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Penalty Enhancement Laws and the Reporting of Patient Assaults on Emergency Department Nurses

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Abstract

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MSCJ, Tiffin University, 2009

BBA, Peirce College, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Assaults on emergency department nurses by patients are higher than any other occupation in the private sector. Professional nursing organizations have lobbied for penalty enhancement laws that increase the categorization of assaulting a nurse on duty from a misdemeanor to a felony. As of 2015, 32 states have implemented these laws. Yet, low assault reporting rates by nurses remains a problem, and little is known about whether penalty enhancements improved reporting rates. The purpose of this correlational study was to evaluate the impact of penalty enhancement laws on self-reporting of assault on emergency department nurses in 6 Mid-Atlantic cities. Constructs from organizational culture theory and rational choice theory were tested to determine if actions taken by nurses after assaults were influenced by the organizational culture within the hospital, by the rational choice actions of the individual nurse, or both. Data were obtained through online surveys of 107 emergency department nurses. Data included demographic information, workplace violence experiences, individual actions, and institutional actions. These data were analyzed using multiple regression. Findings indicate that rational choice actions were a significant predictor of nurse reporting behaviors of patient assaults *(p* <.001). Organizational practices, age, gender, and state penalty enhancement laws were not significant predictors of nurse reporting behaviors of patient assaults. Implications for social change include the development of policies and strategies to improve reporting of assaults in emergency departments. In addition, results may be used to increase awareness of policymakers on the perceived effects of penalty enhancement laws on emergency department nurses.

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Chapter 1: Introduction to the Study

Introduction

Emergency department nurses face challenges every day saving the lives of their patients and healing the sick and wounded. In addition to the pressures of their responsibilities, emergency department nurses also face the threat of physical assault from their patients (Anderson, FitzGerald, & Luck, 2010). In the United States, nurses working in emergency departments have a significantly higher risk of being a victim of workplace violence than workers in other private organizations (Behnam et al., 2011). Even with this higher rate of victimization, emergency department nurses have shown reluctance to formally report these assaults and seek the support of judicial process after these attacks (Casteel et al., 2008). Over recent years, professional organizations such as the Emergency Department Nurses Association and the American Nurses Association have turned to their state governments to implement penalty enhancement laws which provide nurses with the same type of judicial support when assaulted that has been used to protect public servants such as police officers, firemen, and government officials (Crilly, Chaboyer, & Creedy, 2004). These risks of assaults and the reporting behaviors of nurses were explored in my study.

Background of the Problem

The formal reporting of assaults by victims to law enforcement agencies has been the focus of study in the area of victimology for several decades (Anderson, FitzGerald, & Luck, 2010) Initially, law enforcement agencies conducted research on victims of domestic abuse (Barker, 2007). Their purpose was to determine if penalty enhancement

laws, in the form of mandatory arrest laws, would be effective in reducing recidivism in domestic assaults (Barker, 2007). One element that was exposed during these initial research trials was the victim's response to the assault in the form of filing official assault charges against the offender (Cairney, 2013). An issue in domestic abuse was if the victim was unwilling to file a formal report to the police and pursue criminal charges, then it would be highly unlikely that any actions would be taken against the offender and recidivism would likely be higher (Cairney, 2013). To study the effects of increased likelihood of penalty, jurisdictions implemented mandatory arrest laws where police officers responding to a domestic abuse call would always arrest the offender, even if the victim did not press charges (Sherman & Berk, 1984) These studies produced mixed results. The initial study by Sherman and Berk (1984) showed high support for the mandatory arrest laws in reducing further incidents of domestic assault. However, their results did not stand up to tests for reliability, as their study was repeated in other jurisdictions with little support found (Pate & Hamilton, 1992). In their research on spousal abuse, Maxwell, Garner, and Fagan (2001) summarized that "scholars interested in the validity of deterrence theories and policymakers working to reduce intimate partner violence have become less confident about relying on arrest as the primary response to violence between intimates" (p. 1). Additionally, even in areas where mandatory arrest laws resulted in higher initial arrest rates for domestic assault, there were little or no supporting results to show that these laws reduced recidivism or increased the safety of the victims (Hirschel, Buzawa, Pattavina, & Faggiani, 2008). One of the limitations of determining the rates of assault was the need to rely on the victim's reporting of the

incident (Covington, Huff-Corzine, & Corzine, 2014). This issue was addressed by reviewing different law enforcement databases.

One database frequently used for the collection of victim information was the National Crime Victimization Survey developed by the United States Department of Justice. This source became valuable to research in victimology since law enforcement incident reports were not giving a true reflection of assault rates since it was estimated that only 42% of victims of violent crime were reporting the incidents to the police (Jasinski, 2003). As additional information was obtained through their survey, researchers were able to collect more information about the characteristics of both the offenders and the victims of violent crime.

The Bureau of Labor Statistics also became a valuable source of information on violent crime as employees who were injured at work who may be more willing to report the incidents due to workers compensation claims rather than to pursue criminal charges (Rodriguez-Acosta et al., 2010). Reports to the Bureau of Labor Statistics showed that 60% of workplace assaults had occurred in the healthcare arena with the majority of those assaults being committed by patients. This resulted in an injury rate to healthcare workers that were four times the national average (Rodriguez-Acosta et al., 2010). Yet, even with these much higher rates, it was assumed that actual rates of assault were much higher due to a still low reporting rate by the victims (Gates, Gillespie, & Succop, 2011). Additional surveys were conducted by professional agencies to verify this assumption.

The National Emergency Department Safety Study surveyed 69 academic hospitals and recorded over 3,400 reports of physical attacks by emergency department

employees over the 5 years before the survey (Kansagra et al., 2008). Of the respondents, nurses reported feeling the least safe at work. Even with the seemingly high rate of assaults and low feeling of safety from nurses, the authors of the study still recorded a low report-rate of assaults by the participants to law enforcement (Kansagra et al., 2008). Another international survey of emergency department employees found that 27% of the respondents experienced a physical assault by a patient over the previous and only 15% of the respondents filed a formal report about the incident (Behnam, Tillotson, Davis, & Hobbs, 2009). This finding was similar to a study conducted by Chapman, Styles, Perry, and Combs (2010) that reported that only 16% of nurses surveyed who had been a victim of assault from a patient filed a formal report.

Reasons given for the under-reporting of patient assaults on nurses has included a lack of reporting policies in the facility, feelings that these incidents are just part of the job, fear of retaliation from management for reporting, fear of pear pressure from filing charges against a patient, and a general feeling that no actions would be taken by law enforcement even if they filed a formal report (Ferns, 2012; Flannery, LeVitre, Rego, & Walker, 2010; Gacki-Smith, Juarez, & Boyett, 2009; Luck, Jackson, & Usher, 2007; Roche, Diers, Duffield, & Catling-Paull, 2010). One action taken by nursing organizations to alleviate these concerns was to lobby their state governments to implement penalty enhancement laws that would increase the charges for assault on a nurse while on duty from a misdemeanor to a felony (Casteel et al., 2009; Gacki-Smith, Juarez, & Boyett, 2009). As of June 2015, 32 states had passed laws that make it a felony to assault an emergency department nurse (Emergency Nurses Association, 2015).

To further the understanding of the effects of these penalty enhancement laws and the reporting of assaults on emergency department nurses, I identified a gap in the literature and conducted a quantitative study to make recommendations as to the potential changes these laws have had on increasing the reporting of assaults and possibly adding to the security of nurses while working in emergency departments. Based on the perceptions and experiences of emergency department nurses that were surveyed, I hoped to obtain further insight into the reporting habits of emergency department nurses working in academic hospitals across the Mid-Atlantic Region of the United States.

Problem Statement

There has been a problem in workplace violence at emergency departments with nurses being physically assaulted by patients (Blando et al., 2008; Gates et al., 2011; Roche, Diers, Duffield, & Catling-Paull, 2010). Administrative and physical security measures including security officers, metal detectors, CCTV, panic buttons, policies and procedures, and incident reporting programs have been implemented in varying degrees in hospitals across the nation (Blando et al., 2008). However, rates of violence against nurses remain significantly higher than in other professions in the public sector (Crilly, Chaboyer, & Creedy, 2004; Gates et al., 2011). These higher rates have been recorded through participation in private research studies and through the Bureau of Labor Statistics (Gates et al., 2011). Yet, included in the private research is an indication that nurses are only formally reporting 15-23% of these assaults to law enforcement and pursuing legal prosecution (Ferns, 2012). In addition to the physical and administrative control measures implemented at the hospital level, state legislatures have now been

implementing penalty enhancement laws that increase the classification for assaulting an emergency department nurse from a misdemeanor to a felony (Emergency Nurses Association, 2015). Research on workplace violence in emergency departments has yet to provide significant results on the effectiveness of these laws in increasing the reporting rates of assaults on nurses and has yet to show if laws are effective in increasing the safety of emergency department nurses (Wolf, Delao, & Perhats, 2014). Using the factors of victim choices, organizational culture, and levels of state penalty laws, I explored this gap in the literature through a quantitative measure of emergency department nurses response to patient assaults in six states and districts in the Mid-Atlantic Region.

Significance of the Problem

The findings from my study are important since they can help to identify factors that affect the decision-making behavior of emergency department nurses after being the victim of assault and provide an assessment of the potential effect varying levels of state penalty enhancement laws have on those behaviors. My study focused on emergency department nurses working in academic hospitals across six states and districts in the Mid-Atlantic Region and the levels of penalty enhancement laws each of those states have implemented to protect nurses from patient assaults.

The problem of assaults on emergency department nurses has not been limited to a single type of hospital or unique region of the country. Assault rates have reported to be consistently higher for emergency department workers than other employees in the private sector for the last several years in all regions (Kansagra et al., 2008). Offender-related factors attributing to these higher rates of assaults include long waiting times in

emergency departments, heightened emotional states due to traumatic experiences, mental health impairments, and drug and alcohol abuse (Ferns, 2007). These characteristics can be found in patients reporting to emergency departments throughout the country and at both local community hospitals and large academic medical centers (Ferns, 2007). When the incident rates are factored by the number of hours worked, there has been little significance between geographical regions making this a national problem (Behnam, Tillotson, Davis, & Hobbs, 2009; Kansagra et al., 2008). The problem has not been ignored by hospital or professional healthcare organizations.

Previous attempts to decrease these assault rates have been through the implementation of physical and administrative controls with varying rates of success (Gates et al., 2011). Some controls that have shown success were the implementation of workplace violence training, early identification of mental illness in patients, on-site security officers, and facility developed risk assessments and reporting policies (Gates et al., 2011). There has not been a significant finding in the literature that has supported the actual effectiveness of physical controls such as metal detectors or video surveillance (Blando, et al., 2008). Even with combinations of these controls and increased awareness from regulatory agencies, the assault rates on emergency department nurses has remained consistent over the past years (Gillespie, Gates, & Berry, 2013). With the seemingly ineffective results from other controls, nursing and healthcare associations have turned to support from the judicial system to increase the safety of emergency department workers.

As of June 2015, 32 states had implemented penalty enhancement laws with the expectation that the increased judicial punishment for offenders would help to reduce the

rates of assaults (Emergency Nurses Association, 2015). Some states, having no evidence that these laws actually reduced incidents of assaults, implemented the laws as a possible deterrent effect for would-be offenders (Lopez-Bushnell, & Martinez, 2008). Other states, under pressure from special interest groups, implemented these laws with the expectation that increasing the classification of assaults from misdemeanors to felonies would have a significant effect on protecting nurses and directly reducing assault rates (Emergency Nurses Association, 2015). This issue of patient assaults on emergency department nurses has been a complex problem.

In addition to the many factors that may influence the occurrence rates such as patient demographics, nurse demographics, organizational culture, security measures, and state laws, there was also the challenge of obtaining appropriate trends in incidents and details related to the assaults (Emergency Nurses Association, 2015). These elements can only be obtained if there is consistent reporting of the assaults through formal reporting systems. Even with the increased awareness in the healthcare community of these assault rates, nurse reporting of the incidents to law enforcement or other regulatory agencies has been extremely low (Gifford & Anderson, 2010). It was estimated that 75% of assaults on emergency department nurses were not formally reported to law enforcement agencies (Luck et al., 2008). This low reporting rate added to the problem since it would be difficult to develop any findings on the effectiveness of penalty enhancement laws on assault rates if the incidents were not reported.

The under-reporting of assaults had created a challenge in developing trends in the literature. When questioned why they do not report assaults, emergency department

nurses have attributed a perceived lack of support from administration and local law enforcement as one of the main reasons (Gifford & Anderson, 2010). With the implementation of these penalty enhancement laws, which have been lobbied for by healthcare organizations, the next step in research would be to see if these laws do make a difference in the perceptions of nurses who must decide to take the necessary steps to formally report and pursue law enforcement involvement when assaulted.

Purpose of the Research

The purpose of my study was to explore quantitatively the behaviors in relation to the formal reporting of patient assaults by emergency department nurses working in academic medical centers in six Mid-Atlantic States or Districts. Comparing both the theories of organizational culture and rational choice, my study was designed to identify factors that would help healthcare organizations and agencies in determining the value of reporting habits of emergency department nurses in aiding to measure the effectiveness of penalty enhancement laws. The first goal was to identify the factors related to the high rate of assaults on emergency department nurses and the related low reporting rates. The second goal was to collect data from emergency department nurses working in academic medical centers in the Mid-Atlantic Region to determine their current reporting habits of patient assaults with the real or perceived levels of penalty enhancement laws in their states. To meet the minimum sample size based on 15 participants per variable, at least 90 nurses were needed for statistical reasons to complete the survey.

Nature of the Study

My research was a quantitative study seeking exploratory data to measure the reporting habits of emergency department nurses of patient assaults through their responses to a survey instrument. In order to conduct my research, I requested permission to modify and use a self-administered survey, taken through the SurveyMonkey Internet-based application. The original survey was developed by the World Health Organization and was titled Workplace Violence in the Health Sector Survey Questionnaire (World Health Organization, 2003). This survey had been used in several countries around the world by the World Health Organization and the International Council of Nurses (Martino, 2002). This survey consisted of nine sections that measured demographic information about hospitals and the respondents, physical workplace violence, psychological workplace violence, and sexual harassment (Martino, 2002). The survey was modified to include questions that were specific to my area of research. The modified survey was entitled Emergency Department Nurses Assault Reporting Survey. This survey measured variables of nurse demographics, responses to assaults, rational actions, organizational behavior, and penalty enhancement laws. The modified survey consisted of 36 questions that were used to collect data for the assessment of nurses' behaviors in reporting of patient assaults and their perceptions of rational choice and organizational culture components of state penalty enhancement laws.

Research Questions and Hypotheses

This quantitative study focused on emergency department nurses working in academic medical centers in the Mid-Atlantic Region to answer the following research questions:

1. Do rational choice actions of nurses affect their formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0$1= Rational choice actions of nurses have no effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.
- H_a1= Rational choice actions of nurses have an effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.

2. Does organizational culture have an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0$2= Organizational culture has no effect on nurses' formal reporting behavior, which contribute to the effectiveness of penalty enhancement laws.
- H_a 2= Organizational culture has an effect on nurses' formal reporting behavior, which contribute to the effectiveness of penalty enhancement laws.

Using my survey instrument, I measured the dependent variable of emergency department nurses reporting of patient-inflicted assaults. The independent variables that were evaluated consisted of nurse and facility demographics, rational choice perceptions that may have influenced reporting behaviors and organization culture perceptions that may also have influenced reporting habits. Each variable is listed in Table 1 along with

the corresponding survey question that was used to measure the variable and the research question that the variable addresses.

Data was analyzed from the modified Emergency Department Nurses Assault Reporting Survey to explore possible relationships between rational choice actions, organizational culture, and formal reporting of patient-inflicted assaults that may assist in determining the effectiveness of penalty enhancement laws. Frequencies, percentages, means, and standard deviations were at ordinal level data. Descriptive statistics and data analysis were produced using SPSS software.

Independent variables were developed from three survey questions used as control variables related to nurse demographics and presence of state laws, 12 survey questions related to rational choice theory, and 12 survey questions related to organizational culture theory. The dependent variable was built from four survey questions that measured the reported number of assaults and how many times the assaults were not reported, reported informally, or reported formally. A regression model was used to test rational actions and organizational culture influences against nurse reporting behaviors of patient assaults.

Table 1

Variables and Corresponding Survey and Research Questions

Variable Type	Variable	Survey Question	Research Question
Dependent Variable: ED nurse reporting of patient-inflicted assault	Assault incidents	9	
	Assault no report	10	
	Assault facility report	11	
	Assault police report	12	
Independent: Control variables	Age	1	
	Gender	2	
	Work experience	3	
	State	4	
	Work schedule	5	
	Union membership	6	
	RN organization membership	7	
	Staffing level	8	
Independent: Rational choice variable	Individual response	25	1
	No report reason	26	1
	Decision making	27	1
	Court report	28	1
	Retaliation	29	1
	Financial comp	30	1
	Law awareness	31	1
	Increased penalty	32	1
	Law report propensity	33	1
	Max fine	34	1
	Max jail	35	1
	Future reporting	36	1
Independent: Organization culture variable	Responder	13	2
	Patient consequences	14	2
	Response satisfaction	15	2
	Culture comfort	16	2
	Policies	17	2
	Training	18	2
	Encouragement	19	2
	Hospital prevention	20	2
	Acceptable violence	21	2
	Hospital report support	22	2
	Hospital law support	23	2
	Union law support	24	2

Theoretical Framework

The theoretical framework of my research is explained in Chapter 2, the literature review. I explored my topic through the theories of organizational culture and rational choice. Organizational culture was examined through the institutional policies, perceptions of leadership, and behaviors of nursing in reaction to patient assaults. This theoretical framework was based on the theory of organizational culture as explored by Schein (2009) in his explanations of the relationships between leadership decisions, organizational change, and the behavior of individuals within the organization. Schein's theories focusing on the need for assessing the culture of an organization to solve a problem, managing shared assumptions of a group within a culture, and the evolving of the culture of the organization to adapt to elements in the environment was relevant to the focus of my study. Understanding these elements and their effects on the organization could have a direct correlation to the behaviors of individuals responding to incidents of stress such as those resulting from being a victim of assault.

The other theoretical framework explored in my study was rational choice. As it related to my study, rational choice was explored in its relationship to the victim, not the offender. Rational choice theory suggested that individuals would make a cost-benefit analysis in their decision-making process and select the course of action that they perceived as the most satisfying for them (Ward, Stafford, & Gray, 2006). As it related to my study, emergency department nurses may make a rational choice when determining if they want to pursue formal reporting and judicial actions against an offender or if they want to refrain from reporting and allow the offender to avoid punishment.

Overview of Organizational Culture

Schein (2009) explained that the culture of an organization is a product of a group of individuals that share commonalities in dealing with situations in their environment. Schein (2009) defined culture as "a pattern of shared assumptions that was learned by a group as it solved problems that have worked well enough to be considered valid and taught to new members as the correct way to think in relation to problems" (p. 27). These cultures can differ from one organization to another based on the degree to which the organization classifies appropriateness in human behavior.

In a society like the United States, we value the individual's rights above the organizations' so the leader of the organization must take the needs and rights of their employees into account when developing the culture (Schein, 2009). This is a valuable element for an organizational leader to understand when it is necessary to make changes to solve a problem. These individual needs within an organization can be discovered through a culture assessment (Schein, 2009). When the organization faces a change or a problem, the cultural elements that make up the organizations' culture as a whole need to be analyzed to determine if they will aid or hinder a solution (Schein, 2009). In this aspect, the elements of individual needs or rights may be a priority in determining how the organizational culture of a hospital will develop to either support or discourage actions taken when a member is assaulted.

Schein (2009) provided a psychological basis for member anxiety when changes occurred in an organization's culture. He divided these anxieties into "the fear of loss of power, temporary incompetence, punishment for incompetence, loss of personal identity,

and loss of group membership" (p. 87). The fourth element being relevant as it provides the theory that individuals may fear the loss of being part of the group within the organization if they develop a new way of behaving or thinking without the whole group changing their views at the same time (Schein, 2009). Similarly to my research, a nurse who is assaulted may be unwilling to step outside of the norms of the group and pursue formal charges against an offender for assault if the culture of the organization has been to ignore the problem and avoid legal proceedings against patients. Without a cultural change in the organization, it may be difficult for victims to take legal actions against their offenders and thus negate any support the penalty enhancement laws may have to offer.

The continuing success of an organization can be a product of its culture. The culture of the organization is a set of shared assumptions by a group that have been learned and accepted when dealing with external issues and internal relationships (Schein, 2009). The participation and support of the leader, the depth of assumptions the group shares, and the level of success of the organization can measure the strength of the organizations' culture (Schein, 2009). When successful ways of shared thinking and behaving by the group are supported, it is more likely the organization will be successful (Schein, 2009). If an organization continues to support values and behaviors that the group no longer buys into, then there will most likely be a decline in the culture and the ability of the organization to function as a group in a successful manner (Schein, 2009). This is the other end of the issue. When specific subgroups of an organization need to change to meet the threats from their environment, the culture of the entire organization

needs to evolve or a disconnect in values and goals will develop between the members and the leaders (Schein, 2009). If the individual nurses in a hospital support each other in changing behavior and pursuing formal reporting and charges against their offenders, then the organizational leaders will need to adapt the culture of their institution.

Overview of Rational Choice

In rational choice theory, the individual will make a decision based on their pre-conceived beliefs and act on an event in a manner that will satisfy their own desires based on what they believe the outcome of different choices would be (Dietrich & List, 2013). Under these circumstances, the individual is weighing alternatives to a situation and then taking individual action towards the outcome that they believe to be the best alternative for them (Dietrich & List, 2013). This aspect of rational choice is a newer version of the theory that looks at the motivating factors for individuals who have had the ability to develop sound beliefs for alternative actions (Dietrich & List, 2013). This theory was related to my focus for research. When a patient has assaulted a nurse, the nurse is faced with alternative solutions to the problem. They may do nothing, they may tell their coworkers about it and move on, or they may formally report the attack to their administrator and file a formal report with law enforcement. When making this decision, the nurse can take into account the pros and cons that accompany each alternative, and then make a decision to act on the option they feel will give them the highest level of satisfaction.

This new version of rational choice theory explained an individual's propensity for decision-making (Dietrich & List, 2013). However, it does leave the issue of how the

individual develops the belief system to come to a decision. According to Dietrich and List (2013), “While rational choice theory is able to show with great precision how an agent can rationally act, given his or her preferences, one of the theory’s shortcomings is that it says little about where those preferences come from or how they might change" (p. 614). This shortcoming may possibly be explained by the combining of this theory with organizational culture. As provided in the previous section, an individual may develop a system of beliefs based on those of their organization. This may be due to a shared set of values with the organization or it may be due to one of the fear factors of falling out of favor with the group within the organization if commonalities are not abided by. Either for positive or negative reasons, the culture of the organization can hold the potential to develop the set of preferences that the individual then abides by to make a decision based on rational choice.

Time illusion may also factor into an individual’s rational choice. In time illusion, the enjoyment level of the activity affects the perception of time spent on an activity and impacts how much opportunity cost the individual will assign to the activity (Minagawa, 2013). In relation to my research, it was conceivable that the nurse will not find the activities of filing formal reports and following up with providing testimony for legal proceedings against an assaulter to be an enjoyable activity. The opportunity cost the nurse would assign to this activity could be significant if it is given in exchange for his or her own personal time. This can be related to organizational culture. If the organizational leaders allow the nurse to go to the local law enforcement precinct on paid work time, then the nurse may view the opportunity costs as lower and be more willing to report the

assault in a formal manner. Additionally, if the reporting process developed by the organization is streamlined and easy for the victims to complete, they may also be more willing to give up their time to file the formal report.

By applying the concepts of rational choice and organizational culture, support may be found for both of these theories through the data collection of my research project when assessing the reporting behaviors of emergency department nurses.

Definitions

The following list of operational definitions is provided for common terms used in this dissertation.

Academic hospital: "Consists of a medical school, at least one other health professions school or program, and at least one affiliated or owned teaching hospital" (Kohn, 2004, p. 19).

Aggravated assault: "An attack by one or more persons on another with the purpose of inflecting serious bodily injury, including threats and attempts, or an assault committed with a dangerous weapon" (Tonry, 2009, p. 29).

Closed-ended question: "A question that offers respondents a set of answers from which they are asked to choose the one that most closely reflects their views" (Frankfort-Nachmias & Nachmias, 2008, p. 516).

Cross-sectional design: "A research design most predominant in survey research and used to examine relations between properties and dispositions. A cross-sectional design can approximate the posttest-only control group design by using statistical data analysis techniques" (Frankfort-Nachmias & Nachmias, 2008, p. 518).

Likert scale: "A scale designed to measure the strength of attitudes on the ordinal and internal level" (Frankfort-Nachmias & Nachmias, 2008, p. 522).

Organizational culture: "A pattern of shared tacit assumptions that was learned by a group as it solved its problems of external adaption and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems" (Schein, 2009, p. 27).

Penalty enhancement law: "A sentence which is increased by a prior conviction or the serious nature of the circumstances involved from one classification of offense to another higher level classification of offense. Enhanced sentence laws are governed by federal and state laws, which vary by state" (US Legal, 2015, par. 1).

Reliability: "The consistency of a measuring instrument, that is, the extent to which a measuring instrument exhibits variable error" (Frankfort-Nachmias & Nachmias, 2008, p. 526).

Simple assault: "An assault without a weapon and that does not cause serious physical injury" (Tonry, 2009, p. 28).

