Managing Violence and Aggression

NHSGGC has developed a Policy on the Management of Violence and Aggression which recognises the risk of violence and aggression to staff and gives a clear commitment to reducing these risks so far as is reasonably possible. It also outlines managers and employees responsibilities.

The full policy can be viewed here.

Definition

The NHSGGC Policy on the Management of Violence and Aggression has defined Violence and Aggression as *where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.*

All areas where staff can come into contact with the general public during the course of their work are classed as areas where there is an actual or potential risk of violence.

Employers must
- Provide and maintain safe systems of work (e.g. procedures & equipment)
- Provide and maintain a safe working environment
- Provide information, instruction, training and supervision to ensure the health and safety at work of all employees

Employees must
- Take care of their own health and safety and the health and safety of others who may be affected by their acts or omissions
- Co-operate with their employer in health and safety matters including attending training
- Not misuse or interfere with anything provided for health and safety purposes

These duties are qualified by the term *'so far as is reasonably practicable'*.

The principles of managing violence and aggression within the workplace are similar to controlling other risks. Within this framework, three things need to be done to tackle the problem of violence in the workplace
- Researching the problem and assessing the risk
- Reducing the risk
- Checking what has been done

Factors, which may increase the risk, include:
- Working alone
- Working out-with normal hours
- Working and travelling in the community
- Handling cash, valuables or medication
- Providing or withholding a service
- Being in a position of authority
- Working with people under the influence of drink or drugs
- Working with patients suffering alcohol or drug withdrawal
- Working with patients with medical conditions which predispose them to becoming confused or aggressive

- Working with people under stress, anxious or angry
- Assisting colleagues during a violent incident

When risk assessments are being carried out and control measures are being developed the following factors should be considered

- The workplace – access and egress, space and general layout, lighting, temperature, noise, use of workplace e.g. public area, waiting rooms, reception areas, treatment rooms
- Work activities – administration, community care, primary care, mental health services, acute care etc.
- Staffing levels and competence
- Level of training
- Information for patients, relatives, carers and staff
- Security issues e.g. security and alarm systems, communication systems, the role of security staff and the police.
- Response procedures – how employees are helped after an incident

A Violence and Aggression Risk Assessment should be documented for any task/activity which presents a significant risk.

The Violence & Aggression risk assessment form is designed for the assessment of generic activities and tasks. It is not intended to be used to assess risks relating to a specific patient.
A separate **Person Risk Assessment** should be undertaken if an individual is presenting a risk. Where these risk assessments are undertaken they should include Medical input, and should be reviewed and updated when necessary e.g. following a violent incident, significant changes to medication or care.
The significant findings should be communicated to all relevant departments within NHSGGC and other agencies. However, it is important to ensure that the Data Protection Act 1998 is not contravened and that information is shared on a 'need to know' basis.

RISK FACTORS FOR WORKPLACE VIOLENCE CHECKLIST

ENVIRONMENT/WORKPLACE
External
Is there uncontrolled access to buildings and work areas?
Are bus stops and car parks located in close proximity to buildings?
Are there appropriate footpaths and thoroughfares?
Are areas well lit with good all round visibility?
Are there areas where people can hide or move unnoticed? (e.g. trees/shrubbery, waste/storage areas)
Is signage clear, visible and appropriate?
Is there a security presence?

Internal
Are there physical barriers to restricted areas?
Are these areas suitably signed?
Can staff make unobstructed 'swift' exits if necessary?
Are existing security installations working and maintained?
Is signage clear, visible and appropriate?

Is the lighting sufficient or are there dark/shaded areas?

Interactive Areas – e.g. Waiting areas
Is there a reception desk which is easily identifiable, accessible and properly staffed?
Is there good signage?
Is there sufficient space to prevent overcrowding?
Are there private rooms available to deal with sensitive issues?
Are waiting areas segregated from other activities?
Do staff have good observation across the area?
Is the layout confrontational?
Is there physical segregation for staff – is this confrontational/intimidating?
Is seating comfortable and sufficient in quantity?
Is the area noisy? (e.g. trolleys, banging doors)
Are there systems to keep patients informed? (e.g. delays)
Are there means to reduce anxiety/boredom?

