A zero tolerance approach to violence and aggression has been widely adopted in healthcare but health professionals must be flexible in how they tackle such situations.

**Do zero tolerance policies deskill nurses?**

*In this article...*

- **What a zero tolerance approach entails**
- **The implications of this approach for nurses and patients**
- **Alternative solutions**

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**How to manage patient aggression remains an issue in practice.** The zero tolerance policy adopted by many organisations can have a negative impact on patients and staff.

Below are three examples of nurse-patient interactions that are relatively typical of what can occur in nursing and midwifery settings.

- **» Rob Carter, a single male in his early 40s, was admitted to a medical ward following a diagnosis of adult T-cell leukaemia; his mother, who he had been living with, had died in the previous year. Staff described Mr Carter as shy and rarely giving offence but one evening when I visited him at the hospital he was extremely upset. He told me he had been seen by someone from the local psychiatric team after he had shouted at a nurse, telling her to give him some anti-emetic medication.**

- **» During the final stages of delivery of her first baby, Marlene Blaine was tearful and shouted profanities at the midwives and her partner. Throughout, the midwife was soothing and reassuring and, once the baby was born, the attending midwife congratulated both Ms Blaine and her partner.**

- **» Timothy Jenkins presented in an acute delirious state to accident and emergency. The hospital security staff were summoned because nurses were concerned that he would become aggressive. At the sight of the security personnel, Mr Jenkins began shouting and swearing. He was taken to a side room, where he was physically restrained.**

At first sight, these scenarios appear to be examples of good clinical practice, with timely responses to difficult patients. However, one crucial difference is that in the cases of Mr Carter and Mr Jenkins, the health professionals involved decided that outside help was needed – that these patients’ behaviour was beyond their remit. By contrast, the midwife saw that Ms Blaine was in need of the expert support that she could provide.

Each patient in these scenarios is reacting in a way that is understandable, given their situation. Given Mr Carter’s terminal diagnosis, it is not surprising that he may be upset or angry. Coping with delivering a baby can make mothers-to-be behave out of character, as in Ms Blaine’s case, while Mr Jenkins’ actions may be explained by the bizarre behaviour that often follows delirium. So why did the...
health professionals behave differently? Why did they seek outside help to deal with Mr Carter and Mr Jenkins but not to deal with Ms Blaine?

Perhaps the professionals in these examples were following different protocols. However, when we asked nurses (informally) about these and similar situations, they suggested other reasons for the health professionals’ actions. In particular, many voiced that they do not feel they have the skills that are required to deal with patients such as Mr Carter and Mr Jenkins. Arguably, the professionals in the examples did have the skills their patients needed – each patient primarily needed to be listened to and offered carefully gauged reassurance and it is highly likely they would be capable of exercising these skills in other situations, for example with friends.

Other reasons put forward by nurses included that patients such as Mr Jenkins make them fear for their personal safety. However, this is unlikely to have been the case for Mr Carter, who was in bed and verbally expressing frustration about waiting for his medication. Some nurses appeared to see Mr Carter and Mr Jenkins as less deserving than others. They described feeling it was “not their job” to deal with the situation as it would distract them from caring for patients with greater needs.

Nurses based on medical and surgical wards and in A&É defined their roles differently from maternity staff in relation to “challenging behaviour”. Handling such behaviour was seen as part of midwives’ roles, whereas similar behaviours in nursing contexts were seen as “unacceptable” and needed to be handed to other services.

**Zero tolerance approach**
The response to Mr Carter’s and Mr Jenkins’ challenging behaviour shows the effect of a “zero tolerance” approach. Over recent years, this approach has been adopted as a major organisational response to aggression and violence by patients or their relatives towards nurses.

A zero tolerance approach dictates that perpetrators are the problem and tough action should be taken against them, sending the message that violence against nurses is unacceptable and that nurses do not have to put up with it (Armstrong, 2006). It assumes perpetrators can, and should, be responsible for their behaviour.

While the midwife saw Ms Blaine’s behaviour as part of the process of childbirth that had to be managed, Mr Carter’s and Mr Jenkins’ behaviour was seen as separate from their clinical conditions and one that required a non-nursing response. Although a zero tolerance approach aims to minimise risk through policy adherence, this reduces the role of nursing staff in making personal decisions about reacting to challenging behaviour (Holmes, 2006).

Boxes 1 and 2 show the content of two posters that take different approaches to reducing unacceptable behaviours. The list of items and behaviours in the ward entry poster (Box 1) is unwelcoming, and unlikely to stop those who do carry dangerous weapons. Box 2 however, uses a more reasoned approach by informing as well as forbidding.

**Distancing**
Zero tolerance provides a catchy slogan and a simple message; however, it also places challenging behaviour outside of nurses’ remit and protects them from having to deal with some of the emotional and physical challenges that may be a part of their patients’ illnesses. Health professionals have a tendency to “distance” themselves from the emotional aspects of care by seeing patients as “diseased objects” – for example, referring to a patient as “the fractured neck of femur in room 1” (Calkin, 2011).

