

Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations

Alcohol-related presentations are common in emergency departments (EDs) throughout Australia and New Zealand. Two point prevalence surveys indicate that one in eight presentations to EDs are alcohol-related.^{1,2}

ED clinicians are at the forefront of responding to the consequences of alcohol-related harm. Verbal and physical violence and aggression are common in EDs, with adverse effects on staff wellbeing and job satisfaction.³ As little is known about this problem in the local context, our study surveyed perceptions of clinical staff of alcohol-related presentations to Australasian EDs. The study had two main objectives: to quantify the scale of the problem of alcohol-related violence experienced by ED staff, and to assess their perceptions of the effects of alcohol-related presentations on the functioning of the ED.

Methods

A mixed methods, cross-sectional online survey was developed after undertaking a literature search, and refined by the consensus of an expert steering committee. Definitions for verbal and physical aggression were taken from the Medicine in Australia: Balancing Employment and Life (MABEL) Longitudinal Survey (<http://mabel.org.au/>) (Appendix 1). Free-text items were included for qualitative analysis. The survey was piloted, leading to minor modifications of its wording.

The survey was conducted from 30 May to 7 July 2014. Participation was anonymous, voluntary, and consent implied by completion of the survey. The survey link was distributed by email to 156 directors of emergency medicine at EDs accredited by the Australasian College for Emergency Medicine (ACEM). Directors were asked to forward the survey link to all

Abstract

Objectives: To survey emergency department (ED) clinical staff about their perceptions of alcohol-related presentations.

Design, setting and participants: A mixed methods online survey of ED clinicians in Australia and New Zealand, conducted from 30 May to 7 July 2014.

Main outcome measures: The frequency of aggression from alcohol-affected patients or their carers experienced by ED staff; the perceived impact of alcohol-related presentations on ED function, waiting times, other patients and staff.

Results: In total, 2002 ED clinical staff completed the survey, including 904 ED nurses (45.2%) and 1016 ED doctors (50.7%). Alcohol-related verbal aggression from patients had been experienced in the past 12 months by 97.9% of respondents, and physical aggression by 92.2%. ED nurses were the group most likely to have felt unsafe because of the behaviour of these patients (92% reported such feelings). Alcohol-related presentations were perceived to negatively or very negatively affect waiting times (noted by 85.5% of respondents), other patients in the waiting room (94.4%), and the care of other patients (88.3%). Alcohol-affected patients were perceived to have a negative or very negative impact on staff workload (94.2%), wellbeing (74.1%) and job satisfaction (80.9%).

Conclusions: Verbal and physical aggression by alcohol-affected patients is commonly experienced by ED clinical staff. This has a negative impact on the care of other patients, as well as on staff wellbeing. Managers of health services must ensure a safe environment for staff and patients. More importantly, a comprehensive public health approach to changing the prevailing culture that tolerates alcohol-induced unacceptable behaviour is required.

clinical staff in their ED to encourage participation. The ACEM e-bulletin and social media channels were also used to promote the survey. The College for Emergency Nursing Australasia (CENA) also distributed the survey. These distribution channels ensured the survey was targeted at clinicians working in Australasian EDs. At the time of its distribution, 1575 emergency registrars and 1270 emergency physicians were working in ACEM-accredited EDs, together with an average of eight nurses per physician.

The survey distribution methodology meant that a response rate could not be determined. A small number of responses were received from ED staff who were not doctors or nurses; these were excluded from analysis.

Statistical analysis

Quantitative data was analysed using SPSS Statistics for Windows 22.0 (IBM). Proportions with 95% confidence intervals (CIs) were calculated, cross-tabulated by clinician role, and compared in χ^2 tests; $P < 0.05$ was defined as statistically significant. When analysing Likert scale data, "positive" and "very positive" responses were combined, as were "negative" and "very negative" responses. When assessing how frequently alcohol-related aggression was experienced, "frequently" and "often" responses were pooled, as were the responses "occasionally" and "infrequently". Qualitative data were categorised according to thematic keywords derived from the free-text responses, and then analysed by the frequency distribution method.

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Ethics approval

Ethics approval was provided by the Monash Health and Monash University Human Research and Ethics Committees (reference, MUHREC-CF14/1691-2014000782).

