Preventing and managing aggression and violence in the NHS

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Streaming in emergency departments reduces waiting times and stress, and removes the causes of most violent attacks against staff. In spite of this some people will still attack staff. Staff must be protected by a sound trust policy and effective and realistic training, monitored by a good reporting system.

The NHS is Europe's largest employer, employing over 1 million people (National Audit Office, 2003). Reported violent conduct against health staff is on the increase, especially in emergency medicine. Wide variations in reporting practice, different definitions and continued under-reporting make it impossible to say with certainty how far the increase in reported violence reflects an actual increase in incidents, changes in staff reporting practice, or is a true reflection of how trusts are performing in addressing aggression and violence (National Audit Office, 2003).

THE CAUSES OF AGGRESSION AND VIOLENCE

Most people attending emergency departments did not expect to attend hospital when they got up that morning; they have had an accident or become unwell. This will be stressful. Most will behave in a perfectly reasonable manner if they are treated properly. Their condition itself may affect their behaviour and also their ability to tolerate further frustrations.

After arriving at hospital, they will encounter additional stressors which might include difficulty parking, and large 'zero tolerance' signs threatening legal action if staff perceive them to be aggressive. There will also often be no smoking signs and a mobile phone ban. Many stressed smokers will want to smoke; many mobile phone users will want to call a family member or friend to ask for help and alter arrangements. All this occurs often before they even enter the emergency department.

Once inside the department, patients can encounter staff who are busy and who fail to perceive how much their condition, however minor, is causing them distress. If one adds to this list poor staff communication skills, some environmental stressors in the waiting room, and then tries their patience to the limit by extending the expected waiting times offered at triage, many will become angry. Some of those who do make it through this process may snap when, after several hours of waiting, they are told by a junior staff member that their condition is 'inappropriate' and are then discharged to the care of their GP.

Some people, however, will not behave reasonably in emergency departments, regardless of how easy and swift the patient journey is made. Among the many causes of this are mental illness, alcohol and drugs, unrealistic expectations, conditioned behaviour and sometimes just pure evil.

Recent efforts to institute streaming in emergency departments to minimize delays in the provision of emergency medicine will eliminate many of the causes of aggression and violence against staff, but not all.

THE MECHANICS OF CONFLICT

We know from police observations that the average fight between two combatants lasts for just 7 seconds (Northamptonshire Police, 1994). It is clearly not realistic to expect security staff, personal alarms and emergency buzzers to summon help once conflict has started. The efficacy of these security aids remains unproven (Bleetman and Boatman, 2001). The challenge therefore is to train staff to recognize and respond appropriately to the early antecedents of physical conflict and prevent these from ever progressing to violence.

THE NATIONAL COST

In November 1996, the National Audit Office report *Health and Safety in NHS Acute Hospital Trusts in England* highlighted concern over the

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burden on and cost of accidents (including violence and aggression) to the NHS. In their more recent follow-up report *A Safer Place to Work*, the National Audit Office (2003) estimated that the direct cost of work-related incidents is £173 million per annum; this figure does not include staff replacement costs, treatment costs and compensation claims. The financial cost is only part of the story. There are also the human costs including demoralization, high sickness rates, high staff turnover and a deterioration in the service delivered to patients. In 2001–2002, violence and aggression still accounted for 40% of all reported health and safety incidents (National Audit Office, 2003).

REPORTING PRACTICE

The Health and Safety at Work Act 1974 requires employers to identify any and all risks in the workplace and to introduce appropriate measures to provide a safe working environment for staff and visitors. This can only happen if employers are made aware of these risks by staff reporting any and all untoward incidents, including threatened and actual aggression and violence.

Reasons given by staff for not reporting incidents include concern that the incident might be viewed as a reflection of their inability to manage the incident, not wanting the attention that any action might bring, forms being too complicated to record what happened and a culture that accepts violence. Staff also feared that no action would be taken or that the NHS trust was unlikely to give them adequate support (National Audit Office, 2003).

