

Journal of EMERGENCY NURSING

OFFICIAL PUBLICATION OF THE EMERGENCY NURSES ASSOCIATION

- The Experiences of United States Emergency Nurses Related to Witnessed and Experienced Bias: A Mixed-Methods Study
- The Long Tail of COVID-19: Implications for the Future of Emergency Nursing
- Uncovering the Experience: Return to Work of Nurses After Parental Leave
- Determining Clinical Judgment Among Emergency Nurses During a Complex Simulation
- Using Comic-Based Concussion Discharge Instructions to Address Caregiver Health Literacy in the Emergency Department
- Perspective of Emergency Pediatric Nurses Triageing Pediatric Patients in the Emergency Department: A Phenomenographic Study
- Emergency Departments Treating Veterans for Suicide: Ensuring Quality Care for Veterans Outside of Department of Veterans Affairs Health Care Facilities
- Evidence-Based vs Informal Suicide Training: Nurse Confidence and Comfort With Suicidal Patient Care
- Medication Discussions With Patients With Cardiovascular Disease in the Emergency Department: An Opportunity for Emergency Nurses to Engage Patients to Support Medication Reconciliation





Report Information from ProQuest

27 September 2023 06:47

TABLE OF CONTENTS

Search Strategy.....	iv
1. Predicting Workplace Violence in the Emergency Department Based on Electronic Health Record Data: JEN.....	1
2. Staff Duress Alarms for Workplace Violence in the Emergency Department: A Mixed-Methods Evaluation: JEN.....	2
3. Editorial Board: JEN.....	11
4. ENA Advocacy Efforts and The State of Play Regarding Workplace Violence: JEN.....	12
5. Workplace Violence in the Hospital: Strategies for Meaningful Change: JEN.....	14
6. Nurse, Provider, and Emergency Department Technician: Perceptions and Experiences of Violence and Aggression in the Emergency Department: JEN.....	22
7. Pharmacologic Therapy to Mitigate Acute Agitation in the Emergency Department: Case Reports of Diverse Patient Presentations: JEN.....	32
8. Board of Directors: JEN.....	33
9. Implementation of a Behavioral Emergency Response Team in the Emergency Department: JEN.....	35
10. Violence Risk Assessment in the Emergency Department: JEN.....	43
11. Effects of Emergency Nurses' Experiences of Violence, Resilience, and Nursing Work Environment on Turnover Intention: A Cross-Sectional Survey: JEN.....	55
12. Table of Contents: JEN.....	67
13. Workplace Violence: Raising Awareness and Bridging the Gap with Law Enforcement: JEN.....	68
14. Agitated Geriatric Patients and Violence in the Workplace: JEN.....	71
15. Exposure of Emergency Nurses to Workplace Violence and Their Coping Strategies: A Cross-Sectional Design: JEN.....	79
16. Why Won't It Stop: Workplace Violence in Emergency Care: JEN.....	95
17. Screening for Behavioral Health Patient Aggression in Emergency Departments to Reduce Workplace Violence: JEN.....	100
18. Introducing a Digital Occupational Violence Risk Assessment Tool Into an Emergency Department: A Pilot Implementation Study: JEN.....	116
19. Researching Workplace Violence: Challenges for Emergency Nursing Researchers: JEN.....	126
20. Qualitative Analysis of Workplace Assault Outcomes from the Perspectives of Emergency Nurses: JEN.....	129
21. Mental Health and Harassment in the Workplace: JEN.....	140
22. Workplace Violence Emergency Nursing Review Questions: May 2023: JEN.....	145
23. A Systematic Review of Violence Risk Assessment Tools Currently Used in Emergency Care Settings: JEN.....	150
24. Information for Readers: JEN.....	171
25. Addressing a Key Leadership Challenge: Workplace Violence: JEN.....	172
26. Providing Peer Support after Workplace Violence: JEN.....	178
27. The Lived Experience of Workplace Violence Among Emergency Nurses: JEN.....	179

TABLE OF CONTENTS

28. The Experiences of United States Emergency Nurses Related to Witnessed and Experienced Bias: A Mixed-Methods Study: JEN.....	186
29. Perspective of Emergency Pediatric Nurses Triageing Pediatric Patients in the Emergency Department: A Phenomenographic Study: JEN.....	207
30. A Quality Improvement Initiative on Reducing Blood Culture Contamination in the Emergency Department: JEN.....	220
31. Determining Clinical Judgment Among Emergency Nurses During a Complex Simulation: JEN.....	229
32. Emergency Nursing Review Questions: March 2023: JEN.....	246
33. An Important Suggestion for External Jugular Vein Cannulation: JEN.....	249
34. "I Was Here First, Why Did They Go Before Me": Examining Patients'Perceptions of Priority in a Psychometric Study of Emergency Department Triage: JEN.....	251
35. Leadership and Trauma-Informed Care: Working to Support Staff and Teams: JEN.....	253
36. Medication Discussions With Patients With Cardiovascular Disease in the Emergency Department: An Opportunity for Emergency Nurses to Engage Patients to Support Medication Reconciliation: JEN.....	258
37. Board of Directors: JEN.....	260
38. My Commitment to Emergency Nurses: JEN.....	261
39. Information for Readers: JEN.....	264
40. Editorial Board: JEN.....	265
41. The Long Tail of COVID-19 : Implications for the Future of Emergency Nursing: JEN.....	266
42. Using Comic-Based Concussion Discharge Instructions to Address Caregiver Health Literacy in the Emergency Department: JEN.....	278
43. Role Delineation of the Code Blue Team: A Quasi-Experimental Study During COVID-19: JEN.....	286
44. Thank You to Reviewers: JEN.....	288
45. Evidence-Based vs Informal Suicide Training: Nurse Confidence and Comfort With Suicidal Patient Care: JEN.....	289
46. Uncovering the Experience: Return to Work of Nurses After Parental Leave: JEN.....	299
47. Fracture of an Intravenous Cannula in the Hand: A Case Report: JEN.....	312
48. Table of Contents: JEN.....	317
49. Emergency Departments Treating Veterans for Suicide: Ensuring Quality Care for Veterans Outside of Department of Veterans Affairs Health Care Facilities: JEN.....	318
50. The Uncanny Camaraderie Among Emergency Nurses: JEN.....	328
Bibliography.....	331

SEARCH STRATEGY

Set No.	Searched for	Databases	Results
S2	Journal of Emergency Nursing: JEN	Ebook Central, Public Health Database, Publicly Available Content Database	3455°
S1	"nursing"	Ebook Central, Public Health Database, Publicly Available Content Database	579652*

* Duplicates are removed from your search, but included in your result count.

° Duplicates are removed from your search and from your result count.

Predicting Workplace Violence in the Emergency Department Based on Electronic Health Record Data: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Emergency departments are extremely vulnerable to workplace violence, and emergency nurses are frequently exposed to workplace violence. We developed workplace violence prediction models using machine learning methods based on data from electronic health records.

Methods

This study was conducted using electronic health record data collected between January 1, 2016 and December 31, 2021. Workplace violence cases were identified based on violence-related mentions in nursing records. Workplace violence was predicted using various factors related to emergency department visit and stay.

Results

The dataset included 1215 workplace violence cases and 6044 nonviolence cases. Random Forest showed the best performance among the algorithms adopted in this study. Workplace violence was predicted with higher accuracy when both ED visit and ED stay factors were used as predictors (0.90, 95% confidence interval 0.898-0.912) than when only ED visit factors were used. When both ED visit and ED stay factors were included for prediction, the strongest predictor of risk of WPV was patient dissatisfaction, followed by high average daily length of stay, high daily number of patients, and symptoms of psychiatric disorders.

Discussion

This study showed that workplace violence could be predicted with previous data regarding ED visits and stays documented in electronic health records. Timely prediction and mitigation of workplace violence could improve the safety of emergency nurses and the quality of nursing care. To prevent workplace violence, emergency nurses must recognize and continuously observe the risk factors for workplace violence from admission to discharge.

FULL TEXT

DETAILS

Subject: Comorbidity; Emergency medical care; Psychiatric symptoms; Regression analysis; Risk factors; Disease; Nonviolence; Workplace violence; Mental disorders; Chronic illnesses; Hospitals; Data analysis; Emergency services; Nursing; Length of stay; Nurses; Mitigation; Patients; Electronic health records; Learning; Nursing care; Classification; Workplaces; Computerized medical records; Algorithms; Decision trees; Departments; Health records

Business indexing term: Subject: Workplace violence

Identifier / keyword: Emergency department; Machine learning; Workplace aggression; Electronic health record; Predictive modeling

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	415-424
Publication year:	2023
Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.010
ProQuest document ID:	2809541600
Document URL:	https://www.proquest.com/scholarly-journals/predicting-workplace-violence-emergency/docview/2809541600/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-08-01
Database:	Public Health Database

Document 2 of 50

Staff Duress Alarms for Workplace Violence in the Emergency Department: A Mixed-Methods



Evaluation: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Complex personal duress alarms may be implemented as part of a multicomponent approach to preventing and mitigating workplace violence in emergency departments. Evaluation of duress alarms after implementation has been identified as a gap in the literature. The purpose of this quality improvement project was to examine the impact of a duress alarm system on workplace violence and user experience in an urban emergency department.

Methods

A comprehensive system evaluation was performed using a mixed-methods approach, which included retrospective data review, key informant interviews, observations, and a survey. Forty clinical staff at an emergency department in North Carolina were interviewed and provided feedback on the duress system.

Results

Findings indicated that the duress system was not associated with a decrease in workplace violence, and that the majority of clinical staff did not even wear the duress alarm. Staff indicated that the primary barriers to use of the alarm were the bulky design of the alarm badge, inadequate education about the alarm device and process, and the lack of a reliable and timely response from security.

Discussion

Ongoing engagement of clinical staff is critical to the success of health care technology implementations. Staff feedback, periodic re-education, and recurring process evaluations are vital to ensuring the continued relevance of systems, especially when staff safety is the intended purpose.

FULL TEXT

Introduction: Problem Description

Violence in health care has gone viral, but unlike the desirable social media status, this is an insidious virus that is fundamentally corrupting the profession, culture, and environment of care. The updated U.S. Joint Commission (TJC) standards on workplace violence (WPV) prevention call for a multicomponent approach that incorporates 4 ongoing elements: risk assessment, environmental monitoring, training, and an accessible and responsive safety reporting process.¹ Technology can be used to support this methodology but should have structured implementations, be continuously re-evaluated, and include bedside staff in the selection, implementation, and maintenance of the system.

Background

In 2021, more than 411,100 health care professionals were injured at work.² A press statement released by Press Ganey³ indicated that over 5200 nurses reported an assault at work between April and June of 2022. The prevention and mitigation of violence in health care settings is a priority for sustaining the health care workforce; thus, governmental, accreditation, and professional organizations have provided standards, guidelines, frameworks, and tool kits with evidence-based strategies.⁴⁻⁶ Interventions endorsed in TJC standards, Occupational Safety and Health Administration guidelines, and National Institute for Occupational Safety and Health recommendations include the following: staff education and training, organizational safety policies, continuous improvement guided by internal safety reporting systems, periodic risk assessments, and environmental modifications such as safety alarm systems.^{1,7,8,9}

Emergency nurses are at the greatest risk for WPV, largely due to the unique environment in which they work, which is characterized by diverse patient conditions, rapidly varying patient acuity, general accessibility of the department to the local community, physical architecture, excessive wait times, a unique negative progression in patient flow,

and patient overcrowding.^{10,11} Environmental interventions represent the largest portion of modifiable factors impacting WPV.^{5,9,12,13} The literature also provides substantial evidence associating reductions in WPV with strategic architectural design of emergency departments, strategic patterns of physical patient flow through the emergency department, and enhanced security presence at high-risk locations within the department.^{5,9,12,13} Recent systematic reviews have indicated that the most effective strategy to decrease WPV is using a multicomponent approach that includes the combination of health professional and security team education, policy, and environmental interventions to create comprehensive strategies.^{5,9,12,13} The Emergency Nurses Association's position statement supports the multicomponent approach with periodic re-evaluation.¹⁴ Technologies such as module-based virtual education and ongoing training, accessible and responsive safety reporting systems, data tracking and analytics, local and remote environmental monitoring, and safety/security alarm devices are available to facilitate and support WPV initiatives.^{5,12} Although preventing WPV is a clear priority, evidence evaluating security alarms after their implementation in hospitals, and more specifically emergency departments, is lacking.^{10,11,15} Safety and security alarms are devices that are manually activated by a health care worker when they experience an active or rapidly escalating duress situation while located in the environment of care.^{10,11,15} Three types of health care duress/security alarms have been systematically reviewed: stationary panic buttons, audible personal alarms, and complex mobile personal alarms. Stationary panic buttons are silent alarms installed in discrete locations in high-risk areas, which when activated send alerts directly to a base console for a response.¹⁵ These alarms are not mobile, so their locations are predesignated in the associated notification software, and security responds to the general location of the button. Audible personal alarms worn by health care workers emit an extremely loud alarm when activated. This type of alarm is designed to startle the aggressor and prompt responses from nearby individuals; however, notifications to security teams are not sent.¹⁵ Complex mobile personal alarms are the third type of alarm that includes real-time location tracking system technology.¹⁵ These alarms are linked to a central monitoring system to initiate a rapid, location-specific security response. Complex mobile personal alarms are thought to be the most effective type of safety system, although evidence is limited, and evaluations in various settings have not been published.^{10,11,15}

The Agency for Healthcare Research and Quality recommends that electronic duress-system evaluations use both quantitative and qualitative data to capture a comprehensive picture of clinical and user experience outcomes.¹⁶ Best practice for the life cycle of systems recommends evaluating user acceptance of a new system after 3 to 6 months and then performing continued re-evaluations as part of system maintenance.¹⁷ To regain alignment with the nursing process and the life cycle of systems, an evaluation of an ED WPV response safety alarm system is paramount.

Project Aims

This quality improvement project was planned to comprehensively evaluate the functionality, use, and impact of the personal duress alarm system that was implemented in a busy urban emergency department located in the southeastern United States. The project was designed to evaluate staff satisfaction, fidelity in using the alarm system, and outcomes of activation. The project was approved as an exempt project by the institutional review board where the emergency department was located.

Methods Design

This project is presented in accordance with the Revised Standards for Quality Improvement Reporting Excellence.¹⁸ This quality improvement process evaluation used a mixed-methods, convergent parallel design with preimplementation and postimplementation data. Preimplementation data were collected retrospectively from 3 sources: 2 electronic data dashboards managed by the health system and an electronic location tracking system containing quantitative and qualitative records. Postimplementation data were concurrently obtained from these sources, with additional qualitative and quantitative data obtained through unstructured observations, key informant interviews, and a questionnaire.

Setting

This project was conducted in a community hospital located in the southeastern United States in an emergency department that sees approximately 64,000 patients per year. The emergency department at this facility is structured

as 2 overlapping but independent units. The main emergency department is a 49-bed unit for standard emergency medical care, and the behavioral health emergency department is an 18-bed secured unit designed for patients with behavioral health emergencies.

Participants

The participants included the clinical frontline staff of the ED team, the intended end-users of the duress alarm system. This sample ($N = 131$) included nurses, paramedics, nursing assistants, or ED technicians, and behavioral health technicians who worked clinically in the emergency department between April 2021 and November 2022. Additionally, key informant interviews included nurses, travel nurses, paramedics, nursing assistants/ED technicians, and behavioral health technicians who worked clinical shifts during the survey and observation period from October 14, 2022 to November 19, 2022. Public safety and security officer team participants were interviewed directly and surveyed via email during the study period.

Intervention And Measures

The components of the duress system evaluation were modeled after the “Health IT Evaluation Toolkit” published by the digital health care research branch of the Agency for Healthcare Research and Quality.¹⁶ Quantitative and qualitative data were collected and integrated to evaluate the objectives of user experience and reduction of WPV. First, quantitative data were retrieved and collected concurrently from multiple sources. Qualitative data were transformed into quantitative data and then merged to describe the outcomes.

Reduction of WPV was evaluated using the following 2 strategies: First, preimplementation and postimplementation data were retrieved retrospectively from the health system’s interactive electronic WPV dashboard, where data are consolidated and displayed from the safety reporting system; the employee injury reporting system; and incidents reported by health system police/security. Event data from the duress alarm’s event tracking system were retrospectively reviewed, cleaned, and transformed by the principal investigator. All data used for this project were deidentified prior to review. Second, the duress alarm system’s impact on WPV risk was evaluated using standardized environmental risk assessment preimplementation and postimplementation data. The tool used to perform the environmental risk assessment followed guidelines recommended by TJC and Occupational Safety and Health Administration.^{1,8}

User experience was evaluated through a 3-part gap analysis that was structured around staff involvement and responses. The importance of including end-user feedback in the development and ongoing evaluation of systems is emphasized not only in the literature, but also by professional organizations. In their 2019 position statement on WPV, the Emergency Nurses Association announced that not only should nurses be provided with the opportunity to contribute their knowledge and experience to WPV initiatives but also that emergency nurses have a responsibility to do so.^{12,14,19} Components of the gap analysis included key informant interviews, a utilization and usability survey, and a workflow diagram.

Observations included baseline workflow of ED staff on day and night shift as well as the workflow/chain of events that occurred during a duress alarm activation. The duress alarm activation was defined as an incident when the personal duress alarm badge was pressed and resulted in the audible alarm; notification and response of nearby staff; and notification, dispatch, and response of security staff. Prior to data collection, the ED clinical team received education on the duress system during staff trainings, through in-person and email communications, and through a mock duress event.

On the first day of data collection, none of the frontline staff in the medical emergency department or the behavioral emergency department were wearing a duress badge. This finding was unexpected, and to promote the validity of the sample, 3 (previously unplanned) observations were conducted to record the number of clinical staff who were wearing badges. These observations took place between 5 am and 11 pm on nonconsecutive days. Only 5 of the 67 frontline staff observed were actively wearing duress badges.

The duress evaluation project was revised to re-educate the frontline staff about the system and survey, and informant interviews were designed to solicit end-user feedback using electronic survey and key informant interviews. The 6-question electronic survey was sent to all frontline staff members via the electronic health record

secure chat feature while they were on shift and active in the electronic health record. Those who did not complete the survey during the first request were sent a reminder to complete the survey 1 week following the initial request. The principal investigator conducted key informant interviews in a standardized format during randomly selected clinical shifts (7 pm, 7 am, and 11 am) on nonconsecutive days. Observations of the frontline staff were used to gather information about staff wearing badges. Key informant participants were selected from the frontline clinical team for brief key informant interviews. Each participant was asked whether they recognized the duress badge, whether they had worn one during a full shift since the implementation of the duress system, and whether they could demonstrate how to use the duress alarm badge. For those who were not able to identify or activate the duress badge correctly, education was offered. The de-identified key informant responses were recorded on a data collection tool, including the indication for duress activation education. Following the in-person questions (and education), the participants were asked to complete the 6-question survey. A total of 6 interview days took place during the observation period from October 14, 2022 to November 19, 2022.

Data Analysis

Use of the duress alarm system was determined through analysis of the following data: total number of duress alarm activations, number of false alarms, type of duress events (intervention required, officers responding, accidental press, event cleared), and percentage of staff who consistently wore duress alarm badges. System usability was evaluated through the following: current knowledge of badge operation, narrative feedback on barriers to wearing or using duress alarms, suggestions for optimization and improvement and general comments from users, and the process workflow. To evaluate the system's impact on WPV, the number of WPV safety reporting system reports and reported employee injuries were compared to the number of duress alarm activations. The survey data included the demographics of participants working in clinical roles, their number of years of service in the emergency department, and their number of years of service in the profession.

All data transformations and analyses were performed using Microsoft Excel (Version 2211) (Microsoft Corporation) and IBM SPSS Statistics (Version 27) (IBM Corporation). Narrative comments from the survey and duress events in the duress tracking system were individually reviewed, categorized by theme, consolidated, and numerically coded based on frequency. Frequencies were analyzed for all variables, and median notification response times were reported due to outliers. To increase the validity of the comparison of duress alarm events and actual reported WPV events, records labeled as tests were removed and duplicate event records were consolidated. For duress events with multiple badge presses from users in the same location, the first recorded press was considered the event activation. The total number of additional button presses and the number of users were recorded separately. Activations greater than 2 minutes apart or simultaneous activations from unrelated locations were considered separate events. Key informant interviews were conducted with the security team and the frontline staff were interviewed during the same shifts. In addition to the badge survey questions, they were asked open-ended questions about duress alarms, "false alarm" attributes, and policy on response time and activities.

Results Quantitative Analysis

A total of 1896 duress activation event records were evaluated during the 1-month evaluation period. There were 360 valid button presses, 90 different tags, and a total of 255 duress alarm events between April 2021 and September 2022. The median time from a duress button press to event resolution was 3 minutes. Between January 2020 and September 2022, 226 WPV events were officially reported, 147 by security staff and 81 by clinical staff. Between April 2021 and September 2022, 168 WPV events were reported, 104 by security staff and 64 by clinical staff. The frequency of duress alarms and actual safety reports from January 2020 to September 2022 are included in ^{Figure}.

Qualitative Analysis

A total of 40 staff members participated in the key informant interviews and completed the survey. Results from interview questions are shown in ^{Table 1}.

Narrative responses from the interviews and survey indicated the following 3 primary themes: (1) concerns about the reliability and functionality of the device and process, (2) poor duress badge device design, and (3) lack of

knowledge about the system and duress response. The most frequent comments were that the badge is heavy/bulky (28%, $n = 13$), that it does not work when activated (17%, $n = 8$), and that it takes too long for help to arrive (26%, $n = 12$). Twenty percent ($n = 9$) of staff indicated that they did not know either where to obtain a badge or how to use it. Comments made by security dispatchers were divided into 9 different categories, with “false alarm” being the most frequent comment (43.1%, $n = 110$). See ^{Table 2} for categories and frequency.

Discussion

Two key findings emerged from the evaluation of the duress system. First, there was not a decrease in WPV after the implementation of the duress alarm system. Instead, results indicated a dramatic increase in WPV events documented after the duress alarm system was implemented. This should be interpreted with caution—false alarms were common, and the need for validation of a “real” vs “false” alarm were indicated to ensure that there was a shared mental model between the staff, security team, and administration. Secondly, the project demonstrated that communication and frontline user buy-in are needed to support an effective and appropriately responsive duress alarm system. The unfortunate state of ED overcrowding has persisted beyond the peak of the COVID-19 pandemic, and behavioral health-related safety concerns have become more pronounced as emergency departments remain the primary point of entry into health care for patients in crisis. A component of this duress alarm system implementation plan included an agreement with local emergency services to deliver patients with behavioral crises directly to behavioral health emergency departments (if medically appropriate) rather than to alternate emergency departments in the area, which likely contributed to unstable and/or violent patients presenting to this facility. A lack of clinical team participation in the selection of the duress system, unstable staffing issues, and limited education on the new duress system prior to it being activated might have contributed to poor user uptake and the number of false alarms.

The process flow diagram (see ^{Supplementary Appendix}) facilitated the identification of opportunities for improvement. The system uses flashing red lights as a visual cue to alert nearby clinical staff of the location of a user in a duress situation. If a user is inside a patient room, then only the lights outside that door flash; if the lights in the hallway of that room were to flash also, then the likelihood of staff seeing that visual alert would increase. Another opportunity is to strategically place the nurse call bell consoles throughout the unit so that the audible alarms emitted from those consoles can be heard throughout the department. This would maximize the likelihood that nearby clinical staff hear the alarm and physically respond to the location of the individual who is experiencing duress. The current placement of the audible alarm consoles only allows those sitting at the same desk as the console to hear the alarm. The data suggest that frontline staff would benefit from carrying mobile devices that enable duress alarms and communication. Most of the duress buttons, if not worn via a badge, are located behind the head of the bed in patient rooms, and the stationary panic alarms are located under computer desks at the nurse stations—both potentially inaccessible for frontline staff experiencing violence in a patient room.

The project identified key findings relevant to planning and implementing a duress system in an emergency department. Common themes emerged from the coding of key informant data and the survey responses. Frontline staff need to be engaged in aspects of selecting the duress system (and badges), implementing the system, and educating the entire staff in a systematic process. As the primary stakeholders, nurses and other frontline health care providers in the emergency department must be engaged in the entire process.

Finally, the results indicate a need for structured documentation of security officer responses to duress alarms and associated data. Although the comment most frequently used by dispatchers when closing duress events was “false alarm,” records indicated that there was no standard definition for what a false alarm indicates and suggested that “false alarm” could mean numerous things, from an accidental press to a de-escalated event, and use of the comment was at the dispatcher’s personal discretion. This project illuminated the need for process improvement to ensure that information on security response times to clinical staff and the resolution of events is documented. Evidence supports the recommendation for detailed documentation of the security officers’ initial arrival on the scene in response to duress alarms and collection of critical data such as length of time from alarm to response, length of response to the incident, resolution of the incident data, and who was involved if an injury occurred.

Limitations

There are two notable limitations of this evaluation. This was a single-site study performed by a single investigator, and participants were a convenience sample of ED staff on 6 randomly selected days.

Implications for Emergency Nursing

This project identified 4 components that are critical to consider when implementing staff duress alarm systems in emergency departments. First and foremost, bedside nurses should be invited to participate and remain engaged throughout the entire process of the system life cycle. When an alarm device (including the associated infrastructure and software) is selected, it must be a user-centered design. In the case of this project, staff do not wear the badge, because it is impractical and uncomfortable. Future work will focus on working with ED staff to identify potentially comfortable methods of “wearing” the badge (belt, on the back of shirt, neck lanyard, on a vest or sash, on wrist). If staff continue to decline to wear the alarm because of the design, the facility may need to investigate the financial implications of purchasing additional infrastructure or selecting an alternate product for activating the duress alarms (mobile devices, outside-of-room lighting, button at door of patient room).

Including bedside staff in the process of device selection is another way to facilitate user buy-in. If users do not feel that a product is useful, reliable, or relevant, there is a low probability of it being used. Recommendations that may increase buy-in of the project among ED staff include partnering with security to investigate barriers to rapid response to duress locations, involving staff in ongoing testing of the system (planned and unplanned), and encouraging the submission of incident reports when issues with badges are experienced.

Lastly, it is imperative that adequate and timely training is provided to clinical staff. The following recommendations were identified locally, but they are universally applicable to new process implementations in health care. A competency document should be completed at the time of initial training and then included as part of annual revalidation requirements. Training on and education about the duress alarm system, devices, and process should be included as a required part of onboarding orientation. Finally, structured education should be provided in-person to all current staff, and then periodic refresher education should be provided as trends in WPV or safety reports are noted.

Conclusion

Ensuring the safety and well-being of frontline health care workers in the emergency department is critically important. Duress alarm systems, as part of a multimodal real-time response, may be 1 solution to mitigating WPV, but only when all frontline staff and security responders are engaged and working in harmony as a team. The results of this project suggest that frontline staff engagement in the planning and implementation of a duress system is vital. This project also emphasized the need for ongoing staff support, process improvement efforts, and periodic re-education after an implementation has taken place. These elements are critical in the maintenance of technology systems and continued applicability of technology for its end users. Clinical user buy-in, feedback, and partnership with health care technology are vital to the success of complex staff safety interventions in clinical settings.

Author Disclosures

Conflicts of interest: none to report.

Supplementary Data

Supplementary Appendix

Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jen.2023.01.008>.

Utilization/Usability survey

Can you explain what this badge is for?	Can you demonstrate how to operate the badge?	Was badge operation demonstrated correctly?	Have you received official training on duress?	Do you regularly wear a badge?	Have you ever responded to or been involved in a duress event?
Yes: 26 (93%)	Yes: 21 (75%)	Yes: 13 (62%)	Yes: 22 (55%)	Yes: 9 (22.5%)	Yes: 28 (70%)
No: 2 (7%)	No: 7 (25%)	No: 8 (38%)	No: 18 (45%)	No: 31 (77.5%)	No: 12 (30%)
n = 28		n = 21	n = 40		

Frequency	ED		BHED		Total combined	
	Percent	Frequency	Percent	Frequency	Percent	False alarm
30	60.0	80	39.0	110	43.1	Multiple officers responding
5	10.0	25	12.2	30	11.8	Officer(s) arrived; event cleared
4	8.0	49	23.9	53	20.8	Cleared by supervisor
4	8.0	21	10.2	25	9.8	Acknowledged
2	4.0	4	2.0	6	2.4	Intervention required

3	6.0	9	4.4	12	4.7	Accidental press
1	2.0	3	1.5	4	1.6	Other
1	2.0	14	6.8	15	5.9	Total

DETAILS

Subject: Emergency medical care; Quality management; User experience; Workplace violence; Occupational safety; Emergency services; Paramedics; Medical technology; Nurses; Risk assessment; Health care; Quality improvement; Workplaces; Duress; Design; Data collection; Alarms; Environmental monitoring; Nursing

Business indexing term: Subject: Workplace violence Occupational safety Risk assessment Quality improvement

Location: United States--US

Company / organization: Name: Emergency Nurses Association; NAICS: 813920; Name: Agency for Healthcare Research & Quality; NAICS: 923120; Name: Occupational Safety & Health Administration--OSHA; NAICS: 926150

Identifier / keyword: Emergency nursing; Workplace violence; Workplace aggression; Duress alarm

Publication title: Journal of Emergency Nursing.; JEN; Philadelphia

Volume: 49

Issue: 3

Pages: 387-394

Publication year: 2023

Publication date: May 2023

Section: Practice Improvement

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.008
ProQuest document ID:	2809541024
Document URL:	https://www.proquest.com/scholarly-journals/staff-duress-alarms-workplace-violence-emergency/docview/2809541024/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-08-01
Database:	Public Health Database

Document 3 of 50

Editorial Board: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
First page:	A6
Publication year:	2023
Publication date:	May 2023

Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	General Information
DOI:	https://doi.org/10.1016/S0099-1767(23)00069-7
ProQuest document ID:	2809541014
Document URL:	https://www.proquest.com/scholarly-journals/editorial-board/docview/2809541014/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited May 2023
Last updated:	2023-05-05
Database:	Public Health Database

Document 4 of 50

ENA Advocacy Efforts and The State of Play Regarding Workplace Violence: JEN

[ProQuest document link](#)

FULL TEXT

I don't have to tell anyone reading this column about the increasing incidence of violence seen in our emergency departments. At times, incivility seems to be at an all-time high. I'm not sure if this is pandemic related or not. Not too long ago, we were "health care heroes" (a name I never felt completely comfortable with), and it seems in a short amount of time, emergency nurses were gradually back to being threatened and assaulted.

We've all seen news videos of terrible violent acts occurring in restaurants against food service workers and even on airlines against flight attendants. Those actions, which some of us see on an almost daily basis, cannot be recorded

in the emergency department (although it would speak volumes about the workplace violence we endure!). If you're walking through the grocery and someone approaches you in a hostile manner, threatens you, and then assaults you, charges can be brought and pursued against that perpetrator. Why do we seem to often lose that right simply because we clock in to work? I have heard all too often that "it comes with the job!" This is an appalling and pathetic response to a national crisis. Emergency nurses should never be discouraged from pressing charges, although this has often been the case.

In conjunction with Robert Kramer, Emergency Nurses Association's (ENA) Director of Government Relations, we want to update you on our very active presence in combating workplace violence.

At the federal level, ENA's advocacy efforts related to workplace violence help augment our work to support a healthy work environment by supporting two separate bills in the U.S. Congress. First is the Workplace Violence Prevention for Health Care and Social Service Workers Act. We are currently working to support reintroduction of the bill in both chambers of Congress. In the previous Congress, the bill passed the House of Representatives by a 254-166 bipartisan vote. However, it failed to gain traction and move in the Senate. The bill, which is a longstanding ENA priority, would require the U.S. Occupational Safety and Health Administration (OSHA) to develop and implement a national standard that would require hospitals and other health care employers to implement workplace violence prevention plans in their facilities.

ENA also supports the Safety from Violence for Health Care Workers Act to provide federal penalties for assaulting health care workers. This bill has not been reintroduced in this session of Congress, but reintroduction is expected soon.

On the regulatory front, ENA is closely monitoring activity at OSHA, which has signaled that a workplace violence national standard is a top priority. ENA met with OSHA in July 2022 to discuss these topics. OSHA is expected to release a proposed workplace violence rule later this year.

At the state level, ENA monitors workplace violence legislation at the state level that would enhance criminal penalties for those convicted of assaulting emergency nurses while at work. ENA also supports legislation that would compel health care facilities to develop, implement, and maintain workplace violence prevention plans. Recent victories related to this effort include the passage of new laws in New Hampshire, Arizona, Wisconsin, Utah, and Maryland.

Regarding workplace violence at the state level, approximately 31 states allow for those who assault emergency nurses to be charged with felony offenses, and approximately 11 states have enacted workplace violence prevention laws, including Arizona, California, Connecticut, Illinois, Maryland, Minnesota, Maine, New Hampshire, New Jersey, Oregon, and Washington.

I can assure you that the ENA Board of Directors, staff, and our fellow members are there to support you in these efforts. No emergency nurse should ever have to feel alone and isolated after a workplace assault. We, the ENA, stand with you!

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject: Emergency medical care; Workplace violence; Assaults; Prevention; Medical personnel; Advocacy; Fines & penalties; Workplaces; Nurses

Business indexing term: Subject: Workplace violence

Location: New Hampshire; United States--US; Arizona; Maryland

Company / organization: Name: Occupational Safety & Health Administration--OSHA; NAICS: 926150; Name: Congress; NAICS: 921120

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

First page: 309

Publication year: 2023

Publication date: May 2023

Section: President's Message

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: Commentary

DOI: <https://doi.org/10.1016/j.jen.2023.02.004>

ProQuest document ID: 2809540995

Document URL: <https://www.proquest.com/scholarly-journals/ena-advocacy-efforts-state-play-regarding/docview/2809540995/se-2?accountid=211160>

Copyright: ©2023. Emergency Nurses Association

Last updated: 2023-05-09

Database: Public Health Database

Workplace Violence in the Hospital: Strategies for Meaningful Change: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Background

Workplace violence is not a unique problem to organizations. Evidence-based toolkits and strategies are available to help provide a guiding framework for the reduction of workplace violence events. As times and stressors (both personal and environmental) change, hospitals must keep constant attention on how to address and implement initiatives to keep staff safe. This manuscript addresses steps taken at 1 hospital to meet this challenge.

Process

Although a workplace violence committee had been in place for some time, it was identified that not all of the key players were included. Membership was evaluated, and executive-level support was provided. A review of literature was conducted and identified top priorities upon which to focus efforts. Subcommittees were formed to be responsible for these categories of work and to report back to the committee.

Evaluation

Data points and a dashboard were created to monitor trends and effectiveness, especially regarding combating the culture of underreporting. Processes and resources were formalized and made easily accessible to staff. Case studies and direct feedback from staff have been impactful and helped identify additional barriers. Evaluation will continue to occur using process-improvement methodology along with technological assistance.

Conclusions

Workplace violence is not part of the job. Ongoing work is needed to continue to move the needle and make hospitals a safer place to work. Engagement from all levels of the organization is necessary to have a successful program.

FULL TEXT

Introduction

The University of Colorado Health (UCHealth) has been striving to create a culture of zero tolerance for workplace violence (WPV). In 2011, before joining the UCHealth system, a city run hospital, Memorial Hospital, recognized the devastating impact of WPV events on staff members. In fact, they identified a disproportionately high rate of assaults on emergency nurses. When surveyed, approximately 70% of Memorial staff reported experiencing physical abuse and 90% reported verbal abuse and threats while working in the emergency department. These findings coincided with the 2011 Emergency Nurses Association (ENA) study illustrating that, during a week's time frame, half of the 6504 nurses surveyed online reported verbal or physical abuse from patients and/or visitors.¹ In response to these local and national statistics, the hospital formed an interdisciplinary task force to evaluate and implement measures to keep staff safe. The hospital had already developed a multidisciplinary behavioral health (BH) emergency response code in the emergency department to manage escalating patient-related emergencies (called a code gray). In addition, a group of UCHealth Memorial emergency nurses and BH team members, inspired by the 2013 ENA Safe Work Environment Intensive event, implemented additional WPV prevention measures. Following this momentum, in 2015, representatives from the UCHealth Memorial team joined Colorado statewide efforts to pass a bill making it a felony to assault a health care provider in the emergency department. Emergency nurse Heather B. Finch provided a compelling and impactful testimonial that helped pass Senate Bill 15-067. Despite this rich history of striving to keep staff members safe, the UCHealth continued to face challenges surrounding WPV.

UCHealth Memorial Central became a level I trauma center in early 2018. It has become the busiest trauma center in Southern Colorado and lands in the top 3 for volume in the state annually. This growth and challenges from the pandemic have directly affected bedside staff related to WPV, causing increased turnover, a culture of acceptance, and increased frequency of WPV events. The purpose of this project is to share one hospital's experience and the steps taken to address and mitigate WPV.

Methods Literature Review

In February 2022, a review of the current literature was conducted. Focus was put on best practices, evidence-based toolkits, and position statements from multiple agencies and organizations including American Nurses Association, Occupational Safety and Health Administration, American Organization for Nursing Leadership, Emergency Nurses Association (ENA), The Joint Commission, and International Association for Healthcare Security and Safety. The literature supported that a culture change needed to occur and that WPV should not be considered acceptable.²⁻⁴ One key element prominently identified was that WPV awareness and prevention are everyone's responsibility. Leaders at every level and discipline are needed to develop and sustain a successful program.^{2,3,5,6} Other key focus areas that include items that can be categorized as having system and staff impact are highlighted in ^{Table 1.}²⁻⁹ The American Organization for Nursing Leadership and ENA WPV toolkit provided a consolidated and easy-to-use framework to prioritize efforts of the committee.⁵

Underreporting—Battling a Culture of Acceptance

Although WPV events occurred before the coronavirus disease 2019 outbreak, the number of violent events seemed to increase after the pandemic. This followed the identified positive correlation, documented at other institutions, between the increase of coronavirus disease 2019 positivity rates and the frequency of WPV events.¹⁰ Varying reasons exist as to why this eruption of violent events occurred, but regardless of the reason, a culture shift became a realization. Staff has acknowledged their acceptance of violent events and lack of documentation or notification to leadership as factors that contribute to a lack of understanding about frequency of WPV events. It is evident that staff need clear guidance and support on when to document, escalate, and, when appropriate, file a report with law enforcement against patients when violent events occur. All of these issues further contribute to staff unintentionally exposing themselves to continued verbal abuse and physical violence.

Local Change Efforts

To decrease violent events, UCHealth Memorial initiated a campaign of "zero tolerance" in early 2022. This included signs in every patient room and banners in the lobbies describing what types of behaviors by patients and visitors in facilities would not be tolerated. An issue identified with this campaign was that little education was provided to staff about what "zero tolerance" meant. This led to confusion and frustration among the care teams. Complicating matters, many violent events occurring in a hospital setting are from patients with dementia or delirium or who do not have the capacity to make decisions. This additional layer of complexity requires significant preparation, education, training, and documentation to ensure staff have the right tools to deal with these challenging circumstances. Without this, staff will continue to think that "this is just part of the job" and a culture of acceptance will be perpetuated.

Committee Restructure

Starting in March 2021, the nurse administrator at UCHealth Memorial reviewed occurrence reports as part of normal activities in the hospital's daily safety huddle. Documented WPV events are part of these occurrence reports that include both verbal abuse and physically violent events recorded by nurses and other staff after occurrence. A development of violent events resulting in staff injury precipitated an intense review of our WPV policies, protocols, and committee. After this review, it was apparent that a complete restructure of every facet of WPV activities, including the committee, needed to occur.

The Chief Nursing Officer (CNO) identified her responsibility to lead this group as the executive sponsor in August of 2021. The CNO understood the importance of having bedside nurses as members of the WPV committee and requested an emergency registered nurse to cochair this important work. The cochairs reviewed current committee membership. They did not want to eliminate individuals who were passionate about this work; however, they

recognized that key stakeholders were needed at the table. A priority was to keep the committee nimble to make changes quickly. A multidisciplinary group was imperative given that WPV events do not occur only in a hospital setting. In addition to the emergency department and inpatient units, the committee solicited members from off-site facilities such as urgent care sites, outpatient clinics, and free-standing emergency departments. Additional key players to support a well-rounded and robust committee included security partners, human resource personnel, professional development educators, clinical nurse specialists, BH specialists, forensic nurse examiners, and clinical and nonclinical staff and leaders.

Community Partners

In March 2022, the WPV committee discovered that community partnerships play a significant role in providing education to clinical staff about WPV. During after-action reviews, staff stated that, when they filed a report with law enforcement after a WPV incident, they quickly were overwhelmed with the next steps in the process. Staff received communication many years after the event and felt discouraged to report anything further. The committee understood they could not immediately fix the challenges of the justice system. Instead they recognized that educating the team about the process was key. Several executive leaders including the CNO, Associate CNO, and Vice President of Operations met with the local district attorney to provide the feedback from staff. This engagement and collaboration produced a document that allowed a process to be outlined leading to education of the managers and staff to be better prepared, and understand the justice system process. The committee also has collaborated with and provided feedback to local law enforcement, requesting the need for additional support when staff file a criminal report. The partnership with community leaders continues to improve and evolve as they learn more from the WPV committee.

Subcommittee Development

The committee realized the significant work that needed to be accomplished. They were meeting biweekly for 4 months (March to June 2022) and determined that, to be efficient but thorough, they needed a better strategy. In March 2022, a brainstorming session was scheduled. During the session, the group identified 4 areas of needed work to move the committee forward.

- Awareness and algorithms: a focus on making staff aware of the committee's existence and work being accomplished. In addition, providing teams with a step-by-step method for what to do when a violent event occurred. This included developing and distributing an electronic resource for bedside staff and leaders outlining and explaining the process and what to expect after the event. Another key element included in the resource was making key policies accessible to staff. One of those was a hospital document discussing expectations for an environment of mutual respect. This policy includes the organization's zero-tolerance stance on bullying and incivility.
- Response team: creating a team of BH specialists and other key members to be proactive in identifying escalating patients/families/visitors before calling a BH emergency response code (such as how a rapid response team would function to try to reduce code blue events).
- Case review: this team reviews and analyzes BH emergency event responses.
- Data review: the data group developed a dashboard that includes National Database of Nursing Quality Indicators benchmark data and other internal data sets to identify opportunities and trends.

Implementation

Each working group quickly expanded into functional subcommittees starting in March 2022. The groups identified a chair and cochair to lead the charge who helped with prioritization and ownership. The subcommittees began meeting on a bimonthly basis, recognized the need for interdisciplinary representation, and added various key

stakeholders (eg, frontline nurses, technicians, security officers, and BH specialists). The groups were small, with 5 to 7 members, allowing them to efficiently focus and identify priorities. Various initiatives were identified, and the engaged members provided input, design, and implement projects. During the monthly WPV committee meetings, the subcommittee chairs provided overview of the group's focus and project updates and received feedback and/or approval.

Root Cause Analysis

The prevalence of WPV events trended up throughout 2020 and into 2021. In June 2021, 3 particularly violent events against staff members resulting in significant injury to staff were reported via RL Datix Safety Incident Management (<https://rldatix.com/en-nam/company/about-rldatix/>) system, and a root cause analysis (RCA2) was performed by the Patient Safety and Quality Team. When interviewing individual staff members involved in the 3 incidents, several trends started to emerge. Staff shared that the patients who assaulted them had been involved in previous violent interactions with other staff members, but the behaviors were never reported in handoff. Second, patients often had concerning behaviors leading up to the assault, that is, verbal abuse, physical aggression, and balling of fists. Multiple staff members did not feel that they had adequate resources or education to care for aggressive patients. Finally, staff were reluctant to report safety events committed by patients with dementia or other cognitive diagnoses. To gain further insight into violent events and the impact on staff, a questionnaire was developed. After each reported incident of violence, an email was sent to staff by the quality and human resources departments offering support to staff involved and asking questions to get a better understanding of the event, including what could be learned, and what ongoing support may be needed. This process continued to evolve as more work was done in the subcommittees.

In February 2022, staff responses were shared with the committee highlighting the impact of WPV events on employees and providers also encompassing their overall well-being. The details of the abuse and violence along with the suggestions and frustrations shared by staff in the surveys were visceral. The committee chairs requested that the WPV committee invite a staff victim of assault to the committee to share their story in person. This became an opportunity to focus the committee on its mission and the "why" behind the group's efforts. Multiple staff members have shared their stories, provided both insight and solutions, and have asked to join the committee to support other victims of violence.

Awareness and Algorithm Committee

Many hospital system resources were available to staff. However, most staff members were unaware of their existence or unable to locate the information. The awareness and algorithms committee consolidated all the available system resources into one location on the hospital SharePoint site. In September 2022, the committee took one step further by disseminating flyers with a QR code to every unit to ensure ease of access. This allowed staff to access resources aimed at preparing them for, and supporting them during and after, a WPV event. The QR code allowed staff to register for de-escalation classes, review policies and procedures, and sign up for the hospital's peer support program on their mobile device.

Case Review Subcommittee

To further evaluate violent events, a case review subcommittee was formed in August of 2022 initially consisting of 2 patient safety specialists (PSS). All incidents reported in the patient safety incident management were reviewed by the PSS team. Cases involving actual staff harm, significant violence, or emotional harm, along with repeated violent events by the same individual, were considered for additional review. A WPV committee member highlighted that violent events also were reviewed monthly by the BH Review Committee and suggested that the cases be reviewed in one space. Currently, cases are reviewed initially by a PSS as a primary level of review. They then can be taken

to the BH Review Committee for second review, and then findings and trends are presented to the WPV committee for awareness and resource allocation needed for change. Other topics discussed during case reviews include enforcement of the zero-tolerance policy and strategies for dealing with bullying and incivility, especially regarding visitors. Nursing administrators are engaged and are willing to talk to any staff, patient, or family member to explain and assist with enforcement of the policy.

Data Review Subcommittee

Another priority task of the WPV committee was looking at data and trends that could help monitor outcomes, challenges, and successes of the committee's work. In April 2022, a dashboard was created that incorporated information from multiple sources. One of the main challenges was getting a sense of how many incidents were occurring inside of the hospitals. Events were included from databases such as the safety reporting system, security, and employee health records. This information then was broken down on the dashboard by individual clinical units/areas so that higher-risk areas could be targeted. In addition, National Database of Nursing Quality Indicators data and benchmarks were used to gain a semblance of how the organization was comparing with similar ones. As new interventions were implemented, committee discussion occurred on how to display data and track impact. Although it was known that underreporting was a concern, the workgroup felt that establishing a baseline and monitoring trends was a priority.

- A couple of trends surfaced during the review of the data. Two of the units with the highest incidences of WPV were the emergency department and a medical unit that specializes in the treatment of patients with substance abuse and mental health disorders. As a result, focused education opportunities are being provided to include de-escalation training classes, simulation training, and hands-on mock scenarios. In addition, it was identified that some WPV events were related to patients with dementia. The professional development department engaged with a specialist to give staff the opportunity to learn how to effectively interact with patients with dementia to prevent or limit escalation and potential WPV episodes. The committee will continue to assess trends and strategize ways to mitigate staff exposure to WPV.

Monitoring For Effectiveness

One intervention that was implemented across the UCHealth system was the Broset Violence Checklist (BVC) in May of 2022. This allowed easy identification of patients at risk of escalation or those who had physical or verbal outbursts. Screenings of at-risk patients based on behaviors or assessment findings were conducted by nurses in the emergency department. On the inpatient side, screenings were done on admission and at least once per shift during the patient's stay. Once a patient was flagged, visual indicators and electronic notifications increased staff's awareness and interdisciplinary communication. The BVC rollout also permitted the team to look at data from a new perspective. The committee had an appreciation for how underreported WPV events were; however, when a comparison was made from April to June 2022, it was eye opening (^{Figure 1}). The number of physical or verbal events reported in the safety reporting system versus what was being captured out of BVC documentation in the electronic health record was clearly disproportionate. These data supported that additional work needed to be done to support staff at the bedside.

Next Steps

Data analysis and case review allowed the response team subcommittee to identify opportunities to preclude a violent event or behavioral emergency response code. The subcommittee developed a preventative response team led by a BH specialist and comprised a smaller group that could be easily activated when a patient was starting to become escalated or agitated. The goal is to implement measures to address or treat the agitation before a WPV

event. The subcommittee is still working through a pilot program and, if successful, will implement this preventative behavioral response team on a larger scale. In reaction to an unstandardized approach in supporting staff members after an event, 2 of the subcommittees (response team and awareness and algorithms) developed a streamlined resource for managers in offering support to staff available on the hospital intranet. One element included was an electronic post-WPV huddle tool (Figure 2), which is completed after all WPV events. The post-WPV huddle tool documents the event, notifies leadership, prompts implementation of safety measures, and ensures follow-up with involved staff. The resource is organized by time limits and recommendations on how to support staff when they file a law enforcement report and the district attorney has decided to press charges. This document was developed in collaboration with BH experts, hospital risk management, legal, employee health, and the forensic nurse examiner teams. It continues to be refined based on feedback. As the committee worked to implement tools in the inpatient setting, it became apparent that it would be necessary to modify these activities to meet the outpatient setting. In these facilities outside the hospital's walls, resources are significantly different. Security presence is often not available 24 hours a day, 7 days a week, and response teams are not an option. In addition, verbal abuse in the form of telephone aggression is a common occurrence. A significant ongoing action for the WPV committee is continued assessment of employee satisfaction surveys with specific questions addressing WPV. Staff need to feel supported, safe, educated, and heard in the work environment. The WPV committee supports ongoing staff safety surveys to trend and verify the outcomes of implemented process improvement interventions. A great deal of work has been accomplished by the WPV committee. However, progress must evolve in each of these areas.

Conclusion

Literature, data, direct staff stories, and investigations have clearly identified that a change in addressing WPV is warranted. Emergency and inpatient nurses have been called upon to stand up for change. Organizational transformation can begin with one bedside nurse's voice being heard and in joining forces with strong leadership support. In addition, the use of process improvement and technology tools can help provide data to drive change in practice. The bottom line is tolerating WPV, and accepting it as part of the job can no longer be the norm. The rich history of staff advocacy, legislative support, engaged bedside staff, and executive leadership, along with an active local WPV prevention committee, have allowed one hospital the ability to collaborate toward keeping staff safer. All of the previously mentioned WPV prevention efforts have gone through varying degrees of the quality improvement process with bedside staff input that has created a sense of ownership and buy-in. Looking at the scope of work needed to prevent and address WPV can be overwhelming. The committee found it to be beneficial to divide into subcommittees and use the committee as more of an oversight group. Evidence-based toolkits and innovative ideas have helped drive change. More work is needed to keep the momentum and address ongoing concerns. Finally, dissemination of progress to the frontline staff is a priority along with using process improvement methodology to assess effectiveness of interventions.

Acknowledgments

The authors acknowledge and thank Heather B. Finch for her historical work on the topic of workplace violence and testifying before Congress on behalf of nurses, Rochelle Flayter for her guidance on this manuscript, the UCHealth Broset Violence Checklist Optimization Working Group, and the UCHealth South Region Workplace Violence Prevention Committee.

Author Disclosures

Conflicts of interest: none to report.

Identified areas of focus for WPV prevention	
System impact	Staff impact
Conduct risk assessments.	Encourage a culture of reporting.
Identify outcome metrics.	Develop and encourage education and training programs.
Develop guiding policies and protocols.	

DETAILS

Subject: Emergency medical care; Personal development; Law enforcement; Assaults; Trauma centers; Workplace violence; Hospitals; Leadership; Community; Nurses; COVID-19; Patients; Trauma; Teams; Underreporting; Pandemics; Zero tolerance; Workplaces; Internet resources; Nursing; Coronaviruses; Literature reviews; Education; Emotional abuse

Business indexing term: Subject: Workplace violence Leadership

Location: Colorado; United States--US

Company / organization: Name: American Organization for Nursing Leadership; NAICS: 813920; Name: Emergency Nurses Association; NAICS: 813920

Identifier / keyword: Workplace violence; Violence prevention; Workplace violence committee

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

Pages: 345-351

Publication year: 2023

Publication date: May 2023

Section: Injury Prevention

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.005
ProQuest document ID:	2809540991
Document URL:	https://www.proquest.com/scholarly-journals/workplace-violence-hospital-strategies-meaningful/docview/2809540991/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 6 of 50

Nurse, Provider, and Emergency Department Technician: Perceptions and Experiences of Violence and Aggression in the Emergency Department: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Patient/visitor violence and aggression (V&A) in the emergency department occurs daily. Few interventions exist to decrease V&A. Research describing prevalence, severity, and perceived safety among ED clinicians is limited.

Methods

A descriptive survey explored V&A against ED clinicians in one urban emergency department. A sample of nurses, ED technicians, physicians and advanced practice providers participated. Participants completed a demographic survey, Personal Workplace Safety Instrument for Emergency Nurses (PWSI-EN), and ENA V&A frequency checklist. Analysis of Variance (ANOVA) for unadjusted and Analysis of Covariance (ANCOVA) for adjusted associations were used to assess differences in the PWSI-EN survey composite score and “feeling safe in the ED” among ED roles. ANCOVA was adjusted for potential confounders: sex, race, years working in emergency department, and shift worked.

Results

Sixty-five (46.4%) of the 140 ED clinicians returned surveys, which were almost evenly distributed between ED clinician roles and sex. Mean age was 37.2 (range: 21-64) years. All (100%) nurses and providers reported being verbally abused. More nurses reported physical violence (n = 21, 87.5%) than providers (n = 7, 36.8%) and ED technicians (n = 11, 55%). Nurses and ED technicians reported experiencing greater prevalence of physical violence than providers ($P < .05$). Nurses (mean 3.29, range 2.95 to 3.63) were more fearful for their personal safety than ED technicians (mean 3.88, range 3.48 to 4.28) ($P < .03$).

Discussion

V&A are common creating a fearful environment. However, little research regarding clinician perceptions exists. Our study aids in identifying areas for clinician-targeted strategies to prevent ED V&A.

FULL TEXT

Contribution to Emergency Nursing Practice

- What is already known about this topic? Patient/visitor violence and aggression is common in the emergency department resulting in clinicians feeling unsafe.
- What does this paper add to the currently published literature? The Personal Workplace Safety Instrument for Emergency Nurses, originally designed for nurses, is useful with other clinicians. This paper reports the commonality that verbal aggression is to all clinicians and how clinicians spending the most time with patients, such as nurses and ED technicians, experience the most physical violence.
- What is the most important implication for clinical practice? Clinicians in the emergency department reported varying levels of feeling safe, warranting the need for role-specific interventions to prevent patient and visitor violence and aggression.

Introduction

Violent and aggressive acts committed by patients and visitors in emergency departments remain a worldwide problem.¹⁻³ However, when initiating a career in health care, most health care providers never considered there would be a concern about their well-being every working day.⁴ Essentially, health care workers in the emergency department are at increased risk of violence simply by their unique work environment—a place where patients who are intoxicated, have mental health problems, or are known to be violent seek treatment and may require restraints for their own safety and the safety of the health care workers.⁵ However, the exposure to violence and aggression varies by position. Wong et al⁶ found that self-reported exposure to violent episodes was higher for patient care technicians, security personnel, and nurses than residents and attending physicians. Somani et al⁷ evaluated the effectiveness of training in de-escalation and multicomponent interventions to decrease violence and aggression in the emergency department. There is growing consensus that multicomponent interventions including all stakeholders and use of community advisory boards (CABs) are necessary to combat violence and aggression in the emergency department.⁷⁻⁹

Resources such as those provided through the Emergency Nurses Association (ENA) and American College of Emergency Physicians, as well as the jointly sponsored Stop ED Violence campaign,¹⁰ are available, but research on application of these resources is limited. Guidance provided in the ENA Workplace Violence (WPV) Toolkit¹¹ was used in this cross-sectional descriptive study to understand the local context for violence and aggression in the emergency department and understand the perceptions of violence and aggression by different clinicians in the emergency department.

Background

WPV is a complex problem, with nurses identified as a high-risk group worldwide.¹² Researchers showed that other

members of the health care team are also at risk of experiencing WPV, such as first responders, ED technicians, and other clinicians.¹³⁻¹⁶ Patient, family, and environmental risk factors were identified as contributing to the risk of violence and aggression. The patient risk factors include working with people who have a history of violence and drug or alcohol abuse and psychiatric and geriatric patients.⁹ The environmental risk factors include long wait times for patients; poorly lit corridors, rooms, and parking lots; a lack of emergency communication devices; and working in neighborhoods with high crime rates.⁹ Situational conditions also can lead to increased risk of violence and aggression including the unplanned and immediate nature of an ED visit with unpredictability of patient outcomes. In addition, there may be people wanting to do harm to an ED patient. In addition to factors listed earlier, some individuals in the emergency department become angry with ED clinicians owing to enforcement of hospital policies.

17

Few studies have identified clinicians' perceptions of violence and aggression in the emergency department. However, the impact of violence and aggression on ED personnel has been documented.¹⁸ Clinicians have decreased job satisfaction, feel scared, lose sleep, and miss work as a result of violence and aggression in the emergency department.¹⁸ This same study also identified that younger, less experienced clinicians were more vulnerable to violence and aggression.¹⁸ A previous study of nurses who had experienced violence and aggression at work found that more than half felt angry ($n = 1902$, 58.4%), others felt anxious ($n = 1277$, 39.2%), and almost 20% ($n = 626$) felt frightened. More than half ($n = 4096$, 57.7%) reported not feeling protected from WPV, and almost a third ($n = 1931$, 27.2%) considered leaving their position in the emergency department.^{19,20} Additionally, nurses believe that "something could happen at any time."^{17,21} Violence and aggression experienced in the emergency department leads to experiences of stress, burnout, emotional exhaustion, and decreased work productivity and quality of patient care.²²⁻²⁴ ED physicians and nurses have reported burnout and feeling fearful on the job, leading to both physicians and nurses leaving their jobs in the emergency department.²⁵ There is a paucity of research on perceptions and consequences of violence and aggression in the emergency department for ED technicians. Making this issue more complex to address, emergency care providers have incorporated the experience of violence and aggression into their daily practice. Richardson et al²⁶ remind us that the ED culture is often one that encourages individualism and "toughness," whether in a positive sense relating to resilience or in a less constructive manner where it can lead to indifference, unhealthy tolerance, and/or emotional burnout. A metasynthesis of international studies explored nurses' perspectives regarding violence in the emergency department and found that nurses accepted violence as "part of the job" and also a significant safety risk.²⁷ Like nurses, ED physicians reported the same perception of violence as "part of the job," with incidents often underreported.²⁸ Gates et al²⁹ found an alarming 65% of participants in an interdisciplinary sample of ED clinicians who were physically assaulted by a patient did not report the incident to supervisors.

Purpose

The purpose of this cross-sectional descriptive study was to explore the types and frequency of violence and aggression and perceptions of safety by clinician characteristics. Our study aims were as follows:

1. Describe the types and frequency of violence and aggression experienced by clinicians in the emergency department.
2. Explore differences between clinicians' demographic characteristics and their perceived safety from patient/visitor violence.

Methods

We used a cross-sectional descriptive approach to address study aims. This research study was approved by the University of Pennsylvania Institutional Review Board (University of Pennsylvania IRB # 832320) as exempt

research with a waiver of signed consent.

Setting

As is the case in many emergency departments, clinicians in the Penn Presbyterian Medical Center emergency department began expressing concerns about the increase in frequency and severity of aggression and violence from patients and visitors. The hospital was, for many years, considered the local community hospital compared with its nearby quaternary care academic medical center that is part of the same health system. This emergency department serves an underinsured community and several university campuses and a busy metropolitan area. The department was originally designed to address the surrounding community's needs serving on average 37,000 patients per year. In 2015, the health system renovated and expanded the emergency department from 20 to 41 emergency beds with an addition of a 5-bed fast track and a 5-bed trauma bay. After these renovations and designation as a level I trauma center, the yearly ED volume increased to more than 49,000 patients in 2019, the year this study was conducted. Clinicians noted an increase in frequency and severity of patient/visitor violence and aggression with the increased patient volume and the addition of trauma patients. This is consistent with previous research that identified physical violence was substantially higher in trauma certified emergency departments than nontrauma emergency departments.¹⁹

Context

A convenience sample from 140 clinicians working in the Penn Presbyterian Medical Center emergency department at the time of the study with valid email addresses was invited to participate via an online REDCap (Research Electronic Data Capture, Nashville, Tennessee) survey.³⁰ This included all physicians, advanced practice providers, registered nurses (RNs), and technicians. There were no exclusion criteria. Each participant had 2 weeks in the middle of January 2019 to complete the survey.

To aid in identifying the scope of violence and aggression in the emergency department, study leaders assembled a multidisciplinary team consisting of ED personnel—nurses, technicians, a physician, and security representatives. The team identified resources available through the ENA. In 2001, the ENA developed and made available to ENA members a Violence Prevention Toolkit,¹¹ which is no longer available.

Survey Instruments Demographics

A short demographic survey was used to describe the sample of participants that included position, years' experience in the emergency department, and age, sex, race, and ethnicity.

Personal Workplace Safety Instrument

The Personal Workplace Safety Instrument for Emergency Nurses (PWSI-EN) is a 23-item validated survey instrument that measures emergency nurses' perceptions of safety from patient and visitor violence.³¹ Respondents use a Likert response scale (with 1 representing "strongly disagree" and 5 representing "strongly agree") for each item with several items being reverse coded. Higher sum scores for subscales and total scores represent greater perceived safety from patient and visitor violence. Construct validity was confirmed using exploratory factor analysis with 62% variance explained and 6 subscales identified: unit and institutional leadership support, belongingness, trust, understanding processes, training, and security personnel. In addition, known groups validity, linear regression modeling, and subscale correlation analysis confirmed construct validity. Measures of internal consistency (Cronbach's alpha) exceeded accepted standards for subscales ($\alpha > 0.68$) and overall instrument ($\alpha = 0.91$). Although the instrument was not validated in other populations, the instrument was used with providers and technicians in this study given that no other validated instrument exists that measures perception of safety from patient and visitor violence. Cronbach's alpha for use in this interdisciplinary sample was $\alpha = 0.87$, demonstrating strong internal consistency across disciplines.

Frequency of Violence and Aggression Checklist

We modified ENA's WPV staff assessment survey.¹⁸ An item on the ENA's WPV staff assessment survey contains a list of 19 actions that constitute WPV, ranging from name calling and verbal abuse to severe physical violent events. The revisions included asking the participants if they thought these 19 actions constituted WPV and whether they ever experienced each specific violent and aggressive act, and we added "if so, how frequently over their last 6 shifts" they worked.

Survey Distribution

All eligible clinicians received a workplace email that explained the purpose of the study and contained a link to the confidential version of the survey housed in REDCap.³⁰ REDCap is a secure, web-based software platform designed to support data capture for research studies housed at the University of Pennsylvania.²⁹ The survey began with a question asking participants to affirm their consent to allow the research team to use their responses to the survey in the analysis. Reminder emails were sent to participants every 3 days or until they completed the survey over a 2-week period.

Analysis

Descriptive statistics such as counts and percentages for categorical variables and means and SDs for numeric variables were generated to describe responses to the surveys. An analysis of variance for unadjusted associations and analysis of covariance for adjusted associations were used to assess differences in the PWSI-EN survey sum score and the Likert variable, feeling safe in the emergency department, among different roles in the emergency department. Analysis of covariance was run and adjusted for potential confounders: sex, race, years working in the emergency department, and shift worked. Owing to the small sample size and multicollinearity, we assessed the impact of each potential confounder both individually in models and collectively. In addition, differences in violent and aggressive experiences were compared among the clinician types using the chi-square test and logistic regression. All analyses were considered exploratory with the alpha set at 0.05.

Results

Surveys were distributed via email to 140 participants with 65 surveys returned for a 46.4% response rate. Mean age of our sample was 37.2 years (range, 21-64) and almost equally distributed among men ($n = 31$, 47.7%), women ($n = 33$, 50.8%), and 1 transgender (0.015%). Responses were received from 24 nurses (37.0%), 21 ED technicians (32.2%), and 20 providers (30.8%) that consisted of 14 physicians (21.6%) and 6 advanced practice providers (9.2%), with most respondents identifying as White ($n = 46$, 70.8%) and non-Hispanic ($n = 62$, 95.4%). See

Table

Aim 1: DESCRIBE THE TYPES AND FREQUENCY OF VIOLENCE AND AGGRESSION EXPERIENCED BY CLINICIANS IN THE EMERGENCY DEPARTMENT

Almost all clinicians reported experiencing verbal abuse and physical assaults. More than half of respondents (60%, $n = 39$) reported being physically assaulted, with 87.5% of RNs ($n = 21$), 36.8% of providers ($n = 7$), and 55% of technicians ($n = 11$) (see [Figure 1](#)). The most frequent types of violence experienced included being yelled at ($n = 51$, 92.7%), threatened ($n = 39$, 70.9%), sexually harassed ($n = 33$, 60%), hit or punched ($n = 34$, 60.7%), spit on ($n = 29$, 52.7%), and scratched (53.6%). Nurses consistently reported the highest percentage of the various types of violence except for 2 types of violence: being bitten ($n = 7$, 31.8%) and pushed ($n = 8$, 36.4%). The technicians experienced these 2 types of violence in higher percentages ($n = 7$, 43.8%; $n = 9$, 56.2%, respectively) than nurses. Providers had lower percentages of all types of violence in the emergency department except for being yelled at ($n = 15$, 88.2%) and sexually harassed ($n = 10$, 58.5%) than technicians ($n = 14$, 87.5%; $n = 7$, 43.8%, respectively) (see [Figure 2](#)). We then analyzed the different types of violence and aggression acts by clinician type. There were no

statistically significant differences on the following violence and aggression acts by clinician type: called names, hair pulled, sexually harassed, hit by objects, spit on, cursed at, threatened, voided on, or shouted at. However, there were significant differences by clinician type on other violent and aggressive acts. RNs (z -statistic 2.94; P z -statistic 2.00; P $2 = 10.66$; P z -statistic 3.68; P z -statistic 2.61; P z -statistic 2.25; P z -statistic 2.58; $P = .01$) and RNs were more likely to report being scratched (z -statistic 2.15; P z -statistic 2.15; P z -statistic 2.15).

Aim 2: EXPLORE DIFFERENCES BETWEEN CLINICIANS' PERCEIVED SAFETY FROM PATIENT/VISITOR AND DEMOGRAPHIC CHARACTERISTICS

Figure 3 provides the percentage of ED staff that feel safe in the emergency department by location. Most clinicians ($n = 54$, 85.7%) reported being fearful for their personal safety in the emergency department with 22 RNs (91.7%) reporting being fearful for their personal safety. More than half of clinicians ($n = 38$, 58%) reported feeling safe in the emergency department when asked about global perceptions of safety. However, this dropped to 21 of all clinicians (32.3%) and 14 of RNs (21.5%) in the triage area. Only half of clinicians ($n = 33$) reported feeling safe in the fast track area as well. The overall unadjusted association between role in the emergency department and feeling safe in the emergency department trended toward statistical significance (F -statistic = 2.80; $P = .07$). In particular, there was a statistically significant difference between nurses (Mean = 3.29; range, 2.95-3.63) and technicians (Mean = 3.88; range, 3.48-4.28) on the variable feeling safe in the emergency department, with nurses feeling less safe than technicians (t -statistic = 2.25; P t -statistic = 1.39; $P = .170$) after adjusting for years of experience working in the emergency department (≤ 5 vs > 5 years). Furthermore, while controlling for role in the emergency department, the difference between clinicians who worked more than 5 years (Mean = 3.25; 95% confidence interval, 2.93-3.56) and clinicians who worked fewer than 5 years in the emergency department (Mean = 3.74; range, 3.45-4.03) was found to be significant (F -statistic = 5.04; P F -statistic = 1.48; $P = .237$), sex (F -statistic = 0.02; $P = .885$), and shift (F -statistic = 2.97; $P = .099$).

Discussion

Based on this survey, clinicians in the emergency department overwhelmingly felt fearful for their personal safety in the emergency department; the nurse respondents drove this result with more than 91% of nurses reporting being fearful in the emergency department. The greatest areas of concern for all clinicians were triage and fast track areas. This is similar to the findings of Ferri et al,¹ who reported aggression most frequently occurred in the area surrounding the triage location. Technicians consistently reported greater feelings of safety than both providers and RNs, which remained true when shift, gender, and years in the emergency department were considered. Our data did not reveal significant differences when we controlled by race and sex. However, we did find differences in shift worked and years in the emergency department, with clinicians who worked fewer than 5 years in the emergency department feeling safer. This is consistent with previous studies where these findings were attributed to less exposure to violence.^{3,18} This finding also may support that the longer clinicians stay in the emergency department the less tolerant of violence and aggression they become.^{3,18}

Based on our results, it is evident ED clinicians are at high risk of experiencing physical assaults or verbal abuse. Although these are not new findings solely specific to our emergency department, we investigated the experience of the team of clinicians involved in direct patient care. Our study, similar to that conducted by Gillespie et al,¹⁴ found that most physicians experienced verbal abuse, whereas physical harm is worse against RNs and technicians. It is impressive that most clinicians felt fearful for their personal safety. More than half of participants (58%) in our study reported agreeing or strongly agreeing with feeling safe in the general ED environment, but this means that 42% of clinicians did not feel safe in the emergency department. Although recognized by many who work in the emergency department, we found specific ED location influenced perception of safety from violence with only 22% of RNs

feeling safe in triage. Our results correlate to findings from Ferri et al¹ who found that triaging patients was the highest risk nursing activity. They found that nurses were 3 times more likely to experience an episode of patient-related violence during triage, which may support why so many nurses in our study felt unsafe in that assignment (78%).¹ The National Institute for Occupational Safety and Health recommends that health care personnel should not work alone, emergency exits and panic alarms that alert security should be easily accessible, and counters should be deeper than normal to make physical attack more difficult,³² but many triage rooms are designed for easy access to patients and staffed by a solitary triage nurse. Although our emergency department is in an urban location with high poverty and community violence rates, the interdisciplinary research team noted a substantial increase in patient and visitor violence after the transition to a level I trauma center. Previous research reported that working in an urban emergency department was associated with having a significantly higher percentage of respondents reporting verbal abuse than working in a suburban or rural setting.¹⁹ Researchers also found that physical violence was substantially higher in trauma certified emergency departments than nontrauma emergency departments.¹⁹ Our results further support this conclusion. After becoming a level I trauma center, we experienced higher volumes of patients and visitors. In response to the increased volumes, the emergency department implemented the following: (1) added an additional provider in triage; (2) created Forward Flow, a vertical space where patients are evaluated by advanced practice providers; and (3) made modifications to the Supertrack area to decrease patient length of stay.

It is clear from our results that clinicians in our sample experienced violence and aggression differently. Providers, RNs, and technicians all experienced verbal aggression at similar rates. However, RNs and technicians, who spend more time with and in closer proximity to patients and visitors, experienced significantly more physical violence than providers did. This is similar to findings reported by Wong et al⁶ who found that RNs, technicians, and security personnel were more likely to report exposure to violent episodes than attending physicians. In our study, our providers included physicians and advanced practice providers and this relationship of RNs and technicians reporting greater exposure to violent episodes than providers remained true.

The PWSI-EN was originally developed to measure the perceptions of safety from WPV among emergency nurses.³¹ This is the first time it has been used with interdisciplinary clinicians in the emergency department. The high internal consistency of this instrument across disciplines demonstrates the strength of the instrument to measure a common experience in the emergency department. This study supports the use of the PWSI across disciplines. Further studies of the PWSI-EN in larger samples of interdisciplinary ED clinicians are warranted. Furthermore, despite WPV being a common theme among emergency departments worldwide, few interventions have been created to address this issue, prompting our desire to develop an intervention. Results from one study in which interventions were implemented and tested to determine whether they decreased frequency and severity of WPV in the emergency department revealed that the interventions were not effective.¹⁴ Somoni et al⁷ found that multicomponent interventions including all stakeholders are needed to combat violence and aggression in the emergency department. In combination with the ENA Violence and Prevention Toolkit, we hope to take lessons learned from Gillespie et al⁸ and Somani et al⁷ to guide the development and testing of a multimodal intervention to decrease violence and aggression in the emergency department and improve perceptions of safety in the emergency department. Gillespie et al⁸ established a CAB whereby key stakeholders investigated WPV in their local rural and urban emergency departments leading to a creation of several interventional strategies and suggestions. As there was a team effort put forth by the CAB to work in a collaborative and interdisciplinary way, more successful outcomes were expected.

Limitations

Our study was completed in 1 emergency department; therefore, generalizability of results is limited. Regardless, results are similar to other studies.^{1-3,14} Our response rate was less than expected at 46.4% with nurses being underrepresented. Considering that they make up the largest number of ED clinicians, this potentially led to selection bias. Response rates to emailed requests for survey research participation among nurses is often low.³³ The strongly held perception that WPV is “just part of the job”²⁵ could have influenced low response rates among nurses. Finally, because we explored the relationship among several outcomes and potential predictors, a type I error, or false positive, is possible.³⁴ Thus, these analyses should be considered exploratory, and the findings interpreted with caution. Nevertheless, our results provide insight into some consistently dangerous ED encounters that will help to inform the development and rigorous testing of future interventions.

Implications for Emergency Nursing

More than 85% of our sample reported being fearful for their personal safety in the emergency department. Creating standard practices to address this complex issue through interdisciplinary efforts is necessary, and rigorous evaluation of these collaborative efforts is warranted. The interdisciplinary findings of this research need to be further explored. For example, more research is needed to understand why ED technicians reported feeling safe in the emergency department significantly more than RNs and physicians/advanced practice providers when ED technicians, like nurses, spend the most time in close proximity to patients in the emergency department. In addition, the more we know about the types of physical violence experienced by clinicians, the more creative solutions to minimize the impact are important to validate. For example, technicians reported greater episodes of biting and pushing. Innovation and research are necessary to improve the safety for all clinicians working in the emergency department. Therefore, our next steps are to develop and rigorously test a multimodal intervention to determine whether the intervention improves feelings of clinician safety, prevents harm, and decreases violence and aggression.

Conclusion

Few interventional studies have been shown to address perceptions of safety in the emergency department despite years of research on ED violence and aggression. Therefore, we took a step back to gain a better understanding of the clinicians’ perceptions of safety in the emergency department. Clinicians in all roles felt unsafe in the emergency department but to varying degrees, suggesting the need for clinician-specific interventions. Our study results highlight the need for role-specific strategies for interventions to prevent patient and visitor violence and aggression. Effectiveness of these interventions can be tested with all clinician roles including the use of the PWSI-EN survey instrument. Emergency departments transitioning to level I trauma centers or expanding their built environment to address increasing patient volume should be aware that violence and aggression may increase resulting in a significant change to ED culture.

Author Disclosures

Conflicts of interest: none to report.

Variables	N	%
Gender		

Male	31	47.7
Female	33	50.8
Transgender	1	1.5
Position		
ED technician	21	32.2
Male	15	71.4
Female	5	23.8
Transgender	1	4.8
Registered nurses	24	37.0
Male	5	20.8
Female	19	79.2
Providers	20	30.8
Physicians	14	21.5
Advanced practice providers	6	9.2
Male	11	55
Female	9	45
Race		
African American	11	16.9
Asian	4	6.15
Mixed race	4	6.15
White	46	70.8
Ethnicity		
Hispanic	3	4.6

Non-Hispanic	62	95.4
--------------	----	------

DETAILS

Subject:	Research; Emergency medical care; Demographics; Medical personnel; Risk factors; Physicians; Race; Violence; Occupational safety; Nurses; Emergency services; Community; Technicians; Security personnel; Validation studies; Patients; Validity; Perceptions; Trauma; Personal safety; Workplaces; Burnout; Polls & surveys; Departments; Aggressiveness
Business indexing term:	Subject: Occupational safety Burnout
Company / organization:	Name: University of Pennsylvania; NAICS: 611310
Identifier / keyword:	Workplace violence; Trauma center; Interdisciplinary clinicians; Acute care; Emergency department
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	431-440
Publication year:	2023
Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article

DOI:	https://doi.org/10.1016/j.jen.2022.07.008
ProQuest document ID:	2809540984
Document URL:	https://www.proquest.com/scholarly-journals/nurse-provider-emergency-department-technician/docview/2809540984/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 7 of 50

Pharmacologic Therapy to Mitigate Acute Agitation in the Emergency Department: Case Reports of Diverse Patient Presentations: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Nurses in the emergency department often encounter patients exhibiting signs of aggressive behavior. Nurses need to know the pharmacologic treatment appropriate for the patient scenario to ensure safety for the patient and the emergency department team. This case review examines 4 common scenarios where a patient exhibits aggressive behavior. After each case review is a discussion about the appropriate pharmacologic therapy for that patient. The cases portrayed are fictional but based on experience and previous observations.

FULL TEXT

DETAILS

Subject:	Patients; Urogenital system; Emergency medical care; Aggressiveness; Clinical medicine; Blood pressure; Vital signs; Mental disorders; Psychotropic drugs; Occupational safety; Alcohol; Anesthesia; Nurses; Emergency services; Teams; Antipsychotics; Benzodiazepines
Business indexing term:	Subject: Occupational safety
Identifier / keyword:	Acute agitation; Emergency department; Behavioral health; Pharmacologic therapy; Case reports; Aggressive behavior
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia

Volume:	49
Issue:	3
Pages:	336-340
Publication year:	2023
Publication date:	May 2023
Section:	Case Review
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.005
ProQuest document ID:	2809540979
Document URL:	https://www.proquest.com/scholarly-journals/pharmacologic-therapy-mitigate-acute-agitation/docview/2809540979/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-08-01
Database:	Public Health Database

Document 8 of 50

Board of Directors: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
First page:	A8
Publication year:	2023
Publication date:	May 2023
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	General Information
DOI:	https://doi.org/10.1016/S0099-1767(23)00070-3
ProQuest document ID:	2809540973
Document URL:	https://www.proquest.com/scholarly-journals/board-directors/docview/2809540973/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited May 2023
Last updated:	2023-05-12
Database:	Public Health Database

Implementation of a Behavioral Emergency Response Team in the Emergency Department: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Emergency nurses, physicians, and patients experience occurrences of workplace violence. Having a team to respond to escalating behavioral events provides a consistent approach to reducing occurrences of workplace violence and increasing safety. The purpose of this quality improvement project was to design, implement, and evaluate the effectiveness of a behavioral emergency response team in an emergency department to reduce occurrences of workplace violence and increase the perception of safety.

Methods

A quality improvement design was used. The behavioral emergency response team protocol was created using evidenced-based protocols that have been shown to be effective in reducing the number of occurrences of workplace violence. Emergency nurses, patient support technicians, security personnel, and a behavioral assessment and referral team were trained in the behavioral emergency response team protocol. Data on occurrences of workplace violence were collected from March 2022 to November 2022. Postbehavioral emergency response team debriefings were conducted, and real-time education was provided after implementation. Survey data were collected to evaluate the emergency team members' perceptions of safety and of the effectiveness of the behavioral emergency response team protocol. Descriptive statistics were calculated.

Results

The number of reported occurrences of workplace violence decreased by to 0 postimplementation of the behavioral emergency response team protocol. The perception of safety increased 36.5% postimplementation (mean 2.2 preimplementation, mean 3.0 postimplementation). In addition, an increase in awareness about reporting occurrences of workplace violence resulted from education and implementation of the behavioral emergency response team protocol.

Conclusion

Postimplementation, participants reported an increase in the perception of safety. Implementation of a behavioral emergency response team was effective in reducing assaults toward emergency department team members and increasing the perception of safety.

FULL TEXT

Contribution to Emergency Nursing Practice

- Emergency nurses are frequently exposed to occurrences of workplace violence.
- Workplace violence occurrences can be mitigated with the creation and implementation of a behavioral emergency response team to reduce injuries and increase perception of safety.
- Emergency nurses can employ the behavioral emergency response team approach to create safer practice environments for patients to receive care.

Problem Description

Behavioral emergencies from patients and visitors that result in occurrences of workplace violence (OWPV) continue to occur in emergency departments worldwide.¹⁻⁴ Many factors in the emergency department contribute to increased violence and assaults. Increased wait times, understaffing, lack of security support, increased drug and alcohol use in society, lack of mental health resources, and lack of policies and training supported by the organization are several contributing factors.⁵ The effects of physical and psychological assaults range from decreased work satisfaction and performance to missing workdays from injuries to leaving the profession.² Reducing or mitigating assaults is essential to ensuring the safety of the emergency department environment. Accordingly, some researchers have suggested having a response team to reduce the prevalence of OWPV and improve safety.¹ Implementing a behavioral emergency response team (BERT) to respond to people demonstrating increased agitation or violence in the emergency department may be a process that mitigates and eliminates assaults.

Local Problem

In March 2022, OWPV were reported at a rate of 1 to 2 per month at the project site emergency department. The actual number of threats or occurrences was unknown due to lack of reporting by the emergency nurses as identified in the perception of safety survey. Researchers have concluded that OWPV have become significantly higher in emergency departments and that lack of training, lack of security support, and overcrowding are contributing factors.⁶ As the number of OWPV continues to rise in the emergency department setting, the numbers are underreported, and processes need to be put into place to mitigate the events.⁷ The impact of OWPV has a negative impact on nurses' perceptions of safety.⁸ Implementing a BERT protocol focused on responding to OWPV provides a team approach using individuals who have been trained in de-escalation techniques.

Available Knowledge

Workplace violence is defined as actions taken against an individual while in the workplace, either verbal or physical, which are intended to cause intimidation, bodily harm, or property damage.⁶ Threats, intimidation, and abusive actions toward authority are examples of workplace violence.⁶ A literature review of emergency department-specific protocols revealed that using a team approach to behavioral emergencies had produced successful outcomes.^{1,9} The number of aggressive and violent occurrences continues to rise across acute care organizations, and emergency departments are frequently the place where the events occur.⁷ More than 10% of incidents of violence in the workplace occur in health care settings, mainly in the emergency department, but prevalence appears low due to underreporting.⁷ As researchers² have suggested, reducing occurrences of assault can improve the work environment and increase workers' perceptions of safety.⁸

Rationale

The Joint Commission and the Occupational Safety and Health Administration are encouraging organizations to create and implement processes to address OWPV and create safe environments for nurses to work in and for patients to receive care.^{5,6,10} Introducing a process such as a BERT to mitigate OWPV has been shown to improve the environment in which health care providers practice.^{9,10}

Specific Aims

The purpose of the project was to design, implement, and evaluate the effectiveness of a BERT protocol in the emergency department to reduce the number of OWPV by 25% and increase the perceptions of safety of the emergency department nurses, physicians, and technicians by 10%.

Methods Design

A quality improvement (QI) design used a preimplementation and postimplementation survey. Approval was granted by the hospital Institutional Review Board. Participants were informed of voluntary participation in the survey and

ability to withdraw at any time without penalty. Consent was obtained via active participation in the survey.

Context

The QI project was implemented in an inner-city not-for-profit hospital in central South Carolina. The hospital has 296 inpatient beds, 35 emergency department beds, and a locked 5-bed unit for patients with behavioral health problems. The emergency department is 1 of 10 within the 12 campuses in the health care system. The number of annual emergency department visits for fiscal year 2020 was 21,191,¹¹ and for fiscal year 2021 the number was 33,090.¹² There were 85 team members employed in the emergency department at the project site, including registered nurses, licensed practical nurses, patient support technicians, physicians, and physician assistants.

Initial Intervention Development And Implementation BERT Respondents

A team approach was used to respond to occurrences of aggression, verbal threats, threatening behavior, and violence toward people or property and begin to de-escalate such events to reduce harm to patients or emergency staff. The team comprised 3 individuals: an emergency RN, a behavioral health assessment and referral team member, and a member from security. Behavioral health assessment and referral team members are licensed social workers trained to deal with the behavioral health population. All team members assigned to the BERT responder role received individual training before implementing the BERT protocol. Emergency nurses, behavioral health assessment and referral team members, and security members rotated in and out of the team based on their working schedule and shift, because team members work rotating days. Their role in implementing the BERT protocol was in addition to their regular daily assignments, because BERT was not a free-standing team.

Intervention Training

The program director provided in-person educational in-services to nurses, security personnel, and behavioral assessment and referral team members who would be BERT respondents. An educational PowerPoint presentation was sent out to the physicians and physician assistants simultaneously. Education included data related to OWPV that had occurred in the setting during the past 4 months to provide for the intervention's needs and teach workers the process of the BERT protocol, including notification when a patient or visitor starts to have increased anxiety or aggression. BERT notification was an overhead page in the emergency department to notify the BERT respondents to report to the nurse's station to receive a preintervention briefing on a patient. The expected response time was as short as possible. A team lead or designee recorded the time on the electronic debriefing tool postintervention. A preintervention report was provided by the primary nurse or team member who initiated the BERT protocol. The report included a brief history of the patient, any known escalating events, potential safety risks for a patient or team members, and information about what led to the increased aggression. Education included completing a security event report through the hospital security department. Lastly, the team lead or designee completed an electronic debriefing form to provide real-time wins and opportunities related to the OWPV.

Instruments/Data Collection

Implementation of the project started with education and survey distribution simultaneously on June 22, 2022 (Table 1). The survey was distributed to the participants within 24 hours after review and approval by the institutional review board. At the 2-week mark, the survey was closed, education was completed, and implementation of the BERT protocol started on July 6, 2022 at 7 am (on day shift); BERT implementation-related activities took place only on Monday through Friday. This time frame was chosen, because the project chair was available to provide support and education, and to answer questions related to the QI project during these times.

Two weeks into the implementation, data for OWPV from the security database was completed. After 8 weeks of implementation, the survey was administered to the participants for postimplementation assessment. The data for OWPV were collected for the 8-week implementation period. The assessment of perception of safety was obtained

within 2 weeks postimplementation. Analysis of the influence of the BERT protocol on the number of OWPV took place within 8 weeks postimplementation.

Intervention Implementation

The BERT protocol was initiated by any team member in the emergency department who felt that a patient or visitor had shown escalating behavior that was dangerous to the patient, members of the health care team, or the environment. An overhead page was sent out to the emergency department staff. The team responded to the location as quickly as possible. Information from the primary nurse or designee, including patient name, admitting diagnosis, any health history, and events leading up to the BERT activation was provided during the preintervention huddle. Any increased safety issues such as violent behavior or threats also were communicated about with the BERT. The BERT protocol checklist was a template that provided a list of the information that was necessary to have during the preintervention huddle. Once the team received the information, the most appropriate lead from the team was chosen based on the individual's ability to relate to the patient or visitor. The remainder of the team served as support for the team lead and to provide aid if needed. The team engaged with the patient/visitor using de-escalation techniques. The goal of the BERT was to de-escalate the situation without either the patient or the emergency staff being harmed.

After the event had been resolved, the team leader or designee completed the electronic debriefing form. An in-person/virtual verbal debriefing was used to identify opportunities to improve and also the wins that were present. Within 24 to 48 hours, a Crisis Prevention Institute (CPI) lead instructor from the inpatient behavioral health department performed a verbal debriefing with the BERT respondents about successes and opportunities for improvement, if necessary. CPI training focuses on prevention and de-escalating techniques using verbal skills to decrease OWPV and injuries and increase patient and staff safety.¹³ The CPI instructor was a subject matter expert in de-escalation techniques who provided real-time education to the BERT respondents. The project director was included in the debriefing sessions to capture the information and share it with the stakeholders and implement any necessary changes to the BERT protocol. Debriefings discussed what worked well, how the team felt the situation had been managed, any barriers identified, any lessons learned, and how the team felt mentally and emotionally to determine whether follow up was needed. After the debriefing, written documentation of the discussion was provided to the project manager.

Intervention Revision

At the 4-week mark of implementation of the BERT protocol, only 1 activation of the BERT had been initiated. Feedback from the team members was to extend the project to include every day of the week and make it 24 hours a day, because many events were occurring at night. Due to the lack of data and at the request of team members, the project timeline was extended by 4 weeks. On July 28, 2022, BERT protocol activation changed to 7 days a week and 24 hours a day.

Study Of The Intervention Data Sources

From March 1, 2022 to November 9, 2022, the number of OWPV was obtained from the security services event report and imported into an Excel spreadsheet in Research Electronic Data Capture (REDCap) for analysis. REDCap is a secure, HIPAA compliant web application used for surveys. The emergency team members were surveyed preimplementation and postimplementation of the BERT protocol using a perception of safety survey from the Emergency Nurses Association after permission was obtained to use and modify the survey. Modification of the Emergency Nurses Association tool narrowed the focus to specifics related to the QI project. Survey modifications resulted in our using 3 questions from the survey with an additional demographic question. Survey questions included the shift the team member worked, a rating of how safe the team member felt from OWPV, whether the

team member had been instructed to report WPV, and whether the team member had reported OWPV.

Analysis

In the perception of safety survey, the number of participants, shift worked, perception of safety, and instruction to report OWPV were obtained pre- and postimplementation. A 5-point Likert scale was used in the survey to measure perception of safety, with 0 indicating not safe at all to 5 indicating completely safe. Data on the number of OWPV reported, shift team member worked, and event time were collected.

Descriptive statistics were used to compare the nominal data related to groups identified in the survey related to shift work and the perception of safety. Means, medians, standard deviations, and confidence intervals were used to analyze the data. The number of OWPV was calculated each month using the security services event reporting system.

Results

Forty-three participants were included in analyses of the preimplementation data, and 21 participants were included in the postimplementation data related to perception of safety. Professional role, age, and the respondent's name were not included in the survey to maintain confidentiality (Table 2). Most of the participants worked day shift, 61.9% (n = 26 of 42) of them preimplementation and 66.7% (n = 14 of 21) of them postimplementation.

