



Psychosocial Care for Injured Children: Worldwide Survey among Hospital Emergency Department Staff

Eva Alisic, PhD^{1,2}, Claire Hoysted, BSc(Hons)³, Nancy Kassam-Adams, PhD^{4,5}, Markus A. Landolt, PhD^{6,7}, Sarah Curtis, MD, MSc⁸, Anupam B. Kharbanda, MD, MSc⁹, Mark D. Lyttle, MBChB^{10,11}, Niccolò Parri, MD¹², Rachel Stanley, MD, MHSA¹³, and Franz E. Babl, MD, MPH¹⁴, on behalf of Pediatric Emergency Research Canada (PERC), the Pediatric Emergency Medicine Collaborative Research Committee of the American Academy of Pediatrics (PEMCRC), Pediatric Emergency Research in the United Kingdom and Ireland (PERUKI), the Research in European Pediatric Emergency Medicine (REPEM), the Pediatric Emergency Care Applied Research Network (PECARN), the Pediatric Research in Emergency Departments International Collaborative (PREDICT), and the Pediatric Emergency Research Networks (PERN)*

Objective To examine emergency department (ED) staff's knowledge of traumatic stress in children, attitudes toward providing psychosocial care, and confidence in doing so, and also to examine differences in these outcomes according to demographic, professional, and organizational characteristics, and training preferences.

Study design We conducted an online survey among staff in ED and equivalent hospital departments, based on the Psychological First Aid and Distress-Emotional Support-Family protocols. Main analyses involved descriptive statistics and multiple regressions. Respondents were 2648 ED staff from 87 countries (62.2% physicians and 37.8% nurses; mean years of experience in emergency care was 9.5 years with an SD of 7.5 years; 25.2% worked in a low- or middle-income country).

Results Of the respondents, 1.2% correctly answered all 7 knowledge questions, with 24.7% providing at least 4 correct answers. Almost all respondents (90.1%) saw all 18 identified aspects of psychosocial care as part of their job. Knowledge and confidence scores were associated with respondent characteristics (eg, years of experience, low/middle vs high-income country), although these explained no more than 11%-18% of the variance. Almost all respondents (93.1%) wished to receive training, predominantly through an interactive website or one-off group training. A small minority (11.1%) had previously received training.

Conclusions More education of ED staff regarding child traumatic stress and psychosocial care appears needed and would be welcomed. Universal education packages that are readily available can be modified for use in the ED. (*J Pediatr* 2016;170:227-33).

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Every year, tens of millions of children around the world sustain injuries that require hospital care.¹ These injuries can cause not only physical disability but also long-term psychological consequences: approximately 1 in 6 injured children develop persistent stress symptoms that impair functioning and development.²⁻⁵

Several models have been developed to mitigate distress after injuries and other potentially traumatic events. Psychological First Aid⁶ is the most prominent model of psychosocial care, often applied after disasters. It comprises 8 core elements (eg, "stabilization," which includes calming, "promoting connection with social supports," and "informing about coping"), tailored to the needs of the survivor. In the pediatric context, specific recommendations such as the D-E-F protocol⁷ have also been developed. This protocol builds on the A-B-C

From the ¹Monash Injury Research Institute, Monash University; ²Murdoch Childrens Research Institute; ³School of Psychological Sciences, Monash University, Melbourne, Australia; ⁴Children's Hospital of Philadelphia; ⁵University of Pennsylvania, Philadelphia, PA; ⁶Department of Psychosomatics and Psychiatry, University Children's Hospital Zurich; ⁷Department of Child and Adolescent Health Psychology, Institute of Psychology, University of Zurich, Zurich, Switzerland; ⁸Departments of Pediatrics and Emergency Medicine and Women and Children's Health Research Institute, University of Alberta, Edmonton, Alberta, Canada; ⁹Department of Pediatric Emergency Medicine, Children's Hospitals and Clinics of Minnesota, Minneapolis, MN; ¹⁰Emergency Department, Bristol Royal Hospital for Children; ¹¹Faculty of Health and Applied Science, University of the West of England, Bristol, United Kingdom; ¹²Department of Emergency Medicine and Trauma Center, Meyer University Children's Hospital, Florence, Italy; ¹³Department of Emergency Medicine, University of Michigan, Ann Arbor, MI; and ¹⁴Royal Children's Hospital, Murdoch Childrens Research Institute and University of Melbourne, Melbourne, Australia

*List of executive committee members, network sites, and site representatives for PERC, PEMCRC, PERUKI, REPEM, PECARN, PREDICT, and PERN is available at www.jpeds.com (Appendix).

