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Barriers to Reporting Workplace Violence in Emergency Departments: A Systematic Review

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Walden University
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MS, California State University, Fullerton, 2015

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Project Submitted in Partial Fulfillment

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Abstract

Underreporting of workplace violence by emergency department (ED) nurses is a global practice concern. When workplace violence is not reported, the breadth of the issue is not reflected in the data, which is necessary to support legislative action, regulatory requirements, and organizational changes to prevent violence. The purpose of this systematic review of literature was to appraise and synthesize evidence regarding ED nurses' barriers to reporting workplace violence. The practice-focused question addressed the barriers to reporting workplace violence according to emergency nurses. The theory of planned behavior was the theoretical framework for this project. Melnyk and Fineout-Overholt's critical appraisal of evidence was used to evaluate the level of evidence of studies included in the systematic review. Quality of evidence was evaluated using the appropriate EQUATOR Network reporting tools. The search for evidence was conducted through scholarly databases and citation searches and yielded 189 articles for review, of which 7 articles met inclusion criteria and addressed the practice-focused question. The evidence revealed the barriers experienced by ED nurses include workplace violence comes with the job, lack of physical injury, reporting processes, lack of support, and emotional influences. Further research is needed to address the cultural acceptance of workplace violence experienced by ED nurses. The findings of this systematic review of literature can be used to improve training, processes, and perceptions regarding the reporting of workplace violence. This will result in positive change by improving reporting of violence, identify additional interventions to reduce acts of violence against emergency nurses.

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Dedication

This project is dedicated to all nurses and particularly ED nurses who sought a career in caring for others during their worst times only to risk their own personal physical and mental health and future ability to work. As human beings, we are just as important as those we care for. We do not deserve to go to work and be harmed at the hands of those we help. Violence directed at another is a behavior separate from illness and the person. Reporting all acts of violence is imperative to protecting ourselves, our profession, and support the care of all patients by creating safer work environments.

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I would like to thank Dr. Anna Valdez for all of her support and guidance through the completion of this project. Without her, I do not know if I could have completed this. I would also like to thank my husband Randy for being my rock and embracing my passion to push myself to continuously learn and grow. I would also like to thank my daughter Siera for being the reason I became a nurse in the first place. To the rest of my family, Frank, Mary, Juli, Todd, Phil, and Scott thank you for encouraging me to achieve my aspirations.

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Section 1: Nature of the Project

Introduction

The emergency department (ED) is a dynamic patient care setting that provides stabilizing care for patients of all ages, conditions, acuities, cultures, and religions. As a result, the environment of care is fast-paced, chaotic, stressful for patients and staff, and often impersonal, which contributes to a high risk for violence (Koller, 2016). According to the United States Department of Labor Bureau of Labor Statistics (BLS, 2018), violence against healthcare workers was responsible for 12.2% of all injuries sustained by nurses and occurred at a rate of 12.7 per 10,000 full-time employees. This is more than three times the rate of any other industry, which occurs at a rate of 3.8 per 10,000 full time employees (BLS, 2018). The most common source of violence in healthcare are patients or visitors (The Joint Commission [TJC], 2018). However, only 30% of nurses who experience workplace violence report it, thereby underreporting experienced workplace violence (TJC, 2018). ED nurses have been found to experience physical violence four times as often as nurses in other departments (Gates, Gillespie, & Succop, 2011). Additionally, the Emergency Nurses Association (ENA, 2011) found 65.6% of ED nurses who experienced violence did not file a formal report regarding violence.

The nature of this Doctoral of Nursing Practice (DNP) scholarly project was to conduct a mixed methods systematic review of the literature regarding barriers to reporting workplace violence experienced by ED nurses. Identification of barriers to reporting will allow organizations to implement interventions to improve reporting behaviors, which will allow for accurate data to represent the frequency at which violence

occurs. Accurate reporting of violence has social implications for both ED nurses and patients, as it will allow hospitals to identify additional safety precautions required to provide a safe working environment for healthcare providers and a safe environment for patients to receive care (Koller, 2016).

Problem Statement

Emergencies are stressful for patients and their families. Increased wait times, frustration, and perceived chaos of the environment contribute to a high incidence rate of workplace violence directed at emergency staff (Copeland & Henry, 2017). The nature of the environment and patient-nurse relationships place ED nurses in physical proximity to patients, which can result in emotional, physical, or psychological abuse or violence from patients or visitors (Koller, 2016). The ENA (2011) found 97.8% of violent encounters against emergency nurses were perpetrated by patients with 82% of events occurring in patient rooms. Without reporting workplace violence incidents, the extent of the issue is not reflected by the data. The lack of reporting may incorrectly lead hospital administrators to assume interventions are effective, when in fact they are not (Gillespie, Leming-Lee, Crutcher, & Mattei, 2016). This phenomenon of violence against nurses and other healthcare providers is a concern in all emergency settings.

Local Relevance

In California, there is legislative support for the prevention of workplace violence. In 2014, the governor signed into law SB 1299, which required hospitals to adopt a workplace safety plan into their illness and injury prevention plans to protect their employees against violent and aggressive behaviors in high-risk departments (Padilla,

2014). The requirements of this bill included the updating of California health and safety codes for acute care hospitals to include a workplace safety plan. One of the requirements is education of staff regarding how to report violence internally and to local law enforcement (Padilla, 2014). The hospital is also obligated to investigate reports, report to the California Occupational Safety and Health Administration (Cal/OSHA), and maintain records for 5 years, in addition to other requirements (Padilla, 2014).

The California Department of Industrial Relations (DIR) obtains workplace violence data and posts a report online, which was one requirement of SB 1299. In February 2019, 5 years after the passage of the bill, the first report was published online for the reporting period from October 2017 through September 2018. During this period, there were 9,436 reports: 93% from acute care hospitals and 7% from psychiatric facilities (DIR, 2019). Among the incidents reported, 43% of violence resulted in injury, with 93% of offenders being patients and 3% of offenders being someone with the patient (DIR, 2019). However, of the 9,436 reports, law enforcement was contacted 9% of the time, and assistance was requested from hospital security 50% of the time (DIR, 2019). This is consistent with the ENA (2011) findings that demonstrated workplace violence is underreported in emergency settings.

Despite the requirements of California hospitals to implement a workplace violence prevention plan, workplace violence still occurs. Senate Bill 329 was proposed in California in February 2019 and required hospitals to post signage stating that the workplace does not tolerate violence toward staff and assaults and batteries are crimes, which can lead to criminal convictions (Rodriquez, 2019). Through the legislative

process, it was later determined a law already existed that penalized perpetrators with assault or battery of healthcare professionals and carried the same penalties as law enforcement if the violence occurred on the grounds of the hospital. Amendments to the bill have been proposed to include hospital property, inside and outside, inpatient, and outpatient settings (Rodriquez, 2019). However, without reporting experienced violence, aggressors cannot be held accountable for their actions and improvements will not be made to address this problem.

Additionally, there was pending federal legislation with the 116th Congress. Senate Bill 851 and House of Representatives 1309 Workplace Violence Prevention for Health Care and Social Services Worker Act of 2019 is like California's SB 1299. If passed, its requirements would apply to all hospitals in the United States that receive Medicare funding (H.R. 1309, 2019; S. 851, 2019). However, without reporting experienced violence, amendments to legislation and healthcare policies will be impeded.

Significance for Nursing Practice

Workplace violence is one of the most complex and dangerous occupational hazards facing nurses (Koller, 2016). Barriers to reporting workplace violence must be addressed to fully understand the extent of issues facing ED nurses and their ability to provide safe patient care to their assigned patients. Hospitals have an ethical obligation to provide safe working conditions for their staff and a safe environment for their patients (Copeland & Henry, 2017). However, when hospitals are unaware of the actual number of violent events that occur, they will incorrectly believe their interventions are working

and this will hinder the development of additional interventions to mitigate the risk, support nurses, and protect their patients (Koller, 2016).

Purpose

The purpose of this systematic review was to evaluate perceived barriers to reporting workplace violence experienced by ED nurses. Underreporting violent events can undermine a safe work environment. Emergency nurses do not routinely report violence (Speroni, Fitch, Dawson, Dugan & Atherton, 2014). Without reporting, the extent of the issue is not fully realized, and incidents of violence may not be assessed to determine methods to mitigate risk. For interventions aimed to address workplace violence, administrators need to analyze incidents and circumstances in which they occur, which necessitates the reporting of all workplace violence incidents (Gillespie et al., 2016). When ED staff is selective in reporting, the evaluation of existing interventions will not be reliable and interventions will not be as effective (Gillespie et al., 2016).

Gap in Practice

The gap in practice addressed in my DNP project is the inconsistency between actual experienced violence in the workplace and reports. Studies have been conducted regarding barriers to reporting; however, there are no systematic reviews regarding this practice concern. This doctoral project seeks to understand what is inhibiting ED nurses from reporting workplace violence. In general, failure to report is a significant barrier to improvement (Arnetz et al., 2015). The lack of reporting affects improvement in hospital prevention plan strategies, operations, and policy development. Hospital reporting

systems document adverse events which can be used to determine incident and prevalence rates within an organization (Arnetz et al., 2015). Law enforcement support and legislation are affected by the frequency at which violence is reported by ED staff. Without addressing barriers to reporting workplace violence, strategies aimed at prevention and timely interventions are adversely affected. Inconsistencies in reporting do not accurately reflect the issues nurses are facing. Therefore, existing efforts to address this practice problem may not be effective.

Practice-Focused Question

Accurate reporting of workplace violence has safety implications for ED nurses and their patients. However, recognizing the existence of underreporting experienced workplace violence, the project question explored perceived barriers experienced by ED nurses to assist with the identification of possible interventions for implementation. The systematic literature review evaluated the following practice-focused question: What are barriers to reporting workplace violence according to emergency nurses?

Means of Addressing the Gap in Practice

The DNP project systematically evaluated the gap in practice through the identification of perceived barriers to reporting workplace violence. Critical appraisal of the literature assisted with identifying perceived barriers experienced by ED nurses. Dissemination of the findings from the DNP project to stakeholders will assist hospital administrators in implementing interventions aimed at reducing impediments to reporting, thereby addressing the gap in practice.

