Factors Influencing the Intention of Family Members of Patients Admitted to Emergency Departments to Commit Violence Against Health Care Professionals: A Multicenter Cross-Sectional Study

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Contribution to Emergency Nursing Practice

- Violence against health care professionals in emergency departments is often driven by communication gaps and unmet patient expectations. This study highlights the critical role of inadequate communication and the lack of information about the patient in increasing the intent to commit violence.
- The findings identify younger age, lower education level, and unemployment as key predictors of violence intentions among family members. Developing communication strategies targeting these factors is essential.
- To reduce the risk of violence in emergency departments, emergency nurses should establish clear communication and promptly address the concerns of family members, creating a safer and more supportive environment.

Abstract

Introduction: Information regarding the factors influencing the intention of family members of patients admitted to the emergency department to commit violence against health care professionals is limited. This study aimed to determine the factors affecting the intention of family members of patients admitted to the emergency department to commit violence against health care professionals.

Methods: This multicenter cross-sectional study, conducted in 3 Turkish hospitals from December 2023 to May 2024, involved 872 family members of emergency department patients. Ethical approval was obtained (approval no: 2023/83). Data were collected through face-to-face surveys using the Intention to Commit Violence Against Healthcare Workers Scale and the Healthcare Access Experience Form. Analysis was performed with SPSS 22.0 using both parametric and nonparametric tests, with significance set at $P<.05$.

Results: The participants' average age was 35.60 SD = 10.89, with 56.8% male and 61.5% having completed secondary education. Significant factors increasing the intention to commit violence included younger age ($P = .001$), lower education ($P = .001$), unemployment ($P = .001$), and being single ($P = .001$). Although the overall intention to commit violence was low, negative perceptions regarding health care access, such as lack of information about their relative's condition ($P = .001$), inability to see their relative during treatment ($P = .001$), and exclusion from care ($P = .001$), significantly heightened this intention.

Discussion: This study reveals that the strongest factors influencing the intention to commit violence among family members of patients admitted to the emergency department are the lack of information about their relative and inadequate communication.

Key words: Emergency service; Health personnel; Emergency nursing; Patient care team; Violence

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Introduction

Emergency departments are known as health care service delivery areas with intense work pace and high-stress environments. These environments are places where emergency interventions and uncertainties occur. Family members (FMs) of patients may exhibit negative reactions toward health care professionals owing to their concerns and emotional burdens during this process.[1-3] Studies have shown that health care professionals working in emergency departments are the group most frequently exposed to violence.[4-6] The victimization of employees by violence in emergency departments is a serious issue. In 1 study, it was found that 22.3% of health care workers were exposed to physical violence and 87.6% to psychological violence.[2] Another study determined that 66.7% of health care personnel working in emergency departments had encountered violence.[7] Violence against health care professionals can lead to severe consequences, including deaths, life-threatening injuries, job dissatisfaction, decreased attendance, increased leave days, impairment of work functionality, depression, post-traumatic stress disorder, deterioration of ethical values, burnout, and an increase in defensive medicine practices.[6,8]

Violence against health care workers in emergency departments, especially assaults by patients' relatives, has become a global issue.[9] Studies have shown that violence in emergency departments typically manifests as verbal abuse and physical assault, predominantly perpetrated by patients' FMs.[9-11] It has been reported that 96.7% of violence against health care workers in emergency departments originates from patients' FMs.[2] Similarly, a study conducted in Turkey indicated that ED workers experience emotional exhaustion, with a significant portion of violent incidents being attributed to patients' relatives.[1]

