VIOLENCE AND AGGRESSION IN GENERAL PRACTICE

This toolkit tries to provide some practical guidance for GP practices on dealing with this issue, by drawing together links to key documents and policies in place in the NHS or produced by other organisations. The definition of work related violence is not subjective and is: “any incident where a GP or his or her staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health” (HSC 2000/001, NHSE)

Incident reporting is an important part of assessing the nature and extent of the problem. There is little information currently available so please report instances of violent or abusive behaviour, using the PCT standard “near miss” / adverse incident report form. (There is a separate form – VP1 – to inform the police of a patient posing a substantial risk of violence).

Training is a key part of helping staff to feel more confident in difficult situations and South Devon Healthcare run some courses on Personal Safety, Approach to Aggression, Dealing with Aggression and, Breakaway Techniques. These courses can be made available, by request, to primary care staff (web link to South Devon Healthcare Education and Training Department: http://nww.sdevonhc-tr.swest.nhs.uk/

Guidance for staff:
If you require laminated copies of any part of this guidance, please contact us.
- The Royal College of Psychiatrists have produced a short piece of helpful guidance to anticipate and de-escalate violence.
- It is felt that the incidence of oral abuse during telephone calls is increasing and guidance for staff on handling verbal abuse during telephone calls may be useful.
- Some practical guidance on minimising the risk of violence when lone working or during visits has been produced; this may be helpful as these are key areas of risk for primary care.
- Receptionists often take the brunt of verbal abuse and aggression and there are some recommended strategies which may assist in this area.

Policies and procedures:
- There is a draft policy in place for dealing with violence and potential violence against practice staff, which was produced by the Health Authority. Practices may wish to consider producing their own policies as well.
- The GP alert scheme, set up and run by the PPSA for the Devon Health Authorities, is designed to allow practices to identify patients who they believe pose a substantial risk of violence or threat to the police.
- The NHS runs a “Zero Tolerance Zone” Campaign, which includes a primary care programme (web link http://www.nhs.uk/zerotolerance Posters, post cards and a guidance booklet are available.
- Although it is hoped that de-registration is a last resort, GPs have the right to remove patients because of violence; immediate removal is possible if a complaint has been made to the police and an assault has occurred or a patient acts in a way that staff fear for their safety.

The police and legislation:
- Ann Morecraft, Head of the PPSA, has produced a summary of relevant legislation and an extract from a HSC is outlines what happens after a case is reported to the police.
- The Police working with the PCT to help manage this problem. They are developing a “place of safety” facility at Beenland Place (next to Torquay police) station which will have a consulting room and have offered the facility, and a police presence, to GPs consulting with violent and potentially violent patients. There are no plans for similar facilities in Paignton and Brixham although practices may wish to make use of the Torquay site, or, liaise with their local station to request a police presence. There is support in the regulations on the choice of medical practitioner that violent patients compromise their right to GMS in normal premises and distance considerations can be overridden –
this could mean, for example, that patients in Paignton would be required to attend the Torquay place of safety. Protocols on when to contact the police for a presence will be developed.

- **Patient contracts** had also been found to be useful with some individuals.

**Buildings and equipment** can affect staff safety; a risk assessment form is available which includes risk factors for premises, amongst others. If you do undertake a risk assessment, try and involve as many staff as possible and make sure it is documented. If possible, there should be the facility to remove staff and other patients away from a difficult individual. Phone systems and personal alarm systems allow staff to silently call for help. CCTV has a key place as a deterrent, and to assist with prosecutions if necessary, and the new digital systems do not require individual videotapes to be retained. The new digital systems are available at a cost of around £5,800 (60% of cost from an improvement grant would be £3480). An annual service is approximately £80. Improvement grants can help towards the cost of security improvements such as these – up to 60% of the total cost and the PCT would be supportive of any practice applications in this area.

**After care**, following an incident is very important. There is a procedure following an incident and the GP (and staff) Occupational Health Service can provide counselling if post-trauma reactions continue.

There are number of **useful contacts**:

- The Occupational Health Service for Primary Care in Devon and Cornwall – 0117 923 2381 (Wednesday’s only)/ Fax 0117 923 2382 / sue@abbotburke.co.uk
- Devon and Cornwall Police, Crime Reduction Office – 01803 841466
- Torbay Primary Care Trust, 01803 210910
- Patient and Practitioner Services Agency, 01392 205205
- South Devon Healthcare Training Department – 01803 614567 x5400
- Health and Safety Executive (Regional Office), 029 2026 3000
- Victim Support, 01803 665989
- RCN Counselling Service, 0345 697 064
- Unison, 0171 3882366
- BMA Counselling Service, 0645 200169
Protocol for the use of the “GP Alert” scheme by General Practitioners in Devon.

1. “GP Alert” is a tried and tested scheme introduced in Cornwall by the Health Authority and Devon and Cornwall Police.

2. It should be used for patients the practice believe may post a substantial risk of violence or threat. It should not be used as a routine measure for highlighting people who have a mental health problem or who may have caused an isolated disturbance out of character, for some specific reason (e.g. bereavement).

3. To log a patient, practices are asked to adhere to the following steps and not to introduce their own forms or other paperwork.

Procedures

a) Use Form VP1 (see attached Appendix A), ensuring it is sent to the appropriate Area Support Team Inspector (list Appendix B). All sections should be completed as fully and clearly as possible. Give all known details including anything relevant from a public safety perspective, as well as a brief statement as to why the patient is considered to pose a substantial risk. Medical information should not be disclosed.

b) The Devon and Cornwall Constabulary’s Crime Bureau will research the individual, adding any relevant information it holds – such as the individual has a criminal record, holds a shotgun licence etc.

c) The police will create a ‘log’ for each patient labelled as follows:

“The below named person poses a substantial risk of violence. Details have been provided by GPs to assist the police in responding to incidents. The information is strictly confidential.”

d) The reporting practice will then be given the log number by the police – and any other information the police believes the practice should know.

e) If the practice subsequently makes a 999 call in relation to the individual – the log number should be quoted – enabling the police to recognise and respond to the incident in the most appropriate way.

f) The practice must ensure that all staff are aware of the ‘GP Alert’ procedures and know which patients have log numbers so that these can be identified swiftly and used when an incident occurs. Log numbers should also be made available to other relevant professionals including community staff and out of hours cover. Practices providing GMS in a rota scheme should share the log number between themselves.

g) Practices should review logged entries on a monthly basis to ensure information remains relevant and current.
h) The practice must be responsible for notifying the police of any changes in circumstances – such as the patient leaves the area.