Nature of the Doctoral Project

The nature of my doctoral project is a mixed methods systematic review of the literature. Sources of evidence included qualitative, quantitative, and mixed methods studies that address the reporting of workplace violence in the emergency setting. A comprehensive search of the literature was completed using the Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, Cochrane Review, and Joanna Briggs Institute. Databases were searched for studies published between January 1, 2009 and June 30, 2019. Inclusion criteria involved level I-VII studies written in English that explored barriers to reporting violence. Search terms were *workplace violence*, *emergency*, *nurse*, *report*, and *barrier*.

Approach

The *Walden University DNP Systematic Review Manual* was used to guide the project. Using the established research question and inclusion criteria, a comprehensive literature search was completed. Studies selected for inclusion in the systematic review were analyzed for quality and level of evidence using Melnyk and Fineout-Overholt's (2019) process for critically appraising evidence for clinical decision-making. Each step of the process was documented following the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines for a systematic review of the literature (Aromataris & Pearson, 2014). Study selection was documented using the PRISMA flowchart, and study analysis was recorded and presented in a study findings table that displays a synthesis of the evidence.

An assumption of this scholarly project was that ED nurses fail to report experienced workplace violence for various reasons including the patient does not know what they are doing, violence comes with the job, lack of time or support from other staff or department leadership, and personal reasons. Understanding the reasons nurses do not report will assist in determining appropriate interventions to facilitate reporting of violent events, regardless if they sustained an injury or not. Additionally, nurses may be more tolerant of violence from some patients versus others. This tolerance may also contribute to lack of reporting or inconsistencies in reporting intentions and behaviors. Nurse leaders can use findings from this systematic review to reduce barriers to reporting violence, which could improve risk-reduction strategies implemented in emergency settings.

Significance

Stakeholders for this project include healthcare providers, specifically emergency nurses, patients, visitors, and healthcare organizations. With the prevalence of workplace violence, it is essential to study the barriers to reporting workplace violence experienced by ED nurses and the impact on nurse and patient safety. Patient safety is at risk and quality of care is compromised when nurses caring for patients are dealing with sequelae from workplace violence (Ventura-Madangeng & Wilson, 2009). Patient safety is also at risk when experienced ED nurses leave the department or the profession, leaving the ED short staffed or staffed with less experienced nursing staff, which increases risks for errors and increased healthcare costs (Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013; TJC, 2018).

Nurses who experience workplace violence may suffer consequences as a result of exposure to violence, including physical injury (Ashton, Morris, & Smith, 2018). Additionally, personal problems can ensue and impair a person's wellbeing both physically and mentally (Sato et al., 2013). As a result, work performance and personal lives are affected. Dissatisfaction with the ED as a result of workplace violence may result in a reluctance to work in the department and contribute to department and organization recruitment issues (Ashton et al., 2018). Compromises in work performance place organizations at risk and may result in decreases in productivity, low organizational commitment, lawsuits, and reductions in quality care, which increase organizational costs (Ashton et al., 2018).

Patients, nursing staff, healthcare organizations, and their administrators have a vested interest in addressing workplace violence. All four suffer consequences as a result of violence. Addressing barriers to reporting workplace violence is paramount to discovering interventions and development of preventative strategies for mitigating violence and creating a safe patient care environment for nurses to work.

Contributions to Nursing Practice

Identification of barriers to reporting assists with explaining the gap in practice, from experiencing workplace violence to reporting it. Once obstacles are identified, organizations should remove impediments to allow staff to report workplace violence incidents (TJC, 2018). As reporting improves, more data becomes available to analyze. Analysis of data can assist with the development or implementation of evidence-based interventions aimed at preventing, controlling, or responding to workplace violence.

Once initiated, the interventions can then be evaluated for effectiveness. The interventions can be implemented and evaluated for effectiveness with the use of the Plan-Do-Study-Act (PDSA) method to validate performance improvement and decrease exposure to violence.

Transferability

This systematic review was conducted on ED nurses. However, other hospital units and other nursing facilities are exposed to workplace violence as well. Federal legislation for workplace violence prevention encompasses protective measures for all healthcare environments (H.R. 1309, 2019; S. 851, 2019). Experiencing workplace violence is not isolated to the ED or the United States. Violence against healthcare workers is a concern for nurses worldwide (Ashton et al., 2018). Therefore, addressing barriers to reporting workplace violence may be applied to other practice settings.

Implications for Social Change

A goal of this scholarly project was to impact the work environment for ED nurses positively. In identifying barriers to reporting, hospitals can develop interventions designed to bridge the gap between violence and reporting those incidents. Analysis of barriers may lead to the discovery of possible solutions to initiate and increase reporting rates. An increase in timely reporting will facilitate nurse leader's ability to analyze different circumstances that result in violent situations and implement interventions that can result in a safer environment to provide care to patients.

Nurses have the right to personal safety while on the job (Phillips, 2016). Hospitals are required to provide an environment free from dangers known or likely to

cause severe harm or death (TJC, 2018). The effects of workplace violence can be long-lasting; therefore, it is imperative for hospitals to address workplace violence proactively (Wolf, Delao, & Perhats, 2014). The frequency and accuracy of reporting workplace violence is vital, as the data will determine the need for intervention or legitimize current strategies to mitigate exposure to violence are effective. This systematic review of evidence can be used to develop strategies to increase timely reporting of violence in emergency settings.

Summary

Nurses' reporting behaviors can impact the development of effective strategies to address workplace violence in the ED. Without consistent reporting, the extent of the issue is not accurately reflected by data, and data drives performance. When data does not indicate a problem exists, organizations will not be aware of challenges facing their staff. State and federal governments are aware workplace violence exists despite inconsistencies in data; however, the breadth of the issue is not realized. The federal government has attempted to address workplace violence prevention for healthcare workers nationally. It is paramount nurses report workplace violence to determine the effectiveness of interventions aimed at reducing the risk of workplace violence. The purpose of this systematic review was to identify barriers to reporting workplace violence in emergency settings. In Section 2, I will discuss the conceptual framework for the project and summarize existing scholarship on this topic.

Section 2: Background and Context

Introduction

Workplace violence is a persistent and pervasive problem affecting ED nurses, which threatens safe and healthy work environments and poses risks to patient safety. To address these practice concerns requires accurate information about the frequency at which nurses experience violence, circumstances in which violence occurs, contributing factors, interventions, outcomes, and post hoc analysis of events derived from completed reports. Analysis of completed reports can assist researchers, nurse managers, organizational leadership, and legislative representatives to implement interventions aimed at preventing and minimizing workplace violence towards nurses at the department, organizational, state, and federal level (Nowrouzi-Kia Isidro, Chai, Usuba, & Chen, 2019). Analysis of this magnitude is dependent on reporting workplace violence for ED nurses.

Workplace violence is an occupational hazard threatening ED nurses' safety and the quality of care delivered to patients. Despite the frequency of ED workplace violence, many experiences go unreported (Nowrouzi-Kia et al., 2019). Underreporting workplace violence poses a significant barrier to workplace safety improvement efforts (American Nurses Association [ANA], 2019). In this systematic review of literature, I provide a critical analysis of existing literature to identify barriers to reporting workplace violence to address the existing gap in practice.

In this section, I will discuss Azjen's theory of planned behavior (TPB) as the theoretical framework to address the practice issue and Melnyk and Fineout-Overholt's

process for critically appraising evidence for clinical decision-making, which assisted with the evaluation of strengths of the existing literature regarding barriers to reporting workplace violence for ED nurses. Additionally, this section includes background and context for this systematic review, including the application of theories, relevance to nursing practice, local background and context, and the role of the DNP student for completing the systematic review.

Concepts, Models, and Theories

Workplace violence is a complex phenomenon, which may be defined differently as a result of personal perceptions and varying definitions in literature. The use of theories and definitions assisted with addressing barriers to reporting workplace violence by ED nurses. The TPB is the theoretical framework used to address barriers to reporting workplace violence by nurses in the ED. Melnyk and Fineout-Overholt's six steps of evidence-based practice process provided the framework for identification and examination of the level of evidence of studies that met inclusion criteria for the systematic review of the literature. For context, key terminology is defined.

TPB

The TPB was developed by Azjen and has been used in healthcare to assist with understanding staff behavior (Azjen, 1991; Ekayani, Wardhani, & Rachmi, 2017). Azjen posited intention is the most reliable determination of action and is influenced by personal attitudes toward an action or behavior, subjective norm, and nurse's perception of behavioral control (Azjen, 1991; Ekayani et al., 2017). Attitudes, subjective norms, and behavioral control within the context of the theory can be defined further. Attitude to

perform a behavior is determined by the value given to performing the action (Ekayani et al., 2017). Subjective norms are influenced by social pressure, and meaning is assigned to completing the task (Ekayani et al., 2017). Perceived behavioral control is a personal belief in one's capability to perform a behavior (Ekayani et al., 2017).

The TPB has been used as a theoretical framework to study adverse drug reaction reporting by nurses (De Angelis, 2017). The theory assisted with understanding nurses' fundamental beliefs regarding reporting drug reactions and designing interventions to improve nurses' reporting rates. De Angelis (2017) applied TPB to understand nurses reporting practices with an adverse event. However, it is possible that nurses may not find workplace violence to be an adverse event that requires reporting because it applies to the nurse and not the patient.

Evidence-based Practice Process

Critical appraisal of research evidence is imperative for evaluation of appropriateness for application to clinical practice. Evidence-based practice is the incorporation of research into clinical decision-making. Melnyk and Fineout-Overholt provided a framework for the evidence-based practice process, which guided the completion of the systematic review. The steps of the evidence-based practice process include clinical inquiry, formulation of a research question, comprehensive search of the literature, appraisal of the evidence, synthesis of evidence, evaluation of outcomes, and dissemination of the evidence (Melynk & Fineout-Overholt, 2019).

Workplace violence is a significant clinical problem facing ED nurses. However, accurate data regarding the frequency at which violence occurs is needed. This initiated

the clinical inquiry regarding reporting behaviors of ED nurses and the following research question: What are the barriers to reporting workplace violence according to emergency nurses? An exhaustive and systematic search of the literature commenced and was documented following the PRISMA guidelines. Critical appraisal of literature incorporated the rapid critical appraisal process of the evidence-based practice process to evaluate the quality of identified studies meeting inclusion criteria (Melnyk and Fineout-Overholt, 2019). The identified studies were evaluated in terms of level of evidence and synthesized for clinical application as required for the completion of a systematic review.