Results

Responses to the survey were received from 2002 clinicians (emergency physicians, ED registrars, resident medical officers, interns, and ED nurses) working in EDs in Australia and New Zealand (Box 1).

Alcohol-related verbal aggression from a patient had been experienced by 97.9% of respondents (1899 of 1940) in the past year, and physical aggression by 92.2% (1784 of 1935) (Box 2). Appendix 2 breaks down the frequency of alcohol-related verbal or physical aggression experienced during the past year according to clinician type. Eighty-seven per cent of respondents (1682 of 1929) had felt unsafe in the presence of an alcohol-affected patient. Nursing staff were more likely than other ED staff to have felt unsafe (Box 3).

Sixty-eight per cent of respondents (1311 of 1940) reported having experienced verbal aggression often (a few times per month) or frequently (one or more times a week); 42% (807 of 1935) had often or frequently experienced physical aggression from alcohol-affected patients in the past year. Third party aggression (from patients' relatives and carers) was also common. Although most staff had experienced alcohol-related verbal and physical aggression from patients and verbal aggression from a relative or carer in the past 12 months, nursing staff were more likely to have experienced this problem than non-nursing staff (χ^2 test, $P < 0.001$) (Appendix 2).

Forty-eight per cent of respondents (931 of 1931) reported routine screening for alcohol consumption of patients presenting to their ED, and 44% (850 of 1928) reported screening, brief intervention and referral to treatment for patients at risk of alcohol harm.

Thematic analysis of qualitative responses (selected examples: Box 4)

1 Workplace characteristics of the 2002 emergency department staff who responded to the survey

	Number	Percentage
Gender		
Men	700	35.0%
Women	1285	64.2%
Not stated	17	0.8%
Staff role		
ED nurse	904	45.2%
EM physician	507	25.3%
EM registrar	373	18.6%
Medical officer	136	6.8%
Other	67	3.3%
Not stated	15	0.7%
Location		
Victoria	408	20.4%
Queensland	367	18.3%
Western Australia	300	15.0%
New South Wales	298	14.9%
South Australia	211	10.5%
Tasmania	46	2.3%
Northern Territory	29	1.4%
Australian Capital Territory	11	0.5%
Australia (total)	1670	83.4%
New Zealand	313	15.6%
Not stated	19	0.9%
Role delineation of ED		
Major referral	1035	51.7%
Urban district	566	28.3%
Regional/rural	379	18.9%
Not stated	22	1.1%

ED = emergency department; EM = emergency medicine. ♦

showed that alcohol-related aggression was a daily occurrence, as reflected in 24% of free-text comments on this theme (44 of 186). Respondents also commented that such behaviour should not be acceptable in the workplace.

Men and women reported similar frequencies of verbal and physical aggression from patients, but women were more likely to report verbal or physical aggression from relatives or carers (χ^2 test, $P = 0.01$) (Appendix 3).

Alcohol-related presentations were perceived to have a negative impact on waiting times, other patients in the waiting room, and the care of other

patients (summary: Box 5; full results: Appendix 4). Alcohol-related presentations were also widely viewed as having a negative or very negative impact on the workload, wellbeing and job satisfaction of ED staff (summary: Box 5; full results: Appendix 5).

Free-text responses about the impact of these presentations on ED functioning confirmed this. Sixty per cent of respondents (1191 of 2002) provided a comment about the effect of alcohol-related presentations on other patients attending the ED. Most described negative effects, with 48% (569 of 1191) commenting that

2 Frequency of alcohol-related verbal or physical aggression experienced by respondents within the past 12 months (summary)*

	Number of responses	Often/frequently	Occasionally/infrequently	Not at all
Verbal aggression from a patient	1940	67.6% (65.5–69.7%)	30.3% (28.3–32.3%)	2.1% (1.6–2.9%)
Physical aggression from a patient	1935	41.7% (39.5–43.9%)	50.5% (48.3–52.7%)	7.8% (6.7–9.1%)
Verbal aggression from a relative or carer	1923	30.8% (28.8–32.9%)	58.7% (56.5–60.9%)	10.5% (9.2–11.9%)
Physical aggression from a relative or carer	1930	18.9% (17.2–20.7%)	58.0% (55.8–60.2%)	23.1% (21.3–25.0%)

Data are presented as the percentage of received responses, with the 95% confidence intervals in parentheses. * For full results and breakdown by clinician group, see [Appendix 2](#). ♦

other patients experienced distress and felt unsafe if an alcohol-affected patient displayed loud, aggressive, violent or antisocial behaviour. Seventeen per cent (201 of 1191) commented that this distress was heightened in vulnerable patients, including children, the elderly, and in those who were mentally unwell.