Validity: "The degree to which an instrument measures what it is supposed to measure" (Frankfort-Nachmias & Nachmias, 2008, p. 528).

Workplace violence: "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (Blachar, 2011, p. 87).

Assumptions

As a career professional in hospital administration, I assumed that emergency department nurses would not always formally report incidents of patient assaults, regardless of the existence of penalty enhancement laws. I assumed that the emergency department nurses would be the most knowledgeable individuals to provide feedback on the practical and organizational support received for reporting assaults and first-hand decisions on reporting incidents of assaults in the emergency departments.

Scope, Delimitations, and Limitations

Scope

The scope of my research included randomly selected emergency department nurses working in academic hospitals located in the Mid-Atlantic Region. Specifically, the hospitals were located in Massachusetts, New York, New Jersey, Pennsylvania, Maryland, and Washington, D.C. The chief nursing officer or chief of emergency medicine at the selected academic hospitals in these states was emailed a letter of explanation along with a request to forward the survey request on to the emergency department nurses at their facility. The email also included a link to an online survey via SurveyMonkey.

Delimitations

The emergency department nurses employed at the academic hospitals were asked to participate in my study because they were the most knowledgeable about their organization's culture in relation to reporting patient assaults and would be able to provide data in regards to first-hand accounts of patient assaults. The emergency

department nurses were able to respond to the surveys and provide individual accounts of choices made after being a victim of assault, the actions that were taken after the incidents, and their knowledge of penalty enhancement laws in their state. Managers and administrative leaders of the hospitals were not surveyed, as they are generally not the individuals providing direct patient care in the emergency department nor are they generally the victims of patient assaults.

Another delimitation of my study was that it focused on academic hospitals across 6 areas of the Mid-Atlantic Region of the United States. I included the responses of all randomly selected nurses in my study. My results are expected to provide a basis for future analysis that can be expanded to other geographical regions or other levels of healthcare.

Limitations

Options for statistical analysis were limited due to restrictions outlined by the purpose of my study. There was also a limitation in the ability to compare the data collected from my study to other regions or healthcare institutions due to a lack of previously collected data on this topic. Other limitations to my study included the time allowed for completion of the surveys, the respondent's fulfillment of answering the Internet-based survey, the availability of emergency department nurses to participate, and the level of accuracy and honesty in the responses from the participants.

Expected Social Change

My study encourages social change through implications from three aspects. First, it provided for an increased understanding of how emergency department nurses

rationalized their behaviors in response to patient assaults. Second, it provided additional information to the body of literature on rates of patient assaults on emergency department nurses in the Mid-Atlantic Region. Third, my study provided for the increased knowledge of the potential effectiveness penalty enhancement laws have on healthcare organizations and legislative bodies and whether the implementation of stricter laws is the appropriate way to influence behavior under the new era of healthcare.

After the first enrollment period of the Affordable Care Act was completed in 2014, the United States had an additional 9.5 million people with health insurance (Geyman, 2015). One of the goals of the Affordable Care Act was to increase the level of preventive medical care utilized by Americans versus going to the emergency departments for primary medical treatment (Geyman, 2015). The success in reaching this goal has yet to be seen. Since the implementation of the Affordable Care Act, some states have seen a 40% increase in their emergency department visits by individuals who were included in the Medicaid expansion (McClelland et al., 2014). An ongoing increase in emergency department utilization by the newly insured will have the potential to affect the quality of care due to overcrowding.

Overcrowding in emergency departments is one of the elements determined to cause additional stress and anxiety which can lead to assaultive behavior by patients waiting to receive care (Behnam, Tillotson, Davis, & Hobbs, 2011). With the expansion of Medicaid patients utilizing emergency departments, changes in social culture may turn out to be influenced more by changes in organizational behavior which address how

hospitals and the government address the provision of healthcare rather than additional penalty enhancement laws which focus on punishment of the offenders.

Summary

Emergency department nurses are a vital element in our communities for the care of the sick and wounded. My study assessed the assaults nurses face from the patients they serve and how they were supported by their organizations in dealing with these assaults. Additionally, my study assessed the potential effectiveness penalty enhancement laws have on increasing the reporting behaviors of nurses after being the victim of assault with the hope that these laws may someday lead to reductions in patient assaults of emergency department nurses. I demonstrated how organizational culture and rational choice share a relationship in this phenomenon and may account for behavioral traits of nurses when dealing with assault.

In Chapter 2, I review the literature and provide information on the theoretical frameworks of organizational culture and rational choice as it related to the individual victim in an organization. Additionally, in Chapter 2 I examine the history of assaults on special groups of individuals, the development of penalty enhancement laws, and their implication for healthcare workers. A history of workplace violence in the healthcare arena is also provided in Chapter 2 that gives a background on the seriousness of this issue. In Chapter 3, I describe the methodology, design, statistical tests, and survey instrument that used to gather and analyze data. Chapter 4 provides the results and statistical data collected from the surveys. Chapter 5 provides an interpretation of the findings, potential social effects, and recommendations for further actions and study.

Chapter 2: Literature Review

Introduction

The purpose of my study was to examine the risk to nurses from assaults in the emergency department and the possible effects penalty enhancement laws have on reducing these assaults and encouraging nurses to report the incidents to law enforcement. One study by the International Council of Nurses reported that as high as much as 80% of assaults in emergency departments are not reported by nurses (Crilly, Chaboyer, & Creedy, 2004). Even with the implementation of penalty enhancement laws, prosecution of perpetrators would be ineffective if the incidents were not reported to law enforcement by the victims (Pawlin, 2008). Previous studies have analyzed the effectiveness of internal security programs and the frequency of assaults due to changes in state or regulating agency guidelines requiring specific baseline security programs (Behnam, Tillotson, Davis, & Hobbs, 2009; Blando et al., 2008; Kowalenko et al., 2012). However, these articles did not focus on the rates of assaults against emergency department nurses nor their willingness to pursue criminal charges against perpetrators of assaults once penalty enhancement laws had been implemented in their states. This chapter provides an encompassing review of the literature on organizational culture and rational choice theories, research that was conducted in the area of victimology, the history of workplace violence in emergency departments, the implementation of penalty enhancement laws for different aspects of criminal behavior, and the application of different security controls in an attempt to protect nurses from violent behavior.

Workplace violence has been a significant issue for organizations in both the public and private sectors with over 1.5 million incidents being reported annually in the United States (Kansagra et al., 2008). One specific area where workplace violence continued to exceed the national average has been in hospital emergency departments (Behnam, Tillotson, Davis, & Hobbs, 2009). According to data collected by the US Department of Labor (2013), the incident rate of nonfatal injuries for private sector hospital employees was 6.1 per 100 full-time employees and 3.2 for the overall private industry. At almost twice the national average, much attention has been given to determining how to make the workplace safer for hospital employees (Behnam et al., 2009; Crilly, Chaboyer, Creedy, 2004; Gates et al., 2011; Roche et al., 2010). This imbalance in rates of assault has not gone unnoticed and has been the topic of numerous research studies.

Over the past several years, researchers have evaluated the effects of physical security controls on reducing violent incidents against nurses. These controls have included the use of security guards, metal detectors, restricted access, surveillance cameras, and panic alarms (Behnam et al., 2009; Blando et al., 2008; Kansagra et al., 2008). Other research has included administrative controls such as self-defense training, behavior management techniques, management support, incident reporting systems, policies and procedures, and postevent counseling (Gates et al., 2011; Gifford & Anderson, 2010; Hills, 2008; Roche et al., 2010). Patient and environmental characteristics were also included in previous research which included patient race, age, sex, mental status, trauma level of care, hospital location, population density, and nurses

sex, age, and years of experience (Crilly et al., 2003; Flannery et al., 2011; Gates et al., 2011; Ideker, Todicheeney-Mannes, & Kim, 2011). Results from these studies have varied with little consistency in significant findings for controls that have proven to reduce incidents of assaults against nurses. These articles were further analyzed for commonalities and variances in the following sections of this chapter.

Demands to reduce workplace violence have come from professional organizations such as the American Nurses Association, the National Federation of Nurses, and the Emergency Nurses Association through the lobbying of state legislatures to implement stricter criminal penalties for perpetrators that assault nurses while on duty (Gacki-Smith et al., 2009). These penalty enhancement laws have since been implemented in many states across the country. The first states to include nurses in penalty enhancement clauses of state penal codes occurred in 2005 (Justia US Law, 2014). These states were Arizona, Connecticut, Minnesota, Missouri, Nevada, North Carolina, and Washington (Justia US Law, 2014). Since 2005, 23 additional states have added nurses to their list of professionals in state penal codes where increased penalties are applied to perpetrators of assault (Justia US Law, 2014). The effect of these penalty enhancement laws on the rate of patient assault against emergency department nurses has not yet been academically researched. Similar penalty enhancement laws have previously been implemented with mandatory arrest policies for domestic violence which have also had mixed results (Frantzen, Miguel, & Kwak, 2011, Hirschel et al., 2007; McMahon-Howard, Clay-Warner, & Renzulli, 2009; Pate & Hamilton, 1992; Sherman & Berk, 1984). These studies will also be reviewed in the following sections of this chapter in an

attempt to determine if there were any similarities in the effects of these laws that might be indicators of the effectiveness of penalty enhancement laws to protect nurses from assault.

Content and Organization of the Review

This chapter will cover the following topics: A review of the victimology area of study in criminology; the application of organizational culture and rational choice theories; a critique of previous research on the issue of workplace violence in healthcare; an analysis of research conducted in attempts to explain issues in nurse willingness to report patient assaults; an assessment of the applicability and effectiveness of previously implemented penalty enhancement laws for other aspects of criminal behavior; and a critique of quantitative and qualitative design methods previously used in related studies. The section for penalty enhancement laws in other areas was included due to a lack of studies conducted in the healthcare area for newly enacted laws to protect nurses. This inclusion was to provide a background on the possible effectiveness of similar forms of state enacted legislation aimed at protected specific individuals in the community.

Strategy for Searching the Literature

Articles for this literature review were collected from the following databases: Political Science Complete, Business Source Complete, CINAHL Plus, SocINDEX, Oxford Bibliographies, Academic Search Complete, Political Science, Sage Full Text, Criminal Justice Periodicals, Legal Trac, SocIndex with Full Text, Expanded Academic ASAP, Nursing and Allied Health Source, Science Direct, OVID Nursing Journals, and Health Sciences Sage Full Text Collection. Other reference sources that were used for the

collection of secondary data include the following: U.S. Bureau of Labor Statistics, U.S. Department of Labor, American Nurses Association, National Federation of Nurses, Emergency Nurses Association, Justia U.S. Law, and state government Internet sites. Key words and terms used to search these databases were: *nurses, assault, emergency departments, security, workplace violence, victimology, rational choice theory, organizational culture, penalty enhancement laws, hospital violence, nurses association,* and *assault laws*. The search for these key words resulted in approximately 35,217 articles dated between 2004 and 2015. The initial longer period was used to capture research articles conducted on penalty enhancement laws for domestic violence. The search was narrowed down to the years 2005 – 2015 for research specific to workplace violence in hospitals and related legislation. This refined search resulted in approximately 7,244 articles. Further reductions were seen though the inclusion of only peer reviewed articles from scholarly journals relating directly to violence in emergency departments. This refinement narrowed the results down to 698 articles. The primary articles included were limited to publication within the last five years. Older articles were included if they included significant findings from landmark studies that directly affected future research.

Theoretical Framework

There were two theories applied to my research. One theory is rational choice and the other is organizational culture. Rational choice theory focuses on the aspect that individuals will act rationally in their behavior and will calculate the cost and benefits of their options for alternative actions before acting (Scott, 2000). This theory has been applied to criminal behavior in past studies. For my study, I explored the theory of

rational choice and how it pertains to the victim and their decision-making process to take action after an assault. Organizational culture theory focuses on the ideology that an organization develops a culture among its members by sharing assumptions through learned behavior in solving problems and integrating internal activities (Schein, 2009). These shared assumptions that work well for the organization are then passed on to new members as the upheld correct way of acting in relation to the identified problems (Schein, 2009). Both of these theories were explored in their relationship and application to my research.

Social Research in Criminology and Victimology

Criminology is a scientific study of the behaviors and characteristics of offenders (Lauritsen, 2010). It was not until the 1960s that the Administration of Justice started to realize that the official criminal justice statistics provided in the Uniform Crime Reports were insufficient for developing effective policies since there was a significant lack of indicators from the social environment (Lauritson, 2010). Researchers began to develop an interest in the contribution the victims may have had in the crimes committed against them which led to the development of victimology as a separate area of study within the criminological sciences (Lauritsen, 2010).

Students of victimology focused their research on people who have been hurt or suffered negative consequences by the actions of someone else, the possible explanations as to why victims may have become the target of the crime, how the victim's lifestyles may have increased their chances of becoming the victim, and the characteristics of the person who committed the crime (Dillenburger, 2007). This led to the development of the

National Crime Survey and the National Crime Victimization Survey after which quantitative studies began to form the social and lifestyle theories of victimology (Jaishankar, 2008). This development in focusing on victims instead of the offenders helped to build a collection of new crime data.

Even after the collection of victim data from new national surveys, it would still involve the development of special interest advocacy programs before criminal justice systems in most states began recognizing the seriousness victim traumas from repeat exposure to violence and to negative experiences with the criminal justice system (Lauritsen, 2010). One problem at the onset was that victimology started out with microlevel research and gave the perception that the theories being developed were blaming the victims for the occurrences (Lauritsen, 2010). It would not be until larger macrolevel analyses expanded the field into predicting the who, when, and where of victims by linking UCR data with victim data that strong realizations of whether formal involvement from law enforcement and the criminal justice system would mitigate or exacerbate changes of future victimization (Dillenburger, 2007). Preferably, longitudinal studies would be the most useful if the subjects were able to be studied over their life course for better understanding of what the consequence of being a victim had on the individual (Jaishankar, 2008). Further integration of the knowledge gained from victimology theories towards specific types of crimes such as violence against women or specific groups of citizens might then hold the potential for discovering links between violence and victim behaviors.

Rational Choice Theory

Rational choice theory was originally based on the hypothesis that the potential offender will weigh the benefits and risks of undertaking a specific crime based on the elements in the environment surrounding themselves and the target (Brunet, 2002). This theory was based on the premise that an individual will chose to commit a crime if they perceive the benefits of the act to outweigh the risks of the act (Brunet, 2002). As this theory was expanded to other areas beside criminal behavior, rational choice began to be used by sociologists to explain the social interactions between individuals and their environment (Scott, 2000). The application has since been applied to understand choices individuals make in regards to their use of time, information, social acceptance, and hierarchical standing (Scott, 2000). Through these elements, rational choice theory could then help to further studies in victimology.

In rational choice theory the individual will make a decision based on their pre-conceived beliefs and act on an event in a manner that will satisfy their own desires based on what they believe the outcome of different choices would be (Dietrich & List, 2013). When rational choice is applied, the individual will consciously make a decision based on their personal experiences or learned behaviors from their then act upon the option available to them that provides them with what they perceive to be the greatest benefits or least costs (Dietrich & List, 2013). One example would be the avoidance of repeating behavior that resulted in punishment when that act was chosen in the past (Scott, 2000). When this example is related to my study, a nurse may make the rational choice not to report a patient assault because their director reprimanded them the last time they filed a

report. This aspect of rational choice is a newer version of the theory that looks at the motivating factors for an individual who has the ability to develop sound beliefs for alternative actions (Dietrich & List, 2013). Under these circumstances, the individual is weighing alternatives to a situation and then taking individual action towards the outcome that they believe to be the best alternative.

This new version of rational choice theory can explain an individual's propensity for decision making. However, it does leave the issue of how the individual develops the belief system to come to a decision. According to Dietrich and List (2013) "while rational choice theory is able to show with great precision how an agent can rationally act, given his or her preferences, one of the theory's shortcomings is that it says little about where those preferences come from or how they might change" (p.614). Overcoming this gap in the theory could possible be explained by exploring explanations victims gave for their actions.

A theory has been defined as "a set of analytical principles designed to structure our observation and explanation of the world" (Cairney, 2013, p. 1). The two sets of principles provided by organizational culture and rational choice may be complementary to each other. When combined, a wider range of insight into observations about patient assaults on nurses and a more in-depth explanation for formal reporting habits may be possible. This type of complementary behavior in theories was used in prudent choice making. Under this procedure, decisions can be made in a social framework by developing a linear order of preference for a number of options. Once the society has made their determinations on which order of preference the options are aligned, the

individual members of society abide by the agreed order (Houy, 2010). In prudent choice making, the two theories for my study were used, but in reverse order as would normally be assumed. Initially, rational choice is used by the society to determine the order of preference for the given options. Secondly, the individual makes decisions based on the organizational culture and follows the linear priority of options as decided by the society. The complementary function of prudent choice making can be applied to my study when the organization determines the rational choices of what steps are taken after an assault and then the victim follows those decisions that the organization had aligned.

Organizational Culture

Schein (2009) defined culture as "a pattern of shared assumptions that was learned by a group as it solved problems that have worked well enough to be considered valid and taught to new members as the correct way to think in relation to problems" (p. 27). The culture of an organization is a product of a group of individuals that share commonalities in dealing with situations in their environment. These cultures can differ from one organization to another based on the degree to which the organization classifies appropriateness in human behavior.

The formation of cultures in organizations is a product of leadership activities and the experiences that are shared by the members of the organization (Schein, 2010). To develop these cultures, there are realities that are agreed upon by the group that cannot be empirically tested, these are called social realities. Additional within the organization are the realities that the individual has experienced and have learned from personal experience, these are called individual realities (Schein, 2010). The organization develops

the social realities through shared experiences. When a larger group of members within the organization have diverse individual realities, it becomes more difficult for a consensus to be reached within the organization (Schein, 2010). Diverse backgrounds and previous experiences of nurses working together in an emergency department may bring conflicting individual realities to the organization. When this occurs, it can be possible that reporting habits and reactions to incidents of assault may vary between individuals as to what is acceptable behavior. If this were to occur, the organizational leadership would have the challenge of using human-oriented leadership styles in order to work with the subgroups to develop new social realities for the organization upon which consensus in reporting procedures can be developed (Northouse, 2015).

A change in the culture of an organization can come in different degrees of magnitude. Minor adjustments can be changes in existing, routine practices in order to improve current processes. Major adjustments involve the complete department from existing practices and the implementation of new procedures. Both adjustments can be either through administrative process changes or through technical product changes (Austin & Claassen, 2008). These changes can be more difficult to implement when the organization has a formal type of hierarchy culture. In hospitals, formal cultures are normal and necessary in order to maintain hospital regulations and policies. Implementing a change in culture can be more difficult but still may be necessary when the practices of the organization no longer meet the realities of the individuals (Austin & Claassen, 2008). In the example of hospital culture changes, motivation at all levels of

the organization for the change would be paramount if effective organizational change were to take place.

When attempting to make changes to the organizations culture, management can influence social interactions that in turn can have an ability to influence cultural changes. By influencing changes in strategies, goals, and philosophies, the leaders may be able to manage the values deemed important by the organization. Through proper motivation and participation, organizational change could then be achieved once the group decides the solution is a shared success and it gains value (Baumgartner, 2009). Similar to the previous example, changes in values through changed philosophies of behavior may be a tool hospitals can use if there is a problem with reporting behaviors and assaults on their members. The motivation may come from the bottom of the hierarchy since they are the victims; however, the leaders at the top of the organization will need to be open to the requested changes and be willing to trial implementations (Baumgartner, 2009). If there is a shared success in the form of reduced assaults, increased staff safety, or increased employee satisfaction with the organization, then the changes should gain value for all levels of the hospital and be accepted as a new change in organizational values.

Aggravated Assault Defined

For the purposes of my study, the definition of aggravated assault will be "An attack by one or more persons on another with the purpose of inflecting serious bodily injury, including threats and attempts, or an assault committed with a dangerous weapon" (Tonry, 2009, p. 29). This definition will be used inter-changeably with the term physical assault. Any assault, however, is not criminalized until the violent act is attributed to and

prosecuted under a criminal law through the criminalization process. This is significant since there is a need for a violent act to be socially disapproved before the legal system would act upon criminalizing an act (Tonry, 2009). Incidents of aggravated assaults have been criminalized and are now punishable by incarceration, monetary fines, or other penalties under state and federal laws (Petersilia & Reitz, 2012). Cultural meanings of violence do change with time and the expectations of the members of society.

The rights and prerogatives of victims across the United States have grown over the past 30 years for many special interest groups. Domestic violence victims were one of the first groups to receive enhanced protection under the law from assault. Other cultural movements have influenced changes and have also led to the implementation of the penalty enhancement laws now in place for emergency department nurses. According to Tonry (2009), "Changes in police recording of assaults provide an excellent illustration of how cultural meaning of violence are redefined by social movements" (p.32). These changes in the recognized status of special risk groups of citizens has been the foundation for assaults that were once classified as misdemeanors, or not recorded at all, to now be upgraded to felonies.

These changes in classification of assaults are not without negative aspects. By increasing the penalties for misdemeanors, additional burdens are placed on the judicial system for processing felons and incarcerating offenders (Petersilia & Reitz, 2012). In response to the activation of violence-reduction policies and interventions, Tonry (2009) provided that "Each individual dollar spent on prisons, jails, and community corrections is money that states and local areas cannot devote to other pressing needs, including

improvements in education and early childhood interventions that hold some promise for reducing criminality" (p. 45). The cost effect is an important aspect to consider in penalty enhancement laws. The additional funds required to uphold the increased penalties may be worth the diverted finances if they truly do reduce rates of assaults and increase the safety of the victims. However, if the laws are being implemented and additional offenders are spending time in prison while the assault rates on the special risk group remain the same, or increase, then the laws need to be re-evaluated and possibly other alternatives to increase victim safety need to be considered.

Workplace Violence in Hospitals

Rodriquez-Acosta et al. (2010) conducted a retrospective cohort study with nurses at two of the Duke University hospitals. Their data was collected from an internally designed safety surveillance system. Assault rates and ratios were determined by comparing human resources records to workers compensation claims. Their assumption for this study was that more severe incidents were reported more frequently than less severe incidents. Over a seven-year period, they found that there were 220 violence-related injuries reported from a group of 197 nurses. Injuries reportable to the Occupational Safety and Health Administration occurred in half of the incidents. These were injuries that involved medical treatment beyond first aid, some form of financial compensation, or time off from work. Of the injuries that were reported, 86% were from direct patient contact. The overall assault rate that was reported was 1.65 per 100 FTE's (Rodriquez-Acosta et al., 2010). The assault rate of nurses in the ED was lower than other studies. The authors attributed this to under-reporting as nurses in that environment

considered the incidents as part of the job and not worthy of filing reports (Rodriquez-Acosta et al., 2010). The authors used their study to provide support that worker's compensation reports are a worthy resource for studying assault data when compared to HR records to make determinations of employees, job classifications, and other personnel demographics that have a higher risk of assault.

A similar study into the characteristics and activities of violent incidents involving emergency department nurses was conducted in Australia. Crilly, Chaboyer, and Creedy (2004) conducted a descriptive, longitudinal cohort designed five-month study with 108 nurses from two Australian hospitals that shared common demographics for patient population, facility size, and treatment level. The researchers collected the data and conducted the surveys weekly throughout the study period and used four instruments. One was a demographic detail form in regards to the characteristics of the nurses participating, the second was a violence record that recorded information about any violent incidents, the third was a data form that collected the patient's waiting time and triage category, and the fourth was a violence questionnaire which included perceptions of the nurses in regards to the patient's behaviors as it could relate to drug or alcohol abuse, mental illness, or other patient characteristics before the incident occurred (Crilly, Chaboyer, & Creedy, 2004). Of the 66% of the nurses who completed the study, 70% reported experiencing violence during the five-month period. Based on patient admissions, there were two incidents of violence for every 1,000 patients presenting to the emergency departments and approximately five incidents per week. Twenty-six percent of the incidents were physical violence and the majority of the incidents occurred

during the evening shifts. Forty percent of the violent incidents involved patients presenting with irrational behavior, possibly the sign of mental illness (Crilly, Chaboyer, & Creedy, 2004). Results of violence found during this survey were lower than national averages for that time period but percentages of abuse characteristics were consistent with other studies.

A similar study was conducted in the United States by Behnam, Tillotson, Davis, and Hobbs (2009). The authors conducted a prospective, cross-sectional on-line survey with emergency department residents and attending physicians. Sixty-five out of the 134 residency programs in the United States were randomly selected and 263 completed surveys were received (Behnam, Tillotson, Davis, & Hobbs, 2009). In the previous twelve months, 78% of the participants reported experiencing at least one violent act. Higher volume emergency departments that treated more than 60,000 patients a year reported higher incidents of violence. Out of the responding facilities, 40% had control measures in place to screen for weapons, 16% provided workplace violence training, and less than 10% provided self-defense workshops (Behnam, Tillotson, Davis, & Hobbs, 2009). The authors modeled a 34 multiple-choice and four essay questionnaire after the one developed to study emergency department violence in Michigan (Kowalenko, Walters, Khare, & Compton, 2005). Categories in this survey included participant demographics, facility security measures, and experiences with violent patients. The authors reported from their research that 84% of the patients involved in verbally abusive incidents were reported as being intoxicated. From these incidents, 26% of the victims reported actually filing a report in regard to the incident. The authors also reported that

emergency departments with weapons screening devices were more likely to report verbal abuse (Behnam, Tillotson, Davis, & Hobbs, 2009).