**NB:** Practices should not hesitate to use 999 for patients breaching the peace or who fail to leave when asked to do so – irrespective of whether the individual has a log number or not.

“GP Alert” also enables practices to request that available police resources be deployed to the general vicinity when any patient for whom there are significant concerns about the potential for violent behaviour arranges a home visit or routine surgery appointment. This proximity will enable a rapid response should assistance be requested. To access such support – phone the Force Enquiry Centre on 0990 700400 (see Appendix C).

4. **Information Sharing and Confidentiality**

Despite the seemingly sacrosanct nature of patient confidentiality, the law does allow information to be shared, without the individual’s consent, in specific circumstances.

**Medical Defence Union Guidelines**
If a patient threatens a GP or a member of his staff with violence, damages is property or is involved in criminal activity against the GP, the patient loses his right to complete confidentiality.

The GP may choose to inform the police (and the GPC strongly advises GPs to do so.) The information given to the police must be limited to the minimum required (eg. Name, address and details of incident.) Any medical information passed to the police would constitute a breach of confidentiality. Information must be limited to a ‘need to know basis’ only.

**Data Protection Guidelines**
The Health Sector Compliance Manager for the Data Protection Registrar also considers disclosure of patients considered to be at substantial risk of violence to the police for logging purposes to be acceptable, if in the interest of public safety. Again medical information should not be disclosed.

**Department of Health Guidelines**
Guidance on the Protection and Use of Patient Information was issued by the DoH in March 1996 (HSG[96]18). The guidance states that essential patient information may be shared with other agencies to protect the public, including where there is a risk of violence.

5. **Incident Reporting**

It is important for practices to make sure all incidents are reported – even minor ones – where abuse or threat is involved. Appendix D is the template for reporting such matters. Please copy it and ensure that all staff are both aware of it and know to use it. Practices should always retain their own copies of such reports.

Mrs Ann Morecraft
Head of PPSA
July 2000
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GUIDANCE ON MANAGEMENT OF VIOLENCE AND AGGRESSION – RISK ASSESSMENT

This checklist should be used as an aide memoir during the completion of health and safety risk assessments when considering significant factors, which could lead to a violent/aggressive, incident.

Before undertaking a risk assessment, see also policy/procedure No 35 – Procedure for the Completion of General Health and Safety Risk Assessments (March 1998).

It is also advised that reference be made to the Health and Safety Commission book entitled ‘Violence and Aggression to Staff in the Health Services – Guidance on Assessment & Management’. Available from HSE Books.

CHECKLIST

Grounds/Paths

Is lighting adequate
Is it quiet, unfrequented
Is it used during darkness
Is it used at weekends
Are escorts available when/if needed e.g. to car parks at night
Is it used by lone staff
Is it used by female staff
Is it attractive to criminals e.g. car parks

Workplace

Is it too cramped
Is it too noisy
Is it too dark
Is it too cold
Is it too hot
Is it adequately signposted
Is it untidy or dirty
Can telephone or staff conversations be overheard
Can staff rest areas be seen by the public
Is it difficult for staff to summon help
Are signs displayed to remind staff to keep security doors locked
Are windows closed and locked at night
Is it obvious that attractive items (money, drugs etc) are used and kept there
Is unauthorised access possible

Staff Factors

Is it easy for the individual to have eye contact with staff
Is it easy for the individual to speak to or hear the staff
Are staff required to visit a quiet area during the night or collecting records etc
Are staff usually alone
Have staff received appropriate training
Are there occasional and/or unpredictable call outs for visits alone or at night
Do all staff wear name badges
Are staff aware of the support given by the Authority following violent or aggressive events

Lone Workers

Do staff work alone
Is there knowledge of the visits/calls to be made and expected time of return
Do staff have use of the mobile telephones, personal alarms etc
Are visits made at quiet times e.g. night, weekends

Visitor/Facilities

Is the necessary information available to visitors e.g. waiting instructions, directions etc
Are adequate signs and facilities available for toilets, drinks, telephones etc
Is seating adequate in waiting areas
Is there recreational relief (e.g. magazines, toys)
Are there adequate/sufficient disposal facilities?

Source: South & West Devon Health Authority Policy, 2001
LONE/HOME WORKING GUIDELINES

LONE WORKING

• If staff wish to use the office outside their normal working hours they should, if practical, inform someone that they are in the building.

• If working in a remote building alone, staff should consider locking themselves in – but ensure they have identified a safe exit.

• Staff should know where the panic button is or a method of raising an alarm (e.g. fire alarm break glass).

CHECKLIST FOR VISITS

BEFORE LEAVING

Check
• Records: anything known.
• Route and location: be sure how and where to go.
• Vehicle.

Let others know
• Where you are going and how long you will be.
• Where appropriate ring in at regular intervals.

Difficult visit
• Ring in prior to and after visit.
• Telephone or write to make appointments for visits, ensuring that people know who you are and what your role is. If you are unable to keep the appointment at the agreed time, let the individual know.
• If possible, schedule visits to problem areas for particular times of the day, such as the morning when parents are around taking children to school, and when drug activity and drunkenness should be minimised.

Stand-ins
• Brief colleagues on difficulties

EN-ROUTE

Consider
• The time.
• The location.
• The route.

