The Report of the Task Force on

Assaults on Psychiatric Nurses

April 2003

Chapter 1

1.0 Introduction

The Minister for Health and Children established a Task Force to investigate assaults on psychiatric nurses, with a view to exploring preventative measures to reduce the incidence of assaults, and as a practical measure, where assaults have resulted in serious physical or psychological injury, to provide a compensation scheme to be applied to nurses.

Against a background of long standing claims and negotiations by the PNA and SIPTU, and a campaign of industrial action, the nursing unions had sought a compensation scheme for personal injuries suffered as a result of serious assault. A nationwide survey conducted by the Psychiatric Nurses Association, showed that assaults against nurses in Irish mental health facilities were in excess of 800 in the year 2001.

The question of assaults and violence against nurses has been a source of grave concern for all concerned in the Health Service. There is little doubt that society is becoming more violent and this fact is unfortunately reflected in the health services worldwide. Health care workers are assaulted more frequently in the workplace than any other group in the United States (OSHA 1996). The National Health Service (NHS) in the U.K. in a survey (1998/99) found that approximately 65,000 violent incidents occurred against staff in the health service in that year. While there was considerable variation the average number of incidents in mental health/ learning disability Trusts was over three times the average for all Trusts. In an Irish context research by the Psychiatric Nurses Association found that the incidents and severity of assaults has increased over the years.

This report is divided into four chapters; Chapter one contains an introduction, membership of the Task Force and the terms of reference; Chapter two focuses on the reasons for assaults on nurses and details preventative measures based on the findings of national and international reports and literature; Chapter three summarises a survey, conducted by the Task Force, of assaults on psychiatric nurses in the Mental Health Services in Ireland during the year 2001; Chapter four puts forward a proposed compensation scheme for nurses in the Mental Health Services injured by serious assault.

1.1 Membership of the Task Force

Mr Tom McGrath	Independent Chairperson
Mr Brendan Mulligan	Health Services Employers Agency
Mr PJ Lawlor	Director of Nursing Mental Health
Ms Teresa Cody*	Assistant Principal Officer, Nursing Policy Division, Department of Health and Children.
Mr Cormac Walsh	Mental Health Nurse Adviser, Nursing Policy Division, Department of Health and Children.
Mr David Brennan	Department of Finance
Mr Ken Spratt	Department of Finance
Mr Terry Walsh	Department of Finance (replaced David Brennan)
Mr Oliver McDonagh	SIPTU
Mr Pat Hughes	SIPTU
Mr Seamus Murphy	PNA
Mr Ed Mc Donald	PNA
Mr Gerry Coone	PNA
Mr Des Kavanagh	PNA deputised for Seamus Murphy

*Ms Cody served on the Task Force from its inception until her transfer to the Community Division of the department of Health and Children.
Ms Caitriona Mason, Executive Officer, Nursing Policy Division, Department of Health and Children served as secretary to the taskforce.

1.2 Terms of Reference

At the first meeting of the Task Force, on 12th June 2002, the members agreed the terms of reference, having regard to the letter of clarification from the Minister for Health and Children, dated 16th April 2002 (see appendix 1), to read

- Examine the incidence of assaults on nurses and the level of injury therefrom.
- Investigate the reasons for such assaults with a view to the putting in place of effective preventative measures.
- Put forward proposals for an appropriate compensation scheme for nurses injured through assault at work, such proposals to have regard to the special position of psychiatric nurses.
- Prepare and present a report of its findings and recommendations to the Minister for Health and Children;

Chapter 2

2.0 Causes of Violent Incidents.

If the incidents of assaults are to be eliminated or reduced as far as reasonably possible the causes need to be understood. Mental illness, though in itself not a direct cause of violence, may lead to aggressive and violent behaviour. In 1990, Swanson et al., in a study of a community population, reported that in the previous year, people with schizophrenia were four times more likely to perpetrate a violent act than those with no evidence of mental disorder.

The Epidemiological Catchment Area Study conducted in the United States showed that those with a "dual diagnosis" (i.e. with co-existing mental illness and drugs/ alcohol misuse) were sixteen times more likely to perpetrate violent acts than those without mental disorders.