In regards to physical assaults, patients perpetuated 91% of the reported incidents. Of these, 68% of the patients were reported as intoxicated (Behnam, Tillotson, Davis, & Hobbs, 2009). As for physical security measures, 23% of the facilities with full-time security reported zero incidents in the previous twelve months, and all facilities with part-time or no security reported one or more incidents. Additionally, respondents who had participated in self-defense training reported the greatest frequency of all types of violent incidents. The authors hypothesized that this may be due to heightened awareness from the training rather than an actual increase in incidents because of the training (Behnam et al., 2009). Ten percent of the physical assaults by patients included the use of weapons that were most commonly guns or knives, with few incidents where equipment or other items on the patient or in the room were used.

When respondents were questioned in regards to actions taken after the incidents, 24% reported that changes to security procedures in their facility were implemented including increased security presence or the addition of other physical security measures (Behnam, Tillotson, Davis, & Hobbs, 2009). The findings from this survey were similar to other studies in the reported rates of overall violence. The authors attempted to conclude that the addition of weapons screening would decrease incidents, but that was not supported significantly by their research. This lack of a significant finding will be relevant to my study in that it did not support other elements such as weapons screening as a significant guardianship to reduce assaults on emergency department nurses. This

gives limited support into researching other possible means of guardianship to be researched as more significant indicators such as the use of penalty enhancement laws.

In order to analyze other possible factors of assault rates on emergency department nurses, a cross-sectional survey that explored correlations between community crime rates, facility security programs, and emergency department incidents of violence was conducted in New Jersey (Blando et al., 2008). Fifty of the 84 hospitals in the state agreed to participate. Their research involved two surveys; one was given to the hospital security directors and one to the emergency department nurse managers. To control for similarities between the facilities, the financial status of each hospital was calculated by the annual patient service net revenue divided by the number of patient beds and state police Uniform Crime Reports were used to collect the crime statistics for each facility by town and divided by the population to determine a community crime rate. In order to develop an average assault rate, OSHA recordable injuries as a result from a violent event were divided by the average number of employee work hours (Blando et al., 2008).

Based on the information collected from financial records and reported crime rates, the surveyed hospitals were categorized as either large hospitals in a high or low crime rate area or small hospitals in a high or low crime rate area. The authors found that small hospitals in low crime areas implemented the lowest amount of security measures and had the highest rate of budget cuts for security. These same hospitals had the highest median net patient revenue following large hospitals in low crime rate areas (Blando et al., 2008). Assault rates were found to be the highest in small hospitals with high violent

community crime rates followed by small hospitals with low community crime rates. Median assault rates in these smaller hospitals were up to five times higher than in the larger surveyed hospitals (Blando et al., 2008). The authors concluded that the lack of financial resources did not seem to be the reason for lack of security. Rather a perception that security was not needed in those small hospitals or a lack of willingness of leadership to implement strict measures was determined to be more likely based on the responses (Blando et al., 2008).

The study supported the conclusion that all emergency department employees were at risk of assault, regardless of the size of their hospital or the community crime rates (Blando et al., 2008). The authors' conclusion could provide for possible support for state legislation to implement laws for minimum standards in hospital security measures, regardless of the size of the facility. Those laws were passed in California and New Jersey after the completion of this study (Casteel et al., 2009). This study also helped to provide justification for the elimination of certain control variables such as community crime rates, financial status, or facility sizes as significant factors contributing to the rate of patient assaults on emergency department nurses. There was a limitation to the results of this survey in that OSHA recordable injuries were used so any verbal assaults or physical assaults that did not require medical attention were not included in this study.

Another variable that has been included in previous studies as a possible indicator of assault rates was the inclusion of aggression management training for emergency department employees. Australian health and safety statutory laws require health care organizations to provide aggression management programs for their staff (Hills, 2008).

The author of this study explored the relationship between aggression management training, the self-perceived ability of nurses to handle aggressive behavior, and the actual rate of incidents of aggressive behavior on nurses in New South Wales (Hills, 2008). The author used a self-report questionnaire that was sent to a simple random sample of 650 nurses. The survey included questions in regards to self-demographics, participation in aggressive management training in the past five years, and the types of patient aggression they were exposed to in the three months prior to the survey (Hills, 2008). Of the respondents, 60% of the nurses had participated at least once in training in the previous five years and 83% of the nurses reported having been exposed to some form of patient aggression in the previous three months. The majority of the aggressive behavior was verbal abuse. Approximately 70% of the nurses viewed their ability to deal with aggressive situations as low to medium-high. The results showed nurse demographics of gender, age, and experience had little correlation with frequency of aggressive incidents, and participation in the training had low association with verbal abuse and with self-perceived ability to handle the situation (Hills, 2008). The author concluded that there was little support for training having an impact on rates of incidents or the confidence in nurses to handle the situation; however the author did not support the idea that training is ineffective since other studies have found support for it.

Hills (2008) concluded that the training might need to be directly tied to organizational support activities to reinforce the concepts learned. Their results in finding low correlation between aggression management training and assault rates will be relevant to my study. As with other variables research in other studies, the accumulation

of prior research that showed little or no correlation in variables led to the support of looking at penalty enhancement laws as a possible alternative that could possibly have a more significant effect on reducing assault risks to nurses.

One of the larger surveys conducted in this area was completed by Kansagra et al. (2008). They conducted a quantitative study using the National Emergency Department Safety Study. From a sample of 65 emergency departments across the United States, the authors collected 3,518 surveys over a five-year period which reported 3,461 physical attacks (Kansagra et al., 2008). Participating emergency departments in the survey were larger academic institutions in metropolitan environments.

Out of the responding facilities, 20% of emergency departments reported guns or knives in the department on a daily or weekly basis. In addition to alcohol, drugs, and mental issues, long waits and stressful conditions were reported to have added to violent tendencies (Kansagra et al., 2008). In the survey, the authors controlled for emergency department characteristics such as type, location, and patient load and for respondent characteristics of age, race, gender, and experience. The authors found that aggression management training, use of metal detectors, frequency of weapon incidents, and the number of violent incidents was not statistically significant predictors for staff perception of safety (Kansagra et al., 2008).

The emergency departments with metal detectors reported higher numbers of physical attacks and the frequency of weapons was not significant for the actual number of assaults. One limitation proposed by the authors was that the emergency departments with metal detectors and higher weapon incidents could have been because the detectors

were installed in response to the level of crime in the external environment. Another limitation may have been aggressive management training would have been more significant if perceptions were measured before and after the training had been provided to the staff (Kansagra et al., 2008). Taking into account the limitations, this study showed no significant correlation between aggressive management training programs, the use of metal detectors, and the number of assaults.

In addition to surveying nurses for their experiences with patient assaults, Gacki-Smith et al. (2009) surveyed nurses in regards to their reasons for not reporting patient assaults. In this 69 item cross-sectional survey of members of the Emergency Nurses Association, 25% of the respondents reported to have been victims of physical violence at least 20 times in the past three years. Twenty percent reported verbal abuse at least 200 times in the past three years and 50% claimed that verbal or physical assaults against them by patients or their visitors were never reported in writing (Gacki-Smith et al., 2009). Reasons respondents gave for not reported was a lack of physical evidence, empathy for patient, considering it part of the job, or did not consider reporting to be effective to change anything. Additionally, this study supported other findings in which nurses provided the same reasons for not reported as a lack of support, peer pressure, lacking or unclear reporting procedures, or a fear of retaliation from administration or physicians.

In regards to nurse perceptions of reasons for violence, the respondents cited long wait times, high volumes, low staffing levels, and a lack of ability to care for patients with mental illnesses (Gacki-Smith et al., 2009). Physical environmental controls were

not measured in this survey. Responding nurses who reported having no security in the department also reported lower incident rates. The authors concluded this could have been due to the culture and environment of the emergency department and not directly related to the presence of security (Gacki-Smith et al., 2009). The authors proposed from their findings that emergency department problems might have been better addressed by looking at the larger problems that exist outside the emergency department in the community. The authors found no conclusive results from violence training and called for associations to create awareness to state and federal legislators in order to implement stricter laws punishing perpetrators who assault nurses (Gacki-Smith et al., 2009). This recommendation from the authors will make the inclusion of this study relevant to my research as it showed that professional agencies were supporting the use of penalty enhancement laws as a possible means to protect nurses from assaults even though they did not test the proposal in their study.

The difficulty to accurately measure patient assaults on emergency department nurses comes into account since previous studies have reported that only 20-50% of the incidents of assaults against nurses by patients were reported (Henson, 2010). Past explanations for under-reporting have included a perception that violence in the emergency department was just part of the job, victims blamed themselves for the incident due to poor work performance; or there was a lack of knowledge in how their incident reporting system worked (Henson, 2010). An assumption for this study was that the nurses would be more willing to report the incident of assault if they knew they had

the support of the criminal justice system in carrying out a guaranteed level of criminal punishment against the offender.

Landau and Bendalak (2008) proposed that one of the problems with previous studies into workplace violence in emergency departments was either their limitation in scope of small or focused samples, number of professions studied, or their limited use of theory. They used a sample set from all emergency department workers, both medical and non-medical, in all 25 general hospitals in Israel (Landau & Bendalak, 2008). Their study was designed to explore the aspects of the environment, the situation, and the lifestyles of the participants rather than focusing on the characteristics of the offenders. The independent variables they used to predict victimization were; the physical access offenders had to the victims, activities carried out by the victims that made them more vulnerable to the potential offender; and the presence of individuals or devices in place to mitigate an offense (Landau & Bendalak, 2008). The authors used a "domain-specific victimization model" (p. 91) that narrowed the focus by looking specifically at the activities defined within a specific place and with a specific function. Three thousand self-report questionnaires were distributed to all personnel working in the emergency department of the hospitals at the time of the survey; 2,356 were completed for a response rate of 78.5% (Landau & Bendalak, 2008).

Participants were questioned on violent incidents that they or others in the department experienced within the previous 12 months and were questioned on their professional experience, perceptions on ability to deal with violence, and socio-demographics (Landau & Bendalak, 2008). A multivariate regression was used to analyze

the level of contribution the independent variables had on explaining the incidents of violence against the participants. The authors found that 33% were victims of verbal threats and 11% reported being physically attacked by patients (Landau & Bendalak, 2008). Their results showed security and nurses had the highest rates of attacks in the emergency departments. Landau and Bendalak (2008) found that demographics were not a significant indicator. This finding will help to support my use of other independent variables besides victim demographics to test for causation.

Payne and Gainey (2006) conducted research regarding elder abuse in nursing homes. The authors analyzed the effectiveness of legislative policies as being the capable guardianship to protect the victims from abuse. In their study, Payne and Gainey (2006) found that the Government Accounting Office reported in 2002 that the incidents of patient elder abuse in long-term care facilities were significantly underreported. Reasons cited for underreporting included lack of evidence, unwilling or lack of witnesses, or time delays in reporting (Payne & Gainey, 2006). The authors proposed that penalty enhancement laws might help to increase reporting as the promise of more severe punishment would motivate the victims, or their families, to utilize formal controls.

Payne and Gainey's (2006) research questions addressed the characteristics of the motivated offenders, the characterization of their actions, the relationship between vulnerability and victimization, and how effective the criminal justice system was as a capable guardian. They used bivariate and multivariate analyses to detect any relationships between the variables of victim characteristics, offender characteristics, and abuse types. In 25% of the incidents, offenders were characterized as stressed out or

exhausted when committing the assault, 25% had a history of similar offenses, 68% of the cases involved physical abuse, and 10% involved sexual abuse (Payne & Gainey, 2006). As for offenses related to the duty of other staff, failure to report incidents was the highest cited offense. The authors extrapolated data from their results of 467 cases where incarceration of the offender was documented and found no significant effect of increased sentencing in states with mandatory reporting laws versus those who did not.

The authors' research discovered that the judicial systems in states with penalty enhancement laws ruled with lower sentences for offenders than in states with mandatory reporting and penalty enhancement laws (Payne & Gainey, 2006). The authors found that staffing ratios and the presence of managers were the most effective means of reducing incidents (Payne & Gainey, 2006). To further explore penalty enhancement laws as a capable guardian, conducting similar studies in different social environments where the potential criminal justice punishments may have a higher impact on mitigating crime or encouraging the reporting of the crimes could be beneficial.

Averdijk (2011) supported the concept that previous victimization was considered to be a significant predictor of future victimization, so it would bring to question whether victims do not take any protective measures due to work obligations which they are unwilling or unable to implement or they view the opportunity costs of making changes in behavior to be higher than the prospect of reduced risk from further victimization. Averdijk (2011) conducted a longitudinal study by collecting data from the National Crime Victimization Survey over a course of four years. She found that prior victimization did have significant and positive influence on the risk of being a future

victim yet it had no significant influence on the victim's willingness to change behaviors (Averdijk, 2011). One possibility for this lack of willingness for a victim to change behavior is that they either did not consider the crime to be serious enough for them to change their behaviors or they were unable. Additionally, the National Crime Victimization Survey does not include questions in regards to other protections the victims may have taken in lieu of changing behaviors (Averdijk, 2011).

This article will provide relevance to my research as it explored the concept of why victims may not take additional steps to protect themselves even though there were significant indicators that prior victimization is a positive indicator for further risk of being a victim. In relation to my study, this could come into the same question as to why nurses do not take advantage of formal controls by reporting patient assaults.

Earlier studies into reasons for aggressive patient behavior in emergency departments had found patient wait times were a significant indicator (Gacki-Smith et al., 2009). To further explore this possibility, Roche, et al. (2010) conducted a cross-sectional study in 21 hospitals in Australia. The authors used secondary analysis of data collected from a combination of patient records, nurse surveys, and a nursing work-index database. When surveyed in regards to incidents over their previous workweek, 80% of the participants reported verbal abuse and 14% reported physical abuse from patients (Roche et al., 2010). A different perspective of this study was the possible correlations looked at between incidents of assaults, patient outcomes, and worker productivity. A significant correlation was found that as incidents of violence went up, nurse productivity went down, which caused delays in service to patients. Delays in patient service had been

found to be a cause of aggressive behavior from patients (Gacki-Smith et al., 2009). Based on this perspective, the authors concluded that the actual incidents of patient violence could create further increased risks of other aggressive behavior from other patients as service time is delayed.

The authors found that as the proportion of patients waiting for care in the emergency department increased, so did the number of incidents of assaults (Roche et al., 2010). The authors hypothesized that the rates of aggressive behavior was more closely linked to the circumstances in the environment of the department rather than the characteristics of the patients. This hypothesis could be used to control for many of the demographic variables of patients and support examination of other elements inclusive of judicial punishments (Roche et al., 2010). In addition to the exploration of patient wait times, the authors also found a possible reason for under-reporting of patient assaults to be due to the implementation of patient privacy laws such as the Health Insurance and Portability and Accountability Act (Roche et al., 2010). The assumption made by the authors was that this Act might have given nurses the perception that they would be violating the patient's rights if they reported aggressive behavior. This perception could have been significant for the under-reporting of assaults if nurses were uneducated as to their rights or responsibilities in state and federal laws regarding the reporting of patient assaults.

In a qualitative study, Gillespie, Gates, Miller, and Howard, (2010) looked at workplace violence and its effects on nurses in a pediatric ED. Their study questions addressed what occurred during the incidents of violence, what factors, either

environmental or personal, caused the onset of the incidents, and what were the effects on the nurses and the patients after the incidents. They used a case study approach and interviewed 31 participants from a hospital in the Midwest United States. The authors also observed the workplace over a 40-hour period and collected data from hospital and departmental policies and educational programs. The participants were asked questions regarding what they perceived to be the worst violent incident they experienced over the six months prior to the survey.

Reports of verbal and physical incidents were equal with each accounting for 50% of the incidents. Eighty-two percent of the verbal incidents were from family members and the description of the violent acts included the same types of scenarios as was reported in other studies such as hitting, throwing objects, or pushing (Gillespie et al., 2010). Higher risks of violence were found to be correlated to a lower level of experience and higher risks of potential violence were patients who were being admitted for psychiatric purposes, were not being discharged, or when their belongings were taken from them. A perceived increase in risks of violent behavior was attributed to drug or alcohol use or when parents of the patients were not kept informed of the patient's condition (Gillespie et al., 2010). Access control and visitation control were considered by the respondents to contribute to higher risks of violence from the family members. Long waiting times or crowded ED conditions were also considered to increase the risk of violent behavior from the patients (Gillespie et al., 2010). The nurses also expressed in their interviews that they believed that the higher rates of violence in the community had led to an increase in violent behavior in the emergency department since it was becoming

more acceptable as a way of expressing anger or frustration with other individuals or organizations (Gillespie et al., 2010). The majority of the participants did not support the violent behavior from the patients but had an understanding and partial acceptance of the behavior since they attributed it to poor living conditions and families that had drug or alcohol abuse problems (Gacki-Smith et al., 2009).

The participants discussed the negative emotional outcomes on the patients and specifically mentioned a time when a female patient had to appear in court because she physically assaulted an emergency department employee. The nurse had more sympathy for the patient for having to go to court for her actions and felt that other patients or families would negatively view the hospital and would make assumptions that it was the fault of the nurses and not the patient (Gillespie et al., 2010). Only one nurse in the study reported the physical assault to the police and filed charges. This respondent stated that the police were dismissive of her charges when responding to the call; however, she was supported by security, a coworker, and hospital administration at the court proceedings. Other respondents added that they felt employees should be compensated when attending court proceedings to encourage their participation in the judicial process (Gillespie et al., 2010).

In another cross-sectional survey of emergency department nurses who were members of the Emergency Nurses Association, Gates, Gillespie, and Succop (2011) asked participants to describe the most traumatic workplace assault incident they experienced in the previous year, any post-traumatic responses they may have felt over the following days, and their perceived change in work productivity after the event. From

the 231 respondents, 37% reported a negative productivity score indicating that their work productiveness suffered after the incident. Ninety-four percent reported a positive score on the post-effect scale indicating they experienced some form of stress after the event (Gates, Gillespie, & Succop, 2011). There was a significant relationship between the physical assaults and the ability to meet work-related demands. A low level of reporting incidents was found to be consistent with rates from previous surveys. The authors suggested that even though emergency department nurses claimed that these incidents were part of the job, and didn't feel the need to report them (Gates, Gillespie, & Succop, 2011). In this study, the severity or type of violent act was not measured so there was a limitation in making any determination on how specific incidents could impact nursing performance. This study did support previous research in the low reporting rates of assaults and the explanation nurses gave for not reporting.

In a follow-up to previous research, Gates et al. (2011a) conducted a cross-section survey in six hospitals in two states. The objective of my research was to examine the frequency of emergency department violence, determine if employee demographics or characteristics influenced the frequency of violence, and to see if perceptions of self-confidence and safety were related to those characteristics. Participants were asked to describe incidents of violence they experienced in the emergency department in the six months preceding the survey. Out of the 213 participants, 98% reported verbal harassment from patients in the previous six months of which 40% reported more than 10 incidents in that period. Sixty-eight percent reported at least one threat of physical violence from a patient and 9% reported having been physically injured from a patient

assault in the previous six months (Gates et al., 2011). This study did not find any significant relationship between age, race, job category, education, or work shift with the frequency of reported violent incidents.

Fifty-five percent of the respondent who experience a violent incident never reported the event. Six percent responded that they always reported the incidents and the remaining claimed to report the incident sometimes or occasionally (Gates et al., 2011a). As was found in other studies, workplace violence training was not found to be related to incidents of reported violence. Additionally, gender was not a factor in the incidents except for sexual harassment that the females reported at a significantly higher rate (Gates et al., 2011a).

This study did not support previous research from the Emergency Nurses Association that claimed urban nurses were at higher risk of violence (Gates et al., 2011a). This survey did support previous studies in that the majority of the participants responded that they did not feel safe at work, yet there was an extremely low rate of respondents that claimed they ever reported the incidents. This study supported the problem of frequent violent acts being committed against nurses in all demographics yet they are not reporting them on a consistent basis.

In that same year, Gates et al. (2011b) conducted another qualitative study with 12 focus groups and 97 participants. In this survey, they discussed different intervention strategies and pre, during, and post assault information. Pre-event strategies included workplace violence training, development of policies and procedures to prevent aggressive behavior, teaching of de-escalation techniques, communicating no-tolerance

policies to patients and visitors, and increased communication to waiting patients and visitors. During-assault strategies included nonviolent intervention techniques and taking steps to isolate violent patients from others in the area. Post-incident strategies included a debriefing and mandatory reporting of all incidents and of physical assaults to security and police (Gates et al., 2011b). This research program was developed between the authors and six hospitals to be implemented and monitored over a four-year period.

This study found that emergency department nurses had a common theme of frustration with the culture of aggressive behavior being tolerated as part of the job (Gates et al., 2011b). The participants in the focus group wanted stricter communication, posting, and support from administration in letting patients and visitors know of a no-tolerance environment and had frustration with cuts in security or security not being given the proper training and authority to intervene in violent situations (Gates et al., 2011b). Limiting access was agreed as a positive way to reduce risks of violence. Nurses who worked in departments with metal detectors stated that they give a false sense of security and have not seen a reduction in violent behavior even though nurses who worked in departments without detectors thought they would reduce incidents of violence (Gates et al., 2011b).

Isolation and faster admission to psychiatric wards was requested by participants along with multi-disciplinary training of support staff, nurses, and physicians in intervention techniques so they could work together as a team during incidents (Gates et al., 2011b). The majority of the participants wanted specific policies in place that were easy to follow yet provided information on how and what to report and when legal

charges are appropriate and should be filed (Gates et al., 2011b) A lack of a system to track repeat offenders was identified as a problem. One participant stated, "We live in a world where the patients have more rights than the staff and that is beat into us every day" (p. 37). Comments such as these supported other studies that the reason for a lack of reporting was fear of retaliation from the hospital, lack of time to complete lengthy reports, and a perception that nothing would be done anyway. The groups all discussed a want for legal actions and some way to let the staff know if someone had been previously charged with assault in an emergency department (Gates et al., 2011b). This study will be relevant to my study as it provided qualitative information in regards to the emergency department nurse's rational for not reporting and provided support that nurse were looking for some form of legal intervention to support them after these incidents.

Willingness to Report Patient-Related Violence

With assaults on emergency department nurses having shown to be consistent across different demographics and with low correlations to control measures, some researchers focused solely on the willingness of nurses to report the incidents as it would seem that eliminating the events would be impossible. Crilly, Chaboyer, and Creedy (2004) explored characteristics of the types of violence reported by emergency department nurses in Australia. The possible reasons as to why nurses did not report acts of violence against them were a perception that nothing would be done about it, it was part of the job, there was a lack of peer or organizational support, or there was a rationalization to justify why the patient acted aggressively.

Approximately 73% of patients involved in violent acts against nurses were diagnosed with drug or alcohol abuse. Many of the nurses accounted this as an excuse for their behavior (Crilly, Chaboyer, & Creedy, 2004). Another large percent were patients with mental illnesses, and the nurses felt that they were not be properly trained to deal with these individuals' illnesses so this could also lead to increased chances of violent behavior for which they would rationalize the patient's behavior and would not report it.

Similar to the study in Australia, Luck, Jackson, and Usher (2006) collected qualitative data from structured interviews, field observations, and journaling. This study was focused on finding out how the nurses ascribed the reason for the violent behavior of patients and to determine if that had any bearing on whether or not they would report the incident. The authors estimated that 70% of violent incidents were not reported. The primary reason they concluded for not reporting was desensitization to violence (Luck, Jackson, & Usher, 2006). During the field observations, the authors witnessed 16 violent incidents against nurses; none of these incidents were reported to hospital administration. When questioned during interviews, the nurses said they evaluated violence on a case by case basis and there was leniency if the patient's actions were due to mental illness but there wasn't leniency if it was due to drunkenness.

Nurses in this study stated that they were not as emotionally or psychologically hurt by violence directed at the healthcare system, whereas personal attacks had a more lasting effect on them. The nurses felt that verbal abuse that was just random swearing or yelling was not a violent event if it was not directed at them personally. If mitigating factors such as psychological problems existed, the nurses took this into account and

would not consider the events to be a reportable violent incident (Luck, Jackson, & Usher, 2006). In the case of these existing patient clinical conditions, high tolerance from the nurses was demonstrated and they would do their best to give the patient the best care possible and not report the incident. The nurses had developed their own set of normal limits of violence that they would accept and would not report.

An internal study conducted at Royal Surrey County Hospital had only four violent incidents reported in the previous eighteen months (Pawlin, 2008). Hospital management decided to conduct a survey to determine why their rates were so much lower than reported averages. The hospital received about 80,000 patients a year and had eighty permanent staff in the emergency department. A measurement tool was designed internally that could gather both qualitative and quantitative data. The management team used visual analog and numeric rating scales similar to those used to assess patient pain since the clinical staff would already be familiar with using this type of questionnaire. The measurement tool was placed at the nursing stations and staff was instructed on how to complete it. The tool was available for a six-month period and at the same time, staff was asked to complete another questionnaire that asked them how they felt about abuse, and what would cause them to not report abuse.

During the six-month trial, 66 staff members reported 44 incidents of abuse. Provision of the tool to the staff showed a 33-fold increase in rate of incidents from the previous 18 months. Eighty percent of the reported incidents were abuse from patients (Pawlin, 2008). Police assistance was called for 45% of the incidents and 14% resulted in arrests. As for the questionnaire about abuse, 15% reported no experience with abuse,

73% experienced verbal abuse one or more times during the trial period, and 12% reported physical abuse. From the respondents that reported having experienced abuse, 71% admitted to either under-reporting or not reporting abuse at all (Pawlin, 2008). Overall the significant increase in incidents during the trial period demonstrated that there was a problem with under-reporting at the facility. Eighty-two percent of the respondents said a reason for not reporting was the patient had dementia or brain injury. Other reasons given for not reporting were because the patient had apologized or was traumatized, the patient was elderly, or they assumed nothing would be done about abuse. Unique to this survey, 15% of the participants said they were unconcerned about the abuse, and 12% thought it was funny (Pawlin, 2008). This survey did demonstrate consistency in under-reporting and added to the body of literature that supports an issue with assaults not being reported by the nursing staff.

