The problems of aggression and violence for health-care staff

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Aggressive and violent behaviour that is directed at nursing staff by patients and their relatives is a huge problem. Rippon (2000) describes how the number of violent incidents has increased along with the severity of those incidents and suggests that this may reflect the general increase in violence in society.

Statistics show that nurses working in accident and emergency departments (A&E) are most likely to face violent and aggressive outbursts (Health and Safety Commission Advisory Committee, 1997). This article will look at the scale of the problem, including the difficulties encountered by both community and ward-based nurses. It will also examine the major triggers of violence and look at why incidents often go unreported. Finally, prevention and management strategies will be considered.

In order to identify literature for review we used the following key words: violence and aggression; accident and emergency; and hospital settings to undertake searches using Cinahl and PubMed.

Defining aggression and violence

According to Brennan (2000) ‘violence’ is a difficult term to define. He cites research by Van Der Dennen (1980) who discovered 106 definitions of the term. The Health and Safety Commission (1997) definition is: ‘Any incident in which a person is verbally abused, threatened or assaulted by a patient or member of the public.’ Rippon (2000) cites research by Berkowitz (1993) who describes aggression as behaviour that is intended to injure someone psychologically or physically. However, these definitions only address the act of aggression rather than the causative factors.
Rippon (2000) cites the work of Spielberger and Sydeman (1994), who point out how the words anger, aggression and hostility are used interchangeably. Beale et al (1999) offer a definition of work-related violence: ‘Incidents 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.’

For this paper we will use the Royal College of Nursing definition: ‘Violence is any incident in which a health professional experiences abuse, threat, fear or the application of force arising out of the course of their work whether or not they are on duty’ (RCN, 1998).

Scale of the problem

Rippon (2000) describes the issue of violence and aggression as: ‘A pervasive problem and an epidemic that constitutes an occupational hazard.’

Violence is not only a problem for nurses working in A&E departments. Whittington et al (1996) cite research (Health Service Advisory Committee, 1987) that shows how 26% of staff in medical wards, 11% in surgical wards and 10% in orthopaedic wards had been physically assaulted. More than one quarter of community nurses reported at least one incident of verbal abuse in the preceding 12 months and 5.5% reported at least one threat with a weapon. Efforts have also been made to study and understand violence and aggression in a psychiatric hospital. According to one study, out of 90 new patients in a psychogeriatric setting, 14.5% exhibited aggressive behaviour (Shah, 1993).

In their study on violence in general health care settings, Whittington et al (1996) found that 21% of staff who took part had been physically assaulted, of whom 90% worked outside A&E. Another study showed that 620 violent incidents were reported within 21 months on a high-dependency ward of mentally handicapped patients (Shah, 1992), where four patients were responsible for 74% of violent incidents. It is clear, however, that while violence and aggression in psychiatric and A&E settings is more widely publicised, the problem is by no means confined to these areas.

Schnieden and Marren Bell (1995) questioned 300 nurses on their experiences of violence in A&E. Of the 65% that responded, 90% had experienced some form of violence at work. Overall, 35% had been injured by a patient or relative and 86% had encountered verbal violence. Almost half, 48%, had experienced violent threats in the form of obscenities. This research was supported by Rippon (2000) who showed that between 30% and 80% of hospital staff had been physically assaulted on one or more occasions and between 65% and 82% of nursing staff had received verbal abuse from patients.

Triggers of violence and aggression
Research by Schnieden and Marren Bell (1995) showed an increase in violence during antisocial working hours (6pm-7pm) that may be linked to the easy access of casualty departments. Sains (1999) cites the frustration caused by lengthy waiting times as a major causative factor. Findings by Schnieden and Marren Bell (1995) back this up with research they conducted that showed 80% of verbal violence was related to waiting times.

The RCN (1998) describe how low staffing can be linked to an increase in violence and aggression, as a decrease in the number of staff can lead to increased waiting times for patients. Lack of personal space and the waiting room ‘audience’ can also lead to aggression (Sains, 1999).

A sudden illness or accident can trigger strong emotions leading to stress, which can manifest itself in a number of ways, including violent or aggressive behaviour (Needs, 2000). In his report into violence in a US emergency department, Kuhn (1999) showed how an irrational individual who was grieving for a family member injured a member of staff. Other triggers include: adverse stimulation of pain; lack of any options; frustration and the nature of the task being undertaken (Breakwell, 1989).

A major trigger of violence and aggression in the emergency department is the consumption of, and withdrawal from, alcohol and drugs. Intoxication with alcohol and drugs reduces the individual’s capacity to understand and interpret situations, and also decreases inhibitory responses during stressful times (Dolan and Holt, 2000).

**Reporting violent incidents in hospital settings**

Rose (1997) questioned 36 members of staff in the A&E department of a large Irish teaching hospital. Staff at the hospital are required to document all incidents of physical and verbal abuse on an incident form. Interestingly, findings showed 63% of incidents and 29% of physical assaults went unreported. The tendency to report violent incidents increased according to length of service: 71% after 10 or more years, decreasing to 20% among nurses with less than 10 years’ experience.

There is a tendency for community staff not to report incidents, because they find the formal procedures too time consuming, believe incidents are not serious enough, or because they see violence as part of their job (Beale et al, 1999). Research by Whittington et al (1996) found that inexperienced staff were more likely to report incidents of violence. However, although Whittington et al targeted 1006 members of staff, only 36% responded.

