



Patient and visitor violence towards staff on medical and psychiatric wards in India



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ABSTRACT

Background: Patient and visitor violence (PVV) towards staff is common across health settings. It has negative effects on staff and treatment provision. Little data is available from the developing world.

Aims: To examine the prevalence of PVV in India and make comparisons with the existing data.

Methods: We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English in Mysore on medical and psychiatric wards.

Results: 249 staff participated. 16% of staff in psychiatric wards were subjected to some form of PVV in the past 4 weeks which is lower than in the developed world. 57% of staff on medical wards experienced PVV which is similar to the developed world. Patients and Visitors were almost equal sources of this violence. Verbal abuse was more common than threats and physical assaults. Training in aggression management may be a protective factor.

Conclusion: PVV is a significant problem in India, especially on medical wards. Aggression management training may be a way to reduce the prevalence of PVV.

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1. Introduction

Healthcare workers face patient and visitor violence (PVV) all over the world. A recent systematic review on PVV concluded that ‘patient and visitor violence is a serious problem for healthcare staff in general hospitals’ (Hahn et al., 2008). There is consistent evidence from high income countries that violence towards healthcare staff is damaging on various levels: It negatively affects the psychological and physical well-being of healthcare staff as well as having a negative impact on job motivation and, more importantly, the ability to provide high quality care (Arnetz and Arnetz, 2001; Galatsch et al., 2013; Needham et al., 2005; Winstanley and Whittington, 2004). Workplace violence has a negative economic impact on organisations in terms of work days lost and sickness absence (Philbrick et al., 2003). The current

evidence from high income countries indicates that the use of a rating scale for PVV like the Survey of Violence Experienced by Staff (SOVES) (McKenna, 2004) can reliably measure the prevalence of PVV and thus inform strategies to mitigate against it (Aberhalden et al., 2008; van de Sande et al., 2011).

Current data showed patient or visitor violence was commonly separated into three specific categories of incidents: verbal aggression, threats and physical assaults. In the largest nationwide prevalence study of PVV in psychiatric settings from the UK more than half of nurses but fewer doctors and non-clinical staff experienced PVV (Health Care Commission, 2007). Little data is available from South East Asia. One staff survey from Bangalore reported that 87% of staff on psychiatric wards had experienced some form of violence in their career (Balamurugan et al., 2012). Of the remaining studies from middle and low income countries, one Jordanian study amongst medical nurses reported 37% prevalence of verbal abuse and 18% of physical abuse in the last 6 months. Younger and less experienced staffs were more commonly affected. Half of the abused nurses considered leaving the profession (Ahmed, 2012). A nationwide survey amongst nurses in Kuwait reported that verbal violence had been experienced in the 6 previous months by 48% of the group, and physical violence by 7% (Adib et al., 2002).

Abbreviations: HCSW, healthcare support worker; NA, not available; NHS, National Health Service; PVV, patient and visitor violence; CI, Confidence Intervals; SOVES, Survey of Violence Experienced by Staff.

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In medical settings percentage figures for verbal aggression range from 9% in a Swedish study to 97% in a Turkish study. The percentages for threats ranged from 5% in a Jamaican study to 70% in a US study. For physical assaults results ranged from 3% in an Israeli study to 58% in a US study (Hahn et al., 2008).

The European Violence in Psychiatry Research Group (EViPRG) was founded in 1997. It is multi-disciplinary and aims to standardise research in psychiatric and other medical settings (including forensic and civil hospitals, nursing homes and other health care facilities), set standards, make international comparisons, benchmark, and develop and research initiatives to reduce coercion. The Indian Forensic Mental Health Association (IForMHA) was founded in 2013 and headed by one of the authors (RBN), aims to achieve similar goals in India in collaboration with EViPRG. The first step in this direction is to collect the prevalence data in relation to hospital staff's experiences of PVV in India. Therefore, we carried out a pilot study to examine the relationship between reported levels of abuse and staff characteristics to inform further collaborative research to develop culturally acceptable and feasible interventions to reduce the levels of PVV and coercion in India as outlined in the Mysore declaration (Lepping and Raveesh, 2013).