Chapman, Styles, Perry, and Combs (2009) hypothesized that low reporting rates of violent incidents against nurses was due in part to a lack of support from governments and healthcare facilities The authors used a case study approach to look at reasons for non-reporting of assaults by nurses. Before conducting the survey, a retrospective audit of security incidents previously filed by nurses was conducted in order for the authors to gain additional insight of the types of incidents that were being reported and also to give them a base to compare their findings to. Data was collected by the surveys over a two-month period. Seventy-five percent of the responding nurses reported having been involved in at least one incident of workplace violence over the previous twelve months.

There were no significant differences in nurse demographics for age, gender, years of experience, or education level found in this study.

Fifty percent of the participants in this study said they did not report the violent incident they were involved in and half of those who did report said it was verbal to their supervisor or co-worker but did not fill out and official incident reports (Chapman, Styles, Perry, & Combs, 2009). When asked for their reasons for not reporting the incidents, 30% said that is was just part of their job to deal with aggressive patients, and another 50% said that they felt that administration did nothing about it anyhow (Chapman et al., 2009). Other reasons participants gave for not reporting included unfamiliarity with policies, fear of retaliation, or insufficient time to complete paperwork (Chapman et al., 2009). As for all participants in the survey, 70% said they would file a report if they, or a coworker, were physically harmed, if they planned on filing police charges, or if they planned on filing for workers compensation. This study also provided the same support for similar reasons as to why nurses do not report assaults.

Gifford and Anderson (2010) stated that the under-reporting of violent patient incidents not only hinders the ability to collect data in order to develop action plans or reduce future risks, but it creates a lack of patient information which may be important in clinical care by future nurses or physicians of that patient. They also conducted a qualitative study to investigate what affected a nurses' decision to report or not report a patient assault (Gifford & Anderson, 2010). This study took place in one in-patient facility in Canada. All participants were required to have been involved or seen a patient assault within the previous two years. This study used a modified nominal group

technique in which the group ranked their level of agreement on the different ideas that came up during the group discussions.

Common themes for not reporting found by Gifford and Anderson (2010) included a motivation to avoid a legal review board, no expectation that follow-up would occur, unfamiliarity with policies, no post-incident support from management, peer pressure to avoid reporting, self-blame for incident, or the patient was not responsible for their actions. These themes were reflected in the research conducted by Ferns (2012) in which the participants freely admitted that they do not use incident reporting forms and incident data is under-reported. Yet the majority of the participants were not motivated to use the forms as they felt nothing would come out it. Results from the research conducted by Pich et al. (2009) reflected the same nursing comments as to the frustration of reporting incidents that would not result in any actions to increase their safety.

Another theme that developed during the discussions with Gifford and Anderson (2010) was nurses would be more likely to report the incident if it lead to a clinical diagnosis for the patient's behavior. Participants felt that nurses would be less likely to report the incident if they knew it was due to a clinical behavioral issue that would most likely not be able to be treated or changed in the near future (Gifford & Anderson, 2010). Factors that influenced the reporting of assaults were; legal requirements or potential liability, justifications for the need to request assistance or restraints for the patient; perception that reporting would result in increased patient safety procedures, increase in staffing, or needing to justify actions taken by the nurse (Gifford & Anderson, 2010). Factors that influenced not reporting were; perception that claims would not be taken

seriously or followed-up on by management, fear of blame, unfamiliarity with policies or forms, no peer support, embarrassment, male vanity, or a belief that the patient was not mentally capable of understanding or taking responsibility for their actions (Gifford & Anderson, 2010). All groups interviewed shared the same view of high tolerance towards patient assaults, as they perceived it to be part of the job. The most common element between all groups that determined whether or not to report was the patient's mental capacity to take responsibility for their actions.

The reasons for not reporting assaults on nurses have not been limited to the United States. AbuAlRub and Al-Asmar (2011) conducted a quantitative study in Jordan and surveyed 422 nurses from four public hospitals. They used a similar questionnaire developed by the World Health Organization that had been used in the United States. Twenty-three percent of the participants reported having been physically attacked while on the job. Seventy-two percent were very dissatisfied with how the incident was handled after reporting. The majority of participants who had been a victim of patient assault responded that they did not report the incident because they felt it was useless to report since nothing would be done (AbuAlRub & Asmar, 2011). About half of all the respondents reported that they did not report incidents since there were no legal consequences taken against the offenders (AbuAlRub & Asmar, 2011). Similar to other studies conducted in the United States, the authors of this study concluded with recommendations for a need in implementing laws that placed judicial punishment on patient offenders who assault nurses.

In a retrospective documentary analysis of 38 forms, nine semi-structured interviews, and 52 hours of unstructured observation, Ferns (2012) conducted a qualitative study that focused on the record keeping of workplace violence incident reports from one emergency department. The authors rational for this study was that judicial proceedings or any actions from legal would not happen without proper documentation from the victims since the legal view was if something was not documented, then it did not happen.

Of the reviewed incidents of assaults on nurses, 89% of the incidents involved patients or patient family members and 50% were physical assaults (Ferns, 2012). Over half of the forms reviewed were incomplete or lacked important information which would be required to make conclusions about the incidents (Ferns, 2012). A significant majority of the interviewees said there was no point to the forms because there was never any follow-up from management and nothing was ever done to improve worker safety (Ferns, 2012). The participants admitted to understanding the legal need for proper documentation yet all agreed that incidents were significantly under-reported (Ferns, 2012). This brief survey added to the body of literature in that it emphasized the lack of reporting and brought up the other aspect that if reports are not filled out completely or accurately, they still may have no bearing on follow-up actions.

Penalty Enhancement Laws

Penalty enhancement laws have been used in the United States over the last 50 years in order to implement mandatory arrests or other punitive charges against specific types of offenders (Pate & Hamilton, 1992; Sherman & Berk, 1984; Singer & McDowall,

1988). Originally, these laws were implemented to enforce stricter punishments for domestic violence offenders (Maxwell, Garner, & Fagan, 2001). Eventually, these laws were also used to protect other specific groups of individuals in our society such as police officers, firemen, and other public officials (Covington, Huff-Corzine, & Corzine, 2014). As the trend of assaults on nurses continued to remain high over the past several years, professional healthcare organizations began demanding the level of protection for nurses through penalty enhancement laws similar to what was being offered to other special interest victims (Gabe & Elston, 2008; Ray & Ream, 2007). This section provides an overview of the different forms of penalty enhancement laws that have been implemented in the United States and the mixed research that was conducted on their effectiveness in protecting victims.

Not all research has found full support for penalty enhancement laws as an effective predictor for crime rates. Pratt and Cullen (2005) conducted a meta-analysis that focused on macro-level predictors of crime rates. Their analysis found support that social elements are higher factors in crime rates than criminal justice elements. Out of 31 predictors of crime at the macro-level, they found get-tough policies to be a week predictor and not a significant contributor to the explained variation in their model. They found that other criminal justice indicators such as penalty enhancement laws, police force budgets and police force size per capital were among the weakest predictors of crime rates at the macro level (Pratt & Cullen, 2005). Further research in the field was needed to explain other variables that may influence the outcome of those studies such as socioeconomic or socio-structural elements in the environment.

Domestic and Juvenile Violence

The Minneapolis Domestic Violence Experiment is a highly referenced research project that took place in 1981. Sherman and Berk (1984) developed a six-month project with members of the Minneapolis Police Department. The purpose of the study was to determine if different levels of punishment on domestic abuse offenders would influence the rate of recidivism. When officers responded to calls for assistance at domestic abuse incidents, they were given three choices for response to an offender of simple assault; arrest, informal mediation at the site, or an order for the offender to leave the premises for eight hours (Sherman & Berk, 1984). The results of their experiment found that the option for arrest was significantly more effective in deterring recidivism with only 13% committing a repeat assault as compared to a 26% recidivism rate for those who were separated or counseled on site. Overall, the authors claimed a 50% reduction in domestic assault calls after the implementation of the experiment. The report developed by Sherman and Berk (1984) was so widely published and acclaimed by law enforcement; many departments across the nation began implementing mandatory arrest programs for domestic offenders (Cohn & Sherman, 1987; Sherman, Cohn, & Hamilton, 1985; Sherman & Hamilton, 1984). Not all researchers were convinced that mandatory arrest laws were effective in reducing crime rates. Some believed that a single study in one police department was not sufficient research to justify the implementation of stricter penalties on simple assault offenders across the nation.

Within a couple years, the National Institute of Justice provided funding for six other large cities to replicate the initial experiment (Pate & Hamilton, 1992). Out of these

six studies, five cities found no significant support that arrest of the offender deterred future incidents. The research in Miami did find support for the mandatory arrest of offenders specifically if the offender was employed or married (Pate & Hamilton, 1992). The contradicting results of ongoing research led to other criticisms of mandatory arrest laws.

In 1996, the Commonwealth of Virginia formed a subcommittee to review the effectiveness of mandatory arrest laws for domestic abuse (Garner, 1997). The subcommittee reviewed all cases related to arrests for these crimes and measured the rates of future assaults along with victim testimonies. The committee found no evidence that the mandatory arrest laws reduced rates or assaults nor provided increased safety and security for victims (Garner, 1997). This study also reviewed the costs for mandatory arrest laws. Based on the additional millions of dollars the enhancement law cost the commonwealth for increased incarceration and officer time, the subcommittee viewed the law as an unfunded mandate imposed by the State government on local governments.

Citing the findings from previous research that found the mandatory arrest laws to be more effective when imposed on married or employed offenders, the subcommittee proposed that this would support the dismissal of the law in areas of Virginia such as Richmond where this is a high unemployment rate and a higher percentage of unmarried couples (Garner, 1997). In the subcommittee's final proposal to Virginia state legislature, the subcommittee found no evidence to support the mandatory arrest law and petitioned to have the law repealed (Garner, 1997). Further studies would however be conducted before this law would be repealed.

Following up on the National Institute of Justice's Spouse Assault Replication Program, researchers Maxwell, Garner, and Fagan (2001) re-examined the data collected from the six police departments that had participated in the original survey. Instead of using the police statistics that did not show significant support for mandatory arrest for domestic abuse, the authors reviewed all the victim interviews. What the authors found was that, according to the interviews, there was a significant reduction in the recurrence of abuse when an arrest was made (Maxwell, Garner, & Fagan, 2001). Their research provided additional evidence that increased gathering of data can make a significant difference in study outcome depending on what type of data was reviewed. Their study did support the original research in areas where some states that showed no difference in recidivism rates; however, their overall conclusion found "good evidence of a consistent and direct, though modest, deterrent effect of arrest on aggression by males" (p. 9). Given that conclusion, the authors did include in their recommendations that there could still be unwarranted financial burden on local governments and a negative effect on policing when the case-by-case decision for handling of a dispute was taken away from police officers.

In his own analysis of mandatory arrest policies, Celik (2013) also reviewed the results of mandatory arrests from domestic assault incidents reported to the National Institute of Justice. His research did support prior studies where the implementation of mandatory arrests reduced the future rates of domestic assault. New aspects Celik (2013) provided to the body of research was that the implementation of such laws were more effective when proper training was given to police officers in the implementation of the

laws. The negative aspect he found was the mandatory arrest laws took away the input of the victim and had the potential for victims to lose faith in the judicial system if their voice was taken away from the process yet future incidents of assault did not reduce for them (Celik, 2013). This element of effect was addressed by William Blackstone when he published his findings that assaults are an issue for the public good and should be taken out of the hands of the individuals (Stein, 2012). Some historians of criminology viewed that the decisions for the level of punishment should be left up to the government since it can provide an impartial judgment of offenders to protect society whereas the individual can make irrational decisions for prosecution based on familiarity or emotion (Stein, 2012). To support this ideology of governing, research into the effectiveness of court decision in assault cases were needed.

Frantzen, Miguel, and Kwak (2011) conducted research of court decisions in Texas for domestic assaults. Texas was chosen for the study state as it did not have specific state statutes in place for domestic assault. By reviewing the court decisions and recidivism rates of domestic assaults, this study was able to provide one aspect on the effectiveness of taking the decisions to press charges out of the hands of the individual and place it in the confines of the court. The authors found that prosecution and convictions of assault offenders had no significant effect on recidivism. They did find that basing convictions on prior offender history and increased aggressive sentencing on repeat offenders to have a positive effect on recidivism rates (Frantzen, Miguel, & Kwak, 2011). Their study also supported the views of other research in that a flat mandatory

assault law with equal penalties for all offenders was ineffective in reducing future rates of domestic assault.

In an expansion of arrest reviews, Hirschel, Buzawa, Pattavina, and Faggiani, (2007) reviewed the National Incident Based Reporting System for domestic assault rates in 2000. This database included reports from 2,819 police departments from across 19 states. The focus of their research was to determine if mandatory arrest laws implemented at the state level had any effect on a police officer's decision to make an arrest. From this database, the researchers collected 577,862 incidents of assault. From that group, 37% of the assaults resulted in an arrest being made of the offender (Hirschel et al., 2007).

Similar to the research I will conduct in my study, Hirschel et al. (2007) reviewed states in this database that had mandatory arrest laws and compared them to the states that did not have equivalent laws. Based on the intent of the mandatory laws, their hypothesis was that the overall rates of arrest for domestic assault would be higher in states with active mandatory arrest laws given all other variables remain equal. The researchers found that there were higher arrest rates in states with mandatory laws but there were inconsistencies across local jurisdictions. The results showed that officers were more likely to make decisions for arrest or no arrest based on the location of the assault, the relationship between the victim and offender, and the seriousness of the assault (Hirschel et al., 2007). While providing support for the implementation of these laws, the authors did determine that officers were still able to make on-site decisions in regards to the circumstances of the incident. The significance of this study was that it showed one possible response to criticisms that the laws would create a constant stream

of arrests, without involving police intuition, which could cost the local government significant money for unnecessary incarcerations.

In 2009, McMahon-Howard, Clay-Warner, and Renzulli provided research that showed incremental changes in levels of punishment for assault laws may be more beneficial to state legislators in appeasing special interest group rather than actually providing additional protection for victims. The authors used previous studies done in infectiousness to support their views that state legislators may be influenced to implement new laws to match the penalties implemented by their neighboring states (McMahon-Howard, Clay-Warner, & Renzulli, 2009). In their research, the authors identified the years that states implemented penalty enhancement laws and then documented the years that adjoining states enacted similar laws.

The authors found that there was significant correlation to support a theory that states will adopt similar laws as their neighboring states. The political geography of the state did not have a significant effect (McMahon-Howard, Clay-Warner, & Renzulli, 2009). One significant finding from this study was a negative effect of increased penalties being implemented by states at a later date once lesser, incremental, laws had been passed. The authors proposed from their findings that special interest groups would be advised to lobby for the higher penalty enhancement laws from the onset since they are less likely to achieve their goals of mandatory arrests for serious offenders if "compromise legislation" (p. 520) is reached first with state legislators.

Violence Against Healthcare Workers

In 2014, Idaho became the 30th state to implement a penalty enhancement law that makes battery against a nurse a felony (Rajkovich, 2014). Since the implementation of the first penalty enhancement laws to protect nurses in 2005, significant lobbying has been done by professional nursing and healthcare organizations to convince state legislators to enact similar enhancement laws on assaults of nurses as has been afforded to victims of domestic assaults (Gabe & Elston, 2008). In 2010, the state of New York passed a law that makes it a felony to physically assault a nurse. At the signing of the law, the CEO of the New York State Nurses Association stated "This legislation signals to the public that violence against nurses will no longer be tolerated" (Emergency Nurses Association, 2010, p. 4). In 2013, the state of Texas passed a similar law that increased the classification of assault on a nurse from misdemeanor to a third degree felony. In response to this new law, the CEO of the Emergency Nurses Association stated, "This new law will give all Texas emergency nurses and personnel the increased level of protection they deserve" (Emergency Nurses Association, 2013, p. 7). With the enactment of these penalty enhancement laws over the past decade, additional research has been conducted in regards to the rates of assaults on nurses while working in emergency departments.

Not all researchers have felt as confident in the effectiveness of the new laws as some professional organizations. Baines (2005) gathered data from interviews and observations to determine if laws were an effective means to protecting nurse from assault. Baines (2005) argued, "Legal and administrative remedies are unlikely to

experience more than minor success in preventing workplace violence in the work care zone. This is consistent with the similarly uneven results of criminal remedies applied in the realm of wife and partner assault" (p. 133). Baines (2005) suggested from her research that decreased staffing levels, increased patient census, and spending cuts were more influential in creating higher risks of violence than could be offset by judicial actions. Through participant interview, Baines (2005) found that nurses were still unwilling to pursue judicial prosecution after patient assaults since it seemed contradictory to their responsibility to patient care. Additionally, they felt there was a lack of support from hospital administration in pursuing these charges and feared retribution if they did purse legal actions. Baines (2005) concluded that the implementation of penalty enhancement laws did little to protect nurses and in fact could cause increased incidents of violence as it could turn the focus away from the responsibility of hospital management to create a safer work environment.

In 2006, New Mexico state legislation passed their penalty enhancement law to protect nurses. Under the new law, the assault or battery of a nurse during working hours would be upgraded from a misdemeanor to a class C felony (Lopez-Bushnell, & Martinez, 2008). The passing of this bill, as was similar in other states, was presented and lobbied by professional nursing organizations in the state. The authors of this article provided comment that there was no scientific evidence that the passing of these laws will increase the safety of nurses; but they believed it might provide deterrence for potential offenders and support the reporting of the assaults.

In the year following the passing of the bill, the authors monitored incident rates at the University of New Mexico Hospital. Incidents of aggravated assaults stayed the same, incidents of battery increased from 22 to 73, simple assaults increased from zero to four, and total legal actions increased from 27 to 82 (Lopez-Bushnell & Martinez, 2008). The authors hypothesized that the dramatic increases were due to increased reporting and awareness on the part of the staff but stressed that it was too early in the program to make any definitive conclusions and long-term monitoring would be needed.

Additional issues with the implementation of prosecution for patient offenders were found when dealing with psychiatric patients. The National Health System has had similar issues with staff reporting and perceptions for patient punishment as has been seen in the United States after passing penalty enhancement laws (Clark, McInerney & Brown, 2012). The problems the authors of this article focused attention on were the ethical obligations the staff had to the patients, the implementation of fair and impartial treatment for all patients, and the ability of the judicial system to uphold penalties on patients after the nurse pursues criminal charges. In the one instance, the nurses provided the same responses as found in previous studies in regard to their unwillingness to pursue criminal charges (Clark, McInerney & Brown, 2012). The nurses felt guilty for pursuing charges against a patient if they had been diagnosed with a mental incapacity; however, they felt patients should be held responsible for their behavior if they were capable of controlling their actions (Clark, McInerney & Brown, 2012). The divergence of consistency in pressing charges created an issue for the court system as there were concerns as to which cases to prosecute based on inconsistent clinical decision.

The reluctance to prosecute was also increased, as the perception of pressing charges and having the case thrown out of court would not support the zero tolerance policy that the health system had enacted to protect hospital workers (Clark, McInerney & Brown, 2012). The authors monitored one hospital for inpatient offenses in 2010. The court system prosecuted 41 patients who had been charged with assaults on nurses. Thirty of these patients had been diagnosed with some form of a mental or learning disability. The majority of the prosecution resulted in monetary fines with only one person receiving a sentence of 28 days imprisonment (Clark, McInerney & Brown, 2012). The concerns for further research from this article showed that impartial treatment and a consistent decision-making process by both the hospitals and the court system would be needed if patients were going to be successfully held accountable for assaults on healthcare workers.

Methodological Research Approaches

Quantitative Studies

Of the research articles that were reviewed for my study, 35 of the articles utilized a quantitative research method to collect their data. The research articles were divided into three categories; research of the organizational approach, research on arrest rates for domestic violence, and research on workplace violence in hospital emergency departments.

Nine research articles were analyzed for my study that used quantitative research methods to study how mandatory arrest laws had an effect on rates of domestic violence. The initial article that tested the concept of mandatory arrest laws for domestic abuse was

written by Sherman and Berk (1984). The authors used unemployment rates, victim/suspect relationships, prior arrests, age, education, and race as the independent variables. Recidivism of assault within six months was the dependent variable. A linear probability model was used to assess recidivism and the effect of the independent variables.

Three of the research articles used data collected from the National Institute of Justice that conducted follow-up research to test the conclusions made by Sherman and Berk (1984). Celik (2013) and Pate and Hamilton (1992) used similar demographics from police reports as independent variables. Maxwell, Garner, and Fagan (2001) used data collected from victim interviews as their independent variables. All three studies used a logistical regression analysis to assess rates of recidivism of assault as their dependent variable. Only one article found supporting results from the Sherman and Berk (1984) research. The other two found contradicting results and reported no significant effect of mandatory arrest laws on recidivism rates.

The research conducted by Hirschel, Buzawa, Pattavina, and Faggiani (2008) used a multivariate analysis to assess the relationships of incident, victim, offender, and outcome variables across different states. Their dependent variable was arrest rates for assault offenders in domestic violence. Data for their research was extracted from the National Incident Based Reporting System. Their results found mandatory laws to have an effect on increased arrest rates; however they did not find enough supporting evidence that these laws provided increased protection to the victims.

In three studies that were reviewed, the authors analyzed the effect of convictions of offenders on the reduction of violence against women (Frantzen, Miguel, & Kwak, 2011; Gist et al., 2009; Jasinski, 2003). The researchers used similar independent variables of age, education, race, income, relationships, employment, and weapons. Domestic violence recidivism was used as the dependent variable for both articles. All articles found that women reported significantly less violence after actions were taken by the judicial system.

Clay-Warner and Renzulli (2009) compared the legal actions taken by state governments in implementing different levels of mandatory arrest laws for domestic abuse. They monitored the time lapse and level of severity of laws between adjoining states. Their conclusions included the effect of incremental laws being a negative influence on stricter penalties and no significant influence on state government ideology. This was the only article found that suggested qualitative research be conducted in order to determine more specific details on how political actions influence the passage of mandatory arrest laws.

In regards to the aspects of workplace violence and hospital nurses, 21 research articles were analyzed. In initially researching articles to obtain a broad view of the issue, six articles providing research from other countries were reviewed. The countries that were included in the literature review had healthcare systems that were similar to the United States and had reported the same level of patient assaults on nurses. The countries represented in these articles were Australia (Crilly et al., 2003), the United Kingdom

(Pawlin, 2008), the Philippines (Fujishiro et al., 2011), Italy (Magnavita & Heponiemi, 2011), Jordan (AbuAlRub & Al-Asmar, 2011), and Israel (Landau & Bendalak, 2008).

These articles all used similar independent variables of patient demographics, nursing characteristics, security controls, and hospital policies. All articles used assault rates as the dependent variable. Rates of assaults were very similar in all five studies. There was also a common finding that nurse and patient demographics had no significant effect on assault rates. Two studies found that under-reporting was a serious problem and was generally due to a perception from nursing that nothing would be done about the assaults so they were not worth reporting (AbuAlRub & Al-Asmar, 2011; Crilly et al., 2003; Pawlin, 2008).

Two research articles were analyzed where studies on assault rates in emergency departments were conducted after state laws were enacted. Casteel et al. (2008) analyzed the effect the California Hospital Safety and Security Act had on workplace violence using Poisson regression with generalized estimating equations to compare the assault rates from a three-year period previous to the enactment of the law and six-year period post implementation of the law. Hospitals in New Jersey were used as a temporal control. This act required hospitals to implement specific security protocols but did not implement any penalty enhancement laws for offenders. The study found assault rates to decrease in California for about a year to 18 months after the law was passed and then rates rose to levels higher than when the security act was implemented. The authors proposed that the laws have short-term effect but also provided numerous limitations to the scope of their survey (Casteel et al., 2008).

Gates, Gillespie, and Succop (2011) conducted research on the productivity of nurses after being exposed to workplace violence. Hills (2008) also reviewed nurse productivity and the effects of training on nurse's ability to handle the stress of workplace violence. Both studies used victim demographics as the independent variables and measured productivity through active work time or missed work as the dependent variable. The findings were similar for both studies and supported previous research that workplace violence incidents have a negative effect on worker productivity.

Three research articles provided a study into the different types of physical and administrative security controls that are placed in emergency departments and their effect on rates of nursing assaults. Blando et al. (2008) conducted a survey of hospital workplace violence programs in New Jersey hospitals for their data collection. Behnam et al. (2009) collected data from emailed surveys to academic hospitals across the nation. Kansagra (2008) collected data from the National Emergency Department Safety Study that includes academic hospitals from 69 sites across the nation. Independent variables included patient visits per year, security personnel on site, metal detectors, violence training, panic alarms, and physical barriers. The dependent variable in the studies was rates of assault. The findings from these articles were very similar in that none of them found any consistency in security measures from one hospital to another. Additionally, the authors did not find significant correlation between any single security measure with any direct effect on assault rates.

