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Managing, Mitigating and Minimizing Patient Violence in the Emergency Department

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Executive Summary

Introduction of the Problem

Emergency Department (ED) nurses are exposed to verbal and physical violence from patients in their care. The occurrence of violence in the ED is so frequent that nurses, hospital administrators, and the general public consider patient violence as an expectation of the ED nurse's job. Types of violence in the ED include biting, kicking, pinching, hitting, verbal threats to harm the nurse, and name calling. The Emergency Nurse Association (ENA), the Joint Commission, and the Occupational Safety and Health Administration (OSHA) have addressed concerns for nurse safety and the need for hospital administration to address and protect nurses from injury and abuse.

Ascertaining the number of incidents is vital to understanding the scope of the problem. Accurate incident reporting provides administration information on the frequency as well as the environment that may have contributed to the incident. After learning nurses' attitudes, exposure, and concerns regarding patient violence, administration can provide resources to manage, mitigate, and minimize incidences of patient violence and consequences.

Literature Review

Approximately 75% of annual reported workplace violence incidents occur in healthcare or social services settings (Joint Commission, 2018). When nurses do not advocate for themselves, understanding the magnitude of patient violence toward nurses cannot be accurately assessed or addressed. Nurses fail to report incidences of patient violence for many reasons, including failure to identify violence through verbal or physical actions, dismissing the significance of occurrences, time constraints, and sense of lack of support for change.

According to a Joint Commission report (2018), only 30% of nurses report events of patient violence. Teaching nurses to recognize and manage signs of potential violence, mitigate the physical and emotional damage, and minimize the effects that can lead to burnout and job dissatisfaction are vital to providing and maintaining a safe environment of care.

Project Methods

The purpose of the Doctor of Nursing Practice (DNP) project was to determine nurse perception of patient violence, encourage nurses to utilize the provided reporting process for patient violence incidents, and provide hospital administrators with accurate data to make changes to support nurse safety. The change project took place in a 21 bed Emergency Department in a rural, 320 bed hospital located in the Midwest. The project began after Institutional Review Board (IRB) and final stakeholder permission was received.

An extensive literature review provided expert analysis of patient violence occurrences, suggestions for changing the culture of acceptance of patient violence, and skills to address aggressive patients. The inclusion of a content expert to guide nonviolent aggressive patient management techniques, lead to a Crisis Prevention Intervention (CPI) training video to include in the project. A five item Likert scale survey was used to determine pre- and post-project nurse perceptions of patient violence. A10 item open-ended questionnaire was used pre- and post-project to encourage and receive individual nurse feedback on perceptions, experiences, and suggestions regarding ED patient violence.

Evaluation

Information regarding patient violence from the ENA, OSHA, and the Joint Commission, the hospital reporting process, and the CPI de-escalation video link was distributed via a bulletin board presentation, individual and unit meeting discussions, questionnaires, and surveys.

Statistics, as well as general information, pertaining to patient violence were provided to educate and encourage nurses to adopt a culture of non-acceptance and encourage reporting of incidences. Hospital administration became aware of the frequency and type of violent situations when nurses utilized the electronic Event Reporting System (ERS) developed by the hospital for tracking purposes.

Sixty-nine percent of the nurses participated in the pre-project survey and questionnaire, and 50% participated in the post-project survey and questionnaire. The pre-change project results revealed 100% of participating nurses believed patient violence in the emergency department was an expectation of the job. At the conclusion of the change project, there was an increase of 26.1% at the highest level of nurse confidence and ability to recognize five signs of escalating patient aggression. The ability to recognize signs of developing patient aggression is a valuable skill in managing patient violence. Additionally, nurse perception toward effectiveness of incident reporting increased 21.8%. This increase indicated belief in the reporting process, value of reporting violence, and ultimately administrative support and policies to protect nurses from future patient violence.

Impact on Practice

Shared questionnaire and survey responses allowed hospital administration immediate awareness of nurse perception, concerns, and fears regarding potential and realized patient violence. Valuable feedback pertaining to the time investment necessary to utilize the ERS process influenced the new inclusion of reporting patient violence during daily unit information huddles. Notes from the daily huddle provided feedback and suggestions to the department supervisor to share with hospital administration.

During the six week change project, five seasoned ED nurses resigned. Hospital administration had a vested interest in retaining nurses for the knowledge and experience brought to the department, as well as expense of replacing nurse vacancies. In response to the nurses resigning, hospital administration implemented suggestions from the DNP project. Suggestions included efforts such as including crisis prevention techniques in orientation, increasing security presence in the ED, and access to spit shields. Changes in policies and procedures to protect nurses exemplify the value of nurses and affect nurse retention. The discussion of patient violence incidents during daily huddles solidifies the importance administration places on nurse safety. In the future, the formal electronic reporting process might be modified for simplification, based on the comparison of daily reports to formal submissions. The top critique of time consumption of the formal reporting process must be addressed for the ERS to be a valuable tool addressing patient violence.

Conclusion

The change project was successful in discovering nurses' knowledge and concerns for their personal safety, and allowed a platform for expression of concerns and ideas for improvement. The energy exhibited when the nurses provided feedback was inspiring. Only two nurses declined participation due to suspicion of administration retribution. As hospital administration becomes responsive to issues involving nurse safety, a culture of trust and mutual respect will be nurtured. A quick and inexpensive response to the project findings would be to address a nurse's suggestion of signage in the triage/lobby area pertaining to intolerance of patient physical or verbal violence toward staff. The inclusion of patient violence as a topic in the annual nurse competencies could serve as a yearly review and subsequent support for nurse safety. Reviewing skills related to managing violence through recognition of signs of aggression,

mitigating effects of violence through crisis prevention techniques, and minimizing long term effects from patient violence will ensure nurse safety remains a priority.