Decreasing Dialysis Patient-Provider Conflict (DPC)

Provider Manual
2nd Edition

2005 DPC Task Force Members

Richard S. Goldman, MD   Task Force Co-Chair

Glenda S. Harbert, RN, CNN, CPHQ   Task Force Co-Chair
Executive Director, ESRD Network of Texas, Inc.

Karin Anderson-Barrett, BSN, RN, JD   Attorney, DCI Legal Department
Dialysis Clinic, Inc.

Elaine Colvin, RN, BSN, MEPD   Chairperson of ANNA's Ethics Committee

Sandie Guerra Dean, MSW, LICSW   Corporate Social Worker
Fresenius Medical Care NA

Cammie Dunnagan   ESRD Implementation Manager
Computer Sciences Corporation, Inc.

Brenda Dyson   President
American Association of Kidney Patients

Clifford Glynn, CHT   President
National Association for Nephrology
Technicians/Technologists

Kay Hall, BSN, RN, CNN   Director Regulatory Affairs/Licensure and Certification
Gambro Healthcare U.S.

Barry A. Hong, PhD, ABPP   Professor of Medical Psychology,
Department of Psychiatry
Washington University School of Medicine

Liz Howard, RN, CNN   Director of Policies and Procedures &
Adverse Patient Occurrences
DaVita, Inc.

Mark Meier, MSW, LICSW

Consumer Services Coordinator
Renal Network of the Upper Midwest, Inc.

Ida Sarsitis

ESRD Requirements and Liaison Manager
Computer Sciences Corporation, Inc.

Wendy Funk-Schrag, LMSW, ACSW

Patient Services Manager, Renal Care Group
National Kidney Foundation-Council of Nephrology
Social Workers

Ann Stivers

People Services Manager, DaVita, Inc.
National Renal Administrators' Association (NRAA)

Arlene Sukolsky

Executive Director
TransPacific Renal Network

Lisa Taylor, BSN, RN

Executive Director
ESRD Network 12

Sandra Waring, MSN, CNN, CPHQ

Contributor

William Winslade, PhD, JD

James Wade Rockwell Professor of Philosophy of
Medicine, Professor of Preventive Medicine and
Community Health and Professor of Psychiatry and
Behavioral Sciences, University of Texas Medical
Branch, Galveston, Texas; and Distinguished Visiting
Professor of Law, University of Houston Health Law
and Policy Institute

Janet Crow, MBA

Administrator
Forum of ESRD Networks

2005 Subcommittee List

2008 Toolbox Review Subcommittee List

Ethical, Legal, and Regulatory Subcommittee

William Winslade, PhD, JD, Chair

Karin Anderson-Barrett, BSN, RN, JD

Elaine Colvin, RN, BSN, MEPD

Glenda Harbert, RN, CNN, CPHQ

John Newmann, PhD, MPH

Barry Straube, MD

Toolbox Subcommittee

Mark Meier, MSW, LICSW, Chair

Elaine Colvin, RN, BSN, MEPD

Clifford Glynn, CHT

Sandie Guerra Dean, MSW, LICSW

Emily Hodgin, BSN, RN, CNN, CPHQ

Kathi Niccum, EdD

Ramiro Valdez, MSW, PhD

Sandra Waring, MSN, CNN, CPHQ

Taxonomy and Glossary Subcommittee

Wendy Funk-Schrag, LMSW, ACSW - Chair

Sandie Guerra Dean, MSW, LICSW

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Catherine Haralson

Mark Meier, MSW, LICSW

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Kathleen Egan, RN, MSN

Glenda Harbert, RN, CNN, CPHQ

Charlene Harvey

Mark Meier, BS, MSW, LICSW

LT Crystal Russell, PhD, MPH, CHES

Michele L. Spillane

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Introduction

In October 2003, 46 concerned ESRD stakeholders from 27 organizations met in St. Louis, Missouri, for a National Consensus Conference entitled **Dialysis Patient-Provider Conflict: Designing a Collaborative Action Plan with the ESRD Stakeholders**. The Forum of ESRD Networks sponsored this conference, with a grant from ESRD Network 12 and funding provided by the Centers for Medicare & Medicaid Services. The reasons for conflict in the dialysis clinic and solutions for decreasing conflict were discussed. As a result of the Consensus Conference, the Decreasing Dialysis Patient-Provider Conflict (DPC) project was initiated and in 2005, the first edition of the DPC Toolbox was created and distributed to ESRD Networks and dialysis facilities nationwide.

The DPC Toolbox provides resources to help nurses, physicians, social workers, patient care technicians, dieticians, administrators, unit secretaries, and all other staff involved in the daily operations of the dialysis clinic to better understand, respond to, and decrease conflict. In an effort to supply the ESRD community with the most up-to-date and useful information available, a review subcommittee was formed in 2008 to reevaluate the DPC Toolbox's efficacy. Building on its current strengths and successes, measures were taken to improve its user-friendliness and to streamline its content for enhanced readability. The DPC Toolbox you are holding contains many resources. Through your commitment to train your staff on the DPC resources, you will increase competency and improve the skills and approaches of your team to successfully address conflict in your dialysis clinic.

Background

In 2002, the Forum of ESRD Networks and the Centers for Medicare & Medicaid Services (CMS) partnered in an effort to quantify the number of patients that were involuntarily discharged from outpatient dialysis clinics and to understand why these discharges occurred. This quantifying effort included 12 of the 18 ESRD Networks. At the time of the study the 12 networks served 202,293 dialysis patients and 2,889 dialysis facilities, representing 71% of all facilities and patients. The study found that 458

(0.2% of prevalent dialysis population) involuntary discharges occurred in 2002. Of those discharges, 25.5% were related solely to noncompliance with treatment-related issues. The next-highest reason for discharge was verbal threat, which accounted for 8.5% of the discharges.

The study also looked at patient outcome upon discharge in four categories: placement in another facility, using the emergency room for dialysis, unknown, and other. The inquiry found that almost 50% of all discharged patients were required to use the emergency room for dialysis, had an unknown outcome, or were listed as other.

These data point to a level of conflict in the dialysis clinic that must be addressed. The DPC Project provides resources for your clinic to ensure that regular and thorough conflict-resolution training for facility staff occurs and offers recommendations for the development of policies and procedures for handling conflict.

Project Overview

This Toolbox is designed for use by dialysis center leadership and the staff responsible for conducting in-service training and quality improvement. The DPC Project is based upon ESRD network efforts and a Renal Stakeholder Consensus Conference conducted in October of 2003. This conference was sponsored by the Forum of ESRD Networks with support from an educational grant from ESRD Network 12.

With funding from the Centers for Medicare & Medicaid Services (CMS) and working with a Task Force of renal stakeholders and content experts, workgroups developed the tools and resources for staff training. The result was the 1st Edition, which was created in 2005. The DPC Toolbox contains three steps and a variety of helpful tools. The three steps are described in detail in the following pages.

At the core of the DPC Project lies the staff training component. This component is designed for the entire care team with an emphasis on dialysis staff that provide direct patient care and who may not have received training in professionalism or in conflict resolution. The training aims to decrease

patient-provider conflict by building conflict resolution skills, improving communication and increasing understanding of how interactions with patients, their families, and other staff may trigger or escalate conflict in the dialysis setting.

The staff training component was built around the acronym CONFLICT. Each letter of the acronym represents a principle or action that can be used when trying to prevent, decrease, or understand patient-provider conflict. Training components include:

Create a Calm Environment
Open Yourself to Understanding Others
Need a Nonjudgmental Approach
Focus on the Issue
Look for Solutions
Implement Agreement
Continue to Communicate
Take Another Look

This newly revised and updated edition is the result of collaboration between CMS, the ESRD Networks, and the ESRD Network Coordinating Center (NCC). This DPC Toolbox Review Committee made every effort to retain the original integrity of the piece, while implementing the necessary changes to keep dialysis professionals abreast of new information and practices regarding decreasing dialysis patient-provider conflict.

Overview of Each Step

The DPC Project is multifaceted with instructions, exercises, training software, and master handouts for patient care staff. For planning and implementation purposes, it is carried out in three consecutive steps.

Step I involves orientation and review activities for the facility leadership and quality improvement committee. **Step II** consists of staff orientation and training that utilizes classroom activities and an interactive software program. **Step III** comprises ongoing quality improvement activities and includes the training of all future staff.

Step I requires leadership review of the program prior to use so that any needed adaptations or revisions to the training or facility policies, procedures, or protocols are made in advance.

Step I: Management Review and Preparation

By the end of Step I, management will be able to:

- ✓ Familiarize facility leadership with the overall program.

- ✓ Demonstrate, through group discussion, an appreciation for how the culture and policies of the facility influence patient-provider conflict.

- ✓ Demonstrate, through group discussion, an understanding of the rationale behind the concepts of the program and how management can operate to achieve the highest quality patient care.

- ✓ Identify necessary revisions to policies, procedures, and practices to achieve congruence with the DPC Program.

- ✓ Create retrospective facility DPC data and plan future collection, reporting and review.

Step I will require some organizational work and advance reading as well as face-to-face meetings with the facility leadership. The DPC Project suggests a minimum of two face-to-face meetings each with the Medical Director, Director of Nurses, Administrator, and Social Worker.

Total estimated time for Step I:
Meetings–2 hours
Clerical copying–30 minutes
Time for policy and procedure review and revisions–variable

Step II: Staff Training

By the end of Step II, staff will be able to:

✓ Discuss effective use of the DPC model of conflict resolution in their practice through role-play and critical thinking.

✓ Demonstrate, through group discussion, an understanding of the rationale behind the concepts of the program, and how they can operate to achieve the highest quality patient care.

✓ Correctly utilize the DPC Taxonomy & Glossary for completion of DPC forms and discussions of DPC situations.

The staff training component utilizes two approaches: independent individual software training and group training sessions using several key educational strategies to facilitate critical thinking and encourage staff discussion. It is recommended that an initial staff meeting be conducted to introduce the program, followed by the software training for **each staff member**, then **eight group sessions** completed by a final staff meeting to assess implementation.

Total estimated time for Step II:
Initial Staff Meeting–variable
Software training–1-1½ hours
Eight group sessions–30-45 minutes each (4-6 hours total)
Final staff meeting–variable

Step III: Ongoing Quality Improvement

By the end of Step III, the following will have been completed:

The DPC Program will be integrated into staff training, facility quality improvement, and routine facility operations.

✓ All new staff will receive DPC training during initial orientation.

✓ DPC data will be reviewed monthly in routine Quality Improvement activities.

✓ When indicated by the DPC data, Quality Improvement activities will be initiated.

STEP I:
MANAGEMENT ORIENTATION AND PREPARATION

Management Orientation and Preparation

TIME REQUIRED

Two 1-hour meetings

30 minutes–Copying and dissemination

30 minutes–Review of policies and procedures

Variable–Revisions of policies and procedures

PREPARATION/MATERIALS NEEDED

❏ Schedule initial 1-hour meeting with facility leadership

❏ Photocopy and disseminate to each participant for review prior to meeting:

- Introduction, Background, and Project Overview
- DPC Position Statement on Involuntary Discharge: Executive Summary
- DPC Taxonomy & Glossary
- DPC Conflict Pathway

❏ Prepare meeting room:

- DPC Toolbox
- Computer with DPC CONFLICT Interactive Training Program
- Flip Chart (if available) to record brainstorming comments
- Your facility's Policy and Procedure Manual

CONDUCT FIRST LEADERSHIP MEETING

❏ Discuss purpose of DPC and explore:

1. Existing culture of facility related to patient autonomy, patient centeredness, and conflict
2. Congruence of above with recommendations of DPC Toolbox

❏ Brainstorm changes that may be necessary and assign:

1. Policies and Procedures review
   a. Zero tolerance
   b. Grievance policy
   c. Treatment rescheduling policy
   d. Patient comfort policies (blankets, food, music, TV)

    e. Patient care planning

    f. Responses to patient non-adherence, such as requests to come off early

    g. Others—any facility-specific issues

  2. Discuss needed revisions to existing staff training program

    a. Can leadership simply incorporate the DPC training?

     OR

    b. Are there conflicts in existing training that require revision?

  3. If revisions are needed, schedule time for subsequent meeting(s), preferably within 1-2 weeks

❑ Draft Revisions (if any)

CONDUCT SECOND LEADERSHIP MEETING (meet for 1 hour)

❑ Review QI Tools in Toolbox

  1. Policy and procedures

  2. Staff training

❑ Plan staff orientation

  1. Consider who will do the training. Who is the staff person most accustomed to training, making presentations, or speaking in front of groups?

  2. Consider the logistics of scheduling trainings. Will staff need to complete training during normal work hours or be paid overtime to complete during off hours?

CONDUCT QUALITY IMPROVEMENT (QI) COMMITTEE MEETING

❑ Review QI Tools in Toolbox

❑ Review past 6 months of incidents/reports related to patient-provider conflict

  1. Complete DPC Conflict Log on each incident/report

  2. Assign conflict causes and types

  3. Plot incidents/reports on DPC QI tools

❑ Assess, discuss and clarify any misunderstanding or difficulty in assigning causes and types

❑ Plan implementation of use of QI tools

  1. Routine reporting

  2. Data collection methods

  3. Monthly review in QI meeting

Adapting the Program for your Facility

As you read through each program component, keep in mind who your trainees are, who your patients are, and what is appropriate for your facility. The patients, technicians, nurses, and nephrologists who come into the clinic are from different neighborhoods, regions, or even countries. In short — we're all from different places! Moreover, different facilities have different policies, protocols, and procedures. Leaders are encouraged to carefully consider the congruence of existing culture and policy while giving attention to the incorporation of the DPC principles into local policy and practice. While the DPC Program has some flexibility and can be used in a way that reflect the unique qualities of your technicians and patients, the conflict resolution model, Taxonomy & Glossary, and data collection are nationally adopted and should be retained. Some important issues to consider are expressed below.

What is Facility Culture?

Prevailing attitudes, past behaviors, customs, and traditions comprise culture. When cultural expectations of staff and patients differ significantly, conflict is likely to occur. Sometimes, simply enhancing sensitivity to these differences can reduce conflict.

For example, some facilities are informal, loud and boisterous while others are quiet and staid. The first element of the DPC CONFLICT model is "Create a Calm Environment."

This may be difficult to achieve in a unit whose culture has supported loud and boisterous activity. The important thing here is to think about how to balance existing culture with the changes brought about by the facility's implementation of the DPC Project.

Language and Slang

The trainer must also take into account language differences. The DPC modules were developed in English, but many of your training participants and patients may speak different languages or use different terminology. However, adoption of the DPC Taxonomy & Glossary by all staff is critically important to the Project, as terminology will be used to collect data and to discuss situations. Additionally, the DPC Project is a national initiative and should be adopted by all ESRD providers.

Facility Protocols and Rules

Review each section to ensure that the information, recommendations, and exercises are consistent with your facility's protocols. For example, in the DPC scenarios, a patient is allowed to leave without a standing blood pressure. Be sure to give your trainees appropriate guidance on their role in making such decisions. The activity to identify the "Common Patient Concerns" and select chosen responses is an excellent opportunity to ensure that all staff clearly understand how complaints should be handled. It may be that certain issues can be directed to one person and other issues to another. For example, complaints about parking might correctly be directed to the administrator, while complaints about treatment scheduling are more appropriately directed to the Director of Nurses or charge nurse. If something in the program does not seem appropriate for your facility or does not fit how the trainees actually work with patients in your facility, alter the module as needed.

