



Caring together

**EDTNA/ERCA
Recommendations
for Prevention and
Management
of Violence
and Aggression
in renal units**

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BACKGROUND

Violence in healthcare has been defined as any aggressive behaviour “aimed at inflicting harm or discomfort on its victims” (Felton, 1997). Although violence is increasing in most workplaces, it has become a significant problem for those working in healthcare professions (Rippon, 2000).

It would appear that aggression and violence in renal care is a difficult and widespread problem. King and Moss (2004) reported that 71% of 203 US dialysis staff experienced disruptive patient situations in the last 5 years. In a UK survey interviewing nurses working in nephrology wards, 80% of respondents had experienced an episode of violence and aggression in the workplace within the previous 12 months (Sedgewick, 2005). Other UK studies (Jones, *et al.*, 2008; Jones, 2009) in two renal units showed that aggressive incidents are caused by a minority of dialysis patients and relatives. Nevertheless episodes of aggressive behaviour are increasingly reported by healthcare providers.

Strategies to prevent and manage violence and aggression in the healthcare setting have to become a primary health and safety issue. Key components of the program include staff education and training, risk assessment and management practices, the use of patient contracts and policy development (Forster 2005). Others in use for general intervention are restraint and pharmacological management (Farrell & Cubit, 2005).

Intervention strategies include stress management and debriefing for staff victims and a work environment that is not conducive to violent behaviour (Warshaw & Messite, 1996).

Literature recommends the use of strategies for prevention and management of violence and aggression against nurses and other health personnel, but there is a lack of knowledge about the real use of prevention and management strategies in dialysis, nephrological and transplantation units at the European level.

OBJECTIVE

This brochure is dedicated to nurses and other healthcare professionals, to promote the dissemination of information concerning this serious widespread problem in healthcare: aggression and violence by patients, family members, caregivers and other healthcare workers, towards nurses and healthcare workers.

In 2008, the European Dialysis and Transplant Nurses Association/European Renal Care Association (EDTNA/ERCA) carried out a study with the collaboration of twelve European National Associations dedicated to renal care. The EDTNA/ERCA managed the study at international level. Each National President produced a list

of renal units in his/her country and the research team from EDTNA/ERCA invited all the units to participate. Inclusion was voluntary, and participating units were assured that data would be treated anonymously. The data were collected through a questionnaire.

This study demonstrates that violence and aggression prevention and management strategies are not widely implemented in the renal units of European countries. There are some differences between the European countries; in particular, Great Britain seems to have more awareness of this problem. (Zampieron, 2009).

Data suggest that it would be useful to develop recommendations or other educational tools for healthcare workers, useful for prevention and management of this topic, because this problem can be managed only with a total organization response, with duties and responsibilities for all members of an organization. International nurses and other healthcare workers associations can also offer lobbying/networking support for increasing practices oriented to decrease and manage violence and aggression in health institutions. They can also recommend and provided training to high risk groups as means of controlling workplace violence.

In conclusion, we propose that, as suggested also by International Council of Nurses (ICN), nurses and others healthcare workers associations, at the national and international level, to provide:

- public education on violence prevention through various programmes;
- assistance in creating a supportive nursing culture that does not perpetuate the tendency for nurses to blame themselves for incidents of violence;
- consultation on nursing curricula to foster positive nursing images and respect for nurses' rights to dignity and personal safety;
- continuing education programmes on violence and its management; bibliographies on the subject of violence;
- counselling services for members who are victims of violence (emotional, physical, legal); counselling services for members who display violent behaviour (emotional, physical, legal);
- statistical and anecdotal support for development of sound policies against violence; safeguarding nurses' rights to a safe work environment; assisting in development of work methods that provide quality care and maintain adequate staffing levels and promote safe patterns of behaviour (ICN, 2007).

SOME DEFINITIONS

Violence can be:

- Physical: intentional use of force against a person by another, without lawful justification, resulting in physical harm or personal distress; for example: pushing, hitting, punching or hitting with other objects, etc.
- Non-physical: use of inappropriate words or behaviour that causes discomfort and/or constitutes harassment/annoyance; i.e.: verbal abuse and threats,



gestures and rude or vulgar innuendos, sexual or racial harassment. Harassment of a disability or sexual orientation of a person.

