

# A balanced approach to dealing with violence and aggression at work

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**K**estner and Ray (2002) state that: 'Conflict in itself is neither good nor bad; it just is. Situations that may lead to conflict arise continually in everyday life. A situation becomes a conflict because of people's reactions to the circumstances or the actions of others. Those reactions are based on learned values, biases, and life experiences. Conflict exists within people, not as an external reality.'

The level of reported violence against health staff has been increasing over recent years with the National Audit Office (NAO) reporting a 30% increase in reports of violence between 1998/1999 and 2000/2001 (NAO, 2003). Historically, there has been under reporting of incidents of violence in the NHS (Cembrowitz and Shepherd, 1992; Schneiden and Marren-Bell, 1995; Ferns, 2002). The culture of the NHS is one of tolerance, with an emphasis on understanding and empathy. Therefore, a degree of acceptance of what may be considered unacceptable behaviour outside the healthcare environment as part of the job is often quoted as a cause of under reporting (Poster, 1996; Lynch et al, 2003). However, that aside, it could be argued that the general trend in modern times appears to be that of reduced tolerance and higher expectations by people in society of what they have been led to expect from services, such as the NHS, the airlines, and other service industries. Hence, such phrases as 'air rage' and 'road rage' now seem to be part of our common vocabulary.

According to a Department of Health (DoH) report there were 84 273 reported violent or abusive incidents during 2000/2001 (DoH, 2002a). The definition of violence adopted by the Health and Safety Executive (HSE) is 'any incident in which a person is verbally abused, threatened or assaulted in circumstances related to their work' (HSE, 2004). Leather (2002) stated that all healthcare professionals are 'at risk' of exposure to some form of patient/client aggression, and that nurses are particularly at risk with 100% suffering at least one incident in their career'. Indeed, Beech (1999) notes that, in the UK, figures suggest that healthcare workers are four times more likely to experience workplace violence than the general population. Some estimates suggest that healthcare staff are, on average, 26 times more likely to be seriously injured than members of the general public (Breakwell, 1997) and Coombes (1999) has commented that nightclub bouncers have a safer job than some nurses.

The 'NHS Zero Tolerance Zone Campaign' (DoH, 1999b) has adopted the same HSE definition and has developed government initiatives to support staff working in areas of high risk. The campaign centred on two main themes: reinforcing to the public that violence against staff working in the NHS is unacceptable; and reassuring staff that violence and intimidation are unacceptable and will no longer be tolerated (Beech and Leather, 2003). Government targets, when launched

## Abstract

**The Government has introduced tough measures in dealing with violence and aggression in the workplace. Employers have a duty to provide adequate safety measures and training to reduce risks and ensure, where possible the health, safety and welfare of their employees. This article highlights the responsibilities of employers and the pressures in both hospital and community environments on staff at risk from violent or abusive incidents. The patient's perspective is discussed, suggesting that more understanding between patients and staff is needed. The article looks at the 'NHS Zero Tolerance Zone Campaign' and whether this can be enhanced by introducing training of an empathetic nature along with other practical environmental issues. It suggests that there are alternative, and more effective, techniques in dealing with violence and aggression that can be used to defuse a situation before it ever becomes a physical altercation. The philosophies of eastern martial arts can teach us a lot about personal self-esteem and confidence which are two key elements in managing conflict situations.**

**Key words:** ■ Violence ■ Challenging behaviour ■ Staff: job satisfaction

in 1999, were to secure an overall reduction in: incidents of violence to staff; accidents at work — by 20% by the end of 2001/2002 and 30% by the end of 2003/2004; and levels of sickness absence — by 20% by the end of 2001 and 30% by the end of 2003 (DoH, 1999b, 2002a, 2004).

The consequences to the member of staff receiving violent, verbal or physical abuse can be far reaching, and may result in the member of staff being no longer able to continue his/her job and/or requiring psychological help. Rippon (2000) notes that the aftermath of staff experiencing violence in the workplace can involve staff manifesting symptoms of post-traumatic stress disorder including anxiety, impaired work performance and difficulties sleeping. There is evidence that staff may suffer from loss of confidence and self-esteem (Kaye, 1996) and O'Connell et al (2000) found a direct relationship between aggression and sick leave, drug and alcohol usage, burn out and staff turnover among nurses. Nabb (2000) found staff reported developing a negative change in attitude towards work which is very significant as increased stress may lead to increased aggression as increased aggression leads to increased stress.