However, there are limited studies on the reasons why FMs resort to violence against health care professionals in the emergency department. These studies have shown that the most common reason for violence against health care professionals in the emergency department is the unmet expectations of patients and their families.[12-14] Violence against health care professionals in the emergency department arises from various factors such as administrative issues, problems stemming from personnel, security deficiencies, environmental factors, and situations related to patients and their FMs.[13] Insufficient time allocated to patients, inadequate communication, long waiting times, and overcrowded waiting areas,[14] as well as a lack of trust in health care workers or the health care system, and dissatisfaction with the care provided[15] are among the factors that cause the emergence of violence. In addition, unrealistic expectations regarding the professionalism and treatment success of the personnel,[16] increased anxiety levels of FMs, perceptions of low-quality care, and stress owing to the patient's life-threatening condition are also included in these factors.[13] A recent study provides evidence that violence against health care workers in emergency departments can be predicted based on past behaviors. The research emphasizes that patients with a history of violent tendencies pose a higher risk of perpetrating violence in emergency settings. The study highlights that violence remains a constant threat in emergency departments and is often associated with factors such as substance abuse, psychological disorders, and the stressful conditions of the hospital environment. In addition, it is noted that violent behavior can be anticipated based on past incidents, which can have long-term psychological effects on health care workers.[17] No studies were identified focusing on the intentions of FMs to inflict violence on health care professionals in the emergency department. This gap makes it difficult to fully understand the root causes of violence. Therefore, the violence of FMs against health care professionals in emergency departments remains a significant problem.

Although there is extensive research on the prevalence and general causes of violence in emergency departments, there is a significant lack of information regarding the factors that lead FMs to resort to violence. This gap makes it difficult to fully understand the root causes of violence and, therefore, hinders the development of effective prevention strategies. Thus, the factors influencing the violence intentions of FMs who visit the emergency department must be identified. A study on this topic may contribute to the prevention of violence; improvement of interactions among patients, FMs, and health care professionals; and enhancement of the quality of health care services. This study aimed to determine the violence intentions of FMs of patients admitted to the emergency department and how these intentions are influenced by the demographic characteristics of FMs and their negative perceptions regarding their access to health care services.

The following hypotheses were tested in this study:

$H1_1$: The violence intentions of FMs of patients admitted to the emergency department are influenced by their demographic characteristics.

$H1_2$: Negative perceptions related to their experiences in accessing health care services influence the violence intentions of FMs.

Methods

STUDY DESIGN AND SETTING

This multicenter cross-sectional study was conducted between December 1, 2023 and May 1, 2024. The study involved FMs of patients with stable health conditions and acute symptoms who were admitted to the emergency departments of 2 teaching and research hospitals in eastern Turkey and 1 state hospital in southern Turkey. All 3 hospitals where the study was conducted have a "White Code" call system in place. In case of a risk of violence, security personnel can intervene within minutes after a white code call is made by health care professionals. The Strengthening the Reporting of Observational Studies in Epidemiology checklist was used in the reporting of the study.[16]

ETHICAL CONSIDERATIONS

The study was conducted with the approval of the Non-Interventional Ethics Committee of Hasan Kalyoncu University (approval no: 2023/83). A verbal and written informed consent was obtained from all participants.[14] The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki[15] throughout all stages.

PARTICIPANTS

The population of the study consisted of FMs of patients who were admitted to the emergency department of the hospital where the study was conducted, with stable health conditions and nonlife-threatening acute symptoms. The sample of the study consisted of FMs who voluntarily agreed to participate. The sample size was calculated using the G*Power 3.1.9.7 program (Düsseldorf, Germany). The calculation for linear bivariate regression analysis was based on Cohen's effect size table.[18] With a 2-tailed hypothesis, slope H1 of 0.15, α of 0.01, β of 0.05, and a power of 0.95, it was determined that a minimum of 796 participants were required. Considering potential data loss, the sample size was increased by 20%. It was assessed that 1248 FMs were eligible for the study. The FMs were informed about the study. Data from 184 FMs were not included because they declined to participate in the study, and data from 192 FMs were excluded owing to incomplete responses on the data collection forms. The study was completed with data from 872 participants. In this study, 70% of the target population was reached.