Twenty-three per cent of these respondents (272 of 1191) also commented that alcohol-affected patients caused increased waiting times for other patients because they often were treated as a priority. Alcohol-affected patients were perceived to affect other patients by diverting resources (17% of respondents; 205 of 1191) and clinicians (15%; 182 of 1191), and by generally compromising the quality of care that other ED patients received (16%; 188 of 1191).

Discussion

Our study found that more than 90% of ED clinicians had in the past

year experienced physical aggression from a patient affected by alcohol, with 42% experiencing this aggression weekly or monthly. This frequency of physical aggression from a single cause is disturbing, particularly compared with a large survey of Australian general practitioners and hospital doctors in which 32.3% reported experiencing physical aggression in the past year.⁴

Verbal aggression from patients affected by alcohol was an ever-present part of clinical life for ED staff. This compares with 70.6% of a more general cohort of doctors reporting that they had experienced verbal or physical aggression.⁴ While all ED clinician types experience violence and aggression, it is more frequently experienced by ED nurses,⁵ and it has been suggested that nurses see violence and aggression as an inescapable part of their job.^{6,7}

We also found that ED clinicians frequently experience both physical and verbal violence and aggression

from alcohol-affected patients' relatives and carers. While this third party aggression has been reported before, comments made by respondents suggest that accompanying persons were often also affected by alcohol, and this may explain the high rate of aggression. Although there was no difference in their experience of violence and aggression from the patients themselves, female staff were more likely to experience violence and aggression from the carers of alcohol-affected patients. Previous research did not find this gender difference for either doctors or nurses.^{8,9}

Adverse impacts of alcohol-affected patients on other patients and the effective operation of the ED is concerning. The need to divert resources disrupts or delays care for other patients. Effects on the welfare of and care for other patients, particularly vulnerable groups, are further exacerbated by the disruptive and antisocial behaviours of alcohol-affected people in EDs.

Violence and aggression had a negative effect on respondents' perceptions of their wellbeing and job satisfaction. This has been previously reported,⁸ and it has been suggested that this affects the quality of care beyond its obvious effects on workload. Patient aggression and violence has a profound impact on patients, clinicians and the therapeutic relationship.¹⁰ It can also affect staff retention and recruitment, and this highlights the importance of

3 Emergency department staff reporting that they have felt unsafe because of the presence of an alcohol-affected patient in their emergency department*

Staff role	Number	% (95% CI)
Emergency department nurses	863	91.8% (89.8–93.4%)
Emergency department registrars	360	88.6% (84.9–91.5%)
Emergency department physicians	499	82.6% (79.0–85.0%)
Emergency department medical officers	133	72.2% (64.0–79.1%)
Other/unknown	74	85.1% (75.3–91.5%)

* $P < 0.001$ (χ^2 test). ♦

4 Selected qualitative responses to the survey

Alcohol-related aggression and violence in the emergency department (ED)

- Verbal abuse is an hourly occurrence. One or two people removed for physical aggression each shift, a staff member injured severely enough to have days off every few months, patients restrained by security/code black every two to four hours. Serious property damage (window/wall broken) every one or two months. [ED doctor, female]
- Staff are regularly faced with physical/verbal aggression due to alcohol presentations; several members of staff have had chairs thrown at them, one underwent a shoulder reconstruction after sustaining a dislocation from a patient and we are constantly abused. [ED nurse, male]
- If I am out of uniform I do not have to tolerate these behaviours and have a course of action; if I am in uniform, I am fair game! [ED nurse, female]
- I was assaulted and knocked unconscious by a patient. I was put in my own resus[citation] room with concussion and vomiting. I had residual effects for several weeks following. The patient was arrested in the ED. When asked why he hit the doctor, his reply was: "because no-one brought me a **** sandwich." [ED doctor, male]
- I was obviously pregnant and was threatened by a patient (in front of his kids and wife) that he was going to punch me in the stomach. [ED nurse, female]

