HEALTH AND SAFETY AUTHORITY

INSPECTION PROGRAMME IN

ACCIDENT AND EMERGENCY UNITS

MARCH / APRIL 2005

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Overview

On 20th January 2005, the Health and Safety Authority wrote to the Chief Executive of the Health Service Executive and to the Chief Executives of all 39 hospitals with Accident and Emergency, setting out the following requirements:

> That a comprehensive written risk assessment be prepared, in accordance with the Safety, Health and Welfare at Work Act 1989, in relation to each Accident and Emergency Department and
>
> That, by 25th February 2005, they confirm in writing to the Authority that this risk assessment has been completed and that any outstanding matters identified therein are being addressed as a matter of urgency.

On 2nd March the Authority issued a statement that it had received responses from all the hospitals. Following consideration and analysis of those responses the Authority carried out a targeted programme of inspections in 11 ACCIDENT AND EMERGENCY units in order to ensure that hospitals are putting in place all necessary control procedures to ensure that risks are minimised. Details of the hospitals inspected and the dates of those inspections are included in the attached report.

The programme of inspections commenced during week beginning 7th March and was completed on the 13th April. The Authority has reviewed the findings of these inspections and all hospitals inspected have been issued with a report of the inspection in which issues of concern to the Inspectors have been detailed. The hospitals in question have been directed to submit a comprehensive plan for addressing these issues including timescales for corrective action. Deadlines have been set for the submission of the plans. To date, one such deadline has been reached and the required plan has been submitted and is currently being assessed. The remaining responses are expected over the next 4 weeks and deadlines are being monitored to ensure compliance.

The Authority accepts that the hospital authorities operate within a difficult and complex environment and acknowledges the support of staff on the ground for their detailed and incisive comments to our inspection team and for the follow up they have provided.

The Authority acknowledges that the hospitals are now fully engaged in the process of addressing the health and safety in their accident and Emergency units. We look forward to receiving confirmation that the key issues identified by our inspections are being addressed.

While it is inappropriate to comment on inspections in any particular hospital, certain issues have emerged as common to most or all hospitals and these issues will largely be the focus of further activities in Accident and Emergency Units. These can be addressed under 8 key headings:

- Health and Safety Management Systems
- Risk assessment
- Training
- Violence/Aggression
- Manual Handling/Ergonomics
- Slips/Trips and Falls
- Exposure / Contact with harmful agents
- Fire Safety
- Overcrowding

Examples of the types of issues found under each of these headings are included in this report.

Mr. Tom Beegan met with the Chief Executive of the HSE, Mr. Kevin Kelly on Tuesday, 19th April to discuss the outcome of the inspection programme. The Authority is satisfied that the HSE is committed to addressing the areas of concern and will prioritise the management of health and safety so that the issues highlighted by the Inspectors can be resolved as a matter of urgency. The Authority has also secured the commitment of the HSE to look at the health system in a wider sense, and assess the adequacy of its health and safety management model across **all** elements of the system so that a more co-ordinated approach to managing risks can be put in place.

Further activities planned by the Authority in relation to Accident and Emergency units include:

- Assessment of the implementation plans to be submitted to ensure compliance with the Inspectors' requirements
- Follow-up inspections in the hospitals already inspected, as required.
- Further inspections in 4 Accident and Emergency Units not already inspected this year will now be carried out and the same process followed with them.
- The issuing of guidance tailored to meet the needs of Accident and Emergency Units in relation to critical issues including violence and aggression and health and safety management systems.

Inspection Programme:

Objectives:

The objective of the inspection programme was:

To conduct health and safety inspections at Accident and Emergency departments in order to assess the adequacy of their written risk assessment and to ensure that adequate control measures were in place to minimise or eliminate risks. The inspections focused on the four issues which cause 90% of all accidents in the healthcare sector namely:

- Violence and Aggression
- Manual Handling
- Slips, Trips and Falls
- Exposure / Contact with harmful agents

The issue of overcrowding was also considered in that it has the potential to increase the risks to staff under the above headings and to compromise evacuation procedures. Where they were evident, other significant issues such as safety training and fire safety were also examined as part of the inspections.

Inspection Process:

A team of four Inspectors was assigned to the programme and each inspection involved two Inspectors. Before inspection, the hospitals in question were requested in writing to prepare documentation and to facilitate the inspection process.

Inspections were scheduled to ensure hospitals were visited at a range of times, day and night.

Inspections lasted up to 10 hours and the hospitals visited were:

Naas General Hospital – 8th March
Beaumont Hospital – 10th March
Mater Hospital – 14th March
St Joseph's Clonmel – 21st March
Our Lady's of Lourdes,Drogheda – 23rd March
Wexford General – 29th March
Mercy Hospital, Cork – 31st March
Limerick Regional – 4th April
James Connolly Hospital, Blanchardstown – 7th April
Sligo Regional – 7th April
UCH Galway – 13th April

Inspection Outcomes

The reports issued to each hospital give details of the issues of concern in that hospital and the Inspectors' requirement for improvement. While it is inappropriate to comment on Inspectors' findings in particular units, there are clear patterns to be seen in the types of issues encountered in the various units inspected. Accordingly, it is possible to examine these in a general sense under the headings set out below. It should be noted that all these issues are not applicable to every hospital visited though they are broadly representative of the 11 inspected and it can therefore be assumed that they apply to the same extent in the remaining hospitals.

