THE EFFECTIVENESS OF A TRAINING PROGRAM FOR EMERGENCY DEPARTMENT NURSES IN MANAGING VIOLENT SITUATIONS

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ABSTRACT

An Australian Institute of Criminology report (1999) highlighted the health industry as the most violent industry in Australia with registered nurses recording the second highest number of violence-related workers compensation claims, ranking higher than prison and police officers. Workplace violence has become such a common phenomenon that many nurses accept it as a part of nursing. Nurses employed in emergency departments (EDs) are considered to be especially vulnerable to workplace violence.

Although there have been a number of studies reporting on the incidence of workplace violence and its consequences upon nurses, to date there have been no empirical studies that have evaluated interventions which are thought to reduce its occurrence and impact.

This study investigated the effectiveness of a one-day training program in which ED nurses participated. In particular, their knowledge, skills and attitudes relating to management of workplace violence were examined.

Results show that a training program has many positive outcomes which enhance nurses' ability to manage aggressive behaviours. With some basic training, ED nurses can be more prepared to manage violent and potentially violent situations, and by doing so may in fact reduce the incidence of aggression in their workplace by 50%. This has largely been achieved by raising the awareness of ED nurses to the nature of the problem, developing their knowledge and skills in managing aggressive behaviour, and improving their attitudes toward potentially violent patients.

INTRODUCTION

A report by Perrone (1999) for the Australian Institute of Criminology, showed the health industry as the most violent industry in Australia with registered nurses recording the second highest number of violence-related workers compensation claims in 1995/96, ranking higher than prison and police officers. Zernike and Sharpe (1998) reported that nurses at the Royal Brisbane Hospital, Australia, felt they had become acclimatised to aggressive behaviour and accepted it as part of the nature of nursing work. Jones and Lyneham (2000, p.27) argue that this acceptance of violence as 'part of the job' conceals workplace aggression as an important issue for nurses.

There has been a long history of violence in EDs with a Mrs Cardwell, senior night sister, Accident and Emergency Department at St Thomas' Hospital, London, reporting that the Department of Health and Social Services (United Kingdom) issued a circular in 1976 on the management of violent patients (Cardwell 1984). In 1999 the International Council of Nurses claimed that nurses working in EDs are especially vulnerable to physical assault and verbal abuse. Within the general hospital system, EDs have been identified as a high risk public area (Lyneham 2000) where emergency nurses report their lifetime exposure to violence as very high (Levin, Hewitt and Misner 1998). Lyneham (2000), in a study of 650 members of the New South Wales, Australia, Emergency Nurses Association, reported that 100% of respondents experienced some type of violence in the ED. Cembrowicz and Shepard (1992) reported on trauma sustained in an ED in which the majority of injuries resulted from being punched, kicked, grabbed, stabbed, scratched, slapped, head-butted, strangled and hair pulling, and by the use of furniture and fittings, knives, wheelchairs, broken bottles, broken glass, scaffold poles, planks, scissors, stretcher poles, syringes and needles. The

focus of the Cembrowicz and Shepard study was on physical injuries. They concluded that physical aggression was an increasing concern for nurses employed in EDs and hospitals must develop strategies and policies that reduce the risk of nurses being injured. Lyneham (2000) demonstrated that workplace violence continued to be a major issue for nurses and suggested that nurses were not satisfied with the response of administration to violent incidents within hospitals. Enchinias (1991) in the United States of America argued that there were significant differences in problems between rural and metropolitan EDs with lack of funding for staff and inappropriate staff responsibilities contributing to an increase risk of violence in rural EDs compared to metropolitan EDs. Lyneham (2000) suggests that although Australia experiences similar difficulties as the USA, minimal investigations have been conducted.

A factor that may account for the violence against nurses may be a lack of knowledge and skill as indicated by Mahoney (1991) who suggested that some nurses employed in EDs believed that their attitude might incite some instances of violence. Levin, Hewitt and Misner (1998) found that nurses' attitudes and behaviours were important factors related to the risk of violence. This result was supported by Lyneham's (2000 p.15) finding that 'there was an acknowledgement that there are often situations where the emergency nurse's behavior creates or exacerbates a volatile situation'. She concluded there was a lack of institutional support for training to deal with violent situations. One recommendation which is pertinent to the current study was that funds should be available for training at times when ED staff are not part of the shift complement.

