Linking Service and Safety

Together Creating Safer Places of Service

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HEALTH SERVICES
NATIONAL PARTNERSHIP FORUM

Strategy for Managing Work-related Aggression and Violence within the Irish Health Service

Health Service Working Group on Work-related Aggression and Violence

December 2008

Chairman's Foreword

The scale of the challenges associated with work-related violence and aggression in the health service would surprise most people, with reports that two-thirds of staff encounter verbal abuse, one-third are threatened, and one-quarter encounter some form of physical assault within a year. Typically, health services have tended to significantly underestimate both the magnitude and the impact of this problem, in terms of financial, service, and human costs.

While information is often incomplete or insufficient, a great deal of evidence has emerged from the efforts of this Working Group which dictates an urgency in ensuring that we effectively deal with the challenges that our health service employees face on a daily basis. Interestingly, Ireland's experiences are on a par with international patterns. While many countries struggle with this issue, a fully satisfactory response has remained elusive. This report brings greater understanding and clarity to the extent, breadth and depth of the task facing the health service agencies and charts an effective way forward. The efforts of the Working Group in preparing this strategy should place Ireland very much to the fore internationally when the recommendations in this strategy are acted upon.

It is vital to fully appreciate the context in which the risk of aggression and violence arises within health care settings. It is a function of the patient/client and his/her circumstances, the provider (and his/her particular circumstances), the setting or environment and, finally, the nature of the interaction between staff member and service user. It is universally acknowledged that much of what transpires by way of interaction is inherently conflictual. Overly simplistic views of this, and of the response required, do not work. A great deal rests on the nature of risk assessment process, the form of training for the various settings and providers, the nature and completeness of support in the event of an incident, and the clarity of expectations and procedures.
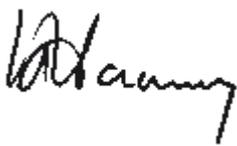
There is limited service-wide standardised practice at present. There is an urgent requirement for explicit national standards in training, which are tailored and driven by the needs of particular settings, greater understanding and coherence around the theme of support and for clear policy guidelines for the many and varied situations. The task is voluminous. The Working Group is however convinced that the work set out in the attached programmes, to be pursued in a balanced parallel fashion, will produce a vastly enhanced environment for all in which to receive or deliver services.

The Working Group urges that the next phase of implementation of the recommendations proceed seamlessly through the efforts of the Central Project Office (CPO) which is to be to be established. The overall programme needs to be driven, guided, led, and 'accredited' by a small centralised and expertly supported team (CPO), which will be aligned and work synergistically with the various service arms and providers within the health service, unions and other stakeholders.

There was consensus within the Working Group that all endeavours in this regard are much more likely to achieve greater success if undertaken in partnership mode. The report's perspective goes beyond the limits that sometimes characterise partnership to more fully embrace the principles of real joint ownership of the challenge of resolving the problem, transparency, 'joint management', and accountability, while acknowledging the fact that ultimately the responsibility for providing a safe working environment rests with the employer.

The proposed way forward is thoroughly considered and draws heavily on evidence and international best practice. It is innovative and unique in approach and comprehensive in scope. Such approaches will serve us very well. For instance, preliminary findings from soon to be published work specifically in relation to the implementation and evaluation of training within the Irish context give reason to be heartened. They strongly indicate that approaches consistent with the recommendations of this report result in significantly improved confidence and diminished risks for staff. Such successful initiatives will not only improve the quality of the working experience of staff and result in significant cost savings due to reduced absenteeism due to staff injury, but will also significantly enhance the quality of services provided. We should rapidly become an exemplar of best practice!

The course could not have been so charted without the tremendous work of the Working Group, sub-groups, expert international advisors, Denise O'Shea, group secretary and in particular Kevin McKenna, project facilitator and report author. The group's efforts were made much easier through having in our midst Kevin McKenna an acknowledged international expert on this subject in his own right. This report, as a result of the efforts of the entire team, will serve as a very significant milestone going forward, both nationally and internationally.

Pat Harvey
Chairman, HSE Working Group on Work-related Aggression and Violence

Contents

Figures and Tables

Notes on Terminology

Health Service Executive [HSE]

References to the Health Service Executive throughout the report as employer and/or corporate entity can be considered as being equally applicable to all health service providers and employers.

Work-related Aggression and Violence

Refers to all manifestations of aggression and violence from services users toward staff related to the performance of their occupational function.

Service User

Refers to all recipients of services, including patients, clients, relatives, friends, concerned others and those accompanying recipients of services. The terms patient and service user are also used in the report without any intended differentiation.

Physical Interventions

Refers to all interventions employed for the purpose of managing potential or actual work-related aggression and violence, but excludes the functional physical contacts customarily involved in care delivery.

Victim

Refers to employees who have encountered work-related aggression and violence, and is not intended to imply a role of 'victim'.

Perpetrator

Refers to individual(s) involved in occurrences of work-related aggression and violence toward staff. The term is used descriptively and is not intended to imply any role of 'perpetrator' or judgment related to occurrences.

Occurrence

Refers to situations in which employees encounter any manifestation of work-related aggression and/or violence irrespective of their gravity. While the term 'incident' is commonly used within the health service, 'occurrence' encompasses events which might be perceived as falling below the threshold of 'incident'.

Acknowledgements

Executive Summary

There is universal recognition that work-related aggression and violence is a serious problem within healthcare which diminishes the quality of working life for staff, compromising organisational effectiveness and negatively impacts on the provision of services [1]. Within the Irish context the problem is both persistent and pervasive, affecting multiple disciplines and settings. While the magnitude of the problem within the Irish context is consistent with experiences internationally, it is nonetheless a concern with 'malicious injury' reported to be the third leading cause of occupational injury reported to the Health and Safety Authority, accounting for 14.9% of all reported occurrences and for 19% of all insurance carrier notifications between 1994-2000 [2].

It is important to acknowledge that very considerable efforts have been made by many individuals and agencies to address this problem within the Irish context. While many of these initiatives have achieved improvements, their potential impact could be much more effectively exploited if embedded within a systematic approach which is strategic, cohesive and unified.

The formation of the Working Group on Work-related Aggression and Violence and their production of this strategy outlines the blueprint by which an integrated best practice organisational response can be achieved. Implementation of this strategy should assure stakeholders that all reasonably practical measures are being taken to mitigate against the very serious potential consequences for the organisation, its employees and those it serves.

The strategy employs four best practice approaches from organisational and health disciplines including [Figure 1]:

- a contextual understanding of aggression and violence within healthcare
- an integrated balanced organisational response,
- a public health preventative approach, and
- a partnership ethos of working.

Approaches Informing Strategy

Contextual Understanding	+	Integrated Response	+	Preventative Approach
		▼		
Partnership Working				

A **contextual understanding** of aggression and violence within the healthcare context challenges the traditional framing of the problem as being either a function of service user behaviour, or staff inability to effectively manage such occurrences. Occurrences considered from a contextual perspective [3] are understood as being a function of a complex interplay between:

- the service user,
- the service provider,
- the interaction taking place, and
- the environment in which the interaction occurs

This contextual consideration of all contributory factors can be employed in informing both proactive and reactive organisational efforts to address the problem.

An **integrated response** acknowledges that effective organisational efforts to manage work-related aggression and violence must achieve a balance between the obligations to:

- provide safe effective services
- comply with health and safety legislation,
- meet corporate risk management obligations and
- adhere to the prevailing professional and statutory legislation

Adopting such an integrated approach locates the organisational response within a broader governance framework and avoids the limitations of singular departmental responses [4].

Adopting a **public health approach** establishes prevention as the core value informing a structured framework of tiered responses. This approach categorises prevention along a three-tiered framework of primary, secondary and tertiary prevention [5].

- **Primary prevention** involves strategies which prevent occurrences in the first instance.
- **Secondary prevention** involves the recognition of potential occurrences at an early stage and the employment of appropriate intervention to prevent further escalation.
- **Tertiary prevention** aims to minimise potential harm to all concerned while occurrences are being managed.

While adopting a preventative approach ensures compliance with professional and regulatory obligations, the real value of this approach is in its potential for simple, often low cost, interventions to result in very significant reduction in occurrences and associated risks [6].

The utilisation of a partnership approach acknowledges that work-related aggression and violence poses a significant problem for the organisation, its employees, and those it serves. The development of this strategy was greatly enriched by engaging a broadly representative working group which gave expression to the perspectives of multiple stakeholders and ensured that their concerns were adequately and equitably addressed. The group, which included employer and employee representatives, regulatory agencies and professional bodies, were unanimous from an early stage that the greatest potential for sustainable success would best be achieved in partnership through which a standardised organisational response could be developed. Indeed, this strategy is testimony to the strength of this partnership approach.

The working group initially scoped the task and explored pertinent initiatives from the previous health service structures. It became clear from this review that despite considerable variation in previous approaches, key themes had consistently warranted attention. Specific subgroups were subsequently established to explore five key themes including:

- Health Safety Quality and Risk
- Provision of staff education and training
- Training and use of physical interventions
- Provision of staff support
- Organisational security responses
- Development of a standardised policy

The work of these subgroups, following consideration by the plenary group, informed the structure and substance of this strategy. While much is known about the extent of the problem and the necessary responses, in many instances the evidence base informing how these should be implemented remains either unclear or incomplete [7]. There was consensus that a number of measures, either as a function of the gravity or urgency of the issue, or the availability of compelling evidence, should be initiated in the shorter term. Other issues, however, are more complex, and as a function of either incomplete evidence or lack of consensus, will require further consideration. The recommendations of this report will ensure that all measures are comprehensively and cohesively addressed in a manner which adequately and equitably addresses the concerns of all.

This report is divided in two parts. The first is an executive summary which briefly outlines key findings and recommendations and is also published as a stand-alone document. The second part provides a more thorough account of the methodology and findings with more comprehensive discussion of the considerations which have underpinned recommendations.

The key findings and recommendations are outlined in the executive summary in ten sections:

1. **Extent of the problem**

2. **Impact and response**

3. **Health Safety Quality and Risk**

4. **Education and training**

5. **Physical interventions**

6. **Supporting staff**

7. **Organisational security responses**

8. **Organisational policy**

9. **Implementation: Structures and process**

10. **Implementation: Actions and outputs**

1.   Extent of the Problem

- Work-related aggression and violence is a problem for many staff to an extent similar to that reported within comparable health services internationally.

- Work-related aggression and violence encountered by staff includes physical and non physical manifestations.

- These manifestations vary by occupational function with some occupational groups at particularly higher risk of particular manifestations of aggression and violence.

- Efforts to accurately quantify the extent of the problem of work-related aggression and violence are hindered by the absence of a standardised definition.

- Work-related aggression and violence is grossly under reported and verbal aggression is especially so.

- There is a bias in reporting behaviour with a tendency to report more serious occurrences.

- Organisational estimates, which rely upon such reports, may subsequently under-estimate the magnitude of the problem and be biased toward serious occurrences.

Recommendations

- *The EU definition[1] of work-related aggression and violence be adopted as the operational definition throughout the health service.*

- *A robust replicable baseline measure of all manifestations of work-related aggression and violence encountered by staff throughout the health service be established.*

- *A standardised reporting system for work-related aggression and violence be implemented with a clearly delegated responsibility at local and national levels.*

- *Awareness be raised among staff of the crucial role of occurrence reporting in informing the implementation of strategic organisational responses.*

- *Occupational specific patterns of work-related aggression and violence be used to inform organisational responses.*

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1   "any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well being or health" Section 2.1 Defining the Problem.

2.   Impact and Response

- Many staff sustain minor injuries from physical assaults while major injuries are rare.

- For some staff however the consequences of being assaulted can be devastating.

- Staff may experience emotional distress subsequent to occurrences of work-related aggression and violence, which is not limited to occurrences of physical violence.

- The extent of staff absences due to work-related aggression and violence remains unknown.

- Estimates of staff replacement costs due to occurrences of work-related aggression and violence suggest a serious financial burden on the healthcare services[2].

- There has to date been no methodically rigorous actuarial measure of the total cost of work-related aggression and violence within Irish healthcare.

- Occurrences of work-related aggression and violence are a function of an interchange between the service user, service provider, interaction taking place and environmental factors.

- Within this contextual understanding, there is an inherent potential for conflict.

- Effectively responding to the problem involves adequately and equitably addressing the concerns of all involved.

- Achieving effective responses is most likely to succeed if undertaken in partnership

Recommendations

- *Awareness of the potential impact of all manifestations of work-related violence be raised at all level of the organisation.*

- *A rigorous actuarial measure of the costs associated with work-related aggression and violence be established.*

- *Methods by which 'return on investment' measures might be employed to evaluate the cost effectiveness of organisational initiatives to address the problem be established.*

- *A contextual understanding of work-related aggression and violence be adopted.*

- *Responses address the potential for conflict within the provision of services.*

- *Responses adequately and equitably address the concerns of all involved.*

- *A partnership approach underpin the development of organisational response.*

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2   Section 2.5 Cost of the Problem.

3. Health Safety Quality and Risk

- Employers have a statutory obligation to ensure so far as is reasonably practicable the safety health and welfare of employees, and others[3].

- Recognition of work-related aggression and violence as an occupational specific hazard imposes a mandate to systematically evaluate the related risks to all involved, and to implement control measures which mitigate against, or eliminate identified risks.

- Such assessments are required by section 19 of the Safety, Health and Welfare at Work Act 2005 which requires that these are explicit in safety statements.

- The extent to which required health and safety risk assessments are completed within the HSE generally, and specifically addressing work-related aggression and violence, is unclear.

- The organisation has a corporate obligation to manage and minimise foreseeable risk.

- Evaluating the risks associated with aggression and violence is difficult within the health service due to the scale of the organisation and the complex range of activities.

- There are significant variations of hazard and risk between and within services.

- There are some well evidenced risk reduction measures which could achieve significant improvements.

- There are a number of high priority risk reduction measures which need to be implemented at the earliest opportunity utilising the best evidence available.

Recommendations

- *All locations have a current safety statement based on a methodical risk assessment process.*

- *Where work-related aggression and/or violence is identified as a foreseeable hazard the safety statement to explicitly outline the control measures required and those responsible for their implementation and ongoing audit/review.*

- *Priority be given to establishing the safety of lone workers and those working alone.*

- *Risk management efforts be undertaken to raise awareness of the uncertain and dynamic nature of risk and to develop the capacity of staff to undertake continuous risk appraisals specific to their service setting and occupational function.*

- *Awareness of the very significant potential risks, both physical and psychological to patients and staff be raised at all levels of the organisation.*

- *A close liaison between those charged with the corporate quality and risk function and the management of aggression and violence be established and maintained.*

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3   Section 4.1 Health Safety Quality and Risk.

4.   **Education and Training**

- The recognition of work-related aggression and violence as a service specific occupational hazard places professional, legislative and moral obligations upon the organisation to provide training in its prevention, recognition, and safe management.

- The majority of staff consider training in the management of work-related aggression and violence as necessary for their occupational function.

- There is a gap between the numbers of staff who need training and that provided.

- There are acknowledged limitations inherent in the practice of providing generic 'systems' and 'one size fits all' approaches to training.

- There has been a training emphasis on management rather than prevention.

- Training needs to reflect the challenges encountered by staff within their service settings, and the prevailing legal, professional and policy parameters within which services are provided.

- The governance and cohesiveness of procuring and providing training is unclear.

- The physical intervention components of some training approaches are a concern.

Recommendations

- *Education and training in the management of work-related aggression and violence be provided to all healthcare employees.*

- *The content and methodology of education and training to correspond to participants professional and organisational responsibilities.*

- *A review of the methodologies and structures for providing staff with education and training be undertaken as a priority.*

- *Education and training be needs assessed, service specific, and in compliance with the prevailing legislation and policies applicable to the service setting.*

- *Education and training to include lone working, conflict resolution and the management of verbal aggression.*

- *Comprehensive guidance be developed to assist those commissioning training.*

- *This guidance to incorporate a cohesive structure of practice standards.*

- *The safety of physical intervention techniques be established as a priority.*

- *A structure to verifiably record education and training completed by individual employees be established.*

5. Physical Interventions

- The use of physical interventions is a complex issue which poses legal, professional and moral dilemmas for individuals, units of service, and the organisation.

- The use of physical interventions is an inherently hazardous procedure which poses potential risks of both physical and psychological trauma to both service users and staff.

- The most significant preventative initiative is the development of services in which the use of seclusion or restraint is minimised.

- In addition to the potential of diminishing risks to all concerned, minimising seclusion and restraint contributes significantly to a broader quality improvement agenda.

- There may be circumstances in which physical interventions is deemed necessary as the only or most appropriate option.

- It is critical that in such situations staff are trained and competent in the employment of safe effective techniques in order to preserve the safety of all concerned.

- The provision of training in physical interventions is currently unregulated, and taught without agreed standards as to how the origin, safety, or effectiveness of techniques is determined.

- There is a need for a structured appraisal of physical intervention techniques currently in use.

- Current practices which are of concern require priority attention from both professional practice and risk management perspectives.

- There is a need for standards to govern the provision of training in physical interventions and the use of these interventions in practice.

Recommendations

- *Health services proactively aspire to the provision of services which are 'seclusion and restraint minimised' at philosophical, organisational and operational levels.*

- *Priority be given to establishing the safety in practice, and fitness for purpose of physical intervention techniques currently in use.*

- *Future provision of physical intervention training be subject to such review prior to commencement.*

- *The use of physical interventions be subject to standards at least comparable to those applying to other patient focused interventions.*

- *Standards governing the provision of training in physical interventions, and the use of these interventions in practice be developed as a matter of priority.*

- *Guidance be developed to inform and standardise decision making in relation to the provision of training and the use of physical interventions.*

6. Supporting Staff

- Employees expect to be supported following occurrences of all forms of work-related aggression and violence.

- There is a legislative requirement on employers to provide appropriate supports.

- Employees value simple supportive measures which consider their wellbeing and validate their reactions to untoward experience.

- While most employees require minimal post-occurrence support, some may require a wider range of support measures over a more prolonged period.

- Consequently, different support measures are required and no singular or uniform approach is appropriate to all individuals or situations.

- Employees highly value support from colleagues and line managers.

- Employees perceive the role of the line manager as critical in the provision of support.

- The extent to which line managers are prepared for, or feel empowered to perform this role remains unclear.

- For a variety of reasons there have been sensitivities surrounding the issue of staff support at various levels of the organisation.

- There is a need to clarify both the understanding of, and interrelationship between key terms including 'psychological distress', 'psychological injury', 'compensation' and 'support'.

Recommendations

- *Awareness of the support needs of employees be raised at all levels of the organisation.*

- *A flexible repertoire of best practice support measures be available to staff with readily available information as to how these measures can be accessed.*

- *Available measures form an integrated multi-layered suite of supports.*

- *Managers be both informed and empowered to understand and undertake the role expected of them in providing support.*

- *Managers' role be undertaken free from any anxiety that providing support is implicated in later determinations of liability related to the occurrence concerned.*

- *Some exemplars of best practice currently in use regionally be considered for widespread distribution and systematic evaluation.* [4]

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4   Section 4.4 Provision of Staff Support.