STEP II:
TRAINER'S GUIDE–
STAFF TRAINING

By the end of Step II,
the following will have been completed:

✓ Staff will discuss using the model for conflict resolution—*CONFLICT*—in their practice through role-playing and critical thinking.

✓ Staff will demonstrate, through group discussion and role-playing, an understanding of the rationale behind the program's concepts and how they can help ensure the highest quality patient care.

✓ Staff will use the Taxonomy & Glossary (located toward the end of this manual) to aid with discussions of situations.

STEP II uses two training approaches: **independent, individual software training through the CONFLICT Interactive Training Program,** and **group training sessions**. It is recommended that a staff meeting be conducted to introduce the program, followed by software training for **each staff member** that will require **1 to 1½ hours** to complete and then eight **30- to 45-minute group sessions**. After that, a staff meeting to assess implementation should be held. The group sessions should be completed as soon as is practical, which may be over a period of several weeks or even months.

Estimated time for Step II completion: seven to eight hours for each participant.

DPC CONFLICT Interactive Training Program

The CONFLICT Interactive Training Program (on a CD-Rom in the Toolbox) contains two training programs: *Conflict Skills* and *Critical Thinking*. Remember, before taking the software training participants must review the DPC ***Decreasing Conflict & Building Bridges*** brochure and the DPC Taxonomy & Glossary. At the beginning of each program, the user is asked to enter his/her name so that a certificate of completion can be printed at the end.

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The *Conflict Skills* program walks the user through the CONFLICT model and asks him/her to apply the model's concepts to a series of video clips depicting different scenarios involving conflict. After watching the clips, the user is asked some questions about the conflict they have just seen and then asked to answer the questions using the concepts of the CONFLICT model. If incorrect answers are entered, the program prompts the user with the correct answer. Users cannot proceed in the program until the correct answers are entered.

During the training, the user will be given a written explanation of the ideas behind the CONFLICT model (Create a Calm Environment, Open Yourself to Understanding Others, Need a Nonjudgmental Approach, etc.), which are explained fully in the accompanying brochure, ***Decreasing Conflict & Building Bridges***.

In the second program, *Critical Thinking*, the user is shown a series of video clips portraying a conflict and the successful resolution of that conflict. These video clips are based on the Taxonomy of *Risk to Self, Risk to Facility*, and *Risk to Others*. Users are asked to integrate all aspects of the CONFLICT model as they respond to the Program's questions.

It should be noted that the software programs were designed to facilitate learning at the user's own pace. The programs include these principles of adult learning:

- **The principle of cognitive load,** which ensures that the learner is not overloaded with too much information at any one time

- **Critical thinking activities,** which ensure that learners engage in deep problem-solving with conflict resolution scenarios (i.e., they apply information, recognize errors, and predict consequences of actions)

- **Critical thinking assessment questions,** which are used to grade responses and provide immediate feedback to the learner and to ensure that the learner's mastery of the test questions builds competence and reflects his or her ability to apply knowledge in real-life situations

Group Training Sessions and Activities

The group training sessions use several key educational strategies to facilitate critical thinking and encourage meaningful staff discussion. They are meant to be completed in 30 to 45 minutes to allow staff to return to work in a reasonable amount of time. These activities are designed to be implemented quickly, to keep participants energized and interested. They are not designed for long debates or drawn-out discussion of the topics.

The purpose of quick activities is to impart a single purpose or learning objective. Once that objective is met, the activity can be ended. Stay aware of the participants' reaction to the activity. Try not to lose their interest or engagement by taking too long to provide information or by allowing discussions to go off the topic.

Some activities lend themselves to in-depth group discussions that may take longer than the recommended amount of time. It is up to the trainer to find the balance between taking extra time for these kinds of discussions and staying on schedule.

There are eight short group sessions. Though they can stand alone and all complement one another, they are designed to follow the order of the *CONFLICT* acronym. The sessions are:

> **C**reate a Calm Environment
> **O**pen Yourself to Understanding Others
> **N**eed a Nonjudgmental Approach
> **F**ocus on the Issue
> **L**ook for Solutions
> **I**mplement Agreement
> **C**ontinue to Communicate
> **T**ake Another Look

There is an additional session called **Common Patient Concerns**. This workshop could be used in conjunction with any of the other workshops.

The aim of the group activities is to increase understanding and build communication skills. The activities encourage participants to explore questions, come up with answers and make possible connections for the causes and prevention of patient-provider conflict.

Generally, there are no "right" answers to the activities and discussion questions. In fact, many activities may be done "incorrectly": By making mistakes while practicing new skills, participants will learn the preferred method from one another.

The trainer's role is to encourage exploration, help participants answer their own questions, and try different tactics. Try not to feed answers or correct ideas. Allow discussion among participants and encourage additional research after the training to help answer participants' queries.

Tips for Trainers

Model Open and Nonjudgmental Behavior

To be open to new ideas, your staff will need a safe, non-threatening environment for learning. As a trainer, your behavior and your reactions to the participants can go a long way toward encouraging a supportive group. These tips can help develop group cohesion:

- Be clear about your expectations for how group members treat one another and how they participate
- Respect participants' feelings and comfort level
- Respect patient and family confidentiality
- Model appropriate responses and behavior
- Demonstrate acceptance and respect for all participants, regardless of race, religion, social class, or sexual orientation
- Demonstrate concepts and use examples when possible
- Encourage group members to share their experiences at their own pace
- Listen
- Let group members react, think, and analyze
- Give compliments

Leading Role-Playing

Most of the sessions focus on communication skills and use role-playing so participants can practice new techniques. The activities were designed to be very simple, so as not to put staff on the spot. The activities also divide groups into pairs so participants can practice with each other without having to perform in front of the group.

Here are some tips for leading role-playing:
- Give clear instructions on the expectations for the activities so partici-pants feel more comfortable
- Serve as the partner for a participant who doesn't have one
- Circulate among participants to provide tips on using skills
- Provide positive feedback
- Thank participants for their efforts
- Ask participants a few questions afterward to let them share what they learned, what they felt, or what was difficult

Because some staff might be resistant or uncomfortable with role-playing, the activities are called "case scenarios" or "practice." If some staff are still resistant, offer them alternatives to ensure that they can still apply some of the learning at their own pace. Alternatives could include writing down their responses to the scenario and asking a partner for feedback, or discussing with a partner different options for responding to a scenario and looking at the pros and cons of those options.

Conduct Staff Training

TIME REQUIRED

Refer to the facility leadership plan for staff training
Two face-to face staff meetings: 1 hour each
Software training: 1 to 1½ hours for each staff member
Eight group sessions: 30-45 minutes each
One optional group session: 30-45 minutes

PREPARATION/MATERIALS NEEDED

❏ Schedule initial half-hour staff meeting to introduce DPC Project
❏ Display the DPC **Decreasing Conflict & Building Bridges** Poster in staff room, if not displayed already
❏ Prepare meeting room:
    1. DPC Toolbox
    2. Computer with software CD
    3. Prepare Handouts
      • Training schedule
      • Any revised facility policies and procedures
      • DPC Brochure: **Decreasing Conflict & Building Bridges**
      • Copies of the Introduction slides from the PowerPoint presentation, if desired
    4. LCD projector to show Introduction slides from the PowerPoint presentation (Slides are located on the CD titled *Dialysis Professionals-Program Documents*. If an LCD projector is not available or desired, use handouts of the slides instead)

CONDUCT FIRST STAFF MEETING

❏ Discuss purpose of and review DPC Project:
   1. Use PowerPoint Introduction slides and/or handouts

❏ Review:
   1. Training schedule
   2. Any revised policies and procedures such as:
      a. Zero tolerance
      b. Grievance policy
      c. Treatment rescheduling policy
      d. Patient comfort policies (blankets, food, music, TV)
      e. Patient care planning
      f. Responses to patient non-adherence, such as requests to come off early
      g. Others—any facility-specific issues

❏ Review and discuss:
   1. DPC Brochure: **Decreasing Conflict & Building Bridges**
   2. DPC CONFLICT Poster
   3. DPC Taxonomy & Glossary
   4. Completion of QI report on each conflict incident
   5. Explain use of data for QI, not as a personnel or disciplinary tool

❏ Demonstrate training software

SUPERVISE SOFTWARE TRAINING

Create a Calm Environment

TIME REQUIRED

45 minutes

PREPARATION/MATERIALS NEEDED

❏ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape so participants can see and interact with one another
❏ Pens, pencils, and paper for participants
❏ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board
❏ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)
❏ Stress-reducing toys, like stress balls or small Slinkies, to give to participants
❏ Prepare and post this information well before participants enter the room (see diagram below):
  ◆ Training title
  ◆ Purpose of training
  ◆ Activities

Create a Calm Environment

Purpose: To explore current and new strategies for remaining calm, even in tough situations

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Group Activities

1. Write down two techniques that you currently use to relax either at work or at home.

2. Write down two strategies or techniques you use to stay calm on the job, even when a situation is stressful.

Group Activities

3. Think of at least two things the staff and the facility could do to promote a feeling of calm throughout the day

Scenario

Wrap-up

Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Create a Calm Environment** training. As you'll see on the flip chart, the purpose of today's training is to explore current and new strategies for remaining calm, even when the situation becomes stressful. We'll also discuss ways that we as a team can be proactive, rather than reactive, in increasing the feeling of calm in our dialysis unit.*

*Let's begin by reviewing our brochure, **Decreasing Conflict & Building Bridges**. Would someone volunteer to read the section called **Create a Calm Environment**?*

NOTE TO TRAINER When the volunteer finishes reading, thank the person and then move on.

Trainer states out loud:

Thank you for reading. You may have noticed that this section of the brochure addresses awareness of our physical surroundings, as well as our thoughts and feelings. It also states the importance of taking the time to calm ourselves and organize our thoughts before we try to engage with the patient. So let's talk a few minutes about strategies or techniques that help to calm us.

Please divide up into pairs. I'd like you and your partner to:

1. *Write down two techniques that each of you currently use to relax either at work or at home.*

2. *Then write down two strategies or techniques you use to stay calm on the job, even when a situation is very stressful.*

If you don't have a partner, I'll do the exercise with you. We'll take five minutes. Go ahead and start.

NOTE TO TRAINER Call time in five minutes.

Trainer states out loud:

OK. Let's come back together in our group. Let's hear what you came up with for No. 1, and I'll post them on the flip chart.

Listen for and post any answers such as: Practice deep breathing, do yoga, read a good book, soak in the tub, listen to my favorite music, knit, pray, talk to a friend, make sure I take my break, work out, etc.

Trainer states out loud:

Good. There are no right or wrong answers. Remember, activities that calm one person might not work for another. It is important for each person to know what works for them. Now, what did you write down for No. 2?

Listen for and post any answers such as: practice deep breathing; keep my voice calm; do not panic; think before I act; reassure the patient, staff, and/or family that everything will be OK; never raise my voice; ask for help from another staff person or supervisor; think of a special time, event, or person; keep a picture of a loved one or a special vacation on my locker as a reminder to relax, etc.

Trainer states out loud:

You all came up with a great list of techniques and strategies for relaxing and remaining calm. Let's look at the list again and circle the ones that we could definitely do here at our facility.

With the group's input, circle the responses that dialysis staff could do on the job.

Trainer states out loud:

Now, working with your partner again, take another five minutes to think of at least two things the staff and the facility could do to promote a feeling of calm throughout the day.

Call time in five minutes.

Trainer states out loud:

OK. Let's come back together to hear what you came up with. I'll post your responses on the flip chart.

Listen for and post responses such as: Try harder to keep the noise down; remember to speak in a calm voice to patients and other staff; do not raise voices or shout over one another; never talk about personal affairs in front of the patient; never talk to staff as if the patient wasn't there; play quiet music; keep the lighting at a comfortable level—not too bright or too gloomy; open the curtains—allow patients and staff to see the world outside; where possible, place live plants, fish tanks, or displays of other small pets like turtles and hamsters—in the clinic's common areas, etc.

Tip for Trainer: You can also mention that live plant life and animal life have been shown to help calm patients and lower blood pressure in health care settings.

Trainer states out loud:

These are good ideas. Of course, we all know that staying calm and relaxed in difficult situations is easier said than done. We also know that conflicts happen even in the best of circumstances and that sometimes, arguing with a patient seems like the only way to get your point across.

Arguments often make us defend our point of view, and we often get frustrated when the other person does not see it our way. We usually want to win the argument, which means one of us has to lose. Arguing also can make us feel like a bully or like we haven't treated the other person right, especially if it's one of our patients. Arguing can also make us feel put down, devalued, or disrespected by the other person.

When there is an argument or conflict, it's best to stay calm. We may be able to create a calm environment by not judging the other person and by not acting like one person has to be right and one person has to be wrong. This will help us to be open to learning from differing viewpoints.

During and after an argument or conflict, some people become very stressed. Different people need different techniques and take different amounts of time to calm down. It is important for each of us to learn ways to calm down quickly. So let's take a few minutes to think about this scenario:

You tried your best not to argue with a patient about bringing snacks into the unit, but she's done it three times in a row. When you remind her about the no-food rule, she says, "I'm a grown woman, and you can just butt out of my life!" You try to stay calm, but you aren't getting through to her about the no-food rule. You lose your cool and start to argue with her about it.

Now working with your partner again, take five minutes to think of two strategies you could use in this scenario to stay calm during the conflict or calm down quickly after the conflict.

Trainer states out loud:

OK, I heard a lot of discussion on this one! Let's go over what you all came up with, and I'll post them on the flip chart.

Trainer states out loud:

Let's look at the list we just came up with. Which of these could be done here at our facility or in the break room? Let's circle them.

Trainer states out loud:

You all did a great job of coming up with things to do to recover from a conflict or argument. I've heard of some other techniques that can be done in the break room, such as:

- *Having a stack of paper/newspapers that we can tear up and toss in the wastebasket*
- *Making paper and markers or crayons available so we can draw a picture that represents what we're feeling*
- *Sitting quietly for a few minutes*
- *Reading the **Decreasing Conflict & Building Bridges** Poster*
- *Writing in a personal journal for a few minutes.*

I know some of these may seem simple or silly, but anything we can do to get ourselves back into a calm place so we can continue our day is worth trying!

Now, working with your partner, take a few minutes to think of things we might do at work after a conflict that would <u>not</u> help the situation or could actually make the situation worse.

NOTE TO TRAINER

Listen for and post answers like rehashing the episode with colleagues, withdrawing from others, sulking, obsessing over the incident, putting yourself down, putting the other person down, yelling, threatening to leave, walking out, etc.

Wrap-Up and Questions

Trainer states out loud:

It looks like we have a good sense of what doesn't work. We can't always avoid conflict, but we know that getting impatient, mad, or upset won't help. We also know that arguing with patients, families or each other almost never works as a form of communication. Fortunately, you all mentioned some very good techniques for relaxing, staying calm, or for regaining composure if a conflict does occur. We all know that remaining calm and relaxed helps us as well as the patient.

Do any of you have any questions or concerns before we finish?

NOTE TO TRAINER

Answer any questions that are raised.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____ .