Perceptions Of Safety

Participants' perception of safety was lower preimplementation (mean = 2.16, SD = 0.92, 95% CI [0.76, 1.17]). Participant had a higher perception of safety postimplementation with mean 2.95 (SD = 0.86, 95% CI [0.66, 1.25]) (Table 2). The percentage increase in perception of safety was 36.5%. Although the increase was not statistically significant, the participants demonstrated that they were aware of the risk for violence.

Reporting Occurrences of Workplace Violence

OWPV were to be reported to allow tracking of prevalence and follow up. The majority of the participants stated that they had reported occurrences both preimplementation and postimplementation (71.4% [n = 30 of 42] and 70% [n = 14 of 20], respectively). No significant difference was noted after the implementation of the BERT protocol. Most participants (83.7% [n = 36 of 42] pre and 90.4% [n = 19 of 21] post) stated that they had been instructed to report physical and verbal abuse regardless of the level of severity or harm. Comparing preimplementation (83.7% [n = 36 of 42]) and postimplementation (90.4% [n = 19 of 21]) data indicated a slightly higher rate in response to trained to report OWPV after implementation of the BERT protocol when training included instructions to report. An unintended positive outcome of increased reporting is that it provides more accurate data, such as data on prevalence and type of WPV, for future interventions.

Occurrences of Workplace Violence

Data on OWPV were obtained through the security reporting database. Preimplementation, 1 to 2 occurrences were reported per month. Intraimplementation and postimplementation, 0 occurrences were reported (Figure).

During the initial 4-week data collection period, there was only 1 BERT activation. Reeducation then was provided to the team. A competitive approach to having the highest number of BERT activations was initiated between the day shift and night shift staff. Over the next 4 weeks, a total of 14 more BERTs were activated.

Workers' perceptions of safety increased by 36.5% along with a reduction of OWPV to 0 postimplementation of the BERT protocol, higher than the expected outcomes of a 10% increase in the perception of safety and a 25% decrease in OWPV.

Discussion Summary

The aim of the QI project described herein was to decrease the number of OWPV in the emergency department and increase the perception of safety of the team members employed at the project site. Researchers have concluded

that implementing BERT protocols reduce OWPV and positively affects team member satisfaction and perception of safety.⁹ Before implementing the BERT protocol, the site did not have a protocol in place to address OWPV. Reporting of OWPV decreased as BERT activations were reported using the organization's safety reporting tool. The perception of safety survey preimplementation and postimplementation was essential to determine how the BERT protocol affected the team members.

The utilization of descriptive statistics following the implementation demonstrated a decreased number of occurrences reported (14 occurrences vs. 0) and an increase in perception of safety (36.5% increase). During the QI project, the times when the team could activate the BERT were changed to 24 hours a day 7 days a week in response to feedback from the participants. After this change, the number of activations of the BERT protocol increased from 1 to 14, likely a co-result of the competition between shifts.

The project's outcomes have been disseminated within the organization. Other emergency departments and inpatient units within the health company have requested more information to implement the BERT protocol. Nonemergency settings in health care are also at risk for OWPV and need processes in place to address the problem.¹⁴ The BERT protocol can be an effective process for an emergency department and any inpatient setting within an organization. Non-mental health or emergency personnel may not have the de-escalation skills to effectively deal with OWPV, and the BERT process can assist with ensuring the safety of the team members.¹ The BERT protocol can increase the safety of the patients, team members, and visitors by creating a safer environment in which to receive and practice health care.¹⁴

Future research can include implementation of the BERT protocol in other health care settings, including inpatient settings, to evaluate whether protocol implementation has the same impact that we observed in an emergency department.^{1,14} The team approach has been shown to be effective.^{9,14,15} Additional research should include a debriefing tool to obtain data post-event on team members' input regarding the event.¹³

Interpretation

The results of this project indicate that the BERT protocol may be an effective process to implement within the emergency department setting. The protocol was used around the clock to capture OWPV during any time of the day. The standardized team approach provided an effective process to increase the safety of the team and patients seeking care in the emergency department setting.

Limitations

Limitations of the project include the number of participants in the survey preimplementation and postimplementation. Due to the need for anonymity of the survey participants, our choices of statistical tests for a comparison of presurvey and postsurvey data were limited. The project was implemented at only 1 site, which limits generalizability. Due to the requirement that study participants be anonymous, no independent samples could be used for statistical analysis. During the first 4 weeks of implementation, an increased need for activating a BERT was noted. After education and development of a competitive atmosphere among team members, a significant increase in BERT team member activations occurred over the next 4 weeks.

Implications for Emergency Nursing

Creating a BERT team should start with identifying individuals engaged in creating a safer workplace. The BERT team may consist of other members of the organization, such as engineering, chaplaincy, administrators on duty, supervisors, or others. The team will need structured education in de-escalation skills through training such as CPI. Once implemented, the appropriate team members should meet regularly to analyze the data related to events and outcomes that have been collected.

OWPV affects all nursing disciplines, although it occurs most often in emergency and behavioral health settings.¹⁵

The increased mental stress, perception of lack of safety, and increased emotional and physical injuries related to OWPV have a negative impact on the nursing profession and patient outcomes.^{3,15-17} Implementing a BERT protocol in the emergency department reduced the number of OWPV to 0 during the project implementation period. It also increased the team members' perceptions of safety. Emergency nurses equipped with the skills to effectively decrease OWPV may have an impact on the mental well-being and stress experienced by nurses and other team members.

Conclusion

The BERT protocol was developed, implemented, and evaluated for its effectiveness in decreasing OWPV and increasing the perception of safety among the team members in an emergency department. BERT protocol activation increased over time through initial training, just-in-time training, and the incorporation of team member feedback. Activating the BERT protocol empowered the team to decrease the number of reported OWPV and increased the perception of safety. Additional research is recommended to determine the implications of the protocol within other disciplines of nursing and other emergency departments.

Author Disclosures

Conflicts of interest: none to report.

Week of project	Project implementation
Weeks 1-2	Obtained email addresses for surveys, emailed surveys to recruit participants, provided informed consent via survey email, and collected preimplementation data related to occurrences of workplace violence during the previous 4 months. Provided in-person in-service educational sessions
Weeks 3-8	Ongoing intervention, debriefings with CPI instructor 24-48 hours post-BERT protocol implementation, real-time training related to feedback from debriefings, DNP project manager observing and coaching and providing real-time education related to not calling BERT
Weeks 9-12	Extended project timeline due to lack of BERT data; intervention increased to cover every day and 24 hours a day
Weeks 13-14	Postimplementation survey sent out, collection of occurrences of workplace violence during the implementation phase
Weeks 15-20	Collection of occurrences of workplace violence during the postimplementation period

Variable	Preimplementation	Postimplementation
Shift		

Day	61.9%	66.7%
Mid	23.8%	9.5%
Night	16.7%	23.8%
Perception of safety		
N	42	21
Mean	2.16	2.95
Median	2	3
SD	0.92	0.86
Confidence interval	0.7619, 1.1744	0.6615, 1.2486
Trained to report occurrences of workplace violence (%)	85%	90%

DETAILS

Subject: Patients; Emergency medical care; Quality management; Behavior; Threats; Perceptions; Workplace violence; Assaults; Medical referrals; Safety behaviour; Implementation; Review boards; Workplaces; Security staff; Nurses; Nurse led services; Emergency services; Teams; Departments; Technicians; Education; Physician assistants

Business indexing term: Subject: Workplace violence

Identifier / keyword: Workplace violence; Emergency department; Assaults; Behavioral emergency response team; Workplace aggression; Perception of safety

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

Pages: 395-402

Publication year: 2023

Publication date: May 2023

Section: Practice Improvement

Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.011
ProQuest document ID:	2809540968
Document URL:	https://www.proquest.com/scholarly-journals/implementation-behavioral-emergency-response-team/docview/2809540968/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 10 of 50

Violence Risk Assessment in the Emergency Department: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Workplace violence is a prevalent problem in health care, with mental health and emergency departments being the most at-risk settings. The aim of this evidence-based practice project was to pilot use of a violence risk assessment tool, the Broset Violence Checklist, to assess for risk of type II violence and record the interventions that nurses chose to implement to mitigate the situation. Additionally, reports made to the hospital reporting system were tracked and compared to previous reporting frequency.

Methods

Following staff education, nurses were instructed to complete checklists for all patients who have a score of 1 or higher, which indicates the presence of at least 1 high-risk behavior, and continue hourly scoring until the score returned to 0 or the patient was dispositioned. The number of incidents recorded, time of day, scores, interventions applied to mitigate violence, and change in scores after interventions were evaluated. The number of Broset Violence Checklist scoring sheets submitted and reports made via the hospital reporting system were compared.

Results

Incidents were most frequent from 11 am until 3 am. The highest scores occurred in the late evening and early morning hours. There were significantly more incidents captured with the use of the Broset Violence Checklist as compared to the hospital reporting system. Incidents significantly associated with higher scores included providing comfort measures, addressing concerns, and applying restraints.

Discussion

The Broset Violence Checklist was used successfully in the emergency department setting to identify behaviors associated with violence. Under-reporting to the hospital report system was identified in this project, consistent with reports in the literature. Specific interventions were not associated with a decrease in Broset Violence Checklist scores.

FULL TEXT

Contribution to Emergency Nursing Practice

- Violence in the emergency department is a significant problem that is often under-reported, and hospital-based tracking systems are frequently underused by emergency nurses resulting in inadequate reporting of the true incidence of violence.
- Violence risk assessment may empower nurses to recognize potential for violence and intervene early.
- Including violence risk assessment into regular practice allows for more robust data collection to guide decision-making regarding protection of staff and patients.

Introduction

The most significant occupational hazard faced by health care workers is violence in the workplace.¹ Workplace violence (WPV) in health care is a common occurrence. In fact, health care and social service workers are 5 times more likely to experience WPV than those in other professions.² Of all nonfatal workplace injuries among health care workers in 2018, 73% were due to violence.² The Federal Bureau of Investigation³ identifies 4 types of WPV as illustrated in ^{Table 1}.

Problem Description

The emergency department is a unique setting that creates an atmosphere where violence may occur. Patients that have a history of violence, are intoxicated, or are mentally ill may present for treatment of acute illness and injury.⁴ The emergency department environment creates additional risk factors, including easy access to the public, understaffing, and long wait for times.⁴

Additionally, WPV in the emergency department often goes unreported. Fear of stigmatizing patients with mental illness or cognitive dysfunction, or those who are experiencing extraordinary stress contributes to the culture of tolerating violent behavior.¹ Underreporting of WPV is attributable to the perception that nothing will be done by the organization to protect staff. According to Buterakos et al,⁵ 68% of emergency nurses surveyed did not report WPV, because they felt reporting would not lead to change, and 44% felt that WPV was just part of the job. These cultural perceptions ultimately lead to staff burnout, turnover, serious injury, or even death, all of which are costly to hospitals on many levels. In 2016, in-facility violence cost United States health care organizations \$234.2 million due to staff turnover, \$42.3 million in medical care and liability, and \$90.7 million for disability and absenteeism costs for a total

of \$428.5 million.⁶ In addition, underreporting can be attributed to a lack of administrative support, cumbersome reporting mechanisms, and a culture that accepts WPV as part of the job.¹

At the project onset, there was not a patient risk assessment routinely completed by nursing staff. A computer-based system was in place for staff to report incidents. Eighty incidents were reported for the 18-month period consisting of fiscal years 2018 and the first half of 2019, which is an average of 3.3 incidents per month.

Available Knowledge

The evidence supports the use of a violence risk tool to assess for the potential for violence. Cue recognition allows for early intervention to prevent and reduce injuries.⁷ Similarly, Sarver et al⁸ reported that early recognition of behavioral cues allows for prevention and early intervention. In their retrospective cohort study, Sarver et al⁸ compared scores of the Broset Violence Checklist (BVC) to the actual occurrence of violence. They found that for every additional point on the BVC, there was a 3.4 times increased likelihood of violence. They concluded that the BVC is an optimal tool for routine screening of patients to provide early recognition of potential escalation to violence. Research demonstrates that the use of the BVC for early identification of escalation helps nurses to direct care and apply appropriate interventions to the situation.⁸

The BVC has been shown to be a valid tool for the prediction of violence. The area under the curve (AUC) is a value of true positives (sensitivity) and true negatives (specificity), where a value of 0.5 is simply chance prediction, and 1.0 indicates perfect predictive value.⁹ Values of 0.9 or greater are considered excellent, and 0.80 to 0.89 are good for predictive value. The lower limit to determine a useful tool is 0.75.⁹

Hvidhjelm et al¹⁰ studied the BVC on an inpatient psychiatry unit. They found the AUC for the BVC was 0.915. When the score was 3 or higher, the sensitivity was 0.656, and the specificity was 0.997 for the prediction of violence in the next 24 hours. Ghosh et al⁹ conducted an integrative review of the literature and found the BVC consistently had a strong AUC of 0.86 to 0.87 and was one of the few tools that could potentially be used in acute care settings.

Specific Aims

The specific aims of this project were to evaluate the use of the BVC in an ED setting to record incidents of violence or potential for violence in real-time, record the interventions that nurses used, and track the reporting of such incidents.

Methods Context

The project commenced in March 2020 and continued for 8 weeks. This coincided with the onset of the coronavirus disease-2019 (COVID-19) pandemic. This project was conducted in a 390-bed community hospital in a suburb of a large midwestern city. This community hospital holds an academic partnership with a university health care system. Staff nurses from the adult emergency department were invited to participate. Nurses who worked exclusively in the pediatric emergency department were excluded as the BVC had not been adequately studied in the pediatric population. A total of 65 nurses were eligible to participate in the project.

Interventions

After nursing education regarding the project was completed, paper BVC scoring sheets (see ^{Supplementary Appendix}) were made available on each of the 3 adult pods of the emergency department. Once completed, they were deposited in a locked drop box to be collected by the project leader. Nurses were asked to start a BVC scoring sheet on any patient that would score at least a 1 and record hourly scores until the patient was discharged or the score returned to 0. Scoring sheets were collected on a weekly basis. Of the 27 unique patients evaluated, 68 score assessments were completed with the frequency of scores summarized in ^{Table 3}. Of those 27 unique patients, 12 (44%) had only a single score assessment completed. It is unclear if the lack of documentation of serial scores was due to attrition or if the patient was dispositioned prior to return to a 0 score. Serial score comparison was completed on the remaining

15 (56%) patients for a total of 41 score comparisons.

Measures

The BVC is a violence risk assessment tool consisting of 6 behaviors that are scored 1 point each for a maximum of 6 points. A point is scored if the patient displays any of the following behaviors: confusion, irritability, boisterousness, making verbal threats, making physical threats, or attacking objects.¹¹ A BVC score of 0 indicates a low risk for violence, 1 to 2 indicates moderate risk, and 3 or greater suggests a high risk for violence.⁸ For this project, nurses were instructed to begin to implement interventions for scores of ≥ 1 and document which interventions were implemented to address the behavior. The types of interventions used also were recorded on the scoring sheet. To evaluate WPV reporting trends, data were pulled from the hospital reporting system from the 18 months prior to the project. Data then were again pulled from the same reporting system for the 8 weeks of the project timeline. The comparison was made to evaluate any discrepancy in reporting trends.

Analysis

Data analysis was performed using IBM SPSS Statistics 26.0 (Armonk, NY). Each BVC total score was considered to be an independent assessment with 68 individual assessments completed on 27 total patients. One assessment was lacking intervention information resulting in 67 usable intervention data points for intervention assessments and analysis. At the end of the 8-week intervention period, the BVC scoring sheets and drop boxes were removed from the department by the project leader. The information on the scoring sheets was entered into an Excel spreadsheet to prepare for statistical analysis. Information on the spreadsheet included sheet number (1-27), time of day, which was categorized in 4-hour increments, BVC score, and interventions. The BVC scores range from 0 to 6, with increasing values implying the increased potential for violence. For the purposes of data entry, the interventions were classified as a nominal value of either 1 or 2, indicating done or not done per the classifications in ^{Table 2}. Serial assessments were compared with prior scores to trend risk of violence over time. Chi-square analysis was completed to assess the associations between BVC score categories and each independent variable.

Ethical Considerations

No patient names or identifiers were used to collect the data. Nursing participation in the project was strictly voluntary. The project was reviewed extensively by the chairperson of the hospital nursing research committee, who approved the project as an evidence-based project and determined that an Institutional Review Board review was not necessary.

Results

A total of 27 unique patients yielded 68 unique BVC score assessments. The highest number of incidents occurred between 11 am and 3 am, with the highest scores occurring between 7 pm and 11 pm. Of the possible 0 to 6 range for BVC scores, no scores of 5 or 6 were recorded. The interventions that nurses implemented when faced with an incident of potential violence that demonstrated statistical significance included offering comfort measures, answering patient questions and concerns, and applying restraints. These interventions were significantly associated with higher BVC scores. No statistical significance was found with alerting the charge nurse, maintaining a buddy system, using a sitter, involving security, and providing sedative, antipsychotic, or anxiolytic medication. During the 8-week-long intervention, 3.5 incidents occurred per week as compared to 3.3 incidents per month for the previous 18 months, as reported to the hospital tracking system. The BVC was successfully used to identify patients with potential for physical violence. A limited percentage of nurses participated in the project, which may have been due to the parallel onset of the COVID-19 pandemic during project implementation. The occurrence of incidents was most frequent and significant during the late evening and early morning hours. Interventions were not significantly associated with a decrease in BVC scores. Incidents were under-reported to the hospital reporting system compared

to the data of incidents from use of the BVC in real time.

A BVC score of 1 was most reported, with nearly equal numbers of scores 3 and 2; no scores of 5 or 6 were reported. Most surveys were completed between 7:01 pm and 3 am, with no scores being completed between 7:01 am to 11 am. For most patients, comfort measures were employed, and questions/concerns were answered. The charge nurse was not alerted, the buddy system was not used, security was not used, pain medications were not given, patients were not medicated, and restraints were not used for most patients. See ^{Table 3}.

Chi-square analysis was completed to assess for associations between BVC score categories 0 to 4 and each independent variable. There were no BVC scores of 5 or 6 and no responses from 7:01 am-11 am; therefore, these items were not included in the chi-square analysis. Lower BVC scores were more frequent during the 11:01 pm-3 am and 3:01 am-7 am time slots, while higher scores were more frequent during the 7:01 pm-11 pm time slots (chi-square $P = .001$, see ^{Table 4}). Those with higher BVC scores were more likely to have comfort measures employed compared to those with lower BVC scores (chi-squared $P = .003$, see ^{Table 4}). Those with higher BVC scores also were more likely to have questions and concerns answered compared to those with lower BVC scores (chi-squared $P = .000$, see ^{Table 4}). Restraints were more likely used for patients with a BVC score of 4 compared to those with lower BVC scores (chi-squared $P = .000$, see ^{Table 2}). There was no statistically significant difference associated with BVC score categories for the following independent variables: alerted charge nurse, implemented the buddy system, used sitter, used security, provided pain medication, or medicated patient (see ^{Table 4}).

ANOVA was completed to compare mean BVC scores for all independent variables. Significantly higher mean BVC scores were recorded between 11:01 am-11 pm, compared to mean BVC scores recorded between 11:01 pm-7 am (ANOVA $P = .000$). Mean BVC scores also were higher for patients requiring restraints (mean BVC score 3, SD = 1.414) compared to those with no restraints (mean BVC score 1.69, SD = 1.049). Mean BVC scores for those requiring a sitter (mean 2.2, SD = 1.105) were slightly higher than those not requiring a sitter (mean 1.62, SD = 1.095) but only approached statistical significance. Comparison for the following independent variables: comfort measures employed, questions/concerns answered, alerted charge nurse, implemented a buddy system, used security, provided pain medication or medicated patient did not reach statistical significance.

Finally, subanalysis was done to look for a change in BVC scores compared to prior recorded BVC score for the same patient. There were 41 assessments that had a prior BVC score recorded for comparison. Of those, scores were unchanged from prior for 24 events, worse from prior (higher BVC score) for 3 events, and improved from prior (lower BVC score) for 14 events. There were no consistent associations noted between independent variables and score change.

During the 8-week intervention period of this project, 27 unique patients were recorded by way of BVC scoring sheets, and 4 incidents were reported to the hospital reporting system for a total of 28 incidents in 8 weeks (1 incident was reported to the hospital reporting system that was not reported via BVC scoring sheets). This is an average of 15.1 incidents per month reporting using the BVC scoring sheet as compared to 3.3 incidents per month for the previous 18 months reported using the hospital tracking system. Incidents were under-reported to the hospital reporting system compared to the data of incidents from the BVC scoring sheet in real time.

Discussion and Implications for Emergency Nursing

Emergency nurses are frequently exposed to workplace violence only to be met with a lack of support when reporting these incidents. There are multiple anecdotes from nurses who were dismissed by hospital administration, law enforcement, and the judicial system when they reported violence. Lipscomb and London¹ report a nurse who had her jaw broken by a patient only to be met with suggestions of “what did you expect?” Copeland and Henry¹² reported emergency nurses perceived that the administration reflexively sides with the patient rather than support

the emergency nurse's concern. The culture of acceptance of WPV must be shifted toward a culture of reporting and mutual respect. Frick et al¹³ report that nurses desire consistent support from ED management subsequent to violent incidents. They further report the importance of tangible policies for protecting staff, an increased presence of security, and de-escalation training to mitigate violence.¹³ Hospital administrators can start by creating policies to encourage reporting, implementation of effective tools to assess the potential for aggression, and communication with clear support of hospital leadership with consistent follow-up of reports and incidents. Further study of effective interventions to prevent and de-escalate violence is warranted in order to create a safer workplace for emergency nurses.

Current methods of reporting violence in the emergency department are not reflective of the actual violence that occurs.¹⁴ ED leadership should recognize the high workload of ED staff and the impact that has on reporting.¹⁴ This project highlights the importance of reporting violence in the workplace. Incidents often occur in the evening and very early morning. These are vulnerable time frames for staff as ED volumes and wait times tend to be highest during these hours. Increased nursing staff and security presence may be indicated to ensure a safer environment. Consistent support of and follow-up on incidents from leadership have been shown to increase reporting.¹⁵ Although many organizations have a policy for zero tolerance for violence, the lack of follow through on reports results in further apathy related to reporting.¹⁴ Emergency nurses deserve to have a safe working environment. Our efforts need to focus on nurse safety with the same determination that we have for patient safety.

This project also demonstrated the feasibility of using the BVC in the ED setting. The BVC has been successfully used to predict the potential for violence in the ED setting with strong validity per Cabilan and Johnston.¹⁶ The literature also supports the use of a violence risk assessment tool in the ED setting starting at triage per Cabilan and Johnston.¹⁵ Sarver et al⁸ suggest that the BVC is a violence risk tool suitable for the ED setting. During this project, the BVC was used to identify 27 incidents in an 8-week time frame, illustrating a higher frequency of incidents than the hospital incident reporting system captured. This is consistent with the under-reporting found in the literature.^{1,5,12.}

¹⁴ The frequency and severity of incidents were shown to be higher in the late evening and early morning hours, suggesting an increased risk for emergency nurses working during those hours. Multiple interventions were used by nurses to mitigate potentially violent situations. The interventions that were significantly associated with higher BVC scores included providing comfort measures and addressing patient questions and concerns. The interventions documented in this project did not have a statistically significant impact on lowering BVC scores, which leads to the question of which interventions would help. Do nurses have the tools they need to de-escalate situations? Nurses made efforts to de-escalate by providing comfort measures and ensuring that questions and concerns were answered, but when that is not working, what else is available short of restraints? Further study is warranted to explore interventions that reduce the risk for ED staff.

Limitations

Despite pre-education provided to the nursing staff in the form of meetings and emails, as well as the regular presence of the project leader on the unit for support in completing the scoring sheets, only 21.5% of nurses participated in the project. This project took place at the onset of the COVID-19 pandemic, which may have altered nurse participation as well as the available number of patients. Further study is needed to evaluate the interventions that nurses attempt to implement to mitigate potential violence.

Due to the short-term nature of the project and financial considerations, the BVC assessment tool was not added to the electronic health record for the purposes of this project. Ideally, this addition would provide ease of use and potentially minimize the need for reporting in an alternate system, as well as enable more robust data mining.

Conclusions

The use of a violence risk assessment tool such as the BVC can empower nurses to record scores and identify at-risk patients in real time. Providing a quick, accessible tool for violence risk assessment allows nurses to record incidents without having to spend excess time away from patient care or staying overtime to complete a cumbersome report. There is a great opportunity to gather more significant and accurate data regarding the prevalence of WPV, which can allow hospital administrators to make better staffing and safety decisions. Underreporting of incidents involving verbal and physical abuse toward emergency nurses must be addressed. Administrators can start by creating open discussions with their staff regarding their perception of violence in their own workplace. Transparency is key. Sharing the data with staff may help validate staff reports and encourage reporting. During this project, nurses were willing to record patients' risk for violence in real time, as opposed to completing a separate incident report, captured far more incidents. The use of the BVC as a routine assessment tool in the ED electronic health record, coupled with intervention strategies, may provide for more accurate data to increase the safety of emergency nurses.

Author Disclosures

Conflicts of interest: none to report.

Supplementary Appendix

BVC Scoring Sheet

Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jen.2023.02.006>.

Type of WPV	Description of WPV
Type I	Random violent acts by a person who has no connection to the workplace
Type II	Violence committed by customers, clients, patients, students, inmates, or any person who receives services in the workplace
Type III	Violence committed by a current or former employee of a workplace
Type IV	Violence committed by a person who has a current or former relationship with an employee of the workplace

Symbol	Intervention
C	Comfort measures: any of the following--quiet environment, food/drink, blanket, TV
Q	Answer and address questions or concerns
CN	Alert the charge nurse

B	Buddy system—enter a room with another staff member for safety
ST	Secure a sitter for the patient
SC	Call security
P	Pain medication, if appropriate
M	Medication
R	Restraints

Characteristic	n	%
BVC score category (N = 68)		
0	8	12
1	25	37
2	14	21
3	17	25
4	4	6
5	0	0
6	0	0
Time of day (N = 68)		
07:01 am-11 am	0	0
11:01 am-03 pm	10	15
03:01 pm-7 pm	9	13
7:01 pm-11 pm	18	27
11:01 pm-03 am (n = 67)	21	31

03:01 am -07 am	9	13
Comfort measures employed (N = 67)		
Yes	47	70
No	20	30
Questions and concerns addressed (N = 67)		
Yes	46	69
No	21	31
Alert charge nurse (N = 67)		
Yes	2	3
No	65	97
Implement buddy system (N = 67)		
Yes	2	3
No	65	97
Used sitter (N = 67)		
Yes	20	31
No	47	70
Used security (N = 67)		
Yes	6	9
No	61	91
Administered pain medication (N = 67)		
Yes	3	5
No	64	96
Administered medication (N = 67)		

Yes	3	5
No	64	96
Used restraints (N = 67)		
Yes	5	8
No	62	93

Characteristic	BVC 0 n	BVC 0 %	BVC 1 n	BVC 1 %	BVC 2 n	BVC 2 %	BVC 3 n	BVC 3 %	BVC 4 n	BVC 4 %	Chi- square p
Time of day (N = 68)											.001
11:01 am-3 pm	0	0	0	0	5	50	4	40	1	10	
3:01 pm-7 pm	1	11	3	33	2	22	1	11	2	22	
7:01 pm-11 pm	0	0	5	28	3	17	9	50	1	6	
11:01 pm-3 am (N = 67)	2	100	13	62	3	14	3	14	0	0	
3:01 am-7 am	4	50	4	40	1	10	0	0	0	0	
Comfort measures employed (N = 67)											.003
Yes	2	4	21	45	8	17	15	32	1	2	
No	5	25	4	20	6	30	2	10	3	15	
Questions/concerns answered (N = 67)											.000
Yes	1	2	18	39	11	24	16	35	0	0	
No	6	29	7	33	3	14	1	5	4	19	
Alerted charge nurse (N = 67)											.060

Yes	0	0	0	0	1	50	0	0	1	50	
No	7	11	25	39	13	20	17	26	3	5	
Implemented buddy system (N = 67)											.060
Yes	0	0	0	0	1	50	0	0	1	50	
No	7	11	25	39	13	20	17	26	3	5	
Used sitter (N = 67)											.128
Yes	0	0	7	35	5	25	5	25	3	15	
No	7	15	18	38	9	19	12	26	1	2	
Used security (N = 67)											.055
Yes	0	0	2	33	1	17	1	17	2	33	
No	7	12	23	38	13	21	16	26	2	3	
Provided pain medication (N = 67)											.296
Yes	0	0	0	0	2	67	1	33	0	0	
No	7	11	25	39	12	19	16	25	4	6	
Medicated patient (N = 67)											.286
Yes	0	0	1	33	0	0	1	33	1	33	
No	7	11	24	38	14	22	16	25	3	5	
Used restraints (N = 67)											.000
Yes	0	0	1	20	1	20	0	0	3	60	
No	7	11	24	39	13	21	17	27	1	2	

DETAILS

Subject:	Emergency medical care; Behavior; Intervention; Risk behavior; Trends; Medical personnel; Injuries; Risk assessment; Hospitals; Violence; Nurses; Emergency services; Evidence-based practice; Mental health services; Pediatrics; Time of day; Checklists; Patients; Workplace violence; Health care; Workplaces; High risk; Nursing; Coronaviruses; Mental health care
Business indexing term:	Subject: Risk assessment
Identifier / keyword:	Workplace violence; Workplace aggression; Emergency department; Violence risk assessment; Broset Violence Checklist
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	352-359.e1
Publication year:	2023
Publication date:	May 2023
Section:	Practice Improvement
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.02.006
ProQuest document ID:	2809540967
Document URL:	https://www.proquest.com/scholarly-journals/violence-risk-assessment-emergency-department/docview/2809540967/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association

Effects of Emergency Nurses' Experiences of Violence, Resilience, and Nursing Work Environment on Turnover Intention: A Cross-Sectional Survey: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Emergency nurses are vulnerable to violence, because they closely face patients or caregivers in emergency situations, where tension and conflicts are heightened. This is known to increase their turnover intentions. This study aimed to analyze the effects of emergency nurses' experiences of violence, resilience, and nursing work environment on turnover intentions.

Methods

This descriptive study analyzed a questionnaire administered to emergency nurses from March 2020 to April 2020. Its participants included 100 emergency nurses from 4 emergency medical centers. The collected data were analyzed using the SPSS/WIN 25.0 program (IBM SPSS Statistics) by frequency, percentage, mean, SD, *t* test, analysis of variance, and multiple regression

Results

The main factors affecting the turnover intentions of emergency nurses were resilience ($\beta = -0.32$, $P = .003$), frequency of violence by patients ($\beta = 0.27$, $P = .003$), and nursing managers' leadership and support for nurses ($\beta = -0.25$, $P = .021$). The explanatory power of these 3 variables was 29.3%.

Discussion

To reduce emergency nurses' turnover intentions, it may be necessary to conduct resilience programs for them. In addition, safety measures to prevent violence at the organizational level and improve nursing managers' abilities, leadership, and support for nurses can reduce nurses' intention to leave.

FULL TEXT

Contribution to Emergency Nursing Practice

- What is already known about this topic? Emergency nurses are vulnerable to violence, because they face patients and caregivers in emergencies.
- What does this paper add to the currently published literature? Experiencing repeated exposure to violence leads to physiological and psychological responses such as tension, headache, sleep disturbance, and isolation; additionally, it increases turnover intention.

••What is the most important implication for clinical practice? It is important that nurses provide optimal care in a safe environment. This will enhance their professionalism so that they can provide high-quality care to patients.

Introduction

Given that patients who visit emergency units could be mentally and physically unstable owing to a sudden illness or accident, emergency unit medical workers often encounter more threatening situations than those in other departments.^{1,2} Nurses, in particular, are vulnerable to violence, because they are confronted by patients or caregivers during the early emergency period, when tensions and conflicts are escalated.³ Although medical institutions are places for patient treatment, they also can be places of violence for nurses.

Although legal standards prevent interference with emergency medical services, cases of violence in emergency units are steadily increasing. Patients and caregivers are the main perpetrators of violence in medical institutions, and medical institution workers have experienced 69.2% and 13% of verbal abuse and assault, respectively.⁴ Experiencing repeated exposure to violence leads to physiological and psychological responses, such as tension, headaches, sleep disturbances, and isolation.³ Physical violence causes greater trauma than verbal abuse, and, in general, experiences of violence increase turnover intentions⁵ and affect nurses' continuity of employment.⁶ Experiences of violence also lead to negative attitudes toward the nursing profession⁷ and decrease the quality of care provided to patients. As a result, the shortage of nurses is further accelerated, intensifying deterioration in the quality of patient care.

Resilience refers to an individual's ability to cope with difficult situations.⁸ The possibility of scientific development has been debated for a long time owing to the ambiguity of its composition, but it has recently begun to attract attention again as its effect as a parameter has been reported.⁵

The nursing work environment is a comprehensive construct that includes physical, social, psychological, and hospital organizational policies to provide high-quality nursing services. A good nursing work environment reduces emergency nurses' turnover intentions. Therefore, nurses' resilience, work environment, and turnover intentions have been addressed in relation to their experiences of violence.⁹ Although studies have been conducted on emergency nurses' experiences of violence and resilience,⁵ as well as their nursing work environment and turnover intentions,¹⁰ most of these studies included only some of the variables, and no studies that included all the variables were found.

Therefore, this study aimed to examine the extent to which emergency units provide basic data for lowering turnover intentions and applying coping strategies against violence, by identifying the extent to which emergency nurses' experiences of violence, resilience, and nursing work environment affected their turnover intentions.

Methods Study Design

This descriptive study analyzed the effects of experiences of violence, resilience, and nursing work environment on the turnover intentions of emergency nurses who experienced violence using a self-report questionnaire. The Strengthening the Reporting of Observational Studies in Epidemiology guidelines were used for the reporting of this research.

Study Participants

The participants included nurses working in 3 shifts in the emergency units of 4 regional emergency medical centers who had experienced workplace violence, understood this study's purpose, and consented to data collection. However, it excluded nursing managers who did not work night shifts, as violence mostly occurs during the night. The minimum sample size was determined using the G*power 3.1.9.4 program.¹¹ Based on multiple regression analysis, referring to the study by Chen et al,¹² the required number of participants was 100, when calculated with an

effect size of 0.2, a significance level of 0.05, a power of 0.85, and 10 predictors. Considering the dropout rate, data were collected from 108 people, but for the final analysis, only 100 people's data were included, because questionnaires with incomplete answers were excluded.

Measured Variables And Research Tools Experiences of Violence

Violence is defined as a threat to oneself, another person, group, or community, or the actual intentional use of physical force or power that results, or is likely to result, in injury, death, psychological damage, development, or deprivation.¹³ This study employed the tool used by Yeon et al¹⁴ to investigate violence in the medical field. The tool measures the frequency and degree of violent experiences by dividing patients and caregivers and consists of a total of 20 items. In this study, the Cronbach's α reliability coefficients were 0.91 for the entire tool, 0.83 for the frequency of experiences of violence, and 0.91 for the degree of violence risks.

Resilience

Resilience is a dynamic process involving positive adaptation within the context of severe adversity.⁸ For resilience in this study, a 30-item tool developed for clinical nurses by Park and Park¹⁵ was used. Each item is on a 4-point Likert scale, and the mean score for each item ranges from 1 to 4, and the summative score ranges from a minimum of 30 to a maximum of 120. In the study of Park and Park,¹⁵ the reliability coefficient Cronbach's alpha was 0.950, and in this study, it was 0.949.

Nursing Work Environment

The nursing work environment is a comprehensive construct that includes not only the physical environment but also organizational policies and management to provide nursing care. This study used the Korean version of the Practice Environment Scale of the Nursing Work Index, consisting of 29 items and 5 subareas for measuring: "staffing and resource adequacy," "nurse-physician relations," "nursing manager's ability, leadership, and support of nurses," "nursing foundations for quality of care," and "nurses' participation in hospital affairs." Each item was rated on a 4-point Likert scale, and the mean score for each item ranges from 1 to 4, and the higher the score, the better the nursing work environment. The Cronbach's alpha reliability coefficient was 0.93 in a study,¹⁶ whereas it was 0.94 in this study.

Turnover Intentions

The construct of turnover intentions includes both the thoughts and actions of voluntarily leaving the current organization or planning to move on.¹⁷ To measure the intention to change jobs, the tool developed by Michaels and Spector¹⁸ was used. In this study, 3 questions were asked, each item was rated on a 5-point Likert scale, and the mean score for each item ranges from 1 to 5. The Cronbach's alpha reliability coefficient was 0.93 in a study,¹⁶ whereas it was 0.94 in this study. with a higher score indicating a higher intention to leave. The tool's Cronbach's alpha reliability coefficient was 0.87 in this study.

Data Collection Method

This study was conducted from March to April 2020. After obtaining permission from each hospital's nursing department, the research survey was publicized to emergency nurses, and consent was sought from nurses who wished to participate. The study's purpose and meaning were explained to individual participants, who took approximately 20 minutes to complete the questionnaire. In total, 108 questionnaires (98%) were collected, of which 8 incomplete responses were excluded from the analysis, and finally, 100 questionnaires (91%) were used for data analysis.

Data Analysis

SPSS/WIN 25.0 was used to analyze the collected data. Means and SDs were used to represent general and job-related characteristics of emergency unit nurses, whose experiences of violence, resilience, nursing work

environment, and turnover intentions were analyzed using *t* tests and analysis of variance, and factors affecting their turnover intentions were analyzed using stepwise multiple regression.

Ethical Considerations

This study was approved by the University Bioethics Committee's Institutional Review Board (Approval number:1044396-202001-HR-021-02). To facilitate participants' understanding of the purpose of the study and to consent to data collection, the reasons for conducting this study and its methodology were explained to them, and only those who voluntarily expressed their intention to participate were included. They were informed about the duration of the study and the option of withdrawing at any time during the study.

Results Participants' Experience of Violence

The average frequency of nurses' experiences of violence from patients within the previous month was 1.03, and verbal abuse was the most frequent, with an average of 2.61. On average, the frequency of experiences of violence from caregivers was 0.86, and that of verbal abuse in the subarea was 2.49 points (Table 1).

Differences In Other Variables According To The Characteristics of The Participants

In this study, 89% of the participants were women, whose average age was 27.7 years, with work experience of 42.6 months. Participants' average nursing work environment score was 2.32 points (4-point scale), and their subareas scores were as follows: "Collegial nurse-physician relations" was 2.59 points; "nursing manager's ability, leadership, and support of nurses" was 2.54 points; the "foundation for quality care" was 2.46 points; "nurses' participation in hospital affairs" was 2.18 points; and "staffing and resource adequacy" was 1.84 points. A negative score was observed among women participants in "nurse participation in hospital affairs," which is a detailed area of the nursing work environment ($F = -2.05, P = .043$) (Table 2).

The average resilience score of this study's participants was 2.72 points, and their average turnover intention score was 3.08 points. The turnover intention level of women participants was high ($F = 2.39, P = .019$), and for those with more than 37 months of emergency unit work experience, it was even higher ($F = 4.31, P = .016$).

Factors Influencing The Participants' Turnover Intentions

The main factors affecting turnover intentions were resilience ($B = -0.32, P = .003$), frequency of violence from patients ($B = 0.27, P = .003$), and, among the detailed areas of the environment, "nursing manager's ability, leadership, and support of nurses" ($B = -0.25, P = .021$). The explanatory power of the 3 variables was 29.3% (Tables 3 and 4, Figure).

Discussion

Participants in this study received more violence from patients than caregivers and frequently experienced verbal abuse. Emergency unit nurses frequently experience verbal abuse from patients and caregivers,¹⁹ with 72% reporting verbal abuse and 17.8% physical violence.²⁰ Therefore, it can be said that many nurses perform nursing tasks in situations where verbal abuse is frequent.

The average score of the participants of this study on resilience was 2.72 points (68 out of 100), which was the same (2.72 points) as that in the study of Kim et al,²¹ which used the same tool, but the average score reported by Kim²² was 2.92 (72.4 out of 100). Considering the report²² that resilience increases with age and clinical experience, this seems to be due to the low average age (27.7 years) and clinical experience (42.6 months) of the participants of this study.

In this study, the emergency unit nursing work environment had an average score of 2.32 points, similar to the 2.42 points reported in a study²³ that used the same tools as in this study. A nursing work environment score of 24 Organizational measures must be implemented to improve the nursing work environment, as individual efforts by nurses alone are insufficient. Among the nursing work environment subareas, "staffing and resource adequacy" had

the lowest average score of 1.84 points, similar to the findings of Bae and Yeom's²³ study. This indicates an urgent need for adequate staffing and resources.

There were significant differences in turnover intentions by sex ($F = 2.39, P = .019$) and emergency work experience ($F = 4.31, P = .016$). Women had higher turnover intentions than men, and those with more than 3 years of experience in an emergency department had higher turnover intention scores. A study²⁵ also reported that women had higher turnover intentions than men, and those with more than 10 years of clinical experience had higher turnover intentions. Therefore, turnover management should be sought differently for emergency nurses, according to their sex and work experience.

In particular, since the outbreak of COVID-19 in 2019, as the number of patients with COVID-19 has increased explosively, nurses' turnover intention is increasing, requiring careful attention from nursing managers. The lack of proper education on infection control tasks, including how to wear protective gear, and frequent changes in emergency unit guidelines caused confusion and increased workload in the nursing situation. In such urgent emergency unit situations, patients and their families, as well as the medical staff, become extremely sensitive, thus increasing the possibility of emergency unit violence.²⁶ As confusion, fear, and feelings of isolation can be alleviated through communication with superiors and colleagues, supportive measures such as promoting communication opportunities with colleagues and superiors in the organization can control turnover intentions.

In this study, the main factors influencing the participants' turnover intentions were resilience, "frequency of violence from patients" among the experiences of violence subareas, and "nursing manager's ability, leadership, and support of nurses" among the nursing work environment subareas, in that order. Resilience improves nurses' work commitment and increases their satisfaction with the nursing work environment.¹⁰ As resilience is increased through peer support²⁷ and resilience training programs,²⁸ which include identifying strengths, understanding and managing stress, changing negative self-talk, promoting positive relationships, and managing conflicts, health care managers must encourage nurses and provide them with opportunities to build their resilience.

Similarly, the more positive the nurses' perceptions of the nursing manager's leadership, the lower their intentions to leave. It is believed that this is because of the respectfulness and strong sense of solidarity that they feel owing to the nursing manager's leadership and support, which can be applied as an effective construct to help devise a plan for dealing with patients.⁸

This study showed that resilience had the highest effect on turnover intentions; therefore, it is necessary to consider it first when dealing with emergency unit nurses' turnover intentions. The effect of peer support on resilience improvement programs has been reported.²⁸ Resilient workers have lower burnout rates and better patient outcomes. However, it should not be overlooked that workplace violence is preventable, and proactive measures are more effective than interventions after it has occurred; therefore, the development of violence prevention and reporting programs is important.²⁹

Nurses have long been expected to make sacrifices, volunteer, and accept threats from patients and caregivers. However, working in the nursing profession should not be unsafe, and nurses should be able to provide optimal care in a safe environment. This study's results are expected to be helpful in alleviating the turnover intentions of emergency unit nurses and enhancing their professionalism so that they can provide high-quality nursing care to patients for a long time.

Limitations

There were limitations in the application of this study's results, because its participants were conveniently recruited from the proximal population, and the size of the sample was not large. Hence, a repeat study with a larger sample of emergency unit nurses is needed. In addition, as no previous studies have analyzed the 3 variables together to

confirm the effects of experiences of violence, resilience, and perceptions of the nursing work environment on turnover intentions, repeated studies related to this are needed in the future.

Implications for Emergency Nursing

When nurses' resilience is increased, they can successfully cope with crises and improve job satisfaction, thereby preventing negative consequences, such as turnover intentions. To create a work environment where nurses can perform nursing activities while maximizing their capabilities, adequate emergency unit staffing and equipment should be provided by considering the characteristics of emergency units, as caring for emergency patients requires a lot of human resources and appropriate equipment. Provision of sufficient facilities and equipment, expansion of professional human resources, and programs to strengthen nursing managers' competency and leadership should be devised and implemented.

Conclusion

This study was conducted to provide basic data for devising a plan to lower turnover intentions by understanding the extent to which the resilience of emergency unit nurses, who had experienced violence, and their perceptions of the nursing work environment affected turnover intentions. Mediating the hospital's nursing work environment and resilience can help nurses cope with crises successfully and improve their job satisfaction without negative consequences such as turnover intentions.

Author Disclosures

Conflicts of interest. none to report.

Perpetrator, (n = 100)	Type of violence	Frequency of violence		Degree of risk of violence	
		Mean	SD	Patient	Verbal abuse
		Mean	SD		
		2.61	1.32	Psychological violence	1.57
		1.23	3.06	Physical violence	0.73
		2.82	1.68	Severe physical violence	2.49
	Sexual harassment	0.36	0.59		1.16
Total		0.61	2.75	1.04	Caregiver

Verbal abuse	2.49	1.32	3.35	0.99	Psychological violence
1.37	1.24	2.93	1.26	Physical violence	0.23
0.58	2.51	1.69	Severe physical violence	0.05	0.22
2.43	1.74	Sexual harassment	0.15	0.43	1.77
1.03	Total	0.86	0.56	2.60	1.05

Variables, (N = 100)	Categories	Experience of violence										Resilience			Turnover intention				
		Frequency of experience of violence					Degree of risk of violence					Patient		Caregiver		Patient			
		M	SD	t/ F (P)	M	SD	t/ F (P)	M	SD	t/ F (P)	M	SD	t/ F (P)	M	SD	t/ F (P)	M	SD	
t/F(P)	Sex	Female	1.04	0.63	0.58 (.560)	0.85	0.57	0.32 (.751)	2.81	1.04	1.70 (.091)	2.65	1.05	1.34 (.183)	2.71	0.40	1.22 (.224)	3.16	0.88

2.39 (.019)	Male	0.93	0.51	0.91	0.53	2.25	0.86	2.20	0.94	2.86	0.40	2.48	0.89	Age (<30)	1.05	0.58	0.65	0.82
0.53	-0.97 (.332)	2.77	1.00	0.12 (.904)	2.56	1.02	-0.61 (.542)	2.70	0.39	-0.98 (.329)	3.13	0.88	0.81 (.419)	≥30	0.71	0.95	0.64	2.73
1.14	2.70	1.12	2.79	0.42	2.96	0.96	Marital status	Married	0.94	0.55	-0.65 (.516)	0.90	0.50	0.38 (.702)	1.06	-1.29 (.200)	0.21	1.04
-0.80 (.424)	2.76	0.47	0.41 (.681)	2.88	0.75	1.03	Single	1.05	0.63	0.85	0.58	2.81	1.03	2.64	2.71	0.39	0.32	0.93
Education level	Associate degree	1.05	0.77	0.04 (.961)	1.03	0.74	0.66 (.519)	2.60	1.00	0.91 (.407)	2.57	0.99	0.39 (.677)	2.67	1.40 (.250)	3.28	0.78	0.70 (.496)
Bachelor	1.03	0.60	0.83	0.53	2.80	1.04	2.62	1.06	2.71	0.39	3.07	0.92	≥Master	0.95	0.85	0.66	2.15	1.81

2.15	1.18	3.04	0.21	2.67	0.81	Ex p e r i e n c e i n t h e e m e r g e n c y u n i t (m o)	≤12	0.96	0.57	0.17 (.840)	0.74	0.53	0.94 (.392)	2.76	1.09	0.25 (.778)	2.57	1.12	0.36 (.696)
2.79	0.39	0.34 (.714)	2.52	0.53	4.31 (.036)		1.07	0.63	0.82	0.56	2.67	0.94	2.50	0.99	2.72	0.43	3.11	0.96	≥37
1.02	0.63	0.94	0.57	2.83	1.12	2.70	1.09	2.69	0.38	3.27	0.88	Total averag e	1.03	0.61			0.86	0.56	

Variables	Categories	n (%)	Nursing work environment											
			Collegial nurse-physician relations			Nursing manager's ability, leadership, and support of nurses			Nursing foundations for quality of care			Nurse participation in hospital affairs		
M	SD	t/F(P)	M	SD	t/F(P)	M	SD	t/F(P)	M	SD	t/F(P)	M	SD	t/F(P)
Staffing and resource adequacy														
Sex	Female	89 (89)	1.81	0.56	-1.82 (.0719)	2.00 (.0569)	0.10 (.922)	2.00 (.0552)	-1.03 (.307)	2.45	0.54	2.45	0.54	-0.92 (.357)
2.15	0.51	-2.05 (.043)	Male	11 (11)	2.14 (.058)	2.00 (.057)	0.76 (.450)	2.00 (.058)	2.57 (.048)	2.00 (.054)	0.54 (.478)	2.00 (.054)	0.54 (.478)	Age < 73 (.03)
1.82	0.55	-0.66 (.507)	2.66	0.62	1.84 (.069)	2.00 (.057)	0.83 (.409)	2.47	2.47	0.41	0.30 (.761)	2.00 (.051)	0.53 (.453)	0.75 (.453)
≥30	27 (27)	1.90	0.62	2.41	0.59 (.064)	2.00 (.054)	2.44 (.062)	0.21 (.832)	0.50	0.50	0.50 (.617)	1.78 (.020)	1.06 (.200)	-0.17 (.865)

2.45	0.75	-1.03 (.303)	2.54	0.70	0.03 (.974)	2.4 5	0 4 1	-0.16 (.876)	2 0 2 6 0 1	0.1 6 (.8 76)	S i n g l e	8 3 (8 3)	1.8 5
0.56	2.62	0.59	2.54	0.54	2.4 7	0 2 4 1 2 8	0.5 1	A s s o c i a t i o n l e g r e e	12 (1 2)	1 0 8 5 7 8	0.3 2 (.7 29)	2 0 6 6 4 7	0.9 (.3 74)
2.64	0.77	0.29 (.751)			2.4 1	0 4 6	0.16 (.849)	2 0 1 5 7	0.2 0 (.8 21)	B a c h e l o r	8 4 (8 5 4)	0 2 5 6 7 1	0.6 1
2.53	0.54	2.47	0.42	2.19	0.5 2	≥ M a s t e r	4 (1.6 2)	0 2 4 1 3 7	0.7 9	2 0 4 4 4 7	2.5 3 3	0 2 4 0 3 3	0.4 6
Experienc e in the emergency unit (mo)	≤12	16 (16)	1.83	0.54	0.1 0 (.9 05)	2 0 0 5 6 9 2 4	1.0 0 (.3 69)	2 0 5 4 3 4	0.92 (.403)	2.5 0	0 3 8	0.41 (.662)	

2.27	0.49	1.63 (.201)	13-36	42 (42)	1.82	.058	.056	0.55	.062	.062	2.50	.042	.026	0.53	≥37	(1.847)
0.57	2.50	0.71	2.46	0.55	2.43	.040	.037	0.52	Total average			1.084	.057		2.059	(.561)

Variables	B	SE	β	t	P	Tolerance	VIF
Constant	5.60	0.53		10.50	.000		
Resilience	-0.71	0.23	-0.32	-3.05	.003	0.66	1.58
Frequency of experience of violence from patients	0.39	0.13	0.27	3.06	.003	0.95	1.05
Nursing manager's ability, leadership, and support of nurses	-0.39	0.17	-0.25	-2.36	.021	0.66	1.51

DETAILS

Subject: Physiology; Safety measures; Workforce planning; Patients; Emergency medical care; Work environment; Prevention programs; Violence; Participation; Nursing care; Questionnaires; Data collection; Data analysis; Nurse led services; Emergency services; Caregivers; Likert scale; Nursing; Resilience; Nurses; Emotional abuse; Leadership

Business indexing term: Subject: Workforce planning Work environment

Identifier / keyword: Emergency nurse; Resilience; Violence; Turnover; Leadership

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

Pages:	461-469
Publication year:	2023
Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.10.001
ProQuest document ID:	2809540965
Document URL:	https://www.proquest.com/scholarly-journals/effects-emergency-nurses-experiences-violence/docview/2809540965/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited May 2023
Last updated:	2023-05-05
Database:	Public Health Database

Document 12 of 50

Table of Contents: JEN

[ProQuest document link](#)

FULL TEXT

DETAILS

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	A3-A5
Publication year:	2023
Publication date:	May 2023
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Tbl Of Contents
DOI:	https://doi.org/10.1016/S0099-1767(23)00068-5
ProQuest document ID:	2809539017
Document URL:	https://www.proquest.com/scholarly-journals/table-contents/docview/2809539017/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited May 2023
Last updated:	2023-05-05
Database:	Public Health Database

Workplace Violence: Raising Awareness and Bridging the Gap with Law Enforcement: JEN

[ProQuest document link](#)

FULL TEXT

Emergency nurses in the United States are making great strides against workplace violence with the support and encouragement of the Emergency Nurses Association (ENA). Many nurses and professional nursing organizations are working tirelessly to raise awareness about the prevalence of violence against health care workers. ENA recently challenged members to raise awareness about workplace violence within their communities. Answering this challenge, many ENA chapters have chosen various methods to disseminate information and advocate for change to stop workplace violence.

The Golden Triangle ENA in Texas felt particularly charged to respond, as there have been many violent incidents against nurses in the rural area of Texas they serve. Multiple chapter members had personally been impacted by workplace violence, and many of these nurses reported they felt that they were discouraged from formally reporting the incident or felt it was a pointless endeavor because “nothing comes of it.” This belief is not uncommon. One study reported that only 19% of violent incidents against health care workers were reported.¹ After dealing with ongoing frustration regarding the normalization of workplace violence, members chose to reach out to local elected leaders and law enforcement to develop a better working relationship.

The purpose of this editorial is to share with readers the process that the chapter followed to get community support to raise awareness of workplace violence and to bridge the gap with law enforcement. A secondary goal is to share ideas that may be beneficial to other emergency nurses and ENA chapters that are working to facilitate a collaborative relationship with community leaders and local law enforcement.

Elected chapter officers began by contacting local city council members to schedule a time to present statistics and information on workplace violence (see ^{Figure}). They were able to attend 4 city council meetings to present them with facts: violence against emergency nurses has reached epidemic levels, and violence against health care workers has been normalized, with many nurses feeling as if this is a “part of their job.” The local city council members were shocked and saddened to learn how prevalent this issue has become. City council members were encouraged to support initiatives, encourage legislation that provides support to health care workers, and raise awareness that workplace violence will not be tolerated. Following the discussion, the elected mayors of 3 separate local cities issued a proclamation for Violence in the Workplace Awareness Day.

After the initial discussion with elected community officials, members began reaching out to all local law enforcement agencies to explain the prevalence of workplace violence and to raise awareness of the perceived lack of support for nurses who are victims of violent crimes in the workplace. Local law enforcement agencies were excited to begin a dialogue on how nurses in the community could feel more supported by law enforcement. These discussions resulted in the Texas ENA’s Violence in the Workplace Declaration being signed by various local law enforcement agencies. This edict declares the support of local law enforcement agencies for health care workers. Also, the district attorney, chief of police, and all of the criminal investigation detectives for the largest local city reached out to each of the major hospitals to meet with the nurses. During this meeting, law enforcement personnel discussed violence prevention and provided nurses with important guidelines to follow if an incident of workplace violence does occur (see ^{Table}). How these events will shape the local health care environment and the relationship between health care workers and law enforcement personnel is yet to be seen, but it has facilitated a dialogue between the 2 groups.

Law enforcement personnel have expressed that they want emergency nurses to feel supported and safe. However, they also have a desire for members to understand why certain charges are pursued and others are dropped based on current legislation and the severity of varying charges. As a result, the chapter is determining if there is enough community support to host an educational conference for health care workers to learn from experts (eg, district attorney, chief of police, county judge) about the legal process that occurs after a report is made. This will allow nurses to better understand why some charges may not be pursued, whereas others are. If there is not enough support for the conference, the speakers will attend a local ENA chapter meeting to provide education and discuss workplace violence concerns with chapter members.

As emergency nurses continue to advocate for change in their communities, it is important not to remain complacent. Unfortunately, as violent incidents against nurses have become normalized, many emergency nurses feel resigned to accept this fate. However, emergency nurses have a large voice and deserve the right to feel safe in the workplace. Hopefully, this overview provides a good starting point or ideas for nurses working to stop workplace violence in their respective communities.

Author Disclosures

Conflicts of interest: none to report.

•Get a license plate or other identifying information if possible of the aggressor•When law enforcement arrives, include a detailed recount of the incident where the reader of the report can visualize what happened, details can't be stressed enough•Include the names of any witnesses of the workplace violence incident in the police report•When completing the police report, list all equipment that may have been destroyed in the act, this may lead to additional charges and demonstrates the level of violence•Include pictures, if applicable, of any injuries or damage that occurred because of the incident•If your state has enhanced charges for health care workers that increase the punishment against offenders, you should remind the officer taking the report to ensure they file the appropriate charges•If security footage is available, notify law enforcement personnel immediately so they can work with the health care organization to obtain footage to use as evidence•Document the injury with photos for multiple days after the event because the injury can change or be more visible•If your state has enhanced charges for health care workers that increase the punishment against offenders, you should remind the officer taking the report to ensure they file the appropriate charges

DETAILS

Subject:	Workplaces; Law enforcement; Workplace violence; Councils; Criminal investigations; Community support; Nurses; Cities; Medical personnel
Business indexing term:	Subject: Workplace violence
Location:	Texas; United States--US
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	317-318

Publication year:	2023
Publication date:	May 2023
Section:	Editorial
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Editorial
DOI:	https://doi.org/10.1016/j.jen.2023.02.003
ProQuest document ID:	2809539011
Document URL:	https://www.proquest.com/scholarly-journals/workplace-violence-raising-awareness-bridging-gap/docview/2809539011/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 14 of 50

Agitated Geriatric Patients and Violence in the Workplace: JEN

[ProQuest document link](https://www.proquest.com/scholarly-journals/workplace-violence-raising-awareness-bridging-gap/docview/2809539011/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Older adults may suddenly exhibit behaviors that are viewed as noncompliant, noncooperative, and threatening. They may even lash out verbally and physically causing injury to health care staff. In addition to taking actions that prevent harm to the staff and the patient, determining what caused this behavior (dementia vs delirium or other cases) will be critical, as well as debriefing the staff after the incident.

FULL TEXT

Law enforcement presents with a patient who appears to be approximately 80 years old. They state they were called for an “altercation” and found the patient in an agitated state. The patient is alert, but mumbling and picking at their urine- and food-stained clothing. You note a strong odor of old urine and body odor and notice the patient is wearing multiple shirts, sweaters, and pairs of pants. In addition to looking disheveled and unkempt, the patient looks frail and undernourished and is refusing to cooperate and allow assessment or treatment. As the ED staff attempts to get the patient undressed and into a gown, the patient starts yelling obscenities and swinging at the staff. At one point, the patient grabs a staff member’s arm, leaving long bloody nail marks. Is this workplace violence? What should be the response?

The increase in episodes of workplace violence, described as physical assault (striking out, hitting, biting, spitting, scratching), sexual assault, and verbal abuse, in the emergency department has been well documented.¹⁻⁷ Studies of agitation in older adults with dementia, delirium, substance use, and psychological issues describe the same behaviors, yet there are minimal recent published data specifically looking at the frequency of violence in the workplace perpetrated by an older adult with these conditions.^{4,8,9} This lack of data may be caused by health care workers tending to not report all episodes of workplace violence.^{1,3-7} Episodes involving older adults are reported even less frequently when staff considers it “part of the job,” if the patient has dementia or delirium, or if they feel the patient has a “reason to act that way.”^{1,3-7}

When an older adult becomes violent in the emergency department, it is important to ask “Why is this patient acting like this?” Other questions to consider asking include:

- What is the safest way to de-escalate and manage the situation?
- What additional precautions are necessary when managing the situation due to the patient’s age, physiology, and frailty?
- Is an episode of workplace violence that causes injury any less harmful to staff when it is an older adult causing the injury?
- What needs to occur after an episode of workplace violence involving an older adult with altered cognition to prevent this from recurring and have the best outcome for all?
- Is the debriefing and treatment of staff and witnesses different when an agitated older adult is involved?

Determine The Why

Agitated and aggressive behavior in older adults is most typically related to dementia, hyperactive delirium, psychiatric disorders, and substance abuse.⁸⁻¹⁶ While taking steps to de-escalate and manage the behavior, it will be important to determine why this older adult has suddenly become violent. Sorting out the why and addressing the underlying cause may help to determine the best course of action and may in fact be lifesaving, especially if delirium is the cause. Creating a plan to help prevent future episodes of agitation is important.

Dementia

Patients with dementia—such as Alzheimer’s disease or Lewy body dementia—typically have a known history of progressively deteriorating cognition and behaviors that may become agitated or violent.^{8,10} Agitation is the third most common neuropsychiatric symptom in dementia, being observed in up to 70% of patients with cognitive

decline.^{8,10} Increased use of the emergency department by patients with dementia and agitation has been noted.⁸ Patients with dementia may pace, fidget, use verbal abuse or threatening gestures, physically lash out, or destroy things.^{8,9} Many patients with dementia present with mild cognitive impairment and confusion, but patients with advanced dementia are more prone to sudden behavioral symptoms including “aggression, agitation, delusions, hallucinations, anxiety, wandering, and apathy.”⁸⁻¹⁰ Changes in environment (being brought to the emergency department, change in amount of light/sunset, change in faces), fear, boredom, overstimulation, and having unmet basic needs such as hunger, thirst, or the need to go to the bathroom are frequent precipitating factors for aggressive behavior.⁸⁻¹⁰ Dementia is often associated with receptive and expressive communication; thus, agitation may be the patient’s only method of communicating.⁸⁻¹⁰ A state of delirium also may be superimposed on the dementia.^{8,9}

Delirium

Patients with delirium tend to have a sudden waxing and waning alteration in cognition.^{8,12-14} Typically, there is a precipitating cause for the delirium, which must be identified and corrected. Mortality associated with delirium ranges from 10% to 26%, and as often as 75% of the time is not recognized in the emergency department.^{8,12} The mnemonic “DELIRIUM” provides a good framework when attempting to get to the bottom of the patient’s agitation and violent behavior.¹¹

- D—drugs
- E—electrolytes/environment
- L—lack of drugs, especially pain meds/withdrawal
- I—infection, including encephalitis secondary to coronavirus disease 2019
- R—reduced sensory input (missing hearing aids, glasses, etc.)
- I—intracranial problems (tumor, bleeding, stroke)
- U—urinary or gastrointestinal issue (full bladder or constipation)
- M—myocardial or cardiovascular/lung issue¹¹

Several of these causes may be life threatening; thus, identifying and treating the cause along with the behavior will be critical. Patients with delirium often have hallucinations or delusions, which may incorrectly be assumed to be a psychosis or dementia.^{8,12-14} Searching for all possible underlying causes will be essential, given that often there is more than one reason for the behavior.^{8,11-14} Patients with delirium are typically unable to maintain attention during an exam.^{8,14} Patients with dementia and psychiatric conditions are usually able to maintain attention.^{8,14} A useful tool is the Delirium Triage Screen, which first assesses the level of arousal (normal, sedated, or agitated) and then checks for attention by asking the patient to spell LUNCH backward.¹⁴ Patients with delirium are typically unable to do so owing to disorganized thinking or because their mentation is too altered. Patients with an altered level of arousal but able to spell LUNCH backward with 1 or no errors most likely do not have delirium. However, they should be evaluated for dementia or depression.¹⁴ As noted earlier, a patient may present with both dementia and delirium.^{8,11,12,14}

Medication reactions can present as delirium.¹³ Narcotics and benzodiazepines tend to cause a hypoactive delirium, whereas hyperactive and mixed delirium are more frequently seen with anticholinergic medications, serotonin-

related drugs, stimulants, and alcohol intoxication.¹³ Steroids, anti-Parkinsonian agents, anticonvulsants, nonsteroidal anti-inflammatories, antihistamines including diphenhydramine, H₂-blockers, anti-nausea medications such as scopolamine and dimenhydrinate, fluoroquinolones, and tricyclic antidepressants also have been linked to delirium.¹³ Withdrawal from benzodiazepines or alcohol also can present as agitation.¹³

Substance Use Or Abuse

Substance use or abuse should be considered as a potential cause of agitation in the older adult.⁸ Alcohol and cannabis are substances commonly used by older adults to control pain.⁸ Alcohol is the most used drug among older adults, with approximately 65% of people at the age of 65 years and older reporting high-risk drinking.^{15,16} In addition to using alcohol to relieve pain, patients report using it to cope with stress or improve their mood or out of boredom. They also report mixing it with other drugs and marijuana.^{15,16} A recent study showed that as many as 61% of adults older than 65 years are using cannabis for the first time.¹⁷⁻²⁴ Older adults report using it for pain, insomnia, and anxiety.¹⁷⁻²⁴ Cannabis products containing higher levels of tetrahydrocannabinol have psychoactive properties that can lead to agitation and increased anxiety.¹⁷⁻²⁴ Higher doses of cannabidiol (CBD) also can cause agitation and anxiety.¹⁷⁻²⁴ Older adults trying edible cannabinoids for the first time have presented to the emergency department with extreme anxiety and agitation owing to cannabis intoxication.¹⁷⁻²⁴ Intoxication can occur when patients expecting immediate effects similar to what occurs when inhaling cannabis ingest additional doses of cannabinoids—typically gummies—owing to not feeling effects right away. Effects of edible cannabinoids take 45 minutes or longer to be felt; thus, patients have often consumed high doses of the drug, becoming intoxicated, anxious, and agitated.^{18,19,21-24} CBDs are generally taken for their relaxing and calming effects, but incidents of anxiety and agitation due to higher doses, or due to the CBD product having been mixed with tetrahydrocannabinol, have been reported.²¹⁻²⁴

Psychiatric Issues

New onset of psychiatric issues in the older adult is unusual, but a patient with “known” behavioral issues may present as a psychosis with violent behaviors, especially if the patient is having visual or auditory hallucinations or has not been taking their medications.^{8,14} Acute anxiety is the most commonly seen symptom in older adults.^{8,14} Schizophrenia is uncommon in the older adult.^{8,14} Depression and mania are the other causes of psychosis seen in the emergency department, but typically the patient has a previously diagnosed condition, and other causes should be investigated as well.^{8,14}

Controlling the Situation

Older adults who suddenly strike out physically or verbally against ED staff will usually have a precipitating reason.⁸⁻

¹⁴ Three actions should take place concurrently. Take steps to calm the environment, the patient, and the responders. Ensure that all (patient and responders) are safe and that life-threatening conditions are being addressed. Determine and address what is causing or caused the behavior, given that addressing the cause may stop the agitated behavior.⁸⁻¹⁴

ADEPT is a mnemonic developed for ED management of an agitated older adult.¹⁴

- A—assess
- D—diagnose that delirium is present and causing the behavior
- E—evaluate why there is delirium
- P—prevent symptoms from getting worse due to being in the emergency department, and prevent falls and other injuries

••T—treat the problem¹⁴

Assessing and treating for hypoxia, hypoglycemia, and other basic comfort needs (food, fluids, bathroom, comfortable body and room temperature, and sense of safety and familiarity for the patient) will be important.^{8-12,14,25}

A complete head-to-toe survey looking for hidden trauma or decubitus ulcer (such as a sacral or foot) infections, which are common causes of agitation in the older adult.¹⁴ Obtaining a 12-lead electrocardiogram, head computed tomography, laboratory tests, and medication history will be important given that ST-segment elevation myocardial infarction, intracranial or neurologic pathology, electrolyte or other metabolic disturbances, and infection also are common causes of agitation in the older adult.^{8,12,14} In fact 30% to 40% of agitated delirium is related to infection (respiratory, urinary, skin, and brain related) and 12% to 39% related to an adverse medication reaction.¹⁴

Determining the events that occurred just prior to the behavior change will be an important part of obtaining the history, given that there may have been a precipitating factor tied to the inability to communicate needs or understand directions or feelings of insecurity. Agitation can be related to staff invading “personal space” when removing the patient’s clothing, attempting to wash them, helping with toileting, or due to procedures causing discomfort while providing care that the patient does not understand.^{9,10,14} Creating a feeling of being safe, rather than being accosted, for the patient who is not processing information correctly is important.⁹

Other tips to facilitate de-escalation include the following:

- Correct overstimulation (excess people, noise, light [the hubbub of the emergency department]) and understimulation (missing glasses, hearing aids, or too little light). Look carefully at the situation and correct the sensory insult.^{12,14,26}
- Remove “tethering objects” when possible (catheters, intravenous tubing, blood pressure cuffs, monitor, and pulse oximeter cables).^{8,14,26}
- Correct bothersome symptoms—including the patient being cold, hot, nauseated, vomiting, in pain, hungry, or thirsty; needing to urinate; or having a bowel movement.^{9,12,14,26}
- Have one person do the communicating rather than multiple people telling the patient what to do. The communicator (someone familiar to the patient when possible) should use frequent eye contact and patiently provide simple, clear, one-action instructions. They should be someone that can be patient, compassionate, and empathic with the patient. If possible, use someone with a face that is familiar to the patient.^{9,12,14,25-27}
- Ask the patient what they would like to do rather than ordering them or assuming the patient will agree to what they are being told to do. Allow the patient to make choices from options determined by the staff.^{9,12,14,25-27}
- Instead of arguing with and attempting to force the patient into the here and now, agree with what they say and redirect them to what you need them to do. Provide reassurance they are safe and that you will provide care. Consequences for noncompliance should be set/stated, yet the speaker should avoid sounding “bossy.”^{9,12,14,25-27}
- Allow the patient to “burn off” energy by pacing, doing distractive activities—such as washcloth folding, playing or listening to music, coloring, rocking in a chair, puzzles, playing with a doll, or other enjoyable activities. Gently move to a safer area/room. Do not restrict movement, as long as no harm to the patient and staff or damage to the area is being inflicted.^{9,10,25,26}

••Recreate a home-like environment and spaces if possible. Make the room more like at “home” with chairs or bench-like chairs (couch) where 2 people can sit together, rather than requiring the older adult to stay in the bed.^{9,14}

26

••When possible, use the faces and voices of family members in person or via phone or video. This may help the patient reconnect with reality.^{9,14,26}

Use Of Medications

Using medications to control the situation is an option, but must be carefully considered. The recommendation most consistently found in studies related to controlling behavior and calming the agitated older adult was to attempt nonpharmacologic approaches first.^{8,10,12-14} Although often used to control behavior in younger patients, the use of a B-52 (benzodiazepine, antipsychotic, and anticholinergic) was specifically culled out as “not recommended.”^{8,9,12-14} Risk of falls and excess sedation when using first- and second-generation antipsychotics was raised.^{8,9,12-14} Haloperidol, OLANzapine, risperiDONE, or QUETiapine were suggested as one-time, low-dose options, if nonpharmacologic interventions were not working or the patient was too agitated to engage in nonpharmacologic approaches.^{8,9,12-14} However, risk of worsening psychosis, respiratory depression, falls, orthostatic hypotension, QT prolongation, torsades de pointes cardiac rhythm, and vital sign instability were associated with all of these medications. (QUETiapine was noted to have a higher risk of orthostatic hypotension.)^{8,9,12-14} Falls remained a concern with any of these medications, especially if repeated doses were needed.^{8,9,12-14} Overall, these 4 medications were noted to have less adverse effects than any other behavioral controlling drug options.^{8,9,12-14} It was noted if a patient developed extrapyramidal symptoms owing to use of any of these medications, diphenhydrAMINE was not recommended due to its anticholinergic effects often causing psychosis.^{8,14} Mortality and morbidity in the older adult population were noted to go up when antipsychotic medications were used; thus, nonpharmacologic interventions were highly recommended.^{8,14}

Pain is a common cause of agitation in the older adult; thus, pain medications should be considered a method of controlling behavior.⁸ This is especially important to consider, because the older adult may not be able to verbalize that they have pain or where it is located other than by agitated behaviors.^{8,9,12-14} Pain medication alone or in combination with an antipsychotic medication should be considered.^{8,9,12-14} Kennedy⁸ provided an in-depth breakdown of the various pain and antipsychotic medication options and alternatives, starting with the recommendation to try nonpharmacologic and non-narcotic options first—such as heating pads, lidocaine patches, acetaminophen, and even one-time doses of nonsteroidal anti-inflammatories (ketorolac) if there were no concerns of gastrointestinal bleeding issues. Concerns related to falls, vital sign instability, respiratory depression, oversedation, and constipation led to frequent recommendations of “start low and go slow,” especially when combining an antipsychotic and pain medication.^{8,10,12-14}

Physical restraint to control the patient during an outburst was advised against due to risks of injury to the patient and staff.^{26,28,29} Review of the literature did not find a recent publication related to the best way to approach physically restraining an older adult. Instead, recommendations were to move people and items away to keep all as safe as possible and let the person wind down.^{8-10,11-14,25-27} If physical restraints are used, it will be important to recognize the impact this action will have not only on the patient but staff who are involved in the restraining episode.²⁹

By providing a calming environment, meeting basic needs including pain relief, reassurance of safety, and some level of independence, the patient may return to their normal cognitive state.

Educating And Supporting The Staff

Despite the violence and injury (physical or verbal) caused by the older adult not usually being deliberate or intended, both still have the potential to cause pain to the staff (physical and emotional).^{6,9,28-31} Staff often is reticent to report the violence inflicted on them by an agitated older adult, because they feel the patient does not mean it or does not know what they are doing.^{1,3-7,9} However, this pain cannot be summarily dismissed simply because an older person inflicted it. Even if no charges are being filed, an internal report needs to be filed, staff debriefed, and the incident investigated.^{6,9,28-31} Staff members should be offered post event counseling related to their injury and/or feelings raised by the event.^{6,9,28-31} In studies of caregivers that deal with agitated older adults, the participants reported guilt, regret, and self-blame related to not recognizing and preventing the escalation or related to the manner in which they handled the patient during the event.^{6,9,29,30} Physical contact or an unkind verbal response by a staff member during the heat of the moment led to increased feelings of guilt, regret, and self-blame.^{6,9,29,30} Staff members also reported feelings of powerlessness, as well as judging themselves inadequate and failures when they were unable to figure out or meet the patient's needs, which led to the outburst.^{9,29,30} Fears of being injured or harming the more frail older adult patients also were reported.⁹ Reports of inadequate training about why an older adult could be agitated or different approaches staff could use when dealing with an agitated older adult were reported, as well as a lack of resources and staff to meet the patient's needs or handle situations when escalation occurred.^{3,6,7,9,29,30} Staff reported feeling disheartened, undervalued, and angry, yet they expressed fear of retaliation or being shamed for not handling the situation.^{3,6,7,9,29,30} Several studies identified these feelings as the reason for burnout and for caregivers leaving areas that routinely provide care for this older, vulnerable population.^{3,6,7,9,29,30} Completing a root cause analysis that thoroughly investigates the episode may be able to identify how it could have been prevented and identify an action plan to prevent similar events in the future.^{28,31} Determining attitude of staff members involved in the episode to ensure no one was looking to escalate the situation will be important.^{8,28,31} Ensuring that all staff has the knowledge to recognize escalating behavior and the knowledge and resources to take action to safely prevent escalation and de-escalate the situation will be important.^{8,26,28-31} Validating the concerns and feelings of the caregivers provides a sense of value.^{9,28-31} Not allowing them to continue to believe that violence is just "part of the job" when providing care for the agitated older adult was identified as critical.^{9,28-31} The Joint Commission in their "Quick Safety –De-escalation in Health Care" document and the ENA "Toolkit for Mitigating Violence in the Workplace" outline information and actions related to violence occurring in the workplace, and both recommend tracking and trending reports of workplace violence and appropriate follow-up and support to the victims and witnesses.^{28,31}

Conclusion

Deliberate or not, the physical and emotional injuries inflicted on the health care worker by an agitated older adult are just as impactful. Staff may have additional emotional turmoil arise owing to the patient being an older, frail adult vulnerable to injury during the confrontation and unaware of what they are doing.^{9,29,30} This turmoil is even greater if there was a need to physically restrain the older adult for everyone's safety.^{9,29,30} Although many health care providers will excuse and not report violent behaviors of an older adult because "they didn't know what they were doing," those staff members are still victims. Ensuring staff reports violent episodes involving older adults, and having a process that evaluates not only what happened but why it happened, can help to identify whether there are additional educational needs of the staff related to the care of and response to an older adult presenting in or developing an agitated state. By ensuring staff has adequate training related to agitated behavior in older adults and post violence episode counseling, the staff can respond in a more effective manner, providing a safer and more effective care environment for the patient and themselves.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Emergency medical care; Drug withdrawal; Behavior; Anxiety; Tetrahydrocannabinol--THC; Workplace violence; Delirium; Older people; Hallucinations; Sex crimes; Dementia; Cognition & reasoning; Drug dosages; Marijuana; Alzheimers disease; Patients; Health care; Drug use; Workplaces; Psychosis; Intoxication; Alcohol; Addictive behaviors; Debriefing; Benzodiazepines; Adults; Emotional abuse
Business indexing term:	Subject: Workplace violence
Identifier / keyword:	Workplace violence, Workplace aggression, Agitation, Older adult, Behaviors
Publication title:	Journal of Emergency Nursing:: JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	320-325
Publication year:	2023
Publication date:	May 2023
Section:	Geriatric Update
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.009
ProQuest document ID:	2809538991

Document URL: <https://www.proquest.com/scholarly-journals/agitated-geriatric-patients-violence-workplace/docview/2809538991/se-2?accountid=211160>

Copyright: ©2022. Emergency Nurses Association

Last updated: 2023-05-05

Database: Public Health Database

Document 15 of 50

Exposure of Emergency Nurses to Workplace Violence and Their Coping Strategies: A Cross-Sectional Design: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Violence against nurses working in the emergency department is a serious problem worldwide.

Methods

This descriptive study used a participant questionnaire and was conducted in-person, using semi-structured interviews with 120 emergency nurses (69 female, 51 male) working in the emergency department between September 1 and November 30, 2017.

Results

Overall, 90% of the study participants were exposed to workplace violence at least once while working in the emergency department, and 94.4% experienced verbal abuse, including insults, shouting, threats, and swearing. Most of such workplace violence came from the patients relatives. Most workplace violence incidents occurred during the 4 pm to midnight time slot and in the triage area. The most important perceived reasons for workplace violence were the long waiting period for treatment and care (79.6%) and not being prioritized for treatment (68.5%). The top 3 coping methods used were reporting to the nurse in charge (78.1%), followed by reaching out to the security personnel (72.8%) and filing lawsuits if exposed to physical violence (65.8%).

Conclusions

Most emergency nurses had experienced workplace violence. Hospital administration should take more effective security measures, hospitals should provide education and training programs for dealing with workplace violence, and programs to support staff members on encountering workplace violence should be implemented.

FULL TEXT

Contribution to Emergency Nursing Practice

- The exposure of nurses working in different regions to violence is a situation that maintains its place on the agenda.
- Our findings reveal that emergency nurses are exposed to violence many times during their working time. Although nurses have developed their own methods, these cannot adequately protect them against workplace violence.

••To prevent workplace violence in the emergency department, security measures should be increased. In addition, training to deal with such violence should be provided.

Introduction

Interpersonal violence has emerged as an ever-increasing negative behavioral pattern worldwide. It is witnessed in internal family dynamics as well as workplaces. Although workplace violence is more common in business feuds, in the recent years, it is becoming increasingly common in the health services sector, especially emergency services.¹ Reportedly, ED workers are at a higher risk of exposure to workplace violence than health personnel working in other hospital departments.²⁻⁴ The World Health Organization stated that workplace violence is a global epidemic that negatively affects health personnel and the delivery of health services.⁵ The Emergency Nurses Association substantiated this by also stating that workplace violence continues to be an important problem that has reached epidemic proportions in the emergency department, especially threatening emergency nurses.⁶

Several reasons make emergency departments susceptible to workplace violence: the fact that patients are usually brought into the emergency department regardless of whether their situation is nonurgent or life-threatening,⁷ the ease of access to emergency services, the frequent over-crowdedness that prolongs waiting time, unrealistic patient expectations, medically and legally inappropriate patient requests for interventions, and visits by behavioral health patients exhibiting nervous and aggressive behaviors.^{3,8,9} More than half of ED professionals are mostly exposed to verbal abuse from patients or their relatives.⁹ Emergency departments are stressful environments for health professionals as well as for patients and their relatives. Patients brought into the emergency department generally require urgent medical attention, which worries them and their relatives. Many patients and their relatives believe that examinations and consultations only delay the treatment process. Consequently, in some cases, they hold health care professionals responsible for the death of the patient. This also makes emergency departments more prone to workplace violence because the patients' relatives turn to workplace violence, blaming the staff of medical negligence.¹⁰⁻¹² Considering such unavoidable exposure to workplace violence and the inability to exit their work area or alter the environment, nurses develop their own unique coping mechanisms. This is more so because, despite the increasing workplace violence in emergency departments, adequate and effective measures have not yet been taken to prevent such workplace violence, the existing measures are insufficient, and all health professionals, especially emergency physicians and nurses, remain under constant threat.^{4,7,9}

In Turkey, emergency departments provide emergency medical services 24/7 for traumas such as injuries, burns, and fractures, and a variety of patient populations such as obstetric and pediatric emergencies and conditions including acute heart disease.^{1,2} The ED team consists of the prehospital intervention team, emergency nurses, emergency physicians, social workers, family counselors, respiratory therapists, and other workers.³ There are few studies on workplace violence against Turkish emergency nurses, and none have investigated the coping methods of emergency nurses exposed to workplace violence in Turkey. Determining the situations of exposure of emergency nurses to workplace violence and their use of coping methods may help solve this issue and provide information on how to take much-needed measures in this regard.

Thus, this study determined emergency nurses' exposure to workplace violence by patients and their relatives and the nurses' use of coping behaviors/methods.

Methods

This descriptive study used a cross-sectional study design. The study participants worked in emergency departments between September 1 and November 30, 2017, in 4 state hospitals located in the city's center affiliated to the General Secretariat of Gaziantep Public Hospitals Association. All of these hospitals are level III general (adult

and child) trauma centers with more than 15 beds each, more than 100,000 patients visiting each hospital's emergency department annually. Before starting the research, we obtained approval of the Local Ethics Committee and written permission from the General Secretariat of Gaziantep Public Hospitals Association. The emergency nurses were informed about the research, and their written consent was obtained. Despite voluntary participation, it was made clear that they could leave the study at any time.

Nurses who worked in the emergency department of any of the 4 hospitals for at least a year and those who were actively working in any of these hospitals during data collection were included in the study. A total of 149 nurses were working in the emergency departments of the hospitals during the period of the study. Of the 149 nurses, 120 (80.5%) met the sampling criteria and voluntarily participated in the study. Of the 29 nurses who were not included in the study, 14 were excluded because they had not completed a year in an emergency department, 10 nurses did not want to participate in the study, and 5 did not participate because they were on annual leave. The data were collected by the researcher through a questionnaire completed by the emergency nurses.

Data Collection Tools

The data were collected through the Data Collection Form developed for this study, consisting of 2 parts and a total of 44 questions. The questions were prepared using similar studies¹¹⁻¹⁷ and were designed to collect information about sociodemographic characteristics and workplace violence in the emergency department.

Sociodemographic Characteristics

These included nurses' age, gender, education level, marital status, current working status, overall work experience in nursing (years), work experience (years) in an emergency department, job description, place of duty in the emergency department, working style, and any in-service training or course on "violence and coping with violence in the emergency department" (there is no formal in-service training on workplace violence in Turkey; however, such trainings can be organized by hospitals from time to time).^{1,13}

Questions About Workplace Violence in the Emergency Department

These included the estimated number of workplace violence encounters in the past year, the most common type of workplace violence experienced, the state of being physically injured when exposed to workplace violence, the state of experiencing psychological or emotional discomfort when exposed to workplace violence, perpetrators of workplace violence, place of workplace violence, the period of time when the incidents occurred, activity/action taken when exposed to workplace violence, reasons for exposure to workplace violence, coping behaviors/methods applied when faced with workplace violence, and frequency of using coping methods.

Emergency nurses also were asked to respond to statements about their behavioral response and what measures they would be willing to take when faced with workplace violence (the response options included "always," "often," "rarely," and "never"). Responses were re-coded to 2 categories: always/often and rarely/never. In this section, one of the options regarding the coping behaviors of nurses was the "white code call," which is a security protocol created by the Ministry of Health for use all over Turkey.^{1,8,13,17} This protocol includes hospital staff dialing 113 to call security personnel to the scene during violent incidents and using the phrase "code white" when they do.

Data Analysis

The data were transferred to SPSS for Windows 23.0 (IBM Corp, NY), and statistical analyses were conducted. Frequencies (n), percentages (%), means, and SDs were calculated. Chi-Square test was used for statistical comparisons. **A P Results**

A total of 120 emergency nurses (69 female, 51 male) working in the emergency department of 4 hospitals participated in the study. ^{Table 1} shows the distribution of characteristics of the nurses working in the emergency department. The mean age of the nurses was 27.5 years (SD = 6.0), 55.8% of them held a bachelor's degree and

above, mean years of nursing experience was 5.2 years (SD = 5.7), and mean work experience in the emergency department was 2.6 years (SD = 2.7). Fifty-nine nurses (49.2%) were between the ages of 20 and 25 years. More than half of the nurses (57.5%, $n = 69$) were female, and 73% ($n = 87$) were single.

Whereas 55% ($n = 66$) of the nurses stated that they were assigned to work in the emergency department at their own request, the rest (45%) stated that they were randomly assigned by the hospital management. Most of the nurses (96.7%) were service/clinical nurses, and most (90.8%) worked in the fields of observation/care/treatment. Most (80.8%) participants worked the day shift (8 am-4 pm). Of those who received training, 100% ($n = 56$) received this training within the scope of the hospital's in-service training program (^{Table 1}).

Most nurses (90.0%, $n = 108$) stated that they had been exposed to workplace violence at least once during their time in the emergency department. When these nurses were asked for an estimated number of times they had been exposed to workplace violence in the past year, 34.3% responded with 2 to 5 times and 43.5% with 11 or more times. The nurses were exposed to verbal abuse most frequently (94.4%). They were mostly exposed to shouting (98.1%), insulting (93.5%), walking toward the nurse (to threaten and intimidate) (83.3%), swearing (76.9%), and threatening (76.9%).

Of the 108 nurses who stated that they were exposed to workplace violence in the emergency department, 94.4% stated that the patients' relatives perpetrated this workplace violence, and 73.1% claimed the patients to be the perpetrators. Regarding the places they experienced workplace violence, 84.3% of the nurses experienced workplace violence in the emergency corridor (triage area), 81.5% in the short-term (24-hour) observation and treatment section, and 78.7% in the long-term (patient requiring treatment longer than 24 hours) treatment and care section. Most (87.5%) stated that they were exposed to workplace violence during the evening shift (4 pm-midnight) (^{Table 2}).

It was determined that 17.6% ($n = 19$) of the nurses who were exposed to workplace violence had physical injuries; 9.3% ($n = 10$) received care and treatment for this injury. A total of 86 (79.6%) nurses experienced psychological or emotional injury/discomfort due to workplace violence, and 17 (15.7%) of them stated that they received treatment and care for psychological injury.

Frequently perceived causes of workplace violence in the emergency department were prolonged waiting time or delays in care (79.6%), not prioritizing the patient/relatives (68.5%), inability to communicate well due to bad attitude of patients and their relatives (54.6%), and patient and/or relatives not being informed adequately (46.3%) (^{Table 3}).

^{Table 4} lists the coping behaviors that nurses used when exposed to workplace violence, ordered by frequency of use. Most often used strategies included reporting the situation to the nurse in charge (78.1%), ensuring that the perpetrators are escorted out by security personnel (72.8%), suing for physical violence (65.8%), physically self-defending (64.0%), and withdrawing from the treatment process (61.4%).

According to the descriptive characteristics of nurses, when the reactions to violence in the workplace are examined in terms of gender, it was observed that there was a statistically significant difference in "I am physically defending myself" ($P = .013$); however, it was not found statistically significant when looking at gender in other behaviors ($P > .05$). According to the education level of the nurses, there was a significant difference in only 1 item, namely, "I refer the perpetrators of violence to the hospital management" ($\chi^2 = 13.794$, $P = .003$); other behaviors did not make a statistically significant difference according to education level ($P > .05$). When the behavioral reactions of nurses to workplace violence were compared according to age, 58.3% of the participants in the 20 to 25 age group and 41.7% of the participants in the 26 to 47 age group marked the item "I direct the perpetrators to hospital management" as "always/mostly." The same item was marked as "rarely/never" by 38.9% of the participants in the 20 to 25 age group and by 61.1% of participants in the 26 to 47 age group ($\chi^2 = 4.300$, $P = .038$, $P > .05$). These statistics are

not shown in the table.

Discussion

This study showed that, parallel to other studies,¹³⁻²⁶ most of the emergency nurses were exposed to workplace violence in the emergency department at least once during their working life. In the current study, similar to Ferri et al,²⁷ most nurses were exposed to workplace violence in the emergency corridor (triage area). Triage areas are usually the most crowded and the first areas where patients and relatives encounter health care workers in the emergency department. In addition, patients visit the emergency department mostly in the evening hours in Turkey.¹ Patients and their relatives are commonly stressed when visiting the emergency department because of the patient's health status. These may be the main reasons why workplace violence is the most common in the triage areas and in the evening shift. Violence is more common because of the fact that triage is the first area that patients visit and everyone wants their patient to be cared for as soon as possible, and because of nervous patient relatives. Additional measures should be taken, and administrative arrangements should be made in such areas where the patient density is usually high.

