



Assessing the experiences of violence among healthcare workers in Calgary emergency departments

Pavneet Singh^{1,2} · Katie Gourlay^{1,2} · Sydney D. Guderyan³ · Sergiu Cociuba⁴ · Jessalyn K. Holodinsky⁵ · Kathryn Crowder^{1,2} · Margriet Greidanus²

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Abstract

Objectives Violence in emergency departments (EDs) is common and underreported. ED healthcare workers are at high risk of workplace violence, increasing burnout rates and healthcare costs. This study aims to (1) describe the perceptions, experiences, and impact of violence on Calgary's ED staff and (2) identify facilitators and barriers to reporting violence in Calgary EDs.

Methods A cross-sectional study design was used to survey nurses, physicians, and other healthcare workers across Calgary EDs using an anonymous questionnaire on Qualtrics. Participants were recruited through online and poster advertisements within EDs, email, and word of mouth. Multiple choice, ranking, and open-ended questions were employed. Chi-square test for Independence and Fischer's Exact Test were conducted to analyze categorical data. Open-ended responses were coded and tabulated as categorical data.

Results 320 healthcare workers participated, including 179 nurses, 77 physicians, 11 HCAs, and 53 other healthcare workers. A majority reported increased ED violence in the last 5 years (81%). While verbal abuse and name-calling were reported as the most common forms of violence (97% and 91%), 82% of participants also reported physical violence, with 75% reporting one or more physical assaults in the past year. 29% reported injury due to workplace assault, with 17% missing work due to injury. The most common barriers to reporting included: (1) no action taken to address incidents, (2) inconvenience of reporting, and 3) nobody was hurt.

Conclusion This study demonstrates that verbal and physical violence are common in EDs. Persistent barriers to reporting highlight the urgent need for clear, consistently enforced policies to prevent and address violence in EDs.

Keywords Assault · Injury · Reporting · Staff · Workplace

Résumé

Pavneet Singh and Katie Gourlay have contributed equally to this study.

✉ Pavneet Singh
singhp@ucalgary.ca

¹ Department of Emergency Medicine, Cumming School of Medicine, University of Calgary, Calgary, AB, Canada

² Alberta Health Services, Alberta, Canada

³ Cumming School of Medicine, University of Calgary, Calgary, AB, Canada

⁴ Department of Community Health Sciences, Centre for Health Informatics, Cumming School of Medicine, University of Calgary, Calgary, AB, Canada

⁵ Department of Emergency Medicine, Department of Community Health Sciences, Department of Clinical Neurosciences, Centre for Health Informatics, O'Brien Institute for Public Health, Hotchkiss Brain Institute, Alberta Children's Hospital Research Institute, Cumming School of Medicine, University of Calgary, Calgary, AB, Canada



Objectifs La violence dans les services d'urgence (SU) est courante et peu signalée. Les travailleurs de la santé aux urgences sont à haut risque de violence au travail, ce qui augmente les taux d'épuisement professionnel et les coûts des soins de santé. Cette étude vise à 1) décrire les perceptions, les expériences et l'impact de la violence sur le personnel des services d'urgence de Calgary et 2) identifier les facilitateurs et les obstacles au signalement de la violence dans les services d'urgence de Calgary.

Méthodes Une étude transversale a été menée auprès d'infirmières, de médecins et d'autres travailleurs de la santé dans les services d'urgence de Calgary à l'aide d'un questionnaire anonyme sur Qualtrics. Les participants ont été recrutés par le biais d'annonces en ligne et d'affiches dans les services d'urgence, par e-mail et de bouche à oreille. Des questions à choix multiples, de classement et ouvertes ont été utilisées. Le test du chi carré pour l'indépendance et le test exact de Fischer ont été menés afin d'analyser les données catégorielles. Les réponses ouvertes ont été codées et mises en tableaux sous forme de données catégorielles.

Résultats 3320 travailleurs de la santé ont participé, dont 179 infirmiers, 77 médecins, 11 HCA et 53 autres travailleurs de la santé. Une majorité d'entre eux ont signalé une augmentation de la violence à l'urgence au cours des cinq dernières années (81 %). Bien que la violence verbale et les injures aient été déclarées comme les formes de violence les plus courantes (97 % et 91 %), 82 % des participants ont également déclaré avoir subi de la violence physique, 75 % ayant déclaré une ou plusieurs agressions physiques au cours de l'année précédente. Vingt-neuf pour cent (29 %) ont déclaré avoir été blessés à la suite d'une agression au travail, et 17 % ont dû s'absenter du travail en raison d'une blessure. Les obstacles les plus courants à la déclaration comprenaient : 1) l'absence de mesures prises pour faire face aux incidents, 2) l'inconvénient de déclarer les incidents et 3) personne n'a été blessé.