Lighting/Decoration/Furnishings

Is the lighting harsh/glaring?
Are there any potential weapons or missiles? (e.g. unsecured chairs, pictures, pot plants, crockery).

WORKING PROCEDURES/ORGANISATION

Organisation
Are there sufficient numbers of competent staff to deal with any foreseeable violence?
Are there special arrangements for higher risk staff? (e.g. young workers, pregnant/new mothers, staff with any disability)
Are there procedures for bank staff?
Are there additional precautions in place for lone workers?
Is appropriate information available to staff on potentially violent and aggressive patients or family?
Are emergency arrangements in place?
Do staff have to travel alone?
Do staff have a mobile workplace?
Do staff work in a community based setting?
Do shift patterns involve working alone or in small numbers?
Do shift patterns involve working late at night or during the early morning hours?
Do staff handle valuable property or possessions?
Do staff handle theft prone materials including drugs?
Do staff deal with complaint handling?

Communication

Can staff attract the attention of others staff if necessary?
Can staff summon immediate support?
Can staff call for assistance if lone or mobile working?
Are systems in place to disseminate information on incidents/patients to other affected staff/Departments?

TRAINING AND EDUCATION

Staff

Are staff trained and competent to deal with potential violent and aggressive situations?

Are staff facing unusual stress in their personal lives?
Are staff aware of incident forms and the system to complete them?
Are staff so busy that it is difficult to display a caring attitude?
Do staff have the opportunity to discuss concerns about violence and aggression?
Aware of attitudes, traits or mannerisms, which can annoy patients/clients etc?

Patients/Relatives/Carers

Is there the possibility of alcohol and/or drug abuse?
Are there rowdy or over anxious groups of people accompanying patients?
Is there the possibility of psychiatric disorders/confused states/behavioural problems?
Is there the possibility of situations perceived by patients or relatives as threatening? (guilt feelings)
Are people likely to be unstable or volatile?
Are people likely to be highly stressed or angry?
Are long waiting times involved (e.g. receiving units, clinics)

Home Visiting Checklist
Are your staff who carry out domicillary visits:
Fully trained in strategies for the prevention of violence?
Briefed about the area where they work?
Given all available information about the client from all relevant agencies?

Have they:
Understood the importance of previewing cases?
Left an itinerary?
Made plans to keep in contact with colleagues?
The means to contact you-even when the switchboard may not be in use?
A sound grasp of the Locality/Department lone working protocol?
Authority to arrange an accompanied visit?

Do they:
Carry forms for reporting incidents?
Appreciate the need for this procedure?
Use the forms?
Know how to control and defuse potentially violent situations?
Appreciate their responsibilities for their own safety?
Understand the provisions for their support by your organisation?

CONSIDERATION OF REMEDIAL MEASURES

ENVIRONMENT/WORKPLACE

It is accepted that the surrounding environment can impact on human behaviour and influence the level of risk should there be potential for an incident. The physical environment may affect the likelihood of violent incidents and the ease with which people respond to them.

In addition to the problems associated with their illness, clients and their relatives have to contend with the stresses of a hospital environment such as the lack of privacy and the fears of being isolated.

1. External Environment

Assessors need an awareness of the geography of the site. Who can access the site, where do they come from and how do they enter the site? Locations of bus stops, footpaths, car parks, thoroughfares and access points are essential. All areas should be well lit in the dark and have good all round visibility. Remove areas where people can hide or move unnoticed in concealed and unused areas, where possible. For example by improving lighting and visibility, cutting back trees and shrubbery and locking waste and storage areas.

Single entrance/exits are easier to control and all signage should be clear, visible and appropriate to avoid frustration and people entering inappropriate areas.

If staff have to park away from their place of work consider allowing late staff to move cars e.g. at 5pm to parking areas nearer and lighter. Escort services at night to car or public transport may also be necessary.