The most common types of workplace violence included shouting, insulting, swearing, threatening, and walking in an intimidating manner toward the nurse. Nearly half of the nurses had been exposed to workplace violence approximately 11 or more times in the previous year. Although this number was similar to those reported in some studies,¹⁸⁻²⁰ it was higher than the results of some other studies.^{27,28} It is overwhelming to realize that emergency nurses are exposed to workplace violence at such serious rates and in similar ways worldwide.²⁹

In this study, most nurses stated that they prefer reporting (78.1%), calling security guards (72.8%), and exercising their legal rights for physical violence (65.8%) when they encounter workplace violence. These frequencies are higher than the rates reported in existing literature.^{15,21} Studies have shown that nurses do not report workplace violence to security guards because they are afraid of the threat of harm by the perpetrators.^{12,21} Roy,²² who investigated the behavioral signs of patient violence in the emergency department, stated that only 10% of victimized nurses took legal action. Mutlu¹ stated that only 14.7% of the emergency nurses became a plaintiff after an incident of workplace violence. In addition, it was stated that 60.3% of the nurses did not initiate any legal action despite being exposed to physical violence, and 50% of them tried coping on their own when faced with both physical violence and verbal abuse.¹ Consistent with the literature, our findings also highlight the need of emergency nurses to be more encouraged and informed about taking legal action against workplace violence.

In the study, it was determined that the nurses (61.1%) who stated that they rarely/never refer the perpetrators to the hospital administrators were between the ages of 26 to 47 ($P = 30$ as age progresses, progress is achieved in coping with physical violence and verbal abuse).

According to the study conducted in the emergency department of a hospital in Iran, it was stated that the older employees were more sensitive and calm in the face of violence. It showed that after getting used to their profession and ED environment, nurses could manage stress-related attitudes better, and they learned to manage their stress as well.

In our study, although the ratio was almost equal for female and male nurses who stated that they would always/mostly defend themselves physically when faced with physical violence, it was observed that the rate of female nurses who stated that they would rarely resort to this method was considerably lower than the rate of male nurses. Ayrançi et al¹² investigated the frequency of exposure to violence in health institutions and health professional groups, and it was determined that while the rate of men being exposed to violence was 48.4%, this rate was higher in women (52.5%), but men responded to violence with violence more than women.¹⁰

Limitations

The study was conducted with only 120 emergency nurses working in 4 state hospitals in Gaziantep, Turkey, and may not be generalizable to other emergency departments. Furthermore, the data were collected using questionnaires and self-reports of emergency nurses. The definition and types of workplace violence were not explained before the questionnaire was administered to the nurses, and the nurses were asked to evaluate using only their then-current knowledge.

Implications for Emergency Nursing

In light of this study’s findings, emergency nurses can take institutional and administrative measures against workplace violence in the emergency department. In addition, these findings can contribute toward formulating legal regulations specific to the field of health, provision of counseling services to nurses who have been exposed to workplace violence, and improving the protection of health care workers against workplace violence. Such measures can prevent workplace violence in the emergency department. Furthermore, this study emphasizes the importance of providing emergency nurses with the necessary training to help them cope with/respond to a violent situation. Because workplace violence has physical, psychological, and emotional effects, and these adversely affect the functionality of the employees at work as well as the quality and cost of nursing care,³¹ individual, institutional, and legal measures should be taken to prevent workplace violence in emergency departments. Every health care worker should be conscious about the prevention of workplace violence in health units and contribute to the development of strategies to prevent workplace violence. Reporting workplace violence during and after the incident, calling security guards to the unit, and seeking legal rights in all types of incidents that fall under the definition of workplace violence can be counted as individual strategies.

Training of emergency nurses on effective coping behaviors and effective communication also will have important effects on reducing workplace violence. It should be noted that every health care worker should be conscious of the prevention of workplace violence in health units and contribute to the development of strategies to prevent workplace violence. Nurses too can contribute to the reduction of workplace violence through maintaining a calmer demeanor when dealing with patients and their relatives, showing empathy, gaining the ability to manage a complex environment, and controlling their own emotions.

Conclusion

This study was conducted to determine emergency nurses’ exposure to workplace violence and their use of coping methods. It was determined that the rate of exposure to workplace violence in emergency nurses is high, which supports the existing literature, which also states that they are more frequently exposed to verbal abuse and try to cope with workplace violence on their own. Taking drastic institutional and administrative measures and training the nurses to equip them to deal with workplace violence and develop coping strategies may be beneficial for the prevention of workplace violence in emergency departments.

Author Disclosures

Conflicts of interest: none to report.

Characteristics	N	%
Age group (y)		

20-25	59	49.2
26-47	61	50.8
Marital status		
Married	33	27.5
Single	87	72.5
Educational status		
Health vocational high school	36	30
Associate degree	17	14.2
Bachelor's and above*	67	55.8
Assignment in the emergency department		
I was assigned at my request	66	55.0
I was assigned randomly	54	45.0
Job description in the emergency department		
Service/clinical nurse	116	96.7
Educational nurse	1	0.8
Charge nurse of the emergency department	3	2.5
Working area in the emergency department		
Trauma/resuscitation area	8	6.7
Observation/treatment/care area	109	90.8
Nursing management division of the emergency department	3	2.5
Shift worked in the emergency department		
Day shift and night (8 am-4 pm and 4 pm-midnight)	97	80.8
Night shift only (4 pm-midnight or midnight-8 am)	10	8.3

Other (variable shift system)	11	10.8
Attending training on "Violence and Dealing with Violence in the emergency department"		
Yes	56	46.7
No	64	53.3
If yes, where did you get the training? [†]		
I received in-service training at the hospital where I work	56	100.0

Features of exposure to workplace violence in the emergency department	n	%
Have you been subjected to any workplace violence during your time working in the emergency department?		
Yes	108	90.0
No	12	10.0
How many times have you been exposed (approximately) to workplace violence in the last year?*		
1 time	2	1.9
2-5 times	37	34.3
6-10 times	22	20.4
≥11	47	43.5
What is the most common form of workplace violence you are exposed to in the ED?*		
Physical violence	6	5.6
Verbal abuse	102	94.4
What type(s) of workplace violence have you been exposed to? [†]		
Shouting	106	98.1

Insulting	101	93.5
Walking toward the nurse (to threaten and intimidate)	90	83.3
Swearing	83	76.9
Threatening	83	76.9
Pushing	54	50.0
Throwing items	50	46.3
Punching	33	30.6
Kicking	28	25.9
Restraint by patient/visitor (forced hold)	27	25.0
Slapping	25	23.1
Attack with a knife or gun	8	7.4
Which of the following people perpetrated the workplace violence? [†]		
Patients	79	73.1
Patients' relatives	102	94.4
Place(s) where you were subjected to workplace violence in ED [†]		
Emergency corridor (triage area)	91	84.3
Short-term (24 h) observation and treatment section	88	81.5
Long-term (patient requiring treatment longer than 24 h) treatment and care section	85	78.7
Emergency examination room	84	77.8
Trauma/resuscitation room	79	73.9
Emergency intensive care unit	35	32.4
Personnel resting room	28	25.9
What time period did you experience the most workplace violence?*		

8 am-4 pm	2	1.7
4 pm-midnight	105	87.5
Midnight-8 am	1	0.8

Causes	N*	(%)†
Long waiting time/waiting of patients due to high patient volume	86	79.6
Perception of the patient/patient's relatives that the patient's care was not being prioritized	74	68.5
Poor communication due to bad attitudes of patients and their relatives or busy work environment	59	54.6
The patients and/or their relatives think that they are not adequately informed	50	46.3
Patient/patient's relatives thinking that they or their patient do not receive adequate treatment and care	39	36.1
Inability to access the health care team	36	33.3
High treatment costs	20	18.5
Bad/negative communication between health care personnel and patient/relatives	20	18.5
Transferring the patient to another hospital	15	13.9

Behaviors	Always+mostly	Rarely+never
-----------	---------------	--------------

N	(%)	N	(%)	I report the situation to the nurse in charge
89	78.1	25	21.9	I ensure that perpetrators are escorted out by security personnel
83	72.8	31	27.2	I sue for physical violence
75	65.8	39	34.2	I defend myself physically

73	64.0	41	36.0	I withd raw from the treat ment proce ss
70	61.4	44	38.6	I repor t the situat ion to the hospi tal mana geme nt
62	54.4	52	45.6	I call for "whit e code" (secu rity respo nse for work place viole nce)

60	52.6	54	47.4	I direct the perpetrators to the hospital administration
60	52.6	54	47.4	I make the necessary explanations that I think can prevent violence (patient information, reasons for delay in treatment, treatment plan and other reasons, etc.)

57	50.0	57	50.0	I get support after violence
43	37.7	71	62.3	I sue for verbal abuse
40	35.1	74	64.9	I continue to treat the patient
33	28.9	81	71.1	I don't react at all, I stay away from the environment

33	28.9	81	71.1	I respond the same way to perpetrators (I react according to the type of violence they use)
27	23.7	87	76.3	I only perceive serious events such as injury as violent
26	22.8	88	77.2	I try to lighten the situation or atmosphere by apologizing

23	20.2	91	79.8	I prefer to remain silent after violence
22	19.3	92	80.7	I ignore violence
20	17.5	94	82.5	I perceive violence as part of the job, I do nothing

DETAILS

Subject: Emergency medical care; Behavior; Coping strategies; Medical personnel; Workplace violence; Hospitals; Verbal abuse; Security measures; Swearing; Nurses; Emergency services; Patients; Sociodemographics; Triage; Workplaces; Security staff; Litigation; Data collection; Nursing; Departments; Health services; Emotional abuse

Business indexing term: Subject: Workplace violence

Location: Turkey

Identifier / keyword: Emergency department; Coping with violence; Workplace aggression; Verbal abuse

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

Pages:	441-449
Publication year:	2023
Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.002
ProQuest document ID:	2809538989
Document URL:	https://www.proquest.com/scholarly-journals/exposure-emergency-nurses-workplace-violence/docview/2809538989/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 16 of 50

Why Won't It Stop: Workplace Violence in Emergency Care: JEN

[ProQuest document link](https://www.proquest.com/scholarly-journals/exposure-emergency-nurses-workplace-violence/docview/2809538989/se-2?accountid=211160)

FULL TEXT

Why Hasn't It Stopped: Workplace Violence in Emergency Care

Workplace violence by patients and visitors against emergency nurses has been ongoing for over 40 years. In 1981, Dubin reported on the conditions most associated with patient violence, including substance use, intoxication, and withdrawal; acute psychosis; paranoia; borderline personality; and organic brain disease. He further warned clinicians to watch for signs of escalation, such as aggressive body posture, speech, and motor activity.¹ These patient conditions and “warning signs” have not changed in the last 40 years, although the catalog of conditions and signs has increased. Additional considerations are patients dissatisfied with care, diagnosed with coronavirus disease-2019, with a chief complaint of injury, and over the age of 60 years, as well as environmental factors such as emergency department crowding and staffing shortages.^{2,3} Given that emergency nurses have had this knowledge for over 40 years, why is workplace violence still a problem? Why hasn't it stopped?

Workplace violence in emergency care persists for a myriad of reasons. As the number of inpatient beds and outpatient treatment centers has decreased over the decades, access to mental health services also has decreased.⁴ These changes created a health care system where the emergency department has become the safety net for mental health care.⁵ However, the emergency department continues to be ill-prepared for managing mental health emergencies due to a lack of expert clinicians to provide diagnoses, treatment, and care, as well as limited availability of rooms to provide the care safely. An additional aspect of this problem is the lack of funding to support mental health services in the emergency department for patients reporting both physical and mental health problems.^{4,6}

Even if the public health crisis for mental health could be curbed, incidents of workplace violence will persist due to the general public not having the resources to manage a situational crisis. In moments of crisis, emotions, fear, and frustration can reduce individuals' abilities to control their actions. As an example, consider a scenario where you, as an emergency nurse, get a call that your 6-year-old child was struck by a motor vehicle running from the school playground onto a city street. Your child was transported to the regional trauma center in the adjacent town. Upon your arrival at the trauma center, you don't recognize anyone. You see a reception desk that has a registration clerk, triage nurse, and security officer. You ask to be taken to your child's bedside. You are informed, “Take a seat, please. We'll get with you as soon as we can. The trauma team is still working on your child.” Are you really willing to “take a seat”? Or are you more likely to raise your voice, try to walk around the person telling you to wait, or even push through the door to get into the trauma bay? Are you willing to use profanity or threats to get to your child? If you say “Yes” to any of these questions, then you are admitting that you are willing to use workplace violence during a situational crisis. This demonstrates that even rational and professional emergency nurses who understand that workplace violence is wrong can experience a circumstance where aggressive behaviors could be used.

The aim of emergency nurses and members of the public health system should always be to strive for the complete eradication of workplace violence so that emergency nurses can work in safe, caring environments. Until that perfect world comes, emergency nurses need to recognize that workplace violence will occur. But workplace violence should not be condoned, and emergency nurses should never give up their efforts toward eradication. Emergency nurses should recognize that workplace violence can happen and plan for it. In 2011, a delegation of emergency nurses traveled to Cuba to study the health care system. The delegation learned that “...anger was an expected outcome for poor health or significant changes in health status” (p. 561) and that health care providers began educating patients and families upon arrival on how to prevent and manage their anger.⁷ If emergency nurses could assume that workplace violence is likely to occur in all patients, then a strategy for universal violence precautions could be routinely used. This perspective could improve the safety of all emergency nurses and persons in emergency care settings.

Definition and Typology for Workplace Violence

The National Institute for Occupational Safety and Health, a division of the United States Centers for Disease Control and Prevention, defines workplace violence as “the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty.”⁸ A definition that more broadly defines the construct in

terms of where work takes place is provided by the International Labor Office, International Council of Nurses, World Health Organization, and Public Services International. They jointly define workplace violence as “incidents where staff is abused, threatened or assaulted in the circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health” (p. 3).⁹ In addition to definitions for workplace violence, there are myriad of terms used to depict workplace violence. Workplace aggression and occupational violence are other terms you will see used in this special issue.^{10,11}

Workplace violence is not confined to the actions of patients and visitors. The University of Iowa Injury Prevention Research Center convened a national panel of experts to discuss workplace violence.¹² From that panel, a new typology for workplace violence based on the relationship of the aggressor to the employee was developed. Type I of this typology is criminal intent violence. In emergency care, type I workplace violence occurs when a person enters the emergency department to seek and injure someone they previously had an altercation with (eg, gang violence). Other actions include a person entering the emergency department seeking to steal property such as purses or opioid medications from an automated medication dispensing machine or keys to patient vehicles.¹³ Type II is customer/client violence. Type II workplace violence is the most frequently reported type of violence in the emergency care setting. This type of violence against emergency nurses includes patient and visitor behaviors such as hitting, spitting upon, throwing objects, etc. The majority of the articles published in this special issue will address type II workplace violence. Type III is worker-on-worker violence. Type III workplace violence in the emergency department occurs when a current or previous employee targets another employee. The behaviors can include verbal abuse and assault; however, they also can include bullying or mobbing-type behaviors.¹⁴ Type IV is personal relationship violence. Type IV workplace violence is rarely addressed in the literature. This type of violence can include a current or previous intimate partner of the emergency nurse coming into the emergency department and demonstrating harassing or assaultive behaviors.

Workplace violence is further defined based on the actions taken or behaviors exhibited by an aggressor, not the intention of the aggressor. For example, an older adult who is confused and pinches or hits an emergency nurse during a physical examination or invasive procedure still commits workplace violence. Despite the older adult not meaning to assault the emergency nurse, physical and emotional pain can still be experienced by the emergency nurse, as noted by Somes in this special issue.¹⁵ Specific categories of workplace violence include verbal abuse, sexual abuse, physical threats, and assaults. Each category can occur across the 4 types (I, II, III, and IV) of workplace violence.

Universal Violence Precautions

The term “Universal Violence Precautions” was first used by Gillespie to describe interventions that emergency nurses could use to prevent or manage workplace violence.¹⁶ This construct is similar to universal bloodborne pathogen precautions in which emergency nurses wear gloves during invasive procedures to prevent the risk of acquiring hepatitis and other bloodborne diseases. Rather than being selective on who might have a bloodborne disease, the emergency nurse assumes everyone might be infected and therefore takes universal precautions. The need for universal violence precautions is similar. The emergency nurse should maintain the assumption that anyone can enact violence at any time, and therefore, the emergency nurse would change how they might typically interact with others to promote personal safety.

The Occupational Safety and Health Administration (OSHA), a division of the United States Department of Labor, provides a framework for workplace violence prevention guidelines.¹⁷ In their framework, there are 5 categories for prevention interventions: (1) management commitment and employee participation, (2) worksite analysis, (3) hazard prevention and control, (4) safety and health training, and (5) recordkeeping and program evaluation. The following ^{Table} provides examples of strategies based on the OSHA framework. Additional strategies are detailed by Howard and Robinson in this special issue.¹⁸

Consequences of Workplace Violence

In this special issue, Gillespie and Berry¹¹ provide a framework for the consequences incurred by patients and visitors, the worker, the workplace, and patient care when workplace violence occurs. The negative impact on

patients and visitors exhibiting workplace violence includes patients being restrained, visitors being evicted or removed from the emergency department, and offenders having charges pressed against them.^{11,28} Worker effects are physical injuries, psychological stress, and supportive care by coworkers.^{11,21,30,31} Effects of workplace violence on the workplace or employer are absenteeism and emergency nurses quitting and seeking employment elsewhere.^{21,32} Consequences to patient care resulting from workplace violence can manifest as a decrease in overall work productivity with patients, delayed treatment for non-violent patients, and errors in patient care.^{11,21}

Special Issue on Workplace Violence

In this special issue, you will find a series of articles focusing on workplace violence against emergency nurses. We recommend paying particular attention to the clinical articles by Spradlin and Dunseth-Rosenbaum,²³ Cabilan et al,¹⁰ and Carr and Derouin.²⁴ The authors provide extensive details of their project procedures and implications for emergency nurses. Spradlin and Dunseth-Rosenbaum²³ describe the components of their intervention: zero tolerance for workplace violence campaign, daily safety huddles, review of policies and procedures, senior leadership support, behavioral health response team, case reviews, and data dashboard.²³ Cabilan et al¹⁰ incorporated the Queensland Occupational Violence Risk Assessment Tool for use with the electronic health record of their emergency patients. The tool is being used to identify patients at higher risk for workplace violence so that preventive interventions can be deployed. Carr and Derouin²⁴ implemented a duress alarm system for emergency nurses to use when needing to call for help during workplace violence.²⁴ Although their project did not reduce the prevalence of workplace violence, they provide sound recommendations for future use of duress alarms to yield a desirable outcome.

Final Thoughts

After you read this special issue on workplace violence, we recommend you continue your exploration of the prevention and management of workplace violence. The articles in this special issue are not exhaustive regarding the recommendations available to emergency nurses. First, it is important to know your rights as an employee before, during, and after workplace violence. For emergency nurses in the United States, please see ^{Box 1}, which displays the rights of workers granted by OSHA.¹⁷ For emergency nurses who practice outside of the United States, we encourage you to contact relevant nursing advocacy groups, legislators, and occupational health agencies to determine your rights. Resources, including position statements, white papers, and policy recommendations, are provided in ^{Box 2}.

We do dream of a future where the tenured emergency nurse reads this editorial and says, “Workplace violence? Was that ever really a thing?” These questions will indicate that the efforts of the emergency nursing and public health community will have achieved their ultimate aim for the safety and well-being of emergency nurses across the globe.

Author Disclosures

Conflicts of interest: none to report.

This work was partially supported by the National Institute for Occupational Safety and Health through the University of Cincinnati Education and Research Center Grant #T42OH008432.

Categories for workplace violence prevention programs	Workplace violence prevention strategies
---	--

Management commitment and participation ^{11,17-21}	<ul style="list-style-type: none"> •Maintaining security/police presence in the emergency department •Distributing personal alarm systems to emergency nurses to activate during a workplace violence incident •Providing mental health services to the victimized emergency nurse following an incident of workplace violence •Requiring all threats and assaults be reported
Worksite analysis ^{17,22,23}	<ul style="list-style-type: none"> •Conducting walkthrough assessments looking for hazards •Talking with staff about their recommendations for improvement and prevention •Assessing for adherence to policies and procedures for workplace violence •Identifying occupational groups/situations most likely to encounter workplace violence
Hazard prevention and control ^{10,15,17-19,23-27}	<ul style="list-style-type: none"> •Adjusting the physical environment to promote safety, such as incorporating high/deep counters, panic buttons, and lockdown procedures •Using comfort carts or other forms of distraction •Screening for risk of workplace violence •Having a chaplain staff stay with a family experiencing a situational crisis •Administering pharmacologic therapy to patients •Conducting safety huddles periodically throughout the day •Reassigning violent patients to a different team member after they significantly threaten or physically assault a team member (when staffing permits) •Conducting root cause analyses
Safety and health training ^{11,17-19,21,23,28}	<ul style="list-style-type: none"> •Providing annual (at minimum) educational programming; suggested topics include: <ul style="list-style-type: none"> ◦Workplace violence policies and procedures ◦Early recognition and violence de-escalation ◦Situational awareness ◦Crisis prevention ◦Stress inoculation training ◦Caregiver fatigue and burnout ◦Mental health first aid
Recordkeeping and program evaluation ^{17,19,23,25,29}	<ul style="list-style-type: none"> •Developing a workplace violence reporting system useful for nonpatient incidents •Reviewing workplace violence data to identify trends •Measuring frequency and severity of incidents to determine if interventions are effective

DETAILS

Subject: Patients; Emergency medical care; Workplace violence; Trauma; Assaults; Mental health care; Trauma centers; Workplaces; Public health; Occupational safety; Emergency services; Disease prevention; Violent crime; Health services; Nurses; Gangs; Emotional abuse

Business indexing term: Subject: Workplace violence Occupational safety

Location: United States--US

Company / organization:	Name: Occupational Safety & Health Administration--OSHA; NAICS: 926150
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	310-316
Publication year:	2023
Publication date:	May 2023
Section:	Editorial
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Editorial
DOI:	https://doi.org/10.1016/j.jen.2023.02.001
ProQuest document ID:	2809538987
Document URL:	https://www.proquest.com/scholarly-journals/why-won-t-stop-workplace-violence-emergency-care/docview/2809538987/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Screening for Behavioral Health Patient Aggression in Emergency Departments to Reduce Workplace Violence: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Patient violence in health care facilities occurs daily. Structured risk assessments, when regularly completed, have been effective in prompting interventions to reduce aggression in Behavioral Health (BH) settings.

Methods

This quasi-experimental study evaluated the effectiveness of the Dynamic Appraisal of Situational Aggression – Inpatient Version (DASA) validated screening tool to reduce aggressive outbursts in an emergency department (ED) setting with BH patients awaiting transfer to a psychiatric facility. The tool was used in 4 non-psychiatric EDs from a large health care system. Chart audits were completed to record initial patient DASA scores observed at triage and at subsequent intervals during the ED encounter. ED staff documented interventions used for patients. Inclusion criteria included adults 21 years and older following a telepsychiatry consultation with a recommendation for BH inpatient admission. Pre-/post-implementation aggressive events were collected to assess ED DASA use. DASA scores from BH ED patients were examined to increase understanding of patient utilization. Staff workplace safety was examined to compare staff safety perception pre- and post-DASA implementation.

Results

Violent events were reported statistically significantly higher post-DASA implementation. There was an increased risk of elevated DASA scores for specific diagnoses and genders. An increased awareness of the importance of reporting workplace violence improved documentation.

Discussion

Using an evidence-based screening tool helped identify BH patients with behaviors associated with aggressive ED events. Proactive use of interventions, including use of Comfort Cart items, de-escalation, and prescribed medications, can positively influence reduction of risk from aggressive behaviors within BH patient populations in EDs.

FULL TEXT

Contribution to Emergency Nursing Practice

- Patient aggression affects health care workers beyond the physical impact; psychological trauma also occurs due to unsafe health care work settings. Supported by recent literature, structured risk assessments that prompted aggression reducing interventions were found to be more successful than staff observations alone within the BH inpatient setting.
- Protocols including early multicomponent interventions including de-escalation, diversional activities, and/or medications may be instrumental when reducing the risk of aggressive outbursts with BH patients.
- Incorporating a screening tool that empowers emergency nurses and technicians to use observation skills and quickly identify which patients may be more prone to aggressive outbursts can provide a safer environment for both patients and health care workers alike.

Introduction

Health care workers are at risk of workplace violence (WPV) from patients in all settings, not just psychiatric facilities, and it occurs daily.¹⁻⁷ Behavioral health (BH) patients in crisis arrive at emergency departments and require stabilization, often waiting extended periods of time for hospital admission. Often, BH patients remain under ED care while waiting for an inpatient bed rather than wait in admissions for medical care.⁸⁻¹⁰ BH patients are more likely to require admission than patients with other conditions and remain in emergency departments for days, and even weeks, without definitive mental health or BH care.¹¹⁻¹³

Patient aggression affects health care workers beyond the physical impact; psychological trauma also occurs owing to unsafe health care work settings.¹⁴⁻¹⁶ In 2018, the Joint Commission released Sentinel Event Alert #59: "Physical and verbal violence against health care workers."¹⁷ The Sentinel Event Alert recommended hospitals implement a screening tool for potential violent patient events. Supported by recent literature, structured risk assessments that prompted aggression-reducing interventions were found to be more successful than staff observations alone within the BH inpatient setting.^{18,19} Exploring the effectiveness of structured assessment tools in other health care settings may be beneficial to reduce occurrences of patient violent events.²⁰⁻²²

The Dynamic Appraisal of Situational Aggression (DASA)–Inpatient Version is a validated, predictive risk evaluation tool used to identify a patient's likelihood of aggression within inpatient BH settings.²³ It consists of 7 observed behavioral elements that allow for consistent recognition of high-risk patients. The tool proactively allows staff to provide support or initiate interventions to de-escalate patients before outbursts occur.²⁴ The DASA tool elements include (1) irritability, (2) impulsivity, (3) unwillingness to follow directions, (4) sensitive to perceived provocation, (5) easily angered when requests are denied, (6) negative attitudes, and (7) verbal threats. DASA uses binary scoring, with "yes" to indicate this behavior is present (and a score of 1 is assigned) or "no" the behavior is not present (and a score of 0 is assigned). The possible range of scores is 0 to 7 with 0 to 1 indicating low risk, 2 to 3 indicating medium risk, and 4 to 7 indicating high risk.²³

Using the DASA tool in BH inpatient settings has shown positive results that include reduced number of restrictive interventions, decreased time in restraints, and fewer patient injuries.^{23,25,26} DASA was found to be highly effective when evaluating BH patients for violence or aggression in an ED setting.¹⁸ In addition, DASA was more effective when it was completed on a frequent, consistent basis.^{18,27,28} Using the DASA tool and associated interventions to prevent violent episodes may be an important step to increasing safety in health care environments.

Regardless of screening tool use, ED staff under-report WPV, because they accept this as a part of their typical shift work; therefore, the actual frequency and occurrence of WPV are largely unknown.²⁹⁻³¹ ED staff reported violence using methods other than the organization's event reporting system (eg, hospital security/police reports). Formal documentation reporting systems have been cited as a barrier to reporting owing to being difficult and time consuming to use.^{32,33}

Multiple aggression screening tools are available for BH patients, such as the Broset Violence Checklist, Brief Psychiatric Rating Scale–Excited Component, SMART Medical Clearance Form, and Short-Term Assessment of Risk and Treatability.³⁴⁻³⁷ These tools showed similar outcomes to DASA regarding utility and results compared with unaided clinical judgments.³⁸⁻⁴¹ DASA also was shown to be more efficient, because it took less time for providers to complete.^{25,35,37} There is limited evidence of using DASA in the emergency department for BH patients, which warrants further investigation.¹⁸

Preliminary Work and Study Purpose

In 2018, a large health care organization in the southeastern United States successfully conducted an internal pilot study implementing and examining DASA's effectiveness in 2 inpatient psychiatric units. Unpublished study results

included decreased patient/staff injuries, reduced number of restrictive interventions, and reduced number of minutes in restraints. The BH nursing leadership team agreed to implement DASA documentation across the entire inpatient service line. The DASA tool was built within the electronic health record (EHR) as part of the BH service line's implementation. The BH nursing leadership team requested incorporating DASA documentation into BH ED records, which resulted in similar findings to the inpatient BH units. The DASA tool was chosen for this study owing to current use across the organization's BH inpatient and ED locations.

The purposes of this study were to (1) examine the utility of the DASA tool to identify and reduce potential aggressive events by ED patients awaiting transfer to a BH inpatient facility, (2) coordinate DASA scores with appropriate interventions including administration of PRN (as needed) medications to address agitation, and (3) evaluate staff perception of safety before implementation/after implementation.

Methods

Guided by the Strengthening the Reporting of Observational Studies in Epidemiology observational research checklist, this quasi-experimental study evaluated the effectiveness of using the DASA screening tool to guide interventions aimed at reducing violent and aggressive behavior in an ED setting with BH patients awaiting transfer to a BH facility. The time period for this research study was September 1, 2019, to March 31, 2020. The pre-DASA implementation time period was September 1, 2018, to March 31, 2019. Using the same protocol for all consultations, psychiatric assessments were completed virtually with the psychiatrist who then provided the BH patient care recommendation to ED staff.

DASA Screening Tool Implementation Procedures

The study team received permission from the author/creator of the screening tool to use the DASA scores in a non-BH patient care setting for study purposes.

The ED clinical nurse specialist and ED leaders from all study locations agreed to (1) add DASA documentation elements to the EHR for emergency departments including scoring totals and (2) emergency nurses recording DASA scores every 8 hours at 6 am, 2 pm, and 10 pm and document behaviors seen during the previous 8 hours. The first DASA score for the patient was recorded when the ED BH patient care protocol was initiated at triage and then continued with 8-hour intervals during the ED stay. Consistent documentation of DASA scores was a primary focus during DASA implementation training.

De-Escalation Training and Interventions

Prerequisite ED training from the Crisis Prevention Institute Nonviolent Crisis Intervention Training was reinforced with emergency nurses and ED technicians, which included de-escalation skills.⁴² The research team created an online learning module that included information about the ED staff's role in this study and how the reduction of violent events can improve workplace safety. ED leaders ensured staff completed the module through the organization's learning management system. ED staff were aware the research team would be collecting and reviewing data for all aggressive events, restrictive interventions, medications administered, and reported injuries. Physician/advanced practice provider training included education regarding study awareness and goals to reduce WPV. Education included reviewing DASA scores and associated risk levels in the EHR. Nurses were educated to notify providers of escalating DASA scores with aggressive behaviors and ask for medication orders as needed. Supplemental education regarding the use of complementary interventions (ie, therapeutic items, self-soothing methods, or providing distraction) also was provided to ED staff to support BH patients (see ^{Table 1}). Comfort Carts were stocked with items such as stress balls, puzzles, coloring books/crayons, and sugar-free hard candies, among other soothing items, and were available for staff to offer any patient needing distraction or help managing their emotions while waiting for care (ie, telepsychiatry evaluation, BH inpatient bed placement, or transport).

Setting and Sample

The target population for this study included patients from 4 acute care (nonpsychiatric) emergency departments: a trauma center, a freestanding emergency department, and 2 rural emergency departments from a large health care system; locations were selected based on their geographic location and utilization of same telepsychiatry protocols. Inclusion criteria for this study included patients who (1) were at least 21 years of age, (2) had a telepsychiatry consult, and (3) received a recommendation for BH inpatient admission after the BH provider consultation. Exclusion criteria excluded patients who (1) were admitted for acute medical care, (2) died during ED stay, or (3) were discharged from the emergency department. To examine patient drug use upon ED admission, the substance use panel screened for amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, and opiates. Approval was obtained from the institutional review board before study commencement. Following the DASA guidelines for inpatient BH care, the same risk categories were implemented in the ED setting for this study.

Procedures: Retrospective Data Review

The research team purposefully used retrospective data from the same sequential months in the previous year to avoid any seasonal bias for BH-related admissions (September 1, 2018, to March 31, 2019). There were 961 ED telepsychiatry adult consults completed, with an average 50% to 60% of those patients being admitted. The comparative sample size calculations were completed before data collection at 80% power.

Approximately 1200 patient records were reviewed by registered nurses on the research team to identify records that met the inclusion criteria for a final sample size of 498 patients.

Data were entered and managed using Research Electronic Data Capture (REDCap; project-redcap.org) hosted by the large health care system. REDCap is a secure, web-based application designed to support data capture for research studies.⁴³ The first 10 DASA scores, as well as documented interventions for each patient encounter, were entered into a REDCap database. The average ED length of stay for patients awaiting BH admission was approximately 3 days.

Pre-DASA/Post-DASA Implementation Staff Survey

The research team developed a brief 8-item Likert scale survey for staff to provide their perception of indirect benefit of DASA implementation. The ED staff at the study locations completed this survey before the initiation of DASA and at the end of the study. The frontline ED staff were asked whether they worked with aggressive patients and to rate their knowledge identifying and addressing potential patient aggression.

Measures and Data Analysis

Using a quasi-experimental study design, a nonparametric Wilcoxon rank sum statistical test assessed the number of aggressive patient events between pre-DASA and post-DASA implementation groups to examine the effect of DASA use in the emergency departments.

In addition, documented interventions for each DASA score (ie, nonpharmacological interventions, restrictive interventions, and use of medication) were collected for the post-DASA implementation patient group. Medication names or administered doses were not collected for this study. Medications were administered to provide a safer care environment for patients/staff and decrease crisis symptoms. Recorded interventions included medications and nonmedications such as distraction, time spent talking with patient, providing comfort items such as a warm blanket, use of a Comfort Cart item, medication, restraint, or any other action to prevent or respond to an aggressive outburst. Interventions were recorded as medication or nonmedication interventions for this study. Medication intervention use also was examined to understand which DASA scores are linked to medication use. In addition, demographics (including patient gender/ethnicity, admitting diagnosis and positive/negative screening for substance use) of the post-DASA implementation patient group were examined to understand the characteristics of BH patients

being admitted to the emergency department.

Responses to the 8-item staff survey were compared using chi-square analyses to examine the differences between the pre-implementation and post-implementation responses, because the data were not normally distributed. *P* value was set to .05 for all analyses.

Results

When comparing the number of pre-DASA implementation and post-DASA implementation aggressive events, there was a statistically significant increase in documented aggressive events reported by staff (^{Table 2}).

Patient records were reviewed for documentation of interventions or medications administered for DASA scores medium risk (2-3) or high risk (4-7) (^{Table 3}).

The final sample size for the post-DASA implementation patient group was 498 patients—approximately 55.0% males and 45.0% females (^{Table 4}). The primary ED discharge diagnoses for BH inpatient admission included 36.1% for depression, 12.1% for schizophrenia, 14.3% for bipolar disorder, 11.5% for suicidality, 4.6% admitted for substance use, and 21.4% for other diagnoses.

The diagnoses with the most high-risk scores were schizophrenia and bipolar for all time periods ranging from 21.1% to 0.0%; DASA scores decreased over time for schizophrenia but not those with a bipolar diagnosis. Patients with a bipolar diagnosis also had, on average, consistently longer ED stays than the overall BH sample population (2.4 days vs 1.8 days, respectively). The diagnoses with the fewest number of High DASA scores were depression, suicidality, and substance use disorders. Each of these diagnoses accounted for less than 5% of high-risk scores over the 3-day window (^{Figure}). More than half of the study population had a positive test result for substance use, regardless of diagnosis (55.3%). There was a small number of patients with positive alcohol results (17.9%).

When examining gender differences, women had slightly more high-risk scores for day 1 than men (score 1, 52.4% vs 47.6%; score 2, 59.1% vs 40.9%; score 3, 57.9% vs 42.1%). This trend was reversed on day 2 (score 4, 36.8% vs 63.2%; score 5, 22.2% vs 77.8%; score 6, 0.0% vs 100.0%). Day 3 scores included 3 recorded high-risk scores; all were men.

When comparing the pre-implementation and post-implementation responses (130 vs 101, respectively), 2 of the 8 survey questions demonstrated statistically significant differences before and after DASA implementation, indicating an improved perception of workplace safety (^{Table 5}).

Discussion

The aims for this study were successfully attained, although provided unexpected results. When examining the utility of the DASA tool in the emergency department, the results indicated that there was a statistically significant increase in aggressive events between pre-DASA and post-DASA implementation, which was not expected. When comparing the pre-DASA period (September 2018-March 2019) with the post-DASA period (September 2019-March 2020), it was noted that documentation of use of restrictive interventions increased by 116% (18 vs 39) and number of reported aggression events increased by 25% (47 vs 59) for all sites. The DASA study team raised awareness that WPV events should be consistently reported through the organization's incident reporting database; therefore, the increased reporting of WPV events was likely caused by increased education and the encouragement to report violent/aggressive events. Consistent with the team's findings, previous research also has indicated that increased reporting of WPV events was caused by WPV education.⁴⁴

In addition, there were gender differences in our study population. Results revealed female patients had more aggressive events and higher DASA scores than males for day 1 of ED admission. However, male patients had higher DASA scores documented on days 2 and 3 with increased documented length of stay. This finding aligns with the Morbidity and Mortality Weekly Report (2016-2018) that stated there were 43.9 ED visits per 1000 persons per

year with a BH disorder and represented more female visits overall.⁴⁵ These findings also coincide with previous research; however, the previous study's population differed from this study's population (inpatient mental health setting vs ED setting, respectively).²⁸ Future research may be valuable identifying correlations between aggressive events with substance use screening results in relation to diagnosis.

Upon further review of DASA scores stratified by diagnosis, the study team felt this information could assist with identifying patient populations at a higher risk of aggressive events. Patients seeking emergency BH care with a schizophrenia or bipolar disorder diagnosis were more likely to have elevated DASA scores. These diagnoses also were previously identified in the inpatient mental health population with having higher DASA scores.²⁸

In addition, these findings support the ongoing collaborative efforts between the pharmacy department and physician leadership in developing medication and intervention protocols to standardize care for high-risk patients. Earlier identification of risk of aggression and the use of interventions may improve patient management and reduce ED lengths of stay. Patients with higher acuity may take longer to secure inpatient admission for proper level of care. As a supplemental intervention, the primary goal for using Comfort Cart items was to decrease possible conflict occurrences with high-risk individuals. Earlier interventions can help mitigate escalating behaviors and provide a safer environment for staff and patients. Treating the symptoms underlying agitation/aggression promotes therapeutic alliance and supports patients in regaining self-control. Given the limited research on the direct effect of Comfort Cart use, future research could be useful to evaluate the effectiveness of diversional activities with BH patients.

The DASA tool identified differences in risk among patients, supporting its ability to predict aggression. Similar to previous research, the research team concluded that patient aggression event documentation was not consistently completed.⁴⁴ Anecdotal comments made by staff nurses such as "it takes too much time" or "nobody looks at that anyway" support the ED staff's lack of consistent reporting.

Staff survey results identified a difference in perceived workplace safety between pre-DASA and post-DASA implementation; however, the direct cause of this difference cannot be determined. Post-implementation survey responses demonstrated favorable increases to the statements "In general, I feel safe when working on my unit" and "My safety is important to my manager/leader." Future research could evaluate the direct relationship between DASA implementation and workplace safety perception.

Limitations

Using the sample limited exclusively to admitted BH patients is a primary limitation. Not all patients with BH-related ED visits are referred for telepsychiatry consults, and approximately half of those evaluated by telepsychiatry do not meet the criteria for inpatient admission. It is unknown how many of these patients had aggressive events. The research team used the top BH-related reasons for ED encounters for analysis rather than the primary admitting diagnosis. Patients were not excluded from the study due to BH diagnosis; this limitation was an observation that did not affect the overall study analysis and results.

During the study phase, a concurrent pilot program was introduced at one study site to include psychiatric technicians (PTs) in the ED staffing matrix to help with milieu management for psychiatric hold patients. The PTs were specially trained in Crisis Prevention Intervention and de-escalation skills focused on managing BH patients. The effect of PTs in the ED setting is an unknown variable for this research study; therefore, we cannot determine the specific impact, because it was not included as part of the initial study scope. Future research regarding the value of PTs in the ED setting may be useful.

The study design did not evaluate the effectiveness of Comfort Cart use, the specific medications administered based on patient DASA scores, or WPV prevalence. A stronger emphasis on intervention responses to DASA

scores would have strengthened this study.

Implications for Emergency Nursing

Tools for detection of potential aggressive events are available to help staff decrease events of WPV. It is imperative that when using these tools, staff follow through on interventions appropriately to maximize efficacy and intended results. When introducing screening tools, such as DASA, nurses and providers must be educated on how to respond appropriately. Empowering clinical staff to recognize potential aggressive behaviors promotes departmental safety preparedness and readiness to proactively intervene when necessary.

The benefit of using the same tool in the emergency department that is currently used by the inpatient BH unit is that the DASA scores can be incorporated in with nursing report. The nurses from the sending/receiving departments using the same scale to evaluate observed behaviors support a more consistent and effective nursing handoff report.

Creating age-appropriate Comfort Carts (toy/play focused vs activity/diversional stimulation) relevant to the patient population provides additional nonpharmacologic patient care options to also help reduce patient aggression.

Despite the lack of documentation, anecdotal reports by emergency nurses support the value of Comfort Carts as alternatives to offering medications to prevent or reduce patient aggression.

Incorporating a screening tool that empowers emergency nurses and technicians to use observation skills and quickly identify which patients may be more prone to aggressive outbursts can provide a safer environment for both patients and health care workers alike. As evidenced by the limited survey results, the implementation of the DASA tool improved the surveyed staff perception of safety within their department and perception of leadership's concern for a safe working environment. DASA screening in conjunction with protocols for responding to escalating patients could support and empower ED staff to recognize that patient violence should not be considered a "normal occurrence" and that earlier interventions can help mitigate the risk of aggressive outbursts.

Conclusion

Using a validated screening tool was beneficial when identifying BH patients with behaviors associated with aggressive events. Developing ED BH protocols to respond to elevated DASA scores is a crucial component to assess and mitigate risk to reduce WPV in ED settings. Protocols including early multicomponent interventions including de-escalation, diversional activities, and/or medications may be instrumental when reducing the risk of aggressive outbursts with BH patients. Increasing staff awareness of the importance of reporting WPV may lead to improved documentation and create safer health care work environments for all.

Acknowledgments

The research team would like to thank study sponsors Dr Jacqueline Dienemann and Jennifer Ziccardi-Colson for their support and leadership throughout this process and for believing that we could make a difference for patients and teammates.

Data, Code, and Research Materials Availability

Institutional review board (IRB) approval was granted via expedited review by the organization's IRB panel for this retrospective medical record review (IRB# 04-19-10E).

Author Disclosures

Conflicts of interest: none to report.

DASA score	Interventions
“Low” risk (scores 0-1)	•No interventions needed•Continue routine monitoring
“Medium” risk (scores 2-3)	•Increased awareness of behaviors•Consider interventions ◦ Offer PRN medications◦ Limit setting with patient ◦ Distraction
“High” risk (scores 4 or higher)	•Increased awareness of behaviors•Notify emergency provider of increased aggression or elevated DASA score• Consider interventions ◦ Offer PRN medications ◦ Limit setting with patient ◦ Distraction◦ Restraints if ordered

DASA implementation time period	DASA monthly aggressive events (median)	P value
Pre-DASA implementation (September 2018-March 2019)	2.0	.029*

Score	Low DASA score (0-1)		Medium DASA score (2-3)		High DASA score (4-7)		Score	Low DASA score (0-1)		Medium DASA score (2-3)		High DASA score (4-7)	
	Yes	No	Yes	No	Yes	No		Yes	No	Yes	No	Yes	No
Score 1 Was any intervention used? (medication and nonmedication)	96.8%	3.2%	69.8%	30.2%	83.3%	16.7%	Score 6 Was any intervention used? (medication and nonmedication)	100.0%	0.0%	66.7%	33.3%	10.0%	90.0%
	n = 397	n = 13	n = 30	n = 13	n = 35	n = 7		n = 117	n = 0	n = 2	n = 1	n = 3	n = 0
Medication intervention used?			60.0%	40.0%	70.6%	29.4%	Medication intervention used?			10.0%	90.0%	10.0%	90.0%
			n = 18	n = 12	n = 24	n = 10				n = 1	n = 0	n = 3	n = 0

Score 2 Was any intervention used? (medication and nonmedication)	Yes 96.8 % n = 390	No 3.2% n = 13	Yes 70.0 % n = 14	No 30.0% n = 6	Yes 72.7 % n = 16	No 27.3% n = 6	Score 7 Was any intervention used? (medication and nonmedication)	Yes 97.6% n = 80	No 2.4% n = 2	Yes 100.0% n = 5	No 0.0% n = 0	Yes 10.0% n = 6	No 0.0% n = 0
Medication or intervention used?			Yes 61.5% n = 8	No 38.5% n = 5	Yes 68.8% n = 11	No 31.2% n = 5	Medication intervention used?			Yes 80.0% n = 4	No 20.0% n = 1	Yes 10.0% n = 5	No 0.0% n = 0
Score 3 Was any intervention used? (medication and nonmedication)	Yes 98.4 % n = 308	No 1.6% n = 5	Yes 73.7 % n = 14	No 26.3% n = 5	Yes 73.7 % n = 14	No 26.3% n = 5	Score 8 Was any intervention used? (medication and nonmedication)	Yes 100.0% n = 66	No 0.0% n = 0	Yes 50.0% n = 1	No 50.0% n = 1	Yes 0.0% n = 0	No 0.0% n = 0
Medication intervention used?			Yes 66.7% n = 8	No 33.3% n = 4	Yes 76.9% n = 10	No 23.1% n = 3	Medication intervention used?			Yes 100.0% n = 1	No 0.0% n = 0	Yes 0.0% n = 0	No 0.0% n = 0
Score 4 Was any intervention used? (medication and nonmedication)	Yes 97.5 % n = 236	No 2.5% n = 6	Yes 69.2 % n = 9	No 30.8% n = 4	Yes 63.2 % n = 13	No 36.8% n = 6	Score 9 Was any intervention used? (medication and nonmedication)	Yes 100.0% n = 47	No 0.0% n = 0	Yes 100.0% n = 1	No 0.0% n = 0	Yes 10.0% n = 3	No 0.0% n = 0

Medication intervention used?			Yes 77.8 % n = 7	No 22.2 % n = 2	Yes 84.6 % n = 11	No 15.4 % n = 2	Medication intervention used?			Yes 0.0 % n = 0	No 0.0 % n = 0	Yes 0.0 % n = 2	No 0.0 % n = 0
Score 5 Was any intervention used? (medication and nonmedication)	Yes 99.4 % n = 163	No 0.6 % n = 1	Yes 66.7 % n = 4	No 33.3 % n = 2	Yes 100.0 % n = 9	No 0.0 % n = 0	Score 10 Was any intervention used? (medication and nonmedication)	Yes 100.0 % n = 36	No 0.0 % n = 0	Yes 10.0 % n = 2	No 0.0 % n = 0	Yes 10.0 % n = 2	No 0.0 % n = 0
Medication intervention used?			Yes 75.0 % n = 3	No 25.0 % n = 1	Yes 44.4 % n = 4	No 55.6 % n = 5	Medication intervention used?			Yes 10.0 % n = 2	No 0.0 % n = 0	Yes 50.0 % n = 1	No 50.0 % n = 1

Demographic variable	N	%
Sex		
Male	273	54.8
Female	223	44.8
Other	2	0.4
Race		
Caucasian	300	60.2
African American/Black	174	39.9
Asian	4	0.8

Native Hawaiian/Pacific Islander	1	0.2
American Indian/Alaskan Native	11	2.2
Unknown	8	1.6
Ethnicity		
Hispanic or Latino	30	6.1
Not Hispanic or Latino	463	93.9
Positive for substance use		
Yes	268	55.3
No	217	44.7
Positive for alcohol use		
Yes	87	17.9
No	399	82.1
Diagnosis		
Depression	179	36.1
Other	106	21.4
Bipolar	71	14.3
Schizophrenia	60	12.1
Suicidal	57	11.5
Substance use	23	4.6
Mania	0	0.0
Other diagnosis (N = 106)		
Schizoaffective disorder	30	28.3
Psychosis	16	15.1

Mood disorder	14	13.2
Adjustment disorder	9	8.5
Neurocognitive disorder	8	7.6
PTSD	7	6.6
Anxiety	6	5.7
Personality disorder	5	4.7
Substance-induced disorder	3	2.8
Violent thoughts/behavior	2	1.9
Panic disorder	2	1.9
Acute stress reaction	1	0.9
Autism	1	0.9
Selective mutism	1	0.9
Social phobia	1	0.9

Survey questions	Pre-study (N = 138), %	Post-study (N = 101), %	P value
I deal with aggressive patients on a daily basis.			
Strongly agree	25.6	30.0	.098
Agree	45.3	29.0	Neither agree nor disagree
16.8	19.0	Disagree	11.7

21.0	Strongly disagree	0.7	1.0
In general, I feel safe working on my unit.			
Strongly agree	10.87	18.81	.048*
Agree	52.17	60.40	Neither agree nor disagree
16.67	10.89	Disagree	17.39
6.93	Strongly disagree	2.90	2.97
I receive adequate training in recognizing aggressive behaviors.			
Strongly agree	21.01	27.72	.573
Agree	61.59	56.25	Neither agree nor disagree
11.59	7.92	Disagree	3.62
1.98	Strongly disagree	2.17	0.99
There is discussion with leaders when patient incidents and/or teammate injuries occur.			
Strongly agree	23.19	31.68	.098
Agree	44.93	48.51	Neither agree nor disagree
16.67	14.85	Disagree	13.77
4.95	Strongly disagree	1.45	0.00

My safety is important to my manager/leader.			
Strongly agree	37.68	53.47	.015*
Agree	44.20	41.58	Neither agree nor disagree
10.87	1.98	Disagree	5.80
2.97	Strongly disagree	1.45	0.00
There is enough staff to handle the patient workload (acuity).			
Strongly agree	5.07	9.90	.314
Agree	32.61	32.67	Neither agree nor disagree
27.54	18.81	Disagree	26.09
25.74	Strongly disagree	8.70	12.87
We often work in "crisis mode" on my unit.			
Strongly agree	8.70	10.89	.961
Agree	32.61	28.71	Neither agree nor disagree
28.99	29.70	Disagree	26.09
26.73	Strongly disagree	3.62	3.96
Communication between shifts is effective and provides information on patients before I begin my shift.			

Strongly agree	21.01	21.78	.331
Agree	57.25	62.38	Neither agree nor disagree
10.87	11.88	Disagree	10.14
2.97	Strongly disagree	0.72	0.99

DETAILS

Subject: Risk reduction; Emergency medical care; Behavior; Intervention; Documentation; De-escalation; Patients; Medical personnel; Workplace violence; Quasi-experimental methods; Risk assessment; Leadership; Emergency services; Nurses; Electronic health records; Trauma; Aggressiveness; Health care; Consultation; Health behavior; Triage; Implementation; Medical screening; Workplaces; Health professional-Patient communication; Patient admissions; Nursing; Departments; Telemedicine; Education; Inpatient care

Business indexing term: Subject: Workplace violence Leadership Risk assessment

Identifier / keyword: Psychiatric; Aggression; Screening; DASA; Emergency department; Workplace violence; Comfort cart

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 3

Pages: 403-414

Publication year: 2023

Publication date: May 2023

Section: Research

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.010
ProQuest document ID:	2809538976
Document URL:	https://www.proquest.com/scholarly-journals/screening-behavioral-health-patient-aggression/docview/2809538976/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-08-01
Database:	Public Health Database

Document 18 of 50

Introducing a Digital Occupational Violence Risk Assessment Tool Into an Emergency Department: A Pilot Implementation Study: JEN

[ProQuest document link](https://www.proquest.com/scholarly-journals/screening-behavioral-health-patient-aggression/docview/2809538976/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Introduction

Occupational violence in emergency departments is prevalent and detrimental to staff and health services. There is an urgent call for solutions; accordingly, this study describes the implementation and early impacts of the digital Queensland Occupational Violence Patient Risk Assessment Tool (kwov-pro).

Methods

Since December 7, 2021, emergency nurses have been using the Queensland Occupational Violence Patient Risk Assessment Tool to assess 3 occupational violence risk factors in patients: aggression history, behaviors, and clinical presentation. Violence risk then is categorized as low (0 risk factors), moderate (1 risk factor), or high (2-3 risk factors). An important feature of this digital innovation is the alert and flagging system for high-risk patients. Underpinned by the Implementation Strategies for Evidence-Based Practice Guide, from November 2021 to March 2022 we progressively mobilized a range of strategies, including e-learning, implementation drivers, and regular

communications. Early impacts measured were the percentage of nurses who completed their e-learning, the proportion of patients assessed using the Queensland Occupational Violence Patient Risk Assessment Tool, and the number of reported violent incidents in the emergency department.

Results

Overall, 149 of 195 (76%) of emergency nurses completed their e-learning. Further, adherence to Queensland Occupational Violence Patient Risk Assessment Tool was good, with 65% of patients assessed for risk of violence at least once. Since implementing the Queensland Occupational Violence Patient Risk Assessment Tool, there has been a progressive decrease in violent incidents reported in the emergency department.

Discussion

Using a combination of strategies, the Queensland Occupational Violence Patient Risk Assessment Tool was successfully implemented in the emergency department with the indication that it could reduce the number of incidents of occupational violence. The work herein provides a foundation for future translation and robust evaluation of the Queensland Occupational Violence Patient Risk Assessment Tool in emergency departments.

FULL TEXT

Contribution to Emergency Nursing Practice

- Occupational violence perpetrated by patients is a worldwide issue that is particularly prevalent in emergency departments. Risk assessment is one of many emerging solutions to prevent occupational violence, but there is limited evidence for its effectiveness in emergency settings.
- In this paper, we describe the pragmatic implementation of and early evidence for the effectiveness of a simple, validated risk assessment tool for emergency departments.
- Anticipating broader translation of the tool, we believe that the paper would be of interest and useful to individuals, because it describes practical steps and strategies to optimize adoption of a risk assessment tool and ultimately to improve occupational violence prevention.

Background

Occupational violence (OV) is defined as “any physical attack or verbal abuse that occurs in the workplace or is associated with the workplace that could potentially lead to physical and/or psychological harm.”¹ OV perpetrated by patients is a global problem, with ED staff disproportionately at risk compared to other health care staff.² Associated detrimental impacts of OV on patients,³ staff, and health services have been well documented,⁴ hence the need for prevention and management.

Risk assessment of patients is a preventive strategy that is gaining substantial traction in emergency departments.⁵⁻⁷ Risk assessment involves identifying the presence or absence of violence risk factors, ideally through application of a validated assessment tool.⁸ The premise for prevention is that timely recognition of a patient’s violence risk prompts de-escalation and proactive management⁷ to reduce the likelihood of OV incidents occurring (see ^{Figure 1}). Without a risk assessment, a common trajectory is that a patient presents to the emergency department and later becomes verbally or physically aggressive. A team is called for help, and then the patient is verbally de-escalated, offered nonpharmacological and, if appropriate, oral pharmacological interventions. If unresponsive to these interventions, the patient might receive restrictive interventions in the form of forced chemical restraint and/or physical restraint. With a risk assessment, a proactive rather than a reactive approach may be taken. A patient in the emergency department is assessed for their violence risk using a tool. The primary nurse (the emergency nurse allocated to the patient) then engages with the patient, attempts verbal de-escalation, and offers nonpharmacological and oral pharmacological interventions. The nurse alerts their team leader or security for

monitoring purposes. In this scenario, use of the risk assessment to recognize violence risk and instigate early proactive interventions could prevent OV and the need for more restrictive interventions.

Emergency nurses have proposed that the necessary attributes for a risk assessment tool to be embedded in practice include the tool being comprehensive, brief, objective, and digital with alerts.⁹ The Queensland Occupational Violence Patient Risk Assessment Tool (QOVPRAO) was developed and rigorously validated to meet these requirements.^{10,11} It prompts review of 3 violence risk factors: aggression history, behavioral concerns, and clinical presentation concerns. The patient then is scored as low (score = 0 risk factors), moderate (score = 1 risk factor), or high (score = 2-3 risk factors) risk of perpetrating OV in the emergency department.¹¹ The QOVPRAO was digitalized and implemented in 1 emergency department that uses an electronic health record (EHR) system. Nurses should have completed the QOVPRAO electronically within 30 minutes of a patient's ED arrival to optimize timely OV risk identification and proactive management (see ^{Supplementary File 1}).

In this paper, we describe our methods for implementing the QOVPRAO using the Implementation Strategies for Evidence-Based Practice Guide or Implementation Guide for brevity.¹² In addition, we report on its adoption and impacts on OV incidents. The implications of this implementation paper are 2-fold.

First, because many emergency departments internationally are faced with the problem of OV,² many also would likely be interested in solutions. Accordingly, knowledge of implementation approaches would be useful to translate potential solutions to OV¹³ such as the QOVPRAO from theory into practice. Furthermore, OV risk assessment using a validated tool is becoming more common in emergency settings,⁵⁻⁷ but with limited evidence to establish its place in OV prevention.¹⁴ The work presented herein would be valuable to emergency clinicians and researchers who may want to use the QOVPRAO to minimize the occurrence of OV in their emergency departments.

Second, adoption and translation of new clinical processes is challenging.¹⁵ For example, previous implementations of risk assessment tools in mental health settings have been met with end user-related and context-related barriers that have precluded their successful adoption.¹⁶ For this reason, implementation should be guided by a conceptual underpinning that helps to explore and overcome such barriers,¹⁷ but fewer than 50% of implementation efforts have done this.^{18,19} Our use of a conceptual underpinning (Implementation Guide¹²) and the way in which it was operationalized in the emergency department would make a valuable contribution to implementation research.

Aims

The aim of this paper was to describe the implementation of the digital QOVPRAO in 1 emergency department and report on early adoption metrics according to the Standards for Reporting Implementation Studies Statement.²⁰

Ethics

The project was approved by the Metro South Human Research Ethics Committee (EX/2022/QMS/91990).

Methods Context

The emergency department is a public, metropolitan, adult tertiary referral hospital in Brisbane, Australia, with over 69,000 presentations annually (in 2021). The emergency department has resuscitation, acute care, short-stay, toxicology, ambulatory care, procedural, and mental health units. An overflow tent, just external to the emergency department, was available from January to October 2022 to accommodate the higher demand placed on the hospital by the COVID-19 surge. The health information system used in the emergency department is FirstNet (Cerner Corporation, Kansas City, USA), which is an EHR system for patient tracking and health information documentation. It also provided a live in-house patient tracking screen, active throughout the patient's emergency department stay, that included the QOVPRAO. FirstNet is a component of a health service-wide EHR through which all patients' health information is documented and can be accessed.

Design Implementation

The Implementation Guide¹² was used to map and plan implementation strategies (see ^{Figure 2}). The QOVPRAO implementation had 4 action stages, each with corresponding interventions for organizational leaders and key stakeholders to:

- Stage 1: Create awareness and interest
- Stage 2: Build knowledge and commitment
- Stage 3: Promote action and adoption and
- Stage 4: Pursue integration and sustained use

Organizational leaders were heads of clinical governance structures with influence on and oversight of the emergency department, OV-related initiatives, and the EHR. Key stakeholders in the implementation were emergency nurses who were end users of the QOVPRAO. Therefore, stakeholders also included the nursing leadership team including clinical nurse consultants who were responsible for coordinating team huddles at the start of ED shifts; nurse educators who were responsible for monitoring and providing for emergency nurses' educational needs; and Response to Occupational Violence Emergencies (ROVE)²¹ nurses, whose primary responsibilities in the emergency department are to monitor, de-escalate, and respond to violence risk and incidents.

Implementation Stage 1: Create Awareness and Interest (July 2020-November 2021)

Several approaches were taken to create awareness and interest among departmental leaders and key stakeholders. First, the tool was formally named the QOVPRAO and disseminated through media releases to fuel local interest and promote a sense of ownership within the health service.²²⁻²⁴ Second, key stakeholders were consulted about the design and workflow of the digital QOVPRAO in the emergency department.⁹ This led to it being a mandatory assessment field in the emergency department, capable of triggering a pop-up alert and visual flag for high-risk patients (^{Supplementary File 1}). Third, the principal investigator (CJC) and nurse informatician (JMcR) engaged with organizational leaders to gain feedback and approval to embed QOVPRAO in the health service EHR. Once in the EHR, clinical informaticians (including CJC and JMcR) conducted an accuracy check to ensure that the QOVPRAO was functioning as intended (ie, automatic calculation of risk factors—when a high score is calculated an icon is to appear on the tracking list) (see ^{Supplementary File 1}).

Implementation Stage 2: Build Knowledge and Commitment (September-November 2021)

Stakeholder's lack of knowledge and confidence can preclude successful implementation.¹⁶ Therefore, education and training are essential to help build knowledge and commitment.^{16,25}

E-learning

E-learning was the default learning modality in the study emergency department. An e-learning package was developed and divided into 2 parts of 15 minutes each to minimize the time commitment involved and conform with emergency nurses' limited availability. The first part, launched on September 3, 2021, focused on understanding the need for and the benefits of using the QOVPRAO, including how to identify patient risk factors, score, and use risk ratings of violence. The second part, which commenced on November 25, 2021, focused more pragmatically on how to use the QOVPRAO in the EHR, providing practice with accessing and applying the QOVPRAO in 2 patient scenarios, identification of the high-risk icon in the EHR, and identification of procedures and interventions for managing patients who pose OV risks.

Emergency nurse educators were pivotal in making the e-learning an essential learning module for all emergency nurses, including newly employed staff. Notifications and reminders for the e-learning were communicated to nurses in shift huddles by clinical nurse consultants and by emails from the principal investigator (CJC).

Implementation Drivers

Commitment to the implementation of the QOVPRAO from organizational leaders was evidenced in part by approvals for staff to be employed as implementation drivers. These implementation drivers, recruited from the nursing workforce, were deployed in the study emergency department to advocate the use of the QOVPRAO among nurses, promote its potential benefits, reinforce shared goals to reduce OV in the emergency department, and provide coverage while nurses undertook and completed the e-learning package.^{26,27} The latter meant that the implementation drivers relieved bedside nurses of their clinical responsibilities for a period of approximately 30 minutes while they completed the QOVPRAO e-learning. In the 2-week period leading up to the QOVPRAO becoming operational, 26 hours over 5 days were covered by 3 implementation drivers (KG, CA, MOS). Skill and staff shortages impacted the study emergency department broadly, particularly from December 2021 to February 2022²⁸ due to shifting priorities as a consequence of the COVID-19 surge, staff sick leave due to COVID-19 infection, and a higher than usual number of casual nurses recruited to meet emergency care demands. These staff shortages forced discontinuation of Implementation Driver time after that initial 2-week period.

Implementation Stage 3: Promote Action and Adoption (December 2021-March 2022)

The QOVPRAO officially became part of emergency nurses' responsibilities beginning on December 7, 2021. Patient assessment and completion of the QOVPRAO required a behavior change¹² in that nurses would begin to form an intention or habit of routinely using the QOVPRAO as part of clinical care. Evidence from a systematic review¹⁶ has suggested that nurses' behaviors toward risk assessment can be influenced by a variety of factors. Barriers to successful adoption include a lack of perceived advantage over current practice, insufficient communication about the implementation, poor access to information about the implementation, and staff turnover (Table).¹⁶ Therefore, the strategies used to promote action and adoption attempted to address each of these barriers (Table) and are discussed in detail in this section.

Activities and Games with Incentives

The potential lack of advantage over current practice was identified during tool development.⁹ Risk assessment tools such as the QOVPRAO need to be complemented by meaningful interventions to enhance their value.⁹ Without such interventions, the QOVPRAO could simply be deemed a data collection tool and abandoned.^{29,30} Meaningful interventions that complement risk assessment tools include verbal de-escalation techniques, behavioral management teams (similar to a ROVE Team²¹ in the local emergency department that responds to violence risk and incidents), safe de-escalation rooms, buddy systems, oral medications, restrictive intervention policies, allocative strategy, security presence or assistance, and fast-tracking of care.³¹

Implementing a full package of OV interventions including those identified above with the QOVPRAO is a much larger project and is outside the scope of this implementation. However, recognizing that it is pivotal to successful adoption, 2 main approaches were used to prompt nurses to action when OV risk was identified using the QOVPRAO. One component of the e-learning was an activity where nurses were required to "drag-and-drop" from a list of all possible interventions they could use to manage patients with OV risk (eg, verbal de-escalation techniques); maintain their personal safety (eg, buddy system); and enhance overall safety in the emergency department (eg, security presence). These interventions were aligned with local policies and procedures for OV management. We then collaborated with nurse educators to launch a treasure hunt game during March and April 2022. The mechanics of the game involved nurses looking for 23 different intervention stickers (the treasure) in the department (Supplementary File 2). The person who collected the largest number of stickers won a cash voucher redeemable at the hospital café. Those who participated but did not win were able to redeem their intervention stickers for confectionery.

Reminders and Feedback

Action and adoption were supported by ongoing reminders and feedback. Two strategies were used to remind workers about and maintain their access to information about the QOVPRAO. First, clinical nurse consultants were tasked with reminding staff during the start of every shift huddle about completing the QOVPRAO for every patient within 30 minutes of ED arrival. Second, the principal investigator (CJC) emailed monthly e-newsletters with the purpose of communicating impacts of the QOVPRAO, such as QOVPRAO adherence, OV incidents, and e-learning adherence. This information and feedback could help motivate nurses to use the QOVPRAO.³²

Strategies for New Nursing Workforce

A higher-than-usual number of contract and agency nurses were recruited to meet emergency care demands and compensate for staff sick leave due to COVID-19 infection. To promote action and adoption among the new nursing workforce, nurse educators made the QOVPRAO e-learning a core learning requirement for contract nurses starting in the emergency department. The agency nurses who did not have access to the e-learning were prompted to complete the QOVPRAO at shift huddles or during their orientation to the department at the start of their shift.

Implementation Stage 4: Pursue Integration and Sustained Use (April 2022 Onward)

Sustainability of implementation involves maintenance of innovation, maintenance or enhancement of behavior change, and (ideally) continuation of benefits after a defined period of time.³³ Recommendations for sustainability of innovations should consider knowledge maintenance, wider translation, continued engagement, and monitoring effectiveness.³⁴

In the local health service, we are engaging and collaborating with organizational leaders to pursue the integration of the QOVPRAO in other emergency departments with the EHR in the health service. Considering the sustainability recommendations above,³⁴ the e-learning was designed so that it readily transferred across e-learning platforms in the health service. Moreover, the effectiveness of the QOVPRAO has been evaluated against clinically relevant outcomes, including safety, patient-centeredness, timeliness, efficiency, and cost effectiveness (will be reported separately).

Data Collection and Analysis

The data collection period was from September 2021 to September 2022. The implementation outcomes of interest were the percent of nurses who completed their e-learning, the percent of patients who had QOVPRAO assessment, and the percent of patients who had a QOVPRAO assessment within 30 minutes (defined as early assessment). The percentage of emergency nurses who completed their e-learning was readily extracted as a report from the e-learning platform (host). For QOVPRAO adherence, data were available as an Excel file download from the EHR, which contained patient details, date and time of ED arrival, date, time of first QOVPRAO assessment, and first QOVPRAO scores. The formula for percent of patients who had a QOVPRAO assessment was $\frac{\text{number of patients who had QOVPRAO assessment}}{\text{total number of patients who presented}} \times 100$. Subsequently, the percentage of patients who had early QOVPRAO assessments was calculated. The number of incidents related to OV perpetrated by patients was extracted from the hospital risk register. For adoption outcomes, descriptive analyses were conducted from the first month of the QOVPRAO (December 2021) and then quarterly until September 2022. Comparisons of OV incidents were made before (September-November 2021) and after the QOVPRAO was introduced (quarterly from January-September 2022).

Results E-Learning Completion

Before the QOVPRAO was operational, 64 of 107 (60%) of enrolled emergency nurses completed their QOVPRAO e-learning. As of September 30, 2022, a 149 of 195 enrolled (76.4%) e-learning completion rate had been achieved.

Adherence to the QOVPRAO

In the first month (December 2021) of using the QOVPRAO, overall adherence was 63%, which subsequently improved quarterly in 2022 (Figure 3 A). Adherence to early assessment was relatively low at 35% in the first month (December 2021) and throughout 2022 (Figure 3 B).

OV Incidents Reported

There was a consistent quarterly reduction in the number of reported incidents in the emergency department since the implementation of the QOVPRAO compared to the baseline period of September 2021 to November 2021 (Figure 3 C). The greatest reduction was observed in the third quarter of 2022 (n = 5), representing an 88.6% reduction in incidents compared to before the QOVPRAO was implemented (n = 44; September 2021 to November 2021).

Discussion

The digital QOVPRAO was successfully implemented in the target emergency department, demonstrating the value of the use of a conceptual underpinning (Implementation Guide¹²). Success was evidenced in part by the majority of nurses completing the e-learning, good adoption of the QOVPRAO, and reduction of reported OV incidents in the emergency department. Following the Implementation Guide¹² the implementation strategies described herein were progressively operationalized over 4 stages. In summary, first consultation meetings with key stakeholders and organizational leaders were held to create awareness and interest. Second, e-learning and implementation drivers were deployed to build knowledge and commitment. Third, incentives, reminders, and feedback were added to promote action and adoption. Fourth, collaboration with organizational leaders and monitoring of clinical outcomes were ongoing to encourage integration and sustained use.

The strategies used herein align with previous risk assessment tools for implementation efforts in the emergency department.³⁵⁻³⁸ The advantage of our study is the use of an implementation framework that provides structure and a rationale for others to tailor or translate for use in their settings. Future users of the QOVPRAO should consider its limitations and their practice implications below.

Limitations and Implications for Emergency Nursing

A potential limitation of e-learning is that not all organizations have the infrastructure to deliver such online learning, nor does everyone have the technological literacy to engage with e-learning.³⁹ In the study setting, e-learning is the primary mode of education, so that by default, nurses are expected to navigate and engage with the QOVPRAO e-learning. Other settings may need to tailor their approach to their default learning modality to build knowledge and commitment. We recommend that the content cover the importance of the QOVPRAO, how to use it, and how it links to local OV management procedures or policies. Without this knowledge, nurses may undervalue and disengage from the innovation,¹⁶ thereby limiting the benefits of the tool for preventing and mitigating OV.

Implementation drivers were unable to comprehensively fulfill their roles due to staffing constraints. This could have influenced the completion of the QOVPRAO e-learning component. However, the absence of implementation drivers enhanced the involvement of nurse educators and clinical nurse consultants in enabling e-learning completion and facilitating QOVPRAO adherence. Something that can be learned from this experience is that successful implementation can be achieved using existing human resources.

There was low adherence to early assessment, which could be explained by the dramatic increase in ED presentations and wave of COVID-19 that overwhelmed emergency departments in local health services, particularly from January to March 2022.^{28,40} As observed previously, overcapacity increases the likelihood of missed nursing care as nurses reprioritize tasks or ration their time.⁴¹ During this time, it is possible that violence risk assessment was not seen as a priority, hence the delay in risk assessment. It also is possible that there might have been a higher-than-usual number of casual or agency nurses working in the department to meet care demands and minimize effects of workforce constraints. Casual or agency nurses may not be familiar with the QOVPRAO, hence

the relative lack of adherence to early assessment. Furthermore, discontinuation (redeployment back to ED direct care) of implementation drivers meant that they were not able to fully advocate the use of the QOVPRAO among nurses and promote the importance of early violence risk assessment.

The generalizability of the QOVPRAO and its impacts may be limited to emergency departments and to settings with an EHR. The utility of the QOVPRAO has not yet been tested in inpatient settings, and there is local interest in extending the QOVPRAO beyond the emergency department. It may be advantageous to use the QOVPRAO over other risk assessment tools validated for inpatients (ie, Broset Violence Checklist, ABRAT, M55)⁴² for 3 reasons. First, the QOVPRAO is a validated tool that is easy to use to assess aggression history, behavioral concerns, and clinical presentation concerns.¹¹ Our recent study showed that the QOVPRAO was used consistently by nurses with varying experiences.¹⁰ Second, unlike other tools that have been exclusively predictive of physical OV,⁴² the QOVPRAO risk ratings—low (score = 0 risk factors), moderate (score = 1 risk factor), and high (score = 2-3 risk factors)—are good predictors of any verbal or physical OV. Third, inpatient risk assessment tools are predictive of physical violence occurring within 24 hours of the risk being identified.⁴² Given that the QOVPRAO was validated in the emergency department, when violence risk is identified, the patient could potentially perpetrate verbal or physical OV in a much shorter period of time conforming with typical ED length of stay. With the QOVPRAO, there could be more urgency to proactively manage the patient's violence risk more quickly.

The QOVPRAO can be adapted to settings without an EHR, and it would still be possible to alert clinicians who are at risk of experiencing OV. In previous studies,^{43,44} patients' paper charts and wristbands were flagged to caution staff about patients' violence risk.

We reinforce the importance of OV management plans to optimize the benefits of the QOVPRAO.¹⁶ Future QOVPRAO users should tailor management plans to their local context. For further guidance, one may refer to a list of interventions proposed by emergency nurses that could prevent OV.³¹

The impact of the QOVPRAO was preliminarily measured using the number of reported OV incidents in the emergency department. Underreporting of OV is universally acknowledged,⁴⁵ so it is questionable whether the reduction observed in this study was a consequence of underreporting, particularly against the backdrop of a COVID-19 surge,²⁸ instead of evidence of effectiveness. Underreporting is a cultural by-product of the individual and also operates at the organizational level. At the individual level, nurses do not report, because they see OV as part of the job or do not have the time to complete incident reports.⁴⁶ At the organizational level, nurses do not report, because of complex reporting infrastructure and poverty of management support when they report an incident.^{47,48} These factors could be in play in the study emergency department. However, during the study period, approaches that are now standard practice were put in place to encourage reporting of incidents. For example, the ROVE nurses (behavioral management team) assisted nurses with completing incident reports.²¹ Subliminally, reminders and feedback as part of the implementation strategy could have shifted nurses' beliefs that management is limiting OV. Therefore, we presume that the likelihood of underreporting is low, and so the reduction of OV that was observed in this study is likely to be a direct outcome of the QOVPRAO.

In summary, future users of the QOVPRAO need to include education and training, recognize the influence of nurse leaders in adoption, tailor OV management plans to the context, and ensure the accuracy of incident reports.

Conclusions

The QOVPRAO, a digital OV risk assessment tool, was successfully implemented in a local emergency department following the Implementation Guide. A combination of implementation strategies addressing key elements from the Implementation Guide that included e-learning, staff implementation drivers, incentives, reminders, and feedback were used. Successful implementation was evidenced by good e-learning completion, good adoption of the

QOVPRO, and reduction of reported OV incidents in the emergency department. Future users of the QOVPRO could translate or tailor our implementation methods to bolster their success implementing it into their clinical settings.

Data, Code, and Research Materials Availability

Study data are available on request and on approval of Metro South Human Research Ethics Committee.

Author Disclosures

Conflicts of interest: none to report.

C.J. Cabilan is a PhD candidate funded by a Queensland Health Advancing Clinical Research Fellowship. The scenarios used in the e-learning were funded by the Metro South Health Study, Education and Research Trust Account. Filming of the scenarios was funded by The University of Queensland School of Nursing, Midwifery and Social Work.

Acknowledgments

The authors acknowledge the nursing staff who supported the implementation. We thank e-health Queensland for technically facilitating the development of the QOVPRO for the EHR and the Office of the Chief Clinical Information Officer for ensuring robust state-wide clinical governance.

Supplementary Data

Supplementary File 1 **Supplementary File 2**

Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jen.2023.01.007>.

Common barriers	Strategies to subvert/overcome barriers
Lack of relative advantage over current practice	1) e-Learning drag-and-drop activity and 2) treasure hunt game (with incentives) to promote action when occupational violence risk is identified
Dearth of communication about the implementation	Daily reminders in start of shift huddles. Monthly e-newsletters containing performance and clinical updates on QOVPRO.
Poor access to information about the implementation	Skill shortage due to staff turnover

DETAILS

Subject: Ambulatory care; Emergency medical care; Nursing education; Risk factors; Risk assessment; Violence; Leadership; Nurses; Emergency services; Distance learning; Internet; Evidence-based practice; Health services; Patients; Electronic health records; Workplace violence; Prevention; Innovations; Implementation; Evidence-based nursing; Online instruction; High risk; Health professional-Patient communication; Mental health; Translation; Clinical assessment

Business indexing term:	Subject: Leadership Risk assessment
Company / organization:	Name: First Responder Network Authority; NAICS: 926130
Identifier / keyword:	Behavior change; Emergency department; Emergency nursing; Implementation science; Nursing; Risk assessment tool; Workplace violence
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	360-370
Publication year:	2023
Publication date:	May 2023
Section:	Practice Improvement
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.007
ProQuest document ID:	2809538951
Document URL:	https://www.proquest.com/scholarly-journals/introducing-digital-occupational-violence-risk/docview/2809538951/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-08-30
Database:	Public Health Database

Researching Workplace Violence: Challenges for Emergency Nursing Researchers: JEN

[ProQuest document link](#)

FULL TEXT

Workplace violence (WPV) in health care settings can create long-term sequelae for nurses, including anxiety, poor sleep patterns, work-related stress disorders, depressive disorders, and psychological distress.¹ Study findings suggest that WPV also may be associated with higher risk of interpersonal violence, psychoactive substance abuse, burnout, suicidal ideation, and suicide.² Identifying interventions that can reduce both the prevalence and effects of WPV is a critically important line of research; emergency department–focused researchers examining elements of WPV must account for significant challenges in conducting meaningful research, including the lack of an accepted definition, challenges in data collection, unclear metrics or outcome measures, and methodological limitations. In this paper, we aim to describe these challenges and offer suggestions to help researchers and others to better define the phenomenon of WPV, the necessary data required, ways to collect data, and outcome measures that can be used to guide intervention development or selection.

Definitions

Researchers examining WPV in the emergency department must first clearly identify the problem that their study will examine, given that there are a number of types and forms of WPV. Experts have classified WPV into 4 distinct types: criminal intent, customer/client, worker-on-worker, and personal relationship.³ Once the type of WPV has been identified, broad definitions for WPV impede research efforts.^{4,5} For example, the Occupational Safety and Health Administration⁶ has a broad definition, “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site,” with workers, patients, and visitors susceptible to be perpetrator or victim. In contrast to this very general definition, Boyle and Wallis⁴ created specific definitions using expert consensus for 6 distinct forms of WPV occurring in the health care sector: bullying, verbal abuse, threat, physical abuse, sexual harassment, and sexual assault. Regardless of the WPV definition chosen for the study, researchers need to choose a definition that fits the scope of the problem they are trying to address and ensure that study participants understand the definition. The definition chosen by researchers is important as they design a study, because the choice of definition may drive data collection about WPV incidents, and victims may choose whether to report WPV based on their personal interpretation of the event, not a standard definition.^{7,8}

Challenges in Data Collection

Collecting appropriate data to establish the parameters of WPV in a given setting can be challenging. The most obvious problem is underreporting of violence, but even in studies where some data can be collected, the nature and format in which data are collected can vary greatly.^{7,9} In a mixed methods study of WPV in California hospitals,¹⁰ researchers reported that data were collected about incidents of violence and separated into physical and nonphysical injuries in their online Workplace Violence Incident Reporting System. Challenges to interpreting those data included a lack of clarity around injury description, given that there was no way to tell the seriousness of the reported injury.¹⁰ Qualitative data collected in this same study¹⁰ suggested other challenges to more complete data, including the problem of who “owned” the reporting process (security, house supervisors, or leadership), the timing of the reporting (some systems required onsite real-time documentation), and to whom the report was made (a phone call to a supervisor vs an online database).

In addition, other researchers identified a gap between incidents that are reported through formal WPV incident

reporting systems and those that are reported informally to ED leadership.^{7,11} These barriers to reporting impede efforts to describe and address incidents of violence, with implications not only for researchers but also for clinical staff. We recommend describing any reporting processes clearly in institutional review board proposal, methods, and results sections and encouraging study participants to report all incidents that meet the definition chosen for the study.

Unclear Outcomes and Metrics

The outcome measures of studies involving WPV focus on the knowledge or satisfaction of health care staff^{12,13} in isolation, rather than a more holistic reduction of incidents. Research examining the effects of educational and training interventions report on the knowledge acquisition and satisfaction of participants without discussing outcomes in clinical settings (eg, changes in WPV incidents preintervention to postintervention).^{12,13} Other literature reviews^{5,14} report that few studies examined a reduction in assaults and/or threats to nurses as intervention outcomes. We recommend that research examining the effects of interventions to mitigate WPV focus on the reduction of number and severity of WPV incidents.

Methodological Limitations

The ways in which studies are designed and the ways in which data are collected also can make it difficult to compare the efficacy of interventions across studies. Fricke et al¹² reported a low level of evidence for interventions in their scoping review, mostly owing to methodological heterogeneity, potential bias of reporting clinicians, and data collection biases. Nikathil et al⁵ found that cross-sectional surveys have been the principal tool used to establish incidence and prevalence findings and that they are limited in establishing true incidence owing to subjective definitions of violence and underreporting of patient-perpetrated assault. The complexity of the problem can lead researchers to use lower-level study designs (descriptive designs, qualitative designs, single group predesign/postdesign), and so the ways in which researchers attempt to study the phenomenon can be, as Nikathil et al⁵ suggest, subjective and hampered by underreporting. Similarly, interventions tend to focus on individuals and do not account for problems such as bias and underreporting.¹⁴

Perhaps a more useful framework is the social-ecological model, a framework posited by the Centers for Disease Control and Prevention and recommended by Gillespie et al¹⁵ used to examine prevention efforts that simultaneously address individual, relationship, community, and societal elements of violence. We recommend that WPV researchers consider using more advanced research designs such as randomized controlled trials and quasi-experimental or case control designs. This might require the coordination of health care systems, rather than individual sites.

Other methodological limitations include the social context of WPV. Nurses tend to normalize WPV as “part of the job”^{8,16} for a variety of reasons, including a customer service orientation, an unwillingness to ascribe intent to patients who are intoxicated, demented, or delirious, or learned helplessness.¹⁶ Often, interventions to reduce or mitigate WPV are aimed at individuals, such as educational training or new reporting systems, but do not address the unit or organizational environment of care, which creates a social environment that places the onus for improvement on the individual nurse rather than the unit or organization. In particular, although de-escalation training is required by many health care organizations and studied as an intervention to reduce WPV, studies evaluating de-escalation training focused on outcomes of knowledge and confidence¹⁴ with little evidence that training reduces the frequency and severity of WPV. We suggest that research on WPV take a system-level, organizational approach.

Conclusions

The challenges to studying WPV are many but not impossible to overcome. Prevalence and risk factors are well understood. More work in preventing WPV needs to be done that considers organizational, community, and societal drivers of violence. It is important to design and conduct more comparative effectiveness research that would help to determine which interventions work best.¹² We encourage researchers to use precise language to define the problem they are examining, system-focused interventions that target the environmental conditions that facilitate violence, and outcome measures that focus specifically on frequency and severity of WPV incidents. Our call to action is for researchers to join forces to tackle this complex problem, develop potential intervention bundles, and

test them using more sophisticated research designs and methods.

Author Disclosure

Conflicts of interest: none to report.

DETAILS

Subject:	Research; Workplaces; Emergency medical care; Researchers; Design; Data collection; Emergency services; Workplace violence; Sex crimes; Nurses; Intervention
Business indexing term:	Subject: Workplace violence
Identifier / keyword:	Workplace violence; Emergency nursing; Research
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	330-332
Publication year:	2023
Publication date:	May 2023
Section:	Understanding Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.004
ProQuest document ID:	2809538608

Document URL: <https://www.proquest.com/scholarly-journals/researching-workplace-violence-challenges/docview/2809538608/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited May 2023

Last updated: 2023-05-05

Database: Public Health Database

Document 20 of 50

Qualitative Analysis of Workplace Assault Outcomes from the Perspectives of Emergency Nurses: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Emergency nurses experience a myriad of negative consequences associated with workplace assault. The purpose of this study was to explore the experiences of emergency nurses using the Ecological Occupational Health Model of Workplace Assault.

Methods

A descriptive qualitative design was used for this study. Data from 167 emergency nurse participants who described an episode of workplace assault were analyzed using a conventional content analysis method.

Results

Fourteen codes emerged from the qualitative data that related to 4 categories for the theme, Outcomes of Workplace Assault. The category "Consequences of Assault to Patients and Visitors" was supported by the following codes: use of limit setting; being evicted or removed from the emergency department; having charges pressed or being arrested; use of restraints; and retaliation against aggressor. "Effects on the Worker" was supported by the following codes: physical outcomes and response; psychological outcomes and response; physical support from peers; apologies; and debriefing/supportive care. "Effects on the Workplace" was supported by the following codes: calling for and response by police or security; and visitor response, support, or assistance. "Effects on Patient Care" was supported by the following codes: impact to treatment and work productivity.

Discussion

Workplace assault in the ED setting is associated with consequences of workplace assault to patients and visitors as well as negative effects to emergency nurses, the workplace, and patient care. Emergency nurses need to seek and also offer emotional support after workplace assault. Providing support could serve as a deterrent to retaliation while minimizing potential adverse impacts to nurses' psychological health and work productivity.

FULL TEXT

Contribution to Emergency Nursing Practice

- Emergency nurses experience a myriad of negative consequences associated with workplace assault.
- In addition to negative effects to emergency nurses, consequences exist for aggressive patients and visitors, the workplace, and patient care.

••Emergency nurses need to seek and also offer emotional support after workplace assault.

Introduction

Workplace assault (WPA) against nurses, particularly in the emergency department, is so prevalent that when orienting new nurses to the specialty, emergency nurses frequently say “When you are assaulted...” as opposed to “If you are assaulted...” Mitra et al¹ reported the prevalence of physical violence in just 1 emergency department at 1853 episodes over a 3-year period,¹ averaging 1 to 2 incidents per day. In other research, prevalence against emergency nurses was documented at 35.8%.²

Emergency nurses experience a myriad of negative consequences associated with WPA.³ Typical consequences are categorized as physical or psychological. Physical consequences include physical injuries, gastrointestinal complaints, migraines, loss of appetite, hyperarousal, insomnia, and nightmares.^{4,5} Psychological consequences include anxiety, depression, fear, frustration, burnout, humiliation, powerlessness, and helplessness.^{4,6-8} When emergency nurses experience WPA, we believe they want to rely on their coworkers for both physical and emotional support. Although some emergency nurses report receiving this emotional support from their peers, other emergency nurses report a lack of emotional support or being blamed for the WPA happening.⁹

WPA also can impact the emergency department and patient care delivery.¹⁰ For example, emergency nurses indicate decreased concentration, diversion from regular nursing care, and decreased ability to provide safe care.^{4,7} Normally, the use of coping strategies buffers the negative impact to care; however, Jeong and Kim reported that the use of emotion-focused coping is associated with a greater intention to leave emergency nursing.¹¹

Although research has been conducted on the consequences of WPA, minimal research has been conducted to study the impact of WPA for aggressors and the workplace. The purpose of this study was to describe the experiences of emergency nurses using the Ecological Occupational Health Model of WPA as an organizing framework. Findings from this study will help to guide future research on WPA and design interventions based on the model.

Conceptual Framework

Levin et al¹² developed the Ecological Occupational Health Model of Workplace Assault after studying workplace assaults by residents against staff in long-term care facilities. This multidimensional framework considers multiple factors contributing to WPA (eg, worker, aggressor, environment).⁷ This framework was later used by Gillespie et al¹³ to study WPA in emergency nurses. The key constructs of this framework are personal worker factors, workplace factors, community and environmental factors, assault situation, and outcomes of WPA. Outcomes of WPA are defined as (1) consequences of assault to patients and visitors, (2) effects on the workers, (3) effects on the workplace, and (4) effects on patient care. The present study focused on the “Outcomes of WPA” construct from the theoretical components to describe the experiences of WPA in emergency nurses.

Methods

A descriptive qualitative design was used for this research study.¹⁵ This study was part of a larger research project aiming to understand changes in work productivity after experiencing WPA. Before data collection, the study was approved by the Institutional Review Board. Potential participants provided informed consent. The Consolidated Criteria for Reporting Qualitative Research was followed for the reporting of this study’s findings.

We solicited participants through a systematic, randomized sample based on zip code of members in the Emergency Nurses Association. A postal invitation was mailed to potential participants with a paper copy of the study packet and letter of information for research. Inclusion criteria were providing stretcher-side care to emergency patients and experiencing an episode of assault or threat of assault within the previous 30 days. Of the 246

emergency nurses who participated in the larger study, 167 (67.9%) emergency nurses met the inclusion criteria for the current study and completed the study procedures.

The study's data collection tool was 1 open-ended question and a series of demographic questions. Responses were mailed back to the research team. The open-ended item requested participants to describe the worst episode of assault or threat of assault within the previous 30 days and document the actions taken and consequences following the episode. Qualitative responses to the open-ended item were transcribed verbatim into Microsoft Word (Redmond, WA) and imported into NVivo 9 (Burlington, MA) for qualitative data analysis using a conventional content analysis method.^{16,17} Demographic questions queried participants' age, race, gender, shift worked, and whether their employer provided violence prevention training. Responses to demographic items were entered into an IBM SPSS Statistics 23 (Armonk, NY) database and analyzed using descriptive statistics.