In 2001, the Department of Health commissioned a report to assess the needs of NHS staff in relation to the provision of training in the recognition and management of violence and aggression and conflict resolution (Bleetman and Boatman, 2001). It was found that in the few trusts that provided a specific reporting process for acts of aggression and violence, there was greater staff confidence in the accuracy and effectiveness of the reporting process. There was also a higher staff reporting rate compared to trusts using a general untoward incidents reporting form.

In October 1999 the Zero Tolerance Zone campaign sent a message to the public that aggression, violence and threatening behaviour would no longer be tolerated in the health service (Department of Health, 2002). It was recommended that NHS trusts and health authorities have systems in place for recording incidents and set targets for reducing violence and aggression by 20% by 2001 and 30% by 2003. It has never been clear how these improvements will be made. Recent trends show an increase in violence against staff (National Audit Office, 2003).

EXPERIENCE WITH STAFF TRAINING

Staff need to be trained to communicate well and provide reasonable customer care. These, and an efficient process of delivery of care, are the cornerstones of preventing most trouble in emergency departments. Staff also need to recognize that effective communication skills will work up to a point when things go wrong. Staff can be taught to recognize that some patterns of human behaviour will indicate when communication skills will work and when they will not. Having recognized that a situation has escalated to such a level, staff need to be taught to effect an immediate escape and summon help, or be prepared to offer a physical response to remain safe and maintain control. This will be required in only the small minority of situations in an emergency department.

Many trusts have introduced training to help staff recognize, avoid and deal with aggression and violence. A closer look at the effects of training found that, in general, staff enjoyed it but were often taught irrelevant skills. Training syllabi more often than not comprise skills considered 'acceptable' by the trust or those favoured by the trainer. Staff were not given skills to address the specific and actual threats in their work environment. An example of this was seen in several hospitals where staff were taught several ways of escaping from hair pulls and clothing grabs when, in reality, they were far more likely to be assaulted with a punch or a slap. One training programme had led to an increase in assaults against staff; they were more willing to 'have a go' after being taught some physical skills as they had not been taught the context of use of force. One trust was able to demonstrate that teaching staff a small number of simple reflexive skills enabled staff to cope with violent patients (Bleetman and Boatman, 2001).

Many trusts reported poor attendance at training. Often trainers were teaching numerous skills in sterile environments; there was a discrepancy between what was taught and what was required and used operationally. When asked how they knew that their skills worked, most trainers responded in terms of staff satisfaction with the training days, not from operational reporting. A review of training manuals revealed that while many trainers taught an excess number of sometimes complex skills, most taught conflict resolution and communication skills (Bleetman and Boatman, 2001).

LEGAL CONSTRAINTS

A commissioned legal review, undertaken as part of the work by Bleetman and Boatman (2001), suggested that any training provided to staff would reduce the NHS's risk of liability. It also identified that self defence is permitted under law, but that force must be reasonable and proportionate, as perceived at the time. Staff must demonstrate a willingness to temporize and disengage in any conflict. The legal right for staff to remain safe at work outweighs ethical considerations in the provision of treatment to patients. It is unlawful for trusts to remove the right of staff to defend themselves. Where staff are faced with a choice between caring for the patient and remaining safe, personal safety is the priority. Staff are entitled to withdraw the delivery of medical care and take any appropriate action to protect themselves and other innocent persons (Bleetman and Boatman, 2001).

Ninety per cent of trusts have policies for managing aggression and violence, but a third of these forbid staff to intervene physically in any conflict. This is unlawful as it prevents staff from exercising their right to self defence (Bleetman and Boatman, 2001).

WHAT CAN WE TEACH STAFF?