Health and Safety Management Systems:

The Authority is concerned at what would appear to be a lack of integration of health and safety into the overall management model, and as a consequence, a fragmented approach to managing it. This is being exacerbated by the fact that there is no senior clinician in charge of Accident and Emergency Units on a 24 – 7 basis. At a more macro level, there were poor links between Accident and Emergency units and primary/community care services.

It should be noted that, the Authority has secured the commitment of the HSE to look at the health system in a wider sense, and assess the adequacy of its health and safety management model across **all** elements of the system so that a more co-ordinated approach to managing risks can be put in place.

Accident and Emergency Risk Assessments:

On each inspection, the Accident and Emergency risk assessment was examined. The quality of the risk assessments varied from hospital to hospital but in a number of cases they were found to have an inadequate assessment in relation to key issues such as violence and aggression, work related stress and chemical agents. In addition a number were incomplete and/or the specific control measures required to mitigate the risks were not clearly identified. On the other hand, there were a number of cases where the risk assessment did not accurately reflect safety procedures already in place on the ground.

In almost all cases the Inspectors identified a need to rationalise documentation so that the safety statement, risk assessment and various safety and health policies or protocols such as infection control, chemicals, manual handling are interlinked and give clear guidance. The Inspectors also felt that there was a need for better records management so that health and safety incidents were more clearly documented and that those incidents are used to update and refresh the safety documentation.

A related concern was expressed by Inspectors regarding inadequate consultation in the risk assessment process. In this regard, the following are

examples of the types of issues, which were noted by Inspectors as being of concern to them:

- Inadequate attendance by safety representatives at hospital safety meetings.
- Inadequate number of meetings of Health and Safety Committee
- No safety representatives in place for Accident and Emergency departments.

Training

Staff safety training provision was inadequate in a number of hospitals, particularly insofar as it related to the handling of violence and aggression. There were also issues regarding the management of safety training records and the following are examples of the types of issues, which have been raised with hospital managers as necessitating further action.

- Medical staff has not received appropriate training on handling of violence and aggression.
- Two day Accident and Emergency induction course for medical staff does not address health and safety issues.
- Poor take-up by medical staff of health and safety courses that have been arranged by the hospital mngement.
- Housekeeping staff have no training in manual handling
- No formal health and safety training for safety representatives.

Violence and Aggression

The extent to which there is a risk of violence and aggression in the hospitals inspected varied from unit to unit but in general it can be said that the risk was found to be more of an issue in larger hospitals. In a number of cases, Inspectors were concerned that the current arrangements for protecting workers from this risk were inadequate and the following are examples of the issues that have been raised with some of the hospitals for immediate attention:

- Uncontrolled access to treatment areas
- Poor management of personal alarm usage
- Lack of static alarms
- Inadequate response times following alarm activation
- Absence of panic alerts
- Policies on jewellery and uniforms not in place or not being implemented
- Inadequate security presence
- Gaps in CPI training (Crisis Prevention Intervention)
- Inadequate CCTV systems or inadequate monitoring of same
- No signage re admittance policy or policy on violent behaviour
- Inadequate cash handling facilities.

Manual Handling / Ergonomics:

In general, it was noted that there were adequate manual handling aids available to staff. However, certain gaps in training records were identified and have been raised by Inspectors as requiring attention. Inspectors also identified some design issues in older Accident and Emergency departments, which increase manual handling risk. Risk was also increased in some Accident and Emergency departments due to access difficulties caused by overcrowding.

Chemicals / Biological Agents

In general control of risks due to biological agents was found to be adequate. However the following are examples of the types of issues that arose during inspection and which have been raised with the individual hospitals:

- Lack of documentation in respect of vaccination status of agency staff and other contracted workers on duty
- Staff non-compliance with clinical waste policy
- Lack of spill control policy and procedure
- Free-standing oxygen cylinders
- Lack of documentation on chemicals used (Material Safety Data Sheet)

Slips, Trips, Falls

Slips, trips and falls are a significant cause of injury in the health care sector. The risks are increased by overcrowding. During this programme of inspections, Inspectors encountered a number of situations when patients on trolleys were obstructing movement around the Accident and Emergency department.

Other problems were cluttered passageways as a result of the lack of storage space for materials.

Fire Safety

In the case of 8 of the hospitals visited, the Inspectors identified issues, which may warrant the attention of the relevant Fire Officer in accordance with the Fire Services Act, 1981. In these cases, a letter has issued to the Fire Officer and the hospitals have been notified of this. The following are some examples of the types of issues to which the hospitals' attention has been drawn:

- Trolleys, chairs, catering trolleys and medical equipment stored in fire-protected corridors.
- Fire exit doors obstructed
- Inadequate evacuation plans
- Obstruction of fire extinguishers

- Some staff unaware of basic fire evacuation procedures and location of fire extinguishers and fire points
- No fire safety certificate available.

Effects of overcrowding

The Inspectors report that there was serious congestion within some Accident And Emergency departments due to overcrowding by patients awaiting admission. Overcrowding can lead to an increased risk of injuries due to slips, trips and falls and manual handling as well as an increased risk of infection and of aggression/violence from frustrated patients. It also has the potential to compromise fire evacuation procedures.

Staff on the ground have also linked the clinical problems associated with overcrowding and the frustration caused by the inability to deliver an adequate service in these circumstances to an increased risk of stress. However it was difficult in the context of the inspection programme to quantify this problem as records management in this area was not adequate.

