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Communication skills training in the management of patient aggression and violence in healthcare

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ABSTRACT

Challenging behaviours may sabotage therapeutic relationships if not addressed appropriately. While medication, environmental planning and staffing resources are requisites for the management of challenging behaviour, effective communication is an important aspect in the management of these challenging behaviours including aggression. Good communication helps the patient become an active partner in the process. Staff training that focuses on communication skills can be useful to both patients and healthcare workers. This paper aims to review the research evidence from existing communication skills training programmes that are exclusively or partly focused on the reduction of aggression perpetrated by patients. This review included one randomized controlled trial protocol, one quasi experimental study, six pre-test/post-test designs, three mixed methods, four qualitative studies, one descriptive survey and four with other designs that were mostly conducted in mental health settings. The findings show that communication skills training improve the confidence of staff in dealing with aggression. However, minimal number of studies with a focus on aggression reduction, the quality of the studies in terms of design and lack of active controlled trials minimizes the generalizability of the findings. These findings reiterate the need for future research with a focus on well designed, active controlled studies to establish the effectiveness of communication skills training as a suitable strategy to minimise and prevent patient aggression.

1. Introduction

Communication is a skill required to build therapeutic relationships, and a tool to diagnose disorders and deliver appropriate therapeutic interventions (Kleinman, 2004; McCabe & Priebe, 2004; McGuire, McCabe, & Priebe, 2001). Education and training are considered to be effective management tools in combating workplace violence and most educational and professional regulatory boards mandate that all healthcare workers train in communication and interpersonal skills (General Medical Council, 2015; Medical Council of New Zealand, 2014; NICE, 2015; Nursing Council of New Zealand, 2010; Scanlon, 2006).

Aggression can occur for a variety of reasons. Several studies proffer staff-patient interactions as a significant antecedent to aggressive incidents especially in mental health and emergency care settings. Negative staff interactional styles and limited communication skills are strong precursors of aggression and violence (Duxbury & Whittington, 2005; Whittington & Wykes, 1996). A “reactive” aggressive approach by patients is often an attempt to regain power and control, while staff use ‘reactive’ crises management techniques to resolve the situation (Duxbury & Whittington, 2005; Schablon et al., 2012; Whittington & Wykes, 1996). Patients report feeling disempowered, restricted, and at the mercy of the controlling style of staff as reasons for their aggression (Duxbury & Whittington, 2005; Schablon et al., 2012). Despite the drive to use non-coercive measures over physical interventions to prevent crises, the response to patient aggression continues to be reactive. Aggression is viewed as something that needs to be managed when it occurs, rather than addressing it therapeutically and preventing aggression from occurring (Duxbury & Whittington, 2005; Schablon et al., 2012; Whittington & Wykes, 1996).

Aggression may not only cause physical injuries, but can also have psychological consequences with high rates of stress and other sequelae for healthcare staff and for the organization (Inoue, Tsukano, Muraoka, Kaneko, & Okamura, 2006; Richter & Berger, 2006). Anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame and shame (Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999); decreased job satisfaction and increased intent to leave the organization (Sofield & Salmond, 2003); and lowered health related quality of life (Chen, Huang, Hwang, & Chen, 2010) were found to be the consequences of healthcare workers' short- or long-term exposure to violence and aggression. Organizational level outcomes of aggression may include high staff turnover and difficulty with staff retention (Kisa, 2008; Owen,

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Tarantello, & Jones, 1998) decreased morale, hostile work environments (Pai & Lee, 2011) absenteeism, more frequent medical errors, more workplace injury claims (Ito, Eisen, Sederer, Yamada, & Tachimoro, 2001; Roche, Diers, Duffield, & Catling-Paull, 2009), economic costs due to disability leaves, and reduced quality of patient care (Campbell et al., 2011). The economic burden of physical and psychological consequences of aggression against healthcare workers is significant, and accounts for approximately 30% of the overall costs of ill health and accidents (Hoel, Sparks, & Cooper, 2001). Moreover, workers' disability and the consequent need of temporary staff increase service costs and have been linked to lower standards of care (Audit Commission, 2001).

Many published guidelines and policies on aggression and violence reiterate the importance of training as a preventive measure. Professional and governing bodies have advocated for different types of training to meet the different needs of staff groups (General Medical Council, 2015; Medical Council of New Zealand, 2014; NICE, 2015; Nursing Council of New Zealand, 2010; Scanlon, 2006). The benefits of training remain obvious; however the quality and effectiveness of this training is difficult to establish due to varied content, duration and lack of objective evaluation following training.

