

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

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Abstract

The haemodialysis nurses at St George Hospital chose to address the problem of aggression in the dialysis unit as their Models of Care project. Aggression had been a long-standing problem in the dialysis unit and the nurses perceived that the amount of aggression had increased but felt powerless and unsupported to address this.

Method

Baseline data was collected using: Incident Information Management System (IIMS) data, that is, the online system used by the hospital to report any type of incident; the Aggression Grading Record of Observation (AGRO) score data; process mapping; patient satisfaction surveys; and staff satisfaction surveys. Two simple strategies of standardised communication were implemented for three months: an illustrated flyer outlining realistic waiting times and a system of nurse to patient allocation. After three months the number of aggressive incidents was remeasured and compared with the baseline.

Results

The baseline incidence of aggressive episodes recorded using the AGRO score was found to be between 2% and 8% of all treatments. Common reasons for aggression included: waiting times (52%), mental health issues (17%), environmental issues (11%) and treatment conflicts (11%). After implementing the strategies for three months, data was collected again. The incidence of aggression dropped to less than 2% for the first two weeks and to less than 1% for the last two weeks of data collection.

Conclusion

Through the use of effective, standardised communication it is possible to reduce the incidence of aggressive episodes to <1% of dialysis treatments.

Background

The haemodialysis unit is a unique environment where patients can attend for treatment over many years. Haemodialysis units often care for patients who are impatient and sometimes angry and hostile. This project investigated the problem of aggression

towards nurses in the haemodialysis setting.

The St George Public Hospital Haemodialysis Unit is situated in a multicultural area of Sydney and is one of the largest haemodialysis units in Australia, currently operating 32 chairs with approximately 114 patients and 50 staff (both full-time and part-time). The

Keywords

Haemodialysis, aggression, communication, information, multicultural.

unit is divided into two areas, one with a higher patient to staff ratio where the less stable patients receive dialysis, and the other where the more stable satellite-type out-patients are cared for.

In September 2009 the St George Public Hospital haemodialysis unit was invited to participate in the Renal Models of Care programme, an initiative of the New South Wales (NSW) Agency for Clinical Innovation (formerly Greater Metropolitan Clinical Task Force) in partnership with NSW Health Nursing and Midwifery Office. Its goal is for nurses to investigate ways of making better use of available resources in the face of a growing population of patients requiring care for end-stage renal disease (Chiarella & Westgarth, 2009).

The haemodialysis nurses at St George Hospital chose to address the problem of aggression between patients and nursing staff as their Models of Care project. Aggression had been a long-standing problem, and the nurses perceived that the amount of aggression had increased but felt powerless and unsupported to address this.

A grant of \$10,000 was awarded from the Australian and New Zealand Society of Nephrology (ANZSN)/Amgen and was used to fund nursing time and resources to implement communication strategies.

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Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

This project had ethics approval from the South East Sydney and Illawarra Area Human Research Ethics Committee.

The aim of the project was to reduce the number of aggressive incidents in the haemodialysis unit to less than 1% of total treatments by improving the haemodialysis experience for patients and staff.

Method

Through the Renal Models of Care programme, two senior nurses were identified to lead the project. A team of nurses was sought to maximise communication and act as resource people across the unit. The final team including project leaders had nine members, plus the guidance of the nephrology clinical nurse consultant (CNC).

Before starting the project it was necessary to explore definitions of 'aggression' and how it is interpreted in health care.

Defining aggression

Many sources suggest that the word 'aggression' has so many interpretations that it is virtually useless for the purposes of scientific analysis (Rippon, 2000; Sommargren, 1994; Whykes, 1994; Scott 1992). As there is no standardised universal definition of aggression and as interpretations vary infinitely as to what constitutes aggression, it is difficult to measure and compare studies relating to aggressive behaviour (Sommargren, 1994).

For this project it was decided to adopt the NSW Health definition of aggression, being:

Any incident, in which employees are abused, threatened or assaulted in circumstances arising out of, or in the course of, their employment including

verbal, physical or psychological abuse, threats or other intimidating behaviours (NSW Health, 2003).

This definition seems quite appropriate in that it includes the term 'intimidation'. As highlighted by O'Connell *et al.* (2000) 89.5% of nurses in their study believed that aggressive behaviour included intimidation and the authors believed future studies should include this in their definition.

The literature reveals that over the last decade the health care setting is becoming a more violent place to work (Rippon, 2000) and this has been attributed to the increasing level of violence in the general population (Lipscombe & Love, 1992). While initially, aggression was thought to be a problem only in areas such as mental health and accident and emergency departments (Sommargren, 1994), a study by O'Connell *et al.* (2000) found that aggression in health care is widespread and not confined to any particular ward setting, with up to 95% of nursing staff in the study encountering verbal aggression in the last 12 months. While there are numerous papers on patient aggression in the health care setting in general (Fern, 2006; Rippon, 2000; Whykes, 1994), very little work had been documented in the setting of the haemodialysis unit until more recently. Jones (2008) has identified that disruptive, abusive and violent behaviour by patients and occasionally their family members is becoming a significant problem in some haemodialysis units, and a survey of nephrology nurses conducted in the United Kingdom (UK) indicated that 80% of respondents had experienced some form of violence or aggression at work within the last 12 months (Sedgewick, 2005).

Measuring the incidence of the problem

A method for measuring the amount of aggression was required to establish a baseline. Anecdotally staff thought that it happened all the time and was increasing, but there was no accurate measurement of how many aggressive exchanges took place as a proportion of the 345 dialysis treatments provided each week at St George Public Hospital.

