"Nursing Students Assaulted": Considering Student Safety in Community-Focused Experiences

RHONDA E. MANEVAL, D.Ed., RN* and JANE KURZ, PhD, RN†

Community nursing experiences for undergraduate students have progressed beyond community-based home visits to a wide array of community-focused experiences in neighborhood-based centers, clinics, shelters, and schools. Our Bachelor of Science in Nursing program chose to use sites situated within neighborhoods close to campus in order to promote student and faculty engagement in the local community. These neighborhood sites provide opportunities for students to deliver nursing services to underserved and vulnerable populations experiencing poverty and health disparities. Some of these neighborhoods are designated as high crime areas that may potentially increase the risk of harm to students and faculty. There is a need to acknowledge the risk to personal safety and to proactively create policies and guidelines to reduce potential harm to students engaged in community-focused experiences. When a group of baccalaureate nursing students was assaulted while walking to a neighborhood clinic, the faculty was challenged as how to respond given the lack of policies and guidelines. Through our experience, we share strategies to promote personal safety for students and recommend transparency by administrators regarding potential safety risks to students engaged in community-focused fieldwork activities. (Index words: Nursing students; Community health nursing; Safety; Clinical education) J Prof Nurs 32:246–251, 2016. © *2016 Elsevier Inc. All rights reserved.*

THERE IS A growing trend within undergraduate nursing education to develop curricula that strike a balance between disease-oriented and health promotion-oriented approaches to nursing education. Historically, the majority of clinical education experiences have occurred in hospitals and other acute and subacute care facilities. In curricula in which health promotion is now a major component, community health experiences are being given increased time and focus. There are a number of factors responsible for this shift (Lynch, 2014) and include recommendations from the Institute of Medicine's Future of Nursing Report (Institute of Medicine Report, 2010), the Carnegie Foundation for the Advancement of Teaching Report: Educating Nurses: A Call for Radical Transformation (Benner, Sutphen, Leonard, & Day, 2010), the Patient Protection and Affordable Care Act (H.R. 3590–111th Congress, 2009; The Patient Protection and Care Act, 2010), and the American Association of Colleges of Nursing (2008). These entities all recommend an expansion of nursing education and services to local communities with an increased focus on health promotion and disease prevention interventions. As a result of the Patient Protection and Affordable Care Act, in 2015, 11.4 million new people enrolled in health insurance coverage (US Department of Health and Human Services, 2015), increasing access to primary health care services. This resulted in an increased need for primary health care providers and for baccalaureate-educated nurses skilled in health promotion and therapeutic lifestyle management. In addition, these new initiatives are contributing to expanded roles for public health nurses such as community health advocates, community educators, public health policy-makers, and researchers (Kulbok, Thatcher, Park, & Meszaros, 2012). Nurses are also working in expanded sites such as neighborhood centers, housing developments, parishes, school health programs, worksites, and homeless shelters (Kulbok et al., 2012).

*Director, Undergraduate Nursing Programs, Associate Professor, Nursing, Michigan State University, College of Nursing, East Lansing, MI 48824.

†Chair, Undergraduate Nursing Programs, LaSalle University, School of Nursing and Health Sciences, Philadelphia, PA 19141.

Address correspondence to Rhonda E. Maneval: Director, Undergraduate Nursing Programs, Associate Professor, Nursing, Michigan State University, College of Nursing, East Lansing, MI 48824, 3840 Lone Pine, Apt 7, Holt. E-mail: rhonda.maneval@hc.msu.edu (R.E. Maneval), kurz@lasalle.edu (J. Kurz)

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In the past, community experiences for undergraduate nursing students were community based, relying on home health care agencies or local public health departments. In this model, the student is assigned to a home health nurse to provide direct nursing care to clients in their homes or to a public health nurse who is providing direct care services to vulnerable or at-risk people. In a community-based model, the focus is on the individual level of nursing care and nursing services with a disease-oriented focus, and although nurses in this model are practicing in the community, they are not practicing public health (Cohen & Gregory, 2009). Programs embracing a health promotion orientation are more often using a community health-focused model rather than community-based model. Cohen and Gregory (2009) defines *community health* as focusing on health promotion and disease prevention that targets populations rather than individuals. The Association of Community Health Nursing Educators (ACHNE) also differentiates between two levels of community nursing, which they term *community-based nursing* and *community-focused nursing* (ACHNE, 2009). ACHNE defines *community-based nursing* as focusing on the individual with the goal of influencing individual health outcomes, while community-focused nursing targets at-risk populations with the goal of attaining health outcomes and reducing risk. Clinical practice experiences in community-focused health encompass a wide variety of sites that may or may not have a professional nursing presence (Pijl-Zieber & Kalischuk, 2011). Examples include homeless shelters, refugee service centers, senior centers, minute clinics, faith-based organizations, community wellness centers, and primary care offices (Thompson & Bucher, 2013).