Open Yourself to Understanding Others

TIME REQUIRED

30 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape so participants can see and interact with one another

❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❑ Handout #1, The Goodness of Friendship

❑ A sheet of paper and pen/pencil for each participant

❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board

❑ Prepare and post this information well before the participants enter the room (see diagram below):
   ◆ Title
   ◆ Purpose of training
   ◆ Activities

Open Yourself to Understanding Others

Purpose: To learn techniques for effective listening and to identify factors that affect how people hear information

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Activities

Listening to the trainer

Follow-up questions to the article, "The Goodness of Friendship"

Activities

Discussion: Points that illustrate the difference between hearing and listening and what may cause those differences

Wrap-up and questions

Welcome and Statement of Purpose

Trainer states out loud:

Welcome to **Open Yourself to Understanding Others** *training. This is a training on communication that focuses not on our voices, but on our ears. That is, understanding the difference between hearing—something our ears do—and listening—something our hearts and minds do. Most of us would probably describe ourselves as good listeners, but for many reasons—which we'll take a look at in a minute—many of us could benefit from some additional practice and training. This training will also identify factors that can affect how people, such as our patients, hear information. We'll also practice techniques for effective listening.*

Let's start by taking a look at the brochure I passed out called **Decreasing Conflict & Building Bridges.** *Would someone volunteer to read the section called* **Open Yourself to Understanding Others***?*

NOTE TO TRAINER After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you for reading. Notice that the very first bullet tells us to listen closely to what we're being told about the complaint. Our first activity helps to illustrate the importance of listening closely. I'm going to begin by reading an article called "The Goodness of Friendship."

NOTE TO TRAINER Read the following article out loud and then pass out paper and pen/pencils.

The Goodness of Friendship

The need for friendship is particularly strong at two stages of our lives. In adolescence, the reassurance of being accepted by a group of friends helps give us courage to strike out on our own and assert our individuality. In old age, having at least one close friend seems to protect us against the insults of aging. Although these two groups have an especially pressing need for friendship, giving and receiving support seem to lessen the impact of stress for all of us.

Friendship, in the most personal sense, is sharing of self, not just a sharing of activity. After adolescence, American men have traditionally shied away from the kind of one-to-one friendship in which they share their deepest concerns. Some of the reasons for this include: 1) competition; 2) group orientated (find one-to-one intimacy awkward); and 3) fear of presenting an unmanly image (expected to be tough, self-sufficient, unemotional, and closed mouth). However, the American taboo on demonstrations of affection between men is lifted for athletes.

In old age, a woman's adeptness at making and keeping friends is an unmixed blessing. Part of women's ability to sustain themselves in their older years depends on their capacity for constructing a network of friends. On the other hand, a widower who depended on his wife as his sole confidant and source of emotional intimacy, as many men do, may be left in painful isolation.

We cannot gain all of our gratifications from our relationships with lovers, spouses, parents, or children. Our friendships both enhance and offer relief from the other emotional roles we play.

(Note: Author/Source Unknown)

Now I have a few questions for you. I'll read the questions one at a time, and you write your answers down. Please don't share your answers with each other.

Read the following questions. The answers are located below the questions; you'll read these later.

1. What is the name of this article?
   ("The Goodness of Friendship")

2. The need for friendship is strongest at what two stages of our lives?
   (Adolescence and old age)

3. Giving and receiving support from friendship seems to lessen the impact of what?
   (Stress)

4. What three reasons were given for why men shy away from close friendships?
   (Competition, group-oriented, unmanly image)

5. What one group of men has the OK to show affection toward each other?
   (Athletes)

6. What enhances and offers relief from the different roles we play?
   (Friendships)

Resource Materials/The Goodness of Friendship (01-20-2005)

After participants have completed the questions, go over the questions again and ask participants to share their answers. Then tell them the correct answers. Ask how many got all of them correct, how many missed one, missed two, and so on.

Group Discussion

Trainer states out loud:

*The previous exercise was called **What Did You Say?** It does a good job of illustrating the differences between hearing, listening, and understanding. Let's talk about some important points about listening:*

1. *Hearing and listening are not the same. Hearing is the act of perceiving sound. Listening involves the intent to understand what is being heard; it is a choice to pay attention.*
2. *People might not listen as well when they are sick, tired, hungry, worried, angry, bored, cold, hot, etc.*
3. *The ability to listen can be affected by many things, such as having strong feelings or opinions about what we're hearing, being preoccupied with something else, or making assumptions about what the other person is going to say and then jumping to conclusions.*
4. *The ability to listen is also affected by the tendency to judge the person speaking or what the person says. If the person isn't liked or respected, there is a tendency to discount what the person says. If what the person says isn't agreed with, there is a tendency to start thinking of ways to discount what is being said without really listening to all of the information.*
5. *People of different cultures sometimes express information differently, and others might not understand the meaning of certain phrases or words.*

So how do we become more effective listeners? Here some things we can do:

1. *Treat every interaction as if it's important. This shows respect for the person speaking and will help the person feel heard.*
2. *Don't impose your own feelings, attitudes, or solutions on the other person, especially if they are talking about a problem. It's easy for us to forget this when our patients make choices that are bad for their health, but we need to remain open to listening to what they are saying.*
3. *Look at the person speaking and focus on what is being said. Repeat or paraphrase what was said to be sure you heard what the other person was trying to explain. Remember your techniques for active listening.*
4. *Listen to both the words being said and the feelings being expressed by the other person.*

5. Be aware of the person's nonverbal behavior—and yours as well. What is communicated nonverbally often speaks louder than words.

6. If you don't understand something the person said, ask them to explain it again. And to make sure the person understands you, ask the person about what you said to see if it was clear to them.

7. It is important to remain professional, especially if the patient is being critical. Don't argue; instead, accept that what is being said is from the patient's point of view. Try to understand what the patient is saying and look into the matter before it becomes a bigger issue.

Wrap-Up and Questions

Trainer states out loud:

We covered a lot of information on listening more effectively. Before we finish, does anyone have any questions or comments about this training?

NOTE TO TRAINER Answer any questions or concerns.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____.

Need a Nonjudgmental Approach

TIME REQUIRED

30 minutes

PREPARATION/MATERIALS NEEDED

❏ Set up training space. This training involves playing music; therefore, the space should have a door you can close. The training room can be setup in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another

❏ An FM radio

❏ Pens, pencils, and paper for participants

❏ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❏ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board

❏ Prepare and post this information well before the participants enter the room (see diagram below):
  ◆ Module title
  ◆ Purpose of training
  ◆ Activities

Need a Nonjudgmental Approach

Purpose: To gain a greater understanding of what it means to work in an environment that understands and appreciates our differences, in both staff and patients

Activities

Group activity: Listening to different kinds of music

Follow-up questions

Group discussion: Comparing this exercise to our work

Activities

Wrap-up and questions

Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Need a Nonjudgmental Approach** training. As you'll see on the flip chart, the purpose of today's training is to gain a greater understanding of what it means to work in an environment that understands and appreciates the differences between staff and patients. First let's take a few minutes to review the **Decreasing Conflict & Building Bridges** brochure. Would someone volunteer to read the **Need a Nonjudgmental Approach** section out loud?*

NOTE TO TRAINER After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you for reading. We know that being nonjudgmental can help us in many aspects of our lives. Being nonjudgmental helps build understanding. So, we're going to do something a little different today. We're going to use music to help us see how being nonjudgmental can be very helpful. This exercise will help us:

- *Understand that people might react to the same situation differently*
- *Identify one way to be open to another person's point of view*
- *Identify two characteristics of professionalism*

So let's get started. First, I'd like to get some feedback from you on some music.

NOTE TO TRAINER Starting at the bottom of the FM dial, find any kind of music, play it for 10-15 seconds, turn down the radio and then ask participants the questions below about the music they heard.

After the questions have been answered, move up the dial to a different kind of music. You'll repeat this process five times; there may be time to do it up to seven times. Try to find at least five types of music: blues, country & western, classical, rap, rock, jazz, pop, R&B, heavy metal, etc.

Trainer states out loud:

OK, now with a show of hands, tell me: Who liked the music you just heard? Why? With a show of hands, who did not like it? Why?

After the last round of listening to the music and answering questions about it, resume the discussion of the topic.

Trainer states out loud:

OK! That was fun. But what does this have to do with our jobs? What do you think this all means?

Listen for and post answers like:
- Music is universal.
- Everyone is different and likes different kinds of music.
- The kind of music a person loves depends on where and when they grew up.
- Not everyone likes every kind of music.
- Some people are stuck on their music like they are stuck in their ways.
- People are comforted by the music that they know.

Group Discussion

Trainer states out loud:

Those are good answers. Music does have a way of defining us. Let's look at how we can compare music with our work in the dialysis unit. Tell me if you agree with these comparisons:

1. Everyone does not react to music in the same way. Asking what each other likes/ dislikes about music can help us learn more about the person, as well as understand the music from another point of view. Likewise, it can be helpful to ask how patients view situations in the facility to learn more about the patient as well as get another viewpoint about the situation.

2. How we respond to each type of music might be influenced by our age, culture, and environment. How we respond to conflicts also could be related to our age, culture, and environment.

3. *We can't assume that just because we like a certain kind of music, everyone else will. Likewise, just because we think everything is fine doesn't mean there isn't or won't be a problem.*

4. *A song can bring back positive or negative memories. Likewise, when something happens during a treatment, a patient may associate it with a past experience. Their reaction could be based on that experience and how it was handled.*

5. *We don't have to like all kinds of music, and we don't have to like all kinds of people. But we do need to respect everyone.*

6. *It helps to be open to all kinds of music. It helps to be open to all kinds of people and to avoid judging them.*

7. *We don't have to persuade others to like the same music we do. Part of being professional is being able to keep our preferences and needs separate from our patients' preferences and needs.*

8. *Music involves harmony. Part of being professional is finding ways to create and maintain harmony with our patients.*

Wrap-Up and Questions

Trainer states out loud:

You all did a great job. I think we learned some things about one another that we didn't know before! Before we wrap-up, do any of you have any questions or comments about our training today?

NOTE TO TRAINER   Answer any questions or acknowledge comments.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____.

Focus on
the Issue

TIME REQUIRED

45 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another

❑ Pens, pencils, and paper for participants

❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❑ Copies of the handout *What are You Trying to Tell Me*?

❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-paper or a dry-erase board

❑ Prepare and post this information well before participants enter the room (see diagram below):
  ◆ Training title
  ◆ Purpose of training
  ◆ Activities
  ◆ List of points for staying focused on the content of following page

Focus on the Issue	Activities	Group Activities
Purpose: To practice communication techniques that can be used in the dialysis clinic to help dialysis professionals stay focused on a single, clearly defined issue.	Group Discussion on key points for how to focus on the issue What are You Trying to Tell Me?	Practicing with partners Wrap-up

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Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Focus on the Issue** training. As you'll see on the flip chart, the purpose of today's training is to practice techniques that can be used in the dialysis clinic to help dialysis professionals stay focused on a single, clearly defined issue.*

*We know that resolving a conflict that involves multiple issues and/or poorly defined issues is next to impossible. Dealing with multiple issues requires more time than a dialysis professional can give during a typical patient's dialysis treatment. Learning to focus on the most important issue will help us understand the basis of the patient's complaint and help us find real solutions to the conflict. Of course, all of this is easier said than done, so let's take a few minutes to look at the key points about focusing on the issue in the **Decreasing Conflict & Building Bridges** brochure, and then we'll practice. Would someone volunteer to read the **Focus on the Issue** section out loud?*

NOTE TO TRAINER

After the volunteer finishes reading, thank the person and then move on.

Trainer states out loud:

Thank you. Those are all excellent points that could help us stay focused on the issue. I've written other helpful points here on the flip chart. Let's go over them together:

- *During a conflict, it's common for additional and unrelated concerns to be raised. Be prepared for this. Maintain a calm presence and direct the conversation back to the original concern.*
- *Be willing to ask the patient to explain their concern if you didn't understand what they are saying.*
- *Avoid assuming that you already know what the patient is upset about.*
- *Ask the patient specific questions to help you clarify and identify their concern.*
- *Do your best to give the patient your full attention when discussing the concern. Tell the patient you are committed to understanding what the concern is about.*
- *Keep in mind that sometimes it's hard for a person who is receiving a dialysis treatment, and perhaps not feeling well, to clearly say exactly what they are concerned about. As a healthcare professional, it is your job to help the patient clarify what their concern is.*

The first and last points are especially crucial because it takes practice and skill to re-direct a conversation or to help a patient clarify what their concern is. So let's take a few minutes now to practice re-directing or clarifying an issue. I'm passing out a handout called **What are You Trying to Tell Me?**

Pass out the handout and go over it with the group.

Practice

(10 minutes)

Trainer states out loud

OK, let's practice. Please pick a partner. If you can't find a one, I'll do the exercise with you.

Think about a conflict situation that has occurred in almost every dialysis setting, such as the temperature of the unit. One of you will be the patient and the other will be the dialysis professional. The patient will start by complaining about the temperature in the unit. As your conversation progresses, the patient will raise other issues such as the eating policy, transportation problems, diet concerns, staff complaints, and so on. The person playing the dialysis professional should try to address all the complaints that the patient makes.

After you have done this for a few minutes, stop and switch roles. But this time, the dialysis professional should use the techniques suggested on the **What are You Trying to Tell Me?** *handout to keep the conversation focused on the original complaint regarding the temperature of the unit.*

Call time in 10 minutes and then open the discussion with the questions below. Write down participants' responses.

Trainer states out loud:

OK, let's come back together and talk about what happened. I'll ask you a few questions and jot down your responses.

1. As the "patient," how did it feel to have all your concerns addressed at one time?

2. *As the dialysis professional, how did it feel to try to address all the patient's concerns at one time?*

3. *What are some reasons why a patient might raise multiple complaints in a conflict situation?*

4. *Do you think that by trying to solve too many problems at once, you could actually make the conflict worse? Why?*

5. *As the patient, how did you feel when the dialysis professional told you his or her understanding of what your complaint was about?*

6. *As the dialysis professional, how did you feel when you were trying to deal with just one complaint?*

7. *What could happen if you quickly assume you know what a patient is upset about without asking the patient to really explain the concern?*

Wrap-Up and Questions

Trainer states out loud:

You all did a great job. I think we learned some techniques for staying focused on an issue or re-directing a conversation to the original issue. Before we wrap up, do any of you have any questions or concerns about our training today?

NOTE TO TRAINER

Answer any questions or acknowledge comments.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____ .

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What are You Trying to Tell Me?

Here are some phrases you can use as you try to focus on the issue:

1. "I think what I heard you say is …"

2. "Let me see if I understood what your concern is about. Tell me if this is accurate … "

3. "It sounds like you are unhappy with …"

4. "I am not sure I fully understand what your concern is. Would you explain it to me again?"

5. "Would you agree with me that your complaint is about … ? Or is there more that I need to understand?"

6. "I am hearing that you have more than one concern. Let's focus on the issue that is bothering you most first."

7. "You first told me that you were upset about the temperature in the clinic, but now I hear us talking about your frustration with your doctor. Let's get back to your concern with the temperature to see if we can address that, and then if we have time today we can talk more about your doctor."

8. "It sounds like you have more concerns than we can deal with at this time. I would like to suggest that we arrange a time very soon when we can sit down and talk privately about what is bothering you."

Look for Solutions

TIME REQUIRED

45 minutes
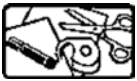
PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another

❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❑ Handout #1: Close-Ended and Open-Ended Questions

❑ Handout #2: Practice Finding Solutions

❑ Pens, pencils, and paper for participants

❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board

❑ Prepare and post this information well before the participants enter the room (see diagram below):
   ◆ Module title
   ◆ Purpose of training
   ◆ Activities
   ◆ List of seven other points for solutions are found on the next page
   ◆ List of differences between Closed- and Open-Ended Questions from Handout #1

Look for Solutions	Activities	Activities
Purpose: To gain a greater understanding of communication strategies that decrease conflict	Key points to resolving conflict The importance of open-ended questions	Brainstorm Wrap-up and questions

Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Look for Solutions** training. As you'll see on the flip chart, the purpose of today's training is to gain a greater understanding of communication strategies that can decrease conflict. This training will also give you a chance to practice developing real solutions that could satisfy both the patient and staff.*

As you have seen in the other trainings, communication and conflict resolution is a process with many stages. At some point in the process, you and the patient will want to start talking about solutions to the conflict. As you think about when to start discussing solutions, look for cues from the patient that indicate they are ready to talk about solving the problem. Cues can be verbal, such as when the patient indicates they want to solve the problem. Cues also can be physical, such as when the patient softens their tone of voice or settles back in their chair into a more relaxed posture.