The literature also suggests that high levels of workplace violence has a direct impact on recruitment and retention of staff (Dalphond

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et al, 2000). Supporting and training staff in recognition of conflict situations and de-escalation techniques should be a priority within the NHS in order to minimize risks to staff.

The estimated costs for the NHS of recruiting and training a member of staff to replace one absent owing to an incident is approximately £5000 (Cox, 2004), and the potential costs of compensation to a member of staff suffering abuse, be it harassment, bullying or violent incident, is vast (there is no cap on how much compensation can be given, especially if there are race, gender or sexual orientation issues). The other major cost implications to the NHS owing to violence in the workplace are listed in *Table 1*.

**Table 1. Cost implications to the NHS owing to violence**

- Increased staff turnover
- Increased recruitment and retention costs
- Increased staff absence from work
- Reduced efficiency and performance at work
- Reduced staff morale
- Reduced staff numbers, especially the loss of experienced staff, leading to increased pressure on those staff left to cope
- Higher incidence of patient complaints
- Higher risk of increased frustration by patients and staff
- Higher risk of violent incidents
- Falling reputation for the hospital/primary care trust

The NAO (2003) suggests that the consequences of violence on staff and professionals working in NHS trusts is approximately £69 million per year. However, what is the message that the 'NHS Zero Tolerance Zone Campaign' is sending out? Is a poster saying 'We don't have to tolerate this' going to dissuade a potential aggressor's behaviour, or just make the rest of us feel like we are under scrutiny and someone somewhere is just waiting for an opportunity to accuse us of being belligerent? Training in proper communication skills to enable staff and patients to be more understanding of the pressures on both sides should surely improve matters.

### The law and violence at work

The Health and Safety at Work Act 1974 states that: 'Employers have a legal duty under the Act to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees.' The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (Statutory Instrument 1995 No 3163) states that: 'Employers must notify their enforcing authority in the event of an accident at work to any employee resulting in death, major injury or incapacity for normal work for three or more days.' The Management of Health and Safety at Work Regulations 1999 (Statutory Instrument 1999 No 3242) identified the risk element stating that: 'Employers must consider the risks to employees (including the risk of reasonably foreseeable violence); decide how significant these risks are; decide what to do to prevent or control the risks; and develop a clear management plan to achieve this.'

The NHS Security Management Service has also instigated recently a new reporting system based on clear legal definitions of violence. It is also developing the role of specialist investigators to obtain evidence about violent

incidents and a new NHS legal protection unit to work with the Crown Prosecution Service to apply criminal and civil actions. Other directives such as section 44 of the Employment Rights Act 1996 outline the staff member's right to withdraw from his/her care environment if he/she feels seriously under threat.

Employees also have a responsibility 'to ensure that any concerns about aggression and violence are brought to the attention of the management and that action is taken' (Dimond, 2002). All of the Government initiatives have been beneficial in highlighting and making the managers responsible to ensure the wellbeing of their staff, and put in place reporting and monitoring systems, but more emphasis is needed in recognition of the trigger factors to patient/client behaviour, and its appropriate management.

### The NHS Zero Tolerance Zone Campaign

The Government's 'four-point plan' drawn up in 1998 stated that: every NHS trust is to report and record all incidents; every NHS trust is to establish clear working relationships with the police and prosecution services and pursue prosecution where necessary; the DoH is to publish guidance on prevention and handling of violence to complement earlier guidance regarding the management of hospital security; and NHS trusts are to set targets for reducing violence against their staff (DoH, 1998).

Following this the NHS Zero Tolerance Zone Campaign was born in October 1999 (DoH, 1999b). A poster campaign was launched raising awareness among staff and the general public that violent behaviour will not be tolerated. Tough action was advocated against people who threaten, intimidate or assault healthcare staff. Prosecutions by NHS trusts have increased in the light of the new guidance, and awareness has increased with more staff than ever before reporting incidents of violent and abusive behaviour. This increased reporting is a key objective of the zero tolerance campaign.

Close relationships with the police and the introduction of the Counter Fraud and Security Management Service (CFSMS) to tackle violence against NHS staff are other measures embraced by the Government in addressing the situation. With all these measures put in place, however, the emphasis appears to be on risk assessment and dealing with the abusive behaviour once it has happened rather than stopping it from happening in the first place.