Conclusion Cette étude démontre que la violence verbale et physique est courante dans les services d'urgence. Les obstacles persistants au signalement soulignent le besoin urgent de politiques claires et appliquées de manière cohérente pour prévenir et traiter la violence dans les services d'urgence.

Mots-clés Agression · blessure · signalement · personnel · lieu de travail

Clinician's capsule

What is known about the topic?

Violence toward emergency department staff is common, harmful, and frequently underreported.

What did this study ask?

How do Canadian ED healthcare workers experience violence, and what barriers affect reporting of violent incidents?

What did this study find?

Verbal and physical violence were highly prevalent, and reporting was limited by perceived futility and reporting burden.

Why does this study matter to clinicians?

Understanding staff experiences and reporting barriers can guide practical policy changes to improve ED processes surrounding workplace violence, improve safety, and support healthcare workers.

Introduction

Violence toward healthcare workers in Canadian Emergency Departments (EDs) is a consequential and growing problem. Up to half of violent incidents in hospitals occur in the ED; 70% of emergency nurses report being assaulted at work, while half of emergency physicians report experiencing workplace assault [1]. Moreover, emergency nurses and physicians alike report a growing rate of violence in Canadian EDs [2]. The 2020 Canadian Association of Emergency Physicians (CAEP) Position Statement on Violence in Emergency Departments recognizes workplace violence as a growing threat to staff retention and wellbeing, stating that urgent action must be taken to develop mitigation strategies for violence and ensure workplace safety for all healthcare professionals [3].

Failing to address workplace violence in EDs threatens both staff and patient safety. Emergency medicine remains a high-risk specialty for provider burnout, and violence is contributing to high rates of depression among emergency physicians [1, 4, 5]. Equally important, nurses and physicians believe that workplace violence negatively impacts the quality of patient care [6]. Economically, violence burdens our already financially strained medical system through lost workdays, staff injuries, increased staffing resources to manage incidents, reduced productivity, and staff attrition [6–8].

Despite these consequences, ED violence continues to be underreported [1]. Previous work has proposed that there are many barriers to reporting, including feelings that violence is an “expected part of the job,” lack of knowledge about reporting, fear of repercussions, and a perception of reporting futility [9]. Understanding these root causes is critical to improving reporting and increasing recognition of the impact of ED workplace violence, as well as support and funding for ED workplace safety initiatives.

This study aims to describe the incidence and characteristics of workplace violence within Calgary, Alberta, Canada’s EDs. The objectives of this study were (1) to describe healthcare workers’ perceptions and experiences of violence in EDs across Calgary and (2) to describe the barriers and facilitators to reporting violent incidents in Canadian EDs.

Methods

Design and setting

The study followed the Consensus-Based Checklist for Reporting of Survey Studies (CROSS) guidelines [10]. A cross-sectional survey was conducted among physicians (including residents), registered nurses, licensed practical nurses, healthcare aides, Emergency Medical Services (EMS) personnel, and other healthcare workers in Calgary’s adult emergency departments (EDs). Calgary EDs include one Level I trauma center (Foothills Medical Centre) and three Level II EDs (Peter Lougheed Centre, Rockyview General Hospital, and South Health Campus). Peter Lougheed Centre is an inner-city ED which serves a relatively higher proportion of patients affected by substance use and social determinants of health, while Rockyview General Hospital sees more older adults and patients with higher socioeconomic status. All hospitals are operated by Alberta Health Services, which provides staff with non-violent crisis management training and on-call security support. To the authors’ knowledge, no violence screening tools or physical screening (i.e., metal detectors) are used. Ethics approval was obtained from the University of Calgary Conjoint Health Research Ethics Board (REB24-0737).

Survey design

The survey was developed by two authors, adapted from a previous study of ED violence [1], and refined through review by the authorship team (Online supplement 1). It included closed-ended, multiple-choice, ranking, and optional open-ended questions addressing demographics, perceived safety, experiences of workplace violence, and impacts on patient care and staff. The anonymous survey was administered using Qualtrics (Provo, UT, USA).

