# JAMES FLETCHER HOSPITAL

# PSYCHIATRIC EMERGENCY CENTRE

# AND

# PSYCHIATRIC INTENSIVE CARE UNIT

# OVERT AGGRESSION SURVEY.

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# JAMES FLETCHER HOSPITAL

# PSYCHIATRIC EMERGENCY CENTRE AND PSYCHIATRIC INTENSIVE CARE UNIT AGGRESSION SURVEY

## Abstract

This survey was implemented to explore, record incidences and develop a base line of aggression and violence in the Psychiatric Emergency Centre and Psychiatric Intensive Care Unit at James Fletcher Hospital.

A modified Overt Aggression Scale (OAS); Yudofsky et al. (1986) was used to record individual experiences of aggression and violence in the work environment. This quick and easy to use tool, has a tick a box format on an A4 size page, which allowed individuals to identify, quantify and qualify their experience of aggression. The results of the survey were compared with the Mental Health Services official reporting tool - the Register of Injuries and Events (RoI&E) forms.

This aggression survey was a three-month trial that allowed staff the opportunity to report their experience of aggression and violence in the workplace. Staff of PEC and PICU, at James Fletcher Hospital were encouraged to participate in the survey. The reporting of events on a different format allowed a comparison in the reporting rates of the two tools used during the three month period.

A total of one hundred and thirty four (134) individual events of aggression and violence were recorded on the OAS form in the three month period of the trial in both units. PEC recorded an OAS aggression rate of 3% for all presentations and PICU recorded aggression rate was 19%. The official reported rate ( in the RoI&E forms) of all aggression experienced by staff in the 3 month survey was 11% or about 1 in 10 aggressive events were reported.

P.r.n. medication events in this study were recorded in an effort to establish the number of extra times patients were approached by nurses to administer extra medication under the current medication treatment practice. Nurses administered 656 p.r.n. during this 3 month study.

The underreporting of aggression, (supported by findings of nurses underreporting in other studies) established by this study should alert managers to the inadequacy of the currently Register of Injuries and Events reporting system as a mechanism for the reporting of aggression. The present levels of aggression and violence experienced by individuals on a daily basis is unacceptable and not consistent with the NSW Department of Health Zero Tolerance policy.

The *Occupational Health & Safety Act 2000*, legislates that employers must ensure the health, safeguard welfare at work of all employees.

**Key words**
Aggression, violence, underreporting, risk, occupational health and safety.

## Introduction

James Fletcher Hospital (JFH) is a sixty four (64) bed Acute Psychiatric Teaching Hospital affiliated with the University of Newcastle and managed by the Hunter Area Health Service.

James Fletcher Hospital consists of a Psychiatric Emergency Centre (PEC), incorporating an Admission Unit and an eight bed Psychiatric Intensive Care Unit (PICU), also known as Waratah. Supporting the PEC there are two (2x20) twenty bed adult general psychiatry units (Acacia and Bluegum), and a sixteen bed dual diagnosis unit (Huon), catering for individuals with a co-morbid psychiatric and substance use/abuse diagnosis. Approximately twenty beds are available for psycho-geriatric patients in the Boronia Ward.

James Fletcher Hospital was initially known as Watt St. Hospital. Watt St, Stockton and Morisset Hospitals were the "Mental Institutions" north of Sydney providing care to individuals and invaluable service to the community. The James Fletcher Hospital complex also provides support service to an approximately 80,000 sq kilometer wedge of north eastern New South Wales, bounded by the Queensland border in the north and the New England Highway south to Newcastle. The name of "Watt St. Hospital" remains to this day as almost part of New South Wales State folklore.

The PICU is one of three gazetted State facilities providing a "Low Security" environment for patients requiring very close observation in a supervised environment. The PICU is utilised to contain and treat violent and aggressive individuals or those with a propensity for the same. Furthermore, highly suicidal (with self injurious behavior or intent), extremely depressed, agitated, highly disruptive, manic or paranoid patients, and those requiring close and/or medical observation are nursed in this unit. Individuals may also include people suffering substance intoxication or withdrawal, as well as adolescents considered at risk.

Difficulties in staff retention and decreased job satisfaction in the Psychiatric Intensive Care Unit (PICU) were the catalyst to explore the occupational health and safety concern of staff of this major provincial PICU, one of three (PICU) in the State of New South Wales. An exodus of long serving senior clinicians from this unit prompted the remaining senior staff to investigate the perceived factors precipitating staff leaving.

A historical positive work ethic in PICU provided a determination by nursing staff to manage difficult patients. Nursing staff their understanding and preparedness to tolerate abhorrent behaviour exhibited by patients lead them to burnout. In essence the professionalism of nursing staff to manage aggressive and violent patients was counter productive leading to underreporting of aggressive events. A perceived reluctance by managers to confront issues of aggression and violence resulted in inaction perhaps due to underreporting of aggressive incidences in official documentation.

Two years ago a crisis in the staffing of the PEC and in particular the PICU, resulted in an exodus of very senior staff (the second occasion), all of whom had considerable years of service in PICU. There are arguably a number of reasons that precipitated that situation, which have not been fully addressed -

1. Four staff 'medical retirements' in fifteen years;
2. The risk associated in their daily work;
3. Perceived lack of support by management; and

4. No improvements in the working environment.

The loss of many experienced clinicians understandably placed considerable load on the remaining staff. The pressure experienced by the new members of staff underscored the occupational risks highlighted by their predecessors' departure. Concerns were raised by junior staff that senior staff minimized or dismissed the impact of violence as "Its just part of the job! Get used to it!" As a result and in response to OH&S concerns nursing staff began to question the actual levels of aggression they experienced in the workplace environment on a daily basis.

Subsequently, a three-month aggression survey was conducted in an effort to look at the issue of aggression and violence reported by staff in the PEC and PICU, at James Fletcher Hospital. This survey was intended to establish a base line record of aggressive events and compare the study results with the official recording system RoI&E currently utilised by the Hunter Area Mental Health Services. At the completion of the survey the data was collated in order to provide a comparison between the study and the current reporting system.

## Literature Review

### Occupational violence

Occupational violence takes many forms and includes "…verbal abuse, threats, physical violence, homicide, behaviours that create an environment of fear, stalking and bullying amongst workers…." (Mayhew & Chappel, 2001). There is significant economic loss to the organisation (Findorff-Dennis et al, 1999, "…including diminished productivity, absenteeism, staff turnover and even lawsuits."

Experienced psychiatric nurses are fewer in number and, as a group, increasingly older than their mainstream colleagues. It is therefore difficult to understand why working conditions for psychiatric nurses have not improved. Recruitment, retention and education of psychiatric nurses is of significant cause for concern.

Safety in the work place is, in an increasingly litigious society, of paramount concern to politicians, beaurocrats and particularly health administrators eager to comply with the requirements of the *Occupation Health & Safety Act 2000*. Whilst significant progress in respect to fire safety, ergonomics and manual handling has been broadcast and enforced, a preparedness to confront the aggression and violence issue in the workplace in particular nursing (Mayhew & Chappel, 2001.) is not clearly evident.

"Concerns about assaults on staff in mental health services are particularly acute. Whittington (1994) found an average rate of reported assaults in psychiatric wards of about one every 11 days, while Gournay et al (1998) found an average of two assaults per week in a sample of inner-London adult acute wards and psychiatric intensive care units." Wright et al (2002).

Research and anecdotal evidence strongly supports the premise that people suffering mental illness are no more violent (and arguably less so), than the general population. However, the behaviour of individuals presenting for psychiatric assessment and subsequent admission (often in police custody and/or with court matters pending), remain extremely problematic.

Mayhew & Chappel (2001. p10), stated:-

> "Some people with mental disorders pose a risk (Flanety, 1996). For example, clients with dementia may threaten every worker who attempts to wash them. Younger males who suffer psychosis or a neurological abnormality, and who have a history of violence and substance abuse, are more likely to assault staff (Turnbull & Paterson, 1999; 17; Flanery, 1996; 63; Simonowitz, 1996; 282; Warshaw & Messite, 1996; 996). Similarly, clients with paranoid schizophrenia may have delusions of persecution and unrealistic perceptions of events, and may strike out in self-defence against these perceived threats (Capozzoli & McVey, 1996: 66). The presence of other staff does not necessarily deter assault; in one US study, nearly 84% of the mental health professionals who were the victims of a violent crime had someone else present at the time (Fisher et al, 1998; 76)."

## Assaultiveness

"Research on patient assaults flourished during the 1980s, after slow progress was made during the 1970s. This decade has seen steady progress but with a more recent decline in the quantity of published research material." The most recent exploration in this area appears to be by Harmon (1997), who cites studies (Casseem, 1984; Jones 1985; Convey, 1986; Carmel and Hunter, 1989 and Poster and Ryan 1993) which confirm that nurses are the most common victims of assaults-

> "The belief that the institutionalised psychiatric patients are no more violent than the rest of the community was replaced by the realisation that, whilst the majority of mentally ill persons tended to be non-violent, a proportion of mentally ill persons were frequently assaultive and that violent behaviour had increasingly become a reason for psychiatric admission." (Harmon, 1997. p12).

Section 9. (1). and Section 10. of the *Mental Health Act 1900 as Amended* clearly acknowledges violence as a factor when treating psychiatric patients. The words "care, treatment or control" are used to describe services provided to involuntary patients. There are no clear limitations or distinctions to describe what action may be required in the "care, treatment or control" of patients under the Mental Health Act:-

> **9. (1)** A person is a mentally ill person if the person is suffering from a mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
>
> (a) for the persons own protection from serious physical harm; or
>
> (b) for the protection of others from serious physical harm, etc.

> **10.** A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:
>
> (a) for the person's own protection from serious physical harm; or
>
> (b) for the protection of others from serious physical harm.

In Harmon (1997) cites Haller and Deluty (1988. p174-5), substantiate this perception and identify a number of possible contributing factors, stating:-

> "Considerable evidence has been marshalled (eg Adler et al 1983; Snyder, personal communication) to indicate that assaults on staff have increased substantially over the past ten years. The increased risk of assaults has been attributed to a variety of factors: (a) understaffed wards; (b) deinstitutionalisation, which has led to the discharge of more manageable patients; (c) an increasing number of readmissions and involuntary admissions; (d) patients' right to refuse medication, often leading to an increase in patient-staff confrontations; (e) diverse mixtures of patients (in terms of pathology) on each ward; and (f) patients being younger and more difficult to manage than in the past years."

Tardiff and Sweillam, (1980. p165), "The authors found, that assaultive patients were more likely to have been referred to the hospital by police or the courts rather than by psychiatric referral." "Further, some ten per cent of the patients admitted to the psychiatric hospitals had a history of assaultive acts prior to admission." (Tardiff and Sweillam 1980.). Fottrell (1980) found rates of assaultiveness of between three and ten per cent, amongst the patient populations at three hospitals they surveyed. In Harmon (1997)

Maintaining a degree of open-mindedness in this potentially contentious issue, Cooper and Mendonca (1991. p165) "comment further on the apparent wide variability of violence amongst patients in various studies,..." rates from 3% to 37% of violence amongst patients. They cited findings by Fottrell's (1980) and Larkin et al (1988), in which 37 per cent of patients were found to be assaultive. According to Cooper and Mendonca (1991. p165), variability in rates of reporting highlight the difficulties of generalisation between units. It is important to note that the research of Larkin et al (1988) was conducted in a 'Special Hospital':-

> "...for patients subject to detention who require treatment under conditions of special security on account of their dangerousness, violence or criminal propensities" (Larkin, et al 1988. p226). In Harmon (1997)

**Reporting by nurses**

Tardiff & Sweillan (1982. p212), assert that aggression in psychiatric hospitals is under reported in relation to analysed incident reports stating that:-

> "...this may not be the ideal method of assessing the actual frequency of assaults on the wards because of the problems of underreporting." Harmon (1997)

Commenting on variations in rates of assault, Tardiff and Sweillam (1982. p214), state:-

> "The fact that the rates of assaultive behaviour that we found in this study and in our previous study.... are higher than the rates reported in other studies.... suggest that the use of incident reports by other authors resulted in underreporting of assaultive behaviour. This major finding suggests that assault is a serious problem in hospitals."

Wallace (2002. p27) cites a number of reasons for nursing staff underreporting: -

> "Staff won't fill out numerous incident forms for several reasons - time, degrees of literacy, fear of retaliation, fear of being labelled, fear of losing their job. And (they believe) that no one does anything about them anyway!"

Harmon (1997. p 40), cites Chinn 1986 in (Rosenthal, Edwards, Rosenthal and Ackerman, 1992, p.350). "My own encounters with nurses discussing issues of violence, both physical and psychological, have convinced me that violence is an issue of mammoth proportions for nurses. However, just as family violence is privatized (sic), violence in the personal and work lives of nurses is silenced and denied."

**Effects of patient initiated assault on nurses**

"It is most likely that the risk of patient assaults intensifies for nurses working in 'forensic' or 'special hospitals' (Larkin, et al 1988. p226). Lipscomb and Love (1992) comment on the findings of Carmel and Hunter (1989) who found that nursing staff employed at a large forensic hospital in California (US) sustained injuries at the rate of sixteen per 100 staff. According to Lipscomb and Love (1992. p221) "... (this) rate of injuries from assaults alone, put this group of workers at a higher risk than that of the most hazardous industry in the country, the construction industry" (Harmon. 1997).

Lawson (1992) conducted a retrospective study into patient assaults at a 440-bed Cumberland Hospital in (Sydney NSW). According to Lawson (1992. p24): "Seventy per cent of all injuries were patient related; of these, the majority (82 per cent) were the results of assaults. This amounts to approximately 130 reported assaults on staff". Lawson (1992), then compared injury resulting from assaults, with injuries associated with other well-recognised occupational hazards (five times injury because of slips and falls; eleven times greater than lifting injuries; sixteen times greater than needle stick injuries), and quote workers' compensation records which show total nursing time lost to the hospital as a direct result of assaults was 877 hours (24 incidents) which compared with 514.5 hours lost because of all other incidences (Lawson, 1992. p24). (Harmon. 1997).

The effects on nursing staff involved in aggressive incidences are many and varied. Cited in Harmon (1997) Conn and Lion cited in Lion and Reid (1983. p65), commented:

> "Following the assault victims typically suffered from the psychological sequelae that have come to be regarded as the "Post Traumatic Stress Disorder" including insomnia, eating disturbances, anxiety, an exaggerated startle response, depression, trouble concentrating and "flashbacks" in which the attack would be vividly relived. Staff members who have been attacked often developed fear of working with unpredictable or dangerous patients, particularly a hesitancy to confront them or set limits. One staff member reported that after she was assaulted, feelings of helplessness and vulnerability when she was at work persisted for months."

Lanza (1983) cited in (Harmon,1997. p29), " ...stated that the reactions such as fear of the patient who committed the assault, anger, anxiety, feeling sorry for the person who committed the assault, body tension, and soreness continued beyond one week. Long-term emotional reactions included anger and anxiety and long-term cognitive reactions including self-blame, extra caution in relation to work practices and concerns about administrative support."

In an Australian study, Holden (1995. p46), found "6.5 per cent of respondents reported no reactions following their assaults. Most commonly experienced reactions were anger (61.9 per cent of respondents), anxiety (41 per cent), helplessness (34.5 per cent), fear (30.6 per cent), resentment (30 per cent), compassion (22.3 per cent) and lower self esteem (12.3 per cent). Holden (1986. p47) reported that the majority of nurses (81.5 per cent) remained on duty following their assault." (Harmon, 1997. p30).

According to Ryan and Poster (1989. p328), two major findings emerged from their study, the first being that the majority of nurses had resolved their "crisis" within six weeks of their assault despite experiencing a number of short-term reactions. Additionally, and perhaps most importantly, some nurses continued to report reactions to their assault six months and one year after the event despite having avoided major injury. As with Conn and Lion cited in Lion and Reid (1983), and Lanza (1983), Ryan and Poster (1989. p328), drew a comparison between the long-term reactions experienced by nurses in their 'responder' sample and symptoms of PTSD (Harmon, 1997. p33).

"However it should be acknowledged that threats, verbal abuse, and physical assaults can also result in emotional damage being sustained by victims, which can in some instances exceed the degree of physical harm inflicted" (Wright et al 2002).

This review of the literature indicates that the seriousness of the injury experienced is not a reliable predictor of the effect that the assault may have on the individual: how staff deal with the assaults is more predictive of effect. Some staff appear to deal more effectively with patient assaults than other individuals but as the literature indicate, this process may take a long time to resolve.

## THE OVERT AGGRESSION SURVEY

**AIM**

The aim of the study is to compare 2 reporting tools, (1) Register of Injuries and Events (RoI&E) and (2) the modified Overt Aggression Scale (OAS), (Appendix 1), developed by Yudofsky et al, 1986, to quantify different occasions, the levels/degrees of intensity of aggression displayed by patients in the PEC and PICU. The results were used to develop a picture of the nurse's professional role in the service. Recorded aggressive events in the OAS study were compared with the official RoI&E recording system, in terms of the number of reported aggressive and violent patient events. The surveys intent was for all episodes of aggression experienced by staff in the PICU and PEC to be recorded, in a three-month period from the 01-04-2002 to 30-06-2002.

Secondly, we aim to utilise an informal interview process to gather verbal reports and utilise simple thematic analysis to process the information from staff on the effects of aggression, actual or threatened on them and staff perceived views re management generally.

Thirdly the p.r.n. medication events were recorded to establish the extra number of times nurses had to approach patients to administer extra medication in the treatment of their illness or behaviour.

**Method**

The modified OAS (Yudofsky et al, 1986) already used in Kestral, was used to record the events of aggression, their frequency and severity. This pilot study was conducted in PEC and PICU to develop a base line measure of aggression and violence experienced by staff on a daily bases. The survey form is an A4 size page with a "tick a box" format for ease of use, with room for comments.

Secondly, the use of unstructured interviews (Polgar and Thomas, 1995. p374), to explore the perceptions of staff and other effected individuals to the experience of aggression / assaults were conducted. There was no questionnaire used for this process just staff views noted and reported.

Staff of both units were introduced to the proposed survey form and agreed to participate in the trial. A ten-minute staff education on the use of these OAS forms was used to ensure accuracy, continuity and relevance.