Examination of the Incident Information Management System (IIMS) data revealed that during the previous 12 months only seven incidents of aggression had been reported. Staff knew that this was not a true picture of the problem of aggression within the unit. As noted by Whykes (1994) when nurses deal with repeated exposure to aggression in varying degrees they become desensitised. It appears that nurses rarely report an incident of aggression if there is no perceived intent (such as dementia, confused, medicated or postop patients) (Fern, 2006). This may account for the under-reporting of aggressive incidents on IIMS. Rippon (2000) concluded that under-reporting may be due to poor reporting mechanisms, excessive paperwork and gender of the victim. Rippon highlighted the fact that anger is a common emotion in the health care setting and it has become accepted as a hazard of the job. The desensitisation of nurses who do not report every event does not diminish the cumulative effect it has on them (Whykes, 1994). When Holden (1985) asked nurses to describe their feelings after experiencing an aggressive incident their responses included fear, anger, anxiety, helplessness and resentment.

At the time of starting the data collection phase, the team members were unable to source an appropriate tool to collect a snapshot of the actual level of aggression

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

within the unit. The Mental Health team at St George Hospital were consulted for ideas on recording and documenting incidents of aggression. To ensure nursing staff compliance on completing this documentation it needed to be simple, efficient and maintain confidentiality. Incorporating aspects of the Mental Health Department's *Behaviour History and Care Plan*, the St George Models of Care team developed the Aggression Grading Record of Observation Score (AGRO; Figure 1). This tool is a simple tick box chart for nurses to easily record every aggressive incident they encounter. To capture the full range of aggression, incidents on the AGRO score were graded across a scale from 'Comment', 'Criticism', and 'Complaint' through to 'Confrontation' and 'Outburst'. Other data that was collected included date, time, reason for the incident, and gender and ethnic background of both the aggressor and the recorder as literature

has suggested a link between culture and aggression (King & Moss, 2004; Yeh & Chou, 2007). Information about the patient's age and their mode of transport to dialysis was also added to the chart for the re-measuring stage. Nurses used the AGRO score to record every incident of aggression they encountered. As the time period for recording the baseline covered the Christmas and New Year holidays it was extended to nine weeks.

Reasons for aggressive behaviour in the haemodialysis unit

An understanding of the reasons behind the aggressive behaviour in the unit was sought. The manager of the Aggression Minimisation programme at St George Hospital was consulted and suggested the following system model (based on NSW Health, 2003) to analyse the problem of aggression in the haemodialysis unit.

The Aggression System Model (Figure 2) shows that triggers to aggression potentially arise from three areas: the clients, that is patients and relatives; the staff members; and the organisation or the environment. The Models of Care team brainstormed what each of these three factors might contribute to the level of aggression in the unit by reflecting upon their experiences. Having worked as staff within the organisation for many years, it was easy for the team to identify triggers to aggression that may arise from the staff or as a result of the organisation or environment. For triggers to aggression arising from the patient, team members used empathy to imagine how dialysis would impact on their own lives and reflected on specific instances of aggression that they had witnessed. When the responses were analysed they fell into four clear categories, illustrated in the following table: issues of control; failures in communication; the clinical or

AGRO Score (Aggression Grading Record of Observation)																
Date	Time	Incident type					Comments about the incident	Is this incident worthy of an IIMS report? Yes/No	Aggressor					Reporter		
		Comment	Complaint	Criticism	Confrontation	Outburst			Patient	Relative	Staff	Gender M/F	Age	Transport Type Bus/ Ambo/ Relative/ Self drive	Ethnic background (check notes if unsure)	Gender M/F

Figure 1. Aggression Grading Record of Observation (AGRO).

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

physical environment; and psychological reasons (Table 1).

A common observation about some of the behaviour was that while it was not overtly loud or violent, nurses thought it was aggressive in a passive way. The comment 'Good afternoon' at 7 am in the morning may appear to be nothing but gentle humour, but when it is repeated day after day and surrounded with comments about the time, how late it is, how late they will get home, then it becomes part of a pattern of behaviour that causes the nurse to feel pressured and harangued. No attempt was made to judge whether incidents were truly aggressive or whether a communication breakdown had led to an exchange being wrongly interpreted as aggression. In this way it was hoped that the data collected

for this project would accurately reflect the amount of aggression perceived by the nurses.

A process mapping exercise was carried out to record a typical dialysis day of eight patients: two who travelled independently; two who were brought to the unit by relatives; two who travelled on the renal bus; and two who came by ambulance.

Patients who drove themselves or who were brought in to the unit by relatives spent up to two hours of their dialysis day waiting. Both of these groups expressed concerns with the availability of parking spots close to the doors, especially the drivers who needed to park and collect relatives. The cost of parking was also an issue and two of the four patients spoken to in these groups had

received parking infringement notices while attending the dialysis unit.

Patients travelling on the renal bus spent up to 2.5 hours waiting, but those who travelled by ambulance were found to spend up to 8.5–9 hours of their dialysis day waiting. These are patients who do not meet the criteria for the renal bus, and who do not have relatives to bring them in, and are usually people who are infirm or immobile. Ambulances are booked for specific times, but because they are an emergency service, they themselves state that pick-up is within two hours of the specified time, and in reality it is often a lot longer than that. Ironically this group of patients complain the least.