Sampling, recruitment, and data collection

Eligible participants included all ED staff across Calgary. Convenience sampling was used through posters, business cards, newsletters, and email advertisements. Posters and business cards displayed a survey link and QR code and were placed throughout all four EDs, including physician and staff lounges. The survey remained open for three months. Because recruitment occurred through multiple passive methods, the number of individuals who received the survey invitation could not be determined.

Data analysis

Statistical analyses were performed in R statistical software (version 4.2.3). Categorical variables were analyzed using chi-square or Fisher’s exact tests, with direction of associations interpreted from descriptive statistics. Open-ended responses were analyzed using inductive thematic analysis. Two investigators (PS and KG) independently coded responses, developed themes and subthemes, and resolved discrepancies through discussion before review by the full research team.

Results

Prevalence of violence

A total of 320 healthcare workers participated, including 179 nurses and 77 physicians (Table 1). Detailed participant characteristics are presented in Table 1. Most respondents (81%) believed ED violence had increased during the previous five years. Verbal abuse (97%) and name-calling (91%) were the most commonly reported forms, while 82% reported physical violence and 75% reported at least one physical assault in the previous year (Tables 2 and 3). Nurses reported significantly more verbal abuse than physicians ($P=0.007$) and other healthcare workers ($P=0.004$), and more physical violence than physicians ($P<0.001$) and other healthcare workers ($P=0.001$). Nearly one-third (29%) had been injured from a workplace assault, and 17% had missed work because of injury. More than half (58%) considered violence an expected part of the job, while 73% reported feeling safe at work (Table 2).

Reporting behaviors and perceived barriers to reporting

Sixty-four percent of participants reported violent incidents to a manager or through the institutional reporting system, whereas 34% did not. The most common reasons for non-reporting were the belief that “nothing is done/no follow-up”

Table 1 Demographics

Gender	n	(%)
Male	83	25.9
Female	236	73.7
Prefer not to answer	1	0.3
Role in ED		
MD (Attending)	73	22.8
MD (Resident)	4	1.2
RN	169	52.8
LPN	10	3.1
HCA	11	3.4
Other*	53	16.6
Sites worked at**		
Foothills medical center	137	42.8
Peter Lougheed center	116	36.2
Rockyview general hospital	71	22.5
South Health Campus	119	37.2
Prefer not to answer	8	2.5
Years in practice		
0–5 years	86	26.9
6–10 years	82	25.6
10–15 years	64	20.0
> 15 years	88	27.5
Violence committed by**		
Patient	303	94.7
Non-patient visitor	205	32.8
Colleague	23	7.2
Other	3	0.9
Non-applicable	1	0.3

* “Other” includes paramedics, protective services, unit clerks, transporters, research assistants & technologists

MD medical doctor, RN registered nurse, LPN licensed practical nurse, HCA healthcare aide

** : Response counts may sum to > 100% as participants were able to select more than one response to this question.

(61%), inconvenience of reporting (52%), and the absence of injury (47%) (Table 4). Thematic analysis identified several overlapping barriers to reporting.

Patient condition/context of aggression

Respondents noted that many violent incidents involved patients with cognitive impairment or psychiatric illness (“patients are very psychiatrically unwell,” “patient had dementia”). Because staff often viewed these behaviors as illness-related, they were less likely to report them.

Normalization of verbal abuse and minor incidents

Verbal abuse and less severe incidents were often normalized as routine aspects of ED work. One respondent stated,

“I could fill out multiple forms per shift for verbal assault from [patients] and families.” Others noted that abuse had become “so normalized that you don’t even see it as a problem” or was dismissed as “just part of the job.”

Perceived ineffectiveness and lack of outcomes

Participants described reporting as ineffective because it rarely produced visible action or prevented recurrence. One respondent stated, “I didn’t receive any management follow up (even an email) to my physical assault.” Others felt that violent patients or visitors faced few consequences and could return to ED without restrictions.

Self-reflection focus over systemic change

Organizational follow-up was perceived as emphasizing staff self-reflection rather than addressing structural issues or providing concrete support measures. As one participant explained, “It is always a self-reflection thing of what could I have done better?” Existing crisis management resources were viewed as insufficient without changes to staffing, security, or policy.

Time constraints and reporting burden

High workloads and complex reporting processes also discouraged reporting. Participants described the online system as time-consuming, difficult to navigate, and poorly suited to a busy ED. One respondent summarized, “Takes too long and nothing changes.” Physicians also reported access difficulties, and completing reports after long shifts often required additional unpaid time.