*Let's start by taking a look at the **Decreasing Conflict & Building Bridges** brochure. Would someone volunteer to read the section called **Look for Solutions**?*

NOTE TO TRAINER After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you. The brochure makes excellent points. I've posted seven other points that should be considered when trying to resolve conflict. Let's go over them together.

1. The objective of conflict resolution is to negotiate an agreement, not to score a victory. Conflict resolution is not about winning or losing—it's about solving a problem.

2. Timing is critical. If either person feels forced or pressured into accepting a solution or isn't ready to discuss a solution, it probably will be difficult to find a long-term resolution to the conflict.

3. Being willing to negotiate a solution doesn't mean you're weak. On the contrary, it shows the patient that you are solution-oriented and willing to listen and work with them to solve the problem.

4. *To find a solution that really works, everyone must be committed to solving the conflict.*

5. *It's often helpful to talk with a neutral third party to find solutions that you might not think of.*

6. *Using open-ended questions can lead to a more thorough discussion of the conflict and the possible resolution.*

7. *Brainstorming possible solutions to a conflict can lead to more effective policies or more efficient ways of operating at the clinic.*

Let's look for a moment at numbers 6 and 7. Both points include valuable skills for dealing with conflict resolution: using open-ended questions and brainstorming. We'll practice these skills next.

Using Open-Ended Questions

Trainer states out loud:

First, we'll talk about open-ended questions. An open-ended question is designed to learn more about the patient's perception of the conflict and to help get the people involved to think analytically and critically about the problem. Open-ended questions usually begin with words such as what, will, or how. A question that starts with why would also be considered an open-ended question, but the word why often has a blaming tone because it is almost always used with the word you, as in: "Why do you…? Why did you…? Why are you…?" For the dialysis setting, it's best to stick to what, will, or how.

Closed-ended questions generally get a "yes" or "no" response and aren't as effective in finding out the patient's perception of the conflict. I've posted the differences between open- and closed-ended questions here on the flip chart, and I'm passing a handout around with the same information.

NOTE TO TRAINER

Distribute the handout on Closed- and Open-Ended Questions.

What you might notice is that using open-ended questions doesn't involve your opinion or impose your judgment on the patient. This is the key to encouraging open, honest communication about the conflict; judgmental language can quickly shut down communication.

Group Activity

(45 minutes)

Trainer states out loud:

OK, let's try it. First, find a partner. If you don't have one, I'll do this exercise with you.

Pick one of the following issues that cause conflict in your dialysis clinic: dialysis start times, dialysis end times, bringing food into the clinic, or the temperature in the clinic.

Now, one person will be the patient who is upset and frustrated, and the other person will be the dialysis professional. The dialysis professional should use closed-ended questions to ask the patient about the problem. After doing this for a few minutes, start over, using open-ended questions this time.

Here's an idea of how this exercise will work. Using the example regarding dialysis start time, a closed-ended question would be something like: "It's really hard for you to get here on time, isn't it?" An open-ended question would be something like: "How did you get here this morning?"

Then, switch roles and repeat the process so both of you get to practice asking open-ended questions.

Let's take about five minutes for the first go-round, switch roles, and then take another five minutes to finish.

NOTE TO TRAINER Call time after 10 minutes.

Trainer states out loud:

OK. Now that you've had a chance to use both closed-ended and open-ended questions, let's work as a group to answer some questions. I'll post some of your comments on the flip chart:

1. When you were the patient, how did it feel when you were being asked closed-ended questions?

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2. *How were the open-ended questions different? How did they help in gaining a better understanding of the patient's perception or frustration?*
3. *When you were the dialysis professional, did using open-ended questions help you to better understand the patient's perception of the conflict?*
4. *As dialysis professionals, what do you see as the benefits of using open-ended questions?*

You all did a great job on this activity. Asking open-ended questions helps you to identify and understand the patient's perception. Open-ended questions bring out responses that can often help lead you to possible solutions. It might seem awkward at first, but the more you practice asking open-ended questions, the more information you'll learn about a situation. You might never ask a closed-ended question again!

Now, we'll focus on finding possible solutions.

Brainstorming Alternative Solutions

Trainer states out loud:

Finding solutions to a conflict takes the ability and willingness to be creative and flexible. This is not to say that we should routinely bend or break clinic rules or procedures to suit one person or that we should "look the other way" to appease a patient who has a complaint. However, in the busy setting of the dialysis clinic, it is not uncommon for staff responses to conflicts or patient complaints to be quick and routine. When looking for ways to resolve conflict, it's OK to take time to think about new solutions and ask others for input.

Group Activity

(10 minutes)

Trainer states out loud:

So let's try another exercise. Think about a conflict you had with a patient in which your response to the patient's complaint seemed to further upset the patient. Keep in mind that your initial response wasn't necessarily right or wrong, just that it seemed to make the conflict worse. Now using the handout that I'm passing

around, write a brief description of the conflict and what your initial response was, and then use the third column to write down possible solutions. The handout has an example to help you get started. Let's take about 10 minutes to do this.

Trainer states out loud:

It sounds like you all were really working on that last exercise. Now let's work as a group to answer some questions about possible solutions:

1. *Was it difficult to come up with alternatives to your initial solution? If so, why?*
2. *Would you feel more or less satisfied if you offered the patient possible solutions? Why?*
3. *When you were thinking about possible solutions, did you feel as though you were "forced" to compromise? If so, why?*
4. *How does proposing possible solutions help patients?*
5. *How does proposing possible solutions help dialysis professionals and the clinic?*

Wrap-Up and Questions

Trainer states out loud:

Finding solutions or proposing possible solutions can be challenging sometimes. So before we leave here today, does anyone have a question or concern about a particular situation you are trying to resolve?

To let the group benefit from its collective expertise and wisdom, invite the group to offer suggestions to the participant(s) dealing with a particular conflict.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____.

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Closed-Ended and Open-Ended Questions

Closed-Ended Question	Open-Ended Question
You don't like this policy, do you?	What is it about this clinic policy that is upsetting you?
Are you mad at me?	Would you tell me a little bit more about why you are angry?
Do you want to solve this problem?	Would you describe to me what you see as the next steps in trying to resolve this problem?
Do you want to work with me on this?	How do you see the two of us working together?
You don't mind if I call in the dietitian, do you?	How would it be if we asked the dietitian to help us solve this problem?

Practice Finding Solutions

Description of Conflict	Initial Response to Conflict	Alternative Solutions to Conflict
Example: A patient asked to see his physician on a day when the physician was not in the clinic visiting patients.	*Example:* The patient was told that the physician wouldn't be in the clinic on this day, so the patient couldn't see the physician. This response angered the patient, who started complaining that the physician was never around and didn't care about the patient's well-being.	*Example:* 1. Tell the patient what the physician's schedule is and when the physician is expected to be in the clinic again. 2. Offer to contact the physician's office to let the physician know that the patient has questions. 3. Ask the patient what they wish to speak with the physician about and agree to write a note for the physician.

Implement Agreement

TIME REQUIRED

30 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another
❑ Pens, pencils, and paper for participants
❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board
❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)
❑ Prepare and post this information well before participants enter the room (see diagram below):
   ◆ Training title
   ◆ Purpose of training
   ◆ Activities

Implement Agreement	Activities	Activities
Purpose: To discuss how to implement an agreement after professional dialysis staff has worked through conflict with a patient	Group discussion Key points on Implementing an Agreement	Wrap-up

Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Implement Agreement** training. As you'll see on the flip chart, the purpose of this training is to discuss how to implement an agreement after we have worked through conflict with a patient. One of the benefits of working through a conflict is that you get to make the changes that you and the patient have agreed upon. Let's start by looking at the **Decreasing Conflict & Building Bridges** brochure. Would someone volunteer to read the **Implement Agreement** section out loud?*

NOTE TO TRAINER After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you for reading. Let's talk about the points this section makes. First, we see that to put changes into action, we first must use action statements to describe the agreement so the patient knows they can count on us to follow through. An example would be: "In the future, I will tell you the name and dose of the medication I am going to give you before giving it."

So let's think for a moment. What action statements have you used with a patient to reassure them that you were going to follow through on an agreement? I'll write them down.

NOTE TO TRAINER Post action statements on the flip chart, and then move on.

Trainer states out loud:

OK, great. The next point from the brochure tells us to document the agreement and tell the necessary parties about the agreement. Let's start with documentation. Why is that important?

NOTE TO TRAINER Post answers on the flip chart, then move on.

Trainer states out loud:

And what could happen to the agreement if we don't document it?

Trainer states out loud:

Good. Now, let's talk about communicating the agreement to the necessary parties. Why is this important? What could happen to the agreement if we forget to do this?

Trainer states out loud:

OK. Let's go back to the example of agreeing to tell the patient the name and dose of the medication they're getting. Who else should you tell about the agreement? Why?

Trainer states out loud:

Great. The final point in the brochure says that consistency is important with any agreement. What happens to our credibility with the patient if we're not consistent with the agreement?

Trainer states out loud:

Who else could we lose credibility with?

Trainer states out loud:

You might say, "Hey, I'm <u>always</u> consistent!" And that's great, but why is it important for the entire staff to be consistent?

Post answers on the flip chart, then move on.

Trainer states out loud:

Let's say that we don't follow through. We just get too busy to keep up our end of the agreement. What happens then?

Post answers on the flip chart, then move on to the wrap-up and questions.

Wrap-Up and Questions

Trainer states out loud:

You all did a great job with this discussion. We know the importance of implementing the agreement by being consistent, communicating it to other parties, and documenting it. The next section in the brochure focuses on the need to continue to communicate. Continuing to communicate about the agreement is a way to monitor any progress in carrying out the agreement. It's also another way to show the patient that you are committed to the actions that you agreed upon. We'll talk about this during the next training session. Before we wrap up today, do any of you have any questions or concerns about our discussion and the points we raised?

Answer any questions or acknowledge comments.

Trainer states out loud:

Thank you all for coming today. Our next training is scheduled for

_____.

Continue to Communicate

TIME REQUIRED

45 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another

❑ Pens, pencils, and paper for participants

❑ Case scenario cards (found at the back of this module). Photocopy each scenario as a handout or write scenarios on index cards (one scenario card for each pair of participants)

❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board

❑ Prepare and post this information well before participants enter the room (see diagram below):
  ◆ Training title
  ◆ Purpose of training
  ◆ Activities
  ◆ List of Benefits of Good Communication found on the following page

Continue to Communicate

Purpose: To share and practice some basic communication skills that can help us listen to and communicate more effectively with our patients.

Activities

Group discussion:

Benefits of Good Communication

Why do patients raise concerns?

Activities

Communication Tips
A. Active Listening
B. Assertive Statements

The importance of continuing follow-up and communication

Wrap-up

Welcome and Statement of Purpose

Trainer states out loud:

Welcome to **Continue to Communicate** *training. As you'll see on the flip chart, the purpose of this training is to share and practice some basic communication skills that can help us listen to and communicate more effectively with our patients—especially when addressing their concerns.*

By communicating effectively with our patients, we can help reassure and calm them if they get upset. It's important to remember that patients have the right to raise concerns and ask questions—anytime. If we keep our focus centered on the patients, then they will feel comfortable enough to raise questions or concerns before they become bigger issues, problems, or even conflicts.

This training session has two sections. One focuses on the process of good communication as a way to prevent misunderstandings or conflict. The second focuses on responding to conflict, and the importance of follow-up communication after conflict has occurred and a solution has been implemented.

Benefits of Good Communication

Trainer states out loud:

OK, let's talk about the benefits of good communication. Research shows that patients who ask questions or raise concerns are more involved in their care. You can probably imagine some of the benefits dialysis professionals experience when practicing good communication with their patients. I've posted a few on the flip chart. Some of the benefits of using methods of good communication might include:

- *More confidence in responding to patients*
- *Less time dealing with disruptions (if preventive measures have already been put into place)*
- *Increased patient/customer satisfaction*

So how do you think good communication would benefit our patients? I'll post your answers on the flip chart.

Listen for and post answers such as:

- Improved dialysis environment
- Increased relaxation during treatment
- Less confusion about expectations

Trainer states out loud:

You all did a good job of coming up with benefits to the patient. I think we all would agree that we could use any tool that helps us communicate better with our patients and one another, especially when we're all so busy. We all know that:
- *We manage a high workload.*
- *Sometimes there are staff shortages.*
- *Patients can be demanding or difficult.*
- *Patients can be disruptive or even abusive.*

But we also know that:
- *Good communication helps us identify reasonable patient requests, so that we can be responsive and provide good care.*
- *Talking with patients calmly can avoid exacerbating the situation.*
- *Since we work directly with patients, we can help identify problems early so that we can inform the appropriate staff.*

So, let's take five minutes as a group to brainstorm some of the reasons patients might raise concerns. I'll write your responses on the flip chart.

Listen for and post answers such as:

- They're scared.
- They want to know what to expect.
- They're frustrated, upset, or sad about their health or their personal life.

Trainer states out loud:

Good answers. We need to remember that patients might have questions or concerns because they're angry, sad, or worried about the loss of control over their health or their lives. We should acknowledge that patients have a right to their feelings, but we also can remind them that they can be directly involved in their renal care. We can remind them that although they may have given up some

control in one area of their lives, they can have a great deal of control over their renal care. Patients might express concerns, legitimate or not, for a variety of other reasons. We need to be aware that a patient might raise questions or concerns because they're dealing with:

- *Mental health concerns, such as depression or anxiety*
- *Mood swings*
- *Cognitive impairments, such as dementia*
- *Alcohol use and abuse*
- *Drug use and abuse*
- *Lack of support from family or other relationships*
- *Cultural differences or misunderstandings*

So we see there are many reasons patients might raise questions or concerns. And we know they often express their frustration here in the facility. I know it's difficult, but we have to try not to take it personally. Instead, we can reassure them and remind them that they can have some control over their renal care. We can also try to figure out if there's anything we can do to make the patient's situation better.

Communication Tips

Trainer *states out loud:*

I've posted two communication tips on the flip chart that we can try. The first is **Active Listening**. *Patients want to be heard, so we practice active listening to show that we care about what they are saying and feeling.*

Here's how to be an active listener:
- *Pay attention to what the patient is saying. Look at the patient and use body language (eye contact, facing the patient, nodding in agreement, not crossing your arms) to show you're following what they are saying.*

- *Tell the patient the feelings that you're hearing them express. For example, you could say, "It sounds like you're feeling tired of this routine" or "It sounds like you find it difficult to stick to your diet."*

The second tip is **Using Assertive Statements**. *Sometimes patients aren't clear about what we want them to do or what the facility rules are. We sometimes need to repeat or rephrase what we said in a way that the individual patient can*

understand. Using assertive statements can help us make ourselves clear to the patient. Assertive statements can also help us show that we're serious without having to raise our voices. An assertive statement focuses on the patient's conduct, acknowledges his/her feelings, and restates his/her behavior.

