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Managing patient aggression during registration: In preparation of Implementing Affordable Care Act (ACA) 1557 intake questions

Highlights

- Hospitals should educate staff about causes of patient aggression.
- External attribution making for aggression predicts successful de-escalation.
- Replicable, communication theory-driven de-escalation training for staff is vital.
- Future work should probe how staff decide to get help managing patient aggression.

Managing patient aggression during registration: In preparation of Implementing Affordable Care Act (ACA) 1557 intake questions

Health professionals face high rates of workplace violence from patients. This study systematically informed registration staff about pre-violent behaviors and tested its impacts on staff approaches to aggression. In this study, staff were concerned that the implementation of the new patient registration questions as mandated by the Affordable Care Act 1557 would cause patients to become aggressive. Using an open-ended questionnaire, this study involved the training of 74 staff at a Central California hospital who perform patient registration, in managing potential patient aggression during the new registration process and tested the effectiveness of the training. Results suggest that trainings are successful in helping staff identify pre-violent behaviors, use newly learned de-escalation strategies, and approach patient aggression from an appropriate perspective. Communication skills trainings are useful for teaching staff to identify patient pre-violent behaviors, and improving staff attitudes and approaches toward patient aggression. Hospitals should educate staff about causes of patient aggression, and communication strategies to de-escalate. Lastly, staff should be encouraged to make external attributions for patient aggression.

Keywords: Workplace violence, Patient care, Patient registration, Communication skills,

Training, Limit-setting, De-escalation

Introduction

The Affordable Care Act 1557 (ACA) aims to reduce health disparity and advance health equity. To this end, hospitals in California that receive federal funding now require new data to be collected. These questions require staff to ask every patient about gender identity, sexual orientation, race and ethnicity and disabilities every time they seek medical attention at the hospital so that data can be examined for the existence of health disparities across groups. In this study, registration staff were tasked with collecting this patient information. As staff were notified of the changing mandated intake questionnaire, they expressed concern that patients may become aggressive upon being asked, what staff perceived to be, sensitive questions. Violence and aggression in hospitals has long been, and still is, a global and largely underreported common concern for both hospital workers and researchers alike (Lavoie, Carter, Danzl, & Berg, 1988). If healthcare workers in this study are better able to communicate with aggressive patients, they may be able to more effectively de-escalate.

Previous research has attempted to not only define the parameters of workplace violence (WPV), but also explain how to best manage and prevent it, especially in the context of healthcare where the violence is patient-perpetrated, and may occur only one time, rather than in a workplace relationship as a pattern over time (see Keashly, 2005 for a review of emotional abuse in the workplace, and West & Beck, 2019 for a review of communication and bullying). Hospital policies have called for different orientations toward said violence. This study defines WPV as “any incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health” (Mayhew & Chappell, 2005, p. 346). Hence, incidences of WPV include verbal abuse, physical

threats, assault and emotional abuse (Lyneham, 2000). WPV is associated with negative consequences for: staff (i.e., with burnout, feelings of incomprehension, Erickson & William-Evans, 2000; and post-traumatic stress disorder, Laposa, Alden, & Fullerton, 2003); the department and hospital (i.e., loss of productivity, increased sickness absence, increased turnover, and early retirement for disability, Martini, D'Ovidio, Ceracchi, & De Santis, 2012); and patients (i.e., increased use of restraints and expensive antipsychotic drugs, Coburn & Mycyk, 2009; dissatisfactory care, and increased likelihood to return to the emergency department, Feinstein, 2014). Clearly, it would be beneficial to prevent WPV for staff, the hospital, and patients. Kinkle (1993) asserts that it is crucial that staff be trained in the identification of pre-violent behaviors, such as loud talking, profanity use, clenched jaw, and rapid pacing (Tishler, Reiss, & Dundas, 2013). Identifying the precursors to violence will help ready staff to employ strategies to ensure that the situation does not escalate.

RQ1: How does training impact staff ability to identify pre-violent behaviors?