Examination of the literature suggested that while some authors recommend training in the prevention and management of violence (Bowie 2000; Mason and Chandley 999), the most significant gap in the research literature was the absence of studies that investigated the effectiveness of interventions which might reduce aggressive incidents and their sequelae. For example, although Nield-Anderson and Doubrava (1993) reported on a program designed for ED staff to defuse aggression, no formal evaluation of the program was conducted. It was considered imperative by the researcher that the role effectiveness of training in the prevention and management of violence be studied and clarified, in order to generate recommendations for policies and procedures that address future acts of aggressive behaviour toward nurses.

The purpose of the present investigation was to determine if a training program in the prevention and management of violence had been experienced as improving knowledge, skills and attitudes of nurses employed in a regional ED with regard to their role of managing aggressive behaviour from patients. The program was presented by four experienced psychiatric nurses who had post basic education in workplace training and assessment.

The one day training program aimed to fulfil the following objectives.

At the completion of the training program participants will:

- Be aware of their work environment and responsibilities.
- Understand what type of behaviour can trigger a reaction.
- Be aware of their colleagues' strengths and weaknesses.
- Understand causes and types of aggression.
- Understand appropriate responses and options.
- Be aware of factors that influence effective communication.
- Demonstrate effective avoidance and deflection techniques.
- Demonstrate effective secure and escort techniques.

METHOD & PROCEDURE

A non-experimental, one group, pre-test post-test research design was used in this study to evaluate the effectiveness of a newly developed training program for nurses working in EDs

PARTICIPANTS

There were 45 effective full time emergency nurses with fractional part-time appointments representing a total of 60 full and part-time staff. To assist with staffing ED, the program was offered during staff time on three separate days with 14 ED nurses attending the first two days and 12 attending the third day (n=40) which represented 66% of all emergency nurses.

Questionnaires were distributed by the ED unit manager to all 60 nurses employed in the ED of a major regional hospital in Victoria, Australia. Thirty (75%) of the 40 nurses who attended the training program completed the pre-test questionnaire two months prior to the commencement of the training program and 22 (55%) RNs completed the post-test questionnaire which was also distributed by the ED unit manager three months following the training program. Pre and post-test questionnaires were identical and participants were requested to complete and voluntarily return un-named questionnaires to the program organiser.

RESULTS

An evaluation questionnaire consisting of 56 questions based on the program's objectives was constructed by the author for a previous study (Deans 2001). Eight items elicited demographic data and nine items elicited information regarding the incidence of physical, verbal and sexual aggression in the ED. Ten items requested information about aggressive behaviour in the ED, eight

items asked questions about how confident participants were in their management of violent behaviour. The final section of the questionnaire identified ED nurses attitudes and thoughts about factors related to violence in the ED. The questionnaire was subjected to split-half reliability and an Alpha score of 0.83 was found.

RESULTS

Twenty four (80%) participants attending the workshop were female with six (20%) male. Age of participants varied with eight (27%) in the 20-29 group, nine (30%) in both the 30-39 and 40-49 group and four (13%) in the 50-59 age group. Twenty of the female and two of the male participants completed both the pre-test and post-test questionnaire. There was also a wide range of participant nursing experience, including RNs, charge nurses and clinical nurse specialists. Participants had spent a mean of five years in their current level of employment. The mean years of employment as an RN was 14 years and seven years was the mean time spent in the ED. Eighteen (60%) of participants had a tertiary qualification.

A series of cross tabulations and Chi-Square tests were conducted on questions related to aggressive behaviours in the ED. An alpha level of 0.05 was used for all tests. Results show the effect of the workshop was statistically significant for assisting participant's knowledge and understanding about the code of practice for managing aggressive situations in the emergency department [x^2 (1, n=22)=4.18, p=0.04]; and more importantly, they knew what it was [x^2 (1, n=22)=6.74, p=0.01]. The workshop also was statistically significant for assisting participants to be 'aware of the constraints that physical limitations have on their own ability to respond to an aggressive situation' [x^2 (1, n=22)=5.88, p=0.05], and to make other staff aware of their own physical limitations [x^2 (1, n=22)=6.21, p=0.01]. The effect of the workshop was not statistically significant for issues relating to 'team response to aggressive situations' [x^2 (1, n=22)=0.70, p=0.30] and 'duty of care' [x^2 (1, n=22)=0.90, p=0.54].

Table 1 shows the incidence of aggressive behaviour experienced by participants at pre-test.

The number of aggressive situations encountered by staff within the past three months was reduced from pre-test (M=8.39, SD=11.3) to post-test (M=4, SD=3.45). While this was not statistically significant [t(df=48)= 1.94, p 0.06] it is clinically significant in that results also show the mean scores for effectiveness of the workshop increased from pre to post-test although this result was not statistically significant either [t(df=47)= -1.69, p 0.09]. Participants rated their knowledge [t(df=48)= -4.3, p 0.001] and skills [t(df=48) = -2.74, p 0.006] higher as a result of the workshop.

