

# An aggression policy that works

Denby A Kitchener, Sharon R Sykes and Allan G McEwan

## Abstract

In 1999, a survey of the clinical staff in Royal Darwin Hospital showed that most instances of aggressive and abusive behaviour by patients or visitors occurring in the hospital went unreported because staff believed there would not be any follow-up investigation or action taken by management. In response, a hospital working party was formed to develop and implement an aggression management policy with practical effective strategies. The principal tool used was an Action Plan that delineated an immediate response to the aggression, as well as long-term strategies such as negotiated care and behaviour modification programs. An advocate is provided for the patient and debriefing for staff members. If the aggressive behaviour continues, early discharge of the patient could be initiated. The fundamental principle of the policy is to prevent fostering a culture of acceptance of aggressive behaviour through appropriate early intervention. In 2002, a follow-up survey showed that 82% of aggressive incidents were being reported and dealt with by management in a timely manner — a significant improvement.

**Aust Health Rev 2004; 28(3): 357-362**

CURRENTLY, MOST AUSTRALIAN HOSPITALS operate an open-door policy for patients and offer 24-hour service in a climate of high patient throughput, high acuity and frequent long waiting times, often leading to an increase in frus-

## What is known about the topic?

Australian hospitals are experiencing an increase in aggressive and abusive behaviour by patients and visitors.

## What does this paper add?

This article provides a case study of the development and implementation of an aggression policy.

## What are the implications for practitioners?

Health care managers should be aware of the need to establish effective aggression management programs to ensure a safe environment for staff, patients and visitors.

tration, verbal abuse and violence (Lyneham 2000, p. 8). In 1999, the Australian Institute of Criminology reported the health care industry to be one of the most violent industries in Australia (Australian Institute of Criminology 1999). Lyneham and Jones reviewed a number of studies and identified issues occurring in hospitals (Jones & Lyneham 2000, p. 27). These issues covered increased waiting times and consequent frustration, increasing use of weapons, inadequate security systems, a culture of silence, inadequate support for mental health programs, a general lack of reporting, a lack of institutional concern and ineffective systems of support. The literature indicated the most likely situation for aggression is when patients are receiving direct attention. This is probably due to the patient feeling out of control in the patient care situation (Cahill et al. 1991, p. 239). The issues identified above are relevant to Royal Darwin Hospital (RDH), an acute 295 bed hospital in the Top End of the Northern Territory (NT). RDH is the only acute tertiary public hospital in the Top End of Australia.

The Northern Territory has a multicultural population of whom 27% are Aboriginal people. The average age of the population is 29.6 years (ABS 2001). Because the hospital is geographi-

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cally isolated from other major health facilities, occupancy rates often exceed 100%. This factor, coupled with the issues identified above, can inflame potentially aggressive situations. The question for health managers is how to manage these difficult situations and resolve the underlying issues with limited resources.

Anecdotal evidence suggests that the majority of patients and visitors in RDH do not display aggressive or abusive behaviour. Of the very small proportion of hospital patients and visitors who exhibit aggressive behaviour, a core group exists who do not respond rationally to reasonable approaches by staff. This article discusses a strategic approach to the behaviour management of patients who do not respond favourably and maintain or increase their aggressive conduct.

In 1999, a survey of clinical staff at RDH highlighted an increase in the incidence of violence and aggression in the workplace (Edmunds 1999). The results of the study indicated that 75.8% of aggressors were male, 64% were patients and 29.3% visitors. Only 58% of staff had expected to encounter abuse on a regular basis either daily or weekly and over a 6-month period. Sixty-eight percent of staff reported more than one aggressive incident and reported feelings of frustration, anger, fear, and feeling humiliated or degraded by the behaviour. They regarded aggression as an unfortunate or inevitable occurrence.