Definitions

To provide context for this systematic review, it is essential to understand key terminology. There are a few types of workplace violence that can occur in the workplace; however, this systematic review will specifically address type two violence in the ED.

Emergency Department (ED): A hospital department or a standalone facility which is obligated to screen for emergency conditions and provide stabilizing medical care to any person seeking medical assistance according to the Emergency Medical and Labor Act (EMTALA; Centers for Medicare and Medicaid Services [CMS], 2012).

Type two violence: Workplace violence directed at a healthcare staff member in a healthcare facility while providing or attempting to provide care to a patient by a patient or visitor (H.R. 1309, 2019; S. 851, 2019). Type two violence is also known as patient-on-worker violence (Arnetz et al., 2014; Norwrouzi-Kia et al., 2019; Ramacciati et al., 2018).

Workplace violence: Any threat or act of violence that occurs in a healthcare facility to an employee providing healthcare services (H.R. 1309, 2019; S. 851, 2019).

Relevance to Nursing Practice

A search of Cochrane Reviews and the Joanna Briggs Institute revealed no systematic reviews regarding barriers to reporting workplace violence according to ED nurses. Additional databases used to search for relevant literature included the CINAHL and MEDLINE. Search terms were *workplace violence*, *emergency*, *nurse*, *report*, and *barrier*. A preliminary search identified 194 studies for review. However, only studies that met inclusion criteria were included in the systematic review. Studies in this review were level I-VII studies written in the English language, published between January 1, 2009 and June 30, 2019 in peer-reviewed journals with full-text, and address barriers to reporting workplace violence in an emergency setting.

Workplace Violence

Workplace violence is complex and multifaceted, with various applications and several definitions in the literature. Workplace violence as it applies to nurses requires a working relationship between a nurse and patients, visitors, family members, or coworkers (Ventura-Madangeng & Wilson, 2009). The nurse, patient, and visitor interaction are a working relationship which results in a sense of power and powerlessness. The perpetrator of violence attempts to use, misuse, or abuse their perceived sense of power to disempower the nurse to maintain, gain control, or gain power over the situation (Ventura-Madangeng & Wilson, 2009). This unequal power

relationship between the roles of patient and nurse contribute to feelings of powerlessness by the patient and contributes to violence (Ventura-Madangeng & Wilson, 2009).

Antecedents of workplace violence occur before the violent incident and include people, external stimuli, and internal stimuli. Two or more people are required for workplace violence to occur and consist of a perpetrator of violence and the nurse as the recipient (Ventura-Madangeng & Wilson, 2009). External stimuli often include institutional health care systems policies and the environment. Institutional systems policies establish rules or procedures to govern practices that contribute to feelings of powerlessness by patients, visitors, or staff, which may inadvertently result in stress and anxiety (Ventura-Madangeng & Wilson, 2009). The environment is the physical setting in which the violence occurs. Perception of the environment may be chaotic and impersonal as a result of poor communication, delays, long wait times, and unmet needs resulting in patient or visitor perception of being unseen and forgotten (Gacki-Smith et al., 2009; Pompeii et al., 2013; Speroni et al., 2014; Ventura-Madangeng & Wilson, 2009). Internal stimuli may include patient condition or diagnosis such as mental illness, dementia, or under the influence of illicit drugs or alcohol, which may precipitate a violent interaction (Pompeii et al., 2013).

Consequences as a result of workplace violence for the nurse may include physical, emotional, financial, psychological, personal and social life, professional, and organizational consequences (Lanctot & Guay, 2014; Speroni et al., 2015). Physical injuries sustained as a result of workplace violence can be minor to deadly and result in short- or long-term physical symptoms (Gates et al., 2011; Lantot & Guay, 2014;

Ventura-Madangeng & Wilson, 2009). Emotional and psychological consequences can result in a myriad of feelings and thoughts including disbelief, fear, anger, embarrassment, anxiety, flashbacks, post-traumatic stress disorder, stress, mistrust, and or humiliation (Gates et al., 2011; Lanctot & Guay, 2014; Ventura-Madangeng & Wilson, 2009). These thoughts and feelings can negatively impact nurses' personal lives. The effect of workplace violence impacts personal relationships and social interactions outside of the work environment (Lanctot & Guay, 2014). Professional ramifications include the inability to concentrate, increased sick leave, burnout, leaving the profession, and decrease productivity and quality of work, which then affects other patients (Lanctot & Guay, 2014; Ventura-Madangeng & Wilson, 2009). Exposure to workplace violence can negatively impact professional relationships with patients and manifest as a decrease in time spent with patients, decrease in interest in the patient, and a decrease in communication with patients and families (Eker et al., 2012). Organizational and financial consequences result with an increase in staff turnover and the inability to retain or recruit nurses (Lactot & Guay, 2014; Ventura-Madangeng & Wilson, 2009). The effects of workplace violence pose a risk to nurses and the quality of care they provide their patients.

Empirical referents provide possible cues to potential or impending exposure to violence in the workplace. The perpetrator may display verbal or behavioral cues such as pacing, tachypnea, restlessness, or agitation before committing a violent act (Ventura-Madangeng & Wilson, 2009). However, violent events may occur without warning as a result of patient behavior, providing patient care, or a result of situational events such as

application of restraints, care transitions, redirecting aggressive patients, or intervening to stop an aggressive patient (Arntez et al., 2015). Perpetrators of violence can be patients, family members, visitors, co-workers, supervisors, or physicians (Kvas & Seljak, 2015). However, patients are the most prevalent perpetrator of violence towards nurses in ED's (Arnetz et al., 2015b; Pompeii et al., 2013). Manifestations of violence can be verbal with the intent to belittle or intimidate, threaten or humiliate a nurse. Additionally, physical violence, aggression, or abuse is the use of forceful physical contact that may result in no injury to serious bodily injury (Ventura-Madangeng & Wilson, 2009).

Practice Implications of Workplace Violence

Current evidence suggests that underreporting workplace violence is a significant impediment to improving the safety of health care providers in the emergency setting. Workplace violence has repercussions for patient safety, the organization, and the lives of nurses. According to Braithwaithe, Herkes, Ludlow, Testa and Lamprell (2017), better organizational cultures and healthy workplaces result in better patient outcomes. When ED nurses experience workplace violence, they experience fear, which can result in feeling they are working in an unsafe work environment (Lantcot & Guay, 2014). Fear and feelings of working in an unsafe environment compromise workplace culture. ED nurses have a right to work in a safe environment (ENA, 2014). Hospital and department leadership are obligated to address the safety concerns of the nursing staff (ENA, 2014). However, the department and organizational leadership must be made aware of these safety concerns through reporting violent situations.

When ED nurses are injured while working, the effect on an organization manifest by direct, indirect, and intangible costs. Direct costs to a healthcare organization include costs associated with the provision of healthcare to the injured nurse including treatment, transportation to and from appointments, and potential litigation (Hussard, Teoh, & Cox, 2019). In 2000, financial analysis of 344 non-fatal workplace incidences was completed and revealed each case involving a registered nurse cost $31,000 with total costs more than $5 million (Gates et al., 2011). As a costly issue facing health care organizations, organizations have a vested interest in implementing effective strategies aimed to decrease workplace violence. Understanding reporting behaviors and barriers to reporting by ED nurses can assist organizations in finding solutions to violence and decrease direct costs associated with injuries and liability to the organization.

Indirect and intangible costs are generally associated with large expenses endured by the organization and the nurse post violent episode. Organizations incur indirect costs as a result of a decrease in productivity of nurse's post violent episode (Gates et al., 2011; Hassard et al., 2019). Decreased productivity by the nurse may result in an adverse effect on patient care. Nurses may be able to perform routine care competently, after a violent episode; however, ED nurses experience trouble coping post-violent encounter (Gates et al., 2011). The impairment to coping compromises the nurse's ability to care for more complex patients that require concentration, detail, or communication skills, which in turn affects the nurse's productivity and compromises patients care (Gates et al., 2011). Additionally, intangible costs include pain, suffering, and decreased quality of life experienced by the nurse (Hassard et al., 2019). Therefore, nurses' have a vested interest

in reporting workplace violence to protect themselves and their patients, yet barriers exist that result in poor reporting of workplace violence.

Reporting of Workplace Violence in the ED

The search of existing literature revealed a global practice issue with ED nurses underreporting workplace violence. In Australia, Hogarth et al. (2016) conducted a phenomenological qualitative study of emergency nurses (n = 15) and found nurses report violence informally to colleagues and formal reporting only occurred when there was physical injury or fear of a complaint from patient or family. Similarly, in Italy, Ramacciati et al. (2018) completed a cross-sectional study of emergency nurses (n = 816) and found that 78.3% of reporting was informal and verbal. In the United States, the ENA (2011) conducted a large violence surveillance study (n = 7,169), which found 65.6% of emergency nurses did not formally report physical violence, and 86.1% did not report verbal violence. In a study conducted with emergency nurses (n = 270) in Turkey, Talas et al. (2011) found that half of the study participants had never reported a workplace violence incident. Albashtawy and Aljezawi (2016) conducted a cross-sectional survey of emergency nurses in Jordan (n = 227) and found that 75% of the study participants were exposed to violence, but only 16.6% formally reported the violence to supervisors or authorities.

Underreporting is a practice concern affecting emergency nurses all over the world. Barriers to reporting are essential to understand to obtain accurate data on violence towards nurses and implement interventions aimed at increasing reporting violence and implement interventions to decrease the frequency. The search of the literature found

various barriers experienced by ED nurses globally. Nurses' attitudes and beliefs influence their reporting behaviors. Further, nurses' perceptions of violence and willingness to tolerate violent acts from sick patients impact reporting behaviors (Hogarth et al., 2016). Rationales by nurses for not formally reporting violence include lack of injury, peer perception of involved staff member and incident, normal expected behavior, and unaware of how to report violence (Albashtawy & Aljezawi, 2016; Copeland & Henry, 2017). Hospital barriers to formally reporting workplace violence include complicated reporting systems, lack of policies and procedures, and staff being encouraged not to report (Hogarth et al., 2016; Ramacciati et al., 2018).

