In my emergency nursing practice, I was often treating patients after they had made some of the worst and riskiest decisions of their lives. A major challenge in emergency nursing is to provide nonjudgmental and compassionate care to patients in the throes of their emergencies, regardless of their risk-taking behaviors of vaccination status, daredevil stunts, alcohol use, drug use, tobacco use, suicide attempt, self-injury, interpersonal violence, sexual activity, weapon use, hazardous vehicle or machine operation, or dangerous or extreme sports and contests. Simply put, we often save patients from their own worst behaviors. Our patients’ risky and emergency-inducing behaviors may seldom align with our personal priorities and values. The nurse may be tempted to engage in othering the patient, placing the patient at risk for lower-quality care.1 Othering is a social process in which the nurse may see those who share their own worldviews within a hierarchically superior in-group and mentally polarize the patient into an out-group associated with biased perspectives of negative characteristics, blame, and subordinate status. We are professionally committed, trained, and socialized to deliver nursing care with a therapeutic and nonjudgmental approach. Ethical principles,2 cultural humility,3 and some theoretical frameworks4-6 can provide useful tools to successfully and effectively deliver nonjudgmental approaches in these patient-care situations. For example, All my Relations (Mitakuye Oyasin) is a spiritual and cultural mindset practice that can be learned through personal heritage, relationships, or immersion in Lakota Native American culture to approach all living things as the nurse would their own kin. This approach, with the deep respect of familial-like bonds, seeks understanding and commonality before judgment and othering. The purpose of this editorial is to briefly introduce the Behavior Change Wheel1 as a shared mental model to nonjudgmentally understand human behavior and develop effective emergency nursing behavior change interventions.

Behavior change is foundational to patient care in emergency nursing. Emergency nursing practice involves supporting patient self-management to care for new wounds, infections, splints, mobility limitations, sensory loss, medication regimens, health care system navigation, follow-up appointments, and more. Best-practice emergency discharge procedures also include lifestyle behavior change coaching interventions such as smoking cessation and improving diet and physical activity habits. On the basis of an ever-evolving scientific foundation, emergency nursing practice also requires near-continuous professional behavior change for the nurse to maintain updated practice standards. Motivating human behavior change is multifaceted and can be riddled with resistance and barriers. Nurse scholars often use the Theory of Planned Behavior5 or the Health Belief Model6 to plan and develop interventions that target behavior change.7-9 For example, McDonald et al7,8 developed an injury prevention program to reduce distracted driving for teen drivers that was based on the Theory of Planned Behavior model components of attitude, norms, and perceived control. Likewise, Burchill et al9 used the theory to assess nursing knowledge, skill, and attitudes regarding blood sample hemolysis prevention.

My own early work was informed by the Health Belief Model10 because I learned through cultural immersion and work experiences in multicultural spaces.11 The Health Belief Model guides the nurse to consider how demographic variables, susceptibility to illness, severity of illness, cost of carrying out the behavior, perceived threat of illness, cues to action, health motivation, and perceived control may affect the likelihood of the patient engaging in any given health behavior. At those times when a patient’s behavior is not congruent with the nurse’s personal worldview or values, these theories inform therapeutic and nonjudgmental professional nursing to both understand
patient motivations and respectfully develop mutually agreed on interventions to target behavior change. An important gap in the Theory of Planned Behavior and Health Belief Model is that a great deal of health behavior was simply never planned, rational, or consciously chosen. Rather, mental shortcuts (called heuristics in psychology), impulse, emotional drives, or unexamined or thoughtless habit may govern patient action. The Behavior Change Wheel incorporates these additional emotional impulse and unhealthy habit dimensions. Better understanding of the Behavior Change Wheel model can aid the emergency clinician in developing effective interventions meant to target behavior change.

First, the emergency nurse can consider 3 foundational questions about the source of behavior using the Behavior Change Wheel:

1. Is the patient capable of the behavior?
2. Does the patient have the opportunity to enact the behavior?
3. Is the patient motivated to enact the behavior?