SOME WORLD WIDE DATA

Violence can affect everyone regardless of age, sex, race, socio-economic class, education, religion and sexual orientation. Violence in the workplace, affects all professions, although in varying degrees.

In the U.S. in 2004, 14% of all accidents at work were caused by acts of violence. The Healthcare setting is one of the most vulnerable areas in terms of episodes of violence and aggression towards any of the professionals. In 2004, 50% of all fatal injuries occurring in the United States which arose from acts of violence and aggression against workers occurred in the health and social services.

Areas at greatest risk are:

- acute hospitals' wards;
- critical care area (urgent and emergency departments, operating room, surgery, intensive care and resuscitation);
- mental health and addiction units and services;
- facilities for the elderly;
- agencies responsible for chronic care.

VIOLENCE AND AGGRESSION AND NURSES

Of all the health professionals, nurses are most likely to become victims of violence, with a three times higher risk compared to other professionals. The explanation is related to the particular nature of the profession; nurses are in direct contact with the patient and his family who are often feeling vulnerable, frustrated or simply not in control of their situation and health. It is with them that the nurses create relationships which have a very strong emotional component.

WHAT LEADS TO VIOLENCE?

Issues related to the perpetrator of violence:

- psychiatric disorders (acute and chronic);
- organic chronic degenerative diseases;
- head trauma;
- effects of anaesthesia in post-operative wards;
- high blood levels of toxins, glucose, electrolytes, oxygen, bacteria (septicaemia);
- drugs and alcohol's abuse;

- presence of pain;
- fatigue/hyperstimulation;
- tension, anxiety, fear;
- confusion, disorientation;
- feeling of not being understood or believed concerning the illness;
- history of violent behaviour due to an aggressive personality, impulsivity, antisocial situation;
- communication difficulties (pathological or related to language or cultural habits);
- ineffective coping skills;
- social problems.

Nurse related issues:

- to judge, label or misunderstand the patient/relative/significant person;
- using a tone of voice and threatening body language;
- to put unrealistic expectations on the patient;
- lack of listening, understanding or respect for the values, opinions, needs, and the faith of the patient, the concern of himself and his family;
- not providing enough information to the patients about his/her health;
- lack of reflection on the impact of their own behaviour on the relationship with the patient;
- numerically insufficient staff and too little time;
- inadequate emotional self-management.

Organizational and structural aspects:

- hospital regulations (ironclad visiting hours, intense working patterns, and restrictive practices);
- long waiting times;
- uncomfortable environment (inadequate spaces - dark, overcrowded, noisy, hot/cold, poor air quality);
- constant coming and going of people (users and hospital staff);
- lack of privacy;
- unfamiliar environment;
- lack of rules related to safety.

CONSEQUENCES OF VIOLENCE

Impact on physical health: traumas, contusions, fractures; injury from bites; injuries from needles and sharps; infectious diseases resulting in (AIDS, hepatitis...); temporary or permanent disability; death.

Psychological and social consequence: high levels of stress; feelings of anger, fear, loss, distrust, guilt; progressive loss of confidence in themselves and in their own abilities; psychosomatic symptoms; post-traumatic syndrome and anxiety; burnout; eating disorders (such as anorexia and bulimia, obesity); abuse of alcohol, tobacco and drugs; lowering of the state of mood; deterioration of the quality of interpersonal relationships, isolation; sleep disturbances, impaired concentration, deteriorating ability to confront negative events; depression risk of suicide; progressive dissatisfaction with their jobs, loss of motivation; reducing the quality of assistance; increased absenteeism, up to requests for the transfer and dismissal.

Economic costs in terms of: hours lost; payment of damages and compensation.

REMEMBER!

VIOLENCE IS NOT INTRINSIC TO WORK!

You can and you should do what you can, with the help of 2 allies:

- 1. Companies have a duty to protect employees from risks to their health.**
- 2. Guidelines and recommendations help to identify ways to behave to avoid confrontational situations.**

FUNDAMENTAL STEPS

1. Prevent violence and aggression: prevention is first and foremost the most important issue; it saves time, resources and the severity of the consequences.
2. Create an atmosphere of non-violence. Be receptive to the needs of the patient, expressed or non-expressed, and always provide clear and precise information.
3. Involve family and significant others in the therapeutic relationship with patients. Learn the characteristics and meaning of the disease from which the patient is suffering, and especially the impact which it has on his/her psychological homeostasis, and try to judge whether the person has adequate coping strategies.
4. Collaborate with your coordinator and your colleagues in the identification and risk assessment in order to determine if you need support for developing a plan for the prevention of aggression or violence. Interventions/management specific: always inform them of any patient attitudes and other noteworthy events.
5. Participate in training courses and updating the knowledge and awareness of the problem, as well as the most appropriate techniques to prevent and manage incidents.