The guidance around promoting the correct sort of ongoing training in communication skills and de-escalation techniques appears scant and its implementation varies greatly from trust to trust. Conflict resolution training tends to be focused towards postregistration, qualified staff and a lucrative, yet poorly regulated, market for institutions and private companies to offer such training and this has exploded in recent years (Beech and Leather, 2003). Currently, the CFSMS is instigating a national curricula focusing on non-physical techniques, customer service, recognition of warning signs, de-escalation models and cultural awareness (CFSMS, 2004) although the specifics of training remain open to interpretation.

### The acute trusts

The hospital environment is an alien environment to all but those who work in it. Patients, relatives or friends have

anxieties when they enter a hospital. They may be fearful for themselves, their friends or family and this anxiety can manifest in unusual behaviour. The simplest of things can trigger heightened emotions that may lead to altercations with staff. For example, difficulty in parking which results in the patient being late for an appointment causes anxiety in the patient and may illicit a cool response from hospital staff, who also are under pressure to keep to schedule.

Patients presenting at the accident and emergency (A&E) department can be challenging to staff, not least as the influence of drugs and alcohol is more prevalent in this environment. Drug and alcohol abuse were found to be a predisposing factor to violence in numerous studies (Schneiden and Marren-Bell, 1995) and meta-analysis of findings from experimental research suggests that the experience of alcohol intoxication is causally implicated in aggression (Bushman, 1997). In a UK study of A&E consultants, 98% of respondents cited alcohol as a 'significant precipitant of abusive behaviour' (Jenkins et al, 1998).

The A&E department is an environment of great emotion, and delays in seeing patients occur very frequently owing to the nature of the cases entering the department. If patients are kept informed of events and waiting times they will naturally be more compliant.

On the wards there are also very challenging circumstances, not helped by possible staff shortages which increase demands on those left on duty. The staffing skill mix also plays a part as certain tasks are only performed by certain grades of staff. This, again, results in delays in certain treatments which can be frustrating for both patients and staff. The Royal College of Nursing (RCN, 1998) links low-staffing levels to an increase in violence and aggression, as a decrease in the number of staff can lead to increased waiting times for patients. In the mental health field, Clinton and Hazelton (2000) note that a shortage of nurses, particularly those with specialized mental health knowledge, erodes the service's ability to provide therapeutic care with a consequential rise in confrontation.

Conflict does not just exist with patients, relatives or friends. There is also conflict internally between all levels of staff on wards or between different departments. A great deal of the trigger factors are the same, such as miscommunication, delays, misunderstanding or personal issues. There are also daily irritations such as changing 'off-duty' rotas, last minute staff absence, unexpected extra workload or lack of management support. This area should not be underestimated. Adomat and Killingworth (1994) found that organizational factors, such as the department's management style and inter-staff conflict, were responsible for more stress than the clinical presentation of patients. Research findings by O'Connell et al (2000) indicated that medical staff were the most frequent causes of nurses' feelings of intimidation and lack of confidence in their own abilities as professionals and that this is a significant stressor.

In the authors' experience, for the most part, patients and relatives are understanding of the demands on staff and are generally grateful for the effort that staff are making. However, society seems to have ever-increasing expectations of what is perceived as the standard of service that people are entitled to receive. The Government emphasizes lower waiting lists and increased patient choice and when this does not occur tempers are frayed. Nabb (2000) suggests that nurses in his study felt that

patients and their visitors had impossibly high expectations of nurses that could not be met in the current economically stretched healthcare environment, which caused visitors to react with anger and violence.

### Community care

The situation in the community is slightly different. The dynamics of the relationship between the staff and patient changes as the staff are 'guests' in the patient's home. Community staff are still very vulnerable to the differing behaviour of the patient or relative and they 'have a duty to warn colleagues of potential dangers' (Dimond, 2002). It may be necessary for a second person to accompany the nurse or doctor in future visits as isolation of victims is a well documented significant risk factor (HSAC, 1997).

With the introduction of the zero tolerance campaign, GPs are now able to remove any patient who threatens violence to them from their list. Instead, 'persistently violent patients can be seen in a location which provides a secure environment for GPs and NHS staff. This ranges from a nearby hospital site with security guards to a local police station' (DoH, 1999a).

Situations may arise in the GP's surgery where it is the receptionist who is often on the receiving end of aggression from the public. The HSAC (1997) noted that the receptionist or secretary in a GP surgery was the centre of the assault in nearly one-quarter of incidents. This, again, may be the result of many trigger factors but it is important that the staff are equipped to deal with situations should they arise.