Inspectors have reported that a number of strategies have been employed by hospital management in an effort to cope with the overcrowding problem. In all cases, escalation policies are in place, which allow use of emergency overflow facilities when numbers waiting reach a particular level. Regular meetings, daily in some instances, are held by bed management committees to consider and address the issues. The hospitals have GP liaison staff who make regular contact in an attempt to control referrals to Accident And Emergency. Consultants are contacted to make additional rounds in an effort to discharge patients as appropriate and free up beds.

In a number of instances, development plans have been submitted to the HSE with the objective of improving Accident And Emergency facilities.

The Inspectors noted that the causes of overcrowding are complex as acknowledged in the recently published 10-point plan for Accident And Emergency departments. They also note that while it (overcrowding) has the potential to increase the risks to health and safety, it can only be alleviated where health and safety issues are tackled within an overall strategy for the general management of the health care sector. In this regard, it is to be hoped that implementation of the “whole system” approach advocated in the 10-point plan will improve the situation for patients and staff alike.

Current position:

1. **All 11 hospitals have been inspected and there are many health and safety issues in Accident And Emergency departments, which require immediate attention.** They include the following issues:

    - The quality of the risk assessments varied from hospital to hospital but in a number of cases they were found to have an inadequate assessment in relation to key issues such as violence and aggression, work related stress and chemical agents.
    - Staff safety training provision was inadequate in a number of hospitals, particularly insofar as it related to the handling of violence.
    - Inspectors were concerned that the current arrangements for protecting workers from the risk of violence were inadequate in a number of hospitals.

    In particular, the Authority is concerned by:

    - **weaknesses identified in the approach to managing safety**, as well as by what would appear to be a lack of integration of health and safety into the overall management model, and as a consequence, a fragmented approach to managing it. This is being exacerbated by the fact that there is no senior clinician in charge of Accident and Emergency Units on a 24 – 7 basis. At a more macro level, there were poor links between Accident and Emergency units and primary/community care services.

    - **the prevalence of overcrowding** in a majority of the hospitals and the associated increased risk of violence and aggression.

2. **The hospitals have been notified of the issues of concern and directed to submit comprehensive plans** to address these issues of concern within a definitive time period.

3. **The Authority has referred issues relating to fire safety to the relevant Fire Officer** in accordance with the Fire Services Act 1981.

4. **The Authority has met with the Chief Executive of the HSE**, Mr. Kevin Kelly to discuss the outcome of the inspection programme. The Authority is satisfied that the HSE is committed to addressing the areas of concern and will prioritise the management of health and safety so that the issues highlighted by the Inspectors can be resolved as a matter of urgency. The Authority has also secured the commitment of the HSE to look at the health system in a wider sense, and assess the adequacy of its health and safety management model across **all** elements of the system so that a more co-ordinated approach to managing risks can be put in place.

Next steps:

Further activities planned by the Authority in relation to Accident and Emergency units include:

1. **Assessment of the implementation plans** to be submitted to ensure compliance with the Inspectors' requirements

2. **Follow-up inspections** in the hospitals already inspected, as required.

3. **Further inspections** in 4 Accident and Emergency Units not already inspected this year, These inspections will focus on the problem areas which have emerged as being common to many of the Accident and Emergency Units.

4. **The circulation to all hospitals with Accident and Emergency Units of sector-specific guidance** on critical issues based on international best practice (See appendices 2 – 4)

APPENDIX 1

List of Hospitals with Accident And Emergency units

There are a total of 39 hospitals with Accident and Emergency facilities. There are listed below. A total of 22 letters were sent out to either the hospital CEOs or to the relevant Health Service Executive.

Hospitals with Accident And Emergency Units

Mullingar General Hospital
Portlaoise General Hospital
Loughlinstown Hospital
Tallaght Hospital
James Connolly Hospital
Our Lady's Hospital for Sick Children
Mater Hospital
Cavan General Hospital
Monaghan General Hospital
Sligo General Hospital
Waterford General Hospital
St Luke's, Kilkenny
St Joseph's, Clonmel
Ennis Hospital
St Joseph's, Nenagh
Mayo General Hospital
Roscommon Hospital
Mercy Hospital, Cork
Mallow General Hospital
South Infirmary, Cork
Tullamore General Hospital
St. James Hospital
St Vincent's Hospital
Beaumont Hospital
Naas General Hospital
Temple Street Hospital
Our Lady of Lourdes(Drogheda)
Navan General Hospital
Dundalk General Hospital
Letterkenny General Hospital
Wexford General Hospital
Our Lady's, Cashel
Limerick Regional Hospital
St. John's Hospital, Limerick
UCH, Galway
Portiuncula, Ballinasloe
Cork University Hospital
Bantry General Hospital
Tralee General Hospital

APPENDIX 2

Guidance in relation to Health and Safety Management Systems

Context:

Following an intensive programme of inspections in Accident and Emergency Units in March/April 2005, the Health and Safety Authority has noted its concerns in relation to health and safety management systems present in a number of the hospitals inspected insofar as they relate to management of risk in Accident and Emergency units.

The Authority acknowledges that staff in Accident and Emergency departments are working hard under difficult circumstances to try and provide the best possible care to patients as they present. However, the Authority is concerned at what would appear to be a lack of integration of health and safety into the overall management model, and as a consequence, a fragmented approach to managing it. This is being exacerbated by the fact that there is no senior clinician in charge of Accident and Emergency Units on a 24 – 7 basis.