6. Use all the guidelines, recommendations and procedures available to you. Have all plans for action, which should be based on scientific evidence, easily accessible for all staff.
7. Inform the patients either by word of mouth or information sheet, of the zero-tolerance policy of the hospital about the violence and aggression. These two words are unacceptable!
8. Inform patients and relatives of the actions taken which will result from any form of aggression or violence.
9. Ensure your own behaviour cannot generate inappropriate responses from others.
10. Learn to recognise early the warning signs of violence and act accordingly (see Table 1 and Table 2).

Table 1 - Warning Signs of Violence and Possible Solutions.

WARNING SIGNS	POSSIBLE SOLUTIONS
Questions and statements repeated over and over again.	Stay calm, self-control, confirm that you are taking into account his/her concerns.
Using inappropriate language in an aggressive way.	Identify the kind of language and ask the help of an interpreter if needed.
Sudden increase or decrease in tone and volume of voice. E.g.- Shouting or refusal to speak.	Enhance motivation/give information in a calm voice.
Rude abusive answer or refusal to respond.	Calmly validate the information/response from the subject.
Rapid breathing.	Breathe slowly in a regular pattern.
Restlessness, agitation, sudden movements, pacing up and down continuously going nowhere.	Try to calm the person involved, invite him/her to sit in a comfortable position or join in the walk (that is the most helpful so long as it is not dangerous).
Invading your or others' personal space.	Move away to establish more space (safe).
Eye contact sustained (staring) or refused (no contact).	If staring then you drop your eyes. If eye contact is refused continue to talk without it.

Table 2 - Other Warning Signs.

<ul style="list-style-type: none"> • Dilated pupils. • Non-verbal depersonalizing language. • Straight rigid posture, dominant attitude of provocation (clenched fists, pointing fingers, etc...). 	<ul style="list-style-type: none"> • Muscle tension in the face and limbs. • Direct threats and threatening gestures. • Throwing objects, or hitting people.
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RESPONSABILITIES OF A COORDINATOR

1. Undertake a risk assessment:

- Analyse: type and place of work, types of patients treated; quantity and type of personnel working, hours of service, presence of procedures/guidelines for the prevention and management policies affected to aggression and violence, presence of a security service, type of organization.
- Structural features: identify the subjects who were the protagonists of attacks in the past; review the circumstances related to the accident (it is permitted to identify situations in which subjects are more prone to react against and the probability of serious harm); communicate to all staff the results of risk assessment.

2. Develop and disseminate a clear policy regarding violence and aggression, referring to data by WHO and principles and policies of associations like the British NHS (Zero-Tolerance Policy).

3. Create specific guidelines/recommendations/procedures (depending on the context in which they will be used) for the prevention and management through a multidisciplinary team between:

- A representative of the Health Department.
- Legal Affairs Area and/or Human Resources Management.
- The head of the Prevention and Protection.
- A representative of the nursing profession.
- A representative of the medical profession.
- A security officer at the workplace.
- A representative of the security services.

In order to create a procedure accepted and used by all team members, implement it formally using educational sessions to ensure correct understanding of the procedures, then monitor its use and its effectiveness. The procedure must:

- Describe the circumstances in which it should be used;
- Define roles and responsibilities;
- Describe the specific risk assessments and how to monitor them
- Include emergency response plans;
- Provide guidance on documentation of accidents and near-misses.

Clinical protocols should be used to manage the aggression resulting from a strictly medical or psychiatric condition; clinical aggression requires a clinical response!

4. Make any structural and organizational measures which might be useful:

- Install, if not already present: CCTV cameras with 24 hour recording, providing surveillance over all environments. Ensure that there are fixed or portable

metal detectors to detect metal weapons (if deemed necessary in relation to risk analysis).