Table 2 shows that the confidence levels of participants were raised for most areas after undertaking the course. Participants reported increased confidence in dealing with aggressive situations and working as a member of a team in responding to aggressive situations. Participants similarly reported increased confidence in reporting aggressive incidents to their line manager. Finally participants also reported increases in confidence in responding to persons who were fearful, frustrated, or who were intimidating and manipulating.

Table 3 shows that participants had improved in their confidence toward issues relating to aggression in the ED. Important areas that showed increases include feeling 'supported from other staff' and from 'management' following involvement in an aggressive incident. This result was tempered by a reduction in how they perceived 'management as caring for them' and that 'incident reports are only a management tool'. However, there was a reduction in responses to 'debriefing not offered enough in my workplace'. There was also an increase in agreement with the statement 'the work environment could be made safer' by participants post course. Table 3 relates to participants confidence levels pre and post introduction of the course. It shows a general improvement in participants attitude toward aggression related issues in the ED. Participants felt an increase in confidence in areas such as being supported by other staff and from management following involvement in an

Table1: Incidence of aggression in ED (pre-test)

Type of Violence	Never	Less than once per year	About once per year	Once per month	Once per week
Verbally threatened	0	1 (3%)	12 (40%)	13 (43%)	4 (13%)
Verbally insulted	0	0	11 (36%)	13 (43%)	6 (20%)
Yelled at	0	2 (6%)	6 (20%)	13 (43%)	9 (30%)
Sexually threatened	18 (60%)	9 (30%)	3 (10%)	0	0
Sexually insulted	14 (46%)	7 (23%)	7 (23%)	1 (3%)	1 (3%)
Sexually touched	22 (73%)	5 (16%)	2 (6%)	1 (3%)	0
Physically threatened	3 (10%)	7 (23%)	11 (36%)	9 (30%)	0
Slapped or struck	9 (30%)	16 (53%)	5 (16%)	2 (9%)	0
Hit with an object	20 (66%)	6 (20%)	4 (13%)	0	0

Table 2: Confidence in managing aggressive behaviour

Questions	Test	not	somewhat	very	extremely
I feel confident with dealing with aggressive situations	Pre Post	4 (13%) 1 (4%)	21 (70%) 13 (59%)	4 (13%) 8 (36%)	1 (3%)
I feel confident to be a member of a team response to aggressive situations	Pre Post	4 (13%) 12 (54%)	14 (46%) 10 (45%)	11 (36%)	
I feel confident in communicating with persons who are/becoming aggressive	Pre Post	2 (6%) 1 (4%)	15 (50%) 11 (50%)	12 (40%) 9 (41%)	1 (3%) 1 (4%)
I feel confident in physical restraining persons who are aggressive	Pre Post	15 (50%) 7 (31%)	9 (30%) 10 (45%)	4 (13%) 4 (18%)	2 (6%) 1 (4%)
I feel confident in being able to physically move freely (ie clothing, hair, disabilities)	Pre Post	2 (6%) 5 (22%)	7 (23%) 14 (63%)	13 (43%) 3 (13%)	7 (23%)
I feel confident about reporting an incident to my line manager	Pre Post	1 (3%)	3 (10%) 17 (73%)	14 (46%) 5 (22%)	11 (36%)
I feel confident in responding to someone who is fearful or frustrated	Pre Post	1 (3%) 1 (4%)	10 (33%) 4 (18%)	15 (50%) 17 (77%)	3 (10%)
I feel confident in responding to someone who is intimidating and manipulating	Pre Post	1 (3%) 1 (4%)	18 (60%) 9 (50%)	8 (26%) 12 (54%)	2 (6%)