Underreporting workplace violence is a significant barrier to implementing effective interventions and strategies to reduce the phenomenon. Studies conducted on barriers to reporting have identified nurse's rationales and perceived impediments to reporting. Hogarth et al. (2016) conducted a qualitative study on nurse's behavior toward reporting working place violence and found the following barriers; nurse's perception of violence, unclear policies and procedures, difficult and time consuming reporting methods, not encouraged to report by management, and nothing changes if they report as contributing factors to under-reporting workplace violence. Copeland and Henry (2017) had similar findings but also found the fear of retaliation from management, reporting is not mandatory, normal patient behavior, nobody was hurt, and it is part of the job as additional barriers to reporting. Gacki-Smith et al. (2009) additionally found the nurse's perception of reporting represents weakness or incompetence. The ANA (2019) found additional contributing factors to underreporting including the lack of consensus on the

definition of workplace violence, fear of being accused of causing the incident, the practice of not reporting unintentional violence, and belief an incident was not serious enough to report.

Strategies to improve reporting behaviors include simplifying reporting processes and providing feedback to nurse's after a report has been completed (Hogarth et al., 2016). Copeland and Henry (2017) suggested communication and education with ED staff regarding the importance of reporting violent events regardless of injury to avoid overshadowing the psychological impact of violence. The Occupational Health and Safety Administration (2015) recommended the involvement of staff in the development of policies and procedures to ensure reporting, monitoring, and feedback without fear of reprisal against employees who experience workplace violence or sustain an injury as a result thereof. The American Association of Nurse Executives and the ENA (2015) recommended promoting personal accountability and ownership of workplace violence by ensuring everyone is aware of their responsibility to report workplace violence. Additionally, the ANA (2019) suggested organizational adoption of zero-tolerance policies will improve a culture of safety and improve reporting behaviors. Flynn (2019) recommended educating nurses on the importance of completing incident, variance reports, or unusual occurrence reports anytime there is an unexpected event. If there is an injury or a situation that posed a risk for injury an incident report is recommended (Flynn, 2019).

Practice Gap

The search of the literature revealed no systematic reviews on barriers to reporting workplace violence by ED nurses to address the gap in practice of experiencing workplace violence to reporting it. A comprehensive search and analysis of existing research conducted on the practice gap assisted in identifying barriers; thereby, assisting with identifying potential interventions and strategies to improve reporting behaviors. Improvement in reporting workplace violence has implications on the provision of patient care, the lives of ED nurses, workplace safety, and organizational costs.

Local Background and Context

Legislation regarding healthcare workplace violence in California began in the 1990s with Assembly Bill 508. During this time, workplace violence in healthcare began to occur with increasing frequency, and inconsistencies in reporting by nurses were recognized (Chu, 1993). This bill required nurses in the ED to receive education and training on de-escalation techniques to avoid an altercation and physical maneuvers to prevent injury if someone became physically violent (Chu, 1993). Additionally, this legislation also required notification of law enforcement within 72 hours of an assault or battery of on-duty hospital staff (Chu, 1993). In 2020, reporting assault or battery to law enforcement occurs in less than 10% of violent events that are reported in California hospitals (DIR, 2019).

Violence in healthcare has been occurring for decades without improvement. Unfortunately, legislative support has been incremental and sluggish to address this practice concern. In 2014, California passed legislation on workplace violence prevention

strategies. However, in 2015, a legislative effort to make an assault of a healthcare professional in the ED a felony was vetoed by the governor of California (Rodriquez, 2015). State legislation designed to improve workplace safety through preventative efforts of workplace violence in California exists; however, this legislation does not apply to Veteran Affairs hospitals, as they are federally governed. Inconsistencies in laws and regulations regarding workplace violence exist and vary by state. Currently, there is no federal standard. In 2019, there was proposed federal legislation to address workplace violence in healthcare. Historically, there have been unsuccessful attempts to pass state and federal legislation. The importance of addressing the barriers to reporting workplace violence is to increase reporting behaviors by nurses and illustrate the breadth of the issue.

Role of the DNP Student

Professional Context

My role as a DNP student in the completion of this systematic review was to examine the phenomena of underreporting workplace violence in emergency settings by critically appraising and synthesizing the existing evidence. Through my 17 years of being employed as a Registered Nurse, I have had the fortunate experience of working in several different roles, both inpatient and outpatient, at the bedside and in leadership. Early in my career, I had experienced workplace violence by being grabbed, scratched, and having patients' nails dug into my arms by several different patients. As my career evolved into working in the ED, I observed violence against emergency nurses occurred significantly more often than in my previous settings. However, I was unaware if other

nurses reported their experiences. As my roles have changed, my exposure has changed, and so has my perspective. As a leader, the impact on patient care, health, and safety of staff, and ED operational concerns are affected both directly and indirectly by workplace violence.

Over time, exposure to violence has become increasingly worse. As a nurse leader, I review completed reports of violence that occur in the ED. In my organization, security tracks violent episodes and submits reports to Cal OSHA as required by California's SB 1299. However, not all violent episodes are reported through the hospital's online system. Law enforcement can be notified directly by the staff without notifying security or completing the hospital's process, or they are not reported at all.

Additionally, law enforcement officers may bring violent persons to the ED for medical care, then leave the known violent person in the ED with hospital staff without the same capabilities of protecting themselves as law enforcement. I have witnessed law enforcement officers verbally discourage ED nurses to report or press charges against a perpetrator. The intention of these statements is unclear and discouraging to ED staff. It is plausible discouraging statements by law enforcement influence-reporting behaviors of ED nurses and contributes to the less than 10% of violent events that occur in California hospitals that are reported to law enforcement (DIR, 2019). It is probable this example, and other reasons, contribute to the underreporting of workplace violence by ED nurses.

Professional Relationship to the Project

My professional role in the completion of the systematic review was to identify barriers to reporting violence through a comprehensive search and analysis of existing

literature on the topic. The completion of the project can assist hospitals with developing strategies to improve reporting at the organizational level and assist professional nursing organizations with additional evidence-based literature support. The resultant improvement in reporting behaviors will demonstrate the significance of workplace violence facing ED nurses and provide accurate data to support the need for legislative and regulatory action.

Motivation for Completing the Project

As an ED nurse leader, I aspire to improve the quality of patient care through the delivery of care provided by ED nurses. To provide safe patient care, nurses must have safe practices, providing care in a safe environment. The systematic review of the literature regarding barriers to workplace violence experienced by ED nurses assisted with identifying nurses' perceptions of impediments to reporting. Reporting workplace violence is imperative for improvement efforts to minimize exposure and improve workplace safety and cultures. I have no relationship or conflict of interest in this project.

Potential Bias

Potential bias exists as a result of my personal experiences with workplace violence. Additionally, the risk of bias may occur in publications, citations, and outcomes of the studies reviewed. Adherence to *Walden University's Manual for Systematic Reviews* and the PRISMA reporting guidelines minimizes potential biases and errors by following a systematic, documented, and transparent process. A second independent reviewer was used to minimize bias, validate findings, and confirm reproducibility.

Summary

Workplace violence and barriers to reporting experienced by ED nurses are complex. Workplace violence requires two people, both a perpetrator and a victim, and an act or behavior with the intent to harm. The violent act may or may not result in an apparent injury or harm. While there are several forms of workplace violence, the focus of this scholarly project is on type two violence, patient or visitor to nurse. The TPB provided a theoretical framework for understanding and identifying barriers to workplace violence. Identification and understanding barriers to workplace violence has implications to the culture of the environment nurses work in, quality of care to patients, direct costs to the organization, and indirect costs to the nurses that require improvement endeavors. Workplace violence and barriers to reporting have been acknowledged as existing since the 1990s. Legislative efforts have been attempted to address workplace violence in ED's with successes and failures. However, this systematic review revealed barriers to ED nurses reporting workplace violence to identify areas of opportunity for improvement. In the next section, I will discuss the collection of evidence and the process of analyzing the evidence.

Section 3: Collection and Analysis of Evidence

Introduction

ED nurses are frequently assaulted and often do not report. Inconsistencies in reporting workplace violence limit the ability of organizations to enact effective policies and procedures to mitigate harm to ED nurses, patients, and organizations. Underreporting inhibits their ability to analyze the various circumstances in which violence occurs. When nurses selectively report workplace violence, partial data is obtained, thereby inaccurately depicting the frequency, circumstances, and conditions in which violence is encountered.

This systematic review identified, analyzed, and synthesized published studies regarding barriers to reporting workplace violence. The findings of the systematic review can assist legislative and regulatory decision makers at the organizational, state, national, and international levels with a synthesis of evidence regarding reasons nurse's do not report workplace violence to enact and support change. Section 3 will provide a detailed description of the literature search, sources of evidence, published outcomes and research, and processes for analysis and synthesis of literature meeting criteria for inclusion.

Practice-Focused Question

Workplace violence is a local, national, and international ED nursing practice concern. However, a systematic review of evidence and analysis of barriers to reporting workplace violence is lacking in existing literature. To address the global issue and gap in

practice involving underreporting experienced workplace violence, I conducted an integrative systematic review of literature.

The doctoral practice-focused question conceived for the systematic review of the literature review is: What are barriers to reporting workplace violence according to emergency nurses? Following a systematic process to identify applicable studies, analyze and synthesize the existing evidence was paramount to determining obstacles ED nurses experience in reporting workplace violence. The identification of barriers will assist nurse leaders and executives to determine possible strategies to improve reporting behaviors by intervening to remove the obstacles. The resultant improvement in reporting can provide accurate data regarding the frequency in which violence toward ED nurses occurs. This data can then be used to assist legislators in supporting legislative efforts to halt workplace violence towards nurses.

Sources of Evidence

Published Outcomes and Research

Sources of evidence used for the systematic review included level I to VII studies published between January 1, 2009 and June 30, 2019. The incorporation of various methods of scientific inquiry into the systematic review will allow for a thorough approach to understanding the various contributing factors that influence ED nurses reported behaviors. A comprehensive search for evidence was completed using Medline, CINAHL, Cochrane Review, and Joanna Briggs Institute databases. Search terms were *workplace violence*, *emergency*, *nurse*, *report*, and *barrier*. Additionally, manual

searches of reference lists occurred to identify additional studies not captured by search terms.