- Provide a single entry for the user, visible from the security checking centre to ensure that the centre is recognizable and known to the user and is easily accessible to the staff.
- Provide access to restricted areas dedicated to the staff; ensure minimum personal space for each user, adequate to ensure privacy.
- Ensure comfortable lounges (equipped with TV, magazines, seats / chairs comfortable enough to sit all, etc..) and designated areas for smokers, ensure good lighting, temperature, humidity and ventilation of the rooms.
- Remove any objects, easily accessible to users, which could be used as a weapon (scissors, knives, glasses...).
- Ensure that there are sufficient personnel for the needs of the area (especially for nights and weekends), and check that the (male-female) ratio is correct for needs and ensure that the racial balance is correct.
- Minimize waiting times and if this is not possible or there are unexpected delays, clearly inform the user of them.
- Ensure that during the delivery of all services there are, at least, two professionals present.

RESPONSABILITIES OF INSTITUTIONS/ORGANIZATIONS

- Create a regulatory system about the attendance of users in the operating unit.
- Organize a reporting system of patients with a history of violence.
- Training and updating, in order to help staff understand:
 - the risk factors;
 - the causes both clinical and non-clinical;
 - the warning signs;
 - strategies for effective communication;
 - preventive measures;
 - workplace policies and procedures;
 - responses during the emergency and post-event;
 - the right to leave and take shelter at any time.

Always proceed with an assessment of training in order to determine whether or not the program achieved the objectives proposed.

- Create and start your own system for backing and supporting staff: stress that this system is at their disposal at all times and there must be no hesitation to use it in case of need.



- Periodically monitor the risk and contributing factors, and the results of implemented solutions.
- Use an approach that includes:
 - exhibition of posters/signs/warnings;
 - specific assistance plan;
 - possible restrictions on visits;
 - alternation of treatment plans;
 - possibility of refusal to provide assistance (except in life threatening situations);
 - possibility to conduct legal proceedings against infringers.

WHAT TO DO IN CASE OF VIOLENCE AND AGGRESSION?

1. Take control of the situation to minimize the possible effects.
2. Stay calm, ask for the help of one or more colleagues and keep in mind your spatial position over the exit sites/safe places.
3. Try using techniques for de-escalation:
 - speak with the subject very carefully, assuming attitudes of empathy (keep eye contact, if the culture allows it, and “Listen with your whole body”);
 - do not be judgemental (making sure that your verbal language is consistent with the non-verbal);
 - focus on the feelings of the person, on his/her perceptions, not only on visual signs (so you feel heard and understood with your opinions valued and not humiliated).
 - do not answer immediately, give the person a few moments of silence (to give him/her time to think, to realize the situation without creating a sense of oppression, and leave any space to vent all the tension);
 - clarify the messages by repeating what you understand (this also allows you to show interest in the person and their situation and maintain open communication).
4. Use interpersonal skills:
 - maintain calm tone of voice and non-aggressive speech, yet direct and open to the person;
 - prevent sudden movement;
 - prevent the presence of too many people (crowded room!);
 - maintain an adequate and safe distance from the subject.
5. Use effective communication skills:

- talk to the person using his/her name;
 - use a calm tone and gentle words;
 - encourage the individual to express his concerns and the reasons for his/her anger;
 - try to negotiate without arguments but be firm saying that language and aggressive attitudes will not be accepted or tolerated;
 - help the subject to maintain control of his/her actions;
 - remind him/her that you are there to try to help him/her;
 - be prepared to compromise and to apologize for a wrong attitude from you or your colleagues.
6. If what you have done is not sufficient (in extreme cases!), you are authorized to:
- implement self-defence techniques designed to free yourself from the grip of the aggressor;
 - activate the alarm system;
 - contact your safety service and/or the police;
 - move away from the subject immediately;
 - use physical restraint and/or medication.
7. Always use a care plan and/or a specific procedure; staff involved should be in an appropriate number to the situation; designate a single member of staff to direct the team; guarantee the physical and psychological welfare of the patient (protect head and neck, compressing the neck); continually reassess the situation to identify any changes. During the procedure which may involve physical techniques including those for de-escalation; closely monitor the physical condition of the subject during and after the intervention. Keep ready to perform BLS and always be aware of the risks related to restraint (increased aggression, injury, death). Free the patient from restraint as soon as it is possible, thus preventing further discomfort and danger.

WARNING!

The physical and pharmacological interventions are not safe procedures and should be avoided as much as possible; any physical and pharmacological interventions deemed necessary should be implemented in proportion to the damage they will prevent.

