Conveying caring: Nurse attributes to avert violence in the ED

Violence towards nurses in Emergency Department’s is a world wide problem that some contend is increasing in severity and frequency, despite the many strategies implemented to prevent violent events. This paper presents the findings of an instrumental case study in a busy rural Emergency Department. Twenty Registered Nurses participated in the study and data from 16 unstructured interviews, 13 semi-structured field interviews, and 290 h of participant observation were thematically analysed. In addition, 16 violent events were observed, recorded via a structured observation tool and analysed using frequency counts. Thematically there were five attributes rural emergency nurses were observed to use to avert, reduce and prevent violence. The five attributes were being safe, being available, being respectful, being supportive and being responsive. We argue that these attributes were embodied in the emergency nurses routine practice and their conceptualization of caring.

Key words: Violence, Emergency Department, Caring, Communication.

INTRODUCTION

Violence in the Emergency Department (ED) is a world wide, endemic problem. The ED is recognized as an area at special risk of violence because of its contextually and environmentally unique circumstance, including: long waiting times for consultation or admission; the unanticipated nature of illness; 24 h opening; intense interpersonal interactions; adverse unexpected outcomes, such as death; and high levels of stress for patients, their families and friends. Structured environments decrease violent incidents when patients are considered ‘transiently violent’, whereas chaotic, noisy,
crowded ED contexts might exacerbate violent episodes especially where patients are confused or disorientated.

Though there are many causes and catalysts for violence, there is a body of literature, and strong evidence to suggest that some forms of violence in ED’s can be reduced and averted through the use of well-developed interpersonal communications skills. Despite understanding that emergency nurses have a shorter window of opportunity to establish trusting therapeutic relationships, communication is an area where they are frequently criticized. This communication shortfall might arguably be explained by the very immediate need for emergency nurses to prioritize life supporting interventions and considerations, such as patient’s airway, breathing and circulation, over establishing therapeutic relationships. This paper reports the findings of a study on violence towards emergency nurses where the agents of violence were patients their family and friends. Participant observation and interviews with emergency nurses were used to gain insights into the strategies nurses in a busy rural ED used to avert violence.

AIM OF THIS STUDY
The research was part of a larger study exploring violence towards emergency nurses. The aim of this part of the study was to identify the strategies emergency nurses use to avert, reduce and prevent violence. Specific objectives were to:

- Observe the routine strategies emergency nurses use in nurse patient interactions to avert, reduce or prevent violence
- Gain insights into the violence prevention and reduction strategies used routinely by emergency nurses

METHODS
An instrumental case study was used to explore strategies that nurses use to avert or reduce violence from patients, their family or friends in an ED setting. The instrumental case study was defined as ‘a detailed, intensive study of a particular contextual, and bounded, phenomena’. The methods for this instrumental case study needed to answer the research question by making possible an exploration of, and understanding about, episodes of care where the patient their family or friends were the agent of violence.

Informal field interviews, semi-structured interviews, researcher journaling and both structured and unstructured participant observation were used to gather data within the framework of the instrumental case study. Twenty emergency nurses consented to participate in the observational part of the study (see Table 1). Naturalistic observation of participants was undertaken to examine all aspects of their routine nursing practice. As a result, 16 incidents of violence towards nurses were observed via a previously piloted structured observation tool. Unstructured observations comprised field notes of detailed contextual data and numerous observations of routine nurse–patient interactions. A total of 290 h of participant observation were undertaken over a 5 month period, during all shifts. In addition, 16 semi-structured 1 h interviews and 13 informal field interviews were generated. A reflective researcher journal complemented and completed the data generation methods. All data were recorded in the field via digital audio-tape, or directly typed into a hand held personal computer.

SETTING
The case study was undertaken in a 33 bed regional Australian ED. The public hospital services a large rural and remote multi-cultural community that consists of a permanent metropolitan population, tourists and a transient seasonal workforce. Ethical approval was granted from University of Western Sydney, James Cook University and the Hospital setting Human Ethics Committees. The ethical principles of voluntary informed consent, confidentiality and anonymity were upheld throughout all phases of the study.