The total number of doses of "pro re nata" or p.r.n. medications (additional medication to that charted routinely, given as required) administered to the aggressive and violent patients in PICU were recorded over the three months. The p.r.n. medications are extra medications given to patient above the normal daily amounts prescribed. The number of times patients were secluded was also recorded over the three months.

**PEC's Role.**

PEC's role is to assess all presentations and admit appropriate persons. Presentations can be self, friend, hospitals, community agencies, mental health, government departments, Medical practitioner, police, court, etc, referrals. The presentations and admissions are processed by professionals who assess, make referrals, record personal, medical, legal and property details, notify appropriate services, arrange accommodation, etc, for each person accepted by the service. Admissions can be voluntary or involuntary.

**PEC Staff Members -**

- 10 female and 5 male positions.
- Mean age 46
- Mean Psychiatric Nursing experience 17.6 years

**PICU Role.**
PICU (8 beds) provides services in a secure and restricted environment. The patients requiring this level of observation are the most disturbed patients who are mentally ill and that are a threat to themselves or others and could not be treated in a less restricted environment. The 8 gazetted beds allows for admissions and treatment of patients generally from the Hunter but additionally from northern and north western NSW to the Queensland border.

**PICU Staff members**

- 3 females and 7 male permanently and
- 3 casual female and 1 part time male positions;
- The staff age range varies from 28 to 66;
- Mean age of all staff is 46.3
- The mean nursing experience of these staff is 20.1 years;
- The mean acute psychiatric nursing experience is 14.6 years.

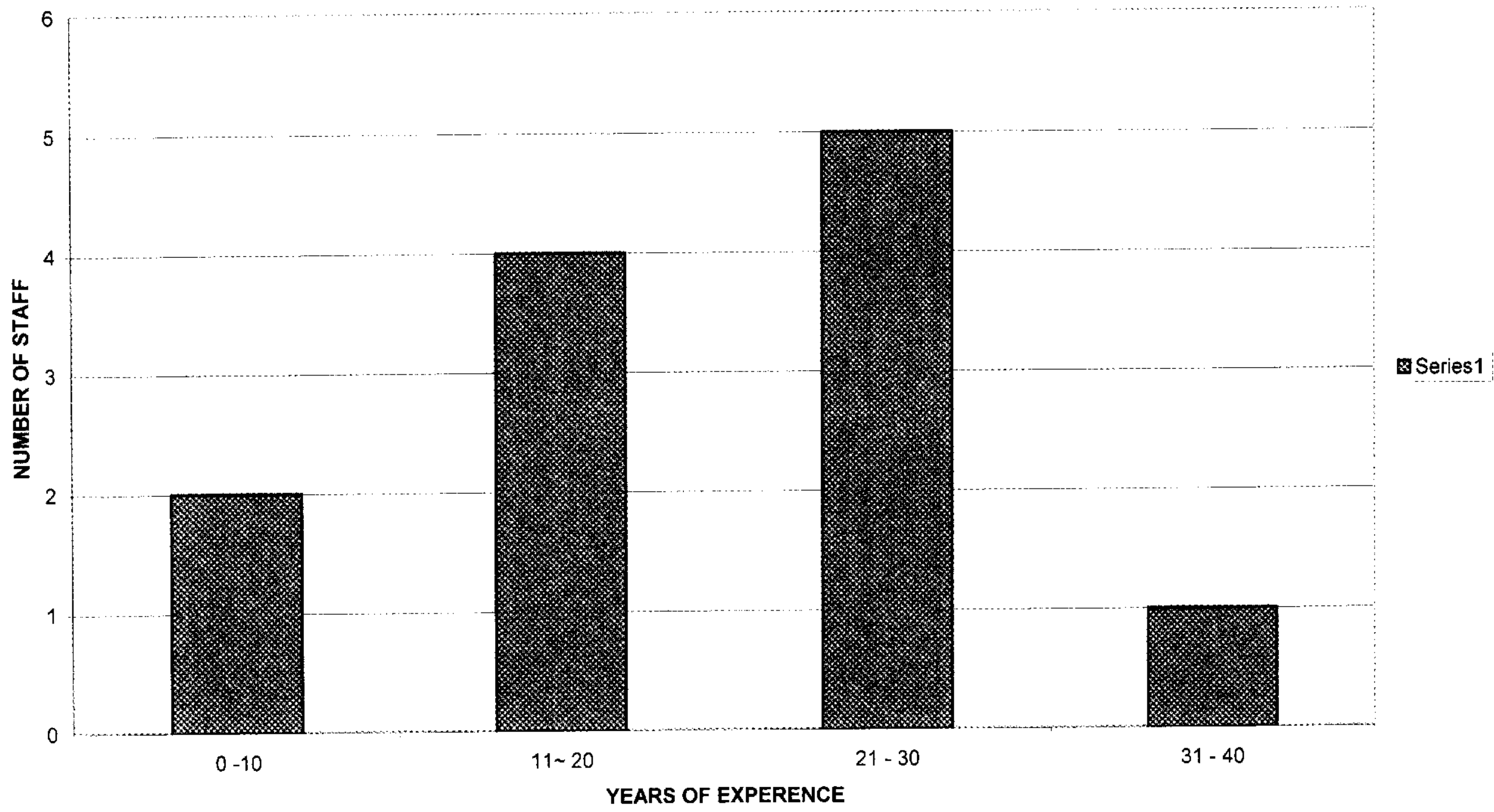
Patients remain in PICU until medically assessed to be –

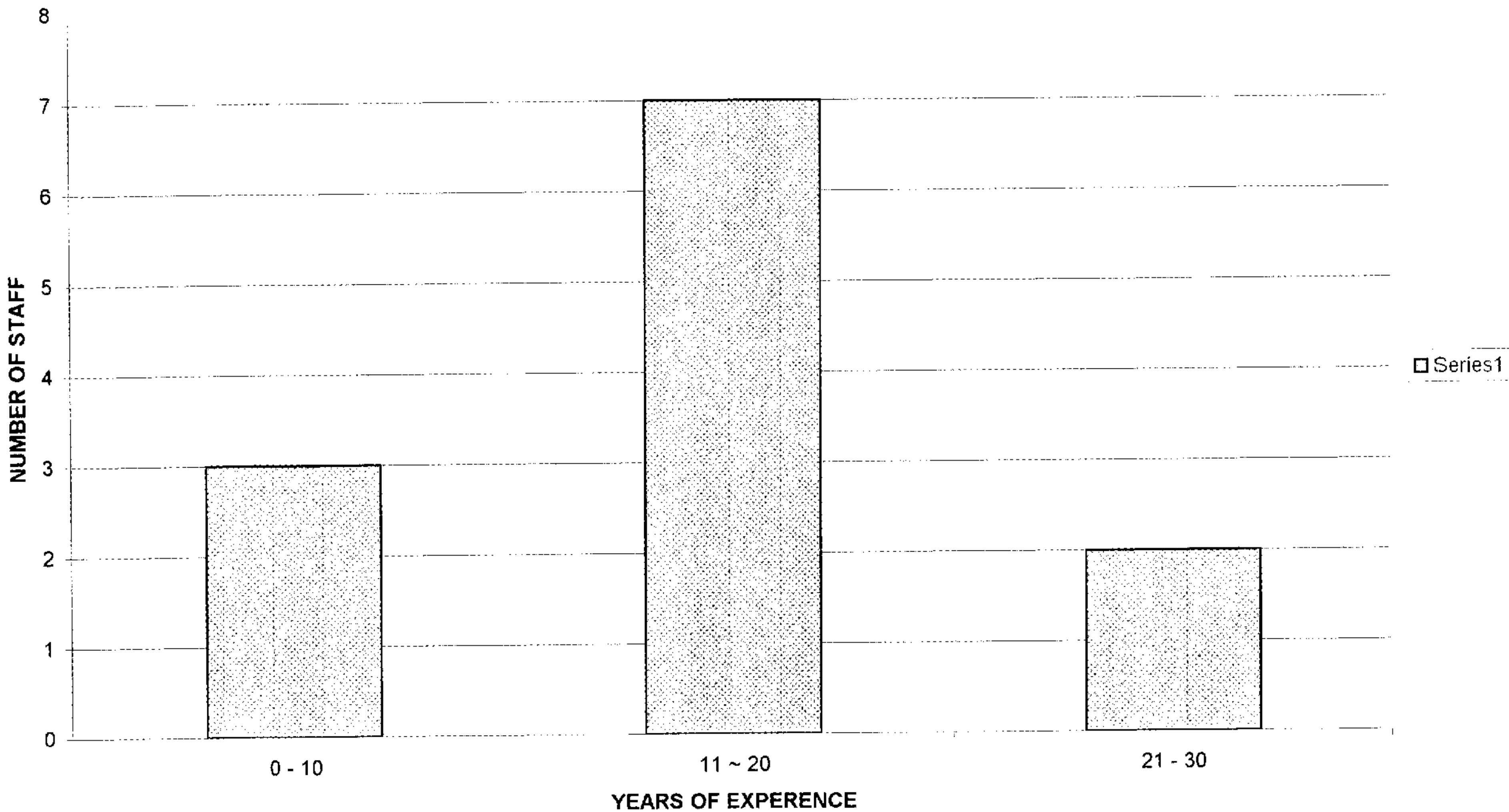
a) of less risk to self or others (than the more acute presentation), and are moved to less restricted areas,
b) When patients acute mental state has settled,
c) The most aggressive and violent patients are moved to more secure units.

No control could be placed on the daily rostering of PEC and PICU staff which includes casual and temporary contracted nurses. Furthermore, it must be noted that during the time of this survey there was a nursing shortage so the most important consideration by management re staffing in PEC and PICU was to fill the daily roster positions with the most appropriate available staff member. At times, the PICU staffing was one regular staff member and one or two causal staff per shift, but as often as possible 3 regular PICU staff members were rostered per shift.

**About the survey tool**
The OAS survey tool was selected for its simplicity and ease of use. The OAS identifies four main levels of aggression,
(1) Verbal,
(2) Physical aggression against objects,
(3) Physical aggression against self and
(4) Physical aggression against others.

These four main headings are further divided into 4 different levels of aggressive behaviour. This format is designed to be as easy as possible to complete and be less time consuming, highlighting the most applicable form of aggression exhibited by the person by marking the appropriate box. Two further sections ask for responses in the area of (5) choice of interventions options and (6) patient motivations assessed. An additional area for comment is provided at the bottom of the form.


STAFF NURSING EXPERENCE - PICU
NUMBER OF STAFF
0
1
2
3
4
5
6
0 -10
11~ 20
21 - 30
31 - 40
YEARS OF EXPERENCE
Series1


ACUTE PSYCHIATRIC NURSING EXPERENCE - PICU
NUMBER OF STAFF
0
1
2
3
4
5
6
7
8
0 - 10
11 ~ 20
21 - 30
YEARS OF EXPERENCE
Series1

Staff were informed that the OAS forms would not replace the official Register of Injuries and Events forms and were encouraged to fill in both forms when aggression events were experienced in the workplace.

**Procedure**

Permanent staff in PEC and PICU were introduced to the proposed survey form and agreed to participate in the trial. Nursing staff education on the use of the OAS was seen as necessary to address any queries nursing staff may have had and ensure a commitment to the trial. Training was necessary to optimize the accuracy and relevance of the trial and to enable permanent staff to further educate casual staff, rostered to the units. The staff-training period did not exceed ten minutes per person.

The plan was to trial the form for a period of one month, then review its appropriateness. This one-month trial would provide a legitimate indication of the efficacy of the tool and staff views re its suitability. The OAS was then utilised for a further two months with the information collected to be correlated at the end of three months. A report was produced and the results presented at the OH&S monthly meeting, to hospital management and NSW Nurses Association.

The completion of the one-month trial raised minor issues related to categorization of events in the previous month and allowed clarification of different nurse's perceptions about aggression they had experienced.

The OAS forms were placed in PEC and PICU in a readily accessible area. Blank OAS forms were placed in one A4 envelope with a similar envelope for completed OAS forms. The completed forms were collected on a weekly basis and noted. The completed forms, once noted were securely stored in a locked filing cabinet in the office of the Nurse Manager IV.

**Appraisal**

A peer review was conducted when the draft survey report was completed. The PEC and PICU staff commented re the accuracy, style, corrections and in part to validate the process. The number of nursing staff that participated in this process was twenty five. Additionally Dr Steele Director of PEC and PICU, Mr D. McLeod (NM4), Mr C. Harmon, Facility of Nursing, Newcastle University, and casual nurse JFH, Dr K Cholowski, PHD Facility of Nursing, Newcastle University (and casual nurse, JFH), Professor M. Hazelton, Mental Health Nursing, Newcastle University providing advice.

## SURVEY RESULTS

**Forward.**
An important note: The total number of reported events does not tally with the number of recorded components of the four sections in the aggression form. The reason being that one reported aggressive event may involve several components of aggression, eg Verbal, Against Objects and Against Others.

Overall 134 (80 male and 47 female) events of aggression were recorded during the study. PICU staff experience 19% of patients admitted behaved aggressively over the 3 month period. This is nearly twice the figure of 10% of aggression reported in other studies. The official Mental Health Service Register of Injuries and Events form reported the aggression rate as only 11%, ie the equivalent of about 1 in 10 cases of aggression experienced by nurses was reported in the officially documentation.

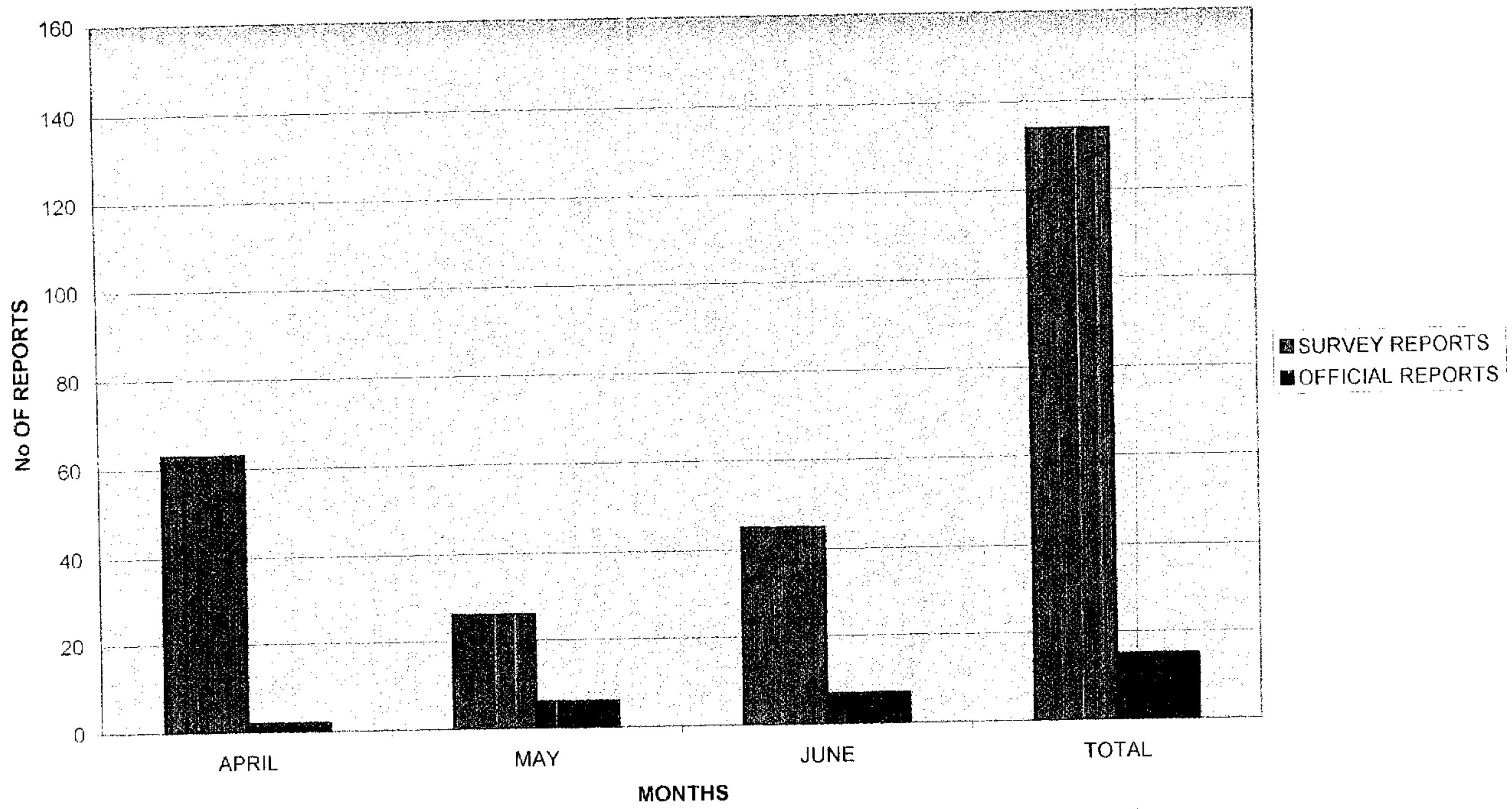
## SUMMARY OF SURVEY

This survey identified that of the 134 aggressive and violent events over the three month period –