It should be noted that while this issue may not be applicable to every hospital visited to the same degree, it can be said that clear patterns have emerged to the extent that the Authority now considers it appropriate to issue the following recommendations to assist all hospitals to address this issue as a matter of urgency. This list of recommendations is not an exhaustive one but will assist hospitals develop a more cohesive and structured health and safety management system.

Recommendations:

An occupational safety, health and welfare management system aims to achieve a managed environment in which the safety, health and welfare of staff, patients, visitors, contractors and others, who are affected by the activities of the hospital is ensured as far as is reasonably practicable**.**

Recommendation 1 – Lead the process

It is acknowledged that the health care system is undergoing major change at present. Objectives, structures and systems are continually evolving with a changing risk environment for safety, health and welfare of all employees.

These demands place an enormous burden on those who manage our hospitals. They must ensure robust and dynamic systems for the management of occupational safety, health and welfare, and effective internal control of risks. They must also ensure the development of an organisational culture incorporating safety, health and welfare, which is continually developing and embedding. At all stages in planning, developing and measuring the performance of the health and safety management system, effective leadership by the Chief Executive is crucial. S/he must take personal

responsibility for ensuring the effectiveness of the health and safety management system and devising specific performance indicators by which progress made in achieving health and safety standards is measured. At each Board of Management or management team meeting, performance against health and safety/risk management standards must be reviewed.

Recommendation 2 – Develop an agreed plan

An agreed plan for development of the occupational safety, health and welfare management system should be developed and available in a written format for all management and staff as well as external agencies. The plan should include the Safety, Health and Welfare Statement and Policy, and aims and objectives to be achieved and measured within a defined time frame. More particularly, it should provide for specific risk assessments to be carried out for each unit of activity so as to ensure compliance with health and safety legislation.

Recommendation 3: Ensure effective consultation.

To create a positive culture, staff at all levels need to be involved to ensure their commitment, which is essential for the success of the safety management system. Occupational safety and health issues and, more particularly, risk assessment must be a standing item on the agenda for each unit meeting and where staff are nominated as safety representatives, appropriate safety training must be provided.

Communication and consultation are of paramount importance if safety, health and welfare management systems are to achieve the positive effect intended. In the absence of effective communication and consultation the system will not work; there may be limited success in certain areas for given periods of time but the system will not have long-term sustainability. The Safety, Health and Welfare at Work Act, 1989 stipulates the need for consultation, therefore it is incumbent on hospital management to provide evidence of effective consultation processes within their hospitals.

Recommendation 4 – Establish an agreed process for the management of documentation

The Safety, Health and Welfare at Work Act, 1989 and the General Application Regulations 1993, require suitable records to be maintained A written record of risk assessments must be retained and all relevant health and safety procedures documented. Risk assessments need to be integrated into the safety statement and brought to the attention of all affected persons and in particular those exposed to risk of injury in the workplace.

All documentation associated with safety, health and welfare at work should be part of a document control system within the hospital i.e. a system that

facilitates ready access to all documents e.g. training records, statutory records, incident reports and minutes of meetings. Standards to support the quality of the documentation are also necessary. Such standards should seek to ensure that all documentation is produced in a way that is user friendly and integrated into the performance reporting arrangements.

Recommendation 5 – Establish clear lines of responsibility and accountability

Shared responsibility and accountability should be viewed as an approach where all staff within the Accident and Emergency unit and indeed, in the hospital as a whole, actually assume a greater responsibility and accountability for safety, health and welfare. It is not about pointing the finger at one another. Rather, the onus is on everyone to be vigilant in identifying and disclosing system weaknesses that create unacceptable conditions, and to collaborate in improving processes and preventing accidents and illnesses.

The occupational safety, health and welfare management system should describe the expected responsibility and accountability of management and staff in the Accident and Emergency Unit. Job descriptions should be reviewed and updated to include responsibility and accountability of safety, health and welfare. In this regard, a senior clinician should be allocated responsibility for the Accident and Emergency unit, and should be given the authority to take the necessary action to address risk issues that arise in the unit on a 24 – 7 basis. By establishing responsibility and accountability in this way, management can ensure a process for the unit that addresses all elements of the risk management system.

Recommendation 6 – Establish Performance Standards

All hospitals should agree performance standards for each unit or area of activity if policies are to be translated from good intentions into a series of co-ordinated activities and tasks.

These standards are the basis of planning and measuring occupational safety, health and welfare achievement and measurement of performance of the system should be undertaken annually.

Standards should set out clearly the contribution expected of staff and management to ensure an environment free of injury, ill health and loss.

Note on Health Service Audit Tool

On 1st March, the Authority announced the launch of a programme to pilot a Health Service Audit Tool, which we believe will significantly contribute to improvements in this area when fully rolled out next year.

The Health Service Audit Tool will enable all those within the health service to identify their roles and responsibilities, understand the key concepts involved and establish the key steps required to achieve a first-rate health, safety and welfare management system. The launch marked the beginning of a six-month programme where five health organisations will pilot the audit tool on the ground.

