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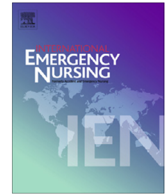

Perceptions of Australian emergency staff towards patients presenting with deliberate self-poisoning: A qualitative perspective

Rose Chapman RN, PhD, MSc (Nursing) [a,b,c,*], Catherine Martin RN, BSc (Hons), M (Bios) [a,b]

[a] Monash Health, 135 David Street, Dandenong, Vic. 3175, Australia
[b] Australian Catholic University, 115 Victoria Parade, Fitzroy Vic 3065, Australia
[c] Curtin University, Kent Street Bentley, WA, Australia

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A B S T R A C T

Introduction/Background: Attitude of staff towards patients who present to the emergency department following deliberate self-poisoning may be integral to the outcome of these events. There is little in-depth understanding of emergency staff perceptions about this vulnerable group.
Aim: Explore staff perceptions about caring for patients who present to the emergency department following deliberate self-poisoning.
Design: Qualitative descriptive study.
Methods: Two open-ended questions enabled 186 clinicians to describe their perceptions about caring for people who present to the emergency department following deliberate self-poisoning. Data were analysed using qualitative data analysis procedures.
Results: Three themes emerged from the data representing staff perceptions about caring for patients who deliberately self-poisoned and included *depends on the patient*, *treat everyone the same*, and *skilled and confident to manage these patients*.
Conclusion: Staff reported mixed reactions to patients presenting with deliberate self-poisoning. These included feelings of empathy or frustration, and many lacked the skills and confidence to effectively manage these patients.
Relevance to practice: Health networks are required to ensure that emergency staff have specialist support, knowledge, skills, and guidelines to provide effective care for this vulnerable population.
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1. Introduction and background

Patients presenting with deliberate self-poisoning (DSP) can add to the burden on the Emergency Department (ED) (Hendrix et al., 2013). Twenty years ago, a large proportion of these patients would be discharged from the ED and admitted to the wards (Boyes, 1994), whereas today the practice tends to be one of utilising ED short stay or observation units for patients with projected short lengths of stay as is often the case with DSP patients (Teo and Cooper, 2013). This change to practice has added to the increased demands and overcrowding on the ED internationally (Olshaker, 2009). Although the numbers of DSP presentations account for approximately 0.6% of all ED attendances (Hendrix et al., 2013), they can be perceived to increase staff workload overall (Bergen et al., 2010; Downes et al., 2009). This may be because DSP presentations are often associated with alcohol co-ingestion (Bergen et al., 2010) and are a common reason for reported behavioural disturbance and aggression (Downes et al., 2009). In addition, DSP patients are at increased risk because they are also more likely to discharge themselves before treatment or against medical advice (Anderson et al., 2003).

Deliberate self-poisoning is the most common form of self-harm (Yip et al., 2011), and patients presenting with self-harm have reported both positive and negative attitudes from ED staff (National Institute for Clinical Excellence, 2004 (CG16)). Some studies examining ED staff attitudes towards patients presenting with self-harm have reported that emergency staff hold negative attitude towards these patients (National Institute for Clinical Excellence, 2004 (CG16)), whereas other studies have found a positive attitude of ED nursing staff towards self-harm patients (Conlon and O'Tuathail, 2012; McCann et al., 2007).

Although DSP is a common form of deliberate self-harm, the majority of research exploring ED staff attitudes have focused on self-harm (Conlon and O'Tuathail, 2012; McAllister et al., 2002) rather than its individual components such as DSP. A study

* Corresponding author. Tel.: +61 3 95541141; fax: +61 3 95548339.
E-mail address: rose.chapman@southernhealth.org.au (R. Chapman).

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assessing ED staff attitude towards self-laceration found negative attitudes towards these patients (Friedman et al., 2006), and it may be that studies assessing attitude towards self-harm in general are confounded by the attitude towards self-injury. In addition, only a few qualitative studies were identified that examined ED staff attitude towards self-harm (Conlon and O'Tuathail, 2012; Hadfield et al., 2009). Conlon and O'Tuathail (2012) used the Self-Harm Antipathy Scale, which included an open-ended question allowing the Irish ED nurses to express their feelings and attitudes towards self-harm patients and their behaviour. Three core themes were identified from the responses to the open-ended question: 'lack of education', 'ED is an unsuitable environment' and 'empathy and antipathy'.

Very few studies have explored the attitudes and perceptions of doctors and nurses towards patients who present following self-poisoning. The majority of these studies were conducted over 30 years ago, and all but one (Ghodse, 1978) were undertaken in psychiatric or hospital ward settings (Creed and Pfeffer, 1981; O'Brien and Stoll, 1977; Patel, 1975; Ramon, 1980), which may not reflect current ED staff attitudes.