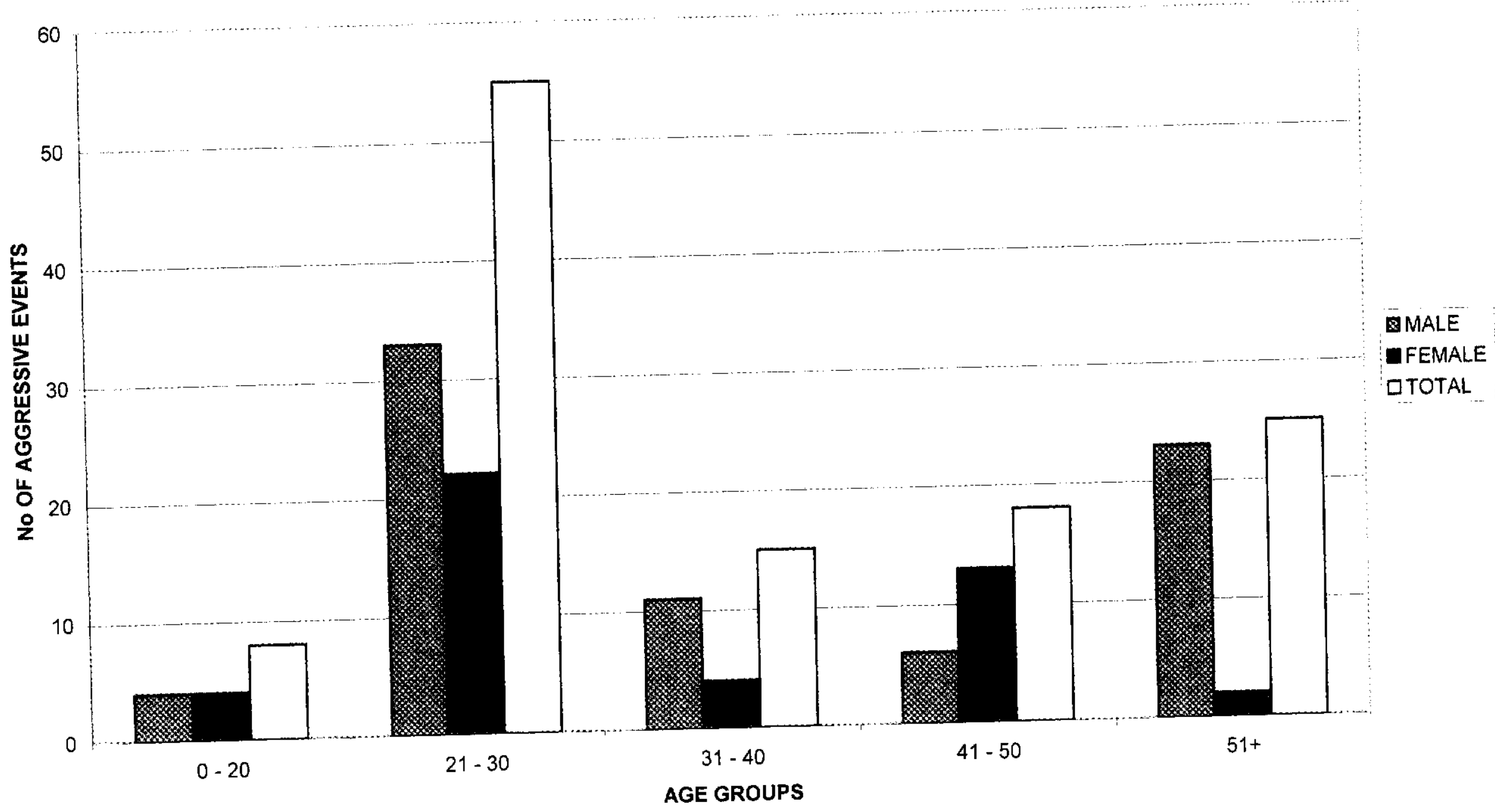
**PICU**

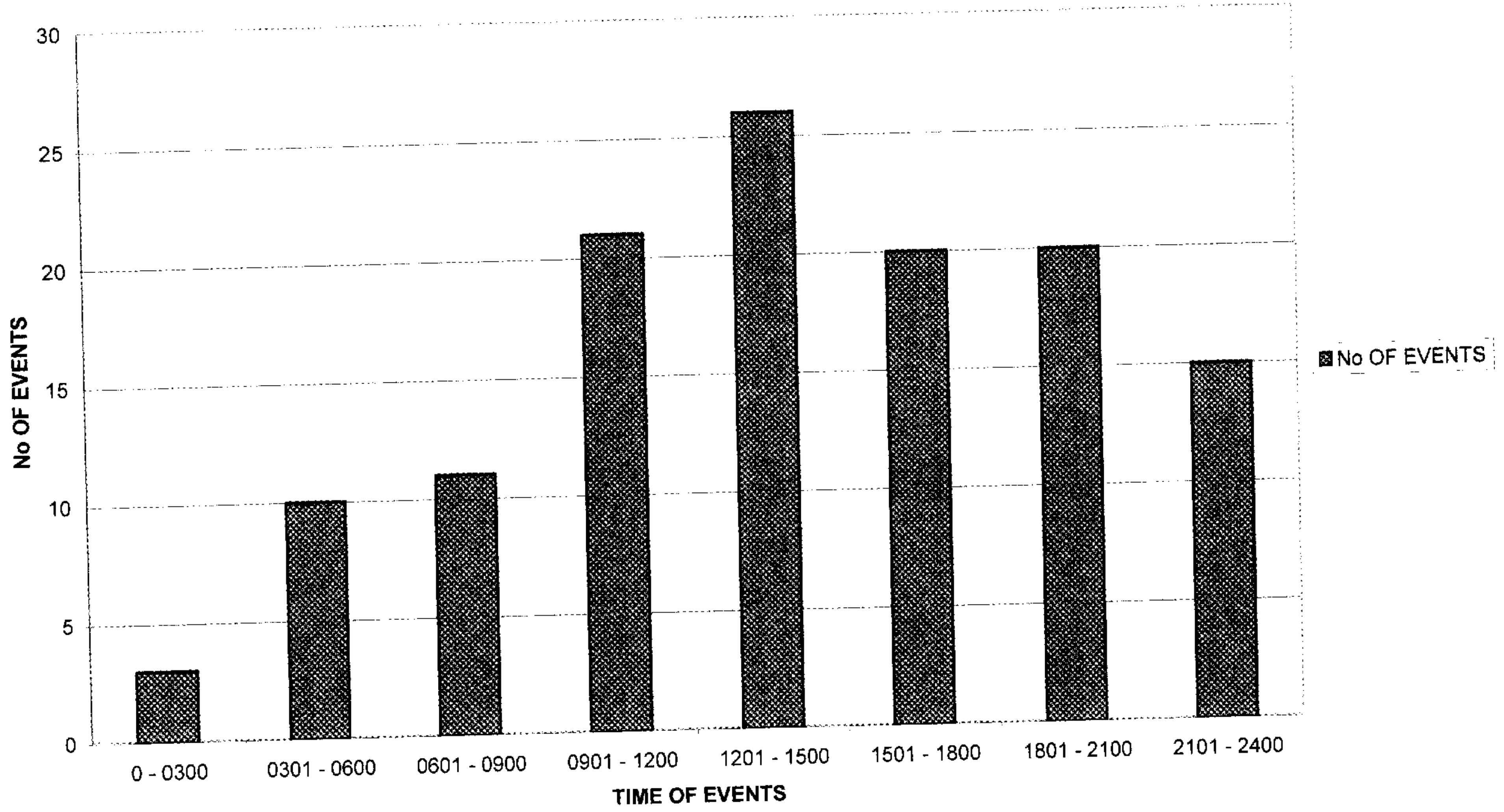
- A total number of 114 reported aggressive events reported;
- Only 11% of aggressive and violent patient events on nurses were reported in this study were reported in the official Register of Injuries and Events data. (FIG 1)
- The 21 to 30 age group was the most frequently involved in aggression (33male and 22 female events) totalling 55 aggressive events recorded. (FIG 2)
- The 2nd most frequently involved age group was the 51+ (23 male and 2 female) with 25 events.
- Members of all age groups were capable of aggression and violence but generally more males than females were represented.
- Times of aggression events peaked between 1201 hrs to 1500 hrs with 26 events the highest recorded. (FIG 3)
- Second highest time period identified was 0901 to 1200 with 21 events.
- Location of the most aggressive area was the dayroom (lounge and dining room area) with 39 events. (FIG 4)
- The second highest location of events was the nurse's station with 30 events.
- Total Verbal Abuse, 119 occasions. (FIG 5)
- Total of Aggression against Object, 61 occasions. (FIG 6)
- Total Aggression against Self, 21 occasions. (FIG 7)
- Total Aggression against Others, 84 occasions. (FIG 8)
- Total number of p.r.n.'s given, 656 times.
- Total number of Seclusions, 47 times.
- The total number of officially recorded events of aggression and violence in the Register of Injuries and Events book that management noted was 15 in the three month period.

(FIG1) NUMBER OF REPORTS COMPARISON



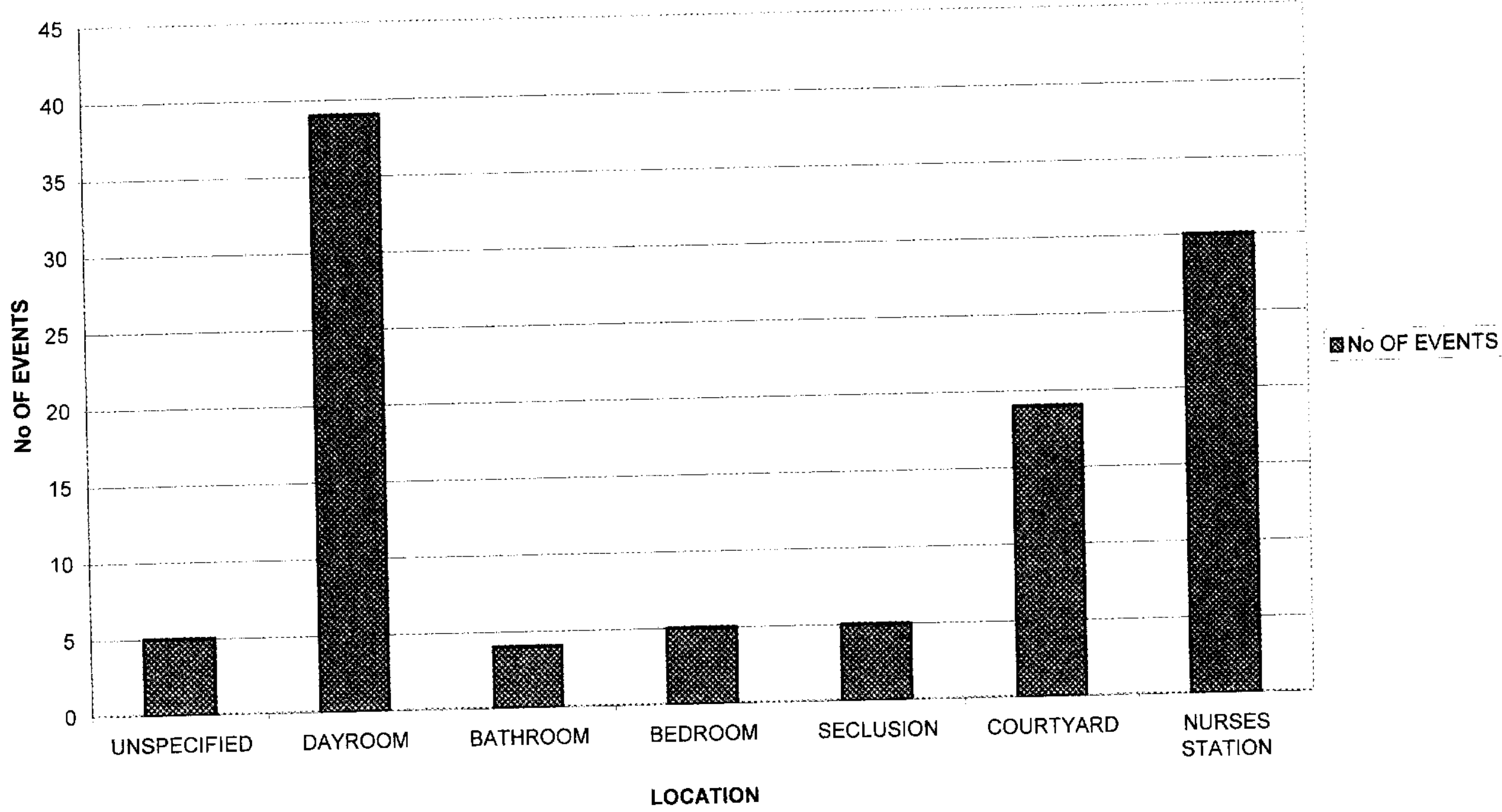
(FIG 2) AGE GROUP DISTRIBUTIONS






( FIG 3) TIMES OF AGGRESSIVE EVENTS

(FIG 4) LOCATION OF EVENTS



## TOTAL RECORDED EVENTS IN PICU.

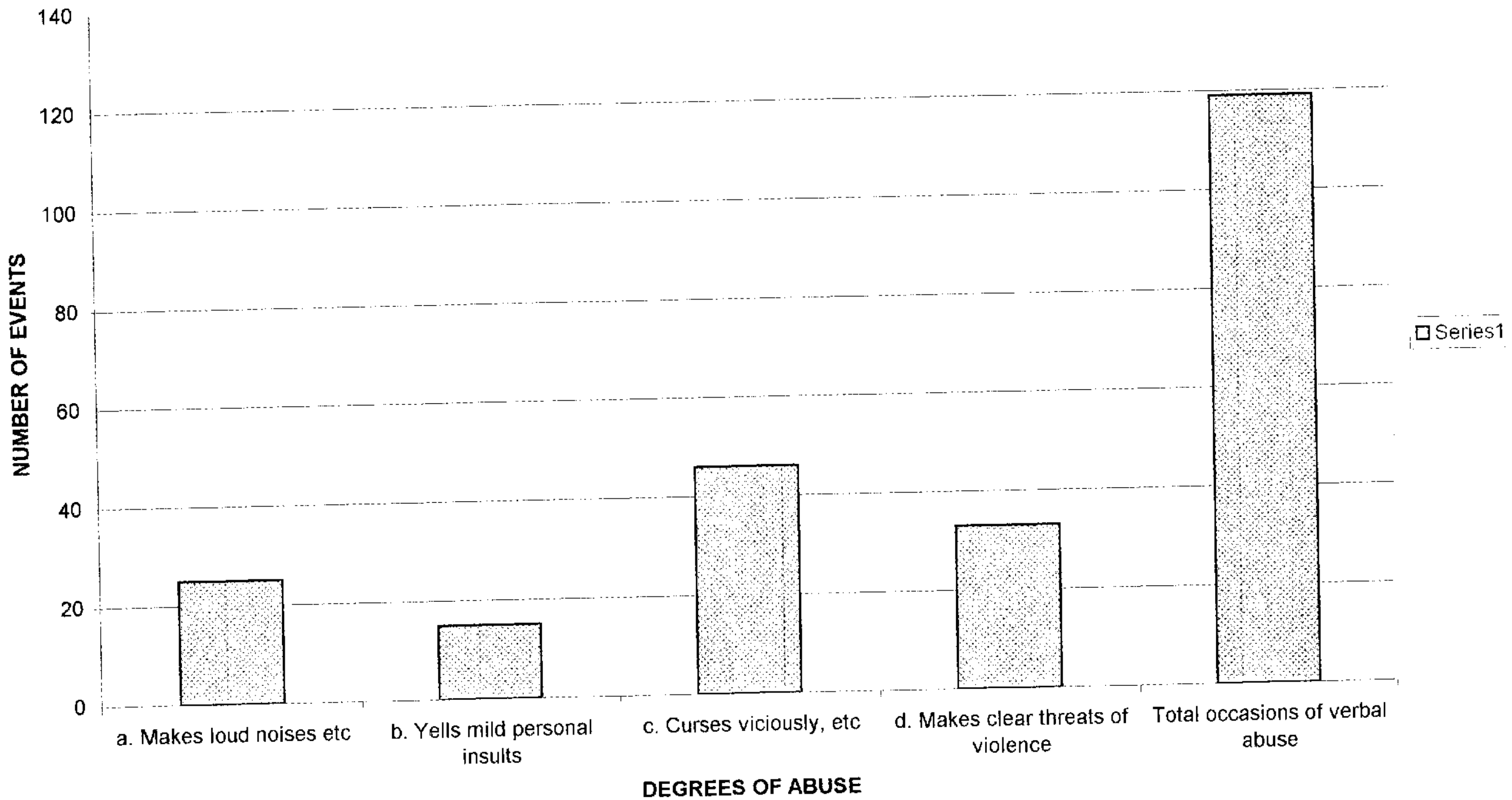
### VERBAL ABUSE

| | |
|---|---|
| a. Makes loud noises. Shouts angrily | 25 |
| b.Yells mild personal insults eg "You're stupid" | 15 |
| c. Curses viciously, uses foul language in anger, makes moderate threats to self and others. | 46 |
| d. Makes clear threats of violence towards others or self (I'm going to kill you) or requests help to control self. | 33 |
| **TOTAL OCCASIONS OF VERBAL ABUSE.** | **119** |