The selection of studies for inclusion in the systematic review occurred in two phases. The first phase consisted of reading the titles and abstracts of all studies. Review of the titles and abstracts identified studies meeting inclusion criteria. Phase two consisted of reading the full text of the articles identified as meeting the inclusion criteria. The full text review validated the studies content for inclusion in the systematic review.

Analysis and Synthesis

Walden University's Manual for Systematic Review guided the completion of this doctoral project. The 12 steps outlined in the manual provided the guidelines for completion of the systematic review. The PRISMA flow diagram was used to document and track database searches for relevant literature. Critical appraisals of evidence using the guidelines by Melnyk and Fineout-Overholt assisted with assigning levels of evidence. Identified studies meeting inclusion criteria and assessed for level of evidence were analyzed and evaluated using the Strengthening of Reporting for Observational Studies in Epidemiology (STROBE) for observational studies, Criteria for Reporting Qualitative Research (COREQ) for qualitative studies, and Mixed Methods Appraisal Tool (MMAT) for mixed methods studies. The use of the PRISMA flow diagram, Melynk and Fineout-Overholt's evidence-based practice process including the critical appraisal of evidence and STROBE, COREQ, or MMAT appraisal guidelines are consistent with the requirements outlined in the *Walden University Manual for Systematic Review.*

The four-phase PRISMA flow diagram provided a framework for documentation of the literature screening process and includes identification, screening, eligibility, and inclusion phases. The identification phase involved identifying the number of studies discovered from database searches separately from the number of additional studies found through reviews of reference lists. The screening process included the number of studies removed as a result of duplication and number of studies screened by title and abstract for inclusion. Full-text review of studies identified by title and abstract were analyzed to determine eligibility for inclusion or exclusion in the systematic review. The final phase determined the inclusion or exclusion of a study with reason and the number of qualitative, quantitative, and mixed methods studies included in the systematic review.

Following the completion of the literature search and identification of relevant studies to be included in the systematic review, an analysis and synthesis of studies meeting criteria was completed. Analysis included an appraisal of the quality of evidence and relevance to the practice question using STROBE, COREQ, or MMAT guidelines as applicable. Additionally, Melnyk and Fineout-Overholt's evidence-based practice process and critical appraisal of studies assisted with assigning levels of evidence of the included studies.

Summary

The purpose of this systematic review was to complete a comprehensive search of published literature to identify barriers to ED nurses reporting workplace violence. The inclusion criteria assisted with determining best evidence to address the practice question. Analysis of studies assisted with determining the quality of the studies and evidence that

addresses this practice problem. Outcomes identified through the search of the literature were synthesized to make recommendations for implementation into practice. Section 4 discusses the findings and recommendations from published literature to address the practice concern of underreported workplace violence.

Section 4: Findings and Recommendations

Introduction

Workplace violence is a persistent and pervasive problem facing ED nurses worldwide. When nurses do not report their experiences involving workplace violence, the circumstances in which violence occurs cannot be analyzed to determine contributing variables or patterns that resulted in violence. Inaccurate data does not support the ER nurses and patients need for legislative support and regulatory requirements for workplace safety improvements. Consequently, underreporting workplace violence is a significant impediment to improving workplace safety for ED nurses and safe environments for their patients (Arnetz et al., 2015).

Underreporting workplace violence was the identified gap in practice, which I sought to address with a systematic review of literature. The practice-focused question was: What are barriers to workplace violence according to by ED nurses? The purpose of the DNP project was to synthesize existing evidence regarding reasons nurses do not report workplace violence. The primary goal of this project was to determine perceived barriers to reporting workplace violence experienced by ED nurses and make recommendations for organizations to address and intervene to remove those barriers, resulting in improved reporting rates. The resultant improvement in reporting behaviors could provide a more accurate reflection of the frequency and circumstances in which violence occurs. Furthermore, accurate data will support the need for legislative action and regulatory requirements to promote safe work environments for ED nurses.

Sources of Evidence

Consistent with *Walden University's DNP Systematic Review Manual*, the sources of evidence were determined following a systematic, transparent, and documented process. The PRISMA flow diagram was used to record the selection process (see Appendix A). The practice-focused question assisted with comprehensive search terms for the literature review. Identified search terms included *workplace violence*, *emergency*, *nurse*, *report*, and *barrier*. Boolean operators were used to focus the search and included *and* and *o*r. Consultation with a Walden University librarian ensured an exhaustive and comprehensive search was developed. Key terms were used to search CINAHL, MEDLINE, Cochrane, and Joanna Briggs Institute databases to identify studies for evaluation. Articles published between January 2009 and June 2019 in peer-reviewed journals written in English and available in full-text that addressed the practice question were retrieved. The search revealed no systematic reviews on the topic and 194 studies for review. An additional six other studies were identified through citation searching of studies that met inclusion criteria. After duplicates were removed, 189 studies were identified for review (see Appendix A).

The systematic review included the analysis of 189 studies by title and abstract addressing the practice-focused question. the titles and abstracts were reviewed, 22 studies were identified as potentially meeting inclusion criteria and required a full-text review. Full-text evaluation of those 22 studies included three studies that did not address the practice-focused question, and 19 studies which met inclusion criteria for further

review and analysis. A Microsoft Excel spreadsheet was developed to track the analysis of studies consistent with Melnyk and Fineout-Overholt's critical appraisal of evidence.

Nineteen studies were analyzed using Melnyk and Fineout-Overholt's critical appraisal of evidence, which assisted with determining levels of evidence and were documented on the spreadsheet. The studies were electronically saved in individual folders identified by year of publication and author for easy retrieval and review. The 19 studies were identified as level VI evidence and consisted of cross-sectional descriptive, mixed methods, and qualitative studies. No systematic reviews, randomized controlled trials, or controlled or uncontrolled cohort studies were identified. Expert opinion or level VII evidence was not incorporated into the systematic review.

The 19 identified studies were analyzed and evaluated using the STROBE for observational studies, COREQ for qualitative studies, and MMAT for mixed methods studies as applicable. An electronic copy of analysis and evaluation via the tool was saved by the appropriate evaluation tool abbreviation, year, author, and stored in an individual folder.

Once the analysis of the 19 studies was completed, 12 studies were excluded because they did not address the practice focused question or did not meet minimum quality standards established for this systematic review. A second independent review of literature and individual studies was conducted by an experienced research prepared nurse. Consensus between myself and the second independent reviewer was established on the inclusion of individual studies, quality, and level of evidence. A total of seven studies were selected for inclusion. One qualitative, one mixed method, and five

quantitative studies were identified that met criteria for synthesis to address barriers to reporting workplace violence according to ED nurses (See Appendix B).

Findings and Implications

Articles included in this systematic review were thoroughly appraised and met inclusion criteria. In this section, the author and year of publication, purpose and aim, design, sample, setting, measures, findings, and levels of evidence of included studies are summarized. Each study was thoroughly analyzed to ensure they addressed the gap in practice involving barriers to reporting workplace violence according to ED nurses. The selected studies included qualitative, quantitative, and mixed methods studies to provide a comprehensive and thorough insight into the reasons ED nurses do not report workplace violence. The comprehensive and systematic appraisal allowed for synthesis of multiple perspectives and resulted in the identification of five key themes related to underreporting of violence in the emergency setting. Themes of barriers to reporting workplace violence include workplace violence comes with the job, lack of injury, reporting processes, lack of support, and emotional obstacles.

Workplace Violence Comes With the job

Gacki-Smith et al. (2009) conducted a cross-sectional study on ED nurses who were members of the ENA (n = 3,465). The purpose was to examine ED nurses' experiences and perceptions of violence. Gacki-Smith et al. (2019) included a validated and pilot tested 69-item questionnaire addressing various elements of workplace violence, specifically including barriers to reporting workplace violence. ED nurses with frequent physical violence experiences (FPVE) were compared to nurses who were non-

frequent physical violence experience (Non-FPVE). ED nurses with FPVE were nurses who have experienced more than 20 encounters of workplace violence in the previous 3 years (Gacki-Smith et al., 2009). Frequent verbal abuse experiences (FVAE) were defined as more than 200 episodes of verbal abuse in the previous 3 years. Gacki-Smith et al. (2009) compared the FVAE responses to nurses who had nonfrequent verbal abuse experiences (Non-FVAE). Limitations of the study included a 10.9% response rate of eligible ENA members, a sample comprised of primarily female nurses (84%) who worked day shifts (52.1%), were staff nurses (59.7%), could have submitted the questionnaire more than one time, and participants could have recall bias (Gacki-Smith et al., 2009). A strength of the study was the study of both physical and verbal violence, as well as the comparison between nurses who have experienced more violence to those who have not. Gacki-Smith et al. (2009) found that ED nurses reported that physical ($p <$ .001) and verbal ($p <$ .001) violence came with the job and was a barrier to reporting workplace violence. According to Melnyk and Fineout-Overholt (2019), the cross-sectional method is an observational design that designated this study as Level VI evidence.

Hogarth et al. (2014) conducted a qualitative study in Australia using a phenological approach with two focus groups ($n = 15$) of ED nurses as the sample population . The purpose was to determine barriers and facilitators to reporting workplace violence as experienced by ED nurses (Hogarth et al., 2014). Limitations included the self-selection of participants, single site, focus groups may not allow for staff to speak freely, and focus groups may result in exaggerated responses (Hogarth et al., 2014).

However, Hogarth et al. (2014) used a predetermined list of questions to prompt discussions in the focus groups. One of the questions directly asked the participants what their perceptions of barriers and enablers were to reporting workplace violence (Hogarth et al., 2014). Hogarth et al. (2014) discovered that physical and verbal abuse occurred with such frequency that the ED staff had accepted these behaviors from patients and families, and they believed the effort required to report was futile. Thereby, resulting in ED nurses accepting workplace violence comes with the job. As a qualitative study, it is assigned as Level VI evidence (Melnyk & Fineout-Overholt, 2019).