- *Focus on the behavior by being specific about what you need the patient to do. For example: "Mrs. Smith, could you please sit very still for just a moment?"*
- *Acknowledge the patient's feelings. For example: "It looks like you're eager to get out of here today."*
- *Restate the behavior and desired outcome, from the patient's point of view. For example: "If you sit still, I can get you on the machine quicker and you can get out of here sooner."*

Active listening and using assertive statements might sound simple, but they take practice. And even with lots of practice, it can be hard to remember to use them when we're dealing with a patient concern or a difficult situation on the unit. So, let's practice a bit now.

Case Scenarios

(15 minutes)

Trainer states out loud:

OK, please choose a partner. If you don't have a partner, I'll do the exercise with you.

NOTE TO TRAINER Start distributing case scenario cards.

Trainer states out loud:

I'm handing out cards with different scenarios on them. One of you will be the patient, and the other will be the dialysis professional. Take turns as the patient reading the scenario and the dialysis professional responding to the patient by using active listening or assertive statements.

After you finish each scenario, give your partner positive feedback on how they did. If you can think of other ways they could have communicated, share those as well.

For example, you might say something like: "You did a really great job giving me direct eye contact. The eye contact would have been even better if you had sat down next to me and nodded in agreement once in a while."

If you don't have to be a partner for a participant, circulate among the pairs and offer assistance. Don't let the role-playing escalate into arguments. The point is to use good communication so that conversations don't turn into disputes.

Trainer states out loud:

OK. It sounds like you've all had a turn being the patient and the dialysis professional so I'm going to call time. I heard lots of great conversations with active listening and assertive statements. You all did great.

Now I'd like to ask the group to share which communication tips you found most helpful in your scenario. Can you imagine using either of these tips in your workplace? Was anything about the scenario practice difficult? If so, what was it?

Trainer states out loud:

You all raised good points about communicating with our patients. It sounds like many of you are already doing some active listening and using assertive statements. I encourage you to keep it up.

We all know that even with these skills, we will sometimes experience conflict with disruptive patients. Getting help early or reporting to appropriate staff sooner rather than later will help the situation. The next section of this training deals with the importance of communication after a conflict has occurred.

Communicating After a Conflict

Trainer states out loud:

I've posted a quotation on the flip chart. Would someone read it out loud?

Quotation: "No relationship, whether personal or professional, is immune to conflict. One constant, though, is that most successful relationships include regular, ongoing communication."

After the volunteer finishes reading the quotation, thank the person and then move on.

Trainer states out loud:

Thank you. None of us want conflict in the dialysis unit, but we can deal with conflicts when they occur. Dealing with conflict is easier if you have some tools to cope with it. Relationships with your patients will withstand the challenges of conflict, especially if you follow up and work with the patient to find solutions.

*There are some basic points about conflict and follow-up in the **Decreasing Conflict & Building Bridges** brochure. Would someone volunteer to read the section called **Continue to Communicate**?*

After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you. Those are excellent points. I've posted four other points on the flip chart. Can I get four volunteers to read each one out loud?

After the participants read the following points, thank them and move on.

- Make an effort to communicate with your patients regularly. A simple "Good morning" or "How are you?" can make a big difference in your relationship with a patient and make it easier to resolve any conflicts.
- Communication involves both talking and listening. Remember to use your active listening skills during conflict resolution as well.

- If the conflict cannot be immediately addressed, tell the patient that you will sit down with them as soon as possible to resolve the issue. Set a specific time when you and the patient can discuss the problem and evaluate possible solutions.
- Not satisfying someone does not mean that your attempt to resolve the conflict has failed.

Trainer states out loud:

Thank you all. Let's talk a bit about that last point. As you work through conflict and continue to communicate with the patient, there probably will be times when the patient is not satisfied with the outcome and becomes hostile or angry. But dissatisfaction and anger do not necessarily mean that your efforts to solve the conflict failed. Dissatisfaction and anger aren't always bad responses. However, you'll need to be prepared to handle a patient's negative response.

So let's practice dealing with a negative response. Working again in pairs, think about a conflict that happened in your dialysis setting and include an agreed-upon solution to the problem. One of you will be the patient and the other will be the dialysis professional. The dialysis professional is checking back with the patient or continuing to communicate about the agreement. But the patient is upset and unhappy with the outcome and repeatedly says that the agreement was unfair or didn't consider the patient's needs. The person playing the patient should act upset, but still be reasonable enough for the dialysis professional to ask questions.

Let's take about 10 minutes to work through your scenario.

NOTE TO TRAINER Call time in 10 minutes.

Trainer states out loud:

OK, good work, everyone. Let's come back together as a group and think about a few questions:
- *For the people who played the dialysis professional, what were your first thoughts about the patient still being unhappy?*
- *What did you do for or say to the patient when you realized they were still unhappy? Was it the best response or do you think you might have handled the patient's reaction differently?*

- *Do you think there are times when it would be better to bring in a neutral third party in to talk to the patient? If so, who in your clinic would be the best person to do this?*
- *Do you think there are times when the patient might have to accept solutions that they may never like? If so, what are some good phrases to use when talking to the patient?*

Wrap-Up/Questions

Trainer states out loud:

We learned a lot about the importance of communication, along with some communication skills we can use to deal with patients' concerns. Do any of you have any questions or concerns about what we talked about today?

Answer any questions or concerns that are raised.

Trainer states out loud:

Thank you all for coming. Our next training is scheduled for

_____.

Case Scenarios

As you use these scenarios, be sure to refer to your facility's specific policies and procedures, and feel free to develop your own scenarios.

Read this situation out loud and ask your partner to respond as the care provider:

I am a brand new patient. I'm very nervous about starting dialysis. One way I deal with my anxiety is to ask lots and lots of questions. I want to have some control over my care. I don't want to be pushy, but I want to know everything there is to know about dialysis. *What do you say to me?*

Read this situation out loud and ask your partner to respond as the care provider:

I am a patient whom you see regularly. I'm often in a bad mood and often complain about dialysis and how miserable it is to be sick. Today, I start cursing at you and say that you aren't helping me and that you're just making it worse. *What do you say to me?*

Read this situation out loud and ask your partner to respond as the care provider:

I am a quiet patient who doesn't usually say much. Today, my arm is hurting, and I yell at you for making it hurt. I say it's your fault, and I appear to be shouting without making much sense. *What do you say to me?*

Read this situation out loud and ask your partner to respond as the care provider:

I am a patient whom you see regularly. I'm often late for dialysis, but I'm usually willing to stay on for my entire treatment period. Today, I was late again, and I insist that you remove me 15 minutes early so I can leave on time. *What do you say to me?*

Take Another Look

TIME REQUIRED

30 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another

❑ Handout #1, Requirement of the Conditions for Coverage and your clinic's policy on filing and handling grievances (one copy for each participant)

❑ Handout, #2, Reviewing Our Clinic's Policy on Grievances

❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)

❑ Pens, pencils, and paper for participants

❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board

❑ Prepare and post this information well before the participants enter the room (see diagram below):
- ◆ Training title
- ◆ Purpose of training
- ◆ Activities

Take Another Look

Purpose: To practice looking at conflict from a quality improvement standpoint.

Activities

Group discussions

- Understanding the grievance process

- Communicating after a conflict

Activities

Wrap-up

Welcome and Statement of Purpose

Trainer states out loud:

*Welcome to **Take Another Look** training. As you'll see on the flip chart, the purpose of today's training is to practice looking at conflict from a quality improvement standpoint. All of us working in dialysis are concerned with quality improvement. In fact, quality improvement in healthcare means that we are always searching for ways to improve the care we deliver. For example, a great deal of clinic time is spent trying to improve dialysis outcomes, the management of anemia, and the efficiency of clinic operations. If we look at conflict from a quality improvement standpoint, we will see that conflict gives us an opportunity to improve quality of care and to improve policies and procedures.*

*Taking another look at conflict will help us see trends or behaviors that cause conflict, identify responses that can de-escalate conflict, and ultimately find ways to decrease conflict. There are some basic points about conflict and follow-up in the brochure **Decreasing Conflict & Building Bridges** that I am passing out. Would someone volunteer to read the section called **Take Another Look?***

NOTE TO TRAINER

After the volunteer finishes reading the section, thank the person and then move on.

Trainer states out loud:

Thank you. Those are all excellent points about reviewing the steps used to address conflict, and we'll use those points in our discussion today.

NOTE TO TRAINER

Begin distributing all three handouts.

Trainer states out loud:

*A big part of addressing conflict is understanding the grievance process. I'm passing out three handouts. The first is called the **Requirement of the Conditions for Coverage**, which states that each dialysis clinic must have a mechanism for patients to express grievances. It's important that we know what the requirements are. The second handout is our clinic's policy on patient grievances. The third has questions about our facility's policy, which we'll discuss.*

Does everyone have all three handouts? OK, now let's break up into pairs. If you don't have a partner, I'll do this exercise with you.

With your partner, read through the facility policy. Then answer the questions on Handout #3 together. Answer the first four as if you were a patient, and answer the last as a staff person. We'll take 10 minutes to read through the clinic's policy and 10 minutes to answer the questions.

Communicating After a Conflict

(20 minutes)

Call time in 20 minutes.

Trainer states out loud:

Great. Let's come back together as a group and see what we came up with. Let's start with question 1, and I'll post your answers here on the flip chart.
Note to trainer: Listen for and post answers for all five questions.

1. *As a patient, and based on the policy you've just read, would you feel comfortable raising a concern in this clinic. Why? Why not?*
2. *As a patient, would you feel empowered by filing a complaint? If not, how would you feel?*
3. *As a patient (who might not be feeling well), does the policy create a process for you to easily file and follow up on a complaint? If not, what would you add to the policy to make it easy to file and follow up on a complaint?*
4. *As a patient, does the current complaint system provide a means by which you will be notified, in writing, of the outcome of your complaint?*
5. *As a staff person, do you think you would be reluctant to inform the patient of his or her right to file a complaint? If yes, why?*

Wrap-Up and Questions

Trainer states out loud:

You all did a great job. There's another point I want to share. As we noted earlier, taking another look at conflict includes using the process of conflict—including patient grievances—to improve the way the clinic delivers dialysis care. It also means taking another look at how we, as clinic staff, handle conflict on the job. When we deal with conflict, we must:

- *Be willing to honestly examine the role we may have played in initiating, maintaining, or escalating conflict*
- *Be open to feedback from others about how we handled conflict*
- *Recognize the strengths we have for handling conflict and be willing to teach those skills to others*
- *Always be willing to learn new skills, approaches, or methods of handling conflict*
- *Never stop trying to understand the causes of conflict*
- *Not limit our conflict-intervention methods to one approach*
- *Be open to the opportunities for learning that often arise from conflict*

Trainer states out loud:

OK. Before we leave here today, are there any questions or concerns about what we heard today?

NOTE TO TRAINER Address any questions or concerns.

Trainer states out loud:

Thank you all for coming. Our next training is scheduled for

_____.

Requirement of the Conditions for Coverage

At the root of many complaints expressed by dialysis patients is a feeling that they are powerless and that they have no outlet within the clinic to voice a concern. Under the federal ESRD Conditions for Coverage, each dialysis clinic must have a mechanism for patients to express grievances. Specifically, the ESRD Conditions for Coverage states:

CFR 42 405.2138(e) – Grievance Mechanism

NEW CFC language to come and assisted to understand and exercise their rights. Grievances and recommended changes in policies and services may be addressed to facility staff, administration, the network organization, and agencies or regulatory bodies with jurisdiction over the facility, through any representative of the patient's choice, without restraint or interference, and without fear of discrimination or reprisal.

Our Clinic's Policy on Grievances

Provide your staff with a copy of your clinic's policy on grievances.

Reviewing Our Clinic's Policy on Grievances

1. As a patient, and based on the policy you've just read, would you feel comfortable raising a concern in this clinic? Why? Why not?

2. As a patient, would you feel empowered by filing a complaint? If not, how would you feel?

3. As a patient (who might not be feeling well), does the policy create a process for you to easily file and follow up on a complaint? If not, what would you add to the policy to make it easy to file and follow up on a complaint?

4. As a patient, does the current complaint system provide a means by which you will be notified, in writing, of the outcome of your complaint?

5. As a staff person, do you think you would be reluctant to inform the patient of his or her right to file a complaint? If yes, why?

Common Patient Concerns

TIME REQUIRED

30-45 minutes

PREPARATION/MATERIALS NEEDED

❑ Set up training space. The training room can be set up in many different ways. The recommended arrangement is a circle or a U-shape, so participants can see and interact with one another
❑ Pens, pencils, and paper for participants
❑ A copy of the DPC Brochure **Decreasing Conflict & Building Bridges** for each participant (The Toolbox includes eight brochures, so you might need to make more copies before the session)
❑ Handout #1, **Common Patient Concerns** (at the back of this module)
❑ Blank flip chart for taking group notes. If no flip chart is available, then use 8½x11-inch paper or a dry-erase board
❑ Prepare and post this information well before the participants enter the room (see diagram below):
  ◆ Module title
  ◆ Purpose of training
  ◆ Activities

Common Patient Concerns

Purpose: To identify some of the most common concerns and solutions we've experienced in our dialysis unit

Activities

Common Patient Concerns

What's in your top 10?

Wrap-up

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Welcome and Statement of Purpose

states out loud:

*Welcome to **Common Patient Concerns** training. As you'll see on the flip chart, the purpose of this training is to identify some of the most common concerns and solutions we've experienced in our dialysis unit. I'm going to pass out Handout #1 called **Common Patient Concerns**. This handout describes many of the issues and possible responses that you might try. Let's take a few minutes to look over the handout.*

NOTE TO TRAINER Take 10 minutes to look over the handout.

Trainer states out loud:

*Okay, so using the handout let's do a brainstorm called **What's in Your Top 10**? Let's think about our own dialysis unit and some of the questions, comments, or concerns we've heard from patients and families. Let's split into pairs. If you don't have a partner, I'll do this exercise with you.*

Working with your partner, come up with your own Top 10 list of concerns that you've heard from patients and families. We don't need to name any of the patients, just the concerns that you have heard. Let's take about ten minutes to do this.

NOTE TO TRAINER Call time in 10 minutes.

Trainer states out loud:

OK, let's hear some of the questions, comments, or concerns in your Top 10. I'll post them all on the flip chart.

Listen for and post answers like:
- "Dialysis takes too long."
- "I want to get off the machine early."
- "Why can't I drink a soda while I'm on the machine?"
- "I want more privacy."
- "It's always cold in here."

Trainer states out loud:

Good job, everyone. This is a good list. Many of these concerns sound very familiar, don't they? As the handout noted, there are some universal concerns that pop up in the dialysis unit. Some of them have quick solutions. For example, if a patient says they are too cold, we can get them a blanket. But many concerns often stem from the very nature of what it means to be on dialysis. Let's face it, there are lots of rules, policies, and restrictions. For example, there are always concerns over diet and fluid intake that, for now, are here to stay. So where a quick answer or solution can't be found, it's even more important to speak to the patient or family respectfully and appropriately.

Let's look over the Top 10 concerns that I've just posted on the flip chart. Starting with the first one, let's discuss a solution that might work. It's OK to use the handout to help us come up with some.

NOTE TO TRAINER
Go through each of the 10 concerns on the flip chart and give participants an opportunity to suggest appropriate solutions. This should take about 15 minutes.

Wrap-Up and Questions

Trainer states out loud:

You all did a good job coming up with possible solutions. And you did a great job thinking about your own dialysis unit and your own experience. We know that even with the best communication skills, we will sometimes have conflict with disruptive patients. Asking for help early or reporting conflict to appropriate staff sooner rather than later will help the situation. It's up to us to help one another to provide support to the patients and help them manage their frustration.

Does anyone have a question or any concerns before we conclude?