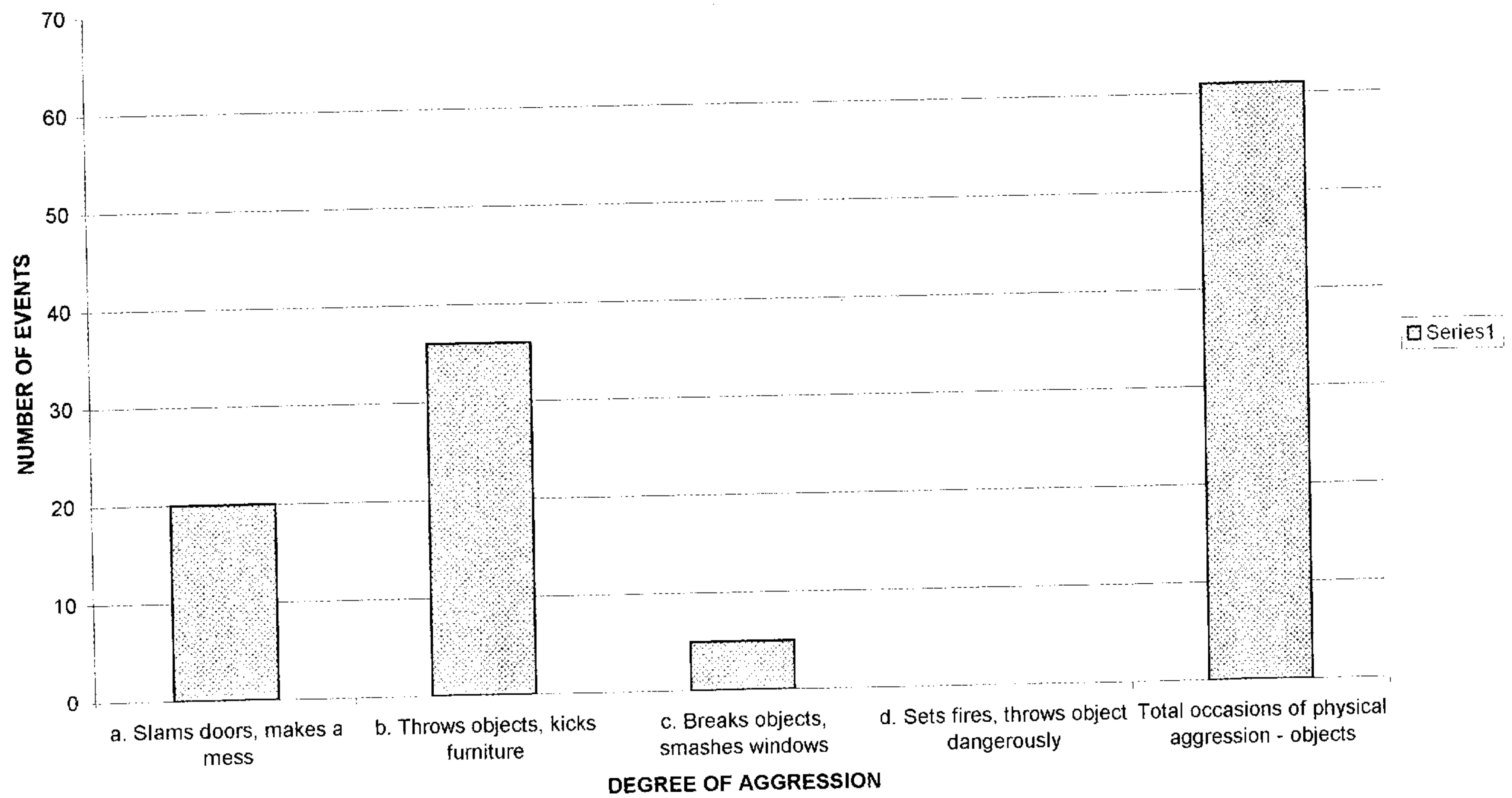
### PHYSICAL AGGRESSION AGAINST OBJECTS

| | |
|---|---|
| a. Slam doors, scatters cloths, making a mess | 20 |
| b. Throws objects down, kicks furniture, without breaking it, hits wall. | 36 |
| c. Breaks objects, smashes window. | 5 |
| d. Sets fires, throws objects dangerously | 0 |
| **TOTAL OCCASIONS OF PHYSICAL AGGRESSION AGAINST OBJECTS** | **61** |

(FIG 5) VERBAL ABUSE



(FIG 6) PHYSICAL AGGRESSION AGAINST OBJECTS



## PHYSICAL AGGRESSION AGAINST SELF

| | |
|---|---|
| a. Picks or scratches skin, hits self, pulls hair with none or minor injury only. | 2 |
| b. Bangs head, fist into objects, throws self onto floor or into objects (hurts self without serious injury. | 15 |
| c. Small cuts or bruises, minor burns. | 0 |
| d. Mutilates self, causes deep cuts, bites that bleed, internal Injury, fracture. loss of consciousness, loss of teeth. | 0 |
| **TOTAL OCCASIONS OF PHYSICAL AGGRESSION AGAINST SELF.** | **17** |

## PHYSICAL AGGRESSION AGAINST OTHERS

| | |
|---|---|
| a. Makes threatening gestures, swings at people, grabs at clothing. | 45 |
| b. Strikes, kicks, pushes, pull hair, (without injury to them) | 30 |
| c. Attacks others causing mild-moderate physical injury (bruises, sprains, welts. | 9 |
| d. Attacks others causing severe physical injury (broken Bones, deep laceration, internal injury). | 0 |
| **TOTAL OCCASIONS OF PHYSICAL AGGRESSION AGAINST OTHERS.** | **84** |

NUMBER OF ADMISSIONS IN PICU IN THREE MONTHS. 167

NUMBER OF PRN's GIVEN IN PICU. 656

NUMBER OF SECLUSIONS IN PICU. 47

BED OCCUPANCY RATE IN PICU APRIL- 85% MAY- 75% JUNE- 93%

| AGE GROUPS. | MALE | FEMALE | TOTAL |
|---|---|---|---|
| 0-20 | 4 | 4 | 8 |
| 21-30 | 33 | 22 | 55 |
| 31-40 | 11 | 4 | 15 |
| 41-50 | 6 | 13 | 19 |
| 51 + | 23 | 2 | 25 |
| **TOTAL** | **77** | **45** | **121** |

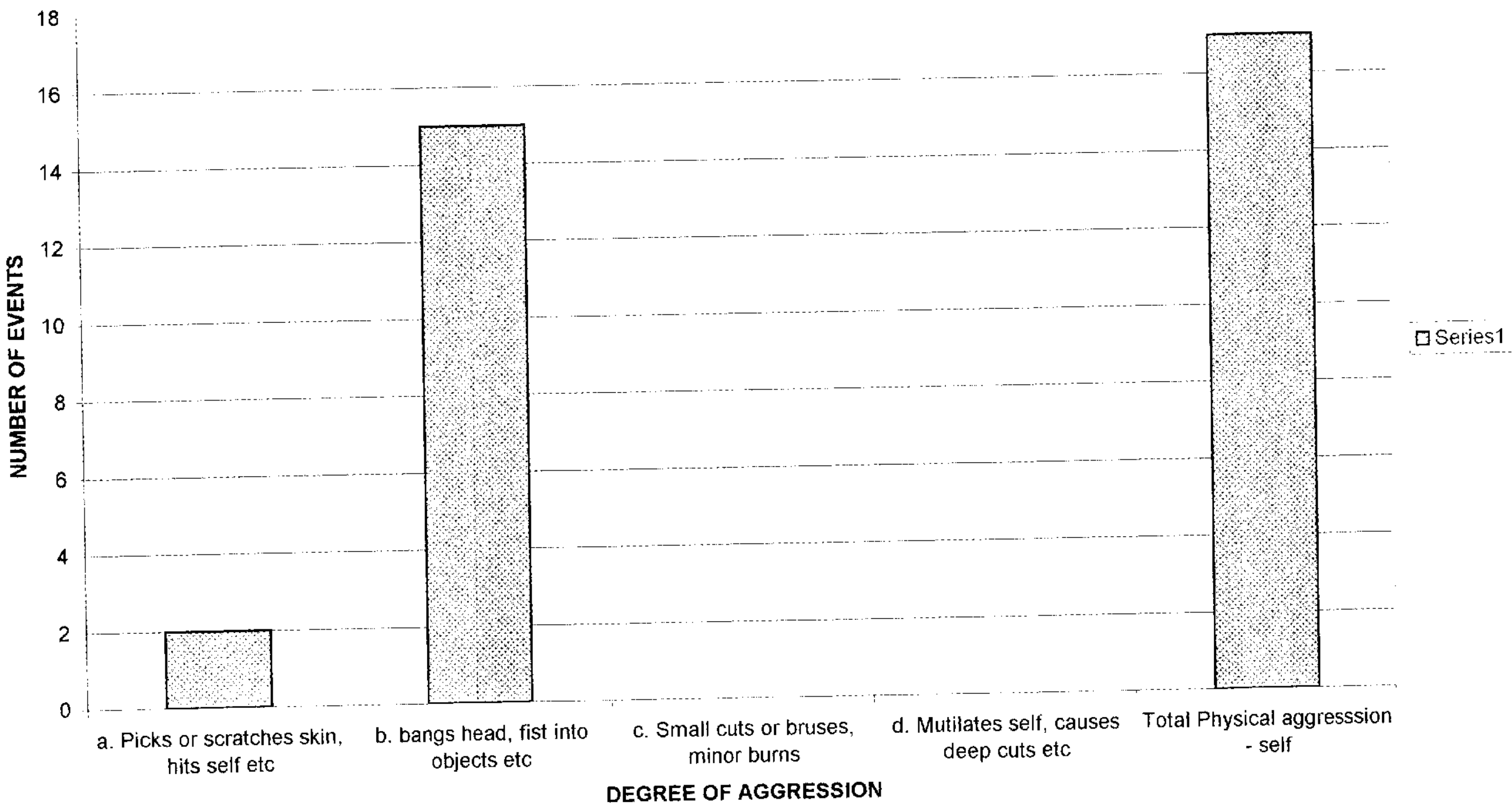
**TIMES OF EVENTS**. (NOT ALL TIME OF EVENTS ENTERED ONTO FORMS)

| TIMES | TOTAL |
|---|---|
| 0- 0300 | 3 |
| 0301-0600 | 10 |
| 0601-0900 | 11 |
| 0901-1200 | 21 |
| 1201-1500 | 26 |
| 1501-1800 | 20 |
| 1801-2100 | 20 |
| 2101-2400 | 15 |
| **TOTAL** | **126** |

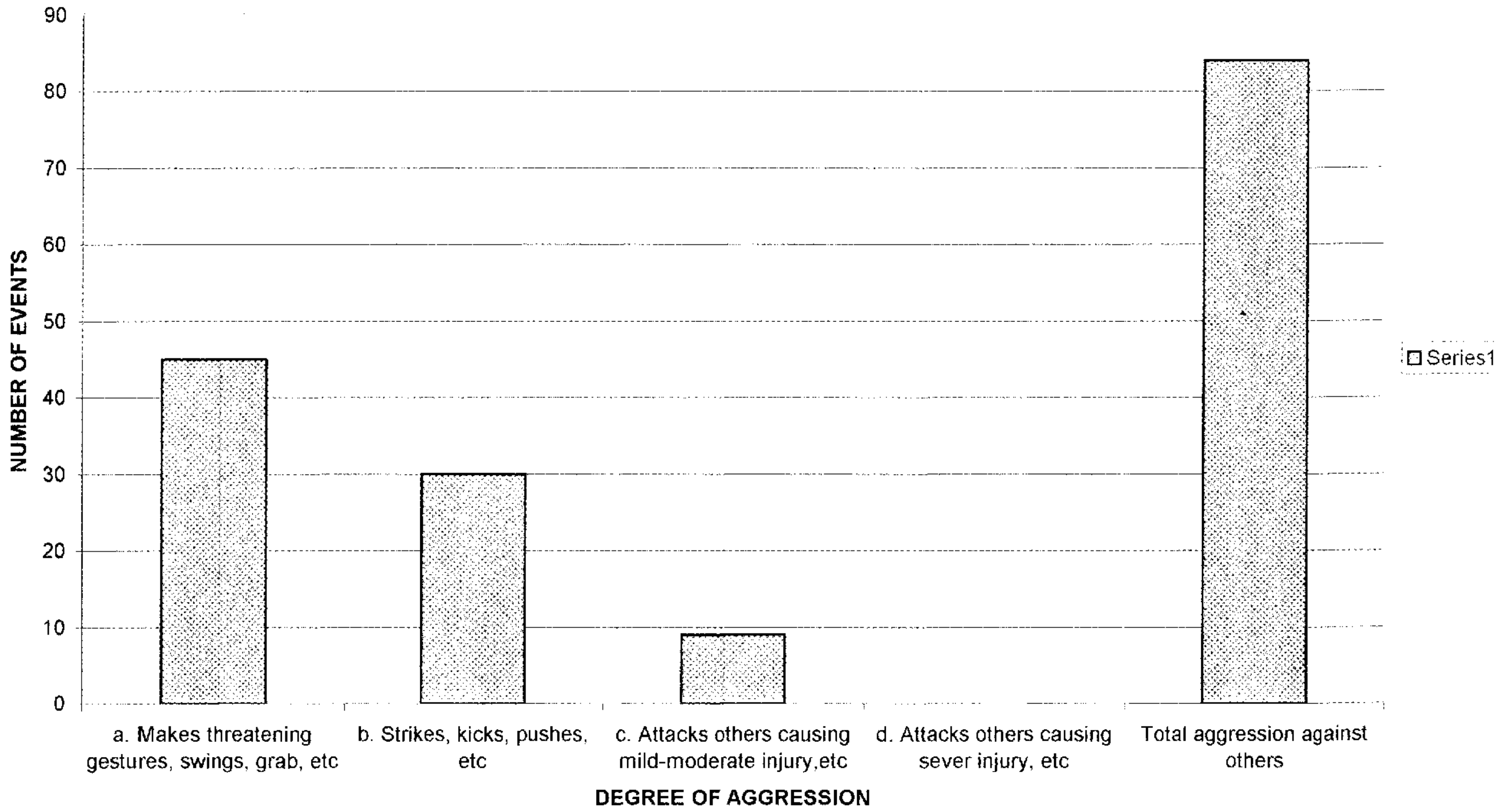
**LOCATION OF EVENTS** (NOT ALL LOCATION ENTRED ON FORMS)

| | |
|---|---|
| PICU | 5 |
| DAYROOM | 39 |
| BATHROOM | 4 |
| BEDROOM | 5 |
| SECLUSION | 5 |
| COURTYARD | 19 |
| NURSES STATION | 30 |
| **TOTAL** | **117** |

(FIG 7) PHYSICAL AGGRESSION AGAINST SELF



(FIG 8) PHYSICAL AGGRESSION AGAINST OTHERS



## PSYCHIATRIC EMERGENCY CENTRE.

**TOTAL NUMBER OF PRESENTATIONS 755**
**TOTAL NUMBER OF ADMISSIONS 437**

AVERAGE DURATION OF AGGRESSIVE EVENT WAS 6.85 MINUTES.
TOTAL DURATION OF AGGRESSIVE EVENTS WAS 137 MINUTES.

**TOTAL AGGRESSIVE EVENTS. - 20**

**AGE GROUPS** (OF THE 20 REPORTS 9 HAD NO DETAILS HERE)

| AGE GROUPS | MALE | FEMALE | TOTAL |
|---|---|---|---|
| 0 – 20 | 0 | 0 | 0 |
| 21 - 30 | 5 | 2 | 7 |
| 31 - 40 | 1 | 0 | 1 |
| 41 - 50 | 1 | 1 | 2 |
| 51 - 60 | 0 | 1 | 1 |

**TIME OF EVENTS.**

| TIMES | NUMBER OF EVENTS | | |
|---|---|---|---|
| 0000 – 0300 | 4 | | |
| 0301 - 0600 | 1 | | |
| 0601 - 0900 | 2 | | |
| 0901 - 1200 | 1 | | |
| 1201 - 1500 | 6 | | |
| 1501 - 1800 | 1 | | |
| 1801 - 2100 | 4 | | |
| 2101 - 2400 | 1 | | |

**LOCATION OF EVENTS**

| | |
|---|---|
| PSYCHIATRIC EMERGENCY CENTRE | 7 |
| OUTSIDE PEC | 1 |
| PEC NURSES STATION | 3 |
| WAITING ROOM | 6 |
| PSYCHIATRIC EMERGENCY CENTRE PHONE | 2 |
| | |
| **TOTAL** | **19** |

**AGGRESSION LEVEL REPORTED FOR ALL PRESENTATIONS WAS 3%**
**AGGRESSION LEVEL REPORTED FOR ALL ADMISSIONS WAS 5%**

## OVERALL SURVEY DATA

| SECTIONS | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|
| PEC event reported as part of total% | 12.7% | 26.9% | 15.6% | 18.4% av |
| PICU event reported as part of total% | 87.3% | 73.1% | 84.4% | 81.6% av |
| Total No of reports | 63 | 26 | 45 | 134 |
| Total No of Officially Recorded Events (RoI&E Forms) | 2 (3.2%) | 6 (23.1%) | 7 (15.5%) | 15 11.19% av |
| Verbal Aggression | 60 | 22 | 37 | 119 |
| Physical Aggression against Objects | 31 | 12 | 18 | 61 |
| Physical Aggression against Self | 7 | 2 | 6 | 15 |
| Physical Aggression against Others | 30 | 11 | 43 | 84 |
| Average daily duration of Aggression | 46.8 min | 12 min | 60 min | 119 min |
| Total hours of Aggression in Month | 23.30 Hrs | 6.08 Hrs | 30.0 Hrs | 59.38 Hrs |

**Limitations of the study**

The collaborators in this survey have no formal research experience or qualifications. The survey was conducted without supervision and may as a result be found lacking in its protocols, scientific rigour and academic professionalism of the authors. Regardless, the survey was an effort to gather information, also alert individuals and the Mental Health Service management to the extensive level of aggression experienced by psychiatric nurses at the "coal face". This important Occupational Health and Safety issue impacts on nurse job satisfaction, nurse commitment to the service, the retention, recruitment, their families and on visitors to these centres. It is hoped that this study will contribute to the education of the future generations of psychiatric nurses.

The authors of this study did not apply for approval by the Hunter Area Health Service Ethics Committee. The initial perception by the authors was that a short, brief report would be produced for the James Fletcher Hospital OH&S committee. It is now obvious that the information gathered was for more detailed than originally envisaged. Several previous attempts by staff to highlight aggression levels in this service have been quashed.

The survey did not consider diagnosis of patients or their referral agents. With hindsight this information would have significantly contributed to the findings, and may form the basis of future research. Additionally, distinction between admissions affected by substance use compared to non-substance use may have been useful.

The p.r.n. medications are extra medications given to patient above the normal routine daily amounts prescribed. The fact that the recorded number of p.r.n. medications given does not distinguish between oral and injections is regrettable. The second point is that number of p.r.n.'s given to each individual patients was not recorded in this survey. These records only appear on

the patients medical treatment sheets in their files. Records of p.r.n. medications were lifted from the PICU p.r.n. register which only recorded the number of p.r.n.s given overall to PICU patients.

The construction of the OAS database only allowed one entry per classification of aggression out of the 4 choices available. Some aggression forms had 2, 3 and 4 responses to the one classification of aggression describing patient behaviour, so the choice indicating the most serious degree of aggression was entered into the database. In addition not all the categories (time, location, etc) of the survey form were filled in by staff, which arguably did not produce truly accurate results in terms of location, information, etc.

Some reported events of aggression and violence were reported by several nurses at the one time (on the one event). In these circumstances only the one event was placed into the data base, rather than all the reports of the one aggressive event.

There are limited results from PEC perhaps due to the staffing mix (some staff did not receive education re the OAS survey form) and the limited time patients spend in PEC being assessed. Most survey forms only having sparse details, few forms being totally complete. Not all the categories on the survey form (time, location, etc) were completed by staff. But overall these figures are the best, most recent and the most accurate ever produced for use in the development of reviewing working conditions in PEC and PICU in relation to safe working practice.

At times the OAS forms would be filled in post aggressive event, but some staff consistently did not complete the survey forms after experiencing aggressive events.