Verzyridis, Samoutis, and Mavrikiou (2014) conducted a cross-sectional survey in nine hospitals ED's in Cypriot. The purpose was to determine the prevalence of workplace violence, perceptions of violence, and suggestions for improving violence rates in ED's in the country (Verzyridis et al., 2014). The sample population consisted of ED nurses (n = 180), physicians (n = 30), and an undisclosed profession (n = 10) (Verzyridis et al., 2014). Vezyridis et al. (2014) used a previously validated survey tool developed by Arnetz (1998) translated into Greek by three independent researchers and validated for content by two nursing professors. The survey tool was then pilot tested before use. Limitations of the study include recall bias and convenience sampling (Verzyridis et al., 2014). A strength of the study was the use of a validated survey tool and a 60.3% response rate (Verzyridis et al., 2014). An important finding was that violence was perceived to be typical of working in the ED in 74.1% of participants (Verzyridis et al., 2014). The perception that experiencing workplace violence as typical of working in the ED is consistent with the theme of workplace violence comes with the

job. The design of the study is consistent with a Level VI study on the hierarchy of levels of evidence (Melnyk & Fineout-Overholt, 2019).

Albashtawy and Aljezawi (2016) conducted a cross-sectional study in a hospital ED located in each of the eight different provinces located in Jordan (n = 227). Albashtawy and Aljezawi (2016) determined 80% of violence in ED's went unreported in their country before the study. The purpose of the study was to explore risk factors to violence and determine the reasons ED nurses do not report workplace violence (Albashtawy & Aljezawi, 2016). Limitations include a convenience sample and recall bias. The study's questionnaire was researcher-developed, expert-reviewed, and pilot tested before use in the study (Albashtawy & Aljezawi, 2016). Additional strengths include a 54.4% response rate and the sample size yielded a medium effect size (0.15) (Albashtawy & Aljezawi, 2016). Albashtawy and Aljezawi (2016) found 57% of the studies participants were accustomed to violence. The perception of being accustomed to violence was the primary finding of their study and is consistent with the theme of workplace violence is comes with the job (Albashtawy & Aljezawi, 2016).The method of the study is consistent with an observational design and, therefore a level VI study, according to Melnyk and Fineout-Overholt's levels of evidence.

Gillespie et al. (2016) completed a descriptive study in a single pediatric ED located in the Midwest of the United States. The purpose was to introduce an intervention to improve reporting rates and to understand barriers to reporting workplace violence (Gillespie et al., 2016). The study included a survey of ED nurses, physicians, and respiratory therapists. A total of 101 participants were recruited pre-intervention and 49

participants continued post-intervention (Gillespie et al., 2016). Limitations include response rate pre-intervention (29%) and post-intervention (15%), participants in the pre- and post-intervention may not have been the same participants, unanticipated obstacles to completing the study as initially intended, convenience sample, and single site (Gillespie et al. 2016). A strength was the use of the workplace violence questionnaire used to survey the staff pre- and post-intervention had strong content validity (*CVI* = 0.90) (Gillespie et al., 2016). A finding included 44.3% of participants felt workplace violence was part of the job (Gillespie et al., 2016). The descriptive nature of the study is consistent with an observational study and, therefore a Level VI study on the Melnyk and Fineout-Overholt levels of evidence.

Lack of Injury

Renker, Scribner, and Huff (2015) used a mixed methods approach to study workplace violence in one United States ED. The purpose sought to gain insight into violence conducted by patients, family, and visitors to ED staff through the identification and description of participant's experiences and perceptions (Renker et al., 2015). The cross-sectional descriptive approach included the use of a survey previously validated and used in the Gacki-Smith (2009) study (Renker et al., 2015). Additionally, Renker et al. (2009) incorporated an ethnographic qualitative approach to their research and conducted interviews with administrative and clinical staff. The sample for the survey included ED nurses (*n* = 41) and paramedics (*n* = 10) (Renker et al., 2015). However, a description or number of the sample for the qualitative component was not disclosed. Limitations include sample size (*n* = 52), response rate of all eligible participants (36%),

single site, no description of qualitative participants, and recall bias (Renker et al., 2015). A strength was the description of the methods used to analyze and interpret the findings from the methods of the study (Renker et al., 2015). The study design designates a Level VI on the Melnyk and Fineout-Overholt hierarchy of evidence. An important finding from the study included participants' description of not having physical injuries as a reason for not reporting workplace violence.

Darawad, Al-Hussami, Saleh, Mustafa, and Odeh (2015) conducted a descriptive study on ED nurses in Jordan. The purpose was to investigate the causes and prevalence of both verbal and physical violence in Jordan ED's (Darawad et al., 2015). The study design yields a Level VI on the hierarchy of studies. The sample selection included random sampling techniques of 300 nurses or nurse's aides that work in governmental, military, private, or university hospitals with a bed capacity of greater than 300 or large ED's throughout Jordan (Darawad et al., 2015). The response rate (n =174) was 58% (Darawad et al., 2015). A limitation included recall bias due to a reflection period of five years, which is longer than other studies on the topic (Darawad et al., 2015). The strengths include random sampling from various hospitals throughout the country (Darawad et al., 2015). Darawad et al. (2015), found 47.7% of their sample believed nurses who sustained minor injuries should not report the incident.

The lack of and perceived low severity of injury as a barrier to reporting workplace violence was a theme found in additional studies that met inclusion criteria. Gacki-Smith et al. (2009) found that the lack of injury was a barrier to reporting physical violence (p = 0.04). Similarly, lack of injury was a barrier to reporting verbal violence (p

< 0.001; Gacki-Smith et al. 2009). Albashtawy and Aljezawi (2016) discovered that no physical harm was done in 31.7% of nurses and served as a barrier to reporting. Perception that no physical harm was done was the second most common barrier to reporting violence by ED nurses in Jordan (Albashtawy & Aljezawi, 2016). Additionally, Gillespie et al. (2015) found lack of physical injuries was found to be a barrier to reporting in 75.4% of the study's participants.

Reporting Processes

A vital component to the completion of a workplace violence report is the knowledge required to complete one. Knowledge of hospital or departmental policies and procedures is a critical component to successful completion of reports. Gacki-Smith et al. (2009) found that ambiguous hospital procedures serve as a barrier to reporting of both verbal ($p < 0.001$) and physical violence ($p < 0.001$). Renker et al. (2015) discovered the same finding in their mixed-method study of ED nurses. In the focus group interviews conducted by Hogarth et al. (2014) ED nurses were unaware of hospital policies and procedures encompassing all aspects of workplace violence. Also, Verzrydis et al. (2015) found that 21.2% of their study participants did not know how to report workplace violence. If the process of completing reports is not known, it serves as a barrier to reporting workplace violence.

An additional consideration of completing a workplace violence report, in addition to the knowledge required, is the action of completing reports regarding workplace violence. Hogarth et al. (2014) discovered that ED nurses found the systems in place for reporting workplace violence were difficult and time-consuming to complete.

Additionally, Gillespie et al. (2016) found that ED nurses believed that reporting took too long to complete in their pre-intervention (14.8%) and post-intervention (21.7%) participants. Therefore, when the system or process used to report workplace violence is unclear and the ability to complete a report is cumbersome, ED nurses are less likely to report workplace violence.

Lack of Support

The lack of support perceived by ED nurses from hospital administration and ED leadership serves as a psychological barrier to completing reports of workplace violence. Gacki-Smith et al. (2009) found that lack of support from administration and ED management to report physical violence ($p < 0.03$) and verbal violence ($p < 0.01$) was a barrier to reporting violence in the emergency department. Darawad et al. (2015) found that ED nurses believed their reports were not considered in 43.4% of their sample. Gillespie et al. (2016) found 49.2% of ED nurses believed no action would be taken before the study was conducted, and post-intervention 34.8% believed nothing would happen if they made a report about workplace violence. Consequently, the perception that nothing changes when reports are completed leads to ED nurses thinking nothing is being done with the reports and it is a waste of time to complete them. Feeling that action would not be taken on reports of violence, coupled with findings that the reporting process is cumbersome and unclear leads to a lack of accurate reporting of workplace violence in the ED.

In addition to believing as though nothing is going to change with the completion of a reports, ED nurses have indicated not being asked to complete report is also a

demonstration of lack of support. Darawad et al. (2014) found 0.6% of responses indicated ED nurses were never asked to complete a report. ED nurses not being asked to complete a report adds to the psychological barrier of lack of support for reporting workplace violence.

Emotional Influence

Emotional responses to violence was identified as a factor influencing low reporting rates. Fear was the primary emotion experienced by ED nurses that prohibited the reporting of workplace violence. Albashtawy and Aljezawi (2016) discovered that 15.9% of their participants feared being blamed for the violence if they reported. Verzrydis et al. (2014) found that 11.2% of their participants feared negative consequences if they reported. However, Gacki-Smith et al. (2009) found fear of retaliation influenced their reporting behaviors. Fear of reprisal from ED leadership for reporting physical violence ($p < 0.001$) and verbal violence ($p < 0.001$) served as significant barriers to reporting (Gacki-Smith et al., 2009). An additional fear of retaliation from hospital administration influenced ED nurses reporting of physical violence ($p < 0.001$) and verbal ($p < 0.001$) violence as barriers to reporting (Gacki-Smith et al., 2009). Notably, fear of retaliation from ED leadership and hospital administration was not the only influence. Fear of retaliation from other nursing staff was noted to be statistically significant for reporting physical violence ($p < 0.007$). Fear of retaliation from ED physicians to reporting physical violence ($p < 0.008$) also occurred (Gacki-Smith et al., 2009).

Fear was the predominant emotion found in the studies for this systematic review, but other emotions contributed to the emotional influence of reporting behaviors. Verzrydis et al. (2014) found ED nurses indicated feeling ashamed (4.5%) and they would be viewed as incompetent (1.3%) if they reported violence. Gacki-Smith et al. (2009) found feeling incompetent served as a barrier to reporting physical violence ($p < 0.02$) and verbal violence ($p < 0.01$). Additionally, Renker et al. (2015) discovered that frustration was another emotional barrier to completing reports because the only time staff had time to complete the documents was after working a shift.