NOTE TO TRAINER
Answer any questions or acknowledge comments.

Trainer states out loud:

Thank you all for coming. Our next training is scheduled for

_____ .

Common Patient Concerns

While we do our best to help our patients, we will hear concerns or complaints from time to time. Most of the concerns we hear fit into one of these four categories:

1. Staff issues
2. Treatment issues
3. Food and diet issues
4. Safety and policy issues

This fact sheet describes some common patient complaints and an appropriate response from the dialysis professional.

Concerns or complaints about staff and how they do their job:

1. You NEVER listen to me, you just act like we're all the same. It's not one size fits all!

Response: I'm sorry you think I'm not listening to you. I do want to hear what you are saying. Please try to be specific about your concerns so I can try to help you. Some aspects of your treatment will have to be addressed by the physician, but I'll do what I can to make you more comfortable.

2. Who taught you how to do this job? You don't know what you're doing!

Response: Please tell me what you think I am doing improperly. I'll explain the procedure to you and why I'm doing what I'm doing.

3. I've been watching you, and you didn't wash your hands like you're supposed to.

Response: It gets pretty busy in here and I did forget to wash my hands. Thanks for reminding me. It won't happen again.

4. You guys just go off and leave us alone. You're so busy talking about your personal matters that you can't bother to come over here and answer the alarms.

Response: I'm sorry that happened. I will tell my center director (or nurse manager) that you have observed times when staff was not responsive. I know she/he will want to make sure this doesn't happen again.

5. Why can't they find somewhere else to talk about their personal matters?

Response: I will let the DON know you have observed this. She/he will probably want to know more about the situation. I'll remind the staff not to talk about their personal lives while they are in the dialysis unit.

6. Why don't you people ever talk to each other? I already told _____ about this!

Response: I'm sorry you have to repeat it to me. I'll make sure your concern gets reported to the proper person (people).

7. Why can't you answer my questions? Aren't you supposed to know this stuff?

Response: I don't want to give you the wrong information if I'm not sure how to answer your questions. That's why I ask the (nurse, dietitian, social worker, etc.) to speak with you. Then we can both learn the correct answer.

8. The [dietitian, social worker, nurse, doctor] is never around when I need to talk to her/him.

Response: I'm sorry she/he isn't here today. Can you tell me what it's about? Is it an urgent matter? Maybe someone else can help you today, and I'll make sure she/he knows you want to see her/him.

Concerns, complaints, or other issues regarding treatment:

9. It's cold in here!

Response: I'm sorry you're cold; many patients tend to feel cold during treatment. I will tell the charge nurse that you think it's too cold in here. Can I help you get more comfortable now, maybe get you a blanket? Could you bring a blanket or maybe wear extra clothing during your treatments? Some people like to wear a glove on their hand as well.

10. I want to get treated first. — or — There's an empty chair, why can't I go on now?

Response: I'm sorry. I understand your frustration. We give each patient a scheduled time window for treatment to make things run smoother for everybody. If we start changing people around, it will disrupt our schedule and affect other people. Would you like to talk to the charge nurse about scheduling a different time?

11. I don't want her to stick me!

Response: That's OK. Please be patient, and we'll have someone else start your treatment when they can. This may mean you have to wait awhile. Later I'd like to talk with you about why you don't want her to start your treatment, OK?
(Note: This answer may be controversial for some units.)

12. I don't want them in my bay.

Response: I hear your concern. Would you like me to get the charge nurse so you can discuss your concerns with her?

13. I want to get off treatment before him.

Response: Are you saying that you want to get off your treatment early or just before he does? If you're asking to get off treatment early, I must recommend that you stay on your full treatment to get the dialysis you need. If you're asking us to take you off before him, well, he has already had his full treatment so it's time for him to come off now.

14. How come my machine keeps beeping?

Response: The machine monitors the treatment and it beeps to help us to give you the best care. Please feel free to ask the staff what they are doing when they reset the machine.

15. Why did we have to wait so long for treatment today?

The [_____] wasn't just right. We had to get it fixed so that you would have a safe treatment.

Complaints and questions about food and diet:

16. Why can't I have more soda?

Response: I understand you would like more, but I have to follow the policy to limit everyone to just one soda.

(Note: This response will need to be facility-specific, since many clinics don't permit drinking that much liquid.)

17. Why can't I eat while I'm on the machine?

Response: The doctor thinks that it is safer if you don't eat because when your blood goes to your stomach to digest the food, that might make your blood pressure drop. Also, we want to make sure you don't choke.

18. I did not drink that much! How did I gain that much weight?

Response: Sometimes fluid can really sneak up on you. Some solid foods have a lot of liquid in them. Maybe before the next treatment, you could fill out our journal sheet to list everything you eat and drink between treatments and discuss it with the dietitian. Then we will be able to determine why this is happening.

Complaints and concerns about safety and policy:

19. It's cold in here and I don't like my arm uncovered.

Response: I'm sorry you're cold. It's for your safety that we have to keep your access exposed; we need to be able to see that everything is OK at all times. You can cover your hand and the other part of your arm (leg, etc.). You also can bring a glove to keep your hand warm. Can I help you re-position to cover everything but the access?

20. Pull the curtains; I don't like everyone watching me.

Response: I understand that you're uncomfortable with the curtains open, but we must be able to see you at all times to be sure your treatment is proceeding safely. Would you like to speak with the charge nurse about a chair that isn't in the middle of the room for future treatments?

21. Why can't my relative/friend come in and keep me company?

Response: Dialysis units can get pretty busy. Extra people in the unit are a distraction and prevent the staff from safely monitoring your treatment. There is also a risk of increased infection with too many people in the unit.

STEP III:
ONGOING QUALITY
IMPROVEMENT

Using Quality Improvement to Decrease Patient-Provider Conflict

One of the goals identified by the members of the DPC Pjroject was to increase Quality Improvement (QI) activities related to conflict in the dialysis facility. In fact, QI techniques are frequently applied when looking at the clinical outcomes of our patients, or when we try to determine a more efficient approach to operating the facility. QI allows us to gather information about a problem and then to apply this information in an effort to improve outcomes. By applying QI techniques to conflict, we can begin to gather data on the number, causes, and types of conflict we are seeing in the dialysis facility. QI allows us to see trends in conflicts, create objectivity toward the conflict, and helps identify areas for additional training related to the conflicts we are experiencing.

The QI tools described below were developed to assist you in tracking the number, causes, and severity of patient-provider conflicts that occur in your facility using the terms and definitions contained in the DPC Taxonomy & Glossary. The DPC project members hope that these tools will help you to identify trends unique to your facility so that you can implement strategies to decrease the frequency and severity of conflicts that occur.

You may choose to use any or all of the tools included here. You may also wish to tailor them to your specific facility and QI program.

1. **The Conflict Log** is an easy way to document pertinent information about each conflict that occurs.

2. **Graphs and Tables** help identify trends and measure progress.

Decreasing Dialysis Patient-Provider Conflict Tracking Tool
Conflict Log

Date Conflict Occurred	Time of Day Conflict Occurred	Name(s) of Patient Involved in Conflict	Name(s) of Staff Involved in Conflict	Cause of Conflict*	Type of Conflict*

Causes of Conflict

A - Physical Environment	Examples: Unit cleanliness, unit temperature, noise level
B - Treatment Related	Examples: Infiltration, medication error, machine alarms
C - Staffing	Examples: Number and composition of staff, staff assignments
D - Staff Professionalism/Training	Examples: Staff talking about personal issues, staff competence
E - Financial	Examples: Nonpayment of fees, patient seeking financial assistance from facility
F - Nonadherence	Examples: Missed treatments, shortened treatments, not following medical advice
G - Scheduling/Transportation	Examples: Wait time, appointment time, transportation
H - Disruptive Behavior	Examples: Yelling, cursing, making inappropriate sexual remarks
I - Other	

Types of Conflict

1 - Nonadherence	Noncompliance with or nonconformance to medical advice, facility policies, and procedures; professional standards of practice, law, and/or socially accepted behavior toward others (Golden Rule).
2 - Verbal/Written Abuse	Any words (written or spoken) with an intent to demean, insult, belittle, or degrade facility or medical staff, their representatives, patients, families, or others.
3 - Verbal/Written Threat	Any words (written or spoken) expressing an intent to harm, abuse, or commit violence directed toward facility or medical staff, their representatives, patients, families, or others.
4 - Physical Threat	Gestures or actions expressing intent to harm, abuse, or commit violence toward facility or medical staff, their representatives, patients, families, or others.
5 - Physical Harm	Any bodily harm, injury, or attack upon facility or medical staff, their representatives, patients, families, or others.
6 - Property Damage/Theft	Theft or damage to property on premises of ESRD facility.
7 - Lack of Payment	Refusal to maintain/apply for coverage or misrepresentation of coverage.

a. Number of Dialysis Patient-Provider Conflicts by Month

b. Types of Dialysis Patient-Provider Conflicts by Month

c. Causes of Dialysis Patient-Provider Conflict by Month

<table>
<tr>
<td>
Decreasing Dialysis Patient-Provider
Conflict Tracking Tool Graphs

Graph #1: Number of Dialysis Patient-Provider Conflicts by Month
At the end of each month, place a dot that corresponds with the number of dialysis patient-provider conflicts that occurred during the month. Connect the dots with a line to assess trends.

Facility Name: _____   Year: _____

Number of Dialysis Patient-Provider Conflicts by Month

20
18
16
14
12
10
8
6
4
2
0

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Month
</td>
<td>
Decreasing Dialysis Patient-Provider
Conflict Tracking Tool Graphs

Graph #2: Type of Dialysis Patient-Provider Conflicts by Month
At the end of each month, draw a bar for the number of each type of conflict that occurred during the month. Look at patterns to assess trends.

Facility Name: _____   Year: _____

Type of Dialysis Patient-Provider Conflicts by Month

5

4

3

2

1

0

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Month
</td>
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3. Documentation Form allows you to examine each conflict that occurs in detail and see how it was handled.

The tools, graphs, and tables are also included on the enclosed CD-ROM for your convenience. You may choose to complete the graphs by hand or in Excel. If you have questions about the use of the tools, feel free to contact your ESRD Network office.

Ongoing Quality Improvement Training

TIME REQUIRED

Variable: 1-3 hours
Monthly or quarterly (minimum) data activities
Quality Improvement Committee Meeting

PREPARATION/MATERIALS NEEDED

❑ Data Preparation Activities
❑ Collect Tracking Tool Documentation Forms
❑ Enter information on Conflict Logs
  • clarify with staff if needed
  • confer with others regarding types and causes of conflict, if needed
❑ Plot Data Graphs
❑ Schedule QI Committee meeting
❑ Prepare meeting room

CONDUCT FIRST LEADERSHIP MEETING

❑ Review DPC data
❑ Discuss
  1. Any trends observed
  2. New interventions needed
  3. Staff training needs
    a. New staff

        i. Initial orientation

        ii. Follow-up for understanding and use of tools in conflict resolution

    b. Retraining for problem behaviors and attitudes

3. Individual patient issues to be addressed during Patient Care Conference

Decreasing Dialysis Patient-Provider Conflict Tracking Tool
Conflict Log

Date Conflict Occurred	Time of Day Conflict Occurred	Name(s) of Patient Involved in Conflict	Name(s) of Staff Involved in Conflict	Cause of Conflict*	Type of Conflict*

Decreasing Dialysis Patient-Provider Conflict Log
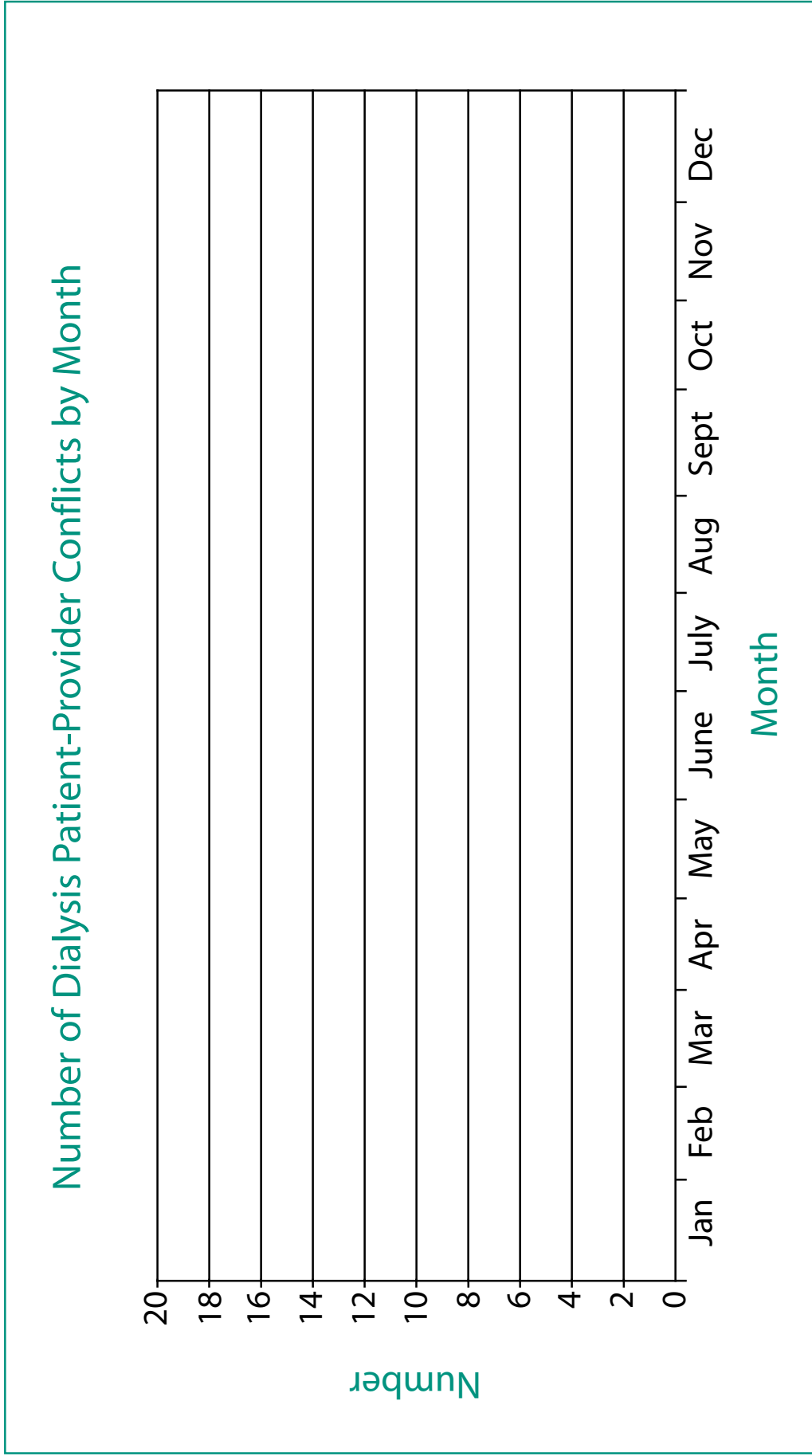## Categories and Definitions

Causes of Conflict	
A - Physical Environment	Examples: Unit cleanliness, unit temperature, noise level
B - Treatment Related	Examples: Infiltration, medication error, machine alarms
C - Staffing	Examples: Number and composition of staff, staff assignments
D - Staff Professionalism/Training	Examples: Staff talking about personal issues, staff competence
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Decreasing Dialysis Patient-Provider Conflict Tracking Tool Graphs

Graph #1: Number of Dialysis Patient-Provider Conflicts by Month

At the end of each month, place a dot that corresponds with the number of dialysis patient-provider conflicts that occurred during the month. Connect the dots with a line to assess trends.