7. Organisational Security Responses

- There is a need to balance the duty to provide services with the obligation to protect the safety and welfare of staff and others and the property of the organisation.

- Responding to perpetrators of aggression and violence within healthcare is complex in that occurrences take place within a professional service relationship.

- Organisations may utilise either engagement approaches which rely upon rational or emotive appeals, or tariff approaches which rely upon the assumption that pre-understood sanctions will modify behaviour.

- In some instances the organisation may be obligated to institute either service specific or individual specific conditions in order to ensure the safety of all concerned.

- Such measures must be reasonable, justifiable, proportionate, time specific. and be equitably and consistently applied.

- Legal remedies available and imposable sanctions remain largely unexplored, with many services unsure of the exact legal parameters governing such actions.[5]

- There is a need for informed legal opinion to guide the policy in this regard.

Recommendations

- *Public support for measures which diminish aggression and violence within healthcare settings be engaged through a campaign which highlights the positive efforts of staff, and the detrimental impact of such behaviours on the service environment.*

- *A formalised liaison between the health service agencies, the Garda Síochána, and the Director of Public Prosecutions be established with the purpose of establishing clarity and agreement in relation to the enforcement options available to services.*

- *A forum including employer and employee representatives, service users, regulatory bodies, justice, enforcement and professional agencies, be established to determine the potential value of tariff based approaches within an integrated strategy.*

- *This forum to bring forward a proposed framework which should guide decision making.*

- *A formalised structure of legal advice be available to guide decision making and the management of complex situations with an agreed structure of access.*

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5   Section 4.5 Organisational Security Responses.

8.   **Organisational Policy**

- Employees require policies to provide them with clarity to guide their decision making in managing work-related aggression and violence.

- The need for such policies has been consistently advocated by professional and regulatory bodies.

- In the absence of clear policies employees rely on practice as their primary guide.

- While some practices may be excellent, their lack of critical appraisal and formal authorisation may create ambiguity, and place employees in situations of uncertainty regarding organisational expectations and authorisation when managing occurrences of aggression and violence.

- It is essential that the policy is congruent with the prevailing legal, professional, and ethical codes which apply to the service setting within which it is to be enacted.

- Some organisational responses require guidance to support the implementation of policy.

- Requirements for guidance include, education and training, staff support, physical interventions, and the deployment of security personnel.

- The present state of multiple coexisting policies developed in previous health service structures needs to be replaced with a standardised health service policy.

- In the immediate short-term an interim policy should be implemented, with an explicit acknowledgement of interim status. This policy should be reviewed within a specified timeframe but no later than twenty-four months from its inception.

Recommendations

- *An interim policy be implemented to avoid uncertainty and provide staff with guidance as to organisational authorisation and expectations of them when managing occurrences of work-related aggression and violence.*

- *Guidance be provided which is capable of service specific adaptation.*

- *Theme specific guidance support policy in areas related to education and training, staff support, physical interventions, and use of security personnel.*

- *The 'interim' status of the policy be made explicit with a defined timeframe for review.*

- *The review be completed within twenty-four months in order to reflect the emerging work of the structures proposed in this strategy.*

9.   Implementation: Structure and Process

It is clear from the preceding sections that a significant challenge exists for the service for which a national, standardised, coordinated response is required. The necessary programme of considered actions and sustained improvements to be achieved will require a clear plan of implementation.

In formulating the implementation plan there was consensus that three key elements of the plan include:

■ That the response should be jointly owned by a employer/employee partnership in association with other regulatory and professional stakeholders.

■ That a dedicated unit responsible for driving and achieving the key actions outlined in the strategy should be established.

■ That initial and substantial efforts should focus in the more immediate term of the first twelve months with a deliberate targeting of high return measures.

While recognising that the primary responsibility for addressing the problem rests with the management of health service agencies as corporate entities, it is recommended that a dedicated resource be established to drive and coordinate the implementations in the shorter term. The structure recommended consists of three interdependent components incorporating a governance function in the Project Joint Governance Group; an executive/operational function in the Central Project Office; and a consultation function in the Multi-agency Advisory Forum. The establishment of these units should coincide with the acceptance of this report.

Implementation Structure

Project Joint
Governance Committee
(PJGC)

Central
Project Office
(CPO)

Multi-agency
Advisory Forum
(MAAF)
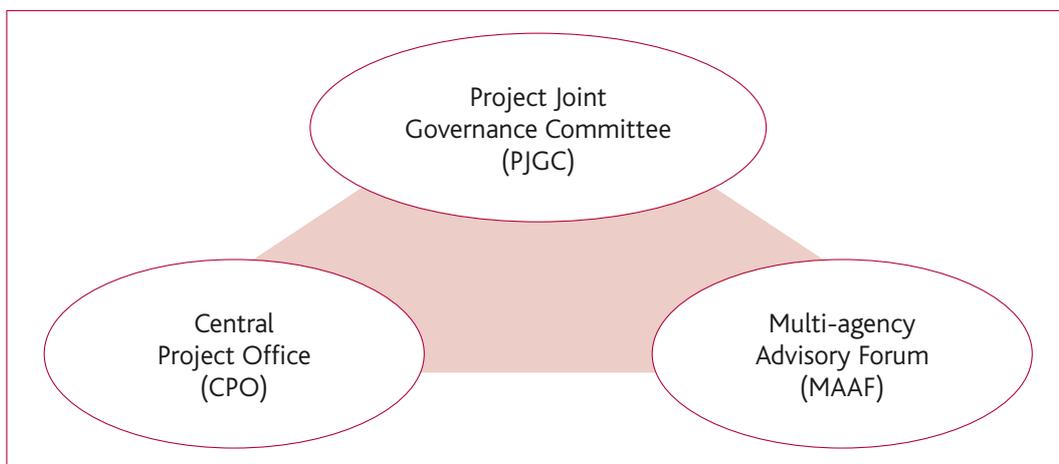
The roles and functions of these units are outlined below:

The Project Joint Governance Committee (PJGC): will take responsibility for overseeing the implementation of a programme of strategic actions in line with the agreed recommendations of this strategy and direct the Central Project Office in the implementation of this work. While health service agencies will assign lead responsibility at a corporate level, those charged with responsibility will rely on the PJGC to guide and oversee the response to this theme.

The Central Project Office (CPO): will implement an effective organisational response to the management of work-related aggression and violence in line with this strategy under the direction of the Project Joint Governance Committee. The mission of this office will be to reassure stakeholders including health service employers, unions and regulatory bodies, that 'all is well' and in line with explicit expectations. The CPO will in the first instance be established for a period of 3-4 years at which time the arrangement will be reviewed.

The Multi-agency Advisory Forum (MAAF): will provide a vital stakeholder consultation function. Forum membership will be coordinated by the Central Project Office, subject to ratification by the Project Joint Governance Committee, and will be broadly representative of professional, regulatory and educational agencies including service user representation. The forum will provide a platform to actively consult and collaborate in implementing key actions of the strategy through the exploitable strengths of consultation, expert resource, and implementation agent.

This arrangement is a very significant joint employer/employee partnership response, of high leverage value, in response to a longstanding and very significant problem. The partnership approach infers collective ownership of the challenge to find and sponsor solutions sustainable into the future. This is consistent with recommendations that social partners actively engage in dialogue at national and organisational level on the protection of workplace health and safety as a means toward improving services and that social partners collaboratively monitor and evaluate such initiatives [8]. The successful functioning of the working group to date, through its commitment to collaborative working in an ethos of partnership, also fits comfortably with the prevailing aspirations toward employee partnership and effective interagency working.

This collaborative approach to managing work-related aggression and violence has the potential to simultaneously improve the service experience of recipients, the quality of the working life for staff, and the overall effectiveness of the organisation. While principle responsibility for the service rests at the corporate level of health service agencies, this proposal recognises that active inclusion of all stakeholders in a partnership response is a crucial ingredient for success.

10. Implementation: Actions and Outputs

The implementation of the recommendations and associated actions requires a strategic, integrated, cohesive and balanced approach. The CPO, once established, will deliver an intensive programme of work over the next three years at which time there will be a substantial review. The expectation is that within this timeframe a very substantial impact will have been made on all priority themes. In three years there should be a real sense that the challenges associated with the management of work-related aggression and violence are being effectively managed within the service.

Recommendations range from awareness raising and system wide education, to very specific deliverables on issues including baseline measurement, costing, and establishing the safety of physical interventions. A number of actions should not be delayed, and be implemented as far as possible within the first twelve to fifteen months. These priority actions have been collaboratively agreed within the working group based on the criteria of potential impact, relevance, cost/return on investment, and organisational readiness. It is important to stress that efforts towards achieving the priority actions in the first instance should not preclude simultaneous commitment to implementing all recommendations.

The eight key areas for immediate implementation incorporate a number of the recommendations within the strategy and are briefly outlined below:

- Standardise definition and classification of aggression and violence
- Ensure completion of risk assessments and safety statements
- Establish the safety of lone workers
- Establish the safety of physical intervention techniques
- Develop standardised guidance on the provision of education and training
- Develop standardised guidance on the provision of staff support
- Develop standardised guidance on the use of physical interventions
- Structure the methodology by which to quantify associated costs

1 | Introduction

1.1. Background

Healthcare is a unique service in that it is structured within a socio-political environment and delivered within professional, regulatory, legal and moral contexts. The Irish public values a high quality health service delivered by staff whose professionalism has been acknowledged globally [9]. It is reasonable for users of the service to expect to be treated, and for staff to expect to work, in an environment which is safe and free from the expectation of being abused, threatened or physically assaulted. In the majority of cases such conditions prevail and the service experience is a positive one for both the recipient and provider. However there are instances when, for a variety of reasons, conflictual situations prevail which have the potential to escalate to aggression and violence toward those providing services. The extent of such aggression and violence within Irish healthcare poses a very significant problem for service users, employees, and organisations providing services [10].

It is important from the outset that two important caveats preface discussion of this problem. Firstly, the Irish health service is not unique in this experience, with extensive professional literature and regulatory agency reports suggesting similar patterns internationally [11,12,13,14]. Indeed, aggression and violence is now recognised as a problem peculiar to healthcare which many countries now struggle to address. Secondly, while conflict may be inherent in some circumstances surrounding the delivery of health services, this should not be equated with any assumption that aggression and violence are inevitable [15].

In as much as the Irish health service is not unique in its experience, neither however is it immune. The indisputable evidence of the magnitude of the problem places professional, statutory, and moral imperatives upon the organisations delivering services to develop an informed and cohesive strategy to address the issue. While the problem has not gone unnoticed, for a variety of reasons, organisational efforts may not have fully appreciated the complexities involved in understanding aggression and violence as being embedded within a service relationship. This has sometimes resulted in responses to the problem in isolation from the context in which the problem occurs [16]. Consequently, there is at least the perception that organisational efforts to date have not yet yielded significant returns on the considerable time and resources invested, or significantly impacted on the everyday experience of those delivering or receiving services [10].

The establishment of the National Working Group within the health service to examine the issue has presented the opportunity to address many of these limitations by developing a strategic corporate response which balances the duties and obligations owed to all. Achieving significant improvements will however require the reappraisal of some fundamental assumptions regarding how the problem is understood and managed. It is only through such an informed view of the complexities of the problem that the clarity of the required responses will become apparent. This strategy outlines the path by which these significant improvements can be achieved.

1.2. Context

Recent reforms within the structures and processes of Irish health service delivery have witnessed a renewed emphasis on the quality and safety of services delivered. In addition to emphasis placed on service provision, there has also been a recognition and acknowledgement of the organisation's human resources as a vital asset. [17].

problem internationally is largely unexplored…

While considerable progress has been achieved in many areas of quality and safety, the strategic management of aggression and violence has lacked sufficient cohesion. It is important to acknowledge that this is not uncommon within health and social care systems generally and is certainly not peculiar to the Irish context [18].

While health systems globally have recognised aggression and violence as a significant problem for some time, serious attention at professional, organisational, and regulatory levels has only emerged within the last few decades. Despite this increasing attention, the problem remains largely unexplored with a knowledge base which has been described as often incomplete, imprecise or contradictory [7].

In recognising the need for a standardised approach in managing the problem within the Irish context, there have been very considerable efforts by many individuals and agencies which have produced a number of internationally acknowledged exemplars of best practice [1]. Notwithstanding these achievements, such successes have often been isolated and fragmented, and their potential impact may have been more effectively exploited if embedded within a systematic approach which is strategic, cohesive and unified.

A number of internal and external influences, which are reflected in organisational guidance [19], have acted as drivers to rectify this. In this context a national working group under the auspices of the National Joint Council, was established to examine and report on the matter of managing work-related aggression and violence toward staff. The terms of reference for the group were to:

Produce a standardised policy for the management of work-related aggression and violence within the health services, having regard to the body of work currently available within the Irish health service and to best international practice.

The group membership was broadly representative of employer and employee representatives, regulatory agencies and professional bodies [Appendix 1].

1.3. Methodology and Scope

The working group acknowledged at an early stage that the greatest potential for success would be achieved by partnership working through which a strategic response to the problem could be developed which adequately and equitably addressed the concerns of all stakeholders.

most informed and considered exploration… undertaken… within the Irish context.

It was also acknowledged that the success of an organisational response rested upon its ability to result in sustainable measures which effectively address the problem. There was consensus that achieving such success was dependent upon the informed consideration of the problem from the perspectives of all stakeholders. The resulting deliberations and the formulation of this strategy represent the most informed and considered exploration of the problem undertaken to date within the Irish context. This strategy, as a first step, provides the platform from which the subsequent development of guidance and policy responses can proceed while implementing a programme of prioritised actions which have a high probability of achieving sustainable improvement in managing this complex problem from the perspectives of all stakeholders. [Figure 3].

Figure 1: Development of Comprehensive Policy

Through the group's initial efforts to understand and agree the scope of the task, it became clear that the potential for conflicts exists at multiple levels within the healthcare context. In order to maintain a central focus of attention clarity was established, and agreement reached, that the work of the group concentrate on the management of work-related aggression and violence directed toward staff by service users related to performance of their occupational role. While other potential conflictual situations were acknowledged, it was considered that these were outside the scope of this working group and are addressed within pre existing health service policies.

There was consensus that this strategy should complement existing policies in a cohesive manner bringing clarity to the function and purpose of each. This strategy subsequently fits cohesively into a suite of responses which includes interpersonal conflicts among staff addressed in the Dignity at Work policy, and the sensitive problem of aggression toward service users by staff addressed in the Trust in Care policy [Figure 4].

Figure 2: Cohesion with Existing Guidance and Policy
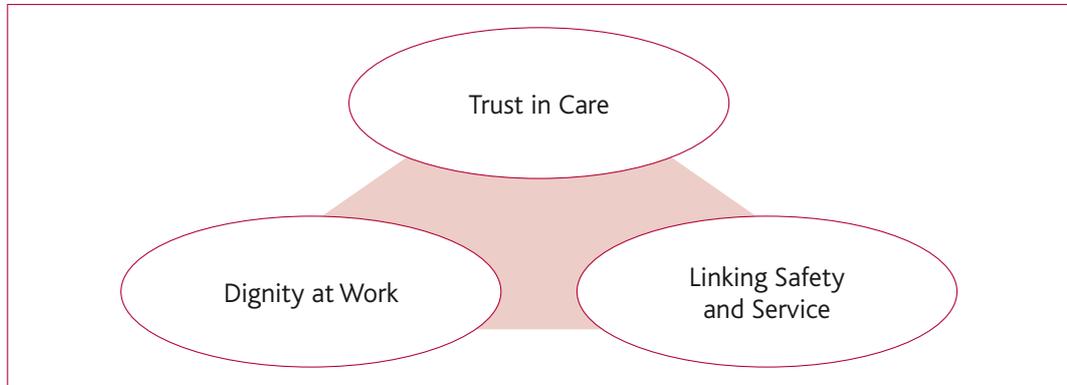
A second challenge to the scope of the groups work surrounded the range of potential circumstances and perpetrators which staff might potentially encounter in the performance of their occupational role. There was consensus that the group limit itself to Type II aggression and violence as described by the International Labour Organisation [8]:

- **Type I**, refers to occurrences in which the assailant has no legitimate relationship to the workplace and the primary purpose of the attack is to acquire cash or some other valuable commodity.
- **Type II**, refers to occurrences in which the assailant is either the recipient of a service provided by the victim or the affected service.
- **Type III**, refers to occurrences in which an assault is perpetrated by another employee, a supervisor, or an acquaintance of the worker.

Having clarified the focus and scope of the task, the group then explored initiatives from the former health service structures. From this review it became clear that, despite considerable variation in previous approaches, key themes had consistently warranted attention. Subgroups were subsequently established to explore these specific themes as outlined below:

- Safety Quality and Risk
- Staff Training
- Physical Interventions
- Staff Support
- Organisational Security Response
- Policy Development

Each subgroup was tasked with collating existing policies, procedures and practices within the health service and considering these in the context of evidence based best practice from both national and international perspectives. It was apparent from this work that there is an established evidence base which could inform initiatives capable of delivering very significant improvements in the short-term. There were however other issues which are either more complex, poorly informed by evidence, or lacking in consensus that would need more measured exploration and consideration.

The work of the subgroups, in addition to consultations with professional and regulatory bodies, and subject experts, both nationally and internationally, informed the formulation of an initial draft strategy. Following consideration by the plenary group, this draft was reviewed by an international subject expert. Feedback from the plenary group in combination with the expert review was then incorporated into the second draft. The revised draft was again considered by the plenary group and similarly sent for independent review by a second international subject expert.

Figure 3: Development of Strategy

Working Group on Work-related Aggression and Violence

Initial consideration of terms of reference, scope and methodology of work and formation of theme specific subgroups

Quality Safety and Risk Subgroup	Training Subgroup	Support Subgroup	Security Response Subgroup	Policy Subgroup

Preparation of draft strategy

Consideration by plenary group	First international expert review

Revision of draft strategy

Consideration by plenary group	Second international expert review

Linking Safety and Service: Together Creating Safer Places of Service

The feedback from the plenary group and expert review was incorporated into the final draft which, by agreement with the group, was then finalised by a small editorial review group.

2 | The Problem

2.1. Defining the Problem

almost two-thirds of staff had encountered verbal abuse

almost one-third encountered threats

While work-related aggression and violence within healthcare does not lend itself easily to definition, there is agreement that the adoption of a standardised, clearly articulated, and measurable operational definition is critical [20]. While the pivotal importance of this issue may not be at first apparent, clarity of definition is essential in facilitating the methodical evaluation of the effectiveness of preventative and management strategies over time and across service settings.