We used conventional content analysis to identify patterns of meaning across the responses to the open-ended question. This inductive approach followed the procedures for thematic analysis recommended by Braun and Clarke.¹⁶ The procedural steps for conventional content analysis began with both investigators (1 male, 1 female) reading the qualitative responses several times. At the time of data analysis, the first author was doctorally prepared (Doctor of Philosophy) with expertise in emergency nursing and occupational health science. The second author was master's prepared with a focus in occupational health nursing, doctoral student (Doctor of Philosophy program), and graduate research assistant.

The investigators then independently highlighted meaning units from the data.^{16,17} The 2 investigators met face-to-face and discussed each meaning unit coming to agreement on what items were important and relevant to the experience of being assaulted or threatened while providing emergency care. The meaning units were clustered to generate codes and a coding schema. Next, the investigators independently coded each line of text based on the coding schema. The investigators again convened face-to-face and discussed the coded data going line-by-line. When a discrepancy occurred in coding, the investigators discussed their rationale for why the exemplar was/was not coded. The discussion continued until consensus was achieved for the data. The final data set coded within NVivo 9 was evaluated by both investigators to confirm that the data were correctly coded within the database and that the coded data adequately represented the codes to which they were assigned. The independent analysis and discussion between investigators (ie, investigator triangulation), achievement of data saturation, and cross analysis using a large sample size (ie, data triangulation) were performed to increase the trustworthiness of the study findings.¹⁸

Results

The study sample consisted of 167 emergency nurses (see ^{Table 1}). Predominantly, the sample was non-Hispanic White ($n = 152$, 91%), was female ($n = 132$, 86%), and worked day shift ($n = 94$, 58%). Race and gender of the study sample was approximate to that of the United States nursing workforce.¹⁹ The mean age of participants was 43 years (range 25-65 years). In addition, the majority ($n = 99$, 62%) of participants received violence prevention training from their current employer.

Fourteen codes emerged from the qualitative data analysis. After the completion of analysis, the codes were organized in relation to 4 categories for outcomes of WPA: (1) Consequences of Assault to Patients and Visitors, (2) Effects on the Worker, (3) Effects on the Workplace, and (4) Effects on Patient Care. The relationship of the 14 codes to the respective categories and study theme of Outcomes of WPA is displayed in ^{Figure 1}. The number of participants providing a response categorized to the 14 codes is noted in ^{Table 2}.

Consequences of Assault to Patients and Visitors

Five codes related to the category Consequences of Assault to Patients and Visitors. These codes were (a) use of

limit setting, (b) being evicted or removed from the emergency department, (c) having charges pressed or being arrested, (d) use of restraints, and (e) retaliation against aggressor. The consequences were experienced by those patients and visitors who enacted WPA.

Use of Limit Setting

Limit setting was performed by 19 nurses (11.4%) in an effort to instruct aggressors to stop their physical aggression (eg, "I reacted by telling him loudly and forcefully not to abuse or assault me at work by throwing things at me") or articulate the limit to the degree of aggression they were willing to tolerate. Participant 228 said, "I also told him that any further threats or disruptions would result in his removal from the ED."

Being Evicted or Removed from the Emergency Department

As aggression escalated and limit setting was not effective, 9 participants (5.4%) reported patients were instructed to leave or were escorted out of the emergency department. After 1 visitor argued with staff in the lobby and threatened to wait outside in the parking lot and shoot staff as they exited the building, "...he was escorted out of the building to his car and told to leave immediately..." (Participant 249). In a different situation, a patient attempted to assault the nurse, and the attending physician requested the patient to be "...physically removed from the ED" (participant 60).

Having Charges Pressed or Being Arrested

A legal consequence of physical assaults was aggressors being arrested by the police or the nurse pressing charges against the aggressor ($n = 25$, 15%). For example, participant 52 wrote, "I had him arrested, I went to court. Judge ordered him extended jail time and to pay a fine." However, this was not true in all cases. Participant 146 believed that it was not worth the effort by writing, "No charges were pressed—it would have taken so much time." Even when charges were pressed, the outcome was not always in the favor of the nurse: "Event was witnessed by police and had to be reported. Several months later a call from district attorney convinced me to drop charges as he had no priors. In hindsight, I wished I'd continued with the charges as I truly feel it was a deliberate act and needed to be punished to some degree" (participant 218).

Use of Restraints

Eighteen participants (10.8%) discussed the need to restrain patients to prevent assault. These restraints included physical force, mechanical restraint, and involuntary medication administration. They described the use of physical force with a patient in order to protect a coworker. For example, participant 10 wrote: "When the patient attempted to take another swing at my coworker, I came up behind the patient and took hold of both of his upper arms and linked them with mine making it impossible for him to swing towards my coworker."

The types of mechanical restraints described to restrain aggressive patients were a taser gun ($n = 7$), handcuffs ($n = 3$), and 4-point restraints ($n = 50$). Taser guns were used by security, not the emergency nurse. Involuntary medication administration ($n = 13$) was described as the use of an antipsychotic medication such as haloperidol given intramuscularly. Some patients received multiple types of restraints. For example, participant 116 reported that one patient "...was physically restrained and chemical restraint was used with intubation; ED physician and further monitoring, level of care on a respirator."

Retaliation Against Aggressor

A few nurses ($n = 6$, 3.6%) had thoughts of retaliating against an aggressor immediately after being assaulted. Although most chose to not take retaliatory action, a few responded with lower level aggression such as "made an ugly face or two" and "yelling at her." However, in 1 case, the aggressiveness combined with lack of cooperation for 1 patient led participant 264 to go "over (to) the prone patient after being tired of him sitting doing nothing in the ED and placed the bed (head of bed) at a 70 degree angle quickly."

Effects on the Worker

Five codes related to the category Effects on the Worker. These codes were (a) physical outcomes and response, (b) psychological outcomes and response, (c) physical support from peers, (d) apologies, and (e) debriefing/supportive care.

Physical Outcomes and Response

Physical outcomes ranged from minor to severe injuries ($n = 27, 16.2\%$). Minor to moderate injuries suffered by nurses were pain and soreness, laceration, and epistaxis. Severe injuries included “nurse blacked-out for a few seconds,” head injury, extremity fractures, jaw dislocation, ruptured ear drum, and permanent loss of vision. The most severe injury reported was by participant 165 involving a police officer who had been hit in the head and initially seemed fine:

“Less than 10 minutes later, the officer told me he had a severe headache and didn’t feel right. He then collapsed in my arms and lost consciousness shortly afterwards. He died from this injury a few days later, never regaining consciousness.”

In addition, participants reported several responses to WPA including feeling a rush of adrenaline, becoming pale, physically shaking, and feeling exhausted.

Psychological Outcomes and Response

Participants identified a myriad of psychological outcomes and responses that they experienced ($n = 98, 58.7\%$), including being annoyed, angry, fearful, anxious, helpless, unsafe, and embarrassed. Of particular note is that the concern extended beyond the emergency department. Participant 148 wrote, “I live very close to the area I work in and many times have been recognized outside of work,” relaying the risk of being victimized outside of the workplace based on a prior interaction with an ED patient or visitor. Some participants also expressed the intrusiveness of the events to their personal lives. Participant 11 penned that “...‘what if’ began to creep into my every thought.” During a reflection of the experience, some felt guilty and blamed themselves for the aggression (ie, “I was angry and upset that I let it happen” and “Did I do something to incite it?”). However, participant 40 expressed that she did not take the aggression personally by writing, “Many years of experience help me to put this situation into perspective: (1) actions not aimed at me as an individual and (2) there was an influence of drugs upon patient.” Participant 75 said about an older adult patient, “I felt very sorry for him and hope it does not happen to me when I get older!”

Physical Support from Peers

The participants consistently reported that when physical assaults occurred, they immediately received physical support from their coworkers or they themselves intervened to protect a coworker ($n = 43, 25.7\%$). Participant 141 wrote, “Within moments, other members of the ED staff were at my side.” Participant 187 reported, “We called a Code Green [violent patient response] to assist with a show of force.” When the firearm of a police officer was taken by a prison patient, participant 191 “...reacted by kicking the patient in the groin long enough for the police to get the gun away from him. I fell onto the patient with my knee in his groin!”

Apologies

Aggressor apologies were infrequently reported by the participants ($n = 5, 3\%$). Four participants said that the patients later apologized to them for their behaviors. For example, participant 160 received an apology after the patient became sober: “Later, after he sobered my nurse colleagues told him of the negative comments he made to me, at which he called me in his room and apologized.” Another patient provided the explanation coupled with the apology that he was in pain at the time of the assault (participant 232). A fifth participant reported that the patient apologized but did so intermittently with ongoing threats of further assault: “He would look me in the eye and tell me he wanted to kill me and at the same time he’d apologize and say he couldn’t help it” (participant 239).

Debriefing/Supportive Care

Although only 2 participants (1.2%) reported receiving debriefing/supportive care after WPA, 1 participant discussed the profound impact that supportive care can have. Participant 160 wrote, "What stays with me about the event is my nursing partner thinking of me and my feelings enough to tell the patient that he needed to apologize to me. That exemplifies staff caring for each other." In the second situation, participant 10 showed that a debriefing can reduce the risk for future physical aggression: "After the situation, my coworkers and I sat down and discussed the case and talked it through. It did make me a bit more aware of my surroundings."

Effects on the Workplace

Two codes related to the category Effects on the Workplace. These codes were (a) calling for and response by police or security and (b) visitor response, support, or assistance.

Calling for and Response by Police or Security

In a large portion of the events, either the participants ($n = 87$, 52.1%) called for security and police to assist in the management of aggressive patients and visitors or security and police witnessed the event and instinctively responded. Participant 27 wrote that her department's "...urgent call resulted in three officers from our local police to come and help with further restraint." Several participants identified that "security responded immediately" or that the "police (were) at (the) bedside." Actions taken by security and police officers were monitoring patients under arrest, guarding prisoners being medically treated, assisting with physical and mechanical restraints, and being present during the care of behavioral health patients. In some cases, police responded to take a police report or to arrest someone committing a physical assault. Unfortunately, security services were not always effective. Participant 43 said, "We had no security." Participant 119 wrote, "At this point I turned and looked at the security guard, made eye contact with him (he was 10 feet away). The guard remained seated by the metal detector (through which the patient did not pass) and watched the patient continue to push me into the doors."

Visitor Response, Support, or Assistance

Six participants (3.6%) described interactions with visitors during the attempt to manage aggressive patients. In one account, the patient's father blocked the patient from leaving the triage room (participant 42). In a second account, the visitor for a different patient "...subdued him (aggressor), as I could not" (participant 48). Neither account depicted whether the visitor was injured. In other accounts, the visitors assumed a passive role with the aggressive patient. For example, participant 45 wrote: "After I was hit, the patient's family member said, 'I told them not to take the restraints off.' She just let me walk into the room, did not say anything and I placed myself in harm's reach to do my assessment."

Effects on Patient Care

Two codes related to the category Effects on Patient Care. These codes were (a) impact to treatment and (b) work productivity.

Impact to Treatment

Several nurses ($n = 22$, 13.2%) stated attempts to de-escalate aggressive patients and visitors. Participant 251 described his ability to successfully de-escalate a patient: "We were able to establish a rapport and I could find areas to give him a little more control." Participant 212 described an unsuccessful de-escalation attempt: "Myself and another RN tried to calm him down. This escalated the patient. He became more combative and assaultive." When de-escalation was not effective, some of these patients received expedited care. Participant 154 wrote that "...eventually the charge nurse took her (the aggressor) in ahead of many other sick patients." As some patients became more upset with wait times or treatment plans, they either left without treatment or left against medical advice: "She did not want to wait and consequently asked the registrar to call her a cab whereupon she left the

building” (participant 249).

Work Productivity

The work productivity for nurses to administer patient care also was affected ($n = 39, 23.4\%$). For example, participant 56 explained that in one event, the “...patient needed 10 people to (gain) control.” This resulted in an increased focus on one patient, with other patients not receiving nursing care for an extended time period. WPA also could lead to nurses’ inability to focus on their work as well as they normally would: “This man scared me. He knew what he was doing and was an angry person. This made me have trouble with work that day” (participant 59).

Discussion

The purpose of this study was to explore the experiences of emergency nurses using the Ecological Occupational Health Model of WPA. The 14 codes generated from the data aligned with the 4 categories from this construct (or theme): Consequences of Assault to Patients and Visitors, Effects on the Worker, Effects on the Workplace, and Effects on Patient Care.

Consequences of Assault to Patients and Visitors

Although some emergency nurses may perceive that aggressors commit WPA with no repercussions, our findings show that aggressors experience limit setting, removal from the emergency department, arrest, and use of restraints. Similarly, Wright-Brown et al⁵ conveyed that some aggressors were arrested after WPA. In other research, the use of restraints was common. Mitra et al¹ analyzed 1853 security responses. Of the responses, physical force was used in 1668 (90%) of the responses, involuntary medication administration in 923 (49.8%) responses, and mechanical restraint in 650 (35.1%) responses. It was not known in the current study whether de-escalation and other efforts were consistently and correctly attempted before use of restraints. When restraints are used, there is an increased risk of injury to both the patient and caregivers applying or administering the restraints.²⁰ A strategy that may need to be considered in ED settings is the creation of a seclusion room free of objects that could harm the patient and emergency nurses, coupled with padded walls, to further reduce potential patient self-harm without the use of restraints.

Six participants described thoughts and actions of retaliation against an aggressor. Although few participants admitted to committing retaliation, the number may actually be profoundly higher. Regardless of the rationale for considering retaliation, emergency nurses need to be mindful of the code of ethics for nursing practice as applied to emergency nursing practice.²¹ In provision 1, the authors discuss the need for nurses to practice with compassion and respect for their patients’ dignity, worth, and unique attributes. This provision translates to the need for emergency nurses to never use or condone retaliation. It is important for emergency nurses to recognize their signs of personal stress and seek assistance from their colleagues if considering retaliation.

Effects on the Worker

WPA can have a profound negative effect on emergency nurses. The WPA in this study led to acute physical and psychological injuries. These patterns of injuries are not unique and have been previously reported in the literature.³⁻

7

In our study, a greater number of participants described a psychological reaction than a physical reaction. Although physical support was described by 43 participants, only 2 participants reported receiving emotional support or a debriefing. This finding reflects the infrequent use of emotional support and debriefings to victims of WPA. Providing emotional support could foster resilience in victimized emergency nurses.²² Teaching problem-focused coping strategies to emergency nurses can lead to a routine use of proactive coping strategies and potentially WPA prevention.¹¹ In addition, staff can be trained to respond to provide debriefing and/or defusing sessions to victims of WPA.^{10,23}

Effects on the Workplace

Emergency nurses need to work collaboratively with security personnel for the prevention and management of WPA.^{20,23,24} In our study, the majority of participants (52.1%), but not all, reported effective support by security personnel. A limitation reported to reduce the effectiveness of security personnel is legal issues,²⁴ which vary by institution and may limit their role, preventing them from physically interacting with aggressive patients or visitors. Establishing a clear policy and role for security personnel for the prevention and management of WPA is warranted. Security personnel are often called to attend only/standby in anticipation of escalating WPA; however, this presence could be perceived as a threat to an agitated person.²⁵ Although having a security presence is essential for staff safety, nurses practicing in a trauma-informed manner might request that security personnel be immediately available but also out of sight of the agitated person until called.

Effects on Patient Care

Novel to this study, multiple participants wrote about the effects on patient care. For example, when WPA occurs, emergency nurses gather together to manage a single violent patient leaving other patients in the emergency department temporarily without nursing care. This overall impact to patient flow and wait times can exacerbate the conditions linked to further WPA.¹⁰ Moreover, the conditions of other patients could deteriorate with resuscitative care delayed while the violent patient is being managed. Our findings reflect the importance to focus on WPA prevention strategies.

Limitations

This study was potentially limited by selection and recall bias. Because participants self-selected to participate in our study, emergency nurses who did not participate might have provided responses different from those reported in this research. This limitation was minimized by having a large sample size ($n = 167$) from across all geographical regions of the United States. Recall bias may have occurred, because several participants provided minimal details in their WPA narrative. For example, 17 of the participants wrote fewer than 50 words in their WPA narrative. This limitation was minimized by over half ($n = 85$, 50.9%) of the participants writing at least 100 words. One participant wrote 709 words for the WPA narrative. Recall bias also was minimized by using an abridged recall period of 30 days. Because of the study design and the anonymity of data collection, probing for further details on the WPA events or confirmation of study findings was not possible.

Implications for Emergency Nursing

Approximately 67.9% of the recruited sample reported an experience of WPA during the previous 30 days. This statistic along with our study findings relays the importance of effective WPA prevention and management programs. Without effective prevention, emergency nurses will be at risk for the negative consequences and effects of WPA observed in this study. Over half ($n = 98$, 58.7%) of the study participants reported negative psychological outcomes and response, but only 2 participants noted the receipt of emotional support after experiencing WPA. Emotional support could buffer thoughts of retaliation as well as protect work productivity that would be negatively impacted (eg, inability to focus on work, fear). Emergency nurses can be trained to use mental health first aid as a strategy to provide emotional support to staff impacted by WPA. In mental health first aid, participants learn about trauma and anxiety disorders.²⁶ They also practice skills for providing this emotional support. In emergency nursing practice, nurses can use these skills to foster the recovery and resilience of emergency nurses who have experienced WPA, enabling them to return to work feeling supported. Nurses also can be screened for symptoms of burnout, which can worsen the consequences of WPA in the practice of emergency nursing. In addition, emergency nurses can participate in training sessions focused on nursing ethics. In this training, they can learn to identify situations that are challenging and plan for patient-centered responses that could reduce the impact of WPA such as the use of limit

setting with aggressors rather than entertaining thoughts of retaliation against aggressors.

Conclusion

WPA in the ED setting is associated with consequences to patients and visitors as well as negative effects to emergency nurses, the workplace, and patient care. Emergency nurses need to seek and also offer emotional support after an incident of WPA. Providing support could serve as a deterrent to thoughts of retaliation while minimizing potential adverse impacts to nurses’ psychological health and work productivity. Future WPA interventions might leverage aggressors’ visitors to assist in the prevention and management of WPA. Further research is needed to explore the long-term outcomes of WPA to emergency nurses, particularly psychological health outcomes (eg, stress, burnout).

Data, Code, and Research Materials Availability

ETHICAL STATEMENT

- Originality and plagiarism: all work presented in this manuscript is original and written by the authors. All content derived from other sources has been adequately cited and referenced.
- Multiple, redundant, or concurrent publication: the findings presented in this manuscript have not been published elsewhere.
- Reporting standards: the report of our original research is an accurate account of the work performed as well as an objective discussion of its significance.
- Hazards and human or animal subjects: the reported study was conducted after approval from the Institutional Review Board of the first author. Participants were notified in writing of this approval as well as their rights to participate or refuse to participate in the research. To further protect the study participants, the data were collected anonymously.

Author Disclosures

Conflicts of interest: none to report.

Peggy Berry was supported by the National Institute for Occupational Safety and Health through the University of Cincinnati Education and Research Center (No. T42OH008432).

Acknowledgments

Proper acknowledgment of the work of others has been given.

Demographic characteristics	Study sample		Nursing workforce*
N	%	%	Race
			Non-Hispanic White

152	91.0	80.6	Non-Hispanic other race
8	4.8	13.8	Hispanic
7	4.2	5.6	Gender [†]
			Female
132	85.7	90.5	Male
22	14.3	9.4	Shift worked [‡]
			Day shift
94	58.0		Evening shift
17	10.5		Night shift
51	31.5		Employer provides violence prevention training [§]
			Yes
99	61.5		No

Participants providing a response by category	N	%
Consequences of assault to patients and visitors		

Use of limit setting	19	11.4
Being evicted or removed from the emergency department	9	5.4
Having charges pressed or being arrested	25	15.0
Use of restraints	18	10.8
Retaliation against aggressor	6	3.6
Effects on the worker		
Physical outcomes and response	27	16.2
Psychological outcomes and response	98	58.7
Physical support from peers	43	25.7
Apologies	5	3.0
Debriefing/supportive care	2	1.2
Effects on the workplace		
Calling for and response by police and security	87	52.1
Visitor response, support, or assistance	6	3.6
Effects on patient care		
Impact to treatment	22	13.2
Work productivity	39	23.4

DETAILS

Subject: Emergency medical care; Occupational health; Assaults; Patients; Content analysis; Violence; Data analysis; Nurses; Emergency services; Codes; Qualitative research; Productivity; Social support; Nursing care; Visitors; Workplaces; Emotional support; Data collection; Retaliation; Psychological well being; Debriefing; Mental health

Business indexing term: Subject: Occupational health

Identifier / keyword: Workplace aggression; Workplace violence; Emergency service; Emergency nursing; Qualitative research

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	450-460
Publication year:	2023
Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.015
ProQuest document ID:	2809538603
Document URL:	https://www.proquest.com/scholarly-journals/qualitative-analysis-workplace-assault-outcomes/docview/2809538603/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 21 of 50

Mental Health and Harassment in the Workplace: JEN



ABSTRACT (ENGLISH)

Harassment in the workplace has become all too common in today's society. Acts of uncivil behavior and bullying create stressful and difficult working environments. Individuals or groups are targeted without legitimate cause, thus creating feelings of stress, fear, anger, and anxiety that can affect mental health. Fear of speaking up owing to retaliation allows the uncivil behavior to continue. Emergency nurses should take action to stop the behavior and may need to seek professional help for mental health care.

FULL TEXT

Contribution to Emergency Nursing Practice

- What is already known about this topic? Harassment experienced by emergency nurses in the clinical setting, can be detrimental to their mental health.
- What does this paper add to the currently published literature? This article adds to the current published literature the importance of supporting emergency nurses who are experiencing harassment in the workplace.
- What is the most important implication for clinical practice? The most important implication for emergency nursing is to be empowered to take action to stop harassment in the workplace when witnessing uncivil behavior and bullying.

Introduction

Workplace environments including emergency departments should promote a culture of safety and respect. Unfortunately, that is not always the case for many individuals. Workplace bullying is noted in various settings, from health care to office workers. It has been reported that up to 94% of the workforce within the preceding 5 years was subjected to toxic working environments, with 64% still working in such conditions.¹ The stress of dealing with a toxic working environment can put a toll on the physical and mental health of the emergency nurse. Daily stress affects their job performance, productivity, and lack of interest in daily functions. Absenteeism is common, because the emergency nurse can find it difficult coping going to work on a daily basis; mental health signs of depression, anxiety, and posttraumatic stress disorder are common in toxic working environments. Working environments suffer owing to uncivil behaviors; the loss of well-qualified nurses within the emergency department can contribute to job turnover, and many times leadership either is not aware of the reason employees leave or looks the other way to avoid confrontations.

Case Study: You Are Not Welcome Here

Kim Chan had worked in 3 Magnet teaching hospitals over the course of her 25 years of nursing practice within emergency nursing. She was excited to begin a new position as a nurse educator at the emergency department of a small West Coast hospital after completing her master's in education degree 1 year earlier.

Upon arrival to her new position, Kim was introduced to the emergency department staff. The charge nurse Nancy was abrupt with Kim upon meeting her. Kim decided to give Nancy the benefit of the doubt, because she may have been busy. Nancy had worked in that emergency department for 15 years and had applied for the nurse educator position that was awarded to Kim. Nancy resented Kim for obtaining the job instead of her and made derogatory remarks to other staff members about Kim's suggestions on nursing education and in-services. During Kim's first in-service to the ED staff, Nancy mocked her teaching methods and did not accept the new practice, because "her ED

did things their way and they were not going to change their practice.” One of the emergency nurses explained to Kim the reason Nancy did not like her, disclosing she was a tough nurse and gave the new nurses a hard time. Owing to the toxic work environment created by Nancy, Kim had difficulty performing her role and began developing anxiety about going to work. Her stress level negatively affected her sleep pattern and appetite, and she considered resigning from her position. Kim decided to speak with the nurse manager regarding the situation. The nurse manager listened to Kim’s concerns and stated she would speak to Nancy; however, she was newer to the emergency department although Nancy had been there for an extended time and had a reputation for being difficult. After speaking to the nurse manager, the toxic work environment did not improve. Kim reached out to Human Resources regarding the situation, and she asked to be transferred out of the emergency department, because her physical and mental health were being adversely affected. Human Resources was able to offer Kim another position within the hospital. The nurse manager received additional training on harassment in the workplace, and Nancy received a verbal warning and counseling. If additional complaints of harassment were to be made against Nancy, the next steps, per Human Resources, would be a written warning and possible termination. The emergency department lost an experienced emergency nurse and qualified nurse educator owing to a toxic workplace environment. Kim attended counseling offered by the hospital’s employee assistance program (EAP) to help her cope with the emotional distress she endured during her employment in the emergency department. Kim transferred to her new position as a nurse educator on a medical-surgical unit and remained in the position for 2 years before securing a position at another hospital working as an emergency nurse educator.

Harassment and Bullying

When we discuss uncivil comportment, the terms harassment and bullying are commonly used. The terms are indicative of persistent toxic behavior. Actions of harassment and bullying are used for control; they include demeaning verbal, emotional, and physical acts and abuse of power.² When the emergency nurse or other individuals are related to a protected class defined by sex, age, race, religion, culture, or disability, the behavior can be defined as harassment.² Bullying is defined as repeated ongoing actions aimed at an individual or group with the purpose to cause harm.³ Minority groups are often targeted; this can be regarded as unlawful behavior. Workers in various roles and positions are affected by harassment, and the actions perpetrated against affected workers present in various ways. Online bullying is a form of harassment commonly used. Derogatory, blameful, and demeaning emails undermine the emergency nurse’s ability to be productive by causing them to experience embarrassment and low self-esteem. Emails may be sent to only the individual being bullied or may include others in the workplace; the purpose most often is to falsely blame the receiver for errors and humiliate them. Bullying has been noted as physical harm: pushing, shoving, threatening, stalking, and intimidating. The latter are all actions used to harass coworkers.³ Gossip, false rumors, and inappropriate comments are conducive to workplace harassment.⁴ Sexual harassment and gender-based harassment are common in health care where females are more prone than males to encounter the behavior.⁵ Sexual harassment can be experienced by both sexes through physical advances or comments made directly to the individual and derogatory rumors in the workplace, via email or social media.

Harm of Harassment on Mental Health

Harassment or bullying is harmful to mental health; the emergency nurse subjected to the repeated behavior should act to stop it, because it can cause health issues, affect their performance in the workplace, and negatively affect their personal lives. The anxiety of having to face on a daily basis the individual or group can negatively affect coping mechanisms. The emergency nurse may feel isolated and helpless without support or guidance on how to stop the situation. They also may feel embarrassed and blame themselves for the uncivil behavior.

Effects of Harassment in the Workplace

Workplace bullying promotes social isolation; the affected individual may be excluded from meetings at work and information pertaining to their job function or may be criticized on their work performance.⁴ Most often, the person that performs the uncivil conduct is popular in the workplace, which can cause challenges for the affected individual wanting to speak up. Unfortunately, when the unhealthy bullying behavior goes unaddressed by coworkers, managers, directors, departments of Human Resources, and administrators, the employees actively engaging in these negative behaviors, unchecked, intensify the frequency and worsen their behaviors.

Harassment can be difficult to cope with in the workplace and impacts affected nurses' professional and personal lives. Nonetheless, harassment can be quickly identified and intervened upon in workplace settings. The key to ending harassment begins by acknowledging that an unhealthy work environment exists, confronting the employees fostering this environment, and establishing workplace policies that address expectations of professional conduct. Policies also must include consequences for harassment in the workplace that employees will face if their behavior does not change.

Tips For Employers in Ceasing Workplace Harassment

- Develop workplace policies that provide clear definitions of harassment and bullying behaviors within the workplace and the expectation of employees to demonstrate civility.
- Require all employees to attend annual mandatory training on the identification and reporting of harassment in the workplace.
- Provide orientation for all new hires that includes training about harassment within the workplace.
- Take progressive actions with employees who have been identified as harassing others in the workplace: verbal warning, offer of EAP support (eg, counseling, anger management), warning in writing, mediation (with the affected person), suspension, and termination.
- Provide support to employees (eg, mediation, EAP, time off from work, shift reassignment or transfer within the organization if available as an option and only if requested by the employee) that have been affected by harassment within the workplace.

Seeking Mental Health Care

Sometimes after experiencing harassment, mental health treatment is indicated as part of the recovery process. Employees that have been psychologically affected by workplace harassment should be referred to EAP programs at their workplaces. This referral process should be explained to all emergency nurses and other employees when hired and annually during harassment training. By addressing employees' mental health associated with harassment sustained in the workplace, quality emergency nurses can be retained and the trauma experienced during bullying can be eradicated early. Hence, healing can begin for affected employees and they can successfully move forward in their professions. Unfortunately, interventions were not deployed early enough to retain Kim in the initial emergency department or the hospital.

Conclusion

It is unfortunate that harassment is experienced in the workplace. However, when it is not tolerated or ignored, it can be stopped. Healthy workplaces can be easily achieved through the commitment by employers to put the health and well-being of all of their employees at the forefront of workplace behavioral expectations and adherence to policies that do not tolerate uncivil conduct.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Emergency medical care; Harassment; Employees; Workplaces; Retaliation; Nurses; Emergency services; Bullying; Behavior; Fear & phobias; Mental health services; Mental health care
Business indexing term:	Subject: Employees
Identifier / keyword:	Harassment; Mental health; Workplace; Employees; Employers; Emergency nursing
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	341-344
Publication year:	2023
Publication date:	May 2023
Section:	Clinical
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.011
ProQuest document ID:	2809538599

Document URL: <https://www.proquest.com/scholarly-journals/mental-health-harassment-workplace/docview/2809538599/se-2?accountid=211160>

Copyright: ©2022. Emergency Nurses Association

Last updated: 2023-05-05

Database: Public Health Database

Document 22 of 50

Workplace Violence Emergency Nursing Review Questions: May 2023: JEN

[ProQuest document link](#)

FULL TEXT

These review questions are based on the Emergency Nursing Core Curriculum and other pertinent resources to emergency nursing practice. They offer emergency nurses an opportunity to test their knowledge about their practice.

Questions

1. Preparation of staff to manage workplace violence includes training and education. Which of the following has demonstrated the ability to increase the level of preparedness for workplace violence in the emergency department?
 2. A. Hybrid training programs
 3. B. Online education including video and knowledge testing
 4. C. Classroom-based training
 5. D. All options show positive outcomes

2.

According to research, on average, how often are emergency nurses exposed to workplace violence during working hours?

- A. Every 2 years
- B. Every year
- C. Every 6 months
- D. Every 2 months

3.

When confronted by an angry patient or family member who you suspect has a concealed weapon, the most important thing you should do is:

- A.throw something to distract the individual and run away.
- B.make noise to attract attention from coworkers about a potential threat.
- C.isolate the person until you ascertain if they are armed.
- D.remain calm and allow the individual to express their concerns.

4.

Engineering control strategies and workplace adaptations that minimize risk to health care workers from workplace violence do not include:

- A.bulletproof enclosures for triage areas.
- B.closed-circuit videos of patient waiting and holding areas.
- C.a code word used to inform someone of an incident/threat.
- D.silent alarm systems.

5.

Which is true regarding the prevalence of violence against nursing staff post pandemic in 2022?

- A.Violence against physicians is more common than violence against nurses.
- B.Most assailants are visitors.
- C.Incidents of violence continue to decline since the pandemic.
- D.More than 2 nurses are assaulted every hour.

6.

A patient appears agitated in triage. Which of the following de-escalation techniques would be the best approach for managing this patient?

- A.Call the crisis team to talk with the patient.
- B.Respect your and their personal space.
- C.Elevate your voice to demonstrate your authority.
- D.Do not give the patient your name.

7.

According to Bowie's typology of violence, which type of violence is most commonly seen by emergency nurses?

- A.Intrusive
- B.Consumer

- C.Relationship
- D.Organizational

8.

Which of the following is a true statement concerning workplace violence?

- A.Studies on the use of metal detectors have shown a positive effect on decreasing violence.
- B.A strong security program reduces the risk of injury to health care workers.
- C.Hospitals in high-crime areas have a higher incidence of violence.
- D.Crowding and staff shortages in emergency departments have not been shown to be a cause of increased violence.

9.

A nurse is assaulted in the emergency department. Which of the following is considered best practice following the assault?

- A.The patient or assailant should be removed from the emergency department without treatment.
- B.The nurse should request the hospital security to report the event to appropriate authorities.
- C.The nurse should report the event to law enforcement and hospital administration.
- D.The incident should be recorded as an Emergency Medical Treatment and Active Labor Act (EMTALA) violation if injury has occurred.

10.

Following a workplace violence event, which of the following actions should occur?

- A.Supportive care for the nurse involved should be of top priority.
- B.The nurse should be removed from the area for the period of investigation.
- C.A cooling-off period should occur for staff before an investigation is conducted.
- D.The patient should be denied any further treatment in the facility or department.

Answers

1. Answer: D

According to evidence, the use of any of the listed techniques have some level of positive increase in staff preparedness for workplace violence events. A, B, and C are all correct in this situation, and all have a benefit with violence preparedness.^{1,2}

1. Answer: D

According to data from the Emergency Nurses Association and U.S. Occupational Safety and Health Administration, it is reported that emergency nurses experience workplace violence in either verbal or physical violence situations every 2 months. Unfortunately, many cases of violence are not reported.^{3,4}

1. Answer: D

De-escalation is the recommended first-line response to potential violence and aggression in health care settings. By allowing the individual to express their concerns and remaining calm may de-escalate the violent behavior. Making noise and startling the person may cause further violent behavior and negative actions (A, B). Isolation may also cause further aggression and use of any potential weapons (C).⁵

1. Answer: C

Engineering controls are physical changes that either remove the hazard from the workplace or create a barrier between the worker and the hazard. Code words can be an effective means for communicating potential danger but are considered an administrative intervention. The other selections would be described as engineering controls (A, B, D).⁶

1. Answer: D

According to Press Ganey quarter 2, 2022 reports released in September 2022, violence against nursing staff is at an all-time high, reaching epidemic proportions. The Press Ganey report surveyed 483 facilities across the United States and revealed that more than 2 nurses were assaulted every hour, equaling more than 5000 assaulted nurses. According to the U.S. National Institute for Occupational Safety and Health, of all health care workers, nurses and those providing direct patient care are most at risk for violence (A). Most assailants are patients (B). Incidents of violence against nurses continue to rise since the pandemic (C).⁷

1. Answer: B

A demonstrated de-escalation technique involves giving respect to the patient and your and their personal space. Crowding the patient may increase their tendency toward violence. It is suggested to have only one person deal with the patient and talk with them, avoiding a crowd (A). Elevation of your voice could further escalate the tendency for violent behavior (C). Active listening should be employed. It is recommended to introduce yourself and your role in their care in a professional manner (D).⁸

1. Answer: B

Consumer violence involves acts of violence based on employee and consumer relationships. Consumer violence is the most common type of violence experienced by emergency nurses and takes place while they are providing care for their patients. Intrusive violence involves assailants with no legitimate relationships to the place of business (A). Relationship violence includes aggressive acts among coworkers (C). Organizational violence is characterized by employers ignoring known aggressive behaviors and violent situations in the workplace (D).⁹

1. Answer: B

A strong and effective security program has been shown to reduce the risk of injury to health care workers. The program should be well visible, well planned, and actively involved in the department operations. Metal detectors are not effective for physical violence (A). Hospitals in high-crime areas have not shown to be more likely to experience violence (C). Many variables have shown to increase the incidence for workplace violence including overcrowding and long wait times because of staffing issues (D).⁸

1. Answer: C

One person intentionally assaulting another person is a crime and should be reported to law enforcement and hospital administration. Further investigation should occur as to the nature and cause of the crime. The patient's

treatment may be delayed until the situation is safe, but the patient cannot be refused treatment, which could constitute an EMTALA violation (A). Although the nurse should work with security to assure safety for the staff and the department, the involved nurse should report the event and not have someone else do it for them (B). The EMTALA violation could occur by the hospital if the patient is refused treatment (D).⁸

1. Answer: A

Following any potential or actual violent event in the department, the nurse or staff involved should receive appropriate supportive care. Compassionate care for the nurse after a significant event can decrease the potential negative effects of violence (A). The nurse should not be disciplined or removed from the work area, as support by colleagues is essential (B). Appropriate investigations should begin immediately to obtain all facts and develop any plans for interventions (C). EMTALA violations could occur if patients are refused medical treatment by a facility (D).⁸

DETAILS

Subject:	Patients; Emergency medical care; Workers; Metal detectors; Workplace violence; Aggressiveness; Law enforcement; Assaults; Pandemics; Medical personnel; Workplaces; Occupational safety; Emergency services; Treatment refusal; Criminal investigations; Core curriculum; Nursing; Security programs; Nurses
Business indexing term:	Subject: Workers Workplace violence Occupational safety
Location:	United States--US
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	333-335
Publication year:	2023
Publication date:	May 2023
Section:	Emergency Nursing Review Questions
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966

Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.003
ProQuest document ID:	2809538597
Document URL:	https://www.proquest.com/scholarly-journals/workplace-violence-emergency-nursing-review/docview/2809538597/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 23 of 50

A Systematic Review of Violence Risk Assessment Tools Currently Used in Emergency Care Settings: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Violence risk assessment is commonplace in mental health settings and is gradually being used in emergency care. The aim of this review was to explore the efficacy of undertaking violence risk assessment in reducing patient violence and to identify which tool(s), if any, are best placed to do so.

Methods

CINAHL, Embase, Medline, and Web of Science database searches were supplemented with a search of Google Scholar. Risk of bias assessments were made for intervention studies, and the quality of tool development/testing studies was assessed against scale development criteria. Narrative synthesis was undertaken.

Results

Eight studies were included. Three existing violence risk assessment tools featured across the studies, all of which were developed for use with mental health patients. Three newly developed tools were developed for emergency care, and 1 additional tool was an adaptation of an extant tool. Where tested, the tools demonstrated that they were able to predict patient violence, but did not reduce restraint use. The quality issues of the studies are a significant limitation and highlight the need for additional research in this area.

Discussion

There is a paucity of high-quality evidence evaluating the psychometric properties of violence risk assessment tools currently used along the emergency care pathway. Multiple tools exist, and they could have a role in reducing

violence in emergency care. However, the limited testing of their psychometric properties, acceptability, feasibility, and usability in emergency care means that it is not possible to favor one tool over another until further research is conducted.

FULL TEXT

Contribution to Emergency Nursing Practice

- Workplace violence is common in emergency care settings and has negative consequences for patients, staff, and services. Structured violence risk assessment is commonplace in mental health settings and is gradually becoming more accepted within emergency care.
- This review has found that violence risk assessment tools may be feasible for use in emergency department. There is currently, however, insufficient high-quality evidence to draw conclusions about the predictive capability of these tools in emergency care settings.
- Violence risk assessment can identify patients in emergency care who are at risk of becoming violent, but the evidence to support choosing one tool over another is not yet available. Further research using these tools in emergency settings is needed before evidence-based recommendations can be made.

Introduction

Globally, staff working in emergency care settings experience violence from patients and visitors at a disproportionate rate. A recent international systematic review and meta-analysis¹ found that emergency departments had the highest 12-month prevalence of violence across all hospital settings. The same review found that nurses had the highest exposure to violence across occupational groups. For the purposes of our study, we use the term violence to describe any nonverbal, verbal, or physical behavior exhibited by a person that makes it difficult to deliver good care safely.² Staff working in emergency department appear resigned to the inevitability of experiencing such violence.³

Workplace violence has wide-ranging detrimental consequences.⁴ Staff absence because of the physical or emotional effects of workplace violence has significant financial implications.⁵ It is estimated that 2% of staff are lost as a consequence of workplace violence, leading to significant recruitment costs.⁶ Violence also causes disruptions to patient care, with nurses losing concentration and working at reduced efficiency⁷ and functioning at a heightened level of anxiety.⁸ Violence also is associated with task delays and medication errors.⁹

Several structured tools have been developed to aid risk assessment of imminent violence, most commonly in mental health settings, but they are being used increasingly in other areas.¹⁰⁻¹² A recent scoping review by Cabilan and Johnston¹³ identified 5 violence risk assessment tools with a history of use in ED settings; however, the review reported that 3 lacked any evidence of predictive validity. In fact, of the 5 tools identified, only 1, the Brøset Violence Checklist (BVC),¹⁴ was intended for use as a risk assessment prediction tool rather than an aide memoire and was the only one whose psychometric properties were evaluated in an emergency care setting. The BVC was developed, and has been used with some success, to predict violence in mental health settings.¹⁵

With evidence that violence risk assessment tools are gradually finding their way into emergency care,¹⁶ it is important not only to identify those that have been implemented but also to establish which tools are practical and effective. Therefore, we aimed to examine the psychometric properties, acceptability, feasibility, and usability of violence risk assessment tools that have been evaluated in emergency care. For the purposes of this review, the constructs of acceptability, feasibility, and usability will be interpreted broadly, respectively, relating to factors affecting users' willingness to adopt interventions, individual or structural factors affecting the extent to which

interventions can be implemented effectively, and factors pertaining to the user experience.¹⁷ In doing so, we aimed to explore the efficacy of undertaking violence risk assessment in predicting and reducing patient violence and to identify which tool(s), if any, are best placed to do so.

Methods Design

We undertook a systematic review; our reporting follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.¹⁸ The protocol for this review was registered at the International Prospective Register of Ongoing Systematic Reviews (CRD42021285461). The protocol was registered as a rapid review, but during conduct of the review, the team agreed that a full systematic review was preferable and achievable within existing resources.

Eligibility Criteria

Eligible studies were (1) primary research; (2) published in peer-reviewed journals; (3) in English language; (4) published since 2007 (the earliest publication date of the tools identified by Cabilan and Johnston¹³); (5) evaluations of the psychometric properties, acceptability, feasibility, or usability of violence risk assessment tools; and (6) focused on emergency care pathways (emergency department and acute medical units [AMUs] or equivalent: for example, admission areas for acute medical patients with a length of stay up to 48 hours). Studies within specialist emergency care pathways (eg, pediatric, psychiatric) were excluded. For the purposes of our review, “violence” refers to both actual and threatened physical acts or verbal abuse perpetrated by emergency attendees (patients or their relatives/friends/companions) against others or objects.

As the broad constructs of feasibility, usability, and acceptability can be captured by both quantitative and qualitative data, we did not exclude any primary research studies based on methodological approach alone.

Search Strategy

A study by Bramer et al¹⁹ found that optimal searches in systematic reviews should include the following databases: Embase, Medline, Web of Science, and Google Scholar. Accordingly, we used these 4 databases for our searches and added Cumulative Index to Nursing and Allied Health Literature Plus to ensure that we captured relevant nursing literature. Owing to the limited search functionality of Google Scholar, we only screened the first 200 references identified by this database, ranked by relevance.¹⁹ Our search strategy was based on Cabilan and Johnston’s¹³ strategy but was amended to capture literature related to our broader conceptualization of the emergency care pathway and to the relevant properties of tools identified. Our search terms were mapped according to the population or problem, intervention, comparison, outcomes, context framework (Table 1), see Supplementary Tables 1-4 for full search terms.

Searches were undertaken in October 2021 and supplemented by regular ongoing searches for keyword terms via Google Scholar until July 2022. In addition, the authors of any relevant articles that were not published in peer-reviewed journals (eg, dissertations) were contacted to ensure that we did not miss any work they might have published. Screening by title and abstract was undertaken independently by 2 reviewers (D.S. and N.H.), with 1 reviewer (D.S.) then completing full-text screening. The shortlist of papers possibly eligible for inclusion was screened by a third reviewer (L.L.D.). Forward and backward chain searching was conducted on all eligible papers.

Risk of Bias and Quality Assessment

All intervention studies were assessed for risk of bias using the Risk of Bias in Non-randomized Studies of Interventions tool.²⁰ The studies that described tool development/testing were assessed against scale development criteria described by Boateng et al²¹; criteria relating to factors and dimensionality were removed as these were not relevant to the development of risk assessment tools. Quality assessment of included studies was undertaken by D.S. and N.H. and checked by L.L.D. and G.D.

Data Extraction and Synthesis

Data were extracted by D.S. and checked independently by N.H. As presented in our protocol, predefined subheadings were amended and/or discarded as appropriate. These decisions were initially made by D.S. and later discussed with the whole team until consensus was reached.

Because of methodological and clinical heterogeneity in the included studies, we were unable to undertake a statistical meta-analysis; therefore, narrative synthesis was undertaken. Statistical information about predictive efficacy, interrater reliability, and intervention efficacy were extracted. Predictive efficacy data included sensitivity and specificity (true positive and true negative cases as proportions of all positive and negative predictions, respectively), positive predictive validity (odds of those predicted to be violent who actually went on to be violent), area under the receiver operating characteristic curve (AUC; a summary statistic [range 0-1] of a tool's overall ability to discriminate between positive and negative cases; interpretation AUC = 0.5 equivalent to chance, 0.7-0.79 acceptable, 0.8-0.89 excellent, 9.0-1.0 outstanding), and odds ratios (the odds that an individual who is violent was assessed as at increased risk of violence compared with the odds that a nonviolent individual was assessed as not at increased risk of violence). Information was extracted for all cut-off points reported. Information about interrater reliability involved kappa, a measure of agreement between independent raters: 0.40 to 0.59 = weak agreement, 0.60 to 0.79 = moderate agreement, 0.80 to 0.90 = strong agreement, and above 0.90 is almost perfect.²² Information about intervention efficacy included *P* values indicating statistical significance and relative risk for all outcomes reported. Data about the feasibility and usability of tools were extracted where available.

Results Search Outcome

As a result of the search strategy, 8 studies were deemed eligible for inclusion (Figure).

Summary of Included Studies

Of the 8 included studies, 2 used cohort designs, of which 1 was retrospective²³ and 1 prospective¹⁶; 2 used quality improvement designs^{24,25}; 1 used a before-and-after design²⁶; 1 used tool development methods²⁷; 1 tested a tool²⁸; and 1 used nonparticipant observation.²⁹ Four studies were deemed intervention studies, with various outcomes,²³⁻²⁶ whereas 4 aimed to test/develop tools.^{16,27-29} Seven studies were conducted entirely in emergency departments, and 1²⁹ included observations of which 82.4% of the observations were conducted in the emergency department. No studies took place in AMUs or equivalent. Four studies were conducted in Australia^{16,26,27,29} and 4 in the United States.^{23-25,28}

Violence Risk Assessment Tools

Three of the studies described the development and testing of new risk assessment tools.^{24,27,29} These were all created for use within emergency care pathways. One was created using extant literature and expert opinion (Queensland Occupational Violence Patient Risk Assessment tOol [QOVPRAO])²⁷; 1 supplemented this approach with chart audits, (Emergent Documentation Aggression Rating Tool [EDART])²⁴; and 1 used nonparticipant observation (Violence Assessment Tool [VAT]).²⁹ Four studies tested existing tools: the Behavioral Activity Rating Scale (BARS),^{23,25} the BVC,¹⁶ and the Dynamic Appraisal of Situational Aggression (DASA)²⁸ (Table 2). The final study combined the BVC with a response framework for use in the emergency department to create the behaviors of concern (BOC) chart.²⁶ All of the existing tools were originally developed either for use in mental health settings (BVC, DASA) or for use with patients with psychosis (BARS).

Quality of Included Studies

Four studies were assessed for risk of bias,²³⁻²⁶ and all were deemed at serious risk (Table 3). Although no studies were excluded based on quality, we were unable to include data from 2 studies in our syntheses of predictive efficacy, validity, and reliability owing to serious risk of confounding. Schumacher et al²³ measured the predictive validity of

the BARS in relation to administration of behavioral management (ie, sedation or physical restraint). However, these interventions were prescribed by medical staff on the basis of BARS scores, thus ensuring a circular relationship where the outcome was inevitable if the predictor was positive. A similar confounder was noted in the quality improvement project described by Legambi et al,²⁵ where preassessment and postassessment data were collected on restraint use. The BARS was incorporated into the electronic health record, which automatically prompted staff to apply restraints on patients who scored 7 (violent). Although all studies were at low risk of bias in classification of interventions because risk assessment was routinely recorded, they were all at moderate to serious risk of bias owing to deviation from intended intervention. The 2 studies at moderate risk either did not provide adequate information on how nurses decided to undertake risk assessment²⁵ or only assessed patients once rather than at regular intervals.²³ The other 2 studies had more serious issues. Campbell et al²⁴ did not report whether restrained patients had been risk-assessed. Risk assessment occurred before the intervention as reported by Senz et al²⁶ as well as after, but no detail was provided about differences in how risk assessment occurred pre- or post-test. Two studies detailed tool development,^{27,29} and 2 tested pre-existing tools^{16,28} (Table 4). Items for the newly developed tools were generated within emergency settings, through observation²⁹ and from the literature,²⁷ whereas items for the preexisting tools were generated in mental health settings.^{16,28} Similarly, content validity and pretesting of questions occurred in mental health settings for the preexisting tools,^{16,28} thus raising some concerns as neither tool was tested for these within the emergency care context. Researchers administered the tools in the development studies through observations²⁹ and from electronic records.²⁷

Data Synthesis

Studies were grouped by risk assessment tool; however, only 2 tools featured in more than 1 study (the BARS and the BVC). The psychometric properties of the tools, where available, are presented in Table 5.

BARS

Legambi et al²⁵ examined restraint use before and after implementation of the BARS and found a nonsignificant difference. During the final weeks of BARS implementation, they administered the System Usability Scale (SUS) to emergency nurses. From 30 (31% response rate) responses, the BARS received a high SUS score (83.46; SD = 11.73), indicating good usability (citing Usability.gov, the authors note that SUS scores greater than 68 indicate good usability, even with a small sample size). However, only 13 (43%) reported feeling as though the BARS helped them to better detect and manage behavioral health patients (the primary target group requiring BARS assessment in the study emergency department). In their review of patient records, Schumacher et al²³ found that only 46% of patients with a psychiatric complaint received a BARS rating at triage, indicating low adoption of the tool.

BVC/BOC

Partridge and Affleck¹⁶ calculated positive likelihood ratios (odds ratios) for the BVC using cut-off scores of 1, 2, and 3. Their findings showed that violent patients were 71.4 times more likely to have a score of ≥ 3 than nonviolent patients; they were 30.3 times more likely to have a score of ≥ 2 and 11.6 times more likely to have a score of ≥ 1 . The study found a predictive value of 16.7% for scores ≥ 1 , 34.3% for scores ≥ 2 , and 55.2% for scores ≥ 3 . This means that more than half the patients who scored 3 or more would go on to exhibit violent behaviors. When using 3 as a cut-off for BVC scores to indicate high risk of violence, sensitivity was 45.7%, and specificity was 99.4%, meaning that just under half of all violent patients and nearly all nonviolent patients were identified by the BVC. Before implementation of the BOC, violence risk assessment was documented 30% of the time; after implementation, this increased to 82%.²⁶ Furthermore, before implementation, violence risk assessment was documented 54% of the time for patients with a mental health or drug and alcohol presentation, increasing to 100% after implementation. Senz et al²⁶ did not assess usability of the BOC; however, they explored nurses' confidence

and abilities in a before-and-after survey. Despite statistically significant improvements in confidence to perform risk screening, there was no change in perceived ability to prevent violence.

DASA

Connor et al²⁸ calculated positive and negative predictive values for the DASA, comparing scores of ≥ 1 with scores of 0. They found that 23% of patients with a score of ≥ 1 would go on to be violent, and 95% of patients with a score of 0 would not exhibit violent behaviors. The summary AUC score of 0.79 fell in the “acceptable” category.

EDART

Campbell et al²⁴ found no statistically significant difference in restraint use before and after implementation of the EDART as assessed by a logistic interrupted time series model with time $F = 2.01$, $P = .13$.²⁴ To explore the usability of the EDART, a survey was administered to emergency nurses 3 months into the study’s implementation phase, receiving responses from 30 participants (62.5% response rate). Feedback about the EDART was overwhelmingly positive, with all respondents agreeing that the tool was easy to use and 28 of 30 reporting that the tool increased their ability to offer early interventions.

QOVPRAO

In the development of the QOVPRAO, Cabilan et al²⁷ found that of the 34 risk items forwarded to end users for relevance rating, 5 achieved a relevant item-level content validity index (I-CVI) (≥ 0.78), with consensus moderation used to direct the inclusion of additional risk items (despite achieving I-CVI scores below the 0.78 threshold). However, in a second round of content validity to rate the relevance of each of the tool’s 3 risk domains, all 3 achieved I-CVIs above the 0.78 threshold. Sensitivity for the QOVPRAO domains ranged from 22% for aggression history to 55% for concerns with clinical presentation; specificity was high for all (92%-98%). The AUC using risk rating of low (no risk domains present), moderate (1 risk domain present), and high (≥ 2 risk domains present) for the QOVPRAO indicated acceptable predictive validity (AUC = 0.77). Testing interrater reliability between a trained and an untrained assessor, the analysis revealed kappa values ranging from 0.60 to 0.75 for the tool’s 3 domains ($P < .001$).

VAT

Jackson et al²⁹ examined the association between the 18 behavioral cues in the VAT and subsequent violence. Patients who resisted health care were 11 times more likely to exhibit violent behaviors than those who did not; those who made aggressive statements were 7.2 times more likely; those who yelled were 6.8 times more likely; and those who used abusive language were 6.0 times more likely.

Discussion

This review identified 8 studies that evaluated the psychometric properties of 7 violence risk assessment tools in emergency departments. The tools were either originally developed in mental health settings or specifically for ED settings. Only 2 tools, the BARS and the BVC, featured in more than 1 study, limiting our ability to pool results. Our findings also are limited by the quality of the included studies, with some suffering from significant methodological flaws such as unmeasured confounding variables and deviations from the intended intervention(s). However, our review addresses an important gap in the literature. The paucity of evidence about these tools’ performance in emergency settings stands in contrast to the significant body of literature on violent risk assessment in psychiatric settings,¹⁵ despite the similarities in violence prevalence across these settings.³²

Only 2 studies examined predictive validity, 1 each of the DASA and the QOVPRAO,^{27,28} with both tools demonstrating moderate performance. In studies of the DASA in mental health settings, results have ranged from acceptable to outstanding,³³⁻³⁵ reflecting similar findings to the 2 studies in this review. However, the clinical context should be factored into any comparisons drawn with findings from ED settings. Violence risk assessment does not occur in a vacuum. In psychiatric inpatient settings, where the DASA and BVC have seen most use and evaluation,

patients are risk-assessed repeatedly throughout an inpatient stay, which will typically be much longer than in emergency care settings. Clinicians' familiarity with patients is likely to factor into their interpretation of patient behaviors and characteristics,³⁶ and the nature of violent incidents also may differ across these very different clinical contexts.³⁷ This underpins the importance of evaluating tools in the settings where they will be implemented, particularly as clinician expertise, preferences, and needs also will differ.

Clinical approaches to risk assessment, which involve unstructured clinical judgment, are largely subjective and reliant on the assessor's expertise, whereas actuarial approaches aim to eliminate bias by standardizing all aspects of the assessment. In mental health settings, this polarity has been somewhat addressed by the introduction of structured professional judgment approaches, which combine ratings of empirically derived risk factors together with consideration of idiosyncratic individual factors, eg, Short Term Assessment of Risk and Treatability.³⁸ Consideration could be given to the development of such approaches in the emergency department.

The tools included in this review all use an actuarial approach, although, as Doyle and Dolan³⁹ note, all risk assessment involves a degree of subjectivity. Only 1 study²⁷ evaluated interrater reliability, reporting moderate results. Some scholars have proposed that a combined clinical-actuarial approach would be optimal for ED settings, allowing clinicians to use the empirical categories set out in an actuarial tool to aid, rather than replace, clinical judgment.⁴⁰ In contrast, emergency nurses have expressed the need for a standardized tool that focuses on objective risk factors, particularly as ED risk assessments must be rapid.¹³ Other studies have similarly concluded that clinicians prefer risk assessment to contain an element of structure, with some suggesting that reliance on clinical judgment alone puts less experienced staff at a disadvantage.⁴¹ In fact, numerous studies have found that staff with less experience (both clinically and in the emergency department specifically) are more likely to experience patient violence in emergency settings.^{42,43} Cabilan et al²⁷ point out that a structured approach to risk assessment does not preclude sensitivity to context and argue that a multidimensional approach, addressing both static and dynamic risk factors, is most appropriate.

Even if a tool improves violence prediction, if it is not implemented properly, it is essentially useless. We found variability in levels of implementation but cannot identify why this was the case. Usability of the BARS and the EDART were examined, with both reporting positive findings,^{24,25} whereas an evaluation of nurses' confidence and perceived ability to prevent violence before and after implementation of the BOC reported mixed findings.²⁶ None of the included studies explicitly assessed feasibility or acceptability. Whereas lengthy risk assessment tools may be impractical in ED settings,²⁷ the BARS, a single-item tool, had low adoption.^{23,25} Lack of understanding and enthusiasm for the tool were cited as possible reasons for this outcome, perhaps pointing to the importance of a strong implementation strategy.²³

The true success of these tools should, of course, ultimately be measured in terms of reductions in violence rather than simply its prediction. Patient violence is harmful in and of itself, yet the interventions used to manage patient violence can be equally damaging. The use of physical, mechanical, and chemical restraint can be physically and psychologically harmful to all involved.⁴⁴ This review found no or nonsignificant reductions in violence after tool implementation, but this is based on limited and poor-quality evidence, so no firm conclusions can be drawn.

Measuring outcomes in terms of restraint use or emergency security responses is, in our view, mistaken because the aim of prediction is to facilitate the early intervention of less coercive measures.

The only strong recommendation that we can make as a result of this review is about what needs to be done to address our identified gap in the literature. Ideally, large-scale, multisite randomized controlled trials are needed to provide good-quality evidence on the use of violence risk assessment tools in emergency settings, exploring their efficacy in terms of predicting and also reducing violent incidents. Based on the recency of the included literature, we

anticipate that small-scale studies will continue to proliferate, and we hope that in the not-too-distant future, systematic review with meta-analysis will be achievable.

Strengths and Limitations

The strength of our findings is limited by the quality of the included studies. However, the lack of strong evidence in this area is a significant finding in itself. By excluding unpublished literature, we may have missed relevant research, although we sought to mitigate this by directly contacting the authors of all relevant unpublished literature to ascertain whether the work was taken further. Finally, the generalizability of our results is limited by the geographical distribution of our included studies, which were all conducted in the United States or Australia. Given the significant body of literature exploring patient violence globally,³² it was disappointing that we could not capture any evidence about violence risk assessment more widely. Similarly, the fact that no studies took place in the AMU limits the assumptions we can make about the tools' suitability for this clinical area. By uncovering these gaps in the literature, this review has highlighted important areas for future research.

Implications for Emergency Nursing

Violence risk assessment can identify patients in emergency care settings who are at risk of becoming violent. However, there is currently insufficient high-quality evidence to draw conclusions about the predictive capacity, acceptability, feasibility, and usability of existing tools in emergency care settings. In the meantime, researchers and emergency nurses looking to implement violence risk assessment strategies should take steps to ensure a strong implementation strategy to maximize uptake. Such strategies may include the use of a violence risk assessment tool, and, in the absence of any strong evidence for choosing one over another, we recommend choosing the tool that aligns most strongly with the specific context it will be used in.

Conclusion

Patient-perpetrated violence is a significant problem in emergency care settings globally. Despite its prevalence, there is a paucity of high-quality evidence evaluating the psychometric properties of violence risk assessment tools currently used along the emergency care pathway. Multiple tools exist, however, and the recency of much of the evidence evaluating their effectiveness indicates that this clinical issue is gaining traction. There is a long way to go before violence risk assessment is as established in emergency care settings as it is in mental health settings. Finding out which tools are most effective in predicting and preventing violence would be a good starting point; the evidence to support choosing one tool over another is not yet available, but the evidence from this review suggests that we are well on our way.

Data, Code, and Research Materials Availability

We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing, we confirm that we have followed the regulations of our institutions concerning intellectual property.

Author Disclosures

Conflicts of interest: None to report.

The study from which this review came, the "Violence in acute medical units and emergency departments (VoicED)" study, was funded by the Clive Richards Foundation, previously the Clive and Sylvia Richards Charity, Hereford, UK [grant number CSRC200135]. The funding comprised salary for a research associate as well as transcription and dissemination costs. Funding was not related to any specific research activity.

Appendix

Google Scholar



NB. 256 character limit

2007-2021: ((risk AND assess) OR (risk AND tool) OR (risk AND instrument)) AND (emergency OR “acute medical unit”) AND (violence OR aggression OR assault OR attack OR abuse) AND (psychometric OR validity OR reliability OR predictability OR feasibility OR usability)

Results then limited to top 200 (by relevance)

DATABASE: MEDLINE		
Search terms:		
1	Subject headings	Risk assessment
Keywords	<p>risk* adj3 assess*, risk* adj3 screen*, risk* adj3 checklist*, risk* adj3 tool*, risk* adj3 scale*, risk* adj3 measur*, risk* adj3 instrument*, "Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing", STAMP, "17-cue assessment tool", "17-cue violence assessment tool", "Staring, Tone, Anxiety, Mumbling, Pacing, Emotions, Disease progress, Assertive, Resources", STAMPEDAR, "Violence Risk Screen Decision Support in triage", VRSDSiT, "Broset Violence Checklist", BVC</p> <p>AND</p>	2
Subject headings	Emergency Medical Services, Emergency Service Hospital [exp]	Keywords

<p>"emergency room*", "emergency department*", "emergency service*", "emergency ward*", "emergency care", "accident and emergency", "accident & emergency", "emergency health service*", triag*, "ED", "ER", "A&E", "acute medical unit*", "AMU", "clinical decision unit*", "CDU", "acute admissions unit*", "acute assessment unit*", "AAU", "acute medical receiving unit*", "AMRU", "assessment and diagnostic unit*", "ADU", "emergency assessment unit*", "EAU", "emergency care unit*", "ECU", "EMAU", "medical assessment unit*", "MAU", "medical assessment and planning unit*", "MAPU", "medical admissions unit*"</p> <p>AND</p>	3	Subject headings
<p>Workplace violence, Aggression [exp], Violence</p>	Keywords	<p>violen*, aggress*, assault*, attack*, harass*, verbal adj3 abus*, physical adj3 abus*, "verbal hostility"</p> <p>AND</p>
4	Subject headings	Psychometrics, Reproducibility of results [exp]
Keywords	<p>"psychometric properties", valid*, reliab*, "internal* consisten*", feasib*, acceptab*, usab*, predict*, evaluat*</p>	Key: Commas indicate terms combined with OR; [exp] = search term exploded

DATABASE: Embase		
Search terms:		
1	Subject headings	Risk assessment [exp]

Keywords	<p>risk* adj3 assess*, risk* adj3 screen*, risk* adj3 checklist*, risk* adj3 tool*, risk* adj3 scale*, risk* adj3 measur*, risk* adj3 instrument*, "Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing", STAMP, "17-cue assessment tool", "17-cue violence assessment tool", "Staring, Tone, Anxiety, Mumbling, Pacing, Emotions, Disease progress, Assertive, Resources", STAMPEDAR, "Violence Risk Screen Decision Support in triage", VRSDSiT, "Broset Violence Checklist", BVC</p> <p>AND</p>	2
Subject headings	Emergency Health Service [exp], Emergency Ward [exp]	Keywords
<p>"emergency room*", "emergency department*", "emergency service*", "emergency ward*", "emergency care", "accident and emergency", "accident & emergency", "emergency health service*", "triag*", "ED", "ER", "A&E", "acute medical unit*", "AMU", "clinical decision unit*", "CDU", "acute admissions unit*", "acute assessment unit*", "AAU", "acute medical receiving unit*", "AMRU", "assessment and diagnostic unit*", "ADU", "emergency assessment unit*", "EAU", "emergency care unit*", "ECU", "EMAU", "medical assessment unit*", "MAU", "medical assessment and planning unit*", "MAPU", "medical admissions unit*"</p> <p>AND</p>	3	Subject headings

Workplace violence {prevention}, Aggression {prevention}, Violence {prevention}, Verbal hostility {prevention}, Assault {prevention}	Keywords	violen*, aggress*, assault*, attack*, harass*, verbal* adj3 abus*, physical* adj3 abus*, "verbal hostility" AND
4	Subject headings	Psychometry [exp], Reproducibility [exp], Validity [exp], Reliability [exp], Usability
Keywords	"psychometric properties", valid*, reliab*, "internal* consisten*", feasib*, acceptab*, usab*, predict*, evaluat*	Key: Commas indicate terms combined with OR; [exp] = search term exploded; {text in braces} = subheadings selected (NB. where not specified, all subheadings were included)

DATABASE: Web of Science	
Search terms:	
1	AND (TS=(risk* NEAR/3 assess*) OR TS=(risk* NEAR/3 screen*) OR TS=(risk* NEAR/3 checklist*) OR TS=(risk* NEAR/3 tool*) OR TS=(risk* NEAR/3 scale*) OR TS=(risk* NEAR/3 measur*) OR TS=(risk* NEAR/3 instrument*) OR TS=("Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing") OR TS=(STAMP) OR TS=("17-cue assessment tool") OR TS=("17-cue violence assessment tool") OR TS=("Staring, Tone, Anxiety, Mumbling, Pacing, Emotions, Disease progress, Assertive, Resources") OR TS=(STAMPEDAR) OR TS=("Violence Risk Screen Decision Support in triage") OR TS=(VRSDSiT) OR TS=("Broset Violence Checklist") OR TS=(BVC))

2	<p>AND (TS=("emergency room*") OR TS=("emergency department*") OR TS=("emergency service*") OR TS=("emergency ward*") OR TS=("emergency care") OR TS=("accident and emergency") OR TS=("accident &emergency") OR TS=("emergency health service*") OR TS=("ED") OR TS=("ER") OR TS=("A&E") OR TS=("acute medical unit*") OR TS=("AMU") OR TS=("clinical decision unit*") OR TS=("CDU") OR TS=("acute admissions unit*") OR TS=("acute assessment unit*") OR TS=("AAU") OR TS=("acute medical receiving unit*") OR TS=("AMRU") OR TS=("assessment and diagnostic unit*") OR TS=("ADU") OR TS=("emergency assessment unit*") OR TS=("EAU") OR TS=("emergency care unit*") OR TS=("ECU") OR TS=("EMAU") OR TS=("medical assessment unit*") OR TS=("MAU") OR TS=("medical assessment and planning unit*") OR TS=("MAPU") OR TS=("medical admissions unit*"))</p>
3	AND
4	<p>(TS=("psychometric properties") OR TS=(valid*) OR TS=(reliab*) OR TS=("internal* consisten*") OR TS=(feasib*) OR TS=(acceptab*) OR TS=(usab*) OR TS=(predict*) OR TS=(evaluat*))</p>
Key: TS = Searched in 'Topic' field	

DATABASE: CINAHL Plus		
Search terms:		
1	Subject headings	Risk assessment, Clinical assessment tools

<p>Keywords</p>	<p>risk* adj3 assess*, risk* adj3 screen*, risk* adj3 checklist*, risk* adj3 tool*, risk* adj3 scale*, risk* adj3 measur*, risk* adj3 instrument*, "Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing", STAMP, "17-cue assessment tool", "17-cue violence assessment tool", "Staring, Tone, Anxiety, Mumbling, Pacing, Emotions, Disease progress, Assertive, Resources", STAMPEDAR, "Violence Risk Screen Decision Support in triage", VRSDSiT, "Broset Violence Checklist", BVC</p> <p>AND</p>	<p>2</p>
<p>Subject headings</p>	<p>Emergency Service, Emergency Medical Services</p>	<p>Keywords</p>
<p>"emergency room*", "emergency department*", "emergency service*", "emergency ward*", "emergency care", "accident and emergency", "accident &emergency", "emergency health service*", "triag*", "ED", "ER", "A&E", "acute medical unit*", "AMU", "clinical decision unit*", "CDU", "acute admissions unit*", "acute assessment unit*", "AAU", "acute medical receiving unit*", "AMRU", "assessment and diagnostic unit*", "ADU", "emergency assessment unit*", "EAU", "emergency care unit*", "ECU", "EMAU", "medical assessment unit*", "MAU", "medical assessment and planning unit*", "MAPU", "medical admissions unit*"</p> <p>AND</p>	<p>3</p>	<p>Subject headings</p>

Workplace violence, Aggression, Violence, Verbal abuse, Patient assault, Assault and battery	Keywords	violen*, aggress*, assault*, attack*, harass*, verbal adj3 abus*, physical adj3 abus*, "verbal hostility" AND
4	Subject headings	Psychometrics, Measurement issues and assessments [exp]
Keywords	"psychometric properties", valid*, reliab*, "internal* consisten*", feasib*, acceptab*, usab*, predict*, evaluat*	Key: Commas indicate terms combined with OR; [exp] = search term exploded

Supplementary Data

Supplementary Data

Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jen.2022.11.006>.

Criterion	Description
Population or problem	Violence toward others, perpetrated by emergency care attendees
Intervention	Structured risk assessment tools
Comparison	Not applicable
Outcomes	Psychometric properties (including validity, reliability, internal consistency and predictive validity), feasibility, usability, and acceptability
Context	Emergency care pathways

Tool	Included studies; developed by (if different)	Development setting/country	Content	Scoring	Interpretation	Risk management
------	---	-----------------------------	---------	---------	----------------	-----------------

Behavioral Activity Rating Scale	Legambi et al, ²⁵ Schumacher et al ²³ ; Swift et al ³⁰	Setting not stated (developed to evaluate the effect of psychotropic medication on agitated behavior in patients experiencing psychosis), United States	Single-item question consisting of 7 categories: 1 = difficult or unable to rouse; 2 = asleep, but responds normally to verbal or physical contact; 3 = drowsy, appears sedated; 4 = quiet and awake (normal level of activity); 5 = signs of overt (physical or verbal) activity, calms down with instruction; 6 = extremely or continuously active, not requiring restraint; 7 = violent, requires restraint	1-7	1-4 = nonresponsive/ no agitation 5-7 = increasing severity of agitation	None identified
BVC/BOC	BVC: Partridge and Affleck ¹⁶ ; Almvik and Woods ¹⁴ BOC: Senz et al ²⁶	BVC: secure mental health, Norway BOC: additional management matrix developed in emergency department, Australia	Six items: - confusion - irritability - boisterousness - physical threats - verbal threats - attacking objects	Each item scored 0 (absent) or 1 (present)	BVC 0 = low risk 1-2 = moderate risk ≥3 = high risk BOC 0 = low risk 1 = moderate risk ≥2 = high risk	BVC: None identified BOC: interventions identified for each level of risk by: general, nursing, medical, security

Dynamic Appraisal of Situational Aggression	Connor et al ²⁸ ; Ogloff and Daffern ³¹	Secure mental health, Australia	Seven items: -irritability -impulsivity -unwillingness to follow directions -sensitivity to perceived provocation -easily angered -negative attitudes -verbal threats	Each item scored 0 (normal for patient) or 1 (increase in described behavior)	0-1 = low risk 2-3 = moderate risk >3 = high risk	None identified
Emergent Documentation Aggression Rating tool	Campbell et al ²⁴	Emergency department, United States	Single-item chart listing 6 behavior levels ranging from “no signs of aggression” to “danger to self and others” (multiple behaviors listed within each level)	0-5	0 = no signs of aggression 1 = early indicators 2-5 = increasing severity	Interventions identified for each level of aggression
Queensland Occupational Violence Patient Risk Assessment tool	Cabilan et al ²⁷	Emergency department, Australia	Three items: - Aggression history - Behavioral concerns - Clinical presentation	0 (absent) 1 (present/yes)	0 = low risk 1 = moderate risk 2-3 = high risk	None identified

Violence Assessment tool	Jackson et al ²⁹	Acute hospital, Australia	<p>Eighteen behavioral cues:</p> <ul style="list-style-type: none"> - Threat of harm - Aggressive statements or threats - Intimidation - Clenched fists - Resisting care - Prolonged or intense glaring - Name calling - Yelling - Increase in volume of speech - Irritability - Pacing near nurses' area - Pacing in confined areas - Sharp or caustic retorts - Demeaning inflection - Belligerence - Demanding attention - Humiliating remarks - Mumbling 	Not stated	Not stated	None identified
--------------------------	-----------------------------	---------------------------	--	------------	------------	-----------------

Authors	Bias due to confounding	Bias in selection of participants	Bias in classification of interventions	Bias due to deviations from intended interventions	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of the reported results	Overall assessment
Schumacher et al ²³	Serious	Serious	Low	Serious	Moderate	Moderate	Low	Serious risk of bias

Campbell et al ²⁴	Moderate	Moderate	Low	Serious	Moderate	Moderate	Low	Serious risk of bias
Legambiet al ²⁵	Serious	Serious	Low	Moderate	Serious	Moderate	Low	Serious risk of bias
Senz et al ²⁶	Moderate	Moderate	Low	Serious	Moderate	Low	Low	Serious risk of bias

Authors	Item generation	Content validity	Pretesting of questions	Administration	Sample size	Predictive validity testing	Interrater reliability
Jackson et al ²⁹	Good	Good	Good	Some concerns	Some concerns	Some concerns	Poor
Partridge and Affleck ¹⁶	Some concerns	Some concerns	Some concerns	Some concerns	Good	Good	Some concerns
Connor et al ²⁸	Some concerns	Some concerns	Some concerns	Good	Good	Good	Some concerns
Cabilan et al ²⁷	Some concerns	Good	Poor	Poor	Good	Good	Good

Tool; included studies	Outcome	Cut-off	Predictive efficacy	Content validity	Reliability	Intervention efficacy
BARS; Legambiet al ²⁵	Restraint use	-	-	-	-	1. No statistically significant difference in restraint use following implementation ($\chi^2 = 0.72, P = .40$)

BOC; Senz et al ²⁶	Planned and emergency security responses (code gray); mechanical restraint	-	-	-	-	1. Reduction in planned Code Grays (RR 2.22) and emergency Code Grays (RR 0.75, absolute risk reduction 0.18%). 2. No reduction in mechanical restraint use.
BVC; Partridge and Affleck ¹⁶	Violence	1	OR 11.6	Not assessed in emergency care, only in mental health settings	-	-
2	OR 30.3	3	OR 71.4	≥1	PP V 16. 7%	≥2
PPV 34.3%	≥3	PPV 55.2%	3	Sens. 45.7% Spec. 99.4%	DA SA ; Co nn or et al ²⁸	Violent or aggressive behavior
Score: 1+ vs 0	PPV 23% vs 5%	Not assessed in emergency care, only in mental health settings	-	-		AUC 0.77
EDART; Campbell et al ²⁴	Restraint use	-	-	-	-	1. No statistically significant difference in restraint use before and after implementation (logistic interrupted time series model with time F = 2.01, P = .13)

QOVPR AO; Cabilan et al ²⁷	Occupational violence	Aggression history	OR 9.0 Sens. 22% Spec. 98%	I-CVI 0.86	K 0.6 0- 0.7 5	-
Behavioral	OR 13.6 Sens. 31% Spec. 98%	I-CVI 0.95	Clinical	OR 7.1 Sens. 55% Spec. 92%	I- CV I 0.8 9	Risk rating 0, 1, 2+
AUC 0.77	-	Moderate risk	Sens. 61% Spec. 91%	High risk	Se ns. 37 % Sp ec. 97 %	VAT; Jackson et al ²⁹
Violence	Resisting health care	OR 11	-	-	-	Aggressive statements
OR 7.16	-	Yelling	OR 6.79	-	Ab usi ve lan gu age	OR 5.98

DETAILS

Subject: Agreements; Patients; Emergency medical care; Databases; Usability; Feasibility; Systematic review; Mental disorders; Violence; Quantitative psychology; Intervention; Workplace violence; Risk assessment; Emergency services; Efficacy; Mental health; Tests; Nursing

Business indexing term: Subject: Workplace violence Risk assessment

Identifier / keyword: Patient violence; Risk assessment; Workplace aggression; Workplace violence

Publication title: Journal of Emergency Nursing; JEN; Philadelphia

Volume: 49

Issue: 3

Pages:	371-386.e5
Publication year:	2023
Publication date:	May 2023
Section:	Clinical
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Evidence Based Healthcare, Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.006
ProQuest document ID:	2809538589
Document URL:	https://www.proquest.com/scholarly-journals/systematic-review-violence-risk-assessment-tools/docview/2809538589/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-09
Database:	Public Health Database

Document 24 of 50

Information for Readers: JEN

[ProQuest document link](#)

FULL TEXT

DETAILS

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
First page:	A10
Publication year:	2023
Publication date:	May 2023
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	General Information
DOI:	https://doi.org/10.1016/S0099-1767(23)00071-5
ProQuest document ID:	2809538588
Document URL:	https://www.proquest.com/scholarly-journals/information-readers/docview/2809538588/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited May 2023
Last updated:	2023-05-05
Database:	Public Health Database

Addressing a Key Leadership Challenge: Workplace Violence: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Workplace violence is a growing concern among health care workers, especially staff working in emergency departments. Emergency department leaders have oversight accountability that includes mitigation of workplace violence risks and staff education related to workplace violence prevention. Challenges associated with workplace violence events include disruption of safe patient care, decreased staff job satisfaction, and increased turnover. Improving safety for staff, patients, and visitors requires a culture focused on safety. A summary of current regulations, standards, and resources available to date is provided, including a list of mitigation strategies that can be easily translated into practice by emergency nurse leaders.

FULL TEXT

Workplace violence is a serious threat to ED staff. Leaders have an obligation to implement changes that enhance the safety of the workplace while also ensuring that ED staff receive education regarding mitigation of workplace violence. Varying definitions of workplace violence exist among organizations and agencies.¹ Several of the following definitions are likely to be relevant to emergency nurse leaders. The Occupational Safety and Health Administration (OSHA) relays “Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.” The CDCs NIOSH indicates “Workplace violence is the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty.” The Joint Commission defines workplace violence as “An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.”² The relevance of these definitions translates to compliance with recent regulatory recommendations regarding each organization’s responsibilities related to workplace safety. Health care workers remain the work group most likely to be injured.

Health care workers accounted for 73% of all nonfatal workplace injuries and illnesses due to violence, with hospital workers 6 times more likely to experience job violence than private sector workers as a whole.³ In 2019, United States hospitals recorded 221,400 work-related injuries and illnesses, a rate of 5.5 work-related injuries and illnesses for every 100 full-time employees.⁴ This is almost twice the rate for private industry as a whole, yet in 2015 researchers found that 88% of health care workers in an American hospital system who self-reported a violent event in the previous year had not documented the incident in the hospital’s electronic system and only 45% had reported the incident to their supervisor.⁵ The study attributed various reasons for the underreporting: lack of physical injury, lack of lost time, time-consuming reporting procedures, lack of supervisory or coworker support, fear of reprisal or blame, belief that reporting will not lead to positive changes, a common perception among health care workers that violence is simply “part of the job,” and varying definitions of violence among employees and within organizations.⁵ A different study showed health care workers who experienced frequent violence indicated a lack of support from hospital administration and ED management as barriers to reporting workplace violence even though more than one-third reported work-related consequences on their well-being and health.⁶

Leaders need to be cognizant of current regulations that may impact workplace violence in health care. Several relevant federal regulations are described in the following paragraphs. OSHA, thought to be the predominant driver

of workplace safety in the United States, first disseminated “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers” in 1996 with updates in 2004 and 2014.⁷ Although OSHA has no standard specific to the prevention of workplace violence, the agency currently enforces Section 5(a)(1) (General Duty Clause) of the OSHA Act against employers who expose their workers to this recognized hazard. Section 5(a)(1) states that employers have a general duty to provide each of their employees a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to their employees (29 U.S.C. 654[a][1]). Section 5(a)(1) does not specifically prescribe how employers are to eliminate or reduce their employees’ exposure to workplace violence. OSHA acknowledges that workplace violence enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. Verbal abuse does not receive the same level of recognition from OSHA.

However, many people who study workplace violence and the prevention programs highlighted by OSHA determined that verbal abuse includes threats, verbal aggression, hostility, harassment, and the other acts of violence, which can cause significant psychological trauma and stress, even if no physical injury takes place. Often, verbal abuse can escalate to physical violence.⁸ In 2017, OSHA initiated a Request for Information to support a proposed rule entitled “Prevention of Workplace Violence in Healthcare and Social Assistance.”⁷ More than 80,000 comments were received by the agency on this topic during the public comment period.⁹ A federal requirement exists that before proposing rules that would have a significant economic impact on a substantial number of small entities, the agency must convene a Small Business Regulatory Enforcement Fairness Act Panel, yet to date the panel has not been assembled.

In April 2021, the United States House of Representatives passed H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Worker Act. A companion bill, S.4182, was introduced in the Senate to require the United States Department of Labor to issue an interim occupational safety and health standard (at a minimum, based on their current guideline). The bill would require certain employers to take actions to protect workers and other personnel from workplace violence, but the bill became inactive at the conclusion of the 117th Congressional session and now awaits resubmission in the 118th Congress.

Under the Centers for Medicare and Medicaid Services hospital emergency preparedness regulations, hospitals must develop and implement an emergency preparedness plan based on community- and facility-based risk assessments, using an all-hazards approach. Emergency preparedness plans must include strategies for addressing emergency events, such as the use of weapons. On November 28, 2022, the Centers for Medicare and Medicaid Services issued an official memorandum reminding hospitals of their obligation under Medicare’s conditions of participation to ensure patients and staff have an environment that prioritizes their safety with effective delivery of care. Expectations in the memo include identifying patients at risk of intentional harm to self or others, identifying environmental safety risks for such patients, and providing education and training for staff.¹⁰

Effective January 1, 2022, new and revised workplace violence prevention standards apply to all Joint Commission-accredited hospitals and critical-access hospitals. Under the Joint Commission standard, hospital leaders must develop and implement policies and procedures to prevent and respond to workplace violence, a process for reporting and analyzing incidents and trends, and a process for follow-up and support for victims and witnesses affected by workplace violence, such as trauma and psychological counseling.¹¹

In 1993, California became the first state to require health care facilities to develop and maintain a violence prevention program. According to the Emergency Nurses Association (ENA), some 31 states have passed laws that allow local prosecutors to seek felony charges against those who assault emergency nurses. These laws also provide parity in terms of protection under the law for emergency nurses when comparing them with other professions protected by similar laws such as police, fire, and emergency medical services.¹² Most recently, ENA and the American Organization for Nursing Leadership collaborated on a compendium of resources intended to assist corporate and individual nurse leaders implement a culture of nonviolence that can be downloaded.¹

A range of risk mitigation strategies implemented to various degrees by hospitals may include the following⁴:

Environmental Considerations

- Emergency signaling, alarms, and monitoring systems
- Security devices such as metal detectors to prevent armed persons from entering the hospital
- Security devices such as cameras and good lighting in hallways
- Security escorts to the parking lots at night
- Waiting areas to accommodate and assist visitors and patients who may have a delay in service
- Triage area and other public areas designed to minimize the risk of assault
- Enclosed staff areas and nurses' stations
- Deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas
- Arranging furniture and other objects to minimize their use as weapons
- Secured staff only rest areas
- Evacuation exits

Administrative Considerations

- Management commitment, including the endorsement and visible involvement of top leadership
- Clearly defined workplace expectations that convey a culture of respect at all levels including intolerance for incivility and bullying among coworkers
- Zero tolerance policies (including prominent signage for hospital visitors addressing violence, supporting staff in the removal of perpetrators of unruly behavior from hospital property, and the willingness to support legal action for violations)
- Emergency communication systems
- Proper staffing
- Workplace analysis and violence prevention plans
- Hazard identification
- Population risks (persons with a history of violence, abuse of drugs or alcohol, gang members, cognitive and mental health factors)
- Weapons and active shooter policies
- Event reporting systems and data analysis
- Analysis and improvement of operational factors that cause patient delays
- Prevent unrestricted movement of the public in clinical areas

- Post-incident debriefings
- Collaboration and relationships with local law enforcement
- Information sharing among health care organizations
- Safety stand downs
- Drills and exercises

Individual Considerations

- Safety starts with self
- Take the initiative to seek education and training
- ENA's Workplace Violence Prevention Course (free)
- Workplace Violence Prevention for Nurses CDC Course No. WB4525–NIOSH Pub. No. 2013-155 (free)
- Improve skills related to situational awareness and de-escalation techniques
- Communicate with patients and family members about long waits
- Provide support to coworkers that are verbally abused or physically assaulted
- Encourage incident reporting
- Volunteer for employer-based committee/task forces to help identify solutions with a “frontline” perspective

Summary

A uniform, regulatory framework addressing workplace violence in health care might improve consistency for state and federal lawmakers. However, continuing to wait for regulatory solutions to a very complex problem is not realistic. The problem remains; our colleagues continue to experience the increasing incidence of violent attacks in the emergency department. Accreditation standards may help lessen the risk by giving a broad framework to address hospital safety, but the timeliness of a standard imposed in 2022 will not have an immediate impact on the needed risk mitigation and safety outcomes that are now past due. Despite increasing awareness, documentation of serious adverse events, and research related to workplace violence, we seem to be a long way from achieving zero harm.

The practice of emergency care is a team sport.¹³ Clearly the ultimate strategy involves all stakeholders—legislators, regulatory agencies, national associations, hospital administrators, nursing and physician leaders, all persons working in emergency departments, law enforcement, and the public—working together to improve safety for patients and staff in the emergency department. As emergency nurse leaders, we have to stand together to advocate for safer work environments for our staff, patients, and visitors. You can be the catalyst for this change!

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Medicaid; Threats; Assaults; Patients; Medical personnel; Workplace violence; Disruption; Injuries; Hospitals; Occupational safety; Leadership; Emergency services; Employers; Safety regulations; Nurses; Mitigation; Medicare; Workers; Health care; Emergency preparedness; Accountability; Trauma; Prevention; Employees; Visitors; Workplaces; Job satisfaction; Illnesses; Murders &murder attempts; Emotional abuse
Business indexing term:	Subject: Medicaid Workplace violence Occupational safety Leadership Employers Medicare Workers Employees
Location:	United States--US
Company / organization:	Name: Centers for Medicare &Medicaid Services; NAICS: 923120; Name: National Institute for Occupational Safety &Health; NAICS: 926150; Name: Occupational Safety &Health Administration--OSHA; NAICS: 926150
Identifier / keyword:	Violence; Emergency department; Threat; Intimidation; Injury; Fear
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	326-329
Publication year:	2023
Publication date:	May 2023
Section:	Leadership Forum
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.001

ProQuest document ID:	2809538586
Document URL:	https://www.proquest.com/scholarly-journals/addressing-key-leadership-challenge-workplace/docview/2809538586/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 26 of 50

Providing Peer Support after Workplace Violence: JEN

[ProQuest document link](#)

FULL TEXT

Figure 1 Emergency nurse providing emotional support to a peer who has been abused by a patient while providing care in the emergency department.

Author Disclosures

Conflicts of interest: none to report.

Submissions to this column are encouraged and may be submitted at jenonline.org where submission instructions can be found in the Author Instructions.

DETAILS

Subject:	Workplaces; Workplace violence; Occupational stress; Peer tutoring; Nurses; Professional relationships
Business indexing term:	Subject: Occupational stress Professional relationships
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
First page:	319
Publication year:	2023

Publication date:	May 2023
Section:	Impressions
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2023.01.012
ProQuest document ID:	2809538584
Document URL:	https://www.proquest.com/scholarly-journals/providing-peer-support-after-workplace-violence/docview/2809538584/se-2?accountid=211160
Copyright:	©2023. Emergency Nurses Association
Last updated:	2023-05-12
Database:	Public Health Database

Document 27 of 50

The Lived Experience of Workplace Violence Among Emergency Nurses: JEN

[ProQuest document link](https://www.proquest.com/scholarly-journals/providing-peer-support-after-workplace-violence/docview/2809538584/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Introduction

Workplace violence remains a significant threat to the United States health care workforce. With increasingly aggressive patients, emergency nurses reported that the increased prevalence of workplace violence impacted their

professional and personal lives.

Methods

This study employed a qualitative, descriptive phenomenological approach with purposive sampling. Participants were asked to describe their lived experience with workplace violence while working as emergency nurses and how this affected them personally and professionally.

Results

Eleven experienced emergency registered nurses from 3 mid-Atlantic hospitals participated in the study. After reviewing, clustering, and validating significant statements, 4 major themes were identified: walking wounded to wounded healer, unexpected shock, betrayal, and resilient but changed.

Discussion

Our findings were consistent with other studies exploring the effects of workplace violence in emergency departments. We validated that trauma has long-lasting effects. Organizations should ensure that programs and processes are in place to support the nurse or health care worker when workplace violence events occur.

FULL TEXT

Contribution to Emergency Nursing Practice

- Workplace violence and assaults on emergency nurses are increasing in frequency, resulting in long-term physical, psychological, and professional consequences.
- This study contributes to an improved understanding of the impact of assault on emergency nurses, repercussions, and implications for the victims, their patient interactions, relationships with peers and leaders, and the nursing profession.
- The need for health care system leaders, police, legislators, and legal systems to emotionally support and legally and legislatively advocate for victims of workplace violence is essential. Workplace violence prevention strategies need to be prioritized.