The unit conducts a patient satisfaction survey every year to gauge whether the

Control		
Patients/relatives	Staff	Environment/organisation
Loss of control, dependent, reliant on others	Inconsistent behaviour, favouritism	Inflexible, dictatory, no clear system
Communication		
Patients/relatives	Staff	Environment/organisation
Uninformed, culturally and linguistically diverse (CALD)	Poor communication skills	Dictatory, slow/poor feedback
Clinical/Physical environment		
Patients/relatives	Staff	Environment/organisation
Tired, stressed, sick, mental health, end-stage renal failure (ESRF)	Tired, stressed, sick, mental health	Staffing/workload issues, heating/cooling, uncomfortable chairs, broken TVs
Psychological		
Patients/relatives	Staff	Environment/organisation
Psychological, psychosocial	Psychological, psychosocial	Obligation to provide life-saving treatment

Table 1. Factors contributing towards aggression.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

service is meeting the patients' needs and data from this survey was used to plan strategies for the Models of Care project. In January 2010 the survey had a poor overall response rate of 56%, which showed that only 27% of the patients who completed the survey strongly agreed with the statement: "The time I wait to be connected to the dialysis machine is usually acceptable". Thirteen per cent of those patients disagreed with the statement. Some comments collected in the survey included: "The only frustrating thing I experience is that I have to be delayed for my dialysis and other patients are placed before me" and "The patients hate waiting to be put on the machines, if they can be taken in faster", revealing the patient's preoccupation with their own treatment and lack of awareness of the unit as a whole. Other low scores showed that

some patients did not feel there was good communication between nurses and patients, and some patients did not feel they had active participation or control of their treatment.

The annual nursing staff satisfaction survey (December 2009) had a 75% response rate. Ninety-four per cent of nurses who responded felt that they worked well together as a team and 83% felt confident as clinicians. However, less than half felt they had enough time to deliver good care to patients. Recorded qualitative comments suggested the need for less task-orientated, more patient-centred care and the introduction of appointment times or the allocation of patients to nurses before the start of the shift. It was felt that the Models of Care project would address some of these concerns.

After this intense period of data collection, information was fed back to the nurses who were invited to brainstorm ways of reducing aggression. Initially it was decided to trial two strategies:

1. Better communication to provide patients with more information about the unit and their treatment that day.
2. Encouragement of nurses to provide patient-centred, consistent treatment that reflected the information given to the patients.

Strategies implemented

Standardised communication

1. Clock flyers

Flyers were developed to show in picture form how the patient's dialysis treatment

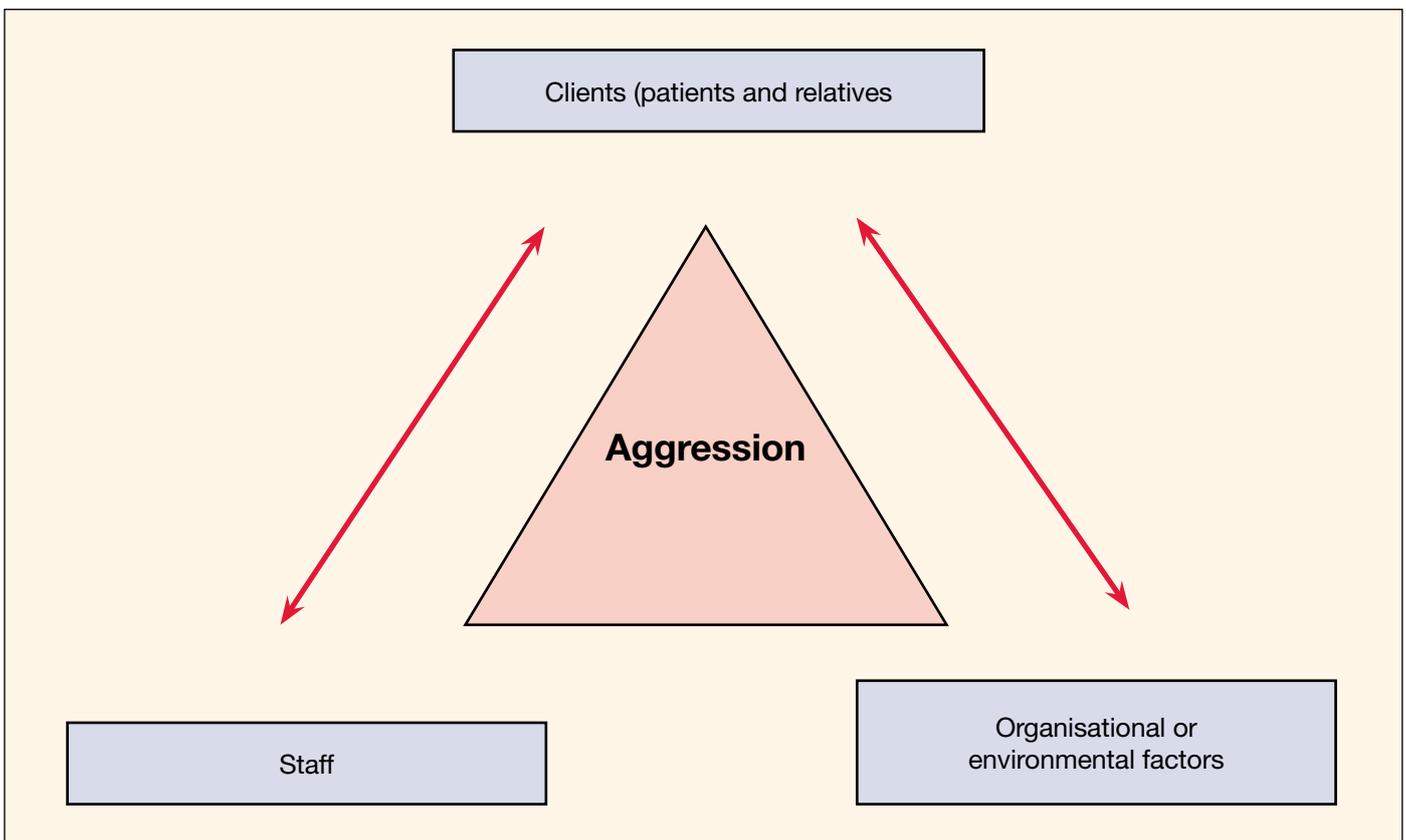


Figure 2. Aggression System Model.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

fits into a typical day in the unit.