The fundamental issue of definition has been identified as a major limitation in the study of work-related violence within healthcare internationally [21,22] with one UK report highlighting that despite a considerable effort of standardisation, more than twenty different definitions of work-related violence remained in use within NHS trusts [18]. The difficulty of definitional confusion is compounded by terminology in professional literature and regulatory reports frequently being used interchangeably.

Lack of a standardised definition has both strategic and operational implications. Broad definitions may result in more occurrences being reported, while narrow definitions may result in a systematic underestimation, both of which may result in an inaccurate quantification of the problem. Operationally this inaccuracy may result in either the unjustified utilisation of resources, or in hindering the implementation of warranted and necessary preventative measures.

almost one-quarter had been physically assaulted

within the previous year at work

It was apparent from the deliberations of the group that a standardised definition be adopted. Following consideration of alternatives from professional, regulatory, and service bodies there was consensus that the EU definition of work-related violence as set out below should be adopted by health and social care agencies for the purpose of reporting and measuring incidents of work-related violence and aggression.

Recommendation 1: Definition

The EU definition of work-related violence: "Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well being or health" [23] be adopted.

2.2. Extent of the Problem

There is a growing international consensus that workplace violence, while a feature of many work settings, poses specific problems for health and social services, affecting multiple disciplines and settings.

Some occupations encounter a disproportionate amount of aggression and violence…

The U.K. Health Services Advisory Committee [13] described violence as a significant problem affecting a wide range of occupations affecting staff at almost any location whatever their occupation or department. While nurses have for some time been identified as a high risk group [11,24,25], reports have also identified the magnitude of the problem for other occupational groups including physicians [26,27], psychologists [28] and social care staff [10,29]. With an increasing emphasis on services being delivered in the community there has recently been increasing recognition of specific problems facing those categorised as lone workers [30,31].

Within Ireland, the first review of the Health & Safety Authority's Advisory Committee on the Health Services Sector [32], for the period 1983-1990, identified assaults on employee as an occupational risk 'peculiar to the health services' (p.13). A more recent report of this committee highlighted that 'malicious injury' is now the third leading cause of occupational injury within the Health and Social Care Sector, accounting for 14.9% of all reported occurrences and for 19% of all insurance carrier notifications between 1994-2000 [2].

The first large scale multidisciplinary study of work-related violence within Irish healthcare reported that almost two-thirds of staff had encountered verbal abuse, almost one-third had encountered threats, and almost one-quarter had been physically assaulted within the previous year at work [10]. The study also reported that a small number of occupational categories encounter a disproportionate amount of work-related violence and that occupation-specific patterns are associated with different manifestations of aggression and violence. For example there was significant variation in occurrences of verbal and physical aggression encountered by different occupational groups. 'High frequency' of encountering physical assaults, defined as more than twenty occurrences within the previous year, was exclusive to the three occupational categories of care attendant, child care and nursing.

More recent research has highlighted that mental health and learning disability nurses are at particular risk of physical assault [33]. Analysis of these patterns has clear implications for planning and providing occupation specific programmes of staff training and support.

Table 1: Comparison of Irish and European Data

Estryn-Behar et al (2007) NEXT Study Nurses' experience of violence from patients/relatives ≥ monthly	
Netherlands	10.4%
Slovakia	17.0%
Poland	19.2%
Finland	19.8%
Italy	19.9%
Belgium	23.3%
Finland	28.0%
France	39.1%
McKenna (2004) SOVES Study One Irish regional health area Nurses' experience of violence >10 in past year	
Verbal Abuse >10	25%
Threats >10	14%
Physical Assaults >10	22%

The Irish findings are consistent with international research. For example the findings from a large scale European study involving more than 34,000 nursing staff in eight countries [12] suggests that the experience of Irish nursing staff is similar to that of their European counterparts. It should be noted that there was some variation in definition and that the Irish study used for comparison was conducted regionally rather than nationally [Table 1].

Notwithstanding these caveats, evidence from the quoted study is largely consistent with other studies conducted within diverse settings of the Irish services including Accident & Emergency departments [34, 35], psychiatric services [36], paediatric services [37], and residential childcare [10,29]. It is therefore probable that the evidence from Irish studies, albeit diverse in methodological approach and service settings, validates the existence of a problem which has been internationally acknowledged for some time.

Inconsistencies in the operational definitions and the methodological approaches of existing Irish studies does however highlight the necessity for a robust measure of the extent of the problem nationally both as a baseline measure, and as a benchmark against which the effectiveness of organisational efforts to address the problem can be measured.

Recommendation 2: Measurement

A robust replicable baseline measure of all manifestations of work-related aggression and violence encountered by healthcare staff be established to serve as a benchmark over time and between services.

2.3. Under-reporting of the Problem

under-reporting by staff…

…consistently cited difficulty…

The effective strategic management of any complex organisational issue is dependent upon an accurate description, quantification, and understanding of the problem. One consistently reported difficulty in addressing the issue of work-related aggression and violence is the extent to which the problem remains unrecognised due to under-reporting by staff [10].

Under-reporting of occurrences is a phenomenon that crosses professional and geographical boundaries [10,28], with even more serious occurrences involving physical assault significantly under reported in some settings [10]. The reasons for this are complex but include perceptions that aggression and violence are 'part of the job', that the perpetrator is not responsible, that there is 'no point' in reporting, and that reporting involves excessive paperwork. Additional factors include subjective feelings of guilt or shame for not having prevented the incident and fears of being blamed or being perceived to have under performed to some degree. The subjective and dynamic qualities of these perceptions, and their influence on formal reporting, needs to considered in any attempt to address this issue [10].

Within the Irish context evidence suggests that, in addition to occurrences being under reported a systematic bias exists towards reporting more serious occurrences [10]. This is significant in that managers and policy planners, informed by inaccurate data, or unaware of the true nature and extent of the problem, may endorse inadequate or inappropriate organisational responses.

…systematic bias towards reporting more severe manifestations … masking the true extent of the problem…

One example of this has been the tendency for training and support responses to focus on more severe manifestations of physical aggression and violence, with inadequate attention given to the more frequent but equally distressing manifestations of verbal aggression. In some settings this may serve to perpetuate inaccurate perceptions of the organisation as unresponsive to staff welfare issues, when in reality well intentioned responses are informed by inaccurate representation of the problem obtained from incident records [10,39].

The usefulness of a reporting system is determined by the extent to which it accurately records critical information related to the contributory variables including the perpetrator, staff involved, service setting, activity being undertaken, and associated environmental factors. There is a need for a user friendly occurrence recording system. Such a reporting initiative has been implemented in the UK NHS [40] with considerable success and might inform the development of a national database within the Irish health service.

The value of the data generated by such a system in informing preventative measures cannot be underestimated. The successful implementation of a standardised reporting strategy will require commitment at all levels of the organisation and clearly delegated functional responsibility at local and national levels.

Recommendation 3: Reporting

A standardised reporting system for all manifestations of work-related aggression and violence be implemented with a clearly delegated responsibility at local and national levels. The implementation be supported by an awareness raising initiative highlighting the importance of reporting at all levels of the organisation.

2.4. Impact of the Problem

Psychological consequences

…tend not to feature fully in attempts to quantify extent…

Work-related aggression and violence impacts significantly on health service provision to an extent which is sometimes not fully appreciated. Management of the problem within healthcare settings poses a range of very significant physical and psychological risks to staff. Early attempts to quantify these impacts frequently focused exclusively on the physical injuries sustained from physical assaults [22,41]. While such reports undisputedly identified the risk of physical injury, they frequently did not investigate or acknowledge the potential psychological consequences associated with physical assault and the potential for serious psychological harm from verbal abuse and threats. [42].

The potential psychological impact of exposure to aggression and violence may be significant both in intensity and duration. Case reports describe post-traumatic stress reactions [43] and studies have reported significant alterations in quality of life extending up to four years following an assault [44]. There is evidence also that being exposed to threats may have measurable effects on the mental health status of those threatened [45]. The psychological impact of work-related aggression and violence is not limited to the victim with reports that those witnessing occurrences, and those involved in the employment of physical restraint in their management, may also be affected. [46].

While the overall rate of serious physical or psychological injury is small, for some, these occurrences represent both personal and professional tragedies. A review by one national nursing association reported that 39 psychiatric nurses had retired prematurely between 1993 and 2001 due to injuries sustained as a result of work-related aggression and violence [47]. A later feature in a national medical publication reported the retirement of a GP following two assaults, the second of which resulted in a broken hip [48].

…premature retirements…

While the impact of work-related aggression and violence upon individuals is becoming more widely recognised, the potential impact upon provider organisations is sometimes less fully appreciated. This potential may manifest in a variety of ways including negatively affecting the quality of services provided. Maier & Van Rybroek [49] suggest, that following occurrences of work-related aggression and violence, staff maintain a 'safe distance' from patients by means of avoidance and minimal interaction. While understandable, this distancing may be experienced as rejection by the service user, which subsequently increases the likelihood of evoking further aggression and violence, thus perpetuating this cycle.

Exposure to work-related aggression and violence increases the risk of non therapeutic, negative, and counter-aggressive responses by staff [50], although proactive and reactive support can mitigate this risk [51]. A large multinational study of nurses across Europe reported strong evidence of a relationship between the frequency of exposure to work-related aggression and violence and the incidence of both staff burnout and expressed intention to leave [12]. These findings may concern employing organisations considering the established relationship between burnout and diminished job performance. The potential loss of expertise related to individuals who have terminated employment or changed clinical specialty subsequent to occurrences of work-related aggression and violence is not insignificant [52]. Stereotypical associations of particular professions as being prone to such occurrences may also adversely affect recruitment [53,54], which has potential consequences for future organisational and service capacity.

…burnout… turnover… diminished job performance… loss of expertise… lowered morale… impact on therapeutic environment…

There are also impacts arising from exposure to aggression and violence for the broader healthcare environment and indeed for our wider society. The negative effects of occurrences within the environments in which people deliver and receive services, lowers morale and compromises the therapeutic milieu.

> ### Recommendation 4: Awareness of Impact
>
> *Awareness of the potential impact of all manifestations of aggression and violence be raised at all levels of the organisation. Any assumption that potential impact is limited to occurrences of physical aggression alone be corrected.*

2.5. Cost of the Problem

One important organisational dimension of work-related violence which remains under researched and poorly understood is the financial cost. Given that injuries associated with work-related violence are the third leading cause of accidents within the healthcare sector and accounted for 19% of all insurance carrier notifications between 1994-2000 [2], a robust actuarial financial measure of the costs of the problem is urgently required. As with other issues this limitation is not unique to the Irish context. A UK report noted that while many studies have highlighted the negative impacts of violence and aggression these effects have not been reliably costed within the NHS, a finding corroborated by the UK Department of Health who reported their remaining a long way from having reliable cost measures [18]. However, one estimate from the UK suggested that the *direct cost* is likely to be at least £69 million per annum which, the report continued, took no account of the human costs such as physical and/or psychological pain, increased stress levels, the impact of violence and aggression on staff confidence and the retention of staff [18].

the exact cost is unknown… with annualised costs of millions, accurate quantification is essential…

While these reports have highlighted direct costs, others have described indirect costs, including the recruitment and orientation of new staff following resignations or disabilities, the extra burden placed on staff during absences, and lowered staff morale [55]. It has been argued that other cost factors should also be considered, such as successful litigation against employers for failure to provide a safe place and/or safe system of work and the costs of premature retirements [56].

One study estimated that the direct pay costs alone to the Irish health service is in the order of millions of Euro on an annualised basis, noting that this estimate did not take into account factors such as replacement costs, potential litigation, training or human costs. Of equal importance was the noted absence of rigorous actuarial evidence or analysis of the financial cost implications [10].

The absence of a quantified financial impact on the service attributable to work-related aggression and violence is not unique to the Irish context. An in-depth expert review commissioned by the International Labour Organisation reported that estimating the financial cost of aggression and violence within the workplace is a complex task. While the report considered stress and violence related costs cumulatively, these were estimated as potentially within the range of 0.5% to 3.5% of GDP [57].

This suggestion highlights two major issues, firstly, the magnitude of the potential cost, and equally the possible range being a seven fold multiple. For example, applying this to the HSE payroll budget would suggest a cost of €50 million at the lower end with the upper estimate a multiple of this amount.

Notwithstanding the very significant financial costs there is also a wider societal cost with suggestions that in order to better utilise human and financial resources it is essential that the 'social and economic waste' caused by aggression and violence is minimised [58].

Recommendation 5: Financial Cost

The financial costs of work-related aggression and violence to the health service be actuarially measured. 'Return on investment' measures be explored to evaluate the cost effectiveness of initiatives implemented.

3 | Responding to the Problem

3.1. Reframing Understanding

Work-related aggression and violence within healthcare has traditionally been framed as exclusively a problem of either service user behaviour, or the inability of staff to effectively manage such occurrences. This is understandable as the main protagonists are frequently service users, and the victims frequently staff. This unidimensional consideration of the problem may not however fully appreciate the complexities involved in understanding occurrences as being embedded within the broader context of service provision [1].

As with many aspects of this problem, this limitation is not one which is unique to the Irish health service. Increasingly both regulatory and professional bodies have acknowledged that a broader range of contributory factors and influences are associated with all manifestations of aggression and violence [3]. These factors can functionally be considered as involving a process of complex interactions between:

- Service users and others
- Service providers
- The interaction taking place and
- The physical and social environment in which the interaction takes place

The strategic organisational management of aggression and violence requires that each of the components of this contextual process is considered in both proactive preventative strategies and retrospective analyses which should inform efforts to address the problem [3].

- **Service Users:** service user characteristics associated both empirically and anecdotally with an increased risk for aggression and violence include physiological factors such as pain, sleep deprivation, organic impairment, intoxication, and psychological factors such as stress, acuity of psychiatric conditions, and cognitive impairment.

- **Service Provider:** Staff characteristics associated with increased risk include age, gender, level of experience, attitude and attributions related to aggression and violence, and whether staff have received training. Some evidence suggests that staff who have been exposed to aggression and violence may be at increased risk of repeat occurrences [49]. Conversely the presence of clear leadership and the absence of conflict among the staff appear to diminish risk [59].

- **Interaction:** While service provision is in the main a positive experience for both those receiving and delivering services, there are situations in which the service is inherently conflictual or in which expectations of service users are, for quite legitimate reasons, not met. These include situations in which services are delayed, requests are denied, or the interaction involves enforcement of rules or regulations. While conflictual situations should not be equated with the inevitability of aggression or violence, evidence suggests that interactions which are subjectively experienced as aversive involve increased risk [60].

- **Environment:** Many care services are provided in environments of heightened intensity and stress. Within such environments, factors associated with increased risk include overcrowding, noise, prolonged waiting times and frustration [59]. There are however many environmental factors which may proactively decrease risk including attention to aesthetics, provision of comfortable surroundings, and access to information [59]. Preventative measures including safe systems of entry and egress, presence of panic alarms and clearly communicated response protocols may also decrease risk [59]. One environmental consideration which warrants particular attention is the increasing number of situations in which employees are isolated or working alone [30,31].

A **contextual** perspective involving these four central factors should replace the prevailing understanding in which the problem is framed as one of either service user behaviour or employee competence. Equally, the provision of healthcare services needs to be understood as a dynamic process in which conflict is frequently inherent and sometimes inevitable. Within this dynamic process many of the contributory factors are, to a greater or lesser degree, beyond the control of the service provider. Examples include the pathology of an individual service user, the gender, age or experience of employees, the enforcement of regulations or legal orders, or the acuity of a service environment at any given time.

This contextual perspective provides a simple, easily understood, evidenced based and readily applicable framework which should be disseminated widely and should inform proactive and reactive management interventions.

Recommendation 6: Contextual Understanding

A contextual perspective which considers contributory factors including:

- *Service User/Others*
- *Staff/Service provider*
- *Interaction involved*
- *Environment in which the service is provided.*

be utilised to inform proactive and reactive measures.

In addition to the contextual understanding of the potential for work-related aggression and violence, it is also important to appreciate the diverse range of behaviours encountered in terms of complexity and risk. For example while disruptive behaviours might present relatively little risk of injury, these can present very significant organisational challenges in terms of service delivery. A classification framework developed for one regional service categorises five potential behaviours as:

- Verbal abuse[6]
- Verbal threats[7]
- Disruptive behaviours[8]
- Physical threats[9]
- Physical assaults[10]

In line with the definition of work-related aggression and violence recommended earlier[11] these behaviours may be encountered in relation to the performance of one's occupational role irrespective of where they actually occur. Evidence suggests however that staff may encounter these behaviours either in person, by telephone, or by other means of communication [Figure 5].

Managing any of these occurrences, whether the perpetrator is on-site or off-site, can functionally be considered as involving five distinct stages namely:

- Immediate risk assessment[12]
- Situational intervention[13]
- Situational resolution[14]
- Post-occurrence review[15]
- Post-occurrence response[16]

This framework provides some insight into the diverse range of potential challenges which staff may encounter, and the broad repertoire of skills needed to assess and respond to these situations. These can require that staff make complex decisions, often at speed and under adverse circumstances. Many conflictual situations arise between the immediate perceived needs of the service user and the perceived response of the service in meeting those needs.

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6   Abusive or offensive language, personally derogatory remarks, profanity or obscene comments.

7   Verbal warnings of intent to injure or cause harm.

8   Behaviours which create an unpleasant and intimidating environment in which to be treated or work, to the extent that the behaviour disrupts the provision of services.

9   Physically threatening acts or gestures with or without use of a weapon.

10 Physically assaultive behaviours with or without use of a weapon.

11 Section 2:1 Defining the problem.

12 Staff in the first instance need to assess the immediate risks to themselves and to others.

13 Staff interventions which attempt to resolve the situation.

14 The outcome of staff interventions to resolve the situation.

15 Staff assessment of the immediate potential of the outcome on service users, employees and others.

16 Retrospective review by individuals and services involved with a transparent audit trail of decision making which guides organisational responses as appropriate.

Expectations may not be met for a variety of reasons which results in conflict. The perceptions of service users may also be complicated either by illness or the stress associated with the experience of illness or disability.