The most fundamental factor underlying behavior is also referred to as the COM-B system, which is an abbreviation for Capability, Opportunity, Motivation, and Behavior (Figure 1). Here, capability, opportunity, and motivation all influence one another and interact with behaviors. The emergency clinician can further consider 2 subcomponents for each of these 3 underlying factors, visualized in the center circle of Figure 2. Capability requires psychological and physical capacity that nurses consider in routine care. Is the patient’s cognitive capacity impaired by a history of stroke? Does arthritis limit their physical ability to complete the desired task? Opportunity requires a physical environment and social culture or worldview for the behavior to occur. On discharge, emergency nurses routinely recommend follow-up with community-based primary or specialty care that requires the patient to have access to the internet or telephone. People experiencing homelessness may have no opportunity to schedule these appointments. Cultural taboos may limit the social opportunity for patients to initially seek or continue some mental health treatments, genitourinary or reproductive care, or palliative care services. Motivation is the emotional energy to induce and direct behavior. Motivation is broken down into reflection and intentional processes of logical decision-making and automatic processes of habit, emotions, and impulses. A great deal of nursing care and instructions to caregivers at discharge involves assessing for gaps in patient capability, opportunity, and motivation for nursing interventions that either provide the target behavior for the patient who is dependent or enable and support the factors leading to the self-management health behavior. Although the Behavior Change Wheel is introduced here in relation to the individual patient, the concepts can also be applied to the unit, the nursing workforce on the unit level, or even a whole population. I found that usual nursing practice routines can often pragmatically overemphasize education alone as the predominant factor in behavior change. Nearly all of my patients cognitively understood in detail that smoking cigarettes was unhealthy behavior and had accurate knowledge about smoking cessation information. But we still routinely provide written instructions, rote...
verbal instructions, and follow-up resources for near-endless internet-based multimedia instruction. The Behavior Change Wheel can be particularly useful for devising strategies when the patient cognitively understands all the facts related to the desired behavior but still lacks other opportunity, capability, or motivation to try or complete the behavior change.

The second layer of the Behavior Change Wheel (Figure 2) is composed of 9 intervention functions to address a deficit in capability, opportunity, or motivation and support successful behavior change. These intervention functions are education, persuasion, incentivization, coercion, training, restriction, environmental restructuring, modeling, and enablement. Successful nursing behavior change strategies often involve 1 or more of these interventions, and not all interventions are appropriate to each given situation. Table 1 includes each intervention, definition, and example in emergency nursing published in the Journal of Emergency Nursing. Many of these interventions focus on targeting emergency nurse workforce behavior, rather than focusing on clinical interventions for patient behavior change. We enthusiastically welcome manuscripts on clinical interventions for positive health behavior change in the patients and families served in the emergency care setting.

Government, organization, and unit policies are necessary to support effective and successful interventions. Thus, the third layer of the Behavior Change Wheel is composed of 7 policy categories: communication/marketing, guidelines, fiscal, regulation, legislation, environmental/social planning, and service provision. Table 2 provides definitions and emergency nursing examples published in the Journal of Emergency Nursing. The Behavior Change Wheel as a shared mental model allows emergency nurses to use systems thinking to analyze the success or failure of interventions with the broad need to strengthen, support, reform, create, or abandon related policies. More details on the links between the policy categories and intervention functions can be found in the original publication on the model by Michie et al.4

In conclusion, the Behavior Change Wheel provides a useful evidence-based mental model for emergency nurses to better understand the barriers and support needed to meet the goals for both patient behavior and emergency nursing workforce behavior with a nonjudgmental and compassionate approach. Emergency nursing practice involves near-continuous patient education, coaching, and support to achieve a new behavior change. The Behavior Change Wheel provides a foundation for critical thinking when assessing if the patient has the skills, motivation, and