### Patient's perspective

As mentioned earlier, there are many factors that may trigger unsociable behaviour. Understanding these factors allows staff to anticipate and defuse a potential situation much more peacefully. Some of these triggers are listed in *Table 2*. The staff are not necessarily made aware of any of these triggers, but a calm environment and pleasant greeting can do much to stave off an altercation. McHale (1999) stated: 'The main causes of aggression against nurses are the patient's loss of control or autonomy over a situation, a feeling of depersonalization and a lack of communication.' He goes on to stress the importance of nurses developing the skills to defuse rather than build up aggression.

### Work environment measures

NHS trusts and primary care trusts need to develop strategies to match the Government targets and reduce the number of violent incidents. Certain trusts, such as the Hull and East Yorkshire NHS Trust, have introduced measures to tackle the problem (*Table 3*). All of the measures in *Table 3* will help but will be useless without proper staff training. Indeed, despite all the dilemmas and contradictions in the literature the vast majority of authors agree that it is universally acknowledged that staff can benefit from training in the issues surrounding aggression and violence (Sains, 1999).

The advice given on the NHS Zero Tolerance Zone website (<http://www.nhs.uk/zerotolerance/>) is that training is crucial. It states: 'Managers should assess the risks to staff and analyse their training needs.' It goes on to say that 'defusion training is the most suitable approach for equipping staff with the

frustration and aggression of patients, family, friends and bystanders' and that 'managers should receive the same training as their staff to ensure continuity' (DoH, 2002b).

Although trusts are endeavouring to meet these guidelines, there are still many who think that teaching a few of their security personnel some 'breakaway techniques' is enough, i.e. physical methods of breaking away from attacks or holds. They have yet to consider training all staff in communication skills, understanding, and recognizing and defusing potential and real violent incidents. 'Breakaway techniques', by the very nature of the term, are only useful when the incident has resulted in a physical interaction. Unless these techniques are being practised on a regular basis, they have the potential to be wrongly performed and may end up being detrimental to the aggressor or staff member. In 1988, the then Department of Health and Social Security (DHSS) noted that elementary self-defence

techniques have little practical value in a real-life incident and might cause serious harm to the assailant or expose the victim to more serious injury. Dimond (2002) states that 'every citizen has the right of self-defence'; however, 'the amount of force used in defence should be no more than is necessary to accomplish the object for which it is allowed'.

There are many continuing debates surrounding the use of control or restraint of patients ('coercive care'; Tannsjo, 1999), with the legal implications including consideration of the

Human Rights Act 1998. The social and legal implications are too vast and varied to discuss here; however, it is interesting to identify some things considered as 'restraint' of the patient. Restraint may occur in many circumstances, e.g. those listed in *Table 4*.

The emphasis should be on striving, wherever possible, to avoid the point when 'breakaway' control or restraint techniques are adopted. Situations differ greatly from environment to environment and the demands bring up many exceptional circumstances, e.g. in mental health trusts, the typical psychiatric patient of today is more likely to be young, male, with a diagnosis of psychosis, substance misuse and a forensic history (Coyne, 2001) which may differ significantly from the average member of the public general nurses come into contact with on a day-to-day basis. However, adopting de-escalation techniques can reduce potential incidents from occurring. De-escalation has been described by Cowin et al (2003) as: 'A gradual resolution of potentially violent and/or aggressive situations through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit settings that is based on respect.' The technique relies on communication skills, verbal and non-verbal, which involve understanding the different stages of a conflict, how to recognize them and how to turn the situation around favourably. Indeed, given the emphasis on a non-confrontational approach perhaps disengagement would be a more appropriate descriptor.

### An alternative approach to conflict management

Kestner and Ray (2002) state that: 'People have particular styles of communication with which they are most comfortable...these styles evolve from people's inherited traits, teachings, and life experiences.' These styles of communication include those listed in *Table 5*. In order to communicate successfully with people it is essential to identify one's own communication style as well as understand others (Kestner and Ray, 2002). This enables people to react appropriately to another's behaviour. It also gives people more confidence in dealing with different types of behaviour.

As mentioned earlier, a significant stressor for an individual nurse is his/her self-esteem and confidence in his/her professional abilities. A well trained and experienced nurse whose self-esteem is high is much more likely to reassure an anxious patient calmly, and have better working relations with other staff, than one who doubts his/her knowledge and ability (Maunder, 1997). Nurses with confidence in dealing with difficult situations are subsequently more likely to promote positive outcomes (Lee, 2001) and it is the authors' opinion that projected confidence comes from inner-confidence. A nurse's self-esteem is eroded if his/her peers or management are not supportive and empowering in his/her communication and management style (Wondrak, 1999). Negative interpersonal interactions, bullying or verbal abuse may undermine staff members' self-esteem and confidence to perform everyday work activities and consequently lead to poor care, increased errors and increased staff turnover (Jackson and Raftos, 1997; Buback, 2004).