Two of the reviewed research articles focused on the characteristics of the patients who assault nurses. Ferns (2007) used history of violence, age, gender, substance abuse,

and mental health as independent variables. Flannery, Farley, Tierney, and Walker (2011) used age, gender, mental diagnosis, history of violence, and substance abuse as their independent variables. Both studies used assault rates as the dependent variable. Findings were similar between these two studies. Both revealed findings that characteristics of patient behavior are significant indicators of violence and recommended that these characteristics be included in patient records to forewarn hospital staff at future patient visits.

Six of the studies focused on the demographics of the victims. These studies used occupation, gender, race, age, years of service, and education level as independent variables. Assaults were the dependent variable. Two of these studies broke down results of assaults by injury (Flannery, LeVitre, Rego, & Walker, 2010; Rodriquez-Acosta et al., 2010). Both studies found similar results that the majority of assaults resulted in no or minor injuries and severe injuries were very rare. Additionally, results from both surveys were consistent in findings that years of service was the only characteristic that was significantly linked positively to assault rates.

Gates et al., (2011) and Chapman, Styles, Perry, and Combs (2010) both published similar findings that under-reporting of assaults was a significant problem. Reasons nurses gave for not reporting reflected the same themes in each survey. The article by Gacki-Smith et al. (2009) concluded that state laws were needed in order to protect nurses from assaults. However, no statistical proof was provided in their survey nor did they include this as a variable.

Roche, Diers, Duffield, and Catling-Paull (2010) conducted their survey as a cross-section collection of data from 94 nursing wards. Using the same independent variables, they found that physical aggression was relevant to decreased patient care. The one difference from previous findings was they found a negative correlation between staff level of education and assault victim rates.

Qualitative Studies

Of the research articles analyzed for this literature review, seven authors used a qualitative research method. Catlette (2005) measured perceptions of safety in the emergency department by nurses. The author conducted a case study with eight registered nurses from two level-one trauma centers from the authors' place of employment. Themes from this article included "degree of feeling safe at work, specific experiences of violence, coping with work-related stress, understanding workplace violence, violence prevention concerns, and educational preparedness for dealing with violence" (p.520). Two common themes developed from the participants in this survey were a feeling of inadequacy in the physical control measures the facility provided for them and vulnerability to assault from aggressive patients and visitors.

Baines (2005) used a qualitative study to review the willingness of nurses to use legal and administrative strategies in response to assaults from patients. Common themes developed in this article were obligations of nurses to care for patients, ethical perceptions of pressing charges against aggressive patients, and the responsibility of the facilities to provide security measures. A common theme from the discussion in this article was the need for the facilities to take responsibility for providing security. Nursing

staff presented the concept that if the hospitals provided sufficient safety measures, then the assaults could be avoided and they would not need to take advantage of the available legal prosecutions.

In a qualitative study of a pediatric emergency department, Gillespie, Gates, Miller, and Howard (2010) interviewed 31 participants at a single hospital. Themes for the discussion were what occurs during violent incidents, what factors contributed to or prevented the incidents, and what the effects of workplace violence were. Results of the discussions were similar to other studies in that the identification of warning signs of aggressive behavior was the most important factor in preventing assaults. Additionally, a lack of training in dealing with aggressive behavior from parents and knowing how to deescalate a situation was a common remark from the participating nurses. Another common response was a lack of reporting assaults. Only one participant in the group reported a previous assault and stated that the police were dismissive of her claim so nothing came from the report.

Four of the qualitative studies included common themes regarding the willingness to report patient assaults (Ferns, 2012; Gates et al., 2011; Gifford & Anderson, 2010; Pich et al., 2009). One unique theme found from the case study research conducted by Gates et al. (2011) was a feeling by the nursing staff that the patients had more legal rights then they did. There was a feeling that administration and the legal department would take the side of the patient to avoid any legal action being taken in retaliation by the patient. Nurses expressed frustration with the situation but felt there was nothing they could do about it and accepted it as part of the job.

Three additional research articles that were analyzed were primarily qualitative studies but included some quantitative elements. Planty and Strom (2007) used victimization surveys to compile common themes in the roles victims take in preventing further incidents. Zelnick et al. (2013) conducted interviews with social service nurses in regards to the acceptance of workplace violence as part of the job. Luck, Jackson, and Usher (2007) interviewed nursing staff in regards to the meanings nurses give to individual acts of violence by patients. There were no unique themes presented from these articles that did not come up in the other qualitative surveys. Quantitative elements were added to each of these articles that included responder demographics. These demographics were provided to provide a snapshot of the characteristic similarities of the participating nurses. There were no significant indicators presented that were unique from the information provided in the quantitative articles previously described.

Summary

This literature review contained several major themes. First, the assault rates for nurses are significantly higher than rates for other occupations in the private sector (U.S. Department of Labor, 2013). This rate of assault has been consistently high for several years and has gained the attention of professional organizations (Behnam, Tillotson, Davis, & Hobbs, 2009; Blando et al., 2008; Kowalenko et al., 2012). Current security measures do not seem to be reducing this risk; so additional efforts are now being implemented in the form of judiciary actions through penalty enhancement laws (Casteel et al., 2009).

The theoretical framework of both organizational culture and rational choice have a potential to be supported by the data collected from my research. Dietrich and List (2013) provided the theory that an individual will make a decision based on their pre-conceived beliefs and act on an event in a manner that will satisfy their own desires after balancing out the benefits and costs of multiple options. Normally applied to criminology, this theory has the potential to be applied to victims. In the case of my research, nurses who have been assaulted have the ability to make a rational choice as to pursue criminal charges against their attacker or to do nothing and allow the offender to go unpunished. Based on the nurses perception of different opportunity costs and possible reactions from coworkers, the organization, or society, the nurse will most likely make a decision based on which path will provide the greatest personal benefit.

In addition to rational choice, organizational culture can play a part in the decision-making process for nurses after being assaulted. Schein (2009) provided a definition of organizational culture as "a pattern of shared assumptions that was learned by a group as it solved problems that have worked well enough to be considered valid and taught to new members as the correct way to think in relation to problems" (p. 27). This culture can have an influence on the decision for a nurse to report a patient assault based on what has been acceptable practices for the group in the organization. If the organization has developed a culture where formal reporting and filing charges against patients as deemed inappropriate, the nurse may be less likely to file a formal report out of fear from retaliation. On the other hand, if the organization has a culture of openness and concerned support between the leaders and the staff, the nurse may be more

comfortable with going to their administrator and filing a formal report along with pursuing criminal charges. There is also the potential for the culture of an organization to change if they do not promote the safety of their staff and a significant event occurs which results in the serious injury or death of an employee. Significantly negative events from the exterior environment can force organizations to re-evaluate their principals and make significant changes to their culture (Schein, 2010).

The use of penalty enhancement laws to protect special victims was a major theme in the reviewed literature. Initially, these laws in the form of mandatory arrest laws for domestic abuse were implemented to protect spouses and other domestic partners from assault (Pate & Hamilton, 1992; Sherman & Berk, 1984; Singer & McDowall, 1988). Over time, new penalty enhancement laws were implemented to protect police officers and other public officials by automatically increase the classification of assaults on these individuals from misdemeanor to a felony (Covington, Huff-Corzine, & Corzine, 2014). Over the past several years, professional nursing healthcare organizations have successfully lobbied state legislators into expanding these penalty enhancement laws to nurses and other healthcare workers in the emergency departments (Gabe & Elston, 2008; Rajkovich, 2014). The success of these laws in regards to protecting nurses from abuse has not been tested with any in-depth research.

An important theme that developed from the literature review was the consistent findings that there was a very low rate of nurses reporting patient assaults. This was the only theme that was fully supported by every research article reviewed (Chapman et al., 2009; Crilly et al., 2004; Ferns, 2012; Gifford & Anderson, 2010; Luck et al., 2006;

Pawlin, 2008). A lack of incident reporting was significant if the testing of new forms of guardianship was to be tested. If nurses were not motivated to report assaults, it would be unknown if the implementation of penalty enhancement laws would be effective.

My study may fill a gap in the literature by analyzing the effects state penalty enhancement laws had on nursing assault rates in emergency departments. These laws were previously studied in their relations to protecting women and other victims of abuse. The viable use of these laws to protect nurses is not known. One previous study that took into account the penalty enhancement law only looked at a single hospital (Lopez-Bushnell, & Martinez, 2008). My research will be conducted across six states. These states will be purposefully selected due to geographic locations, commonalities in size, population, and facility demographics.

The sample states that will be used for my research are Pennsylvania, New Jersey, New York, Massachusetts, Maryland, and Washington D.C. The latter two have no penalty enhancement laws in place that address the protection of nurses (Emergency Nurses Association, 2014). The other four states had enacted these laws in 2010 or 2011. Additionally, the states with penalty enhancement laws have varying levels of penalties for nursing assaults ranging from 90 days imprisonment and a $500 fine to 20 years of imprisonment and a $25,000 fine (Commonwealth of Massachusetts, 2014; New Jersey Assembly Law, 2010; New York Senate, 2010; Pennsylvania General Assembly, 2014). This level of variance will be selected so a regression model can be designed that would measure the effect of the severity of the penalty enhancement laws on the level of nursing assaults. Additionally to the regression model, a simple T test will be added as a stand-

alone statistic to test the hypothesis that nurse reporting of patient assaults would be higher if the state had a penalty enhancement law in place. The following chapter provides an in-depth description of these statistical tests to be used for this proposed study.

Chapter 3: Research Method

Introduction

The purpose of my quantitative study was to explore the reporting of assaults on emergency department nurses from patients in academic hospitals in the Mid-Atlantic Region. My study explored the potential effect the implementation of penalty enhancement laws had on the nurses filing official reports with their agencies and local law enforcement when they were physically assaulted by patients under their care. As described in Chapter 2 of my study, penalty enhancement laws were laws implemented at the state level that implemented mandatory arrests or higher punitive charges against offenders who assaulted individuals in protected groups such as spouses, minors, law enforcement officials, or healthcare providers (Covington et al., 2014). The influence these laws have on victim reporting rates has been previously measured through self-report surveys and police records for spousal abuse (Sherman & Berk, 1984). Based on the literature reviewed for my study, these types of surveys and databases have not been used to explore any possible effect of the penalty enhancement laws on nurse reporting of patient assaults.

Previous research reviewed for my study showed that a lower rate of nurse reporting of patient assaults could be attributed to the victims' perspective that formal reporting is a waste of time (Baines, 2005). Reasons they provided for this included a lack of support from facility administration, no actions taken by the judicial system against the offender, and a fear of retaliation (Baines, 2005). This study implemented a self-reporting survey developed in part from the World Health Organization's Workplace

Violence in the Health Sector survey to explore the possibility that by implementing penalty enhancement laws, states may help to encourage nurses to formally report incidents of physical assault from patients.

Research Questions

My study focused on emergency department nurses working in academic medical centers in the Mid-Atlantic Region and their formal reporting tendencies of physical assaults by patients to answer the following research questions:

Research Question 1

Do rational choice actions of nurses affect their formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0 1$= Rational choice actions of nurses have no effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.
- $H_a 1$= Rational choice actions of nurses have an effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.

Research Question 2

Does organizational culture have an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0 2$= Organizational culture has no effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.
- $H_a 2$= Organizational culture has an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.

Exploratory Research Design

There are certain areas of study in criminology where little is known about the observed events and the variables that account for certain behaviors of individuals. Exploratory research can be used in these areas to identify factors that may be more significantly relevant to the phenomenon or assist in narrowing down a field of variables to help to identify explanations for behaviors (Champion, 2006). As related to my study, the variable of penalty enhancement laws has not been previously researched for its effect on emergency department nurses and their rate of reporting physical assaults from patients. A lack of knowledge about a particular group of people creates an opportunity to focus on a specific aspect of particular social situation which little is known (Champion, 2006). My study focused on the formal reporting behaviors of physical assaults on emergency department nurses that may provide new information on the certain characteristics of the target group that may then need further examination. If significant information was found, this can then lead to further descriptive and experimental research.

Research Design and Approach

The research design I selected for my study was a quantitative, exploratory Internet-based survey instrument that explored the formal reporting habits of emergency department nurses of physical assaults from patients. The survey questionnaire was provided to nurses actively employed in emergency departments located in academic medical centers in six Mid-Atlantic States.

I chose to use a quantitative approach instead of a qualitative approach to test the relationship between variables. Quantitative research is used to collect data from a sample of a population in order to make assumptions about specific characteristics or actions taken by individuals using statistical tests (Champion, 2006). Qualitative research involves the direct observation of the actions of individuals in the course of their daily lives (Frankfort-Nachmias & Nachmias, 2008). A qualitative design of research would not be reasonable for my study as I was collecting data from numerous healthcare facilities across six states. Quantitative methods, similar to the survey I used in my study, have been used in previous quantitative studies which studied the reactions nurses have had when physically assaulted while providing patient care (Gacki-Smith, Juarez & Boyett, 2009; Gates et al., 2001; Roche, Diers, Duffiled & Catling-Pauli, 2010). Surveys have been used to collect data about workplace violence in emergency departments to analyze the effectiveness of physical and administrative controls in protecting healthcare workers (Flannery et al., 2011; Kansagra et al., 2008). The successful use of quantitative surveys to describe characteristics and behaviors of offenders and victims related to workplace violence in healthcare was a significant reason for my choice in using a quantitative approach to my study.

I used an Internet-based survey to collect data for my study. Surveys of this design have the advantage of being accessible to a large group of the population, are easy to navigate, can be completed when the participant has available time, and can be less costly than other methods such as mailing out questionnaires (Alessi & Martin, 2010). The choice for the use of an Internet-based survey for my study was the ability to reach a

large sample of nurses from emergency departments across six states who would have access to the Internet through their jobs and could be completed quickly in their spare time. The objective of the survey for my study was to measure the possible causation between independent and dependent variables. A quantitative survey that uses fixed-response questions can provide objective and straightforward responses from the participants (Frankfort-Nachmias & Nachmias, 2008). This design of a survey was chosen for my study since I collected data that could be placed into statistical measurements to identify trends in nursing behavior.

Self-report surveys, in relation to crimes, may reveal more about actual numbers of incidents than official data sets such as the Uniform Crime Reports or the National Crime Victimization Survey since individuals may be more willing to report the incidents confidentially through surveys rather than reporting through official law enforcement channels (Champion, 2006). Previous rates of workplace violence in healthcare, including physical assaults on nurses, were collected from databases developed by entities such as the National Institute of Occupational Safety and Health and the United States Department of Labor, Bureau of Labor Statistics (Gates et al., 2011). These databases would only include all the actual physical assaults on emergency department nurses if they had been formally reported to law enforcement or other regulating agencies at the time of the incident. By conducting a self-report survey, I hoped to gather a more complete collection of incidents regardless of whether or not the victim had formally reported the crime.

Advantages of fixed-response surveys include (a) the participant responses are easier to score and code, (b) it is easier for the respondents to check a box rather than having to write out descriptive answers, and (c) these surveys will most likely have a higher response rate since they are quicker and easier to complete (Champion, 2006). Disadvantages of these types of surveys include bias in response may occur if the researcher does not include all the possible responses to a question and the respondents may quickly answer the questions in order to complete the survey rather than take time to provide their actual opinions or actions in relation to the subject (Champion, 2006). The survey for my study was self-administered. These surveys are useful since data can be collected from a large sample across a large geographical region in a timely and cost-effective manner however they do run the risk of having a low response rate (Coughlan, Cronin, & Ryan, 2009). Taking into consideration the advantages and disadvantages, I decided that the results of a self-reported, fixed-response survey would be most appropriate for my study.

To conduct my study, I used a fixed-response, Internet-based survey that was self-administered by the respondents. The survey was adapted from the Workplace Violence in the Health Sector Country Case Study Questionnaire (World Health Organization, 2003). This survey instrument has been used by the World Health Organization, in partnership with numerous international nursing and healthcare organizations to collect information on workplace violence in healthcare across several nations (Martino, 2002). The studies conducted to collect data on a national basis were developed as mixed-method studies including both qualitative and quantitative sections. The qualitative

sections of the studies were used to obtain cultural views and opinions from the participants of different countries (Martino 2002). The World Health Organization questionnaire that I adapted for my survey was the quantitative instrument used by the International Council of Nurses while conducting workplace violence assessments of healthcare institutions around the world (Martino, 2002).

The qualitative portion of the 2002 Workplace Violence in the Health Sector research could have been used. However, the purpose of my study was to collect data to determine if the implementation of penalty enhancement laws was an effective variable to use as an indicator that emergency department nurses would formally report physical assaults. To develop a reliable study, a large sample of respondents was needed across a large geographical area. Qualitative studies generally involve the researcher interacting directly with a smaller group of individuals (Frankfort-Nachmias & Nachmias, 2008). For the purposes of my study, the results of a qualitative study would most likely not have provided the statistical information needed to formulate any significant results.

Target Population, Setting and Sample

Target Population

The target population for my study was emergency department nurses working in academic hospitals located in six Mid-Atlantic States. The states selected for my study were Pennsylvania, New Jersey, New York, Massachusetts, Maryland, and Washington D.C.

Within this target population, the sampling frame was actively employed emergency department nurses working in the selected academic hospitals. The names of

the chief nursing officers or emergency medicine chiefs for each hospital were obtained from the hospital's contact information. I emailed each contact with the information about my study and the link to the Internet-based survey with a request that they share the information with their emergency department nurses along with the link to complete the survey.

Setting

These states and one district were selected due to their current levels of penalty enhancement laws that specifically addressed increased penalties for physical assaults on nurses working in emergency departments. At the time of the survey, Maryland and Washington D.C. had no penalty enhancement laws to protect nurses; Massachusetts, New York, New Jersey, and Pennsylvania all had penalty enhancement laws of different levels implemented within a one-year period between 2010 and 2011 (Emergency Nurses Association, 2015). These states were also selected due to their common geographical location on the East Coast that included similar populations. The academic hospitals in each of these areas were selected due to their commonalities in patient bed capacity, emergency department size, and trauma services.

Sample

The target population was academic hospitals in Pennsylvania, New Jersey, New York, Massachusetts, Maryland, and Washington D.C. The sampling frame was the emergency department nurses working in the selected hospitals. Cities or regions within each state were selected based on their similar number of academic hospitals. In New York, New York City was selected; in Maryland, Baltimore was selected; in

Pennsylvania, Philadelphia was selected; and in Massachusetts, Boston was selected. The northern region of New Jersey and the entire district of Washington, D.C. were selected. Hospitals within the selected cities or regions were selected by searching for teaching hospitals with trauma centers in the American Hospital Association Hospital Statistics, 2015 Edition. In order to survey hospitals with similar emergency department patients, children's hospitals, psychiatric hospitals, and rehabilitation hospitals were excluded. Government owned veteran's hospitals were also excluded. The numbers of hospitals that met the qualifications for my proposed study, the average number of patient beds, and the annual emergency department visits are included in Table 2.

Table 2

Average Sizes and Staffing Levels of Surveyed Hospitals

Region	Hospitals Surveyed	Average Patient Beds	Average Annual ED Visits	Estimated RN Staffing Level	Total RNs per Region
Baltimore, MD	2	709	74,827	29	58
Boston, MA	2	623	77,029	29	58
New York, NY	3	1,026	139,833	55	165
Northern New Jersey	2	556	94,331	38	76
Philadelphia, PA	3	658	83,063	34	102
Washington, D.C.	2	460	74,767	34	68
Totals	14				527

Note. Averages for patient beds and annual emergency department visits calculated from data obtained from the American Hospital Association, Hospital Statistics (2015). RN staffing levels based on 1.25 patients per nurse per hour as recommended by the American Academy of Emergency Medicine (2015).

There were two ways to estimate sample size. A power analysis required a mature survey, which had an established standard deviation for each variable. My new survey did not have this, so I used the common estimate of 10 to 15 responses per variable (Field, 2009). My study had six variables that could be statistically significant: one

dependent variable, three control variables, one rational choice independent variable, and one organizational culture independent variable. At 15 responses per variable, a minimum of 90 participating nurses was needed for my study. Based on reviewed research that was conducted with nurses over the past 10 years, average response rates have ranged from 20 to 47% (Chapman et al., 2010; Cook, Dickinson & Eccles, 2009; Crill et al., 2004; Gacki-Smith et al., 2009; Gates et al., 2011; Hills, 2008; Kansagra et al., 2008; Landau & Bendalck, 2008). If a 20% response rate were acquired, the population of 527 nurses would give a sample of 105 participants that would exceed the minimum requirement of 90 responses.

Over 500 nurses were available in my selected sampling frame. My survey was sent out to 14 academic hospitals with trauma centers in metropolitan areas. Estimated emergency department nurse staffing levels were based on a recommended staffing level of 1.25 patients per nurse per hour (American Academy of Emergency Medicine, 2015). Estimated staffing levels were calculated using the following formula:

Average patient visits per year / 8,760 hours in a year = Patients per hour

Patients per hour / 1.25 = Number of nurse positions (1 nurse position is 168 hours per week which requires 4.2 full-time employees to fill)

Number of nurse positions * 4.2 = Estimated nurse staffing level

Estimated nurse staffing level * Number of hospitals surveyed in region = Total nurses per region

Based on average emergency department sizes provided by the American Hospital Association (2015) the number of nurses employed across these 14 hospitals was

estimated to be approximately 527. This sampling frame would then significantly exceed the minimum number of participants that needed to be surveyed. If the minimum number of responses were not received within two weeks of sending out the initial request, a second reminder request was emailed to the nurses in participating hospitals requesting them once again to complete their surveys.

Selection Criteria

The sampling units for my research were emergency department nurses. The sampling frame for my research was academic medical centers in the Mid-Atlantic Region. I used a probability sample design utilizing cluster sampling. Cluster sampling uses two or more stages of selections from a population by first selecting larger groupings within a population followed by the selection of the sampling units from these groups (Frankfort-Nachmias & Nachmias, 2008). Stratified sampling was then used to select hospitals that have similar elements within their groups that are also representative of academic hospitals within the population based on their commonalities in metropolitan environment, patient census, and level of care.

Stage 1:

- The population for my research was nurses working in emergency departments in the United States. To break this down into a manageable and timely research sample, a region within the United States was selected.

- The first-stage cluster sampling from the entire population was the Mid-Atlantic Region states and districts of Massachusetts, New York, New Jersey, Pennsylvania, Maryland, and Washington, D.C.

Stage 2:

- Stratified sampling was used to select hospitals within each state that would include a representative sample of the population who also would be more likely to include the variables that were the focus of my study.
- The second-stage cluster sampling from the region was academic medical centers in metropolitan areas with similar population sizes, patient bases, and levels of medical and trauma services.

Stage 3:

- The area of focus for my study was the physical assaults on nurses working in emergency departments.
- The third-stage cluster sampling from the academic medical centers was the emergency departments. The surveys were sent to the Chief Nursing Officer or the Emergency Medicine Administrator at each of the hospitals in the second-cluster and they were requested to distribute the Internet-based surveys to all of their emergency department nurses.

Stage 4:

- The sampling units were then the emergency department nurses working in the academic medical centers in the Mid-Atlantic Region.

- The Chief Nursing Officer or Emergency Medicine Administrator provided the individual participants in the research with the survey information. I had no influence on the selection of the individual nurses within the emergency departments.

Participants

Emergency department nurses working in academic medical centers in the selected cities of Mid-Atlantic States were the participants of my study. Participation in a self-administered Internet-based survey can be an issue with quantitative research. One of the disadvantages of self-administered surveys as opposed to in-person interviews is a lower response rate between 20 and 40 percent (Frankfort-Nachmias & Nachmias, 2008). Responses to self-administered surveys from nurses and other healthcare professionals has run higher than the general population and has averaged 47% (Chapman et al., 2010; Cook, Dickinson & Eccles, 2009; Crill et al., 2004; Gacki-Smith et al., 2009; Gates et al., 2011; Hills, 2008; Kansagra et al., 2008; Landau & Bendalck, 2008). As stated previously, a minimum of 90 participants was needed to conduct the regression model of data analysis for my study. The projected response rate of 20 to 40 percent from the population was expected to exceed this requirement.

Instrumentation

To conduct my proposed research, a self-administered, Internet-based questionnaire titled Emergency Department Nurses Assault Reporting Survey was developed. This survey was based on the Workplace Violence in the Health Sector Survey Questionnaire (World Health Organization, 2003). Several sections of the original

survey were left out of my study due to irrelevance. These sections included questions in regards to verbal abuse, bullying, mobbing, sexual harassment, racial harassment, and foreign sector hospital information. Additional, original questions were added to the survey that specifically addressed state penalty enhancement laws. The survey measured the dependent variable of reporting of physical assaults. The survey consisted of 36 questions. Eight of the questions were in regards to responder demographics and some were used in the regression model as control variables. The remaining 28 questions were grouped into three composite variables to address the research questions. The three composite variables were:

Workplace violence questions = Q9, Q10, Q11, Q12

Agency actions and organizational culture = Q13, Q14, Q15, Q16, Q17, Q18, Q19, Q20, Q21, Q22, Q23, Q24

Individual actions and rational choice = Q25, Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33, Q34, Q35, Q36

I made minor modifications to the original survey written by the World Health Organization including the removal of questions that were not relevant to my area of study. Permission was obtained from the author before conducting the formal study. Questions in regards to agency and personal actions, and penalty enhancement laws were assessed using questions based on a Likert scale.

Data Collection Procedures

To obtain the required data for my survey, I used the Workplace Violence in the Health Sector Survey Questionnaire from the World Health Organization and modified it

to create the Emergency Department Nurses Assault Reporting Survey. A four-phased approach was used for data collection. The survey questions were designed to correlate with the related elements of workplace violence, nurse reporting habits, organizational culture in regards to the handling of incidents of assault, and state support of nurses through penalty enhancement laws.