2. Space and layout

Ensure sufficient personal space to avoid people feeling crowded and intimidated by others.

Provide private rooms for people to talk about sensitive issues; the same rooms could also be used for people who are becoming disruptive to others.

Avoid using waiting areas as thoroughfares to minimise disturbance and irritation.

In terms of general layout an important consideration must always be staff exit points should a quick withdrawal be necessary. Avoid departmental layouts that appear confrontational. For example, the staff member sitting behind a desk facing the door can be intimidating for the patient and could also block the staff member should they need to exit.

Consider a chill out spot in open plan areas where staff can tactfully take patients who have caused them to become concerned about their safety. All staff should be trained to use such a spot and others can watch if anyone is taken there. Work out ways to check if the member of staff needs immediate help such as using code words.

Ensure that general signage is correct and notify Estates of any deficiency.

3. Lighting, decoration and furnishings

Diffuse and glare-free lighting contributes to a relaxed environment. It needs to be bright enough for all areas to be seen by staff, so that people cannot hide or move unseen.

Subdued wall coverings and surface finishes, pictures and plants create a more relaxing environment, but must be firmly fixed so they are less easily used as weapons. Soft furnishings can contribute to a pleasant relaxed feel.

Be aware of all fixtures and fittings and the potential for them to become weapons and missiles.

4. Noise

Noise can be stressful and background noise should be reduced to a minimum. Common sources include noisy trolleys and banging doors. Sound absorbing surfaces and materials may reduce ambient levels of noise. Can noisy acitivities be carried out at quieter times?

5. Provision of information

People can become annoyed if information is not available. Clear signage should indicate where to report, location of toilets and other facilities. Signs should be clear and indicate routes to waiting areas/reception areas.

Clearly designated property lines help to define interior areas as public, common and proprietary and may generate guidelines for visitors and other non-employees and contractors.

6. Waiting rooms/reception areas

Impeding communication and flow of information between patients and staff can build up anxiety. Staff separated from other staff in waiting rooms may be vulnerable. In reception areas impatience and irritation can often be reduced by having a desk or area which is easily identifiable, accessible and properly staffed. Clear signs indicating where patients should report are also important. In high risk areas screens and security glass are options but remember that screens and other obstacles may impair communication and make the situation worse. Wider desks or counters are a less provocative way of distancing staff from potentially violent people.

Seating should be comfortable, adequate in quantity and secured to the floor to avoid it being used as a weapon. Seating should be arranged informally; cluster arrangements are preferred to rows of chairs as they appear less threat threatening and can avoid a potential aggressor playing to the crowd.

Staff should be sensitive to the unplanned, uncomfortable disruption in the lifestyles of patients/families caused by injury and illness often accompanied by long waits and frustration.

Computerised message boards displaying waiting times can help prevent a build-up in frustration.

7. Boredom and anxiety

Relieve by providing up-to-date reading material, suitably mounted television and kiosks or vending machines. Play areas will help to keep children amused and make life easier for parents and prevent annoying others.

Provision of payphones for people to talk to relatives/friends can help reduce anxiety.

8. Treatment Rooms

Consider selection of furniture and fittings that are difficult to use as weapons and the ease with which staff can escape. Suitable alarm systems and the need for communication between staff, while retaining privacy for patients should be considered.

9. **Mental Heath Units**

Designers of accommodation for people with mental illness need to take account of the health and safety of staff, as well as patient care. The design of facilities should reflect their intended use. What may be suitable for most informal patients, might not be appropriate for patients who present a high risk to staff and others. Those involved need to consider the health and safety implications of the intended mix of patients, their treatment needs, average length of stay and occupancy levels.