Procedure
• Lock car – whilst driving.
• Do not leave portable telephone in view.
• Being followed? Uneasy? Uncertain? Remain with or return to your vehicle, drive away for a short while, drive to a place of safety; if your suspicions are confirmed, contact the police.
As far as is practicable, do not display stickers or anything that identifies the vehicle with a health care professional.

ON ARRIVAL
- Park as near as is practicable to the address to be visited, in such a position as to be able to drive straight off and in well-lit area at night. **Do not** park directly under a street light, as there is a greater probability your car will be broken into.
- Avoid, as far as possible, waste ground, isolated pathways and subways. Particularly at night.
- Keep aware of the nearest place of safety, such as shops.
- Stand well clear of the doorway after ringing or knocking.
- Show identity badges.
- Remain aware of the behaviour of all persons in the house, looking for any signs or signals that may indicate a potential problem.
- Remain aware of the environment and maintain escape routes in case problems arise.

If in Doubt
- Double check address and telephone number. Check the telephone directory or ask the operator to confirm.
- Consider ringing back to confirm.
- Verify information about previous treatment.
- Ask caller to be visible at house window or door as you arrive and to leave light on/curtains drawn back at night.
- Do not enter premises.
- Seek advice/assistance.
- Plan your action.

WHEN VISITS ARE COMPLETED
- Ensure that all parties are satisfied with the interaction that has occurred. If there are problems, make sure that everyone knows what should happen next. Make sure you undertake all that has been agreed.
- Always return to base or phone in at the time you are expected. If your plans change or you get delayed, phone in to let the team know.

PERSONAL SAFETY

On return to car
- Do have the keys ready.
- Do check the interior before getting in.
- Lock the door immediately you get in.

KEEPING YOU AND YOUR CAR SAFE
- Lock it.
- Close the windows
- Do not leave any property on view
- Fit and use security lock.
Consider fitting an alarm with remote personal attach facility.
Etch car registration number on windows etc.
Do not leave registration document in car.
Check that vehicle fuel is OK.

EQUIPMENT
• Torch.
• Personal alarm.
• Does everything work.
• Check batteries and carry spare.

DURING THE HOURS OF DARKNESS
• Where there is a known risk, staff must not put themselves at risk.
• Staff during the hours of darkness should carry a mobile telephone or consider doubling up.
• Staff should carry a personal safety alarm at all times and a torch at night.

PREVENTION
• The best way to deal with violence is to prevent it – always in a professional manner.
• Make appointments if possible.
• Dress appropriately for the area or individual to be visited, particularly when the individual's culture demands that women be well covered up. Do not wear expensive looking jewellery.
• Wear shoes and clothes that do not hinder movement or your ability to run away in an emergency.
• Ensure that transport is regularly serviced.
• Keep bags and equipment in the locked boot of the car.
• Avoid multi-storey car parks when alone.
• Be alert at all times when in the streets and if your bag is snatched, let it go.

DEALING WITH A VIOLENT EPISODE IN AN INDIVIDUAL'S HOME
• Put your own safety first. Leave a situation if you feel unsafe. Professional codes of conduct do not require you to jeopardise your own safety; it is better to leave and find alternative ways of resolving the situation.

• If an individual is disturbed, tension is rising and violence seems possible, you should remember that while that person is disturbed, they are unable to speak from a position of stability and influence.

• If you are sure the aggression is not directed towards you personally and that the person simply needs to “let off steam” at someone about their situation, allow the person to have their say, calm them down and then try to discuss the situation and help them to think of ways to deal with the problems.

• In rare circumstances where the presence of another individual is making the situation worse, it is sometimes best to seek a way of separating the individual from the other person. This might be done be suggesting that you move elsewhere with the individual, or by steering the other person to another part of the house. Be tactful.

• Extra help should be called if it seems that it may be needed. At this point, when violence is only a possibility, other people should not burst upon the scene; this could easily precipitate violence. They should either stay just outside the room where the disturbed individual is, or
if any of the relatives are on particularly good terms with the individual, that person could help talk them through the crisis.

- If violence is directed to a member of the family and they are sustaining injury, attempt to reason with the individual. Help should be summoned if available in the house. If violence is directed to yourself or another party when no help is available, and you are unable to manage the individual, turn and break free, leave immediately and inform the General Practitioner, your Manager and the Police via the emergency 999 service if appropriate.

- Recognise the limits of your own ability to deal with a situation and the time when it becomes prudent to leave.

- Use panic alarms only in situations where there is a clear escape route and use them for surprise only, not for summoning help, unless you are certain there is someone nearby who will definitely come to your help.

Source: South & West Devon Health Authority Policy, 2001
PROCEDURE FOLLOWING AN INCIDENT

• Allow yourself time to recover and, if possible, seek practical support from your colleagues. Even after very minor incidents, feelings may be difficult to control and may affect your ability to deal with any further problems that arise. This is a perfectly natural reaction. If in doubt – take time out!

• Contact your Manager and/or return to base.

• Contact the Police, if appropriate.

• Seek proper medical attention for any physical injuries.

• Be prepared for the natural post trauma reactions, which may occur very soon after the incident or may be delayed.

• Ask for debriefing, if it’s not offered, and for further counseling if post trauma reactions persist.

• Share information with others who might visit and add information to patient notes, if appropriate.

• Report the incident through the formal reporting procedures so that:
  ♦ The incident can be investigated
  ♦ Safety measures can be modified to protect you and other staff in the future.
  ♦ You have a more secure basis for any legal redress relating to the incident.

Source: South & West Devon Health Authority Policy
DEALING WITH ORAL ABUSE DURING TELEPHONE CALLS

Staff are not expected to accept oral abuse or other distressing comments whilst receiving telephone calls as part of their work.

If staff feel that a caller is behaving (i.e. speaking) towards them in an unreasonable manner, they should feel empowered to respond as follows:

“You clearly feel very strongly about the points you are making. To ensure that I fully understand your concerns and can look into them for you, I intend (or may need) to record the remainder of your telephone call”.

If staff have ready access to a recorder (e.g. dictaphone), it may be used – simply hold it near the telephone earpiece. (Note: it is legal to record a telephone call, provided the caller is notified of the fact).