SAMPLE CRITERIA

Inclusion criteria were (1) being older than 18 years, (2) being able to speak and write in Turkish, (3) having no communication barriers, (4) having no mental disabilities, (5) being an FM of the patient who was admitted to the emergency department of the hospital where the research was conducted, and (6) being willing to participate in the research.

Exclusion criteria were (1) FMs of patients whose condition became critical and were taken to the resuscitation room and (2) data from FMs who decided to withdraw from the research after initially agreeing to participate.

DATA COLLECTION TOOLS

The data collection tools used in this study consist of the "Descriptive Information Form" prepared by the researcher, the "Intention to Use Violence Against Healthcare Workers Scale," and the "Experiences of Accessing Healthcare Services Form."

Descriptive Information Form

In the first section of the data collection form, there are questions aimed at determining the age, gender, education level, marital status, family type, and occupational information of the FMs. In addition, this section of the form includes questions designed to determine the patient's propensity to resort to violence in their social life and whether they have received psychological treatment related to violence.

Intention to Use Violence Against Healthcare Workers Scale

This scale, developed by Şanlıtürk and Boy[19] based on Ajzen's "Theory of Planned Behavior," is designed to measure individuals' intentions to use violence against health care workers and the factors that influence this intention.[20] The scale consists of 15 items and is rated on a 5-point Likert scale. It includes 5 dimensions: intention to use violence, past experiences, attitude toward the behavior, subjective norm, and perceived behavioral control. In the scale, the scores for each subgroup are calculated separately. The reliability of the scale was calculated with a Cronbach's alpha value of 0.849. For the data in this study, the Cronbach's alpha value was calculated as 0.855.

Experiences of Accessing Healthcare Services Form

The Experiences of Accessing Healthcare Services Form was developed by researchers through the examination of relevant sources.[1-8] Seven negative experiences related to accessing health care services were identified for FMs. The 7 negative experiences listed on the form were prepared in a 3-point Likert scale format: increases the intention of violence, uncertain, and does not increase. These negative experiences include (1) not being able to obtain information about the condition of my relative, (2) not being able to see my relative during examination and treatment, (3) someone who arrived after me being examined before me, (4) waiting too long for examination and test procedures, (5) believing that the treatment or care given to an FM was inadequate, (6) thinking that the health care professional was inexperienced and inadequate, and (7) not being able to participate in the care of my relative. Expert opinion was sought for the Experiences of Accessing Healthcare Services Form. The content validity index of the form was calculated as 0.96. Given that the content validity index was $0.96 > 0.80$, the data collection forms were deemed appropriate for this research.[21]

DATA COLLECTION FOR THE RESEARCH

Preapplication

Before starting the research, a preapplication was conducted with 20 FMs. Given that no revisions were necessary for the data collection forms, the results of the preapplication were included in the main research data. Before collecting the research data, FMs were informed about the study. The briefing was conducted individually for each FM in a designated room in the emergency department, specifically for informing patients and FMs. During the briefing, FMs were informed that their participation in the study would be anonymous, and they were asked not to write their identity or contact information on the form. It was explained to FMs that the data collected would be kept confidential, not shared with anyone, and used solely for scientific purposes. FMs who voluntarily agreed to participate in the study were asked to sign the consent form. Each FM was given a data collection form and asked to answer the questions individually. FMs completed the survey under the supervision of the researcher. The data collection form was collected from FMs who completed the survey or no longer wished to continue answering the questions. It took approximately 10 minutes for the FMs to complete the survey.

STATISTICAL ANALYSIS OF THE DATA

All questions were mandatory, so there were no missing values. The statistical analysis of the data was performed using the SPSS 22.0 Windows software package (IBM Inc, Canada). Categorical variables were presented as numbers (n) and percentages (%), whereas numerical values were presented as mean ± standard deviation. The normal distribution of the data was assessed using the Kolmogorov-Smirnov and Shapiro-Wilk tests. Parametric tests were applied for data that showed a normal distribution, and nonparametric tests were used for data that did not. In the study, the dependent variable was the intention of the FMs of patients visiting the emergency department to use violence against health care workers, whereas the independent variables were age, gender, education, marital status, and employment status. For comparisons between 2 groups, the independent-samples *t* test was used, and for 3 or more groups, the 1-way analysis of variance test was applied. Factors influencing the intention to use violence were determined using linear regression analysis. Statistical significance was considered as $P<.05$.