Collection Phases

Phase 1. Implied consent was used for my study. An email was sent that introduced the researcher and provided a description of the survey. These emails were sent to the primary contacts at the selected hospitals. These contacts were normally the Chief Nursing Officers or Emergency Medicine Administrators. These emails included a request that the surveys and related survey participation information be forwarded to their emergency department nurses. The emergency department nurses were requested to complete the survey on-line using Survey Monkey. Materials sent with the email included the invitation to participate in the survey along with statements of ensured confidentiality for the institutions and the individual respondents and an electronic implied consent statement. Directions for accessing and completing the survey were also included with the email.

Phase 2. Approximately two weeks after the initial invitations were sent to the hospitals, a follow-up email was sent to the primary contacts expressing thanks for those who have completed the surveys and requesting those who have not to complete the survey. A deadline for completion of the surveys was included with both the initial and the follow-up emails.

Phase 3. Approximately two weeks after the second emails were sent to the primary contacts at the selected hospitals, I sent out the same initial email to the secondary contacts at hospitals that had not responded to the survey request during the initial four weeks of the survey period. A deadline of 2 weeks for completion of the surveys was included with this email.

Phase 4. During the fourth phase, I transferred the data from the Survey Monkey to my personal computer. My home computer was password protected and all data was maintained in an electronic format on the secured computer. Data from my research will be maintained for five years. Any hardcopy printouts of information used in data analysis will be kept in a locked filing cabinet in my home for a period of five years.

Data Coding. Questions on this survey in regards to rational choice and organizational culture used Likert scale responses. The variables from these questions were assigned numeric values to represent the weight and direction of the respondent's favor or disfavor with the presented item (Frankfort-Nachmias & Nachmias, 2008). No response for any question was assigned a zero value.

Data Analysis

To conduct quantitative research, data is collected and measured to test the relationship between variables using a test instrument such as a survey so numeric data can be analyzed using descriptive statistical tests (Champion, 2006). I used descriptive statistics in my research to measure participant responses.

Descriptive Statistics

Through the use of Likert scales, the data collected for the variables in my study were assigned numeric values so descriptive statistical tests could be completed to analyze the data. Statistical Package for the Social Sciences (SPSS 23.0) software was used for the data analysis. Data at the ordinal level was collected from the Likert scales in the survey. At a minimum, means, standard deviations, percentages, and frequencies were produced from this data using the SPSS 23.0 software. Data collected for both the independent and dependent variables was checked for normal distribution.

Correlation and regression analysis. Correlation analysis is a statistical test that examines the relationship between multiple variables (Fields, 2009). For my study, I used descriptive statistics to determine the numeric values representing correlations between multiple independent variables and the dependent variable of nurse reporting of physical assaults. The data collected from the respondents was placed into a correlation matrix. This matrix provided a statistical representation of the relationships between the variables.

Regression analysis can expand the knowledge we have gained from the correlation analysis by placing the data into a regression equation and using that information to predict the values of the dependent variables from the given values of one or more of the independent variables (Fields, 2009). Specifically to my study, a regression equation was used to determine which independent variables were significant in predicting that nurses would formally report incidents of physical assaults. As grouped by the composite variables in my study, regression analysis was used to determine the

dependent variable of nurse reporting of physical assaults using the independent variables of rational choice and organizational culture, and the control variables of age, gender, and the presence of state penalty enhancement laws.

Nurse Assault Reporting Equation.

$$\text{Nurse Assault Reporting} = b_1 \text{ rational choice} + b_2 \text{ organizational culture} + b_3 \text{ age} + b_4 \text{ gender} + b_5 \text{ presence of state laws} + \varepsilon$$

Regression analysis included the comparison of personal experiences, rational choice, organizational culture, and penalty enhancement laws to nurse reporting of physical assaults from patients in academic medical centers.

Regression ordinal variables. Ordinal variables are commonly used in the social sciences to measure variables that have some form of relationship on a scale (Frankfort-Nachmias & Nachmias, 2008). The survey for my study used ordinal data from a Likert scale to create regression models.

Confidence Level

Inferential statistics are used in quantitative research to assist in determining if the alternative hypothesis is likely to be true when examining a sample of a large population (Field, 2009). For my study, a sample of emergency department nurses was surveyed to make inferences in regards to the larger population of the Mid-Atlantic States. My study utilized the commonly used confidence level in social sciences of 95% and $p = .05$.

Validity and Reliability

To gather data on my area of study, I conducted descriptive survey research. This type of research gathers data on a phenomenon by collecting information from a

sampling frame of the population from a single survey (McKenna et al, 2006). This type of research is used to gather information relating to the attitudes, rate of incidents, and the behaviors the participants exhibit in relation to the specific event being researched (Coughlan, Cronin, & Ryan, 2009). In order to gather participant responses to my specific area of research, I developed the Emergency Department Nurses Assault Reporting Survey for data collection. This survey was adapted from the Workplace Violence in the Health Sector Questionnaire developed by the World Health Organization. Validity and reliability tests were needed for this instrument in order to mitigate measurement errors. Limitations of reliability testing are included in Chapter 5.

Validity is the concern that the variables in the measurement instrument are actually measuring what they are supposed to be measuring (Field, 2009). Specifically to my instrument, I was concerned with construct validity. Construct validity assesses "whether a given indicator is empirically associated with other indicators in a way that conforms to theoretical expectations about their interrelationship" (Adcock & Collier, 2001, p. 537). Since this instrument measured new research in an exploratory manner and I was concerned with the reliability of the information gathered at the individual level, internal consistency of the instrument was measured using Cronbach's alpha (Jones & Norrander, 1996).

The original questionnaire developed by the World Health Organization that was used to develop my survey has been used by multiple international agencies to measure workplace violence in hospitals around the world. The results of these studies are included in the literature review in Chapter 2. Reliability of the results can be

extrapolated from the similarities in results from the multiple uses of this survey by different organizations in different cultures.

My instrument measures different factors and had more than 12 items. When this many items are being measured together, high correlations can lead to falsely concluded interpretations of Cronbach's alpha (Field, 2009). In order to ensure the measurement of covariance within factors, analysis will be measured on two subscales of the independent variables within the survey.

- Agency actions and organizational culture = Q13, Q14, Q15, Q16, Q17, Q18, Q19, Q20, Q21, Q22, Q23, Q24
- Individual actions and rational choice = Q25, Q26, Q27, Q28, Q29, Q30, Q31, Q32, Q33, Q34, Q35, Q36

Feasibility and Appropriateness of Study

In order to conduct this survey, I used the Internet-based hosting service provided by Survey Monkey to collect data. I had full access to this service through a subscription I previously purchased for work-related research so there was no additional cost for my study. My study was feasible since there was very limited personal costs associated with the data collection, the target population contact information was easily available through my professional contacts, and the research was easily manageable based on the proposed phases of collection and analysis. As there was an expectation that all nurses working in similar academic hospitals would have the same level of access to technology and available time for survey completion, no selection bias was anticipated.

Informed Consent and Ethical Considerations

My research was conducted in compliance with Walden University's Institutional Review Board (IRB). IRB approval was obtained at the required stage of the dissertation process and is included with this document as an appendix. A random sample of emergency department nurses was selected from academic hospitals in six Mid-Atlantic States/Districts. An email was sent to the selected academic hospitals inviting the emergency department nurses to participate in the study. This email included a letter explaining the purpose of the study and the contact information for the researcher, dissertation chair, and IRB at Walden. Nurses who participated in this survey had complete confidentiality and were not asked to disclose their personal information. Participation was completely voluntary. The letter included in the email also provided instructions for accessing the survey and informed the participant that their access to the survey would be considered implied consent. Individuals and the hospitals were not identified in my study. Information related to steps taken to ensure ethical and moral conduct is included as an appendix to this document.

The terms and conditions of privacy for the Internet-based service were supplied by Survey Monkey and were abided to while collecting and analyzing data. After the completion of this dissertation, Survey Monkey was contacted and formally requested to delete all information provided by the respondents within 30 days.

All data collected from the participants in this survey is protected. Electronic data is maintained on a personal computer in my home which is password protected. Hardcopy data is stored in a locked file cabinet in my home. All data, both electronic and

hardcopy will remain in a secured state for a period of five years from the date of publication of the study. After that time period, all hardcopy data will be shredded and all electronic data will be deleted.

Summary

The purpose of this quantitative study was to examine emergency department nurse behaviors in reporting physical assaults in Mid-Atlantic States that have varying levels of penalty enhancement laws in place that specifically call for increased judicial punishment for offenders who assault nurses while on duty. This chapter described the non-experimental research design that will be used to measure nurse reporting of physical assaults. The chapter provided an outline of the design of the research, the sample set and sampling method, the phases for data collection, the development of the test instrument, and a review of the statistical significance process that is to be used to analyze the data collected. Results from the data collection process are provided in chapter 4. Interpretation of the findings, potential for social change, and recommendations for further actions and research are provided in chapter 5.

Chapter 4: Results

Introduction

Research in workplace violence in the healthcare setting has suggested that the lack of reporting by the victims has been an problem with tracking and implementing action plans to mitigate future occurrences (Emergency Nurses Association, 2015; Taylor & Rew, 2010; Valente & Fisher, 2011). Using the factors of agency actions suggesting organizational culture in action, individual actions suggesting rational choice in action, and levels of state implemented penalty enhancement laws, I explored this phenomenon by quantitatively measuring the response and reporting behaviors of emergency department nurses working in six Mid-Atlantic Regions of the United States. The purpose of my study was to quantitatively explore reasons emergency department nurses use to justify their reactions after being a victim of physical assault from a patient and any potential influence state penalty enhancement laws may have had on those actions. In this chapter, I provide the results of the quantitative survey and discuss findings derived from an analysis of the collected data.

Data were collected from nurses working in emergency departments at academic hospitals located in Massachusetts, New York, New Jersey, Pennsylvania, Maryland, and Washington, D.C. to determine current incident reporting practices after being a victim of physical assault from a patient. The research provided data to assist in making determinations of what factors influenced nurses to report or not report the incidents. The research questions I addressed in my study were as follows: (a) Do rational choice actions of nurses affect their formal reporting behaviors, which contribute to the effectiveness of

penalty enhancement laws? (b) Does organizational culture have an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws? The research questions were answered using data collected from surveys completed by nurses working in emergency departments of academic hospitals in the Mid-Atlantic Region using the Emergency Department Nurses Assault Reporting Survey that was based on the Workplace Violence in the Health Sector Survey Questionnaire (World Health Organization, 2003).

Research Tool

As described in Chapter 3, the Emergency Department Nurses Assault Reporting Survey was a self-administered, web-based questionnaire. The survey measured the dependent variable of emergency department nurse reporting of patient-inflicted physical assaults, control variables of nurse demographics, and two independent variables of rational choice actions and organizational culture actions. The survey consisted of 36 questions, or scales, that were used to collect the data related to the variables. The data collected from the 36 scales were divided into two subscales in order to address the research questions.

Validity and Reliability

The Emergency Department Nurses Assault Reporting Survey was a modified version of the Workplace Violence in the Health Sector Survey Questionnaire (World Health Organization, 2003). The research coordinator at the World Health Organization was contacted to request permission to use the modified version of the Workplace Violence in the Health Sector Survey Questionnaire and to request any data on previous

testing completed for reliability and validity of the instrument. Permission was granted to use the modified version for my study; however, even though the original survey had been used for several years in countries around the world, there was no data available on previous documentation of reliability and validity of the original instrument. Modifications I made to the original instrument were to remove demographic questions in relation to country, profession, sector, clients; removal of verbal abuse, bullying/mobbing, sexual and racial harassment sections; removal of open-ended questions; addition of unique questions about state penalty enhancement laws; and addition of unique question related to the two theories I tested in my research.

The participants for my study answered questions about facts relating to their responses to previous incidents of assaults. Some perceptions were relevant in regards to potential influences state penalty enhancement laws might have on deterring future events or influencing nurses to formally report incidents. Since this was exploratory research into a new aspect of assaults on emergency department nurses, initial reliability of the modified survey was tested through Cronbach's alpha (Field, 2009). Consistency in response to the survey was evaluated overall for the instrument and for the subscales of organizational culture and rational choice. Using Cronbach's alpha, the overall reliability of the test instrument was .84 (see Table 3), which indicated an acceptable level of reliability for the survey. Each subscale was also determined to be reliable using Cronbach's alpha.

Table 3

Test of Reliability Using Cronbach's Alpha

Overall reliability of research tool	.839
Agency actions (organizational culture)	.923
Individual actions (rational choice)	.834

All values from the reliability tests for Cronbach's alpha were greater than .8 indicating a generally accepted level of Cronbach's alpha for a reliable survey (Field, 2009). The results developed from SPSS for the reliability measurement were included as an appendix to my study.

Exploratory Factor Analysis

The research tool was used to gather data that was analyzed in order to answer the two research questions. Relationships within the variables of the two measured subscales were confirmed using exploratory factor analysis. Interrelations of the raw data in each of the two indexes were determined by conducting preliminary exploratory factor analysis. This analysis was conducted to ensure normal distributions at the interval level of the variables for each of the two indexes. Exploratory factor analysis for my research included the Kaiser-Meyer-Olkin (KMO) measurement, Bartlett's test of sphericity $X^{2,}$ and principal component analysis (PCA). By conducting these measurements, I was able to determine the relationship between the variables. Factor analysis is commonly used with large data sets but can still be a reliable measurement on sample sets as small as 10 respondents and 30 variables (Field, 2009). The purpose of conducting exploratory factor analysis was to develop a foundation for future research of assaults on emergency

department nurses and their reporting behaviors using the variables and subscales used in my research.

The PCA was conducted on both indexes using orthogonal rotation (varimax). Results are shown in Tables 4, 5, and 6. The Kaiser-Meyer Olkin measure verified adequacy of the two indexes in the sample were .752 for the organizational culture subscale and .699 for the rational choice subscale which were both above the acceptable level of .5 and indicates the sample size is adequate for factor analysis (Field, 2009). Bartlett's test of sphericity X^2 was 860 for the organizational culture index, 677 for the rational choice index, and 482 for the nurse-reporting index. All measurements were at $p < .001$ and were highly significant. Bartlett's measure was used to test the null hypothesis that the original correlation matrix is an identity matrix. The Bartlett's tests for this data were significant which showed that the data was not an identity matrix and that here were some relationships between the variables and thus factor analysis was appropriate. The determinate value in the correlation matrix for Research Question 1 was 0.001 and 0.0001 for Research Question 2, which were greater than the necessary value of 0.00001. The results of these tests eliminated concerns for multicollinearity in the raw data. The correlation matrix of the data was included as an appendix to my study.

Table 4

Test for Organizational Culture Independent Composite Variable

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.752
Bartlett's Test of Sphericity	Approx. chi-square	860.156
	df	55
	Sig.	<.001

Table 5

Test for Rational Choice Independent Composite Variable

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.699
Bartlett's Test of Sphericity	Approx. chi-square	677.278
	df	66
	Sig.	<.001

Table 6

Test for Nurse Incident Reporting Dependent Composite Variable

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.628
Bartlett's Test of Sphericity	Approx. chi-square	482.754
	df	6
	Sig.	<.001

Data Demographics

The target population for this survey was N = 527. Using the selection model described in Chapter 3, my research project yielded 107 respondents, which was a 20% overall response rate from the population to the test instrument over a 4-week survey period. Research involving nurses and other healthcare workers has shown an expected response rate of approximately 20% (Curtis & Redmond, 2009). Field (2009) recommended 10-15 responses per variable to be an acceptable response rate to develop a suitable sample set size. I received a 20% response rate. Ten to15 responses per variable would be 50-75 responses. My response of 107 participants produced a medium to large effect size of the data for regression analysis (Field, 2009).

The first section of the survey collected demographic data about the respondents. This section asked respondents about their age, gender, years of experience, location, work shifts, staffing levels, and membership in labor unions or professional nursing organizations. Of the 107 participants, 87 were female and 20 were male. The average participant age was 45 and the average length of employment as an emergency department nurse was 8 years. The demographic section of the test instrument showed that responses from each of the six regions surveyed ranged from 11% to 27% of the total sample received (see Table 7).

Table 7

Responses from Emergency Department Nurses by Region

Region	Penalty Enhancement Law in Place	Number of Respondents	Percent of Sample Responded
Baltimore, Maryland	No	15	14%
New York, New York	Yes	15	14%
Northern New Jersey	Yes	17	16%
Southeastern Pennsylvania	Yes	29	27%
Boston, Massachusetts	Yes	12	11%
Washington, D.C	No	19	18%
Total		107	100%

A review of the responses to the surveys showed that:

- 55% agreed or completed agreed that their union or professional nursing organization supports state penalty enhancement laws put in place to protect nurses
- 61% agreed or completed agreed that they were aware of penalty enhancement laws in their state to protect nurses from patient assaults

- 63% agreed or completely agreed they would be supported by their hospital to formally repot incidents of physical assaults by patients
- 77% agreed or completely agreed that their facility provides them with training on workplace violence incident reporting procedures
- 78% agreed or completed agreed they should be financially compensated for their time outside of work spent in the judicial process when taking legal actions attains a patient who assaulted them
- 79% agreed or completely agreed that their facility has policies and procedures in place for the reporting of violence in the workplace
- 79% agreed or completely agreed that their hospital should be responsible for preventing incidents of patient assaults on nurses

Data Analysis

The raw data collected from the 36 questions of the test instrument were grouped into three subscales to answer the research questions. Each of the three subscales was developed by the methods outlined in Chapter 3. The control variables were demographic information collected from questions Q1 through Q8 of the survey. Descriptive variables of age, gender, and state laws from the demographic information were used in the regression model. The independent variable of organizational culture actions was an aggregation of questions Q13 through Q24. The independent variable of rational choice actions was an aggregation of questions Q25 through Q36.

The dependent variable of nurse reporting of patient assaults was indicated in both research questions. The dependent variable index was developed from an aggregation of

questions Q9, Q10, Q11, and Q12. Q9 asked the participants how many times they were a victim of physical assault from a patient over the last 1 - 2 years. Q10 asked the participants how many times they reported the incident to only a coworker or supervisor. Q11 asked the participants how many times they filed an incident report to hospital administration. Q12 asked the participants how many times they filed a formal report of the incident to police. To develop the dependent variable, the full value of Q9 was added to weighted responses of Q10 – Q12. The questions received a greater weight as the level of formal reporting increased. The weighted equation used for the dependent variable was:

Nurse Assault Reporting = Q9 + (Q10*0.10) + (Q11*0.30)+(Q12*0.60)

An independent-sample *t*-test was run for the dichotomous variable of state penalty enhancement laws (see Table 8). States without a penalty enhancement law in place were assigned a value of zero. States with a penalty enhancement law in place were assigned a value of one. On average, nurses who worked in states with penalty enhancement laws showed a lower propensity to report patient assaults ($M = 4.66$, $SE = .973$) than nurses who worked in states that did not have penalty enhancement laws ($M = 13.35$, $SE = 3.159$). This difference was significant $t(39) = 2.631$, $p < .05$ with a medium-sized effect of $r = .38$.

Table 8

Independent t-Test for States With or Without Penalty Enhancement Laws

	t-test for Equality of Means				
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Equal variances not assumed	2.631	39.396	.012	8.69541	3.30560

Correlation Matrix

A correlation matrix was generated for comparison of the variables gathered from the raw data that was used to develop the indexes. Using Person's (r) two-tailed test, $p < .05$, a significant relationship was found between 20 rational choice variables and 24 organizational culture variables. The strongest relationship was between hospital policies and procedures are in place and training had been provided to nurses on policies, $r = .840$ for organizational culture elements and between the belief that laws would decrease assaults and laws would increase the willingness to report, $r = .701$ for rational choice elements. In order to answer the research questions for this exploratory study, I determined if there were significant relationships among organizational behavior, rational choice, and nurse reporting of patient assaults. As the dependent variables increased, nurse reporting increased, and as the independent variables decreased, nurse reporting decreased. The control variables of age, gender, and presence of state penalty enhancement laws were not significant and had no effect on the strength of the dependent variables and their correlation to the independent variable. The correlation matrix was provided as an appendix to my study.

Research Question 1

To address Research Question 1, I compared the correlation matrix to the responses of emergency department nurses' actions based on rational choice actions from questions Q25 through Q36. The correlation matrix for Research Question 1 indicated that the strongest relationship (.701) existed between nurses' belief that increased legal penalties would decrease assault rates and a willingness to formally report assaults if their state had a penalty enhancement law. The lowest value for Pearson's (*r*) was .004 between how nurses responded to the assault incident and nurses' belief that increased legal penalties would decrease assault rates in their facility. Field (2009) recommended that values greater than .3 were acceptable values that indicated a significant positive relationship for correlation. This would provide suggestions for researchers for further studies.

Other higher correlations were observed between nurses not willing to confront patients in court and beliefs that laws would increase reporting habits (.579), nurses' belief they should be financially compensated for time spent in judicial process and their awareness of state penalty laws (.564), nurses not willing to confront patients in court and nurses' fear of retaliation from their hospitals for formally reporting incidents (.540), nurses weighing the personal pros and cons of reporting before acting and the manner in which the nurse responded to the incident (.538), and nurses' belief they should be financially compensated for time spent in judicial process and beliefs that laws would increase reporting habits (.535). Eight other correlations were observed between .342 and

.490 that may have some level of significance for future research. All correlations are shown in the table in Appendix J.

An Analysis of Variance (ANOVA) test was used to find the *F*-ratio (see Table 9). This ratio is used to determine if the variance explained by the model are significant (Field, 2009). The *F*-ratio was 15.653, $p < .001$. There was a significant effect of rational choice behaviors on nurse reporting habits, $F(2,104) = 15.653$, $p < .001$.

Table 9

Research Question 1 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1439.029	2	719.515	15.653	<.001[a]
	Residual	4780.523	104	45.967		
	Total	6219.553	106			

Note: a. Predictors: Rational Choice Actions (Q25-Q36).
b. Dependent Variable (Q9-Q12)

Research Question 2

To address Research Question 2, I compared the correlation matrix to the responses of emergency department nurses' actions based on organizational culture influences from questions Q13 through Q24. The correlation matrix for Research Question 2 indicated that the strongest relationship (.840) existed between nurses' knowledge of hospitals having workplace violence policies in place and nurses receiving training on policies and incident reporting procedures. The Pearson's (*r*) between nurses' response to their organization belaying their fears of workplace violence and nurses' response that their organization considers workplace violence to be acceptable behavior

was -.641. Field (2009) recommended that values greater than .3 were acceptable values that indicated a significant positive relationship for correlation. This would provide suggestions for researches for further studies.

Other higher correlations that were observed which might be considered for future research included hospitals support of state penalty enhancement laws and hospital support of incident reporting (.596), nurse satisfaction with hospital response to incidents and hospital ability to belay worries of workplace violence (.572), hospital support of penalty enhancement laws and hospital ability to belay worries of workplace violence (.555), hospital ability to belay worries of workplace violence and hospital provision of training in workplace violence prevention (.553), hospital ability to belay worries of workplace violence and hospital implementation of workplace violence policies (.544), and hospital implementation of workplace violence policies and hospital support of nurse reporting of assault incidents (.535).

An Analysis of Variance (ANOVA) test was used to find the F-ratio (see Table 10). This ratio is used to determine if the variance explained by the model are significant (Field, 2009). The F-ration was 18.217, $p < .001$. There was a significant effect of organizational culture behaviors on nurse reporting habits, $F(1,105) = 18.217$, $p < .001$.

Table 10

Research Question 2 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	919.524	1	919.524	18.217	<.001[a]
	Residual	5300.029	105	50.476		
	Total	6219.553	106			

Note: a. Predictors: Organizational Culture Actions (Q13-Q24). b. Dependent Variable (Q9-Q12)

Regression Analysis

For my study, the regression model used for the research questions was an equation as follows:

Nurse Assault Reporting = .10 organizational culture + .30* rational choice + -.07 age + .01 gender + -.13 state laws + **ε**

The standardized beta values were used to determine the importance of each of the independent variables as predictors for the regression model since the three variables of organizational culture, rational choice, and state laws were not measured on the same scale (Field, 2009). The predictor with more significance to nurse reporting behaviors of patient assaults was rational choice actions with a standardized beta value of .30, $p < .05$. The organizational cultural activities variable was not a significant predictor of nurse reporting behaviors of patient assaults with a standardized beta value of .10. Age, gender and the presence of state penalty enhancement laws were not significant predictors. The standardized beta for states having enhancement laws was -.13, which corresponds to the lower reporting rate found in the t-test. However, the -.13 was not significant.

Positive beta values shown in Table 11 indicated a positive relationship between rational choice actions and organizational culture activities. Even though both elements showed a positive relationship to nurse reporting behaviors, organizational culture activities were not significant. The VIF of less than 10 for each model was used to eliminate concerns for multicollinearity (Fields, 2009). The Durbin-Watson statistic was 1.653 (see Table 12). This test of two observations was used to test for independence and serial correlation between errors. This test statistic varies from 0 – 4 where values under 2 indicate some level of positive correlation (Fields, 2009). The score of 1.653 indicated that the assumption that the errors in this regression model were independent.

The adjusted R^2 for the regression model shown in Table 12 was .18. This indicated that rational choice actions accounted for 18% of the variation of why nurses reported being a victim of assault by a patient. As additional predictors of age, gender, and presence of state laws were added, the adjusted R^2 declined indicating that the predictors did not improve the model more than what would have been expected by chance (Fields, 2009). The remaining 82% of the variation was still open for explanation. Possible explanations could have been post-incident stress, negative stigmata, or other predictors not included in the model. These other possibilities are included in chapter five for recommendations for further study.