If no recorder is available, and the caller continues to speak in a manner that upsets the member of staff, the following should be stated:

“I need to arrange a tape recorder – I will now end this telephone call and ring you back shortly; please may I have your number”.

In the event of a distressing telephone call, an incident report should be completed in the usual way. If a tape exists, it can be transcribed and included with the report.

Alternatively, if staff do not have ready access to a tape recorder they should respond –

“You clearly feel very strongly about the points you are making. To ensure that your concerns are addressed, please may I have your telephone number, and I will ask my Manager to call you back”.

Source: South & West Devon Health Authority Policy, 2001
Risk Assessment and Action to anticipate and de-escalate Violence

- All staff should be trained to recognise warning signs of violence and to monitor their own verbal and non-verbal behaviour.
- Training should include methods of anticipating, de-escalating or coping with violent behaviour.

Implementation Points

Levels of training to be considered:
- Staff at low risk (e.g. secretarial)
- Staff at medium risk (e.g. reception area)
- Staff at high risk (e.g. acute unit)
- Trainers

Possible antecedents of violence:
- Increased restlessness, bodily tension, pacing, arousal.
- Increased volume of speech, erratic movement.
- Facial expression tense and angry, discontented.
- Refusal to communicate, withdrawal.
- Thought processes unclear, poor concentration.
- Delusions or hallucination with violent content.
- Verbal threats or gestures.
- Warning signs from earlier episodes.
- Service users self-reporting angry or violent feelings.
- Carers reporting users’ imminent violence.

Tactics for de-escalation:
- Maintain adequate distance.
- Move towards safe place, avoid corners.
- Explain intentions to patient and others.
- Appear calm, self-controlled, confident.
- Ensure own non-verbal communication is non-threatening.
- Engage in conversation, acknowledge concerns and feelings.
- Ask for facts of problems, encourage reasoning.
- Ask for weapon to be put down (not handed over).
- Consider methods (e.g. medication).
- Be aware of how to call for help in emergency.

Debriefing:
All staff those involved with the incident should be considered.

Facilitate discussion about:
- What happened
- Any trigger factors
- Their role in the incident
- How they feel now
• How they might feel in the next few days
• What can be done about it

**Short-term Prediction of Violence**

There is not sufficient evidence to formulate guideline statements.

The following risk factors, however, are associated with violence:

**Demographic or personal history**
• A history of violence
• Youth, male sex
• Stated threat of violence
• Association with a sub-culture prone to violence

**Clinical variables**
• Alcohol or other substance misuse, irrespective of diagnosis.
• Active symptoms of schizophrenia or mania, in particular if:
  - Delusions or hallucinations are focused on a particular person.
  - There is a specific preoccupation with violence.
  - There are delusions of control, particularly with a violent theme.
  - There is agitation, excitement, overt hostility or suspiciousness.
• Lack of collaboration with suggested treatment.
• Antisocial, explosive or impulsive personality traits.

**Situational Factors**
• Extent of social support.
• Immediate availability of a weapon.
• Relationship to potential victim.
**TORBAY PRIMARY CARE TRUST - EVENT RECORDING FORM**

<table>
<thead>
<tr>
<th>DATE OF EVENT</th>
<th>Location of Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporters Name</td>
<td>Profession</td>
</tr>
<tr>
<td>Organisation:</td>
<td>Other involved organisation or Clinical Speciality/Ward or Department if relevant</td>
</tr>
<tr>
<td>Patient Identifier</td>
<td>(Computer Number or other internal code)</td>
</tr>
</tbody>
</table>

**What happened?** (Include - severity, people, equipment involved) **Consequence** Harm or problem to the patient, organisation or others

**Near Miss Adverse Event**

**What action was taken or proposed?** (Immediate and longer term)

If appropriate please attempt to score this event:

- **Consequence**
  - Insignificant (no injury) = 1
  - Minor - (short term) = 2
  - Moderate (semi permanent injury) = 3
  - Major (permanent injury) = 4
  - Catastrophic (death) = 5

- **Likelihood of this recurring?**
  - Almost Certain = 5
  - Likely (probably but not a persistent issue) = 4
  - Possible (may recur occasionally) = 3
  - Unlikely (but possible) = 2
  - Rare (can't believe this will ever happen again) = 1

Please rescore considering what might have happened without intervention:

- **Near Miss Adverse Event**
  - Insignificant (no injury) = 1
  - Minor - (short term) = 2
  - Moderate (semi permanent injury) = 3
  - Major (permanent injury) = 4
  - Catastrophic (death) = 5
HOW TO USE THIS FORM

- The form should be freely available to everyone working in your organisation
- To score your form – multiply Consequence by Likelihood – a score greater than 4 should result in a root cause analysis
- Use the form to record any ‘events’ good or bad that occur in your organisation
- Events resulting in injury or serious harm should always be immediately drawn to the attention of the Manager and Partners of your organisation.
- Share the events with your team, and with us at the Primary Care Trust

What to record?
- Adverse Events (including ‘near misses’) - An occurrence which could have or has caused physical or psychological harm to a patient or a member of your team - these should be reported to within three days of the event

- Significant Events - any event that has had a significant effect on your organisation and impacts on the delivery of patient care
  For example:
  A new system or idea someone has developed which has had a positive impact
  A system that has failed
  Something that you would like to change in another organisation but don’t have the time or resources to change it yourself

You might also like to use this form to report the description and outcome of a patient complaint or compliment, although it should not replace the standard Practice Complaints Procedure.

Scoring and categorising the Event
There is a new National Adverse Event Reporting System run by the National Patient Safety Association which will receive all events from health which have a score of 16 or above. It is anticipated that Primary Care will be feeding into this system by 2003. The system uses the Australian Risk Scoring system of Consequence by Likelihood scoring to identify the level of risk.
We have developed a system of coding events into categories using those used by South Devon Healthcare Trust and from the type of events already received. A list of these codes is attached. We are coding the events at two levels. First by category and then by reason eg Treatment Delay – Patient referred back to Primary Care, or Communication – Discharge notice late or not received
Using the codes below, try to identify the right category or reason for your event.