Results

The characteristics of FMs of patients who applied to the emergency department with the intention to commit violence against health care workers are presented in Table 1. Significant differences were found between age groups (18-29 vs 30-44, $P = .001$; 30-44 vs ≥45, $P = .032$). In terms of education, differences were noted between primary and secondary ($P = .001$), between secondary and bachelor's and above ($P = .002$), and between primary and bachelor's and above ($P = .015$). Employment status differences were seen between employed and unemployed ($P = .004$) and between unemployed and housewife ($P = .038$). Marital status showed a significant difference between married and single ($P = .001$). In addition, differences were found in patient relationships, such as sibling-son ($P = .020$) and father-son ($P = .045$).

The average scores on the Violence Intention Scale for FMs are presented in Table 2. The "Past Experiences" subscale had a low average score of 1.29 ± 0.77, suggesting limited previous violent encounters. The "Attitude Toward Behavior" subscale scored 1.83 ± 0.61, indicating that violence is generally not condoned, although there is a notable expectation for "better care." The "Subjective Norm" subscale's score of 2.03 ± 0.81 reflects minimal social pressure to commit violence. The "Perceived Behavioral Control"

TABLE 1
Comparison of family members' total scores on the intention to commit violence with demographic characteristics ($N = 872$)

Descriptive characteristics	n (%)	Violence Intention Scale score	Test, *P* value
Age (mean ± SD*: 35.60 ± 10.89, youngest [18] to oldest [71])			
18-29	286 (32.9)	2.01 ± 0.62	f = 9.106, $P = .001$
30-44	386 (44.3)	1.84 ± 0.50	1-2 = $P < .05$
≥45	200 (22.8)	1.89 ± 0.60	2-3 = $P < .05$
Gender			
Women	377 (43.2)	1.92 ± 0.58	t = 0.690, $P = .491$
Men	495 (56.8)	1.94 ± 0.56	
Educational status			f = 24.015, $P = .001$
Primary education	117 (13.4)	2.22 ± 0.70	1-2 = $P < .05$
Secondary education	536 (61.5)	1.84 ± 0.51	2-3 = $P < .05$
Bachelor's degree and above	219 (25.1)	1.99 ± 0.57	1-3 = $P < .05$
Employment status			
Employed	579 (66.4)	1.84 ± 0.51	
Retired	37 (4.2)	2.08 ± 0.63	f = 18.811, $P = .001$
Unemployed	114 (13.1)	2.25 ± 0.70	1-3 = $P < .05$
Housewife	142 (16.3)	1.97 ± 0.56	3-4 = $P < .05$
Marital status			t = 4.186, $P = .001$
Married	594 (68.1)	1.87 ± 0.52	
Single	278 (31.9)	2.05 ± 0.66	
History of experiencing violence			
Never experienced violence	600 (68.8)	1.91 ± 0.57	f = 1.122, $P = .326$
Experienced violence during childhood	234 (26.8)	1.96 ± 0.59	
Currently experiencing violence	38 (4.4)	2.03 ± 0.42	
Relationship to the patient			
Mother	154 (17.7)	1.86 ± 0.53	f = 3.771, $P = .002$
Father	102 (11.7)	2.06 ± 0.64	
Sibling	130 (14.9)	2.04 ± 0.65	3-5 = $P < .05$
Spouse	166 (19.0)	1.91 ± 0.51	2-5 = $P < .05$
Son	127 (14.6)	1.81 ± 0.54	
Daughter	193 (22.1)	1.93	

f, 1-way analysis of variance; post hoc, Bonferroni and Tukey's honestly significant difference test; t, independent-samples *t* test.
* Violence Intention Scale score average.

subscale averaged 1.93 ± 1.28, showing a low perceived ability to act violently. The overall average score of 1.68 ± 0.84 suggests a generally low intention to commit violence.