It is worth taking note that during the survey period major renovations to the PEC area were carried out. Resultantly a number of admissions that would normally have been processed through PEC were managed on the ward of their geographical origin, resulting in fewer patients being processed through PEC and may have influenced the incidence of aggression and violence reported in PEC.

## GENERAL DISCUSSION

The results highlight The Rosenthal Effect (Polgar and Thomas, 1995:372), confirming the expectations of the researchers who were anecdotally aware of the disparity in the actual and the reported incidences of aggression and violence.

The difference in the number of reports of aggression in the PEC as compared with the PICU, is glaring (PEC totalling 20 compared to the PICU total of 114). Some reasons for this huge difference may be:

- Patients arriving in PEC with police, the police presents on admission influencing patient behaviour.
- Patients medicated before handcuffs removed.
- Patients spend limited time in the admissions unit.
- The most difficult patients and the ones assessed as having the potential for aggression and violence were moved to PICU for medication and containment before the assessment process is completed.
- PEC does not resemble a hospital ward/unit.

- The hospital supervisor presence in PEC during admissions.

The 3% of aggression recorded in PEC is equal to the lowest reported level of aggression in the literature reviewed. The average reported rate in all the literature reviewed is around 10%. Could the presence of the supervisor during the assessment process in PEC have such a huge influenced affecting staff reporting rates of aggression and violence in this study?

Recording and following up of aggressive events in PEC was more difficult than in PICU and becoming increasingly apparent that due to –

a) The relative short stays in PEC before transfer to appropriate unit.
b) There were no files (the files followed the patient) in PEC to audit.
c) PEC and PICU have distinctly different roles and operations.
d) I did not work every shift and every day to monitor the OAS forms.
e) Patients considered to have the most potential for violence were moved to PICU.

The fact that not all incidences were recorded indicates that the number of aggressive events is higher than this survey report identifies.

Total number of incidences recorded in the OAS survey was one hundred and thirty four (134) as opposed to fifteen (15) incidences officially recorded in the RoI&E forms. The reason or reasons for this huge difference between the study results reports and the official reports to management is not clear. In the present hospital culture, staff identified issues such as:

- discounting of staff concerns,
- management long term inaction in addressing staff concerns,
- the budget,
- staff reduced reporting rate,
- staff loss of confidence in this management,
- staff perceived lack of commitment by management,
- management responses to staff reporting all incidences and
- management not wanting to know the realities of working conditions in the workplace.

Throughout the survey period in PICU, a mental note (by the surveyor) was made on file review of aggressive and violent events recorded in patient files, but not in the OAS or the RoI&E forms. In later peer review with the authors of the patient file entries, the non recording of events of aggression, a number of reasons for underreporting were revealed, such as:

- Another form to fill in,
- No time,
- Forgot,
- No body does anything anyway,
- It's a waste of time.
- No body was hurt.

The importance of filling in the RoI&E as well as the survey forms was emphasised to all staff. Nurses obviously did recognise aggression and violence by patients but this recognition did not always result in the equivalent number of official reports to management as in this survey. Only a

small percentage 11% of the total patient's aggressive events experienced by nurses were reported in both PEC and PICU on the official RoI&E forms.

**PICU Patient Population**

Larkin's (1988), study of assaultiveness in a "Special Hospital", in long term forensic units is noted. The distinct and different population groups is acknowledged by the researchers. Having said this, aspects of patient's conditions in PICU are simular. Larkin et al, (1988) study could explain one aspect for the huge disparity of aggression figures in this survey between PEC and PICU. PICU in James Fletcher Hospital has some identical features as the special hospital in Larkins study such as:

Containment
Involuntary status
Presented by police
Referred by court and facing criminal charges
Forensic histories
Restricted rights
Must comply with Unit policies and Mental Health Act requirements.
Limited privacy due to the need for close observation
Acuity of unit and patients

Patients in PICU are held against their will and treatment is often given against their will. Often a complex mix of patients, a gender mix as well as patients with criminal histories, aggressive and violent histories, mentally ill and disordered patients are all treated together in a confined area. The length of stay is unclear and significantly longer than in PEC (Admission Unit).

However patients' exhibiting extreme aggression and violence may be transferred to more secure units such as Kestrel (Morisset Hospital grounds) and Long Bay (Sydney). Transfers to Kestrel are dependent on bed availability in this unit. At times transfers can require protracted negotiations and may be achieved only where patients are swapped between the two facilities. Swaps are where a patient from Kestrel high secure unit is trialled in PICU with the general unit population. This situation also involves increased risk of further overt aggression.

Generally during these management negotiation periods for patient transfers to be moved to a more secure units, the staffing numbers in PICU do not change and nor do the management protocols and practices in the unit (except in the most extreme circumstances). There have been a number of times that security in PICU has been breached by a number of physically aggressive and violent patients and at times the police have been called to assist.

**Administration of p.r.n medications**

P.r.n. medications administered in the three-month survey totalled 656 and averaged 3.9 p.r.n.'s per patient while in PICU. The range of p.r.n. medications administered per patient varied greatly between patients. For example, a male patient received numerous oral p.r.n.s and 35 sedative Intra Muscular Injection (IMI) over a period of ten (10) days due to his aggressive and violent behaviour towards other patients and staff.

Over time the reduction in prescribed, symptom appropriate, therapeutic, medical intervention with appropriate doses of medication on admission plus the current low level of medication patients receive within mental health services place the patient and nurse at extra risk. Nurses are placed in an increasing number of occasions of imminent danger administering patient refused p.r.n. medications. Health services fear litigation re the threat of medical malpractice, which influences the current treatment of patients. Closely linked to this medical practice (which itself may possibly be viewed as medical malpractice), is the perceived increased rate of p.r.n. medications administered to patients and the number of additional occasions a resistive, non compliant patient is approached by nurses to administer medications.

The repeated number of approaches into danger to administer p.r.n. medication is the issue. The increased number of occasions that nurses administer p.r.n. medications to patients who are resistive and needing nurse restraint needs review. This increase in medication numbers i.e. the increased number of approaches to patients, and the associated risk to nursing staff making the numerous approaches must be acknowledged by management. Appropriate strategies in dealing with this issue must be developed with staff.

Additionally, there is a considerable important but a vague area of recognition for nurses that participate in the restraint of patient's that needs clarification. OH&S has individual lifting weights limits, the hospital has a no lift polices, etc but when medicating a non compliant and physically resistive patients, the activities of the restraint process put nurses in a potentially dangerous situation where injuries can occur. The weight limits, the bending of knees in the lifting process, back protection polices come to nothing in the physical activity of the restraint process due to the emergency of the situation and many, varied body positions that may be required to control the patients movement.

The physical restraint process of people who are affected by drugs (such as Amphetamines, THC, etc and their own Adrenaline) pose a serious and potentially danger of injury to nurses and themselves. There are many muscles involved in this physical process. Muscle strain is activated instantly (in a microsecond) with unmeasured pressures exerted by the nurse on numerous body parts reacting in the physical restraint process. This issue needs to be acknowledged as a dangerous process and potential high area for injury to nurses.

**Seclusion.**

The seclusion room is a dual purpose room, a bedroom and when necessaryis used as a seclusion room. This room is not a specifically designed seclusion room. From its present design there is always a increased risk when secluding patients in a non specific seclusion room. There were 47 seclusions during the 3 month trial

**Qualitative (unstructured interviews)**

**Underreporting**

Underreporting is a major cause for concern, as management lacks important current and accurate data to consider in there decision making process. The reasons for underreporting are many and varied. Review of the literature, in discussion with nursing and medical staff during this study, supported the common view that underreporting is a common feature among nurses.

Views expressed to the researcher by nursing staff during the survey period go some way in an attempt to explain underreporting of aggressive and violent events, included :-

- Working in the psychiatric hospital is similar to working in a society within a society. Behaviours that are seen to be unacceptable in "normal" society (commonly the reason for the patient's admission) can be common place in the hospital setting. Staff appear to become accepting of these idiosyncratic patient behaviours (staff desensitisation process). This milieu influences the staff's future outlook in respect to what is acceptable behaviour in general. These inappropriate behaviour that staff are exposed to (sometimes deviant behaviour) can influence personal value system. Staff develop a deeper tolerance to patients' inappropriate behaviour with an acceptance of behaviour that is unacceptable to the public in the community.

- Staff acceptance of aggression and violence may have been a contributed factor to underreporting and there is an acceptance by some staff that aggression and violence are part of their professional career.

- There was a common perception among staff that management is dismissive of the increased risk of violence and aggression in the work place. Budgetary constraints are seen to maintain nursing levels to baseline staffing numbers, rather than staffing for risk minimisation. "You can't roster people on in case a violent individual might turn up!"

- There was general agreement between staff that the ever-increasing volume of paper work to be completed reduces time to deal with patients. Completing another task eg this survey, MHOAT forms, unit data records, etc imposed on their time by at times doubling up information recorded. Some staff reported simply forgetting to fill in aggression incident forms due to work demands/pressures.

- Increased demands on staff, whose numbers have decreased over the past fifteen years or so regardless of substantially increased demands in accountability, and economic reform with little perceived outcomes other than those considered commercially sustainable.

- Staff concern re risks of horizontal violence from colleagues, in the form of ridicule for reporting trivial matters in this survey or incident forms were reported.

- Vertical violence (covert threats from management) for reporting to management, management perceived insignificant and inappropriate matters.

- Fear of being identified and labeled by management.

- Fear of not being rostered casual shifts, "if seen to be rocking the boat".

- The common staff belief that, "No one does anything anyway when things are reported" and "has done nothing about reported events for a long time".

**Legal Issues**

The spirit and the premise of the OH&S Act 2000 is that any injury to workers (mental and physical health) must be prevented. The reduction of staff member's general health and physical wellbeing must not occur. The general premise of the OH&S Act 2000 is that the prospect of injuries or disability, increased stress and strain to staff should not exist.

The OH&S Act 2000, states-

Part 2 Duties relating to health, safety and welfare at work.

Division 1 General duties.

8. Duties of employers.

(1) Employees

An employer must ensure the health, safety and welfare at work of all the employees of the employer.

That duty extends (without limitation) to the following:

(a) ensuring that any premises controlled by the employer where the employees work(and the means of access to or exit from the premises) are safe and without risk to health,
(b) ensure that any plant or substance provided for the use by the employees at work is safe and without risk to health when properly used,
(c) ensure that systems of work and the working environment of the employee are safe and without risk to health,
(d) providing such information, instruction, training and supervision as may be necessary to ensure the employees' health and safety at work,
(e) Providing adequate facilities for the welfare of the employees at work.

Justice Schmidt's (Butrej, 2002:28), made it very clear that staff safety is paramount and comes before the provision of the "least restrictive environment" required by the Mental Health Act. To quote Justice Schmidt's decision (paragraph 89),

> "Empathy, care, and possible pity for such patients are, however, not a proper basis upon which employees may be permitted to place themselves into danger."

Further (paragraph 90), Justice Schmidt stated,

> "No matter how dedicated to patient welfare a nurse or other employee might be, it is inconsistent with the requirements of the Act that the defendant permit them to be the subject of physical assault, or indeed repeated physical assaults, by patients who are not restrained from harming others. Employment on such a basis is not permitted by the Act."

The "least restrictive environment" must therefore be one that still provides for the safety of staff and patients (Butrej, 2002:28).

**Staff education**

Staff education is a very important tool that can improve all aspects of working effectively and safely in the health service. Increased staff skills through education and training can be "the making or breaking" of effective service delivery. The staff safety issue in the workplace is one of the measures staff use to gauge the management commitment to them. Competency Based education for Aggression Minimisation should be considered a priority due to its importance in

preventing staff and patient injuries. There is not only a legal requirement for staff education but also a moral obligation for the service to protect its staff.

Aggression Minimisation training is presently not standardised in mental health services and is considered inadequate by numerous staff:- Appendix II copy of concerned staff member letter to OH&S. Staff reported that management arranged a one day education program (the 2002, "Casual Nurse Expo") which attempted to address numerous topics on the one day. Some staff felt the Aggression Minimisation topic (addressed in a 1 hour talk) was inadequately addressed.

These staff members did not feel confident to participate or help other staff deal with in-patient aggressive incidences in the workplace. Other staff in the Mental Health Service reported receiving 2-3 day training in Aggression Minimisation. Some staff, from other Area Health Services stated that they had received 5 days of training in Aggression Minimisation. A major concern was that there appear to be little standardised education and no outcome measures regarding the competence or proficiency levels of the staff that undertake aggression minimisation training.

**Perceived contributors to violence**

Highly disturbed individual patient behaviours in PICU impact negatively on all other patients in this unit, especially at night. Other patients, visitors and staff generally experience or witness disturbed behaviour by patients before the disturbed patient can be treated in privacy. The small area of this unit (there are no private segregation area) and the acoustics in the unit are such as to allow sound levels to travel about the unit unchanged in volume.

In the PICU nurses' station, clinicians are unable to discuss treatment options, maintain privacy and anonymity of the patient because of the physical environment. Additionally, the part time seclusion room is part of the units eight bed capacity and is not sound proofed, thus when in use, the loud noise negatively impacts on all patients, visitors and staff in PICU and the adjoining Bluegum Ward.

The "fishbowl" effect of the staff office, intended to provide a high degree of visibility, protruding into the patient areas, has the unfortunate consequence of not providing privacy for either patients or staff. It has had the effect of creating on occasion, a two-way them and us mentality. The office is a major focal area for the patients in the unit and the place where the majority of information is held about them, and the second highest location for aggressive and violent outbursts by patients.

The courtyard is small and has a caged roof for containment purposes. There is no grassed area and limited sunlight access.

Increasing numbers of dual diagnosis patients with substance abuse and drug intoxicated patients associated with antisocial traits disorders contribute to the increasing aggression in the service. These patients with poor impulse control generally behave in a threatening and aggressive manner, often in response to substance intoxication or subsequent withdrawal syndrome. Again patients held against their will, combined with containment and no access to drugs (enforced detoxification) can be of greatest concern due to their aggression and violent acting out.

Adler et al (1983), sighting Snyder's personal communication, recognized under staffing as one of the factors contributing to an increase level of assaults on staff.

Inexperienced nursing staff is a contributing factor to aggression and violence. Initial staffing of the PICU was determined upon staff having a minimum of (5) five years acute psychiatric experience, a requirement that with time has proved difficult to satisfy. The complexities of working in PICU subsequently place inordinate pressure on senior and junior staff in this dangerous, volatile and demanding environment.

The rostering of inadequately trained or experienced staff to PICU may increase the number of events of aggression and violence. Inadequately trained or inexperienced staff also increase the pressure on the In Charge of shift person in that one or more persons need close supervision, ie in PICU at this, point the in charge of shift person has 10 people that they closely oversee.

PICU recorded 19% of aggressive and violent inpatients. Units where high levels of aggression and violent behaviour are experienced in the workplace on a daily basis must be acknowledged as dangerous workplaces. Staff work continuously under elevated stress levels (physical, mental and emotional). Staff locked in this unit for eight (8) hours per day for five (5) shifts per week with aggressive patients must pay a toll in some way.

**Aggression and violence effects on staff**

Some staff reported suffering fear, anxiety, and low self-esteem, in anticipation of going to work in PICU. On completion of the shift some staff reported feeling relief and happiness to have survived the shift. Some staff point blank refuse to work in PEC and/or PICU.

Discussions with a nurse's spouse revealed that she often became aware of aggressive and violent incidences in the work place, because of the nocturnal actions of her effected partner, evidenced by, restlessness, thrashing, punching and kicking during sleep following incidents at work.

The difficulties of the work environment in PICU are well recognized by management. The general accepted practice by line managers is not to roster overtime shifts back to back in PICU. Most staff of the hospital view working in PICU as highly pressurised, dangerous and the workload huge, a fact reinforced by staff who have resigned from the unit previously.

**Admission of aggressive and violent patients**

A history of aggression and violence remains the most reliable predictor of aggression and violence on current and or subsequent presentations. This element is paramount to better flag individuals before their arrival for assessment. Presently the old files are the only indicators of patient aggression and violence. The old files do not necessarily have alert pages or particular alert notation of aggression and violent behaviour. The only way to identify the risk of aggressive or violent behaviour is to completely read the old file.

Present staffing level in PEC is one nurse, one doctor and at times a supervisor. For the perceived busiest times, an "E" shift (1300hrs – 2100hrs) commences increasing the staffing levels to two nurses, one doctor and one supervisor. There are many occasions when two patients being assessed simultaneously and more assessments waiting. At most times assistance is available

from a security officer and the option to draw extra staff from the wards. All staff carry duress alarms and if needed a Code Black response team of 5 additional nurses may be called in an emergency.

The present staffing levels and current processes in both PEC and PICU may be insufficient where threatening; aggressive and violent patients are processed for admission. At times the most difficult individuals are moved and contained temporarily in PICU while admission procedures are completed in the safety of PEC. This is often a major imposition on an always busy and volatile PICU unit, generally with a 91% (average in 2002) occupancy rate. At night in PICU sedated patients are woken by the new patients loud and angry reaction to being admitted.

Known aggressive and violent people and those considered at risk need to be processed in the safest possible way for all concerned. Addressing this important issue needs urgent managerial policy and procedural intervention. The responsibility for the lack of improvement in working conditions for nurses arguably lies in three main areas; (1) Health Management, (2) the Nurses Association, (3) Psychiatric Nurses themselves, all of whom for numerous reasons attempt to circumvent, deny or minimise the problem or its impact.

The previously identified inadequate staffing level in PICU was established in an OH&S Risk Assessment (2002). Staffing levels in PICU at James Fletcher Hospital are lacking when compared to the other two NSW PICU. In February 2002 a survey of the three other PICU's established that the James Fletcher Hospital PICU was working one and one half nursing position down compared to the other state facilities.

Patient to nurse ratios is only one of management's measure of service to the patient and in part establishes the nurse's workload. The patient to nurse ratios rate in Wisteria unit in Ibis ward at Morisset Hospital servicing 6 immobile patients is 3:1, compared to PICU with 8 mostly young, angry and volatile patients which has the same 3:1 staffing ratio. This situation highlights the flaws in using nurse to patient ratios as a measurement tool to calculate staffing levels.

