Zero tolerance of violence against healthcare staff


Summary

A government campaign aimed at stopping violence against healthcare staff is a start in dealing with the problem of aggression in the workplace. Staff attitudes will also need to be addressed, particularly in those areas where violence has become an accepted part of the job, if zero tolerance is to be achieved.

While fully supporting the recent launch of the government’s campaign to stop violence against staff working in the NHS, it is the author’s view that zero tolerance will remain a distant objective in many health settings. It is hoped that the campaign (DoH 1999) can do much to evolve the attitudes and behaviour of the troublesome minority of people who attend A&E departments, and of the staff and managers who currently endure aggressive and violent behaviour in the course of their work there.

However, the particular characteristics, deficits and limitations of patients, residents or clients in many other clinical or social settings make communication and comprehension of the zero tolerance message extremely difficult, and it is these groups that this article is oriented towards. This is not to say that nothing can be done – far from it. Difficult patient characteristics and deficits merely place a greater onus on care staff and managers to adapt those things that are within their control to change, rather than passively expecting patients to desist simply because a new Department of Health initiative has been launched. These include their own attitudes, knowledge, expectations, organisational procedures and work environments.

An incident of bad practice

A clinical incident was related to the author by a concerned personal tutor working in a nursing department who presented an entry from a student nurse’s personal portfolio. It related to an incident that had occurred during a three-week placement in an area of care for older people. The student described the incident and the immediate response of the ward staff when she reported it to them (Box 1). The tutor queried whether this could be part of a mythical ‘rites of passage ceremony’ that was peculiar to mental health nursing. This was rather sad; professional ward managers and service managers would definitely not see it in those terms.

The actions of the staff in this incident leave one feeling exasperated, annoyed and ashamed. They seemed to oppose and erode the messages underlying a three-day unit on managing and preventing aggression in health settings that is delivered to all pre-registration nursing students during the first year of their course at the Department of Nursing and Midwifery, Keele University. This unit emphasises risk assessment, proactive behaviour, open communication, the rights of staff to work in a safe environment and contains material on:

- The potential we all carry for aggression.
- The range of factors potentially involved in an incident.
- The possible contributory role of staff in exacerbating an incident.
- The importance of dynamic risk assessment and scanning.
- The importance of documenting and communicating information.
- Proactive nursing interventions to prevent or minimise any incident.
- A safe and therapeutic approach.
- Breakaway skills.

Problems in dealing with violence

Yet, the group of staff described in the example are probably not alone in their archaic approach. It is apparent that, for whatever reasons, this accepting approach to violence in health settings is still commonplace. It is adopted by many groups of staff working in specialty areas of health and social care, be it mental health, nursing older people, adult or learning disability. Hence, situations like the one described in Box 1 are still likely to be experienced by student nurses during clinical allocations.

Inadequately trained staff, who lack proactive skills or an enlightened philosophy, will (mis)manage the reality of violence in a variety of ineffective ways. They might deny its presence or

key words

- Staff attitudes
- Student: nurses
- Violence

These key words are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review.
Box 1. Student’s experience

A first-year female student nurse, destined for adult branch, was on the second week of a three-week placement on a ward for older people with mental illness, as part of her mental health/learning disability experience. She was assisting a female patient and supporting her as she walked along a corridor. A male patient approached from the opposite direction. The student nurse was already aware of his potential for aggression because he had assaulted her in the first week of her placement. She realised that he intended to hit the woman and so placed herself between the man and the woman she was supporting. The man then thumped the student nurse in the stomach, making her breathless. She managed to walk the woman to the day room and sit her down in a chair. A group of healthcare support workers were in the day room and the student nurse reported the incident to them. They started to laugh at her. One said he knew it would happen and another suggested that they had previously been more seriously injured.

At this point the student excused herself. She later returned when she had regained her composure. No violent incident form was completed, so effectively the incident was denied, and it was as though it had never happened. She reflected on the incident, her approach and the response of the staff. During the third week of the placement and the subsequent three-week learning disability placement she adopted a different approach. She tried not to dwell on the bruises that she received. She became cool and detached and only offered care and contact when absolutely necessary. This change allowed her to cope with the frequent verbal and physical abuse that she encountered on placements. She reflected on the incident, her approach and the response of the staff. During the incident was denied, and it was as though it had never happened.