A zero tolerance approach offers procedures and protocols that help distance staff from seeing patients as individuals. This presents a risk that, by following protocols, professionals are gradually prevented from fully assessing their patients’ needs and the personal circumstances surrounding their illnesses.

**Implications**
Although zero tolerance approaches aim to protect staff interests, there are several ways in which they do the opposite. In Mr Carter’s case, by saying she could not handle his emotional needs the nurse made him angrier and more upset, leaving him feeling alienated and more likely to trouble nurses in the future. Calling in security staff to deal with Mr Jenkins probably enhanced his paranoia, making it more difficult to develop a therapeutic relationship with him. Both Mr Carter’s and Mr Jenkins’ office.

**BOX 1. WARD ENTRY POSTER**

**Please note…**
The following are not allowed in the unit:
- Cigarette lighters and matches
- Glass (bottles, jars etc)
- Tinned food and drinks
- Mobile phones
- Weapons
- Illicit drugs
- Alcohol (including intoxicated visitors)
- Cameras
- Sharp objects (scissors, needles, razor blades)
- Aerosol sprays and cans
- Electrical Equipment (mains powered)
- Plastic bags
- Violence

Poster on an acute care mental health unit, Victoria, Australia, 2011

**BOX 2. FEET ON SEATS POSTER**

Feedback from our customers shows us that people putting their feet on train seats is a habit they find particularly annoying. This also includes the framework sections between, and either side of, the seat cushions.

Enforcement teams on the Merseyrail network may film and interview people who put their feet on seats, or any part of the seat structure, as evidence for prosecution.

Feet on seats falls within Merseyside Electrics 2002 Ltd Railway Bye-Laws. Failure to comply with these instructions may lead to prosecution.

Merseyrail, Liverpool, UK, 2011
families were also upset when they heard what had happened and became wary in their own relationships with staff.

By outsourcing their response, the nurses missed therapeutic opportunities. Mr Carter needed to know that those caring for him could accept that he shouted out of frustration and did not mean it personally. Mr Jenkins needed professionals who could provide a stable and reassuring presence to help orientate him to his surroundings.

Outsourcing the management of challenging behaviour can leave nurses feeling deskilled. Training by experts in zero tolerance approaches reinforces dependence on outside personnel, whereas it might be more beneficial for everyone involved to teach nurses how to diagnose psychological illness, apply psychological techniques and refer patients on to counselors, psychologists or psychiatrists.

The final problem of a zero tolerance approach is that its emphasis on staff training has resulted in numerous courses being developed, which have rarely been subject to systematic evaluation (Nachreiner et al, 2005). Many nurses have reported that their training for challenging behaviour does not meet their needs (Farrell and Shafiei, 2012). Apart from wasting valuable time, poor training can make matters worse as it can encourage nurses to unhelpfully intervene in ways that risk escalating incidents (Nachreiner et al, 2005).

Alternative solutions

To effectively respond to these situations, nurses need to reclaim the management of problems like the challenging behaviour exhibited by Mr Carter and Mr Jenkins. They need to see such patients’ behaviour as needing a nursing formulation and response, rather than seeking one that is driven by outsiders. Of course, having the right attitude is not enough; situations such as Mr Carter’s and Mr Jenkins’ present complex and sometimes dangerous challenges – it would be naïve to assume that all nurses need is a “can do” attitude.

Instead of training that is formulaic, during which staff are taught set responses to challenging behaviours, we need training that is based on learning how to assess the complex needs of patients displaying these behaviours. This should include helping nurses to understand their own responses and resources when challenged (Farrell and Salmon, 2010; Farrell et al, 2010). Nurses also need to be empowered to create environments that promote social behaviour among patients and staff. Increased quality of nurse-patient relationships and supportive teams protects against the risk of aggression (Camerino et al, 2008; Alexander and Fraser, 2004).

It is impossible to offer training that covers what to do in every possible situation, so nurses need to be creative and imaginative in making good clinical judgements and preventing incidents. Unfortunately, if training in how to communicate with patients and their families – and how to manage challenging behaviour – is prescriptive, it can reduce the creativity nurses and other professionals need (Salmon and Young, 2011). Nurses need to be able to help themselves, and each other, by linking training to real-life care.

Case presentations

An important but scarcely explored way for nurses to exchange practice ideas is using case presentations in the context of peer commentary. Within clinical teams, case presentations can be used to reflect on similar scenarios and enlist the varying skills and insights of different team members. They also have a value in connecting nurses across teams, nationally and even internationally, where those joining the case discussion do not know the situation directly and are not involved clinically. Case presentations and their discussion are one way that nursing can ensure its professionalism in the face of local pressure and influences.

We argue that challenging behaviour is an area in which nursing needs to rediscover its professionalism. Therefore, we invite colleagues to share their experiences of such behaviour – and their perspectives on these – with readers. Please comment on this article at www.nursingtimes.net/zerotolerance to share your own experiences of challenging behaviour and discuss them with fellow Nursing Times readers.

References