Any successful strategy to minimize violence and aggression in the clinical area must project the importance of a stable nursing team and a caring ethos to both clients and colleagues.

Nurses frequently emphasize the importance of team spirit and professional affirmation as positive reinforcements of their self-worth (Chambers, 1998). Teams, therefore, should strive to be

**Table 2. Factors that may trigger unsociable behaviour**

- Fear and anxiety
- Past experiences: personal and in the workplace
- Lack of self-confidence and self-esteem
- Personal problems
- Misunderstandings
- Lack of communication
- Troublesome journey to hospital or clinic
- Pain
- Disease: some conditions affect the patients' mood and behaviour
- Drugs or alcohol

**Table 3. Measures to tackle violent incidents**

- Closed circuit television (CCTV)
- Security guards
- Building design — making access for staff more secure
- Creating a more ambient environment by using proper lighting and more calming décor
- Local press support for stopping violence
- Close working relations with the police
- Counselling services and links with the 'Victim Support' service
- Poster campaigns and information leaflets
- Security vehicle on patrol on site
- Security forms
- Changing room layouts to ensure that staff have ease of exit and cannot be cornered
- Installing panic buttons and ensuring all staff have proper training in their use
- Creation of an 'emergency drill' so that staff know exactly what procedure to follow in the event of an incident or potential incident
- Providing good facilities for children, e.g. play areas
- Implementation of a system delivering regular updates of waiting times for patients, i.e. improving communication systems for patient information
- Improving waiting area facilities, e.g. removing tattered furniture and graffiti
- Keeping treatment areas more secure, i.e. keeping syringes out of sight

Source: Lathwood (2004)

supportive. The Nursing and Midwifery Council (NMC, 2002) emphasizes that nursing staff must work with other members in healthcare environments that are conducive to safe, therapeutic and ethical practice.

Staff will not develop important interpersonal skills, such as an ability to collaborate and negotiate, without such skills being nurtured by colleagues. Poor multi-disciplinary communication can lead to tension, disempowerment and result in an anxious or frustrated patient and/or nurse. Research from the mental health field emphasizes that excessive aggressive interactions occur more frequently in departments demonstrating a lack of nursing staff cohesion and positive leadership (Cowin et al, 2003) and staff's negative-controlling styles have been highlighted as a cause of aggression (Harris and Morrison, 1995). In essence, one's communication with colleagues is invaluable preparation for communicating with patients and relatives.

Development of individual confidence and self-esteem with an emphasis on teamwork is crucial to reduce one's risk of assault either verbally or physically from the general public or from other staff because a dysfunctioning or unhappy nursing team will project less job satisfaction and higher stress levels. Job satisfaction, like stress, has been proposed as both an antecedent and consequence of workplace aggression towards staff and others (Glomb, 2002).

Stewart (1998) states that: 'Being willing to engage in dialogue, to listen to the points of view of other people and to search for collaborative ways of working have created opportunities in many fields for handling conflict in such a way that it does not escalate into violence.' Therefore, conflict is not necessarily always a negative thing. It can generate many positive outcomes and be a motivator for change.

A lot can be learnt from the eastern philosophies and the practice of martial arts in dealing with conflict (Westbrook and Ratti, 2001). Understanding these philosophies and putting them into practice helps develop one's confidence and self-esteem and encourages a more empathetic yet powerful approach to occurrences in daily life (Westbrook and Ratti, 2001). There are many different martial arts but they have one thing in common — that of respect for one's partner or opponent, and the power of a calm mind. One art that is most useful in today's daily life, and has been used successfully in conflict management, is that of aikido. The principles that may be related to conflict management and everyday life are listed in *Table 6*.

Warner (2003) identifies three basic conditions in conflict resolution that are reflected in this art, and that she calls the three 'A's. She states that:

**'Parties to a conflict must 'Acknowledge' its existence — rather than try to avoid or deny it, 'Accept' their involvement, 'Appreciate' the feelings and viewpoints of all parties to the problem — without making judgments, and be open to new ideas that might lead to solutions.'**

Aikido is a gentle yet extremely powerful defensive martial art. From many different methods of attack, with or without weapons, it centres on disarming the opponent safely and non-aggressively (Westbrook and Ratti, 2001). The heart of aikido is about acknowledging, accepting and working with your partner's energy, being willing to adapt and change as necessary. This is just as

relevant in everyday life as in the physical practise of aikido. In order to acknowledge, accept and work with your partner's energy one must be calm, relaxed and focused. This is not always easy in today's society with all of its demands, and it requires continual practice to maintain this state under adverse conditions. However, trying to draw upon one's training in, for example, communication skills, is much harder when tense or agitated.