As part of the Royal College of Psychiatrists' work on the management of imminent violence, three focus groups of mental health users and one focus group of carers were held. These groups identified a number of key issues that frequently influenced the development of violent incidents. These included;

- Access to privacy (telephones, toilets, showers, private conversations with relatives and friends).
- Access to open spaces and fresh air, (having the ability to leave the ward).
- Making the clinical setting more "homely" including access to television, having lockers, and access to private telephones.
- Access to spacious facilities (confrontations may be caused because of cramped facilities).

The groups also defined that the characteristics of the human environment influenced the severity of violence. These included boredom, lack of opportunity to participate in therapy and social groups, and staff attitudes. Psychiatric units often have major deficits and the National Audit (Royal College of Psychiatrists 2000) found that there were particular problems with – sight lines being impeded, exits and entrances not being within the sight of staff, accessible exit doors, and moveable objects being of a safe weight, size, and construction. From an Irish context, "Guidelines on Good Practice and Quality Assurance in Mental Health Services" (Department of Health and Children, 1998) forms a guide towards good practice and quality assurance by addressing standards in 'the process' and 'setting' of mental health care.

2.1 Effects of Incidents of Violence.

Incidents of assault in the workplace have psychological, physical, social and environmental effects. The physical and/or psychological injury that occurs can cost the nurse involved days lost at work, permanent or temporary disability, fear, depression, anxiety, self-doubt, irritability and or disturbed relationships with family and /or work colleagues. In areas of higher incidence of health care workplace assault the environment in which the staff work tends to be fragile. The nursing staff develops feelings of isolation, taking the view that management is unsupportive and uncaring (OSHA 1996).

This view manifests itself in the underreporting of incidents of assaults. Literature shows that nurses tend to underreport incidents or threats, feeling that it is part of the job (Williams and Robertson 1997). Some nurses feel that the inability to cope with violence or threats is an individual weakness (Simonowitz 1995). There is evidence that nurses underreport incidents of violence due to non-supportive administrative environments or the incident is considered not serious enough to report. Some serious incidents are not reported because reporting procedures are too time consuming or there is a lack of

agreement on the definition of violence or awareness of the reporting system. (Beale et al 1999, Owen et al 1998, Royal College of Psychiatrists 2000).

In such circumstances there can be the feeling by those involved that the incident is their fault. Nursing staff begin to feel victimised and chose to leave the profession or seek relocation to facilities where they feel safer.

2.2 Prevention

It is evident from all the sources researched that violence in the health care workplace is prevalent and on the increase. In the Irish context the trend has been recognised and improvements are being considered and implemented. However there are not in existence nationally, consistent policies on how to prevent violence and make health care facilities safe and secure for staff. (A legal requirement under the present and proposed health and safety legislation).

There is a need for management to establish effective and consistent workplace violence prevention programmes. There is also a need to put in place clear and unambiguous policies to direct managers on how to prevent and handle violent incidents.

In any consideration of effective preventative measures it must be accepted that the needs of the patient are paramount. Whilst the objective of the service is to provide a high quality of therapy, security and safety for patients, in so doing there is a duty to provide a safe working environment for staff.

A high priority should be placed on eliminating the factors likely to give rise to incidents of assault and of valuing nurses' health and safety on the same level as that of patients. Prevention should be geared towards endeavouring to achieve, as far as possible, the elimination of risk.

The benefits from such approach would include;

- Reduction in staff absenteeism
- Retention of nurses
- Reduced retirement through ill health
- Greater compliance with legislation
- Improved staff morale
- Improvement in the quality of care as a consequence of improvements in the relationship of staff and patients
- A reduction in costs

2.3 Recommendations

- There is a wide range of facilities in the mental health area. Assaults will not necessarily be prevalent at the same level in all facilities. Standard procedures should be put in place in each facility to evaluate the incidence, severity and cause of assaults in each workplace, together with measures by which such risks can be identified and eliminated or controlled as far a reasonably possible.
- The guidelines on an Occupational Health Safety and Welfare service for Health Service Staff, particularly those relevant to incidents of assaults in the workplace, should be implemented in full and the provision of appropriate services and supports as required should be made available by Occupational Health Departments.
- Training for safe working practice should be implemented for staff in all mental health facilities with particular attention being paid to students or less experienced staff.
- The curriculum for nursing staff should include both instruction and hands-on techniques for safe working practices, with the course content being based on the level of risk of violence in each type of mental facility.