Table 3: Attitudes toward aggression in ED

Questions	Test	SA	A	D	SD
Aggressive behaviour should only be dealt with by security staff	Pre Post	3 (10%) 3 (13%)	9 (31%) 2 (9%)	16 (55%) 16 (72%)	1 (3%) 1 (4%)
Aggressive persons should not be treated by nurses	Pre Post	15 (17%) 1 (4%)	18 (62%) 15 (68%)	6 (20%) 6 (27%)	
I am cared for by management in my workplace	Pre Post	2 (7%) 2 (9%)	18 (69%) 12 (54%)	3 (11%) 8 (36%)	3 (11%)
The way I respond can contribute to aggressive behaviour	Pre Post	7 (23%) 5 (22%)	14 (46%) 11 (50%)	7 (23%) 5 (52%)	2 (6%) 1 (4%)
The way I communicate can contribute to aggressive behaviour	Pre Post	6 (20%) 5 (22%)	13 (43%) 10 (45%)	10 (33%) 6 (27%)	 1 (4%)
Debriefing not offered enough in my workplace	Pre Post	7 (25%) 4 (18%)	13 (46%) 8 (36%)	7 (25%) 9 (40%)	1 (3%) 1 (4%)
I believe that the other staff actively support me following my involvement in an aggressive situation	Pre Post	8 (27%) 2 (9%)	15 (51%) 18 (81%)	5 (17%) 2 (9%)	1 (3%)
I believe my work environment could be made safer	Pre Post	12 (41%) 14 (63%)	15 (51%) 8 (36%)	2 (7%)	
Management of aggressive behaviour not my responsibility as a nurse	Pre Post	7 (23%) 5 (22%)	17 (56%) 14 (63%)	6 (20%) 3 (13%)	
I am aware of my emotional reactions when confronted by an aggressive person	Pre Post	3 (10%) 19 (86%)	25 (83%) 3 (13%)	2 (6%)	
I am aware of my physiological reactions when confronted by an aggressive person	Pre Post	2 (7%) 1 (4%)	25 (86%) 20 (91%)	2 (7%) 1 (4%)	
Nurses can use as much force as is necessary to restrain someone who is aggressive	Pre Post	1 (3%) 1 (5%)	10 (34%) 8 (42%)	16 (55%) 10 (52%)	2 (7%)
I understand that attending to someone who is aggressive is part of my role in ED	Pre Post	3 (10%) 2 (9%)	20 (69%) 17 (77%)	5 (17%) 2 (9%)	1 (3%) 1 (4%)
Incident reports are only a management tool	Pre Post	2 (6%) 1 (5%)	17 (56%) 12 (57%)	10 (33%) 7 (33%)	1 (3%) 1 (4%)
I personally feel safe in my work environment	Pre Post	17 (58%) 17 (77%)	10 (34%) 4 (18%)	2 (7%) 1 (4%)	
I believe that management actively support me following my involvement in an aggressive situation	Pre Post	1 (3%) 2 (9%)	13 (43%) 13 (49%)	11 (39%) 7 (32%)	3 (10%)

aggressive incident. Interestingly, participants felt less confident in management caring for them and the use of incident reports after undertaking the course. Also of note was the perceived improvement in workplace debriefing with the item 'debriefing not offered enough in my workplace' scoring lower post course.

DISCUSSION

There is little doubt that regional ED nurses continue to experience unacceptable levels of workplace violence with all ED nurses in the study reporting that they had experienced verbal aggression. This finding is consistent with findings reported by Lyneham (2000) in her study of New South Wales emergency nurses. Participants had also experienced significant levels of physical and sexual aggression.

Given, that the education program will not reduce the exposure of ED nurses to workplace aggression, results show that with some basic training, they can be more prepared to manage violence, and by so doing may in fact reduce the incidence of aggression by de-escalating potential violent situations. It is reassuring to report that the incidence of aggression was halved in this study. This has largely been achieved by raising the awareness of ED nurses to the nature of the problem, improving their knowledge and skills in managing aggressive behaviour and their attitudes toward potentially violent patients.

It is also a positive result that nurses have an increased confidence about reporting aggressive incidents to line managers. If the reporting behaviour of nurses can be changed from a traditional culture of non-reporting or as a 'part of the job' acceptance as indicated by Jones and Lyneham (2000, p.27), the true nature and extent of the problem may be better understood and more appropriately dealt with by governments and health organisations and agencies. It is essential that the conspiracy of silence in which human service workers are hesitant to acknowledge any difficulties in coping with the day-to-day realities of workplace violence is addressed and minimised.

This result however, needs to be viewed in light of participants reporting that they 'were not cared for by management' and that they 'believed their work environment could be made safer'. What is of most concern is that participants viewed incident reports of violent situations as only a management tool. It is clear there must be a process which permits nurses to report violent behaviour within an environment that is perceived as both supportive and interventionist. Similarly, there remains a need for nurse managers to become more skilled in managing those nurses who have been recipients of violent behaviour. It would also appear that nurses receive most of their support from their peers which is consistent with previous studies (Farrell 2001). Farrell's study reported that nurses' main concerns regarding nurse managers was their failure to implement supportive structures when incidents arose or to take appropriate action to prevent their recurrence. He concluded, that it would be expected 'all managers take action following major incidents of aggression' (p.30).