Factors increasing FMs' intentions of violence owing to negative perceptions of health care services are shown in the Figure. The most significant factor was "Not receiving information about my relative's condition" (61.2%), followed by "Not being able to see my relative during examination and treatment" (59.6%). Other factors included "Someone who arrived after me being seen by a doctor while I am still waiting" (51.7%), "Having to wait too long for examination and tests" (45.3%), "Thinking that the treatment or care provided to a family member is inadequate" (44.5%), "Believing that the health care professional is inexperienced and incompetent" (44.2%), and "Not being able to participate in my relative's care" (39.6%).

TABLE 2
Distribution of family members' Violence Intention Scale score averages ($N = 872$)

Propositions	Mean ± SD*
Intention to commit violence	1.32 ± 0.73
1. I intend to commit violence against health care workers during my next hospital visit.	1.32 ± 0.73
2. Past experiences	1.29 ± 0.77
3. I have previously committed violence against health care workers.	1.29 ± 0.77
Attitude toward behavior	1.83 ± 0.61
4. Committing violence against health care workers during my next hospital visit is a desirable behavior for me.	1.36 ± 0.87
5. Committing violence against health care workers during my next hospital visit is not a desirable behavior for me.	1.70 ± 1.31
6. Committing violence against health care workers will ensure that I/my relative receive better care	1.67 ± 1.22
7. Receiving better care for me/my relative is beneficial for me/my relative.	4.10 ± 1.34
8. Committing violence against health care workers during my next hospital visit is harmful for me/my relative.	1.92 ± 1.46
9. Committing violence against health care workers during my next hospital visit is beneficial for me/my relative.	1.54 ± 1.14
Subjective norm	2.03 ± 0.81
10. Most people like me commit violence against health care workers.	1.58 ± 1.07
11. When it comes to receiving good care for me/my relative, I want to do what others like me would do.	2.77 ± 1.55
12. My family supports me in committing violence against health care workers	1.43 ± 1.01
13. I care about my family's opinions regarding my committing violence against health care workers.	2.09 ± 1.50
14. When it comes to receiving good care for me/my relative, I want to do whatever my family thinks I should do.	2.29 ± 1.33
Perceived behavioral control	1.93 ± 1.28
15. I am certain that I will commit violence against health care workers during my next hospital visit.	1.45 ± 1.05
16. Committing violence against health care workers during my next hospital visit is up to me.	2.41 ± 1.51
Total score	1.68 ± 0.84

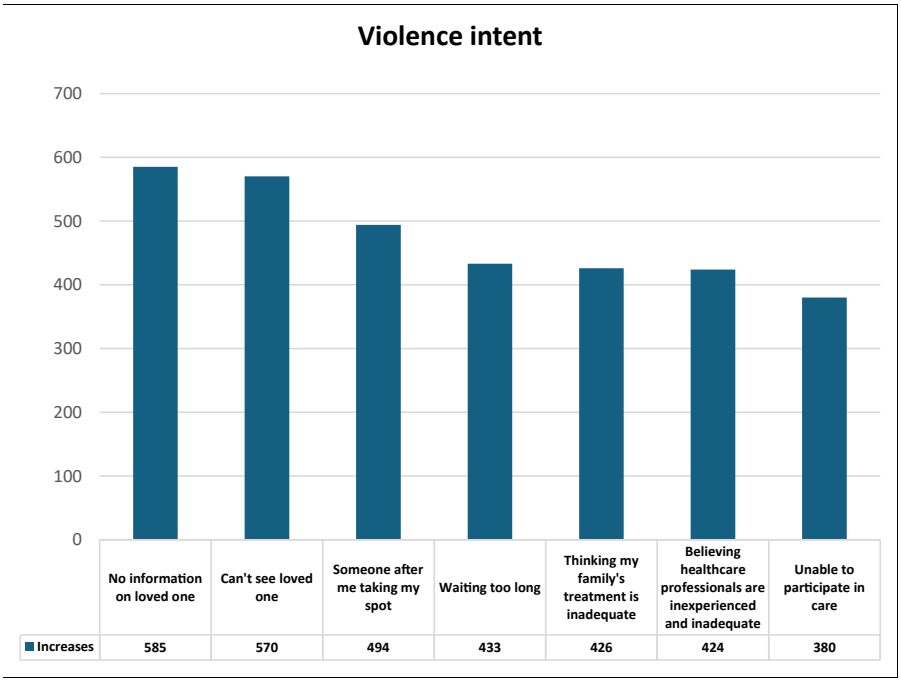
* Violence Intention Scale score average.