The flyers were given to each patient personally by members of the Models of Care team who explained the text and answered any questions. Instead of a complex system of appointment times, the day was divided into 'Morning' and 'Afternoon'. Morning patients were told that although the unit opened its doors at 7 am, the first patient would not be connected to the machine before 7.30 am and the last patient may not be put on dialysis until 9.30 am. The afternoon patients were told that they would not be called in to the unit until 2 pm, allowing staff time to finish with the morning patients and have time for handover and staff education and that connection of afternoon patients may not be finished until 4 pm. The flyers contained half a page of script, but it was felt to be more important to have the information represented in picture form for people who did not read English.

The clock pictures were also produced as large posters and displayed in the waiting

room. By providing this information, it was hoped that patients would have a more realistic idea of how long it takes for everyone to get connected to the machines at the start of each session, that they would be better prepared for the length of time they may have to wait and that they would choose not to arrive at the unit early in the hope that, "someone may call me in".

2. Patient allocation

Patient allocation was introduced to improve communication between staff and patients. The unit has two areas as previously described and four distinct rooms. A whiteboard was put up in the waiting room and the patients' seating allocation written up before each shift along with the name of the nurse who was allocated to connect them to the machine.

Prior to this project there was no clear system for equitably connecting patients to the machine. It was widely believed

by patients that those requiring longer treatment should go in first, but nurses often had knowledge of clinical or social reasons that would upset this order. Patients would wait in hope as each nurse became free, only to be frustrated when they were not the next one attended to.

With patient allocation, the nurse would know which patients they were taking care of that day. Nurses were encouraged to greet their patients at the start of the shift or as they arrived and let them know how soon they would be connected to the machine. This dealt with specific complaints that had been recorded about, "never knowing where we are sitting" and feeling "forgotten" in the waiting room, thus hopefully alleviating treatment anxieties.

After three months, the effectiveness of these standardised communication strategies was evaluated. In a focus group the patients were asked their opinion of the new allocation board and their responses were overwhelmingly positive.

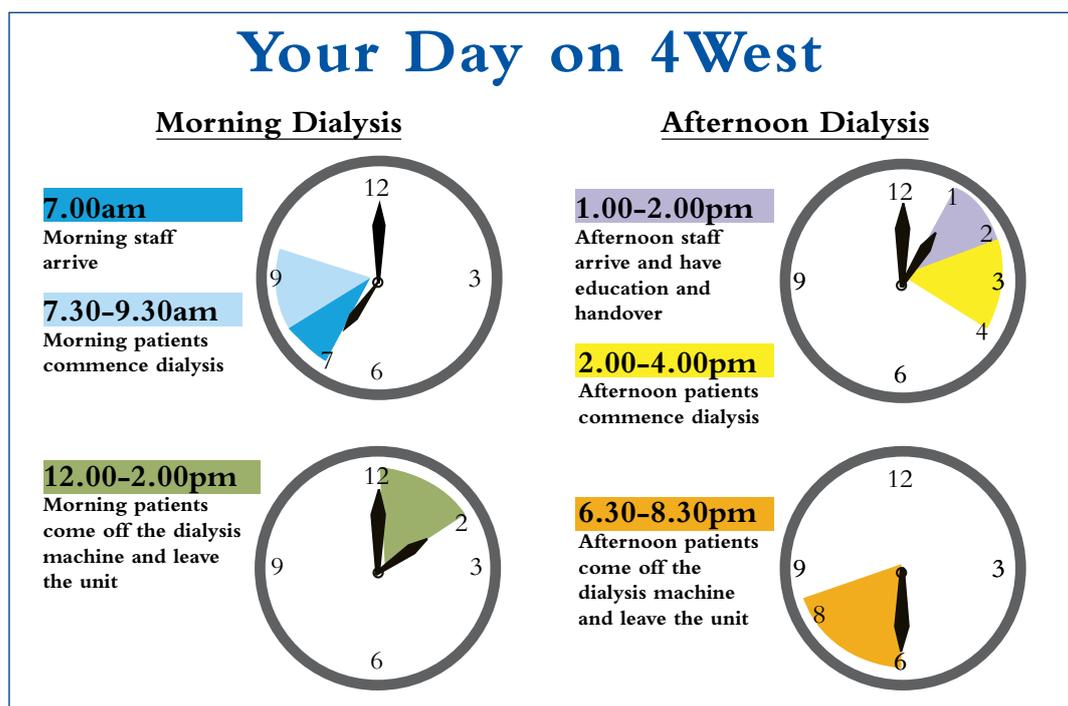


Figure 3. Clock flyers illustration.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

The AGRO score was reintroduced and nurses were asked to record every aggressive incident again for a period of four weeks.

Results

Baseline

Over a nine-week period of baseline data collection, a total of 124 incidents of aggression were recorded. As a percentage of the 345 treatments provided by the unit each week this reflected 2–8% of treatments (Figure 4). The goal for the project was to reduce this to no more than 1%.

The relationship of aggression to waiting times is illustrated clearly when the times of aggressive incidents are examined (Figure 5). Spikes of incidents occur early and again in the middle of the day when patients are waiting to be connected to the haemodialysis machine.