Introduction

Workplace violence (WPV) remains a significant threat to the United States health care workforce. According to the US Bureau of Labor Statistics from 2011 to 2018, WPV increased from 6.4 full-time workers per 10,000 to 10.4 full-time workers per 10,000 full-time workers.¹ WPV is an act of aggression or threat of physical or verbal exposure at work.² Violence can be described as physical and psychological.³ Physical violence is an assault including slapping, punching, spitting, and sexual groping.^{4,5} Psychological violence is a verbal aggression, with intent to cause harm, including threats of a lawsuit, bullying, or sexual harassment.^{4,5} In a survey conducted in 2021, health care participants were asked about types of violence that had occurred in their work environments.⁶ Among the responses, 100% reported verbal aggression, 82% reported physical aggression, 36% had experienced obstruction of care, 35% reported discrimination, and 27% reported weapon threats. Upon review of the literature from 136 articles, Spector et al⁵ reported that among a sample of 151,347 nurses, 36.4% were exposed to physical violence, 66.9% were exposed to nonphysical violence, and 32.7% reported being physically injured. Nurses accounted for 12.2% of WPV event exposures, and emergency nurses experienced more exposure to WPV.^{1,7}

WPV events precipitated by patients, families, and visitors are a concern.⁸ Precipitating factors causing a high rate of WPV among emergency nurses included: crowding, wait times, poor communication, holds/boarding, and patients with a history of violence, mental health disorders, and substance abuse.^{4,9-11} Several studies identified that evidenced-based interventions for nurses, including environmental changes and de-escalation education, increased nurses' confidence and skills to decrease WPV events.¹²⁻¹⁴ In addition, health care organizations must be

responsible to develop policies and processes to prevent WPV events.

Researchers suggested that organizational support resulted in improved trusting relationships between the employee and the employer through a psychological contract.^{15,16} The contract is reciprocal, with implied mutual obligations.¹⁷ Violation of the agreement, such as nonsupportive actions from leadership, may result in employee disengagement and mistrust, affecting the nurses' work performance, and potential adverse outcomes.¹⁵ This organizational betrayal "brings with it painful disappointment and discouragement."¹⁸

Many organizations have published position statements and guidelines promoting a violence-free environment.¹⁹⁻²¹ Despite the support from organizations, WPV prevails. Owing to the frequency of WPV events, underreporting and accepting WPV as an intrinsic part of the job prevail.^{4,9-11,22} The adverse effects of WPV are immediate and with long-term sequelae. Repeated experiences of WPV may negatively affect one's mental and physical health and work performance in the long term.^{11,13,23} In addition, the lingering effects of WPV events are similar to posttraumatic stress disorder.²⁴ Many nurses are wounded by the experience; however, they continue to care for their patients. Conti-O'Hare²⁵ posits that nurses need to recognize their wounds from WPV events.²⁶ The nurse must process, transform, and transcend to heal; otherwise, the nurse may become the walking wounded. The wounded nurse may experience lasting emotional and physical trauma that may affect nursing care.^{24,25} Nurses need to heal to move from walking wounded to wounded healer.²⁶ After the process of healing, the nurse transcends to a wounded healer with experiences of pain and suffering providing insight and the ability to understand and empathize with others.²⁵ Research has identified resiliency as an attribute that enables nurses to adapt and recover from workplace stressors including WPV events. Resiliency is necessary for nurses to continue to provide safe patient care and prevent themselves from negative physical and psychological injury.²⁷ Cooper et al²⁷ identified that social support from colleagues and managers promotes resiliency. During a WPV event, nurses rely on their working relationship between coworkers including physicians and security to assist or manage the event.

Despite many nursing organizations and health care facilities providing guidelines and policies regarding WPV, these events persist. It is important to continue to monitor and understand the types of WPV and the effects on nursing staff. This study examined the impact of WPV on emergency nurses' personal and professional lives.

Methods

This qualitative study employed a descriptive phenomenological approach. This approach is useful to elicit and better understand an experience through the voices and reactions of those who have lived the experience, as well as the situations and/or conditions preceding and following the event. This study aimed to acquire an exhaustive description of WPV on emergency nurses (registered nurses) working in 3 geographically diverse mid-Atlantic emergency departments who had experienced verbal aggression or physical assault by a patient and/or visitor in the emergency department. Semistructured, in-depth interviews were conducted after purposive sampling. All emergency nurses were invited for consideration via email. Data analysis was consistent with the procedures suggested by Colaizzi.²⁸ The research question grounding this study was, "What is the experience of the emergency nurse assaulted by a patient or visitor?" Colaizzi's²⁸ method provided a logical process and structure to explore this phenomenon and identify and organize themes and better understand the experience of the participants. Sensitive to the fact that this topic could generate negative perceptions and reactions, the researchers made every attempt to suspend judgment or bias through bracketing.

The institutional review board deemed the research exempt. Upon approval by the institutional review board, data collection began. All ED registered nurses employed for at least 1 year who had experienced assault by a patient or visitor within the past 5 years were eligible to participate. An invitation to participate was emailed to all emergency nurses in the 3 emergency departments, asking them to respond if they were eligible and interested in participating

in an interview. Among the enrolled respondents, 10 were female, and 1 was male. Participants were deidentified using a number at the time of enrollment, for confidentiality. Informed consents were obtained. Methods and findings were reported according to Consolidated criteria for reporting qualitative research (COREQ) guidelines.

The research team compiled a semistructured 6-question interview guide, intended to guide the private interviews, which took 60 to 90 minutes. The lead investigator conducted and recorded the interviews, with permission of the participant. A coinvestigator took notes pertaining to body language or physical nuances, which may not have been discerned on recordings.

The leading question was, "Tell me about your experience with either verbal aggression or physical violence from a patient or family member in the ED." Open-ended questions such as, "Tell me, how did this event affect you?" and clarifying questions, such as, "Tell me, in as much detail as possible, what led up to the incident?" and, "Then what happened?" were used to encourage participants to infuse their event with detail. Participants were asked how the experience affected them personally and professionally, how their organization responded to the assault, and what they had done to facilitate recovery.

Data Analysis

Consistent with Colaizzi's²⁸ 7 steps, participant narratives were transcribed verbatim and validated by the individual participants. Reading and rereading of the transcripts helped the research team to focus on context and understanding of the emerging experience. The team extracted significant statements. The meaning of each significant statement was identified and then organized into clusters of themes, similar in type, to achieve a synthesis of themes or symbolic representations. Participants again validated the themes. Comparing new interviews to previous interviews allowed the team to identify similarities and differing experiences and achieving saturation. The researchers recognized saturation after 7 interviews; however, in respect for the participants' experience, all were interviewed. After the interview process, the team independently reviewed the transcripts and themes using iterative analysis to achieve consensus of the theme clusters. Member checks were conducted among participants, and all participants acknowledged that the themes and meanings reflected their lived experience of assault.

Results

Eleven nurses chose to share their experience and the professional and personal impact of the assault. Interviews were conducted between December 2019 and February 2020. Five participants represented 1 campus, and 3 were from 2 other campuses. There was a breadth of violence ranging from verbal aggression to physical assaults. For perspective, assaults included name-calling, cursing, spitting, punching, kicking, attempting knife attack, twisting of limbs, throwing a soiled bedpan, body slamming, threatening family members, and threatening a nurse with a gun found to be loaded. In this section, verbatim quotes illustrate the depth of the impact of the assault. The extracted themes included the following: walking wounded to wounded healer, unexpected shock, betrayal, and resilient but changed.

Themes Identified Walking Wounded to Wounded Healer

The first theme identified was walking wounded to wounded healer. The nurse participants were experienced emergency nurses; they thought they came to "just tell their story," and they expressed surprise when they realized that telling their story elicited emotions. For most, telling their story was intense and painful. Among 10 participants, it took an average of 4 minutes before tears streamed down their face as they reflected on painful memories long ago buried. "He spit in my face and my mouth...I was devastated... I cried for days...I would have rather been punched."

Many of the participants reported that these situations are just part of their job; 1 participant stated, "I accept it and

understand it could happen any day I come to work.” Another shared, “We all [take it] for granted, that this is part of the job, that this happens, it’s normal and it’s something we deal with.” One participant reported being kicked in the knee, and their peers responded “as if this is normal and something that we just deal with.” Perceiving assaults as an everyday event is a significant safety threat. Reporting events becomes low priority as staff numbs to the frequency.

In our nursing culture, we tend not to talk about our “wounds.” We “suck it up” and bury the emotions and move on to the next patient. Based on the theory developed by Conti-O’Hare,²⁵ “walking wounded” can be defined as individuals who have not effectively coped after a traumatic incident.²⁶ Nurses can become the walking wounded after experiencing WPV, whether verbal or physical in nature. One participant expressed, “It made me angry, it has changed the way I interact with my colleagues and the drug addicted.” Another shared, “I always loved being a nurse, but now, I honestly don’t like what I do.” One participant expressed, “But I love what I do, and I love being an ER nurse so much, I don’t want to do anything else, but I think it is a matter of time before something bad happens.” The wounded healer heals all others but is never fully able to heal their own personal wounds.²⁹ When victims talk about their experience and work on resolving the pain of the trauma, they can become wounded healers, reestablishing therapeutic relationships and having a positive impact on the health care system, their patients, and their profession.

Unexpected Shock

The second theme was that of unexpected shock. Unexpected shock is when someone’s behavior is unlikely, and it surprises the caregiver when it happens. Participants reported, “I was stunned,” “I didn’t see it coming.” Another participant explained, “...but he was not aggressive coming in, he showed no signs of aggression up to that point, it was shocking.” The act of violence that the participants experienced and shared happened suddenly, without warning. For example, one stated they were shocked “Because you don’t expect it... You literally just went into the room, wholeheartedly wanting to help somebody, and suddenly you get kicked into a wall, it blindsides you.” Nursing strives for situational awareness in all situations, awareness of the threat of violence from patients and visitors, but most do not think it is likely going to happen to them. Another participant stated, “It’s part of the job, it happens every day, and every time it happens, I am shocked.”

Betrayal

The third theme was betrayal. Brewer³⁰ describes betrayal as “a deep violation of trust or confidence or violation of moral standard committed by an institution toward a nurse.” Participants reported feeling betrayed by patients they were caring for, providers, leadership, security, workers’ compensation, and the judicial system; by providers who failed to help prevent or assist during incidents, and by leadership for not ensuring a safer environment and for not following up with them after an incident. One participant stated, “They say we are a family, but I didn’t feel like family.”

Participants expressed feeling betrayed by security who often did not arrive in time to help. Many expressed feeling betrayed by the judicial system for making it difficult to file criminal charges. One participant described having to go to the police station after their 12-hour shift and made to wait hours only to meet with attempts by police to dissuade them from pressing charges, because it “probably won’t go anywhere.” “The reality is, we take care of the police when they are injured, but they don’t take care of us.” Finally, they conveyed betrayal by worker’s compensation: “They made me feel like I was trying to take advantage,” “Like I was in the wrong,” and “A system that makes the employee feel as if they are dishonest.”

Resilient but Changed

The last theme was resilient but changed. Defined by the American Psychiatric Association, resilience is when a

person can bounce back and thrive after major challenges or circumstances.³⁰ Most self-reported to be resilient: “I am resilient, but I have changed—while we may call ourselves resilient, we never return to baseline. Each time you are assaulted, it takes a piece of you.” Others described that their interactions with patients and their work relationships changed after the assault.

After experiencing WPV, participants’ mindsets changed for how they viewed their work, their patients, and day-to-day tasks. The participants gave statements such as the following: “You have to treat every patient as if they are the one who is going to assault you—at all times,” “I don’t think I will ever feel that nothing will happen, and everything will be okay; it was an eye opener that bad things can happen, regardless of the resources and backup you have.” One participant explained, “You build up a wall when you are in the ER... You try not to... I think I have my guard up a lot more than I ever did.”

Discussion

The findings were consistent with other studies exploring the effects of WPV. We learned that trauma is indeed a relentless and persistent predator. No matter how long ago the event occurred, the memories elicited emotions, often surprising the participants. To thrive personally and have a positive impact on patients, organizations, and our profession, victims need to attempt to heal and reestablish therapeutic relationships.

Betrayal was an overwhelming perception among participants. An unnamed author once said, “The saddest thing about betrayal is it never comes from your enemies, it comes from those you trust.” Once betrayed, trust is difficult to earn back. Organizations must commit to safety through actively listening to the concerns of the workforce. Trust may be enhanced when organizations acknowledge events, address corrective actions, and communicate effectively, as well as provide staff with de-escalation resources and environmental changes. Studies have identified evidence-based interventions for nurses, including environmental changes and de-escalation education and increased nurses’ confidence and skill to decrease WPV events.^{13,14}

All of the participants self-reported to be “resilient,” but resilient does not equal whole. It means they are “okay to continue.” Wounds heal, but these wounds do not heal in a few days. Nurses may experience anxiety or stress after WPV events, which may endure for years. Studies have shown repeated WPV events can negatively affect one’s mental and physical health, as well as long-term work performance.^{11,13,23} In all of the instances, the participants had unexpected shock, as none of the instances were expected when the event occurred. Organizations must incorporate situational awareness in their WPV prevention training programs.

An organization’s postincident response may influence an employee’s developmental recovery. Employees need to feel genuine support from leadership and colleagues as they progress through their recovery. After an assault, leaders need to be emotionally present for the victim and monitor for signs of posttraumatic stress. Leadership should encourage nurses to use employee assistance programs. Do not ask the victim whether they “need” help, make it happen. Health care organizations should implement psychological first aid or a critical incident stress management program after critical incidents for everyone involved, to help them deal with the trauma of the experience. These types of programs aim to reduce the likelihood that the involved personnel may develop posttraumatic stress disorder. Finally, to quantify the breadth and depth of these events, encourage staff to report every event. Streamlined reporting processes and reporting guidelines are necessary. WPV incidents are vastly underreported, and studies have shown that it is related to lack of trust in the reporting, fear of retaliation, and lack of guidelines or policies.^{31,32} To encourage staff reporting, staff should see and feel that reporting will result in change. A postincident management plan may support the nurse through healing; it also may affect outcomes important to the organization, such as absenteeism, retention, engagement, patient outcomes, errors, and overall financial performance.

Limitations

This study has several limitations. The purposive sampling occurred within 1 geographically diverse hospital system. A more interprofessional, culturally diverse, and gender-diverse sampling may have elicited different perceptions and responses to the assault. The sensitivity of the topic also may be a limitation, because of inherent biases.

Implications for Emergency Nursing

Attempts to mitigate these events and consequences are essential. Hospitals need to hardwire policies, procedures, and community partnerships to prevent violence against their staff. Establishing seamless occurrence reporting strategies and developing a response plan for when violence does occur may help to foster trust between staff and hospital leaders. Committing to a zero-tolerance policy and ensuring adequate resource allocation for workplace safety are essential measures that all health care facilities should undertake to ensure physical, logistical, and environmental safety.

Assaults occur throughout the health care workplace. The authors encourage nurses and other health care workers to tell their story, speak about the unspeakable, and respond proactively to shed light on this phenomenon and help diminish the frequency and consequences of assault in the workplace.

Conclusion

This study identified that those impacted by WPV had long-term personal and professional consequences. This study is important as it contributes to an improved understanding of the impact of assault on emergency nurses, repercussions, and implications for the victims, their patient interactions, relationships with peers and leaders, and the nursing profession. Victims of violence are at risk for physical, emotional, and psychological trauma.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Patients; Emergency medical care; Hospitals; Health care; Workplace violence; Personal information; Workforce; Assaults; Betrayal; Nursing care; Review boards; Workplaces; Leadership; Data analysis; Nurses; Emergency services; Walking; Medical personnel; Clustering; Qualitative research; Interviews; Post traumatic stress disorder
Business indexing term:	Subject: Workplace violence Leadership
Location:	United States--US
Identifier / keyword:	Workplace aggression; Verbal aggression; Assault; Emergency nurse
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	3
Pages:	425-430
Publication year:	2023

Publication date:	May 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.004
ProQuest document ID:	2809538583
Document URL:	https://www.proquest.com/scholarly-journals/lived-experience-workplace-violence-among/docview/2809538583/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-05
Database:	Public Health Database

Document 28 of 50

The Experiences of United States Emergency Nurses Related to Witnessed and Experienced Bias: A Mixed-Methods Study: JEN

[ProQuest document link](https://www.proquest.com/scholarly-journals/lived-experience-workplace-violence-among/docview/2809538583/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Introduction

The purpose of this study was to obtain a broad view of the knowledge, attitudes, beliefs, and lived experiences of

emergency nurses regarding implicit and explicit bias.

Methods

An exploratory, descriptive, sequential mixed-methods approach using online surveys and focus groups to generate study data. Two validated instruments were incorporated into the survey to evaluate experiences of microaggression in the workplace and ethnocultural empathy. Focus group data were collected using Zoom meetings.

Results

The final sample comprised 1140 participants in the survey arm and 23 focus group participants. Significant differences were found in reported experiences of institutional, structural, and personal microaggressions for non-white vs white participants. Respondents who identified Christianity as their religious group had lower mean scores on items representing empathetic awareness. Respondents who identified as nonheterosexual had significantly higher mean total Scale of Ethnocultural Empathy scores, empathetic awareness subscale scores, and empathetic feeling and expression subscale scores. Thematic categories that arose from the focus group data included witnessed bias, experienced bias, responses to bias, impact of bias on care, and solutions.

Discussion

In both our survey and focus group data, we see evidence that racism and other forms of bias are threats to safe patient care. We challenge all emergency nurses and institutions to reflect on the implicit and explicit biases they hold and to engage in purposeful learning about the effects of individual and structural bias on patients and colleagues. We suggest an approach that favors structural analysis, intervention, and accountability.

FULL TEXT

Contribution to Emergency Nursing Practice

- Racism and other biases pose significant disparity concerns in people who are racialized as non-white and the lesbian, gay, bisexual, transgender, queer, intersex, and asexual plus populations specifically, but also in patients with disabilities. The relational basis of nursing as a profession makes identifying and challenging individual and systemic bias difficult.
- This paper provides both quantitative and qualitative data describing nurses' experience with bias; more importantly, it offers explanation and interventions to reduce harm.
- In both our survey and focus group data, we see evidence that racism and other forms of bias are threats to safe patient care and the well-being of nurses. Systemic solutions are suggested.

Introduction

The profession of emergency nursing is a varied health care practice in terms of patient presentations across the lifespan and across the acuity continuum. The assessment skills and clinical judgment of emergency nurses are critical to the rapid identification of physical or psychological instability and the provision of safe, effective patient care.

Cognitive challenges to accurate assessment and safe care include implicit and explicit bias in the forms of racism,^{1,2} ableism, transphobia, and decisional anchoring regarding psychiatric and substance-using presentations.³ Racism and other biases pose significant disparity concerns in people who are racialized as non-white and the lesbian, gay, bisexual, transgender, queer, intersex, and asexual plus (LGBTQIA+) populations specifically,⁴⁻⁷ but also in patients with disabilities.⁸

Almost 30 years ago, Barbee⁹ described the attributes of nursing as a profession that prevented an open reckoning with racism in nursing education and practice. She outlined 4 elements allowing nurses to avoid openly dealing with racism in the profession: (1) an emphasis on empathy, (2) an individual orientation, (3) a preference for homogeneity, and (4) a need to avoid conflict. Iheduru-Anderson et al¹⁰ suggested in their integrative review that

nursing is still unable to identify and mitigate bias in either practice or nursing education. This is highlighted in a recent podcast presented by *Journal of the American Medical Association*¹¹ questioning the existence of racism in medicine and the discomfort that white physicians feel with the term. The podcast demonstrated an egregious blindness to the systemic and institutionalized racism that affects clinical decision making, what Martinez¹² discusses as an epistemology of ignorance.

The same elements that challenge a discussion of racism and other biases in health care also make a discussion of bias in nursing education and nursing practice difficult. The disciplinary foci of nursing, as described by Barbee,⁹ centers on the nurse-patient relationship with emphasis on collaborative, shared care planning. Identifying implicit biases that are structurally supported in this individual context may be challenging. It is here that descriptions of both structural inequities in nursing education and microaggressions in the workplace keep the profession from reflecting on the effects on the patient populations they accompany in care. Microaggressions are a subtle and often daily form of oppression that reinforce unjust power differentials between groups and negatively impact the well-being of people who experience microaggressions.¹³

The United States nursing population is between 73% and 81% white,^{14,15} and the National League for Nursing¹⁶ reports that 81% of nursing faculty self-identify as white, but only 60% of the United States population identifies as white. This overwhelming white majority in the profession allows white nurses to identify with a professional role without necessarily acknowledging the racial disparities that dominance can perpetuate.¹⁷ In particular, the lack of diverse faculty and nursing staff deprives the discipline of valuable perspective in academic preparation, clinical care, and theoretical work. Non-white nurses and nursing students also report an almost constant barrage of microaggressions in their daily work.¹⁸ The National Commission for Addressing Racism in Nursing¹⁹ conducted a national survey to evaluate the prevalence of racism in nursing and found that more than half of the participants think there is “a lot of racism in nursing” and 63% of nurses had personally experienced racism, indicating that racism continues to be a serious concern in nursing.

Structural racism and other forms of discrimination take a toll on the nursing profession, the individuals working within it, and, ultimately, the patients and communities they serve. However, little is known about racism and discrimination as they pertain to emergency nurses and emergency nursing practice. The purpose of this study was to obtain a broad view of the knowledge, attitudes, beliefs, and lived experiences of emergency nurses regarding implicit and explicit bias, with the aim of identifying areas of priority for educational and workforce interventions.

Methods

This study used an exploratory, descriptive, sequential mixed-methods approach using a survey and focus groups to generate study data. Survey data were collected to ascertain prevalence of bias among emergency nurses, with focus data used to expand understanding of the survey results.

Sample

A purposive sample was recruited for both survey data collection and focus group participation from a population of emergency nurses working in United States emergency departments. The sample was recruited using the membership of the Emergency Nurses Association (ENA) and social media. Inclusion criteria included English-speaking emergency nurses practicing in United States emergency departments. Focus group participants were recruited from the larger sample of emergency nurses who consented to survey participation.

Quantitative Data Collection

Using Qualtrics software (Provo, UT), survey data were collected online about nurses' demographics, work experience, and education, as well as information about biases experienced in their workplace. Two validated instruments were incorporated into the survey to evaluate: (1) experiences of microaggression in the workplace and

(2) ethnic empathy.^{20,21}

Survey Instruments

The Racial and Ethnic Microaggressions Scale (REMS)²⁰ is a 45-item, validated measure evaluating respondents' experiences of the following 6 factors: (1) assumptions of inferiority, (2) second-class citizen and assumptions of criminality, (3) microinvalidations, (4) exoticization/assumptions of similarity, (5) environmental microaggressions, and (6) workplace and school microaggressions. Respondents used a 5-point Likert scale to report the frequency of experiencing each item, ranging from "I did not experience this event in the past six months" to "I experienced this event 10 or more times in the past six months."

The Scale of Ethnocultural Empathy (SEE)²¹ is a 31-item, self-report, validated instrument that measures empathy toward people of racial and ethnic backgrounds different from one's own. Findings from validation studies suggest evidence for a positive, moderate association with a measure of general empathy and a high negative association with a measure of prejudice.²² SEE items can be divided into 4 subscales: empathetic feelings and expression, empathetic perspective taking, acceptance of cultural differences, and empathetic awareness. Items are rated on a 6-point Likert-type scale (1 = strongly disagree that it describes me to 6 = strongly agree that it describes me). Subscale items are summed to generate individual subscale scores and all items are summed to generate total SEE scores, with higher scores representing higher levels of ethnocultural empathy.

Qualitative Data Collection

A series of 6 1-hour focus groups were held via virtual Zoom (Zoom Video Communications, San Jose, CA) meetings, which were transcribed by the Zoom software. The transcriptions then were proofread for accuracy by the research team. To expand understanding of the lived experience of emergency nurses in the United States related to institutional, structural, and personal bias, the following questions, derived from a review of the literature and the application of Barbee's⁹ work on racism in nursing, framed the discussion:

1. Have you seen or experienced racism, homophobia, ableism, or other forms of discrimination while a nursing student?
2. Have you seen or experienced racism, homophobia, ableism, or other forms of discrimination while a practicing emergency nurse?
3. How do you think that bias affects emergency nurses in their ability to do their work?
4. How do you think bias affects patient care?
5. How do you think bias affects emergency nurses' interactions with other health care team members?

Data Analysis

Survey data were downloaded to SPSS v. 28 for Windows (IBM Corp, Armonk, NY) for analysis. For continuous variables, normality was assessed visually using histograms and normal quantile-quantile plots. In addition, the ratio of the standard deviation to the mean was computed for each continuous variable. Summary findings for continuous variables are reported as means and standard deviations, with their 95% confidence intervals (CIs) where appropriate. Categorical variables are summarized using frequencies and percentages. In some cases (eg, racial identity), small sample sizes necessitated collapse of the data (eg, white vs non-white) to facilitate statistical comparison. For categorical variables, group comparisons were made using chi-square analysis or Fisher exact test, as appropriate for the data. CIs around the difference between proportions were computed as described by Wilson²³ and Newcombe.²⁴ For continuous variables, comparisons of group means were made using the *t* test for

independent samples or one-way analysis of variance, as appropriate for the number of groups being considered. Scheffe's test was used to facilitate post hoc comparisons following analysis of variance. In addition, we present mean differences and their 95% CIs to aid in data interpretation. To account for multiple comparisons, Bonferroni's correction was applied when interpreting the results of statistical testing to avoid making a type I error (accepting a false positive).

Qualitative data from Zoom transcripts were analyzed using Mayring's²⁵ 8-step process by each member of the research team individually and then again collectively to come to consensus on themes and categories. Member checking was conducted, with 13 of 23 participants responding that we had accurately captured the discussion. No changes to the discussion were necessary based on participant comments.

Protection of Human Subjects

Institutional review board approval was obtained from Advarra, Inc (Columbia, MD), before the recruitment of participants for the study. The study was approved as exempt from further review with a waiver of signed consent. Survey participants were given a summary of the study and assurance of confidentiality on the opening screen of the online survey. Completion of the online survey implied consent.

To encourage participants to speak freely, a Certificate of Confidentiality was obtained from the National Institutes of Health to ensure the privacy of participant research information, preventing it from being shared with anyone not connected to the research study. Every effort was made to have the researchers collecting focus groups be diverse and culturally concordant with the participants. Focus group slots were made available, and researcher identities were posted for each potential slot so that participants were informed of the positionality of the researchers and could choose groups where they felt comfortable discussing these issues. Focus group participation was limited to persons who met the study criteria and completed the informed consent document and initial survey. Focus group participants were provided with a summary of the study and assurance of confidentiality both on the opening screen of the online registration and at the start of each focus group session. They also were asked to complete a demographic survey before participating in the focus group.

Results

We consider race²⁶ and gender identity²⁷ to be socially constructed rather than biological variables, and these descriptions are used to aid in characterizing the sample/study participants and their experiences. We recognize that the human genome project confirmed that race is a social and political construct with no natural division of humans based on genes,²⁸ and so we included racialized categories to be able to stratify data and explore whether being racialized in specific groups affects the experiences of bias in emergency nursing. The final survey sample comprised 1141 emergency nurses, 82.4% of whom identified as white and 85.8% who identified as heterosexual. Sixty-three percent identified as following a form of Christianity, and 21.4% identified as nonreligious/secular/atheist. Eleven percent reported having a disability, but only 2.9% of this group identified as disabled. Eighty percent of the respondents identified as female, and 80% reported having a bachelor's or master's degree in nursing. Sixty percent of the respondents reported their primary role as charge or staff nurse, working in general community hospital emergency departments that had an average of 30 treatment spaces, and saw an average of 149 patient visits per day. Participants averaged 18 years of experience in nursing, 12 years of emergency department-specific experience, and 5-year tenure in their emergency department. Survey participants represented all 50 states, the District of Columbia, and 1 participant was from a United States territory (see ^{Table 1}).

Focus Group Participants

An initial email was sent to the interested group ($n = 259$), with 1 reminder email. This initial recruitment sample was obtained from the larger survey sample in which the final question asked whether survey participants would like to

be contacted to participate in a focus group. Of the potential 259 participants, 64 registered to participate (25%) with 23 (36%) attending a focus group session. Individual focus groups ranged in size from 2 to 7 participants. The frequencies of select variables that depict the range of historically underrepresented groups in our sample from survey through focus group participants are presented in ^{Table 1}. Proportions of the various underrepresented groups across progression through the study are roughly equal; 4 of 6 variables are highest in the final focus group participation column. A targeted attempt was made on social media (Facebook, LinkedIn, Twitter) to recruit for 2 additional focus groups (1 non-white, 1 LGBTQIA+). This yielded 1 additional interested participant (LGBTQIA+); these focus groups were not held owing to an insufficient number of registrants.

Q1: What is the experience of emergency nurses in the United States related to institutional, structural, and personal bias?

The overall question was answered using survey data from the REMS and SEE and qualitative focus group data. We report quantitative data first, with explication from qualitative data second.

Survey Data Race

Analysis of responses to the REMS revealed significant differences in reported experiences of institutional, structural, and personal microaggressions for non-white vs white participants. Some examples of this are differences in non-white vs white responses to how often they experienced various items on the scale such as “Someone assumed that I grew up in a particular neighborhood because of my race” (non-white 52% vs white 26%, *P P P P P P P P* Table 2).

Analysis of responses to the SEE also revealed significant differences in ethnocultural empathy when comparing responses for non-white and white participants. We observed significant differences across all 4 SEE subscales (empathetic feeling and expression, empathetic perspective taking, acceptance of cultural differences, and empathetic awareness) and in total SEE scores, with non-white participants consistently endorsing higher levels of ethnocultural empathy than their white counterparts.

Some of the largest differences in mean scores on individual items included understanding what it feels like to be the only person of a certain race or ethnicity in a group of people (non-white 5.05 vs white 3.06), relating to the frustration that people feel about having fewer opportunities owing to their racial or ethnic backgrounds (non-white 4.47 vs white 3.35), and being aware of institutional barriers that discriminate against racial or ethnic groups aside from one’s own (non-white 4.44 vs white 3.71).

Participants who identified as non-white had higher mean scores on items relating to empathetic feeling and expression such as sharing the anger of those who face injustice because of their racial or ethnic background (non-white 4.78 vs white 4.28), appreciation for the cultural norms of people from other racial or ethnic groups (non-white 5.04 vs white 4.72), and expressing concern about race or ethnicity-based discrimination (non-white 4.51 vs white 4.00).

Participants who identified as white endorsed more difficulty relating others’ stories about day-to-day experiences with racial or ethnic discrimination (non-white 4.99 vs white 4.08) and putting themselves in the shoes of someone racially or ethnically different from themselves (non-white 5.07 vs white 4.23), both items from the SEE empathetic perspective taking subscale. Additional details on ethnocultural empathy in study participants are presented in ^{Table 3}.

Religion

Owing to the small sample size, we collapsed self-identified religious affiliations into Christianity and non-Christianity, with the latter group including faith and nonfaith ideals (ie, Buddhist, Muslim, Hindi, Secular, Atheist, nonreligious, and other) given that there were a small number of participants endorsing individual non-Christian faith traditions. When comparing ethnocultural empathy for Christian and non-Christian participants, statistical differences

were noted with significantly higher mean scores across all 4 SEE subscales and total SEE scores for non-Christian participants (Table 3).

Respondents who identified Christianity as their religious group had lower mean scores on items representing empathetic awareness such as awareness of institutional barriers that affect people of other racial or ethnic groups (Christian 3.60 vs non-Christian 4.42), insight into how other racial or ethnic groups are systematically oppressed in our society (Christian 3.91 vs non-Christian 4.92), and awareness of how society treats racial or ethnic groups other than one's own differently (Christian 4.44 vs non-Christian 5.09).

Respondents who identified as non-Christian had higher mean scores on the items representing empathetic feeling and expression, including sharing the anger of those who face injustice owing to their racial or ethnic background (Christian 4.20 vs non-Christian 4.74) and expressing concerns about discrimination to people from other racial or ethnic groups (Christian 3.96 vs non-Christian 4.38). Full details of ethnocultural empathy findings by racial identity and religious preference are presented in Table 3.

Gender Identity, Sexual Orientation, and Generation/Age Group

Several gender identity groups (nonbinary/gender nonconforming, 2-spirit, other, prefer not to say) were too small to support statistical comparisons; however, in comparing REMS and SEE data for participants who identified as either male (including transmen) or female (including transwomen), no statistical differences were noted. When comparing SEE mean scores for participants who identified as heterosexual vs nonheterosexual (lesbian, gay, bisexual, pansexual), several significant differences were noted. Respondents who identified as nonheterosexual had significantly higher mean total SEE scores (4.82 nonheterosexual vs 4.60 heterosexual, $P = .002$).

As with gender identity, several generation subgroups (generation Z, silent generation) were too small to support statistical comparison; however, several differences were noted when comparing other groups (baby boomer, generation X, millennials [generation Y]). On one-way analysis of variance, significant differences were noted in mean empathetic awareness subscale scores ($P = .007$) and the generation X vs millennials comparison (4.63 millennials vs 4.34 generation X, $P = .004$), indicating that millennial generation participants demonstrated higher levels of empathetic awareness than did their generation X and baby boomer generation counterparts. For the acceptance of cultural differences subscale scores, significant differences were observed when comparing baby boomer vs generation X (5.06 baby boomer vs 5.25 generation X, $P = .002$), baby boomer vs millennial (5.06 baby boomer vs 5.44 millennial, $P = .001$). This again suggests that millennial generation participants endorsed higher levels of acceptance of cultural differences than their generation X or baby boomer counterparts.

Too few participants ($n = 33$) identified as disabled to support statistical comparison.

Focus Group Data

Thematic categories that arose from the focus group data included witnessed bias, experienced bias, responses to bias, impact of bias on care, and solutions (see Table 4 for integrated results).

Witnessed Bias

In this first category, participants reported observing incidents of bias directed at other ED staff and at patients. This bias was described as display of public tolerance for a colleague or patient but feeling private intolerance for the same person; there was reported nontolerance of overt bias but clear existence of overt bias. One participant shared: 'I've seen so much bias, with nurses in the ER while they don't show it in the patient room they'll go back out into the nurse's station and bad mouth that patient. . . we're very nonjudgmental whenever we're face to face with that patient, but then we go out and about and it's kind of what I call patient bashing. (J, group A)

Another described: A lot of them are Black and they're coming for, like a lot more . . . but they're coming, because they don't have a primary care they can't get to primary care. And then it ends up being like if someone is coming in

there, like a like 20-year-old Black female, they like get an eye roll immediately. (B, group C)

Emergency nurses also reported witnessing bias against LGBTQIA+ patients and staff specifically owing to “discomfort” or “not understanding.” In particular, members of the transgender community were reported as being the targets of bias, as described in the following quote: They (other staff) approached her (a transgender female physician) less, and you could tell through just even their dialogue they were uncomfortable how to address her even just simply by her name, you know, doctor. And the other thing that I did notice was patients were uncomfortable, so it was bias from patients to her care. (J, group C)

In addition, participants reported that, although they perceived a decrease in overt gender bias over the past 20 years or so, an “old boys’ network” still exists. Between the two the females constantly having to defend their opinion, their assessments, their diagnosis, I just feel that it’s much more trying for us to get our point across still than it is for our male colleagues, whether they be physicians, PAs, nurse practitioners, or techs. (A, group D)

In discussing other witnessed bias, participants recognize that delivery of linguistically appropriate care can mean delays and that the immediate challenge to appropriate care is the time lag and the effort involved. They report a normalization of overt commentary and bias from peers and patients. . . . in my town we’ve had a large influx of Burmese immigrants, as well as Punjabi immigrants and a lot of times those patients need a language [phone] . . . and so, my colleagues have said, I don’t want to go in there. I’m going to be on the phone forever. So I’ve experienced or witnessed that bias. (C, group B)

The way the participants discussed witnessed bias suggested that emergency nurses can acknowledge their own bias but fail to acknowledge or understand how their own bias causes harm, only describing the biases of other nurses as harmful. A lot of them are Black and they’re coming for like a lot more primary care, because they’re on Medicare they don’t want to pay their ER fees so they’re not as worried about that. And that’s a little bit of an assumption on my part, but then I feel like there ends up being bias, because we see so many people that are coming for maybe not emergent but they’re coming, because they don’t have a primary. (B, group C)

Experienced Bias

In discussing personally experienced bias, participants in this study reported a pattern of retraumatization—the repeated trauma of being held responsible, penalized, or blamed for reacting to racism directed toward them. Emergency nurse participants who identify with systematically marginalized groups reported daily harm from a constant process of justifying their existence in the workspace, from both patients and leadership.

A participant shared: Sometimes it’s like inappropriate like just being called you know, n****r, like “when are you going to stop being a n****r,” that kind of thing. Another time and one patient asked me, you know, was I Baptist and I was like, you know, “Why you asked me that?” And it’s the “Most colored people are Baptist,” that kind of thing. To you know, make blatantly, maybe wanting a different nurse, and they want a white nurse. I have experienced that. (N, group F)

And another reported: I mean it’s [been] for me for having people have me pretty much go over my entire résumé and asked me how I got into the expensive school that I went to, to ask me if I was a real nurse to being called a, hold on to your pants, . . . a house n****r by a family member and then being called into the office by the manager What I had actually said at the time was, “You know it’s 2010 we don’t call people that now and that’s not appropriate.” (L2, group B)

White participants reported frustration with what they understood to be bias toward them for their treatment or management of patients from other racialized groups. They reported their frustration as a challenge to their ability to provide equal care to all patients. I have experienced an overt bias toward anyone who is not of their nationality that “You can’t understand me, because I am of this nationality.” . . . It’s become unkind and very accusatory and that

even though [I] constantly explain, “Look our staff is very diverse, our population’s very diverse, we treat everyone the same. Nursing is not about bias, it’s about getting you the care you need.” . . . It starts out very, very confrontational now . . . and some of those cultures now [can be] confrontational toward us and it’s ugly, it’s unkind. (L, group B)

Emergency nurses discussed how they “pick their battles” both in self-advocacy and in calling out colleagues after witnessing or experiencing bias. Participants reported not intervening when witnessing bias out of reluctance to become targets themselves, as described by one participant: You find that a lot of times people won’t intervene, because they don’t want to then have a target on them. Or you’ll notice that there’s like a relationship shift, right? You’ll notice that now people aren’t interacting with you the way that they normally did, because you stuck up for somebody else. (J, group D)

Another participant shared: But you kind of feel, or at least I did, that you had to pick and choose, because if you were going to report everything that happened to you first off you could probably not have a lot of work done. You don’t want to hear people say, you know, “Oh she’s pulling the race card.” (L2, group B)

They described resistance to engaging in a more authoritative response; in particular, white nurses reported focusing on cajoling or educating people, rather than setting more systemic expectations for behavior and practice. They reported that they felt directly calling out of behavior did more harm than good.

For example: . . . I don’t think I ever straight called someone out, I would say I, in like my professional career. I have been called out, you know face-to-face, and actually I feel like it does more harm in the moment than help. (J, group C)

And: I wouldn’t ever get into that conversation with another nurse. I wouldn’t ever confront that nurse. I’m not going to make a difference; I’m not going to change their mind. I’m not going to change their opinion, it’s really not worth it. (J, group E)

Some participants reported leaving jobs where they felt they could not confront bias effectively. Yes, absolutely I know . . . personally, I have left positions, because my immediate supervisor had found out about my sexual orientation and decided to target me with bogus write-ups, so I personally have been affected, yes. (J, group E)

Participants also reported responding to a colleague’s bias toward a patient by attending to the patient without comment to their peer or report to superiors. They explained this behavior by suggesting that they were reluctant to call something “racist” without knowing for sure the individual’s intent. In addition, nurses reported that they are unlikely to intervene by speaking to the nurse or provider when they become aware of bias in care, nor would they escalate the incident to management’s attention. Rather than speaking with the nurse at the time bias is observed, nurses discussed intervening directly with the patient. I just usually intervene in the moment, the best way I can. Or I’ll just say, you know, I’ll . . . “Let me go talk to them, let me just go talk to them. I’ll take care of it,” or “I’ll go give that med for you” and then I can intervene that way. (M, group E)

Non-white nurses reported that they had responded to bias from patients directly at times: The honest-to-God truth is that it didn’t stop until I said something inappropriate back. Um, and I said after about a whole half hour of this I said, “How about I stop being a n****r as soon as you stop being a honky.” And then the patient was so in shock that I said that, but that’s not how you handle situation. I just felt like upset that I had to go there, because you know you’re not supposed to stoop to another person’s level. (N, group F)

On a couple of occasions, nurses from populations that have been historically marginalized (eg, Black, gay) also expressed frustration with speaking up about microaggressions and discrimination they experienced because of the frequency of these incidents and the psychological and personal harm that resulted. You still don’t feel as if you’re getting backed by leadership or management. If you are to say something like “Don’t treat me that way,” you don’t

have the right to do that, because what we see is that they do have the right to do that and then they're kind of supported in that behavior. . . (L2, group B)

Impact of Bias on Care

Emergency nurses described that exhibiting bias in assessment or care may downplay symptoms, delay care, or undertreat patients. They explained that bias may affect the frequency of patient assessment, communication with the patient and/or family, and ongoing care. One instance I'm thinking specifically, we have a patient with sickle cell and is often, like, highly undertreated. I hear comments all the time, "Well I just gave her, you know, X amount of pain medication," like, "I'm, I can't, you know . . . I can't give any more than that; that's not safe." Just not even recognizing maybe the bias there towards the disease, an individual for pain meds. (J, group C) We have a huge problem with addiction, mainly opiates, but it affects the care from the minute the patient arrives — if they're transported as an overdose they stay in overdose and they can stay in overdose for an entire shift, and then a new shift comes in and recognizes, oh, something else is wrong, like you can be an overdose who also has a head bleed, for instance, or a fractured arm, but you know you have in your head, this is just an overdose and you just sort of get the vitals, undress them, go about your way, but we have to remember that. (A, group D)

In addition, the therapeutic relationship between patient and nurse can be damaged, and consequentially, care may suffer. Focus group participants reported that patients exhibiting bias may ultimately have less experienced or angry nurses assigned to them whereas allies who are uncomfortable with racist patients describe not wanting to provide optimum patient care, because the patient's perceived racist behavior is bothering their coworkers to the point of making the work environment intolerable, as described below. I said, "Hey, can you go take vitals on them?" and somebody else was like, "Nope, no, no one who is not white is allowed to set foot in that room, because that patient is a jerk." And like, I took that very seriously, as did everybody else, so I'm pretty sure that none of us wanted to go in there after that, and then whatever was supposed to be happening for other patients that we were supposed to be taking care of might not be getting done, because you had to pull somebody else to come with you to go in that room half the time, because patient was inappropriate. (N, group F)

Solutions

Participants in this study reported a perception that institutions are implementing diversity, equity, and inclusion programs as a "checkbox" but the institutions are not focused on actual dismantling of institutionalized biases, diversity-equity-inclusion staff education, and holding individuals accountable for biased behavior. Many of our participants discussed a knowledge of widespread bias in practice but reported a preference for solutions that they themselves could employ, such as modeling behaviors that were more patient centered. The most frequently discussed systemic solution was that of increasing diversity among staff and administration. This was recognized by many participants as a way to improve the socioclinical environment; however, it was equally common to recognize the difficulty of recruiting and retaining a diverse workforce.

One participant offered: What you really need are people to talk to people who are not like them, because, in my experience that's what helps people understand that people who don't look like you or don't think like you, are still actual people that you can connect . . . (D, group F)

Discussion

The purpose of this study was to obtain a broad view of the knowledge, attitudes, beliefs, and lived experiences of emergency nurses regarding implicit and explicit bias in the ED workplace, with the aim of identifying areas of priority for educational and workforce interventions. Our sample reflected the general demographic breakdown of nursing in both the survey and focus group arms.

We chose to frame the categories within the structure described by Barbee.⁹ In her work, Barbee makes an

argument that specific characteristics of nursing, such as an emphasis on empathy, a focus on the individual, a preference for homogeneity, and a need to avoid conflict prevent a full discussion or reckoning with racism. We maintain that these same characteristics also create challenges for addressing other forms of bias, including ableism and bias against the LGBTQIA+ community, and so have chosen to use this framework to discuss our findings about the many forms of bias reported in this study.

Empathy and the Focus on the Individual

Barbee⁹ discussed an emphasis on empathy as a barrier to discussion of racism specifically in nursing; she describes her difficulty of writing about a problem in which the challenge of identifying racism in nursing lies in its subtlety and embeddedness. Empathy, as Barbee described it, is transformed into an identification with caring and work and an individual orientation to providing care. Empathy does not acknowledge the structural elements, such as laws, policies, and processes, that are created and enforced outside the individual nurse. Barbee's⁹ work is reinforced by the work of Iheduru-Anderson et al,¹⁰ whose integrated literature review suggested that little has changed.

Our participants discussed an individual orientation in both managing and responding to witnessed bias. In survey responses, we saw that white-identifying respondents were more likely to have difficulty putting themselves in the shoes of others who are racially or ethnically different or to relate to stories of other people's experiences with racism or discrimination. Similarly, although our focus group data confirmed this to a large extent, the nurses who offered possible responses to bias were likely to identify individual rather than structural reactions, such as talking to the person who exhibited bias or modeling "better" behavior. In the case of intervening during the care of a patient who was the target of racism or other bias, nurses reported that they might ignore the colleague altogether and respond by providing care to the patient without comment or without reporting this negative behavior up the administrative chain. There was a resistance to structural changes from white participants, preferring these more targeted individual interactions. This focus on individual responses results in the perception that racism is an interpersonal event and therefore remedied by interpersonal interaction^{29,30} rather than acknowledging the historical and structural systems that perpetuate discrimination toward minoritized social groups. Similarly, Waite and Nardi³¹ discussed the implications of colonialism and racism for nursing leaders, specifically calling out the tendency of leaders to rely on education and conversation to mitigate racism. These individually oriented responses or systemic responses of education do little to name or dismantle the structures that support this negative behavior and could explain, in part, the perpetuation of systemic bias and racism in nursing.

However, we found that specific groups of participants, specifically millennials, those who identified as non-white, and who identified as non-Christian, endorsed higher levels of ethnocultural empathy. This is possibly related to the higher levels of education for all millennials and specifically the higher participation in the workforce of women. Most millennial voters affiliate with the democratic party or lean democratic,³² and this may account for generational differences on specific issue areas, from views of racial discrimination and immigration to foreign policy and the scope of government. There is an increased prevalence of interracial marriage among millennials; in this generation, only 56% of the population identified as non-Hispanic white.³³ Other authors reported that non-white people endorse higher levels of ethnocultural empathy,³⁴ which aligns with our findings. With regard to religious identification and empathy, Galen³⁵ reported that the oft-assumed association between persons who identify their religious affiliation as Christian and prosocial behaviors and attitudes is false and may be a result of self-reporting, a conclusion supported by our findings as well.

A Preference for Homogeneity

Both our sample and the nursing population in general are approximately 80% white in comparison with the general

population of the United States, which is approximately 60% white. A preference for homogeneity manifests as a repeated statement of “We’re all the same, we treat everyone the same” or taking a “color-blind” approach: “the color-blind individual, by ostensibly failing to see race, fails to see racism and falls into racist passivity. The language of color blindness—like the language of ‘not racist’—is a mask to hide racism”³⁶ (p.10). Although our white participants were insistent in this claim, they also provided anecdotes of discrimination toward Black patients. One example described how Black patients from a catchment area presenting to an emergency department in a white, wealthy suburb were “labeled” when colleagues interpreted those presentations as less emergent, suggesting that the very presence of a person of color in an emergency department in a white majority geographic area is immediately subject to judgment. The literature presents us with evidence that bias against women, non-white identifying, and transgender people exists, specifically in the areas of pediatrics,^{4,37,38} mental health,³⁹ pain management,⁴⁰ and sepsis.⁴¹ Our survey data revealed a relationship between identifying as non-white and agreeing with statements such as “I was told that people of color do not experience racism anymore” and “I was told that people of all racial groups experience the same obstacles.” The insistence on homogeneity does harm to patients, because it impedes the ability of a nurse to challenge their own bias-induced blind spots in assessment and treatment. In addition, when we take a “color-blind” approach, we erase the experiences and histories of Black, indigenous, Latinx, Asian, Pacific Islander, and other people of color, thereby ignoring the racist policies and structural inequities that produce poorer health outcomes for our patients and their communities.

A Need to Avoid Conflict

Both nurses who witnessed bias and those who experienced it discussed the need to “pick their battles,” regarding whether to challenge a patient or colleague in the moment. Most reported direct responses to bias as rare and as a last resort, particularly when they are the “only” person of color, LGBTQIA+, or disabled person in the department or if they do not want to be targeted as “difficult.” These data are supported by work on bullying in ED settings,⁴² where emergency nurses were reluctant to call out inappropriate behaviors and biases, and this extended to nurse-patient assignments incongruous with a nurse’s experience level or workload. Similarly, in this study, nurse-patient assignment was used to avoid dealing with patients who exhibited discriminatory or aggressive behavior toward staff who were non-white, transgender, or gay. In addition, in previous bullying research, emergency nurses tended to use strategies such as being the guilty bystander,⁴³ avoiding challenging colleagues or patients so that they do not become the target, or maintaining the status quo, where they will attend to patients but not challenge colleagues or report the biased behavior up the administrative chain for fear of causing trouble. Rarely did they call it out or use more direct responses to address bullying behaviors.⁴² This suggests that an individualized, passive approach to reducing the widespread occurrence of violence at work is not an effective strategy, whether these workplace violence occurrences are microaggressions or acts of physical aggression.

Solutions

Nurse participants suggested that one necessary solution to address bias in health care is to increase diversity. Similarly, other organizations have emphasized the need for increased diversity for nursing students and faculty and nurses in practice.⁴⁴⁻⁴⁶ However, these papers did not directly address entrenched structural racial inequities as a core contributor to health inequities.

Approaches to address the negative impact of implicit bias and cognitive stressors on health disparities, medical decision making, and inequities in patient care include shared decision making with patients, empathy for their situation, and emotional regulation,⁴⁷ increasing opportunities for contact with individuals from different groups (Institute for Healthcare Improvement and Institute for Healthcare Improvement Multimedia Team, 2017; National Academies of Science Engineering and Medicine, 2021),⁴⁸ and bias-mitigating strategies, such as counter

stereotypic imaging, habit replacement, mindfulness, partnership building, and perspective taking.⁴⁹ However, these suggestions from important health care organizations are targeted at individual providers, not at systems, and may not help tackle systemic racism and bias in nursing.

Systemic and institutional changes are needed to address bias, including racism, in health care organizations. Historically, nursing leaders have viewed bias as an interpersonal issue, while neglecting the need to focus on evidence-based systemic and institutional actions. Although individual-level work is needed for nurses and other health care professionals to gain an awareness of personal biases, Marcelin et al⁵⁰ discussed that a shift in culture is necessary at the organizational level. Using the nursing process, emergency nurse leaders must assess the climate and outcomes in their unit and health system. Traditional assessment strategies such as climate surveys are a good step, but leaders must move beyond assessing the climate and culture of their organization to taking meaningful steps to create change. The path to addressing bias in health care and health inequities must be laid out with clearly defined actions and systems for accountability. Marcelin et al⁵⁰ discussed several strategies including developing a leadership commitment to culture change, diversity and cultural humility training, intentional diversification of experiences, stereotype awareness, and mentorship/sponsorship of historically excluded people. McLemore⁵¹ proposed a retrofit, reform, and reimagine model that can be used to determine the best approach to address the systemic factors that perpetuate bias and health inequities including policies, processes, and systems. Using these approaches, nurse leaders working in collaboration with their communities can identify the types of strategies needed to ensure health equity.

Limitations

The limitations of this study include the use of a convenience sample drawn from ENA members leading to potential for selection bias. In addition, those who voluntarily participated in a study about experiences involving racism and other biases may have different thoughts and feelings than nonresponders. A large and diverse survey sample and further corroboration from focus group findings allow some generalizability. However, given that both survey and focus group samples were recruited from the ENA member database, there may be response bias that does not reflect unknown differences between members and nonmembers.

Implications for Emergency Nursing

We recommend, in addition to individual reflection, staff education, and staff accountability, that organizations be required to implement actions to mitigate inequities such as examining the ways that institutional and systemic policies and processes perpetuate bias and racism in nursing. Organizations, including nursing schools, must commit to implementing evidence-based strategies for increasing the recruitment and retention of nurses from diverse communities, teaching all employees about cultural humility and the importance of culturally informed care, opening and maintaining a dialogue with systematically marginalized groups to address their concerns, and implementing meaningful changes that reduce bias, racism, and other forms of discrimination. It is important to have systems of accountability built into an organization; health care facilities can make their diversity, equity, and inclusion goals public and provide regular updates on their progress, thus holding themselves accountable to the communities they serve.

Conclusions

In both our survey and focus group data, we see evidence that racism and other forms of bias are threats to both safe patient care and the well-being of nurses. It is well established that nurses commonly carry some bias, whether it is recognized by the individual or not (Groves et al).⁵² We challenge all emergency nurses to reflect on the implicit and explicit biases they hold, to educate themselves on how to identify and manage their personal biases, and to engage in purposeful learning about the effects of individual and structural bias on patients and colleagues.

Data, Code, and Research Materials Availability

Ethical approval from Advarra, Inc IRB (Columbia, MD) # Pro00054611.

Author Disclosures

Conflicts of interest: none to report.

Demographics	Survey	Focus group progression		
	Participants (N = 1134) n (%)	Interested (n = 259) n (%)	Signed up (n = 64) n (%)	Participated (n = 23) n (%)
Non-white (any)	218 (19.2)	76 (29.3)	12 (18.8)	6 (26.1)
Gender (all)	1094 (96.5)	253 (97.7)	63 (98.5)	22 (95.6)
Non-heterosexual	130 (11.5)	36 (13.9)	7 (9.4)	2 (8.7)
Non-Christianity(including no religion)	356 (31.4)	94 (36.3)	25 (39.1)	10 (43.5)
Disabled	132 (11.6)	33 (12.7)	9 (14.1)	4 (17.4)
Disabled identity	33 (2.9)	7 (2.7)	1 (1.6)	1 (4.3)

Racial and ethnic microaggressions scale item	White vs non-white		
	White	Non-white	Difference
	n (%)	n (%)	% (95% CI) P value
I was ignored at school/work because of my race.	102 (11.5)	99 (45.8)	34% (28-41) P <.001
Someone's body language showed they were scared of me because of my race.	103 (11.6)	95 (44.0)	32% (26-39) P <.001
Someone assumed that I spoke a language other than English.	132 (14.9)	131 (61.0)	46% (39-53) P <.001

I was told that I should not complain about race.	133 (15.0)	83 (38.4)	23% (17-30) P <.001
Someone assumed that I grew up in a particular neighborhood because of my race.	228 (25.8)	111 (51.6)	26% (19-33) P <.001
Someone avoided walking near me on the street because of my race.	29 (3.3)	57 (26.4)	23% (18-29) P <.001
Someone told me that she or he was color-blind.	269 (30.5)	95 (44.2)	14% (7-21) P <.001
Someone avoided sitting next to me in a public space (eg, restaurants, movie theaters, subways, busses) because of my race.	58 (6.6)	68 (31.6)	25% (19-32) P <.001
Someone assumed that I would not be intelligent because of my race.	60 (6.8)	107 (49.5)	43% (36-50) P <.001
I was told that I complain about race too much.	64 (7.3)	56 (25.9)	19% (13-25) P <.001
I received substandard service in stores compared with customers of other racial groups.	112 (12.7)	122 (56.5)	44% (37-51) P <.001
I observed people of my race in prominent positions at my workplace or school.	728 (82.6)	149 (69.3)	13% (7-20) P <.001
Someone wanted to date me only because of my race.	59 (6.7)	46 (21.4)	15% (9-21) P <.001
I was told that people of all racial groups experience the same obstacles.	309 (35.0)	117 (54.2)	19% (12-26) P <.001
My opinion was overlooked in a group discussion because of my race.	125 (14.2)	81 (37.5)	23% (17-30) P <.001
Someone assumed that my work would be inferior to people of other racial groups.	52 (5.9)	92 (42.6)	37% (20-44) P <.001
Someone acted surprised at my scholastic or professional success because of my race.	41 (4.7)	115 (53.2)	49% (42-55) P <.001
I observed that people of my race were the CEOs of major corporations.	732 (83.3)	117 (53.9)	30% (22-36) P <.001

I observed people of my race portrayed positively on television.	757 (86.5)	162 (75.0)	12% (6-18) P <.001
Someone did not believe me when I told them I was born in the United States.	26 (2.9)	48 (22.2)	19% (14-25) P <.001
Someone assumed that I would not be educated because of my race.	35 (4.0)	89 (41.6)	38% (31-44) P <.001
Someone told me that I was "articulate" after she/he assumed I wouldn't be.	82 (9.3)	103 (47.7)	38% (32-45) P <.001
Someone told me that all people in my racial group are all the same.	338 (38.4)	107 (49.5)	11% (4-19) P = .003
I observed people of my race portrayed positively in magazines.	724 (81.6)	148 (68.5)	13% (7-20) P <.001
An employer or coworker was unfriendly or unwelcoming toward me because of my race.	150 (17.1)	86 (40.0)	23% (16-30) P <.001
I was told that people of color do not experience racism anymore.	228 (32.7)	108 (50.0)	17% (10-25) P <.001
Someone told me that they "don't see color."	414 (47.1)	124 (57.7)	11% (3-18) P = .005
I read popular books or magazines in which a majority of contributions featured people from my racial group.	625 (71.6)	107 (49.8)	21% (15-29) P <.001
Someone asked me to teach them words in my "native language."	63 (7.7)	93 (43.9)	36% (39-43) P <.001
Someone told me that they do not see race.	388 (44.1)	125 (58.1)	14% (7-21) P <.001
Someone clenched her/his purse or wallet upon seeing me because of my race.	22 (2.5)	48 (22.9)	20% (15-27) P <.001
Someone assumed that I would have a lower education because of my race.	29 (3.3)	100 (46.5)	43% (37-50) P <.001
Someone of a different racial group has stated that there is no difference between the 2 of us.	230 (26.1)	109 (50.7)	25% (17-32) P <.001

Someone assumed that I would physically hurt them because of my race.	49 (5.6)	45 (20.9)	15% (10-21) P <.001
Someone assumed that I ate foods associated with my race/culture every day.	141 (16.0)	117 (54.4)	38% (31-45) P <.001
Someone assumed that I held a lower paying job because of my race.	26 (3.0)	87 (40.5)	38% (31-44) P <.001
I observed people of my race portrayed positively in movies.	736 (83.8)	154 (72.3)	12% (5-18) P <.001
Someone assumed that I was poor because of my race.	40 (4.6)	85 (39.7)	35% (29-42) P <.001
Someone told me that people should not think about race anymore.	341 (38.8)	103 (48.8)	10% (3-17) P = .008
Someone avoided eye contact with me because of my race.	138 (15.8)	83 (38.9)	23% (16-30) P <.001
I observed that someone of my race is a government official in my state.	797 (90.8)	144 (67.3)	24% (17-30) P <.001
Someone told me that all people in my racial group look alike.	223 (25.4)	102 (47.7)	22% (16-30) P <.001
Someone objectified one of my physical features because of my race.	140 (15.9)	107 (50.0)	34% (27-41) P <.001
An employer or coworker treated me differently than white coworkers.	30 (3.4)	106 (49.3)	46% (39-53) P <.001
Someone assumed that I speak similar languages to other people in my race.	104 (11.9)	120 (56.0)	44% (37-51) P <.001

SEE item	White vs non-white			Christian vs non-Christian		
	White	Non-white	Difference	Christ ian	Non- Christi an	Difference

	Mean (SD)	Mean (SD)	Mean difference (95% CI)	Mean (SD)	Mean (SD)	Mean difference (95% CI)
I feel annoyed when people do not speak standard English.	4.68 (1.27)	5.03 (1.27)	-0.35 (-0.54 to -0.16)	4.65 (1.33)	4.99 (1.13)	-0.34 (-0.049 to -0.18)
I don't know a lot of information about important social and political events of racial and ethnic groups other than my own.	4.55 (1.23)	4.62 (1.37)	-0.08 (-0.26 to 0.12)	4.52 (1.26)	4.69 (1.20)	-0.15 (-0.31 to 0.01)
I am touched by movies or books about discrimination issues faced by racial or ethnic groups other than my own.	4.50 (1.36)	4.69 (1.47)	-0.18 (-0.39 to 0.02)	4.46 (1.39)	4.73 (1.37)	-0.25 (-0.43 to -0.07)
I know what it feels like to be the only person of a certain race or ethnicity in a group of people.	3.06 (1.80)	5.05 (1.44)	0.13 (-2.24 to -1.73)	3.45 (1.90)	3.45 (1.89)	-0.06 (-0.30 to 0.18)
I get impatient when communicating with people from other racial or ethnic backgrounds, regardless of how well they speak English.	5.48 (0.85)	5.55 (0.93)	-0.07 (-0.19 to 0.06)	5.51 (0.83)	5.52 (0.87)	0.01 (-0.10 to 0.12)
I can relate to the frustration that some people feel about having fewer opportunities owing to their racial or ethnic backgrounds.	3.35 (1.57)	4.47 (1.70)	-1.12 (-1.36 to -0.89)	3.48 (1.66)	3.71 (1.67)	-0.22 (-0.43 to -0.01)
I am aware of institutional barriers (eg, restricted opportunities for job promotion) that discriminate against racial or ethnic groups other than my own.	3.71 (1.73)	4.44 (1.78)	-0.73 (-0.99 to -0.47)	3.60 (1.75)	4.42 (1.67)	-0.80 (-1.02 to -0.58)
I don't understand why people of different racial or ethnic backgrounds enjoy wearing traditional clothing.	5.61 (0.81)	5.65 (0.87)	-0.04 (-0.16 to 0.08)	5.56 (0.86)	5.72 (0.69)	-0.17 (-0.26 to -0.07)
I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences.	4.35 (1.36)	4.62 (1.38)	-0.27 (-0.47 to -0.07)	4.35 (1.38)	4.56 (1.31)	-0.24 (-0.41 to -0.07)
I feel irritated when people of different racial or ethnic backgrounds speak their language around me.	5.05 (1.21)	5.16 (1.26)	-0.11 (-0.30 to 0.07)	4.99 (1.26)	5.28 (1.05)	-0.30 (-0.46 to -0.15)

When I know my friends are treated unfairly because of their racial or ethnic backgrounds, I speak up for them.	4.84 (1.07)	4.99 (1.14)	-0.16 (-0.32 to 0.01)	4.83 (1.10)	4.97 (1.04)	-0.13 (-0.27 to 0.01)
I share the anger of those who face injustice because of their racial and ethnic backgrounds.	4.28 (1.37)	4.78 (1.37)	-0.50 (-0.70 to -0.29)	4.20 (1.41)	4.74 (1.27)	-0.52 (-0.70 to -0.35)
When I interact with people from other racial or ethnic backgrounds, I show my appreciation of their cultural norms.	4.72 (1.01)	5.04 (1.09)	-0.32 (-0.47 to -0.17)	4.73 (1.05)	4.89 (1.01)	-0.17 (-0.30 to -0.03)
I feel supportive of people of other racial and ethnic groups, if I think they are being taken advantage of.	4.76 (1.07)	4.92 (1.27)	-0.16 (-0.32 to 0.01)	4.73 (1.12)	4.91 (1.12)	-0.19 (-0.33 to -0.05)
I get disturbed when other people experience misfortunes owing to their racial or ethnic backgrounds.	5.01 (1.08)	5.26 (1.06)	-0.25 (-0.41 to -0.09)	4.96 (1.10)	5.27 (1.00)	-0.28 (-0.41 to -0.14)
I rarely think about the impact of a racist or ethnic joke on the feelings of people who are targeted.	5.10 (1.16)	5.13 (1.24)	-0.03 (-0.21 to 0.15)	5.08 (1.17)	5.19 (1.14)	-0.15 (-0.29 to 0.00)
I am not likely to participate in events that promote equal rights for people of all racial and ethnic backgrounds.	4.49 (1.54)	4.75 (1.56)	-0.25 (-0.48 to -0.02)	4.35 (1.58)	4.98 (1.37)	-0.62 (-0.80 to -0.43)
I express my concern about discrimination to people from other racial or ethnic groups.	4.00 (1.36)	4.51 (1.35)	-0.52 (-0.72 to -0.31)	3.96 (1.36)	4.38 (1.37)	-0.40 (-0.57 to -0.23)
It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own.	3.11 (1.40)	4.55 (1.48)	-1.44 (-1.65 to -1.23)	3.36 (1.54)	3.46 (1.46)	-0.08 (-0.28 to 0.11)
I can see how other racial or ethnic groups are systematically oppressed in our society.	4.12 (1.61)	4.70 (1.63)	-0.58 (-0.82 to -0.34)	3.91 (1.64)	4.92 (1.39)	-1.00 (-1.18 to -0.81)
I don't care if people make racist statements against other racial or ethnic groups.	5.60 (0.80)	5.60 (0.82)	-0.01 (-0.13 to 0.11)	5.57 (0.84)	5.66 (0.74)	-0.10 (-0.19 to 0.00)

When I see people who come from a different racial or ethnic background succeed in the public arena, I share their pride.	4.81 (1.14)	5.19 (1.05)	-0.39 (-0.55 to -0.22)	4.84 (1.15)	4.97 (1.06)	-0.14 (-0.28 to 0.00)
When other people struggle with racial or ethnic oppression, I share their frustration.	4.24 (1.27)	4.87 (1.27)	-0.63 (-0.82 to -0.44)	4.25 (1.33)	4.58 (1.18)	-0.33 (-0.49 to -0.17)
I recognize that the media often portrays people based on racial or ethnic stereotypes.	5.01 (1.18)	5.19 (1.10)	-0.18 (-0.35 to -0.01)	4.95 (1.21)	5.25 (1.04)	-0.28 (-0.43 to -0.14)
I am aware of how society differentially treats racial or ethnic groups other than my own.	4.56 (1.31)	5.04 (1.24)	-0.48 (-0.68 to -0.29)	4.44 (1.34)	5.09 (1.13)	-0.65 (-0.81 to -0.49)
I share the anger of people who are victims of hate crimes (eg, intentional violence because of race or ethnicity).	5.13 (1.15)	5.30 (1.13)	-0.18 (-0.35 to -0.01)	5.11 (1.17)	5.30 (1.06)	-0.19 (-0.33 to -0.04)
I do not understand why people want to keep their indigenous racial or ethnic cultural traditions instead of trying to fit into the mainstream.	5.32 (1.00)	5.32 (1.24)	0.01 (-0.15 to 0.16)	5.23 (1.07)	5.51 (0.97)	-0.30 (-0.43 to -0.17)
It is difficult for me to put myself in the shoes of someone who is racially and/or ethnically different from me.	4.23 (1.29)	5.07 (1.18)	-0.85 (-1.03 to -0.66)	4.37 (1.33)	4.50 (1.23)	-0.14 (-0.031 to 0.03)
I feel uncomfortable when I am around a significant number of people who are racially/ethnically different than me.	4.85 (1.17)	5.03 (1.26)	-0.18 (-0.35 to 0.00)	4.89 (1.19)	4.94 (1.16)	-0.06 (-0.21 to 0.09)
When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group.	4.12 (1.44)	4.19 (1.57)	-0.07 (-0.29 to 0.15)	4.07 (1.45)	4.34 (1.45)	-0.30 (-0.49 to -0.11)
It is difficult for me to relate to stories in which people talk about racial or ethnic discrimination they experience in their day-to-day lives.	4.08 (1.29)	4.99 (1.21)	-0.91 (-1.10 to -0.72)	4.22 (1.32)	4.34 (1.29)	-0.14 (-0.31 to 0.03)

Quantitative findings: bias and empathy	Qualitative findings: bias and empathy
<p>There were significant differences across all 4 SEE subscales and total SEE scores, with non-white participants consistently endorsing higher levels of ethnocultural empathy than their white counterparts. (total mean difference [95% CI]: -0.43, t = -7.956, df = 238.581, P <.001)</p>	<p>A seasoned nurse explained her experience with both implicit and explicit bias saying, "I've seen so much bias with nurses in the ER, while they don't show it in the patient room they'll go back out into the nurse's station and bad mouth that patient...what I call patient bashing."</p>
<p>Nonheterosexual participants had significantly higher mean total SEE scores, empathetic awareness subscale scores, and empathetic feeling/expression subscale scores. (total mean difference [95% CI]: -0.22, t = -3.637, df = 1054, P <.001)</p>	<p>A participant described her nursing colleagues' discomfort in working with a transgender female physician: "They [other staff] approached her less, and you could tell through just even their dialogue, that they were uncomfortable how to address her even just simply by her name, you know, doctor."</p>
<p>Participants who identified with Christianity had lower mean scores on items representing empathetic awareness (eg, institutional barriers, systematic oppression, societal treatment) and its effects on people of other racial or ethnic backgrounds. (total mean difference [95% CI]: -0.28 [-0.36 to -0.19], t = -6.540, df = 1042, P <.001)</p>	<p>. . . in my town we've had a large influx of Burmese immigrants, as well as Punjabi immigrants and a lot of times those patients need a language [phone] . . . and so, my colleagues have said, I don't want to go in there. I'm going to be on the phone forever. So I've experienced or witnessed that bias.</p>
<p>Mixed methods inferences: expansive Findings from FG and survey participants were expansive such that the quantitative findings (SEE scores) expanded our knowledge regarding differences in perceptions (by race, gender, religious affiliation) regarding the scope of existing biases, the recognition of harm, and empathy toward people of different racial and ethnic backgrounds than one's own. FG participants reported and acknowledged the occurrence and general intolerance of overt bias (eg, race, gender, and nonconforming sexual identity) directed at ED patients and staff; however, they also described bias as a display of public tolerance for a colleague or patient while harboring private intolerance for the same person. In the context of empathy (which is a cornerstone of nursing), qualitative findings served to expand our understanding of how an individual orientation to providing care influences nurses' perceptions. Empathy does not require or elicit acknowledgment of the institutional and structural elements (eg, policies and processes) that perpetuate bias and racism, nor does it challenge individual nurses to reflect on the ways that they themselves might contribute to its continuation in the workplace.</p>	

DETAILS

Subject:	Emergency medical care; Intercultural sensitivity; Learning; Accountability; Racism; Patients; Focus groups; Structural analysis; Bias; Microaggressions; Workplaces; Nurses; Emergency services; Empathy; Polls & surveys; Christianity
Location:	United States--US
Identifier / keyword:	Bias; Emergency nursing; Workplace environment; Mixed methods; Clinical judgment

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	175-197
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.008
ProQuest document ID:	2781604617
Document URL:	https://www.proquest.com/scholarly-journals/experiences-united-states-emergency-nurses/docview/2781604617/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-03
Database:	Public Health Database

Document 29 of 50

Perspective of Emergency Pediatric Nurses Triageing Pediatric Patients in the Emergency Department: A

Phenomenographic Study: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Triage, a process to determine illness severity, is implemented by emergency nurses to prioritize treatment and provide care for a maximum number of patients using limited resources. The competency of emergency nurses and a highly reliable triage are crucial for the provision of emergency care. Pediatric patients are different from adult patients in certain aspects, such as growth-phase characteristics, communication ability, and the onset of disease; these aspects often pose challenges during their primary triage. This study explored how emergency nurses triage pediatric patients using the Korean Triage and Acuity Scale.

Methods

Eleven emergency nurses ($N = 11$) working in the pediatric emergency department of a university hospital in Seoul, South Korea, were recruited using purposive sampling methods. Phenomenography was used to investigate the strategies by which these nurses use the Korean Triage and Acuity Scale to triage pediatric patients.

Results

The findings comprised 2 descriptive categories: 6 approaches on how to triage patients (categories of how) and 3 strategies (categories of what) used by pediatric emergency nurses to triage pediatric patients with the Korean Triage and Acuity Scale.

Discussion

The experience and proficiency of emergency nurses are essential factors for the effective triage of pediatric patients. Our findings qualitatively elucidate different ways of understanding pediatric triage and indicate the need for pediatric triage education programs.

FULL TEXT

Contribution to Emergency Nursing Practice

- Most pediatric patient data are provided by parents. Hence, pediatric emergency nurses need specialized clinical knowledge and skills for gathering information.
- The main findings of this study are that pediatric emergency nurses triage patients by using an integrated approach with structured triage system guidelines, their level of competencies, and the available ED resources.
- Our key implication for emergency nursing practice is that a better understanding of pediatric emergency nurses' cognitive structures may promote the development of an improved and more competent pediatric triage system.

Introduction

Triage aims to prioritize and categorize patients visiting the emergency department for the provision of first aid and emergency treatment.^{1,2} The triage system appears in many formalized systems worldwide. The Australian Triage Scale, Canadian Triage and Acuity Scale, Emergency Severity Index, Manchester Triage Scale, and South African Triage Scale are representative of international triage scales.³ In Korea, the Canadian Triage and Acuity Scale-based Korean Triage and Acuity Scale (KTAS) is currently used.⁴

The KTAS triages patients in the emergency department based on symptomatic evaluation. The emergency nurse accords the patient a KTAS score, depending on their symptoms; this score determines the patient's waiting time while the provider evaluates the corresponding treatment requirements (emergency, KTAS stages 1-3;

subemergency, KTAS stages 4-5).⁴ The KTAS categorizes pediatric and adult patients as 15 years, respectively.⁴ Pediatric patients require specific severity assessment methods and additional considerations, owing to their anatomy and physiology, as well as psychosocial behaviors.⁵ The first-impression assessment is based on the Pediatric Assessment Triangle, which assesses the patient's overall appearance, respiratory capacity, and circulation.⁶ However, triage for pediatric and adult patients is currently similar, despite the need for variations in evaluating pediatric emergencies based on the patient's growth phase.⁷ Emergency nurses use their capabilities and judgment to triage pediatric patients.^{1,8} Therefore, it is necessary to impart training in professional pediatric triaging to improve emergency pediatric treatment outcomes.⁹

Triage is a rapid process that may result in an overestimation or underestimation of the emergency.⁸ Global studies report insufficient evidence for the validity of pediatric triage systems and raise concerns regarding undertriages.¹⁰ Moreover, studies report variations in pediatric triage between general and pediatric emergency nurses.^{9,10} Ebrahimi et al¹¹ investigated the level of inter-rater reliability of pediatric triage systems through a meta-analysis of literature in electronic databases up to March 1, 2019; even though their findings suggest an acceptable reliability in the pediatric emergency department, further studies are needed. According to Heffernan et al,¹² the accuracy of 4 pediatric emergency triage systems (SALT, JumpSTART, Triage Sieve, and CareFlight)¹³ was poor, demonstrating an unacceptable degree of undertriage. Another study⁷ reported that although the inter-rater reliability of the pediatric triage system was accurate, discrepancies in the down-triage proportions for abnormal heart and respiratory rates varied according to the triage performers' professions. Several studies suggest that insufficient training of triage performers, particularly nurses, is a major reason for low triage accuracy.^{14,15} Furthermore, most pediatric patients consult nonpediatric specialty centers,¹⁶ which reinforces the need for systematic pediatric triage education for all ED personnel.⁹

According to the Emergency Nurses Association, triage should be performed by registered nurses who have completed standardized training courses.¹⁷ However, these courses do not include training in decision-making and effective communication skills, which are required during the triage process.¹⁸ Furthermore, variable triage guidelines and inconsistencies in nurses' entry qualifications to triage, in-hospital workflow management, and inadequate triage training among different hospitals may contribute to the causes of low triage accuracy.¹⁹

A recent study suggests that triage accuracy depends on the work experience (particularly, triage implementation) of emergency nurses, given that triage scales are used to assess a patient's illness or injury severity and they do not provide information on triage decisions.²⁰ Specific protocols are required for primary triaging of pediatric patients; therefore, it is important to understand the cognitive structure of the triaging systems used by pediatric emergency nurses and integrate this knowledge into general emergency nursing education. Therefore, this study sought to gain an understanding of the perspective of pediatric emergency nurses while triaging pediatric patients using the KTAS.

Methods Design

This qualitative study used a phenomenography approach, given that the focus of the methodology was describing the variations—or perspectives—of pediatric triage and how pediatric emergency nurses triage their pediatric patients.

Methodological Considerations

Phenomenography aims to qualitatively clarify the different ways in which human beings experience a phenomenon.

²¹ The basic concept is that the only world with which human beings can communicate is the world of their own experience.²¹ The underpinnings of phenomenography relate to the philosophy of phenomenology; in both approaches, the research aims to illuminate human perception and experiences.²² However, the difference between the 2 methodologies is that phenomenology describes an individual's conscious and lived experience of a

phenomenon.²³ In contrast, phenomenography describes differences in the ways to understand and experience another individual's experience of the phenomenon.^{21,22} One great strength of phenomenography is the methodology of examining collective human perspectives on the phenomenon in question, rather than individual perspectives.²² This methodology is referred to as a second-order perspective (how emergency nurses triage pediatric patients in the emergency department) that aims to describe people's thoughts about the world, rather than a first-order perspective to capture the world's essence.²² These features of phenomenography are presented in the results section as categories of description (the varying ways of experiencing a phenomenon) and an outcome space (the hierarchical relationship between categories of description).²⁴

As an evolving research methodology, phenomenography centers on the "conceptualization method" of participants' world experience.²¹ It also provides a means by which knowledge on how people experience phenomena can be revealed.²³ Therefore, this method was appropriate for our study.

We adopted phenomenography research by applying a second-order perspective and investigated the "conceptualization method" of pediatric emergency nurses who triage patients using the KTAS tool, to determine these nurses' subjective perspectives during triage.

Participants

The authors posted notices in the pediatric emergency department of a university hospital located in Seoul, South Korea, to recruit participants. A total of 11 emergency nurses were recruited using purposive sampling. The participants were KTAS certified and experienced in pediatric patient triaging (the opportunity to complete KTAS education and acquire qualifications is provided to nurses with >1 year of ED experience) (Table 1). Given that there is no fixed number of appropriate research subjects in phenomenography, in-depth interviews were conducted until qualitative interview data reached theoretical saturation.

Vignette Construction

Four clinical case vignettes comprising vital signs and pain were created, based on previously reported causes of triage errors in the KTAS evaluation^{7,8,25} (Table 2), to explore the perspectives of participants during triage of pediatric patients using KTAS.

Vignettes 1 and 2 focused mainly on vital signs. In vignette 1, fever was the main complaint. A previous study reported that, in Korea, pediatric patients aged 1 to 4 years frequently visited the emergency department, and the most common cause was fever.²⁵ Therefore, vignette 1 was established as a 12- to 48-month-old child admitted to the emergency department with fever. Vignette 2 was a case of fever in patients who take immunosuppressants. Although level 2 was specified, based on KTAS, it was established after considering that emergency nurses' decision-making process was unclear and differed in clinical practice. Vignettes 3 and 4 considered pain as the main concept. Studies reveal that the highest incidence of abdominal pain among pediatric patients requiring hospitalization was among those aged 5 to 14 years.²⁵ Hence, vignette 3 was set as a case of abdominal pain in a 5-year-old child. Considering language development in the preschool age, although it is easy for such a child to express the desired words, relatively unclear communication is a possible factor. Vignette 4 was a case of a pediatric patient who visited the emergency department without a specific underlying disease, often owing to injury-related causes, including fractures. This case was chosen to understand the experience of the emergency nurse in a situation where triage was decided based on pain alone, in the absence of other related factors, including underlying diseases.

Five experts (2 pediatric ED physicians and 3 KTAS-qualified emergency nurses with >8 years of clinical experience in pediatric triage) performed a content validity analysis of the 4 vignettes. The questionnaire for validation was a 5-point Likert scale (ranging from 1 = lowest to 5 = highest) comprising 2 items: whether they agreed that the 4

vignettes were akin to a situation experienced at the pediatric emergency department and whether the 4 vignettes included the general indicators required for KTAS. Validity was calculated by comparing the sum of scores graded 1 and 2 with that graded 4 and 5.²⁶ The calculated content validity was 0.95.

Data Collection

Data were collected between February and March 2021 at a single university hospital in Seoul, South Korea. Individual interviews were conducted in the ED meeting room and were based on the 4 vignettes. The interviews lasted 30 to 40 minutes and were audio recorded and transcribed verbatim. Field notes were taken during the interview to record participants' points. The interview questions were as follows: (1) What are the KTAS stages for each vignette? (2) On what basis did you decide the KTAS stage for each vignette? (3) What factors influence the KTAS stage for each vignette? and (4) For patient triage using pediatric KTAS, what do you think are the most important competencies in a nurse?

Data Analysis

Data were analyzed according to the phenomenographic procedure described by Dahlgren and Fallsberg.²⁷ The process comprised 7 steps: familiarization, compilation, condensation, grouping, comparison, naming, and contrastive comparison.²⁷ First, the researchers read the transcribed data repeatedly to familiarize themselves with each interview. Subsequently, the representative statements pertaining to the participants' opinions were underlined and summarized. The researchers compared the statements to identify sources of variations, such as differences and similarities in the nurses' experiences; similar statements were grouped together. Concepts and categories were identified by confirming their relationships, and thus, descriptive categories were derived and named to express a substantial meaning. Finally, for contrastive comparison, the significance of the relationships between the descriptive categories was identified. The logical relationship conceptions (descriptive categories) were represented through an outcome space.²²

The final phenomenography result, the outcome space (a diagrammatic representation), presents the relationship between the descriptive categories and their hierarchical structure.²²

Ethical Considerations

This study was approved by the institutional review board (IRB) of Seoul National University, Seoul, Republic of Korea (IRB no. H-2101-097-1189). After explaining the purpose of the study to all participants and confirming their voluntary participation, the first author distributed the consent form containing the purpose protocol to each participant. Participants provided a written informed consent to participate in the study. Their confidentiality was maintained by deidentifying interview records, and collected data were in a coded and depersonalized format; data folders were stored on a password-protected computer.

Results

The inter-rater agreement regarding the triaging of the 4 vignettes by the 11 pediatric emergency nurses was 81.8%. The KTAS had a maximum of 2 levels of disagreement in vignette 1 and a 1-level disagreement in vignettes 2, 3, and 4 (Table 3).

How Nurses Triage Pediatric Patients Using KTAS

We identified 6 descriptive categories of how nurses triaged pediatric patients using KTAS.

Categories of How 1. The Constructed Guideline Base

The constructed guideline base refers to the nurse finding a reference point that corresponds to the main complaint, assessing other patient indicators, and considering these in the patient classification, based on the KTAS guidelines. This involves the nurse assessing the patient's vital signs or pain score, checking whether this value is within the normal or abnormal range, and subsequently triaging the patient according to the KTAS guidelines.

Categories of How 2. Recognition of Variations That Can Be Explained by the Characteristics of Children

This category states that a mere ED visit can affect pediatric patients; therefore, it relies on environmental factors in the emergency department that may give these patients a feeling of instability. In addition, it focuses on characteristics of the pediatric patient's developmental stage.

Categories of How 3. Coordinating the Child's Body Indicators With the Child's Appearance

This category indicates that the observed outward appearance of the pediatric patients coordinates with their measured indicators.

Categories of How 4. Consideration of Possible Change in Level of Emergencies

This category considers the level of emergency that the pediatric patient's symptoms may trigger. The nurse may decide that an acute situation may become serious, even if the patient's emergency level is relatively low during their ED visit. This helps to avoid delays in the appropriate treatment time. Conversely, it prevents overestimating the pediatric patient's triage level owing to verbal/nonverbal patient expressions, even if the level of emergency that can cause these symptoms is not high.

Categories of How 5. Recognition of Resources in the Emergency Department for Treatment Intervention

This category relies on nurses recognizing the human/material resources that are involved in treating a pediatric ED patient and applying this knowledge in triage. It focuses on efficiently using limited ED resources enabling the right patient to receive timely care.

Strategies Nurses Use to Triage Pediatric Patients Using KTAS

We identified 3 descriptive categories of what strategies nurses use to triage pediatric patients using KTAS.

Categories of What 1. Sticking to the Evidence

This category uses objective criteria, without influence by surroundings during triage and determination of the patient's emergency level. This signifies a need for an evidence-based process that nurses can use to clearly recognize the KTAS criteria and accurately triage the patient.

Categories of What 2. Construction of a Possible Prediction Frame

This category relies on nurses' aptitude to acquire sufficient knowledge and experience (including in ED scenarios) in predicting future situations while triaging pediatric patients. The emergency department is a place where diverse patients present with complaints of several symptoms. Nurses construct a predictable frame about "what may happen" and "how to manage" to accurately triage patients in a relatively short period.

Categories of What 3. Mapping Out the Cooperative Network to Be Used

This category presents the emergency department as a place where medical staff of various professions collaborate. Therefore, the nurse who triages a first-time pediatric patient should aid in the formation of a cooperative team network that swiftly responds to the patient's needs.

Next, the supporting quotations from emergency nurses' interviews for these findings are presented (^{Table 4}).

Structure of the Outcome Space

Our results were presented as the outcome space, a perspective of how pediatric emergency nurses determine the triage category. Categories of description were conceptually organized within each frame, according to their referential aspects.²² The outcome space was created around a referential focus of "categories of how" and "categories of what," structured as "what the guidelines say," "possible variations," and "how to cope." These descriptive categories also were integrity-based hierarchies (^{Figure}). At the lowest level, nurses triaged pediatric patients according to the guidelines. At the intermediate level, nurses cited possible variations in triaging pediatric patients beyond the guidelines. "Mapping out the cooperative network to be used" referred to the communication ability and acumen of pediatric emergency nurses who were the first point of contact for a pediatric patient visiting

the emergency department. In addition, “recognition of resources in the ED to intervene in treatment” involved the pediatric emergency nurses’ comprehension of the workflow process of the emergency department, including human/material resources. The referential focus of “how to cope,” which indicated that nurses effectively coped with pediatric emergencies, was structured as the highest level.

Discussion

This study defined descriptive categories based on the qualitatively different ways in which emergency nurses triage pediatric patients in the emergency department. Our findings show that the descriptive categories of KTAS-based triaging of pediatric patients mandate nurses to follow established criteria or adapt to the situation, based on the characteristics of individual patients. In addition, available ED resources or the possibility of an acute situation were considered.

We also obtained insight on the applicability of the pediatric emergency nurses’ practical knowledge in triaging patients. An existing literature review reported situations wherein the determination of patient severity via only the triage and acuity scale was difficult, owing to pediatric patient characteristics.⁹ In the present study, the referential focus “possible variations” presented the pediatric emergency nurses’ experienced-based perspective; they suggested that these variations were a reference factor for triaging pediatric patients in the emergency department. Therefore, the nurses’ empirical knowledge about pediatric patients’ characteristic reactions to the ED setting, their outward appearance, and gradual change of their condition help determine triage.

In this study, the descriptive categories of “how” and “what strategies” that emergency nurses use to triage pediatric patients revealed that participants wanted to maintain objectivity in emergency classification (comply with evidence-based guidelines). Work in the emergency department has a team approach; nurses have a significant responsibility in the initial triage, which determines the priority of the care team during the subsequent patient management process. Hence, emergency nurses require support for their role, and initiatives are needed to reduce their stress related to resolving system issues.²⁰

Most participants presented an objective viewpoint, based on each pediatric patient’s characteristics and the physiological basis of triage. Nevertheless, some nurses focused on managing patient characteristics, in addition to the appropriate use of ED resources. This indicates that even nurses who triage pediatric patients are aware of their additional responsibility to lead the overall flow of the emergency department. Emergency nurses’ work stress increases, owing to conflicts with the physicians, while they are coordinating the efficient treatment flow for inpatients. Simultaneously fulfilling the needs of the patients and physicians may cause further conflicts with physicians owing to prioritization differences.²⁸ Therefore, emergency nurses should play an integral role in managing the emergency department in a cohesive manner and creating a cooperative network. One study suggested that ED staff considered their respective ethos to facilitate interprofessional collaboration.²⁸ However, this indicates that ED resources and the nurses’ culture should be considered when performing triage. In our findings, the referential focus of “how to cope” implied that, during triage, nurses considered constructing a cooperative network by recognizing ED resources for a multidisciplinary team approach.

Data on effective training methods for general emergency nurses pertaining to pediatric triaging in the emergency department are currently inconclusive. Thus far, literature has focused on pediatric patient classification methods and reported that simulation programs and standardized curricula may be effective.^{9,29} Therefore, 2 methods of pediatric classification education—namely, paper case studies and fidelity simulations—were considered effective training methods for general emergency nurses.^{30,31} Significantly, a previous study noted that educational simulations based on various scenarios applicable to an ED situation in any medical institution are effective for understanding the triage of actual pediatric emergency patients.³¹

Our findings suggest that effective training for pediatric triage in the emergency department should include active discussions with health care providers involved in triaging for knowledge sharing and improved comprehension, in addition to the training methods currently used. This approach could reduce medical errors by ensuring a cooperative relationship between multidisciplinary health care providers³² and positively affect the integrated management of emergency nursing practice.²⁸ Therefore, emergency nurses should efficiently discern a situation through effective communication and teamwork with ED personnel; this competence development concerns the provision of high-quality nursing and ensuring patient safety in pediatric emergency department.

Limitations

This study has some limitations. First, the data were obtained from a purposive sample of pediatric emergency nurses working at a single university hospital in South Korea. Hence, the participants might not be representative of pediatric emergency nurses at other locations. However, this study aimed to use a phenomenographic methodology to identify the nature and empirical structure of the triage of pediatric patients determined by emergency nurses and not to generalize the characteristics of a phenomenon. Second, because this study was conducted in the ED environment of one university hospital in South Korea, our results may vary depending on other countries' emergency system settings and situations. Third, based on our results, the nurses' triage concurrences for the 4 vignettes were relatively high, given that they had already performed triage at the pediatric emergency department. However, most nurses who triage pediatric patients are general emergency nurses, who are unfamiliar with the characteristics of children¹⁴; hence, these nurses' pediatric triage concurrence with the KTAS may be lower than reported in the present study. Fourth, our study used a limited number of case-based vignettes. Researchers specifically chose the familiar vignettes seen at pediatric-specific emergency departments in our country; therefore, further studies with large sample-sized multicenter settings are required for validation.