Table 11

Nurse Reporting of Patient Assault Coefficients

Model		Beta	t	Sig.	VIF
1	(Constant)		-1.371	.173	
	Org Culture	.325	3.524	.001	1.000
2	(Constant)		-2.092	.039	
	Org Culture	.100	.907	.367	1.567
	Rat Choice	.375	3.402	.001	1.567
3	(Constant)		-.700	.486	
	Org Culture	.130	1.128	.262	1.712
	Rat Choice	.335	2.823	.006	1.817
	Age	-.085	-.898	.371	1.166
4	(Constant)		-.724	.471	
	Org Culture	.131	1.131	.261	1.714
	Rat Choice	.332	2.779	.006	1.829
	Age	-.092	-.934	.352	1.228
	Gender	.025	.279	.781	1.055
5	(Constant)		-.030	.976	
	Org Culture	.095	.798	.426	1.811
	Rat Choice	.302	2.485	.015	1.898
	Age	-.074	-.754	.453	1.250
	Gender	.012	.137	.891	1.067
	Law	-.133	-1.317	.191	1.310

The *t*-statistic for the presence of state penalty enhancement laws was -1.317. This negative value may indicate that there was an adverse effect on reporting habits of nurses when a state law was in place and that the presence of state laws lowered the probability of nurses reporting the assault. However, this statistic was not significant and could be an element for exploration in further studies.

Table 12

Regression Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Durbin-Watson
1	.325[a]	.106	.097	12.35666	.106	
2	.442[b]	.195	.180	11.77801	.090	
3	.449[c]	.202	.178	11.78895	.006	
4	.450[d]	.202	.171	11.84209	.001	
5	.464[e]	.216	.177	11.79967	.013	1.653

Note. a. Predictors: (Constant), Org Culture. b. Predictors: (Constant), Org Culture, Rat Choice. c. Predictors: (Constant), Org Culture, Rat Choice, Age. d. Predictors: (Constant), Org Culture, Rat Choice, Age, Gender. e. Predictors: (Constant), Org Culture, Rat Choice, Age, Gender, Law. f. Dependent Variable: Nurse Reporting

Summary

My study answered the following: (a) Do rational choice actions of nurses affect formal reporting behavior to assist in determining the effectiveness of penalty enhancement laws? (b) Does organizational culture have an affect on nurses' formal reporting behavior to assist in determining the effectiveness of penalty enhancement laws? The research questions were answered through ANOVA tests and regression analysis. The data for this analysis was collected with a survey instrument distributed to emergency department nurses working in academic medical centers in 6 geographical locations of the Mid-Atlantic Region using the Emergency Department Nurses Assault Reporting Survey. The study's findings indicated that nurse incident reporting behaviors following a patient inflicted assault were significantly related to rational choice actions. There was also a positive relationship between nurse reporting behaviors and

organizational culture activities; however this relationship was not as strong as rational choice actions.

While formal reporting of patient-inflicted assaults by nurses are still far lower than would be expected, the findings supported that there are positive relationships between one element that could be focused on to encourage higher rates of reporting. These elements are interpreted in chapter 5 along with implications for social change, recommendations for actions, limitations of the study, and recommendations for further study.

Chapter 5: Discussion, Conclusions, and Recommendations

Overview of the Study

The purpose of my study was to quantitatively explore emergency department nurse reporting habits of patient inflicted assaults in academic hospitals located in six Mid-Atlantic Regions. Research has suggested that nurse reporting of these assaults was critical in order to determine if specific control measure put into place have had any effect on reducing these acts of violence (Casteel et.al., 2008; Coughlan, Cronin, & Ryan, 2009; Ferns, 2014; Gates et.al., 2011; Pawlin, 2008). One control measure that has been put in place with the premise of protecting nurses from these assaults was state penalty enhancement laws that escalated the punishment for assaulting a nurse while on duty. Since the implementation of these laws in states in the Mid-Atlantic Region, a quantitative analysis had not been conducted to determine any effectiveness or other influence these laws may have had on nurse incident reporting behaviors or rates of assault. Using the factors of organizational culture, rational choice, age, gender, and presence of state laws, I explored this gap by quantitatively measuring the reporting habits of emergency department nurses working in academic hospitals in the Mid-Atlantic Region in response to an assault by a patient. In this chapter I discuss the findings derived from the study, implications for social change, and recommendations for future actions and study.

My research collected data to assist in determining what factors related to emergency department nurse reporting habits. The research questions I addressed in my study were: (a) Do rational choice actions of nurses affect their formal reporting

behaviors, which contribute to the effectiveness of penalty enhancement laws? and (b) Does organizational culture have an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws? The research questions were answered from data collected from surveys distributed to nurses working in emergency departments at academic hospitals in the Mid-Atlantic Region using the Emergency Department Nurses Assault Reporting Survey.

To conduct my study, I employed stratified sampling to 14 hospitals that have similar elements within their groups that are also representative of academic hospitals within the population based on their commonalities in metropolitan environment, patient census, and level of care. Based on average emergency department sizes provided by the American Hospital Association (2015) the number of nurses employed across these 14 hospitals at the time of the survey was approximately 527. The research tool was the Emergency Department Nurses Assault Reporting Survey, a derivative of the Workplace Violence in the Health Sector Survey Questionnaire developed by the World Health Organization (2003). One hundred and seven emergency department nurses participated in the study for a 20% response rate that was an acceptable measurement sample (Field, 2009). A factor analysis of the data confirmed this acceptability as detailed in Chapter 4.

Based on the research conducted for the literature review in Chapter 2, I developed four variables for my study as the dependent variable of nurse reporting habits, the independent variables of rational choice actions and organizational behaviors, and the control variables of age, gender, and state laws. The dependent variable was developed through the combination of questions Q9-Q12, the organizational culture independent

variable was developed through the combination of questions Q13-Q24, and the rational choice independent variable was developed through the combination of questions Q25-Q36 from the survey instrument. Control variables added to the regression equation of age, gender, and the presence of state penalty enhancement laws were Q1, Q2, and Q4. These variables were used to generate a correlation matrix in order to measure nurse-reporting behaviors. These variables were further described in Chapter 3. The data analysis of the findings was presented in Chapter 4.

Interpretation of the Findings

Using a correlation matrix, I discovered a significant relationship between 20 rational choice and 24 organizational culture individual variables using Person's (r) two-tailed test, $p < .05$. This indicated that a statistical relationship existed between many of the variables used to develop the regression (Field, 2009). There was a statistically significant relationship between the rational choice actions and organizational culture behaviors, $r = .602$ using Pearson's (r) two-tailed test, $p < .01$ indicating a statistical relationship between the composite variables. There was a mixed relationship between the two composite variables and the dependent variable. There was a medium effect relationship between rational choice actions and nurse reporting behaviors, $r = .435$ and a weak effect relationship between organizational culture and nurse reporting behaviors, $r = .325$. Based on the correlation matrix, both of these relationships were positive.

In response to specific questions about penalty enhancement laws; 64% of the nurses responded that they were aware of penalty enhancement laws in their state that implement a mandatory increase in the level of punishment for patients who physically

assault a nurse, 36% believed that increased legal penalties such as fines or jail terms for patients who physically assault nurses would help to decrease the rate of assaults in their facility, and 28% agreed that they would be more likely to file a formal report of the incident if their state implemented a penalty enhancement law that increased the punishment for patients who assault nurses.

To answer the research questions from this exploratory study, a linear regression analysis was used to explore the relationships between rational choice actions, organizational culture behaviors, and nurse reporting behaviors. An ANOVA analysis of the linear regression which included both independent variables and the control variables showed a significant linear trend of rational choice actions on nurse reporting habits, $F(5,101) = 5.553$, $p < .001$. This indicated that rational choice actions did have a positive effect on the propensity for emergency department nurses to report incidents of patient assaults.

Research Question 1

Do rational choice actions of nurses affect their formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0 1$= Rational choice actions of nurses have no effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.
- $H_a 1$= Rational choice actions of nurses have an effect on formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.

Research Question 1 Interpretation

In order to answer Research Question 1, emergency department nurses were asked to provide their response to rational choice actions that may determine their propensity to report patient assaults. Data was collected from the research tool; 54% of the nurses who reported being a victim of patient-inflicted assault over the previous 1-2 years said they completed an incident report after the assault and 2% of the nurses said they pursued legal actions against the perpetrator after their incidents. Of the nurses who responded that they did not report the incident, 68% responded that they did not report the incident because the reporting process takes too long and 62% responded that they felt nothing would be done if they did file a report. Eighty-two percent of the nurses responded that hospital should financially compensate them for time spent in the judicial process when taking legal actions against a patient who assaulted them.

A regression analysis was used to determine that rational choice actions were significant in predicting nurse reporting behaviors. The full regression analysis that included both independent variables and the control variables produced a significant beta value of .302, $p < .05$ for rational choice actions, while controlling for age, gender, and presence of state laws. These findings may provide support for the rational choice aspects of decision-making when it comes to emergency department nurses propensity to report patient-perpetrated assaults. Based on the research and the analysis for Research Question 1, I rejected the null hypothesis and favored the alternate hypothesis that rational choice actions of nurses have an effect on formal reporting behaviors to assist in determining the effectiveness of penalty enhancement laws.

Research Question 2

Does organizational culture have an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws?

- $H_0$2= Organizational culture has no effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.
- H_a2= Organizational culture has an effect on nurses' formal reporting behaviors, which contribute to the effectiveness of penalty enhancement laws.

Research Question 2 Interpretation

In order to answer Research Question 2, emergency department nurses were asked to provide their response to organizational culture behaviors that may determine their propensity to report patient assaults. Data was collected from the research tool. Fifty-six percent of the nurses said that after being a victim of physical assault from a patient, actions were not taken by anyone in their facility to investigate the causes of the incident. Sixty-six percent of the nurses said that after being a victim of physical assault from a patient, there were no consequences for the patient who assaulted them. Fifty-four percent of the nurses said they were not satisfied with the manner in which the incident was handled by their facility though 34% of the nurses replied that they were encouraged to report incidents of workplace violence by their hospital administration. Eighty-five percent of the nurses responded that they believed their hospital should be responsible for preventing incidents of patient assaults on nurses and 65% of the nurses responded that their hospital would support nurses who formally report incidents of physical assaults by patients.

A regression analysis that included both independent variables and the control variables was used to determine that organizational culture behaviors were not significant in predicting nurse reporting behaviors. The full regression analysis produced a nonsignificant beta value for organizational culture behaviors, while controlling for rational choice, age, gender, and presence of state laws (standardized beta = .094, $p >$ .05). This finding did not provide support for the organizational culture behaviors of decision-making when it comes to emergency department nurses propensity to report patient-perpetrated assaults. Based on the research and the analysis for Research Question 2, I failed to reject the null hypothesis that organizational culture has no effect on nurses' formal reporting behaviors that determine the effectiveness of penalty enhancement laws. Additionally, the control variables of age, gender, and presence of state laws had no significant effect on the regression analysis results.

Limitations

There was a limitation in the ability to compare the data collected from my study to other regions or healthcare institutions due to a lack of previously collected data on this topic. Other limitations to my study included the time allowed for completion of the surveys, the respondent's fulfillment of answering the Internet-based survey, the availability of emergency department nurses to participate, and the level of accuracy and honesty in the responses from the participants.

Implications for Social Change

My study encouraged social change through implications from three aspects. First, it provided for an increased understanding of how emergency department nurses

rationalized their behaviors in response to patient assaults. Second, it provided additional information to the body of literature on rates of patient assaults on emergency department nurses in the Mid-Atlantic Region. Third, my study provided increased knowledge of the potential effectiveness penalty enhancement laws have on healthcare organizations and legislative bodies and whether the implementation of stricter laws is the appropriate way to influence behavior under the new era of healthcare.

A significant influence was shown between rational choice actions and the propensity for emergency department nurses in the Mid-Atlantic Region to report patient-inflicted assaults. This was supported from findings from the data analysis collected from the survey instrument. The literature review showed that an individual will make a decision based on their preconceived beliefs and act on an event in a manner that will satisfy their own desires based on what they believe the outcome of different choices would be (Dietrich & List, 2013). Applying the theory of rational choice to the findings from my study, hospital administrators should be open to understanding that nurses may be more willing to report incidents of patient-inflicted assaults when the nurses believe that the outcome of reporting would meet with their own desires for personal satisfaction. This could possibly change the reliance on hospital administrators from focusing their efforts on implementing stricter hospital controls to focusing on the needs, desires, and perceptions of their nurses in regards to workplace violence.

Even though the ANOVA analysis showed organizational culture behaviors had a significant correlation to nurse reporting habits, the regression analysis determined that organizational culture behaviors were not significant in predicting nurse reporting

behaviors. Hospitals have seen that overcrowding in emergency departments was one of the elements determined to cause additional stress and anxiety leading to assaultive behavior by patients waiting to receive care (Behnam, Tillotson, Davis, & Hobbs, 2011). Normally, changes in organizational culture can be used to implement actions that effect the way an organization conducts its business and treats its employees. My research showed that while hospital administrators may still be well advised to utilize the aspects of organizational culture to enhance how they conduct business, there was not significant support to show that changes in organizational culture may affect nurse reporting of patient assaults.

To cause social change, the data collected from my research could assist with an understanding of how the potential victims of patient-inflicted assaults perceive and utilize the implementation of penalty enhancement laws. Sixty-five percent of the nurses who participated in the survey agreed that they were aware of penalty enhancement laws in their state that increased the level of punishment on individuals who assaulted nurses while on duty. Thirty-six percent of the participating nurses agreed that increased legal penalties such as fines or jail terms for patients who physically assault nurses would help to decrease the rate of assaults in their facility. Twenty-eight percent of the responding nurses agreed that if their state implemented a penalty enhancement law that increased the punishment for patients who assault nurses, they would be more likely to file a formal report of the incident. Even with 65% of the respondents being aware of penalty enhancement laws in their states, only 2% of the respondents who had been a victim of patient-inflicted assault pursued legal actions that would have taken advantage of these

laws. Additionally, when asked how strict penalty enhancement laws should be in their state, 65% of the nurses responded that there should be no financial limit on monetary fines and 56% responded that there should be no limit on maximum jail terms. When broken out by state, a clearer picture was seen as to how the implementation of penalty enhancement laws compared to what nurses expected (see Table 13).

Table 13

Comparison of State Penalty Enhancement Laws to Nurse Responses

State	Current Max Fine	Current Max Jail term (years)	Aware of a PE law in their state	Agree laws would reduce assaults	Agree would file a report if there was a law	Agree with state's max fine or above*	Agree with state's max jail term or above*	% of times assault reported to police
MD	No Law	No Law	94%	13%	7%	87%	67%	0%
NY	Not Stated	7	73%	27%	13%	93%	93%	0%
NJ	$15,000	3-5	47%	53%	35%	82%	76%	11%
PA	$25,000	10	69%	38%	45%	62%	41%	5%
MA	$5,000	2-5	42%	42%	33%	83%	75%	0%
D.C.	No Law	No Law	90%	26%	11%	100%	84%	1%

Note. *If the state did not have a law in place the minimum responses of $500 fine or 2.5 years of jail term were used

As shown in Table 13, for the four of the six regions surveyed with a penalty enhancement law in place, the majority of nurses responded that they believed the fine or jail term for patients who assault nurses while on duty aligned with the state's current law. The only exception was Pennsylvania where only 41% agreed with the maximum jail term being 10 years or more. The remaining 59% believed the jail term should be lower. One of the most significant implications that can be seen from the responses in Table 13 was the difference between the percent of nurses who replied that they would report assaults to law enforcement if there were a penalty enhancement law in their state

and the percent of assaults they actually reported. With the exception of Massachusetts and New Jersey, the majority of respondents claimed they were aware of the penalty enhancement laws in their state. However, as seen from the responses, there was still an exceptionally low reporting rate to law enforcement even though the respondents claimed they were aware of the laws and agreed with the imposed penalties for the perpetrators.

To address social change, the implementation of penalty enhancement laws passed by state legislatures to increase the protection of nurses may need to be re-evaluated. The data collected from this survey do not necessarily show support for these laws increasing the propensity for emergency department nurses to participate in the judicial process and report assaults that could have the potential to reduce future incidents.

Recommendations for Action

When individuals are assaulted, trending of the risk of future assaults is difficult to monitor and track if the incidents are not reported (Gifford, & Anderson, 2010; Planty, & Strom, 2007). As per the responses collected from the emergency department nurses in my study, the presence of penalty enhancement laws may not be the best motivational factor to influence nurse-reporting habits of patient-inflicted assaults. Rational choice actions were shown to have a significant influence on reporting habits. Since nurses have responded to this survey that personal gains were important to the decision-making process, additional actions may be recommended that would increase a willingness to report assaults. For example, victim assistance programs are focused on helping the victims deal with and recover from being a victim of a crime. Focus on this area may

increase the propensity for nurses to report assaults as my study showed a significant influence rational actions have on the decision-making process for nurses after being a victim of assault.

Organizational culture was not shown to have a significant explanation for nurse reporting behaviors based on the data collected for the regression analysis in my study. Additional changes in organizational culture could possibly have an effect if hospital administrators re-evaluated how they approach the topic of patient assaults on nurses. This could include a culture of more approachable administration or a complete re-design of how administrators get directly involved with the concerns and needs of their front-line employees. Schein (2010) discussed the need for leaders of an organization to sometimes have to completely break down the way they handle aspects of their business and start again from scratch. A lack of organizational culture influence on reporting behaviors could indicate that nurses are not aware of any support from leaders in their facility or an actual absence of support from administration. Re-evaluating how an organization handles the support of their employees after being a victim will need to start and be supported from the top levels in order to be effective (Schein, 2010). Changing the culture of hospitals would be a long-term proposal, however, based on the lack of influence these elements had in my study, it may be an area that hospital administrators might want to explore.

Recommendations for Further Study

My quantitative study focused on emergency department nurses working in academic hospitals in Mid-Atlantic Regions and their reporting habits of patient-inflicted

physical assaults. Further research should be conducted in other regions of the United States or on a complete nation-wide approach. This could provide a wider assessment of the assault reporting process as described in Chapter 2. Additional research should be conducted to compare the responses from nurses working in non-academic hospitals in urban environments and in community hospitals in rural environments. This could be used to explore differences in nursing behaviors between different work environments as the same perceptions or solutions may not be applicable across geographic regions or facility structures. For example, are organizational culture behaviors more important in smaller community hospitals? Are rational choice decisions affected by the level of community involvement? Are state laws more effective when they have been in effect for longer periods of time? My study could be used as a foundation for further research in these areas.

Implications for Future Research

Different nurses may view the pros and cons of formally reporting patient-inflicted patient assaults in different ways based on their personal perspectives. For example, an emergency department nurse may perceive the relevance of reporting an assault differently than a nurse working in an intensive care unit or in a pediatric or psychology ward. Further research could be conducted with nurses working at different units within hospitals to determine variances in the levels of importance for reporting patient assaults and what affects their propensity to report assaults.

My research explored emergency department nurse-reporting behaviors of patient-inflicted assaults across academic hospitals in the Mid-Atlantic Region. Some

additional reporting research considerations are implications for future research. Some of these additional areas of concern for future research include the following:

- Do nurse incident-reporting behaviors change after they have participated in the legal prosecution of a patient who has physically assaulted them?
- What is the effect of hospital provided victim assistance programs on incident-reporting behaviors of nurses after being a victim of physical assault?
- What additional research can scholars provide to hospital administrators and state policy makers that encourage a participative culture from nurses who have been the victim of patient-inflicted assaults?
- What additional research methods can be utilized to further understand the decision-making process of nurses when determining whether or not to report physical assaults inflicted upon them by a patient?

Biases and Effects

In my research, I may have formulated biases. As a professional in the field of healthcare administration, I assumed that emergency department nurses in academic hospitals would not have a high propensity to report patient-inflicted assaults. My initial views assumed that emergency department nurse reporting habits were as stated in the null hypothesis of the two research questions. However, the data I collected caused for a rejection of the null hypothesis in the first research question related to rational choice actions. Controlling for selected variables, the data also produced an unanticipated result that penalty enhancement laws would not have any effect on reporting behaviors. I also assumed that the emergency department nurses working daily with the patients were the

most knowledgeable individuals to provide responses to how patient assault incidents were handled. In order to protect the confidentiality of the respondents, the survey was anonymous so I cannot confirm or deny this assumption.

Conclusion

Physical assaults on nurses continue to be an area of concern for both nurses and healthcare organizations. My study assessed the propensity of emergency department nurses working in academic hospitals in the Mid-Atlantic Region to formally report these assaults. In my research, I described the theoretical framework of rational choice and organizational behavior. I provided information on the relationship between reporting habits and rational choice decisions. Within my research, I provided a critical review of the literature and focused on the history of the victimology, how organizational culture effects employee behavior, and how rational choice actions can affect victim responses to assaults. Additionally, the review of the literature demonstrated how assaults on nurses continues to be an area of concern in light of the implementation of numerous forms of physical and administrative security controls within hospitals. I also presented a key issue in the effectiveness of states implementing penalty enhancement laws that were designed to provide a layer of protection for nurses from patient-inflicted assaults. The findings from my study offered recommendations for social changes for hospital leaders and state legislators in assessing and developing control measures to provide protection for nurses from future assaults. This included suggestions for future research concerning assault-reporting habits across different levels of hospital care and across different demographics.

While the literature showed that hospital administrators and political leaders have understood the seriousness of these assaults and have implemented control measures at different levels, assault rates continue to remain consistent while reporting levels remain low. Using the factors of rational choice, organizational behavior, and the presence of penalty enhancement laws, I explored the gap of knowledge by quantitatively measuring the assault-reporting habits of emergency department nurses in the Mid-Atlantic Region after being the victim of assault perpetrated upon them by one of their patients. There was a measurable relationship between these factors, but increased awareness of these incidents indicates that there are more challenges to confront before a positive change can be recognized. Hospital leaders, political officials, and the nursing community should be willing to confront these challenges in an open and shared discussion in the hopes of developing controls to mitigate the risk of future assaults.

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Appendix A: Survey Instrument

EMERGENCY DEPARTMENT NURSES ASSAULT REPORTING SURVEY

General Questions

1. What is your age?
   □ _____

2. What is your gender?
   □ Male □ Female

3. How many years of work experience as an emergency department nurse do you have?
   □ _____

4. In what state/district are you employed as a nurse in an emergency department?
   □ Maryland □ Washington D.C. □ Massachusetts
   □ New York □ New Jersey □ Pennsylvania

5. What is your normally scheduled work shift?
   □ Days □ Evenings □ Nights □ Weekends

6. Are you a member of an organized labor union?
   □ Yes □ No

7. Are you a member of a professional nursing organization?
   □ Yes □ No

8. The number of staff present in the same work setting with you during most (more than 50%) of your work time is:
   □ None □ 1-5 □ 6-10 □ 11-15 □ Over 15

Workplace Violence Questions

9. In your perception, how many times in the last 1-2 years have you been a victim of physical assault from a patient in your workplace?
   □ _____

10. How many times in the last 1-2 years have you been a victim of physical assault from a patient while on duty and only told a co-worker or supervisor about the incident?
    □ _____

11. How many times in the last 1-2 years have you been a victim of physical assault from a patient while on duty and filed a formal report of the incident with your hospital administration?
    □ _____

12. How many times in the last 1-2 years have you been a victim of physical assault from a patient while on duty and filed a formal report of the incident with the police?
    □ _____

Organization Questions

13. If you were a victim of physical assault from a patient, were actions taken to investigate the causes of the incident by: (check all that apply). If you were not a victim, skip to question 16.
    □ Management/employer □ Union □ Professional Association
    □ Community group □ Police □ No One

14. If you were a victim of physical assault from a patient, what were the consequences for the patient who assaulted you? (check all that apply)
    □ None □ Verbal warning issued
    □ Care discontinued □ Reported to police
    □ Aggressor prosecuted □ Don't know

15. If you were a victim of physical assault from a patient, please provide your response to the following statement "I was satisfied with the manner in which the incident was handled by my facility."
    □ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

16. My organization embraces a culture that belays my worries about violent assaults from patients.
    □ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

17. My facility has policies and procedures in place for the reporting of violence in my workplace.
    □ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

18. My facility provides me with training on policies explaining workplace violence and how to use the incident reporting procedures when a victim.
    □ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

19. I am encouraged to report incidents of workplace violence by: (check all that apply)
    □ No one □ Family/Friends □ Colleagues □ Union □ Supervisor □ Administration

20. I think the hospital should be responsible for preventing incidents of patient assaults on nursing.
    □ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

21. I believe incidents of patients physically assaulting nurses are related to my facility considering workplace violence to be acceptable behavior.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

22. I feel that nurses would be supported by my hospital to formally report incidents of physical assaults by patients.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

23. My hospital supports state penalty enhancement laws for stricter prosecution of patients who assault nurses.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

24. My Union or Professional Nursing Organization supports state penalty enhancement laws for stricter prosecution of patients who assault nurses.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

Individual Questions

If you were the victim of physical assault from a patient more than once in the previous 1-2 years, please answer the following questions based on the one incident which you perceived to be the most severe. If you were not a victim, skip to question 28.