Professional bodies and experts have developed guidelines and recommendations to be covered in aggression prevention and management programmes (General Medical Council, 2015; Medical Council of New Zealand, 2014; NICE, 2015; Nursing Council of New Zealand, 2010). The content of training focuses on prevention, calming and negotiation, basic to complicated situations, control and restraint training, crises resolution, overview of aggression, post incident debriefing, trauma, self-control and institutional policies and protocols. Most training programmes continue to focus on crisis management rather than prevention and the content of these training include physical interventions like breakaways, restraint and seclusion (Muralidharan & Fenton, 2012).

Three literature reviews conducted since 2000 highlight the importance of communication skills training within healthcare. Fleischer, Berg, Zimmermann, Wüste, and Behrens (2009) investigated two aspects in the nursing literature on nurse-patient communication and interaction by reviewing 97 citations published up until the literature search in September 2008. Another review by Chant, Jenkinson, Randle, Russell, and Webb (2002) focused on communication skills training in healthcare and found 17 studies in pre-registration nursing education, 26 studies in post-registration nursing education and 27 studies in other disciplines evaluating communication skills training. The third review was specific to nursing care and identified 14 studies focused on the evaluation of the effects of communication training programs for nurses (Kruijver, Kerkstra, Francke, Bensing, & van de Wiel, 2000). The findings of all three reviews report the lack of well-designed, randomized controlled intervention studies with appropriate outcomes that would underpin the effect of educational or structural interventions to improve communication skills. With the last review reported in 2009, and the topic being an active area of research, a current review of the literature on the effect of communication skills training in the management of patient aggression and violence within healthcare is considered worthwhile.

2. Purpose and scope of the present review

2.1. Aim

Currently, there is paucity of studies on the effectiveness of communication skills training for improving interaction between healthcare workers and patients, and subsequently preventing patient aggression. The aim of this literature review is to highlight the potential effect of communication skills training as a patient aggression prevention strategy for healthcare workers and to indicate future venues for research, education and practice.

2.2. Design

For this review the search strategy was identified and PRISMA reporting guidelines were used.

2.3. Search strategy

Search of electronic databases including CINHAL, Medline, Embase, PsychINFO, and ProQuest was conducted to identify articles. Studies conducted between 1996 and 2016 were included in the review. The electronic search was conducted using key terms, combination of key terms and appropriate truncation. The key terms used were *aggression*, *communication*, *communication skills*, *communication techniques*, *healthcare staff*, *healthcare personnel*, *nurses*, *patient aggression*, *aggression reduction*, *support staff*, *reduction*, *minimization*, *intervention*, *healthcare workers*, *training*, and *violence*. Following review of the titles and abstracts of articles for relevance, reference list of enlisted articles was hand searched for relevance and inclusion in the review. Further articles were found through expert suggestion as well as manual search of references in the found articles.

2.4. Inclusion criteria

The criteria for inclusion of articles in the review were: the focus of the training programme being fully or partly on communication skills as an aggression reduction or prevention strategy; healthcare workers/trainees/caregivers as participants; studies conducted in hospital or community settings; studies conducted in all areas of healthcare like psychiatry and emergency department; studies published in English; studies published between 1996 and October 2016; quantitative studies like cross sectional surveys, quasi experimental studies, RCTs; qualitative studies; descriptive articles that described communication skills training.

2.5. Exclusion criteria

The exclusion criteria were: the training programme was not fully or partly on communication skills as an aggression reduction or prevention strategy; studies that had no healthcare staff/caregivers as participants in the training programmes; articles not published in English; articles published before 1996 and after October 2016; articles which the full text was not available; research that was deemed irrelevant to the research questions: epidemiology of manual restraints and seclusion, aggression outside of healthcare, domestic violence, violence outside of healthcare, horizontal violence/bullying, pharmacological research focused on generally reducing aggression in certain disorders, non-human research; secondary research articles that analysed communication skills training for aggression reduction.

2.6. Search outcomes

Relevant publications were selected based on the inclusion/exclusion criteria as mentioned above. A total of 985 articles were initially identified. After 519 duplicates were removed, the result was 466 potentially relevant articles. These 466 potentially relevant articles were screened on title and abstract, and 235 articles excluded as they were irrelevant and did not include communication skills training. Following this initial screening, 231 articles were assessed for inclusion against the set criteria and a total of 86 articles were included in the full text review after exclusion of 145 articles. A total of 20 articles were included in this review after exclusion of another 66 articles for reasons that included no specific communication skills training component and other inclusion/exclusion factors. The search strategy is outlined in Fig. 1: Search Decision Flow Diagram for the review.