Legal, medicolegal, and organizational concerns

Participants described uncertainty regarding chart access and legal responsibilities, and believed policies limited responses to repeat offenders. One respondent stated, “No laws are in place to support [healthcare workers],” reflecting a broader sense of helplessness and skepticism about the value of reporting.

Security response and hospital response

Following respondents’ most recent assault, 24% reported no hospital response, while the most common intervention was placement of a behavioral flag in the patient’s chart (52%) (Online supplement 2). Four themes were identified: insufficient or delayed responses, reliance on physical restraint, inadequate management support, and systemic workplace factors. Participants also described security and management responses as slow or inconsistent. One respondent reported,

Table 2 Incidence of violence by gender, years in practice, and role

Gender (%)			Years in practice (%)				Role in the ED (%)		
	Females	Males	0–5 years	6–10 years	10–15 years	>15 years	Physicians	Nurses	Others
<i>n</i> (%)	73.9	26.1	26.9	25.6	20.0	27.5	24.1	55.8	20.1
Feeling safe at work									
Yes	69.8	80.7	79.1	68.3	70.3	71.6	87.0	68.5	67.2
No	29.8	19.3	20.9	30.5	28.1	28.4	12.9	30.9	32.8
Prefer not to answer	0.4	0.0	0.0	1.2	1.6	0.0	0.0	0.6	0.0
Violence expected part of job									
Agree	73.9	26.0	26.9	25.6	20.0	27.5	24.1	55.9	20.0
Disagree	57.6	57.8	68.6	58.5	57.8	46.6	58.4	53.1	70.3
Prefer not to answer	41.1	42.2	31.4	41.5	39.1	52.3	41.6	45.2	29.7
Prefer not to answer	1.3	0.0	0.0	0.0	3.1	1.1	0.0	1.7	0.0
Physically assaulted at work									
Yes	74.0	25.9	26.5	25.9	20.2	27.4	24.3	56.5	19.2
No	89.7	85.3	85.7	90.2	85.9	91.9	74.0	96.1	85.2
Prefer not to answer	10.3	14.6	14.3	9.8	14.1	8.0	25.9	3.9	14.7
Prefer not to answer	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Times assaulted in the last year									
None	73.9	26.0	26.5	25.9	20.2	27.4	24.3	56.5	19.2
Once	21.3	29.3	15.5	21.9	31.2	26.4	44.2	16.2	18.0
2–5 times	17.9	23.2	15.5	19.5	18.7	22.9	23.4	20.1	11.45
6–10 times	35.0	32.9	42.9	36.6	29.7	27.6	24.7	36.9	39.3
More than 10 times	6.4	4.9	10.7	7.3	3.1	3.4	3.9	6.1	9.8
Other	17.5	9.8	14.3	13.4	14.1	19.5	2.6	6.9	18.0
Prefer not to answer	0.8	0.0	0.0	0.0	3.1	0.0	0.0	0.6	1.6
Prefer not to answer	0.8	0.0	1.2	1.2	0.0	0.0	1.3	0.0	1.6
Injury at work due to assault									
Yes	73.8	26.2	26.5	25.9	20.2	27.4	24.3	56.5	19.2
No	27.8	32.5	25.0	20.7	31.2	39.1	10.4	30.7	47.5
Prefer not to answer	70.5	66.3	71.4	78.0	68.7	60.9	89.6	68.2	49.2
Prefer not to answer	1.7	1.2	3.6	1.2	0.0	0.0	0.0	1.1	3.3
Missed shift due to injury from assault									
Yes	73.9	26.0	26.5	25.9	20.2	27.4	24.3	56.5	19.2
No	17.1	18.3	16.7	9.8	18.7	24.1	5.2	19.5	26.2
Prefer not to answer	81.6	81.7	82.1	89.0	81.2	74.7	94.8	79.3	72.1
Prefer not to answer	1.3	0.0	1.2	1.2	0.0	1.1	0.0	1.1	1.1