Figure 4: Classification of Work-related Aggression and Violence
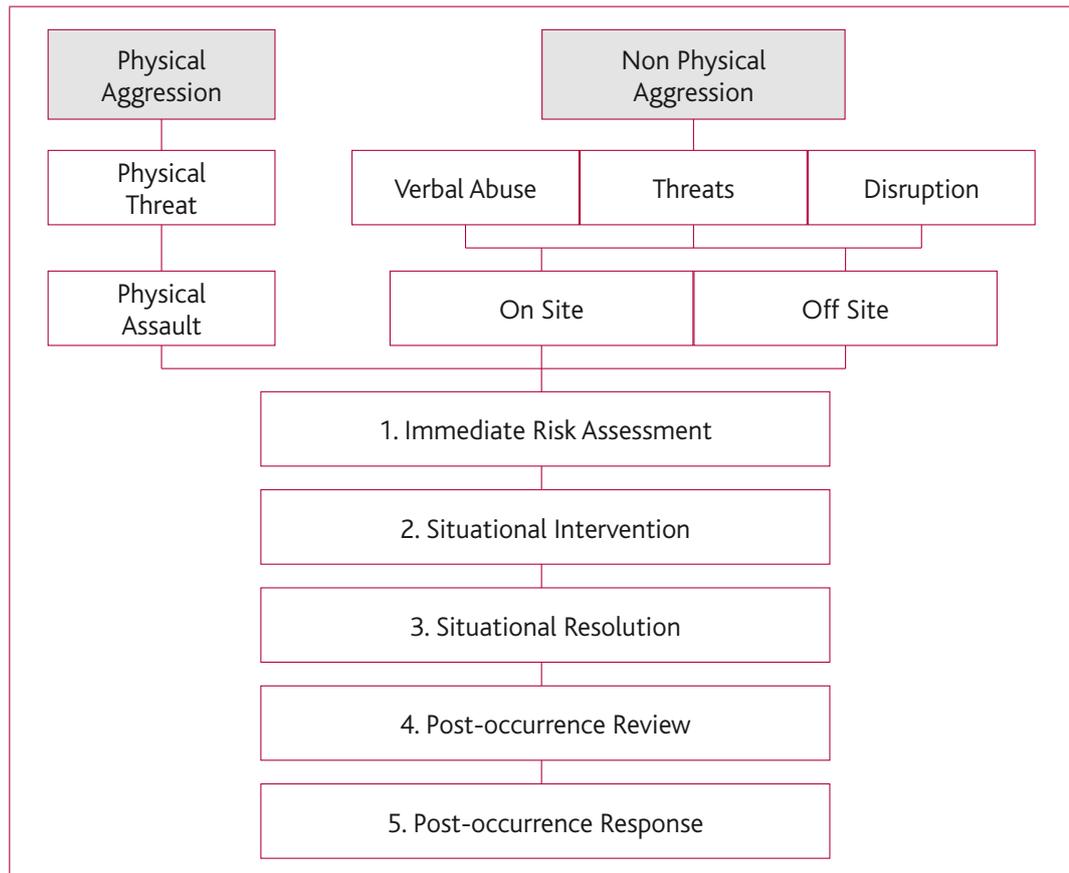
Irrespective of origin, the potential for conflict needs to be appreciated, and staff skilled in the management of such situations. It is equally important that while conflict may be considered inherent in service provision, that this should not be equated with the inevitability or acceptance of aggression and violence. While the frequency, magnitude and impact of non physical aggression has only recently become acknowledged [10,42] it is important that organisational responses incorporate consideration of such occurrences. In the final analysis, while staff must be prepared for, and competent in, the management of complex aggression and violence, it is equally critical that they are prepared for and supported in their role as agents of conflict resolution.

Recommendation 7: Conflict and Non Physical Aggression

Recognition of the magnitude and impact of conflict and non physical aggression be incorporated within the organisational response.

3.2. Reframing Organisational Response

Four perspectives… Service provision… Health and safety… Risk management… Policy…

The effective organisational management of aggression and violence presents a challenge in achieving a balance between the provision of safe effective services, while complying with both the organisations' statutory health and safety, and corporate risk management obligations. In addition organisational responses must comply with the diverse legislation and professional codes which prevail in different service settings. An integrated organisational response must therefore address the problem from a number of perspectives.

From a **service provision perspective**, the compassionate and skilful management of occurrences in which service users experience difficulty controlling their behaviour requires that staff are competent to effectively recognise, assess, and intervene while managing the safety of all concerned. The challenges faced by staff vary greatly in terms of complexity and risk, the range of which can be appreciated when comparing the short-term intense aggression in A&E settings, with the longer term aggression encountered in services for people with dementia and learning disability [61,62].

…legal imperative…

From a **health and safety perspective** employers have a statutory obligation to ensure so far as is reasonably practicable the safety and health of employees, and others[17]. The indisputable risks associated with aggression and violence within healthcare impose organisational health and safety obligations which, must be addressed within any integrated response.

From a **risk management perspective** organisations are obligated to ensure that all reasonable and practicable control measures are put in place to satisfy their duty of care to patients and staff. Many of the potentially serious risks associated with work-related aggression and violence are foreseeable[18]. It is critical therefore that the organisation considers and addresses these risks from the perspectives of the service user, the staff, and the organisation.

From a **policy perspective** staff must be provided with the information necessary to guide their decision making and inform their actions. In addition to providing decision-making guidance, policies must comply with the prevailing legislative and professional codes which vary significantly between and within services. For example while all services must adhere to constitutional, civil, and legislative law, the legal frameworks governing childcare, mental health services and services for the elderly vary significantly as a function of the divergent needs of the populations served. Subsequently an integrated organisational response must address the variance in obligations and actions by providing staff with service specific guidance [1].

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17 See Section 4:1 Health Safety Quality and Risk.
18 See section 4:1 Health Safety Quality and Risk.

…perspectives should not… be considered as mutually exclusive…

…important that each perspective is adequately and equitably addressed…

Within previous health service structures responsibility for managing work-related aggression and violence was often assigned to either health and safety departments, risk management departments, or to individuals within these departments. While in some instances individuals and departments achieved impressive results, insufficient cohesion of a unified focus limited these accomplishments. There have been cautions against responses driven primarily from singular perspectives which run the risk of demonstrating compliance with the statutory mandates without delivering sustained organisational change or improvement [63]. While not diminishing the efforts of individuals or departments it is important to recognise the critical need for integration in achieving an effective organisational response.

While there is general agreement in advocating integrated responses, achieving such responses in practice is more difficult. One means of achieving an integrated organisational response is the adaptation of a balanced scorecard approach [64]. Essentially this approach is a management technique which, it is suggested, improves systems approaches to problems by identifying the critical success factors necessary to achieve goals, and addressing these factors in a balanced way [65]. While originating in the business world, this approach has been successfully adapted to public services [66], within the health services [67], and to the design and provision of training [1].

Recommendation 8: Balanced Scorecard Approach

A balanced scorecard approach be adopted with the critical success factors of:

- *Service provision,*
- *Health and safety,*
- *Risk management, and*
- *Compliance with policy and regulation*

…balanced scorecard approach…

…partnership working…

The adoption of a contextual understanding of the problem and a balanced scorecard response are congruent with good governance and recommendations by the International Labor Organisation [68], which urged caution in the utilisation of over-simplistic solutions to the issue of workplace violence. They advocate the adoption of approaches which foster the development of "smart organisations" in which learning by continuous reflection on current experiences develops the capacity to meet existing and future demands [69].

Within organisations, achieving a "total organisational response" requires a partnership between the employer organisation, employees and their representative associations [70], while the broader national efforts requires a collective and collaborative effort between employers, employees, professional, and statutory bodies [8]. Recognition of the need for such collaborative working is reflected in the structure and processes of the working group in the preparation of this strategy.

Achieving cohesion can be difficult to accomplish in practice within public sector organisations which sometimes struggle to achieve genuine joint-working as individual 'units' tend to focus on singular rather than unified agendas, particularly when such agendas are overlaid with professional boundaries and different statutory responsibilities [4]. For this reason the critical role of partnership must be acknowledged and all efforts made to preserve and extend the impressive collaborative working which has underpinned the functioning of the Working Group to date.

Recommendation 9: Partnership

A partnership working approach which adequately and equitably addresses the concerns of all stakeholders underpins the development of organisational responses.

4 | Strategic Actions

4.1. Health Safety Quality and Risk

Health and Safety as a legal imperative… Quality and risk as a governance imperative… …distinct but complementary

…the nature of the risk is dynamic and volatile, rather than stable… compounded by the fact that the variables associated with the risk are in large part outside the absolute control of the service setting

There has been an increasing organisational recognition of the wisdom of having the functions of health and safety, and that of quality and risk integrated as a unified effort. Notwithstanding this, these functions can be considered as distinct but integrated functions. Health and safety obligations can be considered from the statutory obligations enshrined in legislation whereas quality and risk obligations can be considered as part of a broader corporate obligation of good governance. It is important to stress that irrespective of the discrete origins of obligations, these are complementary both in purpose and function.

The legal obligation imposed upon employers by health and safety legislation requires that organisations put in place all reasonably practicable preventative and protective measures in order to create safe places and processes of work for their employees and others. Enshrined in this obligation is the requirement that employers conduct systematic risk assessments of workplace hazards which are likely to result in accident or injury. Such assessments must then inform the implementation of the control measures deemed necessary to minimise associated risks. The current Safety, Health and Welfare at Work Act [71] in sections 19[19] and 80[20] make these obligations explicit, in addition to the specifying the liability on individuals within the employing agency whose duty it is to ensure that these measures are enacted and the duty upon employees to work in a safe and responsible manner and co-operate with their employer to comply with the law.

From a quality and risk perspective, the mission is broader than one of legislative compliance. The ultimate aim is to create an organisational culture in which the processes and systems for managing risk, both proactively and dynamically, are embedded as normative in operational practice rather than as separate or distinct activities. The very significant risks associated with the management of work-related aggression and violence, both for service users and staff, requires such an integrated, proactive and dynamic risk management approach [1].

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19 "Every employer shall identify the hazards in the place of work under his or her control, assess the risks presented by those hazards and be in possession of a written assessment (to be known and referred to in this Act as a "risk assessment") of the risks to the safety, health and welfare at work of his or her employees, including the safety, health and welfare of any single employee or group or groups of employees who may be exposed to any unusual or other risks under the relevant statutory provisions."

20 "Where an offence under any of the relevant statutory provisions has been committed by an undertaking and the doing of the acts that constituted the offence has been authorised, or consented to by, or is attributable to connivance or neglect on the part of, a person, being a director, manager or other similar officer of the undertaking, or a person who purports to act in any such capacity, that person as well as the undertaking shall be guilty of an offence and shall be liable to be proceeded against and punished as if he or she were guilty of the first-mentioned offence".

There are a number of frameworks which describe methodologies by which organisations might meet their legislative and corporate obligations to minimise and manage the risks associated with work-related aggression and violence. The ILO proposes a structured approach of three phases specific to the management of work-related aggression and violence [8]:

Thus management of the risk tends to demand more responsive actions in real time than proactive alone…

- The first phase involves **assessing and describing** the magnitude of the problem in order to determine both the nature of the hazards and the level of associated risk within the working environment.

- The second phase involves **designing and implementing** a strategic programme of preventative and reactive measures designed to address identified hazards and to minimise associated risks.

- The third phase involves **monitoring the effectiveness** of the overall strategy, by the systematic evaluation of measures to determine their effectiveness.

The HSE has adopted the Australian New Zealand Risk Management Standard 4360:2004 as the operating standard for generic risk management consisting of structured framework of five phases [72]:

Staff therefore may be called upon to make complex decisions, at high speed, under adverse circumstances.

- The first phase **'describing the context'** involves analysing the organisational, environmental, and operational contexts within which risks must be addressed.

- The second phase **'risk identification'** involves identifying both the nature of the hazards and the level of associated risk within the working environment.

- The third phase of **'risk analysis'** involves analysing risk in terms of likelihood and consequence, and considers control measures currently in place.

- The fourth phase of **'risk evaluation'** involves considering the degree of inevitable or acceptable risk, with an audit trail of the decision making which can inform future risk management efforts.

- The fifth phase of **'risk treatment'** involves implementation of strategies which either avoid, reduce the likelihood, reduce the consequence, or transfer the identified risk.

The role, purpose, and function of both frameworks are conceptually very similar, the difference being one of scope and method. While both provide viable methodologies to approaching the management of work-related aggression and violence, there are a number of difficulties specific to the problem which present challenges.

Evaluating risk is a function of the scale and complexity of the organisation [8]. It is unsurprising that such evaluations are especially difficult within the health service generally, and in relation to work-related aggression and violence in particular. Not only is the scale of the organisation immense, but the range of activities is highly complex, with very significant variations in the hazards and risks associated with work-related

aggression and violence, both between and within services. Attempts to quantify and analyse the associated risks are further complicated by incomplete or inaccurate records due to systematic underreporting which, as noted previously, may not only grossly underestimate the true extent of the problem, but also yield estimates which are disproportionately biased toward more serious occurrences [10].

Organisational efforts to manage the risks associated with work-related aggression and violence are hindered by incomplete evidence as to the safety and effectiveness of risk management measures [1]. For example, while the provision of security personnel is often cited as a primary environmental response, there is little evidence to support the presumption that the deployment of security personnel increases safety or diminishes risk. Those responsible for managing risk must struggle, not only with limited evidence of overall effectiveness, but also with a lack of comparative analysis of the effectiveness of specific risk management measures. There is little evidence to support the manager for instance in comparing the effectiveness of expensive measures such as employing security personnel with much less expensive measures such as security technologies.

…staff need to be adequately prepared to recognise, assess, and manage the dynamic nature of risk relevant to their own service setting.

In addition to the difficulties in quantification, risk appraisal methods which rely upon matrix analyses of potential risk in terms of likelihood, potential impact, and cost of preventative strategies may not fully appreciate the dynamic and highly volatile nature of risks associated with aggression and violence within healthcare settings. This volatility means that risk management efforts exist within uncertainty, and subsequently staff need to be adequately prepared to recognise, assess, and manage the dynamic nature of risk relevant to their own service setting. Notwithstanding the value of proactive risk assessment, staff must also appreciate the importance of continuous risk appraisal.

Recommendation 10: Dynamic Risk

Ongoing risk management efforts raise awareness of the uncertain and dynamic nature of risks associated with occurrences of work-related aggression and violence. Develop the staff's capacity to undertake continuous risk appraisal relative to their service setting and occupational function.

A further consideration is that many of the variables which contribute to the likelihood and consequence of occurrences are to a significant degree beyond absolute organisational control. For example even the most expertly designed waiting area can become a volatile environment due to unexpected crowding, prolonged waiting times, the presence of disruptive individuals or any combination of these. Similarly the service is duty bound to undertake some inherently aversive interactions which incur higher risk, such as enforcement of smoking regulations or child protection functions.

Notwithstanding these challenges it is imperative that the organisation acknowledges the very serious risks associated the management of work-related aggression and violence. An awareness of the nature and magnitude of these risks, for service users, employees, and for the organisation needs to be widely disseminated, and appreciated as an issue of importance at all levels of the organisation.

Recommendation 11: Awareness of Risk

Awareness of the potential risks, both physical and psychological, to patients and staff associated with the management of aggression and violence to be raised at all levels of the organisation.

An important initial step in meeting legislative and corporate obligations is to establish absolute compliance in relation to the legally required workplace-specific risk assessments, and the implementation of the necessary control measures. The robustness of this process is important, as ultimately these assessments serve as the platform upon which strategic organisational interventions are planned and implemented. It is critical therefore that the organisation assure itself of full compliance with risk assessment obligations, and specifically those addressing issues of work-related aggression and violence, as a priority.

Recommendation 12: Safety Statements

All health service locations have in place a current safety statement informed by a methodical risk assessment process. Where aggression and/or violence is identified as a foreseeable hazard, safety statements explicitly outline the control measures required and those responsible for their implementation and ongoing audit/review.

It is important to recognise that service settings include all locations in which services are provided. An important consideration in this regard is the increase with which services are provided in community locations in which employees may either be isolated from others or work alone. Both research and recent anecdotal evidence have highlighted not only the extent of problem for lone workers, but also the seriousness of the potential risks [30,31].

Ensuring the safety of lone workers presents significant challenges for the organisation from health and safety and risk management perspectives. Risk assessments and control measures are complicated by the diversity of risk involved in lone working both between and within services. Notwithstanding this difficulty, employees in such situations must be adequately prepared to assess and respond to potential risks and supplied with protective measures which enhance their safety. Two key components are the provision of education and guidance to all lone workers, and evaluation of the need for safety devices such as alarm technologies. Providing education is a relatively low cost measure which should include generic and service specific guidance. Recent advances in communication and satellite technologies have significantly improved the quality and lowered the cost of

providing employees with safety devices. Evidence based examination of lone working technologies is at an advanced stage in the UK, and this work might inform efforts to address the issue in the very short-term [73].

Recommendation 13: Lone Working

Lone workers receive service specific education and guidance and are provided with safety enhancing technologies appropriate to their occupational function.

…there are a number of well evidenced risk reduction measures… could achieve significant improvement in the very short-term…

Notwithstanding the limited evidence mentioned earlier, there are a number of well evidenced risk reduction measures which could achieve significant improvement in the very short-term. There are other concerns which, while less robustly supported by evidence, also warrant urgent intervention as a function of the magnitude of the associated risks.

There are therefore a number of high priority risk reduction measures which should be implemented at the earliest opportunity relying the best available evidence. Issues included for urgent action include developing responses in relation to:

- Risks inherent in lone working and working alone
- Risks associated with non-physical aggression and violence
- Risks associated with physical aggression and violence
- Risks associated with behavioural manifestations of medical conditions such as cognitive impairments, systemic illnesses and substance use/or withdrawal
- Risks associated with the provision of training in physical interventions
- Risks associated with the use of physical interventions in practice
- Risks associated with the psychological impact of aggression and violence

Achieving an effective organisational response to the issue of work-related aggression and violence from both health and safety, and quality and risk perspectives will require a cohesive integrated approach [1]. Health and safety priorities include establishing full compliance with risk assessments while, quality and risk priorities include addressing high risk issues which can achieve significant impact in the shorter term. It is critical however that these efforts are not simply integrated with each other, but also with the broader organisational strategy for managing aggression and violence. It is imperative therefore that a strong working liaison exists between those responsible for health and safety, quality and risk, and the implementation of the aggression and violence strategy.

Recommendation 14: Cohesion of Approach

A liaison between those charged with the implementation of this strategy and those responsible for health and safety, and quality and risk, be established to ensure cohesion of effort.

4.2. Education and Training

The recognition of work-related aggression and violence as a service specific occupational hazard places professional, legislative and moral imperatives upon the organisation to provide training in its prevention, recognition, and safe management. These imperatives are mandated by regulatory, professional, and advisory bodies at national and international levels. These mandates consistently share three key themes in their recommendations, that training requires immediate attention; addressing the issue should involve inter-agency collaboration; and that training should be supported by evidence [2,59,74-77].

While evidence suggests that training may reduce risks to staff, improve their clinical effectiveness, and results in cost savings from reduced injuries and related expenses [78,79,80], efforts to provide training are seriously hindered by the absence of research evidence or clear guidelines as to what constitutes safe, effective, and acceptable practice. These deficits have been identified by professional and regulatory bodies nationally and internationally, to be a matter of concern which requires urgent attention [2,75-77].