- All staff should be instructed in interventions including verbal skills, self-protection skills and physical interventions.
- Management should be instructed in threat assessment and incident management.
- Ongoing in-service training should be made available to all staff to continuously update skills to enable staff to eliminate or control incidents of assault.
- Discussion should be initiated with appropriate bodies to standardise training courses and to accredit qualifications of those conducting or partaking in such courses.
- A forum should be established to examine procedures for reporting and collecting data on incidents of assault with a view to making available standard data in respect of all mental health facilities.

2.4 Conclusion

These recommendations in themselves will not succeed in achieving the elimination of incidents of assault if the environmental issues referred to above are not addressed. Commentators suggest that the environment is a major factor in the cause of incidents of violence in mental facilities. Workplace evaluation should be instituted in all facilities to identify existing hazards and situations that create or constitute hazards or areas where hazards may occur likely to increase to incidents of violence. It is incumbent on employers that appropriate service and supports are made available to injured nurses.

Chapter 3

3.0 Survey of Assaults on Psychiatric Nurses, 2001

A presentation entitled 'An Exploration of Aggression and Violence experienced by Nurses in Mental Health Care Practice in Ireland' informed the Task Force of the issues relating to the management and prevention of violence in the psychiatric setting. The presentation included the categorisation of assaults, identification of locations where assaults most frequently occurred, training issues for nurses in the management and prevention of violence and the nature of reporting of incidents by nurses.

3.1 National Statistics on assaults

The Task Force identified the necessity to have an accurate account of the number of assaults on psychiatric nurses in a given year. A number of bodies gather and collate statistics annually on assaults against nurses working in the mental health services as follows

- The Health and Safety Authority
- The Inspector of Mental Hospitals
- Irish Public Bodies insurances

The relevant data gathered by these bodies is specifically for the purposes of the individual organisation, be it insurance, inspection or health and safety, consequently different definitions and criteria of assault are used by each organisation.

Under section 2.72 of the Mental Treatment Act 1945, the Health Boards must report, to the Minister of Health and Children, all incidents, accidents and assaults that occur in psychiatric hospitals. These figures are reported annually in the Report of the Inspector of Mental Hospitals.

The Health and Safety Authority record accidents or assaults that result in more than three days off sick, the published figures do not distinguish nurses working in the mental health services as a separate group from the larger 'Health and Social Work' grouping. There was however an almost a twofold increase in the number of reported injuries, that resulted in more than three days absence, of personnel in the 'Health and Social Work' group, from a total of 383 in 2000 to a total of 679 in 2001.

Irish Public Bodies insurance company gathers data on all reported assaults or incidents that may lead to a claim for compensation against a hospital or public body. There were 69 recorded incidents of assault on nurses in the mental health services in 2001.

The taskforce, informed by the findings of the PNA survey of assaults on psychiatric nurses in 2001, the presentation and considering other sources of information, decided to independently verify and classify the number of assaults on nurses in the Mental Health Services for the year 2001.

3.2 Questionnaire

Using a modified version of the European Violence in Psychiatry Research Group's (EViPRG) classification and definition of assault, a questionnaire (see appendix 4) was sent to 38 Directors of Nursing in the Mental Health Services. The questionnaire sought to identify;-

- The number of assaults on psychiatric nurses
- The classification of assaults on psychiatric nurses
- The amount of sick leave as a result of assault
- The location where the assaults occurred
- The nature of the injury suffered

Directors of Nursing in the Mental Health Services were requested to identify, in partnership with nurse union representatives, the number of assaults/incidents recorded for the year 2001in their service. A number of reporting mechanisms were available to Directors of Nursing for the purposes of identifying assaults or violent incidents and these included; Accident/Incident forms; Day/Night reports; and other reports. There was a response rate of 87% to the survey.

3.3 Results

The survey revealed a total of 1662 assaults/incidents on psychiatric nurses in the year 2001. There were 558 reported injuries as a result of the 1662 assaults/incidents. 108 nurses were off sick as a result of an injury sustained through an assault/incident, representing 6.5% of the total assaults/incidents recorded (see table 3.2 for length of sick leave).

