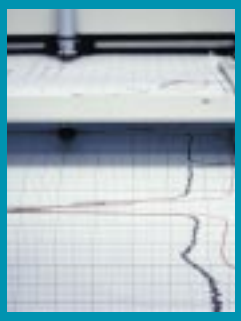
PREVENTION OF VIOLENCE IN HEALTHCARE

HEALTH AND SAFETY AUTHORITY



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PREVENTION OF VIOLENCE IN HEALTHCARE

"19% of all insurance claims over a six year period are as a result of 'assault' " – extract from the report of the advisory committee on health service sector to the H.S.A, May 2001

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VIOLENCE

What is Violence?

Violence can be from a patient, relative or friend of a patient.
It may be:

- **Verbal abuse**
- **Threat of assault**
- **Physical assault**
- **Assault with a weapon** – (the most serious)

What are the effects of Violence?

Both immediate and long term effects may result, there is the physical effects which are obviously more severe if weapons are used, and sometimes psychological problems and loss of confidence even when the physical effects are minimal.

Is my employer obliged to protect me from violence at work?

– Yes.

Violence at work is more that simply a criminal justice issue, e.g. explaining to a psychiatrically disturbed patient that their actions might result in criminal prosecution is not an effective way of protecting the worker.

Employers are obliged under the 1989 Safety Health and Welfare at Work Act to identify the hazards in a workplace, assess the risks to staff and put in place appropriate control measures, this applies to the issue of violence at work as much as any other danger in the workplace.

HAZARD IDENTIFICATION AND RISK ASSESSMENT

Which Staff are most likely to be affected?

Those who have direct patient contact especially nurses and ambulance personnel and others who deal with patients in acute situations. Those who are perceived as blocking or preventing patients getting what they want e.g. clerks in A&E after prolonged waiting.

Which Areas are most likely to be involved?

(1) Accident and Emergency Departments

(2) Psychiatric, mental handicap and elderly care units

(3) Ambulance work

(4) Residential care of young persons

(5) Lone community workers eg GP's , Nurses, Social Workers

How do violent situations develop?

- Some patients mental condition causes violent behaviour (confused states, hypoglycaemic episodes in diabetics, psychiatric admissions)
- Where people don't know what is going on. Waiting in a queue without feedback of expected time to be seen or how fast the queue is moving.
- "Drink taken". This is a common factor in many violent situations
- Breaking bad news: From grief reactions to unavailability of beds or given hospital bill.

SAFEGUARDS TO BE CONSIDERED

Training

- Customer care/empathy with clients/timely information to clients
- Identifying and calming down potentially violent situations
- Distraction techniques, non verbal communication
- Breakaway techniques/control and restraint/therapeutic crisis intervention
- Instruction about use of panic buttons and mobile phones (see below)
- Dress code (use of clip on ties, no necklaces or scarf's)

Workplace

Signs are important, as they not only provide information but also show that the rules of the institution are applied to all patients equally. Routes of appeal should also be indicated to unhappy clients so that they can relieve themselves of aggressive frustration by writing to the chief executive etc rather than take it out on the unfortunate staff member who is only following orders. Statements concerning the hospital policy towards persons who show aggression to staff should be posted prominently.

Safe refuges should be available for staff to retreat to in cases of serious violent disorder for instance in an Accident & Emergency department where groups of persons may be involved in violent disorder. The safe refuge should have a lockable entry door, telephone or panic button and preferably an emergency exit door. If the reception/clerking area is fitted with a protective barrier/glass panel it should not interfere with communicating with clients as this in itself will produce a negative attitude from those using the service.

In some instances the control measures can vary according to the time of day – more drunks use the services at night time and so the controls in place after the pubs have shut should be greater than in the afternoon when more staff and clients are around to help deter violence.

The waiting area of accident and emergency departments should be separated by a lockable door from the treatment area. Plant pots should be plastic, TV and tables should be fixed and chairs should be of a design which minimises their use as weapons (see diagram).

In residential type situations, where steak type knives are used they should be kept in a wooden block or shadow board so that if one is missing it can be searched for promptly and when not in use they should be kept under lock and key.

Chairs used in areas of high likelihood of violence should have the front and back legs connected together as opposed to four straight spikes.

CCTV is no substitute for the senses of sight and sound (it is preferable to have a reinforced glass door rather than a CCTV camera), therefore porters and nurses stations should be sighted with the best possible line of sight of patients and entry points. Car parking areas should be well lit with nearby bushs removed. Infra-red sensor activated lights are useful deterents. Where CCTV is used it should be prominent and deterent signs posted, the monitor should be visible to clients as it acts as a deterent, e.g. at hospital entrance lobby.

Since assault with a weapon is the most serious form of assault it is the most important thing to prevent. It is preferable to meet clients on healthcare premises rather than in their homes or elsewhere (in situations of potential conflict). For example, if the client has environmental control then they know where to obtain a knife or other weapon.

In the case of peripatetic (community based) workers it is essential that they have a means of immediate communication (ie a mobile phone). They should be trained to use code words or phrases recognisable to other staff they phone indicating a potential problem without alerting the potential assailant. There are mobile phone automatic logging systems available which will activate and send a pre-recorded message out to other phones if a worker fails to cancel their message after a home visit.

Staffing Considerations:

There should be staff available to respond to calls for emergency help.

Interview Rooms:

There should be a viewing window, panic button and the employee should be closer to the door and preferably have a table between themselves and the client.

Welfare Arrangements:

Counselling must be available for all staff after a violent incident.

Community Care:

Social workers, public health nurses, community psychiatric nurses and General Practitioners and others who visit patients in their homes may be at risk in certain situations. Patients prone to violence, with a known history, should be identified. Information on such patients should be circulated to other collegues who may be involved with them and appropriate control measures used eg seeing them in a health centre, visiting in pairs, speed dial use on mobile phone. A patient labelled as aggressive should have a re-assessment after an appropriate period. The timing of the reassessment should take into account the potential seriousness of the initial incident and compliance with treatment.

Staff involved in high risk situations such as re apprehension of an absconded patient should be properly equiped with stab resistant vests, training, sufficient in numbers and good communications.

REPORTING OF VIOLENCE

As well as sending a completed Accident Report Form (IR1) to the Health and Safety Authority for all accidents incurring more than 3 days lost time, all violent incidents should be recorded internally on a suitable form.

It is worth remembering that some victims may not wish to talk about a disturbing incident at this time.

Useful Data on the Report

(1) Who was involved? Personal data about the victim and, where possible, the assailant should be recorded separately. The victim data should include age, sex, job, and extent of training in handling violence.

(2) What happened? A full written description, including any weapon used.

(3) Why did it happen?

(4) Where did it happen? Not just the unit but the ward, waiting area, reception desk, etc.

(5) When did it happen – day of the week and time of day are important in identifying trends.

(6) Which protective systems failed? Were procedures (eg. escort to car park or residency) by-passed. Did a communication alarm fail to work?

(7) Forms should be completed and signed by the victim and the victim's immediate superior.

These records should be used as basis for discussion and devising suitable protection measures.

- **It may not be possible to prevent all episodes of violence at work.**
- **It is possible to reduce the chances of it occurring.**
- **It is possible to minimise the consequences.**

Achieving a Healthy and Safe Working Life -Together

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