…a 'product' solution to a 'process' problem…

service… tailored around training… rather than training… tailored around service…

Training provision has largely relied upon 'off the shelf' systems of training in which training content frequently was more reflective of the experience and preference of the trainers rather than any rational analysis of the training needs of staff [18]. One major limitation of such approaches is that training is often far removed from the complex realities of the diverse legislative, and service contexts within which services are delivered. At best this renders cohesion between staff needs and training provided as a function of chance rather than design, and at worst results in the provision of training with which the organisation might have reservations from professional, legal and safety perspectives [1].

It is uncertain if the considerable investment of human and financial resources in unproven training approaches has significantly impacted the organisational management of aggression and violence. Without commenting on any individual proprietary programme, the fundamental deficit of such approaches rests in the application of a 'product' solution to a 'process' problem in which service delivery is tailored around the training provided rather than the training being tailored around the needs of service delivery.

While this is not a predicament which is unique to the Irish health service [18], it is one which must be addressed. Those commissioning training are in the precarious position of having to balance the pressing need to provide staff with training with the absence of guidance as to what constitutes safe and effective practice.

The current unregulated environment in which the training provision is largely ad hoc needs to be replaced with one in which those commissioning training have definitive clear guidance on which to base their decision making [10].

Actualising the potential contribution of training provision in effectively managing aggression and violence will require that coordinated, structured, and quality assured training is provided as part of a broader strategic organisational response [1]. Achieving this will require a methodical reappraisal of the role, function and provision of training within the organisation.

…a public health approach…

…primacy of prevention…

Adopting a public health approach provides a useful framework on which to structure to the provision of training [5]. Structured in this way the organisational value of the primacy of preventing harm is clearly communicated.

Primary prevention should include the provision of training in strategies to avoid occurrences of aggression and violence in the first instance. Adopting a contextual understanding of the problem highlights the reality that some aspects of service provision are inherently conflictual. Subsequently staff need to be competent in the identification assessment and resolution of conflict.

Secondary prevention should include training in the recognition, assessment and management of escalating situations. While manifestations of escalation may vary greatly in the large majority of instances, the loss of control by an individual frequently follows a linear progression with readily identifiable behavioural indicators. Each stage of this progression requires stage-specific interventions [81-83]. Staff therefore need to be competent in the recognition and assessment of the escalation process, and in the use of stage specific de-escalation skills which have been demonstrated to diminish the associated risks to all concerned [79,83-87].

Tertiary prevention should include the management of situations in which risk is imminent and interventions are necessary in order to preserve the safety of all concerned. Staff confronted with such situations need to be competent in service user and situation specific risk assessment and management. In addition staff need to be able to manage their personal safety, and effectively employ interventions to safely contain individuals who have lost control of their behaviour to the extent that they pose a risk to themselves or others [83,84,88]. It is critical that staff who may have to manage such occurrences fully comprehend the potentially very serious physical and psychological risks involved, and are competent to both minimise these risks and manage any contingencies [83,84,89].

The provision of training has frequently reflected the assumption that aggression and violence are either a function of service user behaviour, or staff inability to manage such occurrences. This perception has resulted in responses which either focus on 'managing' the patient or 'training' the staff. Subsequently training has frequently been disproportionately focussed on tertiary prevention measures employed to 'safely manage' occurrences of aggression and violence [1,18]. While considerable clinical and research efforts have focussed on how such interventions might be **'employed more safely'** there has arguably been less attention devoted to determining whether or how to minimise circumstances in which these interventions should be **'employed at all'**.

…three fundamental shifts…

preventative focus…

provide to all…

educative rather than training

Adopting a contextual understanding of work-related aggression and violence within healthcare should contribute significantly to the provision of training in that the prevention and management of the problem can be considered from a total organisational perspective. This will require three fundamental shifts:

- Firstly the frame of reference underpinning training needs to shift from a predominantly reactive to a preventative focus, with an emphasis on 'prevention' rather than 'management'.

- Secondly training must engage employees at all levels of the organisation with the content and methodology customised to reflect participants' professional and organisational responsibilities. By way of illustration, while the educational needs of a senior manager, a middle manager and a frontline care worker differ greatly it is critical that all have an understanding of the problem relevant to their respective organisational functions.

- Thirdly the current practice of providing 'training' perpetuates the perception of managing aggression and violence as a skill rather than a knowledge base. This should be replaced with an 'educational' ethos in which clearly articulated aims, objectives and learning outcomes are developed from the perspectives of 'participant', 'content' and 'provider' with the assessed needs of the participant as the key determinant [Figure 6].

Figure 5: Participant Centred Education and Training

Participant's Needs Assessed	▶	Content Determined	▶	Provider Commissioned
Aim Objectives and Learning Outcomes				
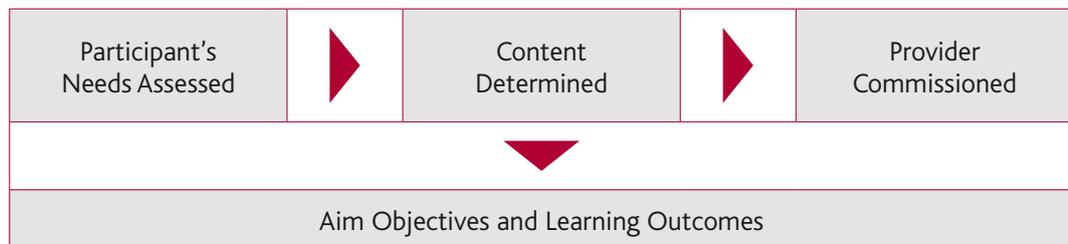
The scale of the task of providing education in the management of aggression and violence to all employees poses a challenge considering the size and diversity of functions within the organisation. What is increasingly clear is that training needs can at best be only partially met by 'one size fits all' 'systems' approaches which are provider led, frequently with significant commercial influences at play [1]. A shift is needed from provider led to participant centred education in which learning outcomes are service specific, needs assessed and fit for purpose.

Recommendation 15: Education and Training

Education and training in the management of aggression and violence be provided to all healthcare employees with the content and methodology reflecting their professional and organisational responsibilities.

*…shift
…from provider
led to
participant
centred
education…*

*learning
outcomes…
service specific…
needs assessed…
fit for purpose.*

Effective educational responses should be determined by a structured analysis of the:

- Task analysis of the service setting in which staff work
- Analysis of the places and processes of work
- Appraisal of records in assessing foreseeable risks
- Consideration of the prevailing professional, legal and policy parameters within staff work [1,74,83,90].

While it is impractical to prescribe all educational responses, a structure of educational response might include the following key content areas:

- Aggression and violence management for senior managers
- Aggression and violence management for frontline managers
- Safe practice in lone working and working alone
- Understanding and managing conflict within healthcare
- Recognition of escalation and de-escalation interventions
- Personal safety in providing physical care
- Disengagement interventions
- Safe physical containment
- Risks associated with the use of physical interventions

Considering the critical judgements from organisational and service perspectives which are influenced by the education and training provided, the provider plays a pivotal organisational role. It is critical therefore that the organisation is satisfied with the process of training needs analysis and with the safety, quality, effectiveness, and fitness for purpose of the education and training provided. It is also critical that the organisation has taken measures to ensure the integrity and competency of those providing training. A critical appraisal is required to examine how this can be most effectively achieved. Possible options include utilising existing health service educational structures to fulfil the task, engaging proprietary providers, or exploring some form of partnership with educational and training providers. In any event staff currently providing training will be afforded the opportunity in the first instance to continue this role within the emerging structures and standards.

*…scope for
redeployment of
resources…*

While meeting a challenge of this magnitude and complexity will involve resources, it is important that three significant factors are considered in tandem with resource implications. Firstly the required resources should be considered relative to the current expenditure on training, the value of which remains uncertain. Secondly considering the very significant financial costs involved, sound procurement procedures could improve both the fitness for purpose and value for money. Finally given the legal, professional, and organisational mandates to provide training, resources committed to this purpose need to be considered relative to the potential costs involved in failing to adequately meet these obligations.

Recommendation 16: Resourcing Education and Education

Structures and methodologies be developed to ensure the effective utilisation of resources allocated to the education and training of staff in the management of aggression and violence.

While the considerations involved and the development of definitive guidance will require some time, there are a number of measures which could return significant improvement in the short to medium-term including:

…measures which could return significant improvement in the short to medium-term…

- Exploring the use of multimedia and communication technologies in providing some components of education and training.
- Effectively recording all standardised and service specific education received by employees to avoid unnecessary repetition. The Welsh 'Passport' scheme structures the recording of training provided in a manner, which is readily understood and easily transferable between settings or employers [94].
- A standardised structure of core educational content should be provided in all pre-registration and preparatory courses for those entering the health services. For example, lone working might be effectively included in courses which prepare public health nurses, albeit that some service specific adaptation might be required within the induction process. A collaborative engagement with preparatory educators and professional bodies should reduce the ongoing task of providing education/training, standardise core educational content, reduce disruption in service settings, and deliver significant cost savings and service improvement.

Recommendation 17: Recording Education and Training

A verifiable, readily understood and easily transferable record of education and training in the management of aggression and violence provided to employees be developed.

Very significant improvement is possible in the provision of education and training to staff. This improvement will however require a cohesive effort between those with service provision, procurement, and educational responsibilities and is most likely to succeed if the coordinating function is clearly delegated. This collaboration of expertise can achieve considerable improvements in establishing the safety, fitness for purpose, and cost effectiveness of education and training provided. It is critical that these efforts are integrated within the broader organisational governance which recognises not only the potential, but also the limitations of education and training. Those engaged in this process must be supported by organisational guidance which provides a structure by which education and training is assessed, designed, procured, delivered and evaluated.

Recommendation 18: Education and Training Guidance

Comprehensive guidance be developed to support those charged with the commissioning and provision of education and training.

4.3. Physical Interventions

physical interventions… a complex issue which poses legal, professional and moral dilemmas… a last resort… …inherently dangerous procedure…

It is widely acknowledged that the use of physical interventions is a complex issue which poses legal, professional and moral dilemmas for individual units of service and for the organisation. While there is consensus that these interventions should be considered a last resort in all instances, it is also acknowledged that on occasion such interventions are not only unavoidable, but may well be the only clinically correct option. The dilemma arises in that the use of physical interventions is an inherently dangerous procedure, which poses potential risk of both physical and psychological trauma for both staff and patients [46,89,91-95]. Consistent with previous sections, consideration of physical interventions can be approached from the preventative perspective of primary, secondary and tertiary prevention.

The most significant primary prevention initiative is the strategic adaptation of a commitment at organisational, philosophical and operational levels to the provision of services in which the use of seclusion or restraint are minimised. The implementation of such strategies has achieved considerable success in other jurisdictions, notably in the US [96,97]. Implementation of the US developed strategy has been replicated in Australia and New Zealand and early indications suggest that the approach may be transferable to other regions and systems [98]. In addition to diminishing risks to all concerned, minimising seclusion and restraint contributes significantly to a broader quality improvement agenda. It is important to acknowledge that 'minimisation' is not synonymous with 'elimination' so that individuals and services are not placed in situations of jeopardy. Achieving seclusion/restraint minimised services has enjoyed most success where there has been a strategic plan of implementation with clear leadership and organisational support [99]. While the magnitude of the task should not be underestimated, achieving such services not only provides safer environments for all concerned, but also more enriched environments in which to receive or provide care.

…strategic… commitment … seclusion or restraint… minimised service…

Recommendation 19: Minimising Physical Interventions

Proactively aspire to provide services which are 'seclusion and restraint minimised' at philosophical, organisational and operational levels.

Notwithstanding efforts toward achieving seclusion/restraint minimised services, there may be circumstances in which physical interventions may be the most appropriate option. It is critical in such situations that staff are competent in the safe employment of effective techniques in order to maximise the safety of all concerned.

…circumstances in which physical interventions may be the most appropriate option…

Secondary prevention focuses on the structures and processes which are necessary to ensure that risks associated with the use of physical interventions are minimised. These structures require that a robust system of governance is in place which includes:

- Standards ensuring the safety and effectiveness of interventions
- Standards governing those providing training in the use of interventions
- Standards governing the circumstances under which interventions may be used

There is currently significant uncertainty surrounding the selection of such interventions from professional, practical and legal perspectives. Concerns exist in relation to the inadequacy of regulation or standards and to the effectiveness of interventions from clinical and safety perspectives [10]. These concerns were corroborated during deliberations of the working group in relation to the safety of specific physical intervention techniques. What was clear from these deliberations was that the range of physical intervention techniques currently in use nationally has not been comprehensively evaluated. In effect while some techniques have been thoroughly risk assessed, there are some which are the subject of safety concerns, and others which to date have not been critically evaluated. This is a significant issue, considering the very serious physical and psychological risks to both patients and staff inherent in the use of these techniques which have been consistently reported in professional literature, regulatory reports and public inquiries [22,41,83,84,89,91-95,].

…physical intervention techniques currently in use …have not been comprehensively evaluated…

Consistent with other issues, concerns regarding the safety of specific physical intervention techniques are not unique to the Irish context. There are currently two, as yet unpublished, pieces of significant work addressing these concerns being conducted in the UK [100]. One of these has undertaken a structured assessment of physical intervention techniques against five criteria including:

- Physiological risks associated with use
- Biomechanical risks associated with use
- Psychosocial considerations of use
- Legal defensibility of use
- Ethical considerations in use.

The other is a research project which is investigating the use of a standardised instrument by which to evaluate physical intervention techniques [101].

As these two evaluations become available, their methodology and findings should be reviewed as possible templates for a structured appraisal of techniques in use in the Irish context. Notwithstanding the potential value of this emerging work, current practices are understandably a matter of concern which requires priority attention from both professional practice and risk management perspectives.

There are a number of options by which this issue could be approached. One approach would be the development of a singular set of physical interventions with endorsement for use throughout the service. While the standardisation in such an approach is enticing, the capacity of any one currently available programme of physical interventions to be widely disseminated across the service could present practical and logistical difficulties. An alternative would be to have all interventions currently in use subjected to a standardised risk assessment and evaluation of fitness for purpose within a specified time frame. While this approach might cause less disruption to services in the short-term it does place the organisation in the position of having to operate with some uncertainty in the interim.

Recommendation 20: Safety of Physical Interventions

Establish the practice safety and fitness for purpose of physical interventions currently in use as a priority.

> *…physical interventions need to be understood as… patient focused… within a professional care context.*
>
> *…shifts the focus from one of managing aggression and violence to one of professional care.*

Notwithstanding the priority of establishing the safety of physical interventions, it is also important to examine the circumstances which have resulted in the current predicament in the first instance. One significant factor has been the perception of physical interventions as a **'skill taught to staff'** rather than as an **'intervention done to patients'**. Physical interventions need to be understood as a patient focused intervention purposefully employed within a professional care context. This effectively shifts the focus from one of managing aggression and violence to one of professional patient care.

A simple analogy by which to consider this proposition is to compare the use of physical interventions with a radiological or pharmacological intervention, for example the use of an X-ray or an over the counter analgesic. When considered in this context, the need for standards and regulation become quite apparent. Standards for either of these examples would ensure the quality process of development, in addition to setting the criteria by which the safety, effectiveness, and contraindications of the intervention are determined. Regulations would govern the circumstances under which the intervention might be used, in addition to setting standards for prescription, administration, documentation of use, and the recording of subsequent outcomes. Similar to other interventions employed in the healthcare, a procedure should be in place by which adverse events associated with the use of an intervention are centrally recorded.

Recommendation 21: Regulation of Physical Interventions

The use of physical interventions be subject to standards and regulation at least comparable to those applying to other patient focussed interventions.

In addition to establishing the safety of interventions in use currently, it is also necessary to establish governance over the training in, and use of, these interventions. Similar to the issue of training mentioned previously there are a number of alternatives through which this can be approached. The organisation should consider whether establishing and maintaining standards can be most effectively achieved by developing a repertoire of approved interventions endorsed for use within the services utilising resources from within existing educational structures to fulfil this task, by engaging with the proprietary providers, or through exploring some form of partnership.

Whichever approach is adopted it is essential that governance is also exercised over those providing training in the use of physical interventions. The current situation of unregulated provision of training in the use of interventions, which have such potentially serious associated risks both to patients and staff, is less than adequate. This challenge, like so many others is not unique to the Irish health service, with reports from the UK suggesting that more than 700 providers currently provide more than 100 different systems of training with little regulation [102]. Very considerable efforts have been made to improving the situation in the UK, representing a number of years work by a dedicated team. A proposed structure of accreditation and regulation of training providers is currently under Government consideration, and if adopted, might inform the advancing of this agenda within the Irish context.

It is imperative that a future state is achieved in which the provision of training in, and the use of, physical interventions is monitored by some delegated authority to ensure that the necessary standards are established and maintained. Similar to the issue of education and training, it is essential that those charged with these responsibilities are supported by clear organisational guidance.

Recommendation 22: Physical Interventions Guidance

Standards governing the training in, and the use of physical interventions be developed as a matter of priority.

4.4. Staff Support

Despite even the most ardent preventative and control measures by the organisation the reality remains that some staff will be exposed to various manifestations of aggression and violence and may understandably be distressed. Staff may experience emotional, biophysiological, cognitive, and social reactions and have intense unexpressed feelings towards their assailant which can be distressing to many professionals when their role as carer and victim collide [103].

…early studies relied predominantly on measures of physical injury…

Individual reactions vary greatly and may not necessarily be a function of the severity of the occurrence alone. Rather, reactions are a function of a complex interaction between the individuals affected, the perpetrator, the occurrence, and environmental variables. For most staff reactions are uncomplicated and require minimal post-occurrence support. Others however experience more significant reactions either as a function of intensity or duration, and may require a wider range of support measures over a more prolonged period [43,104,105]. Consequently no singular or uniform approach is appropriate to all individuals or situations. The need therefore is for a flexible repertoire of measures that should form an integrated multi-layered process of supports.

More recent evidence acknowledged… potential psychological distress…

Early studies which investigated staff reactions were limited in their frequent reliance on measures of physical injury [22,24]. More recent evidence has acknowledged not only the potential psychological distress which staff may experience following physical aggression, but also the potential distress experienced from occurrences of verbal aggression alone [10,42]. This is significant in that reactions may vary considerably in terms of presentation, intensity and duration. While it is reasonable for staff to expect support, organisational efforts to meet this need have been hindered by a lack of unified understanding or clear guidance as to what constitutes best practice in terms of appropriateness or effectiveness.

Recommendation 23: Awareness of Staff Support

Awareness of the support needs of staff who encounter occurrences of all manifestations of work-related aggression and violence be raised at all levels of the organisation.

provision of… support has proven effective…

There is evidence that staff, not only welcome, but expect support following occurrences of work-related aggression and violence [10]. The provision of such support has proven effective in not only ameliorating the distress associated with these reactions [106] but also in shortening recovery time, and reducing insurance claims, utilisation of sick leave, and associated medical expenses [107].

It is noteworthy however that different types of support are required following exposure to different manifestations of aggression and violence, and that no singular or uniform response is appropriate to all individuals and/or situations.