A working party was formed to address the issues and develop and implement an Aggression Management Policy that would allow nurse managers and clinicians to minimise the incidents and effects of aggressive behaviour of patients and visitors. It was recognised that in the management of aggressive incidents there were no definitive answers to the problems, but applying practical strategies to encourage behavioural change could be successful. The working party worked in partnership with the Northern Territory Police Service to secure the services of a Senior Constable. The 'Hospital Police Officer' is now stationed in a full-time capacity in the hospital. In addition to under-

taking police service work with inpatients (eg, motor vehicle accident reports/domestic violence etc), the officer guides and assists staff in the management of aggressive situations, both potential and actual, and has become a valuable member of the Aggression Management Working Party.

The working party agreed that it was imperative that clinical staff recognise the benefits of using aggression management strategies as an intrinsic part of delivering quality patient care. Management of aggressive behaviour has traditionally been viewed by most health care workers as outside their scope of practice and responsibility and not perceived as the 'real business' of health care providers.

The policy aims to reverse this view by reinforcing three main principles:

- The patient is responsible for their own behaviour.
- All staff have a responsibility to report aggressive incidents.
- Managers have a responsibility to act on incidents reported.

## The policy

The policy provides guidelines and strategies for the management of aggressive and abusive behaviour occurring between patients and staff, visitors and staff, and between staff members. Significantly, the policy promotes staff accountability in reporting verbal abuse or physical aggression and requires managers to deal with incidents in a timely and appropriate fashion. Staff accountability is a significant step forward as in the past staff had been reluctant to report incidents because they believed nothing could or would be done by management. The 1999 survey found that 20% of incidents were not reported. According to Edmunds (1999, p 16), staff believed there was no point in reporting. Since implementation of the policy, there has been a significant increase in the reporting of aggressive incidents by staff, thereby allowing managers and clinicians the opportunity to minimise the effects of aggressive incidents in the work place.

The policy requires that managers put in place appropriate measures to reduce the impact of aggressive behaviour on patients and staff. The policy aims to clarify the roles of all staff in reducing aggression and assisting in:

- Provision of a safe environment for patients, visitors and RDH staff.
- Identification of potentially aggressive and/or abusive situations in RDH.
- Assessment and control of risks in situations identified as presenting a potential for aggression and/or abuse.

The policy recognises that the underpinning principles of aggression management are:

- RDH has an obligation to maintain a safe environment for patients, visitors and staff in the hospital.
- RDH does not condone any form of abuse, aggression or violence.
- RDH management of abuse, aggression or violence is aimed at preventing or minimising its consequences.
- RDH management of aggression will occur in the least restrictive environment recognising the use of best practice techniques consistent with safety for all concerned.
- RDH supports staff education programs in aggression management techniques.
- RDH staff all have a responsibility to report aggression.
- RDH will manage appropriately abusive behaviour displayed by any patient, visitor or staff member occurring at any time along the continuum of care, to minimise the impact on those involved and those in the vicinity of the incident.

The policy employs a methodology based on the theory that if behaviour is addressed early along the continuum it will minimise the impact on those involved and those in the vicinity of the incident. Inappropriate behaviour should be addressed when it occurs to prevent escalation of the situation. The technique allows patients, visitors and staff negotiated boundaries of behaviour (Cherry & Upton 1997, p. 15). The policy has been developed specifically to suit the needs of RDH, however the concepts can be applied in other acute health care facilities.

## **Advocacy**

A principle of the policy is the provision of an advocate of the patient's own choice. This is mandated in the policy for any patient involved in an incident. During all stages of aggression management action, the patient must be offered an advocate of their choice to ensure natural justice. A patient advocate can include the Hospital Complaints Officer, a relative or friend, hospital staff member, member of the clergy, or any person nominated by the patient.

## **Use of Action Plans**

The Action Plans are a tool designed to guide staff in managing aggressive incidents. They outline the steps required for staff at the time of the incident and options for follow-up action. A key element is that the aggressor is informed of their inappropriate behaviour, informed that it is not tolerated and made aware of the consequences of continued aggressive behaviour. There are two Action Plans — one for instances of verbal abuse and a second for cases of physical assault. Both plans provide a list of prompts, options and resources that allow staff to manage the incident. The Action Plans outline steps dealing with escalation of or repeated incidents on the part of the aggressor, and when repeated incidents occur or the level of aggression increases more senior personnel must become involved in the management of the incident.

