and patient outcomes. J Nurs Scholarsh. 2010. 42:13-22.

19. Lau JB, Magarey J, Wiechula R. Violence in the emergency department: an ethnographic study. Int Emerg Nurs. 2012. 20:126-132.
20. Shafran-Tikva S, Chinitz D, Stern Z. Feder-Bubis P. Violence against physicians and nurses in a hospital: How does it happen? A mixed-methods study. Isr J Health Policy Res 2017. 6: 59.
21. Seow E. Leading and managing an emergency department-A personal view. J Acute Med. 2013. 3:61-66.
22. Crilly J, Chaboyer W, Creedy D. Violence towards emergency department nurses by patients. Accid Emerg Nurs. 2004. 12: 67-73.
23. Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence at triage: A qualitative descriptive study. International emergency nursing. 2011. 19. 12-19.
24. Lau JB, Magarey J, Wiechula R. Violence in the emergency department: an ethnographic study (part I). International emergency nursing. 2012. 20. 69-75.
25. Davey K, Ravishankar V, Mehta N, Ahluwalia T, Blanchard J et al. A qualitative study of workplace violence among healthcare providers in emergency departments in India. Int J Emerg Med. 2020.13: 33.
26. Palestine Red Crescent Society Medical Volunteers Face Assault and Arrest during their Humanitarian Duty. Informing humanitarians worldwide a service provided by UN OCHA. 2010. Available from: https://reliefweb.int/report/occupied-palestinian-territory/prcs-medical-volunteers-face-assault-and-arrest-during-their
27. Baig LA, Shaik H, Polkowski M, Ali SK, Jamali S, et al. Violence Against Health Care Providers: A Mixed-Methods Study from Karachi, Pakistan. The Journal of emergency medicine. 2018. 54: 558-566.
28. Brophy JT, Keith MM, Hurley M. Assaulted and Unheard: Violence Against Healthcare Staff. New solutions: a journal of environmental and occupational health policy: NS. 2018. 27:581-606.
29. AL Bashtawy M, Aljezawi M. Emergency nurses' perspective of workplace violence in Jordanian hospitals: A national survey. International emergency nursing.2016. 24: 61-65.
30. Fallahi-Khoshknab M, Oskouie F, Najafi F, Ghazanfari N, Tamizi Z, et al. Physical violence against health care workers: A nationwide study from Iran. Iranian journal of nursing and midwifery research. 2016. 21: 232-238.
31. Howerton Child RJ, Sussman EJ. Occupational Disappointment: Why Did I Even Become a Nurse?. Journal of emergency nursing. 2017. 43: 545-552.
32. Hassankhani H, Parizad N, Gacki-Smith J, Rahmani A, Mohammadi E. The consequences of violence against nurses working in the emergency department: A qualitative study. International emergency nursing. 2018. 39: 20-25.