…no singular or uniform approach is appropriate to all individuals or situations…

Apart from the good governance aspects of providing adequately resourced, appropriate pre and post-occurrence supports to staff likely to be exposed to aggression and violence, there is also a legislative requirement. Case law has established employer responsibility for 'psychiatric' injury where such injury has resulted from the employees working conditions and/or workload [108].

Recommendation 24: Availability of Staff Support

Best practice support measures be provided to staff with readily available information as to the services available and how these can be accessed.

Provision of effective staff support can be approached from a preventative health perspective of primary, secondary and tertiary interventions.

Primary interventions involve the creation of a supportive environment in which the organisation demonstrates that the safety and welfare of staff is highly valued. Messages which articulate this position and provide information on the supports available to staff exposed to occurrences of work-related aggression and violence should be widely disseminated. These should incorporate immediate and follow-up support measures taking account of specific support needs including adequate management back-up, appropriate levels of staffing and built-in mechanisms of ongoing support in high-risk areas [77]. Staff in general, and especially in high-risk workplaces, should be provided with education about the potential impacts of work-related aggression and violence and how to support colleagues [109].

…Staff value simple supportive measures…

Secondary interventions involve meeting the immediate needs of individuals following an occurrence. This includes the assessment of physical injury, for which any treatment indicated should be promptly provided or arranged. The second priority is to provide supportive reassurance until the safety of all concerned is established and the emotional intensity has subsided sufficiently, for individuals to safely go off duty [110].

…for the minority… more comprehensive support… should be provided on an individual needs assessed basis…

Tertiary interventions involve structured operational and process reviews which acknowledge the gravity of the occurrence and ensure that any remedial measures necessary are implemented in order to minimise the risk of future occurrences. While many staff recover quickly and normalise the majority of occurrences, a minority of reactions can be unusually intense or prolonged [43,104,105]. The availability of appropriate specialist services in such circumstances should be provided or arranged [18,107].

Staff value simple supportive measures that enquire after their wellbeing and validate their experience in the first instance. Staff are reticent to have their experiences medicalised, perceiving their responses as more worthy of expression than treatment [10]. For the minority who experience significant or prolonged reactions, more comprehensive support which might include emotional, financial, organisational and vocational measures which should be provided on an individual needs assessed basis [77].

There seems to be consensus that colleagues and managers are the preferred choice as the source of this support [10,111,112,113]. The credibility of managers as a source of support reflects their dual function of having both experiential understanding of the service and organisational position. While formal supports may be perceived as medicalising, the support of colleagues and managers is perceived as normalising and reassuring. It is critical however that managers not only understand this expectation, but are both informed and empowered to undertake this role [10].

Recommendation 25: Supporting Managers

Prepare and empower managers for their pivotal role in supporting staff who encounter occurrences of all manifestations of work-related aggression and violence.

For a variety of reasons the provision of staff support has been a sensitive issue at various levels of the organisation. The situation has not been helped by the lack of clarity surrounding the understanding of key terms. There is a need to clarify both the understanding, and interrelationship between key terms including 'psychological distress' 'psychological injury' 'compensation' and 'support'.

…colleagues and managers… are preferred choice…

need to be informed and empowered…
…free from any anxiety… of later determinations related to… occurrence.

- **Psychological distress:** Refers to a continuum of potential short-term reactions following an occurrence which may vary in intensity.

- **Psychological Injury:** Refers to persistent intrusive symptoms which may meet diagnostic criteria for psychiatric illness.

- **Support:** Refers to a continuum of measures encompassing primary secondary and tertiary components designed to mediate the negative effects of exposure to work-related aggression and violence.

- **Compensation:** Refers to recompense in lieu of loss or harm suffered. Occupational compensation is enshrined in employment contract, whereas legal compensation is determined judicially[21].

While it is important that clarity is achieved from both clinical and organisational perspectives, it is critical is that managers feel empowered and supported in outreaching to a member of their staff who has encountered work-related aggression and/or violence. Managers need to provide this support free from any anxiety that its provision will influence later determinations related to the occurrence. In the simplest sense the collegial, organisational and moral imperatives to support staff needs to be understood as good managerial practice and distinct from the process by which later causative determinations are made.

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21 A compensation scheme addressing work-related assault injuries is currently being finalised.

Programmes for front line managers currently being provided regionally [114] could be evaluated as a template for informing broader national programmes in the shorter term, while in the future staff support responsibilities should be incorporated into all preparatory courses for managers irrespective of whether these are provided internally by the organisation or externally by educational providers. There are a number of other regional initiatives which equally merit consideration as templates for broader organisational dissemination including the feasibility of use of trained peer supporters for early support responses.

Achieving improved practices of staff support will involve acknowledging the pivotal role of the manager and providing them with adequate guidance, empowerment, and support so that they understand and are equipped to meet organisational expectations.

Recommendation 26: Staff Support Guidance

Guidance for those responsible for the provision of staff supports be developed.

4.5. Organisational Security Responses

Responding to perpetrators of aggression and violence within healthcare is unique in that occurrences take place within a professional service relationship. While such occurrences are, in many instances, a function of underlying pathology and unintended by the perpetrator, neither are they deserved by staff.

…dilemma… having to balance… service obligations to service users with duty of care owed to staff…

In the aftermath of such occurrences the organisation faces the dilemma of having to balance the service and ethical obligations to service users with the duty of care owed to staff. This presents a challenge from legal, professional and moral perspectives. There is little empirical investigation or professional commentary to guide organisations as to what constitutes best practice. From a legal perspective the organisation may be called upon to account for the responses implemented and to demonstrate that these were reasonable, justifiable, proportionate and time specific. Additionally the organisation may be called upon to demonstrate that responses have been equitably and consistently applied.

Achieving such uniformity is complex, in that occurrences of aggression and violence within healthcare may include anything from behavioural manifestations of impending medical and behavioural emergencies to deliberate malicious acts. The aggression manifested by an acutely delirious patient, which may signal an impending medical emergency, can be easily differentiated from the behaviour of a client who is deliberately aggressive toward staff in order to ensure that their request is granted. While the perpetrators of behaviours which are clearly a function of physical or psychological pathology may be excused, those perpetrating clearly malicious acts should be held to account. The transparency surrounding the decision making of such determinations is critical and considering the multi-factorial complexity involved, as in previous themes, there are is no singular 'one size' response which 'fits all' circumstances.

Fundamentally responses can be categorised as those which rely upon either engagement or tariff approaches [115].

- Engagement approaches communicate with target audiences by utilising rational and emotive appeals.
- Tariff approaches rely upon the assumption that pre-understood sanctions will modify behaviour.

By way of example, efforts to modify driver behaviour might employ engagement approaches including media advertising, poster and/or leaflet campaigns, which communicate simple key messages in an effective manner. Conversely, tariff approaches, employed for the same purpose, might rely upon the imposition of penalty points in an effort to modify driver behaviour.

These approaches are not mutually exclusive. There is no reason to doubt that the success of engagement approaches witnessed in other settings cannot be replicated within healthcare settings. Publicity campaigns could effectively communicate that staff are doing their utmost and, in a non confrontational way, reinforce the message that aggression and violence are unacceptable.

> ### *Recommendation 27: Public Engagement*
>
> *Engage public through a campaign highlighting the positive efforts of staff and the detrimental impacts of aggression and violence upon those delivering and receiving services.*

Tariff approaches are considerably more problematic in that their deterrent value relies upon the capacity of potential perpetrators to rationally process the relationship between their behaviour and its consequences. This capacity is potentially diminished in highly stressful situations such as health emergencies, or when seeking services or entitlements in times of duress. Notwithstanding enthusiastic engagement efforts, there is also a need for a framework within which the organisation can employ tariff approaches where warranted. While few disagree with the necessity for such responses, the challenge is in finding consensus relating to a decision framework which adequately and equitably balances the obligations and rights of all concerned in a professionally, legally, and morally sound manner.

One approach to broadly frame such efforts is the adoption of the three category typology of aggression and violence encountered within the workplace including [8]:

- **Type I**, refers to occurrences in which the assailant has no legitimate relationship to the workplace and the primary purpose of the attack is to acquire cash or some other valuable commodity.
- **Type II**, refers to occurrences in which the assailant is either the recipient of a service provided by the affected workplace or the victim.
- **Type III**, refers to occurrences in which an assault is perpetrated by another employee, a supervisor, or an acquaintance of the worker.

Categories I and III are quite clearly outside the scope of this strategy and may be adequately addressed either through the judicial system, the Dignity at Work policy, or some combination of these.

Category II occurrences are a much more complex issue in that the determination of culpability in the presence of pathology poses very significant challenges and dilemmas.

Consideration of pursuing criminal charges against perpetrators has only emerged in professional literature within the last twenty-five years [116] and is the subject of divided opinion. Some have proposed that not only are criminal charges sometimes justifiable, but also morally preferable, in that failing to do so excludes occurrences from entry on the public record, which the argument suggests is better served by this information in the event of future occurrences [117]. The suggestion is that recidivist and first-time offenders warrant different attention within the judicial system, and that the public interest might be better served by having persistent offenders treated in more structured and protective settings. A converse argument cautions against criminal charges, citing a number of reasons including the inherent conflicts between the dual roles of helper and adversary, the potential of compromising the patient's confidentiality, and potential injury to service users as a function of having a criminal record [118]. This debate has not featured prominently within the Irish context, despite occurrences of serious violence toward employees within the health service.

…a statutory obligation to protect the welfare of staff and others… duty to protect the property of the organisation…

Notwithstanding this debate, employers have obligations to protect the welfare of staff and others and a duty to protect the property of the organisation. Where the behaviour of service users is persistently aggressive, to the extent that it poses a risk to the safety of staff or others, the organisation may be obligated to institute measures which protect the safety of all concerned. In such circumstances, there is a need for a structured process of sanctions which balances the duty owed to the service user, with that owed to staff and other individuals using the service.

The process of bringing prosecution against perpetrators would require coordination and consensus with other agencies including the Garda Síochána and the Director of Public Prosecutions. This is a complex issue with the potential for intra-agency conflict among service providers, or inter-agency conflict between service providers and external agencies. Experience from the UK suggests however that potential conflicts surrounding the desirability and priority given to pursuing prosecutions can be reduced through collaborative interagency working [119].

Recommendation 28: Interagency Liaison

A formalised relationship between the hse, the garda síochána, and the director of public prosecutions be established with the purpose of achieving effective interagency working in managing organisational responses to occurrences of aggression and violence.

…the complexities of this issue… require a thorough and balanced consideration from the perspectives of all concerned…

Managing the complexities of this issue will require a thorough and balanced consideration from the perspectives of all concerned. A forum with constituents from professional bodies, employee and employer agencies, service users, regulatory bodies, the justice department and enforcement agencies should be established to facilitate this consideration and to develop a decision making framework which reflects a balanced input from all stakeholders.

Recommendation 29: Decision Making

A stakeholder forum be established to determine the potential value of various approaches and to bring forward a framework to guide decision making and implementation.

While not preempting the work of such a forum a decision framework might outline a pathway of differentiated responses incorporating sequential phases:

- **Case review** phase might initially focus on the individual(s) involved to determine how best to diminish the likelihood of recurrence and might include such measures as symptom management, care contracts or revising clinical care plans.

- **Care review** phase might then focus on the structures and processes by which services are provided, and might include such measures as designated appointment times and locations, or dealing with specifically delegated staff.

- **Sanction review** phase might then focus on seeking organisational or legal remedy from high risk or persistent aggressors including service sanctions and formal complaints up to and including criminal or civil proceedings.

Legal remedies by which sanctions can be imposed remain largely unexplored, with many services unaware of the exact legislation relevant in such circumstances. There is a need for informed legal opinion to support policy in this regard. In addition to a decision making framework, recourse to legal opinion is also required. The support of a legal advisory service should be considered both in the development of decision making frameworks and in supporting services in discharging these duties.

reasonable, justifiable, proportionate and time specific… equitably and consistently applied.

Recommendation 30: Legal Advice

Legal advice be provided to guide services in the structural and procedural options available in the management of complex situations.

4.6. Organisational Policy

…Clarity of guidance in decision making is essential…

Policies should provide staff with the information necessary to guide their decision making. Clarity of this guidance is essential so that employees are protected from the precarious position of having to make decisions in circumstances of uncertainty [120].

The need for policies which support and guide the management of aggression and violence has been consistently identified by professional and regulatory bodies [1,18,74,76,121]. The UK nursing body [76] has called for accessible comprehensive policies which are subject to regular review while an An Bord Altranais [74] guidance requires that all clinical areas have 'well defined and rationally structured policies', with which nurses are thoroughly familiar, in addition to the specific legal provisions governing any interventions utilised. Practice standards have also advocated that frameworks which guide staff be subject to annual review which should incorporate evidence from local audits, occurrences, inquiries, and positive practice initiatives [84]. Despite these mandates, professional and regulatory agencies consistently report that policies are limited in a number of important areas, including the lack of clear guidance on the use of physical interventions [75,76], insufficient involvement of staff in policy formulation, and concern that many policies have not been subjected to legal review [18].

…in absence of clear policies is … staff must rely on practice as their primary guide…

One major concern resulting from the absence of clear policies is that staff must rely on practice as their primary guide. While some practices may be excellent, their origin is often vague and their lack of critical appraisal and formal authorisation may create ambiguity potentially placing staff in a situations of uncertainty as to organisational expectations and authorisation when managing occurrences of aggression and violence [122]. Reliance on practice rather than policy is further complicated by the requirement that interventions employed by staff must, in all instances, be compliant with the prevailing legislative, professional, and policy frameworks within which services are delivered [1].

state of uncertainty… organisational expectations and authorisation

The formulation and implementation of a policy should authorise and guide the measures employed in any strategic organisational response to the management of aggression and violence. Careful consideration must be given to the implications of policy directives to ensure a reasonable likelihood of successful implementation. It is critical that the policy is congruent with the prevailing legal, professional, and ethical codes which apply to the settings within which the policy is to be enacted.

Two final and critical points are that any policy must be communicated to all concerned and that once implemented an organisation may be held accountable to demonstrate consistent adherence to its own policy.

…a dilemma between the urgent need to implement a policy, and the …careful consideration …necessary to ensure… viable and achievable

…more complex than it might initially appear…

The present state of multiple coexisting policies from previous health service structures needs to be replaced with a standardised policy which engages both internal and external stakeholders in the formulation stages and which enjoys not only organisational ratification, but the endorsement of the professional and regulatory bodies to whom the service is accountable. Without this critical consideration a policy may become an aspirational document rather than an operationally and philosophically considered commitment to specific courses of action which reflects the contemporary state of evidence based best practice and organisational objectives [10].

There is consensus that key components of a policy should include:

- operational definitions
- commitment to adopting a contextual understanding of the problem
- emphasis of the commitment of preventative measures
- identification of those responsible for implementation and monitoring
- declaration of the responsibilities of employer and employees
- clear position that aggression and violence are unacceptable
- direction in relation to the provision of staff training
- directions in the management of non physical aggression
- directions in the management of physical aggression
- directions in managing situations involving weapons
- direction in the use of physical interventions
- directions in relation to organisational follow up to occurrences
- direction in relation to reporting occurrences
- direction in relation to provision of supports for staff
- directions in relation to staff and service users complaint procedures

While policy can guide and support the decision making of staff, it is essential that such policies are considered within service specific situational contexts. In relation to the management of work-related aggression and violence, both staff and professional agencies have called for the clarity of direction which only explicit policies can offer. The provision of policy should however enable the management of potential or actual aggression and violence by employing measures which are considered appropriate in the first instance within the clinical/service context in which these occur.

The policy must be able to support rather than conflict with, or substitute, the use of common sense and sound professional judgment in the first instance recognising that not only are the reasons underlying work-related aggression and violence often complex, but so too is its appropriate management.

While agreement exists in relation to key components of an organisational wide policy, a number of specific situations emerged within the deliberations of the working group which require a level of subject guidance beyond that typically found within policy documents. While guidance must be enabled by policy it must also be amenable to service specific implementation. Examples include the recommendations in previous sections for specific guidance in relation to education and training, staff support and the physical interventions.

A separate issue discussed at a plenary session of the working group following consultation on earlier drafts related to the issue of the employment of security personnel, both as direct employees of the organisation and through contractual arrangements with proprietry security service providers. There is at least the perception that the use of such personnel has increased. There appears to be considerable uncertainty surrounding the procurement, education and training preparation of such personnel, and the role function and purpose of security personnel within diverse service settings. While many of the issues which emerged will be addressed through implementation of the recommendations included in this report, there was agreement that this is an area which requires specific guidance.

Recommendation 31: Security Services Guidance

Guidance on the role purpose and function of security personnel and the procedures surrounding procurement of such services be developed.

A dilemma exists between the urgent need to formally implement a standardised policy, and the need for the careful consideration and consultation necessary to ensure that what is implemented is both viable and achievable. While this was a subject of some debate, it was unanimously acknowledged that a delegated responsibility is necessary to coordinate this task which is more complex that it might initially appear.

A viable option to move this issue forward is the formulation of an interim policy in the very short-term, with the explicit acknowledgement of interim status and specified timeframe determined within which the policy would be reviewed.

Recommendation 32: Corporate Policy

An interim policy be issued to staff with a revision within 24 months which will reflect emerging evidence and guidance.

5 | Mapping the Course Forward

5.1. Implementation: Structures and Process

It is clear from the preceding sections that a significant challenge exists for the service for which a national, standardised, coordinated response is required. Such an approach is consistent with the ILO [8] recommendation that social partners actively engage at national and organisational level in dialogue which focuses on the protection of workplace safety and health as a means toward improving services. It is also recommended that social partners collaboratively monitor and evaluate workplace violence initiatives. This collaborative approach also fits comfortably with the prevailing aspirations within the health sector toward employee partnership and effective interagency working.

Achieving the necessary programme of considered actions and sustained improvements will require a clear plan of implementation. In formulating this plan there was consensus that three key elements of the plan include:

- That the response should be jointly owned by a management/employee partnership in association with other regulatory and professional stakeholders.
- That a dedicated unit responsible for driving and achieving the key actions outlined in the strategy should be established.
- That initial substantial efforts should focus in the more immediate term of the first 12-15 months with a deliberate targeting of high return measures.

While recognising that the primary responsibility for addressing the problem rests with the corporate management of health service agencies, it is recommended that a dedicated resource be established to drive and coordinate the implementations in the shorter term. This structure recommended consists of three interdependent components including an overseeing function in the Project Joint Governance Committee, an executive/ operational function in the Central Project Office, and a consultation function in the Multi-agency Advisory Forum. The roles and functions of these units are outlined below and the recommendation is that the establishment of these units coincide with the acceptance of this report.

Recommendation 33: Implementation Framework

A tripartite structure consisting of a Project Joint Governance Committee, a Central Project Office, and a Multi-agency Advisory Forum be established to coincide with acceptance of this strategy.