**Environmental factors**

The PICU unit has 8 beds, four single rooms and two shared bedrooms, a shared dining, lounge, court yard areas. One single room is the part time seclusion room. The nurses station is a square bubble type, Lexan lined, placed against an external wall protruding into the lounge and dining area separating the court yard and the entrance area.

Presently patient's personal space and privacy in PICU is limited. Patients do not have quiet space to remove themselves from other intrusive and demanding patients. Careful planning is needed to address the environmental, safety and control factors in any proposed unit being built in the future. The design must be an improvement in size, layout, etc, than the present facility.

Staff reported the renovations to PEC (Admission Unit) appear to have significantly improved the working environment. The risk of aggression and assault remains.

**Nursing views**

This survey was developed to measure the aggressive and violent conditions faced by psychiatric nurses on a daily basis, in the "front line". It has been written from the nursing point of view to

alert others of the increasing dangers in this workplace. The recognition that nurses working conditions need to be exposed and improvement immediately implemented motivated the authors.

The response (for the code Black - person in trouble) team is made up of only five (5) nurses, although the NSW Department of Health, Emergency Department guidelines recommends at least seven (7). The response team is picked 3 times a day for the 3 shifts in the 24 hour period. There are varying gender ratios, ages, physical conditions, philosophical views (re aggression), etc that make up the response team. At times a security officer responds to the code Black.

Although in this hospital the view is that staff belong to a treatment teams, doctor, psychiatrists, psychologists, social workers, welfare offices, occupational therapist, receptionist, etc may be directly threatened by patients and call a code Black, but these professions do not respond to a code Black situation only nurses. This circumstance again highlights the danger for nurses placed in the most potentially aggressive and violent situations.

The literature review did not clearly identify any management intervention options in dealing with aggression in Mental Health Services. What is identified in "THE RECOGNITION, PREVENTION AND THERAPEUTIC MANAGEMENT OF VIOLENCE IN ACUTE IN-PATIENT PSYCHIATRY" in the United Kingdom study are numerous recommendations to improvement for staff and patient safety. Some of the UK recommendations should be implemented into this service. These recommendations are incorporated into the recommendation section of this study.

Anecdotal evidence suggests that management does not seriously take on board staff safety issues or support staff concerns related to their working conditions in Mental Health generally. The perception is that management has a history of discounting any changes or improvements suggested by staff. Important to note is that line managers are perceived by unit based nurses to be subject to severe vertical pressure to operate to the specified budget.

Previous nurse initiated aggression surveys at James Fletcher Hospital in 2000 and 2001 were stopped by upper management when numerous reports identify aggression and violence in the workplace at unacceptable levels.

This survey recorded aggression experienced by staff at levels of one hour (60 minutes) per day. This translated to 30 hours of pure aggression endured by nursing staff per month. PICU recorded a patient aggression and violence level of 19%. Staff locked in this unit for eight (8) hours per shift for five (5) shifts per week with patients with aggressive behaviour and nature are expected to always act in a professional nursing manner. Are these levels of stress in PICU acceptable?

The future challenge for management is to work at altering the current nursing staff perception that management shows little interest in issues that are important to nursing staff and as a consequence nothing has been accomplished by nursing and medical staff reporting these incidences in the past. The Area Health service as a self-insurer should be cognisant of the reality that reducing aggression is good risk management.

The difficulties in nurse retention and the lack of experienced psychiatric nurses are very real. Mental Health Services need to be proactive in addressing the working environment issues of nurses and hence improve the recruitment and retention of psychiatric nurses in the future.

## CONCLUSIONS

Findings in this survey mirror issues identified in past research and again confirm the imminent danger of working in this field.

This survey clearly identifies numerous areas of considerable concern in the workplace,

- relating to underreporting of aggression by nurses,
- the working environment,
- inadequacy of staffing and training levels,
- perceived lack of managerial concern and action,
- levels of p.r.n. medications and
- the present hazardous conditions nurses are exposed to on a daily basis.

The aggression and violence levels of 19% reported by nurses in this study is twice the level generally reported in international and national research. One in ten aggressive and violent events were reported in the official RoI&E forms.

The underreporting of aggression in the official recording systems (a systems failure) is considered a major contributor to the devolution of the present working conditions. The present policies/management of nurses does not reflect changes in patient behaviours with increasing levels of aggression and violence in the workplace. The survey results suggest that the present levels of aggression and violence are at unacceptable levels and are well above levels reported in international studies. A review of all present operations systems and standards is in order.

The introduction and interpretation of Economic Rationalism, the Mental Health Act and the OH&S Act, have had different areas of focus and influence in the workplace. The focus of this study on the OH&S issues and the survey results suggest that presently nurses are working under unsafe physical, mental and emotional health conditions. This situation must be addressed by improving operational systems presently utilised in this workplace.

The present medical management of patients has also been identified as an important OH&S issue impacting on the safety of nurses, ie the current level of p.r.n. medication use. The repeated number of approaches to patients a nurse in presently making is the issues during this study period. The present number of six hundred and fifth six additional medication administered to patients (generally against their will) identified in this survey appears excessive.

Lastly, the current perception of management by nursing staff needs addressing to allow for better lines of communication. The flow of all accurate information and data is needed by the decision makers before decisions are made. Under the OH&S act management and staff are encouraged to share responsibilities affecting the safety of their workplaces. This survey data introduces a huge opportunity for changes in relationships between management and staff and the positive prospect for improving present safety and working conditions for staff.

## RECOMMENDATIONS

- All levels of management in the Hunter Mental Health Service need to demonstrate to all staff their serious commitment to the Department of Health's "Zero Tolerance" policy to aggression and violence in the workplace.

- Develop explicit and clear policies stating Hunter Area Mental Health Services position on all forms of aggression and violence in the workplace. In addition policies and management procedures updated detailing specific handling of situations such as:
  - Patient restraint.
  - Medication of patients without their consent.
  - Patient use of prohibited drugs while treated in hospital.
  - Services initiate criminal proceedings for assaults on staff.
  - Relationships developed with other services eg Courts, Corrective Services, Police etc in regards to interdepartmental services co-operation re assaultive people.
  - Nurses Job Descriptions reflect the true nature of tasks preformed daily.

- These policies (explicit and detailed policies stating Hunter Mental Health position on all forms of aggression and violence in the workplace.) be translated into practical working procedures and practices for all staff to adhere to and be protected by working within these policies and guidelines.

- An immediate review of nurse and patient management protocols and working conditions in PEC and PICU be conducted addressing current concerns.

- Management and Workcover address the underreporting of aggression and violence phenomena currently identified.

- Review of incident and accident forms to explore the development of alternative and easier to complete forms. Staff attitudes towards the OAS perhaps due to ease of use as opposed to more formal and complicated RoI&E form needs further investigation to increase the efficiency of staff reporting aggressive events.

- Management evaluate the effectiveness and appropriateness of current Aggression Minimisation training employed in Mental Health Services for staff to "Best Practice" levels acknowledged internationally.

- Management expand the current aggression Alert system to a readily accessible comprehensive record of aggression and violent events for individual patient before presentation, so the safest possible admission process can be arranged before the patient arrives.

- Regular in house mock training and exercise in the management of aggression in Aggression Minimisation is initiated in an effort to maintaining high staff skill levels, be a good team building activity, improving confidence in de-escalation, defusing, and actual number of violent incidents.

- Staff identification, name tag details need to be review in an effort to reduce individuals personal information available to patients in line with overseas practices.

- Additionally a serious attempt must be made to encourage staff to report all aggressive events to increase the collective awareness of the risk of aggression and violence in the workplace.

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# APPENDIX 1

HUNTER HEALTH
*Improving Health in the Hunter*

# Hunter Mental Health Service
# Psychiatric Emergency Centre & Psychiatric Intensive Care Unit

| Attach ID Label | |
|---|---|
| Name: | Clinicians Name: |
| MRN # | Signature: |

## Overt Aggression Scale* (modified)

**Date** ....../....../....... **Time**.................**AM/PM** **Duration**................. **Location**.............................

### 1. Verbal Aggression

- ❑ **a**. Makes loud noises. Shouts angrily.
- ❑ **b**. Yells mild personal insults eg. "You're stupid".
- ❑ **c**. Curses viciously, uses foul language in anger, makes moderate threats to self and others.
- ❑ **d**. Makes clear threats of violence towards others or self eg. " I'm going to kill you" or requests help to control self.

### 2. Physical Aggression Against Objects

- ❑ **a.** Slams doors, scatters clothing, makes a mess.
- ❑ **b.** Throws objects down, kicks furniture without breaking it.
- ❑ **c.** Breaks objects, smashes windows
- ❑ **d.** Sets fires, throws objects dangerously.

### 3. Physical Aggression Against Self

- ❑ **a**. Picks or scratches skin, hits self, pulls hair with no or minor injury only.
- ❑ **b.** Bangs head, fists onto objects, throws self onto floor or into objects (hurts self without serious injury).
- ❑ **c.** Small cuts or bruises, minor burns.
- ❑ **d.** Mutilates self, causes deep cuts, bites that bleed, internal injury, fracture, loss of consciousness, loss of teeth.

### 4. Physical Aggression Against Other People

- ❑ **a.** Makes threatening gestures, swings at people, grabs clothing.
- ❑ **b.** Strikes, kicks, pushes, pulls hair without injury to person.
- ❑ **c.** Attacks others causing mild/moderate physical injury (bruises, sprains, welts).
- ❑ **d.** Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury)

### 5. Interventions

- ❑ **a.** None.
- ❑ **b.** Talking to patient.
- ❑ **c.** Closer observation.
- ❑ **d.** Physical restraint.
- ❑ **e.** Immediate oral medication.
- ❑ **f.** Immediate IMI medication.
- ❑ **g.** Isolation or segregation.
- ❑ **h.** Seclusion.
- ❑ **i.** Medical attention for perpetrator.
- ❑ **j.** Medical attention for victim.
- ❑ **k.** Other

### 6. Motivation

- ❑ **a.** Material gain.
- ❑ **b.** Provocation.
- ❑ **c.** Psychosis.
- ❑ **d.** Self defence.
- ❑ **e.** Unknown.
- ❑ **f.** Other

**Could this incident have been prevented?**
**If YES, *please comment.***

**Additional comments:**

* Yudefsky et al. 1986. American Journal of Psychiatry. Vol. 143. No.1. PP.35-39

# APPENDIX 2

20th March,2002

Mr Michael Witkowycz
Occupational Health & Safety Delegate
James Fletcher Hospital

Dear Michael

Pursuant to our discussion re concerns for casual nurses who attended the casual nurses expo. in the performance of their duties as HMH employees. It appears that there have been other issues also that I feel have been seriously overlooked.

It would be appreciated if you would investigate and answer the following questions:

a) Chris Kewley's letter stated that the attendance was "not compulsory" but that "annual certification" for "training or equivalent has been undertaken will be a requirement of ongoing employment with HMH".

b) Mandatory training was given for aggression minimization, CPR, among other things, but these two gave casual staff the most concern. The issue of CPR was proficiency of staff members to perform CPR when there was not enough time for all to have techniques examined. Seeing that this is mandatory, should we at least ensure our capabilities as practicing nurses?

c) Aggression minimisation training was a 1-hour talk on defusing a verbally hostile situation. I personally found this disturbing when other staff have had two days training, and just last week it was deemed necessary to train HA's for at least 2 hours at Waratah!

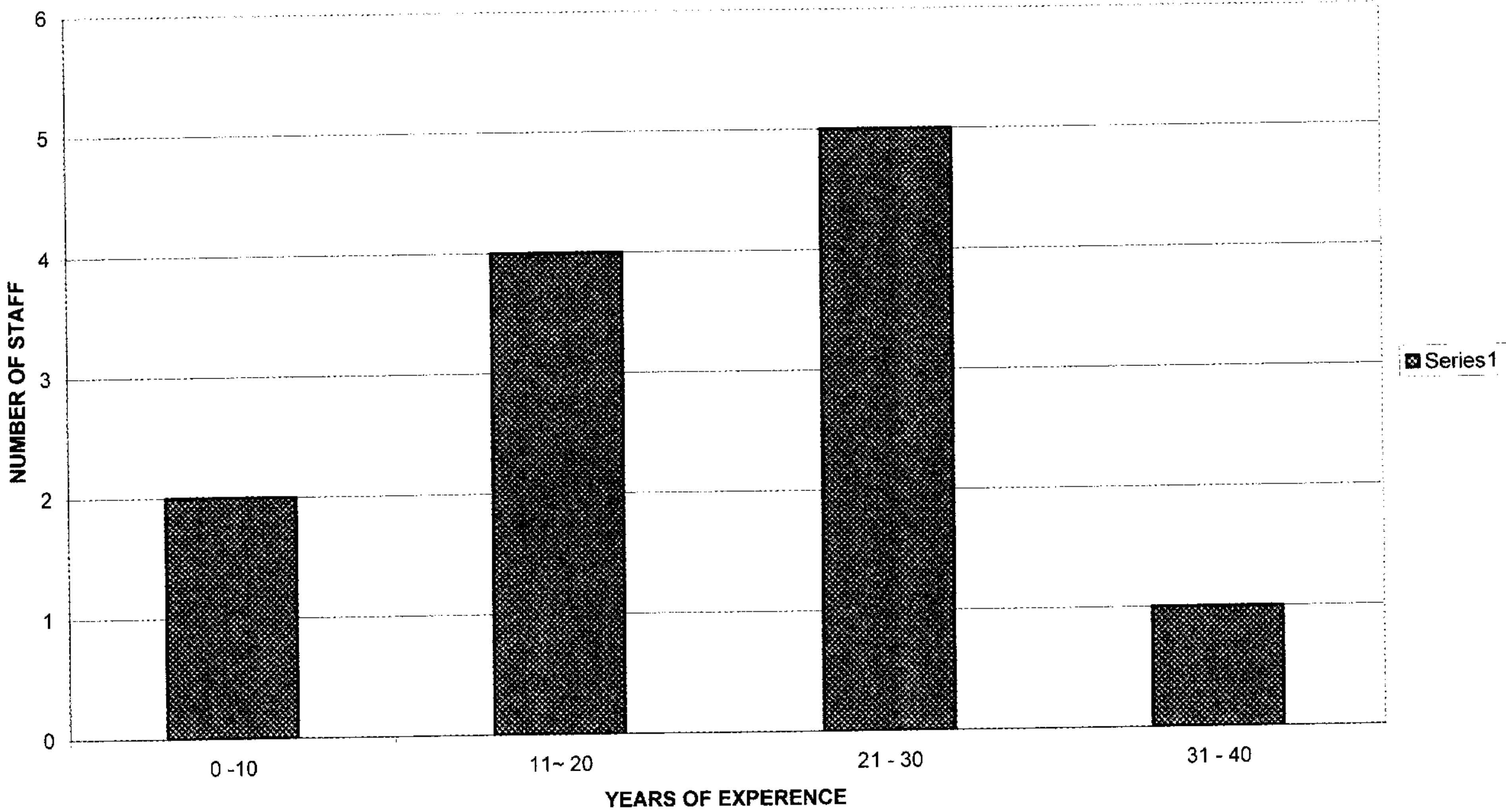
Often I work night when minimal staff is on hand and yet I can be named on the response team with 1 hour training. To say that the increased risk of working in PICU does not even warrant HMH spending a few extra dollars on staff safety is damnable.

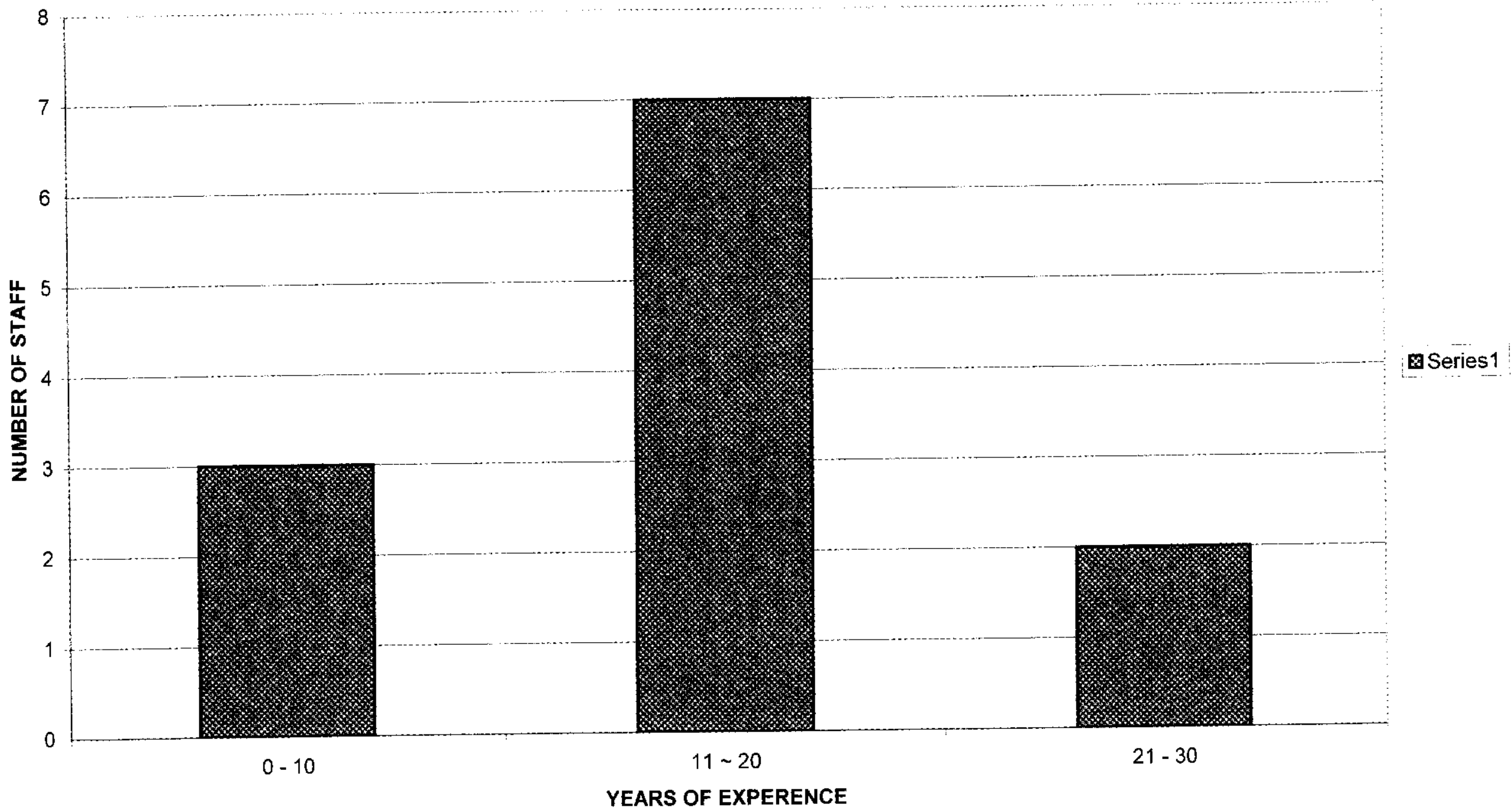
Mandatory training for psycho geriatrics entails two days A.M training for all contracted staff states the NUM of that unit, but casuals who work there may be trained for just 1 hour.