One of the principles of aikido practised in this country is to 'put yourself in your partner's place' (Tohei, 1978; Maruyama, 1984; Westbrook and Ratti, 2001). This principle is key in dealing with conflict situations. Being able to see, or make the effort to see, the situation from the other person's point of view, allows much more empathy and a clearer way through to reaching resolution (Tohei, 1978; Warner, 2003). This principle can be taught in many different ways and is extremely effective, not only in conflict management but also in such things as managing diversity training, management skills and leadership training, and even in the business world of sales training (Kestner and Ray, 2002; Warner, 2003).

Another principle is to 'perform with confidence'. Again, this principle can be used in daily life. When performing physical aikido techniques people being attacked will only be able to defend successfully if they show confidence in the defensive technique they are using. Similarly,

#### Table 4. Different forms of restraint

- Physically: by one individual upon another
- Physically: by use of apparatus, such as cot-sides
- Withdrawal of a person's physical aids, e.g. wheelchair, rendering him/her immobile
- Use of medication
- Verbal control, e.g. bullying

Source: Cox (2004)

#### Table 5. Styles of communication

- *Avoidance*: ignoring a problem in the hope it will disappear
- *Accommodation*: trying to take into consideration the wants and needs of others at their own expense
- *Passivity*: failing to respond or initiate activity
- *Assertion*: a neutral but positive and firm style
- *Aggression*: often puts the receiver on the defence
- *Collaborative*: problem solving
- *Flexible*: a mixture of all styles

Source: Kestner and Ray (2002)

#### Table 6. The principles of aikido that may be related to conflict management

- Acknowledgment and acceptance
- Being calm and focused
- Put yourself in your partner's place
- Perform with confidence

Source: Westbrook and Ratti (2001)

#### Table 7. Emphasis for conflict management training

- Causes and recognition of trigger factors
- Communication skills and de-escalation techniques
- Recognition of importance of staff confidence and self-esteem
- Putting yourself in your patient's place
- Learning from alternative approaches to conflict resolution
- Clinical risk assessment
- Organizational environment
- Monitoring and reporting of incidents
- Raising awareness of the issues
- Introducing a change of culture in the hospital/clinic to embrace the importance of tackling the problem
- Learning from measures introduced by other trusts

if a nurse or doctor is confident in his/her skills, the patient and his/her relatives will have much more confidence and feeling of security in that member of staff and in the hospital, resulting in less potential aggravation (Kestner and Ray, 2002; Warner, 2003).

Developing staffs' confidence and self-esteem, in conjunction with communication skills and training in the environmental factors of their workplace, can help to reduce the numbers of incidents and create a more harmonious work environment (Kestner and Ray, 2002; Warner, 2003). The training, as with all effective training, needs to be ongoing with feedback from the staff and follow-up sessions. Table 7 summarizes the training needed in conflict management.

### Conclusion

Violent incidents need to be reduced in the workplace. The cost implications of doing nothing are vast and increasing. The Government has stipulated targets that must be met. Reporting of incidents is vital in monitoring their incidence and assessing the success of measures implemented to combat violence. It is important to address the environmental, practical measures that can be introduced, such as clean, tidy and more ambient atmosphere, as well as panic buttons, and emergency drills, but it is absolutely essential to provide staff with appropriate and effective training. Introducing alternative approaches and principles learnt from other disciplines in training, focusing on better understanding of the trigger factors, and looking at teaching better communication skills may be the more successful approach to tackling the problem. BJN

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### KEY POINTS

- The level of reported violence against health staff has been increasing over recent years.
- The consequences to a member of staff receiving violent verbal or physical abuse can be vast and may result in the member of staff needing psychological help and/or leaving his/her job.
- Self-confidence, high self-esteem and good communication skills do much to allay the fears of patients, relatives and colleagues, and can diffuse a potentially volatile situation.
- Supporting and training staff in recognition of conflict situations and de-escalation techniques should be a priority in order to minimize risks to staff.
- The use of eastern philosophies and techniques, such as Aikido, have been used successfully in conflict resolution and are worth considering as an alternative method to complement such teaching methods as good communication skills.