Implications for Emergency Nursing

Emergency nurses should recognize that pediatric emergency patients require a focused assessment. Our results described that the cognitive structures of pediatric emergency nurses on triage provided deeper insight into the triage process, to ensure patient safety and acquire proficiency in emergency nursing. Based on our findings, a resolution for an appropriate pediatric triage system can be developed, increasing awareness of available educational opportunities.

Conclusion

The objective of rapid triage in the emergency department is to enable medical staff (physicians and nurses) to identify patients at potential risk, based on clinical data, subjective information and previous experience, and a cognitive and intuitive process in emergency services.³³

This study explored the cognitive structure of emergency nurses' perspectives of pediatric triage using KTAS.⁴ We also observed the need for enhanced educational resources, pediatric emergency nursing clinical competencies, and appropriate allocation of ED resources for an accurate pediatric triage assessment.

We believe that an awareness of the differences among emergency nurses regarding their understanding of the pediatric triage process is a powerful tool to develop a curriculum for nursing education and is a meaningful suggestion in diverse ED environments. We suggest that further validation studies be performed regarding descriptive categories of our results.

Data, Code, and Research Materials Availability

Owing to ethical concerns, the individual interviews' supporting data cannot be made openly available. This study was based on the participants' interview data, and the IRB consent upholds the certainty that individual participants are guaranteed anonymity of personal information and safety of research data. Upon publication of this study,

quotes from participants who shall remain anonymous can be shared.

This study was approved by the IRB of Seoul National University, Seoul, South Korea (IRB no. H-2101-097-1189). After explaining the purpose of the study to all participants and confirming their voluntary participation, the first author (Y.J.A.) distributed the consent form containing the purpose protocol to each participant. The participants provided a written informed consent to participate in the study.

Author Disclosures

Conflicts of interest: none to report.

Acknowledgments

The authors thank the nurses of the emergency department at the Seoul National University Hospital, Seoul, Republic of Korea, for participating in this study.

Characteristics	Values
Total participants, N	11
Gender: female, n (%)	11 (100)
Age, mean (SD), y	31.7 (3.3)
Educational degree	
Bachelor's, n (%)	10 (91)
Master's, n (%)	1 (9)
Registered nurse, n (%)	11 (100)
Nursing experience, mean (SD), y	7.7 (3.6)
Pediatric nursing experience, mean (SD), y	5.5 (2.6)
KTAS triage experience, mean (SD), y	4 (2.2)

Core concept	Vignettes	Case-vignettes
--------------	-----------	----------------

Vignette related to vital signs	1	<p>Patient A (F/38 months) visited the ED, crying in her mother's arms. According to the mother, the patient refused to eat in the past 5 hours and has had a fever of 38.2 °C (100.76 °F). There is no history of any underlying diseases. The exact time of taking antibiotics is unknown.</p> <p>Vital signs: blood pressure, unchecked; body temperature, 38.7 °C (101.66 °F); heart rate, 189 bpm; respiration rate, 38 breaths per minute</p>
2	<p>Patient B (M/4 years) visited the ED with a fever of 38.9 °C (102 °F) approximately 3 hours earlier. The patient regularly takes immunosuppressants.</p> <p>Vital signs: blood pressure, 110/68 mm Hg; body temperature, 36.7 °C (98.06 °F); heart rate, 102 bpm; respiration rate, 22 breaths per minute</p>	Vignette related to pain
3	<p>Patient C (M/5 years) was transferred to the ED from a nearby pediatric clinic. He is stomping his feet and having abdominal pain. His parents are demanding a fast treatment process and report no change in his feces. Patient C says "my belly hurts," looking around the ED curiously.</p>	4

Vignettes	Core concept	No of participants rating KTAS levels (N = 11)					Inter-rater agreement (%)			
		Level 1	Level 2	Level 3	Level 4	Level 5	1	Vital signs	1	0
1	0	81.8		86.4	81.8	2	0	10	1	0
0	90.9	3		Pain	0	0	2	9	0	81.8

Categories		Representative quotations
How nurses triaged pediatric patients using KTAS (categories of how)	Categories of how 1. The constructed guidelines base	“The pulse is 189, which is abnormal, so I triage the patient as level 3 by selecting ‘Vital signs outside the normal range.’” (nurse with 10 years of clinical experience)
Categories of how 2. Recognition of variations that can be explained by the characteristics of children	“The vital signs are not well measured, because the child is crying, but even if the child has a fever and a fast pulse, it is a situation in which the pulse can rise to this level when the child has a fever and is crying a lot. I don’t think it will. It doesn’t seem like it’s because the child is playing well or something like that, so I did level 4 at the level of a child who has a fever, but looks healthy. Children who do not usually have a specific underlying disease cry, sneeze, and have a phobia of the hospital itself, have poorly measured vital signs, and even if they are measured, they are not accurate.” (nurse with 9 years of clinical experience)	Categories of how 3. Coordinating the child’s body indicators with their appearance
“The child complained of severe abdominal pain as he rolled around, but his vital signs are well measured, and he says he is sick, but he is focused enough to slowly observe something while looking around here and there. So, it looked like a situation where it didn’t look that painful, so I gave it to level 4.” (nurse with 9 years of clinical experience)	Categories of how 4. Consideration of possible changes in levels of emergencies	“I give level 2, because a child who has a fever on immunosuppressants can have a shock situation. However, there is no clearly identifiable deformation, and for the broken arm, I think I give a slightly lower level. Because it doesn’t look that urgent. Just because a child’s arm is broken doesn’t mean anything will happen right away. It is different if there is an obvious deformity or in the case of a child with underlying disease.” (nurse with 4 years of clinical experience)

<p>Categories of how 5. Recognition of resources in the emergency room for treatment intervention</p>	<p>“Giving level 3 or higher is also related to resource allocation. It seems that the child can sit and wait. In the pain of children, of course, I see the face scale, but I consider this part.” (nurse with 4 years of clinical experience) “Since the child has fallen on the floor and complains of pain in the right elbow, we will proceed with the imaging test even if there is no visual deformation. If there is any evidence of fracture in the child, it will be linked to orthopedic treatment, so I gave level 3 in this case.” (nurse with 5 years of clinical experience)</p>	<p>What strategies nurses use to triage pediatric patients using KTAS (categories of what)</p>
<p>Categories of what 1. Sticking to the evidence</p>	<p>“The nurse must not be agitated. The caregivers of pediatric patients are very irritable. Of course, there are times when the situation itself is a great event. So, if I can’t control my mind and shake myself, things seem to get twisted. Nurses should never lose their composure and evaluate based on evidence.” (nurse with 4 years of clinical experience)</p>	<p>Categories of what 2. Construction of a possible prediction frame</p>
<p>“I believe that nurses should be able to anticipate situations where the unpredictable can happen. If I see a lot of patients and know, ‘Oh, this could happen,’ should I say it’s easier to do?” (nurse with 10 years of clinical experience) “When classifying patients using KTAS, the necessary competency for nurses is the ability to quickly and accurately judge emergency situations.” (nurse with 3 years of clinical experience)</p>	<p>Categories of what 3. Mapping out the cooperative network to be used</p>	<p>“When a patient arrives at the emergency room, it is necessary to quickly classify the degree of emergency and treat it as quickly as possible. The emergency room requires collaboration with other medical professionals, so a nurse needs to connect it to the right medical team as soon as possible.” (nurse with 7 years of clinical experience) “There is something I can do for my child in a short time, but if that judgment is ambiguous, I should not hesitate to ask for help as much as possible, and it should be possible.” (nurse with 9 years of clinical experience)</p>

DETAILS

Subject:	Patients; Emergency medical care; Educational programs; Research methodology; Accuracy; Validity; Phenomenology; Vital signs; Decision making; Communication skills; Triage; Health education; Pain; Emergency services; Fever; Competence; Nursing; Pediatrics; Interviews; Nurses; Education; Pediatric nurses
Location:	South Korea
Identifier / keyword:	Emergency nursing; Phenomenography; Triage; Qualitative research
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	244-254
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.10.007
ProQuest document ID:	2781604397
Document URL:	https://www.proquest.com/scholarly-journals/perspective-emergency-pediatric-nurses-triaging/docview/2781604397/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association

Last updated: 2023-08-30

Database: Public Health Database

Document 30 of 50

A Quality Improvement Initiative on Reducing Blood Culture Contamination in the Emergency Department: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Contaminated blood cultures may have detrimental effects on patients, the organization, and antimicrobial stewardship. Patients in the emergency department may need blood cultures collected before antimicrobial therapy. Contaminated blood culture samples may contribute to prolonged hospital stay and also are associated with delayed or unnecessary antimicrobial therapy. This initiative aims to improve the emergency department's blood culture contamination rate that will eventually benefit the patients who will receive timely and proper antimicrobial therapy, and benefit the organization fiscally.

Methods

This quality improvement initiative used the Define–Measure–Analyze–Improve–Control (DMAIC) process. The organization targets blood culture contamination rate of $\leq 2.5\%$. Control charts were used to study how blood culture contamination rate changed over time. In 2018, a workgroup was formed to work on this initiative. Improved site disinfection using 2% Chlorhexidine gluconate cloth before the standard procedure of blood culture sample collection was initiated. Chi squared test of significance was used to compare blood culture contamination rates 6 months before and during feedback intervention as well as contamination rate from source of blood draw.

Results

Blood culture contamination rates 6 months before and during feedback intervention showed significant decrease (3.52% before intervention and 2.95% after intervention; $P < .05$). Contamination rates differed significantly based on the source of blood culture draw (7.64% via line, 3.05% via percutaneous venipuncture, and 4.53% via other; $P < .01$).

Discussion

Blood culture contamination rate continued to decrease with the use of a pre-disinfection process with 2% Chlorhexidine gluconate cloth before blood sample collection process. Practice improvement also was evident with effective feedback mechanism.

FULL TEXT

Contribution to Emergency Nursing Practice

••Current literature supports the need to reduce blood culture contamination rates in emergency departments.

However, limited evidence is found investigating the comparison of blood culture contamination rates collected from percutaneous venipuncture to other collection sites.

- This article contributes evidence on the effectiveness of specific evidence-based interventions to reduce blood culture contamination rates, including preinfection with 2% Chlorhexidine gluconate cloths when collecting samples for blood cultures, and surveillance and feedback.
- Key implications for emergency nursing practice include integrating evidence-based practice changes with a robust feedback mechanism to reduce blood culture contamination rates in the emergency department setting.

Introduction

Blood cultures are important diagnostic tools for identifying the pathogens responsible for a patient's infection.¹ When indicated, blood cultures should be obtained before starting antimicrobial therapy.¹ Contaminated blood cultures may have detrimental effects (eg, unnecessary antibiotic exposure and prolonged length of stay) on the patient, to the organization, and to antimicrobial stewardship efforts.^{2,3} Other consequences include unnecessary antibiotic exposure with the potential for downstream unintended consequences (eg, possible allergic reactions and *Clostridioides difficile* infection).⁴ Skoglund et al⁵ found that the average length of stay was 2 days longer in patients with contaminated blood cultures than in patients with negative cultures. That same study found that direct and indirect hospital costs of a contaminated blood culture were \$12,824 compared with \$8286 for a negative blood culture (cost savings of \$4538 for preventing a contaminated blood culture).⁵

Studies have been made exploring factors associated with increased contamination in blood culture samples in emergency departments. Chang et al² found that blood culture contamination was more likely to occur in critically ill patients, that is, triage levels 1 and 2 (modified Canadian Triage and Acuity Scale), probably because these patients received urgent care, restricting the time for appropriate blood sampling procedures. The same study² adds that underlying conditions, that is, end-stage renal disease and older age, were associated with blood culture contamination in emergency departments. Chang et al² also discussed that these patients might frequently visit health care facilities and potentially carry skin commensals with antimicrobial resistant genes. In addition, it was explained that blood draw challenges were more likely in these patient groups due to poorly accessible veins. Literature shows several strategies taken by different organizations to improve their blood culture contamination rates. Self et al⁶ and Doern et al⁴ found that the use of blood culture collection kits and standardized procedures have been associated with a significant decrease in blood culture contamination. Surveillance and feedback systems also have been shown to result in improved blood culture contamination rates, particularly when contamination rates are reported in a timely manner and directed individually to those who collected the samples.^{7,8}

The University of California Davis Medical Center emergency department's blood culture contamination rates were noted to be above the target rate of 2.5%, ranging from 2.79% to 7.28% from 2018 to 2020. The department runs approximately 40 sets of blood culture tests per day. Reducing blood culture contamination aligns with the emergency department's strategic quality and financial stewardship goals. A multidisciplinary workgroup worked robustly to improve this metric using evidence-supported practice changes.

Methods

This process improvement initiative, which was started in 2018 by University of California Davis Medical Center emergency department, used the Define–Measure–Analyze–Improve–Control (DMAIC) model of quality improvement. Data (blood culture contamination rates, dates and times of sample collection, and patients' health record numbers) were collected from EPIC (Epic Systems Corporation) electronic health record reports that feed daily to the organizational dashboards.

This initiative was rolled out in 2018 and has been an ongoing process of analyzing issues, addressing identified issues, and evaluating measures undertaken. Spot analyses were performed as needed. Descriptive statistics were

used to study specific time frames (spot analyses for July 2020 and August to September 2021). Contamination rates were plotted against control charts by intervention phases to determine process control and special cause variation. Contamination rates 6 months before and during feedback intervention and contamination rate difference based on source were analyzed using Chi squared test of significance. Statistical analyses were performed using Stata 17.0 (StataCorp LLC). Reporting guidelines⁹ were followed to report this initiative's methods and results.

Define

The emergency department was not meeting the target blood culture contamination rate of $\leq 2.5\%$. The Centers for Disease Control and Prevention¹⁰ states that because blood is a normally sterile body site, positive blood cultures with a known pathogen have a generally overall high positive predictive value for infection. However, blood culture contamination is a significant problem. In general, all blood culture contamination occurs during collection; the source of contaminants is usually the patient's skin or the hub or cannula of an indwelling catheter (ie, when an existing catheter is used to obtain the specimen). Frequent causes include poor collection technique and insufficient skin disinfection.¹⁰

Measure

The organization targets a blood culture contamination rate of $\leq 2.5\%$. The emergency department's blood culture contamination rate from 2018 to 2020 ranged from 2.79% to 7.28% (fiscal year 2019-2020, mean = 4.56%; fiscal year 2020-2021 mean = 3.86%).

The University of California Davis Medical Center determines blood culture contamination by the number of contaminating organisms from percutaneous and/or line blood draws per total blood culture samples collected. If blood culture samples yield to growth of an organism that is not a true pathogen or when multiple nonpathogenic organisms are identified, it will be flagged contaminated (Jordan Jones, CLS, email communication, August 08, 2022).

Whenever an organism on the list is identified, the electronic health record automatically flags the cultures as a possible contamination. Contamination flags and comments are not removed when a provider requests susceptibility testing unless there is $>50\%$ of blood culture sets, for an episode (3-day collection period), turned positive with 1 morphotype, and there are no other organisms present in the cultures. There also must be more than one set of culture bottles and this generally applies to the coagulase-negative *Staphylococci* and *Streptococcus* species. Contamination flags also are not routinely removed for other organisms on the contamination list. Blood culture samples from central venous access devices (CVADs) and percutaneous venipuncture collection sets are not treated differently—determining whether there are $>50\%$ of the sets collected within a 3-day episode positive with the same single organism. For example, if there are multiple coagulase-negative *Staphylococci* identified in a report denoting multiple morphotypes, the contamination flag will not be removed if one of the 2 organisms is present in multiple sets.

Analyze

Through structured problem-solving and continuous improvement approach, several causes of sample contamination were identified as follows: education gap, inappropriately prepared venipuncture site, supplies needed for sample collection were not stored in one location, blood cultures were not included in initial workup orders, fast-paced workflows, time-sensitive procedures, variety of patient population (prehospital environment significantly adds to skin contaminants), drawing blood culture samples from existing intravenous access, contaminated samples drawn from ultrasound-guided intravenous access insertion, contaminated samples from CVADs, and contaminated samples among pediatric patients, patients with coronavirus, and critically ill patients.

Improve

A multidisciplinary workgroup (consisting of ED leadership, clinical nurse leaders, clinical resource nurses, clinical nurses, infection prevention, quality and safety, laboratory) worked collaboratively to improve this metric since 2018. The team worked to heighten department awareness on its standing on this metric. Information was continuously shared through preshift huddles and workgroup meetings wherein strong team engagement was present. Education was reinforced through several avenues such as incorporating content in new-hire orientation, just-in-time coaching, and periodic skills day. Blood culture sample collection has been a standardized procedure for nurses and was added to the Best Practice Advisory for patients meeting Sepsis Analytic Model score ≥ 8 . The use of diversion devices, which passively sideline skin contaminants, had been considered but was not voted on due to cost (\$15 per device); alternatively, the team decided to focus on reinforced skin antisepsis instead (Table 1). Notably 2% Chlorhexidine gluconate cloths were added (cost \$6) to the standard blood culture sample collection supplies with the purpose of thoroughly cleansing the skin surface before blood draw. The added step of cleaning the site with 2% Chlorhexidine gluconate cloth was not applicable for patients sensitive to chlorhexidine or patients younger than 2 months of age.¹¹

It also was emphasized not to draw blood culture samples from existing intravenous accesses. For CVADs, education was rolled out not to routinely draw from these accesses unless the provider suspects infection from the source and orders collection from the access; in that case, one set of blood cultures need to be collected from the CVAD after scrubbing the hub, changing the needleless connector, and scrubbing the hub again, without discarding the first blood draw,¹² and the other set has to be collected from another source. The new process was reviewed by stakeholders and was finalized and published as a departmental policy. To reduce variation in practice, an instructional video demonstrating the practice change was developed and socialized to all ED staff, new-hire and temporary staff included. Dedicated phlebotomists were hired to support staffing-related issues.

Control

ED blood culture contamination rate has been closely monitored since 2018. Starting with overall departmental rates, data available were optimized, generating inferences such as contamination rate per individual collector and contamination by microorganisms. Chart reviews were conducted to determine rates by patient acuity and room placement, time of collection, and other circumstances surrounding contamination. Monthly organizational recognition was given to staff nurses who had the greatest number of blood cultures collected without contamination. Regular just-in-time feedback was provided to staff nurses who collected contaminated blood cultures, allowing discussion to identify contributing factors and risk mitigation. Nurses who had repeated patterns or increased contamination rate without improvement were referred to department leadership for further action (ie, repeat skills check-off with clinical resource nurse or educator). Individual contamination rate also was added as a discussion point in the staff performance evaluation wherein department leadership had the opportunity to revisit this skill with staff.

Findings

From January to December 2018, the workgroup was formed. Possible causes of blood culture contamination were identified. Teaching and coaching were found not effective. This prompted the trial of adding preinfection with 2% Chlorhexidine gluconate cloth before blood culture sample collection process. Trends could not be drawn from blood culture contamination rates; unpredictable upticks and decline were noted. By December 2018, the contamination rate was at its highest at 7.28%.

In 2019, reports also were validated. The use of a diversion device in collecting blood culture samples was considered but was held due to cost. At that time, the contamination rate started to show less variation as demonstrated by narrower control limits. Contamination rate during this period ranged from 3.36% to 5.72%.

In 2020, contamination rate fluctuation was noted as well as increased practice variation, which is indicated by widening control limits. A spot analysis done in July 2020 shows that 58% of contaminated blood culture samples were from critically ill patients with shortness of breath as their chief complaint and that the median time from room to blood culture draw was 36 minutes. Discussion was started on possibly adding blood culture collection order on critically ill patients or on some targeted patient population. Dedicated phlebotomists also was started but later met staffing challenges. Blood culture contamination rate during this period ranged from 3.56% to 6.44%.

From January to August 2021, it was determined that the preinfection with 2% Chlorhexidine gluconate cloths was helping reduce blood culture contamination, and a request was made to produce blood culture collection kits with this additional product. A Best Practice Advisory to order blood cultures also was added for patients whose Sepsis Analytic Model score was high (≥ 8). Reports received were further analyzed, and contamination rate per collector was added to the reports enabling more targeted feedback. Decrease in contamination rate and narrowing of practice variation were notable during this period. Blood culture contamination rate ranged from 2.20% to 4.47%. The target blood culture contamination rate was met by the department on 3 occasions: February, May, and June 2021.

The following details were drawn from data collected from August to September 2021: 85.7% of contaminated blood samples ($N = 91$) were collected from the main emergency department (adult pods and resuscitation area), 8.79% were collected from boarding ED patients, 3.3% were collected from pediatric patients, and 2.2% were collected from rapid care area. All contaminated samples ($N = 91$) from this period were collected within 36 hours of patient arrival to emergency department, 10% of contaminated samples were taken within the first 30 minutes of patient's ED arrival, 25% of contaminated samples were extracted within the first 65 minutes of patient's ED stay, 50% of contaminated samples were taken within the first 3 hours of ED stay, and 75% were taken within the first 7 hours of patient's ED stay.

Another spot analysis showed that there were 137 contaminated blood culture samples from July to September 2021, 25% of which were collected from 12 midnight to 09:59 AM, 25% were taken from 10 AM to 02:59 PM, 25% were taken from 3 PM to 07:59 PM, and the other 25% were collected from 8 PM to 11:59 PM. Thus, 50% of the contaminated samples were collected from 12 AM to 02:59 PM, and the other half were collected from 3 PM to 11:59 PM.

Control measures were reinforced since September 2021. On a daily basis, collectors whose samples turned contaminated were notified by email. This process prompted in-person discussion and feedback. Staff nurses were receptive to this process, which is timely, collegial, constructive, and individualized. To further decrease practice variation, a video demonstrating how to use the blood culture collection kit was developed and shared with all staff nurses. This content also was included in the new-hire staff nurses' orientation program. Reward and escalation workflows also were established. Contamination rates of staff nurses also have been included as a discussion point in their performance evaluation. This period has shown a progressive decrease in variation and a downward trend in contamination rate. Blood culture contamination rate in this period ranged from 2.86% to 4.64%.

Blood culture contamination rates also were compared 6 months before (March to August 2021) and 6 months during (September 2021 to February 2022) feedback intervention and showed significant decrease (3.52% preintervention and 2.95% postintervention; P Table 2). From March 2021 to February 2022, blood culture contamination rates significantly differed based on the source of blood culture draw (7.64% via line, 3.05% via percutaneous venipuncture, and 4.53% via other; P Table 3).

Figure 1 shows the emergency department's blood culture contamination rate from January 2018 to July 2022, which indicates that the overall monthly rate shows a downward trend. From September 2021 to July 2022 (Figure 2),

contamination rate from blood culture samples collected from percutaneous venipuncture ranged from 2.27% to 4.39%. Alternatively, from September 2021 to July 2022, contamination rate from blood culture samples collected from other sources (eg, peripherally inserted central catheter, CVADs) (Figure 3) ranged from 2.17% to 8.16%. Figure 4 demonstrates that the emergency department's monthly overall contamination rates were strongly attributable to the contamination rates from other sources. For instance, in July 2022, the overall contamination rate was 3.06%. It can be noted that contamination rate from percutaneous venipuncture was only 2.67%, but this was greatly affected by the contamination from other sources, which was 6.67%.

Discussion and Implications

Reducing blood culture contamination in the emergency department has been a challenge due to several factors such as patient volume and acuity, fast-paced workflows, time-sensitive procedures, and staff transition. This improvement initiative investigated and integrated effective measures (ie, use of dedicated phlebotomy,^{13,14} education and feedback¹³) in reducing blood culture contamination.

Site predisinfection with 2% Chlorhexidine gluconate cloths significantly reduced skin contaminants. It can be noted that ED patients come from various circumstances such as private residences, the field, or other facilities. This alone is an uncontrollable variable in maintaining aseptic technique during specimen collection indicating the importance to adhere to aseptic technique. Staff nurses were remarkably found to be more receptive and engaged in blood culture contamination reduction initiative with timely, informal, collegial, and individualized feedback.

It remains a challenge to reduce contamination from blood culture samples collected from other sources, such as CVADs. In collecting such samples, the emergency department adheres to scrubbing the hub, changing the needleless connector, and scrubbing the hub again, drawing blood culture samples without discarding the first blood draw.¹² It is of great interest how blood culture samples collected from these sources turned contaminated in the emergency department despite compliance to established workflow. There were several instances wherein blood culture samples collected from a CVAD resulted as contaminated in the emergency department, and upon recollection on the floor (for an instance, repeat blood culture within 3 days of admission), blood culture samples collected from the same CVAD was not flagged contaminated.

Conclusion and Recommendations

In this 4-year period, the emergency department only reached the target rate on 3 occurrences. Keeping the contamination rate $\leq 2.5\%$ has been a challenge, but the department is making progress in gradually reducing it and narrowing practice variation. Key drivers for the success of this practice and process improvement initiative are reinforced skin antisepsis (predisinfecting the site with 2% Chlorhexidine gluconate cloth before blood culture sample collection) and an effective surveillance and feedback mechanism. It is critical to note that predisinfecting the sample collection site was instrumental in this initiative. Of equal importance is leveraging timely and individualized feedback to sample collectors.

To date, the department has gained control in reducing contamination on blood cultures collected from percutaneous venipuncture. Future direction is headed to sustaining progress, reinforced coaching and feedback, and more focus on other sources (ie, CVADs) given that the department's overall contamination rate is significantly affected by the increased contamination from these sources.

The use of diversion device might be worth reconsidering given that it was found effective in some studies.^{13,15,16} The authors will continue to search, appraise, and synthesize evidence on (1) how skin contaminants differ from contaminants found on lines and (2) how to further reduce blood culture contamination, more specifically in samples collected from other sources.

Author Disclosures

Conflicts of interest: None to report.

Acknowledgments

The authors thank Toby Marsh, MSA, MSN, RN, FACHE, NEA-BC; Stacy Hevener, MSN, RN, CSSGB, CPHQ; Brynne Kessler, MSN, RN-BC, CSSGB, CPHQ, and University of California Davis Medical Center PCS Quality and Safety Department; Rupinder Sandhu, MBA, RN; Frances Noriega, MSN, RN; Jaime Heitmeyer, MBA, RN, CEN; Swapna Peter, MSN, RN, CCRN; University of California Davis Medical Center ED Leadership; UC Davis Medical Center ED Unit-Based Practice Council; Yvonne Hansen, MS, RN, CCRN, CEN, TCRN; Marsha Hoefft, BSN, RN, CEN, MICN, TCRN; Tara Lynn Barragan, BSN, RN, CEN, TCRN, CPEN; Keith Taggatz, BSN, RN, TNCC, MICN; Anika Kutschmar, BSN, RN, CEN; ED Clinical Nurse Leaders, Clinical Resource Nurses and Clinical Nurses; Sarina Fazio, PhD, RN; and Lori Kennedy, PhD, RN, ACNP-BC.

1.Clean each sample collection site with one 2% Chlorhexidine gluconate cloth.*Not applicable for patients with hypersensitivity or patients <2 mo of age.2.Perform hand hygiene.3.Clean the blood culture bottle tops.a.Cleanse tops with 3.15% Chlorhexidine gluconate/70% Isopropyl alcohol pad for 5 s and dry for 5 s or 70% Isopropyl alcohol pad for 15-30 s.b.Allow to dry.4.Scrub sample collection site in a back-and-forth motion.a.Clean the skin with 70% Isopropyl alcohol pad for 15-30 s. Allow to dry.b.Disinfect the skin with 2% Chlorhexidine gluconate/70% Isopropyl alcohol applicator for 5 s. Allow to dry. For patients who are sensitive to chlorhexidine or patients <2 mo of age, cleanse the skin using 10% Povidone-iodine sticks. Allow to dry.

Contaminated	6 mo during feedback (March-August 2021)	6 mo bef ore fee db ac k (S ept em ber 20 21- Fe bru ary 20 22)	Tot al	
--------------	--	---	-----------	--

No	Frequency	8456	55 00	13, 95 6	$\chi^2 (1) = 4.0122$ Pr = 0.045 Fisher's exact = 0.046 1-sided Fisher's exact = 0.025
Row percenta ge	60.59	39.41	10 0.0 0	Co lu mn per ce nta ge	96.44
97.05	96.68	Yes	Fr eq ue nc y	31 2	167
479	Row percentage	65.14	34. 86	10 0.0 0	Column percentage
3.56	2.95	3.32	Tot al	Fr eq ue nc y	8768
5667	14,435	Row percentage	60. 74	39. 26	100.00

Contaminated	Line source	Other sources	Perc utan eous veni punc ture sour ce	Total	
--------------	----------------	---------------	--	-------	--

No	Frequency	546	801	12,209	13,956	$\chi^2 (1) = 38.2101$ Pr <0.01 Fisher's exact <0.01
Row percentage	3.91	5.74	90.35	100.00	Column percentage	92.54
95.47	96.95	96.68	Yes	Frequency	44	38
397	479	Row percentage	9.19	7.93	82.88	100.00
Column percentage	7.46	4.53	3.05	3.32	Total	Frequency
590	839	13,006	14,435	Row percentage	4.09	5.81
90.10	100.00	Column percentage	100.00	100.00	100.00	100.00

DETAILS

Subject: Infections; Culture; Emergency medical care; Quality management; Feedback; Intervention; Pathogens; Catheters; Emergency services; Skin; Organisms; Contamination; Phlebotomy; Nurses; Patients; Electronic health records; Delayed; Length of stay; Disinfection; Antibiotics; Process controls; Blood tests; Quality improvement; Evidence-based nursing; Cost control; Venipuncture; Hospital costs; Education; Management; Antimicrobial agents

Business indexing term: Subject: Process controls Quality improvement Cost control

Location: United States--US; California

Identifier / keyword:	Blood culture contamination; Infection prevention; Antimicrobial stewardship; Emergency department; Quality improvement
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	162-171
Publication year:	2023
Publication date:	Mar 2023
Section:	Clinical Nurses Forum
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.005
ProQuest document ID:	2781604318
Document URL:	https://www.proquest.com/scholarly-journals/quality-improvement-initiative-on-reducing-blood/docview/2781604318/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-31
Database:	Public Health Database

Determining Clinical Judgment Among Emergency Nurses During a Complex Simulation: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Clinical judgment is imperative for the emergency nurse caring for the acutely ill patients often seen in the emergency department. Without optimal clinical judgment in the emergency department, patients are at risk of medical errors and a failure to rescue.

Methods

A descriptive observational approach using the Lasater Clinical Judgment Rubric evaluated nurses during a task that required recognition of clinical signs of deterioration and appropriate clinical care for simulated patients.

Results

A total of 18 practicing emergency nurses completed only 44.6% of the patient assessments leading to low levels of clinical judgment throughout the simulation. Nurses expressed 4 levels of clinical judgment: exemplary ($n = 1$), accomplishing ($n = 6$), developing ($n = 9$), and beginning ($n = 2$). On average, nurses completed 69% of required tasks.

Discussion

Assessments were completed less than half the time, demonstrating a breakdown in the noticing phase of clinical judgment. The nurses shifted to task completion focus with minimal use of clinical judgment. As the nurses remained task oriented, several medication and medical errors were noted while caring for the simulated patients. Experience and education did not influence observed clinical judgment among the participants. Given the extreme demands placed on the emergency nurse, it cannot be assumed that nurses have developed or can use clinical judgment when caring for their patients. Time and training targeting clinical judgment are essential for emergency nurse development.

FULL TEXT

Contribution to Emergency Nursing Practice

- Clinical judgment is essential to providing sound patient care. Clinical judgment requires the nurse to notice a patient's condition, interpret the condition, respond to the needs of the patient, and reflect on that response.
- The main finding of this paper is that emergency nurses often shift their focus to task completion rather than clinical judgment when under a typical workload of the emergency department.
- Recommendations for translating study findings into emergency clinical practice include evaluating clinical judgment using simulated experiences and providing targeted education to fill the identified gaps and maintain workload levels that allow the emergency nurse to implement its use.

Introduction

Clinical judgment is essential in providing care for patients in the emergency department. It is developed through practice to gain experience and knowledge to provide continuous critical analysis of patient needs.¹ Tanner² describes this in nursing as "an interpretation of the patient's needs, concerns, or health problems to determine an action to be taken, modifications of standard approaches, or new approaches based on the patient's response to

treatment” (p. 204). The emergency nurse must be able to apply evidence available in the situation to the patient’s medical needs while detecting and interpreting the clinical indications of deterioration.³ Developing effective clinical judgment improves the emergency nurse ability to deliver safe and effective patient care in the emergency department despite challenges such as staffing deficits, fatigue, and other barriers to quality care.^{4,5} This development can occur in the emergency department through cumulative experience with the broad complaints seen and through targeted education to address high-risk, low-incidence patient presentations.

A lack of clinical judgment can lead to medical errors, estimated to be the third leading cause of death in the United States.⁶ A medical error can occur with the omission or commission of an act, error in the execution of a task, or deviation from an approved process that may or may not cause patient harm.⁶ Medical errors are often classified as either a medication error⁷ or a failure or delay in rescuing a patient.⁸ Failure to rescue has been linked to the concept of failing to recognize, failure to relay the information to the provider, and failure to react to the patient condition.⁹ A failure to rescue can occur in any health care setting, including the emergency department. The condition of the patient when they present to the emergency department must be accurately assessed and reported to the provider, and appropriate care must be implemented in a timely manner. Effective clinical judgment by the emergency nurse is critical in the limitation of failure to rescue in the emergency department.

Emergency departments are complex environments with multiple patients, protocols, and demands that lead to an environment at high risk of medical errors and that requires a high level of clinical judgment. Clinical judgment assists the emergency nurse to develop skills in rapidly and accurately assessing and interpreting the clinical meaning of assessment findings. In a setting where patients are essentially unknown and acutely ill, it is challenging yet vital for the emergency nurse to be able to make meaning of assessment data and conclusions about the risk and need for intervention.² The high workloads typical to the emergency department limit the time needed for the emergency nurse to use clinical judgment, often leading to a focus on task completion rather than applying good clinical judgment¹⁰ and then appropriately prioritizing care.

Simulation is useful for providing clinical experiences and targeted education in the development of clinical judgment¹¹ and nursing skills¹²⁻¹⁵ in a realistic yet safe environment and as a means to evaluate the clinical judgment of the nurse.^{11,16} Lasater¹⁶ expanded upon the thinking like a nurse concept² to develop the Lasater Clinical Judgment Rubric (LCJR) to evaluate the stages of clinical judgment based on the translation of this model through high-fidelity experiences in the simulation setting. Clinical judgment was modeled using 4 aspects, noticing, interpreting, responding, and reflecting.² The effective use of simulation to evaluate clinical judgment in nursing education^{11-13,17,18} should continue into the health care setting to evaluate and enhance the professional development of the emergency nurse.^{19,20}

Understanding promotion of clinical judgment within the emergency department is critical to the safe and effective care of acutely ill patients. The use of clinical judgment, barriers to use, and patient outcomes can be explored effectively within a simulated environment. Thus, the objective of this pilot study was to use the LCJR to explore clinical judgment within a sample of emergency nurses with varying levels of education and experience in a simulated learning environment representative of the emergency setting. It was hypothesized that more experienced nurses would demonstrate higher proficiency and clinical effectiveness and that a higher patient load would result in lower levels of observed clinical judgment. Pilot data collected in this study were used to calculate power analysis for future expansion of this work.

Conceptual Framework

This study integrated a model of professional development with a method for assessing clinical performance to conceptualize the development of clinical judgment in emergency nurses. Benner’s²¹ novice to expert model

describes the progression of a nurse through 5 levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Successful progression requires the nurse to develop clinical judgment through the application of experience to current situations. According to this model, a nurse typically will achieve competency in their work after 2 to 3 years of experience and then continue to develop to the proficient level with additional experience. Benner²¹ notes that not all nurses will achieve the expert level, although some will continue to progress to this level. The model posits that for a nurse to advance their level of competence, mentorship and guidance in the clinical setting are essential.²¹ This model of progression emphasizes a development of critical thinking that may be viewed through a lens of cognitive activities described by Lasater.¹⁶

The LCJR was developed to assess the expression of clinical judgment in nursing students by examining the 4 stages of noticing, interpreting, responding, and reflection.¹⁶ Although the true measurement of clinical judgment may be confounded by the context of care, the nurse's background, and the nurse-patient relationship,² observed clinical judgment also reflects the base level intersection of confidence, aptitude, skill, and experience¹¹ in the emergency nurse. Thus, to investigate expertise, the rubric was applied to active emergency nurses of various levels of experience within a simulated ED assignment.

Methods Study Design

This pilot study used a descriptive, observational approach to determine emergency nurse recognition of clinical cues of deterioration and appropriate clinical care for simulated patients in the simulation laboratory of the primary investigator's academic nursing institution. Emergency nurses were assigned either 3 or 4 simulated patients and evaluated through direct observation of the research team using the LCJR and an experiment-specific task checklist.

Setting

The simulation environment consisted of 4 rooms equipped to appear like an emergency department with supply carts, telemetry monitoring, and hospital bed. The telemetry monitors were programmed to look like the monitors within the local hospital. A nurse's station was provided outside of the simulation rooms with telemetry for remote monitoring of the simulated patients. The environment is arranged around a central observation room that includes audio-visual monitoring equipment in each room and one-way glass for visual observation.

Simulation Development

The simulation was designed with recommended modifications to the National League for Nursing Jeffries Simulation Framework to include 2 high-fidelity mannequins, 2 standardized patients,²² and a standardized family member for the pediatric patient. Simulations were chosen from a bank of validated simulation experiences provided through the mannequin manufacturer.²³⁻²⁵ The scenario and expected outcomes for each patient are described in [Table 1](#). A random subsample of nurses with 5 years' experience ($n = 11$) received a fourth patient to determine whether the addition of a fourth patient produced an observable impact on emergency nurse performance.

Scenario

Individual participants reported to the simulation laboratory to complete the study. Before the start, each received a tour of the simulation space, orientation to the equipment, the standardized patients, and high-fidelity simulators. The scenario began with a nursing handoff report for the 3 current patients. The initial patients in the scenario included a pediatric patient being seen for an exacerbation of his asthma that was stable awaiting admission to the floor (patient 1), a young adult with a severe headache and elevated blood pressure with complete workup and awaiting medication administration (patient 2), and a new middle-aged patient with a complaint of recent-onset chest pain (patient 3) (see [Table 1](#)). All participants received the same handoff report and were permitted to choose their patient prioritization. Of note, the second patient had a blood pressure of 190/140 mm Hg and the third patient had a blood pressure of 90/40 mm Hg, both requiring immediate intervention.

At the 25-minute mark of the simulation, 11 participants received a fourth patient experiencing influenza symptoms during the COVID-19 pandemic. Randomization was completed before participants arriving to the simulation using a digital randomization tool.²⁶ The fourth patient was added at random for participants having 5 years' experience received the fourth patient to ensure meaningful workload in the scenario. At 35 minutes, patient 2 developed a higher blood pressure, became nonverbal, and demonstrated weakness on the left side, necessitating lifesaving rescue. The simulation was stopped when the participant recognized the deterioration of patient 2 and called for additional support or at 10 minutes after the change in status. After the completion of the simulation, a plus-delta method debriefing session²⁷ was conducted by a trained member of the research team, allowing for self-assessment of both positive feedback and discussion of areas of improvement for each learner.

Participants

After approval of the institutional review board at the primary investigator's academic institution, emergency nurses were recruited from a community-based hospital in West Alabama. For inclusion in this pilot study, participants had to be a nurse actively practicing at the bedside in the emergency department with **Variables Data Collection** Outcome measures included (1) completed nursing assessments, (2) stages of clinical judgment as scored by the LCJR,¹⁶ and (3) completion of nursing tasks. Multimodal data were collected through direct observation of nurses engaged in the simulation, completion of the LCJR, an expected actions checklist, and discussion after simulation with participants and among the researchers to clarify any discrepancies. Informed consent and demographic data were obtained from all participants. Observation was conducted by the lead investigator who is a certified EN and a second investigator trained in emergency nursing. The LCJR¹⁶ was completed for each participant and discussed among the research team after each simulation. Although no experimenters were blind to study aims, analyses used objective performance criteria to reduce the impact of observer bias.

Clinical Judgment Assessment Description

Stages of clinical judgment for the simulation was measured using the LCJR (^{Table 2})¹⁶ to produce a numerical value. Clinical judgment was scored by the first author while the participant completed the simulation then discussed with the participant during the debrief process. At the completion of the simulation, all members involved in conducting the simulation discussed the results and achieved consensus on the assigned score. Video recording of the simulation allowed for members of the team to review video to resolve any disagreements.

The standard scoring for the rubric evaluates nurses on 11 signs of clinical judgment on a scale of 1 (beginner), 2 (developing), 3 (proficient), and 4 (expert), corresponding to total score indicators of 11 as a beginner (minimum score), 22 as someone developing, 33 as the proficient accomplishment of the criteria, and 44 as exemplary performance (maximum score). Based on Benner's²¹ novice to expert model suggesting that a nurse achieves competency after being on the job for 2 to 3 years, we would expect those participants with 5 years' experience to perform as proficient practitioners with some progressing toward or achieving the expert level.

Task Completion

Task completion was measured using a checklist developed and scored collaboratively by the research team through direct observation of the simulation. The checklist encoded 17 critical actions required to achieve competent quality of care for all patients. Scores are reported as percent of activities completed owing to differences between participants in the number of patients they received. Accuracy of the checklist was verified by discussing actions with the participant during the debrief of the scenario after simulation completion. Patient assessments were verified through direct observation of each patient encounter and then discussed at the completion of the simulation during the debrief process.

Analysis

All data were collected on paper, entered into spreadsheet software, and transferred to SPSS version 27 (IBM, Chicago, IL) software for analysis. Participants were placed in groups based on their years of experience and assignment to the fourth patient condition for *t* test comparison. Descriptive data were analyzed for the participants.

Results

Participants ($n = 18$) were primarily female (72%) with an average age of 31.1 years (range: 21-43) and an average emergency nurse experience of 3.5 years (range: 0.75-9). All nurses held an Associate Degree in Nursing (ADN) except for 3 nurses with >5 years' experience who held a Bachelor of Science in Nursing (BSN). See ^{Table 3} for full demographic data. All demographic questions were asked using a free-response space to allow the participant to provide their personally preferred descriptors, if any. Demographic data were collected for the purpose of ensuring a sample representative of the workforce at the recruitment site. No significant differences were noted based on demographic data or the addition of the fourth patient relating to scores on the LCJR or task completion.

Completed Nursing Assessments

Nursing assessment completion was determined by direct observation of the nurse interacting with the simulated patient and then discussed during the debrief session. Nursing assessment was completed 44.6% of the time on the assigned patients with 5 participants completing all required assessments. Pediatric patient 1 was assessed by 8 of the 18 nurses (44%) with 5 completing the assessment who had 5 years' experience (60%). Patient 2 (severe headache with elevated blood pressure) was assessed by 5 nurses (27.8%) with 4 nurses having 5 years' experience (20%) completing this assessment. The patient with chest pain was assessed by 8 nurses with 6 nurses with 5 years' (40%) completing the assessment. Of the participants receiving the patient with influenza symptoms ($n = 11$), 8 nurses completed the assessment consisting of 3 5 years' experience (100%). Total assessments completed were 0 ($n = 5$), 1 ($n = 6$), 2 ($n = 1$), 3 ($n = 3$), and 4 ($n = 3$), with 5 nurses assessing all patients.

Clinical Judgment Scores Achieved

Total clinical judgment scores observed by the research team for the simulation ranged from 20 to 44. Average scores for the nurses with 5 years' experience 30.4 (SD = 8.3). The scoring for participants during the simulation is presented in ^{Table 2}. One participant completed the simulation with an exemplary score, 6 achieved a score of accomplishing the simulation, 9 scored as developing, and 2 scored in the beginning range.

Noticing

Average scores in the noticing category ranged from 1.3 to 4 across all participants. The mean score for noticing was 2.1 with a mean score of 2.1 for nurses with 5 years' experience. Most nurses (11 of 18) scored as beginners in the category of recognizing deviation. When caring for the patient presenting with chest pain, only 8 nurses appeared to notice the hypotensive state of the patient before treating the patient with a nitrate.

Interpreting

Average scores for the interpreting category range from 1 to 4. The average across the participants was 1.97, with scores of 1.92 for the nurses having 5 years. Eight of the nurses with 5 years scored as beginners in the prioritizing data category of interpreting. When caring for the patient presenting with chest pain, only 8 of the 18 nurses addressed the hypotensive state of the patient during treatment indicating a lack of interpreting the patient need before treatment.

Responding

Average scores for the responding category range from 2.25 to 4. The average across the participants was 2.9, with scores of 2.8 for the nurses having 5. Ten participants, 7 with 5 years, scored as beginners in the well-planned intervention category of responding. In responding to the hypotensive state seen in the patient presenting with chest pain, only 8 nurses treated the hypotension in this patient.

Reflecting

Average scores for the reflecting category range from 2.5 to 4. The average across the participants was 3.3, with scores of 3.34 for the nurse having 5 years. Four participants scored as developing in this category with none scoring as beginners. In reflecting upon the care of the patient presenting with chest pain, 10 nurses did not treat the hypotension in the patient even after giving the nitrate and subsequent drop in blood pressure related to the treatment.

Completed Nursing Tasks

Patient care was measured through the completion percentage of the “expected actions” listed in ^{Table 4}. One nurse with >5 years’ experience completed almost all the expected actions for all patients. Task completion percentage ranged from 59% to 88% of the task with an average of 69% of the tasks being successfully completed. Among the nurses with 5. Among the nurses with a BSN, 68.7% of the tasks were completed whereas the ADN nurses accomplished 69.5% of the tasks. Task completion for each patient can be found in ^{Table 5}.

Discussion

The purpose of this study was to investigate clinical judgment in a sample of emergency nurses with varying levels of education and experience as they engaged a complex quality of care task in a simulated learning environment representative of the emergency setting. In response to higher proficiency and clinical effectiveness, the addition of the fourth patient, increasing the patient ratio to 4:1, was expected to increase the workload for the nurse participants and affect clinical effectiveness, but it did not have a significant effect on the outcomes. It is hypothesized by the research team that this increased patient load did not affect the participants as expected owing to the patient ratio being lower than the nurses experience on their unit, familiarizing them with incomplete execution of standard-of-care activities.

To investigate lower levels of observed clinical judgment, we used a standard simulation in this study with outcome measures including (1) complete nursing assessments, (2) completion of nursing tasks, and (3) clinical judgment stage as scored by the LCJR. The simulation was representative of a typical assignment in the emergency setting. Results of the analysis demonstrate that participant nurses completed an average of 44.6% of expected nursing assessments and 69% of expected tasks in the simulation. Participants with 5 years’ experience scored an average of 30.4 (SD = 8.3) on the LCJR. Of the 18 participants, most performed in the developing range or below.

Specifically of concern, based on the framework presented by Burke et al⁹ of recognizing, relating, and reacting to the condition of patient 3 who was experiencing chest pain, a failure to rescue occurred in 11 participants. Most of the participants failed to recognize or treat the low blood pressure before administering the nitrate.

Overall, our findings indicate that a normally assigned patient load was not associated with expected differences in level of clinical judgment given nurse education and experience, but gravely, this was caused by pervasive deficits in all areas of the clinical judgment framework described by Lasater¹¹ and Tanner.²

Completed Nursing Assessments

An appropriately focused assessment (noticing) is fundamental to effective clinical judgment²⁸ and is the basis for making quality decisions involving patient care.²⁹ In this study, only 44.6% of the required assessments were completed with only 5 nurses completing assessment on all their simulated patients. A nurse is unable to notice, interpret, respond appropriately, and reflect on patient care² without an assessment. This lack of assessment and ability to practice sound clinical reasoning leads to failure to rescue⁵ as seen with both patient 3 (chest pain) and patient 2 (headache and elevated blood pressure).

Clinical judgment^{2,9} remains vital in reducing failure to rescue and medical and nursing errors. Competent patient assessment is critical for all nurses³⁰ and must be completed on all emergency patients; however, assessment is

easily missed when the emergency nurse is performing in crisis mode.³¹ It is possible that this problem originates in the initial training of nurses. Hughes et al³² report that 44% of nursing faculty in the study reported student performances that received failing grades yet nevertheless reported passing those students. This was reported both as a function of lack of time in the clinical area to fully assess students and of coercive or disruptive student behaviors. This lack of preparation of the new graduate nurse places a heavy burden on the clinical agency to develop new graduate nurses to a level of fundamental competence in the complex environment of the emergency department.

Clinical Judgment

Participants of this study were hypothesized to fall into the beginning, developing, accomplished, and exemplary levels of Benner's novice to expert model²¹ based on their experience in nursing. In this study, participants scored below their expected level of clinical judgment with a higher-than-expected percentage of participants scoring as beginning within each component of the LCJR given the experience of the sample.

This simulation demonstrated a breakdown in the noticing phase of clinical judgment represented best by the low completion rate of patient assessments. When caring for patient 3 experiencing chest pain, only 44% (6 nurses with 5 years) noticed the low blood pressure during their assessment. Doing somewhat better at interpreting, most knew that the standard treatment for patients experiencing chest pain is to administer nitrates and selected analgesia,³³ which often causes a decrease in blood pressure in patients who are hypotensive.^{34,35} The need to treat the blood pressure before administering the nitroglycerin was noted by 6 of the nurses having

The lack of noticing the low blood pressure by the nurses led to the inability to engage in successful interpreting of the abnormal parameter, also leading to inappropriate responding to the patient crisis. Without completing an assessment, 7 less experienced and 3 more experienced nurses treated the patient and administered the nitroglycerin. A lack of reflecting through reassessment of the patient led 4 nurses to give a second nitroglycerin and metoprolol, resulting in further hypotension. One nurse proceeded to erroneously administer morphine to the patient without an order for the medication. A shift in practice occurred away from clinical judgment while caring for this patient to incorrect task performance. Across participants, there was a concerning pattern of failure to assess the patient condition and inconsistencies in application of assessment data.

Experience and expertise in nursing are often seen as the same but should not be used interchangeably.³⁶

Experience did not translate to higher levels of clinical judgment for this observed simulation when assessed using the LCJR.¹¹ Based on Benner's²¹ novice to expert model, it was expected that the more experienced nurses would have all demonstrated proficient clinical competence levels, yet 80% of the more experienced participants scored in the developing stage. This is corroborated by previous research that reported that in a medical-surgical unit even the experienced nurses demonstrated poor clinical judgment.³⁷ Of concern in this area is the finding from our study that when faced with the complex workload typical of an ED assignment, the focus changed from using clinical reasoning to task completion, leading to errors in treatment and failure to rescue.³⁸⁻⁴⁰

The question remains of the importance of experience in clinical judgment beyond competence as a practitioner.³⁷

Fero et al⁴¹ examined the performance of nurses' clinical judgment and reported no difference between new graduate nurses and those with 37 Further research is needed to examine the relationship between years of experience and clinical judgment specific to emergency nurses.

The development of nursing expertise is influenced by education in theory and practical knowledge,⁴² and professional values⁴³ that can be applied to actual situations but no difference in clinical judgment was seen between ADN- and BSN-prepared nurses. Beyond the initial education of a nurse, mentorship and training are critical in the development of clinical judgment.^{21,44,45} Given the high rate of turnover currently being experienced in nursing,⁴⁶ the

ability to place new graduates with experienced nurses to develop clinical judgment can be difficult.

Completed Nursing Tasks

Nurse workload has been associated with negative patient outcomes, often based on the omission of care needed for a patient.⁴⁷ In our observed simulation, we found indications that given the typical workload of the emergency department, nurses tend to become a “machine,” rather than applying sound clinical judgment,³⁸ which leads to missing vital steps in patient care. A nurse who feels overloaded at work is more likely to have an error in patient care⁴ as attention shifts to task completion rather than the application of clinical judgment and reasoning to the situation.⁴⁰ The participant that missed the stroke stated, “[I was] overwhelmed by the simulation. My focus was on the chest-pain patient, because they needed the most things done.” Such a focus on task completion during multitasking has shown to be a risk to patient safety.³⁹

A focus on task completion rather than assessment can result in even typical workloads contributing to failure to rescue. This was noted specifically in the care of our simulated patient with chest pain where lack of assessment, lack of interpretation, and lack of response created a situation in which the simulated patient deteriorated. Failure to rescue has previously been explained as being caused by inattentive blindness or the inability to notice a change, because it is unexpected even among expert practitioners.^{48,49} Failure to rescue has been linked to the workload of emergency nurses⁵⁰ and is of great concern in the emergency department. In this study, we assumed that experience improves clinical judgment as a function of exposure to paradigm cases as described by Benner,²¹ but this is not what was observed. Again, the causes of the repeated failure to rescue in this study seem to be linked less to the workload and more to a lack of assessment and interpretive skills.

Limitations

The study had important limitations. This was a self-selecting group of emergency nurses from the 1 regional medical center, limited to a small sample, academic preparation lacking diversity, and a single work environment. Although this sample was representative of nurses employed at this hospital, it did not provide a sample with adequate size and diversity to determine whether clinical judgment or task completion was influenced by the education level of the participants. Although not generalizable to all emergency nurses, these results contribute to a growing body of knowledge emphasizing the importance of emergency nurse workload and training on patient outcomes.

Implications for Emergency Nurses

Emergency nurses are routinely under a heavy workload, simultaneously caring for multiple patients, including some who are critically ill. The observed clinical judgment during this simulation was much lower than expected. It cannot be assumed that years of experience in the emergency setting alone translate to higher levels of clinical judgment. Educators and unit leadership might better align the resources of the department and hospital to support the success of the emergency nurses via continuing education, simulated practice, and evaluation of clinical judgment rather than isolated tasks or “skills” to provide for patient needs. Surge policies and means to decompress the emergency department are critical in allowing the emergency nurse to be able to take the time to assess and manage each patient rather than forcing a focus on task completion.

Conclusions

Emergency nurses are constantly under a heavy workload, simultaneously caring for multiple critically ill patients. The observed clinical judgment during this simulation was much lower than expected with even the experienced nurses scoring in the developing stage of LCJR. It cannot be assumed that years of experience alone translates to higher levels of clinical judgment in the emergency department. Given the cognitive and practice demands placed on the emergency nurse, it also cannot be assumed that all nurses have clinical judgment capacity related to their

experience or educational levels when caring for their patients. Along with continuing education, the priority of unit leadership might be to limit nursing workload, allowing the emergency nurse to develop and use sound clinical judgment rather than forcing a focus on task completion.

Education for the emergency nurse also must focus on developing and enhancing clinical judgment. This means that unit educators should continue to evaluate nurses with simulation-based learning experiences to identify gaps in clinical reasoning after their formal education completes and remediate appropriately. These authors recommend that further research be conducted using larger samples and multiple sites to determine whether our findings are representative of contemporary nursing practice in more than one setting.

Data, Code, and Research Materials Availability

Ethical approval from the University of Alabama (IRB #20-12-4144).

Author Disclosures

Conflicts of interest: none to report.

This publication was supported by grant #T42OH008436 from the National Institute for Occupational Safety and Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views on the National Institute for Occupational Safety and Health.

Patient	Scenario	Expected actions
Pediatric simulator Mother at bedside: SP ²⁵ Asthma	Asthma exacerbation Stable but wheezing slightly Awaiting bed availability on floor Vital signs: • BP: 109/74 mm Hg • HR: 126 bpm • RR: 26 cpm • O2 saturation: 90% on 100% face mask	•Update provided to mother •Respiratory assessment of patient •Administration of methylPREDNISolone
Young adult: SP ²³ Headache, elevated BP, stroke during simulation	Headache Elevated BP Basic laboratory tests drawn Awaiting CT results Vital signs: • BP: 190/140 mm Hg • HR: 90s bpm • RR: 24 cpm • O2 saturation: 94% on RA	•Update patient •Results of CT scan •Treat BP •Neurological assessment •Treat headache

<p>Middle-aged patient simulator²⁴ New-onset chest pain</p>	<p>New-onset chest pain 7/10 pain No significant history No home medications Cardiac workup/EKG orders Vital signs: • BP: 90s/50s mmHg • HR: 130s bpm • RR: 20s cpm • O2 saturation: 93% on RA</p>	<p>•Cardiovascular assessment•Obtain 12-lead EKG•Initiate peripheral IV access•Address patient BP•Treat patient chest pain•Address patient heart rate</p>
<p>Elderly patient: SP²⁵ Influenza-like symptoms</p>	<p>New patient Fever, cough, congestion Very needy Distracts staff Vital signs: • Real-time vital signs of SP • Assess patient complaint • Administer ordered medications • Provide for needs of patient</p>	

Category of clinical judgment	1	2	3	4	5	6	7	8	9	10	11	12	13	14*	15*	16*	17*	18*
Noticing																		
Focused observation	2	3	3	3	3	2	3	2	2	2	2	2	2	3	2	4	2	2
Recognizing deviation	1	3	3	3	3	1	3	1	1	1	1	1	1	2	1	4	1	1
Information seeking	2	3	3	3	3	2	2	3	1	1	1	2	1	3	1	4	1	2
Interpreting																		
Prioritizing data	1	3	3	3	3	1	3	1	1	1	1	1	1	2	1	4	2	1
Making sense of data	2	3	3	2	3	1	3	1	2	2	2	2	1	2	1	4	2	2
Responding																		

Calm, confident manner	3	4	3	3	4	3	3	3	3	3	3	3	3	3	3	3	4	4	3
Clear communication	3	4	4	3	4	3	3	3	3	3	3	3	3	3	4	4	4	4	4
Well-planned intervention	1	3	3	3	4	1	3	2	1	1	1	1	1	2	1	4	1	1	
Being skillful	3	3	3	3	4	2	3	2	3	2	3	3	2	4	4	4	4	3	
Reflecting																			
Self-analysis	3	3	3	3	3	3	3	3	3	2	3	3	2	3	2	4	2	3	
Commitment to improve	4	4	4	4	4	4	4	4	4	3	4	4	3	4	3	4	4	4	
Total score	25	36	35	34	38	23	34	25	24	21	24	25	20	32	23	44	27	26	

Participant	Age	Sex	Years of experience	Degree
1	21	F	0.75	ADN
2	22	F	1	ADN
3	28	F	1	ADN
4	43	F	3	ADN
5	33	F	2	ADN
6	35	F	0.75	ADN
7	35	M	2.5	ADN
8	24	F	1	ADN
9	26	M	4	ADN
10	27	F	2	ADN

11	29	F	2	ADN
12	28	M	3	ADN
13	28	F	5	ADN
Mean	29.2		2.1	
Nurses with <5-y experience above, >5-y experience below				
14	40	F	6	BSN
15	39	F	9	BSN
16	37	F	8	ADN
17	33	M	7	BSN
18	32	M	5	ADN
Mean	36.2		7	
Mean total	31.1		3.5	

	Expected actions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Pediatric patient	Update mother	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment		X	X		X		X					X		X		X		X	Medication
					X	X	X			X			X	X	X	X	X		Migraine patient
																			Update patient

X	X		X		X		X	X	X	X	X	X	X	X	X	X	X	As se ss me nt	
X	X		X		X									X				Re vie w CT	X X
X	X		X	X	X	X	X	X	X	X	X	X	X	X	X		Tre at blo od pre ss ure		X X
X	X		X	X	X		X	X	X	X	X	X		X		Tre at he ad ac he	X		X
	X		X				X	X					X			Ch est pai n pat ien t	As se ss me nt	X X	
X			X		X		X			X		X			EK G	X	X	X	X X
X	X		X	X	X	X	X	X	X	X	X	X		IV ac ce ss	X	X	X	X	X X

X	X	X	X	X	X	X	X	X	X	X	X	Tre at blo od pre ss ure		X	X	X	X			X
				X				X				Tre at ch est pai n	X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X	X	X	X	Ad dre ss he art rat e	X	X			X	X	X		X
X			X		X	X	X	X	Infl ue nz a sy mp to ms	As se ss me nt		X	NA	NA	NA	NA	X			
NA	NA	NA	X	X	X	X	X	X	Me dic ati on		X		NA	NA	NA	NA	X		X	NA
NA	NA		X		X			Ne ed s	X	X	NA	NA	NA	NA		X	X	NA	NA	
NA	X	X	X	X	X	X	Pe rce nt		59	82	71	64	79	64	82	59	65	59	64	

Patient	Scenario	Completion
Pediatric simulator Mother at bedside: SP Asthma	Asthma exacerbation Stable but wheezing slightly Awaiting bed availability on floor. Vital signs: <ul style="list-style-type: none"> • BP: 109/74 mm Hg • HR: 126 bpm • RR: 26 cpm • O2 saturation: 9% on 100% face mask 	<ul style="list-style-type: none"> •All updated the mother. •8 completed the assessment. •9 administered the ordered medication.
Young adult: SP headache, elevated BP, stroke during simulation	Headache Elevated BP Basic laboratory tests drawn Awaiting CT results Vital signs: <ul style="list-style-type: none"> • BP: 190/140 mm Hg • HR: 90s bpm • RR: 24 cpm • O2 saturation: 94% on RA 	<ul style="list-style-type: none"> •15 nurses updated the patient. •All reviewed the CT results. • 14 treated the high BP, and 7 treated the headache. • Of those treating the BP, only 6 nurses with less than 5-y experience and 3 nurses with more than 5-y experience treated the BP within the first 10 min of the simulation. • A neurologic assessment was completed by 3 participants across both groups. • 1 nurse performed a National Institutes of Health stroke scale assessment.
Middle-aged patient simulator New-onset chest pain	New-onset chest pain 7/10 pain No significant history No home medications Cardiac workup/EKG orders Vital signs: <ul style="list-style-type: none"> • BP: 90s/50s mm Hg • HR: 130s bpm • RR: 20s com • O2 saturation: 93% on RA 	<ul style="list-style-type: none"> •8 participants completed the assessment. •7 treated the low BP. •12 addressed the high heart rate. •All participants started the IV, obtained an EKG, and provided treatment for the chest pain. • 7 nurses with <5 y and 4 nurses with >5 y gave the patient with chest pain nitroglycerin without correcting the BP (90/50). • With the administration of the first nitroglycerin the BP was lowered to 84/46, yet 4 nurses (3 < 5 y, 1 > 5 y) gave the second nitroglycerin and metoprolol without correcting the BP despite the decrease related to treatment. •1 nurse (<5 y) administered morphine to the patient with chest pain without an order for the medication.
Elderly patient – SP Influenza-like symptoms	New patient Fever, cough, congestion Very needy Distracts staff Real-time vital signs of SP	<ul style="list-style-type: none"> •8 completed the assessment. •5 provided the ordered medication. •10 provided for the patient's needs.

DETAILS

Subject:	Laboratories; Task completion; Emergency medical care; Telemetry; Clinical training; Patients; Professional development; Nurses; Emergency services; Caregiving; Workloads; Pediatrics; Medical errors; Deterioration; Simulation; Drugs; Standardized patients; Acutely; Blood pressure; Patient satisfaction; Critical incidents; Nursing; Clinical nursing; Clinical decision making
Business indexing term:	Subject: Professional development Workloads
Identifier / keyword:	Emergency nurse; Clinical judgment; Failure to rescue; Patient outcome assessment
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	222-235
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.010
ProQuest document ID:	2781604292
Document URL:	https://www.proquest.com/scholarly-journals/determining-clinical-judgment-among-emergency/docview/2781604292/se-2?accountid=211160

Copyright: ©2022. Emergency Nurses Association

Last updated: 2023-06-21

Database: Public Health Database

Document 32 of 50

Emergency Nursing Review Questions: March 2023: JEN

[ProQuest document link](#)

FULL TEXT

These review questions are based on the Emergency Nursing Core Curriculum and other pertinent resources to emergency nursing practice. They offer emergency nurses an opportunity to test their knowledge about their practice.

Questions

1. A 7-month-old patient is brought to the emergency department in cardiac arrest. An intraosseous device is placed in the proximal tibia by the nurse. Which of the following would be confirmatory for correct placement?

2. A. Bright red blood upon aspiration
3. B. Movement of the device at the insertion site
4. C. Pink frothy aspirate obtained
5. D. Moderate resistance with fluid administration

2.

A 26-week-pregnant patient complains of dizziness upon standing, vaginal bleeding, severe abdominal pain, and a very tight abdomen. You would suspect?

- A. Placenta previa
- B. Premature labor
- C. Abruptio placenta
- D. Uterine irritability

3.

A patient is brought to the emergency department after experiencing an electrical shock from a loose wire. Which of the following assessment findings would cause the most concern?

- A.The entrance wound appears to be on the left hand.
- B.The patient experienced a momentary loss of consciousness.
- C.Sinus rhythm with an isolated premature ventricular contraction.
- D.The urine myoglobin level is 0 ng/mL.

4.

A patient is brought to the emergency department by Emergency Medical Service (EMS). The patient has a history of a lung transplant 14 months ago and has been on prednisone (Deltasone) 80 mg daily for rejection prevention. The patient has missed the last 2 doctor visits. The wife describes a change in his alertness and a depressed state. Multiple bruising is noted on both arms and the patient has a swollen abdomen and states his face looks full. Based on this history, you would suspect:

- A.Thyrotoxicosis
- B.Cushing's syndrome
- C.Organ rejection
- D.Addison's syndrome

5.

A patient is being discharged from the emergency department after an ankle injury. The patient has a posterior ankle splint in place and prescribed crutches with a 3-point gait. Which of the following actions would demonstrate proper crutch walking technique?

- A.Crutch tops in the axilla during maneuvering crutches
- B.Moves crutches and injured ankle forward simultaneously
- C.Steps forward with the injured ankle and then moves crutches forward
- D.Crutches held close to patient's hips during movement

Answers

1. Correct answer: C

(C) Pink, frothy aspirate or bone marrow may be obtained with aspiration of a properly placed intraosseous device, but is not always present. (A) Aspiration of bright blood would indicate a blood vessel penetration as opposed to the intraosseous canal. (B) If the device is properly seated in the bone, it should not move after insertion. (D) After an initial bolus administration, the device should allow for fluid to flow with very little resistance.¹

1. Correct answer: C

(C) Abruptio placenta is a major life-threatening complication for both the mother and the fetus. The condition occurs when the placenta prematurely separates from the uterine wall. The highest incidence occurs between 24 and 28 weeks of pregnancy. Symptoms include intrauterine bleeding, vaginal bleeding, severe abdominal pain, hemorrhagic shock, and uteroplacental insufficiency. (A) Placenta previa is a displacement of the placenta either covering the uterine os or partially covering the os. Signs include painless vaginal bleeding, usually after 20 weeks

of pregnancy. Vaginal examination must be avoided if placenta previa is suspected. (B) Premature labor presents with abdominal pain, regular or frequent, contraction type. In pregnancy, uterine irritability is used to describe nonlabor inducing contractions that occur frequently. (D) These contractions may be painful or painless and may not have any consistency or pattern. An example would be Braxton Hicks contractions.²

1. Correct answer: B

(B) Any loss of consciousness after an electrical injury would be considered serious and require further evaluation. (A) Wounds should not be labeled as entrance or exit wounds but contact points. Any contact point should be evaluated for skin injury and any potential underlying tissue injury. Underlying tissue with a hand injury would not take precedence over a loss of consciousness. (C) Cardiac dysrhythmias may be present after an electrical injury, especially atrial fibrillation and ST wave changes. An isolated premature ventricular contraction should not be concerning, but may require further evaluation. (D) A urine myoglobin of 0 ng/mL would be a normal finding. Rhabdomyolysis with myoglobinuria may occur after significant electrical injury.³

1. Correct answer: B

(B) Cushing's syndrome may be observed in a patient with prolonged use of a corticosteroid such as prednisone (Deltasone). Signs include hypertension, abdominal swelling, fatty tissue deposits in the face (moon face) and between the shoulders (buffalo hump), altered mood, depression, thinning skin, and bruising. A tapering of the prednisone (Deltasone) must be initiated to avoid further complications such as bone loss and infection. (A) Thyrotoxicosis may be observed in patients with excessive thyroid hormone and appear with a hyperdynamic state such as hypertension, tachycardia, and hyperthermia. (C) A patient with an organ rejection would appear septic or signs of failure of the transplanted organ. Chronic rejection can take place over many years as the body's immune response slowly attacks the transplanted organ. (D) Addison's disease, also called adrenal insufficiency, is an disorder that occurs when the body has a deficiency of certain hormones such as cortisol and aldosterone. Patients with Addison's disease may have slowly developing symptoms, often over several months. Symptoms include extreme fatigue, weight loss, salt craving, hypoglycemia, and hypotension.^{4,5}

1. Correct answer: B

(B) Crutches should be used to protect an injured leg or extremity, not cause further damage. When using a 3-point gait, the patient should place their weight on the noninjured leg and move injured leg and crutches forward simultaneously. (A) Crutches should be fitted to allow at least 2 inches or 2 to 3 fingerwidths below the axilla, with no weight in the axilla. (C) Stepping forward with the injured extremity would require weight bearing on the injury, contrary to the non-weight-bearing concept. (D) Crutches should be 6 to 12 inches out from the patient to provide a base for the body to move through the crutches.⁶

DETAILS

Subject: Ankle; Emergency medical care; Premature labor; Placenta; Emergency services; Abdomen; Pregnancy complications; Consciousness; Core curriculum; Vagina; Nursing; Fainting; Hypertension

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue:	2
Pages:	305-307
Publication year:	2023
Publication date:	Mar 2023
Section:	Emergency Nursing Review Questions
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.013
ProQuest document ID:	2781604288
Document URL:	https://www.proquest.com/scholarly-journals/emergency-nursing-review-questions-march-xa0-2023/docview/2781604288/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-03
Database:	Public Health Database

Document 33 of 50

An Important Suggestion for External Jugular Vein Cannulation: JEN

[ProQuest document link](#)

FULL TEXT

Dear Editor:

I read the article titled “External Jugular Vein Peripheral Intravenous Catheters: An Emergency Nurse’s Guide” with great interest.¹ In the article, the authors provide important information about the intravenous (IV) insertion procedure of external jugular cannulation (EJV), which is considered to be one of the popular rescue approaches to difficult IV access. I would like to share my experience as an anesthesiologist with 25 years of experience. Peripheral IV cannulation is vital in anesthesia and intensive care units. EJV access is handy in cardiac arrest or emergency situations in the operating room and intensive care units and provides emergency access for the anesthesiologist.

Fortunately, the overwhelming majority of EJV cannulations are placed successfully. Traditionally, confirmation of the correct peripheral IV cannulation is made by visualizing an appreciable flash of blood into the chamber of the syringe.¹ However, as mentioned in the study by Adams and Zaryske,¹ a challenge with EJV is that it might be impossible to get a flash of blood into the syringe, owing to the lower blood pressure in the EJV.² Even though the common confirmation method for routine peripheral venous procedures is the visualization of blood in the chamber of the syringe, according to my clinical experience, the inability to observe blood does not always indicate incorrect placement for EJV cannulation. Hence, what should be done before considering the EJV cannulation as unsuccessful?

Sound advice could be found in a study published by Bechmann et al.² They suggested attaching a small syringe to the needle and holding gentle negative pressure on it while advancing the needle to increase blood return into the syringe and confirm entry into the EJV to solve this problem. We are using an alternative technique in our department which we strongly suggest to our residents when they try to perform EJV cannulation.

During the procedure, if the physician believes that they entered the EJV but no flash of blood appears in the chamber of the syringe, the needle (but not the plastic catheter) should be withdrawn into the plastic catheter slowly; blood may now appear in the plastic catheter (Figure). I am very curious to know which techniques would authors recommend for solving this problem.—*Seza Senturk Apiliogullari, MD, Department of Anesthesia and Intensive Care, School of Medicine, Canakkale Onsekiz Mart University, Canakkale, Turkey; E-mail: drsezaapili@gmail.com.*

ORCID identifier: <https://orcid.org/0000-0001-6116-4322>. **Twitter:** @SApiliogullar.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Anesthesia; Intensive care; Catheters
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
First page:	155
Publication year:	2023
Publication date:	Mar 2023

Section:	Letter to the Editor
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Letter
DOI:	https://doi.org/10.1016/j.jen.2022.11.007
ProQuest document ID:	2781604197
Document URL:	https://www.proquest.com/scholarly-journals/important-suggestion-external-jugular-vein/docview/2781604197/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-03
Database:	Public Health Database

Document 34 of 50

“I Was Here First, Why Did They Go Before Me”: Examining Patients' Perceptions of Priority in a Psychometric Study of Emergency Department Triage: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Unrealistic patient expectations for wait times can lead to poor satisfaction. This study's dual purpose was: (1) to

address disparities between patients' perceived priority level and the Emergency Severity Index (ESI) assigned by emergency room triage nurses; and (2) to evaluate validity and reliability of using the Patient Perception of Priority to be Seen Survey (PPPSS) to investigate patient expectations for emergency department urgency.

Methods

A two-group pretest-posttest quasi-experimental approach compared patient urgency opinions to nurse urgency ratings with and without a scripted educational intervention. This tested how closely patient perceptions were related to triage nurse ratings.

Results

Reliability for the PPPSS was acceptable (reliability = 0.75). Patients who were rated lower urgency on the ESI by triage nurses tended to self-report higher urgency ($\rho = -0.44, P < .01$). Attitudes were more consistent in the posttest patient group who were exposed to the scripted verbal description of emergency department procedures ($\chi^2(1, N = 352) = 8.09, P < .01$). Patients who disagreed with emergency nurse scores tended to be younger on average (eg, <40 years old; $\rho = 0.69, P < .01$). Male identified patients tended to be rated both by nurses and themselves as higher urgency ($\beta = 0.18, P = .02$).

Discussion

We recommend the PPPSS for nurses and researchers to quickly assess patient expectations. Additionally, promoting patient understanding through a scripted educational strategy about the ESI system may also result in improvements in communication between patients and nurses.

FULL TEXT

DETAILS

Subject:	Emergency medical care; Self report; Educational programs; Waiting times; Perceptions; Urgency; Quasi-experimental methods; Triage; Research nurses; Emergency services; Reliability; Nurses; Patient satisfaction; Attitudes; Patient communication
Identifier / keyword:	Emergency department; Triage; Patient perception; Psychometrics; Educational intervention
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	294-304.e5
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia

Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.09.017
ProQuest document ID:	2781604072
Document URL:	https://www.proquest.com/scholarly-journals/i-was-here-first-why-did-they-go-before-me/docview/2781604072/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-09-0 1
Database:	Public Health Database

Document 35 of 50

Leadership and Trauma-Informed Care: Working to Support Staff and Teams: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

The concept of “trauma-informed care” as a paradigm in public health and human services has evolved over the past 30 years. Can trauma-informed practices be used as a leadership tool to help address staff/colleagues as they grapple with the concerns associated with a complex health care landscape? Trauma-informed care shifts the focus from “What’s wrong with you?” to “What happened to you?” This powerful approach to addressing stress might help set the stage for caring and meaningful interactions among staff and colleagues before exchanges become fraught with blame and unproductive or toxic impacts on team-based relationships.

FULL TEXT

“They may forget what you said—but they will never forget how you made them feel.”—Carl W. Buehner
Epic storms, massive flooding, intense wildfires, unrelenting street violence, workplace violence, raging interpersonal violence, unprecedented political conflict, and a global pandemic have escalated stress and emotions for the public but the toll stress has taken on health care workers is just starting to be understood as nurses are reported to be

leaving the workforce in droves. In a survey of 1500 nurses conducted by Nurse.org,¹ including more than 100 that identified the emergency department as their primary specialty:

- 87% feel burned out.
- 84% are frustrated with administrators.
- 84% feel they are underpaid.
- 83% feel their mental health has suffered.
- 77% feel unsupported at work.
- 61% feel unappreciated.
- 60% have felt uncomfortable having to work outside of their comfort zone in the past year.
- 58% of nurses have felt frustrated with their patients.
- 58% of nurses have felt unsafe at work in the past year.

According to the survey, despite all this 70% of nurses still think that nursing is a great career and 64% would encourage others to join the profession.

When you hear the word “trauma,” it is common for emergency nurses to revert to images of broken bones, blood, and efforts to initiate rapid, organized interventions. However, trauma is pervasive in other ways, such as the toll it takes on the emotional well-being of patients and the staff that cares for them. The American Psychological Association defines trauma as an emotional response to a terrible event like an accident, rape, or natural disaster.² Merriam-Webster dictionary³ defines trauma as an injury to living tissue caused by an extrinsic agent; it also recognizes trauma as an emotional upset.

It would be naive to think that the constant exposure to pain and suffering complicated by ongoing system issues, such as understaffing, workplace violence, pay disparities, and a lack of respect does not have a mental health impact on staff members.

Wolff⁴ suggests, “For health-care workers, social support reduces occupational stress and prevents common psychological distress and psychiatric symptoms; however, coworker support is also significant for health-care workers, as it impacts self-efficacy and professional efficacy. Notably, negative social support is associated with stress and anxiety among medical staff.”⁴

Prolonged and repeated exposure to the level of stress, anxiety, and grief exacerbated by the intensity of the COVID-19 pandemic, in itself, is cause for special attention.

How do we provide the appropriate resources, and how do we keep each other safe, physically and psychologically? Trauma-informed practices show promise in helping to address these issues.

Not unlike experiences in military personnel, a prevailing attitude among health care workers seems to suggest that character flaws are responsible for a traumatic stress response, and the classification of stress as an anxiety “disorder” reflects weakness of the individual.⁵ Meanwhile in hospitals, the demand to support flexible schedules while maintaining operations, reassigning those who may be furloughed, and managing needs related to the use of travelers to supplement staffing has challenged even the strongest leaders. Of greatest importance is how we maintain trust during turbulent times and allow staff/colleagues to be able to share their concerns in a safe manner. The concept of “Trauma Informed Care” (TIC) as a paradigm in public health and human services has evolved over

the past 30 years. The focus of TIC is on the relationship of long-term traumatic experiences and the manner in which health/behavioral care services are delivered in the present. As emergency nurse leaders, we need to dig deep to find the right tools to help staff/colleagues as they grapple with the concerns associated with a complex health care landscape. Can trauma-informed practices be used as a leadership tool to help address these concerns? According to the Center for Health Care Strategies, “Trauma-informed care shifts the focus from ‘What’s wrong with you?’ to ‘What happened to you?’⁶” This powerful approach to addressing stress might help set the stage for caring and meaningful interactions among staff and colleagues before exchanges become fraught with blame and unproductive or toxic impacts on team-based relationships.

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies 6 key principles of a trauma-informed approach in a framework entitled “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach⁷”:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

TIC works to support an environment of empowerment, which we do routinely while advocating for our patients. Emergency nurse leaders must be present and ensure this occurs for our staff and each other. As our most valuable resource, our staff must be supported, listened to, valued, and acknowledged. We cannot solve all concerns, and we cannot always put into play all suggestions, but listening, ensuring an open door, and circling back on the “why” are imperative.

SAMHSA’s framework supports an understanding of the “3 E’s of Trauma⁷”:

1. Events—which may vary from person to person and be physical or emotional in nature. The repetition of these events is what constitutes the trauma.
2. Experience—influences how each individual perceives the event. A particular event may be perceived as a trauma for one individual, but not for others. How each individual experiences the event is linked to that individual’s past experiences.
3. Effects—a critical component to understand what happened to cause trauma. Some effects occur immediately, and others build and affect people over time. The effect of a perceived trauma may affect many things including an individual’s coping mechanisms, cognitive processes, and memories.

Because each of us has different perceptions of events and different life experiences, the effect of the perceived trauma is different for each person. It is essential for emergency nurse leaders to understand that although we may not feel a strong impact or effect of an experience or event, that may not be true for others.

As part of its framework, SAMHSA has developed a simple method to remind us how to keep a compassionate and trauma-informed perspective called the “Four R’s” or key assumptions in a TIC approach, noting that these are common and normal ways of reacting when we have lived through difficult experiences:

1. Realization—understanding the widespread impact of trauma and potential paths for healing.
2. Recognize—identifying signs and symptoms of trauma in patients, families, staff, and others involved with the system.
3. Respond—fully integrating knowledge about trauma into policies, procedures, and practices.
4. Resist retraumatization—avoiding the problems and pitfalls that lead to strong emotional reactions.

As emergency nurse leaders, we must recognize that every individual is affected differently. We need to be present to listen and seek to understand the impact of the trauma-related events. Organizations that wish to consider cultural changes that support staff and patients are encouraged to view SAMHSA's issue brief: key ingredients for successful trauma-informed care implementation.⁸

As leaders we should ask ourselves the following questions as we consider the 6 key principles.

1. Do we understand how our staff define safety?
2. Do people in our emergency department and organization feel safe?
3. How do we demonstrate transparency?
4. What do we do to help peers support each other?
5. Do we provide an atmosphere that supports collaborative and mutual decision making or is everything top down?
6. How do we channel the great experiences of our staff?
7. What do we do to develop and empower our workforce?
8. Do we support failures as a stepping stone to learning and success?
9. Do our policies and protocols incorporate racial, ethnic, cultural, and individual needs?

We must be aware of and recognize the signs of trauma among one another. There are formal screening tools available to assist with this, but often as leaders we discover these subtle cues as we engage in conversation with staff and other leaders. We should ensure that we have policies and processes in place to promote a culture of resilience, while supporting diversity, equity, and inclusivity. To be successful in this approach, a comprehensive approach to TIC must be adopted at both the clinical and administrative levels.

It is a privilege to lead. It takes integrity, courage, humility, and a sense of humor. It is okay to be vulnerable, to let others know that although we may not have the right solution or answer, we will do everything in our power and challenge every barrier as we search for the best answer. Understanding the tenets of TIC is just one method to be better prepared as leaders to support others.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Emergency medical care; Blame; Health care; Anxiety; Collaboration; Public health; Trauma; Stress; Human services; Pandemics; Medical personnel; Workplace violence; Empowerment; Leadership; Mental health; Teams; Nurses; Colleagues
Business indexing term:	Subject: Workplace violence Leadership
Identifier / keyword:	Leadership; Stress; Empowerment; Support
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	172-174
Publication year:	2023
Publication date:	Mar 2023
Section:	Leadership Forum
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.001
ProQuest document ID:	2781604057
Document URL:	https://www.proquest.com/scholarly-journals/leadership-trauma-informed-care-working-support/docview/2781604057/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-03

Document 36 of 50

Medication Discussions With Patients With Cardiovascular Disease in the Emergency Department: An Opportunity for Emergency Nurses to Engage Patients to Support Medication Reconciliation: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

This study aimed to investigate the level of patient involvement in medication reconciliation processes and factors associated with that involvement in patients with cardiovascular disease presenting to the emergency department.

Methods

An observational and cross-sectional design was used. Patients with cardiovascular disease presenting to the adult emergency department of an academic medical center completed a structured survey inclusive of patient demographics and measures related to the study concepts. Data abstracted from the electronic health record included the patient's medical history and emergency department visit data. Our multivariable model adjusted for age, gender, education, difficulty paying bills, health status, numeracy, health literacy, and medication knowledge and evaluated patient involvement in medication discussions as an outcome.

Results

Participants' ($N = 93$) median age was 59 years (interquartile range 51-67), 80.6% were white, 96.8% were not Hispanic, and 49.5% were married or living with a partner. Approximately 41% reported being employed and 36.9% reported an annual household income of <\$25,000. Almost half ($n = 44$, 47.3%) reported difficulty paying monthly bills. Patients reported moderate medication knowledge (median 3.8, interquartile range 3.4-4.2) and perceived involvement in their care (41.8 [SD = 9.1]). After controlling for patient characteristics, only difficulty paying monthly bills ($b = 0.36$, $P = .005$) and medication knowledge ($b = 0.30$, $P = .009$) were associated with involvement in medication discussions.

Discussion

Some patients presenting to the emergency department demonstrated moderate medication knowledge and involvement in medication discussions, but more work is needed to engage patients.

FULL TEXT

DETAILS

Subject:	Health literacy; Patient safety; Socioeconomic factors; Drugs; Medical history; Cardiovascular disease; Health status; Cardiovascular diseases; Health professional-Patient communication; Patient participation; Nurses; Emergency services; Reconciliation; Numeracy; Medical errors; Emergency medical care; Communication; Patient education; Drug administration
Location:	United States--US
Identifier / keyword:	Medication reconciliation; Patient involvement; Medication; Cardiovascular; Emergency department
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	275-286
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.002
ProQuest document ID:	2781603962
Document URL:	https://www.proquest.com/scholarly-journals/medication-discussions-with-patients/docview/2781603962/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association

Last updated: 2023-03-07

Database: Public Health Database

Document 37 of 50

Board of Directors: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title:	Journal of Emergency Nursing:: JEN; Philadelphia
Volume:	49
Issue:	2
First page:	A8
Publication year:	2023
Publication date:	Mar 2023
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	General Information

DOI: [https://doi.org/10.1016/S0099-1767\(23\)00017-X](https://doi.org/10.1016/S0099-1767(23)00017-X)

ProQuest document ID: 2781603961

Document URL: <https://www.proquest.com/scholarly-journals/board-directors/docview/2781603961/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-03-07

Database: Public Health Database

Document 38 of 50

My Commitment to Emergency Nurses: JEN

[ProQuest document link](#)

FULL TEXT

I became an emergency nurse shortly after graduating from nursing school in the early 1990s. As a new graduate and novice emergency nurse, I remember feeling excited and overwhelmed with my new role. I had so much to learn in those early years. One of my primary sources of information and education was the *Journal of Emergency Nursing* (JEN). There was always a journal copy in the ED break room, and I read every issue cover to cover. I appreciated that the journal published articles that I could apply in practice in real time, and I learned a lot about emergency care standards.

As I gained experience as an emergency nurse, I wanted to give back to the profession. When I finished my master's degree, I decided to become a peer reviewer for JEN. I thought it was a way to give back to the nurses who mentored me and reviewed my work during graduate school. Within a few years, I became a JEN section editor, and eventually, I was invited to join the JEN Editorial Board. I was fortunate to be mentored by Dr. Anne Manton, who appointed me to an associate editor role. I spent 13 years working as an editorial team member at JEN. Each year, I grew fonder of the journal and my emergency nurse colleagues.

In those early days as an emergency nurse, I would never have imagined that one day I would be the editor in chief of JEN. I am honored and humbled to be back on the editorial team and entrusted with the editor role. I share my background because I want you to know how much the journal and emergency nurses mean to me. I often think about what emergency nurses are experiencing in the current health care climate. I know how hard it is to be an emergency nurse, and I am committed to JEN continuing to provide clinical and research guidance for emergency nurses worldwide. To achieve this goal, I will collaborate with the editorial team, editorial board, publisher, and Emergency Nurses Association (ENA) leadership to make some journal content and delivery adjustments.

According to the recently conducted August 2022 JEN Readership Survey, most readers value the journal, and half of respondents (51%) stated that they read every issue. More than half of the readers who participated in the ENA survey felt the inclusion of clinical practice guidelines (64%) and ENA position statements (52%) were essential to include in the journal. I agree with the readers. A prominent message from the reader survey was that the quality of the articles in JEN is very good to excellent and that readers desire more clinical articles. To that end, I intend to

increase the number of clinically relevant articles in the journal and identify and implement methods for making the rigorous research published more accessible to busy emergency nurses. I will be working with the editors and editorial board members to develop a plan for the journal that meets the unique needs of emergency nurses at all levels of practice and in diverse emergency settings. It is my goal that all emergency nurses see the JEN as their journal.

In the coming months, I will be listening to leadership and readers to understand better how the journal can continue to grow while being the premier journal for emergency nurses worldwide. I will meet with several groups to obtain feedback about where the journal excels and where changes are warranted. I welcome feedback from you, the readers of JEN. Some of the areas of focus I am committed to addressing in JEN include, but are not limited to, nurse wellness and healthy practice environments, health and social equity, emerging practice issues such as novel or resurging viruses, and clinical practice guidelines and articles that inform the daily practice of emergency nurses. Nurse wellness and safe, healthy practice settings are critical in emergency nursing. The upcoming May issue of the JEN will be a special issue on workplace violence curated by guest editor Dr Gordon Gillespie. Workplace violence continues to be a serious issue in emergency nursing that must be addressed. In addition, emergency nurses are experiencing significant burnout related to a myriad of practice issues, which the current pandemic has exacerbated. Rodriguez et al¹ conducted a multisite United States-based study assessing ED health care professionals' symptoms of anxiety and burnout, work stressors related to coronavirus disease 2019 (COVID-19), and risk of post-traumatic stress disorder. Findings from this study indicated that 68% of emergency nurses felt some level of stress and anxiety related to the COVID-19 pandemic, and 55% of nurses reported experiencing burnout symptoms in the previous week. Another alarming finding was that 23% of nurse respondents screened positive for post-traumatic stress disorder.¹ These findings are consistent with findings from a multicenter study conducted by Chor and colleagues.² Chor et al² found that the mean score for nurses on the Copenhagen Burnout Inventory was 51.3 (SD 19.6), which indicates moderate to severe burnout, and that was the overall average score for all nurses. The COVID-19 pandemic has taken a significant toll on emergency nurses worldwide who were already working in stressful practice settings and experiencing high burnout levels.³

When reflecting on the high levels of stress that emergency nurses experience, it is vital to consider the additional stress experienced by nurses who have been historically marginalized and excluded in nursing. A survey conducted by the Commission to Address Racism in Nursing found that 63% of nurses have experienced racism in their practice setting.⁴ Wolf et al⁵ conducted a study exploring the experiences that emergency nurses practicing in the United States had with bias and found that racism and other forms of bias were prevalent and detrimental to nurse wellness and patient outcomes. These issues directly affect emergency nursing practice. A recent The Future of Nursing 2020 to 2030 Consensus Study Report from the National Academies of Science, Engineering, and Medicine⁶ focused primarily on nurse wellness and health equity. In keeping with this focus, I encourage authors to submit articles about nurse wellness, healthy practice environments, bias, strategies to improve health outcomes, and health equity in emergency nursing. Furthermore, the editorial team will modify the journal author guidelines to ensure that articles published in JEN use inclusive and respectful language that honors the diverse nurses and communities that emergency nurses accompany in care.