Unintended Limitations

The existence of workplace violence in the ED has gained attention in the last several decades. Many studies have been completed on the various aspects of workplace violence, including the rate of exposure, precipitating factors, mitigation, the role of security, in the ED and the hospital, etc. However, studies that specifically addressed barriers to reporting workplace violence for ED nurses were limited. Several studies exist that pertain to barriers to reporting workplace violence; however, the study populations included various other nurses employed in other departments, which led to the exclusion of these studies. Barriers to reporting workplace violence by ED nurses were not isolated and contributed to a small portion of the samples (Ahmed, 2012; Copeland & Henry, 2017; Sato et al., 2013). Since ED nurses experience workplace violence four times more often than other departments, the influence of nurses employed in different departments in the study sample confounded the results. Therefore, the studies would not accurately address the practice-focused question specific to ED nurses and were excluded.

Implications for Social Change

Evidence collected and incorporated into the systematic review assisted with identifying barriers to workplace violence experienced by ED nurses worldwide. This study specifically addressed ED nurses but also has implications for nurses in all departments since workplace violence and barriers to reporting occur in various nursing settings. The TPB provided the framework for the study. Intention to report workplace violence is influenced by attitudes, subjective norms, and behavioral control (Ekayani et al., 2017). The perception workplace violence comes with the job can be attributed to the personal attitudes of ED nurses. Subjective norms are the social pressure and meaning assigned to completing the reports, in which the theme of lack of support and emotional influence was identified as contributing factors. Whereas, behavioral control is an ED nurses' capability to perform the completion of a report addressed by the theme of report processes that influence the completion of reports regarding workplace violence.

The study and use of the TPB as a theoretical framework for understanding behaviors has positive social implications for addressing barriers to reporting workplace violence for ED nurses. Understanding the barriers to report workplace violence allows for the development of interventions to be discovered to improve reporting practices. A safe work environment has implications for patient safety and the safety of the nurses caring for them.

Recommendations

Barriers to reporting workplace violence by ED nurses were the gap in practice addressed in this systematic review. The findings in this study do not provide conclusive

insight into all the potential variables that may influences nurses' reporting behaviors. It does, however, synthesize the existing literature on the topic and identifies areas for intervention and future study. Recommendations include suggestions for education, policies and procedures, support, and reporting mechanisms.

Education

Education of ED nurses regarding the importance of reporting workplace violence is crucial (Hogarth et al., 2016). Nursing orientation should include training on workplace violence. A focus of education should be on new nurses, younger nurses, and nurses new to the department. Vezrydis et al. (2014) found that nurses with 5 years or less of experience were more likely to experience significantly more WPV than nurses with more experience ($p = 0.001$). Specifically, when nurses with 5 years of experience or less were compared to nurses with 20 years or more experience, the younger nurses were more likely to experience workplace violence ($OR = 5.845$; Verzrydis et al., 2014). Darawad et al. (2015) found a significant negative relationship with years of nursing experience by age ($r = -.263$, $p = 000$), emergency experience ($r = -.218$, $p < 0.004$), and age ($r = -.203$, $p = .007$). A focus of education should be on younger and newer ED nurses. However, annual education and training should reinforce the need to report workplace violence for all ED nurses (Albashtawy & Aljezawi, 2016; Darawad et al., 2014). Education should involve reporting violence, how to report, risk factors, and how to communicate (Albashtawy & Aljezawi, 2016).

Policies and Procedures

A recommendation to improve reporting workplace violence includes the development of policy and procedures that are clear and consistent (Gacki-Smith et al., 2009). It is essential to engage ED nurses in the development of policies and procedures related to workplace violence and address reporting processes (Hogarth et al., 2016). Collaboration amongst hospital administration, ED leadership, and ED nurses in the development of policies and procedures can strengthen policies and procedures to ensure consistency (Vezrydis et al., 2014). The developed policies should specifically mandate the reporting to occur when violence happens (Albashtawy & Aljezawi, 2016). Policies and procedures provide a framework and reference for ED nurses for nearly all processes that occur in hospitals. Hence, the importance of the development in collaboration with the staff most likely to encounter workplace violence.

Support

Organizational commitment to the elimination of barriers to reporting is essential to reducing workplace violence (Gacki-Smith et al., 2009). Gillespie et al. (2016) found that support from hospital administration and ED leadership was an enabler to reporting workplace violence. A facilitator to reporting workplace violence perceived by ED nurses included being asked to complete a report (Gillespie et al., 2016). A show of support by asking staff to report workplace violence may assist with the improvement in reporting behaviors (Vezrydis et al., 2014). Another recommendation to demonstrate support of staff includes the formation of inter-disciplinary teams, including leadership and staff, to

develop a plan for prevention, potential mitigation, response to, and reporting workplace violence (Gacki- Smith et al., 2009).

Reporting Mechanisms

The evidence demonstrated that the perception of completing reports are cumbersome and lengthy. The simplification of reporting mechanisms may enhance compliance with reporting (Hogarth et al., 2016). Simplification of reporting processes was an enabler to reporting workplace in the study completed by Gillespie et al. (2016). In their interventional study, which introduced an intervention to improve reporting rates, the ease of reporting was identified in 12.2% of the pre-intervention population and improved to 19% in the post-intervention sample (Gillespie et al., 2016). Including the ED staff in the development of the reporting tools, whether electronic or paper, may also serve as a facilitator to improve reporting workplace violence (Hogarth et al., 2016).

Strengths and Limitations

Strengths

Underreporting workplace violence has negative implications for ED nurses. Improvement in reporting is crucial for accurate data to support the need for legislative action and regulatory requirements. A strength of the project was the use of the TPB as a framework to understand which factors influence ED nurse's intention to report. The use of a theoretical framework demonstrates a scholarly approach to the application of theory into practice.

Another strength of the systematic review is the literature support depicting underreporting workplace violence is a practice issue concerning nurses worldwide.

Following a scholarly process consistent with *Walden University's DNP Systematic Review Manual,* the sources of evidence included in the systematic review included a documented and transparent process. A second doctoral-prepared scholar independently reviewed the process for obtaining the evidence, the inclusion of studies, and validated the interpretation of the findings to minimize bias in the application of the evidence in the systematic review of the literature.

Limitations

A significant limitation of the study is the low level of evidence available for incorporation into the systematic review. The practice focus question was not conducive to conducting a higher level of evidence studies. Additional limitations of this systematic review include study design decisions such as sampling techniques, sample sizes, and recall bias that do not support the ability to generalize the various studies independently.

Future Opportunity

In conducting the systematic review, the barriers to reporting workplace violence were discovered through a comprehensive approach and application of quantitative, qualitative, and mixed-method studies. Recommendations to improve reporting rates and address the barriers to reporting were addressed by many of the studies. Specifically, recommendations to address the lack of support and reporting processes were found. It must be acknowledged none of the studies made recommendations to address the barriers to reporting of workplace violence comes with the job, lack of injury, and emotional influences.

When ED nurses perceived there were no barriers to reporting workplace violence, they were more likely not to frequently experience physical violence ($p < 0.01$) or verbal violence ($p < 0.01$; Gacki-Smith et al., 2009). Future studies are needed to discover potential interventions aimed at addressing these influences on reporting behaviors. Large multisite studies on workplace violence are also needed to continue the investigation into barriers to reporting workplace violence (Hogarth et al., 2016). Future studies on interventions aimed at improving reporting rates, including education, are also needed (Gillespie et al., 2016).

Section 5: Dissemination Plan

Introduction

In fulfilling requirements for a systematic review of the literature, Section 5 includes both the dissemination plan of the final project and a self-analysis. Indirectly, this project advocates for improvement in workplace violence reporting through the analysis of published and peer-reviewed literature regarding barriers that influence ED nurses' decisions to report. The findings from this systematic review can assist stakeholders in making systems changes. The recommendations can improve reporting rates within organizations, encourage ED nurses to acknowledge the importance of reporting workplace violence, facilitate legislators' understanding that workplace violence is a serious practice issue facing ED nurses, and prompt regulatory bodies to enforce safe work environments for ED nurses. Advocacy and commitment to improving policies relevant to healthcare and healthcare improvement are essential for doctoral-prepared nurses (American Association of Colleges of Nursing, 2006).

Dissemination Plan

Workplace violence in the ED is a worldwide practice issue. Inconsistencies in reporting behaviors for ED nurses are a significant barrier to improvement. Understanding the obstacles ED nurses perceive as impediments to reporting workplace violence is crucial for implementing interventions aimed at improving reporting rates. Sharing the findings of this study is essential to create safer work environments for ED nurses and their patients. At the healthcare organization level, findings and recommendations from this project will be disseminated within my organization through

the workplace safety committee. The goals of this team are to improve the culture of safety for employees within my healthcare organization through various applications of research and evidence-based practice. The dissemination plan for this project also included an abstract submission for presentation at the ENA annual conference in September 2020. Presentation at the conference will allow for an extensive, in-person, and national audience of ED nurses with varying backgrounds and clinical experience. Additionally, I plan to submit the systematic review to the Journal of Emergency Nurses for publication. If accepted, this project will contribute to existing evidence-based literature regarding the topic of barriers to reporting workplace violence according to ED nurses.

Analysis of Self

The completion of this scholarly project required diligence, patience, and self-reflection. As a former ED and Intensive Care Unit nurse and current ED manager, my passion for workplace safety and lack of tolerance of violence towards nurses were essential to acknowledge and eliminate personal bias. Workplace violence in healthcare is a broad topic with different applications and considerations, including contributing factors, the practice environment, and patient populations at risk for violence. However, underreporting workplace violence was identified as a significant obstacle to improving workplace safety and decreasing the frequency by which ED nurses encounter workplace violence. The lack and inconsistencies of reporting behaviors do not allow for analysis of violent situations to determine potential mitigating interventions aimed at improving workplace safety.

As a Nurse Leader

As a former critical care nurse and current ED manager, I recognize the impact of violence from patients toward ED nurses has on perceptions of workplace safety and the ability of nurses to deliver quality patient care. I also understand eliminating violence is not a realistic expectation. The barriers to reporting workplace violence need to be improved upon to support ED nurses to report workplace violence. ED nurses should be empowered to advocate for themselves through reporting events that placed them at risk of physical or psychological harm. The findings and recommendations from this systematic review allowed for the identification of the reason's nurses do not report and potential strategies to implement to improve ED nurses' reporting behaviors within my department and organization.