In a previous paper, we reported quantitative findings based on the Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ) developed by McAllister et al. (2002), which we revised to determine the attitude of ED nurses and doctors towards patients who present with DSP. We found that doctors and nurses had a positive attitude towards patients who presented with DSP as determined by the ADSHQ score (Martin and Chapman, 2014). We briefly reported on the qualitative analysis of two open-ended questions added to the questionnaire, and in this paper we report on the in-depth exploration of these findings.

Negative attitude towards DSP patients could manifest itself in negative behaviour such as anger, avoidance of and punitive action towards the patient (National Institute for Clinical Excellence, 2004 (CG16)), which may be compounded in a busy stressful environment such as the ED. Understanding ED staff attitudes will determine if, and what type of, educational and other supportive interventions are required for ED staff to ensure the delivery of consistent and equitable practice to this group of patients.

2. Method

Quantitative and qualitative data were collected using an anonymous self-administered validated questionnaire (McAllister et al., 2002). The survey was distributed to all doctors and nurses working within three EDs in one hospital network ($n = 410$) to investigate their attitude towards patients who present to the ED with DSP, irrespective of the reason why the person self-poisoned. This was based on the National Institute for Clinical Excellence definition of self-harm 'self-poisoning or self-injury, irrespective of the apparent purpose of the act' (National Institute for Clinical Excellence, 2004 (CG16), p16). The instrument, content, factor structure, and performance of the scales are described elsewhere (McAllister et al., 2002). We added two open-ended questions to the survey, requesting the participants to provide information about how they felt when caring for a patient who deliberately self-poisoned. In addition, ED staff were invited to provide any other thoughts, feelings or perceptions they had regarding patients who deliberately self-poison. Ethical approval was gained from the human research ethics committees of the university and hospital. Consent was implied by return of the questionnaire.

2.1. Data analysis

Data from the open-ended questions were transcribed verbatim. The transcriptions from the survey were reflected on and coded line-by-line, and analysed following the standards of qualitative data analysis procedure, i.e., categorising and clustering (Speziale-Streubert and Carpenter, 2003), and significant words and phrases were identified. The key words or phrases were underlined, and significant meanings listed, aggregated and categorised. All transcribed data were compared with each other for patterns and recurring themes as they emerge from the data. Following this procedure, the major intent of the transcripts were conceptualised (Berg, 2009).

Trustworthiness was achieved by addressing credibility and transferability of the data (Lincoln and Guba, 1985). Credibility was ensured by giving a sample of the transcripts to two experts in qualitative data analysis, who coded and categorised the data individually, with overall agreement and consistency between the experts' analysis. Transferability was established by developing rich descriptions and maintaining an audit trail to allow comparison of our study with those conducted in similar contexts. The following section provides statements that illustrate the main categories.

3. Results

The demographic characteristics of the sample have been presented elsewhere (Martin and Chapman, 2014); however, in summary the respondents were mainly female, nurses and aged between 27 and 55 years. The respondent's qualifications ranged from hospital based to university qualifications including pre and post-graduate qualifications. Less than half had attended DSP education and training. Twenty-six percent had worked in the ED for two years or less.

From the 186 surveys returned (Martin and Chapman, 2014), 169 included written comments to the two open-ended questions. These open-ended questions elicited the participant's feelings and perceptions about caring for patients who present to the ED following DSP. Three themes emerged from the data including *depends on the patient and the situation*, *treat everyone the same* and *skilled and confident to manage these patients*. Each theme had a number of sub-themes (or finer level processes) that emerged from, and which afford a better understanding of, the data. Table 1 presents a summary of the themes and sub-themes and examples. The following section focuses on the evidence for each of these themes and sub-themes in turn.

3.1. Depends on the patient and the situation

Staff noted distinct and separate reactions towards people who present to the ED with DSP depending on the patient and or the situation. As one participant wrote: "*...It depends if it's* [DSP] *an actual suicide attempt or a way to get admission to psych* [mental health] *ward...*" Another one stated:

> ... Depends on the situation. I feel for someone who has felt overwhelmed by a situation and maybe self-poisoned on an impulse, which they either regret after doing so, or remain feeling so hopeless and depressed that they still wish to die. I feel exasperated and annoyed with a patient if I perceive them to have self-poisoned (especially if it was to a minor degree) then notified someone to help them...

Participants experienced mixed emotions depending on the patient's reason for admission and the situation within the department. Therefore, sub-themes that emerged included feelings of 'empathy' and 'frustration'. For those patients who were perceived to have made a real attempt at suicide all staff mentioned that they felt compassionate and reported feelings of empathy, sympathy and concern. One participant wrote: "*... . If it is a true suicide*

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