Completion of the Form
- Please complete the form as clearly as possible.
- In order to keep within Caldicott guidelines, PLEASE DO NOT use any patient identifiers, such as name or address or NHS number you may wish to add a patient identifier for your own records provided this does not contravene Caldicott.
- Finally, send a copy to Hazel Crook at Torbay Primary Care Trust, Rainbow House, Avenue Road Torquay. Please mark the envelope ‘Private and Confidential’.

Coding

| Level one Category | Level two Reason for Event | Level two
|--------------------|---------------------------|----------------
| A Allergic Reaction | 01 Mis/delayed diagnosis of Patient Condition | 20 Training Need
| B Assault | 02 Waiting times | 21 Patient details faxed
| C Unexpected Death | 03 Insufficient beds | 22 Patient confidentiality breach
| D Communication | 04 Referral back to primary care | 23 Verbal abuse
| E Consent | 05 Inaccurate/Incorrect results recorded | 24 Physical abuse
| F Drug related | 06 Instrument/device still in situ | 25 INR Monitoring failure
| G Equipment | 07 Wrong patient treated | 26 Correspondence unclear
|                    |                          | 27 Information not acted on
|                    |                          | 28 Procedure failure
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>08</td>
<td>Discharge notification late or not received</td>
</tr>
<tr>
<td>Poor Outcome</td>
<td>09</td>
<td>Discharge details incomplete/wrong</td>
</tr>
<tr>
<td>Resources</td>
<td>10</td>
<td>Patient referral lost or not completed</td>
</tr>
<tr>
<td>Treatment Delay</td>
<td>11</td>
<td>Wrong drug prescribed</td>
</tr>
<tr>
<td>Transfer poorly managed</td>
<td>12</td>
<td>Wrong dose prescribed or taken</td>
</tr>
<tr>
<td>Computer system failure</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Computer details incorrect</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Delayed discharge</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Patient referral lost or not completed</td>
<td>33</td>
<td>Poor information transfer between NHS</td>
</tr>
<tr>
<td>Insufficient Medication supplied on discharge</td>
<td>34</td>
<td>Equipment failure</td>
</tr>
<tr>
<td>Dressings not supplied on discharge</td>
<td>35</td>
<td>Transfer problems</td>
</tr>
<tr>
<td>Insufficient equipment</td>
<td>36</td>
<td>Patient dissatisfaction with treatment</td>
</tr>
<tr>
<td>Non compliance of medication</td>
<td>37</td>
<td>Daywork left to out of hours</td>
</tr>
<tr>
<td>Drug waste or stock control</td>
<td>38</td>
<td>Death Notification not received or late</td>
</tr>
<tr>
<td>Equipment not organised on discharge</td>
<td>39</td>
<td>Insufficient Staff</td>
</tr>
<tr>
<td>Successful Teamwork</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>
NOTIFICATION TO DEVON AND CORNWALL CONSTABULARY OF VIOLENT PATIENT/PATIENT CONSIDERED TO BE AT SUBSTANTIAL RISK OF BECOMING VIOLENT.

This information will be treated by Devon and Cornwall Constabulary as private and confidential. The Health Sector Compliance Manager for the Data Protection Registrar agrees to disclosure of patient information where there is a substantial risk to public/staff safety. GPs are therefore asked to consider carefully individual circumstances before completing this form.

FORM TO BE RETURNED TO: SEE LIST OF AREA SUPPORT TEAMS
Attached Appendix B

| Patient’s Name: | ........................................................................................................ |
| Patient’s Date of Birth: | ........................................................................................................ |
| HomeAddress: (including postcode) | ........................................................................................................ |
| Home Telephone Number: | ........................................................................................................ |
| Usual GP: | ........................................................................................................ |
| Practice Address: (including postcode) | ........................................................................................................ |
| Practice Telephone Number: | ........................................................................................................ |
| Mobile Number: | ........................................................................................................ |
| Pager Number: | ........................................................................................................ |
Reporting Form
For Violent Incidents in General Practice

Details of Practice: Dr………………………………………………………………………..

DISTRICT: North Devon/Mid Devon/Exeter/East Devon/
Teignbridge/Torbay/W Devon- S Hams/Plymouth

Address at which incident took place:

Date & Time of incident:

Where did incident take place (eg reception area; consulting room)

Who was involved? Please specify for each person whether patient, visitor, GP, receptionist etc.

Brief description of incident, including any injuries sustained:

Return to: Area Support Team Inspector for appropriate area.
Contract for General Medical Services with

insert patient’s name and address

I accept that ................. Primary Care Trust is undertaking to provide me with a NHS practitioner for general medical services and that as my part of the contract for those services I will abide by the following conditions:-

1. I will always pre-book routine appointments and will accept the next available date and time offered.

2. I will agree to see ONLY the doctor with whom I am given an appointment at the designated venue.

3. I will ask for appointments ONLY with the practice where I am currently registered and I will not approach other surgeries and doctors.

4. I will not expect to be seen immediately on arrival and accept that appointments may be delayed.

5. I understand that requests for unbooked consultations for routine matters will not be granted by the doctors on duty.

6. I understand that if at any time I cause disturbances or threaten the practice staff or the GPs, I will no longer be treated.

7. I understand that in view of my past behaviour, a police representative may be present in the building at the time of my appointment.

Signed:

...........................................................................................Date...................................

insert patient’s name under signature line
• Existing legislation to help deal with violent and abusive patients.

The article below was circulated in September 1999, Link Letter 29 and August 2000, Link Letter 40. This legislation needs to be tried and tested – remember we are being told that there should be zero-tolerance towards those who abuse or threaten healthcare staff!