Table 3 Types of violence reported

Types of Violence	Gender		Years in practice				Role in the ED		
	Females	Males	0–5 years	6–10 years	10–15 years	>15 years	Physicians	Nurses	Others
Verbal abuse	231	80	82	79	64	87	73	179	60
Physical violence	201	61	70	63	51	79	48	166	49
Threats	217	70	71	73	61	83	64	173	51
Sexual innuendo	207	48	66	68	52	70	52	160	44
Sexual groping	111	20	35	31	28	37	11	94	26
Spitting	194	67	60	66	57	79	59	155	48
Name calling	218	75	76	76	61	81	67	171	56
Threat of lawsuit	195	66	57	65	61	79	57	159	46
Other	32	15	11	7	10	19	12	22	13
None	2	1	2	0	0	1	0	0	3

Table 4 Reasons for not reporting

Selected Choice	n (%)
Nobody was hurt	144 (47.0)
Inconvenient to report	159 (52.0)
Nothing is done/No follow-up to reports	186 (61.0)
Would be perceived as weak by peers	14 (5.0)
Nobody else reports these incidents	65 (21.0)
Fear of retaliation from management	32 (10.0)
Concerned about patient satisfaction scores	1 (0.1)
Reporting is not supported by management	46 (15.0)
Reporting is not supported by administration	40 (13.0)
It is not mandatory to report	39 (13.0)
I didn't know I could report using the online reporting system	36 (12.0)
Concern about patient's response to incident consequences (i.e., behavior flag in chart)	7 (2.0)
Other	70 (23.0)
Prefer not to answer	4 (2.0)

"If you have ever decided not to report an assault, what were the reasons for not reporting?" (check all that apply)—Selected Choice

"*Calgary Police Service was called by myself, not the hospital,*" while another noted that security attended but "*nothing ever seems to happen*" afterward.

Reliance on physical restraints

Responses were perceived as overly focused on containment, particularly physical restraint, rather than prevention. Participants felt these measures did not reduce future risk. Limited access to practical de-escalation training was also identified.

Inadequate management support

Participants reported limited follow-up, a lack of accountability, and a dismissive attitude toward concerns/incidents from management. Comments such as "*Management asks what can you do better*" reflected a perception that responsibility was shifted toward individual staff members.

Table 5 Impact on patients

Selected choice	n (%)
Loss of productivity from emergency staff or physicians	222 (72.0)
Emotional trauma affecting your ability to perform your duties	227 (73.0)
Increased anxiety	240 (77.0)
Increased wait times (incident takes physicians or nurses away from the ED)	242 (78.0)
Less focus from emergency staff or physicians	197 (64.0)
Physical harm	149 (48.0)
Increased leave without being seen/treated	136 (44.0)
Other	16 (5.0)
Prefer not to answer	6 (2.0)

"How have patients been adversely affected" (Check all that apply.)—Selected Choice

Systemic workplace factors

Understaffing, high workloads, unclear protocols, and a workplace culture that tolerated violence were viewed as contributing to recurrent incidents. This was perceived to increase stress and burnout.

Perceived impact of violence on patients

Most respondents (92%) believed workplace violence harmed patient care (Table 5). Reported effects included increased wait times (78%), staff anxiety (77%), emotional trauma affecting performance (73%), and reduced productivity (72%). Participants described violence as diverting attention from other patients, delaying care, creating fear among patients and families, and reducing staff willingness to engage fully with threatening individuals. Violence was also viewed as contributing to burnout, attrition, and an unsafe care environment.

Perceptions of viable interventions to improve safety

Participants identified establishing, communicating, and enforcing clear policies as the most important step to improving ED safety. Other recommendations included increasing security staff in EDs, verbally screening visitors for weapons, having consequences for violent incidents, and reporting all violent incidents to police.

Discussion

Interpretation of findings

Violence toward healthcare workers was highly prevalent across Calgary emergency departments, with frequent verbal, physical, and sexualized aggression and significant emotional, operational, and patient-care consequences. Many participants viewed violence as an expected part of ED work and had limited confidence that reporting would lead to meaningful institutional action. Aggression associated with psychiatric illness, cognitive impairment, or intoxication was often considered illness-related, contributing to underreporting, while burdensome reporting systems and inconsistent security or administrative responses further discouraged reporting. Nurses reported greater exposure than physicians, likely because of their prolonged direct patient contact and central roles in triage, bedside care, and medication administration. These findings support clearer reporting expectations, improved security response protocols, and structured de-escalation strategies to better protect frontline staff.