If you are altering existing facilities or designing new ones, you need to take account of the health and safety of staff at the outset. Particular factors to consider include:

- The need for staff to be able to see what is going on, while ensuring an appropriate degree of privacy for patients;
- The benefits of enough appropriate space, including space outdoors, which can help calm patients and reduce any feeling of imprisonment;
- The value of appropriate facilities for therapeutic activities;
- The need for effective supervision and visibility of entrances and exists which have to remain unlocked;
- The provision of secure storage for potentially dangerous items, such as kitchen and occupational therapy equipment;
- The provision of suitable 'extra care' facilities to cope with foreseeable need;
- The need to reach and use staff facilities, such as toilets, safely.

11. **Security Arrangements**

There are three areas of security;

- monitoring/vigilance systems – CCTV with clear signage;
- communication systems – mobile phones/radios;
- alarm systems.

Alarm systems can be fixed systems operated by panic buttons and can be useful in treatment rooms for example where they are easily accessible and their location is only known to staff.
Personal or shriek alarms also have their value but remember that while personal alarms may deter they may also aggravate a potential attacker. They are most effective when other people can hear them and respond to them. Sometimes it is best to activate the alarm before throwing it away from you in order to distract your attacker and to facilitate escape. Vehicle or personal systems with 'alarm on release' to monitor movements in and out of patients homes are another useful option. In high risk areas the preferred option may be personal units linked to building alarm systems.

All need to be regularly maintained and tested – choice will depend on the nature of the workplace and the activities undertaken.

Other security devices include;
- two-way mirrors;
- card key access systems;
- panic–bar doors locked from the outside only;
- geographic locating devices in mobile workplaces;
- secure lockable doors;
- security guards or receptionists to screen persons and to control access;

- security officers – with suitable qualifications and training, maintaining a presence.

If any special equipment is provided as a control measure, steps must be taken to monitor and maintain the efficiency of the system. E.g. if a panic button system is installed staff must be trained in how to respond when the system is activated. Similarly the system should be regularly checked to ensure that it is operating properly.

WORKING PROCEDURES AND ORGANISATION

As far as possible there should be a relaxed, friendly atmosphere where rules are kept to a minimum. Staff should continually explain to patients and relatives what has or is about to happen – or why nothing is happening! Lack of knowledge creates emotional instability/anxiety, which can lead to aggression.

Reception Staff

Reception staff are often the first people that patients or family/friends meet and therefore contribute to first impressions and may defuse anxiety or add to it. Staff need training on the information to be collected and on dealing with violence and aggression. Appointment systems must be realistic and achievable. Notify patients if their appointment is delayed. This simple courtesy can significantly reduce tension.

Reception staff in GP surgeries need to collect sufficient information to prioritise personal and telephone callers. They need clear criteria to help them decide whether to refer matters to a GP, practice nurse or other person, or whether to deal with it themselves.

Community / Primary care

Those working in the community face additional risks. It is difficult to modify the working environment, so it is especially important to consider working arrangements carefully. If a home visit is not essential for healthcare reasons, arranging to meet the patient or client elsewhere may reduce the risk. You might be able to use a local health centre or GPs' surgery.

Generic assessments of the risks of visiting particular areas or client groups may help staff decide on the precautions to take for specific visits; for example, by identifying particular types of visit which should not be carried out during the evening or night, or by a lone member of staff.

The potential risk of violence should be assessed before any home visit. Such assessments need to consider:

Information passed on at referral;

Information from other agencies, such as the police and social services;

Past history of violence (patients or relatives);

The effect of staff uniforms on patients or their relatives;

Recent medical and personal history including information on:
- Behaviour
- Mood
- Medication

▭ Aggressive outbursts

It is useful to set up systems to ensure exchange of information and co-operation between all agencies that might visit patients in the community.

Consider the following precautions for visits, which present a risk of violence, or where there is not enough information to make a proper assessment;

Meeting a patient or client elsewhere;

Two or more staff visiting together;

Arranging for security staff or others to provide an escort;

Provision of alarm and/or communication devices;

Special liaison with local police/other agencies (possibly a combined visit).