Personal safety of students has always been a concern during community experiences (Lang, Edwards, & Fleiszer, 2008). In the past, students would travel to client homes or within the community with an experienced nurse or faculty member. The experienced nurse navigated the environment and provided a degree of safety and security for the student. With the increased use of community-focused health experiences has come an increased concern regarding student safety. In our BSN program, which is located in a large urban community, students utilize public transportation and travel about the city to a variety of community sites. Students typically are not going into client homes but, rather, traveling to sites located in neighborhoods with high needs for health care services but which also have high crime rates, frequent episodes of gang-related violence, high levels of street drug usage, abandoned and neglected buildings, and deteriorating infrastructure. Strategies to limit risk and enhance safety are needed given the desire to expose students to a variety of community-focused experiences in high-need areas. To date, there is a limited amount of research available on the topic of personal safety during community-focused experiences and nursing students. There is some related literature that explores the topic of personal safety, but it is primarily focused on community-based models of care and home care workers.

Literature Review

Home care safety risks associated with geographic location include high-crime neighborhoods, gang presence, illegal drug activity, street loitering by youths and men, poor neighborhood lighting, presence of abandoned and deteriorated buildings, and poorly maintained streets (Fazzone, Barloon, McConnell, & Chitty, 2000; Fitzwater & Gates, 2000; Gellner, Landers, O'Rourke, & Schlegel, 1994; Hayes, Carter, Carroll, & Morin, 1996; Kendra, Weiker, Simon, Grant, & Shullick, 1996; McPhaul, Lipscomb, & Johnson, 2010; Sylvester & Reisener, 2002). Fazzone et al. (2000) performed a qualitative study with 50 direct home care staff and 11 administrators in the midwest. Participants were asked to describe unsafe conditions within the patient's home or neighborhood. Participants reported going into areas where gunfights and drive-by shootings were common and “where police would not go.” Other unsafe conditions near patients' homes included men or adolescents loitering on the street, gang activity, police raids, broken glass or debris, “run-down” homes, poor lighting, rats, and hostile dogs. Organizational and administrative issues impacting safety included the lack of policies and procedures and/or the lack of enforcement of those policies, lack of familiarity with the community and neighborhood, delay of security assistance, absence of a “check-in” system when staff traveled in high-risk areas, lack of administrative support, and failure or delay of staff to report incidents. Participants also reported that although they receive some training on personal safety, it was inadequate to meet their needs. Recommendations include ongoing education and training and comprehensive personal safety policies and procedure that address the actual threats to safety found in the environment.

Sylvester and Reisener (2002) conducted a mixed-methods descriptive study to explore perceived risks and actual exposures to danger in the home care environment. Of the 43 participants, 16% felt unsafe when making home visits, 30% felt that agency measures were not in place to ensure their safety, and 20% felt that the agency did not respond to safety concerns by staff (Beaver, 2014). Strategies undertaken to address these issues included a comprehensive list of safety recommendations for staff to utilize when traveling. The list includes suggestions such as getting directions, carrying a cell phone, not carrying a purse, being aware of surroundings, walking confidently, using eye contact, avoiding isolated areas, and leaving unsafe situations immediately and contacting a manager. Home care patients were also required to sign an agreement to remove safety risk from the environment such as weapons, animals, and illegal drugs. Patients were also required to agree to not expose the staff member to verbal or physical abuse. As a result of these measures, staff reported feeling less unsafe and more supported by the agency.

A few studies focus on nursing students' feelings regarding the risk to their personal safety when engaged in community clinical experiences (Carroll, Morin, Hayes, & Carter, 1999; Leh, 2011; Morin, Hayes, Carroll, & Chamberlain, 2002). In a descriptive qualitative study, Leh (2011) asked nursing students about their feelings

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