For example, in the first instance of verbal abuse (depending on severity), it may only be necessary for the staff member to advise the patient that the behaviour was unacceptable and should not be repeated, and the patient's concerns addressed. If further episodes occur, it may require the intervention of the Clinical Nurse Manager of the unit, with or without the support of other members of the RDH Aggression Response Team. If an incident continues or the situation escalates, the Aggression Management Team should become involved promptly. Additional departmental staff such the General Manager, Medical Superintendent and legal representatives may also need to become involved.

If the above practice is followed and the incident managed appropriately, a safe outcome should be the end result for everyone involved in or near the incident. Staff can be reassured that positive action is being taken to address the problems, thereby providing a safe environment in which to work.

In addition, the Action Plans identify available resources that can be utilised should the safety of staff or other people be an issue, for example, hospital security staff or police. The Action Plans provide guidelines and alternatives for actions such as assessment by the Medical Officer. Aggression management alternatives include restraint, sectioning under the Mental Health Act or the development of a behaviour contract. In some instances it may be required to discharge or restrict access of the aggressor to the hospital building and/or grounds.

Staff found that when applying Action Plans to manage an aggressive incident most patients quickly recognised their behaviour was inappropriate and generally cooperated. Unfortunately, some patient's behaviour cannot be controlled by reflection, and despite the endeavours of staff to address their concerns these patients continue to behave unreasonably. However, while these people have behaviour problems they still may require clinical care. In these instances, inappropriate behaviour can often be managed using negotiated care that suits both the patient and staff. Under these circumstances, it is essential that the patient must have an advocate. All actions and the consequences of continuing to behave inappropriately must be carefully explained to the patient so they can make an informed decision about their care or management plan.

For example, if a patient chooses only to have a dressing done once a day instead of twice daily, it may mean the wound does not heal within a reasonable period, thereby lengthening their hospital stay. All of the issues and likely consequences must be carefully explained to the patient and documented. Use of Action Plans allows the management of differing aggressive incidents and patients, and guides staff toward positive outcomes. Recognition is given in the

policy to the need to offer staff a formal or informal debriefing by a skilled person and to record whether the staff member accepted or refused the debriefing.

### **Supportive initiatives**

A practical initiative has been the placement of signs advising 'Zero Tolerance' of aggressive behaviour at all entrances to the hospital and on each of the ten levels of the main ward block. The signage is frank and pictorial to promote understanding of the hospital's attitude to aggression. In addition, the manager also provides support people for staff should they have to attend court as a witness or complainant.

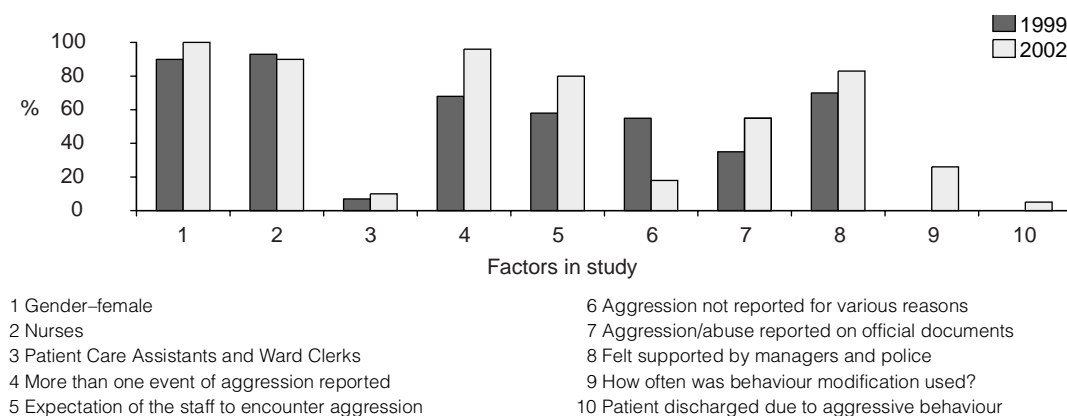
Staff education became a priority and in-service education was implemented to provide staff with the knowledge and skills required to defuse aggressive incidents. The sessions incorporated theoretical and practical aspects of aggression management. A small grant was secured to subsidise an in-hospital aggression management course for staff. The team put in place a pilot Aggression Management Response Team (AMRT) in the Emergency Department (ED), and, following their success, the team now responds to all incidents hospital-wide.