It is necessary to implement this new initiative because:

- There are increased demands on all health care organisations to demonstrate excellence in governance
- Delivery of a quality service to patients is linked with a range of management functions that must strive for best practice
- Staff are the key to delivering a quality health service that also requires good management

The five pilot sites are: Adelaide and Meath Hospital (incorporating the National Children's Hospital) in Tallaght, Cheshire Ireland, HSE Midlands, HSE North Eastern, HSE South Western Area.

APPENDIX 3

Guidance in relation to Overcrowding in Accident and Emergency Units

Context:
Overcrowding in Accident and Emergency units may increase the risk of injuries due to slips, trips and falls, manual handling, aggression/violence from frustrated patients and may also lead to an increased risk of infection. It also has the potential to compromise fire evacuation procedures and may increase the risk of stress for staff.

The general principles of prevention as set out in the General Application Regulations require, inter alia

(a) The avoidance of risks

(b) The evaluation of unavoidable risks.

(c) The combating of risks at source.

(d) The adaptation of work to the individual, especially as regards the design of places of work, the choice of work equipment and the choice of systems of work, with a view, in particular, to alleviating monotonous work and work at a predetermined work rate and to reducing their effect on health.

(e) The development of an adequate prevention policy in relation to safety, health and welfare at work, which takes account of technology, organisation of work, working conditions, social factors and the influence of factors related to the working environment.

Managers of Accident and Emergency units should have regard to these principles when assessing risks and given the potential for overcrowding to indirectly increase risks of injuries and ill-health as mentioned above, and the need to combat risks at source, it is imperative that every effort be made by the HSE to address the overcrowding issue in order to minimise the risks associated with the hazards identified.

The HSA guidelines on health and safety management systems for Accident and Emergency units stipulate that hospital management must ensure robust and dynamic systems for the management of occupational safety, health and welfare, and effective internal control of risks.

In this regard, in addressing the issue of overcrowding, the HSE needs to determine, on a hospital by hospital basis, after undertaking the necessary risk assessment and staff consultation whether extra capacity can be achieved within existing units. In doing so, they should have regard to international best practice in areas such as improving workflow issues and increasing the use of more appropriate community based interventions to reduce the out of hours pressure on Accident and Emergency units.

APPENDIX 4

Guidelines for Addressing Workplace Violence and Aggression in Accident and Emergency Departments

Context:

While workplace violence affects practically all sectors and all categories of workers, the health sector, and more particularly, Accident and Emergency units, is at major risk (ILO). Health and Safety Authority Inspectors carrying out an intensive programme of inspections in Accident and Emergency Units in March/April 2005 reported that in the case of a number of hospitals inspected, they were concerned that the current arrangements for protecting workers from this risk were inadequate to the extent that the Authority now considers it appropriate to issue the following recommendations to assist all hospitals to address this issue as a matter of urgency. This list of recommendations is not an exhaustive one but will, once again, greatly assist the hospitals in developing best practice in this area.

Recommendations:

Recommendation 1 – Recognise Workplace Violence
Early recognition of the risks of violence allows for intervention before violence manifests itself. In this regard, the following should be considered.

Departments at Risk

While all departments in a health care setting may potentially be exposed to workplace violence, some are at higher risk than others. Such risk should be assessed having regard to the specific situation and conditions in which each department operates with special attention paid to those departments that are:

- located in highly populated and high crime areas
- small and isolated
- understaffed
- under the strain of reform and downsizing
- working with insufficient resources, including inappropriate equipment
- functioning in a culture of tolerance or acceptance of violence
- working with a style of management based on intimidation
- noted for poor communication and interpersonal relationships

In this respect, attention should also be paid to abnormally high levels of absence on grounds of sickness, high levels of staff turnover and previous records of violent incidents.

Potential Perpetrators

A number of factors of risk have been identified which may help in preventing workplace violence.

Warning signals in individuals can include:

- aggressive/hostile postures and attitudes
- repeated manifestations of discontent, irritation or frustration
- alterations in tone of voice, size of the pupils of the eyes, muscle tension, sweating
- the escalation of signals and the building up of tense situations

Warning signals involving groups can include:

- Abuse of equipment/environment and ignoring housekeeping rules
- Complaints about waiting times/queries and repeated requests for feedback on waiting times
- Being in cramped conditions, poorly ventilated, without information update

Potential Victim

A number of factors of risk have been identified under this heading, which may help in preventing workplace violence.

Profession
Although all professions in the health sector are potentially at risk of workplace violence, some appear to be at special risk:

- nursing and ambulance staff: at extremely high risk
- doctors, support and technical staff: at high risk
- all other allied professionals: at risk

Real or perceived vulnerability
This can apply to:

- members of minorities
- people in training or on placement
- workers in precarious job situations
- young people
- women

Experience/attitudes/appearance.
These can include:

- being inexperienced
- the display of unpleasant, irritating attitudes
- absence of coping skills
- wearing uniforms or name tags

Uniforms or name tags have proved to act both as a deterrent to and a trigger of workplace violence depending on the circumstances. Consequently, recourse to them and the way uniforms or name tags are used, is a matter that should be carefully assessed and decided upon according to the specific situation under consideration.

Recommendation 2 - Assess the risk

Once work-related violence has been identified as a hazard, hospital management should ensure that appropriate risk assessment is conducted at their workplaces. Management and staff and their representatives should work together to develop appropriate strategies to assess risks. Managers, in consultation with staff and their representatives, should take measures to ensure that the additional risks attached to working on high-risk tasks, in particular circumstances, or at specific times of the day or night, are mitigated by appropriate preventive interventions. This is particularly relevant in an Accident and Emergency context.