Analysis of the recorded comments showed the reasons for each of the incidents (Figure 6). Fifty-two per cent

were related to waiting. Seventeen per cent of the reasons were related to patients with mental health issues such as dementia. Environmental factors and treatment conflicts each rated 11% and small numbers were associated with communication, transport, other patients and, worryingly, aggressive nurses.

Remeasuring phase

The AGRO score was reintroduced three months after the strategies were implemented and nurses recorded every aggressive incident again for a four-week period. During that time a total of 14 incidents of aggression were recorded. This represented 1% of the 345 treatment sessions provided by the unit each week. During the remeasuring phase waiting times has been overtaken by clinical issues as the leading precursor for aggression, although the sample size was very small.

Discussion

The baseline results of this study show

that aggression is a problem for nursing staff at St George Hospital Haemodialysis Unit, a fact reflected in studies from haemodialysis units around the world (Sedgewick, 2005; Jones, 2008; Hashmi & Moss, 2008; Zampieron, 2010). King and Moss (2004) documented a 20-fold increase of difficult/disruptive patient situations between 1994 and 2002. This is supported by an ESRD Network report that conducted a survey in 2000 and found that 69% of the 203 dialysis unit care givers felt they had witnessed an increase in difficult and disruptive patients within the previous five years. Under-reporting of aggression further diminishes the extent of this problem in health care (Rippon, 2000; Sommargren, 1994) and in the haemodialysis setting (Jones, 2008). Waiting times, mental health issues and staff–patient communication were highlighted in our study as causal factors contributing to aggression. These findings are supported by Jones (2008) who also noted themes of waiting and staff–patient

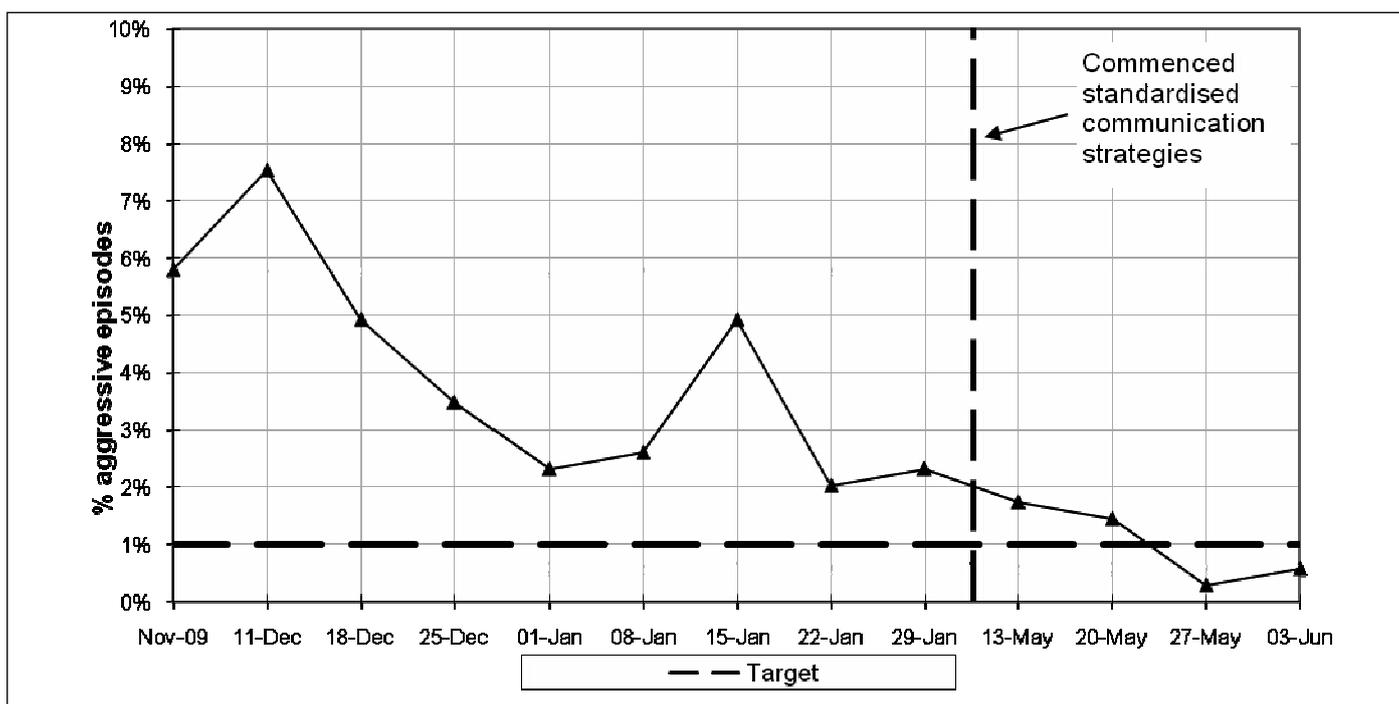


Figure 4. Percentage of aggressive incidents per total number of treatments per week, measured using the AGRO score.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

communication as potential precursors to aggression in the results of her qualitative data collected from two haemodialysis units in the United Kingdom.

In order to maintain any change, the strategies used must be sustainable. The National Health Service (NHS) Institute for Innovation and Improvement has developed a Sustainability Model (Maher *et al.*, 2010) consisting of 10 factors that play an important role in sustaining change in health care such as staff involvement and training, staff attitudes, clinical leadership and the organisation's culture. A score of 55 or higher suggests that the project is sustainable. Using the NHS Sustainability Model, the St George Hospital Models of Care project scored 66.7. Project leaders have met with the unit's clinical managers to feed back results of the study and reinforce the effectiveness of standardised communication in reducing aggression. Resources necessary for the strategies

to continue have been made available. The clock flyers have been saved on the hospital intranet and a supply of paper copies is on hand. Guidelines for patient allocation have been created and team leaders assist staff with planning for the next shift; and regular education in effective communication is regularly offered using a variety of expert staff from within the hospital. New nurses to the unit learn these strategies during orientation as they are now adopted as part of the unit's workplace culture.