The impact of alcohol-related presentations on patient care

- They can feel threatened and intimidated in an environment where they should feel safe. They are often shocked and offended by what they see or hear. [ED nurse, female]
- I always feel terrible when there is a parent with a sick kid and they are exposed to behaviour and language and sometimes violence or even police presence; it's very unfair towards them. [ED doctor, female]
- A woman and her 4-year-old daughter in a cubicle had a drunk man open the curtain and urinate over the bed thinking he was in the toilet. Distressing for mum and child. [ED nurse, female]
- Other patients in the ED often have delayed care because of intoxicated patients, and sometimes even important tests or observations are missed or forgotten because the intoxicated patient is taking up so much of our time — either vomiting, abusing staff or other patients, creating a scene, or generally being unsafe. [ED nurse, female]
- They use resources that may otherwise go to another case. If you have one remaining bed and two patients, and one of them is highly intoxicated, they will get preference over the patient who may be quite ill but is able to sit in the waiting room. [ED nurse, female]

community education about alcohol-related harms and of changing the culture of unacceptable behaviour.⁹

The MABEL study found that medical practitioners were less likely to experience aggression in workplaces where strategies to reduce aggression

had been implemented.¹¹ Environmental and human factors should be taken into account to reduce the risk of workplace violence, while resources that enable appropriate medical care and access to safe sobering-up facilities will assist EDs to manage alcohol-affected patients.

Study limitations

Selection and non-responder bias inevitably affects voluntary surveys. ED clinicians who have recently experienced aggression and violence from alcohol-affected patients may be more likely to respond. Further, as the survey was anonymous, it

5 The impact of alcohol-related presentations on emergency department function and care of other patients* and on emergency department staff[†] (summary)

	Number of responses	Positive/very positive	Neutral	Negative/very negative	Don't know
On patients					
On waiting times	1980	0.5% (0.3–0.9%)	13.7% (12.3–15.3%)	85.5% (83.8–86.9%)	0.4% (0.2–0.7%)
On other patients in the waiting room	1980	0.4% (0.2–0.8%)	4.4% (3.6–5.4%)	94.4% (93.3–95.3%)	0.8% (0.5–1.3%)
On the care of other patients	1982	0.6% (0.4–1.1%)	10.9% (9.6–12.4%)	88.3% (86.8–89.6%)	0.2% (0.1–0.5%)
On emergency department staff					
On staff workload	1991	0.8% (0.5–1.3%)	4.7% (3.8–5.7%)	94.2% (93.1–95.2%)	0.3% (0.1–0.7%)
On staff wellness	1981	0.7% (0.4–1.2%)	24.6% (22.7–26.5%)	74.1% (72.1–76.0%)	0.6% (0.4–1.1%)
On staff job satisfaction	1983	1.3% (0.9–1.9%)	17.4% (15.8–19.1%)	80.9% (79.2–82.6%)	0.4% (0.2–0.8%)

Data are presented as the percentage of received responses, with the 95% confidence intervals in parentheses. *For full results and breakdown by clinician group, see [Appendix 4](#).
[†]For full results and breakdown by clinician group, see [Appendix 5](#). ♦

was difficult to ensure that respondents did not complete the survey several times. However, our review of respondents' IP addresses and their demographic data suggests that this was unlikely. More than half the respondents worked in major referral hospitals, suggesting that this group was over-represented. Recall bias was minimised by asking respondents only about the past 12 months. Definitions of violence and aggression were provided in the survey to limit misclassification of events by respondents. Misclassification may,

however, have resulted in some respondents confounding alcohol-related presentations with those related to other drug use, or to a combination of alcohol and drug use.

Conclusions

Alcohol-related verbal aggression was commonplace for the clinicians who responded to this survey. Physical violence was experienced by a large majority. This violence and aggression has a negative impact on the care of other patients and on the

wellbeing of clinicians. Managers of health services must ensure a safe working environment for staff. More importantly, however, a comprehensive public health approach to changing the prevailing culture that tolerates alcohol-induced unacceptable behaviour is required.

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