It was noted, from the completed questionnaires, that the number of nurses reported 'off sick' (3.3%) did not correlate with the number of assaults reported as 'severe physical violence' (4.4%). Severe Physical Violence was defined in the survey as *"an attack on a person that results in severe injuries being sustained"*. Examples may include broken bones, deep lacerations, internal injuries, loss of teeth, loss of consciousness necessitating medical treatment or hospitalisation' (see appendix 2 for definitions of assault/violence used in the survey). It is assumed that following such an assault that the nurse would be unfit for duty and need to report off sick.

Each hospital where this discrepancy occurred was contacted by phone. It was established that in these instances, the Directors of Nursing Mental Health and Union Representatives had used the term or category 'severe physical violence' to describe an incident or assault where the nurse had sustained a number of punches and/or several kicks, or a weapon was used by the assailant, or the nurse was trapped and isolated from colleagues. These assaults had not resulted in sick leave or severe injury (i.e. broken bones, deep laceration) but were deemed more severe than mild violence, by those completing the questionnaire (mild physical violence is kicking, hitting, pushing, punching, scratching, hair pulling etc.). However these behaviours either do not lead to injury or at most the consequences of these behaviours are limited to minor physical injuries, for example bruises, sprains, welts etc.).

Table 3.1 Number of incidents and sick leave relative to category of violence

Category	Recorded	%	Sick leave
Non-threatening verbal aggression	55	3.3%	None
Threatening verbal aggression	284	17.0%	None
Humiliating aggressive behaviour	30	1.8%	None
Proactive aggressive behaviour	25	1.5%	None
Passive aggressive behaviour	16	1.0%	None
Threatening physical aggression	172	10.3%	2 (0.1%)
Destructive aggressive behaviour	80	4.8%	None
Mild physical violence	678	40.8%	51 (3.1%)
Severe physical violence	74	4.5%	55 (3.3%)
Mild violence against self	183	11.0%	None
Severe violence against self	20	1.2%	None
Suicide attempts	36	2.2%	None
Completed suicide attempts	2	0.1%	None
Sexual intimidation/harassment	6	0.4%	None
Sexual assault	1	0.06%	None
Total	**1662**	**100**	**108 (6.5%)**

Table 3.2 Category and length of sick leave of nurses as a result of assaults

Category	1-7Days	7Days-1Month	1Month-3Months	3Months-6Months	6Months-I Year	Over 1Year	Total
Threatened Physical Violence	0	0	1 (.06%)	1 (.06%)	0	0	**2**
Mild Physical Violence	18 (1.1%)	19 (1.1%)	7 (.36%)	4 (.24%)	1 (.06%)	2 (.12%)	**51**
Severe Physical Violence	15 (.90%)	15 (.90%)	7 (.42%)	8 (.50%)	4 (.24%)	6 (.36%)	**55**
Total	**33**	**34**	**15**	**13**	**5**	**8**	**108**

(Percentages quoted are relative to the total number of assaults)

Table 3.3 Nature of injuries sustained as a result of assault

Nature of Injury	No of reports	%
No Reported / Apparent injury	1104	66.5 %
Sprain	30	1.6 %
Bruising/tenderness	249	15.0 %
Head/facial injury	43	2.6 %
Burn/scald	2	0.1 %
Cut/graze/scratch	140	8.4 %
Cut requiring suture	3	0.2 %
Back/neck injury	37	2.2 %
Stress related	38	2.2 %
Fractured bone	6	0.4 %
Torn clothes	2	0.12%
Needle stick injury	3	0.2 %
Bite	5	0.3 %
Total	**1662**	**100%**

3.4 Locations

The Mental Health Services throughout the country are at different stages or levels of development along the framework outlined in Planning for the Future (Department of Health and Children, 1984). There are 19 services with admission units attached to general hospitals while there are still16 admission units/wards on the campus of psychiatric hospitals in Ireland. Some mental health services have a combination of admission facilities available to them. The decision to admit a patient to either one or other facility is based on a risk assessment and the legal status of the patient.

A discussion document on services for the disturbed mentally ill was prepared by the Mental Health Division of the Department of Health and Children, in consultation with the health boards, and finalised in February 2000. It now forms the basis for policy in this area. The document envisages that each health board should have a Psychiatric Intensive Care Unit for disturbed patients. Health boards are now pursuing this objective as part of their overall development plans for the mental health services.