When faced with extremely aggressive or abusive people, RDH has obtained court orders, such as restraining orders, and has considered using other types of health facilities for management of extremely aggressive or abusive patients. The Aggression Management Policy outlines a step-by-step process for managing patient care when the patient is subject to a court order or in another facility. In extreme cases, where all other avenues within the policy have been exhausted, the final option available is to consider discharging the patient to ensure the safety of staff, other patients and members of the public.

### **Changes in attitude**

A trial of the Aggression Management Plan was conducted in a general orthopaedic and general medical ward in a follow-up study in 2002. The study aimed to measure the incidence of aggres-

### Comparison of 1999 and 2002 surveys



Source: Edmunds 1999; Edmunds 2002.

sive behaviour, staff attitudes and degree of reporting over a three-month period. The findings of this study found 80% of staff expected to encounter abuse on a regular basis either daily or weekly. Over 96% of staff reported they had experienced more than one aggressive incident in the 3 months of the study and reported different emotions in response to the aggressive behaviour. Responses included: 'Everyone should be responsible for their own actions' and 'Each case of aggression is different'. Staff were personally offended by the incident/s and were at times angry but could understand some patients' frustration. While many stated that aggressive behaviour was inappropriate, many recognised it as a component of their work environment.

The comparison between the outcomes of the 1999 and 2002 surveys is shown in the Box. The 1999 study respondents were mainly female, however all were female in 2002. The respondents were predominantly nurses in both surveys. There was a marked increase in reporting incidences of more than one aggressive episode (>80% compared with 68%) in the latter study. In 2002, staff felt they were more likely to encounter aggressive incidents but were now more likely to report the incident than before because they had more support from managers. The number of unreported

aggressive incidents dropped from 60% in 1999 to less than 20% in 2002.

The scope of the 2002 study did not allow for the identification of the reasons for the increased incidence in reporting aggression in the workplace. This may be a result of increased incidence of aggression, heightened awareness of the issues, or a greater confidence in an appropriate response by management. Clearly the 2002 study demonstrates staff are reporting a higher proportion of incidents than in the past.

Implementation of the Aggression Management Plan allowed hospital management to manage and minimise aggressive incidents and lessen, where possible, the impact of aggressive behaviour on patients, visitors and staff. Staff have been encouraged to report incidents, and management have been encouraged to act to prevent the reoccurrence of aggressive or abusive behaviour. A change in the perception of aggressive behaviour appears to have emerged between the 1999 and 2002 surveys. In the first sample staff viewed the aggression to be personally directed by the aggressor. The later sample shows staff adopting a more objective attitude to aggression despite an increased incidence in aggressive and abusive behaviour. Following the apparent success of the trial of the Aggression Management Plan and the

implementation of the Aggression Response Team, education sessions and other initiatives described above, the Plan was implemented throughout RDH in October 2002.

## Conclusion

The Royal Darwin Hospital Aggression Management Policy has been successful in changing staff attitudes to the management of aggressive incidents in the clinical settings in RDH. The policy recognises there are no definitive answers to the issue and that rigid guidelines are not always appropriate. It does, however, offer practical strategies to manage incidents in the workplace and to bring about a change in attitude and behaviour. Early intervention ensures that an acceptance culture is not fostered in the aggressor.

The options in Action Plans guide the employee and response team through available resources and strategies to effectively manage the aggressive behaviour to ensure optimal patient outcomes. The Royal Darwin Hospital staff indicated that applying the policy effectively manages the risks and gives staff the guidance and confidence to address this growing problem in our acute care hospital.

## Competing interests

None identified.

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(Received 14 Nov 2003, accepted 28 Sep 2004)

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