Two main strategies scholars have identified to manage and prevent patient aggression are de-escalation and limit-setting (See Table 1 for a summary of strategies and violence indicators). De-escalation strategies refer to the use of communication skills, both verbal and nonverbal, to diffuse potentially aggressive and violent situations by redirecting the patient to a calmer personal space (Cowin et al., 2003).

RQ2: What de-escalation strategies do staff report using following training?

Limit-setting broadly refers to establishing boundaries of what behaviors are desirable and acceptable/unacceptable (Roberton, Daffren, Thomas, & Martin, 2012). Despite many hospitals strongly agreeing that training for WPV prevention is important and should be

available or even required for frontline staff, this is not often the case (Frazier, Liu, & Dauk, 2014).

There are two approaches to limit-setting and managing patient aggression, in addition to a zero-tolerance approach. The first type is called *correcting*. When using this type of limit-setting, patient aggressive behavior is seen as deviant and the HP should strive to control and correct the behavior, highly valuing discipline and order. The second type is *acknowledging*, which focuses more on using compassion to prevent violence and aggression, and the HP attempts to be cooperative and achieve cooperation. This approach values respect of the patient more highly than discipline and order. Limit-setting strategies from the *acknowledging* perspective include using empathic statements and showing genuine concern for the patient (Petit, 2005). This perspective has traditionally been more successful in preventing escalation and disruptive behavior (Lyneham, 2000).

RQ3: How does training impact the approaches staff use to manage WPV?

Table 1
Indicators of Likely Patient Aggression and De-escalation Strategies

Indicators	**De-escalation strategies**	**Limit-setting techniques**
Pacing	Provide adequate personal space	Give warnings to patients
Confusion	Use open body language	Demand relatives leave
Irritability	Low, calm voice tone	Show authority
Threats	Open ended sentences	Hospital policies on WPV
Attacking objects	Avoid punitive or threatening language	Maintain order
Angry/grumpy demeanor	Manage others in the environment	Discipline when rules are broken
Pacing	Explain what you intend to do	Empathetic statements
Loud Speech	Assertive, brief instructions	Show genuine concern
Frequent changes in body position	Ask for facts about the problem Encourage reasoning	
Tense posture	Nonthreatening NV Comm	
Squinting the eyes	Empower patients to feel in control	
Not giving eye contact	Show concern and empathy	
Penetrating staring	Move patient to less confrontational space	

Shouting	Mirror patient's mood
Whispering or mumbling	Active listening
Coercive behavior	Validate patient feelings and concerns
Crying	Ask questions
Rocking	
Wringing hands	
Defensiveness	
Shaking fists	
Increased sarcasm	
Dilating pupils	
Poor concentration	
Blocking escape routes	

Materials and Methods

Data were obtained as part of a larger program evaluation of the implementation of the Affordable Care Act 1557 requirement of a new intake questionnaire. As such, all staff who complete registration at a community hospital in Central California in every department underwent a three-hour training called "Respect & Care". The training discussed why these questions are crucial to higher quality care, and how to best ask them to prevent WPV. The first author delivered a 50-minute portion of the training on eight occasions to groups of 20-30 participants discussing de-escalation strategies (Table 1; Slides used for this presentation are available upon request from the first author). Staff then role-played aggravated patient scenarios. Following approval from a local IRB, an invitation email containing the open-ended questionnaire link was sent out to 189 staff who attended training approximately three months earlier by an employee at the hospital through an internal email address created for this project. 102 people voluntarily responded, and the final sample included 74 participants.

Of the final sample 21.6% were male (n = 16), 77% were female (n = 57), and 1.4% (n = 1) did not report their gender identity. Participants ranged in age from 22-70 years old (M = 42.5,

SD = 12.9), and worked at the hospital ranging from five to 492 months (M = 94, SD = 102.4). With respect to employment status, 10.5% were part-time employees (n = 8), 78.9% were full-time employees (n = 60), 7.9% were per diem employees (n = 6), and 2.6% did not report their employment amount (n = 2). 42.1% reported never taking a de-escalation or limit-setting training before (n = 32), 46.1% reported taking a training at the same hospital where this study took place (n = 35), 9.2% reported taking a training elsewhere (n = 7), and 2.6% did not respond (n = 2). Participants were employed across 23 departments at the hospital (e.g., laboratory, spiritual care, occupational therapy, outpatient surgery).