Analysing Available Information

A great deal of information is usually available that should be properly exploited. To this purpose:

- official records concerning incidents, absenteeism, turnover should be carefully analysed
- workplace inspections should be carried out regularly
- periodical general and situation-specific surveys should be carried out among the staff
- discussions with workers and their representatives should be developed
- an ongoing relationship with occupational health services should be maintained
- contacts with other employers, employers' organisations, relevant governmental organisations, customer/patient advocacy groups and insurance companies should be maintained.

Identifying situations at special risk

There are a number of work situations that have been identified as being at special risk of workplace violence. Workers in Accident and Emergency Units are exposed to the entire range of such situations of risk and this makes this category of workers unique in terms of the importance and spread of workplace violence.

Situations at special risk typical in Accident and Emergency Units

(i) Working in contact with the public
A wide variety of occupations in Accident and Emergency Units involve contact with the public. Increasingly, exposure to the public generates higher risks of violence.

(ii) Working with objects of value
Wherever valuables (e.g. cash, drugs, syringes/needles, expensive equipment) are, or seem to be within “easy reach”, there is a risk that crime, and increasingly violent crime, may be committed. Workers in Accident and Emergency units the health sector, such as administrative staff handling cash and those dealing with the dispensing and storage of drugs, are exposed to such a risk.

(iii) Working with people in distress
Frustration and anger arising out of illness and pain, psychiatric disorders, alcohol and substance abuse, can affect behaviour and make people verbally or physically violent. The incidence of violence faced by workers in contact with people in distress is very common and Accident and Emergency unit workers are at the forefront of this situation.

Recommendation 3 – Agree Appropriate Interventions

Once the potential existence of work-related violence has been recognized and the situations at risk identified, action to deal with the violence should be taken.

To this end, there are a range of interventions, which can be used. However, before any intervention is made, there are two pre-conditions, which must be in place. They are, the establishment of a policy against workplace violence and the allocation of policy responsibilities.

Establish a policy against workplace violence

Hospital managers should in so far as is reasonably practicable, promote workplace practices that help to eliminate workplace violence.
The first intervention that management should make is to develop a clear policy statement of intent, which should be issued and communicated by top management, recognizing the importance of efforts to eliminate workplace violence. This policy should include the definition of workplace violence, a statement that no workplace violence would be tolerated and a commitment to support any action targeted at creating an environment free from workplace violence and its direct adverse consequences. It should also address the provision of a fair complaints system that is free from retaliation and that protects against abusive or frivolous complaints, and the provision of information, education, and training in this area. Policies should also outline those measures being implemented to prevent, control and, as appropriate, eliminate workplace violence.

The policy should be communicated to all those concerned and should be accompanied by initiatives to raise awareness among employers, workers, the general public, clients and customers.

Allocate policy responsibilities

The policy should in particular include a statement that supervisors and managers have a duty to implement the policy and to demonstrate leadership by example. The policy needs to also include a commitment to provide managers with the ability and the means necessary to carry out the policy at all levels within the hospital and in all units.

Having ensured that the two pre-conditions referred to above are in place, management must then agree and implement the most appropriate interventions. Potential interventions can be considered under the following headings:

Staffing Interventions:

The adequate presence of staff, in terms of numbers and qualification should be ensured, especially:

- At peak periods, during patient transfers, emergency responses, meal times and at night.
- In admission units and crisis or acute care units
- For patients with a history of violent behaviour or gang activity

Available staff should be used in the most effective way and arrangements should be made in this respect with the staff concerned, including:

- arranging staff rotation for particularly demanding jobs and for those who are new to the job
- detailing how staff move between different working areas
- arranging rosters to ensure staff have assistance in case of violent situations
- arranging assignments so that workers in dangerous situations do not work alone.

Interventions related to management style

Management is a natural point of reference within organisations. When the management exemplifies positive attitudes and behaviour at the workplace, the entire organisation is likely to follow suit. A management style based on openness, communication and dialogue, in which caring attitudes and respect for the dignity of individuals are priorities, can greatly contribute to the diffusion and elimination of workplace violence.

Information and communication

Circulation of information to staff and open communication between units can greatly reduce the risk of workplace violence by defusing tension and frustration among workers.
The provision of timely information to patients and their friends and relatives, is also crucial in lessening the risk of assault and verbal abuse. This is particularly the case in situations involving distress and long waiting periods, as often occurs in Accident and Emergency departments. In particular:

- protocols or codes of conduct, explaining the obligations as well as the rights of patients, relatives and friends, should be compiled, distributed, displayed and applied
- sanctions in response to violence against personnel, should be made known

Information on the risks involved in specific situations and effective communication channels should be provided to workers at special risk, such as ambulance staff. This includes:

- providing emergency codes so that staff can request help without having to explain the situation and, therefore, without alerting an assailant
- providing information on the possible risks involved in future contacts and their location
- maintaining links with the local police to acquire up-to-date information on problem locations or known violent patients
- providing alarm systems as indicated below under “workplace design”

Work practices

Changing and improving work practices is a most effective, inexpensive way of diffusing workplace violence. Since every working situation is unique, a combination of different measures should be used which can best respond to each situation.