Comparison to previous studies

Our findings are consistent with previous research showing that workplace violence is common in emergency departments, is predominantly verbal, and disproportionately affects nurses, likely because of their greater visibility, accessibility, and duration of direct patient contact [1, 11–14]. The normalization of verbal abuse observed in our cohort has also been widely reported, with repeated exposure contributing to a culture in which aggression is expected and its effects are minimized [1]. Similar to prior Canadian studies, most participants perceived that ED violence has increased in recent years [11, 12, 14, 15]. Underreporting was also common, reflecting previously identified barriers such as time-consuming reporting processes and the belief that reporting will not lead to meaningful action [1, 9, 16].

Previous studies have also shown that aggression associated with psychiatric illness, cognitive impairment, or intoxication is often viewed as unintentional and unavoidable [13]. Some research frameworks exclude these events from definitions of workplace violence, despite their substantial contribution to staff burden, which may underestimate the true prevalence of violence in emergency care [11]. Our findings reinforce these concerns. Participants also described negative effects on staff wellbeing, work performance, and patient care, consistent with literature linking workplace violence to depression, post-traumatic stress symptoms, absenteeism, high-risk health behaviors, and intentions to leave the profession [4, 5, 7, 8, 14].

Strengths and limitations

This study provides the first comprehensive assessment of emergency department violence in Calgary, Alberta, Canada, capturing both quantitative prevalence data and qualitative insights that deepen understanding of reporting behaviors and workplace culture. The combination of structured survey items and narrative comments strengthens the validity and contextual relevance of the findings.

Several limitations should be considered. Voluntary participation may have introduced selection bias, and the total eligible workforce could not be precisely determined, preventing calculation of an exact response rate. Some terms, including “verbal violence,” were not explicitly defined and may have been interpreted inconsistently. The absence of interviews or focus groups limited the depth of qualitative exploration. In addition, the study was primarily descriptive, with inferential analyses limited to selected group comparisons; identifying independent predictors of workplace violence was beyond its scope and should be addressed in future research.

Health system implications

These findings support moving beyond passive reporting mechanisms toward coordinated, transparent, and enforceable strategies for preventing and responding to workplace violence. Participants emphasized the need for clear departmental policies, streamlined reporting processes, reliable security responses, and meaningful administrative follow-up. Reporting may improve surveillance and identify patterns of violence, but it is unlikely to reduce incidents without broader institutional action, including adequate staffing, accessible security support, environmental modifications, and clear consequences for violent behavior. Non-violent crisis management training was often perceived as unhelpful, consistent with evidence that brief de-escalation or self-defense programs may improve knowledge without producing sustained improvements in confidence or performance [17]. Environmental interventions, including video surveillance, visible signage, and structured post-assault debriefing and support, have been associated with reductions in workplace violence and may help address factors such as long wait times, understaffing, and delayed security responses [12–14, 18–20]. Metal detectors may also be considered, although their potential to increase the perceived stigmatization or marginalization of some patient populations should be carefully evaluated. Structured behavioral-management frameworks such as Project BETA (Best Practices in the Evaluation and Treatment of Agitation) may complement these interventions by supporting early recognition of agitation, verbal de-escalation, and least-restrictive management

of aggression associated with psychiatric illness, intoxication, or cognitive impairment [21, 22].

Research implications

Future research should incorporate in-depth qualitative methods to better understand the emotional, operational, and cultural factors contributing to violence and underreporting in EDs. Longitudinal studies may clarify trends over time and evaluate the impact of institutional interventions, which would help to guide effective policies in the future. Importantly, research frameworks should explicitly include violence associated with cognitive impairment, psychiatric illness, and intoxication, as these represent a major portion of violent encounters and contribute substantially to staff burden.

Conclusion

Workplace violence is highly prevalent in Calgary emergency departments and may adversely affect healthcare workers and patient care. Underreporting reflects burdensome reporting systems, normalization of violence, attribution of aggression to medical causes, and limited confidence in institutional or legal support. Participants also described inconsistent security and management responses and identified clear, well-communicated departmental policies as the most important intervention. These findings, which may be relevant to other Canadian EDs, support further research, dedicated prevention initiatives, and stronger system-level policies to improve workplace safety.