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ED Emergency department
PERN Pediatric Emergency Research Networks

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model (airway, breathing, and circulation) that is familiar to acute care clinicians providing resuscitation. After providers have attended to the A-B-Cs and addressed physical health needs, the protocol points them to distress of the patient (D), emotional support for the patient (E), and support for the family (F).⁴

Although emergency department (ED) staff have been recognized as having a pivotal role in preventing persistent distress in injured children,⁸ conscious awareness of post-traumatic stress and practices to promote psychological recovery appear not to be commonplace in the ED, and there are suggestions that specific training is needed.^{2,8,9} Our goal was to examine ED staff's perspectives in an international context. In particular, we aimed to understand: (1) their knowledge of traumatic stress in children, attitudes toward providing psychosocial care, and confidence in doing so; (2) differences in these outcomes according to demographic, professional, and organizational characteristics; and (3) their training preferences.

Methods

We assessed ED staff's perspectives with a web-based self-report questionnaire. The Human Research Ethics Committee of the Royal Children's Hospital Melbourne approved the study as primary institutional review board (HREC 33085).

We targeted ED physicians and nurses from hospitals around the world (allied health workers and mental health staff were also eligible to participate but represented small groups; their data are not reported in this paper). In settings where hospitals did not have separate EDs, we approached staff who were routinely providing initial hospital care to injured patients. Respondents were recruited by means of the association of Pediatric Emergency Research Networks (PERN) in North America, Europe, and Australasia¹⁰ and national health care provider forums and associations (eg, the DXY website for Chinese health care providers and the College of Emergency Nursing Australasia), with the request to forward the survey link to ED staff in participants' networks. This snowball approach was chosen to obtain as many responses as possible from staff in countries where there was less organization in professional associations. Data collection took place between July 1, 2013, and February 1, 2014. To reduce barriers to providing a frank account of hospital performance, participation in the survey was anonymous, although we did collect basic demographic information. Respondents indicated informed consent by completing the questionnaire. They could send a separate e-mail to the research team to participate in a drawing for one of 20 \$15 gift vouchers.

Measure development involved literature review,^{6,7,11-13} a qualitative interview study with ED staff,¹⁴ drafting of questionnaire items, including new questions and items adapted from 2 existing measures for parent knowledge and provider attitudes,^{15,16} review of draft questions by 8 experts in emergency medicine, emergency nursing, mental health,

and injury classification, and piloting with 12 ED staff, including the use of a "think-aloud" protocol.¹⁷ We solicited reviews on cultural appropriateness of the questions from staff or academics from each major language area that we were targeting. The questionnaire was translated into 12 languages (2 translators per language) and accessed through SurveyMonkey.

The questionnaire consisted of 65 items in 7 main categories: personal and work characteristics (demographics, profession, and work location; 12 items); individual knowledge of traumatic stress (7 multiple choice items); individual confidence in providing psychosocial care (mapped on the 8 core elements of Psychological First Aid; 18 items with a 4-point Likert scale and an option to indicate that the provider thought it was not their job); barriers to providing psychosocial care (6 items with a 3-point Likert scale); the department's performance in providing psychosocial care (3 general questions and 8 items for each element of Psychological First Aid, all with a 4-point Likert scale and the "not our job" option); training wishes and experiences (8 items with varying answer formats); and open questions to solicit further comments, in particular regarding cultural considerations. The full survey is available from the authors.

Data Analyses

All analyses were conducted in IBM SPSS 22 (SPSS Inc, Chicago, Illinois). We derived a knowledge score as a count of correctly answered knowledge questions (0-7). A total attitude score comprised the count of psychosocial care elements (0-18) seen as part of the respondent's job. An individual confidence score was computed by averaging the confidence scores (1-4) of all aspects of psychosocial care that a respondent saw as their job. We computed descriptive statistics, and then used multiple regression analyses to examine which respondent characteristics were related to higher knowledge and confidence scores (we report the initial models as well as the final models with significant factors only).¹⁸ Because age, experience in patient care, and experience in the ED were strongly correlated ($r = .79$ to $r = .90$; $P < .001$), we included only experience in patient care in the regression models. Because visual inspection showed that confidence scores were negatively skewed, these were reversed, log transformed, and reversed again before analysis.

Results

The sample consisted of 2648 ED staff (59.3% female, mean age 39.5 years, [range 18-65; SD = 9.7; median = 38.0]) residing in 87 countries. The 5 countries with the most respondents were China (17.3%), US (16.2%), United Kingdom (12.5%), Australia (9.5%), and Canada (9.0%). One-quarter of respondents (25.2%) operated in a low- or middle-income country. The majority of respondents (78.5%) worked in an urban setting, and 14.7% worked in suburban and 6.7% in rural settings.

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