- client flow should be tailored to suit needs and resources
- overcrowding should be avoided (see appendix 3)
- waiting times should be kept to a minimum and feedback given systematically to those waiting regarding their waiting time, or the waiting time of the patient they are accompanying , if they are a relative/friend.
- workers should be given margins of flexibility so that rules and policies are not interpreted by patients as intolerable constraints
- night workers, especially women and those moving from building to building or working in isolated areas of a building, should, if at all possible, work together or in close proximity to each other

Job design

Job design is an essential factor in respect of violence at the workplace from fellow employees as well as from the public. An efficient design should ensure that:

- tasks performed are identifiable as whole units of a job rather than fragments
- jobs make a significant contribution to the total operations of the unit or hospital, which can be understood by the worker
- jobs provide an appropriate degree of autonomy
- jobs are not excessively repetitive and monotonous
- sufficient feedback on task performance and opportunities for the development of staff skills are provided
- jobs are enriched with a wider variety of tasks
- work overload should be avoided
- pace of work is not excessive
- access to support workers or team members is facilitated
- time is available for dialogue, sharing information and problem solving

Working time

To prevent or diffuse workplace violence, working time management should avoid excessive work pressure by:

- arranging, as far as possible, working time in consultation with the workers concerned
- avoiding long hours of work as people become more vulnerable to fatigue and irritation as the shift progresses
- avoiding a massive recourse to work overtime
- providing adequate rest periods
- creating autonomous or semi-autonomous teams dealing with their own working time arrangements
- keeping working time schedules regular and predictable
- keeping, as far as possible, consecutive night shifts to a minimum

Physical environment

The physical features of a workplace are key factors in either defusing or acting as a potential trigger of violence. Special attention should be therefore paid to the level and ways in which workers, patients and visitors are exposed to such factors and to the adoption of adequate solutions, in line with existing law and practice, to reduce or eliminate any negative impact. In particular:

- levels of noise should be kept to a minimum to avoid irritation and tension among workers, visitors and patients
- colours should be relaxing and attractive
- bad odours should be eliminated
- good illumination should be maintained to improve visibility in all areas, particularly access, parking and store areas especially at night
- Access to welfare facilities should be well lit, monitored and safe

- measures should be taken to provide adequate temperature/humidity/ventilation especially in crowded areas and in hot weather
- all physical structures and fixtures should be well maintained

Workplace design

In the specific context of possible violence and aggression in the workplace, especially in those areas open to the public, the design of workplaces requires special attention and involves the following additional factors:

Access

- safe access should be provided to and from the workplace
- multiple areas of public access to Accident and Emergency units should be minimized
- security services should be placed at the main entrance, near visitors' transit route and in the Accident and Emergency department
- there should be a 'safe area' using protective glass and with access to panic buttons and cctv for extreme emergency situations
- the reception area should be easily identifiable by patients/visitors, easily accessible and visible to other staff
- access to staff areas (e.g. changing rooms, rest areas) must be restricted and limited to personnel
- staff parking areas should be located within close proximity to the workplace

Space

- there should be sufficient space among visitors and patients to reduce personal interference and the build up of tension
- adequate workspace should be provided to facilitate provision of services
- adequate space/facilities should be provided for personnel to relax
- spacious and quiet reception areas with sufficient space for personnel, should be provided
- protective barriers should be used for workers at special risk and to separate dangerous patients from other patients and the public

Waiting areas

- there should be comfortable seats especially where long waiting is involved
- boredom should be reduced by providing activities (e.g. reading materials, television, toys for children)

Fixtures and fittings

- furniture should be arranged in such way as to prevent entrapment of staff

- in interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp corners or edges, and where appropriate, be affixed to the floor

Premises

- treatment rooms should have two exits or where this is not possible, they should be so arranged as to allow easy means of exit
- treatment rooms in emergency services should be separated from public areas
- the possibility of providing a separate room for emotionally disturbed patients, intoxicated patients, confronting gangs and similar cases, should be given special consideration bearing in mind however, that in certain circumstances, recourse to such a facility may be perceived as discrimination and thus further exacerbate the situation
- toilets, areas providing food, drink and public telephones should be signposted, easily accessible and properly maintained
- privacy should be respected as much as possible.

Alarm systems and surveillance cameras

- surveillance cameras should be installed in potentially dangerous areas
- alarm systems e.g. telephone, beeper, short-wave radio, should be provided to workers where risk is apparent or may be anticipated to alert or notify other colleagues in the event of a problem
- the use of silent systems is advised in order to avoid the reaction of the assailant. If silent systems are not available the victim should avoid using the systems before the assailant has left in order to avoid angry reactions from him/her
- a reliable response system when an alarm is triggered should be arranged
- the type of alarm system should depend on the risk assessment for the particular area.

Training

Training to cope with workplace violence should be based on a set of policies and provided on a continuous or periodical basis depending on the specific needs, to all workers and their representatives, supervisors and managers. Training should include:

- orientation to the workplace environment, management policies and grievance procedures
- information on the different types of workplace violence, physical and psychological, and best practices for its reduction
- information on gender, multicultural diversity and discrimination to develop sensitivity to such issues
- improving the ability to identify potentially violent situations
- instilling interpersonal and communication skills, which could prevent and defuse a situation of potential workplace violence
- developing competence in the particular functions to be performed

- preparing a “core group” of mature and specially competent staff and workers’ representatives who can take responsibility for more complicated interactions
- assertiveness training or empowerment, especially for women
- self-defence, as required according to risk assessment

Guidelines for specific occupations should further identify the special training needs and skills required for preventing or coping with workplace violence under particular circumstances.