DATA ANALYSIS
All of the digitally recorded data were transcribed. A thematic analysis of the textual data was undertaken and data were managed using the software package NVivo 2 (NVIVO 2 (2004), QSR International Pty Ltd, Melbourne: Australia). Codes and themes were developed.
contextually to the evolving instrumental ‘case of’, the
research question and the phenomena of interest.
Nominal and ordinal numeric data derived from the struc-
tured observations were analysed using frequency tables.
Using measures already accepted for the chosen data gen-
eration methods, methodological rigor was established
within the framework of the instrumental case study.22,23
Reflective researcher journaling, a philosophical and
methodological log and member checking of emergent
themes contributed to the credibility of the findings.24,25

RESULTS
Observational and narrative data revealed five broad
attributes that the emergency nurses demonstrated in
their practice, particularly when patients, their family or
friends showed any potential for violence (see Table 2).
The five attributes were being safe, being available, being
respectful, being supportive and being responsive. Though these
approaches did not avert violence in 100% of cases, as
evidenced by the fact that there were still 16 episodes of
violence observed over the 290 h of observations, they
did successfully avert and reduce potentially violent
episodes on numerous occasions. These attributes were
observed to be calming and reassuring when used during
nurse patient interactions. These attributes are discussed
below.

Being safe
Personal safety for self and others was important for the
participants who stated that every person in the ED needed
to be physically and emotionally safe, particularly during a
violent or potentially violent event. Upholding personal
safety was embedded in their nursing practice and was
manifest in a number of ways including use of environmen-
tal assets, managing the physical environment and using
high-quality, professional interpersonal skills.

. . . I guess even in their stupor get through to them that they
are in a safe place and they don’t have to perhaps act violent
if they are frightened or scared or so out of their tree that they
don’t know where they are . . . and just constantly sort of talk
over them almost ‘Yes, yes, I understand. It’s okay. You’re
safe. We’re trying to do our best for you. We are trying to
make you comfortable’. Just keep going on and on like a
broken down record. You know. And try and reassure them
somehow. (Helen)

Table 2 Nursing attributes

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<th>Nurse attributes</th>
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. . . they are confused, they are scared and so you’ve got to try
and figure out why they are scared and try and, I don’t know,
find some sort of strategy to make them feel safe . . . (Donna)

Participants used the environmental assets provided by
the layout of the emergency department and those sup-
plied by the facility to enhance safety. Eight of the 16
participants interviewed mentioned the physical barrier of
the triage door and window and six mentioned the per-
sonal and stationary duress alarms as effective violence
intervention strategies, though only one participant, on
one occasion, was seen to equip herself with a personal
duress alarm.
The secure physical environment was used for violence prevention, and this included how visitors were managed. Participants reported that they used the security of the locked doors to determine who was admitted into the ED, or who could be asked to leave. Managing the number of people inside the ED at a given time was a strategy that was also observed.

*I think your environment plays a part in your approach, you know, prevention of violence... and I don’t like a lot of people around the bed, you know, because they can wind up the patient, they can wind up the relatives next door, they can pass smart remarks . . .* (Bea)

Another way the participants’ maintained safety was to be alert to the presence of potential weapons and to remove them from the area. In addition to the obvious physical objects that patients sometimes carry with them, hospital equipment, such as intravenous medication poles, were potential weapons and thus were removed if they represented a threat. Participants acknowledged removing equipment had a disadvantage because at a later time either themselves or their colleagues spent time looking for the equipment. Participants, however, were pragmatic about this and determined their safety, the patient’s safety and the safety of others was the priority.

Participants revealed an awareness of their own body language and physical positioning and this was observed during violent events and during routine nursing practice. This awareness was also part of what they encouraged and modeled to less experienced ED staff. Specifically, they identified that they needed to have a clear safe exit for themselves during all interactions with patients, and accompanying friends and family members.

*I suppose just not getting yourself into a corner, that sort of thing. If you are bit suspicious . . . standing at the doorway and never put yourself into a situation that you can’t really get out of . . . and if you are unsure always having somebody else with you.* (Marg)

Participants discussed the practicality of positioning themselves around the patient’s bed in such a way that they could not be physically hurt. Observations confirmed that during violent events, or when there was the potential for violence, participants often stood beside the bed at the patient’s waist height, preventing patients from being able to hit or kick them. While relating the story of a less experienced nurse escorting a patient with a history of violence and mental illness, Jane said,

*... she decided to walk beside the bed with him and nearly hold his hand. I had to say to her, no, that’s not safe, that isn’t a safe practice. He’s okay . . . you don’t need to be right beside him. Walk to the side away from him or to the back or to the front or wherever you want to walk, but you keep yourself safe first . . .* (Jane)

**Being available**

Being available was an important aspect of averting and reducing violence, and participants were frequently observed offering information and comfort, because they were aware of the multitude of potential stressors associated with being in a hectic and unfamiliar ED setting. One of the ways participants conveyed their availability was through the use of well-developed, professional communication skills, such as empathy, attending, listening, reflective listening, paraphrasing and repeating instructions or information using ‘plain language’, and use of interpersonal skills were frequently observed.