While this project has demonstrated the effectiveness of these standardised communication strategies, further improvements in communication with patients could be investigated. Currently orientation to the unit is quite inconsistent. Ideally a person with worsening end-stage renal disease attends pre-dialysis education and is orientated to the ward environment well before the start of the dialysis, receiving written

and verbal information over a period of months, allowing plenty of time for questions and reviews. However, it is often the case that a person starts dialysis urgently, either as a late referral chronic kidney disease (CKD), or with acute renal failure, neither of which allows much time to reflect upon the new lifestyle that is beginning. This project highlighted how unplanned the current orientation process is, and would recommend the development of a more structured orientation pathway that is accessible to patients from various entry points, delivered by identified members of nursing staff and covering defined topics.

The written resources available to patients are all in English, while the patient group is multicultural. Funding from the Multicultural Health Awards has been granted to translate basic introductory pamphlets, including the clock flyer, into languages other than

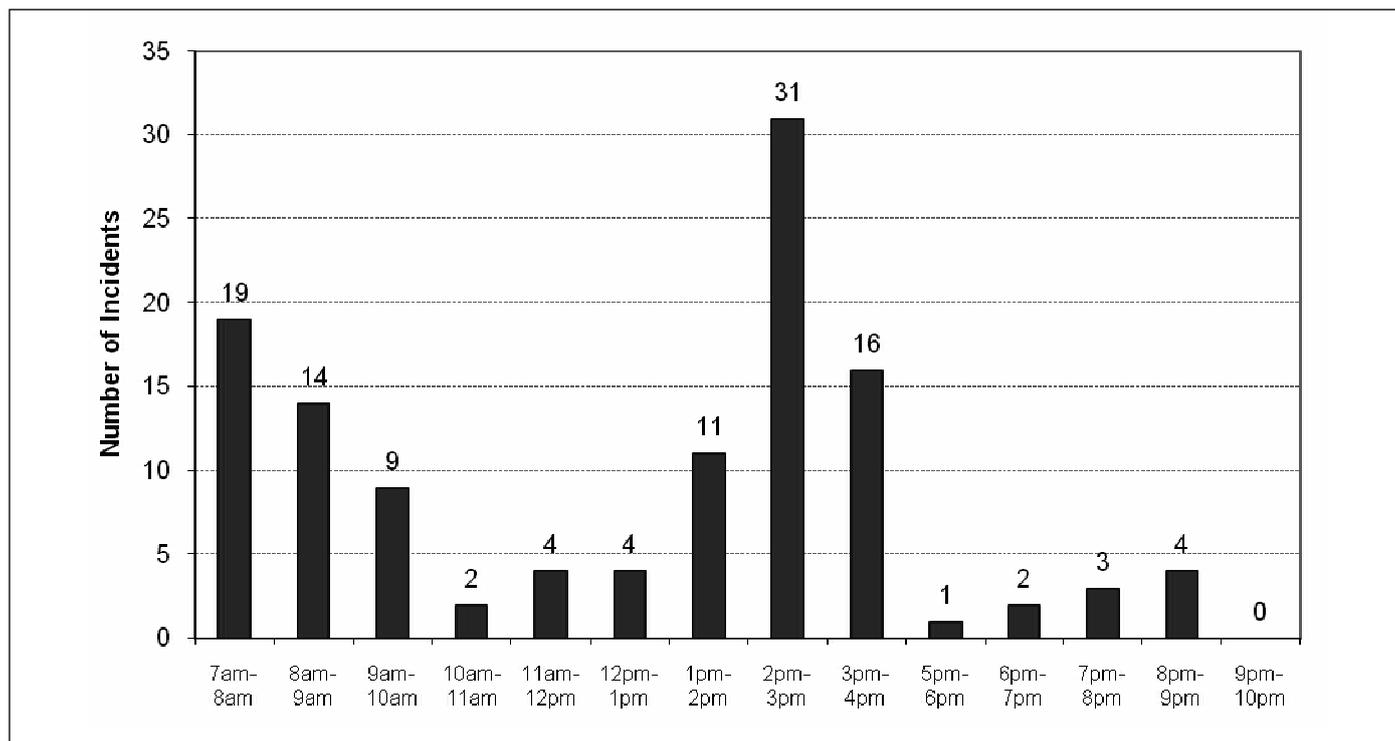


Figure 5. Shows aggressive incidents grouped by time of the day.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

English, and make these available through the hospital intranet. The value of written information is that the words are carefully chosen and it can be referred to again and again. However, it cannot be assumed that all patients can read (Australian Bureau of Statistics, 2006) and literacy should be sensitively ascertained at the start of the patient orientation process. The use of interpreters and the education of family members may be more effective in conveying accurate information to the patient.