Assistance and counselling

Assistance and counselling to help individuals recognize the danger in their present behaviour and assistance to change their conduct/attitude (e.g. domestic violence, substance abuse, or that resulting from stress, depression, insomnia) should be made available.

Well-being promotion

Maintaining physical fitness and emotionally stable psychic conditions is an effective way to cope with workplace violence. Special attention and encouragement should be given to the development of the habit of regular physical exercise, proper eating and sleeping habits, relaxation techniques and leisure activities, particularly those involving socialisation among staff members.

Dealing with the often overlapping and conflicting demands of the workplace and the family can be very stressful and generate tension and dissatisfaction. The provision of the means to reconcile work and family responsibilities such as flexible working time arrangements, the creation of crèches at the workplace or special assistance given to single parents, can effectively contribute to the prevention of workplace violence.

After-the-event interventions

After-the-event interventions should be directed to minimise the impact of workplace violence and to ensure that such violence will not be repeated in future. They should be targeted not only at the victim but also at the perpetrator, the witnesses and all other staff directly or indirectly concerned by a violent incident / behaviour.

Response plans
Management plans for handling situations of workplace violence and for helping all those affected by workplace violence to deal with the distressing and often disabling after-effects of a violent incident / behaviour as well as to prevent severe psychological problems from developing later, should be made available and tested in advance.

Reporting and recording

Reporting and recording systems are essential for identifying places and work activities where violence can be a problem. All incidents, involving both physical and psychological violence, as well as minor and potential incidents where no actual harm has resulted, should be reported and recorded.
The manager should establish procedures to register all cases of workplace violence and mechanisms to respond to such cases should be available. Periodic review of such reports of incidents as an indicator for improving workplace safety measures, should be carried out.
All workers should know how and where to report, without fear of reprisal or criticism.
A report form should be designed to elicit the following information:

- where the incident occurred, including the physical environment
- the date and time of day
- activity at the time of the incident
- details of the victim
- details of the alleged perpetrator
- relationship between victim and alleged perpetrator
- account of what happened
- witnesses
- outcome
- measures undertaken after the incident
- effectiveness of such measures
- recommendations to prevent a similar incident happening in the future

Workers should also be encouraged to report on conditions or situations where they are subjected to excessive or unnecessary risk of workplace violence; and to make suggestions for reducing the risk of violence or improving working conditions.

Medical treatment
Immediate medical treatment should be available, and its existence known to all those affected by workplace violence. Special care should be exercised when dealing with victims of sexual offences since the medical examination can be reminiscent of the offence itself and therefore particularly distressing.

De-briefing
Debriefing as required should be made available to all those affected by workplace violence. It would include:

- sharing personal experience with others to diffuse the impact of violence
- helping those who have been affected by workplace violence to understand and come to terms with what has happened
- offering re-assurance and support
- getting people to focus on the facts and give information
- explaining the subsequent help available.

Counselling
Counselling by specialist or peer groups should be also made available as required. Specialist counselling should be provided directly by the health care

institution as part of occupational health or its own clinical psychology service, or, if these are not available, by referral to external services.

Management support
The management should provide immediate and protracted support to all those affected by workplace violence.
In particular, the management should:

- deal with the immediate aftermath of violence
- minimise the impact of workplace violence by taking care of or advising on provision of leave, costs and legal issues
- provide information and support to the families of those affected
- initiate a timely internal investigation
- follow-up the case for as long as is necessary

Representation and legal aid
Trade unions, professional organisations, and if necessary colleagues, should be involved in providing representation and legal aid, as required. This would involve:

- assistance and support with Garda Siochana procedures
- consulting with sources of legal aid in regard to options
- attending meetings, investigations and hearings
- stewards having access to training in workplace violence

Grievance procedures
Procedures should be available which may help solve problems before a situation further deteriorates.
The complainant and the perpetrator, if they are both employees, should both be:

- seen privately
- informed that the organization will take the complaint seriously and that every endeavour will be made to sort the case out quickly
- advised on what is likely to happen next
- assured of confidentiality
- protected from further violence and the spreading of rumours

Rehabilitation
Recovery from workplace violence may involve a long period of rehabilitation. Workers should be supported during the entire period of rehabilitation, allowed all necessary time to recover but also encouraged to return to work. The sooner the victim can return to work, the easier it would be for him/her to rejoin the group and the worker will have missed out on less of the current information needed for effective job performance. However, workers should not be subjected to too much stress at first and flexibility such as in the form of part time work, a different assignment or support of a co-worker can allow the victim to recover self-confidence. For victims of workplace violence it is important that, when they return to work, they feel safe in their environment both from physical and psychological violence.

Recommendation 4 – Evaluate the effectiveness of chosen interventions

Evaluation of the effectiveness of anti-violence plans and measures should include:

- monitoring, on a continuous basis, and regular dissemination of the results of measures introduced
- involving the workers in developing the criteria for evaluation and receiving regular feedback from them to check how well they are working and to make modifications as necessary
- organising periodical joint meetings of management and workers to discuss the measures put in place
- reviewing the management plan on a regular basis including the assessment of policy implementation.
- re-assessing the workplace culture, work organisation and the quality of the environment to effectively respond to workplace violence
- activating a risk management cycle to make the combat of workplace violence an ongoing process within organisations