Looking to the future

It is for these reasons that the NHS Zero Tolerance Zone Campaign in England, launched by health minister John Denham and a cross-government department ministerial team on October 14 1999, is so relevant and important (see further information for details). The campaign was initiated by Frank Dobson and subsequently developed by joint working between the Department of Health, NHS Executive, the Home Office, the Lord Chancellors Department, and the Crown Prosecution Service.

Perhaps new legislation that protects ‘whistle-blowers’ might help staff who fear repercussions for reporting incidents to take action. Many are still seeking further changes in the law. Currently, there are increasing demands for ‘assault of a government employee’ to be made a specific offence, in just the same way as ‘assault of a police officer’ became a separate entity a couple of years ago.

The two principal aims of the NHS Zero Tolerance Zone Campaign are to reinforce to the public that violence against staff working in the NHS is unacceptable and, also, to reassure staff that violence and intimidation are unacceptable and will no longer be tolerated.
As mentioned previously, some patients or clients might not be able to comprehend the implications of the first aim. Despite official warning notices and repeated verbal explanations, they might be unreachable by virtue of their psychotic mental state, level of consciousness or intellectual ability. Obviously, this should not be a presumption made of everyone who has mental illness, dementia or learning disability, but it would apply to many in-patients in psychiatric, nursing older people and learning disability settings.

While scope for changing the behaviour of some patients is limited, there is great potential for achieving the second aim. Hopefully, NHS staff such as those described in Box 1 can move (or be moved) from a position of learnt helplessness/hopelessness to an empowered position. Here they will have confidence, both in their own ability to manage situations and in the determination of their own managers and staff in other organisations to support them. Nothing less will suffice if the enormous physical and psychological costs to individual staff and financial and staff retention/recruitment costs to the NHS are to be met. Prerequisites for this enlightened position are accurate contextual information about the current problems in particular services and appropriate levels of up-to-date training and education for all staff. The campaign stresses the need for managers to complete risk assessments and arrange suitable training for staff. These requirements have been highlighted in earlier reports (HSAC 1987, 1997, Leather et al 1998).

The campaign literature asserts repeatedly that ‘...staff working in the NHS should know that their safety comes first. They should not be in situations that make them feel unsafe.’ This vital message is still not clearly understood. From personal experience, many student nurses who attend the three-day unit often have an idealistic view of the ‘duty of care’ concept as being primary and unbounded. Yet, the case studies and examples of good practice in various clinical settings that accompany the campaign show that there is an accepted limit to staff efforts and responsibility.

This phenomenon of misguided selflessness and the need for a more enlightened counter-message has been identified more widely. While writing about nurse education in the US, Whitley et al (1996) cite an editorial by Carroll-Johnson (1993) that suggests nurses ‘...may find ways to excuse patient and family violence rather than insisting on their personal safety and polite treatment’. More recently, Echternacht (1999) stated that ‘...nurses, as compassionate caregivers, are taught to put the patient’s needs first. Priority consideration must also be given to our own safety and the safety of our students.’

The zero tolerance campaign literature (DoH 1999) asserts that ‘...training should be up-to-date, relevant, purposeful, backed by evidence, given by experts and include scope for feedback’. It suggests that successful training will be sensitive to service needs, simple to understand and recall, and supported by memory aids – points addressed recently by the author (Beech 1999).

Therefore, much can be done, often at little cost, to modify environments, reduce boredom and frustration, predict aggression, have carefully considered and agreed care plans in place, and intervene early to ensure that staff are safe at work. In this way, one can change the expectations of staff and patients and, by keeping staff close to patients rather than physically and psychologically isolated from them, improve the quality and quantity of care they receive. Further, nurses are ideally placed to initiate and carry through many of these developments, given their permanent presence in many settings and protracted contact with patients.

Conclusion

The government has set explicit targets for the reduction of violent incidents over the next four years. Hopefully, the current campaign can help to meet these targets, influence staff training and attitudes and reduce service acceptance and tolerance (to zero). In so doing, it will banish the sort of incidents, staff attitudes and behaviours experienced by the student nurse described in this article into history.

REFERENCES

Further information
Copies of the Zero Tolerance Resource Pack are available from NHS Responseline: 0541 555455. See also the NHS Zero Tolerance Zone Campaign website: www.doh.gov.uk/zero.htm