Approach toward WPV. Participants answered open-ended questions about their attitude toward patient aggression. They were asked “What is your attitude toward aggressive patients?” and “Please describe how you think patient aggression should be handled.”

Experience of WPV. Participants were asked to list the number of WPV events they have experienced since the training. Then, in an open-ended response, participants described managing patient aggression. They were provided with the WPV definition included in this study. The prompt then read “With that in mind, how many experiences of workplace violence have you experienced since the training? Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you both communicated using your body language.”

Managing patient aggression. In an open-ended response, participants listed as many de-escalation or limit-setting strategies they could remember using since the training, and which strategies they have found to be the most effective in managing patient aggression.

For the approaches variable, responses were first approached deductively to classify responses into the three main approaches to managing patient violence described by prior

literature (i.e., correcting, acknowledging, Petit, 2005; and zero-tolerance, Hodge & Marshall, 2007). However, upon coding, a qualitative content analysis was undertaken to both maintain the benefits of quantitative content analysis, and qualitatively expand and preserve other categories. Thus, all comments were analyzed and not rashly included in the deductive, a priori categories (Mayring, 2004). Reliability was ensured by having a research assistant engage with the data. The research assistant viewed 94% of the responses in the same way.

Results

RQ1 – Identifying pre-violent behaviors

Staff answers suggest that as a result of the training, staff were more knowledgeable and adept at identifying indicators of possible violence and aggression[1]. Common descriptors of patient behaviors included tense posture, vocally loud, emotional (i.e., frustrated, angry), under the influence, "making the same points over and over again" (P14), "disruptive to others" (P17), agitated facial expressions, "many have mental health problems or are altered" (P24), confused, and "anxious, fidgeting, red face" (P38). These responses closely mirror the findings from previous research such that staff recognized "altered" patients who are under the influence, and those with a mental health disorder as commonly aggressive and staff responses align with the indicators of violence summarized by Table 1 taught to staff in the Respect & Care trainings.

Importantly, several respondents also explained that they recognize that the patient may have been upset by something prior to entering the hospital. For example, P74 said that aggressive patients are "hard to please, no matter how much you bend backwards. Regardless,

[1] Of the 45 people who responded to the question about their experiences with WPV, 19 people reported no experiences.

we like to be friendly with them and feel confident sometimes they come in already upset for other reasons so we don't take it personal". This response shows that when staff made external attributions for patient aggression, they were likely to not take it personally and continue to try to be friendly.

RQ2 – De-escalation strategies used by staff

Common responses about which strategies staff used following the training included using more active listening, eye contact, calm voice tone, giving explanations of what they are about to do to ensure patient understanding. Number of strategies listed by staff ranged from 1-11. All strategies listed in the responses aligned with strategies taught in the training and represented in Table 1.

RQ3 - Staff approaches to managing patient aggression

Coding of open-ended responses about how to manage patient aggression resulted in five categories; acknowledging (n = 37), combination (n = 8), correcting (n = 5), and zero-tolerance (n = 3). Table 2 shows the demographics for each category.

Responses were classified as *correcting* if they mentioned maintaining control and being firm. In this category, participants said that management of patient aggression should be done by "Set a limit somehow that they need to remain calm and respectful in order for the interaction to continue. Otherwise, ask them to take a seat so you can get help" (P3). Although participants were helpful to patients, ultimately, they saw patient behavior as something to be controlled.