8. If you are a coordinator or have other responsibilities:
- implement a critical-incident management plan, organizing staff training time to use;

- install, if not already present, systems for alarm/panic (personal and wall) in places of high risk with emergency buttons to activate in critical situations and train the staff of their proper use;
- mark Emergency exits;
- establish, if not already present, a security service specifically trained and dedicated (active mainly at night); and a link with the Police forces;
- allocate some rooms for the possible isolation of patients or persons potentially violent or detained, with the appropriate security measures.

WHAT TO DO AFTER THE EVENT?

1. Adequately support yourself and/or your colleagues. Do not be afraid to ask for help; do not be ashamed to seek support. It is normal to need it from others!
2. Review and analyze the event along with the rest of the staff, trying to identify the context in which it occurred (background, demonstrated behaviour, consequences). Ask all present to make the reappraisal of risk.
3. Remember to fill out the forms as soon as possible to document the event, if any, or write everything in your nursing file or other document available. Always refer to all that happened. This document is kept to monitor the incident and will through, systematic review, uncover the elements in common which can be used to improve prevention and aid management. Report the episode of violence, both real and potential, completely, by entering:
 - units and precise physical location where this event occurred, date and time, general information about the aggressive patient/subject;
 - factors that led to the outbreak of violence, characteristics which are known and the consequences that resulted;
 - how the situation was handled (in as much detail as possible): number and type of people involved (staff / non-staff); actions committed in the post-event, both to the patient and to those involved, the outcome of risk analysis carried out in the post-accident. Do not forget to sign the document.
4. Examine your feelings and emotions, your mood and always ask: “How do I feel?” Remember, reflect and re-examine your feelings and your emotions: first a personal reflection, then share everything with your colleagues. If you still are not free from the event, ask for help! A professional (i.e., a psychologist) can certainly give you a hand!
5. Remember always to notify the incident to the Coordinator or to whoever will make it more tangible and real, and can better deal with the problem and implement additional measures for prevention and management. If you are a Coordinator or have other key responsibilities:

- verify the physical health and, above all, the mental health of your staff: whether the victim of violence needs medical support and/or psychological and at what level;
- establish a system of report cards of violent incidents with specific documentation;
- the “sentinel event” (death or severe damage from violence perpetrator) should be reported according to the protocol of sentinel event monitoring of the Ministry of Health. Once completed, the form must be included among the patient’s clinical notes;
- document which Institutions and what activities of the staff support systems were involved in violence and aggression: counselling (with a specialist), debriefing (with a specialist and/or peer); team meetings to work through the feelings and sensations, and review the event itself; psychological / psychiatric support;
- identify the magnitude of the effect (and possibly damage) violent event on the staff involved;
- provide the treatment of the first “rescue” (if deemed appropriate).

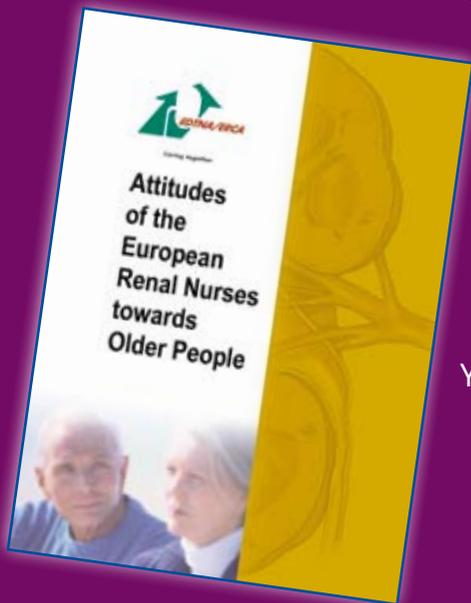
IN SUMMARY: 3 FUNDAMENTAL STEPS

- 1. PREVENT.**
- 2. If, despite everything, event of violence and aggression still occur TAKE CONTROL and try to minimize the possible effects.**
- 3. After the event: Adequately SUPPORT yourself and/or your colleagues.**

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NEW PROJECT:

Attitudes of the European Renal Nurses towards Older People

You are invited to contribute to the next EDTNA/ERCA project in collaboration with National Associations.

For further details please contact the EDTNA/ERCA Secretariat or visit our website.

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