Baseline data recorded using the AGRO score highlighted mental health issues as the second highest reason for aggressive incidents after waiting times. This was largely due to a small number of patients with dementia, whose aggressive outbursts resulted from their reduced cognition. Advanced age is no longer a reason to deny haemodialysis to a patient evidenced by ANZDATA reports that show a 150% increase in patients

starting dialysis in the 75–84 years age group from 2000–2006 (McDonald *et al.*, 2006). There are now more patients in the haemodialysis community with age-related mental impairment (Sehgal *et al.*, 1997) and, in addition, studies have shown that the prevalence of cognitive impairment and dementia is higher in people with end-stage renal disease than it is in the general population. (Kurella *et al.*, 2006) While the literature has shown that nurses commonly under-report aggression from patients where they feel that the patient is not responsible for their actions (Fern, 2006), the aggression still impacts upon them and strategies should be sought to minimise its incidence. Strategies for nursing patients with reduced cognition include the use of familiar surroundings and belongings, staff getting to know patients well in order to be able to distract and divert the conversation, and reducing visual and auditory stimuli that may be unsettling. These strategies are challenging to

implement in a busy hospital dialysis unit with a large group of staff. Excellent communication should be maintained between nurses, nephrologists and family members at all times, as increasing confusion and aggression on dialysis may become an unreasonable risk to both the patient and the staff, and be a prompt to begin end-of-life discussions with the family (McKeown *et al.*, 2008).

A 2010 study by the European Dialysis and Transplant Nurses Association and the European Renal Care Association (ETNA/ERCA) (Zampieron *et al.*, 2010) has listed many strategies for the prevention of violence and aggression in the haemodialysis unit. One of their fundamental steps recommends creating an atmosphere of non-violence by providing clear and precise information to patients. Another step is to minimise waiting times and inform patients when delays are unavoidable. These recommendations have formed the basis

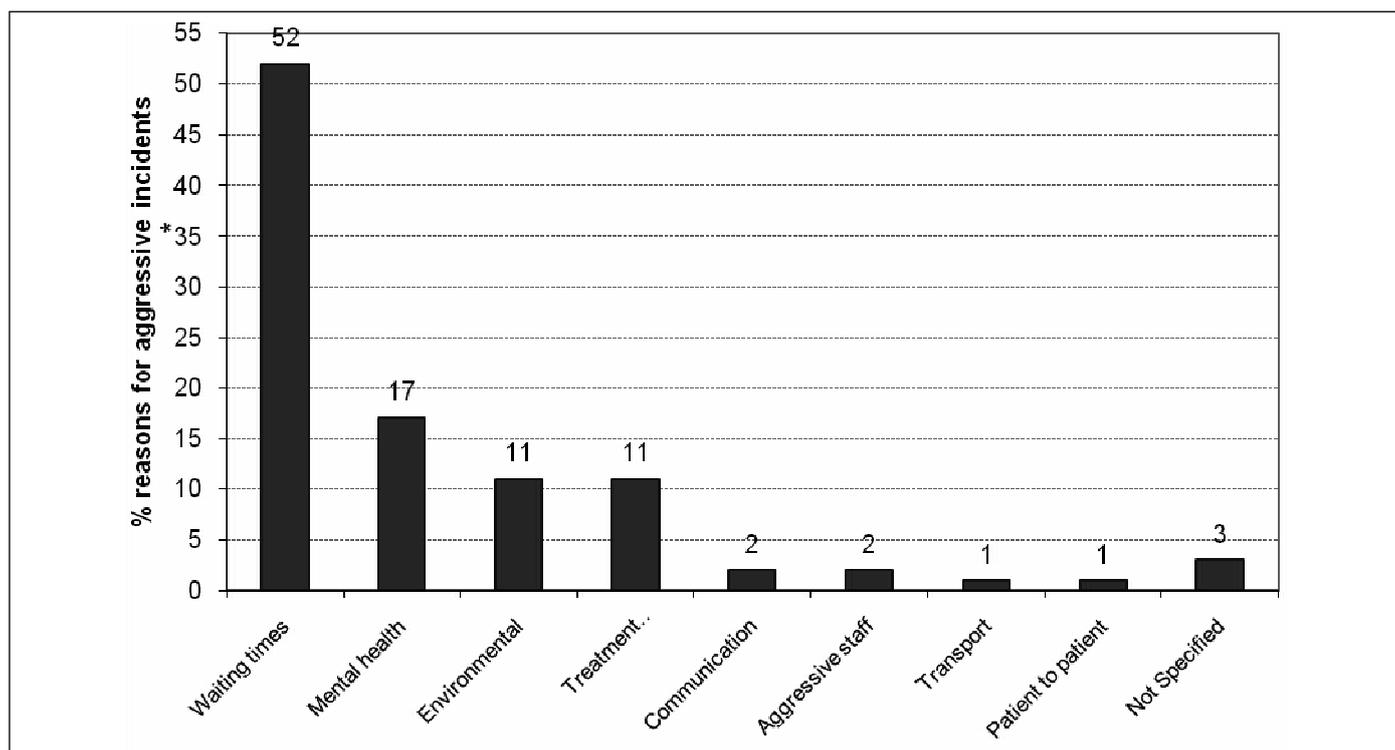


Figure 6. Shows reasons for aggressive episodes.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

for the strategies implemented by the St George Hospital Models of Care project. Further suggestions made in this document include risk assessment, the development of specific guidelines or policies and physical measures such as adequate lighting, heating and seating, secure units with controlled entry points, closed-circuit television cameras and metal detectors to detect metal weapons. Other studies have seen a positive influence on dialysis patient adherence through the use of behavioural contracts (King & Moss, 2004). It would seem prudent that haemodialysis units and their associated renal departments and hospital managers are prepared by developing clear policies for the management of patients who display aggressive behaviour.

At the start of this project it was found that there are many inconsistencies when comparing studies on violence and aggression. Varying definitions,

methodologies and perceptions as to what constitutes aggression makes comparison of the data difficult and there is a need for a standardised definition and measurement tool, such as the Staff Observation Aggression Scale – Revised (SOAS-R), to collect results for comparative purposes. (Rippon, 2000; Somargren, 1994; Scott, 1992; Whykes, 1994). Further investigation is required to develop strategies into the problem of aggression in haemodialysis units and its impact on nursing staff.