This study has a number of limitations. Firstly, the researcher was unable to randomly select a sample from the population of ED nurses and, secondly, the small sample size reduces the generalisation of results to other ED nurses in other settings. Thirdly, the absence of a control group which did not receive the training program makes it problematic to promote the effectiveness of the program. However, the study has generated some findings upon which to make a number of recommendations.

Tertiary education

Nursing curricula in tertiary education programs must systematically include content that prepares nurses to manage both aggressive behaviour and their own negative responses to aggressive behaviour. This may prove to be difficult. A survey of Canadian schools of nursing (Ross, Hoff and Coutu-Wakulczyk 1998) found that although there was a sensitivity to the importance of including content of aggression in nursing, the approach to this content was largely incidental and heavily dependent on individual academic's interests. However, such early preparation can reinforce strategies to best manage aggressive behaviour from future patients and their relatives.

In-service education

In-service and continuing education programs for nurses should also be implemented and evaluated. Staff development programs, using such strategies as role play, videotape playbacks, debriefing sessions and case management, would assist all clinical staff to become aware of how they can contribute to the overall coping strategies used by victims of violence. Courses on self-awareness, assessment, and diagnosis of aggressive or potentially aggressive patients and staff would be beneficial if implemented in addition to promoting a team approach.

Implications for management

Reports from this and other studies demonstrate that emergency nurses frequently experienced workplace violence from patients and frequently failed to report such incidents. There are some important implications for hospital managers, some of which have been suggested by other researchers (Farrell 2001; Lyneham 2000) and are further explored below. To implement the strategies suggested, changes in infrastructure and/or personnel may be required. For example, security or occupational health and safety staff may need to be appointed, professional educational programs may have to be established and policies regarding reporting and responding to violent incidents may need to be instituted or upgraded.

Primary prevention of workplace violence

Preventing, or at least reducing workplace violence in EDs would appear to be a first priority for nursing administrators. Before this can be achieved there is a need by the profession to acknowledge and claim ownership of the psychological and professional injury experienced by its members resulting from workplace violence. Therefore, a professional nursing culture that acknowledges its own contribution to the problem can contribute to individual and professional recovery.

Health agencies could be advised to consider displaying written warnings to potential aggressors in strategic locations in their buildings. These warnings may prohibit workplace violence toward staff and notify potential aggressors that abusive behaviours may result in prosecutions.

Secondary prevention of workplace violence

When workplace violence does occur, all physical, verbal and sexual incidents should be reported and documented. A central register could be maintained in order to identify trends of work-related aggression. Spratlen (1997) suggested that an ombudsman can play a significant role in the continuing problem of aggression in the workplace. The role of an ombudsman acting as an independent objective person would gain the confidence of nurses and thereby facilitate the processing of complaints about workplace violence without the concern of retribution.

Further, there is a need to establish formal and informal debriefing sessions for nurses who have been assaulted. Brayley et al (1994) suggested the establishment of a violence management team to manage patients who exhibit aggressive behaviour in the general hospital.

Tertiary prevention of workplace violence

State and territory occupational health and safety legislation is required to include protection of employees against acts of aggression in their workplace. From a legal perspective, hospitals and other health agencies may have to adopt policies that more vigorously assist nurses to pursue perpetrators of aggression through the legal system. This would significantly increase the visibility of the problem and provide encouragement to other nurse victims. Pursuing legal options may prove to have a symbolic value in raising community awareness that aggression toward nursing staff is unacceptable. Also, by offering legal recourse, remediation for being assaulted may assist in the healing process. It is worth noting that since the completion of this project the hospital utilised as the setting has introduced a zero tolerance policy with notices displayed on the walls of ED that violence is unacceptable and perpetrators will be prosecuted.

CONCLUSION

There is little doubt that because of the nature of ED's and the vulnerability of staff who work within them, there will always be exposure to violent situations. This study has demonstrated that with a single one-day training program there can be a reduction in violent incidents as well as a concomitant increase in staff confidence. What is urgently required is for funding to be invested into structured training programs at undergraduate, postgraduate and continuing education levels that will prepare nurses to more effectively manage aggressive behaviour. Results have heightened the importance of training nurse managers to provide support to those who have been victims of aggression. Managers should receive comprehensive and focused training in how to support the role of ED nurses in their workplace.

The importance of ongoing research into interventions that reduce the level of or response to workplace aggression has been highlighted by the current study.

The benefits to be reaped from such interventions will more that adequately compensate for those monies lost through sick leave, work cover premiums and reduced quality of care.

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