Figure 6: Implementation Structure
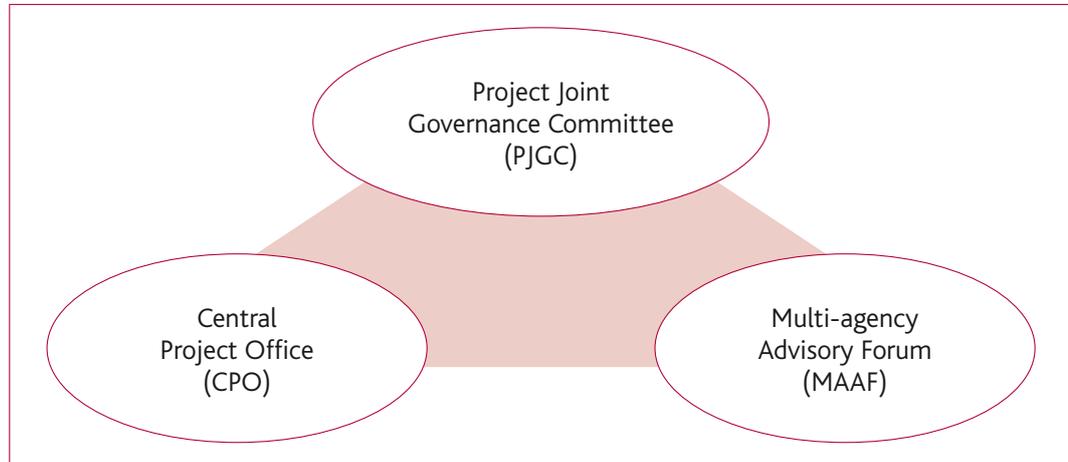
The Project Joint Governance Committee (PJGC) will take responsibility for overseeing the implementation of a programme of strategic actions in line with the agreed recommendations of this strategy and guide the Central Project Office in the implementation of this work. While health service agencies will assign lead responsibility at a corporate level, those charged with responsibility will rely on the PJGC to guide and oversee the response to this theme. In this way corporate responsibility is respected while acknowledging that the active inclusion of all stakeholders in the partnership response is a crucial ingredient for success.

The PJGC will have an independent chair agreed between Unions and Management and membership will include:

- 3 representatives of the health service agencies
- 3 union representatives
- 1 patient advocacy representative
- 1 educationalist
- 1 subject expert
- 1 legal advisor
- The Director of the Health Service National Partnership Forum

This arrangement is a very significant joint employer/employee partnership response, of high leverage value, in response to a longstanding and very significant problem. The partnership approach infers collective ownership of the challenge to find and sponsor solutions sustainable into the future. The PJGC will make its decisions, as a norm, on the basis of unanimity. In the absence of unanimity, a majority decision will suffice but in every circumstance the respective management and union representatives must be in concurrence.

The Central Project Office (CPO) will implement an effective organisational response to the management of work-related aggression and violence in line with this strategy under the guidance of the Project Joint Governance Committee. The mission of this office should be to reassure the major stakeholders including the health service employers, employees, and regulatory bodies that 'all is well' and in line with explicit expectations. The CPO will in the first instance be established for a period of 3-4 years at which time the arrangement will be reviewed.

In particular the CPO will have responsibility for ensuring that:

- best practice policies and guidance are provided in relation to all aspects of the required organisational response. While this work will be iterative by process, in the first instance the office will work toward the implementation of the recommendations of this strategy

- the necessary frameworks are in place so that the key actions in relation to the central themes of the strategy are clearly understood, communicated, operationalised and complied with

- key actions related to risk management are integrated within the broader risk management effort

- best practice is developed in the provision of staff supports

- there is a system of formalised approval of all training (whether in-house or outsourced) – which must be driven by 'need assessment'

- procedures in relation to security responses are developed in line with the key recommendations.

The office will in its own right serve as an expert resource to the broader system, guiding and directing appropriate actions. The CPO will submit an annual report to the PJGC outlining its activities for the year, in addition to ongoing accounts of progress on the implementation of the strategy. The HSE through the Human Resource function will rely on the PJGC to review and sign off on both the annual report and plan of work for the following year.

The Multi-agency Advisory Forum (MAAF) will provide a vital stakeholder consultation function. Membership of the forum will be coordinated by the Central Project Office subject to ratification by the Project Joint Governance Committee. Membership will be broadly representative of professional, regulatory, and educational agencies in addition to service user representation. The group will provide the opportunity to actively engage in consultation and collaborative working in the implementation of the key actions of the strategy. The forum will provide three exploitable strengths, including those of resource, consultation forum, and agent of implementation.

Notwithstanding the value of the expertise within MAAF the efforts of the working group will benefit very significantly from the continued liaison with agencies undertaking similar work in other jurisdictions. While many agencies have already given generously of their time and resources, two agencies, the Security Management Service of the UK National Health Service and the European Violence in Psychiatry Research Group are

worthy of special mention. It is recommended that relationships with these and other relevant agencies be developed in order to facilitate expert consultation and collaborative sharing of best practice and evidence-based initiatives. Significant learning is available from the successes and limitations of the considerable work undertaken by the Security Management Services which might not only inform the necessary debates, but also offer a forum through which initiatives can be quality assured and reviewed. Similarly there is a valuable research resource available within the European Violence in Psychiatry Research Group, through which emerging evidence is shared.

Recommendation 34: External Agencies

Liaison with agencies involved in managing work-related aggression and violence within health and social care settings in other jurisdictions be established in order to facilitate collaborative sharing of expertise and best practice.

5.2. Implementation: Actions and Outputs

The recommendations and associated actions outlined need to be implemented adopting a strategic, integrated, cohesive and balanced approach. The CPO, to be established with the launch of the strategy, will deliver an intensive programme of work over the first three years at which time there will be a substantial review. The expectation is that within this timeframe a very significant impact will have been made on all priority themes. In three years there should be a real sense that the challenges associated with the management of work-related aggression and violence are being effectively managed within the service.

The actions required range from awareness raising and system wide education to very specific deliverables on matters such as baseline measurement, costing, and establishing the safety of physical interventions. Delivering success is contingent upon two critical factors, resourcing and adequately matching authority with responsibilities. Additional resource requirements, including CPO budget, are relatively modest, principally as a function of the potential to utilise and redeploy human and financial resources.

Considering that the recommendations are in large part interdependent and complementary, the successful implementation of the strategy requires a cohesive and coordinated sequencing of actions. While some actions will consume considerable efforts by CPO personnel, others will require external and expert engagement with the time demands of CPO personnel limited to a commissioning and steering role. There are a number of actions which should not be delayed, and should be completed to implementation stage as far as possible within the first twelve to fifteen months. These priority actions have been collaboratively agreed within the working group based on the criteria of potential impact, relevance, cost/return on investment, and organisational readiness. It is important to stress that efforts toward priority actions in the first instance should not preclude simultaneous working toward advancement on all themes.

5.3. Implementation: Short-term Targets

Standardisation of Definition

Measures will be implemented to standardise definition including:

- Adopting of EU definition of work-related aggression and violence
- Developing operational categorisation of work-related aggression and violence
- Integrating definition in guidance and policy statements

Target: A system wide definition adopted within **six** months

Completion of Safety Statements

Measures will be implemented to ensure that safety statements with specific reference to work-related aggression and violence are completed in all places of work including:

- Developing structure for risk assessment of work-related aggression and violence.
- Ensuring full compliance with completion of risk assessments and safety statements which incorporate work-related aggression and violence.
- Ensuring that safety statements incorporate explicit control measures.

Target: Complete compliance with safety statements within **six** months

Baseline Measure

The planning and structure of the baseline measure will be initiated with a number of key actions

- Agreeing parameters of study investigation
- Finalising structure and methodology of the baseline measure

Target: Parameters of study agreed and commissioned within **twelve** months

Safety of Lone Workers

Measures will be implemented to ensure the safety of lone workers including:

- Systematically categorising risk associated with lone working
- Developing and implementing lone worker training
- Exploring and piloting of safety technologies, e.g. alarm devices

> **Target:** Lone worker assessment and training be available to 10,000 within **twelve** months

Safety of Physical Interventions

Measures will be implemented to ensure the safety of physical intervention techniques currently in use within services including:

- Cataloguing physical interventions currently in use nationally
- Establishing a framework by which the safety of techniques can be measured
- Commissioning the expertise to undertake evaluations
- Establishing a repertoire of safest practice

> **Target:** All high risk physical interventions evaluated within **six** months

Development of Guidance

Measures will be implemented to provide guidance to assist decision making including:

- Developing standardised guidance on the provision of education and training
- Developing standardised guidance on the use of physical interventions
- Developing standardised guidance on the provision of staff support

> **Target:** Guidance on education and training issued within **four** months
> Guidance use of physical interventions issued within **eight** months
> Guidance on staff support issued within **twelve** months

6 | Conclusion

This report sheds light on a largely unspoken reality with which healthcare organisations and their employees struggle on a daily basis. The magnitude of the problem is surprising, considering that the *raison d'être* of the service is the provision of care. These services are frequently provided under highly emotive and stressful circumstances during which those involved may respond in ways which are not typical of their usual behaviour. Indeed many manifestations of work-related aggression and violence are primarily a function of illness or disability, and are unintended by the assailant. In as much however as they are unintended, they are equally undeserved by employees and in such instances all involved are adversely affected.

Understanding this contradiction of service recipient as assailant and service provider as victim, is complex. This complexity is reflected in the very diverse manifestations of the problem encountered within different services, which are often more reflective of the interaction taking place than they are of the individuals involved. While much is known about the problem, this report has highlighted that many vital areas of information remain incomplete.

One critical point consistently highlighted is the extent to which the Irish experience of the problem, and the difficulties in achieving an effective response, mirrors international experiences. This is in effect a healthcare phenomenon, and not one which is unique to the Irish context. While we are not unique in this challenge, neither however are we immune, and this recognition imposes an imperative to implement an organisational response which can assure those concerned that all reasonably practical measures are being taken to minimise associated risks. This report acknowledges the very considerable efforts to date within the Irish healthcare system to meet this obligation. Notwithstanding these efforts, the deliberations of the working group have highlighted a number of issues which need to be addressed as a matter of priority.

There is a risk when considering the work ahead, to not fully appreciate the extent and value of the work accomplished to date. While many healthcare organisations continue to struggle in their efforts to address this problem, with various degrees of success, a fully satisfactory response has remained elusive. The careful consideration reflected in the recommendations of this strategy sets forward a structured plan of actions which should result in an organisational response which at the very least equals that of comparable healthcare systems internationally.

Of equal value is the fact that this strategy demonstrates how partnership working can give expression to multiple perspectives so that we move forward in confidence that the plan of actions will address stakeholder needs in an adequate and equitable manner. This level of partnership working should neither be underestimated nor undervalued and indeed the shared learning from this collaborative working has added value for all partners beyond the scope of this project. The commitment to collaboratively embracing the challenges identified, coupled with a commitment to establishing 'facts' rather than 'faults' has resulted in this strategy which is both comprehensive in scope and innovative in approach. This has not gone unnoticed, as evidenced by the fact that the work of the group has been presented at an EU social dialogue forum, and as a keynote paper at the first international congress on violence within the healthcare sector, attended by delegates from 47 countries covering all continents.

In the final analysis the complex issue of work-related aggression and violence is one which compromises the care experience from the perspectives of both recipient and provider. Despite the considerable challenges identified in managing this problem, it is important that we are neither reticent in its recognition, or doubtful that we can achieve excellence in implementing an effective response.

It is clear from the work of this group that there is no simple, single or quick fix solution to this problem. However the careful collaborative consideration which has underpinned the production of this strategy will serve it well as we meet the challenge in an informed, considered, balanced and cohesive way.

7 | **References**

1.   McKenna, K., Paterson, B. (2006) Locating training within a strategic organisational approach to the management of aggression and Violence in Richter, D. and Whittington, R. eds. *Violence in Mental Health Settings; Causes Consequences Management*. Springer, New York. p.231-249.

2.   Advisory Committee on Health Services Sector (2001) *Report of the advisory committee on health services sector*. National Authority for Occupational Safety and Health, Dublin.

3.   Poyner, B., Warne, C. (1988) *Preventing violence to staff*. HMSO Publications, London.

4.   Cameron, A. (2001) *The art of partnership: A practical guide*. British Institute of Learning Disabilities, Kidderminister.

5.   Paterson, B., Leadbetter, D., Miller, G., Crichton, J. (2007) *Adopting a Public Health Model to Reduce Violence and Restraints in Children's Residential Care Facilities* in Nunno, M., Day, D. and Bullard, L.B. For Our Own Safety: Examining the Safety of High-risk Interventions for Children and Young People. Arlington, USA, Child Welfare League of America Inc. p.127-141.

6.   Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Joachim Haug, H., Fischer, J. (2008) Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial. *British Journal of Psychiatry,* 193: p.44-50.

7.   Paterson, B., McComish, A., Bradley, P. (1999) Violence at Work. *Nursing Standard*, 13(21): p.43-46.

8.   Rogers, K.A., Chappell, D. (2003) *Preventing and responding to violence at work*. International Labour Office, Geneva.

9.   Government of Ireland (1998) *Commission on Nursing A Blueprint for the future*. Government Publications Office, Dublin.

10.   McKenna, K. (2004) *Study of work-related violence*. North Eastern Health Board, Kells, Co. Meath, Ireland.

11.   Winstanley, S., Whittington, R. (2004) Aggression towards health care staff in a UK general hospital: variation among professions and departments. *Journal of Clinical Nursing,* 13(1): p.3-10.

12.   Estryn-Behar, M., Duville, N., Menini, M.L., Camerino, D., Le Foll Sans le Nezet, O. (2007) Factors associated with violence against healthcare workers Results of the European Presst-Next study. *Presse Medicale,* 36(1): p.21-36.

13.   Health Services Advisory Committee (1987) *Violence to staff in the health services*. UK Health & Safety Executive, Sheffield.

14.   NIOSH (1996) *Violence in the workplace. Risk factors and prevention strategies*. Government Printing Office Publication, Washington, DC.

15. Fisher, J.A. (2003) Curtailing the use of restraint in psychiatric settings.
     Journal of Humanistic Psychology, 43(2): p.69-95.

16. Leadbetter, D., Paterson, B. (2005) *From moral panic to moral action*. Paper presented
     at the Child Welfare League of America/Cornell University/Stirling University Joint
     symposium on high risk interventions in human services. Cornell University, New York.

17. Department of Health and Children (2001) *Quality and Fairness A Health System For You*.
     Government Publications Office, Dublin.

18. National Audit Office (2003) *A safer place to work: Protecting NHS hospital and
     ambulance staff from violence and aggression*. Report HC 527 Session 2002-2003.
     The Stationery Office, London.

19. Health Service Executive (2006) *Corporate Safety Statement*. Health Service Executive,
     Naas, Co. Kildare, Ireland.

20. Fottrell, E., (1980) A study of violent behaviour among patients in psychiatric hospitals.
     British Journal of Psychiatry, 136: p.216-221.

21. James, D., Fineberg, N.A., Shah A.K., Priest, R.G. (1990) Increased violence in an
     acute psychiatric ward: A study of associated factors. *The British Journal of Psychiatry*,
     156: p.846-852.

22. Carmel, H., Hunter, M. (1989) Staff Injuries from inpatient violence. *Hospital & Community
     Psychiatry*, 40: p.41-46.

23. Wynne, R., Clarkin, N., Cox, T., Griffiths, A. (1997) *Guidance on The Prevention of Violence
     At Work*. European Commission, DG-V, Ref.CE/V-4/97-014-EN-C.

24. Love, C.C., Hunter, M.E. (1996) Violence in public sector psychiatric hospitals.
     Benchmarking nursing staff injury rates. *Journal of Psychosocial Nursing & Mental Health
     Services*, 34(5): p.30-34.

25. Wells, J., Bowers, L. (2002) How prevalent is violence towards nurses working in general
     hospitals in the UK? *Journal of Advanced Nursing*, 39(3): p.230-240.

26. Zahid, M.A., Al-Sahlawi, K.S., Sahid, A.A., Abu-Shammah, H. (1999) Violence against
     doctors: Effects of violence on doctors working in accident and emergency departments.
     European Journal of Emergency Medicine, 6(4): p.305-309.

27. British Medical Association (2003) *Violence at work: the experience of UK doctors*.
     British Medical Association, London.

28. Bernstein, H.A., (1981) Survey of threats and assaults directed toward psychotherapists.
     American Journal of Psychotherapeutics, 35(4): p.542-549.

29. Keogh, P. (2001) *The Nature and Extent of Workplace Violence Experienced by Social
     Care Workers*. Irish Association of Care Workers, Dublin.

30. Smith, M. (2007) *Royal College of Nursing Lone Working Survey.* Research Report. Sheffield Hallam University.

31. Security Management Service (2005) 'Not Alone' – A guide for the Better Protection of Lone Workers in the NHS. Security Management Service, London.

32. Advisory Committee on the Health Services Sector (1992) *Report of the advisory committee on health services sector to the Health and Safety Authority.* National Authority for Occupational Safety and Health, Dublin.

33. NHS Security Management Service (2006) *Mental health and learning disabilities* report available at *http://www.nhsbsa.nhs.uk/SecurityManagement/422.aspx*

34. Rose, M., (1997) A survey of violence toward nursing staff in one large Irish Accident and Emergency Department. *Journal of Emergency Nursing*, 23(3): p.214-219.

35. Ryan, D., Maguire, J. (2006) Aggression and violence-a problem in Irish Accident and Emergency departments? *Journal of Nursing Management*, 14(2): p.106-115.

36. Maguire, J., Ryan, D. (2006) Aggression and violence in mental health services: categorizing the experiences of Irish nurses. *Journal of Psychiatric and Mental Health Nursing*, 14(2): p.120-127.

37. Hand, C. (2008) *Workplace violence in an Irish Pediatric Hospital: A study of the experiences of nurses and healthcare assistants*. M.Sc. Dissertation. University College Dublin, Dublin.

38. McKenna, K., (1999) *Nurses experience of work related assault in Irish General Hospitals*. M.Sc. Dissertation. Department of Nursing, University College Dublin, Dublin.

39. Irish Nurses Organisation (1993) *The experience of stress amongst Irish nurses. Summary Report*. Irish Nurses Organisation, Dublin.

40. Health Care Commission (2007) A Mental Health and Learning Disability Trusts: Key findings from the 2006 survey of staff. Health Care Commission, London. Health Care Commission (2007) B Acute Trusts: Key findings from the 2006 survey of staff. Health Care Commission, London.

41. Love, C.C., Hunter, M.E. (1996) Violence in public sector psychiatric hospitals. Benchmarking nursing staff injury rates. *Journal of Psychosocial Nursing & Mental Health Services*, 34(5): p.30-34.