Admission Units are areas of higher risk of aggression and consequently assault and this fact is borne out in the figures in table 3.4. Many mental health services are developing smaller *Psychiatric Intensive Care Units* or *High Dependency Units*. These units, usually six-bedded and an annex of the admission ward, provide observation and treatment of patients for whom management on an acute ward is not possible. These units have higher nurse/patient ratios and are proven to have a positive effect on reducing the incidence of violence and aggression with a resultant reduction in the number of assaults against nurses.

Table 3.4 Locations

Location	Number and % of assaults
Forensic Hospital	68 (4.1%)
Psychiatric Hospital Secure Unit	121 (7.1%)
Admission Unit	709 (42.6%)
High Dependency/ Intensive care	108 (6.6%)
Continuing Care	223 (13.5%)
Alzheimer's Unit	17 (1.0%)
Rehabilitation Unit	24 (1.4%)
Campus/grounds	15 (0.9%)
General Hospital Psychiatric Unit	204 (12.4%)
Campus/grounds	8 (0.4%)
Community Day Hospital	2 (0.1%)
Day Centre	8 (0.4%)
High Support Hostel (including respite)	32 (1.9%)
Medium Support Hostel	
Low Support Hostel	3 (0.18%)
Patient's Home	3 (0.18%)
Intellectual Disability Services	114 (7.0%)
Other sites	3 (0.18%)
Total	**1662 (100%)**

3.5 Conclusion and recommendation

The use of a very broad definition of violence in this survey has revealed many differences in the interpretation and recording of assault and violent behaviours in the mental health services. The survey also revealed differences in the admission criteria, and the range and access to facilities within and between Health Board mental health services. These differences make the task of extrapolating values for accurate comparison of the incidence of assaults between mental health services and the different type of facilities within them more difficult.

The Task Force recommends that national standard definitions of violent behaviours and assault be agreed and adopted by all Health Boards and Hospitals. The use of standard definitions by all the mental health services will generate compatible data for the accurate comparison and analysis so that the incidence of assaults and the interventions (use of risk assessment tools, training, intensive care units etc.) used by each mental health services can be evaluated and compared. This in turn will improve planning of mental health services; the quality of the mental health services and reduce the incidence of assault against nurses working in the mental health services.

Chapter 4

4.0 Psychiatric Nurses Compensation Scheme

The Task Force, as part of its remit, to put forward proposals for an appropriate compensation scheme for nurses in the mental health services assaulted during the course of their duties, considered a number of schemes applicable in the public sector (i.e. Garda, Prison Officers' compensation schemes).

The Task Force also included in their considerations a very detailed oral presentation and written suggestions from a representative of the State Claims Agency, and submissions from the Trade Unions.

The Task Force, having taken into account all of the information and evidence made available, took the view that any compensation scheme introduced should provide that claims, in respect of nurses seriously injured as a consequence of serious assault in the course of their duties, be dealt with in an efficient, cost effective and expeditious manner. Accordingly the Task Force makes the following recommendations: -

- That the current compensation scheme, the 'Revised Serious Physical Assault Scheme' (5/6 scheme), for nurses injured as a result of serious assault be continued.
- That a compensation scheme be introduced as outlined below for nurses injured as a result of serious assaults which will provide a lump sum in respect of pain and suffering and out of pocket expenses, this payment not to include loss of earnings.
- The scheme to be a "no fault", non-statutory scheme.

4.1 Compensation Scheme in respect of Personal Injuries sustained by Nurses in the Mental Health Services, as a result of Serious Assault.

4.1.1 Definitions.

Injury
Injury means any serious impairment of a person's physical or mental condition.

Nurse
Nurse means a Registered Nurse working in the Mental Health Services.

Patient
(a) Patient means a person ordinarily understood as being a patient, whether voluntary or involuntary, in any psychiatric hospital, or institution which is managed by, recognised by or, directly or indirectly funded by a Health Board or the Department of Health and Children.

(b) A patient who is a resident in any Hostel or other sheltered or community based residence, which provides psychiatric services.

(c) A person in the community who is or has been a patient / client of such psychiatric services or any person upon whom a nurse in the mental health services must attend on or visit, as part of his/ her duty.