The strongest factors influencing FMs' intentions of violence based on their descriptive characteristics are presented in Table 3. Gender (male) ($\beta = 0.143$, $P = .001$), educational status (primary education) ($\beta = -0.306$, $P = .001$), employment status (unemployed) ($\beta = 0.236$, $P = .001$), and marital status (single) ($\beta = 0.178$, $P = .001$) significantly affect the intention to commit violence. Age, history of experiencing violence, and relationship to the patient did not show a significant effect ($P > .05$) (Table 3).

The strongest factors influencing FMs intentions of violence owing to negative perceptions of their health care access and experiences are presented in Table 4. Not receiving information about my relative's condition ($\beta = -0.461$, $P = .001$), not being able to see my relative during examination and treatment ($\beta = -0.395$, $P = .001$), someone who arrived after me being seen by a doctor while I am still waiting ($\beta = -0.252$, $P = .001$), having to wait too long for examination and tests ($\beta = -0.222$, $P = .001$), thinking that the treatment or care provided to a family member is inadequate ($\beta = -0.201$, $P = .001$), believing that the health care professional is inexperienced and incompetent ($\beta = -0.198$, $P = .001$), and not being able to participate in my relative's care ($\beta = -0.167$, $P = .001$) were identified as significant factors affecting the intention to commit violence (Table 4).

Discussion

This study aimed to explore the intentions of violence toward health care personnel among FMs of patients admitted to the emergency department and how these intentions are



FIGURE

Factors increasing family members' intentions of violence owing to negative perceptions of access to health care services ($N = 872$).

influenced by FMs' descriptive characteristics and negative perceptions of their health care access experiences. The most significant finding is that the inability to receive information about the patient's condition and the inability to see their relatives during the examination are the primary factors influencing the intention to commit violence. This suggests that addressing the information and access needs of FMs is crucial in reducing violence intentions. Hypotheses $H1_1$ and $H1_2$ were confirmed, and the study contributes valuable data on understanding violence tendencies in emergency settings. It also underscores the importance of information sharing and addressing FMs' concerns in preventing violence.

Younger age groups[18-29] and those with lower education levels showed higher intentions of violence. In addition, unemployed and single individuals had higher violence intention scores than others. The experience of previous violence significantly affected the intention to commit violence, whereas factors such as increased education levels and marriage mitigated these intentions. Research shows that demographic characteristics influence

TABLE 3

Models showing the strongest factors influencing family members' intentions of violence based on their descriptive characteristics

	Descriptive characteristics	B (odds ratio)	Test/*P* value	95% CI Min-Max
Intention to commit violence	Age	0.012	−0.342/.733	−0.004 to 0.003
	Gender (male)	0.143	4.271/.001	0.900-0.243
	Educational status (primary education)	−0.306	−9.470/.001	−0.296 to 0.194
	Employment status (unemployed)	0.236	7.153/.001	0.083-0.146
	Marital status (single)	0.178	5.321/.001	0.138-0.300
	History of experiencing violence	0.050	1.484/.138	−0.017 to 0.119
	Relationship to the patient	−0.030	−0.871/.384	−0.031 to 0.012