**Violent and Abusive Patients – how the law can help**

I have researched whether practices can invoke any particular laws to assist them when faced with violent or abusive patients. There are laws in the statute book that may be of use – slim comfort at the time, but which – if quoted – might prompt a swifter response from the Police. However – to gain maximum value and perhaps to send some messages out to the less pleasant patients – practices will need to be aware that a court appearance, or a written statement at minimum – will be required in the event of a prosecution.

The laws are: Protection from Harassment Act (1997) and Section 30 of the Criminal Justice Act (1988)

**The Protection from Harassment Act 1997**

The Act deliberately does not define harassment (although it was drawn up in response to a series of stalking cases). It makes it an offence for a person to pursue a course of conduct which amounts to or which he/she knows (or ought to know) amounts to harassment – which includes causing another person alarm or distress or putting people in fear of violence. The Act refers to a ‘course of conduct’ – which involves that which is viewed as harassment on at least two occasions. The offence carries a stiff penalty – up to 6 months in prison and a heavy fine (currently £5,000 maximum). Putting someone in fear of violence has an even stiffer penalty – up to 5 years imprisonment and/or an unlimited fine.

Civil Law also allows for you to sue someone who has been guilty of harassment and to claim damages against them; or to debar them from returning to cause more harassment by means of an injunction. Breaches of an injunction also carry the stiffer penalty of up to 5 years in prison and/or unlimited fine.

(The Police are able to issue a “protection from harassment” notice on individuals which requires them, for example, to only attend at the main surgery and/or not to turn up without an appointment).

**Criminal Justice Act 1988 – Section 39**

This covers the offences of ‘assault’ and ‘battery’. Assault is putting someone in fear of violence and battery is the actual application of force. These have the advantage that they can be invoked after just one instance rather than the ‘course of conduct’ in the Harassment Act. The penalties are again a maximum of 6 months imprisonment and/or a fine up to £5,000. This Act could be used for example if an abusive patient approached a receptionist/GP etc shouting and waving their fists – assault. If they then went on to punch the staff member, the offences of assault and battery would have been committed.

My purpose in reminding practices of these Acts is to highlight that there are laws to assist you when faced with violent and abusive patients. You do not have to put up with them. If however, you do call the Police and ask for someone to be charged under one or other Act –
remember you will have to be prepared to attend court as a prosecution witness. In the case of the Harassment Act, you will need clear documentation to show the patient pursued a ‘course of conduct’. I am sure however, that if these laws are used and some of the more unpleasant types are convicted messages will go around the grapevine that doctors’ surgeries are not the place to let rip. You will of course, wish to take your own legal advice on these matters.

For further information contact: Ann Morecraft (01392) 207428

Source: PPSA Link Letter
South & West Devon Health Authority

Title: Draft Policy For Dealing With Violence Towards GPs and Their Staff

Produced in response to: HSC 2000 / 0001

Written by: Adrian Jacobs

Date: 15th February 2000

Consultation process to involve:

- PCGs / LCGs
- LMC
- PPSA
- Practice Manager Groups

Target Completion Date: April 2000

Introduction

HSC 2000/001 requires Health Authorities to develop a local action plan to combat violence towards GPs and their staff. The action points to be covered are:

- Better recording mechanisms which allow GPs to report incidents.
- Support and advice services for victims of violence.
- Mechanisms for providing GMS to violent patients in a limited number of locations.
- Arrangements for Police / security support for GPs undertaking home visits and surgery consultations where there is a reason to believe there is a risk of violence.
- Support for any security investment required to deliver the action plan.
- Written co-operation arrangements between the HA, the local police and any other organisations.
- Use of Local Development Schemes as a means of delivering GMS to violent patients.
- Arrangements to protect the interests of the families of violent patients.
- Arrangements for the protection of mentally ill patients.

HAs are expected to prepare their action plan during 1999/2000 and to have these in place by April 2000.

This paper is a first draft of an action plan for South & West Devon

1. General Action Points

- Any policy or action related to this issue will need the input from the following groups / organisations:
  - Devon LMC
  - Practice Manager Groups
  - PCGs / LCGs
  - PPSA
• The timescale of the whole process is such that the deadline for action is likely to be missed if there is to be a proper consultation process.

2. Information Requirements

Current Situation –

• Violence to GPs and their staff does not appear to be a major problem in South & West Devon, however the only source of information that we have is from the PPSA. GPs are required to notify the HA if they remove patients from their list because of violent behaviour. Despite this there are occasions when GPs and their staff have “tolerated” such behaviour without removal from the list (e.g. one off episodes where the patient has been intoxicated).
• We have no reliable information reporting systems that capture data on episodes of violence towards staff in General Practice.

Objectives

The HA sets up a reporting system using a standard format that requests the following data using this definition - “An incident where a GP or his or her staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety well-being or health.”

• Nature of Incident
• NHS number of patient involved
• Details of staff involved
  
  Age
  Sex
  Post

• Does the individual concerned have a history of violence
• Nature of any physical injuries incurred?
• What treatment was needed?
• Time taken off work to recover
• Action planned against the individual concerned – e.g. None / notify police / Remove patients from list / Seek injunction / Other

Actions required

• The HA to work with PCG/Ts and the LMC to develop a template (preferably electronic) to record events. This will be issued to practices who will asked to make returns to the Primary care Support Team would administer the database.

3. Support and advice services for victims of violence.
Current situation

- GPs suffering from stress related problems have access to counselling services through a small fund that is administered by Dr David Longdon on behalf of the LMC.
- There are no formal arrangements in place for members of GP’s staff other than those available from their own GP.
- The HA and LMC have agreed to invest £50k in a project led by to develop an occupational health service for all primary care staff in Devon and Cornwall and has appointed two experienced occupational health staff work up a project plan.

Objectives

- Occupational health service in place for all primary care staff that will include explicit arrangements for support and advice services for victims of violence.
- The service to be in place by April 2002.

Actions required

- Better information as outlined in paragraph 2 so that we are able to identify those in need of help. This will include raising the level of awareness in primary care. The publication of this action plan will help to achieve this.
- Interim arrangements will need to include the identification of a small budget to purchase counselling services for victims of violence.
- Health Authorities will need to work closely together to deliver the occupational health services.