42. Gerberich, S.G., Church, T.R., McGovern, P.M., Hansen, H.E., Nachreiner, N.M., Geisser, M.S., Ryan, A.D., Mongin, S.J., Watt, G.D., (2004) *An epidemiological study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. Occupational & Environmental Medicine,* 61: p.495-503.

43. Caldwell, M.F. (1992) Incidence of PTSD among staff victims of patient violence. *Hospital & Community Psychiatry*, 43: p.838-839.

44. Findorff-Dennis, M.J., McGovern, P.M., Bull, M., Hung, J. (1999) Work related assaults. *The impact on victims. American Association Occupational Health Nurses Journal*, 47(10): p.456-465.

45. Whittington, R., Shuttleworth, S., Hill, L. (1996) Violence to staff in a general hospital setting. *Journal of Advanced Nursing*, 24(2): p.326-333.

46. Bonner, G., Lowe, T., Rawcliffe, D., Wellman, N. (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9(4): p.465-473.

47. Psychiatric Nurses Association (2002) *Assault on Nurses; PNA launch campaign for compensation*. Psychiatric Nurses Association, Dublin.

48. McGuinness (2004) Action calls as GP's bombed, assaulted. *Irish Medical Times,* p.1.

49. Maier, G., Van Rybroek, G. (1995) Managing countertransference reactions to aggressive patients. *Patient Violence and the Clinician*. American Psychiatric Press Inc., Washington, DC.

50. Paterson, B., Duxbury, J. (2007) Restraint and the question of validity. *Nursing Ethics*, 14(4): p.535-545.

51. Kent, R. (1997) *Children's Safeguards Review*. The Scottish Office, Edinburgh.

52. Badger, F., Mullan, B. (2004) Aggressive and violent incidents: perceptions of training and support among staff caring for older people and people with head injury. *Journal of Clinical Nursing*, 13(4): p.526-533.

53. Jackson, D., Clare, J., Mannix, J. (2002) Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management*, 10(1): p.13-20.

54. Wells, J.S.G., Ryan, D., McElwee, C.N. (2000) 'I don't want to be a psychiatric nurse': an exploration of factors inhibiting recruitment to psychiatric nursing in Ireland. *Journal of Psychiatric and Mental Health Nursing*, 7(1): p.79-87.

55. Dawson, J., Johnson, M., Kehiayan, N., Kyanko, S., Martinez, R. (1988) Response to patient assault: a peer support program for nurses. *Journal of Psychosocial Nursing*, 26(2): p.8-15.

56. Blair, D.T., New, S.A. (1991) Assaultive behavior: know the risks. *Journal of Psychosocial Nursing*, 29(11): p.25-31.

57. Hoel, H., Sparks, K., Cooper, C. (2001) *The Cost of Violence/Stress at work and the benefits of a violence/stress-free working environment*. Report commissioned by International Labour Organisation. University of Manchester Institute of Science and Technology available at *http://www.ilo.org/public/english/protection/safework/whpwb/econo/costs.pdf*

58. Di Martino, V. (2003) Workplace violence in the health sector: relationship between work stress and workplace violence in the health sector. ILO, Geneva.

59. Royal College of Psychiatrists (1998) The management of imminent violence: clinical practice guideline to support mental health services. Royal College of Psychiatrists, London.

60. Whittington, R., Richter, D. (2006) From the Individual to the Interpersonal: Environment and Interaction in the Escalation of Violence in Mental Health Settings in Richter, D. and Whittington, R. Eds. *Violence in Mental Health Settings; Causes Consequences Management.* Springer, New York.

61. Hastings, R.P. (1995) Understanding factors that influence staff responses to challenging behaviours. *Mental Handicap Research*, 8: p.296-320.

62. James, I. (2001) Training carers in behavioural management skills. *Dementia: Management of Behavioural and Psychological Symptoms*, ed Ballard, C. Oxford University Press, Oxford. p.150-165.

63. Zarola, A., Leather, P. (2006) *Violence and aggression management training for trainers and managers: A national evaluation of the training provision in healthcare settings.* HSE Books, Norwich, HMSO.

64. Kaplan, R.S., Norton, D.P. (1996) Using the balanced scorecard as a strategic management system. *Harvard Business Review*, Jan-Feb: p.75-85.

65. Hepworth, P. (1998) Weighing it up – a literature review for the balanced scorecard. *Journal of Management Development*, 17(8): p.559-563.

66. De Waal, A. (2003) The future of the balanced scorecard: an interview with Professor Robert S. Kaplan. 7(1): p.30-35.

67. Moulin, M. (2004) Eight essentials of performance measurement. *International Journal of Health Care Quality Assurance*, 17(3): p.110-112.

68. International Labor Organization (2000) *Violence at Work*. International Labor Organization, Geneva.

69. Senge, P., Kleiner, A., Roberts, C., Ross, R., Roth, G., Smith, B. (1999) *The dance of change: The challenges of sustaining momentum in learning organizations*. Doubleday, New York.

70. Cox, T., Cox, S. (1993) Psychosocial and organizational hazards: Control and monitoring. *Occupational Health Series*, 5. World Health Organization, Copenhagen.

71. Government of Ireland (2005). *Safety, health, and welfare at work act*. Government Publications Office, Dublin.

72. Health Service Executive (2007) Risk Management in the HSE; An Information Handbook. Office of Quality and Risk. Health Service Executive, Ireland

73. NHS Security Management Service (2007) Lone Worker Device – NHS National Trial Evaluation Report. NHS Security Management Service, London.

74. An Bord Altranais (1997) *Guidance to nurses and midwives on the management of violence/challenging behaviour.* An Bord Altranais, Dublin.

75. National Council for the Professional Development of Nursing (2003) *Agenda for the Future Professional Development of Nursing and Midwifery*. National Council for the Professional Development of Nursing, Dublin.

76. United Kingdom Central Council for Nursing Midwifery and Health Visiting (2002) *The Recognition Prevention and Therapeutic Management of Violence in Mental Health Care*. UKCC, London.

77. International Labour Office, International Council of Nurses, World Health Organisation, Public Services International (2002) *Framework Guidelines for Addressing Workplace Violence in the Health Sector*. International Labour Office, Geneva.

78. Infantino, J., Musingo, S. (1985) Assaults and injuries among staff with and without training in aggression control techniques. *Hospital & Community Psychiatry*, 36: p.1312-1314.

79. Turnbull, J., Paterson, B., Aiken, I. (1992) An evaluation of a training course in the short term management of violence. *Nurse Education Today*, 12: p.368-375.

80. Martin, K. (1995) Improving staff safety through an aggression management program. *Archives of Psychiatric Nursing*, IX(4): p.211-215.

81. Felthous, A. (1984) Preventing assaults on a psychiatric inpatient ward. *Hospital & Community Psychiatry*, 35(12): p.1223-1226.

82. Maier, G., Stava, L., Morrow, B., Van Rybroek, G., Baumaan, K. (1987) A model for understanding and managing cycles of aggression among psychiatric inpatients. *Hospital & Community Psychiatry,* 38(5): p.520-524.

83. National Institute of Clinical Excellence (2005) Violence: The short-term management of disturbed/violent behavior in psychiatric in-patient settings and emergency departments. National Institute of Clinical Excellence, London.

84. National Institute for Mental Health in England (2004) Mental health policy implementation guide developing positive practice to support the safe and therapeutic management of aggression and violence in mental health in-patient settings. National Institute for Mental Health in England, Worcestershire.

85. Whittington, R., Wykes, T. (1996) An evaluation of staff training in psychological techniques for the management of patient aggression. *Journal of Clinical Nursing*, 5(4): p.257-261.

86. Wondrak, R. (1988) Dealing with verbal abuse. *Nurse Education Today*, 12(2): p.276-280.

87. Beech, B., Leather, P. (2003) Evaluating a management of aggression unit for student nurses. *Journal of Advanced Nursing*, 44(6): p.603-612.

88. Morton, P. (1987) Staff roles and responsibilities in incidents of patient violence. *Archives of Psychiatric Nursing*, 1(4): p.280-284.

89. Blofeld, J. (2003) *An independent inquiry set up under HSG(94)27 into the death of David "Rocky" Bennett*. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, Cambridge.

90. Health and Safety Authority (2006) *Health and Safety Authority Guidance Document for the Healthcare Sector; How to develop and implement a Safety Management System*. Health and Safety Authority, Dublin.

91. Paterson, B., McComish, S., Bradley, P. (1999) Violence at work. *Nursing Standard,* 13(21): p.43-46.

92. Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., Allen, D. (2003) Restraint-related deaths in health and social care in the UK: Learning the lessons. *Mental Health Practice*, 6(9): p.10-17.

93. Nunno, M.A., Holden, M.J., Tollar, A.T. (2006) Learning from tragedy: A survey of child and adolescent restraint facilities. *Child Abuse and Neglect,* 30: p.1333-1342.

94. Welsh Assembly Government National Health Service (2004) All Wales NHS Violence and Aggression Training Passport and Information Scheme. All Wales NHS Steering Group for the Management of Violence and Aggression available at *www.wales.nhs.uk/documents/AllWales_viol_agg_passport*.

95. General Accounting Office of the United States (1999) *Report to congressional requesters: Mental health: Improper restraint or seclusion places people at risk*. United States General Accounting Office, Washington, DC.

96. National Association of State Mental Health Program Directors (2008) Training Curriculum for the Reduction of Seclusion and Restraint. National Technical Assistance Center, Alexandria, VA.

97. LeBel, J., Goldstein, R. (2005) The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination. *Psychiatric Services*, 56: p.1109-1114.

98. Huckshorn, K.A., Director, National Technical Assistance Center. US National Association of State Mental Health Program Directors (2008) Personal Communication at Preventing Violence Trauma and Use of Seclusion and Restraint in Mental Health Settings training event. April 02nd 2008, Baltimore, Maryland.

99. Colton, D. (2004). *Checklist for assessing your organization's readiness for reducing seclusion and restraint.* Commonwealth Centre for Children and Adolescence Staunton, Virginia.

100. Miller, G., Associate Director – Risk Reduction West London Mental Health Trust, UK National Health Services (2008) Personal Communication at European Network of Trainers in Management of Aggression conference Promoting a Shared Vision of Practice and Organisational Excellence in Training. November 18th 2008, Amsterdam.

101. McDonnell, A., Martin, A., Leadbetter, D., Paterson, B. (2009) *Developing a tool to evaluate the risks associated with using physical interventions - report of project undertaken by BILD* in (ed) Allen, D. (2009) (second edition). Ethical Approaches to Physical Interventions, British Institute of Learning Disabilities, Kiddeminster.

102. Tucker, R. (2005) interview with O'Hara, J.: Social Care Risk Assessment. Guardian, Wednesday October 19 2005. Available at: *http://society.guardian.co.uk/socialcare/story/0,,1595039,00.html*

103. Lanza, M.L. (1992) Nurses as patient assault victims: an update, synthesis, and recommendations. *Archives of Psychiatric Nursing*, 6(3): p.163-171.

104. Richter, D. (2005) Posttraumatic stress disorder in mental hospital following a patient assault: empirical data and prevention measures. Proceedings of the 4th European Congress on Violence in Clinical Psychiatry; eds Palmstierna, T., Nijman, H. and Oud, N., Oud Consultancy, Netherlands.

105. Needham, I. (2006) Psychological Responses Following Exposure to Violence in Mental Health Settings. Richter, D. and Whittington, R. eds. Violence in Mental Health Settings; Causes Consequences Management. Springer, New York.

106. Dawson, J., Johnson, M., Kehiayan, N., Kyanko, S., Martinez, R. (1988) Response to patient assault: a peer support program for nurses. *Journal of Psychosocial Nursing*, 26(2): p.8-15.

107. Flannery, R., Hanson, M., Penk, W. (1994) Risk factors for psychiatric inpatient assaults on staff. *Journal of Mental Health Administration*, 21(1): p.24-31.

108. McGrath v. Trintech Technologies Ltd. (2004) High Court of Ireland Decisions, BAILII High Court of Ireland Decisions & Anor [2004] IEHC 342 (29 October 2004) available at URL: *http://www.bailii.org/ie/cases/IEHC/2004/342.html*

109. Paterson, B., Miller, G. (2006) Promoting Safe and Therapeutic Services. NHS Security Management Services, London.

110. Mitchell, J. (1983) When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medical Services*, 8(1): p.36-39.

111. McKenna, K. (1999) *Nurses experience of work related assault in Irish General Hospitals*. M.Sc. Dissertation. Department of Nursing, University College Dublin, Dublin.

112. Graydon, J., Kasta, W., Khan, P. (1994) Verbal and physical abuse of nurses. *Canadian Journal of Nursing Administration*, 7(4): p.70-89.

113. Irish Nurses Organisation (1993) *The experience of stress amongst Irish nurses. Summary Report.* Irish Nurses Organisation, Dublin.

114. Donohue, S., Mahon, J., McNutt, M. (2008) Unpublished report of evaluation of pilot programme entitled 'Supporting your staff around workplace trauma'. Staff Support Service, Health Service Executive, Dr Stevens, Dublin.

115. Rose, N. (1999) *Power of Freedom: Reframing Political Thought*. Cambridge University Press, Cambridge.

116. Hartel, J. (1993) The prosecution of assaultive clients: treatment considerations. *Perspectives in Psychiatric Care*, 29(3): p.7-14.

117. Phelan, L., Mills, M., Ryan, J. (1985) Prosecuting psychiatric for assaults. *Hospital & Community Psychiatry*, 36(6): p.315-322.

118. Applebaum, K.A., Applebaum, P.S. (1991) A model hospital policy on prosecuting patients for presumptively criminal acts. *Hospital & Community Psychiatry*, 42(12): p.1233-1237.

119. NHSSMS and CPS (2008) *Memorandum of Understanding between the NHS Counter Fraud and Security Management Service and the Crown Prosecution Service.* Crown Prosecution Service Publications, Crown Prosecution Service, London.

120. Perrow, C. (1988) *Complex organizations: A critical essay.* Third edition. Random House, New York.

121. British Institute of Learning Disabilities (2001) *Code of practice for trainers in the use of physical interventions*. British Institute of Learning Disabilities, Kidderminister.

122. Stevens, B. (1995) *The nurse as executive*. Third edition. Aspen Publications, Maryland.

123. International Labor Organization (2003) *Code of practice on workplace violence in services sectors and measures to combat this phenomenon*. International Labor Organization, Geneva.

8 | **Appendices**

Appendix 1

Membership of the National Working Group on Work-related Aggression and Violence

Mr. Pat Harvey	*Chairman*
Mr. Kevin McKenna	*Project Facilitator*
Ms. Denise O'Shea	*HSE-Employers Agency (Secretary to the group)*
Ms. Mona Baker	*Temple Street Children's Hospital*
Ms. Michelle Bermingham	*Health Service Executive*
Mr. Paul Braham	*HSE Dublin Mid Leinster*
Mr. Kevin Callinan	*IMPACT*
Ms. Mary Culliton	*HSE Dublin Mid Leinster*
Mr. Shay Donohoe*	*HSE Dublin Mid Leinster*
Ms. Maura Donovan	*Stewarts Hospital*
Mr. Donal Duffy	*Irish Hospital Consultants Association (IHCA)*
Ms. Edwina Dunne	*HSE Dublin Mid Leinster*
Mr. Andrew Fagan	*Social Service Inspectorate*
Dr. Malachy Feely	*Department of Health and Children*
Ms. Mary Gorry	*HSE HR Corporate*
Mr. Fintan Hourihan	*Irish Medical Organisation (IMO)*
Mr. David Hughes	*Irish Nurses Organisation (INO)*
Ms. Breege Kelly	*HSE West*
Ms. Margo Leddy	*HSE Dublin North East*
Mr. Eugene Lennon**	*Department of Health and Children*
Ms. Miriam McCluskey	*SIPTU*
Mr. Liam McNamara	*Psychiatric Nurses Association (PNA)*
Mr. Brendan Mulligan	*HSE-Employers Agency*
Mr. Seamus Murphy	*Psychiatric Nurses Association (PNA)*
Ms. Phil Ní Sheaghda	*Irish Nurses Organisation (INO)*
Ms. Louise O'Reilly	*SIPTU*
Mr. Kevin Plunkett	*HSE South*
Mr. Martin Rogan	*HSE Dublin Mid Leinster*
Ms. Cornelia Stuart	*HSE Dublin North East*
Mr. Rory Talbot	*St Vincent's Hospital, Fairview*
Mr. Larry Walsh	*Health Service National Partnership Forum*
Mr. Michael Walsh***	*Health & Safety Authority*

* Mr. Shay Donohoe retired in December 2007.

** Mr. Eugene Lennon was replaced in January 2008 by Mr. Eddie O'Reilly (Department of Health and Children).

*** Mr. Michael Walsh was replaced by Mr. Peter Skinner in April 2008.

Appendix 2

Membership of the Subgroups

Support Subgroup

Mr. Shay Donohoe	*HSE Dublin Mid Leinster*
Dr. Peter Noone	*Specialist in Occupational Health Medicine*
Ms. Phil Ní Sheaghda	*Irish Nurses Organisation*
Mr. Kevin Plunkett	*HSE South*

Training Subgroup

Ms. Michele Bermingham	*HSE South*
Ms. Mary Farrelly	*National Council for Nursing and Midwifery*
Mr. Des Kavanagh	*Psychiatric Nurses Association (PNA)*
Mr. Thomas Kearns	*An Bord Altranais*
Mr. Liam McNamara	*Psychiatric Nurses Association (PNA)*
Ms. Catherine O'Neill	*Ethicist Royal College of Surgeons*
Ms. Louise O'Reilly	*SIPTU*
Mr. Kevin Plunkett	*HSE South*

Health Safety Quality and Risk Subgroup

Mr. Paul Braham	*HSE Dublin Mid Leinster*
Mr. Seamus Murphy	*Psychiatric Nurses Association (PNA)*
Ms. Cornelia Stuart	*HSE Dublin North East*

Policy Subgroup

Ms. Mary Gorry	*HSE Dublin Mid Leinster*
Mr. Dave Hughes/Ms. Phil Ní Sheaghda	*Irish Nurses Organisation (INO)*
Ms. Breege Kelly	*HSE West*
Mr. Eugene Lennon	*Department of Health & Children*
Mr. Brendan Mulligan	*HSE Employers Agency*
Mr. Gavin Stanley	*Irish Medical Organisation (IMO)*

Organisational Security Response Subgroup

Ms. Mary Culliton	*HSE Dublin Mid Leinster*
Mr. Donal Duffy	*Irish Hospital Consultants Association (IHCA)*
Mr. Fintan Hourihan	*Irish Medical Organisation (IMO)*
Ms. Margo Leddy	*HSE Dublin North East*
Ms. Miriam McCluskey	*SIPTU*

Subgroups facilitated by Mr. Kevin McKenna Project Facilitator and Ms. Denise O'Shea.

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