TABLE 4
Models showing the strongest factors influencing family members' intentions of violence owing to negative perceptions of their health care access experiences

	Negative perceptions	β (odds ratio)	Test/*P* value	95% CI Min-max
Intention to commit violence	Not receiving information about my relative's condition	−0.461	−15.320/.001	−0.186 to −0.144
	Not being able to see my relative during examination and treatment	−0.395	−12.700/.001	−0.144 to −0.118
	Someone who arrived after me being seen by a doctor while I am still waiting	−0.252	−7.690/.001	−0.137 to −0.109
	Having to wait too long for examination and tests	−0.222	−6.724/.001	−0.123 to −0.098
	Thinking that the treatment or care provided to a family member is inadequate	−0.201	−6.058/.001	−0.108 to −0.077
	Believing that the health care professional is inexperienced and incompetent	−0.198	−5.966/.001	−0.096 to −0.065
	Not being able to participate in my relative's care	−0.167	−4.998/.001	−0.078 to −0.054

violence intentions differently. Willits'[22] study demonstrated that situational factors could strongly affect tendencies toward violence, with provocation and aggressive cues increasing violent inclinations. Wang[23] highlighted education level as a critical factor, noting that lower education levels could increase violent tendencies. O'Donnell et al[24] also indicated that demographic factors such as education level, ethnicity, and marital status influence the risk of exposure to violence. Conversely, Przybysz-Zaremba and Katkonienė's[25] study found that men living in rural areas with high alcohol consumption had higher tendencies toward violence. These studies reveal the complex effects of demographic and socioeconomic factors on violence intentions.

The low intention of FMs to commit violence suggests that violence is generally not socially approved, and social norms significantly influence this intention. However, the expectation of receiving better care can increase the intention to commit violence, particularly when individuals feel inadequate in controlling these urges. Effective communication and managing patient relatives' expectations are crucial in preventing violence. Research indicates that violence in health care often stems from communication deficiencies. Can and Hayli[26] highlighted that violence against health care workers frequently arises owing to communication problems and unmet expectations. Yeşilbaş[27] emphasized that violence in health care is widespread but preventable through adequate communication and education. Saeedi and Al-Othman[28] also found that verbal and nonverbal communication breakdowns provoke violent behaviors. These findings align with similar results in the literature.

Figure illustrates how negative perceptions of health care access among FMs increase their intentions of violence. Not receiving information about their relative's condition and not being able to see their relative during the examination significantly heightened the intention of violence. In addition, the prioritization of others for examination and long waiting times were key factors. These findings emphasize the critical importance of information sharing and managing waiting times in health care services for violence prevention. The literature highlights that violence intentions in health care often stem from communication deficiencies. Saeedi and Al-Othman[28] showed that communication breakdowns between health care workers and patients could trigger violent behaviors. This study supports the findings in the Figure, demonstrating that information sharing and effective communication in health care services are crucial in reducing violence intentions.

Factors such as gender (male), low education level, unemployment, and being single significantly increase the intention of violence among FMs, whereas age, previous experience of violence, and the relationship to the patient do not show a significant effect. Research indicates that gender, education level, and employment status have significant impacts on the intentions of violence toward health care workers. Gates and Gillespie[29] found that males are more likely to exhibit violent tendencies toward health care workers, and a low education level increases the risk of violence. Unemployment also increases tendencies toward violence, given that economic stress and unemployment can elevate aggression levels. These findings support the demographic factors seen in Table 3 as significant influences on violence intentions.