4. Mechanisms for providing GMS to violent patients in a limited number of locations.

Current situation

- There are no formal arrangements in place.
- GPs working in co-operatives and commercial deputising services are accompanied by a driver and this helps to increase safety for medical staff.

Objectives

Clear, agreed procedures and places of safety for handling the problem. This will include:

- agreement with local police about the use of police stations as places of safety for those providing care.
- A&E departments
- GP owned premises and community hospitals that have staff who are properly trained to deal with violent patients

Actions required

- PCG/Ts to work with local police, Trusts and social services to agree a limited number of locations where medical services can be provided for patients who are likely to be violent.
• Investment in training programmes for staff working in these units.

5. **Arrangements for Police / security support for GPs undertaking home visits and surgery consultations where there is a reason to believe there is a risk of violence.**

**Current situation**

• There are no formal arrangements in place.
• Local informal arrangements appear to work well but we have no data to confirm this.

**Objectives**

Clear agreed local policies to be developed and put in place by April 2001

**Actions required**

• HA and PCG/Ts to work with local police to draw up and publish written policies as set out in paragraph 7.

6. **Support for any security investment required to deliver the action plan.**

**Current situation**

• No investment in security has been identified other than that set through investment in practice premises.
• GPs are encouraged to install panic buttons in appropriate locations within their premises.

**Objectives**

• The level of investment to be linked to the size and distribution of the problem.
• Clearer plans can be drawn up when more information is available using the mechanisms outlined in paragraph 2.

**Action required -**

• PCG/Ts to include a section in Primary Care Investment Plans

7. **Written co-operation arrangements between the HA, the local police and any other organisations.**

**Current situation**

• No formal written agreements exist.

**Objective –** Agreed written arrangements with police to be in place by July 2000.

**Action required -**
HA to work with the Police, PCG/Ts and the LMC to draw up and agree a written policy that can be implemented in all PCG/T areas.

8. **Use of Local Development Schemes, PMS Pilots or other incentive schemes as a means of delivering GMS to violent patients.**

**Current situation**

- No incentive schemes in place

**Objective**

- Appropriate schemes that are linked to the size and distribution of the problem.

**Action required -**

- HA to work with PCG/Ts and the LMC to develop appropriate incentive schemes in appropriate locations, that meet the needs of patients and primary care staff.
- The exact nature of such schemes will depend on information from the new reporting systems described in paragraph 2.

9. **Arrangements to protect the interests of the families of violent patients.**

**Current situation**

- It is important to ensure that the families of violent patients are not disadvantaged by the violent behaviour of a single family member.
- There is no data available on patients who have been removed from a GPs list because of the violence of one member of the family but it is likely that this has occurred in the past.

**Objectives**

- Provision of places of safety for treating such patients and elimination of the removal of such patients from GPs lists

**Actions required**

- Better information arrangements as set out on paragraph 2.
- PCG/Ts to work with HA, PPSA and LMC to put in place arrangements described above that will reduce / eliminate the need for GPs to remove the families of violent patients from their list.

10. **Arrangements for the protection of mentally ill patients.**
Current situation

- Most incidents of violence from patients who are mentally ill are covered by the mental health act. Despite this there are occasions when mental illness has not been recognised as the cause of the violent episode.

Objectives

- To raise awareness amongst those involved.
- Improved access to information subject to Caldicott recommendations for those dealing with violence in a health care setting.

Actions required –

- Improved access to multi-disciplinary training programmes
- Implementation of the Electronic Health Record and Electronic Patient Record as set out in the IT Local Implementation Programme.

Adrian Jacobs

15th Feb 2000
What happens after a case is reported to the police?

The police are responsible for investigating crimes, and will charge offenders when there is sufficient evidence to do so. Alternatively, the police may decide to issue a warning, or to formally caution an individual. A caution is sometimes given by the police where an offence has been committed but they decide not to take the person to court because that person has admitted the offence and agreed to be cautioned. Whether a caution is an appropriate response will depend upon the seriousness of the offence and agreed to be cautioned. Whether a caution is an appropriate response will depend upon the seriousness of the offence and will involve consideration of such factors as the offender’s previous record and his/her attitude to the offence.

A police caution is not an easy option when dealing with an offender but is a serious form of disposal and will affect how that person is dealt with in future. Records of all cautions for reportable offences are entered on to the Phoenix database of the Police National Computer. Should the person re-offend, the fact that he or she has a previous caution will be a factor in the police decision whether or not to prosecute. In addition, a previous caution may be cited in court and could, therefore, increase any sentence received for the new offence.

If the police decide to charge someone, the case is passed to the Crown Prosecution Service [CPS]. The CPS is a national service which prosecutes criminal cases in England and Wales referred to them by the police. CPS lawyers are governed by the Code for Crown Prosecutors. All cases have to be reviewed to make sure that they pass the two tests set out in the Code. The first test is the evidential test – there has to be sufficient evidence for there to be a realistic prospect of a conviction. Criminal cases have to be proved beyond reasonable doubt, so there must be clear and reliable evidence that the offence was committed. In assault cases it is necessary to prove that the offender either meant to harm someone, or knew that his/her behaviour created a risk of harming someone, but still carried on.

*It is only if the papers pass the evidential test that the second test is applied. This is the public interest test. The Code says “although there may be public interest factors against prosecution in a particular case, often the prosecution should go ahead”. The Code sets out public interest factors in favour of prosecution. It states that “a prosecution is likely to be needed if…… the offence was committed against a person serving the public (for example, a police or prison officer or a nurse”).*

Assaults against staff working in the NHS are therefore regarded as serious matters, worthy of prosecution.