Declarations

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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References

1. Copeland D, Henry M. Workplace violence and perceptions of safety among emergency department staff members: experiences, expectations, tolerance, reporting, and recommendations. *J Trauma Nurs*. 2017;24(2):65–77.
2. Hamdan M, Hamra AA. Burnout among workers in emergency departments in Palestinian hospitals: prevalence and associated factors. *BMC Health Serv Res*. 2017;17(1):407.
3. Drummond A, Chochinov A, Johnson K, Kapur A, Lim R, Owens H. CAEP position statement on violence in the emergency department. *Can J Emerg Med*. 2021;23(6):758–61.
4. Vidor EF. Violence in the emergency department puts patients and physicians at risk [Internet]. KevinMD.com. 2018. <https://kevinmd.com/2018/10/violence-in-the-emergency-department-puts-patients-and-physicians-at-risk.html>. Accessed 22 Jun 2025
5. Emergency Nurses Association. Workplace Violence. <https://www.ena.org/practice-resources/workplace-violence>. Accessed 22 Jun 2025
6. Marketing General Incorporated. ACEP Emergency Department Violence Poll Research Results. 2018. <https://www.emergencyp-hysicians.org/siteassets/files/pdfs/2018acep-emergency-department-violence-pollresults-2.pdf>. Accessed 22 Jun 2025
7. Lim R, Aarsen KV, Gray S, Rang L, Fitzpatrick J, Fischer L. Emergency medicine physician burnout and wellness in Canada before COVID19: a national survey. *CJEM*. 2020;22(5):603–7.
8. Caruso R, Toffanin T, Folesani F, Biancosino B, Romagnolo F, Riba MB, et al. Violence against physicians in the workplace: trends, causes, consequences, and strategies for intervention. *Curr Psychiatry Rep*. 2022;24(12):911–24.
9. De Wit K. Burnout and depression among Canadian emergency physicians. *CJEM*. 2020;22(5):559–60.
10. Sharma A, Minh Duc NT, Luu Lam Thang T, Nam NH, Ng SJ, Abbas KS, et al. A consensus-based checklist for reporting of survey studies (CROSS). *J Gen Intern Med*. 2021;36(10):3179–87.
11. Aljohani B, Burkholder J, Tran QK, Chen C, Beisenova K, Pourmand A. Workplace violence in the emergency department: a systematic review and meta-analysis. *Public Health*. 2021;196:186–97.
12. Nikathil S, Olaussen A, Gocentas RA, Symons E, Mitra B. Review article: workplace violence in the emergency department: a systematic review and meta analysis. *Emerg Med Australas*. 2017;29(3):265–75.
13. Gillespie GL, Pekar B, Byczkowski TL, Fisher BS. Worker, workplace, and community/environmental risk factors for workplace violence in emergency departments. *Arch Environ Occup Health*. 2017;72(2):79–86.
14. Hou Y, Corbally M, Timmins F. Violence against nurses by patients and visitors in the emergency department: a concept analysis. *J Nurs Manag*. 2022;30(6):1688–99.
15. Fernandes CMB, Bouthillette F, Raboud JM, Bullock L, Moore CF, Christenson JM, et al. Violence in the emergency department: A survey of health care workers. *CMAJ Can Med Assoc J*. 1999;161(10):1245–8.
16. Richardson SK, Grainger PC, Ardagh MW, Morrison R. Violence and aggression in the emergency department is under-reported and under-appreciated. *N Z Med J*. 2018;131(1476):50–8.
17. Wirth T, Peters C, Nienhaus A, Schablon A. Interventions for workplace violence prevention in emergency departments: a systematic review. *Int J Environ Res Public Health*. 2021;18(16):8459.
18. Okundolor SI, Ahenkorah F, Sarff L, Carson N, Olmedo A, Canamar C, et al. Zero staff assaults in the psychiatric emergency

- room: impact of a multifaceted performance improvement project. *J Am Psychiatr Nurses Assoc.* 2021;27(1):64–71.
19. Touzet S, Occelli P, Denis A, Cornut PL, Fassier JB, Le Pogam MA, et al. Impact of a comprehensive prevention programme aimed at reducing incivility and verbal violence against health-care workers in a French ophthalmic emergency department: an interrupted time-series study. *BMJ Open.* 2019;9(9):e031054.
20. Timmins F, Timmins B. An integrative review of waiting time, queuing, and design as contributory factors to emergency department violence. *J Evid Based Med.* 2021;14(2):139–51.
21. Richmond JS, Berlin JS, Fishkind AB, Holloman GH Jr, Zeller SL, Wilson MP, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med.* 2012;13(1):17–25.
22. Wilson MP, Pepper D, Currier GW, Holloman GH Jr, Feifel D. The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry Project BETA psychopharmacology workgroup. *West J Emerg Med.* 2012;13(1):26–34.

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