Prevention and Minimisation of Clinical Aggression

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Outline

- Introduction
  - Background

- Aggression prevention & minimisation interventions
  - Advocacy and evidence

- Conclusions and implications
What is workplace / clinical aggression?

- Variations in terminology and definitions
  - Perpetrator action/behaviour
    - Intention to harm, achieve outcome
    - Target motivated to avoid
    - Action/behaviour a violation of norms

- Numerous sources
  - Internal (co-workers)
  - External (patients, patients’ relatives or carers & others)
Research in health settings

- Widely researched in nursing, less so in medicine
  - Limited body of Australian studies

- Sources (12-month prevalence)
  - Verbal forms 2-4 times more prevalent than physical forms
  - Up to ~95% from patients
  - Up to ~50% from patients’ relatives/carers

- Impact / consequences
  - Psychological and physical impacts
  - Decreased job satisfaction and organisational commitment
  - Increased absenteeism, work restrictions/modifications/transfers, quitting the job or leaving the profession altogether
  - Compromise to safety and quality of patient care
Where does it occur?

- Rural cf. Metropolitan +
  - Contradictory evidence

- Lower cf. Higher SES communities +
  - Evidence of elevated risk

- Public cf. Private sector work +
  - Evidence of elevated risk

- Hospital cf. Community-based work +
  - Evidence of elevated risk

- Clinical field or discipline of work
  - Evidence of elevated risk → patients and carers experience frustration, distress, cognitive impairment or arousal (eg emergency, psychiatry, aged care)
Work arrangements and conditions

- Evidence of elevated risk:
  - Longer working hours +
  - Shiftwork, shift switching, mandatory overtime
  - Staff shortages, time pressures
  - Performing physical tasks
  - Insufficient lighting
  - Home visits and after-hours work +
Personal characteristics

- **Perpetrators – elevated risk**
  - Male, mental disorder, substance misuse, history of aggression

- **Clinician gender +**
  - Contradictory evidence ... stronger evidence of elevated risk of gender-based and sexual aggression for female clinicians

- **Clinician age and work experience +**
  - Consistently elevated risk for younger and less experienced personnel

- **Clinician cultural / linguistic background +**
  - Contradictory evidence ... some evidence of elevated risk of discrimination in overseas-born clinicians

- **Clinician personality +**
  - Little research evidence in clinician populations
Is this what is required?
Aggression prevention and minimisation

- High-level advocacy for a diversity of approaches
  - ILO, ICN, WHO, OSHC (US)

- Research evidence limited, including in health care settings
  - Expert opinion and theory

- Routine activity theory
  - Situational aspects of aggression
  - Perpetrator opportunity, target vulnerability, credible guardianship

- Hierarchy of controls
  - Risk elimination through engineering or design
  - Risk minimisation through hazard reduction, enclosing the hazard
  - Risk reduction through administrative and engineering controls, and education and training
Environmental design approaches

- Design enhancing or diminishing safety (CPTED, SCP, BWT) **
  - Sight lines, surveillance, access control, activity support
  - Physical barriers between workers and public, bright lighting, security alarms, cash drop-boxes that staff cannot open
  - Image management, territorial reinforcement and target hardening
  - Combinations of strategies

** Some evidence of effectiveness, but limited research in medical and other health care settings
Prevention and minimisation of clinical aggression

- Access control
- Natural surveillance
- Target hardening
- Territoriality
- Defensible space
- Activity support
- Formal surveillance
Environmental design – health care

- Expect to be effective in health care settings
- Interventions need to be fit for purpose:
  - In *generalist* environments, service users *may* be aggressive
  - In certain *specialist* environments, service users *more* likely to be aggressive due to cognitive impairment or arousal
  - Danger of *deflecting* aggression to more vulnerable targets or settings
  - Risk that environment becomes too *unattractive or challenging* for legitimate users
Key interventions – strategic core

- **Organisational policy** *
  - Levels of tolerance
  - Systems and processes
  - Rights and responsibilities

- **Incident reporting and follow-up systems**
  - Detect patterns of aggression to inform targeted prevention and remedial actions
  - Evaluate the impact of initiatives

- **Patient/public access restrictions and facility security systems** *
  - Ensure external and internal facility access to legitimate users
  - Reduce opportunity for aggression toward persons and property
  - Reducing vulnerability of potential targets

* Some evidence of effectiveness
Key interventions – education and training

- Fundamental component of any aggression minimisation program
- Improve knowledge and understanding *
  - Organisational policies and legal responsibilities
  - Risk assessment and control protocols and resources
  - Enhance interpersonal and behaviour management skills
- Equivocal evidence on impact and outcomes
  - Clinicians nonetheless recognise its value
  - Levels of participation (especially medical) less than optimal
- Need for the “right kind” of education and training
  - Existing skills and experience
  - Primary work role

* Some evidence of effectiveness
Key interventions – engineering controls

- **Duress alarms**
  - Relatively inexpensive vulnerability reduction strategy
  - Can alert other personnel to the need for a rapid response

- **Optimised clinician escape**
  - Relatively inexpensive vulnerability reduction strategy
  - Simple as being seated closer to the exit than the patient

- **Optimised patient waiting conditions** *
  - Minimising provocations
  - Noise levels, temperature, comfort
  - Communication, waiting times
  - Quality of service encounters

* Some evidence of effectiveness
Key interventions – administrative controls

- Warning signs
  - Communicating organisational expectations of service encounters
  - Restrict the range of possible excuses or defences for aggression

- Flagging high risk persons
  - Communicating risk and applying individual-specific approaches

- Restricting or withdrawing access to services
  - Serial perpetrators and high-risk individuals
  - Assure the safety of service providers and other service users

- After hours / off campus services
  - Mix of structural, material and administrative interventions
  - Focussed on reducing clinician vulnerability

* Some evidence of effectiveness
Security Design Guidelines for Healthcare Facilities

www.iahss.org
Conclusions

- Risk of exposure to WA can be reduced
- Need to consider
  - Policy direction
  - Systems and processes
  - Work location, conditions and resources
  - Personal profile factors
  - Knowledge and skills of personnel
- Need to build the evidence base in health settings
Implications

- Enhance legislation and policy
  - Strengthen work health and safety legislation and policy, monitoring and enforcement capabilities
  - Accountability for minimising risk (performance and remediation)

- Financial incentives and support for change

- Ongoing research
  - Developing and testing interventions
  - Publishing outcomes
Publications – workplace aggression


Hills, DJ & Joyce, CM (under review). A review of research on the prevalence, antecedents, consequences and prevention of workplace aggression in clinical medical practice.

Hills, DJ, Joyce, CM & Humphreys, JS (under review). Workplace aggression prevention and minimisation in Australian clinical medical practice settings – a national study.
Thank you

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