The most significant factors influencing violence intentions among FMs are negative experiences, such as not receiving information about their relative's condition, not being able to see their relative during examinations, long waiting times, perceived inadequate care, and a belief in the inexperience or incompetence of health care professionals. These findings highlight the crucial role of information sharing and communication in reducing violence risk. The literature supports this, showing that negative health care experiences and communication deficiencies can heighten violence intentions. Macrae[30] noted that communication errors could severely affect patient safety, increasing violence intentions. Baby et al[31] found that inadequate communication skills often lead to violence, and enhancing these skills can reduce its occurrence. Jiang and Hong[32] also identified ineffective communication as a key factor in increasing violence tendencies, aligning with the negative experiences presented in Table 4. These findings align with similar results in the literature.

Emergency nurses are health care professionals who frequently interact directly with patients and their families in a highly intense and stressful work environment. Strategies to prevent violence should particularly focus on enhancing communication skills and prioritizing the provision of information to patients' families. Nurses can address 1 of the main causes of violence, which is the lack of information, by providing clear and timely updates about the patients' condition to their families. Moreover, involving the families in the treatment process and listening to their concerns can be effective in reducing tension. In addition to communication, it is crucial for nurses to be aware of and implement safety protocols that allow easy access to security personnel during emergencies. Developing skills to manage violence through training programs and simulations can also contribute to nurses feeling more secure. These strategies will help create a safer working environment in emergency departments and enhance nurses' job satisfaction.

This study provides significant contributions to understanding the factors influencing violence intentions within the context of the Theory of Planned Behavior. By filling gaps in the literature, the study shows that the violence intentions of FMs of patients admitted to the emergency department are closely related to information deficiencies and communication problems. Practically, these findings highlight the need to improve information sharing in emergency departments and develop effective communication strategies to address FMs' concerns. In this context, training programs and interventions aimed at enhancing health care workers' communication skills are recommended. Future research should explore the generalizability of these findings across different demographic and clinical groups and assess the effectiveness of strategies aimed at preventing violence. This study provides a solid foundation for developing new approaches to enhance safety in health care services, both theoretically and practically.

Limitations

The limitations of this study include restricted generalizability owing to data collection from hospitals in specific regions and the possibility that participants' responses may have been influenced by social desirability bias. Nevertheless, the study makes a unique contribution to the literature by providing a comprehensive analysis of the violence intentions of patient relatives and highlighting the role of communication deficiencies in these intentions.

Implications for Emergency Nurses

Emergency nurses are often the first to interact with patients and families in the emergency department, making them crucial in managing expectations and preventing violence. Clear, timely communication about the patient's condition and care process can reduce violence risk. By considering demographic factors such as age, education, and employment status, nurses can develop tailored communication strategies to address family needs. These approaches can enhance safety and improve care quality. Future research and policies should focus on evidence-based strategies that support nurses in effectively engaging with families to reduce violence risk.

Conclusion

This study has shown that the intentions of violence toward health care professionals among FMs of patients admitted to the emergency department are closely related to the lack of information about their patients and negative experiences encountered during the health care access process. The results emphasize the need to enhance information sharing in emergency departments and develop effective communication methods that address patient relatives' concerns to reduce violence intentions. These findings underscore the importance of ensuring safety in health care services and the significance of strategies aimed at preventing violence incidents. Future studies are recommended to test these findings in different contexts and evaluate the long-term effects of these strategies.

Author Disclosures

Conflicts of interest: none to report.

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The data sets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Before the research commenced, ethics approval was obtained from the Hasan Kalyoncu University (Gaziantep, Turkey) Non-interventional Research Ethics Committee on December 4, 2023 (approval no. 2023/83). Each stage of the study was conducted in accordance with the Declaration of Helsinki of the World Medical Association. This study was conducted in accordance with the ethical principles specified in the Good Clinical Practice Guidelines of the Ministry of Health of the Republic of Turkey.

All patients provided written and verbal informed consent to participate in the study

This study was retrospectively registered with ClinicalTrials.gov (registration number: NCT0618646).

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