(d) A person presenting for or receiving periodic or ongoing treatment at any Clinic or Hospital or Day Care Centre of the Mental Health Services.

Serious Assault

A serious assault is an assault where the injury sustained results from: -

an actual assault by a patient

or

the application of restraint to a patient where such restraint/ control is deemed to be reasonably necessary to prevent the patient from injuring a nurse or another staff member, or another patient, or a member of the public, or the patient himself / herself or property.

and that

results in severe injuries necessitating medical treatment or hospitalisation (examples may include broken bones, deep lacerations, internal injuries, loss of teeth, loss of consciousness and post-traumatic stress disorder.).

4.1.2 The scheme applies to;

(a) Nurses who have been injured as a result of a serious assault whilst in the course of their duties.

(b) Nurses who have been injured as a result of a serious assault in the course of their duties in the three years prior to the date of the introduction of this scheme of compensation.

(c) Nurses who have been injured as a result of a serious assault whilst in the course of their duties and who have instituted proceedings before a Court of Law and who wish to have their claim processed in accordance with the provisions of this compensation scheme.

4.1.3 Persons to whom compensation may be awarded.

Compensation in respect of injuries may only be awarded to the person on whom those injuries were inflicted.

4.1.4 Claims for Compensation under the Scheme.

(a) Any person who claims to be entitled to compensation in accordance with the provisions of this scheme may apply to the Chief Executive Officer or his/her representative for such compensation.

(b) The claim shall be made within a period of six months from the date on which the injuries were sustained.

(c) The claim shall be made in a form, to be prescribed and shall state all matters as may be required.

(d) Where the claim is made in respect of injuries sustained before the date of the introduction of the compensation scheme (see 4.1.2 b), the claim shall be made within six months after the date of the introduction of the scheme.

(e) All parties shall furnish such information (previous medical reports, vouched costs, etc.) in relation to the claim as shall be specified by the Assessment Board as necessary for the consideration of the claim, within a time specified by the Assessment Board.

(f) The Chief Executive Officer concerned or such other person as he / she may designate, shall arrange for the information provided, together with such information on the incident as may be relevant to be referred to the Assessment board within one month of receipt of the application.

(g) The Assessment Board shall consider the application together with all relevant information.

4.1.5 Assessment Board

(a) The Assessment Board shall consist of appropriate persons, including a panel of specialist medical practitioners, as may be considered by the Minister for Health and Children as necessary in exercise of the functions of the Assessment Board.

(b) The Minister for Health and Children shall appoint the members of the Assessment Board.

4.1.6 Functions of the Assessment Board

(a) The Assessment Board shall have responsibility for the examination and assessment of claims for compensation in respect of injuries to nurses as a result of serious assault.

(b) The Assessment Board shall establish the necessary procedures for the purposes of carrying out its function.

(c) The Assessment Board appointed shall have authority/discretion to award compensation in any individual case.

(d) Where parties to the claim do not co-operate or furnish such information as may be relevant to the Assessment Board the Board may make such decision in respect of the claim as it considers appropriate.

(e) The Assessment Board shall prepare an annual report for the Minister for Health and Children.

4.1.7 Awards by the Assessment Board.

The standard of proof for the purposes of assessment of a claim shall be the “balance of probabilities”. Where the Assessment Board, having considered a claim for compensation under the provisions of this scheme, is satisfied the scheme applies to the injuries, and the claimant is the person on whom the injuries were inflicted, the Board may make an award to the claimant and shall fix the compensation in accordance with the following provisions: -

a) The compensation award in respect of the injuries sustained shall be determined and calculated in accordance with the compensation scheme Book of Quantum.

b) The Book of Quantum shall be based on the levels of general damages awarded by the Courts in respect of injuries similar to those covered by the scheme. The levels of compensation shall be discounted to reflect the fact that claimants under the scheme are not required to prove legal liability.

c) Compensation shall be by way of a lump sum. The lump sum shall be composed of general damages (pain and suffering), and special damages (medical and other out of pocket expenses) payable within a period of one month. The lump sum shall not include loss of earnings.

d) The Assessment Board may give consideration to the making of interim awards in special cases pending the final assessment of the claim.