It is sensible if procedures require staff who carry out home visits to prepare plans of their movements and to report back to base periodically. Reporting back might be appropriate after identified visits, and at the end of the day or shift. The movement plans need to be kept by someone responsible, who knows what to do if the person involved does not call in when expected.

The report of the DHSS Advisory Committee on Violence to Staff includes a useful checklist on home visiting, which is reproduced at Appendix 4.

Mental Health Services

If you are a manager of a mental health unit, you need to define clear criteria on the range of patients you can treat and the types of patient who cannot be accommodated for health and safety reasons. Health authorities are responsible for finding suitable facilities for patients; if local provision is not suitable for some patients, a system may be needed to arrange other suitable accommodation.

It is important to seek a full history when accepting a patient. This will affect not only clinical decisions; it may also influence decisions about the suitability of the patient for a particular unit, and about working patterns, such as levels of observation and supervision. And decisions about working patterns may affect staffing levels and training.

Shift handovers are usually carried out between nursing staff and those who share their shift patterns. All other staff who work in a unit also need to receive relevant information as soon as possible after they come on duty, and if they have been away for a period, for example on holiday.

Clear handover procedures are needed to ensure that all relevant information is passed on to those who need it. This might include, for example, information about unusual occurrences or behaviour patterns and any incidents during the previous shift. Such routine exchanges between staff can also act as a form of debriefing, allowing employees to release their frustration by sharing information with others.

Staffing

Ensure there are always enough suitably trained, competent staff to cope with any foreseeable violence.

Consider the acceptability of working alone and necessary precautionary measures.

Staff should always be aware of the need to promote the dignity of the patient/relative/visitor accepting them as a person in need, regardless of behaviour, class creed or colour, ensuring that they are given every opportunity of expressing their fears, frustrations and suspicions in the course of conversation.

Staff must be consistent, whether the patient/relative/visitor is likeable, irritating or socially deviant, although the degree of personal control, which may be needed to achieve this, should not be under-estimated. Dealing with disturbed patients/relatives/visitors calls for professional skills and qualities of tolerance, flexibility and good humour.

When violence has been controlled, there should be no change in staff attitudes to the patient/relative/visitor.

Work out emergency arrangements, review regularly and use any incident reports for improvements.

Ensure new staff including bank staff are properly informed about local arrangements. It may help to prepare a checklist to run through with them.

Staffing plans and work practices – such as escorting patients and prohibiting unsupervised movement within and between clinic areas, should be considered.

Written working procedures need to specify the staff required to implement them. Decisions about staff levels and competence need to take into account such issues as:

- The acceptability of lone working in isolated premises or in the community and the possibility of pairing staff for certain community visits;
- Limiting the length of time which staff work alone;
- Cover for breaks, nights, weekends and handover periods;

The need to cater for unpredictable workloads;

- The need to respond effectively to a violent incident while maintaining adequate levels of care of other patients; for example, by calling on a suitably trained and staffed control and restraint team.

Communication

Ensure that staff involved in violent incidents can summon appropriate assistance as required. This may involve suitable shift and working arrangements or the use of mobile telephones and radios. In treatment rooms for example, panic alarm buttons may be necessary.

Protocols for informing members of staff that a colleague is out, where they have gone and approximate time of return should be planned and the appropriate reaction determined.

Communications between departments should be established to pass on information about incidents or potentially violent patients.

Staff should be encouraged to offload with shift debriefing at end of shift to discuss problems. For more serious issues contact with a member of the Employee Counselling Service may be a necessary means of support.

TRAINING AND EDUCATION

Staff Training

Appropriate knowledge and understanding is required by all so that early recognition of the indicators, which may lead to a violent episode can be identified and dealt with to avoid a violent situation developing.

Staff Training in the management of aggression should be considered. The level of training relevant to each group/member of staff should be risk assessed and clearly indicated on the Risk Assessment Form – Section D. The Ward/Dept Manager/Practice Manager should ensure that the training needs for the department are identified and contact made with the Health and Safety Department or Aggression Management Services to ensure attendance on the appropriate courses are scheduled well in advance