A commissioned educational review surmised that:

> **'...training must address a very small number of robust and adaptable skills, capable of acquisition and maintenance to mastery levels by a wide continuum of adult learners, lacking in motivation to master or apply such skills. Skills need to be deployed under high levels of stress, infrequently, within environments neither socially nor physically conducive to safe or skilled gross motor activity. There is a need to restrict the number of physical skills taught to approximately 5 to 7' (Bleetman and Boatman, 2001).**

In 1994, the police service introduced new conflict resolution skills training (Northamptonshire Police, 1994). This teaches officers to recognize patterns of human behaviour and to respond lawfully and effectively to conflict. Proper positioning and communication skills form the basis of this training. Officers are taught to read behavioural cues and to respond appropriately. A small number of physical skills are taught; skill effectiveness and injury rates are carefully monitored through a reporting process. This package is delivered to operational officers in less than 3 days. Since the removal of the height limit for police officers, physical skills have had to be designed to be effective and safe for small and short officers.

There is some evidence from this police experience, and from the 2001 Department of Health study, that a small number of reflexive, physical skills delivered in training within the context of a communication skills package are effective in protecting staff and reducing complaints and litigation.

A recent study on the efficacy of training examined staff response to a simulated standardized threatening scenario provided by a female police trainer (Fayeye, 2003) (*Figure 1*). Staff were scored on their ability to maintain a safe distance, communicate effectively and protect themselves from a physical threat. They were also required to indicate their post-event actions. Staff who had been trained in physical skills fared better in the simulated threatening scenario, they also reported the event better, and had greater confidence in their ability to handle the situation.

Figure 1. A staff member deals with a simulated threatening incident.

SO WHAT WORKS?

It has finally been acknowledged that in spite of all previous attempts at public education, more than half of attenders at emergency departments will present with minor conditions. Once thought of as 'inappropriate', these patients used to be fitted in between 'genuine emergencies'. Streaming in emergency departments recognizes that these patients require a service and provides it to them in a timely, resourced and planned fashion. This fresh look at how care is delivered, together with reasonable customer care and the

sensible use of environmental security measures, will go a long way to reducing the threat to staff. A competent reporting process will enable the situation in general to be monitored, and also allow careful evaluation of the effect of any and all initiatives to reduce the threat of aggression and violence.

Staff training in the management of aggression and violence needs to include the causes and consequences of assault, legal and ethical constraints, and how to report untoward incidents. Staff need to learn to recognize trouble and prevent it from escalating. Important skills include correct positioning, appropriate and effective communication and a small number of physical skills. Among the skills that seem to work are de-escalation and assertion, disengagement (running away), and simple, reflexive physical skills that staff are able to recall under stress. Any physical skills taught must be effective irrespective of the age, size and gender of the staff member, should be effective with a low injury potential and relevant to user's operational role (Northamptonshire Police, 1994; Bleetman and Boatman, 2001). Training syllabi need to include skills that staff need, not the skills that trainers or trusts think they need.

The Home Office Safer Hospitals Project is now underway in a number of pilot sites. The cornerstone of this initiative is a computer-based reporting system which requires staff members to record how they managed a situation and to describe the outcomes of their intervention. In this way, it will be possible to determine exactly what works and what does not. This will enable trainers and hospital managers to monitor the effectiveness of training, changes in work practice and introduction of security measures to improve safety in our hospitals. **HM**

Conflict of interest: none.

Bleetman A, Boatman P (2001) *Training in Conflict Resolution Skills and the Management of Aggression and Violence in Non-mental Health Settings: an Overview of Current Provision and Future Requirements.* Department of Health, London

Department of Health (2002) *NHS Zero Tolerance Zone. Preventing violence against staff working in the NHS.* Department of Health, London http://www.nhs.uk/zerotolerance/prevent/train.htm

Fayeye OO-O (2003) The efficacy of training Accident and Emergency staff to avoid, recognise and manage aggression and violence. Intercalated BMedSc Project. University of Birmingham Medical School, Birmingham

National Audit Office (1996) *Health and Safety in NHS Acute Hospital Trusts in England.* HC 82. National Audit Office, London

National Audit Office (2003) *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression.* National Audit Office, London

Northamptonshire Police (1994) *Unarmed Defensive Tactics Manual.* Training Department, Northamptonshire Police Headquarters, Northampton

KEY POINTS

- Violence against health-care staff remains a problem.
- Trusts need a good reporting system and sound staff protection policy.
- Training needs to be effective and realistic, driven by staff requirements.