4.1.8 Legal Costs

The scheme is a “No Fault” scheme and the claimants are not required to prove legal liability, accordingly the scheme does not provide for the payment of legal costs.

Appendix 1

CLARIFICATION

The following clarification is provided to the letter from the Minister for Health and Children of 11th April 2002 to the General Secretary of the psychiatric Nurses Association regarding discussions on the introduction of a compensation scheme for nurses injured in the course of their work. **This clarification is issued on the understanding that it will be recommended for acceptance and the PNA will call off their threatened industrial action scheduled for the 16th of April 2002.**

The Psychiatric Nurses Association acknowledges the complexities associated with the introduction of a compensation scheme for nurses assaulted in the course of their work. The Minister confirms to the PNA that as part of the Government decision making process on appropriate compensation scheme regard will be had to the findings of the Task Force and the empirical evidence provided to date by the PNA on the incidence and consequences of assaults on Psychiatric Nurses.

While it is recognised that it may be difficult to deal with this issue in relation to any one group of health service workers in isolation from the other public sector groups, regard will be had however to the recommendations of the Task Force on the special position of psychiatric nurses on the feasibility of an appropriate compensation scheme.

The Task Force will be chaired by a senior person, the composition of the Task Force and the chairperson will be agreed between the parties.

The Task Force will include in its terms of reference the following

"To examine and report on the factors relevant to the introduction of an appropriate compensation scheme".

The findings and recommendations of the Task Force will be accepted and progressed within an agreed time scale.

15th April 2002

Appendix 2

Royal College of Psychiatrists Clinical Practice Guidelines.

Calming Features in the clinical environment.

- All areas are clean and tidy.
- Reception areas are well planned.
- There are separate/ designated areas for patients with police escorts.
- There is adequate natural lighting and fresh air.
- Noise levels are controlled and crowding prevented.
- There is a perception of space.
- Private space and rooms are provided
- Ensured privacy in toilet, bathroom and single sex areas.
- Provision of private staff rest areas.
- Ambient temperature and ventilation are adequately controlled.
- Safe activities inside and outside are provided, ensuring an access to fresh air
- Non-smoking and smoking areas are provided.
- Personal effects are safe and accessible.

Ensuring a safe environment.

- There is a safe area for severely disturbed people (strong fabrics, secure fittings, reinforced glazing, sound insulation and toilet and washing facilities).
- Sight lines are unimpeded.
  Exits and entrances are within sight of staff
- Some doors have one way locks, preventing intruders from entering but allowing exit.
- Doors are easily accessible; i.e. can facilitate prompt exit.
- Seating can be arranged so that alarms can be reached and doors not obstructed.
- Alarms are accessible in areas where one patient and one clinician may work together.
- Collective responses to alarm calls are agreed and consistently applied.
- Clinicians are aware of policies and procedures prior to incidents.
- Movable objects are of safe weight, size and construction.

Appendix 3

Definitions of the categories of aggressive and violent experiences.

Non-threatening verbal aggression; For example people making loud noises, shouting, cursing, yelling personal insults, however not being perceived as a clear threat by you.

Threatening verbal aggression; For example people cursing viciously, using foul language in anger, making clear violent threats towards you, having angry outbursts, threatening violence on you outside of your work situation, any of which is perceived by you as frightening and threatening and which results in emotional distress.

Humiliating aggressive behaviour; For example, people expressing clear personal insults, abusive cursing, name-calling.
Making discriminatory remarks/gestures, spitting, which is perceived as making an impression on you and alters your pride and self-esteem, in other words you feel humiliated. There is a separate heading for perceived sexual intimidation or harassment.

Proactive aggressive behaviour; For example, proactive behaviours may include behaviours that you perceive are intended to initiate a quarrel with you or others with the intention of evoking a negative social response. In other words, you feel provoked by the behaviour of others to respond with actions or remarks, which are not socially acceptable for you.

Passive aggressive behaviour; For example, behaviour that is perceived by you as irritating, annoying, resistive and/or counteractive without at the same time being openly aggressive. In the case of patients, they may seem to show cooperative behaviour, however the underlying behaviour is perceived as totally opposite while being overtly compliant.