FIGURE 2
The Behavior Change Wheel. (Reprinted with author permission from Michie et al4 and under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.)
<table>
<thead>
<tr>
<th>Interventions</th>
<th>Definition</th>
<th>Example from the <em>Journal of Emergency Nursing</em></th>
</tr>
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<tbody>
<tr>
<td>Education</td>
<td>Providing information or instruction focusing on knowledge and understanding</td>
<td>Knowledge test scores improved for emergency nurse participants using the ENA toolkit as an educational intervention on terminology, effective communication techniques, and types of gender-affirming surgeries in care of the patients who identify as LGBTQ+.12,13</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Communication intended to appeal to feelings that motivate action</td>
<td><em>Let’s Choose Ourselves</em> intervention included a component about adolescent attitudes toward cell phone use during driving. The behavioral target was decreasing distracted driving as injury prevention.8</td>
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<tr>
<td>Incentivization</td>
<td>Connect action to reward or to expectation of reward</td>
<td>The Culture Change Toolkit included public recognition for emergency nurses on a gratitude board (“kudos” board) located in the emergency employee break room and a thank-you card program.14</td>
</tr>
<tr>
<td>Coercion</td>
<td>Connect action to punishment/cost or expectation of punishment/cost</td>
<td>Theoretically, emergency nurses can file police reports or press criminal charges against a patient who assaults the nurse at work in some jurisdictions.15</td>
</tr>
<tr>
<td>Training</td>
<td>Providing demonstration, information, or instruction focusing on attaining skills</td>
<td>A simulation intervention was designed for emergency nurses addressing skills of airway management and weight-based dosing calculation for a pediatric patient in status epilepticus.16</td>
</tr>
<tr>
<td>Restriction</td>
<td>Reduce opportunity to take a particular action or assign rules and prohibitions to prevent an action</td>
<td>Physical patient restraints may be applied for emergency patients who are assessed as a danger to self or others, thus reducing the opportunity for violent behavior, preferably after less-restrictive interventions and de-escalation have been attempted.17</td>
</tr>
<tr>
<td>Environmental restructuring</td>
<td>Changing the physical or social context</td>
<td>Reducing sensory stimuli for patients with autism by dimming lights, providing a patient room, and limiting the number of interactions with staff, visitors, or other patients may prevent overwhelming or overloading the patient.18</td>
</tr>
<tr>
<td>Modeling</td>
<td>Providing an example</td>
<td>A newly licensed nurse observes an emergency nurse preceptor’s professional behavior of interacting with compassion and respect during patient care.19</td>
</tr>
<tr>
<td>Enablement</td>
<td>Remove barriers to action, increase opportunity or capability for action</td>
<td>Personalized care plan interventions were designed to increase opportunity to use available outpatient specialists and resources for patients with ≥4 emergency visits in the last year for the same health problem.20</td>
</tr>
</tbody>
</table>

ENA, Emergency Nurses Association; LGBTQ+, Lesbian, Gay, Bisexual, Transgender, Queer+. 
opportunity for the health behavior. Does the nurse have a habitual practice of delivering patient education in a set routine that isn’t reaching the patient? Perhaps the patient does not have a deficit in cognitive capacity and understanding but a gap in motivation and opportunity. The Behavior Change Wheel can help emergency nurses think through the full breadth of potential intervention functions in addition to rote or habitual practices of merely providing more information alone. Above and beyond individual patient behavior, the theory can also help craft more effective nursing workforce practice change and population health interventions.

### TABLE 2

<table>
<thead>
<tr>
<th>Policy</th>
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</tr>
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<tbody>
<tr>
<td>Communication/marketing</td>
<td>Disseminating a message broadly using any or all components of multimedia modalities</td>
<td>In a single-institution study, the intervention as an electronic health record banner reminding the triage nurse to adhere to guidelines for sickle cell vaso-occlusive crisis. The intervention increased the proportion of patients triaged according to guidelines. Although this intervention was not yet a policy at the institution, the study is an example of testing a potential new communication dissemination method policy for the organization.</td>
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<tr>
<td>Guidelines</td>
<td>Creating documents to recommend protocols or practices</td>
<td>ENA’s Clinical Practice Guidelines such as the one on the Massive Transfusion Scoring Systems recommend specific nursing care activities. In another example, outpatient antibiotic prescribing behavior for acute uncomplicated cystitis demonstrated poor concordance with national guidelines for empiric therapy prescribed with 22% duration, 77% of the dosing, and 70% of the therapy concordance.</td>
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<tr>
<td>Fiscal</td>
<td>Using systems of insurance payment, organizational budgeting and payments, or taxation to increase or reduce costs</td>
<td>Sexual Assault Nurse Examiner/Forensic Nurse staffing program was redesigned to provide more thorough staffing coverage over a multihospital system with overall cost savings.</td>
</tr>
<tr>
<td>Regulation</td>
<td>Establish rules or principles of action or practice</td>
<td>The ENA has advocated on the local, state, and national levels to establish, standardize, and expand the sexual assault nurse examiner role to best serve patients with care needs resulting from interpersonal violence or criminal behavior.</td>
</tr>
<tr>
<td>Legislation</td>
<td>Making or changing laws</td>
<td>ENA’s Government Relations team has successfully advocated for injury prevention and trauma system legislation addressing mandatory seat belt use, motorcycle helmet wear, ED violence, firearm safety, domestic and violent crimes, and trauma-funding reauthorization.</td>
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<tr>
<td>Environmental/social planning</td>
<td>Designing, changing, or regulating the physical or social context</td>
<td>Using a parking garage space, the triage and screening of patients with respiratory presentations was physically redesigned into a telemedicine-enabled drive-through system for patients with respiratory presentations to lower exposure risks to coronavirus disease.</td>
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<td>Service provision</td>
<td>Creating or delivering a service line</td>
<td>A bridge paramedic academic program was developed and delivered specifically for those already licensed as health care professionals.</td>
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REFERENCES