Facility Name: _____   **Year:** _____

Number of Dialysis Patient-Provider Conflicts by Month

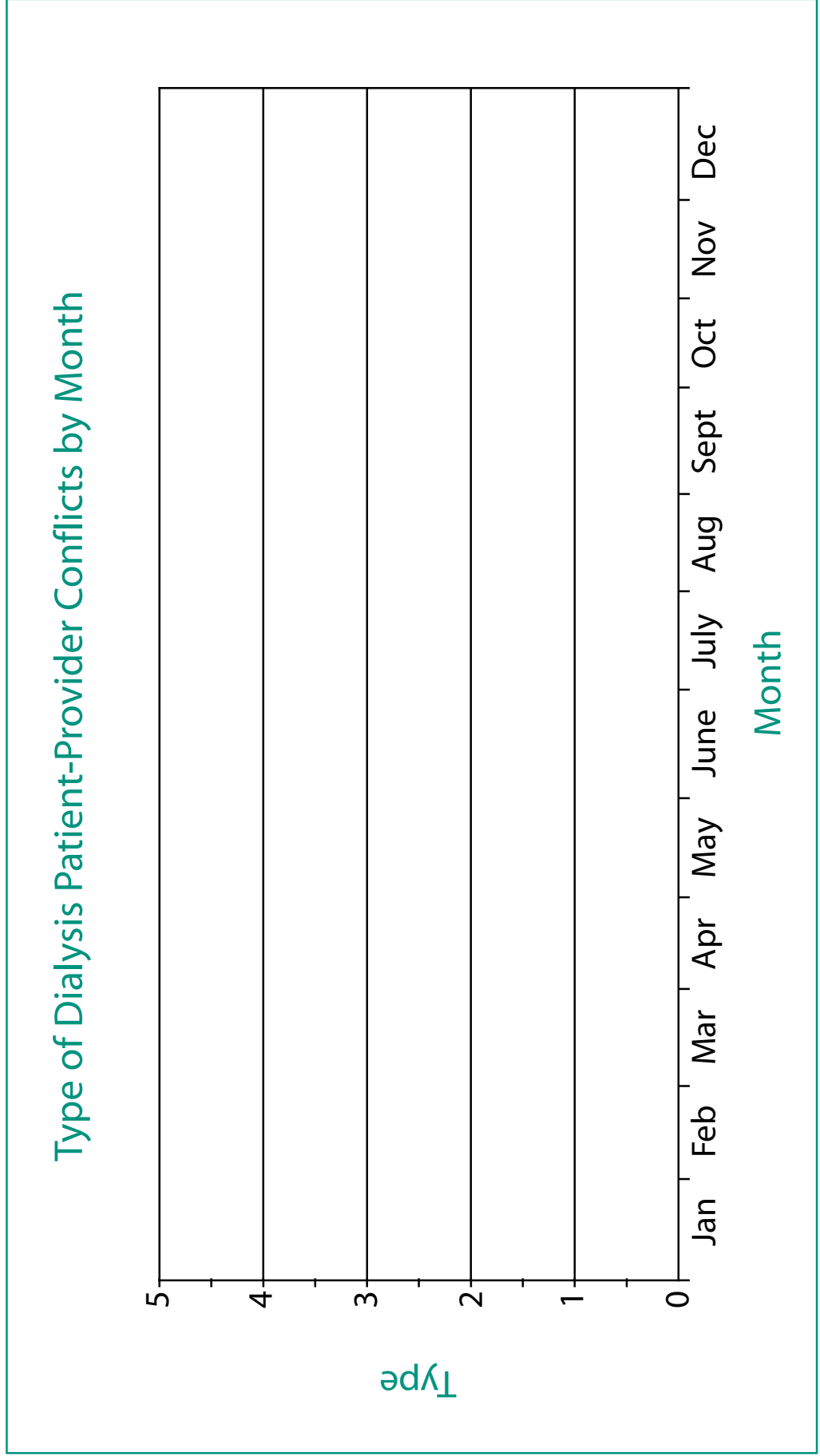| Number												
20												
18												
16												
14												
12												
10												
8												
6												
4												
2												
0	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec

Month

Decreasing Dialysis Patient-Provider Conflict Tracking Tool Graphs

Graph #2: Type of Dialysis Patient-Provider Conflicts by Month

At the end of each month, draw a bar for the number of each type of conflict that occurred during the month. Look at patterns to assess trends.

Facility Name: _____   **Year:** _____

Type of Dialysis Patient-Provider Conflicts by Month

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
5												
4												
3												
2												
1												
0												

Type

Month

Table #1: Causes of Dialysis Patient-Provider Conflict by Month

At the end of each month, indicate the number of conflicts by cause that occurred during the course of the month. Look at patterns to assess trends.

Facility Name: _____   **Year:** _____

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	**Total**
Physical Environment													
Treatment Related													
Staffing													
Staff Professionalism/ Training													
Financial													
Nonadherence													
Scheduling/Transportation													
Disruptive Behavior													
Other													
Total													

Decreasing Dialysis Patient-Provider Conflict
Tracking Tool Documentation Form

Date Conflict Occurred:	Time of Day Conflict Occurred:
Name(s) of Patients Involved in Conflict:	
Name(s) of Staff Involved in Conflict:	
Type of Conflict*:	
Cause of Conflict*:	
Description of Conflict:	
Intervention/Resolution of Conflict:	
Is the patient(s) satisfied with the outcome of the conflict?	
Is the staff member(s) satisfied with the outcome of the conflict?	
Could the conflict have been handled more effectively? If yes, how?	

Causes of Conflict

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DPC POSITION STATEMENT
ON INVOLUNTARY DISCHARGE:
EXECUTIVE SUMMARY

Decreasing Dialysis Patient-Provider Conflict
National Task Force Position Statement on Involuntary Discharge
Executive Summary

The Task Force[i] believes that there is a substantial need to give providers guidance regarding the Ethical, Legal and Regulatory issues related to the involuntary discharge of ESRD patients by either the nephrologist or a certified dialysis center or facility. Most ESRD patients are covered by the Medicare ESRD Program and as such are entitled to receive a payment subsidy to their ESRD providers by the federal government for the life saving chronic treatments they require. Dialysis facilities become certified for this purpose and accept Medicare funding to provide these treatments and other services to Medicare Beneficiaries. When conflicts arise related to patient behaviors that are deemed unacceptable by the providers, then questions arise as to the rights and obligations of both the patient and provider in the Medicare entitlement system. This paper sets forth the following positions:

- Medicare beneficiaries with ESRD are entitled to partial government payment to providers for chronic dialysis treatments under the Social Security Act.

- Providers have legal authority to refuse to treat patients who are acting violently or are physically abusive thereby jeopardizing the safety of others.

- The use of contracts to facilitate effective and efficient use of facilities is permissible.

- Although a patient may unilaterally terminate the patient-physician relationship, the physician may terminate the physician-patient relationship only after taking steps necessary to fulfill ethical obligations and to avoid legal abandonment of patients.

- A certified facility cannot provide dialysis without a treating physician and thus must discharge a patient if the treating nephrologist terminates the patient physician relationship, or transfer the patient's care to another treating nephrologist within that facility. However, both the physician and the facility are obligated ethically, legally and by regulation to assist the patient in securing life saving treatment with another facility and/or nephrologist.

- It is unethical for patients to be left without treatment based solely upon non-adherent behaviors that pose a risk only to them i.e., nonadherence to medical advice.

- Groups of providers should not exclude patients from acceptance and treatment from all their facilities or other physicians, except for irreconcilable cases of verified verbal/written/ physical abuse, threats or physical harm. These groups should endorse and act on the ethical obligation to transfer patients to others within their group. An important purpose of transfer is to ensure that personality, language or cultural issues particular to an individual patient, professional or facility are not significant causes of the problem behavior of the patient.

Background

In the early years of dialysis, those fortunate enough to have access to the treatment followed closely the recommendations of their providers. However, an increase in dialysis patients in recent years and a shift in the demographics of the patient population have changed that pattern. Staffing issues have also contributed to the situation. Once nurses served on the front lines of dialysis care, spending time tending not just to the disease's physical demands but emotional ones as well. As dialysis has evolved and financial pressures have outpaced facility reimbursement increases, facilities, aiming to streamline operations for financial efficiency, now rely on technicians to do the jobs nurses once performed. Technicians may inadvertently exacerbate the potential for conflict because they have not had the formal education or professional training of licensed caregivers. Technicians may not be as proficient licensed caregivers in defusing potentially explosive encounters. If situations escalate out of control, dialysis units – faced with monetary and staffing constraints – may find it easier to dismiss problem patients rather than thoroughly assessing and responding to their complex problems. All these factors combine to set the stage for conflict.[ii]

In the years 1999 & 2000 the ESRD Networks (NWs) perceived an increase in the number of contacts and complaints regarding disruptive and abusive patients. The number of involuntary discharges of patients both with and without placement in a new facility increased for various reasons including nonadherence (non-compliance) to treatment regimens. A workgroup organized by the **Forum of ESRD Networks** designed a Centers for Medicare & Medicaid Services (CMS) approved national project with the purpose and goal of beginning to quantify the number of HD/PD patients involuntarily discharged, gain an understanding of the reason(s) for the discharges, describe the characteristics of the involuntarily discharged patient population and identify placement outcomes for these involuntarily discharged patients. Over 70% of ESRD facilities and patients in the US in 2002 were included in the project. Of the 285,982 patients included in the project, 458 (0.2%) were reportedly involuntarily discharged. Treatment non-adherence was the leading reason for discharge nationally at 25.5% (117 patients), followed by verbal threat at 8.5% (39 patients). Other reasons for discharge were lack of payment at 5.2% (35 patients), combinations of verbal abuse, verbal threat and physical threats at 5.2% (24 patients) and verbal abuse at 5% (23 patients).

The Task Force noted that discharged patients are at high risk for morbidity and mortality. Any ESRD patient without access to regular chronic dialysis and the necessary support services is at increased risk. An unknown number of deaths have occurred due to lack of access to dialysis. Although the numbers are thought to be small, these deaths may have been preventable. They evoke disturbing ethical questions, particularly in the case of any discharge for nonadherence (resulting only in a danger to self rather than a danger to others) when the patient has exercised his/her legal and ethical right to consent to or refuse medical treatment.

The **Forum of ESRD Networks** convened a national consensus conference in October of 2003 to explore dialysis patient provider conflict. Renal stakeholders and CMS participated in the conference during which action options were identified to address these issues. CMS subsequently

funded a national project titled Decreasing Dialysis Patient-Provider Conflict (DPC project) to act upon several of the action options, including the need to clarify the rights and obligations of patients and providers in an entitlement system. A national **Task Force** was formed for this project and a subcommittee activated to examine the legal, ethical and regulatory issues of entitlement and to produce a statement for national consideration.

This statement addresses three levels of behavior:

1. Behaviors, physical acts, nonphysical acts or omissions by a patient that result in <u>placing *his/her own health, safety or well-being at risk*</u> (frequently referred to as non-adherence to medical advice).

2. Behaviors, actions, or inactions by patients and/or family, friends or visitors perceived to <u>put the safe and efficient operations *of the facility at risk*</u> (for example frequent "no-show" for treatment or non-payment, frequently referred to as non-adherence to facility policy and procedures).

3. Behaviors, actions or inactions by patients and/or family, friends or visitors that are perceived <u>to place the health, safety or well-being of *others at risk*</u> (commonly referred to improper behaviors that impinge on the rights of others).

Discussion

Ethical & Legal Issues

Physicians cannot be, nor should they be, forced to accept a particular patient into their care. Physicians have no legal or ethical obligation to sustain or maintain a relationship with an unco-operative patient. However, once a relationship has been established between the physician and patient, a legal and ethical obligation exists to continue that relationship until it is formally terminated or until the patient voluntarily withdraws from care. <u>These ethical obligations are not absolute</u> and providers should clearly consider the safety and well-being of others when weighing this decision[iii, iv]. If a situation arises where neither party can provide what the other needs, the relationship may be terminated; however, a physician may not abandon his/her patient. The physician must give notice and the patient must have an ample opportunity to secure the presence of other medical attendance[v]. A minimum of 30 days notice has been recognized in case law and good faith assistance of the physician is recommended. In cases when no other nephrologist either practices in the geographic area where the patient is treated or no other nephrologist will accept the patient, the physician has a duty not to abandon his/her patients and should make a concerted effort to work out an acceptable treatment program.

Treatment Issues

Referral to an alternate provider may be impossible due to refusal of other providers to accept the patient or due to a lack of alternate providers in the area. In such cases, aggressive steps are needed to continue treating the patient. These steps include but are not limited to the following:

- Evaluation of the role of metabolic side effects of treatment, endocrinopathies and medications on patient behaviors.

- Focused interventions by each member of the interdisciplinary team including a complete assessment of needs and planned interventions together with referral to a mental health specialist that may result in beneficial changes[vi] or consultation with an Ethics Committee[vii]

- Isolation of the patient during treatment or moving the patient to another shift

- Psychiatric evaluation as required by facility for continued treatment; in some cases this may involve a court-order

- Attendance of family members/significant others during treatment to contain patient behavior; in some cases this may involve a court-order

- Cases that involve physical attack or other violent conduct where others are placed at risk are best handled by referral to the appropriate law-enforcement agency

Providers should thoroughly document inappropriate patient behavior and provider efforts to assist patients achieve more appropriate conduct. If the decision is made to discharge a patient involuntarily, there should be clearly documented evidence that the patient's rights have been protected, that aggressive measures to modify inappropriate conduct have been attempted and been unsuccessful. Finally, as stated by CMS to ESRD Networks a) providers are "required to assist with alternate placement" b) "(placement) is not the responsibility of the Network" c) "whenever possible the patient's nephrologist should be involved in the discharge and transfer planning"[viii]. Earnest attempts to accomplish an orderly transfer[ix] to another provider must be fully documented.

Protocols should be adopted that make available, where possible, the intra-corporate placement of discharged patients whose behaviors *place themselves at risk* since some behavioral problems may be resolved by the characteristics of a new environment and new treatment team. These protocols should include an alternate provision for placement consultation with providers from different organizations in cases where transfer within the same corporation is not possible. Prohibition on intra-corporate transfers is inappropriate except in well-documented cases when a patient places *others at physical risk*.

While the use of "Zero-Tolerance" policies is adopted in some settings, these policies are very often inappropriately and inconsistently enforced and open to broad subjective interpretation. The use of Zero Tolerance Policies is supported only for behaviors that place *others at physical risk*. Aggressive measures should be attempted to resolve conflicts involving other inappropriate non-violent behaviors.

It is the position of this Task Force that terminating the patient/provider relationship on the basis of behaviors that place _only the patient at risk_ is unjustified. In the limited instances where the behaviors are so pervasive as to create significant _financial &/or operational risk to the facility_, consideration could be given to employing an approach wherein the "privilege" of a regular outpatient appointment slot is withdrawn after advance notice and informed consent and the patient assigned to dialysis by vacant spots that arise when other patients are hospitalized, absent or dialyzing elsewhere. This approach may be successful in continuing to offer dialysis and

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provide appropriate support services while allowing regular assignments to adherent patients, and eliminating the financial burden of repetitive "no-show" behavior. In such a treatment plan, if the patient demonstrates compliance with regular treatment, a regular slot can be offered when available and a treatment contract employed. If the patient is in emergent need of dialysis when no spot is available, the patient would be directed to the Emergency Room for acute services, as is routine in ESRD care.