Aggressive 'splitting' behaviour; For example, people who are perceived as being involved in manipulative behaviour playing staff or patients off against each other and or tending to influence more vulnerable clients to support them in their opposition against staff which creates conflict or disharmony among staff.

Threatening physical aggression; For example, people throwing objects without obvious direction and/or injury, slamming doors, kicking/striking objects without breaking them, scattering cloths, making a mess marking or defacing objects, urinating on the floor, making threatening gestures, grasping cloths, making threatening approaches, threatening violence with weapons, which you perceive as threatening.

Destructive aggressive behaviour; For example, people breaking objects, smashing objects, setting fires, throwing objects, causing damage through behaviours such as kicking or striking out.

Mild physical violence; For example, people kicking, hitting, pushing, punching, scratching, pulling hair, biting, attacking you etc., however these behaviours either do not lead to injury or at most the consequences of these behaviours are limited to minor physical injuries, for example bruises, sprains, welts etc.

Severe physical violence; For example, people attacking you with severe injuries sustained as a result. Examples may include broken bones, deep lacerations, internal injuries, loss of teeth, loss of consciousness necessitating medical treatment or hospitalisation.

Mild violence against self; Self directed violence, people picking or scratching their own skin, hitting themselves, pulling their own hair, banging their head, hitting objects with their fists, throwing themselves on the floor or into objects resulting in no or minor self injury.

Severe violence against self; For example people mutilating themselves resulting in deep cuts, bites that bleed, cigarette burns with serious injury as a result, cuts or major burns,

internal injury, fractures, loss of consciousness, loss of teeth necessitating medical attention or hospitalisation.

Suicide attempts; For example people overdosing on medication, cutting their wrists, jumping form buildings etc, but not resulting in 'completed' suicide.

Completed suicide attempts;

Sexual intimidation/harassment; For example people making obscene gestures, demonstrating behaviour that is perceived by you as being of an intrusive or exhibitionist nature. Asking for sexual contact, requesting to date. Making uninvited sexual remarks/innuendos. Chasing, calling or writing to you privately and uninvited. Threatening you with assault or rape. Demonstrating sexist behaviour, confronting you with pornographic material.

Sexual assault; For example people assaulting you physically with what you perceive as an intention of having non consensual sex with you or succeeding in having penetrative sex.

Appendix 4

Questionnaire used to survey Assaults on Psychiatric Nurses

Nature of Injury and sick leave resulting from assaults/incidents for the year 2001

Recorded Sick leave, Nature of Injury sustained	Recorded Injury	1Day-1Week	1Week 1Month	1Month 3Months	3Month 6Month	6Month 1 year	Continue Off sick	Retired
Sprain								
Bruise								
Head Injury								
Burn/scald								
Cut/graze/scratch								
Cut requiring sutures								
Back injury								
Stress related								
Other (specify)								

Classification of assaults / incidents resulting in injury to nurses for the year 2001

Sick Leave **Category of Assault**	Recorded Incident/ Assault	1Day 1Week	1Week-1Month	1month-3month	3month 6month	6month 1year	Continue Off sick	Retired
Non-threatening verbal aggression								
Threatening Verbal aggression								
Humiliating aggressive behaviour								
Proactive aggressive behaviour								
Passive aggressive behaviour								
Threatening physical aggression								
Destructive aggressive behaviour								
Mild physical violence								
Severe physical violence								
Mild violence against self								
Severe violence against self								
Suicide attempts								
Completed suicide attempts								
Sexual intimidation/harassment								
Sexual assault								

Location/setting of assaults/incidents resulting in injury to nurses for the year 2001

Sick Leave Location/Setting of assault	Recorded Assault	1Day 1week	1week 1month	1month 3month	3month 6month	6month 1year	Continue Off sick	Retired
Psychiatric Hospital… admission ward								
Psychiatric Hospital… continuing care ward								
Psychiatric Hospital… rehabilitation unit								
Psychiatric Intensive Care Unit								
Psychiatric Hospital… Secure Unit								
Psychiatric Hospital… Forensic								
Psychiatric Hospital… Campus								
Psychiatric Unit attached to General Hospital								
General Hospital Campus								
Community: Day Hospital								
Community: Day Centre								
Community: High support accommodation								
Community: Medium support accommodation								
Community: Low support accommodation								
Community: Patients Home								
Other site								

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