Conclusion

By introducing systems of effective standardised communication, the incidence of aggression from patients towards staff in the haemodialysis unit has been reduced at St George Hospital. The strategies of patient allocation and illustrated flyers have given patients a better understanding of the running of the unit, improving their haemodialysis experience by acknowledging their

presence and reducing their treatment anxieties. In implementing these changes, nurses have had to enhance their skills of organisation, planning and effective communication. The reduction of aggressive incidents from 2–8% of treatments down to <1% of treatments has improved the work environment for nurses.

Aggression and violence is on the rise in the health care setting and has been identified as a problem in the haemodialysis setting internationally. This project has found that aggression can be reduced through the use of effective, standardised communication strategies. Investment of time is required to educate and engage staff in developing a culture of transparency and non-violence. Appropriate resources should be made available to patients to ensure consistent transfer of information, preferably at the time of orientation to the dialysis community. The development of policies

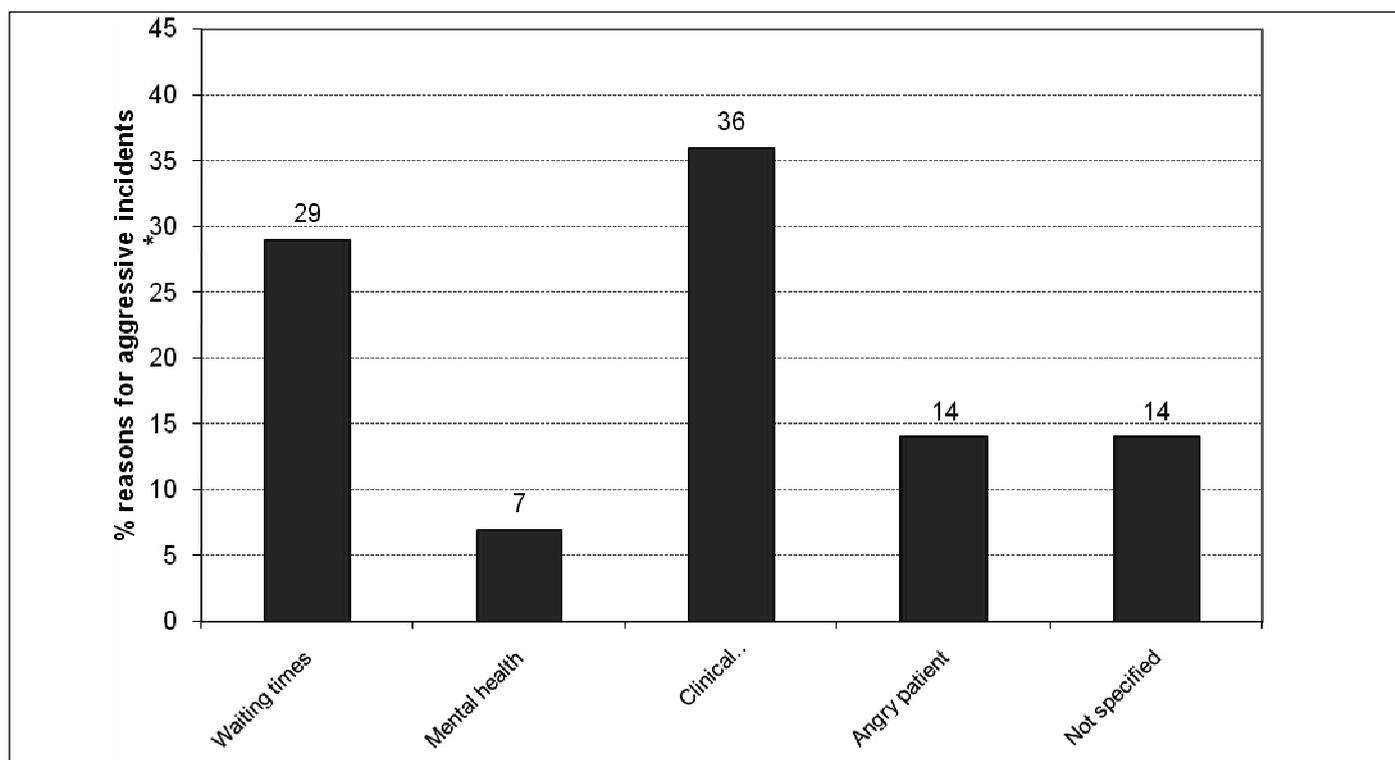


Figure 7. Reasons for aggressive episodes during the remeasuring phase.

Reducing aggression in the haemodialysis unit by improving the dialysis experience for patients

relating to the management of disruptive patients' behaviours is essential, as is investment in staff training in techniques to prevent and manage incidents. More research in the specific area of aggression in the haemodialysis unit is required to identify trends and to assist in further development of appropriate management strategies.

Summary of recommendations

This project limited its work to investigating the effectiveness of improved communication upon the incidence of aggression. The data collected indicated that there were other areas of intervention that may also have an effect. These included the development of a clear orientation pathway for patients joining the haemodialysis community with realistic expectations about time frames and acceptable conduct. Written orientation and educational resources could be translated for patients from culturally and linguistically diverse backgrounds. Policies for the management of mental health patients and for the management of aggressive/violent patients could be developed, along with investment in staff training in the use of those policies. More studies are required in the area of aggression in the haemodialysis setting to establish solid data and to develop universal strategies. For this a standardised definition of 'aggression' and a universal tool for measuring frequency, nature and severity of aggressive incidence should be agreed upon by researchers.

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