The COVID-19 pandemic and the recent resurgence of monkeypox demonstrated the importance of timely guidance on managing novel viruses and illnesses that are emerging or uncommon in specific regions. Emergency nurses must be prepared to pivot and adapt to issues such as novel viruses, climate change, and disasters that will continue to affect their practice. JEN must also be prepared to pivot to address the real-time learning needs of emergency nurses. Therefore, the editorial team at JEN will strive to minimize our time from submission to publication, especially for time-sensitive clinical and research topics.

This year readers can expect to see an increase in clinical and special section articles addressing current practice issues and challenges. The editorial team will continue to publish robust and rigorous research articles and explore ways to make that content easier to comprehend and apply in practice. I understand that measuring a journal's impact goes beyond traditional metrics, and I am committed to JEN positively affecting nurse and clinical outcomes.

I welcome your thoughts and feedback as the editorial team develops a shared vision for the future of JEN.

Author Disclosures

Conflicts of interest: none to report.

DETAILS

Subject:	Emergency medical care; Nurses; Emergency services; Coronaviruses; COVID-19
Location:	United States--US
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	153-154
Publication year:	2023
Publication date:	Mar 2023
Section:	Editorial
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Editorial
DOI:	https://doi.org/10.1016/j.jen.2022.12.013
ProQuest document ID:	2781603959
Document URL:	https://www.proquest.com/scholarly-journals/my-commitment-emergency-nurses/docview/2781603959/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association

Last updated: 2023-03-03

Database: Public Health Database

Document 39 of 50

Information for Readers: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title: Journal of Emergency Nursing:: JEN; Philadelphia

Volume: 49

Issue: 2

First page: A10

Publication year: 2023

Publication date: Mar 2023

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: General Information

DOI: [https://doi.org/10.1016/S0099-1767\(23\)00018-1](https://doi.org/10.1016/S0099-1767(23)00018-1)

ProQuest document ID: 2781603919

Document URL: <https://www.proquest.com/scholarly-journals/information-readers/docview/2781603919/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-03-03

Database: Public Health Database

Document 40 of 50

Editorial Board: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 2

First page: A6

Publication year: 2023

Publication date: Mar 2023

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: General Information

DOI: [https://doi.org/10.1016/S0099-1767\(23\)00016-8](https://doi.org/10.1016/S0099-1767(23)00016-8)

ProQuest document ID: 2781603912

Document URL: <https://www.proquest.com/scholarly-journals/editorial-board/docview/2781603912/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-03-03

Database: Public Health Database

Document 41 of 50

The Long Tail of COVID-19 : Implications for the Future of Emergency Nursing: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

COVID-19 has led to exacerbated levels of traumatic stress and moral distress experienced by emergency nurses. This study contributes to understanding the perspectives of emergency nurses' perception of psychological trauma during COVID-19 and protective mechanisms used to build resilience.

Method

The primary method was qualitative analysis of semistructured interviews, with survey data on general resilience, moral resilience, and traumatic stress used to triangulate and understand qualitative findings. Analyses and theme development were guided by social identity theory and informed by the middle range theory of nurses' psychological trauma.

Results

A total of 14 emergency nurses were interviewed, 11 from one site and 3 from the other. Almost all nurses described working in an emergency department throughout the pandemic as extraordinarily stressful, morally injurious, and exhausting at multiple levels. Although the source of stressors changed throughout the pandemic, the culmination of continued stress, moral injury, and emotional and physical exhaustion almost always exceeded their ability to adapt to the ever-changing landscape in health care created by the pandemic. Two primary themes were identified: losing identity as a nurse and hopelessness and self-preservation.

Discussion

The consequences of the pandemic on nurses are likely to be long lasting. Nurses need to mend and rebuild their identity as a nurse. The solutions are not quick fixes but rather will require fundamental changes in the profession, health care organizations, and the society. These changes will require a strategic vision, sustained commitment, and leadership to accomplish.

FULL TEXT

Contribution to Emergency Nursing Practice

- Emergency nurses work in stressful environments exposing them to significant rates of moral distress, traumatic stress, and workplace violence; often leading to a high prevalence of burnout. The impact of COVID-19 on emergency nurses' trauma and resilience remains under documented.
- This study contributes to the research on emergency nurses' lived experiences providing care during the COVID-19 pandemic. Particularly, how morally injurious situations and trauma impacted nurses' professional identity.
- Emergency nurses have been wounded during the pandemic. It is imperative to develop and implement interventions to support nurses' mental health and well-being and repair nurses' professional identity.

Introduction

Emergency departments are a vital part of the health care system, handling a wide variety of patient concerns and acting as a safety net for many people. In addition, emergency departments are also one of the most stressful environments for nurses, with significant rates of burnout, moral distress, and traumatic stress.¹⁻³ Emergency nurses experience high rates of workplace violence from patients and family members^{4,5} and, like all nurses, have high rates of other workplace injury.⁶ Emergency departments struggle to retain nurses,^{7,8} which places remaining nurses under increased strain and puts patients at risk. Limits in resources during the pandemic, especially nurse staffing, have led to an increase in "ED boarding,"⁹ where individuals are admitted for treatment but still occupy space in the emergency department awaiting transfer. This backlog of ED patients contributes to increased stress and increases the likelihood of errors and decreased quality of care.¹⁰

The consequences of this historic, unprecedented event for nurses go beyond "burnout," a workplace phenomenon characterized by emotional exhaustion, lack of efficacy, and callousness.¹¹ The combination of individual, health system, and societal factors are deeply wounding to the moral fiber, identity, and integrity of nurses. Emergency nurses have been placed into situations during the pandemic that led to moral injury.^{12,13} Moral injury in health care is a type of suffering characterized by exposure to circumstances that violate one's values and beliefs, eroding integrity, capability, and perception of basic goodness, and creating psychological, behavioral, social, or spiritual distress.¹² These nurses faced challenges with ever-changing protocols, shortages of resources, expedited time constraints, and the responsibility of refusing patient visitors.^{14,15} Emergency nurses were expected to provide care and follow guidelines, often against their own beliefs and values as a nurse and as part of the nursing profession. This left emergency nurses with massive emotional struggles leading to guilt and remorse, wishing that they could have performed differently, even though the decisions were likely unavoidable at the time.^{12,14} Work-related trauma, feelings of institutional betrayal, and moral injury came together to create potentially morally injurious events and erosion of nurses' moral core, identity, and worth.^{13,16}

These various types of trauma, moral injury, and system-wide abandonment have contributed to nurses leaving, or considering leaving, the profession.¹⁷ A major driver of attrition may be erosion of their nursing identity; nurses with low professional identity are more likely to report intent to leave jobs and the profession.^{18,19} As the COVID-19 pandemic continues, nurses face obstacle after obstacle; their self-concept and integrity as nurses have been

challenged, especially in relationship with patients, families, coworkers, leaders, and organizations.^{12,13,15} Moral resilience, “the capacity of an individual to preserve or restore integrity”²⁰ (p. 489), has been proposed as a protective resource to support nurses whose integrity has been threatened or violated.²⁰ Moral resilience, a domain within the broader construct of resilience, harnesses the inherent integrity of persons to restore their moral agency to choose actions that are aligned with their values.²¹ Like generic resilience, it is a strength-based construct that empowers people to respond to adversity rather than become victimized and powerless.²¹ Understanding emergency nurses’ experiences of the COVID-19 pandemic and how it impacted them and their professional identity may provide information useful for designing and implementing interventions to support them and the health care system. The purpose of this exploratory study is to better understand the perspectives of emergency nurses’ psychological trauma and resilience during COVID-19 and protective mechanisms used to build resistance. This will not only inform local interventions but also contribute to the emerging body of knowledge on trauma and resilience during a pandemic.

Methods Theoretical Frameworks

Foli’s Middle Range Theory of Nursing Trauma articulates how nurses’ daily caring work exposes them to many potentially traumatic events²² (see ^{Table 1} for critical concepts). Emergency nurses are particularly susceptible to trauma, including secondary trauma, vicarious/secondary trauma, historical trauma, workplace violence, system-induced trauma, insufficient-resource trauma, second-victim trauma, and trauma from disaster, resulting from the experience of and witnessed suffering of primary trauma.²² In addition to usual trauma exposure, during the pandemic, emergency nurses experienced increased risk of disaster-related trauma, insufficient-resource trauma, system-induced trauma, and workplace violence. Unfortunately, the COVID-19 pandemic has further exacerbated existing problems and created new concerns for emergency nurses.^{15,17,23}

Social identity is a person’s awareness of who they are based on membership in a group(s). Social identity theory was developed during the 1970s by Tajfel and Turner²⁴ to emphasize the importance of group membership to social identity and accentuate how group membership can be a source of pride and self-esteem. This theory explains phenomena that occur between groups, such as discrimination and stereotyping.²⁵ More recently, social identity theory has gained merit as a framework explaining social identity and group memberships’ relationships with health and well-being,²⁶⁻²⁸ highlighting how body and mind are conditioned by group belonging.²⁹ This framework has been used to examine stressful life transitions, including reactions to trauma, using the social identity model of identity change³⁰ (SIMIC) and shows that negative responses to trauma can lead to significant changes in social identity. Social identity theory has been applied to the nursing profession and suggests that the nursing identity is constructed through a process of social belonging in multiple communities (the professional, the health system, the unit, etc.), in relationship with other individuals (patients, coworkers), and in relationship with external groups (eg, the public).³¹ The SIMIC was used to understand changes in emergency nurses’ professional and personal identity from their experiences during the COVID-19 pandemic.

Methods/Design

This study used a concurrent, mixed-methods design.³² The primary method was qualitative interviews, with survey data used to triangulate and understand qualitative findings. A qualitative descriptive approach guided this study, which seeks to provide a straightforward description of a phenomenon of interest.³³ Univariate descriptive approaches to statistical analysis were used for quantitative data, and integration occurred through weaving of qualitative and quantitative findings to triangulate emergency nurses’ experiences. Analysis and theme development were guided by social identity theory²² and informed by the middle range theory of nurses’ psychological trauma.²² Participants provided their consent to participate. The potential risk of psychological distress during the interview

was outlined, and information was provided for employee assistant program. The study was approved by the Institutional Review Board of Reading Hospital and Missouri Baptist Medical Center.

Sample and Setting

Study sites were 2 magnet-designated, acute care hospitals. One site is a midwestern hospital whose emergency department is not a trauma center and cares for 100 patients per day, with approximately 40 of those being patients with COVID-19. The second site is a level 1 trauma center on the U.S. East Coast and is the tenth busiest emergency department in the U.S.

The target population was nurses working in the emergency department with patients with COVID-19. Fourteen nurses from the emergency department who provided direct care for patients with COVID-19 participated in this study. All participants were Caucasian females with professional nursing experience ranging from 2 to 20 years of practice. Two nurses were master's prepared, and 12 nurses had Bachelor of Science in Nursing degrees. Purposeful sampling was used, with potential participants identified by clinical staff as those who had rich experiences on the phenomenon.

Team

The research team consisted of 4 doctorally prepared nurse researchers, 4 critical care nurses, a medicine nurse, 1 nurse administrator, and a hospital chaplain. Each stage of the research process was evaluated by the entire group to reduce individual researcher bias. Two doctorally prepared nurse researchers conducted all interviews (1 at each site). Frontline nurses who were not participants in the study confirmed themes and identified and provided member checking, which increases credibility of findings as based in the data and the lived experience of those who experience the phenomenon.³⁴

Recruitment

After approval, a study flyer was emailed to all nurses working in the emergency departments who had direct contact with patients with COVID-19 and placed throughout ED units. The flyer provided a brief study description, eligibility criteria, and investigator's contact information. Research team members also attended shift huddles to describe the study and provide additional flyers. Fourteen emergency nurses contacted investigators, and all 14 nurses were eligible and agreed to participate. They completed surveys followed by interviews. Interviews were scheduled at a mutually convenient time. Data saturation was met with a sample of 13 participants. A confirmatory interview was completed to verify saturation.

Data Collection Strategy

Written consent was obtained before completing surveys. Participants completed surveys of the following measures using a secure web application for managing databases developed by Vanderbilt University (REDCap), before semistructured interviews: the 10-item Connor–Davidson Resilience Scale³⁵ (CD-RISC 10; assesses resilience), the revised Impact of Event Scale^{36,37} (IES-R; measures traumatic stress), and the 17-item Rushton Moral Resilience Scale³⁸ (RMRS; measures moral resilience). Participants were informed that participation was completely voluntary, that they were free to withdraw at any time without penalty, that participation and nonparticipation would not be considered as part of their employment, and that they could refuse to answer any questions. Participants all chose to be interviewed in person; interviews took place in private offices and were recorded for later transcription. Interviews lasted an average of 30 minutes. Semistructured guides were used for interviews. Survey data were not available to the interviewer and were integrated during analyses. (See ^{Table 2})

Data Analysis

Qualitative descriptive design allows the researcher to discover the who, what, and where of events or experiences while gaining insight from participants regarding a poorly understood phenomena.³³ Because this study sought to

understand the traumatic stress and resilience of emergency nurses who cared for patients with COVID-19, qualitative description was the most appropriate method. The research team read transcribed interviews in their entirety to develop an overall understanding of participant experiences. The template style was used to organize data using codes.³⁹ Template style is a particular type of thematic analysis focused on hierarchical coding, which can be changed with the needs of the study and ongoing analyses. Initial codes were developed a priori based on constructs of resilience, traumatic stress, and moral resilience. Codes were expanded upon and added to through inductive analysis through an inductive-deductive hybrid approach.⁴⁰ Team members evaluated codes and assisted with theme development and verification. The research team had ongoing discussions to ensure that participant experiences and perceptions were not dismissed because of researcher bias.

Results

A total of 14 emergency nurses were interviewed, 11 from one site and 3 from the other. Nurses had high levels of both general resilience and moral resilience (CD-RISC 10, 31.2 [SD = 4.4]; RMRS 45.9 [SD = 4.6]). CD-RISC 10 scores were as follows: 25th percentile = 29; 50th percentile = 32; 75th percentile = 36. RMRS is a 17-item scale, with higher scores indicating greater resilience. There are no established cutoff scores for the RMRS. Despite having high levels of resilience and moral resilience, participants revealed that the adversity they faced exceeded their individual capacity to prevent psychological trauma from occurring. Almost all reported that they had been highly impacted by the events of the COVID-19 pandemic (IES-R median = 28, range 8-73). Nurses described working in an emergency department throughout the pandemic as extraordinarily stressful, morally injurious, and exhausting at multiple levels. Although the stressors changed throughout the pandemic, the culmination of continued stress, moral injury, and emotional and physical exhaustion almost always exceeded their ability to adapt to the ever-changing landscape in health care created by the pandemic. The particular experiences of nurses differed for individuals and between settings, but important patterns emerged during analyses, demonstrating shared experience. Two primary themes were identified: losing identity as a nurse, and hopelessness and self-preservation. See ^{Table 2} for exemplar quotes.

Losing Identity As a Nurse

Emergency nursing was exhausting and physically taxing for participant nurses, with virtually no downtime, but they cared deeply and had strong professional identity as a nurse. This identity developed from their membership in the profession of nursing.²⁷ Unfortunately, as they felt unmoored from the social connections and reinforcements that had previously affirmed and supported this identity, their self-concept of being a nurse fell apart slowly throughout the pandemic. In this study, there were several factors that threatened nurses' identity and core values: being able to provide compassionate, respectful, and safe patient care and a commitment to the organization, patients, and the community. Four subthemes describe the different factors that related to the loss of identity as a nurse, with each nurse experiencing a unique blend of these experiences: (1) potentially morally injurious situations; (2) broken social contract with the community; (3) betrayal by the organization; and (4) traumatic stress responses to the experience of being a nurse during the COVID-19 pandemic.

Potentially Morally Injurious Situations

Folli's second-victim trauma, which is stress experienced by clinicians involved in incidents with harm to others for which they feel responsible, was evidenced through their moral injury. Morally injurious events are situations in which one's moral code is violated either through their own transgressive actions or inactions or through perceived betrayal by others.⁴¹ Respondents reported being unable to fulfill their professional ethical values and commitments to provide safe care for their patients. A shortage of nurses and organizational resources relating to Folli's insufficient-resource trauma further damaged the nurses' professional identity. Despite these constraints, nurses

were expected to be able to provide care that was commensurate with their competence and skill. They reported that systems that had previously worked, such as temporary ED boarding, were breaking down and causing patient injury. The emergency nurse participants experienced situations in which patient care decisions made by other team members did not align with their ethical values. Despite these challenges, nurses' moral resilience scores measured by the RMRS remained above 37, with the highest score of 54, indicating higher moral resilience.

Broken Social Contract with the Community

Social identity requires interactions with people in the "in group" and the "out group" to support the alignment with their nursing image. Nurses' social contract with the community is integral to their nursing identity.⁴² Participants of this study asserted that that social contract was broken, and nursing's identity as the "heart" of the health care system has been severed. Community members who had not been vaccinated or were violent toward staff violated their sense of how nurses support the community and are, in turn, supported by them. SIMIC conveys the loss of support and threatens social identity and well-being.²⁸ They could not see themselves as being able to fully commit to the health of the community when the community would not fulfill its part of the social contract, which eroded their sense of being a nurse.

Betrayal by the Organization

Relating to Foli's system-induced trauma, participants' well-being suffered greatly from failure of health care organizations to provide support, leading to the loss of professional identification as nurses. Nurses felt that there was a significant misalignment between what their organization provided to them and what they needed and deserved during the COVID-19 pandemic. Organizational cost-saving measures added to the nurse's perceptions of their health care organization's betrayal of their commitments when they were asking nurses to do more with less or to assume additional risk. They provided examples of nurses being furloughed, supplies being unavailable or rationed, (especially personal protective equipment), and loss of benefits such as retirement and tuition reimbursement that made the job worthwhile. They described organizational responses to resource scarcity as lack of caring or support. Attempts by health care organizations to offer typical forms of support felt stigmatizing, and inequities in compensation made them feel devalued. All of these came together and led to the conclusion that they were no longer a valued member of the health care team, a core element of nursing identity.

Traumatic Stress Responses to the Experience of Being a Nurse During COVID-19

Nurses report their experience of working during COVID-19 as being traumatic but often in a cumulative way, rather than a single traumatic event. Emergency nurses felt depleted, numb, lacking compassion, and possessing a sense of anxiety and dread. They had a disconnection from their work and purpose and fears about infecting their loved ones. They reported experiencing unfamiliar intensity of emotions along with an escalation of distress. Trauma experienced by nurses during COVID-19 undermined the values of nurses' identity. Nurses' commitment, significance, and deeply distressing experiences were not recognized or addressed by the community or health care organizations and consequently jeopardized nurses' identity. They acknowledged the mental health consequences of their experiences and impact of attempting to explain their experiences to others. This finding was confirmed with 12 participants who completed the survey. An IES-R score of 33 or greater is indicative of probable diagnosis of posttraumatic stress disorder.³⁶ Five of 12 participants (42%) scored above 33, with the highest score 73. These trauma experiences, which were tied to their experiences as nurses, made their professional identity sometimes painful, rather than a source of strength and meaning.

Hopelessness and Self-Preservation

The first theme described their previous experiences, but emergency nurses also spoke about themselves now and in the future during the long tail of COVID-19. A sense of hopelessness permeated their work and made them take

actions to preserve themselves. Many of the factors that led to the loss of nursing identity contributed to their hopelessness, a sense that their life and work were at an all-time low. Some nurses were stuck in this hopeless phase, not knowing what to do but feeling a deep sense of “this does not matter” as they struggled on. Others described how they had felt hopeless but gathered the strength to make changes. The erosion of their nursing identities profoundly changed their commitment to their jobs and the profession. They concluded that it was not possible to simply return to practice as it was before COVID-19. They created mental and emotional barriers around work and began searching for new roles and new ways of being. Working as a “travel” nurse was a common “next step” toward self-preservation, with nurses looking for similar clinical experiences but better pay, which they hoped would make the work more meaningful. Others searched for jobs in outpatient settings or discussed leaving the profession entirely. Self-preservation was viewed as a demonstration of their strength, as they realized that their needs did not align with their previous identity or current situation.

Discussion

This study contributes to the research on frontline nurses’ lived experience providing care during the COVID-19 pandemic, especially how potentially morally injurious situations and trauma impacted their nursing identity. Consistent with other qualitative and quantitative findings, emergency nurses experienced various types of trauma caring for patients during the pandemic.^{14,43} Traumatic stress was comparable to those experiencing or witnessing profoundly difficult events such as war and assault.^{44,45} Foli’s middle range theory of nurses’ psychological trauma-informed data interpretation with theoretical assumptions that all nurses experienced trauma, and the 7 types of trauma were reflected in their experiences. Furthermore, it facilitated a method to identify and distinguish the different types of nurse-specific trauma experienced by participants.

This study expands the understanding of how emergency nurses experience traumatic stress and potentially morally injurious events, which have an eroding effect on nurses’ identity. This erosion of professional identity in these changed circumstances creates a disorientation that unmoors even the most confident nurse. When they are unsure who they are and what they stand for, their foundational values as a nurse are violated, and their integrity is threatened. Moral injury results when there is a traumatic or unusually stressful circumstance where people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and expectations.^{14,15} When nurses’ core ethical values are threatened by morally injurious situations, their identity as a nurse suffers.¹⁵ Despite the reality that the pandemic created unprecedented resource constraints, nurses continued to appraise their identity based on pre-pandemic standards and, in some instances, viewed their inability to provide the usual level of care harshly, even though alternatives were not possible. Nurses’ professional identities were eroded by the transgressions and betrayals of others, such as decisions made by leaders to constrain the usual decisions nurses make in implementing their roles. Even more damaging is when these events lead to fundamental questioning of “Am I still a good person?” for having participated in or precipitated actions contrary to their personal and professional values, producing negative moral and patient outcomes.

Facing traumatic stress, lack of support from the health care system and, often, active opposition from the community, emergency nurses felt discouraged and disengaged. Their identity as a nurse, often carefully constructed for years, was broken down. The reciprocal social relationships and purpose that had helped them to manage in difficult times was no longer effective. Even for the resilient, identity breaks down when these interactions no longer support a positive social identity or a sense of belonging in a valued group. A fracture in the social contract with the public has been particularly injurious for nurses.⁴² Professional identity is formed and continues to evolve throughout a nurse’s career and is affected by self-concept (enacting the role) and context (setting). A misalignment results in additional stress and difficulty in retention. Nurses who feel that their nursing identity is fraying from

unsupportive systems that violate their sense of being a nurse leave the profession or change jobs.^{46,47}

Nurses in this sample reported feelings that vacillated between hopelessness and empowerment exercising their moral agency choosing actions that preserved their health, well-being, and integrity. Instead of viewing leaving as abandonment or failure, choosing to change their situation could be viewed as integrity-preserving action.²¹ Viewing their actions as indicative of their resilience aligns with the quantitative findings that found that, despite their struggles, emergency nurses had high levels of general and moral resilience. The problem was not a deficit of resilience but rather that external circumstances limited their ability to enact their values. Harnessing their inner resources despite the adversity to do what is right personally and professionally is a hallmark of moral resilience. In this context, choosing to leave a position or the profession can be an ethical decision that demonstrates moral fortitude and integrity. Shifting the narrative from victimization to taking empowered action and exercising self-stewardship is critical in moving forward.⁴⁸

Limitations

This study has some limitations. Nurses were recruited from 2 institutions, and all were female. There were few nurses from ethnic/racial minority groups. Nurses who had already left the emergency department were not included. These factors limited the voices and perspectives of the unrepresented. Further research should examine the perspectives of emergency nurses not represented in this study. In particular, understanding the perspectives and needs of nurses who left the emergency department may be important for recruitment and retention.

Implications for Emergency Nurses

Moral injury and damage to nurses' identities must change from being understood as rare or extreme events to something that many, if not most, nurses experienced during the COVID-19 pandemic.^{49,50} This normalization process is important and has implications for administration and policy. First, we must recognize that "common" should not be taken as "acceptable"; the largest health care workforce in the United States is deeply wounded, which cannot be denied. Rather, normalization is acknowledging that the profound consequences of cumulative trauma and injury cannot be ignored or treated only at the individual level but as a systemic problem. Rather than seeing injured nurses as abnormal or the "problem to be fixed," managers and administrators must adopt a trauma-informed workplace approach that accepts nurses as being in a process of recovery and transformation.⁵¹ The impact on nurse's identity highlights the need to establish pathways for nurses to return to practice if they have chosen to leave jobs or the profession. Loss of identity may not be permanent; some nurses who experience trauma and moral injury may seek to return, and administration must proactively seek to make this process welcoming and successful.

Nurses are frustrated with health care institutions and leadership. A lack of acknowledgment, unmet needs, and feelings of powerlessness during the pandemic have led nurses to feel betrayed.²³ The profession of nursing has been affected significantly with changes in practice and delivery of health care.^{52,53} Nurses need encouragement to seek assistance with their mental health and well-being. Likewise, solutions are needed to prevent incivility toward nurses, including those who left during the pandemic and have returned to practice. Leaders need to provide a safe place for nurses to talk about feelings as well as have crisis response available when issues arise.

Conclusion

The consequences of the pandemic on nurses are likely to be long lasting. The levels of trauma experienced by emergency nurses eroded their identity as nurses and caused them to doubt that continuing as a nurse is a worthwhile professional decision. Nurses need to mend and rebuild their identity as a nurse. They will not heal without acknowledgment of their trauma, feelings of betrayal, and reconstruction of their professional identity. This will require sustainable system-level interventions as well as individual supports. Betrayal from the organizations that

were supposed to support them in their work sharply eroded their nursing identity and continues to impair efforts in rebuilding it. The solutions are not quick fixes but rather will require fundamental changes in the profession, health care organizations, and society. These changes will require a strategic vision, sustained commitment, and leadership to accomplish.

Acknowledgments

I would like to express my gratitude to Kathy Leach, PhD, RN, and Ashley Comeau, MSN, RN, for their assistance with recruitment and data analysis of this study. A special thanks to the Collaborative Nursing Faculty-Staff Research Grant Program for providing funding to support this study.

Author Disclosures

Conflicts of interest: none to report.

Nurse-specific traumas	Examples from this study
Vicarious/secondary trauma ▪ Indirect trauma that occurs when exposed to difficult or disturbing images or stories	“The hardest part was seeing them see their loved ones dying.”
Historical trauma ▪ Multigenerational trauma experienced by populations historically subjected to long-term mass trauma	Not discussed
Workplace violence ▪ Emotional, psychological, or physical trauma experienced because of direct assaults, threats, or harassment in the workplace	“It’s more of dealing with the general public, where it just becomes a drag. When I come into work, I’m like, who is going to yell at me tonight. People have been attacking staff when we tell them to put a mask on. Patients will say, you’re wrong, you don’t know what you are talking about.”
System-induced trauma ▪ Psychological trauma stemming from organizational systems that have been created to abate trauma	“I was just waiting for someone to die for us to change our process. It was such a bizarre process, and it felt like we were hurting people. We didn’t really know what we were doing. It was hard to go to bed at night.”
Insufficient-resource trauma ▪ Psychological trauma that occurs when there is a lack of knowledge, personnel, equipment, or supplies needed to perform professional duties	“People have gotten out of nursing altogether, because COVID broke them. We keep trying to get our staffing back to where it needs to be but as soon as we get two people hired, four people leave.”
Second-victim trauma ▪ Traumatic stress experienced by clinicians involved in incidents with harm to others for which they feel responsible	“He was my first patient that’s ever died that I’ve felt physically responsible. That sat with me for a long time. I mean, it just sucks, because we need help in here.”

<p>Trauma from disasters • Psychological trauma experienced by clinicians who play an active role in natural disasters or traumatic events</p>	<p>“It’s always hard. Every death or code hits me differently. There have been times where I have to step away. Even if I don’t know the person, I still have to mentally debrief from it.”</p>
--	---

<p>Losing identity as a nurse</p>
<p>Potentially moral injurious situations (RMRS 45.9 [SD = 4.6])</p>
<p>•“Basically, it’s a cluster F-U-C-K, just how unsafe my job has gotten.”•“There have been times where it’s been unsafe, and that—I was not okay with that. I went home crying one time, and it takes a lot for me to get that upset, because I’m just so used to the ER. It’s one thing to be drowning and to be exhausted. It’s another thing for it to feel unsafe, which I’m not okay with for two reasons. One, for my patients, I don’t want patients being in an unsafe environment, but, also, that’s my license.”•“It’s a crisis, when you have people in these rural areas, that you can’t get up here, because there’s not a bed for them. When we’re holding patients in the ER, for 36 hours, because there’s no bed. We’re not trained to do that. When I’ve got 30 people out in my waiting room, that nobody’s monitoring. I’ve got 30 people out there. They’re sick. They’re just waiting. It feels like a third world country. It just really does. This isn’t how it’s supposed to be.”•“I’m one person. I don’t know what the heck I’m supposed to do. I have them on the monitor, no one else is helping me, and we were going back and forth. It was right before we did, once the doctor finally came in the room and we were intubating—or about to intubate that gentleman, the ICU doctor is calling to say, ‘Actually, don’t intubate,’ so then the emergency room doctor and the ICU doctor are arguing. It was just this total chaotic feeling.”•“Why are we trying to keep this one, or this person, alive. They’re so old and their quality of life is not going to be good. Why are we intubating them and doing all this stuff to them? I don’t think that’s more—I don’t think that’s professional values.”</p>
<p>Broken social contract with the community</p>
<p>•“Honestly, I feel like a lot of people are just won’t take responsibility and won’t stay home and won’t get the vaccine and this could’ve ended a lot—maybe not ended, but could’ve been a whole lot better if people would’ve just acted like adults.”•“I feel like people who maybe would’ve been a little more restrained before this started are now—they just let loose and they don’t care.... I still have good patients that are nice, but a lot of people are just mean and don’t care and we get yelled at.”•“I’ve noticed my coworkers, their very first question would be like, ‘Are they vaccinated or not vaccinated?’ because that’s gonna change how they treat the patient, and that is extremely disheartening, and it shows a lot of people’s true colors.”</p>
<p>Betrayal by the organization</p>

•“Oh, it’s horrible. I’ve never wanted to cry at work and now pretty much want to every day.... We furloughed a bunch of nurses that left, didn’t come back. I think a lot of people burned out; a lot of people got scared. Now, we have the nursing shortage.”•“My eyes have been opened up to, at the end of the day, it just feels like a hospital is still a business at the end of the day, and all they care about is making money...that’s not why I joined nursing to begin with.... It just makes me question my entire career.”•“It was either Emergency Nurses Week or Nurses Week... but that’s when they told us they were taking away our 401K match and all this other stuff. They weren’t giving us raises or any of this other stuff. It was just kind of like, you’re dealing with all this shit, but you’re not going to get any of this other stuff to make it worth it, so here you go.”•“When we got emails that we’re low on PPE and you have to wear the same N95 for three, four, five shifts, and you have to send it off to hospital to have it cleaned, and then that process, after they realized wasn’t even correct, that we had to stop doing that, or saving our isolation gowns.”•“Now, we’re seeing a hundred patients a day, and there’s nowhere for them to go. For the first time, I’ve worked in this ER for 17-18 years, we’re boarding. I had a 93-year-old woman in the waiting room for six hours the other day, 93-year-old. That kills my heart. That is so hard to see. It’s defeating is what it is.”•“You only get an email whenever you mess up. You never get an email like, ‘Oh, you did a really good job. Pat on the back.’ Nobody cares. Nobody cares at all, like, ‘Okay, you triaged nine people in 30 minutes.’ Nobody cares at all. You only get called out if you do bad things. The only emails I get, it’s like, ‘Oh, you forgot to raise that two milligrams of morphine in the Pyxis. Don’t forget.’ It’s just stuff like that... they send out the weekly huddle, and random people get a kudos, but I don’t know. I don’t feel like you get recognized.”•“They post little pieces of paper in the bathroom, like, ‘Oh, okay, you can reach out to this therapist,’ but, I mean, that’s pretty much it, so then if you do that, then you’re gonna get labeled like, ‘Oh, okay, well, (Nurse) had to go therapy, because she’s having anxiety or PTSD,’ blah, blah, blah, and then, ‘Oh, I don’t think we can talk to her that way.’ You know what I mean? Nobody wants to get—and that’s such a big stigma that shouldn’t be that way of being labeled like that.”•“I think it is too hard, because you hear these people that are like leaving here and going to travelers, and they’re making \$100 an hour, and these are people that have been nurses for less than two years. Then here, I’ve been a nurse for nine.”

Traumatic stress responses to the experience of being a nurse during COVID-19 (IES-R median 28 range 8-73)

•“I just feel empty. It just feels like I come into work. I do my job.”•“I have anxiety before I go into work, the night before. I have anxiety walking into work. I have anxiety the entire time I’m at work, and the only sense of peace that I feel that day is walking out, knowing like, ‘Oh, I get to go home. Thank God. I made it through.’ I mean, it’s hugely impacted. I can’t talk about work. I used to be able to talk about work. I don’t want to talk about work.”•“I’m taking care of these patients. I’m trying not to bring this stuff home. I’m trying to be safe myself so then I don’t get COVID, and then there’s that anxiety of taking care of these patients that this is my job. I need to do that, but then I also don’t want to get COVID or something to happen to this baby that I’ve tried seven years for and just did all of those things, and it finally worked. I just felt like there was a lot of anxiety with it.”•“Oh, it’s horrible. I’ve never wanted to cry at work and now pretty much want to every day.”•“I think mental health was a huge challenge at that point, at least for me.”•“I just try to explain the mental and emotional stress of it is exhausting.”

Hopelessness and self-preservation (CD-RISC 10 31.2 [SD = 4.6])

▪ “I’m just not as happy as I normally would be. Because I watch the news and stuff and I come home from here and I’m just maybe in a bad mood, would be more often than I normally would be. I try not to be, and I just don’t want to go.” ▪ “Mm-hmm. I feel like, ’cause I still go in and I do what I’m supposed to, but like I don’t—I won’t talk to people. I just go in and I do what I’m supposed to. I don’t want to make that sound like I’m not doing what I’m supposed to, ’cause I’m taking care of people. I’m definitely doing that, but I’m not as maybe talkative and stuff ’cause I’ve got a bunch of stuff to do. I just want to get it done. I just want to get through my shift and get out of here.” ▪ “Even if they gave those resources, I feel like it’s not gonna make a change, and that’s a big reason why I’m leaving. It just feels like there’s just no end in sight. We don’t have the resources. Staffing-wise, if they would address that issue, that would help a lot. A pay increase, that would always be nice. I don’t even think I have an answer for that one in the least. I’m sorry. (Laughter)” ▪ “We had people quit to go travel, because why wouldn’t you go make more money than doing this, if you’re gonna get yelled at. You might as well go do this and make money.” ▪ “I physically need to remove myself, so I’ve been searching for a job since August. People are always like, ‘Oh, I’m getting out of here,’ and I never thought I would get to that point. It just was so heartbreaking, but it’s gotten to that point ’cause this was a great place to work. I love my coworkers. It’s just pushed me over the edge to where the night before I go into work, I can’t sleep. I have so much anxiety. It’s been keeping me up at night. Walking into work, I just have no idea what’s gonna happen. I mean, that’s how the emergency room kind of always is, but it’s just gotten so much worse.” ▪ “We have no choice. The only choice we have is to quit, and where that’s gonna get us? Because every single job is like this now.”

DETAILS

Subject:	Emergency medical care; Social identity; Protective factors; Values; Social development; Trauma centers; Hopelessness; Workplace violence; Hospitals; Traumatic stress; Nurses; Emergency services; Resilience; Interviews; Leadership; COVID-19; Patients; Psychological trauma; Qualitative research; Health care; Fatigue; Trauma; Stress; Pandemics; Medical research; Burnout; Professional identity; Moral injury; Nursing; Departments; Preservation; Injuries; Psychological distress
Business indexing term:	Subject: Workplace violence Burnout Professional identity
Location:	United States--US
Identifier / keyword:	Emergency department; Nurses; Trauma; COVID-19; Moral resilience
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	198-209
Publication year:	2023
Publication date:	Mar 2023
Section:	Research

Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.10.006
ProQuest document ID:	2781603856
Document URL:	https://www.proquest.com/scholarly-journals/long-tail-covid-19-implications-future-emergency/docview/2781603856/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-16
Database:	Public Health Database

Document 42 of 50

Using Comic-Based Concussion Discharge Instructions to Address Caregiver Health Literacy in the Emergency Department: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

This study compared the effectiveness of comic-based with text-based concussion discharge instructions on improving caregiver knowledge. This study also examined the role of social determinants of health on comprehension instructions.

Methods

This was an observational study of the caregivers of pediatric concussion patients. Caregivers' health literacy and

demographics related socioeconomic factors were obtained. After the patients' evaluation in the emergency department, caregivers were given printed comic-based concussion discharge instructions. Caregivers were contacted 3 days later and tested overall knowledge of discharge instructions' content. These survey results were compared with historical controls who received text-based instructions.

Results

A total of 120 participants were recruited, and 86 participants completed follow-up procedures. When comparing the caregivers' recall ability with a comic-based vs traditional text-based instructions, caregivers with comic-based content were more likely to accurately recall overall discharge instructions (77.5% vs 44%, $P < .001$), particularly physical rest and activity restrictions (86.5% vs 63%, $P < .001$). Caregivers also were less likely to misidentify a red flag symptom (7.5% vs 19%, $P < .04$). Comic-based instructions did not increase recall of cognitive rest instructions or postconcussive symptoms. When examining demographic factors, caregivers who could not recall 3 postconcussive symptoms were more likely to be Hispanic or Black, less likely to be college educated, and more likely to have low health literacy.

Discussion

Novel methods should be explored to adequately prepare caregivers for continuing postconcussive care at home. Discharge instructions must be tailored to address caregivers' baseline health literacy and how caregivers digest and retain information.

FULL TEXT

Contribution to Emergency Nursing Practice

- Comic-based discharge instructions may be more effective than the traditional text-based discharge instructions in improving the caregivers' recall of concussion discharge instructions.
- Clinicians are encouraged to explore a variety of resources, such as infographics, to maximize the delivery of high-quality discharge instructions for families of varying health literacy.
- Identifying social determinants of health and addressing health literacy is critical to effective delivery of discharge instructions to families in the emergency department.

Introduction

It is estimated that nearly 2 million cases of pediatric mild traumatic brain injury (mTBI) (also known as concussion) occur annually in pediatric patients at the age of ≤ 18 years in the United States.^{1,2} The initial acute care visit (eg, emergency department or urgent care) is often the only point of care for pediatric patients with mTBI. Traditionally, management of suspected mTBI in the acute care setting has primarily focused on identifying patients at risk of intracranial injury and passively recommending symptom monitoring, activity restriction, and follow-up for patients with prolonged symptoms.²⁻⁵ Patients and families then must independently navigate the health care and school systems to chart their path to recovery from injury. However, this approach has led to disparities in mTBI care and clinical outcomes, with some studies demonstrating that 6⁷

Keeping in mind that the initial acute care visit may be the only point-of-care contact for a pediatric patient with mTBI, it is prudent that content management and delivery are adherent to the Centers for Disease Control and Prevention (CDC) best practices to optimize addressing these disparities. CDC recommends that health care providers give patients and their families with comprehensive discharge instructions about common postconcussive symptoms and symptoms indicative of more severe injury, colloquially known as "red flag" symptoms within the medical community.⁸ In the ED setting, pertinent information is typically conveyed by physicians and nurses via verbal communication with a printed set of text-based discharge instructions for the family. Evidenced-based guidelines for discharge instructions allow physicians to maximize the effectiveness of their communication with

patients and their families regarding their diagnosis. However, regardless of the accuracy and quality of the information contained within discharge instructions, their effectiveness may be limited by method of delivery, the health literacy of those receiving instructions, or the socioeconomic disparities affecting those receiving instructions.⁹ Several studies have demonstrated that approximately one-half of all parents who present to emergency departments have a low baseline health literacy.¹⁰ Unsurprisingly, this also affects parents' ability to retain information and recall the appropriate interventions for overall recovery and worsening conditions during the discharge process.^{11,12} Despite current best efforts to improve the process, our recent study of caregivers of patients with mTBI demonstrated that nearly 20% of caregivers given text-based discharge instructions failed to identify at least 3 common postconcussive symptoms, and 19% falsely identified a red flag symptom (eg, facial droop, slurred speech, seizure, coma) as a common postconcussive symptom.¹³ Given these findings, it is imperative to consider alternative ways to deliver discharge instructions to address low health literacy in caregivers and explore any potential variables that contribute to poor retention.

Several studies have explored the feasibility of novel and alternative methods for delivering discharge content that is easily digestible for families.¹⁴⁻²⁰ However, very few studies to date have assessed the effectiveness of these alternative methods as adequate tools to directly address the problem of information delivery and retention to low health literacy populations, especially caregivers in the context of pediatric concussions. The purpose of this study was to evaluate the effectiveness of comic-based concussion discharge instructions compared with traditional text format discharge instructions in improving caregivers' knowledge of pediatric mTBI in relation to their child's current condition, recovery, and ability to successfully recall common and "red flag" concussion symptoms. This study also analyzed any additional demographic factors (such as race/ethnicity, sex/gender, education, and level of health literacy) that may have been associated in the comprehension of concussion discharge instructions to determine whether comic-based discharge instructions are more or less effective as a vehicle for discharge delivery in families with potential health care disparities.

Methods

This was an observational study of the parents or guardians of patients treated in the emergency department for mTBI. The study occurred within the emergency department of Children's Wisconsin, a tertiary care center. Participants included in the study were caregivers of patients aged 6 to 18 years who were evaluated and diagnosed as having mTBI, as defined by the criteria set in the Acute Concussion Evaluation form (which has been endorsed by the CDC as a standardized tool to evaluate for mTBI). Exclusion criteria included patients being admitted, non-English speaking families, and patients without a legal guardian present. After informed consent, the caregivers' baseline health literacy was assessed by administering the Newest Vital Sign (NVS), a validated tool for assessing health literacy. NVS scores of 0 to 3 of 6 were considered low health literacy, and scores of 4 to 6 were considered adequate health literacy. After this assessment, caregivers also were asked to complete a demographic survey that evaluated different socioeconomic factors. After the survey was completed, caregivers were finally given a handout of concussion discharge instructions in a comic format (see ^{Figure 1}). Verbal instruction was given as part of usual care at the time of discharge. Research assistants observed the ED discharge instruction process, and key points were recorded using a discharge content checklist.

Caregivers then were contacted 3 days after the patient's discharge from the emergency department and asked to complete a follow-up survey via a phone call. The survey was divided into 2 sections; "Content Questions" tested caregivers on their ability to correctly recall the information from comic-based vs text-based discharge instructions (which served as a metric for comparison of retention rate with each set of discharge instructions). "Readability Questions" assessed the caregivers' response to how well organized and understandable the discharge instructions

were in a comic-based format vs a text-based format. The survey responses from the “Content Questions” section were scored based on the number of correct answers.

Results of the current sample who received comic-based discharge instructions were then historical controls from our recent study in which recall was assessed for text-based discharge instructions and usual care verbal instructions.¹³ “Readability Questions” also were scored to compare the understandability of comic-based and text-based discharge instructions using the Patient Education Materials Assessment Tool for printable materials (see Table 1).²¹ The Patient Education Materials Assessment Tool is a systematic method to evaluate and compare printed patient education materials based on whether patients will be able to understand (understandability score) and act on information (actionability score). The significance of both results were analyzed using a chi-square test of independence and 2-sample unpaired *t* tests as the standard statistical methods of analysis (with significance set as

P Results

A total of 120 participants were recruited in the emergency department to receive comic-based discharge instructions, and 86 participants successfully completed the follow-up survey. Demographic data on caregivers are as follows (see Table 2): 77.9% were female, 20.9% self-identified as Black, and 15.1% were Hispanic. The median age was 39.5 years, 44.2% were college graduates, and 52.3% reported a household income >\$40,000/year. Overall average score was 4.69 on the NVS test with 17.5% of caregivers’ scores suggesting low health literacy. After being provided comic-based discharge instructions, 77.5% of caregivers recalled overall recommendations for postconcussive management, with 86.5% being able to recall physical rest and activity restrictions and 38.8% being able to recall cognitive rest, such as school restrictions; 70% successfully recalled 3 postconcussive symptoms. At the same time, 30% could not name 3 of these symptoms (15 caregivers could not recall 2 or more postconcussive symptoms; 3 caregivers reported other symptoms not listed in the discharge instructions such as neck, back, or chest pain; and 2 caregivers named unusual symptoms, such as “seeing the color orange.”). Moreover, 7.5% of caregivers misidentified a red flag symptom as a common postconcussive symptom, with the most common misidentification being seizures, slurred speech, and not being able to wake up/blacking out.

When examining demographic factors, caregivers who could not recall 3 postconcussive symptoms were more likely to be Hispanic or Black (55.6% vs 23.1%, $c^2 = 5.31$, $P = 9.71$, *P* Figure 3), and more likely to have low health literacy (3.83 vs 5.14, *P* Figure 4). Misidentification of red flag symptoms was not associated with health literacy level or any demographic factors. There was no statistical difference between gender and recall ability ($c^2 = .62$, $P = .43$). When comparing successful recall of postconcussive symptom and the caregivers’ NVS scores, those who could successfully recall discharge instructions were significantly more likely to have higher NVS scores (4.95 [SD = 1.47], 95% confidence interval 4.55-5.34) than those who could not recall the discharge instructions (4.12 [SD = 1.94], 95% confidence interval 3.32-4.92, $t [78] = 2.11$, $P = .02$) (see Fig. 4).

When comparing the results of caregivers’ ability to recall discharge instructions in a comic-based format ($n = 86$) vs a traditional text format ($n = 99$) from the previous study,¹³ caregivers who received comic-based discharge instructions were more likely to accurately recall overall discharge instructions than those with a traditional text format (77.5% vs 44%, $c^2 = 20.03$, $P = 12.58$, *P* Figure 2). Interestingly, comic-based discharge instructions had no effect on the caregivers’ recall of cognitive rest instructions (38.8% vs 40%, $c^2 = .05$, $P = .82$) or postconcussive symptoms (70% vs 80%, $c^2 = 3.75$, $P = .05$) than text-based instructions. However, caregivers with the comic-based discharge instructions were less likely to misidentify red flag symptoms (7.5% vs 19%, $c^2 = 5.02$, $P = .03$) than caregivers with text instructions.

Discussion

Although the discharge process in the emergency department has evolved to include print-out instructions to

reinforce supportive care instructions and return precautions for parents and guardians, current studies show that a physical copy of text-based instructions alone is not enough, and alternative methods (such as a visual aid) may be required to supplement or even replace the current discharge process. Although previous studies have explored the ease of access and usability of alternative methods, this study demonstrated that an alternative visual aid supplement in the form of a comic-based format seemed to better enhance memory retention of the discharge instruction contents than the traditional text-based format only. Even if overall retention and recall of information decline over time, the comic-based instructions still demonstrated some retention of pertinent information, such as red flag symptoms, more effectively than text-based instructions alone. Investigators have developed alternative means to communicate concussion information and guide recovery using web-based¹⁵⁻¹⁷ or smartphone applications.¹⁸⁻²⁰ These novel approaches may offer promise to improve concussion education and management, but need to be studied to ensure they are accessible for patients with low health literacy.

This study also highlighted potential racial and socioeconomic disparities that may be correlated to the caregivers' ability to recall the contents of the discharge instructions. We found that Black and Hispanic caregivers were approximately twice as likely as white caregivers to demonstrate unsuccessful recall of discharge contents in this study, supporting the growing evidence of racial disparities in health care. Education level and baseline health literacy seemed to influence the caregivers' ability to understand and recall discharge instructions. Although the role of socioeconomic factors and health literacy is complex, it is nonetheless essential to acknowledge that they contribute to health care disparities that providers must address to achieve equitable care for all.

Limitations

This study had several limitations. One of 3 of subjects was lost to follow-up. In addition, subjects were historical controls for whom health literacy, education, and household income were not available. Therefore, we could not assess whether comic-based instructions were better for patients with low health literacy. Further research is necessary to understand the relationship among socioeconomic factors, health literacy, and the best approach to address this health inequity.

Implications for Emergency Nursing

Several alternative methods, such as video instructions, phone applications, and web-based content, have been introduced as options to deliver high-quality discharge instructions to families in the emergency department effectively. However, their effects on improving recall with discharge instructions have yet to be thoroughly explored. This study highlights the efficacy of visual aids, such as a comic-based format, as an appropriate alternative method that nurses can use to improve memory retention for concussion care recommendations before discharge from the emergency department and to address the families' understanding of symptoms and treatment of patients with mTBI. Regardless of the methods selected, nurses are highly encouraged to use a multimodal approach (such as text instructions with a supplemental visual aid and verbal reinforcement) to maximize the delivery of discharge instructions to families caring for patients with mTBI owing to the importance of postconcussive care and follow-up in overall recovery. In addition to delivering discharge contents, nurses should be aware of any social determinants of health that could influence the caregivers' ability to digest and recall discharge instructions.

Conclusion

Addressing health literacy is critical to providing appropriate discharge education and improving postconcussive care. A visual supplement, such as a comic-based format, incorporated into discharge instructions can improve memory retention of discharge content in families caring for patients with mTBI. This can serve as one of many methods to help reduce the burden of concussions for families discharged from the emergency department and may help address social determinants of health affecting caregivers understanding.

Author Disclosures

Conflicts of interest: none to report.

PEMAT-P	Text based	Comic based
Understandability score	52.9%	88.2%
Key differences:		
•Layout: uses visual cues to draw attention to key points	N	Y
•Visual aids: make content more easily understood	N	Y
•Visual aids: reinforce rather than distract from the content	N/A	Y
•Visual aids: clear titles and captions	N/A	Y
•Visual aids: illustrations clear and uncluttered	N/A	Y
•Visual aids: uses simple tables	N/A	Y
Actionability score	42.8%	71.4%
Key differences:		
•Uses the charts, graphs, tables, or diagrams to take actions	N	Y
•Uses visual aids whenever they could make it easier to act	N	Y

Caregiver demographic	% (n) / median (IQR)
Gender, % (n)	
•Female	77.9 (67)
Age, median (IQR)	39.5 (35-45)
Race, % (n)	

•Black	20.9 (18)
•White	70.9 (61)
•Asian	0 (0)
•Native American	1.2 (1)
•Pacific Islander	1.2 (1)
Ethnicity, % (n)	
•Hispanic	15.1 (13)
Educational level, % (n)	
•8 grade or less	1.2 (1)
•Some high school	3.4 (3)
•High school	16.2 (14)
•Some college	34.8 (30)
•College	20.9 (18)
•Advanced degree	23.3 (20)
Insurance, % (n)	
•Private	66.3 (57)
•Public	36.0 (31)
•Self-pay	1.2 (1)
Household income, % (n)	
•<\$20,000	7 (6)
•\$20,000-\$30,000	11.6 (10)
•\$30,000-\$40,000	14.0 (12)
•>\$40,000	52.3 (45)

Health literacy, median (IQR)	5 (4-6)
•Low literacy (NVS <3), % (n)	17.4 (15)

DETAILS

Subject:	Emergency medical care; Symptoms; Health literacy; Socioeconomic factors; Health education; Concussion; Social factors; Demography; Emergency services; Caregivers; Ethnicity; Patient education; Pediatrics; Recall
Identifier / keyword:	Comic; Concussion; Discharge instructions; Health literacy; Pediatric emergency department
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	236-243
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.006
ProQuest document ID:	2781603822

Document URL: <https://www.proquest.com/scholarly-journals/using-comic-based-concussion-discharge/docview/2781603822/se-2?accountid=211160>

Copyright: ©2022. Emergency Nurses Association

Last updated: 2023-03-03

Database: Public Health Database

Document 43 of 50

Role Delineation of the Code Blue Team: A Quasi-Experimental Study During COVID-19: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

The purpose of this study was to assess if implementing a code role delineation intervention in an emergency department would improve the times to defibrillation and medication administration and improve the nurse perception of teamwork.

Methods

A quantitative quasi-experimental study used a retrospective chart review to gather data. A pre- and post-test measured nurse perception of teamwork in a code using the Mayo High Performance Teamwork Scale (MHPTS) after a code role delineation intervention using a paired samples *t*-test. Pearson *r* correlations were used to determine relationships between nurse participant ($N = 30$) demographics and results of the MHPTS scores.

Results

A significant increase in teamwork was noted in 5 of the 16 items on the MHPTS regarding improved communication and identified roles in a code: the team leader assures maintenance of an appropriate balance between command authority and team member participation ($t = -5.607, P < .001$), team members demonstrated a clear understanding of roles ($t = -5.415, P < .001$), team members repeat back instructions and clarifications to indicate that they heard them correctly ($t = -2.400, P = .029$), all members of the team are appropriately involved and participate in the activity ($t = -2.236, P = .041$), and conflicts among team members are addressed without a loss of situation awareness ($t = -2.704, P = .016$). There was significance between total pre- and post-test scores ($t = -3.938, P = .001$).

Discussion

Implementation of code role delineation identifiers is an effective method of improving teamwork in a code in an emergency department setting.

FULL TEXT

DETAILS

Subject:	Patients; Emergency medical care; Intervention; Drugs; Communication; COVID-19; Quasi-experimental methods; Teamwork; Leadership; Chart reviews; Emergency services; Codes; Test scores; Delineation; Drug administration; Nurses; Defibrillation; Roles; Clinical outcomes
Business indexing term:	Subject: Teamwork Leadership
Identifier / keyword:	Code blue; Nurse role delineation; Nurse teamwork; Emergency department
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	287-293
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.11.013
ProQuest document ID:	2781603816
Document URL:	https://www.proquest.com/scholarly-journals/role-delineation-code-blue-team-quasi/docview/2781603816/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-05-16

Database: Public Health Database

Document 44 of 50

Thank You to Reviewers: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 2

Pages: A13-A14

Publication year: 2023

Publication date: Mar 2023

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: Credits

DOI: [https://doi.org/10.1016/S0099-1767\(23\)00019-3](https://doi.org/10.1016/S0099-1767(23)00019-3)

ProQuest document ID: 2781603779

Document URL: <https://www.proquest.com/scholarly-journals/thank-you-reviewers/docview/2781603779/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-03-07

Database: Public Health Database

Document 45 of 50

Evidence-Based vs Informal Suicide Training: Nurse Confidence and Comfort With Suicidal Patient Care: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Emergency nurses are on the front line of patient care for suicidal persons, yet many nurses report feeling unprepared to effectively manage suicidal patients owing to a lack of suicide-specific training. The purpose of this study was to examine the suicide-specific training experiences of emergency nurses and evaluate how training relates to burnout, confidence, and comfort working with suicidal patients.

Methods

Emergency nurses at critical access and community hospitals completed an anonymous online survey during work hours. The survey included questions about training experiences, burnout, confidence, and comfort working with suicidal patients, perceptions of the quality and interactive nature of training, and desires for future suicide-specific intervention training.

Results

Group comparisons among the 117 emergency nurses revealed that those who received evidence-based/expert-delivered training reported greater confidence, comfort, and perceived ability to treat suicidal patients and lower burnout than those who received informal or no training. Those with informal training reported greater confidence and ability to treat suicidal patients, but similar levels of comfort and burnout as those with no training. Mediation analyses showed that training was associated with greater comfort working with suicidal patients through its effect on increased confidence. A majority desired additional suicide-specific training.

Discussion

Evidence-based/expert-delivered professional training in suicide intervention is associated with improved confidence, comfort, and perceived ability to care for suicidal patients and lower burnout. Providing evidence-based suicide intervention training may improve quality of care for suicidal patients by improving emergency nurse confidence and comfort for treating these high-risk patients.

FULL TEXT

Contribution to Emergency Nursing Practice

- Suicide-specific intervention training is associated with improved nurse confidence and patient care. Benefits of different types of training and mechanisms of training impact have not been thoroughly examined.
- Evidence-based suicide intervention training is associated with increased confidence, comfort, and perceived ability to care for suicidal patients and lower burnout than informal/lay person training.
- Suicide-specific training is associated with increased comfort caring for suicidal patients because of its positive relationship with confidence.

Introduction

Worldwide, there are approximately 700,000 deaths related to suicide every year,¹ and ED visits related to suicide continue to increase.² Approximately 45% of patients who die because of suicide have contact with a health care provider within a month before their death and up to 90% within a year before their death.³ Nurses who work in the emergency department tend to be among the first to have contact with a person in a suicidal crisis and often play a central role in managing care; thus, nurses are said to be on the “front lines” of suicide prevention.^{4,5} However, research has shown that many nurses do not receive adequate training to equip them to care for patients who are suicidal, and those who do often report the training is insufficient.^{4,6} Lack of sufficient training, even an ED-specific orientation training, has been associated with nurse burnout and turnover.⁷

Burnout may be particularly high among emergency nurses who lack suicide-specific training, given those with little training tend to report higher levels of hopelessness, fears, frustrations, and inadequacies in their care of suicidal patients.⁸ High burnout also is associated with more negative attitudes and decreased comfort working with suicidal patients.⁹ These experiences have all been associated with poorer patient care, including avoidance of suicidal patients, insufficient suicide risk assessment, and poor engagement with patients,^{1,10-12} which then is linked to poorer patient outcomes. Lack of suicide-specific training among nurses also has been shown to correspond with lower levels of confidence in caring for suicidal patients, greater anxiety/fear, and negative attitudes or apathy toward suicidal patients.^{4,11,13} Conversely, nurses who receive suicide-specific training have demonstrated positive changes in their attitudes, perceived competence, fear/anxiety, and knowledge for working with suicidal patients in the short term.¹⁴ In addition, qualitative reports from mental health nurses show that receiving training resulted in improved attitudes toward, confidence in, and an increased willingness to engage with suicidal patients.¹⁵ Although training contents and styles have varied considerably across studies, they consistently find that training has contributed to improvements in nurses’ ability to respond appropriately and engage in more effective suicide risk assessment and management of patients,^{12,16} underscoring the importance of suicide-specific training for emergency nurses.

Although studies have shown that training is associated with a variety of emotional, cognitive, and skill-based improvements for nurses, there remains a lack of knowledge about whether different types of training produce stronger positive changes than others. A recent study of mental health care providers (2.1% nurses) found that the perceived sufficiency of suicide-specific training was a significant mediator of a training’s relationship to improved comfort and willingness to work with suicidal patients.¹⁷ This result is similar to that reported by Jahn and colleagues¹⁸ who found that perceived sufficiency of training was more strongly related to lower fear of patient suicidal behavior and greater knowledge and skill working with suicidal patients than years of professional experience. Few studies have examined how the sufficiency, quality, or content of nurse trainings relate to the positive outcomes mentioned earlier. It may be that evidence-based or expert-delivered suicide prevention/intervention trainings are perceived as more sufficient and produce stronger outcomes than other less formal or agency-created trainings. Evidence-based

trainings are likely to provide current, evidence-based best practices and reflect training in suicide intervention core competencies,^{19,20} whereas agency-created or informal trainings may provide less depth or skill-emphasis and focus on procedural tasks such as documentation rules. However, the nurse training literature lacks information about whether evidence-based/expert-delivered suicide trainings relate to more positive outcomes than the informal trainings often provided by hospitals to staff as part of professional development. This study aimed to address this gap in knowledge.

In addition, there is limited research examining mechanisms that may explain how training affected nursing attitudes and comfort for working with suicidal patients. Studies show that perceived self-efficacy, or the belief and confidence in one's ability to perform a task, is a strong predictor of comfort and willingness to attempt the task.²¹⁻²³ According to the theory of planned behavior,²⁴ confidence to engage in a behavior (eg, intervene with a suicidal patient) is the strongest predictor of whether a behavior will occur. Supporting this idea further, Osteen and colleagues¹⁶ found that self-efficacy significantly mediated the effects of an evidence-based suicide intervention training on mental health providers' (17% nurses) use of suicide intervention practices 4 months after training. However, this is 1 study and focused on a broad range of mental health providers, so its generalizability to emergency nurses is uncertain. It is very possible that nurses' attitudes toward and comfort working with suicidal patients are positively affected by training through increased confidence, but studies have not yet examined this possibility among nurses.

The aim of the current study was to examine how training experiences, or lack thereof, relate to emergency nurses' confidence, attitudes, and burnout when working with suicidal patients. We hypothesized that nurses who report receiving suicide-specific, evidence-based/expert-delivered training will report higher levels of confidence, less burnout, and more positive attitudes/comfort working with suicidal patients than those reporting informal/lay person trainings or no training. Second, we hypothesized that confidence would mediate the relationship between training experience and attitudes/comfort working with suicidal patients. Knowing this information will assist with decisions about professional development and training initiatives for emergency nurses who care for suicidal patients.

Methods Participants And Procedures

The targeted participants of this study consisted of emergency nurses within critical access (eg, **Survey Measures** Participants were asked to state their age, gender identity, race/ethnicity, type of nursing degree, years of experience, and how often they encounter suicidal patients (response range 1 = rarely to 4 = almost always/most shifts).

To measure emergency nurses' confidence in suicidal patient care, an adaptation of an 8-item scale used to measure undergraduate nurses' confidence in care for oncology patients²⁵ was used. Items were adapted so that instead of referring to care of oncology patients, items referred to suicidal patients. Consistent with the original scoring guidelines, participants responded to each item (eg, "How confident are you in your ability to manage suicide risk of a patient?") using a 10-point Likert-type scale ranging from "0; Not at all confident" to "10; Totally confident." Total scale scores are calculated by averaging the response values across items so that higher scores indicate greater confidence. The adapted scale has not been psychometrically validated but internal consistency estimates within our sample were strong (Cronbach's $\alpha = 0.92$). In addition, a principal axis factor analysis with oblimin rotation supported a single factor structure (eigenvalue = 5.297) accounting for 66.22% of the variance with all item loadings >0.680 (range = 0.680-0.859).

The occurrence of burnout within our sample was measured using the 9 items of the emotional exhaustion and depersonalization subscale from the Nurse-Experienced Time Pressure, Burnout, and Patient Safety Interaction Questionnaire.²⁶ Scale scores are calculated by averaging the response values so that higher scores indicate higher

burnout. This burnout subscale has strong psychometric properties and had strong internal consistency within the current sample (Cronbach's $\alpha = 0.89$).

To evaluate comfort/attitudes toward working with suicidal patients, the full, 11-item Understanding Suicidal Patients Scale²⁷ was used. Items evaluated comfort working with and attitudes toward suicidal patients (eg, "I find it difficult to understand a person who attempted suicide" reverse coded; "A patient who has attempted suicide is the kind of person whom I like to help"). Total scale scores are calculated by averaging the response values across items so that higher scores indicate greater comfort and more positive attitudes toward patients. The Understanding Suicidal Patients Scale has shown strong psychometric properties in previous studies,^{28,29} and in the current sample, an adequate internal consistency was observed (Cronbach's $\alpha = 0.63$).

To measure experiences with suicide-specific training, participants responded to items evaluating the perceived quality and amount of suicide-specific training they had received. Items asked participants to estimate how many trainings in suicide risk assessment/intervention they have had, the recency of their last training (range = "Within the past week to more than 2 years ago"), how interactive the training was (eg, did it include role plays or simulations; 0 = not at all interactive; 10 = very interactive), the perceived quality of the training received (0 = very poor; 10 = extremely good), and perceptions of whether the training provided adequate skills to care for suicidal patients (1 = strongly disagree; 5 = strongly agree). Additional items asked participants to rate the extent to which training improved their ability to care for suicidal patients (0 = no improvement; 10 = extreme improvement) and levels of agreement to a statement reflecting a desire to receive further training in treating suicidal patients (1 = strongly disagree; 5 = strongly agree). Finally, participants also indicated which trainings they had participated in from a list of 11 options that presented "suicide-specific evidence-based/expert-delivered," "informal/lay person," or "no training" categories (see Table 2). Evidence-based/expert-delivered interventions refers to those providing professional skill development. Some programs listed such as Question, Persuade, Refer and Yellow Ribbon do have an evidence base support their use as a general public suicide awareness program but they do not provide clinical/professional skill intervention training so were categorized as "informal/lay person trainings."). Participants who reported more than one training experience were coded according to their highest-level training (eg, if reporting both hospital-provided training and expert training, they were coded into the evidence-based/expert-delivered group).

Data Analysis

Before analyses, data were inspected for normalcy, outliers, and missingness. All variables demonstrated acceptable skew (-0.68 to 0.59) and kurtosis (-0.06 to 0.55). Missing data were $2 = 1.76, P = .624$, so missing values were replaced with the item mean. Descriptive statistics were calculated and reported as frequencies, percentages, means, and standard deviations. Group differences were tested using a MANCOVA with years of experience and frequency of contact with suicidal patients as covariates, with follow-up pairwise comparisons using a Bonferroni correction. Bivariate Pearson correlations were calculated to ensure significant relationships among the variables before running mediation analyses. Tests of the mediation hypothesis controlled for the effects of years of experience and frequency of contact with suicidal patients. Mediation analyses were conducted using model 4 of the PROCESS macro³⁰ for SPSS (IBM Corp, Armonk, NY) that included 5000 bootstrapped resamples and bias corrected confidence intervals to determine significance. We conducted all analyses using the SPSS version 24.0.

Results

A total of 132 nurses accessed the survey. Six declined to participate and 15 had more than 50% missing data resulting in a final sample size of 117 emergency nurses (88.9% female, 97.4% white). The mean age of participants was 41.38 years (SD = 10.28; range 24-63), with an average of 13.82 years of experience (SD = 9.52, range = 6 months-41 years). Almost every nurse ($n = 115, 98.3\%$) reported having some experience with suicidal patient care.

Additional descriptive information about the sample is presented in ^{Table 1}.

As shown in ^{Table 1}, almost all participants ($n = 115$, 98.3%) reported working with suicidal patients in the emergency department and a majority do so often to almost always ($n = 86$, 73.5%). A quarter of the emergency nurses ($n = 29$, 24.8%) reported receiving no training for working with suicidal patients. Of those who received training, 54 (46.2%) reported receiving unstructured/lay person trainings, most of which included employer-provided, brief webinars around procedures and charting, whereas 34 emergency nurses (29.1%) reported having completed at least one suicide-specific, evidence-based professional skill intervention training (see ^{Table 2}). A notable majority ($n = 86$, 73.5%) reported agreeing/strongly agreeing with a desire to receive more training for working with suicidal patients in the emergency department, 24 (20.5%) reported being neutral, and 7 (6%) disagreed with wanting more training. Training-group comparisons showed there were significant differences among the 3 training groups, $F(14,210) = 7.25$, $Pd = 1.39$, across all variables assessed (see ^{Table 3}). Overall, the pattern of results indicated emergency nurses who received suicide-specific evidence-based/expert-delivered intervention trainings reported more perceived ability to care for suicidal patients, comfort and confidence working with suicidal patients, and the lowest burnout than those who received unstructured/lay person or no training. Those with informal/lay person training reported more positive outcomes than those with no training on most variables but did not differ from each other on comfort working with suicidal patients (mean difference = 0.01, $P = .89$) and burnout (mean difference = 0.06, $P = .78$). A similar pattern of differences was observed for feeling as though training provided adequate skills for working with suicidal patients. Of note, there were no differences between the evidence-based/expert trained group and informal/lay person training group on perceived quality of training received, but the evidence-based/expert trained group reported more interactive training than both the informal/lay person and no-training groups, $F(2111) = 37.23$, $Pd = 1.64$ (see ^{Table 3}).

Bivariate correlations showed significant relationships between training, confidence, and comfort ($r = 0.29-0.48$). Burnout did not have a significant correlation with any of the other variables ($r = -0.07$ to -0.18) and therefore was not included in any mediational analyses. The model specifying confidence as the mediator of the effect of training on comfort working with suicidal patients was significant, $F(3113) = 4.04$, $Pd = 0.65$, explaining 12.4% of the variance in comfort working with suicidal patients. Training had a direct, significant effect on increased confidence (standardized $b = 0.45$, $t = 5.81$, $Pt = 2.95$, $Pt = 0.22$, $P = 0.82$), but the indirect effect of training through confidence was significant, standardized effect = 0.14, standard error = 0.06, 95% confidence interval, 0.04 to 0.26. This indicates that confidence fully mediated training's effect on comfort working with suicidal patients, supporting the study hypotheses.

Discussion

These findings support our hypotheses, showing that training is associated with increased confidence, positive attitudes/comfort, and perceived ability to care for suicidal patients and reduced burnout among emergency nurses above and beyond the effects of years of experience. In addition, the positive effects seem to be more robust for nurses who have received evidence-based/expert-delivered, suicide-specific intervention training and therefore are likely to provide a better foundation to ensure high-quality ED care of suicidal patients. Previous studies evaluating the pre-post effects of different suicide training programs have documented improvements in nurses perceived knowledge, attitudes toward, and comfort and willingness to work with suicidal patients.^{14,31,32} The current results further support these findings and extend them by showing that the type of training received may be important, with evidence-based/expert-delivered suicide intervention trainings being related to stronger positive outcomes for nurses. In addition, our data show that one potential reason for why training improves comfort working with suicidal patients is because training likely increases confidence in one's ability to work this high-risk population of patients.

The current data show that emergency nurses who received evidence-based/expert-delivered training on suicide interventions reported a more positive outcome on all the variables relative to those who had only informal/lay person training and those reporting no training. The evidence-based/expert training group nurses were more confident and comfortable working with suicidal patients, reported greater perceived adequacy of their skills, and reported lower burnout. This has important implications given other research showing that increased confidence in one's abilities and skills is associated with enhanced patient care^{16,31,33} and important to providing high quality services. Although the informal/lay person training group of nurses did report more confidence and improved ability to treat suicidal patients than the nurses who had no suicide-specific training, these 2 groups did not differ on their comfort treating suicidal patients or burnout. This suggests that although informal/lay person training may contribute some benefit over no training, it does not seem to relate to improved comfort working with suicidal patients. Nurses who have low comfort working with suicidal patients have been found to hold more negative attitudes toward suicidal patients, which then is related to poorer patient interactions, outcomes, and satisfaction with services.^{4,12} Nurses with lower reported comfort working with suicidal patients also may be more likely to experience increased distress when working with these patients,^{10,15} potentially contributing to the higher burnout observed among emergency nurses.³⁴ Thus, providing evidence-based, suicide-specific intervention training to nurses may be one way to enhance patient care while also potentially improving nurse job satisfaction and reducing burnout. Additional studies are needed to examine how different types of training affect patient care and nurse burnout.

The finding that training is associated with emergency nurses' comfort working with suicidal patients through its effect on increased confidence adds to the literature examining training effects. Most previous work has emphasized pretraining and posttraining outcomes without attending to some of the mechanisms for the changes observed. The current data show improved confidence in one's ability, skill, and capability for treating suicidal patients is one factor likely to underlie the beneficial effects of suicide-specific training, above and beyond years of experience (see also Manister³⁵). This finding also is consistent with recent work documenting that self-efficacy acts as a mediator between training and improved care of suicidal patients.^{16,31} Further complementing these results, a large portion of the current sample indicated a strong desire for additional suicide-specific intervention training to support their work in the emergency department, which also is consistent with other studies.^{15,36} Given that many nurses in our sample reported frequent work with suicidal patients, often daily, providing foundational suicide-specific intervention training appears essential to supporting high quality patient care.

Limitations

Owing to the cross-sectional survey design of this study, cause and effect relationships cannot be determined so additional experimental and longitudinally designed studies are needed. Our data also are limited by the homogeneity of the sample (predominantly female, white), small sample size, and restricted geographic region, all of which limit generalizability. However, we did have relatively equal distribution between community/city and critical access/rural emergency departments. The use of only self-report assessment has limitations of response biases and potential retrospective recall inaccuracies. In addition, our measure of confidence in suicidal patient care was adapted from a different measure without previous evaluation of its psychometric properties, and although reliability and factor analyses in the current sample suggest it likely has validity, additional psychometric evaluation is needed. Given the focus on suicidal patient care, participants may have responded in more socially desirable ways to the items than how they truly feel, but we did not account for this in our study. Some participants who reported receiving no suicide-specific training still reported receiving some hours of training (eg, related to job onboarding/charting) and rated the quality of training. It is unclear why they responded in this way, and review of their responses indicated most reported hours of training related to new employee training regarding procedures related to suicidal patients,

but we had no way of further validating these responses. Furthermore, the assessment of the recency of training limited the longest option to 2 or more years ago, making it hard to know how many of the 18 participants (15.4%) endorsing this option may be recalling the impact of a training completed 3, 5, or even 10 years ago. Finally, our low overall response rate may have been influenced by the timing of our study that occurred during a COVID-19 surge in the region, resulting in staff who were generally too busy to complete the survey. Thus, those who did complete the survey may have been more comfortable with, or interested in the topic of, working with suicidal patients.

Implications for Emergency Nursing

These findings suggest that providing some type of suicide-specific intervention training is likely better than no training, but when they can, hospitals may want to consider providing their nurses with evidence-based/expert-delivered, suicide-specific intervention trainings for working with suicidal patients. Doing so may help to prevent or lower burnout and improve nurse confidence and also may contribute to improved patient care. Studies indicate emergency nurses often believe they lack the skills and knowledge to assess and treat suicidal patients effectively, which impedes their ability to provide high-level care.^{4,14} Providing evidence-based and skill-focused suicide intervention training is likely to best meet nurses' needs. Finally, although the current study did not examine specific curriculums or styles of instruction, suicide prevention experts have outlined key competencies³⁷⁻³⁹ supported by research for treating suicidal patients and recommendations for the use of interactive teaching methods (eg, role plays, simulations).^{40,41} Providing interactive, evidence-based training specific to assessing and managing suicide risk among ED patients is likely to benefit both the nurses providing care and the patients receiving care.

Conclusion

Emergency nurses who have greater confidence in their ability to care for, and comfort working with, suicidal patients tend to provide better care with more positive patient outcomes. The current results support providing evidence-based/expert-delivered suicide-specific intervention training to emergency nurses to enhance nurse confidence and comfort in their abilities to assess, intervene with, and treat suicide risk among patients.

Author Disclosures

Conflicts of interest: none to report.

Demographic statistics	Frequency (%)
Sex	
Male	13 (11.1)
Female	104 (88.9)
Race/ethnicity	
White/Caucasian	113 (97.4)
Black/African American	1 (0.9)

Native American	2 (1.7)
Type of hospital	
Critical access	67 (57.3)
Community hospital	50 (42.7)
Have you worked with a suicidal patient in the ED?	
Yes	115 (98.3)
No	2 (1.7)
Nursing degree	
BSN (RN)	82 (70.7)
ADN (LPN)	15 (12.9)
Other (APRN, etc.)	19 (16.4)
How often do you encounter patients who are suicidal in the ED?	
Rarely	7 (6.0)
Occasionally	24 (20.5)
Often	58 (49.6)
Almost always/most shifts	28 (23.9)
Years of experience	
<5 y	18 (15.4)
5-10 y	38 (32.5)
11-20 y	36 (30.8)
21-30 y	18 (15.4)
31-40 y	7 (6.0)

Training option	n (%) of participants	Categorization
Question, Persuade, Refer*	3 (2.6)	Informal/lay person
Applied Suicide Intervention Skills Training	1 (0.9)	Evidence based
Yellow Ribbon*	3 (2.6)	Informal/lay person
Assessment and Management of Suicide Risk	8 (6.8)	Evidence based
Zero Suicide	4 (3.4)	Evidence based
Recognizing and Responding to Suicide Risk	5 (4.3)	Evidence based
Collaborative Assessment and Management of Suicide	4 (3.4)	Evidence based
Agency-offered/hospital-offered professional development	37 (31.6)	Informal/lay person
Agency-offered/hospital-offered documentation or procedure training	16 (13.7)	Informal/lay person
Continuing education program by suicide expert	26 (22.2)	Evidence based
Other†	28 (23.9)	--
Have not received suicide-specific training	29 (24.8)	No training

Outcome variable	No training n = 28 Mean (SD)	Informal/lay person training n = 54 Mean (SD)	E-B/expert training n = 34 Mean (SD)	Univariate effect size d
Total scale: comfort	3.58 (0.39)	3.59 (0.34)	3.77 (0.29)*†	0.49‡
Total scale: confidence	5.99 (1.65)	7.18 (1.65)*	8.10 (1.30)*†	1.05§
Total scale: burnout	3.45 (1.02)	3.40 (0.91)	2.95 (0.76)*†	0.56‡

Item: improve ability to treat	1.03 (1.68)	4.56 (2.40)*	5.72 (2.46)*†	1.59 [§]
Item: provided adequate skills	2.36 (1.16)	3.20 (1.12)*	3.81 (1.23)*†	0.97 [§]
Item: overall perceived quality	0.92 (1.76)	4.86 (2.37)*	5.50 (2.53)*	1.61 [§]
Item: interactive	0.78 (1.64)	3.87 (2.12)*	5.10 (2.00)*†	1.64 [§]

DETAILS

Subject: Emergency medical care; Intervention; Patients; Professional development; Burnout; Suicide; Community hospitals; Nurses; Emergency services; Confidence; Quality of care; Comfort; Risk assessment; Fear & phobias; Ability; Professional training; Quantitative psychology; Working hours; High risk; Mental health; Polls & surveys; Nursing; Attitudes; Suicides & suicide attempts

Business indexing term: Subject: Professional development Risk assessment Burnout

Identifier / keyword: Emergency nurse; Suicide; Patient care; Burnout; Attitude of health personnel

Publication title: Journal of Emergency Nursing; JEN; Philadelphia

Volume: 49

Issue: 2

Pages: 266-274

Publication year: 2023

Publication date: Mar 2023

Section: Research

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.003
ProQuest document ID:	2781603778
Document URL:	https://www.proquest.com/scholarly-journals/evidence-based-vs-informal-suicide-training-nurse/docview/2781603778/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-03
Database:	Public Health Database

Document 46 of 50

Uncovering the Experience: Return to Work of Nurses After Parental Leave: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

To understand the experiences of emergency nurses who have returned to work after parental leave, specifically relating to the return to work transition, work-life balance, work engagement, and opportunities to continue human milk expression.

Methods

Nurses ($N = 19$) were recruited from 5 emergency departments within 1 hospital system in the United States Midwest. Nurses ($n = 11$) were eligible to participate in a one-on-one interview if they had returned from parental leave within 6 months of the interview date. Nurses ($n = 8$) were eligible to participate in a focus group if they had returned from parental leave within 2 years of the interview date. Interviews were structured and data collection concluded when researchers believed data saturation was reached. Interviews were audio recorded and transcribed verbatim. Data were analyzed using Braun and Clarke's qualitative thematic analysis 6-phase framework.

Results

Three major themes from the data were identified: (1) work engagement, (2) lactation, and (3) childcare. Work engagement was broken down into the subthemes: lack of communication, perceived engagement expectations, and actual engagement. Lactation was broken down into the subthemes: the act of pumping, lactation breaks, and lactation rooms. The coronavirus disease 2019 pandemic impact on return-to-work is described under each major theme.

Discussion

Our findings provide insight into the unique challenges and experiences of nurses navigating parental leave and

return-to-work in the emergency department. Strategies such as provision of managerial check-ins, return to work reorientation, lactation break coverage, enhanced supplementary lactation support, and leadership-provided accommodation may lighten the burden of these challenges and improve the returning nurse's job satisfaction.

FULL TEXT

Contribution to Emergency Nursing Practice

- To the best of our knowledge, this is the first study describing the emergency nurse experience of parental leave and return to work. ED characteristics, such as limitless patient volumes, violence, overcrowding, and patient boarding, likely affect the return to work experience.
- Work engagement, lactation, and childcare were the major themes identified during data analysis. Coronavirus disease 2019 affected each theme.
- Organization driven strategies, such as provision of managerial check-ins, return-to-work reorientation, supplementary lactation support, and leadership-provided accommodation, may lighten burdens experienced by emergency nurses navigating parental leave and return to work.

Introduction

Nurses are the largest group of health care professionals in the United States, and 88.9% of registered nurse positions are held by women.^{1,2} Roughly 50% of United States nurses are of childbearing age.^{1,2} This suggests that nearly half of the nursing labor force may navigate parental leave, return to work, and the unique challenges associated. Although there are studies focusing on women returning to work after parental leave, there is a lack of studies describing the return-to-work experience of United States nurses.

Returning to work after parental leave can be a stressful time for new parents. Nurses may face additional stressors during return to work given that their working environment is often low in flexibility (eg, needing someone to cover breaks), commonly consists of 12-hour shifts, and involves physical and mental demands not found in other professions.³ Gorman⁴ conducted a literature review of studies looking at emergency nurse resilience. One theme discussed was the ED work environment and the unique challenges associated with it.⁴ These challenges may influence nursing return-to-work. Notably, emergency departments do not place limitations on patient volumes and are unpredictable in nature.⁴ Emergency nurses are susceptible to occupational stress when there is a mismatch between their job demands, the amount of control they have over these demands, and the support networks available.⁴

Parental leave in the United States is often 12 weeks, drastically less than that offered in a neighboring country, Canada, where parents may take 78 weeks of leave.^{5,6} Many women continue to report significant health concerns related to childbirth at 6 months postpartum and beyond.⁶ During this time, women may be struggling with anxiety, depression, physical recovery from childbirth, and/or fatigue associated with caring for an infant.⁷⁻⁹ A study evaluating return-to-work in the academic setting found that women who reported worse health at work reentry had symptoms of anxiety or depression nearly every day.⁷ The experience of ill health in the postpartum period also can contribute to absenteeism and presenteeism in the workplace.^{7,10} More research is needed to understand the experience of parental leave among United States nurses within the hospital setting. Owing to the limited data on this topic, we chose to conduct a qualitative descriptive study to better understand this phenomenon.

During an era when nursing retention and engagement are a growing priority, health care institutions may find value in understanding return to work experiences to identify interventions that support parents working in the nursing profession.^{11,12} The purpose of our study was to shed light on the return to work experience of emergency nurses,

with a particular focus on the return to work transition itself, work-life balance, work engagement, and opportunities to continue human milk expression.

Methods Organizational Support Theory

The organizational support theory was used during data interpretation.¹³ The theory emphasizes perceived organizational support: the extent to which employees perceive that their organization values their contributions and cares for their well-being.¹³ If an organization wishes to optimize perceived organizational support, the following principles should be considered: (1) employee attribution (correctly understanding the needs of your employees), (2) social exchange (when employees feel supported by their organization of employment they, in turn, feel a responsibility to support the organization in achieving its goals), and (3) self-enhancement (optimal perceived organizational support is associated with fulfillment of an employees' socioemotional needs).¹³

Participants and Setting

Participants ($N = 19$) were recruited using convenience sampling from a large, university-affiliated health care system in the United States Midwest. Recruitment methods included posted flyers and emails sent out to the entire ED nursing listserv where recruitment took place. Participants were recruited from 5 emergency departments within the health care system across urban, suburban, and rural areas. Many participants ($n = 10$) worked at the largest hospital, located in an urban setting. Participants who had returned from parental leave within the previous 6 months were eligible to participate in a one-on-one interview, and those who had returned from parental leave within the previous 2 years were eligible to participate in a focus group. Some participants were interviewed before the COVID-19 pandemic began, whereas others were interviewed during the pandemic. See ^{Table 1} for a breakdown of participants interviewed using one-on-one interviews vs focus groups and whether the interview occurred before or during the COVID-19 pandemic.

Study Design

For this qualitative descriptive study, we aimed to understand the return to work experiences of emergency nurses after parental leave. We used structured interview guides (^{Table 2}) for one-on-one interviews and focus groups. The focus group interview guide was a pared-down version of the one-on-one interview guide. Interview questions were adapted from a qualitative study evaluating the return-to-work experiences of occupational therapists after taking parental leave.¹⁴ Author permission to use and adapt this interview guide was obtained. Institutional review board approval was received in October 2019 and data collection occurred from November 2019 to December 2020. Interviews and focus groups were initially conducted in-person but were moved to a virtual format owing to the COVID-19 pandemic. Before the COVID-19 pandemic began, one participant for the one-on-one interviews requested a phone interview, as opposed to in-person.

Data Collection

Interviews, one-on-one (11) and focus group (3), were facilitated by the first author. Focus groups also were attended by an observer (second or fourth author) for the purpose of recording nonverbal communication, voice tone, and voice inflection. Authors involved in the interview process received training from experts in research methodology (authors 3 and 5) on how to optimize rigor, validity, and reliability in qualitative methodology when conducting and analyzing interviews. One strategy used to support rigor, validity, and reliability was the use of a structured interview guide (^{Table 2}). Each 30- to 60-minute interview began with the first author obtaining verbal consent, by reading the consent form verbatim, allowing participants to ask questions, and the opportunity to proceed or withdraw from the interview. Once consented, the structured interview commenced. To avoid influencing participant responses and groupthink, the facilitator and observers minimized verbal and nonverbal cues of agreement or disagreement with the interviewee's answers.¹⁵ Interviews were audio recorded and transcribed

verbatim. Confidentiality was ensured by interviews occurring in private spaces, names of participants not being associated with statements made, and requiring focus group participants to avoid discussing any interview details after the conclusion of the focus group.

We theorized that the farther out a participant was from return to work, the greater the limits to their recall. One-on-one interviews were chosen for those with optimal recall (returned to work within 6 months of interview date). Focus group interviews were chosen for those at increased risk of recall difficulties (returned to work within 2 years of interview date). We theorized that participant recall of memories may be optimized in a focus group setting, where the dialogue between participants may cause a memory to reemerge.¹⁶ Interviews and focus groups were held until researchers believed data saturation was reached, and the properties and dimensions of each theme were well defined.

Data Analysis

Data analysis was conducted by the first and second author using Braun and Clarke's¹⁷ qualitative thematic analysis 6-phase framework: (1) familiarize self with data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) define themes, and (6) produce a report.¹⁷ To minimize bias, the first 3 phases of qualitative thematic analysis were completed independently. This independent work involved (1) listening to the audio recordings and reading the interview transcripts and notes repetitively, (2) line-by-line coding, and (3) grouping of similar codes into themes. Initial themes were similar among authors. The third and fifth authors, being experts in research methodology, assisted with reviewing and defining each theme (Figure). All authors contributed to the delineation of the study results through this report.

Rigor and Trustworthiness

All authors involved in data collection and analysis were nurses with a bachelor's degree or higher. Three of the authors identified as female; the fourth author identified as male. The first author had experienced return to work after taking parental leave at an emergency department featured in this study. As nurses and/or parents, we engaged in reflexivity by acknowledging how our personal experiences may influence how we understand and interpret participants' experiences.¹⁸ Validity and credibility of findings were assured by using a research team to analyze and discuss the meaning and interpretation of the data.¹⁹ More specifically, prolonged engagement with the data and peer debriefing ensured credibility.¹⁹ Prolonged engagement with the data involved multiple rounds of transcript reading and analysis consisting of coding, revising codes, and regular team discussion lasting a total of 8 months. Peer debriefing included team members sharing and revising analysis and selection of quotes and themes.¹⁹ A sufficient description of methodology and contextualization of participants' experiences supported the transferability of findings.¹⁹ We demonstrated confirmability through discussions about potential biases and using peer debriefing to ensure an accurate presentation of the data.²⁰

Results

Three major themes from the data were identified: (1) work engagement, (2) lactation, and (3) childcare. Work engagement was further broken down into subthemes related to lack of communication, perceived engagement expectations, and actual engagement. Lactation was further broken down into subthemes related to the act of pumping, lactation breaks, and lactation rooms. Data were collected before and during the COVID-19 pandemic. The data collected during COVID-19 demonstrated interconnectedness between COVID-19 and return to work; therefore, the impact of COVID-19 is described within each major theme (Figure).

Theme 1: Work Engagement

Data pertaining to work engagement are divided into the subthemes: lack of communication, perceived engagement expectations, and actual engagement.

Lack of Communication

Communication with staff is an important tool for organizations to use in demonstrating support for their employees.

¹³ Dissemination of information at this organization often occurs either at large (eg, human resources) or through departmental directors, managers, or charge nurses. Participants overwhelmingly described a lack of communication around parental leave and return to work expectations. Through both the processes of preparing for and returning from parental leave, participants described relying on coworkers with parental leave experience for direction. Participants felt disappointed that this guidance was not actively provided by the organization. Participants described being unsure whether their leave was approved, sometimes up until giving birth, and spoke of receiving inconsistent information depending on the leave personnel they conversed with. Some participants endorsed that, during their leave, their hospital system transitioned to a different third party leave administration company. Communication of this change was missed and only discovered when a peer informed them. Participants endorsed wishing the process was better structured. I feel like the first thing that's coming to mind is how to apply for the leave and everything like that, and I feel like the general direction was, "Oh, you should just ask somebody that went on maternity leave before" or "Call HR (Human Resources)." There wasn't a lot of guidance. Participants did not feel as though the organization was supporting them through leave and return to work because of this lack of communication.

Perceived Engagement Expectations

Perceived engagement describes what nurses believe is expected of them when returning from leave. Participants described their return to work after approximately 12 weeks of leave as "business as usual," being expected to immediately perform at the same capacity as when they left. With ED policies and procedures in continual flux, most participants wished for brief reorientation. Nurses commonly reported a desire to check in with management upon return, providing an opportunity for them to ask questions and discuss needs and expectations.