*I guess my way of trying to calm it then is communication, communication, communication . . . we’re your team, you can come and find us, put your head out. We’re listening, you might not see us, but you call and we’ll come . . .* (Helen)

**Being respectful**

Respect for people was central to the violence prevention approach adopted by the participants. Respect was conveyed through courteous language, effective non-verbal communication skills, and in adopting an open and non-judgmental stance.

*People can pick up by your mannerisms, your body language if you’re intolerant to them. I think it just um, perhaps comes down to respect, respect of yourself and respect that that is a person. That they have rights and they have needs and they have every right to be here.* (Helen)

*... that’s just a bit of respect and acknowledgement . . .* (Muriel)

Rapport building was an important attribute for conveying respect for people and acknowledging the stress of the situation they found themselves in. Taking the time to
establish rapport showed these nurses desire for harmonious, respectful relationships with patients their family and friends.

I think you know, walk around, you know, converse with the patients, try to establish a bit of a rapport and just listen . . . (Bea)

Being respectful included being calm, speaking in a quiet calm manner, giving people space and using non-threatening, open-body language.

. . . um so they are presented with a polite, friendly, non-threatening manner in a caring sort of comforting environment . . . we don’t invade their space, we stand back, we acknowledge them by their name or whatever they might like to be called by, um, we take them seriously . . . even giving them a warm blanket sometimes makes a huge difference in just making them feel a bit safe, its making them feel as I said welcomed, cared for and we’re not here to hurt them, its trying to communicate that in a way through body language and through, just through physical things that we do for them . . . give them a lot of respect . . . (Pam)

Participants also discussed the development of respectful helping relationships with patients, and this meant being able to set boundaries for people regarding what behaviours and language were acceptable, and what were not acceptable. Fourteen of the 16 participants interviewed stated that they felt comfortable in clearly asserting that violence would not be tolerated.

. . . we definitely don’t um you know tolerate anything aggressive towards us because were here to help you and we’re not here to cop all your violence. (Dianne)

Being supportive

Support was shown in a number of ways through the initiation of subtle behaviours and communications that showed that the participants genuinely understood and cared for patients their family and friends.

. . . I just step back and calm down a bit, and calm them down and explain, and get them a drink and something to eat and they settle down. Once they knew what was happening; that someone cared about them, that they weren’t forgotten. (Jane)

As a means of decreasing stress, frustration and preventing violence participants routinely orientated patients, as well as those accompanying them to the ED, unless workload circumstances were prohibitive. Offering people accompanying patients support and practical comforts, such as food, beverages and use of the hospital telephones, was frequently observed. Participants reported these supportive strategies were an effective means of diffusing potential agitation, and therefore violence.

. . . lots of use of personal communication skills and . . . can I get you a cup of tea, can I make you a sandwich, are you comfortable there, you know like there’s a lot of that. . . . or can we do something else for you or do you want to use the ‘phone or, you know, a lot of that happens. (Donna)

The frustration of waiting times and the stressors of the unknown—unknown diagnosis, unknown prognosis and unknown treatment options—were continually recognized by the participants. Clear unambiguous, jargon free communications were reported as being an effective way of ensuring people were able to understand the triage system. Participants identified that keeping people informed about all aspects of their ED presentation or admission was an invaluable strategy for violence prevention and de-escalation and it improved patients their family and friends sense of control over their situation.

I keep people up to speed about what’s happening. I tell them what’s going to happen as soon as they hit the department. I advise them how long they potentially have to wait. I advise them about what we are going to do, what they can do . . . and I just continually keep them abreast of what’s happening. (Dianne)

The concept of being supportive went beyond supporting patients and their accompanying family and friends. The participants also actively supported one another. Frequently, they informed each other about their location, and commented that the geographical layout of the ED assisted them to support each other in violent or potentially violent situations.

