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Cues that predict violence in the hospital setting: Findings from an observational study

Debra Jackson[a,*], Lesley Wilkes[b,1], Lauretta Luck[c,2]

[a] Faculty of Health, University of Technology Sydney, PO Box 123, Broadway, NSW 2007, Australia
[b] Family and Community Health Research Group (FaCH), School of Nursing and Midwifery, University of Western Sydney and Conjoint Appointment, with Nepean Blue Mountains Local Health District, Australia
[c] School of Nursing and Midwifery, University of Western Sydney, Locked Bag 1797, Penrith, NSW 2751, Australia

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Summary
Background: The prevalence of violent acts in the health care environment has been the cause of increasing concern. Several cues associated with violence towards nurses in the acute care setting have been identified qualitatively. However, larger scale observational studies to determine the potential of these cues to predict physical violence, are lacking in the acute health setting.
Purpose: To report an observational study determining whether particular behavioural cues are predictive of patient-to-nurse physical violence.
Method: Non-participant structured observations.
Discussion: Clinical observation ($n = 1150$ h) resulted in 1501 observed cues for violence in 220 patients; 36 of whom were observed to become violent. Five (5) behavioural cues were found to predict violent acts.
Conclusions: Findings suggest five behavioural cues could be used to assess potential physical violence. Additional research needs to be undertaken to further validate the efficacy of these cues in the acute hospital setting.

* Corresponding author. Tel.: +61 02 9514 4817; fax: +61 02 9514 4835.
E-mail addresses: Debra.Jackson@uts.edu.au (D. Jackson), l.wilkes@uws.edu.au (L. Wilkes), lauretta.luck@uws.edu.au (L. Luck).
[1] Tel.: +61 02 47 343 181; fax: +61 02 47 343 182.
[2] Tel.: +61 02 9685 9568.

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Introduction

Violence against nurses is a worldwide issue in health sector organisations (Balamurugan, Jose, & Nandakumar, 2012; Chapman, Styles, Perry, & Combs, 2010; Jackson, Clare, & Mannix, 2002). While there is a lack of definitional consistency in the literature regarding the term 'violence', it is generally accepted that violence in the health sector includes physical assault, threatening behaviour, bullying, verbal abuse and various forms of harassment (Pich, Hazelton, Sundin, & Kable, 2011; Luck, Jackson, & Usher, 2006). In a recent study Chapman et al. (2010) found 75% of nurses ($n = 332$) working in a nontertiary hospital in Australia had experienced some form of violence but only 16% had reported it through offical mechanisms as being an incident of violence. These results reflect the findings of previous research in Australia and internationally (Farrell, Bobrowski, & Bobrowski, 2006; Pinar & Ucmak, 2011; Winstanley & Whittington, 2004), despite the fact that the non-reporting of violence is contrary to current health policies in Australia (New South Wales Ministry of Health, 2012; Victorian Government Department of Human Services, 2007). Further, the Australian health sector policy mandates that health employees are trained in the prevention and management of violence.

There is evidence in the literature that the early and timely recognition of predictors of violence, followed by the subsequent implementation of de-escalation strategies, can positively affect the outcome of potentially dangerous events (Chapman, Perry, Styles, & Combs, 2009; Cowin et al., 2003). This paper reports the results of an observational study to determine whether particular behavioural cues could be used to predict the potential for physical violence against nurses.

Background and significance

Violence against nurses in the workplace has a significant impact on their physical and psychosocial health (Gates, Gillespie, & Succop, 2011; Pinar & Ucmak, 2011; Roche, Diers, Duffield, & Catling-Paull, 2010). To date, most of the work undertaken on predictive measures of violence against nurses and health care workers has been derived from the mental health nursing context (Daffern, 2007; Doyle & Dolan, 2002; Luck, Jackson, & Usher, 2007; Woods & Lasiuk, 2008). This assessment has been undertaken using either unstructured clinical professional judgement or structured clinical methods. The unstructured clinical professional judgement entails specialist nursing assessment of a patient including: knowing the patient, their history, beliefs and background, tuning in, observing for possible signs and causes of agitation, considering the possibilities (including assessing the patient's potential for violence) and working as a team. Structured clinical methods based on actuarial and clinical risk assessments such as the Staff Observation Aggression Rating Scale-Revised (SOAS-R), the BrØset Violence Checklist (BVC) and the HCR — 20, are based on actuarial and clinical risk assessments and require a lengthy process of assessment which is focused on long term predictions of violence (Clarke, Brown, & Griffith, 2010; Lyneham, 2000; Sturrock, 2012).

From the perspective of busy general ward areas and emergency departments these assessment methods are difficult to implement. They require time-consuming and extensive evaluations to assist in predicting violence, and specialist education in mental health assessment which nurses working these areas may not have. There is a need for violence assessment tools that non-specialist nurses can use effectively and quickly in all areas of health care.

Prior to our research in 2010, no previous work on developing tools for predicting patient violence against nurses in non-mental health areas had been reported in Australia and internationally. In Canada, Kling et al. (2006) developed an alert system for reducing violence in an acute hospital. They utilised audits of patient histories to determine the most common indicators found in patients who became violent. These included factors such as previous violence, verbal hostility or threatening behaviour, shouting and demanding, hallucinations, confusion, withdrawal or agitation (Kling et al., 2006). From this, Kling et al. (2006) developed a flagging system for potentially violent patients to be used by nurses in the acute hospital setting and found that while users reported the system as useful, the system was ineffective in preventing the progression to a violent act. This finding was confirmed by subsequent work (Kling, Yassi, Smailes, Lovato, & Koehoorn, 2011).

Other researchers have developed behavioural cues predictive of violence through survey studies (Chapman, Perry, Styles, & Combs, 2009) which extended the work of Luck et al. (2007) observational study in an emergency department in Australia. Both these studies have utilised nurses' perceptions of violence and in the work by Luck et al. (2007) this data was enhanced by observations of violent events. Luck et al. (2007) highlighted the lack of violence assessment tools that can reliably predict potential violence against nurses, and that do not require specialist mental health education. Further, because of the contextual differences between mental health units and other nursing environments, coupled with the different nursing skills required in these areas, it may be that the mental health nursing approaches are not easily transferable to general clinical areas, and particularly the ED environment. What is needed by non-mental health nursing staff, therefore, is a systematic and valid technique that enables the consistent identification of the potential for patient violence, especially in patients with an unknown history.

Method

A non-participant, structured observational approach was selected for this study because only overt behavioral cues and physically violent behaviors were sought. Observations were conducted by research nurse observers ($n = 9$) and took place during all shifts over a 4 month period in 2010. The advantage of this type of observation is that data about events in the real world, and the social actions and interactions are able to be described independent of the players (Bucknall, 2003). The observations were conducted in public spaces in a number of clinical areas in a large acute hospital in Sydney, Australia. The hospital had a zero-tolerance policy for violence and aggression towards staff.