Nurses described actively and passively requesting accommodation from leadership (eg, reducing hours, flexible scheduling, excusing occasional tardiness). Mostly, nurses spoke positively of leadership accommodation; however, when unaccommodated, they questioned whether they were valued at the organization. Fears of receiving a poor annual review and even termination were discussed. Parental leave requires nurses to use, and commonly exhaust, their paid time off (PTO) and/or "leave" hours allotted by the state. As a result, if a nurse is unable to attend their shift after return to work (eg, personal illness, caring for a sick child), they may not have the PTO or leave hours to cover it, which could result in institutional penalization....I don't think that working parents deserve special circumstances, but I think just on a human level of understanding and being a little bit more compassionate to your employees about, "I might be running late" and "I might be just doing the best I can..." Yeah, so I think that makes it hard for me, in particular, to maintain my loyalty to this facility and the department, because it tends to make me wonder, "Am I valued?"

Actual Work Engagement

Participants expressed genuine joy in return to work, specifically through the lenses of reuniting with peers and resuming their nursing roles. Many described infant care as monotonous and were thankful to break from that to "use a different part" of their brain. Participants often described their role of nurse as being central to their identities: "The adult interaction and just getting back to something that was part of me. Nursing has always been a part of my life and really important to me, so validating that part of my identity still, that it wasn't lost, that was important." However, in addition to this joy, most participants expressed new limits in their work engagement and tension in balancing their parental and working roles. Many were dissatisfied with their current work-life balance and described reprioritizing their child and/or family above work. Reducing work hours and declining extra commitments (eg,

overtime, volunteering, committees) were some of the ways nurses disengaged in search of improved work-life-family balance. Some participants with a high level of work engagement before parental leave described wishing to maintain that same level of engagement upon return to work, whether that was achievable or not. Other participants, many of whom were parents to multiple children, demonstrated reduced workplace engagement before parental leave and continued disengagement upon return to work. However, many who described their current state as disengaged hoped this was temporary, endorsing intent to reengage with their career at a later point. "I'm committed when I'm there, but outside of that I don't have a lot to give right now, but hang on, I will again."

Limitations in the "ability to give" led nurses to feel insecure in their positions, fearful of job loss, and generally anxious and stressed, which often led to further disengagement.

COVID-19 Impact on Work Engagement

Early in the pandemic, some obstetric providers were instructing pregnant nurses to start parental leave early.²¹ However, existing leave policies did not specify the risk of contracting COVID-19 as a medical indication for early leave, despite the recommendations of some nurses' obstetric providers. Some nurses who successfully took leave early described having less time off with their baby after birth. Because of COVID, I was taken out of patient care 4 weeks before my due date. I did a lot of work from home, and I had to use up a lot of PTO, because there was only so much work from home stuff that I could do, and I was really trying to avoid taking parental leave before my due date because of COVID, because I wanted that whole 12 weeks after I gave birth.

Nurses who took leave during the COVID-19 pandemic described heightened struggles with disengaging. ED response changed on a near-daily basis and nurses on leave expressed fears of feeling "lost" when they returned if they did not stay aware of changes during leave. Nurses reported taking it upon themselves to check their work email regularly to keep abreast of departmental changes (eg, pandemic response) and to gain a general sense of how their peers were faring.

The pandemic pushed committee meetings to virtual platforms, allowing attendance from home. Nurses described being able to continue committee participation upon returning to work because of the virtual platform but expressed uncertainty toward continuing if in-person participation were to be reinstated.

Upon returning, similar to times before the COVID-19 pandemic, nurses did not receive gentle reinsertion or reorientation to the department. They instead described feeling as if they were "on their own" to figure it out. Nurses also recognized the risk of their work environment and had fears of bringing home COVID-19 infection to their family. Some described fear in assisting with care of COVID-19 positive patients. This demonstrates the returning nurses' "child first, work second" reprioritization and a barrier to fully engaging with work.

Theme 2: Lactation

All participants were lactating upon return to work and needed to perform human milk expression (pump) while at work.²²⁻²⁴ Most participants did not meet personalized lactation goals, despite readjustment of expectations owing to the demands of the job, and experienced reduced milk supply upon returning. Data collected about lactation were organized into 3 subthemes: the act of pumping, lactation breaks, and lactation rooms.

The Act of Pumping

A single human milk expression (pumping) session involves multiple steps in addition to actual lactation.^{22,24} These steps include transport of equipment, locating an available and appropriate area, supply setup, human milk expression, milk storage, cleaning equipment, supply storage, and transport back to nurse assignment.^{22,24} Some participants felt as though peers who had not personally experienced lactation in the workplace were unaware of said steps and why lactation breaks require a significant amount of time. There's some loss of time getting to the place to pump, getting everything ready or washed up at the end. Even though you may be only pumping for X

amount of minutes, there's extra time on top of that, so there's just always this pressure of time, feeling that you're taking time and you need to get back.

Nurses described rushing through the steps of lactation in an attempt to be respectful to their peers and resume their nursing assignment.

Lactation Breaks

Participants wished to express human milk at work at the same time of day that they would be feeding their infant if they were at home (approximately every 3-4 hours). However, owing to the unpredictability and busyness of the emergency department, many participants adjusted those expectations, recognizing that they would need to be flexible with timing of these breaks (eg, taking a lactation break later in the shift). Participants spoke of the importance of self-advocacy in both requesting a lactation break and finding coverage. Some nursing assignments were reported as easier (eg, team leader) or harder (eg, triage) to step away from. Participants often felt supported by peers with human milk expression experience, but emphasized that even this was dependent upon whether it was convenient for their peers: I think most were supportive when it was convenient [for my peer]. I think most were supportive if I wasn't busy, but it wasn't a priority to them if we were busy if that makes sense. So, as long as it wasn't going to be super inconvenient for them, it was no big deal; of course, I could go; but if it was going to be inconvenient for them, then there was a little bit more hesitation.

Participants did not describe active pushback from peers when requesting and taking breaks; however, nurses described fears of how their peers perceived them for taking breaks. Some recalled overhearing peers speak negatively of lactating nurses. Participants described experiencing profound guilt and anxiety while taking a lactation break, ranging from worrying about their patients while away to feeling guilty about peers covering their assignment. Participants described having to "catch up" on patient care upon returning. I had two pretty sick patients... ..I had asked my neighbors to cover me and take care of some things, and at that time I was met with, "Oh, yeah sure, no problem." And then when I came back, no one had done anything or checked on any patients and my patient was hypotensive.

To counteract this, breaks were rushed, resulting in inability to relax, which is an essential component of successful letdown in human milk expression.²⁵ I stress about how long I've been away. I don't take my time. I grab my stuff and run up to the lactation room and pump really fast and then come back down, throw everything in my locker, in the freezer, pee really fast and then run back to my assignment, so it's not a leisurely time for pumping.

Overall, nurses described tension between fulfilling their "nursing role," burdening peers, and providing for their child. Participants desired intentional and planned lactation break coverage, thinking this would lead to less stress, anxiety, and guilt.

Lactation Rooms

Participants' reports indicated that lactation room characteristics varied markedly across the health care system. Differences in lactation rooms by hospital site included distance from the emergency department, availability to staff only or the public as well, availability of equipment, likelihood of availability, and cleanliness. Participants reported that some lactation rooms did not contain a sink for washing hands and cleaning pumping equipment. If barriers were great, nurses chose to express human milk in spaces not designated for lactation (eg, offices, break room). For us, we have a pumping room, but it's about a 5-minute walk from the department, and I found myself at first taking the time, but then I was realizing I was having to cut that pumping time short, so I stopped doing that, and I just would step into somebody else's office that was not being used.

When participants conducted human milk expression in spaces not designated for lactation, they noted that those rooms lacked the supplies or privacy, among other characteristics and qualities, necessary to fully support human

milk expression. However, for those who felt it necessary to use such spaces, it was evident that the alternative options were even less appealing.

COVID-19 Impact on Lactation

Each emergency department had an individualized pandemic response and experience (eg, staffing and patient volumes), all of which influenced lactation breaks. For some, staffing improved and patient volumes decreased, making it easier to take appropriately timed lactation breaks. In the pre-COVID era it would have been very difficult to do that [pumping], and the guilt of stepping away would have been a lot higher. However, we have been very well-staffed and not as volume-heavy with patients, so I think I've been very lucky with coming back to work during this time.

For others, the opposite was true, given that staffing was inadequate and patient volumes increased. For these participants, the COVID-19 situation created more barriers to taking lactation breaks. "Someone is like, 'You should just tell him you have to take a break.' I'm like, 'But nobody's getting a lunch break, so it sounds like a diva to be like, I have to go take a [lactation] break. None of you got one, but I need one.'"

Theme 3: Childcare

Nurses expressed that childcare was a heavy source of stress upon returning to work. This appeared to be most pronounced in first-time parents. Participants described worrying about their work schedule upon return and whether it would align with their childcare plan. While on parental leave, I was concerned about scheduling, how my schedule would be once I returned to work. That was actually pretty stressful for me, just being on maternity leave, and I'm like, "Okay, I didn't do my schedule." "God, how is it gonna look when I come back?" "Are they gonna honor when I call them and say (when) I can work." So that was a little stressful just because of childcare issues.

Nurses considered the price of childcare and indirect costs of working (eg, parking, gas) to assess whether working made financial sense. For some, the takeaway income after these costs was minimal, creating a mental conflict. In the end, those nurses chose to continue working. Motivators for continuing to work included the desire to maintain their career and responsibility to provide health insurance coverage for their families.

Participants described feeling conflicted, stressed, and guilty about leaving their infant under the care of others. Nurses described worrying that their child would not take a bottle or cope well without them. They also described sadness in missing key milestones owing to perceptions of parental leave being too short and the child too young. Simultaneously, nurses saw benefit to self and child in allowing others to watch their child, stating, "I like coming to work. It's good for me. I think it's good for my kids to have to learn to be with someone that's not me."

When childcare was provided by immediate family, this provided a significant sense of relief. Alternatively, nurses lacking family to provide childcare endorsed increased anxiety and difficulty focusing at work.

COVID-19 Impact on Childcare

Arranging childcare for infants during the pandemic was often affected by fear for the child's safety. For many, daycare was not viewed as an option. Because of the pandemic, we didn't want to enter her into daycare for illness reasons, for-you know, in case of getting her sick and me thinking that it was COVID-related or also potentially getting other kids sick, because I'm working in the emergency department, and if I bring home something. As an alternative strategy, when possible, participants collaborated with their partners to cover childcare. Some described changing their schedules or going to part-time status to achieve this childcare arrangement.

Discussion

Findings from this study suggest that parental leave and return to work are a transitional process associated with heightened stress. Because roughly 50% of the nursing profession is composed of women of childbearing potential, a substantial number of nurses navigate this stressful transition.^{1,2}

The organizational support theory suggests that when organizations invest in family-focused supports for their employees, employee perceived organizational support increases.¹³ When perceived organizational support increases, job performance and work engagement follow suit.¹³ Therefore, organizations wishing to optimize perceived organizational support may choose parental leave and return to work as one focal point. The organizational support theory recognizes the importance of understanding employee needs to ensure appropriate supports are available.¹³ Findings from this study pinpoint areas that emergency nurses identified as sources of stress and may represent areas where increased organizational support is needed. Perceived organizational support strategies for nurses navigating parental leave and return to work are discussed next.

Engagement

Navigating the time period before, during, and after parental leave requires nonintuitive and department-specific knowledge.²⁶ Our participants reported a lack of communication from leadership regarding the process of taking parental leave and return to work. This is consistent with other studies in which physician mothers reported confusion and lack of communication regarding parental leave policies.²⁶⁻²⁸ Our findings suggest that pertinent parental leave information should be easily located, comprehensible, and, perhaps, directly provided to employees.²⁶ Based on recommendations of our participants, much of this pertinent information may be effectively disseminated using one-on-one check-ins between the department manager and employees. These check-ins also may provide the opportunity for employees to ask questions and communicate concerns. Managerial efforts to create a personal connection with employees, including understanding details of their home situation or struggles, may assist in engaging staff.^{13,29}

In addition, participants in our study reported that reorientation to the unit, or a gradual return to work process, may have helped to lessen their stress. This is consistent with literature suggesting that employers who wish to retain working parents may consider offering support such as flexible scheduling, the option to return to work at reduced hours, and having open and honest conversations about what will and will not work.^{7,14,30} A “gentle” return to work option consisting of fewer work hours for the first few weeks may be beneficial for some nurses, given that more than one-quarter of postpartum mothers report not feeling in optimal health (mental or physical) at the time of return to work.⁷ During reorientation, education on departmental and practice changes that occurred during their leave should be emphasized.

Our research participants reported wanting to be engaged at work at the level they were before parental leave, but learning to balance work and life responsibilities as a new parent made it difficult to achieve this goal. Previous literature emphasizes that achieving a healthy work-life balance is challenging for returning parents and trade-offs are inevitable when working and also being a parent.³⁰ Managerial check-ins may be used to understand sources of work-life imbalance to, at minimum, demonstrate compassion, which may increase the employee’s commitment to the organization.¹³ Another option that organizations may wish to consider in support of staff engagement is allowing virtual attendance for committee meetings. A study looking at using a virtual platform for family educational services during the COVID-19 pandemic found an increase in client engagement and satisfaction in addition to improvements to program access and equity.³¹ Participants spoke of being able to continue participating on hospital committees, because the pandemic had pushed meetings to a virtual platform. If it were not for the virtual platform, they could not conceive continued committee involvement after returning to work

Lactation

Findings from this study suggest that more lactation supports are needed as evidenced by the amount of stress, anxiety, and guilt associated with lactation in the workplace. Previous research demonstrates that the more challenges employees experience surrounding human milk expression in the work setting, the lower their job

satisfaction.³² This suggests that minimizing challenges faced by lactating employees may be seen a priority to employers, perhaps through the provision of lactation supports.

One lactation support that our participants reported to be lacking was the provision of planned, covered lactation breaks. A study of United States nurses found that finding time to take a lactation break was the biggest barrier to maintaining lactation in the workplace.³ Although our participants were allowed to take lactation breaks, they spoke of needing to self-advocate and, at times, sensed peer frustration while taking them. There also appears to be a correlation between department busyness and ease of stepping away for a lactation break.^{3,23} Participants who returned to work during the pandemic spoke of either reduced or heightened barriers to lactation breaks, directly related to their department's experience of the pandemic (eg, less busy and increased staffing or more busy and decreased staffing). Literature suggests that for lactation supports to be truly effective, they must be accompanied by a genuine sense of support from peers and leadership.²³ La Leche League International estimates that the lactation portion of human milk expression takes 15 minutes or more per breast and recommend double pumping (pumping both breasts simultaneously) to maximize milk supply.³³ Those 15 minutes do not account for all other required steps of taking a lactation break that were discussed in the Results section of this study.^{22,24} Based on our findings, if organizations do not have sufficient staffing to support consistent lactation break coverage, they may want to consider strategically assigning lactating nurses to roles in the emergency department that are easier to step away from.

Investment in high-quality lactation rooms is another lactation support strategy that organizations may wish to consider. Literature has shown a correlation between the quality of lactation rooms and staff satisfaction with both the lactation room and ease of human milk expression.³⁴ Furthermore, when employees perceived lactation rooms to be high quality, they subsequently feel more supported by peers, leadership, and the organization.^{34,35} Based on our findings, ideas to increase lactation room quality include installation of lockers proximal to the lactation room for storage of personal breast pumps and supplies, presence of human milk designated mini fridges, and providing multiple lactation rooms (ideally, staff designated) near departments. These ideas may ease challenges associated with lactation in the workplace.

Childcare

Our participants identified childcare as a major source of stress during return to work. Childcare management during return to work has been pinpointed as a stressor in the literature and the COVID-19 pandemic appears to have amplified these challenges.^{26,30,36} Our participants who navigated return to work during the COVID-19 pandemic spoke of adapting childcare arrangements owing to daycare changes and concern for child safety. This aligns with Shanafelt, et al,³⁶ who identified sources of stress for health care professionals in the United States during the COVID-19 pandemic, including fears of bringing home a workplace exposure and access to childcare. In our study, participants spoke of seeking leadership accommodation to support their childcare arrangements. Perceived organizational support was compromised when participants were unaccommodated and they questioned whether they were valued.¹³ This outcome may incentivize organizational leadership to, when possible, be flexible in supporting and accommodating needs of the returning nurse's childcare arrangement.

Our participants spoke to the financial burden presented by childcare costs. A United States study evaluated the relationship between cost of childcare and maternal employment broken down by state.³⁷ The authors found that, in states where childcare costs were higher, mothers were less likely to work full time and more likely to work part time.³⁷ Inversely, when childcare costs were lower, mothers were more likely to work full time.³⁷ One of our participants mentioned that, after accounting for childcare, gas, and parking costs, their take-home income was marginal. This factor led the participant to consider reducing hours and even resigning. Organizations wishing to retain staff with

young children may want to consider aiding in childcare costs or providing staff with affordable childcare options.³⁷

Limitations

Demographic details of our participants were not collected to mitigate risk of them being identified by leadership and peers. Because we were collecting data about workplace experiences and interviewing current employees of the organization, we felt anonymity was particularly important. We recognize that a lack of demographic data for our participants may reduce the transferability of this study.

Data were collected before and during the COVID-19 pandemic. Data collected before COVID-19 were done almost exclusively in-person, whereas data collected during the COVID-19 pandemic were done virtually. It is possible that our results would be different if data were collected using one method (eg, only in-person or only virtually). In addition, data collected during the pandemic looked different from data collected before COVID-19. This suggests that the return to work experience was different for these 2 groups and may have been more appropriately analyzed as separate data sets. Although both data sets spoke to similar aspects of return to work, data collected during the pandemic had COVID-19 laced into nearly every response. This speaks to the level of impact that COVID-19 has had on emergency nurses. We chose to analyze both data sets together, because our data collection was far from complete when the COVID-19 pandemic began.

Conclusion

Our findings shed light on the experiences and challenges emergency nurses face when taking parental leave and returning to work. These experiences and challenges may be used to inform policy and allocation of resources with the returning nurse in mind. Strategies such as managerial check-ins, reorientation, enhanced lactation support, and leadership-provided accommodation may improve the returning nurse's job satisfaction. Policy change and implementation of such supports will require departmental, and perhaps, organizational awareness of the challenges faced by this group and commitment to make it better. More research is needed in this area, especially as the COVID-19 pandemic continues, and changes to the nursing profession are ever-present.

Author Disclosures

Conflicts of interest: none to report.

This work was supported by the Northwestern Medicine's Nurse Scholar Program.

Type of interview	Total number of interviews	Number completed before COVID-19	Number completed during COVID-19	Conduction method	Number of participants
One-on-one	11	6	5	In-person: 5 Phone: 3 Zoom: 3	Per group: 1 Total: 11
Focus group	3	1	2	In-person: 1 Phone: 0 Zoom: 2	Per group: 3, 3, 2 Total: 8

Question
1. Thinking back to the time leading up to going on parental leave, please describe what aspects of preparation for parental leave were easy or straightforward.
2. Please describe what aspects of preparation for parental leave were difficult.
3. How many weeks of parental leave did you take?
4. Did you find yourself thinking about work while being on parental leave, please elaborate?
5. Since becoming a parent to your new baby, do you feel differently about working (for example, do you have thoughts of not working, working less, working more, changing roles, etc.), please describe?
6. Please describe what (if any) aspects of return to work you looked forward to.
7. Please describe what (if any) aspects of return to work you stressed about.
8. Please describe anything that made your transition back to work easier.
9. Please describe anything that made you transition back to work harder.
10. Is there anything that could have helped with your transition back to work?
11. Were you lactating when you returned to work (if no, skip to question 17)?
12. Please describe what your lactation goals were upon returning to work, for example: avoiding supplementing with formula, pumping every "x" number of hours, etc.
13. Did you achieve your lactation goals, please elaborate?
14. Please describe your experience surrounding use of lactation rooms in the workplace.
15. Please describe your experience surrounding use of lactation breaks in the workplace.
16. When taking lactation breaks, please describe how you believe your coworkers felt?
17. Please describe your experience with balancing work and personal life since returning from parental leave.
18. Please describe how you are satisfied with your work-life balance.
19. Please describe how you are dissatisfied with your work-life balance.
20. Please describe how your experience with return to work after parental leave has influenced your engagement in your role as a nurse at the organization.

21. Is there anything else you would like to share about your experience?

DETAILS

Subject:	Research methodology; Milk; Interviews; Breastfeeding &lactation; Parents &parenting; Focus groups; Employees; COVID-19; Child care; Saturation; Nurses; Pandemics; Emergency services; Job satisfaction; Coronaviruses; Return to work; Leadership; Work-Leisure conflict; Family leave; Career transitions; Emergency medical care; Maternity &paternity leaves; Female employees; Work life balance
Business indexing term:	Subject: Employees Maternity &paternity leaves Female employees Work life balance
Location:	United States--US
Identifier / keyword:	Return to work; Parental leave; Emergency service; Hospital; Job satisfaction; United States; COVID-19
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	210-221
Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article

DOI: <https://doi.org/10.1016/j.jen.2022.10.005>

ProQuest document ID: 2781603756

Document URL: <https://www.proquest.com/scholarly-journals/uncovering-experience-return-work-nurses-after/docview/2781603756/se-2?accountid=211160>

Copyright: ©2022. Emergency Nurses Association

Last updated: 2023-03-07

Database: Public Health Database

Document 47 of 50

Fracture of an Intravenous Cannula in the Hand: A Case Report: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Background

Intravenous cannula insertion is important, given that it is the most common invasive procedure in the emergency department for blood sampling, fluid resuscitation, and intravenous drug administration. Complications of intravenous catheterization include pain, phlebitis, extravasation, inflammation, and embolization. Fracture of an intravenous cannula is rare, but delayed removal may result in secondary damage, such as vasculitis or embolization, with critical consequences. Here, we report a case of intravenous cannula fracture that occurred in our emergency department.

Case Presentation

A 63-year-old woman with a history of left ovarian cancer visited our emergency department owing to poor oral intake and general weakness. Intravenous catheterization using an 18 gauge cannula was attempted for intravenous fluid administration by a skilled operator, but it failed owing to collapsed veins and poor skin condition. After several attempts, a vein in the patient's hand was ruptured, and the patient complained of severe pain. The cannula was removed, but one-third of the cannula tip could not be seen. X-ray imaging was performed to locate the fragment of the cannula, and venotomy was performed for removal of the foreign body in the emergency department.

Conclusion

Emergency physicians and nurses should be vigilant about potential risk factors that can cause fracture of an intravenous cannula, and after the fracture is discovered, rapid removal of the cannula tip should be performed in the emergency department.

FULL TEXT

Contribution to Emergency Nursing Practice

- Intravenous cannula fracture is rare, with vague symptoms, and thus may be missed by emergency physicians or nurses. Delayed diagnosis and removal can lead to secondary damage, such as vasculitis or embolization, with critical consequences.

- This case report highlights the risk factors of an intravenous cannula fracture. Oversized catheterization, poor vessel condition, high-risk insertion sites such as the hand, and reattempted catheterization at the same site may cause fracture of a cannula.

- Key implications for emergency nursing practice found in this article are that emergency physicians and nurses should be aware of these risk factors. If a fracture of an intravenous cannula is suspected, physicians/advanced practice nurses should perform early screening tests and rapid removal of the cannula tip.

Introduction

Intravenous cannula insertion is the most common invasive procedure in the emergency department.^{1,2} This procedure is clinically important, because blood can be sampled through the cannula, and it also can be used for intravenous administration of drugs and fluids.

However, catheterization also can cause various complications, including pain, phlebitis, extravasation, inflammation, obstruction, and even embolization.¹⁻⁵ Given that fracture of an intravenous cannula is rare, it may be missed by emergency physicians or nurses, and other complications such as phlebitis or extravasation may be assumed in patients with pain or swelling at the cannula insertion site. However, delayed removal of the cannula tip may result in secondary damage, such as injury in surrounding tissue, vasculitis, migration, or embolization.⁶⁻⁹ Here, we present a case of an intravenous cannula that broke during catheterization in a patient's hand in our emergency department.

Case Report

A 63-year-old woman with a history of left ovarian cancer with metastasis presented to our emergency department owing to poor oral intake and general weakness. Upon arrival, vital signs including noninvasive blood pressure, pulse, body temperature, and oxygen saturation were confirmed to be normal. Skilled nurses then attempted intravenous catheterization using an 18 gauge cannula, but this failed because the patient's veins were collapsed and her skin condition was poor. After several attempts, the patient complained of severe pain at the site of catheterization in the left hand. The cannula was removed immediately, but one-third of the cannula tip could not be seen, and a bruise developed at the insertion site. To prevent migration of the broken cannula tip, a foam compression dressing was applied to the proximal area (Figure 1).

Simple radiography was performed for differential diagnosis. On the X-ray image, a linear foreign body (FB) with a length of 1.1 cm and depth of 0.3 cm was observed at the site and was assumed to correspond to the left basilic vein (Figure 2A). A venotomy was immediately performed under local anesthesia in the emergency department (Figure 3A and B). After the surgical intervention, the piece of broken cannula measuring approximately 1.1 cm was found (Figure 3C and D).

After the procedure, there was no palpable FB in the vicinity, and the FB was not visible on follow-up X-ray (Figure 2B). The patient also reported that the pain had improved. After a few days of hospitalization, the patient had no dyspnea, chest pain, or pain at the site, and vital signs were confirmed to be normal, indicating no secondary complications.

Discussion

Seven cases of a broken intravenous cannula, including our case, are summarized in Table 1. Intravenous cannula shearing refers to catheter destruction or injury that occurs during or after intravenous catheterization.² It may occur in patients with severe vascular sclerosis, such as our case, by reducing the elasticity of blood vessels, making intravenous catheterization difficult, and requiring multiple attempts.^{6,10} In addition, there were a few case reports

that intravenous cannula shearing occurred after direct trauma to the cannula insertion site. Bakhshi et al⁶ reported a case that a cannula was broken owing to direct injury to the insertion site by falling. Khoo et al¹¹ also reported a case that a cannula was broken owing to self-infliction in a patient with poor coordination. Performing intravenous catheterization using a large bore cannula (16 G or 18 G), especially in patients with a poor vascular state or suspected dehydration, may cause cannula shearing. This is because patients with a poor vascular state or suspected dehydration may have more collapsed vessel condition than others, so a cannula that is larger than the diameter of the vessel may require multiple attempts owing to the risk of catheterization failure.⁹⁻¹³ During a reattempting catheterization, the needle may completely or partially transect a plastic catheter, which may cause the distal part of the catheter to remain as the FB.¹⁰ To reduce these risks, it is necessary to avoid use of an oversized cannula, reattempting catheterization, and high-risk insertion sites such as the hand owing to its vulnerable anatomy (smaller vessel size, curved structure, close to the bone, and highly mobile site).⁴ In addition, high-risk patients should be observed closely; palpate the surrounding cannula insertion area when the emergency nurses or physicians have tried in catheterization several times; follow up the patient's symptoms such as pain, chest pain, and dyspnea.

The remaining broken cannula in a vein not only causes simple complications but also can result in serious complications and even death.^{7,9,12} Minor and major complications of broken intravenous cannula are summarized in Table 2. Turner and Sommers⁹ reported a case in which a broken cannula tip was found in the right atrium of a patient after sudden death. Gschwind also reported a case in which a 5-mm small FB in the patient's cubital vein migrated into the heart.¹² Migration of an intravenous FB to the heart may result in symptoms such as dyspnea or chest pain.^{9,12} Therefore, as soon as an intravenous cannula fracture is discovered, emergency physicians and nurses should pay attention to the patient's symptoms, apply a compression dressing to prevent migration, and remove the FB before serious complications can occur.^{7,12} X-ray imaging is recommended to confirm the broken cannula tip in the patient's body, and more detailed examinations can be performed by computed tomography in the emergency department.^{6,7} After detection, surgical interventions such as venotomy should be performed immediately.^{7,10,11} The strength of our case report is that it gives emergency physicians or nurses a lesson to suspect intravenous cannula fracture when high-risk patients complain of symptoms such as focal pain and FB sensation after intravenous catheterization. However, there is a limitation that our case report does not represent a large number of patients.

Implications for Emergency Nurses

Fracture of an intravenous cannula is rare, with vague symptoms, and thus may be missed by emergency physicians or nurses. However, delayed diagnosis and removal can lead to secondary damage, such as vasculitis, embolization, or migration to the heart, with critical consequences. Oversized catheterization, poor vessel condition owing to previous diseases, high-risk insertion sites such as the hand, and reattempted catheterization at the same site may cause fracture of an intravenous cannula. Therefore, emergency physicians/advanced practice providers and nurses should be aware of these risk factors, and if a fracture of an intravenous cannula is suspected, physicians/advanced practice providers should perform early screening tests and rapid removal of the cannula tip in the emergency department.

Conclusion

Intravenous cannula fracture is a rare but potentially critical complication. Oversized catheterization, poor vessel condition owing to previous disease, high-risk insertion sites such as the hand, and reattempted catheterization at the same site may cause fracture of an intravenous cannula. Emergency physicians/advanced practice providers should be aware of potential risk factors and conduct early screening tests when in doubt. If found, the intravenous

FB should be removed immediately in the emergency department.

Data, Code, and Research Materials Availability

Ethical approval has been exempted by our hospital institutional trial review board (IRB file no. 2022-06-017), and we received an informed consent from the patient.

Acknowledgments

This work was supported by Soonchunhyang University research fund (grant no. 10220006).

Author Disclosures

Conflicts of interest: none to report.

Authors	Sex/age (y)	Preceding factors	Symptoms	Mechanism	Method	Size	Location	Reattempted catheterization
Bakhshi et al ⁶	M/28	Enteritis	FB sensation	Unknown, found after discharge	X-ray	-	Fore arm	No
M/30	None	Pain	Fall injury	X-ray	20 G	Wrist	No	Singh et al ⁷
M/-	Enteritis	FB sensation	Found after removal of cannula	CT	-	Fore arm	No	Turner and Sommers ⁹
F/54	MI	Chest pain, dyspnea	Unknown, found at autopsy	Autopsy	18 G	Fore arm	No	Khoo et al ¹¹
F/30	Intoxication	Pain	Self-inflicted injury	X-ray	16 G	Hand	Yes	Arun et al ¹⁰
M/31	None	FB sensation	Reinsertion of a guide needle	Palpation	18 G	Hand	Yes	Present case

Complications	Results	Author
Minor complications	Local inflammation	Bakhshi et al ⁶
	FB sensation	Arun et al ¹⁰

	Focal pain	Khoo et al ¹¹
Major complications	Migration to another site	Singh et al ⁷
	Death	Turner and Sommers ⁹

DETAILS

Subject:	Intubation; Autopsies; Emergency medical care; Pain; Risk factors; Catheters; Vital signs; Phlebitis; Physicians; Vasculitis; Strength; Nurses; Emergency services; Dyspnea; Catheterization; Invasive; Ovarian cancer; Intravenous drugs; Patients; Delayed; Embolization; Blood tests; Fractures; Veins & arteries; Inflammation; Case reports; Resuscitation
Identifier / keyword:	Peripheral catheterization; Cannula; Complications
Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	156-161
Publication year:	2023
Publication date:	Mar 2023
Section:	Case Review
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Case Study, Journal Article

DOI:	https://doi.org/10.1016/j.jen.2022.11.012
ProQuest document ID:	2781603709
Document URL:	https://www.proquest.com/scholarly-journals/fracture-intravenous-cannula-hand-case-report/docview/2781603709/se-2?accountid=211160
Copyright:	©2022. Emergency Nurses Association
Last updated:	2023-03-06
Database:	Public Health Database

Document 48 of 50

Table of Contents: JEN

[ProQuest document link](#)

FULL TEXT

TVM:UNDEFINED

DETAILS

Publication title:	Journal of Emergency Nursing;; JEN; Philadelphia
Volume:	49
Issue:	2
Pages:	A3-A5
Publication year:	2023
Publication date:	Mar 2023
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: Table Of Contents

DOI: [https://doi.org/10.1016/S0099-1767\(23\)00015-6](https://doi.org/10.1016/S0099-1767(23)00015-6)

ProQuest document ID: 2781603672

Document URL: <https://www.proquest.com/scholarly-journals/table-contents/docview/2781603672/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-05-23

Database: Public Health Database

Document 49 of 50

Emergency Departments Treating Veterans for Suicide: Ensuring Quality Care for Veterans Outside of Department of Veterans Affairs Health Care Facilities: JEN

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Introduction

Veterans die by suicide at higher rates than nonveterans. Given that the emergency department is often the first point of entry to healthcare following a suicide attempt, it would be beneficial for community providers to have knowledge of the characteristics, medical issues, and effective treatments most often associated with those having served in the military to ensure guideline concordant and quality suicide care. This study aimed to identify assessment and referral practices of emergency departments at rural community hospitals related to care for suicidal veterans and explore the feasibility and acceptability of identifying veterans in need of postdischarge aftercare.

Methods

This qualitative exploratory study involved content analysis of semistructured interviews. Ten emergency clinicians from 5 rural Arkansas counties with high suicide rates were interviewed about their experiences working with suicidal patients within the emergency department and perceptions of assessment, management, and referral practices.

Results

Although most of the emergency departments had a process for assessing for suicide risk, emergency clinicians did

not always feel confident in their knowledge of assessing and caring for suicidal patients. Military history was not included in assessment, treatment, or aftercare planning, nor were brief interventions such as safety planning or lethal means safety education provided.

Discussion

Best practices for suicide assessment and management of veterans exist; however, challenges specific to the emergency department regarding staff training and engaging the community to effectively link at-risk veterans to needed care hinder implementation. Veteran-inclusive assessment and intervention practices could enhance the quality of care provided in community emergency departments.

FULL TEXT

Contribution to Emergency Nursing Practice

- Veterans are at high risk of suicide, and rural veterans are at higher risk of suicide than nonrural veterans.
- Although emergency departments typically inquire about veteran status for billing purposes, this status is not used in assessing, treating, or referring patients for additional care. Implementing veteran-specific suicide assessment and intervention best practices could improve quality care for all ED patients.
- Emergency departments can improve suicide care for at-risk veterans. Identification of veteran status can allow for veterans affairs treatment after discharge. Additional education about mental health and suicide prevention should be provided to emergency clinicians, including using available VHA online education about veteran-specific suicide risk factors and community service providers.

Introduction

The 2022 Veterans Health Administration (VHA) Suicide Report continues to document an alarming rate of veteran suicide, with 16.8 veterans dying by suicide daily.¹ Given that the emergency department is often the first point of entry to health care after a suicide attempt, it would be beneficial for community providers to have knowledge of the characteristics, medical issues, and effective treatments most often associated with those having served in the military to ensure guideline concordant and quality suicide care.²

Studies investigating health care utilization among those who die by suicide within the general population reveal that many contacted a health care provider in the year before death,³⁻⁹ indicating a missed opportunity for screening and identification of risk. In addition, rural compared with urban veterans have increased suicide risk stemming from constraints on mental and physical health care access; lower quality of life; socioeconomic inequalities in income, education, and community resources; and increased firearm ownership.¹⁰⁻¹⁵ Individuals at risk of suicide may present for care in a variety of settings to include primary care clinics, social service agencies, urgent care, or the closest medical facility with an emergency department.^{16,17}

Current Joint Commission standards mandate that emergency departments screen patients at risk of suicide,¹⁸⁻²⁰ and thus, all health care providers in the emergency department, especially frontline workers such as nurses, should have knowledge of suicide screening.²¹⁻²³ Risk assessment and mitigation,²³ including lethal means counseling and the ability to develop a suicide safety plan, may also be helpful.^{2,18,24} Training all clinical staff in the emergency department provides an opportunity to discuss what broader systems are in place when a patient presents to the emergency department in crisis.²⁰ By all staff in training, it emphasizes how other services and professionals might be available to high-risk patients that nurses could consider triaging to. This qualitative pilot study aimed to assess real-world practices in rural community emergency departments in a southern state with a high rate of suicide. Our goal was to determine whether assessment of suicide risk and military service history among patients reporting suicidal ideations or attempts were common practices in this setting. We also aimed to explore the acceptability and

feasibility of community emergency departments referring at-risk veterans to mental health care at a VHA facility or other community organizations after discharge. Finally, this study explored policies and practices of emergency departments regarding suicide risk assessment, identification of military history, aftercare planning for patients with identified suicide risk, and tracking of aftercare.

Methods Study Design And Theoretical Framework

This study was a qualitative exploratory study design involving semistructured interviews with key informants (see below) and content analysis.²⁴⁻⁴⁰ Key informant interviews aimed to identify current clinical practices related to the care of suicidal patients and explore the acceptability, feasibility, and determinants of the use of a standardized suicide screening and risk assessment, identification of military history, and discharge and referral practices for continuity of care between community emergency departments and VHA facilities or other mental health organizations. The Consolidated Framework for Implementation Research, which outlines 5 theory-driven domains associated with implementation, informed qualitative key informant interview questions exploring determinants of suicide prevention practices.^{29,30} Ethical approval to conduct the study was attained from the Central Arkansas Veterans Health Care System Institutional Review Board. The Consolidated Criteria for Reporting Qualitative Research was used in the development of this manuscript.³¹

Selection Of Key Informants

This study used purposive sampling of clinicians working in community hospital emergency departments in rural counties with high rates of suicide deaths. Emergency clinicians, including physicians, nurses, social workers, and other health care providers, and administrators at 2 of 10 identified hospitals were sent a recruitment email by the research team and invited to participate. We conducted interviews with emergency clinicians recruited from these 2 hospitals before the COVID-19 pandemic. After a year-long delay owing to health care deployment and focus on the pandemic, we collaborated with our Arkansas Department of Health partners to send a recruitment email to the point of contacts for rural hospitals in Arkansas. Our inclusion criteria were community hospitals located in the top quartile of rural identified counties that had a high number of veterans and/or a high suicide rate in their service area. This secondary recruitment effort resulted in the addition of 3 hospitals, for a total of 5 hospitals in the study. The study spanned July 2019 to March 2021 with funding provided by the VHA.

Setting

The novelty of this work is two-fold: first, few contemporary studies have assessed suicide prevention practices in nonveteran emergency departments, and second, the geographic setting is understudied in regard to suicide. Arkansas (the study location where the study team is employed) is a rural state that is home to approximately 227,840 veterans, of which an estimated 114,261 (50.15%) are enrolled in Veterans Affairs (VA) health care.^{32,33} The justification for the study is also based on the state having a high rate of gun ownership and in 2019 ranked 14th nationally in suicide deaths, with 62.7% of suicide deaths in Arkansas involving a firearm and 70.6% of those were veterans.³²⁻³⁷

Personal Characteristics

The first author, a female who has a doctorate in counseling, conducted the interviews. She was employed by the VHA and completed postdoctoral training in mental health services research, completed a mentored suicide prevention research fellowship, and has conducted numerous qualitative studies using interviews. The senior member of the research team is a National Institute of Mental Health postdoctoral fellowship trainee in suicide research and has been a VHA social work researcher for nearly 20 years who provided guidance and feedback on this and other completed collaborative projects and manuscripts.

Relationship With Participants

A relationship was established between the first 2 study sites and the first author before study commencement owing to her work on a statewide initiative to integrate veterans into the state suicide prevention plan. The participants knew this background and the reasons for doing the research owing to the research team sharing the informed consent and study documents with the participants before participation as part of recruitment efforts. The interviewer's reasons for conducting this study were based on demographic knowledge of county-level suicide rates in the state of Arkansas, her home state, and the high rate of suicide in rural areas in this and other areas of the United States.

Data Collection Methods, Instruments, And Technologies

Eligible participants—those employed in an emergency department located in the state of Arkansas—were emailed a description of the study purpose and a copy of the previously pilot-tested interview questions, and an interview was scheduled. The semistructured interview guide focused on 6 categories: the practices and procedures emergency departments use in the (1) identification of military history, (2) assessment for suicidal ideation and suicide risk, (3) treatment/stabilization for reported suicidal crisis, and (4) aftercare instructions and referral practices; (5) perceptions of common suicide attempt methods among ED patients; and (6) recommendations about how to improve care for veterans reporting suicidal crisis (see ^{Table}). During the interview, the interviewer explained the study and conducted the interview. Interviews lasted approximately 30 minutes. There were no repeat interviews owing to technology challenges or returned transcripts of interviews or field notes for member checking.

Data Analysis

Each interview was audio recorded using Audacity for Windows version 3.0.0³⁸ and stored on a VHA secure server. Audio recordings were transcribed verbatim by administrative staff trained in transcription services. Transcripts were reviewed by the principal investigator, who is a doctorally trained clinical researcher with experience in qualitative methods, for completeness and accuracy. She corrected any errors or omissions before entry into Atlas.ti, version 7³⁹ a software program that facilitates management, coding, and analysis of narrative data. Two members of the study team who were trained in qualitative analysis read each interview and coded them independently to identify primary themes that emerged. Coding and saturation were discussed, and any discrepancies were identified and discussed until 100% agreement was met. Resulting themes were guided by the previously developed interview guide and discussed and approved by 2 additional doctoral-level investigators from the team who possess qualitative expertise to ensure there were no additional identified concerns.

Reporting

Criteria for assuring scientific rigor in qualitative research include consistency, reliability of coding, auditability, and validity.^{40–43} An audit trail was kept of the procedures, with all quotes identifiable. To assure consistency and mitigate bias, all interviews used the same broad opening and probing questions, and transcripts were monitored for problems such as drift or failing to probe for answers in enough detail to maximize the interview content. Participant quotations are presented to illustrate the major themes and findings, which were consistent.

Results

Participants included 10 clinicians, including 6 nurses (4 emergency nurses, 1 nurse case manager, and 1 nurse patient experience specialist), 2 social workers, 1 case worker, and 1 emergency physician employed in rural community hospitals in Arkansas.

Perceptions Of Suicide Attempt Method

All participants perceived that overdose was the most prominent method of suicide attempt among their ED patients. Most participants perceived the drugs used by most patients for the suicide attempt were drugs the patient obtained illegally. Other suicide attempt methods reported included cutting, hanging, and asphyxiation. No participant

mentioned firearms as a method used by patients for suicide attempts or mentioned lethal means counseling as an intervention. One participant said, "Usually if somebody attempts with a firearm, they are successful, honestly."

Setting, Intervention, And Individual Characteristics: Current Practices And Procedures Identification of a Patient's Military Service

Each of the 5 emergency departments identified veteran status only during administrative registration at triage and only for billing purposes. Emergency clinicians did not inquire about military service as part of clinical assessment or treatment practices. Veteran status was also not considered for treatment or for referral purposes. One participant indicated it is only discussed if the patient disclosed their veteran status voluntarily: "The only true time that would be assessed is when our ...insurance people go and talk to the patient and ...they tell them at that time they are a veteran or say if they have TRICARE or something like that." Another participant stated, "Point blank, we don't ask that question in the emergency department." Participants reported no identified barriers to asking about military history as it related to assessment and triage, and they consistently indicated the military service questions could be added to the triage questioning with relative ease if approved by the leadership of the facility. They also indicated that collecting these data could be facilitated through the electronic health record system.

Suicide Screening and Risk Assessment

Most participating emergency departments reported some procedure for identifying suicidal ideation among all patients presenting to the emergency department; however, one suggested that they asked questions about mental health more broadly but did not ask all patients about suicidal ideation. Although no participant was able to specify the exact suicide assessment instrument used, participants indicated that the questions generally asked whether the person had thought of harming themselves, and if so, they would be asked additional questions that would guide the plan for treatment. One participant described the assessment as, "Every time for every patient during triage, we ask if they feel like they want to hurt themselves. We ask if they have felt down, depressed, or hopeless. Do you have any thoughts of harming yourself? Do you have a plan? Have you recently thought about killing or harming yourself?" No participant was able to provide copies of assessment tools or exact wording of triage questions.

Treatment/Stabilization Process

All participating emergency departments described procedures to stabilize the patient in a separate, safe location, removing all potentially harmful objects, and monitoring to determine whether inpatient or outpatient services were warranted. Participants reported observation time varied based on the patient's intoxication level. If the individual was deemed to be at imminent suicide risk, they would be immediately referred to inpatient services. However, if intoxicated, the patient would be held in the emergency department until sober enough for the clinician to reassess. One participant said, "Half of them we see are intoxicated with other drugs onboard. The other half is just truly intoxicated with a blood alcohol level of 0.2 or 0.3 and say that they don't want to live anymore, whether that's associated with depression or alcohol.... We have to sober them back up and then reassess."

Aftercare Instructions and Referral Practices

Participants were asked to describe their aftercare instructions. If outpatient services were warranted, most participants said this was done by referral, with one institution providing a warm hand-off either by phone or online telehealth visit. One facility had an inpatient mental health unit, whereas others had to collaborate with other facilities that provided inpatient mental health care. Participants at one hospital mentioned a community mental health provider serving the catchment area that would either meet the patient at the hospital for further assessment or conduct the assessment using an online, face-to-face platform. One participant said, "The main thing we do is always contact [name of local counseling clinic]. We can also do video conferencing with them. They can talk to ...and interview the patient." Some participants said that a patient can be held at a critical care unit until an inpatient

facility was identified and a bed made available.

Three of the 5 participating emergency departments provide a resource document to the patient at discharge. Three emergency departments are using nonharm contracts with patients. Two of the participating emergency departments provide a follow-up call to the patient after discharge. Some participants discussed concerns for their facility's aftercare instructions, such as concerns about access to timely follow-up care. One participant said, I believe it says on the ER discharge paperwork, follow up within 3 to 5 days. A lot of times that's not physically possible. They can't actually get into a community behavioral health provider within that time frame. Either they can't get their insurance pre-approved, or they don't physically have an opening for those patients, especially here in rural Arkansas. So, our ideal is 3 to 5 business days, but I think probably the reality is more like 10 to 14 days.

This participant went on say, Fourteen days is not a feasible amount. It's not going to meet their needs. So, a reasonable amount of time where they could look forward to that tomorrow or the next day. And then in the very near future set up a longer appointment where we can visit. I feel like technology and that local connection, meeting them at their local VA clinic or whatever. It's kind of like a carrot of a thing, a face-to-face connection.

Another participant reported that when a patient indicates they are a veteran, are enrolled in care through the VHA, and are suicidal, a referral is made to the VHA, but placement in VA-supported community services is not always possible. The participant said, With some VA doctors, it's hard to get patients' home health. Those are some barriers with that. It takes a lot. Usually there's a call list. We'll call, get the person on the list. Most of the times we've done it, the patient ended up just staying here, and then was ready for discharge and we just discharged them. I don't think it's been really successful chance for us, but it is an option in case they needed it. It takes so many days that, at that point, they were already ready for discharge.

Implementation Process: Recommendations To Improve ED Care For All Suicidal Patients

In general, participants indicated a need to improve management and treatment of all patients with suicidal thoughts or attempts in the emergency department. Overall, reports from ED staff indicate they thought treatment options for suicidal behavior were limited compared with traditional procedures in the emergency department. Participants identified their roles being to provide emergency care for physical ailments and having limited, if any, training in mental health care. Participant comments were primarily within 2 target areas: staff training and education and engaging the community to support linkage and referral efforts.

Training and Education of Emergency Clinicians on Mental Health and Suicide Interventions

Participants recommended additional education about mental health, suicide risk factors, and suicide treatment options owing to the limited resources available in rural settings. One participant said, I want to get an in-service for my nurses over mental health.... Just some tactics about building rapport.... We're not mental health, but just to get some education because sometimes there is a day or 2 gaps where we have to take care of patients while waiting placement. Our techs and nurses would obviously benefit from anything to take better care of somebody who is going through a crisis.

Another participant commented how they were trained not to cross the line of providing mental health care but instead leaving that for the mental health professional. They said, Mental health is one of the biggest stigmas in the United States as we speak right now. No one knows what to do with it. Nobody knows when you can talk about it. I have nurses that struggle if somebody is suicidal, and I'm like, they already know they are suicidal. Let's build a rapport with them and treat them. There's just this stigma and this cloud that goes along with it. So, I do think that we would definitely benefit from getting involved, diving deep into our community.

Community Support Efforts for Linkage and Referral

Comments were made indicating disbelief that the health care system was going to solve the suicide crisis. One

participant suggested that veteran-serving organizations will need to collaborate to effectively link at-risk veterans to needed care, saying, "It's not going to be one organization that comes in and says, 'OK, we are pushing out mental health for veterans.'" It's not going to be just the VA.... It's going to be a collaboration to kick it off, and it will be tough.... We are not mental health. We don't have a mental health facility at [town name], so the biggest thing would have to be in a collaboration effort with organizations to push out and work together to figure out what this community would need, what our weaknesses are, and how to best serve them.

In addition to recommending improved access to mental health services in the emergency department and collaboration among veteran-serving organizations in the community, participants recommended the development and promotion of web resources, including telehealth, websites, chatrooms, and online support, that link veterans in suicidal crisis to health care services, resources, and peer support. In addition, several comments were made about the need to develop and promote community services for treatment and postdischarge support. This included linking those experiencing suicidal thoughts to community resources, support groups, and other people with similar experiences. One participant said, "If they feel alone in the things that they go through, as a health professional, I cannot understand. I was not in a war zone. I can't imagine what they have seen. I can't imagine what they have gone through and all of the trauma that has taken place. My perspective in the things we are lacking, it doesn't necessarily start in our ED, but in this community. They don't need to feel alone. They don't need to feel like they can't talk about it. Or, they need to be surrounded by people that understand what they've gone through and can help them and that is the safe place."

This participant went on to say, "These people feel like they have got no help. We could identify them all day long, but pushing them off to the next thing, if you don't have a community-based resource where you have people who have walked through that. I have a friend who, her husband dealt with (posttraumatic stress disorder), and he helped veterans with the same thing around the world and travels. I think that's what we need, because I don't think our health care system is ever going to be able to address that. But I think if we individualize the problem and make it community based, I think that would help.... Build that community around the veterans and what they are going through."

Participants also recommended improving veteran-centric care and support by welcoming veterans from the community to volunteer by assisting other veterans who were seeking care in that facility. One hospital reported current discussions on improving veteran awareness and support among providers to include magnets on the doors of identified veterans so that staff would know about their military service, as well as instituting a veteran ambassador program where identified veterans would receive a visit each day from a veteran ambassador. This would be an opportunity to learn more about any concerns or needs of the veteran and the potential for linkage to resources. Although the participant indicated there were veterans interested in establishing the program, identified barriers included facility buy-in and commitment to build the infrastructure needed to promote and sustain efforts.

Discussion

This study is novel in that it documents the variability in management practices of patients with suicide ideation in rural Arkansas emergency departments, as well as the lack of assessment and referral practices related to identifying military history, suicide risk, and postdischarge aftercare of patients admitted to community emergency departments serving rural Arkansas. Although all hospitals assessed veteran status for billing purposes, this was not a characteristic used in assessing, treating, or planning aftercare of patients. Participants recommended identifying military history as part of assessment practices for diagnosis and treatment, recognizing the importance of using this information in aftercare planning to promote continuity of care and connection with veteran-specific mental health services, and believed this would be possible at their hospital if presented to and approved by hospital

administration. Finally, participants in this study identified many implications for improvements that could be made in the areas of suicide care education and involving the community for support.

Our findings highlight the need to educate all emergency clinicians, including nurses, social workers, and physicians, about suicide risk, suicide prevention interventions, lethal means counseling, and mental health broadly, as well as about risk factors and services specific to veterans. The VHA currently provides training for clinical and nonclinical staff about suicide and how to assist people experiencing warning signs for suicide, and the online ICAR^{2E}⁴⁴ tool was created by the American College of Emergency Physicians and the American Foundation for Suicide Prevention for civilian patients at risk of suicide. However, clinicians in this study were unaware of these resources. Findings from this study suggest that all emergency clinicians might benefit from these resources to better manage suicidal patients in general and to coordinate available services and care within the broader health care environment. Another finding is that collaboration with veteran-serving organizations might better link at-risk veterans to needed care from existing community services and resources, as well as providing more services that promote these connections to veteran-specific services.

Limitations

One limitation of this study was the extended time frame and changes to recruitment for the project owing to the coronavirus disease 2019 pandemic. Some ED staff responded to recruitment emails reporting inability to participate owing to the competing demands on their time owing to the pandemic. Potential sample bias may be caused by the recruitment modification using a snowball approach seeking participants from any rural hospital in the state and limiting the sample owing to budget and timeline restrictions, yet there was great consistency in the responses received from the 10 participants, and unless specified, we only reported findings consistently reported by at least 8 participants. A second limitation is that responses about policies and procedures are only the opinions of the participants. Each interview ended with a request to receive a copy of the facilities policies and procedures for treating suicidal patients in the emergency department. Although many indicated they would send the documents, none were received. Additional methods and resources for collecting this information may be needed in future studies.

Implications for Emergency Nurses

Many clinicians noted practices that are at odds with current best practices for managing ED patients at risk of suicide.^{45–48} Three of the participating emergency departments in this study disclosed that they are using nonharm contracts with patients at risk of suicide—a practice that is no longer recommended by suicide prevention organizations, given that it does not protect the clinician against subsequent malpractice claims and may unethically restrict a patient's choices when they may be already struggling for control.⁴⁹ Despite evidence about the efficacy of safety planning,^{50,51} lethal means counseling,^{52,53} and postdischarge caring contacts,⁵⁴ no emergency department in our study reported use of these as part of a routine clinical practice. Training on suicide prevention interventions,⁵⁵ such as safety planning, coupled with stabilization and medication management, as indicated in the VA/Department of Defense CPG for the Assessment and Management of Patients at Risk for Suicide (<https://www.healthquality.va.gov/guidelines/MH/srb/>), could potentially improve care for ED patients and promote safety in the time between ED discharge and follow-up.

Other recommendations for emergency departments to include in veteran-specific assessments include screening for posttraumatic stress disorder (PTSD).⁵⁶ The VA/Department of Defense CPG for PTSD and Acute Stress Disorder (<https://www.healthquality.va.gov/guidelines/MH/ptsd/>)⁵⁷ recommend screening for comorbid conditions such as PTSD when evaluating a patient's suicide risk. In the nonmilitary population, approximately 6% to 7% of adults experience PTSD; however, in the veteran population in 2016, the VHA reported 10.6% of veterans had a

diagnosis of PTSD. In veterans who served in Afghanistan and/or Iraq, 26.7% had a diagnosis of PTSD. Because the veteran’s medical history may not be available in the emergency department, additional screening using the Primary Care PTSD Screen for DSM-5⁵⁸ and the PTSD Checklist for DSM-5⁵⁹ may be warranted.

Conclusion

Findings from this study indicate that participating ED providers assessed for suicidal ideation within ED settings, but the staff did not always feel confident in their knowledge of suicide and how to intervene. In addition, military history, which confers increased suicide risk, was not taken into consideration for treatment and referral, nor were veterans linked back to treatment at the VA, which uses evidence-based interventions such as safety planning, lethal means safety education, and postdischarge caring contacts. These suicide prevention strategies, which are unavailable in many community emergency departments, have been shown to reduce suicide mortality. Identification of veteran status in the emergency department can potentially improve connections to VA care, thereby increasing the potential for suicidal veterans to receive evidence-based interventions in VA settings after ED discharge. Although further investigation using a larger sample is warranted, findings suggest a need for all emergency clinicians, especially emergency nurses who are on the front lines, to have educational opportunities to learn about issues commonly reported by those with military service history, such as suicide risk, and interventions for suicide in the emergency department and veteran-specific health care services and resources.

Author Disclosures

Conflicts of interest: none.

This work was supported by the Department of Veterans Affairs Health Services Research and Development Award #PPO-18-278. The Central Arkansas Veterans Health Care System, North Little Rock, AR, provided infrastructure and resources. The results described are based on data analyzed by the authors. The views expressed in this article are those of the authors and do not necessarily represent the views of the United States government, Department of Veterans Affairs, Veterans Health Administration, universities, or other affiliates.

Data are stored, monitored, and available per the Central Arkansas Veterans Health Care System Institutional Review Board guidelines.

Acknowledgments

The authors thank the participants for their contributions to this study.

CFIR domain	Example interview questions
Intervention characteristics	What kinds of changes or alterations do you think you will need to make to identify military history, assess for suicide risk, refer Veterans for mental health treatment, and track aftercare? Are these practices acceptable and feasible within your emergency department?

Inner setting	Would your emergency department assess for suicide risk of ED patients? Would your ED ask about military service history or Veteran status? How well does this inquiry fit into your existing practices? How do you think your organization's culture (general beliefs, values, assumptions that people embrace) will affect whether and how these questions are asked? What are the discharge practices for patients reporting suicide risk? What tracking or follow-up practices does your emergency department use for patients reporting suicide risk?
Outer setting	How well do you think these procedures will meet the needs of the individuals served by your hospital? How do you think the individuals served will respond to these procedures?
Characteristics of individuals	On a scale from 1 to 10, how confident are you that you will be able to successfully implement the inquiry of military history, provide veteran-specific referrals at discharge, and provide follow-up to discharge suggestions? What gives you that level of confidence (or lack of confidence)? Would each of these practices be acceptable to and feasible for you in your practice?
Implementation process	Who would need to be engaged to implement identification and tracking of veterans at risk of suicide? What costs would be incurred to implement the practices described? Would each of these practices be acceptable and feasible within your ED system?

DETAILS

Subject: Emergency medical care; Veterans; After care; Content analysis; Risk assessment; Suicide; Community hospitals; Emergency services; Best practice; Quality of care; Interviews; Nurses; Medical referrals; Military history; Health care; Feasibility; Prevention; Pandemics; Rural communities; Brief interventions; Rural areas; Mental health; Departments; Qualitative research; Firearms; Scholarships & fellowships; Suicides & suicide attempts; Continuity of care

Business indexing term: Subject: Risk assessment

Location: Arkansas; United States--US

Identifier / keyword: Suicide; Emergency departments; Critical care; Veteran; Treatment; Continuity of care

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 2

Pages: 255-265

Publication year:	2023
Publication date:	Mar 2023
Section:	Research
Publisher:	Elsevier Limited
Place of publication:	Philadelphia
Country of publication:	United Kingdom, Philadelphia
Publication subject:	Medical Sciences--Nurses And Nursing
ISSN:	00991767
e-ISSN:	15272966
Source type:	Scholarly Journal
Language of publication:	English
Document type:	Journal Article
DOI:	https://doi.org/10.1016/j.jen.2022.12.004
ProQuest document ID:	2781603668
Document URL:	https://www.proquest.com/scholarly-journals/emergency-departments-treating-veterans-suicide/docview/2781603668/se-2?accountid=211160
Copyright:	Copyright Elsevier Limited Mar 2023
Last updated:	2023-08-01
Database:	Public Health Database

Document 50 of 50

The Uncanny Camaraderie Among Emergency Nurses: JEN

[ProQuest document link](#)

FULL TEXT

Camaraderie is defined as a mutual trust and friendship among people who spend a lot of time together (sounds like a bunch of emergency nurses, right?). I absolutely love the camaraderie that I have experienced—and continue to experience—over the years with my fellow emergency nurses!

Trust must be earned with this camaraderie, and trust is an incredible asset among emergency nurses. When your coworkers trust you, you have reached the highest pinnacle of professional success. Value this attribute, for it's not easily attained. I need to be able to trust a nurse I'm closely working with. When you think about it, we often spend more time with our coworkers than with our own family—especially during the many holidays we are required to work. Emergency Nurses Association (ENA) members have worked side by side with their own coworkers for many, many years. Emergency nursing is one of the few professions where we have nurses from every generation working side by side. In a term of endearment, we have many “work daughters” or “work sons” that we have helped to orient and mentor. Although in recent years, the tenure in emergency nursing has certainly changed, that dynamic synchrony of an experienced weekend crew or our awesome night shift staff can never be forgotten! How many of us are guilty, when asked to pick up a shift, of checking the schedule first before delivering an answer to see who is working? If it's a good crew—sign me up! Generally, most of us enjoy being busy in the emergency department. During those busy times, there's a certain positive flow and energy that is palpable, and it somehow fuels our soul. And yet, those days when it is literally out of control as you hit the ground running, it can absolutely drain us like nothing else! Verbalizing “we can do this” or “we've got this today” can go a long way. We are all willing to work hard along with somebody. It's a little more frustrating to work for somebody when they're not showing the same amount of effort. After a quick report, we often look around to see “Who are my people today? Who's got my back? Who will help me when I don't even ask for help (but they can tell I need help by the look on my face)?” We've all worked with another nurse who never asks for help, and if they ever do, we know they're drowning!

Or there may be a situation when you suddenly hear a coworker start to use a louder or different tone of voice, either in speaking to a family or in asking for help, and you know it's “all hands on deck” right now! But there's also that feeling you get when you see a fellow emergency nurse getting stressed over a patient's changing condition. You immediately know that if they are stressed, everybody should be too! In camaraderie, nonverbal communication can be at an all-time high. A slight eye roll, a head nod (or shake), and a certain physical posturing can speak volumes to our coworkers! We tend to read our coworkers like a book!

With camaraderie comes wisdom. We can tell immediately when a coworker is troubled or stressed, especially if it's beyond the work environment. A tenured coworker automatically pitches in and helps, as the unspoken support is what's needed most. And a thank you from the recipient is never expected; it's just what we do to help each other. In addition, we also have a unique camaraderie and familiarity with our physicians and providers, unlike any other area of nursing. We work alongside them 24/7—think about that. They know us and we know them—their quirks, their strengths, and their weaknesses. Those providers know when an experienced nurse comes to them expressing concern about a patient, they had better listen up! We tend not to ever “cry wolf!”

This camaraderie carries over into our ENA work. It's very gratifying to see our members from around the world bond immediately at a conference, during a committee meeting, or at a local chapter meeting. We connect at a level that is often difficult to explain to someone outside the emergency nursing profession.

Cherish this camaraderie. I hope it inspires you as an emergency nurse. Nurture it and build on it. It's what great teams are made of, and I'm so glad we have you on our ENA team!

Author Disclosure

Conflicts of interest: none to report.

DETAILS

Subject: Emergency medical care; Nurses; Emergency services; Nursing; Work environment; Professional relationships; Teamwork

Business indexing term: Subject: Work environment Professional relationships Teamwork

Publication title: Journal of Emergency Nursing;; JEN; Philadelphia

Volume: 49

Issue: 2

Pages: 151-152

Publication year: 2023

Publication date: Mar 2023

Section: President's Message

Publisher: Elsevier Limited

Place of publication: Philadelphia

Country of publication: United Kingdom, Philadelphia

Publication subject: Medical Sciences--Nurses And Nursing

ISSN: 00991767

e-ISSN: 15272966

Source type: Scholarly Journal

Language of publication: English

Document type: Commentary

DOI: <https://doi.org/10.1016/j.jen.2022.12.010>

ProQuest document ID: 2781603662

Document URL: <https://www.proquest.com/scholarly-journals/uncanny-camaraderie-among-emergency-nurses/docview/2781603662/se-2?accountid=211160>

Copyright: Copyright Elsevier Limited Mar 2023

Last updated: 2023-03-07

Database: Public Health Database

Bibliography

Citation style: APA 6th - Annotated with Abstracts - American Psychological Association, 6th Edition

Predicting workplace violence in the emergency department based on electronic health record data: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 415-424. doi:<https://doi.org/10.1016/j.jen.2023.01.010>

IntroductionEmergency departments are extremely vulnerable to workplace violence, and emergency nurses are frequently exposed to workplace violence. We developed workplace violence prediction models using machine learning methods based on data from electronic health records.**Methods**This study was conducted using electronic health record data collected between January 1, 2016 and December 31, 2021. Workplace violence cases were identified based on violence-related mentions in nursing records. Workplace violence was predicted using various factors related to emergency department visit and stay.**Results**The dataset included 1215 workplace violence cases and 6044 nonviolence cases. Random Forest showed the best performance among the algorithms adopted in this study. Workplace violence was predicted with higher accuracy when both ED visit and ED stay factors were used as predictors (0.90, 95% confidence interval 0.898-0.912) than when only ED visit factors were used. When both ED visit and ED stay factors were included for prediction, the strongest predictor of risk of WPV was patient dissatisfaction, followed by high average daily length of stay, high daily number of patients, and symptoms of psychiatric disorders.**Discussion**This study showed that workplace violence could be predicted with previous data regarding ED visits and stays documented in electronic health records. Timely prediction and mitigation of workplace violence could improve the safety of emergency nurses and the quality of nursing care. To prevent workplace violence, emergency nurses must recognize and continuously observe the risk factors for workplace violence from admission to discharge.

Staff duress alarms for workplace violence in the emergency department: A mixed-methods evaluation: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 387-394. doi:<https://doi.org/10.1016/j.jen.2023.01.008>

IntroductionComplex personal duress alarms may be implemented as part of a multicomponent approach to preventing and mitigating workplace violence in emergency departments. Evaluation of duress alarms after implementation has been identified as a gap in the literature. The purpose of this quality improvement project was to examine the impact of a duress alarm system on workplace violence and user experience in an urban emergency department.**Methods**A comprehensive system evaluation was performed using a mixed-methods approach, which included retrospective data review, key informant interviews, observations, and a survey. Forty clinical staff at an emergency department in North Carolina were interviewed and provided feedback on the duress system.**Results**Findings indicated that the duress system was not associated with a decrease in workplace violence, and that the majority of clinical staff did not even wear the duress alarm. Staff indicated that the primary barriers to use of the alarm were the bulky design of the alarm badge, inadequate education about the alarm device and process, and the lack of a reliable and timely response from security.**Discussion**Ongoing engagement of clinical staff is critical to the success of health care technology implementations. Staff feedback, periodic re-education, and recurring process evaluations are vital to ensuring the continued relevance of systems, especially when staff safety is the intended purpose.

Editorial board: JEN. (2023). *Journal of Emergency Nursing*, 49(3) doi:[https://doi.org/10.1016/S0099-1767\(23\)00069-7](https://doi.org/10.1016/S0099-1767(23)00069-7)

ENA advocacy efforts and the state of play regarding workplace violence: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 309. doi:<https://doi.org/10.1016/j.jen.2023.02.004>

Workplace violence in the hospital: Strategies for meaningful change: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 345-351. doi:<https://doi.org/10.1016/j.jen.2023.01.005>

BackgroundWorkplace violence is not a unique problem to organizations. Evidence-based toolkits and strategies are available to help provide a guiding framework for the reduction of workplace violence events. As times and stressors (both personal and environmental) change, hospitals must keep constant attention on how to address and

implement initiatives to keep staff safe. This manuscript addresses steps taken at 1 hospital to meet this challenge. Although a workplace violence committee had been in place for some time, it was identified that not all of the key players were included. Membership was evaluated, and executive-level support was provided. A review of literature was conducted and identified top priorities upon which to focus efforts. Subcommittees were formed to be responsible for these categories of work and to report back to the committee. Data points and a dashboard were created to monitor trends and effectiveness, especially regarding combating the culture of underreporting. Processes and resources were formalized and made easily accessible to staff. Case studies and direct feedback from staff have been impactful and helped identify additional barriers. Evaluation will continue to occur using process-improvement methodology along with technological assistance. Workplace violence is not part of the job. Ongoing work is needed to continue to move the needle and make hospitals a safer place to work. Engagement from all levels of the organization is necessary to have a successful program.

Nurse, provider, and emergency department technician: Perceptions and experiences of violence and aggression in the emergency department: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 431-440.

doi:<https://doi.org/10.1016/j.jen.2022.07.008>

Introduction Patient/visitor violence and aggression (V&A) in the emergency department occurs daily. Few interventions exist to decrease V&A. Research describing prevalence, severity, and perceived safety among ED clinicians is limited. Methods A descriptive survey explored V&A against ED clinicians in one urban emergency department. A sample of nurses, ED technicians, physicians and advanced practice providers participated. Participants completed a demographic survey, Personal Workplace Safety Instrument for Emergency Nurses (PWSI-EN), and ENA V&A frequency checklist. Analysis of Variance (ANOVA) for unadjusted and Analysis of Covariance (ANCOVA) for adjusted associations were used to assess differences in the PWSI-EN survey composite score and "feeling safe in the ED" among ED roles. ANCOVA was adjusted for potential confounders: sex, race, years working in emergency department, and shift worked. Results Sixty-five (46.4%) of the 140 ED clinicians returned surveys, which were almost evenly distributed between ED clinician roles and sex. Mean age was 37.2 (range: 21-64) years. All (100%) nurses and providers reported being verbally abused. More nurses reported physical violence (n = 21, 87.5%) than providers (n = 7, 36.8%) and ED technicians (n = 11, 55%). Nurses and ED technicians reported experiencing greater prevalence of physical violence than providers (P < .05). Nurses (mean 3.29, range 2.95 to 3.63) were more fearful for their personal safety than ED technicians (mean 3.88, range 3.48 to 4.28) (P < .03). Discussion V&A are common creating a fearful environment. However, little research regarding clinician perceptions exists. Our study aids in identifying areas for clinician-targeted strategies to prevent ED V&A.

Pharmacologic therapy to mitigate acute agitation in the emergency department: Case reports of diverse patient presentations: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 336-340.

doi:<https://doi.org/10.1016/j.jen.2022.12.005>

Nurses in the emergency department often encounter patients exhibiting signs of aggressive behavior. Nurses need to know the pharmacologic treatment appropriate for the patient scenario to ensure safety for the patient and the emergency department team. This case review examines 4 common scenarios where a patient exhibits aggressive behavior. After each case review is a discussion about the appropriate pharmacologic therapy for that patient. The cases portrayed are fictional but based on experience and previous observations.

Board of directors: JEN. (2023). *Journal of Emergency Nursing*, 49(3) doi:[https://doi.org/10.1016/S0099-1767\(23\)00070-3](https://doi.org/10.1016/S0099-1767(23)00070-3)

Implementation of a behavioral emergency response team in the emergency department: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 395-402. doi:<https://doi.org/10.1016/j.jen.2023.01.011>

Introduction Emergency nurses, physicians, and patients experience occurrences of workplace violence. Having a team to respond to escalating behavioral events provides a consistent approach to reducing occurrences of workplace violence and increasing safety. The purpose of this quality improvement project was to design, implement, and evaluate the effectiveness of a behavioral emergency response team in an emergency department

to reduce occurrences of workplace violence and increase the perception of safety. **Methods** A quality improvement design was used. The behavioral emergency response team protocol was created using evidenced-based protocols that have been shown to be effective in reducing the number of occurrences of workplace violence. Emergency nurses, patient support technicians, security personnel, and a behavioral assessment and referral team were trained in the behavioral emergency response team protocol. Data on occurrences of workplace violence were collected from March 2022 to November 2022. Postbehavioral emergency response team debriefings were conducted, and real-time education was provided after implementation. Survey data were collected to evaluate the emergency team members' perceptions of safety and of the effectiveness of the behavioral emergency response team protocol. Descriptive statistics were calculated. **Results** The number of reported occurrences of workplace violence decreased by to 0 postimplementation of the behavioral emergency response team protocol. The perception of safety increased 36.5% postimplementation (mean 2.2 preimplementation, mean 3.0 postimplementation). In addition, an increase in awareness about reporting occurrences of workplace violence resulted from education and implementation of the behavioral emergency response team protocol. **Conclusion** Postimplementation, participants reported an increase in the perception of safety. Implementation of a behavioral emergency response team was effective in reducing assaults toward emergency department team members and increasing the perception of safety.

Violence risk assessment in the emergency department: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 352-359.e1. doi:<https://doi.org/10.1016/j.jen.2023.02.006>

Introduction Workplace violence is a prevalent problem in health care, with mental health and emergency departments being the most at-risk settings. The aim of this evidence-based practice project was to pilot use of a violence risk assessment tool, the Broset Violence Checklist, to assess for risk of type II violence and record the interventions that nurses chose to implement to mitigate the situation. Additionally, reports made to the hospital reporting system were tracked and compared to previous reporting frequency. **Methods** Following staff education, nurses were instructed to complete checklists for all patients who have a score of 1 or higher, which indicates the presence of at least 1 high-risk behavior, and continue hourly scoring until the score returned to 0 or the patient was dispositioned. The number of incidents recorded, time of day, scores, interventions applied to mitigate violence, and change in scores after interventions were evaluated. The number of Broset Violence Checklist scoring sheets submitted and reports made via the hospital reporting system were compared. **Results** Incidents were most frequent from 11 am until 3 am. The highest scores occurred in the late evening and early morning hours. There were significantly more incidents captured with the use of the Broset Violence Checklist as compared to the hospital reporting system. Incidents significantly associated with higher scores included providing comfort measures, addressing concerns, and applying restraints. **Discussion** The Broset Violence Checklist was used successfully in the emergency department setting to identify behaviors associated with violence. Under-reporting to the hospital report system was identified in this project, consistent with reports in the literature. Specific interventions were not associated with a decrease in Broset Violence Checklist scores.

Effects of emergency nurses' experiences of violence, resilience, and nursing work environment on turnover intention: A cross-sectional survey: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 461-469. doi:<https://doi.org/10.1016/j.jen.2022.10.001>

Introduction Emergency nurses are vulnerable to violence, because they closely face patients or caregivers in emergency situations, where tension and conflicts are heightened. This is known to increase their turnover intentions. This study aimed to analyze the effects of emergency nurses' experiences of violence, resilience, and nursing work environment on turnover intentions. **Methods** This descriptive study analyzed a questionnaire administered to emergency nurses from March 2020 to April 2020. Its participants included 100 emergency nurses from 4 emergency medical centers. The collected data were analyzed using the SPSS/WIN 25.0 program (IBM SPSS Statistics) by frequency, percentage, mean, SD, t test, analysis of variance, and multiple regression. **Results** The main factors affecting the turnover intentions of emergency nurses were resilience ($\beta = -0.32$, $P = .003$), frequency of violence by patients ($\beta = 0.27$, $P = .003$), and nursing managers' leadership and support for nurses ($\beta = -0.25$, $P = .021$). The explanatory power of these 3 variables was 29.3%. **Discussion** To reduce emergency nurses' turnover intentions, it may be necessary to conduct resilience programs for them. In addition,

safety measures to prevent violence at the organizational level and improve nursing managers' abilities, leadership, and support for nurses can reduce nurses' intention to leave.

Table of contents: JEN. (2023). *Journal of Emergency Nursing*, 49(3), A3-A5. doi:[https://doi.org/10.1016/S0099-1767\(23\)00068-5](https://doi.org/10.1016/S0099-1767(23)00068-5)

Workplace violence: Raising awareness and bridging the gap with law enforcement: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 317-318. doi:<https://doi.org/10.1016/j.jen.2023.02.003>

Agitated geriatric patients and violence in the workplace: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 320-325. doi:<https://doi.org/10.1016/j.jen.2022.12.009>

Older adults may suddenly exhibit behaviors that are viewed as noncompliant, noncooperative, and threatening. They may even lash out verbally and physically causing injury to health care staff. In addition to taking actions that prevent harm to the staff and the patient, determining what caused this behavior (dementia vs delirium or other cases) will be critical, as well as debriefing the staff after the incident.

Exposure of emergency nurses to workplace violence and their coping strategies: A cross-sectional design: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 441-449. doi:<https://doi.org/10.1016/j.jen.2022.09.002>

IntroductionViolence against nurses working in the emergency department is a serious problem worldwide.**Methods**This descriptive study used a participant questionnaire and was conducted in-person, using semi-structured interviews with 120 emergency nurses (69 female, 51 male) working in the emergency department between September 1 and November 30, 2017.**Results**Overall, 90% of the study participants were exposed to workplace violence at least once while working in the emergency department, and 94.4% experienced verbal abuse, including insults, shouting, threats, and swearing. Most of such workplace violence came from the patients relatives. Most workplace violence incidents occurred during the 4 pm to midnight time slot and in the triage area. The most important perceived reasons for workplace violence were the long waiting period for treatment and care (79.6%) and not being prioritized for treatment (68.5%). The top 3 coping methods used were reporting to the nurse in charge (78.1%), followed by reaching out to the security personnel (72.8%) and filing lawsuits if exposed to physical violence (65.8%).**Conclusions**Most emergency nurses had experienced workplace violence. Hospital administration should take more effective security measures, hospitals should provide education and training programs for dealing with workplace violence, and programs to support staff members on encountering workplace violence should be implemented.

Why Won't it stop: Workplace violence in emergency care: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 310-316. doi:<https://doi.org/10.1016/j.jen.2023.02.001>

Screening for behavioral health patient aggression in emergency departments to reduce workplace violence: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 403-414. doi:<https://doi.org/10.1016/j.jen.2022.09.010>

IntroductionPatient violence in health care facilities occurs daily. Structured risk assessments, when regularly completed, have been effective in prompting interventions to reduce aggression in Behavioral Health (BH) settings.**Methods**This quasi-experimental study evaluated the effectiveness of the Dynamic Appraisal of Situational Aggression – Inpatient Version (DASA) validated screening tool to reduce aggressive outbursts in an emergency department (ED) setting with BH patients awaiting transfer to a psychiatric facility. The tool was used in 4 non-psychiatric EDs from a large health care system. Chart audits were completed to record initial patient DASA scores observed at triage and at subsequent intervals during the ED encounter. ED staff documented interventions used for patients. Inclusion criteria included adults 21 years and older following a telepsychiatry consultation with a recommendation for BH inpatient admission. Pre-/post-implementation aggressive events were collected to assess ED DASA use. DASA scores from BH ED patients were examined to increase understanding of patient utilization. Staff workplace safety was examined to compare staff safety perception pre- and post-DASA implementation.**Results**Violent events were reported statistically significantly higher post-DASA implementation.

There was an increased risk of elevated DASA scores for specific diagnoses and genders. An increased awareness of the importance of reporting workplace violence improved documentation. Discussion Using an evidence-based screening tool helped identify BH patients with behaviors associated with aggressive ED events. Proactive use of interventions, including use of Comfort Cart items, de-escalation, and prescribed medications, can positively influence reduction of risk from aggressive behaviors within BH patient populations in EDs.

Introducing a digital occupational violence risk assessment tool into an emergency department: A pilot implementation study: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 360-370. doi:<https://doi.org/10.1016/j.jen.2023.01.007>

Introduction Occupational violence in emergency departments is prevalent and detrimental to staff and health services. There is an urgent call for solutions; accordingly, this study describes the implementation and early impacts of the digital Queensland Occupational Violence Patient Risk Assessment Tool (kwov-pro). Methods Since December 7, 2021, emergency nurses have been using the Queensland Occupational Violence Patient Risk Assessment Tool to assess 3 occupational violence risk factors in patients: aggression history, behaviors, and clinical presentation. Violence risk then is categorized as low (0 risk factors), moderate (1 risk factor), or high (2-3 risk factors). An important feature of this digital innovation is the alert and flagging system for high-risk patients. Underpinned by the Implementation Strategies for Evidence-Based Practice Guide, from November 2021 to March 2022 we progressively mobilized a range of strategies, including e-learning, implementation drivers, and regular communications. Early impacts measured were the percentage of nurses who completed their e-learning, the proportion of patients assessed using the Queensland Occupational Violence Patient Risk Assessment Tool, and the number of reported violent incidents in the emergency department. Results Overall, 149 of 195 (76%) of emergency nurses completed their e-learning. Further, adherence to Queensland Occupational Violence Patient Risk Assessment Tool was good, with 65% of patients assessed for risk of violence at least once. Since implementing the Queensland Occupational Violence Patient Risk Assessment Tool, there has been a progressive decrease in violent incidents reported in the emergency department. Discussion Using a combination of strategies, the Queensland Occupational Violence Patient Risk Assessment Tool was successfully implemented in the emergency department with the indication that it could reduce the number of incidents of occupational violence. The work herein provides a foundation for future translation and robust evaluation of the Queensland Occupational Violence Patient Risk Assessment Tool in emergency departments.

Researching workplace violence: Challenges for emergency nursing researchers: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 330-332. doi:<https://doi.org/10.1016/j.jen.2023.01.004>

Qualitative analysis of workplace assault outcomes from the perspectives of emergency nurses: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 450-460. doi:<https://doi.org/10.1016/j.jen.2022.09.015>

Introduction Emergency nurses experience a myriad of negative consequences associated with workplace assault. The purpose of this study was to explore the experiences of emergency nurses using the Ecological Occupational Health Model of Workplace Assault. Methods A descriptive qualitative design was used for this study. Data from 167 emergency nurse participants who described an episode of workplace assault were analyzed using a conventional content analysis method. Results Fourteen codes emerged from the qualitative data that related to 4 categories for the theme, Outcomes of Workplace Assault. The category "Consequences of Assault to Patients and Visitors" was supported by the following codes: use of limit setting; being evicted or removed from the emergency department; having charges pressed or being arrested; use of restraints; and retaliation against aggressor. "Effects on the Worker" was supported by the following codes: physical outcomes and response; psychological outcomes and response; physical support from peers; apologies; and debriefing/supportive care. "Effects on the Workplace" was supported by the following codes: calling for and response by police or security; and visitor response, support, or assistance. "Effects on Patient Care" was supported by the following codes: impact to treatment and work productivity. Discussion Workplace assault in the ED setting is associated with consequences of workplace assault to patients and visitors as well as negative effects to emergency nurses, the workplace, and patient care. Emergency nurses need to seek and also offer emotional support after workplace assault. Providing support could serve as a

deterrent to retaliation while minimizing potential adverse impacts to nurses' psychological health and work productivity.

Mental health and harassment in the workplace: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 341-344. doi:<https://doi.org/10.1016/j.jen.2022.09.011>

Harassment in the workplace has become all too common in today's society. Acts of uncivil behavior and bullying create stressful and difficult working environments. Individuals or groups are targeted without legitimate cause, thus creating feelings of stress, fear, anger, and anxiety that can affect mental health. Fear of speaking up owing to retaliation allows the uncivil behavior to continue. Emergency nurses should take action to stop the behavior and may need to seek professional help for mental health care.

Workplace violence emergency nursing review questions: May 2023: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 333-335. doi:<https://doi.org/10.1016/j.jen.2023.01.003>

A systematic review of violence risk assessment tools currently used in emergency care settings: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 371-386.e5. doi:<https://doi.org/10.1016/j.jen.2022.11.006>

Introduction Violence risk assessment is commonplace in mental health settings and is gradually being used in emergency care. The aim of this review was to explore the efficacy of undertaking violence risk assessment in reducing patient violence and to identify which tool(s), if any, are best placed to do so. Methods CINAHL, Embase, Medline, and Web of Science database searches were supplemented with a search of Google Scholar. Risk of bias assessments were made for intervention studies, and the quality of tool development/testing studies was assessed against scale development criteria. Narrative synthesis was undertaken. Results Eight studies were included. Three existing violence risk assessment tools featured across the studies, all of which were developed for use with mental health patients. Three newly developed tools were developed for emergency care, and 1 additional tool was an adaptation of an extant tool. Where tested, the tools demonstrated that they were able to predict patient violence, but did not reduce restraint use. The quality issues of the studies are a significant limitation and highlight the need for additional research in this area. Discussion There is a paucity of high-quality evidence evaluating the psychometric properties of violence risk assessment tools currently used along the emergency care pathway. Multiple tools exist, and they could have a role in reducing violence in emergency care. However, the limited testing of their psychometric properties, acceptability, feasibility, and usability in emergency care means that it is not possible to favor one tool over another until further research is conducted.

Information for readers: JEN. (2023). *Journal of Emergency Nursing*, 49(3) doi:[https://doi.org/10.1016/S0099-1767\(23\)00071-5](https://doi.org/10.1016/S0099-1767(23)00071-5)

Addressing a key leadership challenge: Workplace violence: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 326-329. doi:<https://doi.org/10.1016/j.jen.2023.01.001>

Workplace violence is a growing concern among health care workers, especially staff working in emergency departments. Emergency department leaders have oversight accountability that includes mitigation of workplace violence risks and staff education related to workplace violence prevention. Challenges associated with workplace violence events include disruption of safe patient care, decreased staff job satisfaction, and increased turnover. Improving safety for staff, patients, and visitors requires a culture focused on safety. A summary of current regulations, standards, and resources available to date is provided, including a list of mitigation strategies that can be easily translated into practice by emergency nurse leaders.

Providing peer support after workplace violence: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 319. doi:<https://doi.org/10.1016/j.jen.2023.01.012>

The lived experience of workplace violence among emergency nurses: JEN. (2023). *Journal of Emergency Nursing*, 49(3), 425-430. doi:<https://doi.org/10.1016/j.jen.2022.11.004>

Introduction Workplace violence remains a significant threat to the United States health care workforce. With increasingly aggressive patients, emergency nurses reported that the increased prevalence of workplace violence impacted their professional and personal lives. **Methods** This study employed a qualitative, descriptive phenomenological approach with purposive sampling. Participants were asked to describe their lived experience with workplace violence while working as emergency nurses and how this affected them personally and professionally. **Results** Eleven experienced emergency registered nurses from 3 mid-Atlantic hospitals participated in the study. After reviewing, clustering, and validating significant statements, 4 major themes were identified: walking wounded to wounded healer, unexpected shock, betrayal, and resilient but changed. **Discussion** Our findings were consistent with other studies exploring the effects of workplace violence in emergency departments. We validated that trauma has long-lasting effects. Organizations should ensure that programs and processes are in place to support the nurse or health care worker when workplace violence events occur.

The experiences of united states emergency nurses related to witnessed and experienced bias: A mixed-methods study: JEN. (2023). *Journal of Emergency Nursing*, 49(2), 175-197. doi:<https://doi.org/10.1016/j.jen.2022.11.008>

Introduction The purpose of this study was to obtain a broad view of the knowledge, attitudes, beliefs, and lived experiences of emergency nurses regarding implicit and explicit bias. **Methods** An exploratory, descriptive, sequential mixed-methods approach using online surveys and focus groups to generate study data. Two validated instruments were incorporated into the survey to evaluate experiences of microaggression in the workplace and ethnocultural empathy. Focus group data were collected using Zoom meetings. **Results** The final sample comprised 1140 participants in the survey arm and 23 focus group participants. Significant differences were found in reported experiences of institutional, structural, and personal microaggressions for non-white vs white participants. Respondents who identified Christianity as their religious group had lower mean scores on items representing empathetic awareness. Respondents who identified as nonheterosexual had significantly higher mean total Scale of Ethnocultural Empathy scores, empathetic awareness subscale scores, and empathetic feeling and expression subscale scores. Thematic categories that arose from the focus group data included witnessed bias, experienced bias, responses to bias, impact of bias on care, and solutions. **Discussion** In both our survey and focus group data, we see evidence that racism and other forms of bias are threats to safe patient care. We challenge all emergency nurses and institutions to reflect on the implicit and explicit biases they hold and to engage in purposeful learning about the effects of individual and structural bias on patients and colleagues. We suggest an approach that favors structural analysis, intervention, and accountability.

Perspective of emergency pediatric nurses triaging pediatric patients in the emergency department: A phenomenographic study: JEN. (2023). *Journal of Emergency Nursing*, 49(2), 244-254. doi:<https://doi.org/10.1016/j.jen.2022.10.007>

Introduction Triage, a process to determine illness severity, is implemented by emergency nurses to prioritize treatment and provide care for a maximum number of patients using limited resources. The competency of emergency nurses and a highly reliable triage are crucial for the provision of emergency care. Pediatric patients are different from adult patients in certain aspects, such as growth-phase characteristics, communication ability, and the onset of disease; these aspects often pose challenges during their primary triage. This study explored how emergency nurses triage pediatric patients using the Korean Triage and Acuity Scale. **Methods** Eleven emergency nurses (N = 11) working in the pediatric emergency department of a university hospital in Seoul, South Korea, were recruited using purposive sampling methods. Phenomenography was used to investigate the strategies by which these nurses use the Korean Triage and Acuity Scale to triage pediatric patients. **Results** The findings comprised 2 descriptive categories: 6 approaches on how to triage patients (categories of how) and 3 strategies (categories of what) used by pediatric emergency nurses to triage pediatric patients with the Korean Triage and Acuity Scale. **Discussion** The experience and proficiency of emergency nurses are essential factors for the effective triage of pediatric patients. Our findings qualitatively elucidate different ways of understanding pediatric triage and indicate the need for pediatric triage education programs.

A quality improvement initiative on reducing blood culture contamination in the emergency department: JEN. (2023). *Journal of Emergency Nursing*, 49(2), 162-171. doi:https://doi.org/10.1016/j.jen.2022.11.005

IntroductionContaminated blood cultures may have detrimental effects on patients, the organization, and antimicrobial stewardship. Patients in the emergency department may need blood cultures collected before antimicrobial therapy. Contaminated blood culture samples may contribute to prolonged hospital stay and also are associated with delayed or unnecessary antimicrobial therapy. This initiative aims to improve the emergency department's blood culture contamination rate that will eventually benefit the patients who will receive timely and proper antimicrobial therapy, and benefit the organization fiscally.**Methods**This quality improvement initiative used the Define–Measure–Analyze–Improve–Control (DMAIC) process. The organization targets blood culture contamination rate of $\leq 2.5\%$. Control charts were used to study how blood culture contamination rate changed over time. In 2018, a workgroup was formed to work on this initiative. Improved site disinfection using 2% Chlorhexidine gluconate cloth before the standard procedure of blood culture sample collection was initiated. Chi squared test of significance was used to compare blood culture contamination rates 6 months before and during feedback intervention as well as contamination rate from source of blood draw.**Results**Blood culture contamination rates 6 months before and during feedback intervention showed significant decrease (3.52% before intervention and 2.95% after intervention; $P < .05$). Contamination rates differed significantly based on the source of blood culture draw (7.64% via line, 3.05% via percutaneous venipuncture, and 4.53% via other; $P < .01$).**Discussion**Blood culture contamination rate continued to decrease with the use of a pre-disinfection process with 2% Chlorhexidine gluconate cloth before blood sample collection process. Practice improvement also was evident with effective feedback mechanism.

Database copyright © 2023 ProQuest LLC. All rights reserved.

[Terms and Conditions](#) [Contact ProQuest](#)