With the increase in medical litigation in recent years, it is likely that reporting and documentation of incidents has begun to improve to reflect this.

**Preventing problems**
One important question is how we can reduce or prevent aggression and violence. Brennan (2000) states that: ‘For too long violence has been accepted as part of a nurse’s job.’ He discusses the need for ‘zero tolerance’ when dealing with violence in a hospital setting. Poor communication between staff and patients is a trigger to violent outbursts (Dolan and Holt, 2000). The triage system should not only provide a way of prioritising patients in terms of urgency but also of obtaining information. Williams (1992) cited in Dolan and Holt (2000) emphasises that during triage the patient can be assessed and can obtain information on their illness and on waiting times. Due to the sheer unpredictability of the workload, however, the frustration caused by changing waiting times can be difficult to address (Sains, 1999).

**Managing violence and aggression**

In the document Dealing with Violence Against Nursing Staff the RCN states that: ‘Raising staff knowledge and awareness, while rehearsing and developing interpersonal skills for defusing such behaviour are important first steps in managing the problem of violence’ (RCN, 1998). It should be acknowledged that most of the research included in this review would have been undertaken before the RCN produced these guidelines.

If a patient becomes aggressive, staff need to know how to de-escalate the situation (Sains, 1999). Work by Patterson et al (1997) cited in Sains (1999), defines these skills as: ‘A set of verbal and non-verbal responses which, when used correctly, may reduce the person’s hostility.’

The literature discussed supports the view that staff both in general wards and in A&E could benefit from training to help them handle aggression and violence. Schieden and Marren Bell (1995) found that only 50% of staff working in accident and emergency had been trained to deal with violence. Of those who had been trained, half had been taught how to deal with violent patients and half had been taught to deal with verbal abuse.

While all those who took part in this research attended an induction programme, only 18.4% had received training as part of the programme. Less than one-fifth of staff had been trained in violence management techniques in one particular hospital (Rose, 1997). Beale et al (1999) also found that many staff were still not received training.

Sains (1999) describes how training should address understanding aggression and violence, assessing danger and taking precautions when dealing with violent individuals. Of those attending the RCN Emergency Nurse Forum, the majority had attended only lectures and role-play sessions, with 80% never having attended an update. There was no research relating to the content of the training sessions (Schnieden and Marren-Bell, 1995).
Schnieden and Marren Bell (1995) provide no evidence of staff training in ‘breakaway’ techniques, an area Dolan and Holt (2000) describe as giving nurses the confidence to deal with violent situations. While most of the reviewed literature shows the importance of risk assessment in the effective management of aggressive and violent situations, none offered any evidence of how it is carried out, what needs to be assessed, or records of improvements made in the hospitals surveyed. It must again be noted that most of the reviewed literature and research would have been carried out before the publication of the RCN guidelines.

**Practical measures to reduce violence**

Risk assessment is regularly undertaken by nurses (Brennan, 2000). Its aim should be to provide information in order for decisions to be made about protecting staff at work (RCN, 1987). The Health and Safety Commission (1997) offer a five-step approach:

- Identify hazards
- Identify who might be harmed
- Evaluate the risks and whether the existing precautions are adequate
- Record findings
- Review and revise the assessment.

While this assessment is useful in setting up preventative measures and improving services, it is time consuming and would be difficult to implement in a triage setting, where contact with a potentially violent patient may last only a few minutes. This form of assessment is best implemented at departmental or trust level.

In order for departments and trusts to develop appropriate policies on violence and aggression the importance of incident reporting cannot be overstated. A National Audit Office (1996) survey of health and safety in NHS acute hospital trusts in England confirmed that the third most common accident involving hospital staff was physical assault. The RCN (2000) shows that reporting systems for violence are inadequate and do not produce accurate information. The focus is on staff to report all incidences of violence and aggression in order for trust managers to implement appropriate training and policies. Hospital trusts should provide simple incident reporting systems to ensure investigations take place and audits are undertaken.

**Counteracting violence**
Research into violence and aggression shows that training courses should cover certain areas (Box 1). Training is best undertaken in tailored in-house sessions so that the potential for violence in the workplace is not overstated, causing nurses to become fearful for their safety. The programme should include the early identification of potentially violent behaviour, including looking for aggressive body language and facial expressions, verbal threats or gestures, refusal to communicate and the identification of previously violent patients (RCN, 1998). The use of various techniques may reduce the risk or severity of violence and aggression (Box 2).

Conclusion

Work-related violence and aggression is a significant problem for nurses working in A&E. It is interesting to note that none of the research reviewed how stress levels are affected when patients are allocated hospital beds. Could a decrease in stress at this point explain the decrease in violence reported in the general ward setting?

The triggers for violence and aggression provided similar findings, although there was little statistical evidence. Interestingly none of the research looked at patients’ views on the cause and management of violence and aggression. In working towards evidence-based practice, patient observations could provide a valid way of gaining information.

There is a need to follow up and learn from these studies and undertake further comprehensive research. Developing a tool that can measure all types of aggression and its severity will enable administrators and managers to draw up effective policies to help fight violence in the workplace.

Reference:


Brennan, W. (2000) We do not have to take this: dealing with violence at work. RCN Nursing Update 14: 28, 4-12.


Health Service Advisory Committee (1987) Violence to Staff in the Health Service. London: HMSO.