Responses were classified as *acknowledging* if they included thoughts about listening, empathy, respect, acknowledgment of emotions, or compassion (Petit, 2005). Participants explained that patient aggression should be handled "In a calm but consistent manner, providing listening presence and acknowledging their feelings and concerns" (P20). It is promising that the

majority of participants held an *acknowledging* management strategy, as that was the strategy taught in the training. Based on research previous research, responses were deductively classified as *zero-tolerance* if they mentioned refusing service (Hodge & Marshall, 2007), as the small number of responses in this category said that they "should be able to make patient responsible for aggression by being able to refuse service" (P74).

The inductive category that emerged from the data was *combination*. This category was where participants explained some combination of being firm and controlling patient behavior, while also being sure to show respect and empathy. For example, participants made comments like "A patient should always be treated with respect and empathy. Also we can calmly let the patient know that we can help them but they would also need to treat us with the same courtesy that we extend to them" (P71).

Lastly, a serendipitous finding emerged from the data where eight of the 51 participants who responded to this question said they would get help from another person if the patient aggression escalated to physical violence. For example, one person said "If physical need to call Security. But otherwise, trying to find the reason why they are upset, and deescalating the problem" (P8). Future work should probe how staff decide to get help managing patient aggression to systematize these processes.

Table 2.
Demographics by Approach to WPV

Demographic	**Acknowledging Approach**	**Correcting Approach**	**Combination Approach**
Employment length	M_{months} = 106.36	M_{months} = 112.63	M_{months} = 49.20
Age	M_{age} = 41.79 years	M_{age} = 48.13 years	M_{age} = 40.60 years
Employee type	80.60% (n = 29) full-time	62.5% (n = 5) full-time	80% (n = 4) full-time
Gender	72.2% (n = 26) female	75% (n = 6) female	80% (n = 4) female
Prior training	58.4% (n = 21) yes	77.5% (n = 7) yes	60% (n =3) yes

Discussion

This study trained medical and non-medical staff completing non-medical tasks (i.e. patient registration) in existing de-escalation strategies found by previous research. Overall, staff report paying attention to the indicators of violence, and de-escalation and limit setting strategies outlined by Table 1. These results suggest that staff, as a result of this training, are better able to identify indications of patient aggression, take a desirable approach to managing aggression, and know what strategies to be able to deploy in order to de-escalate the situation.

Regarding approaches to patient aggression, generally, and as taught, those who held an acknowledging approach toward patient aggression were also more likely to report using a larger number and variety of de-escalation strategies they learned in the training, and share stories of successfully de-escalating patient aggression to prevent violence. Those who held a correcting, acknowledging and correcting, or zero-tolerance approach exhibited worse outcomes. By making an external attribution for the aggression, and holding an *acknowledging approach*, staff identified pre-violent indicators, used more strategies taught in the training, and successfully de-escalated WPV three months after the training.

Limitations of this study suggest some important future directions. Due to the online data collection, responses could not be probed further in situ, and there was no consideration of patient characteristics. Also, results of this study aligned with previous research such that communication skills training improved the effectiveness of the interaction (Street, 2003). However, a skills-focused approach paints healthcare communication interaction as only interpersonal in nature, which ignores many of the communicative issues stemming from healthcare's intergroup context (Watson & Soliz, 2019). As such, f~~F~~uture work should use semi-structured interviews to enable more in-depth responses, framed by a robust interpersonal and

intergroup communication theory such as Communication Accommodation (e.g., Giles 2016), and should consider how the group memberships of staff and patients impact these interactions. Qualitative interviews would also allow for learning more about how healthcare staff manage their own emotions while de-escalating interactions with patients (i.e., double-faced emotion management, Tracy & Tracy, 1998)

Practical Implications

Given the above findings, hospitals should educate staff about causes of patient aggression. Staff should continue to be reminded that patient aggression is not personal, nor is it because the patient has some sort of negative character trait. Instead, if staff can be reminded and encouraged to make external attributions for patient aggression, they may be more likely and able to calmly deploy de-escalation strategies, and successfully prevent WPV. Continued training with attending rigorous evaluations having theoretical bite (as above) would be beneficial.

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