2. Methods

2.1. Setting

We investigated prevalence of PVV in general medical and psychiatric wards in 2 hospitals in South India. The medical wards were in the Holdsworth Memorial and Krishnarajendra Hospital, Mysore. It is a missionary hospital governed by the Church of Southern India. The hospital is situated in a busy quarter of Mysore city and provides low cost care to the less privileged. HMH has most specialities with 330 beds and an emergency department. It does not have separate psychiatry wards. At Holdsworth Memorial Hospital, there are two registered nurses for a 40–50 bedded busy ward. They are assisted by two nursing aids, but no volunteers. Each ward has a security guard whose primary work is to guard the entry and restrict 'the family members and visitors' outside the visiting hours. The guards have no formal training in de-escalation. The psychiatric state hospital of Mysore Medical College and Research Institute (MMCRI) was used for data collection on psychiatric wards. MMCRI is a state-run (free-to-patients) hospital that serves a catchment area of 1500,000 population, with 135 primary health centres. The hospital has most specialities with 1050 beds and a 10 bedded intensive care unit (ICU). 800–1000 patients attend outpatient departments daily. The department of psychiatry at MMCRI has 10 male and 10 female psychiatric inpatient beds. Staffing includes 6 psychiatrists in total and 2 registered nurses per shift. Thus, there will be one nurse for 10 psychiatry beds round the clock. There is one security guard for the inpatient care 24 h a day on shift, who manages the visitors and prevents inpatients from absconding from the hospital. The hospital policy is to admit a patient with an attendant, preferably a close relative. The nurse and the security guard have no formal training in de-escalation. Approximately 60% are involuntary admissions. Most patients come from lower middle to lower economic backgrounds and are severely ill on admission. The study was approved by the research and ethics committee at Mysore Medical College and Research Institute Mysore, India.

2.2. Instrument

We replicated a previous study conducted in North Wales (Lepping et al., 2013). We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English, a staff questionnaire to investigate the prevalence of verbal abuse, threats and assaults on staff by patients, visitors, co-workers or

others in the past 4 weeks. This validated tool includes questions about staff experience with violence within the last 4 weeks, as this timeframe yields the best results, creating least problems with recall bias (McKenna, 2004). The SOVES-A also asks whether a staff member had formal de-escalation and/or breakaway training in the last 3 years, and whether they have ever received training in the management of potentially violent individuals. It takes 5 min to complete the SOVES-A.

2.3. Administration of the tool

Two of the authors (MK & RBN) distributed the tool by approaching staff on medical and psychiatric wards during a four week period in September 2013. Staff completed and returned the tool on the same day.

2.4. Analysis

We used Pearson's Chi-square analysis on nominal data, with Fisher's exact and trend analysis values used where appropriate. For continuous data *t*-tests and regression were used. All analyses carried out with SPSS (SPSS, 2004).

3. Results

We approached 141 and 101 number of staff from HMH and MMCRI, respectively, between September and October in 2013 to complete the SOVES-A. Of those, 136 (96%) from HMH and 81 (81%) from MMCRI returned the completed questionnaire. The total number of participants in the study was 249, 40 (16.1%) of which were male, and 62 (24.9%) female (missing data: 147 or 59%). 136 worked in a medical setting (67.5%), 81 in a psychiatric setting (32.5%). The study population consisted of 136 nurses (54.6%), 16 Healthcare social worker (HCSW) (6.4%) and 97 other professionals (39%) such as doctors, psychologists, research assistants, ward clerks and pharmacists. 44 (17.7%) of the participants worked part time, and 196 worked full time (78.7%) (missing data: 9 or 3.6%). The vast majority worked in hospital settings (186 or 74.7%), 42 in clinics (16.9%), and 13 (5.2%) in other settings (missing data 8 or 3.2%). The mean age was 31.3 years (range: 19–58). The average number of hours worked per week was 48.6 (range: 6–84). The mean percentage time spent each day with direct patient contact was 84.6% (range 1–100). The mean work experience in years was 5.7 (range: under 1 to 42). 14 staff (5.6%) has formal de-escalation training, 10 (4%) had PVV management training. Table 1 shows the prevalence of PVV for each type of abuse suffered. Table 2 shows the source of abuse for the different frequencies and types. Table 3 shows the prevalence of PVV for different settings and professions.

Thirty-nine percent of staff reported some form of violence in the past 4 weeks; 57% of medical staff and 16% of psychiatric staff (Chi-sq. = 36.5, $p < 0.001$), a result that remained statistically significant across all three types of abuse. In addition, we found that in keeping with evidence from other countries (Hahn et al., 2008; Lepping et al., 2013), more time spent with the patient results in significantly more abuse of any kind ($t = -2.40$, $df = 201$, $p = 0.017$). This remained the case for all three types of abuse individually. We observed that the category 'others' were also at an

Table 1
Prevalence of PVV for each type of abuse suffered.

Type of abuse	Yes	No	Missing
Suffered verbal abuse	97 (39.0%)	151 (60.6%)	1 (0.4%)
Threatened	42 (16.9%)	195 (78.3%)	12 (4.8%)
Suffered physical abuse	22 (8.8%)	144 (57.8%)	83 (33.3%)

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