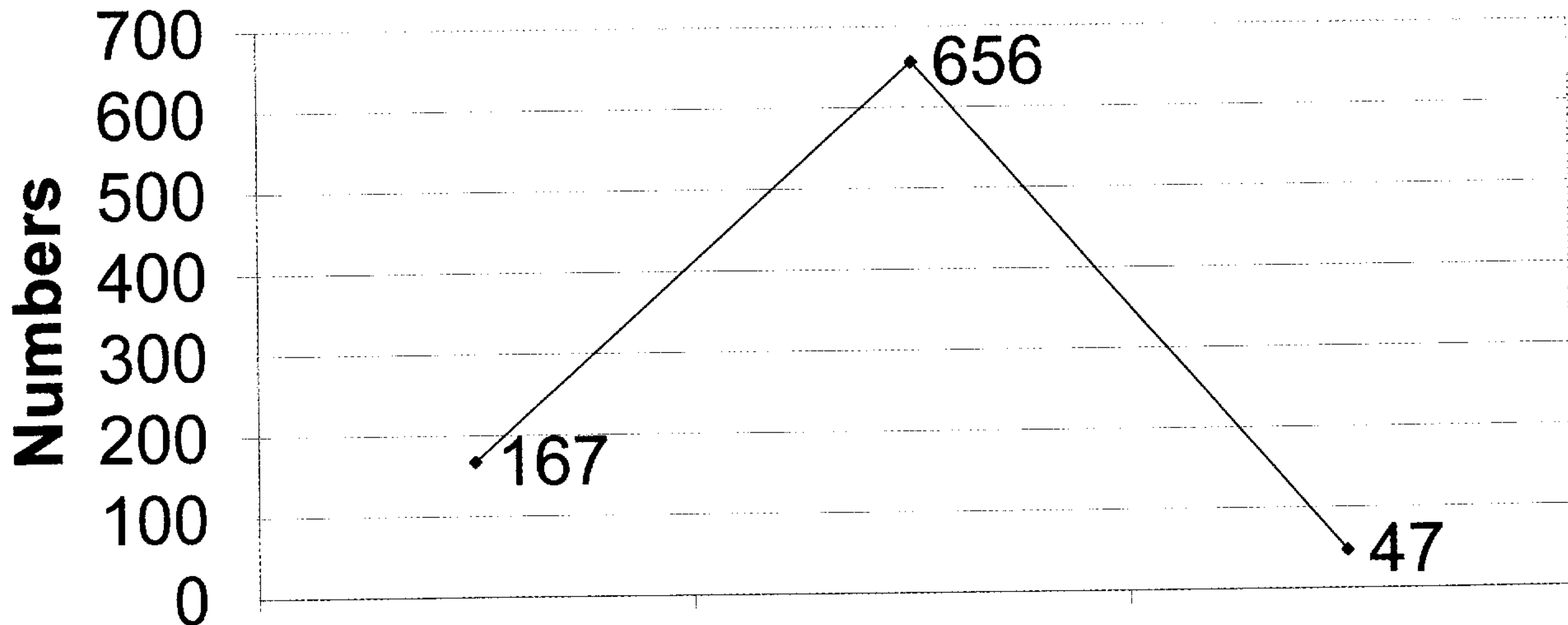
d) As the occupational health and safety officer for casual staff you have indicated that there appear to be no guidelines for what training actually provides. There are no guidelines for minimum training for nursing staff in aggression minimization. I have a certificate that says I have been trained but NOT how many hours instruction I have received. As several staff have been injured recently at James Fletcher, with potentially more serious consequences, I see the lack of guidelines as a matter of grave concern that needs to be addressed. Has this been undertaken by the OH&S committee? What is the committee's position on OH&S standards different for some casuals in comparison to the rest of HMH nurses?

I look forward to a reply to my concerns and appreciate your assistance in this matter.

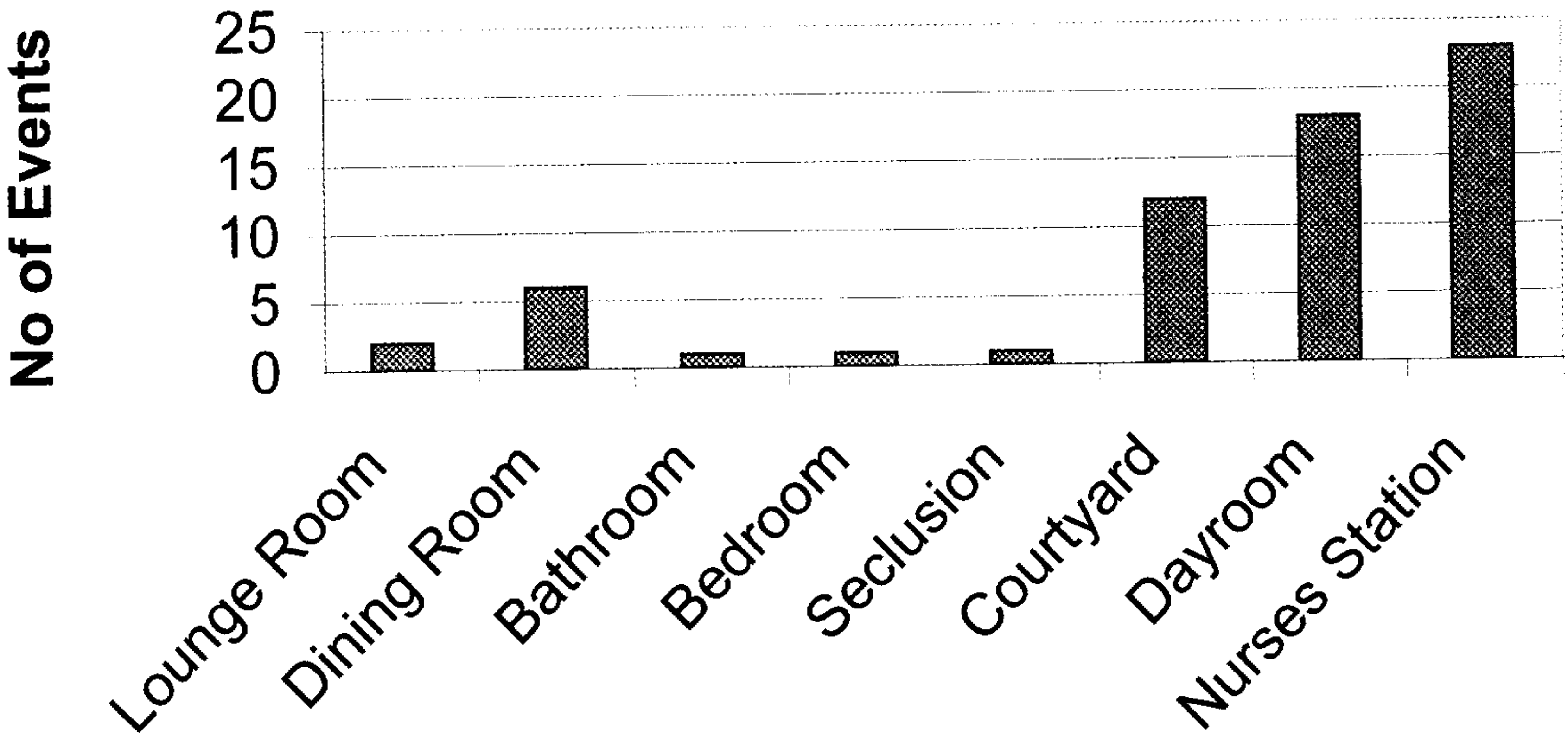
Kind Regards,

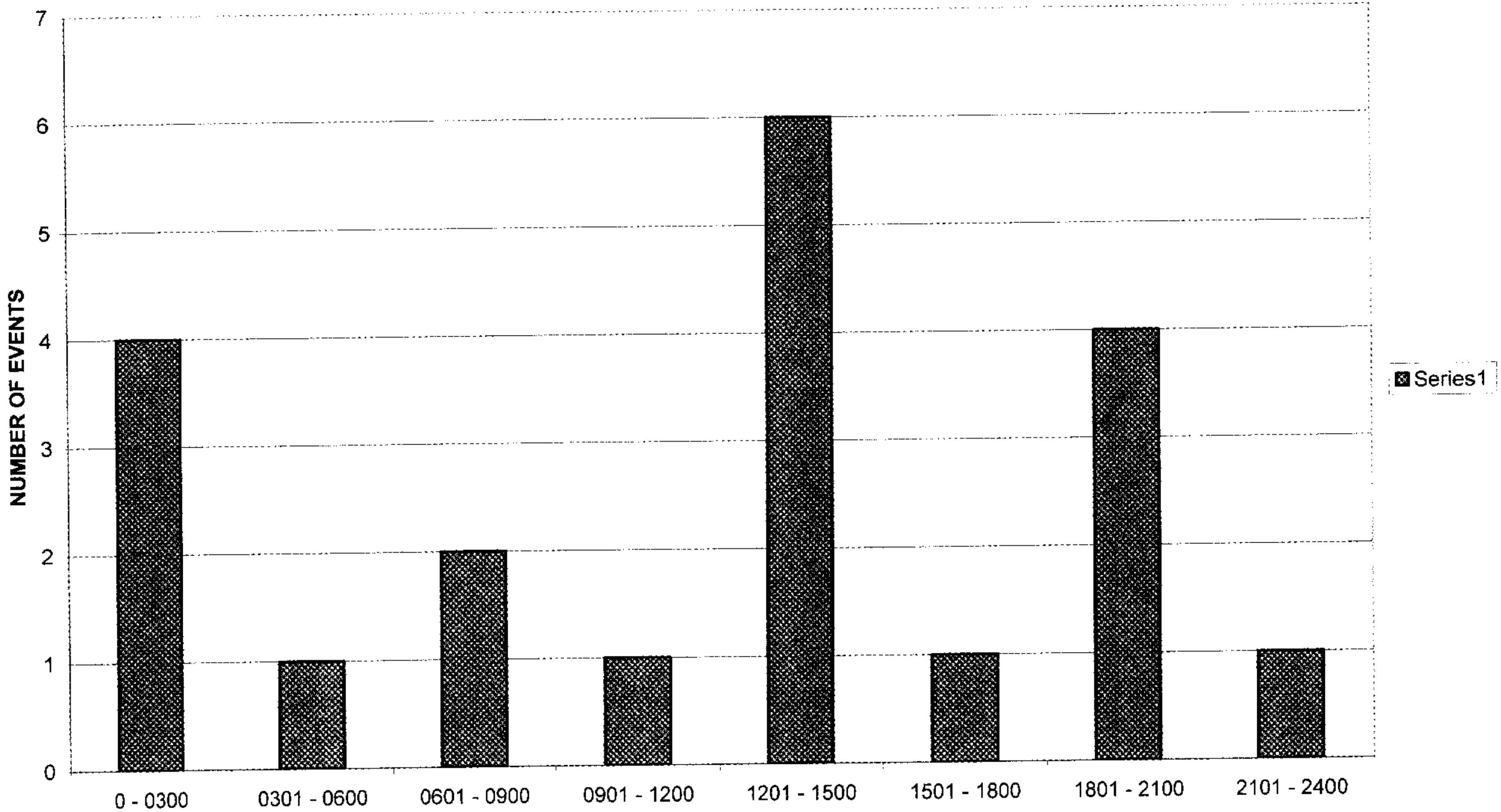

STAFF NURSING EXPERENCE - PICU
NUMBER OF STAFF
6
5
4
3
2
1
0
0 -10
11~ 20
21 - 30
31 - 40
YEARS OF EXPERENCE
Series1


ACUTE PSYCHIATRIC NURSING EXPERENCE - PICU
NUMBER OF STAFF
0
1
2
3
4
5
6
7
8
0 - 10
11 ~ 20
21 - 30
YEARS OF EXPERENCE
Series1

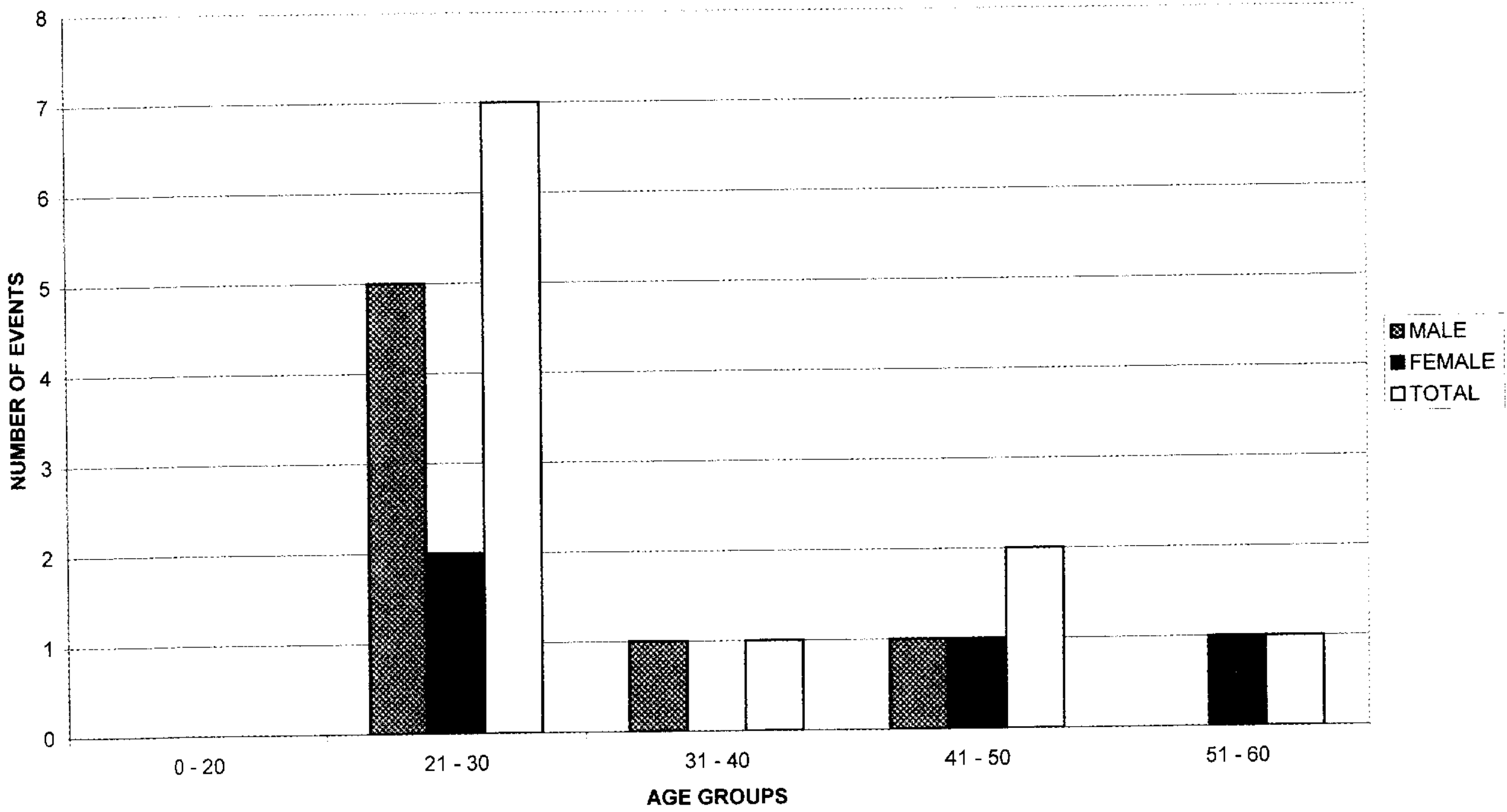


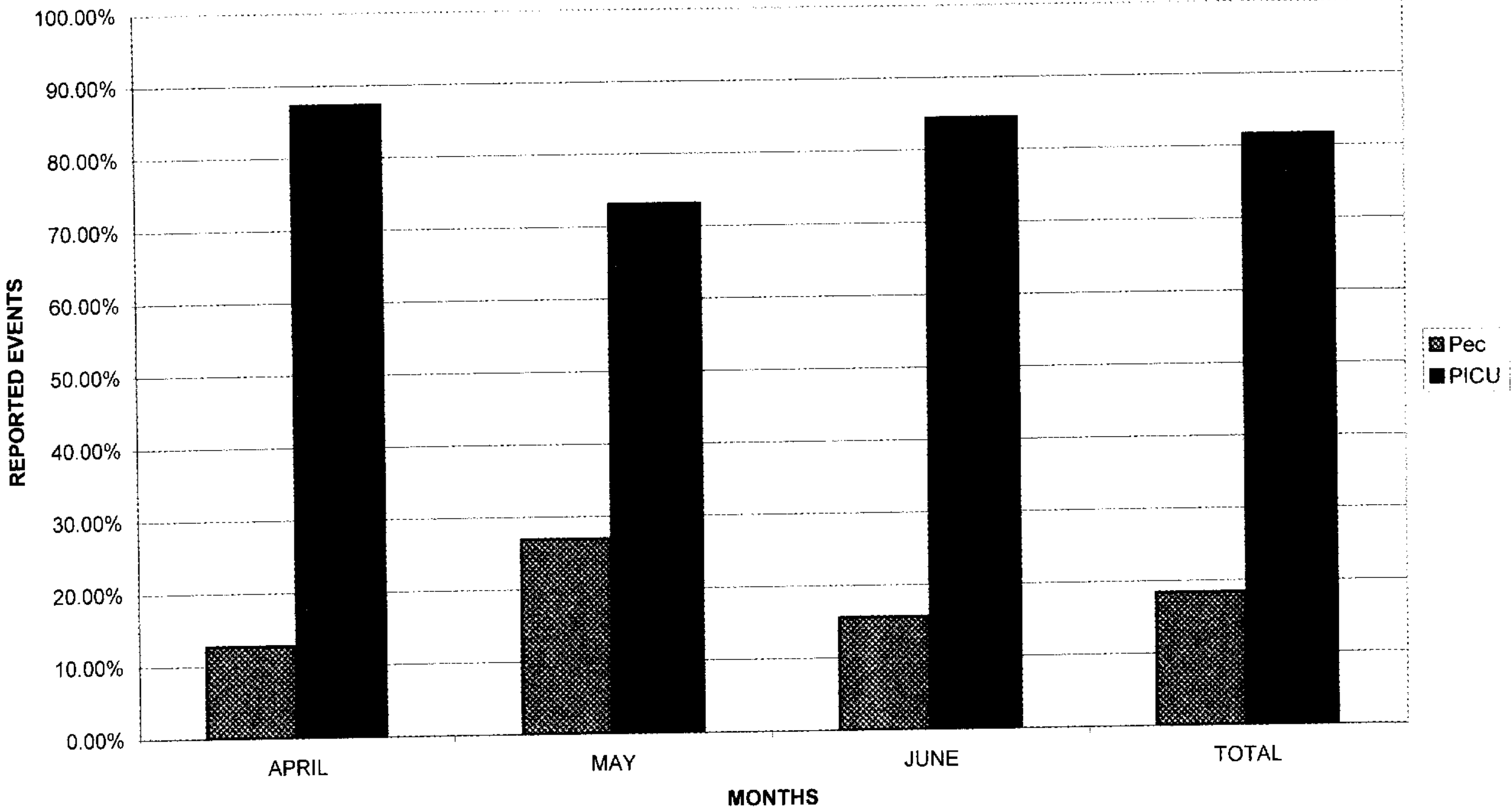
Waratah Statistics
Numbers
700
600
500
400
300
200
100
0
656
167
47
No of Admissions
No of PRN's medications
No of Seclusions
General Data