Effects on Outcome Data

Under Congressional mandate, Networks evaluate the quality of care rendered by ESRD providers. This oversight function may lead some providers to regard patients *whose behaviors place themselves at risk* as liabilities to their facility's quality indicator profiles. In other words, nonadherent patients could be viewed as a 'risk to the facility' by worsening the facility's outcome measures. Although current data systems do not allow for case mix adjustment or censoring of patient data with poor outcomes due to nonadherence, it is the position of this Task Force that no negative conclusions should be drawn about practitioner or facility quality of care based upon data for patients who do not cooperate with the prescribed regimen. The NW Medical Review Boards, therefore, in their quality oversight role should not hold providers responsible for aberrant quality indicators in such cases, since patients cannot and should not forcibly be made to receive dialysis therapy as prescribed, nor comply with other aspects of the treatment program, including diet and medication orders, if they choose otherwise. The Networks should request further information from providers in cases where facility outcomes appear as outliers, allowing facilities the opportunity to justify outcomes that are directly related to the continued care of patients who do not cooperate with the treatment regimen.

Recommendations

1. When discussions regarding discharging a patient arise, the interdisciplinary care team should consider the ethical, legal, and regulatory obligations toward the patient who requires life-sustaining treatment.

2. Treatment should continue without bias or discrimination towards patients whose behaviors place only them at risk.

3. Although current data systems do not allow for case mix adjustment or censoring of patient data with poor outcomes due to non-adherence, it is the position of this Task Force that no negative conclusions should be drawn about practitioner or facility quality of care based upon data for patients who do not cooperate with the prescribed regimen. We recommend that the Network Medical Review Boards and other quality oversight agencies consider the effect of non-adherence on aberrant quality indicators, since patients cannot and should not forcibly be made to receive dialysis therapy as prescribed, nor comply with other aspects of the treatment program, including diet and medication orders, if they choose otherwise. It is recommended that further information be requested from providers in cases where facility outcomes appear as outliers, allowing providers the opportunity to justify outcomes

that are directly related to the continued care of patients who do not cooperate with the treatment regimen.

4. All members of the renal health care team should receive training in conflict resolution and develop skills in this area.

5. Each facility should develop a comprehensive, multidisciplinary policy for intensive intervention that recognizes the rights of both patients and staff and includes early consultation with provider support services and the ESRD Network, to resolve conflicts among patients, renal care team professionals, and the facility.

6. Consideration of potential contributing clinical side effects of treatment, endocrinopathies and medications on patient behaviors should be documented.

7. In the rare event a decision is made to terminate the physician/provider- patient relationship for behaviors which put the facility or others at risk, multidisciplinary renal care team good faith attempts at intensive interventions should have occurred over a reasonable period of time prior to the decision. Treatment should be continued until the patient-provider relationship has been legally and appropriately terminated. This includes advance notice and directly contacting other nephrologists and dialysis facilities to obtain alternate care. It is recommended that transfer within provider groups be facilitated if required to ensure continued treatment.

8. In addition to the provision of a list of other nephrologists and dialysis facilities the discharging facility has an ethical responsibility to the patient with a life threatening condition to actively participate in a well documented, good faith effort to obtain dialysis placement to ensure continuity of care. This involves:
    a. Active involvement of the patient's nephrologist
    b. Provision of accurate medical records and information to <u>prospective providers</u> in accordance with HIPAA and/ or the Federal Privacy Act including the reason for discharge
    c. Informing the patient of his/her rights under HIPAA to:
        i.   Review records for transfer AND
        ii. Submit a statement in a reasonable time prior to the transfer for inclusion in medical record if not in agreement with the record
    d. Prospective providers have an ethical obligation to earnestly consider accepting patients who have been discharged by other providers. This may require:
        i.   A face to face meeting with the potential provider, patient and family
        ii. Use of treatment trials and behavior contracts

9. When chronic placement is not obtained, the discharging physician and facility should work with area providers to ensure continued treatment.

This position statement was adopted by the DPC National Task Force on January 14, 2005
The statement has been endorsed by the following renal stakeholders:

American Association of Kidney Patients
American Nephrology Nurses Association
Gambro Healthcare
National Association of Nephrology Technicians/Technologists
National Renal Administrators Association

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[i] Decreasing Dialysis Patient Provider Conflict Project National Task Force: Center for Medicare & Medicaid Services representatives- Ida Sarisitis, Gina Clemons, Condict Martak, Brady Augustine, MS, Barry Straub, MD; Richard S. Goldman, MD, Co-Chair; Glenda F. Harbert, RN, CNN, CPHQ, Co-Chair; Karin Anderson-Barrett, BSN, RN, JD (DCI); Elaine Colvin, RN, BSN, MEPD (ANNA); Sandie Guerra Dean, MSW, LICSW (FMC); Cammie Dunnagan (eSource); Brenda Dyson (AAKP); Wendy Funk-Schrag, LMSW, ACSW (CNSW & RCG); Clifford Glynn, CHT (NANT); Kay Hall, BSN, RN, CNN (GHC); Barry Hong, PhD, ABPP (psychologist); Liz Howard, RN, CNN (Davita); Denise Rose, JD; Ann Stivers (NRAA); Mark Meier, MSW, LICSW; Arlene Sukolsky; Lisa Taylor, BSN, RN; Sandra Waring, MSN, CNN, CPHQ (Forum of ESRD Networks); William Winslade, PhD, JD (medical ethicist).

[ii] Report of the Dialysis Patient-Provider Conflict (DPPC) A Consensus Project with the Participation of the Community of Stakeholders Final Report. 2003.

[iii] Section 5 (a) (1) of the OSHA Act "Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

[iv] OSHA Safety and Health Program Management Guidelines (Federal Register 54 (16:3904-3916, January 26, 1989). OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

[v] American Medical Association Council on Ethical and Judicial Affairs states that a "physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable notice and sufficient opportunity to make alternative arrangements for care".

[vi] ESRD Network of TX, Inc. Intensive Intervention With The Non-Complaint Patient Booklet

[vii] Renal Physicians Association/ American Society of Nephrology Clinical Practice Guideline Shared Decision Making in the appropriate Initiation and Withdrawal from Dialysis

[viii] Centers for Medicare & Medicaid Services ESRD Network Organization Manual 130.11

[ix] Subpart U Conditions for Coverage of Suppliers of ESRD Services 405.2138

DPC
TAXONOMY & GLOSSARY

When conflict occurs in the dialysis facility, the contributing behaviors can be organized into three categories (Taxonomy) based on who is placed "at risk":
1. Behaviors by a patient, staff, family members, or others may result in placing the patient's own health, safety, and well being at risk.
2. Behaviors by patients, staff, family members, or others may put the safety and effective operations of the dialysis facility at risk.
3. Behaviors by patients, staff, family members, or others may put the health, safety, or well being of others at risk. Others include other patients, staff, or anyone else in the dialysis facility.

The table below includes behaviors that define types of conflict. This list is not all-inclusive, but explains the main behavioral contributions to conflict and specific examples of behavior by patients, staff, family members, or others that contribute to putting the patient, the facility, or others at risk.

Glossary	Taxonomy		
	Patient at Risk	Facility at Risk	Others at Risk
1. Nonadherence: Noncompliance with or nonconformance to medical advice, facility policies and procedures; professional standards of practice, law, and/or socially accepted behavior toward others (Golden Rule).	**a. Patient Example:** Missed or shortened treatments may result in need for hospitalization or death. **b. Staff Example:** Negative comments or scolding of a patient for nonadherence that may lead to conflict. Withholding opportunity to reschedule missed treatment.	**c. Patient Example:** Unreasonable refusal to allow certain staff to provide care, causing disruption in facility schedule, or refusing to follow clinic rules and policies. **d. Staff Example:** Unreasonable refusal to care for a particular patient, refusal to enforce policies and procedures, or unauthorized manipulation/change to a prescribed treatment/physician's orders.	**e. Patient Example:** Actions that encourage other patients to miss treatments or not follow treatment requirements/clinic policies **f. Staff Example:** Inconsistent enforcement of dialysis schedule and/or not providing full dialysis treatments. Not following facility policies and procedures that would provide intervention for patients' nonadherence.
2. Verbal/written abuse: Any words (written or spoken) with an intent to demean, insult, belittle, or degrade facility or medical staff, their representatives, patients, families, or others.	**a. Patient Example:** Name-calling, insults, use of obscenities, and verbal or written sexual harassment. **b. Staff Example:** Demeaning words directed at patients, or use of disrespectful language.	**c. Patient Example:** Verbal incidents that cause disruption or delay in the ongoing treatment of other patients. **d. Staff Example:** Insults or demeaning words directed at other staff, and causing disruption or delay in the facility operations.	**e. Patient Example:** Verbal or written abuse directed at other patients or others in the facility. **f. Staff Example:** Verbal or written abuse directed at others at the facility.
3. Verbal/written threat: Any words (written or spoken) expressing an intent to harm, abuse, or commit violence directed toward facility or medical staff, their representatives, patients, families, or others.	**a. Patient Example:** Threatening statements directed toward others that intimidate or cause fear. **b. Staff Example:** Threatening statements that cause patients to feel intimidated, fearful, or otherwise unsafe while receiving treatment in the facility.	**c. Patient Example:** Threats that result in the need for facility use of additional resources (e.g. security guard) for the safety and protection of patients, staff, and visitors. **d. Staff Example:** Threats directed at a patient or patients that result in patient transfer to another facility. Legal action against staff or the facility may occur as a result of a verbal threat.	**e. Patient Example:** Threats that create an unsafe environment for other patients, staff, and others. **f. Staff Example:** Threats that create an unsafe environment for patients, staff, and others.

Glossary	Taxonomy		
	Patient at Risk	**Facility at Risk**	**Others at Risk**
4. Physical threat: Gestures or actions expressing intent to harm, abuse, or commit violence toward facility or medical staff, their representatives, patients, families, or others.	**a. Patient Example:** Threat of self-harm (e.g. suicide, pulling out needles or catheter) or other actions such as raising one's hand as if to strike. **b. Staff Example:** Threatening to hurt patient during needle insertion or other threatening actions such as threatening to perform a procedure without patient's consent.	**c. Patient Example:** Threats that result in need for facility use of additional resources (e.g. security guard) for the safety and protection of patients, staff, and visitors **d. Staff Example:** Threats directed at a patient or patients that result in patient transfer to another facility. Legal action against staff or the facility may occur as a result of a physical threat.	**e. Patient Example:** Threatening to use and/or possession of a weapon or any instrument capable of injuring others with the intent to intimidate or harm others, either in the facility or on the premises. **f. Staff Example:** Threatening to use and/or possession of a weapon or any instrument capable of injuring others with the intent to intimidate or harm others, either in the facility or on the premises.
5. Physical harm: Any bodily harm/injury or attack upon facility or medical staff, their representatives, patients, families, or others.	**a. Patient Example:** Any incidents of physical harm such as changing machine settings, pulling own bloodlines, or refusing medication. **b. Staff Example:** Withholding treatment from the patient without just cause. Intentionally causing pain or injury to patient or patient's access.	**c. Patient Example:** Incidents that result in law enforcement intervention and facility use of additional resources (e.g. security guard) for the safety and protection of patients, staff, and visitors. **d. Staff Example:** Physical harm directed at patient(s) that result in patient transfer to another facility. Legal action against staff or the facility may occur as a result of harm.	**e. Patient Example:** Incidents of physical harm to others in the facility (e.g. other patients, visitors, medical, or facility staff) including sexual harassment. **f. Staff Example:** Incidents of physical harm to others in the facility (e.g. other patients, visitors, medical, or facility staff).
6. Property damage/theft: Theft or damage to property on premises of ESRD facility.	**a. Patient Example:** Vandalism or damage to dialysis equipment or facility premises. **b. Staff Example:** Stealing from patient.	**c. Patient Example:** Intentional and malicious damage of equipment/property. **d. Staff Example:** Intentional and malicious damage of equipment/property.	**e. Patient Example:** Stealing or damaging the property of others. **f. Staff Example:** Stealing or damaging the property of others.
7. Lack of payment: Refusal to maintain or apply for coverage or misrepresentation coverage.	**a. Patient Example:** Refusing to apply for insurance coverage for which patient is eligible. **b. Staff Example:** Intentionally providing inaccurate or inadequate information to a patient about insurance resources.	**c. Patient Example:** Withholding or refusing to deliver insurance payments to facility. **d. Staff Example:** Uninsured or under-insured patients affect facility's ability to provide adequate staffing.	**e. Patient Example:** Lack of payment may result in the elimination of some patient services, for example, preferred dialysis shift schedule. **f. Staff Example:** Reduced hours, layoffs, or reassignment to another facility location if facility is unable to operate due to inadequate revenues.

DPC
TIPS AND IDEAS

DECREASING DIALYSIS PATIENT-PROVIDER CONFLICT (DPC)
"Tips for Defusing Anger"

1. **Breathe Deeply:** Get your heart rate and breathing to a normal rate. Doing this in front of an angry person can also "model" this technique for them.

2. **Remove Yourself:** If possible remove yourself from the situation and deal with the anger when you or they are feeling calmer or "centered." Let the other person know that you definitely want to talk, but at another time.

3. **Reframe the Situation:** Consider another possibility for the conflict or outcome. Help others understand their anger by providing "plausible alternative reasons" for the situation.

4. **Ignore Personal Attacks:** In the long run, it will gain you more respect.

5. **Exercise Regularly:** Exercise allows your body to build up energy reserves and stimulates the release of endorphins, the body's natural calming hormones. Think of this as a preventative technique.

6. **Violence is Unacceptable:** If you are concerned that a situation is about to become violent, you should make every effort to distance yourself and your patients from the violent individual. Do not put yourself in a situation where you are in an isolated area with a potentially violent person. It is important that your facility be prepared to deal with any potentially violent situation. Take the time to become familiar with your local law enforcement agencies and seek out their advice for coping with a violent situation.

DECREASING DIALYSIS PATIENT-PROVIDER CONFLICT (DPC)
"Six Steps to Resolving Conflict"

Step 1: Share your feelings.

• Focus on describing how you feel about the situation or the other person's behavior.

• Use "I" statements.

• You cannot work toward a resolution if you don't understand how the other person feels.

Step 2: Define the problem.

• Determine if the situation is a disagreement, a misunderstanding, or a conflict of interest.

• Both of you may see a different problem, so the conflict cannot be resolved until the real problem is brought to the surface.

• Describe the conflict as a mutual problem.

• Ask the person to state the problem from his or her point of view.

• Restate what you heard. "If I understand you correctly, this is how you see the situation…"

• State the problem from your perspective.

Step 3: Explore options. Look for possible solutions to the problems of both parties.

• Brainstorm solutions; think of ideas together.

• Consult with each other. Don't dictate.

• Sit beside each other to create a feeling of partnership.

• Start with easy issues, and then move on to more difficult ones.

• Tell the other person what outcome you want and ask what they want.

• Offer to negotiate differences.

Step 4: Select and negotiate one option to work on.

- Both people must agree that the chosen solution is worthwhile.

- Plan how the solutions will be implemented.

- Even if you don't come to an agreement, agree to work toward a resolution that benefits everyone, and schedule a follow-up meeting.

Step 5: Take action.

- The conflict cannot be resolved unless you put the plan into action.

- Make a commitment to work on it.

- If you run into trouble, don't stop working on your plan until you get back together to review progress.

Step 6: Get feedback.

- Thank the person for stating his or her concerns.

- Make sure the plan is working and both parties are still comfortable.

- Schedule time to discuss the specific problem and how things are working out.