Where are the cases heard?
All criminal cases begin with a hearing in a magistrates’ court. Assaults are dealt with both in the magistrates’ court and the Crown Court. Some assault charges can only be dealt with in the magistrates’ court where the maximum penalty is six months imprisonment. The advantages of hearings in the magistrates’ court are that they can
be dealt with more quickly, the courthouse is likely to be more local to witnesses, and
hearings are more informal, so it is easier to be at ease when giving evidence.
Most serious charges of assault are dealt with in the Crown Court, where there are
greater powers of punishment. Some cases can be heard either in the Crown Court or
the magistrates’ court. The alleged offender has a choice as to where the case is heard
but the magistrates have to be satisfied that their powers of punishment are sufficient
before they agree to hear the case. To help magistrates decide whether to hear a
case, guidelines have been issued by the Lord Chief Justice – the National Mode of
Trial Guidelines 1995. These set out factors that make a case more serious. In cases of
violence, one of these factors is “serious violence...caused to those whose work has
to be done in contact with the public or who are likely to face violence in the course
of their work”.

What happens if I am required to give evidence as a witness?
The police will tell you if you need to appear in court as a witness. All agencies
within the criminal justice system work together to provide a co-ordinated service to
witnesses, implementing national standards of witness care. Giving evidence in court
can be stressful but the people involved - the police, the CPS and court staff - will
give you as much information as possible about what is likely to happen. All Crown
Courts and many magistrates’ courts have Witness Service Schemes run by Victim
Support and local magistrates’ courts charters set standards of service to witnesses.
The CPS has made a public declaration of its principles in the CPS Statement of
Purpose and Values: “We will show sensitivity and understanding to victims and witnesses”.

Information about standards of victim/witness care can be found in the following
publications:
· Statement on the treatment of victims and witnesses by the CPS – explains CPS
  policies about victims and witnesses and how commitments are put into practice;
· Home Office leaflet “Witness in Court” – tells witnesses what to expect when asked
to go to a magistrates’ court or the Crown Court to give evidence.
· Home Office publication “The Victim’s Charter” – a statement of service standards
  for victims of crime.
· Court Service publication “Court Charter” – sets out important standards which can
  be expected in the Crown Court.
· Each Magistrates’ Courts’ Committee publishes their own charter, available from
  local magistrates’ courts.

Sentencing
You may attend the sentencing hearing if you wish, even if you were not present at
earlier hearings as a witness. The CPS will keep you informed about the progress of a
case and tell you when your attacker is to be sentenced. An unexpected guilty plea at
an earlier hearing could however result in sentence being given immediately. The
sentence is a matter for the court alone; magistrates and judges are independent from
any individual or organisation.
In sentencing the judge or magistrates take into account all the circumstances in
which the offence occurred and those of the offender:
· The circumstances of the offence will be known to the court if your attacker has
  pleaded not guilty and a trial has taken place. If they have pleaded guilty the
  prosecutor will set out the facts of the case.
The circumstances of the offender will be available to the court from:
- the defendant’s legal representative when presenting mitigation to the court;
- the defendants themselves if not legally represented;
- the probation service, medical or psychiatric reports ordered by the courts.

The sentencing guidelines, issued by the Magistrates Association to its members, make it clear that an assault is made more serious if the victim is a person who is assaulted while serving the public.

The Lord Chancellor, who is also President of the Magistrates Association, has said that it is entirely legitimate for magistrates to respond decisively to a particular form of criminal behaviour, such as assaults on NHS staff, and to impose a sentence which has a deterrent component.

Magistrate’s courts can impose up to six months imprisonment for common assault or assault occasioning actual bodily harm. If appropriate magistrates’ courts can commit to the Crown Court which can pass a stiffer sentence. The Crown Court can impose substantial periods of imprisonment and, in cases involving the very worst type of attacks, a sentence of life imprisonment may be imposed.

Compensation
Magistrates can award compensation for personal injury, loss or damage up to a total of £5,000 for each offence. You can expect the court to consider the possibility of compensation whether or not you make a claim, but if there is any information you wish the court to consider in this respect, you should pass this to the Crown Prosecution Service. If no compensation is given you can expect the magistrates to give their reasons for not making an award. Compensation may only be awarded if the offender has means.

Whether or not a criminal court awards you compensation you may pursue a separate claim in the civil courts either privately or with the assistance of your union/professional association or NHS employer.

Another way of seeking compensation is through the Criminal Injuries Compensation Scheme. If you have been injured because of a crime of violence you can apply for compensation under the scheme. It doesn't matter whether the offender has been caught or not. Copies of the information pack with an application form can be obtained from the Police, Victim Support, Citizens Advice Bureau or direct from the Criminal Injuries Compensation Authority, Tay House, 300 Bath St, Glasgow, G2 4JR. Tel 0141 331 2726
ISSUES FOR RECEPTIONISTS AND THE RECEPTION AREA

Receptionists often take the brunt of verbal abuse and aggression. Some practices have adopted uniforms for receptionists to increase patients’ respect for them.

Recommended communication strategies towards patients include:
- Trying to be positive, always offering the patient something rather than outright refusal;
- Referring the aggressive or aggrieved patient to a more senior member of staff – such as the practice manager or a doctor – rather than entering into arguments;
- Not exceeding one’s responsibility by appearing to make judgements about patients needs;
- Respecting the dignity of all patients and “befriending” the vulnerable ones.

Recommended organisational features include:
- More than one receptionist on at all times;
- Established routines for unlocking and locking up premises (and not doing these on one’s own);
- Being able to communicate quickly and discreetly with doctors during surgery e.g. to alert them to aggressive patients via dedicated phone or message on computer;
- Electronic signboards or monitors through which patients could be easily informed about doctors running late.

Reception area:
- Reception desks should ideally be sufficiently wide and/or high to prevent aggressors reaching over and grabbing staff. Screens are more controversial. A side room/area where aggressive/upset patients can be taken away are useful.
- Panic buttons from the reception desk connected to police stations are favoured in high risk areas.

(Source: Primary Care – Preventing Violence and Abuse Against General Practitioners and Their Staff – We don’t have to take this Resource Guide, NHS, 2000)