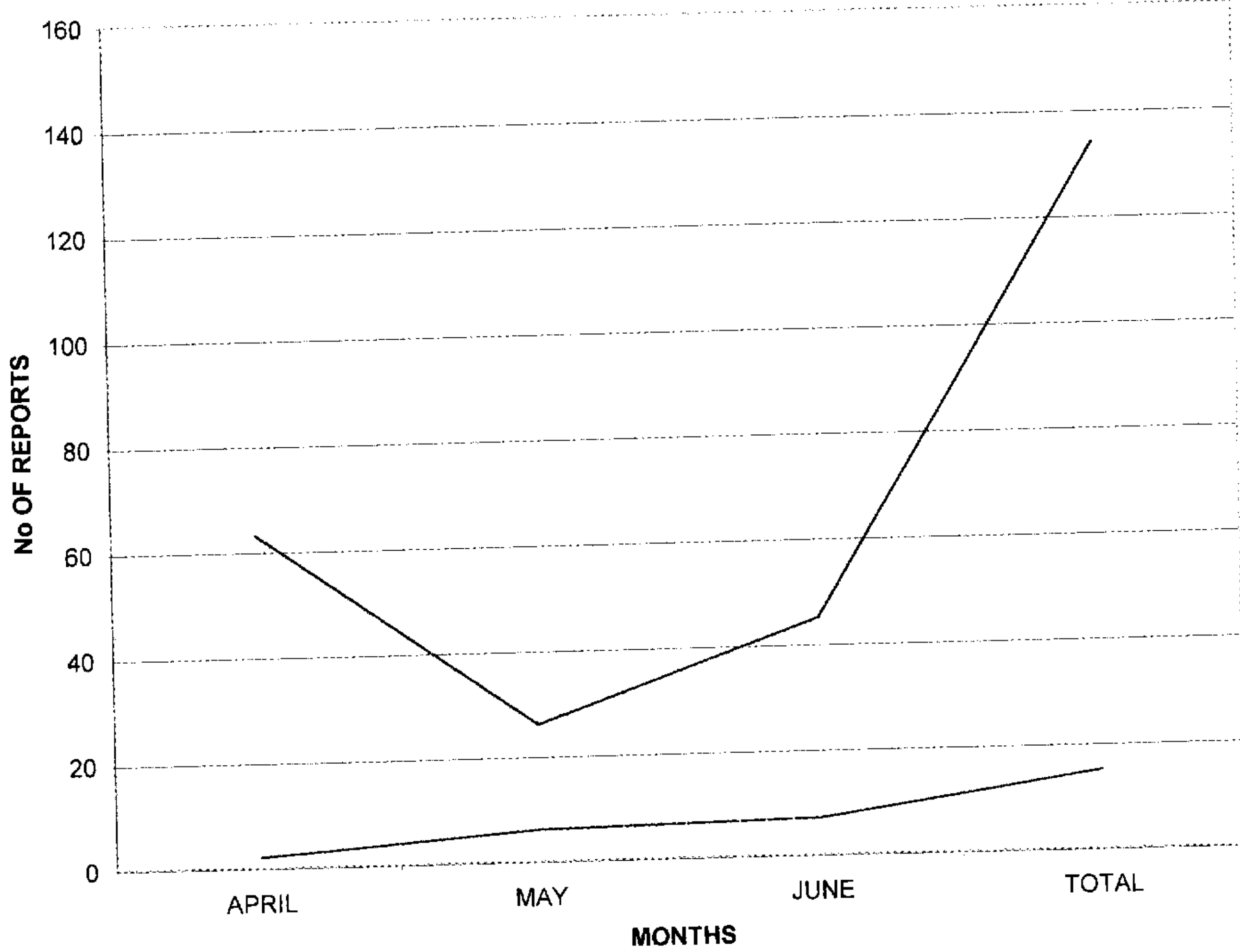

Location of Events
No of Events
25
20
15
10
5
0
Lounge Room
Dining Room
Bathroom
Bedroom
Seclusion
Courtyard
Dayroom
Nurses Station
Location

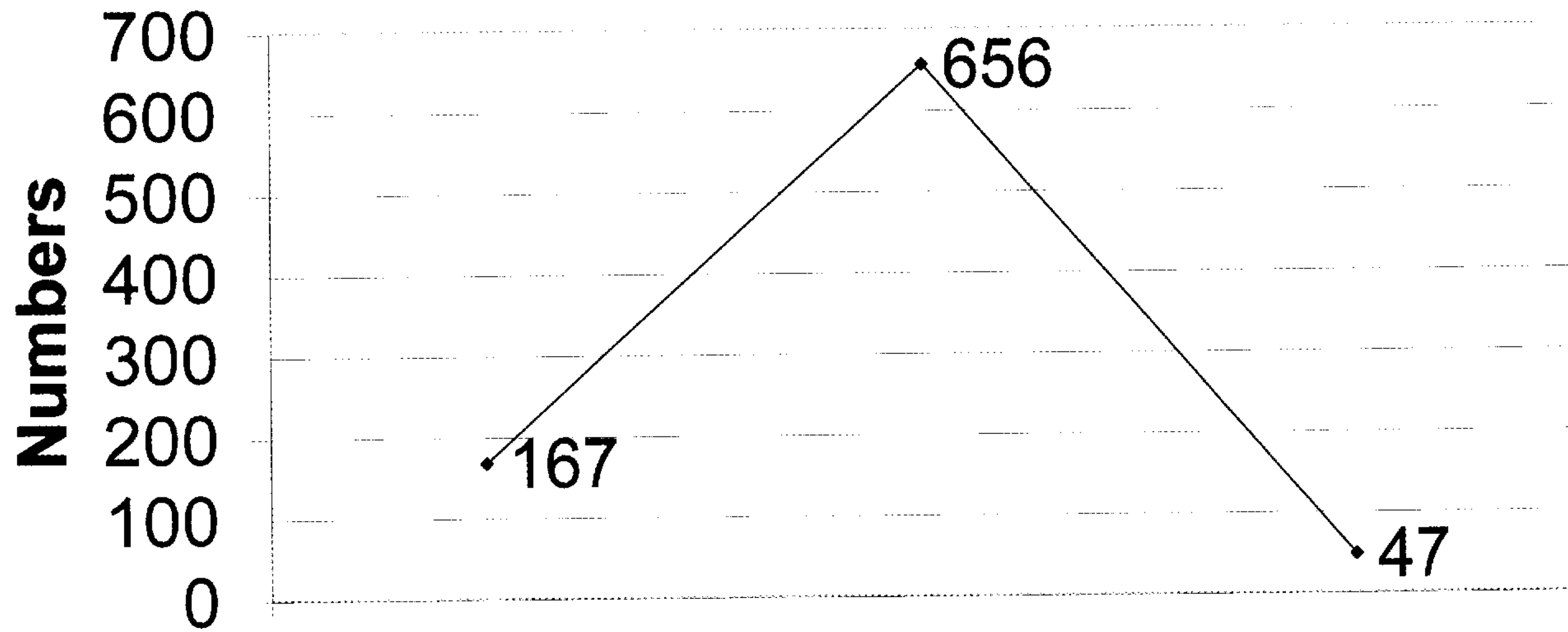


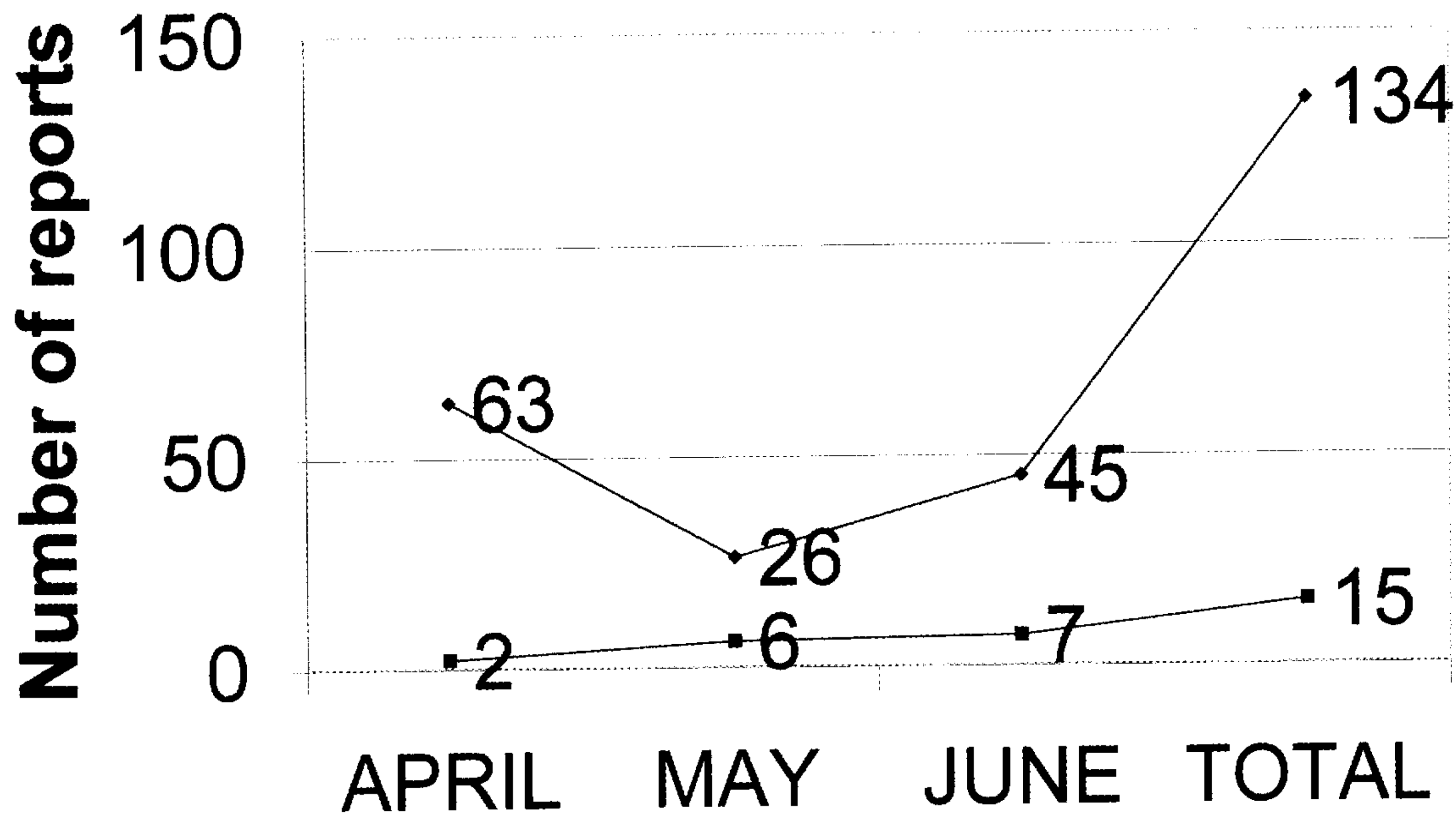
EVENT TIMES PEC
NUMBER OF EVENTS
0
1
2
3
4
5
6
7
0 - 0300
0301 - 0600
0601 - 0900
0901 - 1200
1201 - 1500
1501 - 1800
1801 - 2100
2101 - 2400
Series1


AGGRESSION IN PEC
NUMBER OF EVENTS
8
7
6
5
4
3
2
1
0
0 - 20
21 - 30
31 - 40
41 - 50
51 - 60
AGE GROUPS
MALE
FEMALE
TOTAL


PEC v PICU COMPARISON
REPORTED EVENTS
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
APRIL
MAY
JUNE
TOTAL
MONTHS
Pec
PICU


REPORTED LEVEL DIFFERENCE.
No OF REPORTS
160
140
120
100
80
60
40
20
0
APRIL
MAY
JUNE
TOTAL
MONTHS
TOTAL No OF REPORTS IN SURVEY
TOTAL No OF OFFICIAL REPORTS


Waratah Statistics
Numbers
700
600
500
400
300
200
100
0
167
656
47
No of Admissions
No of PRN's medications
No of Seclusions
General Data


Reported Events Comparison.
Number of reports
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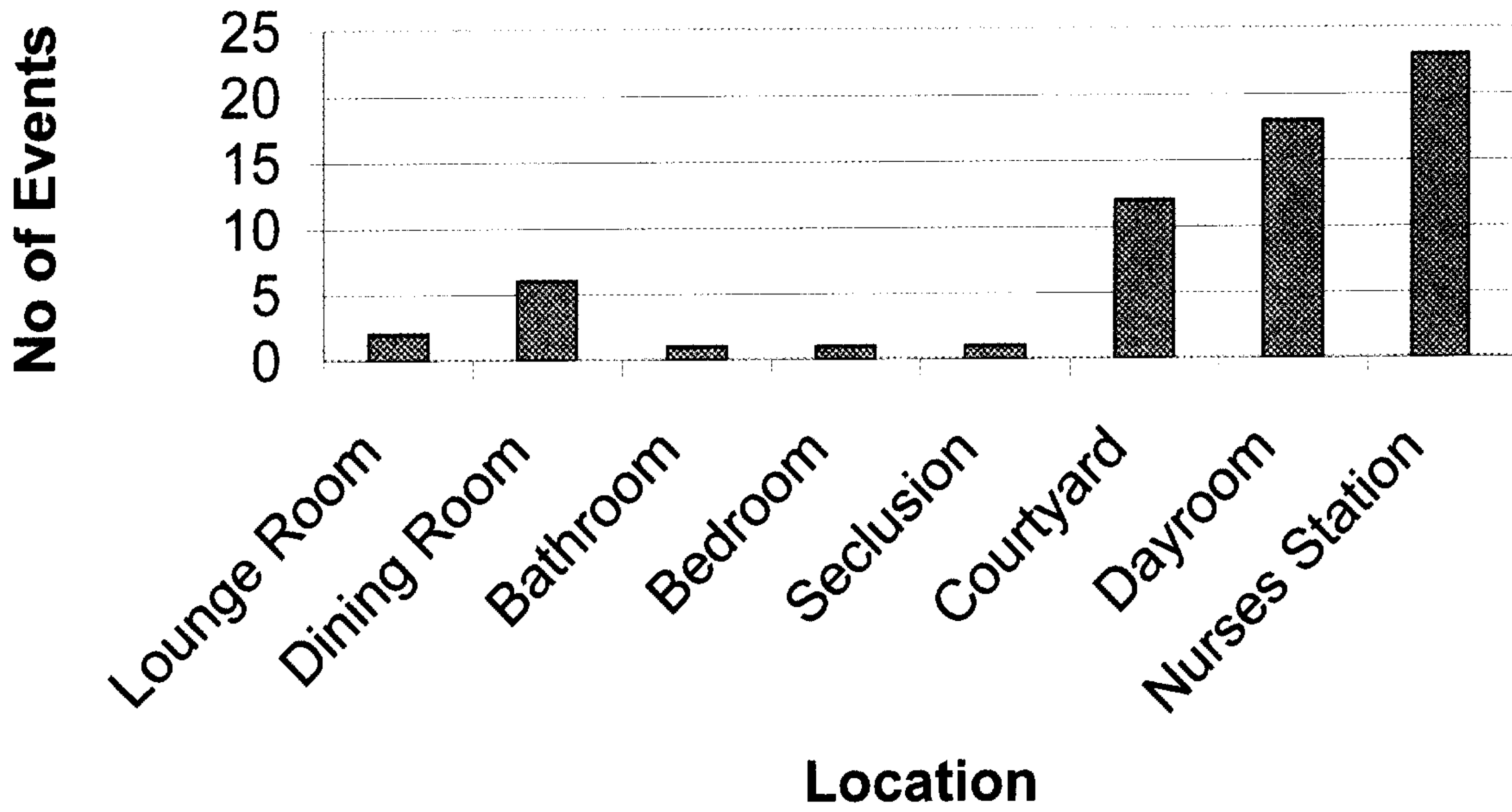
100
50
0
63
26
45
134
2
6
7
15
APRIL
MAY
JUNE
TOTAL


Location of Events
No of Events
25
20
15
10
5
0
Lounge Room
Dining Room
Bathroom
Bedroom
Seclusion
Courtyard
Dayroom
Nurses Station
Location