. . . the curtains can all go back so we can all see and hear each other. We’re not enclosed in rooms with doors closed. You’re always hearing interactions, you know, I guess there’s a privacy thing there to, but, from a staff perspective it’s quite reassuring knowing that you might only have to say, not even

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scream, just sort of say I need help in here and someone can actually hear you and come in. (Helen)

**Being responsive**

Being responsive included being responsive to patient’s emotional and physical needs. These needs might not have been explicitly stated by the patient, yet once recognized, they were responsively and proactively acted on by the participants. One of the responsive violence prevention strategies was to minimize the physical and verbal communications and stimuli for people who were confused, disorinentated to time, place or person, agitated or highly anxious. This not only involved removing items that were potential weapons but also minimizing the number of people talking to the patient and the number of people the patient could see. When reflecting on a violent event involving a patient intoxicated by alcohol and disorientated to time, place and person, Pam commented:

Can you imagine you’re lying down on this bed, and you have a lot of people touching you, in your face asking you a lot of questions? It’s quite overwhelming and if you can minimise that I think you minimise the impact you have and reduce their stress levels and . . . everybody was yelling him. . . . I don’t think that was helping. And that’s why also I went round the back. I got out of his view. . . . the less people that were actually throwing things in his face, like verbally and also touching him . . . (Pam)

Participants were responsive to patients their family and friends when they proactively kept people informed about the waiting times and educated people presenting to ED about the triage system. Providing information about the length and reason for their wait to see the doctor, or get transferred to a ward, implicitly acknowledged that this can be part of the reason why people become agitated and violent.

. . . I’ve always reiterated the number one reason why people get violent in the Emergency Department is the waiting times. I mean, there’s no question about it, if they have to wait, they get pissed off [laugh] . . . like go out into the waiting room, and if you can tell people that it’s going to be forever, I’m really sorry, is there anything I can do for you, you can usually kind of stave things off then, and people just want to know what’s going on, you know, they don’t want to be just left there and they don’t understand the hospital processes, and they don’t understand that things can’t be done immediately . . . (Muriel)

**DISCUSSION**

The five attributes participants used in their routine nursing practice to avert, reduce or prevent violence were: being safe, being available, being respectful, being supportive and being responsive. Though these attributes were used in everyday practice, they were used in particular ways to avert and reduce the risk of violence. Identification of these five attributes contributes to delineating the routine skills and practices of rural emergency nurses. Although the use of communication skills is congruent with the existing literature on nurse’s violence prevention and de-escalation strategies, this research highlights that it is more than well-developed interpersonal skills alone.

Emergency nurses engage in intense, often brief interactions with patients their family and friends, in a demanding and stressful environment. Yet emergency nurses have been maligned by some critics who contend that because their practice is necessarily bounded by the need to maintain life within the context of the ‘medical emergency’, they are not fully attuned to the emotional and social needs of patients. It is evident from these findings, however, that emergency nurses are concerned about, and care for, the emotional and social needs of persons presenting to the ED. Findings of this study support those of other studies that encourage nurses to use conscious, high level interpersonal communication skills and techniques to create safe environments and therapeutic nurse patient relationships, and so reduce or prevent violence.

As part of their practice, the participants contextualized the mandate of workplace safety for themselves and those attending the ED. This finding has not been previously revealed in the emergency nursing literature. This study has also shown how communication skills and interpersonal skills were practiced, informally modeled, shared and applied during the participants’ routine nurse—patient interactions. The use of personal positioning, environmental management and interpersonal communication skills to prevent violence has been noted in the mental health nursing literature. This study, however, revealed how the participants incorporate these skills into their routine emergency nursing practice and this is a new contribution to the nursing literature.
These five attributes were embedded in the daily practice of these emergency nurses. Though the term ‘caring’ is contested in the nursing literature, these emergency nurses revealed their conceptualization of nurse ‘caring’ through the enactment of these five attributes. While these participant nurses conveyed caring through their embodied caring practices. Their integration of these five attributes, which the participants termed ‘caring’, was reflected in their interviews and observed to be integrated in their practice.

It is important to remember that emergency nurse’s specialty is Emergency Department nursing, where a diverse range of illnesses, accidents, medical, surgical and psychiatric problems can unexpectedly present. These findings reveal that violence reduction and prevention skills are being effectively implemented by emergency nurses, not all violence can be averted using these attributes. By implementing these attributes in their routine daily practice, however, these emergency nurses are defining themselves and their caring practices.

CONCLUSION

The five attributes highlight the ways that nurses can embody caring within even the most acute setting. Participant observation and interviews revealed the salience of the emergency nurses ‘caring’ as a means of averting, reducing and preventing some of the violence they experience in the workplace. Further, this study sheds light on how emergency nurses’, through their embodied caring practices, awareness of their environment and application of highly developed communication and interpersonal skills, keep patients their family and friends safe and enhance their sense of control in an unfamiliar and hectic environment. These findings contribute new knowledge to the nursing literature. We recommend further research to make visible previously invisible aspects of emergency nurses practice and to recognize the knowledge that is embedded in the practice of expert nurses, including research exploring the generalizability of these attributes to other ED’s and other specialties.

REFERENCES


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