As a Scholar

Following a scholarly, systematic, documented, and transparent process aligned with Walden University's Manual for Systematic Reviews guided the completion of the systematic review. The completion of this systematic review involved a demonstration of clinical scholarship and analytical methods for evidence-based practice (AACN, 2006). Adherence to the guidelines established in the *Walden University's Manual for Systematic Reviews* was imperative for successful completion and minimizing personal bias. A second independent scholar's analysis the process for evidence-selection and validated the findings of the systematic review process and findings. Acknowledging my passion for combating workplace violence on behalf of patients and nurses did not influence my ability to be objective in the review and analysis of literature regarding

reasons nurses do not report workplace violence. Fundamentally, workplace violence and underreporting are intertwined; however, they are different.

Workplace violence is a complex, multifaceted concern prompting the scientific inquiry to understand the reasons nurses do not reporting workplace violence through a search and synthesis of existing evidence. Objectively synthesizing evidence allowed for the determination of barriers to reporting workplace experienced by ED nurses according to the scientific literature. This knowledge will enable me to make real and sustainable changes to improve reporting behaviors, which will impact nurse's exposure to workplace violence through analysis of completed reports.

As a Project Developer

The translation of evidence for clinical practice consists of the development of a project based on an identified need for practice change, which requires research and the synthesis of evidence. The completion of this project is a demonstration of my ability to translate evidence to address real world practice problems. The completion of this project was difficult, and I faced several challenges involving time management and multiple revisions. Time management was a struggle resulting from an underestimation of the intensity of the search of the literature, the time-consuming nature of reviewing and analyzing studies, and synthesizing the evidence, which was overcome through determination and organization. The revisions needed for the prospectus, proposal, and project drafts were disappointing; however, they contributed to a greater appreciation for scholarly writing that could not have happened any other way.

Summary

Underreporting workplace violence for ED nurses is a worldwide practice concern affecting nurses and the quality of care delivered to ED patients. Barriers to reporting workplace violence included workplace violence comes with the job, lack of injury, reporting processes, lack of support, and emotional influences. The identification of these barriers allows for recommendations to improve workplace violence reporting rates, education, policy and procedure development, support, and reporting processes for ED nurses. These recommendations can assist in improving workplace violence reporting rates, resulting in data depicting the frequency in which violence occurs in the ED. With accurate data interventions can be implemented to positively impact social change by creating safer environments for patient's and nurses. However, future research is needed to discover potential solutions to combat the cultural acceptance of violence demonstrated by the barrier workplace violence comes with the job. The dissemination of this scholarly product can be used by stakeholders to address underreporting in their organizations and support the need for future research.

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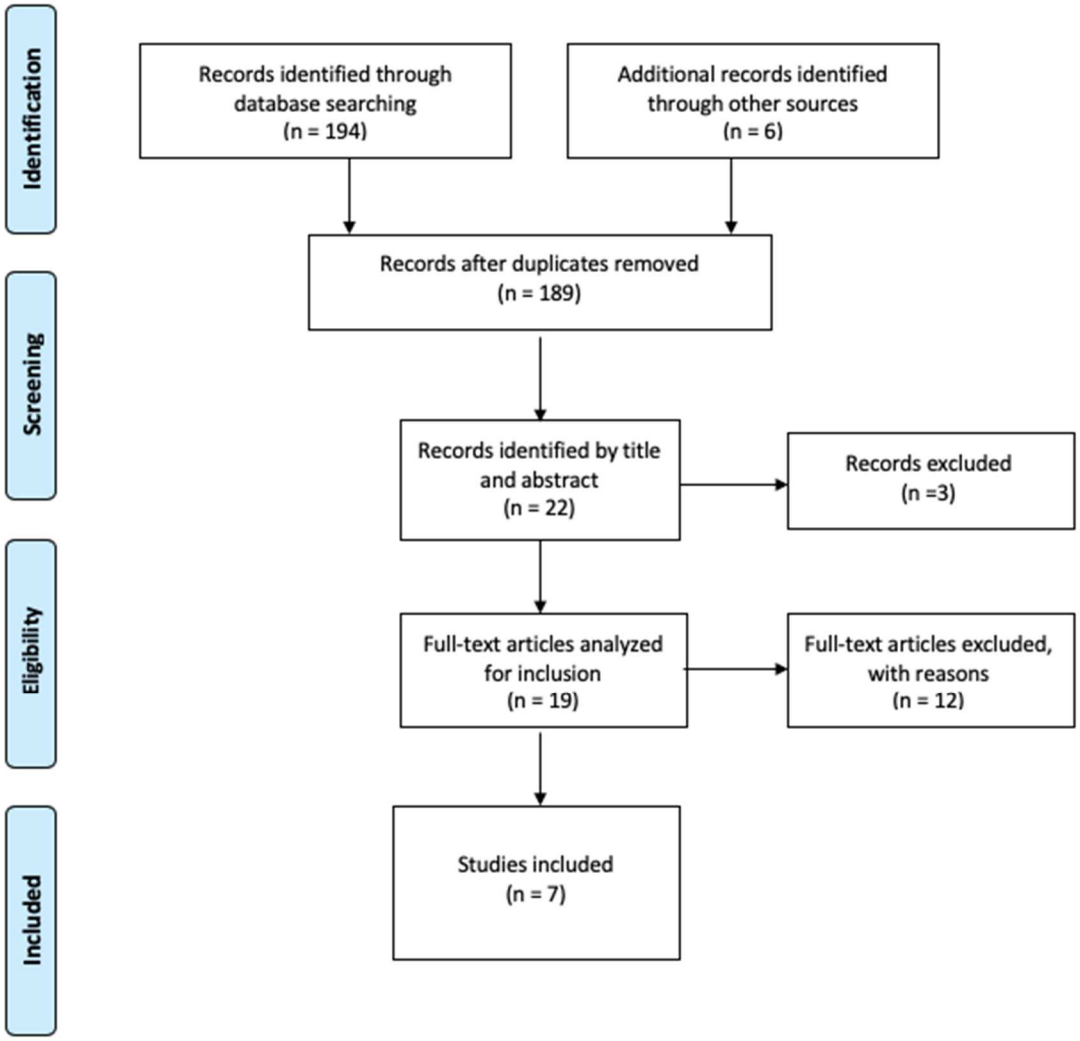
Appendix A: PRISMA Flow Diagram



Appendix B: Evidence Table on Barriers to Reporting Workplace Violence

Author(s)/Year	Purpose/Aim	Design/Sample/ Setting	Measures	Findings Related to Barriers to Reporting WV	Level of Evidence (7-point scale) *
Albashtawy and Aljezawi, 2016	The study's purpose was to explore risk factors to violence and determine the reasons ED nurses do not report workplace violence.	Cross-sectional descriptive study *n* = 227 (ED nurses) 54.4% response rate from eight hospitals in Jordan from different provinces.	Researcher developed survey tool with expert review and pilot testing.	No harm or physical injuries from WPV; Accustomed to violence; Discouraged from reporting WPV.	VI
Darawad et al., 2015	The purpose of the study was to investigate the causes and prevalence of both verbal and physical violence in Jordan ED's	Cross sectional descriptive study *n* = 174 (ED nurses) 58% response rate Multisite hospitals in Jordan from different sectors.	Survey form adapted from two previously published studies (Ergun & Karadakovan, 2005; Gacki-Smith et al., 2009)	Not willing to take legal action against a patient or relative even though they reported it was ethically appropriate to take legal action; Did not feel psychologically harmed.	VI

(table continues)

Gacki-Smith et al. 2009	The purpose of the study was to examine ED nurses' experiences and perceptions of violence encountered by patients and visitors.	Cross-sectional descriptive Online with ENA members *n* = 3,465 (ED Nurses) 10.9% of eligible ENA members	69 item researcher designed online survey	Violence is an unavoidable part of the job; Concern about customer satisfaction scores; Ambiguous reporting processes; Lack of administrative support; Fear of retaliation; Concern over being viewed as incompetent or weak; No physical injuries; Perception that verbal abuse does not need to be reported.	VI
Gillespie et al., 2016	The study aimed to introduce an intervention to improve reporting rates and to understand barriers to reporting workplace violence	Descriptive study using quality improvement design Pre-intervention *n* = 101 (29% response rate) Post-intervention *n* = 49 (16% response rate) Urban, hospital-based pediatric ED in Midwest USA	Workplace Aggression Reporting Questionnaire	Severity of the incident too minor; No action would be taken; Workplace aggression (WPA) was not intentional; Takes too long to report; WPA is a part of the job.	VI
Hogarth et al., 2016	The purpose of the study was to determine barriers and facilitators to reporting workplace violence as experienced by ED nurses.	Phenomenological qualitative study *n* = 15 (two focus groups with *n* = 8, *n* = 7) Large ED in Melbourne, Australia	Semi structured focus group interviews	Violence accepted as a part of the job; Not considered violence unless injury was sustained; Fear of retaliation from perpetrators; Reporting is difficult and time consuming.	VI

(table continues)

Renker et al. 2015	The purpose of the study sought to gain insight into violence conducted by patients, family, and visitors to ED staff through the identification and description of participant's experiences and perceptions.	Cross-sectional mixed methods Not for profit adult teaching hospital in Midwest USA *n* = 51 (41 ED nurses and 10 paramedics) 36.6% return rate	Standardized survey from Gacki-Smith (2009) study with quantitative data field to measure violent experience and open-ended questions.	Perceived lack of administrative support; Ambiguous reporting process; Lack of physical injuries; Lengthy and time-consuming reporting process that often had to be competed after work; Lack of consequences for perpetrators of violence; Violence is a part of the job.	VI
Vezyridis et al. 2014	The purpose of the study was to identify perceived prevalence, characteristics, precipitating factors and suggestions for improving workplace violence in Cyprus Republic ED's.	Retrospective cross-sectional descriptive study Nine public emergency departments in the Republic of Cyrus *n* = 220 (ED nurses and physicians) 85.7% of eligible participants	Violent Incident Form (translated to Greek) validated by study by Arnetz (1998).	Violence is a part of the job; Not knowing how to report the incident; Not considering reporting important; Fear of negative consequences; Feeling ashamed or incompetent; Not being asked to complete a report.	VI