25. How did you respond to the incident? (check all that apply)
□ Took no action
□ Told the person to stop
□ Told friends/family
□ Told a colleague
□ Transferred to another position
□ Completed incident/accident form
□ Completed a compensation claim
□ Tried to pretend it never happened
□ Tried to defend myself physically
□ Sought counseling
□ Reported it to a senior staff member
□ Sought help from association
□ Pursued prosecution
□ Sought help from the union

26. If you did not report or tell anyone about the incident, why not? (check all that apply)
□ Did not feel it was important
□ Felt ashamed
□ Did not know how to report it
□ Felt nothing would be done if reported
□ Afraid of negative consequences
□ Felt guilty
□ Reporting process takes too much time
□ Didn't blame the patient for their actions

27. After the assault, I considered the pros and cons to me personally of following through with formal prosecution procedures against the patient before making my decision on how I would report the incident.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

28. I would be more willing to report incidents of physical assaults if I knew I would not have to face the risk of confronting the patient or their family in court at a later date.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

29. I feel that there would be retaliation against me by hospital management for filing an assault report with law enforcement against a patient who physically assaulted me while I was on duty.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

30. I believe I should be financially compensated by the hospital for my time spent in the judicial process when taking legal actions against a patient who assaulted me (i.e., police interviews, depositions, court appearances, etc.)
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

31. I am aware of penalty enhancement laws in my state that implement a mandatory increase in the level of punishment for patients who physically assault a nurse.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

32. I believe that increased legal penalties such as fines or jail terms for patients who physically assault nurses will help to decrease the rate of assaults in my facility.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

33. If my state implemented a penalty enhancement law that increased the punishment for patients who assault nurses, I would be more likely to file a formal report of the incident.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

34. I believe that the appropriate maximum fine imposed on a patient who physically assaults a nurse while on duty should be:
□ No Fine □ $500 □ $5,000 □ $15,000 □ $25,000 □ No Limit

35. I believe the appropriate maximum jail term for a patient who physically assaults a nurse while on duty should be:
□ No Jail Time □ 2.5 years □ 5 years □ 7 years □ 20 years □ No Limit

36. In the future, if a patient assaulted me while I was on duty, I would file a formal report with law enforcement.
□ Completely Disagree □ Disagree □ Neutral □ Agree □ Completely Agree

Appendix B: Consent Form

CONSENT FORM

(Implied Consent)

You are invited to take part in a research study of patient assaults on emergency department nurses in the Mid-Atlantic Region. You were invited for the study because you are an emergency department nurse working in an academic medical center. This form is provided to you as "informed consent" so you may understand this study before making your decision whether to participate or not.

A researcher named Thomas I. Runkle, who is a doctoral student at Walden University, is conducting this study.

Background Information:
The purpose of this study is to explore incidents of physical assaults by patients on emergency department nurses. This study seeks to identify factors relating actions taken by emergency department nurses after being a victim of assault and decision-making influences from the environment. Data will be collected from academic medical centers in the Mid-Atlantic Region to determine the current reporting behaviors of individual nurses after being a victim and what factors affect the decision-making process.

Procedures:
If you agree to participate in this study, you will be asked to:

- Complete an online 36-question survey.
- This survey generally takes 10-15 minutes to complete. However, please take as long as you wish.
- Please **DO NOT** fill in your name anywhere on the survey.
- After completing the survey on line, simply press *Done* and close out of the survey.

Voluntary Nature of the Study
Your participation in this study is voluntary. This means that your decision of whether or not to be in this study will be confidential and respected. No one in your hospital will be able to be informed of your decision so you will not be treated any differently if you decline from being a part of this study. If you feel stressed during the study you may stop at any time. You should also feel free to skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:
There are no foreseeable risks to this study. Your responses to this survey will remain anonymous and will not identify you or your hospital in the results. The data collected

through responses to this survey will be aggregated into a sample set of data and will not identify specific hospitals or people. The expected benefits of this study will be the contribution to knowledge and insight to the reporting of patient assaults by emergency department nurses and knowledge of penalty enhancement laws designed to provide judicial support to nurses working in the Mid-Atlantic Region.

You can be provided with a copy of the completed dissertation or a summary of the analysis and findings of the study.

Compensation:
There is no anticipated compensation to this study.

Confidentiality:
Any information you provide in response to this survey will be kept anonymous. Your information will not be used for any purposes outside of this research project. In addition, the researcher will not include your name, your hospital's name, or any other elements that could identify you in any part of the research.

Contacts and Questions:
You may ask any questions you have now by email. Or if you have questions later, you may contact the researcher via email. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is 02-09-16-0193884 and it expires on February 8, 2017.

You may print this Consent Form for your records.

Statement of Consent:
I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By opening the link below and participating in the survey, I am agreeing to the terms described above.

Appendix C: Hospital Invitation to Participate

TO: (hospital contact name/title)

FROM: Thomas I. Runkle
PhD Doctoral Candidate
Walden University

DATE: (date of mailing)

SUBJECT: Doctoral Research of Assaults on Emergency Department Nurses

I am a Doctoral Student with Walden University conducting research to determine reporting actions taken by emergency department nurses in response to being a victim of physical assault from a patient. The sample for this research is taken from academic medical centers in the Mid-Atlantic Region. I am writing to ask for your willingness to share this survey with the nurses working in your Emergency Department and requesting them to participate in this research study. Professionally, I am the Associate Administrator at Hahnemann University Hospital in Philadelphia, PA. This study is the subject of my doctoral dissertation and is not associated with Hahnemann University Hospital, Drexel University, or Tenet Health System.

Your Emergency Department nurses are invited to participate in a research study that examines the reporting of assaults on nurses by patients and nursing perceptions of state penalty enhancement laws that have been implemented to increase the legal level of crime classification and minimal charges brought against offenders who assault nurses working in emergency departments. Only nurses employed in emergency departments of academic medical centers located in metropolitan areas of Massachusetts, New York, New Jersey, Pennsylvania, Maryland, and Washington, D. C. are eligible to participate in this study. The purpose of this study is to better understand nurse-reporting behaviors of patient assaults and any possible effect penalty enhancement laws have had on those behaviors. Participation in this study is voluntary. There are no foreseeable risks or discomforts to participating in this survey. By accessing the controlled Internet site, the participants are providing their voluntary consent to participate in this survey.

The anticipated benefits of this study will be the contribution to knowledge and insight to the reporting of patient assaults by emergency department nurses and knowledge of penalty enhancement laws designed to provide judicial support to nurses working in the Mid-Atlantic Region. There is no anticipated compensation for participation in this study. Participants should keep a copy of the consent form and for additional information contact Dr. Leilani Endicott, Research Participant Advocate.

Your emergency department nurses are asked to complete the *Emergency Department Nurses Assault Reporting Survey*, a 36 question Internet-based survey. All surveys are

coded; therefore the identity of the respondent and hospital will be protected. This survey should take approximately 10-15 minutes to complete. Please ask all emergency department nurses to answer the survey from their own perspective.

All information gathered as part of this research will be held in the strictest confidence. At no time will any information regarding specific participants or hospitals be released to any individuals or institutions. It is possible that the analysis of this information will be published in the future. However, at no time will your name, the names of the participating nurses, your hospital's name, or any other identifying information be used.

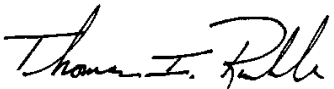
If you would like an electronic copy of my completed dissertation or if you would like a summary of the analysis of my findings from this study, please feel free to request one by emailing me.

I have obtained IRB approval from Walden University to conduct this research. Walden University's approval number for this study is 02-09-16-0193884 and it expires on February 8, 2017. If your hospital requires me to go through your IRB process before inviting your employees to participate in a survey, I would request that you please provide me with their contact information so I can obtain the appropriate approvals.

If your hospital does not require their own IRB approval, I would request that you please forward the attached **CONSENT FORM** to your emergency department nurses so they can have an opportunity to participate in this survey.

If you have any questions about this study, please feel free to contact me through the information listed below.

Thank you,



Thomas I. Runkle, PhD Doctoral Candidate
Walden University
Public Policy & Administration Ph.D. Program

Appendix D: Follow-up Email to Participants

From: Thomas I. Runkle
To: (Insert name of participant)
Subject: Follow-up to Emergency Department Nurses Assault Reporting Survey

Dear Chief Nursing Officer,

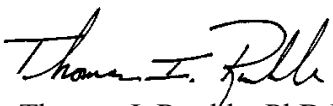
I hope this message finds you well. If you have already forwarded the *Emergency Department Nurses Assault Reporting Survey* to your emergency department nurses, thank you for your participation! The responses of the nurses is essential to assessing the reporting habits of patient assaults on nurses and the corresponding information relating to penalty enhancement laws in the Mid Atlantic Region.

If you have not had a chance to encourage your emergency department nurses to complete the survey yet, they are still invited to participate in the *Emergency Department Nurses Assault Reporting Survey*. All answers are completely anonymous and the participation of your nurses is greatly appreciated. They may complete the 36-question Internet-based survey. This survey should take approximately 10-15 minutes to complete. Please request that your emergency department nurses answer the survey from their own perspective.

All information gathered as part of this research will be held in the strictest confidence. At no time will any information regarding specific participants or hospitals be released to any individuals or institutions. It is possible that the analysis of this information will be published in the future. However, at no time will your name, the names of the participating nurses, your hospital's name, or any other identifying information be used.

Please print or forward this email to your emergency department nurses and ask them to participate in this survey by accessing the Internet link. If you have any questions or concerns, please feel free to contact me.

Thank you,



Thomas I. Runkle, PhD Doctoral Candidate
Walden University
Public Policy & Administration Ph.D. Program

Appendix E: Permission of Original Author

From: Thomas I. Runkle
To: Laura Sminkey, Communications Officer, World Health Organization
Subject: Request Permission to use Workplace Violence in the Health Sector Survey

Ms. Sminkey:

I hope this letter finds you well. As a career hospital administrator, I greatly appreciate the dedicated work and research that you and your colleagues at the World Health Organization have provided over the years. In addition to my professional career, I am a doctoral student at Walden University in the Public Policy and Administration Ph.D. program, specializing in Public Policy matters. I am defending my proposal in the near future and am preparing to conduct research for my doctoral dissertation.

My research focuses on the reporting habits of emergency department nurses after being the victim of physical assault by a patient. In relation to reporting habits, I am also analyzing any related influences state penalty enhancement laws which implement mandatory increases in offender sentencing for assaulting nurses have on reporting behaviors. I am surveying emergency department nurses working in metropolitan academic hospitals located in the Mid Atlantic Region of the United States. I am requesting permission to utilize specific questions from the Workplace Violence in the Health Sector Country Case Studies Research Instruments Survey Questionnaire (2003), developed by the World Health Organization, International Labour Office, International Council of Nurses, and Public Services International. My research is purely quantitative and focuses on a specific element of workplace violence and a specific area and group of nurses in healthcare facilities. For this reason, I have made some modifications to the survey instrument as follows:

- Removed demographic questions in relation to country, profession, sector, clients
- Removed the verbal abuse, bullying/mobbing, sexual and racial harassment sections
- Removed open-ended questions
- Added unique questions about state penalty enhancement laws
- Added unique question related to the two theories I am testing in my research; organizational culture and rational choice
- Removed any references to WHO, ILO, ICN, PSI in the instrument (but will be credited in the body of the research paper)
- Renamed the survey as the *Emergency Department Nurses Assault Reporting Survey*

The research will be conducted in Massachusetts, New York, New Jersey, Pennsylvania, Maryland, and Washington, D.C. The survey will be sent to Chief Nursing Officers of academic medical centers in metropolitan areas. The Chief Nursing Officers will be requested to provide the survey to their Emergency Department nurses for participation. I have attached a draft copy of the modified survey instrument for your review.

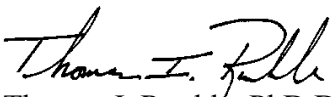
This research will be conducted as a fulfillment requirement in completing the dissertation in the Ph.D. program. My Chair is Dr. Mark Devirgilio.

I hope that you are the correct person to send this request for permission to use this survey instrument in the modified form as stated. If there is someone else I should contact for permission, that information would be greatly appreciated.

Additionally, I have been attempting to find published statistical data that has been collected in regards to the validity and reliability of the original survey instrument but have had no success up to this point. If you are aware of any published data, I would be grateful for any information you could share.

I look forward to your response. Thank you for your time and consideration.

Respectfully,



Thomas I. Runkle, PhD Doctoral Candidate
Walden University
Public Policy & Administration Ph.D. Program

Original E-Mail
From: SMINKEY, Laura Ann
Date: 01/04/2016
To: Thomas Runkle
Subject: Permission to use Workplace Violence in the Health Sector Survey

Dear Thomas,

Many thanks for your email and your interest in this topic.

You have our permission to use the survey instrument in its modified form. We ask simply that you note that this is a modified version of the original which may be found on WHO's web site.

This project when it was initiated years ago was led by another department in WHO, and the person who was in charge has retired. We maintain the pages related to this project on our departmental web site, but I am not sure if there is anyone anymore at WHO who is working specifically on this topic. Having said that there is some attention given to the topic in the context of humanitarian relief efforts, which you can read about here: http://www.who.int/mediacentre/events/2015/world-humanitarian-day/en/

Given this, I am not aware of any data generated by use of this survey instrument, but perhaps my colleague, Berit, may be able to advise.

Kind regards, Laura

Appendix F: Reliability of Survey Instrument

Table F1

Case Processing Summary

Case Processing Summary

		N	%
Cases	Valid	66	100.0
	Excluded[a]	0	.0
	Total	66	100.0

a. Listwise deletion based on all variables in the procedure.

Table F2

Reliability Statistics

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.579	.636	3

Appendix G: Correlation Matrix of Data for Research Question 1

Table G1

Correlation Matrix

		How RN Responds	Why Not Report	Pros and Cons	No Confront	Hosp. Retal.	Financial Comp.	Aware of Laws	Laws < Assault	Laws > Report
How RN Respond	Pearson's (r)	1	-.014	.538**	-.223*	-.153	.434**	.490**	-.004	.073
	Sig. (2-tailed)		.887	.000	.021	.117	.000	.000	.968	.456
	Sum of Squares	27104.355	-123.047	1261.308	-543.037	-278.561	1012.682	1069.187	-8.168	141.075
	Covariance	255.701	-1.161	11.899	-5.123	-2.628	9.554	10.087	-.077	1.331
	N	107	107	107	107	107	107	107	107	107
Why Not Report	Pearson's (r)	-.014	1	.386**	-.042	.214*	.218*	.048	.044	.101
	Sig. (2-tailed)	.887		.000	.668	.027	.024	.624	.650	.303
	Sum of Squares	-123.047	2872.243	294.196	-33.206	126.916	165.252	34.028	30.075	63.411
	Covariance	-1.161	27.097	2.775	-.313	1.197	1.559	.321	.284	.598
	N	107	107	107	107	107	107	107	107	107
Pros and Cons	Pearson's (r)	.538**	.386**	1	.103	.218*	.342**	.361**	.011	.140
	Sig. (2-tailed)	.000	.000		.289	.024	.000	.000	.914	.150
	Sum of Squares	1261.308	294.196	202.505	21.757	34.355	68.935	68.215	1.907	23.486
	Covariance	11.899	2.775	1.910	.205	.324	.650	.644	.018	.222
	N	107	107	107	107	107	107	107	107	107
No Confrontation	Pearson's (r)	-.223*	-.042	.103	1	.540**	.164	.014	.438**	.579**
	Sig. (2-tailed)	.021	.668	.289		.000	.091	.883	.000	.000
	Sum of Squares	-543.037	-33.206	21.757	218.636	88.533	34.402	2.822	81.860	100.729
	Covariance	-5.123	-.313	.205	2.063	.835	.325	.027	.772	.950
	N	107	107	107	107	107	107	107	107	107
Hosp. Retal.	Pearson's (r)	-.153	.214*	.218*	.540**	1	.286**	.084	.256**	.406**
	Sig. (2-tailed)	.117	.027	.024	.000		.003	.390	.008	.000
	Sum of Squares	-278.561	126.916	34.355	88.533	122.991	45.028	12.336	35.897	52.935
	Covariance	-2.628	1.197	.324	.835	1.160	.425	.116	.339	.499
	N	107	107	107	107	107	107	107	107	107
Financial Comp.	Pearson's (r)	.434**	.218*	.342**	.164	.286**	1	.564**	.342**	.535**
	Sig. (2-tailed)	.000	.024	.000	.091	.003		.000	.000	.000
	Sum of Squares	1012.682	165.252	68.935	34.402	45.028	200.916	105.991	61.308	89.196
	Covariance	9.554	1.559	.650	.325	.425	1.895	1.000	.578	.841
	N	107	107	107	107	107	107	107	107	107
Aware of Laws	Pearson's (r)	.490**	.048	.361**	.014	.084	.564**	1	.135	.162
	Sig. (2-tailed)	.000	.624	.000	.883	.390	.000		.164	.095

		How RN Responds	Why Not Report	Pros and Cons	No Confront	Hosp. Retal.	Financial Comp.	Aware of Laws	Laws < Assault	Laws > Report
	Sum of Squares	1069.187	34.028	68.215	2.822	12.336	105.991	175.888	22.701	25.355
	Covariance	10.087	.321	.644	.027	.116	1.000	1.659	.214	.239
	N	107	107	107	107	107	107	107	107	107
	Pearson's (r)	-.004	.044	.011	.438**	.256**	.342**	.135	1	.701**
Laws	Sig. (2-tailed)	.968	.650	.914	.000	.008	.000	.164		.000
Decrease	Sum of Squares	-8.168	30.075	1.907	81.860	35.897	61.308	22.701	159.869	104.280
Assaults	Covariance	-.077	.284	.018	.772	.339	.578	.214	1.508	.984
	N	107	107	107	107	107	107	107	107	107
	Pearson's (r)	.073	.101	.140	.579**	.406**	.535**	.162	.701**	1
Laws More	Sig. (2-tailed)	.456	.303	.150	.000	.000	.000	.095	.000	
Willing	Sum of Squares	141.075	63.411	23.486	100.729	52.935	89.196	25.355	104.280	138.542
Report	Covariance	1.331	.598	.222	.950	.499	.841	.239	.984	1.307
	N	107	107	107	107	107	107	107	107	107

**. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Appendix H: Correlation Matrix of Data for Research Question 2

Table H1

Research Question 2 Correlation Matrix

		RN Sat.	Org Cult Belays	Policies	Training	Hosp. Resp.	Acceptable Behavior	Supp. Report	Hosp. Laws	Union Laws
Satisfaction	Pearson's (r)	1	.572**	.464**	.473**	-.263*	-.569**	.453**	.343**	.123
	Sig. (2-tailed)		.000	.000	.000	.033	.000	.000	.005	.325
	Sum of Squares	100.258	49.394	37.439	40.515	-19.030	-53.167	35.136	22.515	7.788
	Covariance	1.542	.760	.576	.623	-.293	-.818	.541	.346	.120
	N	66	66	66	66	66	66	66	66	66
Org Cult Belays	Pearson's (r)	.572**	1	.544**	.553**	-.170	-.641**	.555**	.420**	.091
	Sig. (2-tailed)	.000		.000	.000	.173	.000	.000	.000	.467
	Sum of Squares	49.394	74.485	37.848	40.788	-10.576	-51.667	37.091	23.788	4.970
	Covariance	.760	1.146	.582	.628	-.163	-.795	.571	.366	.076
	N	66	66	66	66	66	66	66	66	66
Policies	Pearson's (r)	.464**	.544**	1	.840**	-.150	-.427**	.535**	.395**	.406**
	Sig. (2-tailed)	.000	.000		.000	.228	.000	.000	.001	.001
	Sum of Squares	37.439	37.848	64.985	57.879	-8.758	-32.167	33.409	20.879	20.697
	Covariance	.576	.582	1.000	.890	-.135	-.495	.514	.321	.318
	N	66	66	66	66	66	66	66	66	66
Training	Pearson's (r)	.473**	.553**	.840**	1	-.212	-.518**	.533**	.482**	.344**
	Sig. (2-tailed)	.000	.000	.000		.088	.000	.000	.000	.005
	Sum of Squares	40.515	40.788	57.879	73.030	-13.061	-41.333	35.273	27.030	18.576
	Covariance	.623	.628	.890	1.124	-.201	-.636	.543	.416	.286
	N	66	66	66	66	66	66	66	66	66
Hosp. Responsible	Pearson's (r)	-.263*	-.170	-.150	-.212	1	.203	.115	.041	-.025
	Sig. (2-tailed)	.033	.173	.228	.088		.103	.356	.744	.841
	Sum of Squares	-19.030	-10.576	-8.758	-13.061	52.121	13.667	6.455	1.939	-1.152
	Covariance	-.293	-.163	-.135	-.201	.802	.210	.099	.030	-.018
	N	66	66	66	66	66	66	66	66	66
Acceptable Behavior	Pearson's (r)	-.569**	-.641**	-.427**	-.518**	.203	1	-.616**	-.446**	-.090
	Sig. (2-tailed)	.000	.000	.000	.000	.103		.000	.000	.470
	Sum of Squares	-53.167	-51.667	-32.167	-41.333	13.667	87.167	-44.500	-27.333	-5.333
	Covariance	-.818	-.795	-.495	-.636	.210	1.341	-.685	-.421	-.082
	N	66	66	66	66	66	66	66	66	66
Hosp. Supp. Report	Pearson's (r)	.453**	.555**	.535**	.533**	.115	-.616**	1	.596**	-.017
	Sig. (2-tailed)	.000	.000	.000	.000	.356	.000		.000	.894

		RN Sat.	Org Cult Belays	Policies	Training	Hosp. Resp.	Acceptable Behavior	Supp. Report	Hosp. Laws	Union Laws
	Sum of Squares	35.136	37.091	33.409	35.273	6.455	-44.500	59.955	30.273	-.818
	Covariance	.541	.571	.514	.543	.099	-.685	.922	.466	-.013
	N	66	66	66	66	66	66	66	66	66
Hosp. Supp. Laws	Pearson's (r)	.343**	.420**	.395**	.482**	.041	-.446**	.596**	1	.086
	Sig. (2-tailed)	.005	.000	.001	.000	.744	.000	.000		.491
	Sum of Squares	22.515	23.788	20.879	27.030	1.939	-27.333	30.273	43.030	3.576
	Covariance	.346	.366	.321	.416	.030	-.421	.466	.662	.055
	N	66	66	66	66	66	66	66	66	66
Union Supp. Laws	Pearson's (r)	.123	.091	.406**	.344**	-.025	-.090	-.017	.086	1
	Sig. (2-tailed)	.325	.467	.001	.005	.841	.470	.894	.491	
	Sum of Squares	7.788	4.970	20.697	18.576	-1.152	-5.333	-.818	3.576	39.939
	Covariance	.120	.076	.318	.286	-.018	-.082	-.013	.055	.614
	N	66	66	66	66	66	66	66	66	66

**. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Appendix I: Multiple Regression Analysis

Figure I1

Organizational Culture Histogram

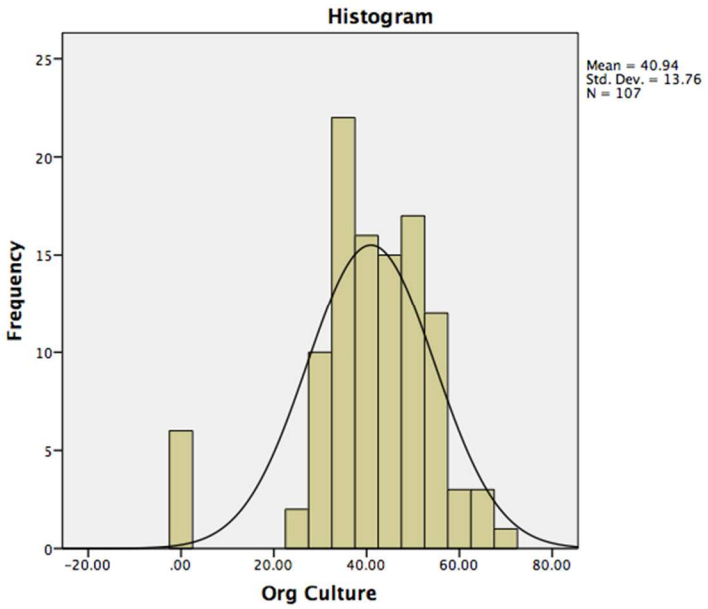
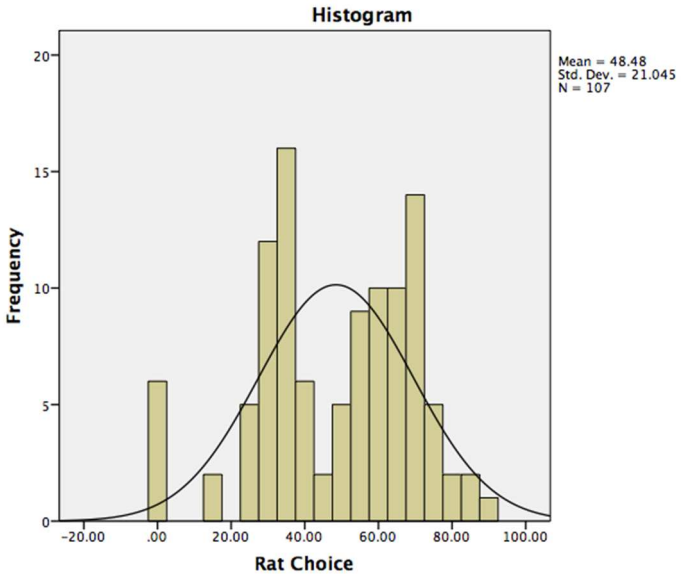


Figure I2

Rational Choice Histogram



Appendix J: P-Plot of Nursing Assault Reporting

Figure J1

P-P Plot for Dependent Variable