Safety awareness among junior psychiatrists and provisions for their safety in the workplace

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Violence in the workplace is of great concern to trainee psychiatrists. A questionnaire was devised to assess knowledge of safety issues, and precautions available, among junior doctors. The results, which revealed gaps in provision of safety training and facilities in this area, have been forwarded to the relevant directorates with a view to setting standards suitable for audit review.

Violence in the workplace is of great concern to any junior doctor who has faced a violent incident themselves or has been made aware of one through colleagues. It is more common than expected – O'Sullivan & Meagher (1995) found that 39% of psychiatrists had been assaulted at work and 12% had sustained physical injury. As the level of violence occurring on in-patient units increases (James *et al*, 1990), so does the level of concern among junior doctors and this is reflected by the increase in articles published on the topic (Rosenbaum, 1991).

The Collegiate Trainees' Committee (CTC) have long been aware of this problem and have wanted to ensure that all juniors are taught how to manage a violent incident and have adequate backup. They set up a working party in 1989 and the report (CTC Working Party, 1991) made a number of recommendations. The points raised have been incorporated into the *Statement on Approval of Training Schemes for General Professional Training* (Royal College of Psychiatrists, 1996). If these standards are not achieved or maintained in hospitals, then training schemes may have their approval removed. The Statement was reviewed by the CTC in November 1995 and revision suggested. Moreover, the Management of Health and Safety at Work regulations (Health and Safety Executive, 1992) require hospitals to assess health and safety risks to employees, record measures resulting from this risk assessment and give adequate training so staff are capable of avoiding risks. Black & Guthrie (1990) drew attention to the risks taken by psychiatrists when doing domiciliary visits and this is becoming more important as community psychiatry grows.

The aim of this paper is to assess the level of awareness of safety issues among junior psychiatric trainees and the precautions taken to ensure their personal safety in the workplace. Emphasis was placed on what the trainees believed was available rather than what actually was.

The study

A questionnaire was constructed using the recommendations laid down by the CTC in 1991 as a guideline. Responses were limited, giving only the choice of a positive response, a negative response or 'don't know'. At the end of the questionnaire, respondents were given the opportunity to add comments. A copy was sent to every junior psychiatric trainee working at that time in all the psychiatric hospitals in a Welsh county. This study involved three large psychiatric hospitals as well as a number of smaller outlying units.

The findings

The response rate was 19 out of 26 (73%) of whom the majority (13 out of 19) were senior house officers (vocational or GP trainees). Fifty-three per cent of respondents were female. The mean length of training in psychiatry was 2.5 years and the mean length of time spent in this Health Authority 2.6 years. The responses are summarised in Table 1.

Comments

Many respondents added personal comments at the end of the questionnaire. Support was voiced for issues raised in the questionnaire, particularly the availability of personal alarms, positioning of interview rooms, furniture and panic buttons, the availability of legal advice and a nominated counsellor after an incident. One drew attention to the risks taken by pregnant doctors in violent incidents. One emphasised the concern that change is slow as individuals are 'fearful of rocking the boat'.

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Table 1. Positive responses to items of questionnaire

	n responding positively	Total *n* responding	(% positive response)
On starting first psychiatric post			
Induction course available and able to attend	14	19	(74%)
Information given on facilities available for managing violent incidents	10	15	(66%)
at the sites expected to cover			
information regarded as sufficient to answer their concerns	5	10	(50%)
Information given regarding ensuring personal safety	9	19	(47%)
information regarded as sufficient to answer their concerns	5	9	(55.5%)
Breakaway Techniques course available and able to attend	18	19	(95%)
refresher course available	6	18	(33%)
Advised to have ex-directory telephone numbers	1	19	(5%)
Advised not to list private address or telephone numbers in medical directory	0	19	
Present post			
Access to personal alarm to carry at all times	1	19	(5%)
known policy for responding	0	1	
Panic buttons situated in interview rooms			
all	2	19	(10.5%)
some	8	19	(42%)
known policy for responding	3	10	(16%)
Furniture in interview rooms positioned appropriately to ensure safety			
all	1	19	(5%)
some	13	19	(68%)
Interview rooms suitably placed to allow requests for assistance to be responded to rapidly			
all	4	19	(21%)
some	12	19	(63%)
Able to obtain a nurse to accompany during patient assessments	15	19	(79%)
Able to obtain a porter/nurse to accompany during visits to outlying units within grounds of hospital at night	5	19	(26%)
Acknowledged channel for taking concerns regarding safety	17	19	(89.5%)
Known appointed consultant for counselling staff who are assaulted	1	19	(5%)
Help available regarding appropriate course of action from legal point of view	1	19	(5%)
Known monitoring system to record violent incidents towards staff	0	19	
Known regular review of local arrangements regarding safety issues	0	19	
Adequate precautions to allow safety in on-call residency out of hours	6	18	(33%)
Community duties			
Chaperone available when visiting patient of opposite sex	1	7	(14%)
Member of MDT available when visiting an unknown, unpredictable patient	3	7	(43%)
Access to a two-way radio	0	7	
Access to a mobile phone	1	7	(14%)
Advised to ensure that another member of staff knows of visit	0	7	
Experience of violence			
Have been personally involved in a violent incident	7	19	(37%)
Was approached by a senior colleague with offer of counselling	1	7	(14%)
Often feeling vulnerable or fearful for personal safety at work	9	19	(47%)

Comments

The response rate (73%) suggests the high level of interest and concern among junior doctors regarding this issue. The frequency with which responders added extra relevant comments at the end of the questionnaire seemed to confirm this. The questionnaire, although lengthy, was straightforward and unambiguous, and hence, all respondents provided valuable figures. However, this questionnaire aims to assess the level of *awareness* of the availability of safety facilities rather than what is actually available, although the former might indirectly reflect the latter. To obtain details of the latter, it would be necessary to pose a similar questionnaire to the administrative teams of the Trusts and Health Authority. If a discrepancy was found, this might reflect a communication problem between the administrative levels and the junior clinical staff, rather than a lack of provision, and would need to be addressed appropriately.

The sex ratio was evenly balanced and there was no evidence to suggest that it was the female members of the group who provided the majority of the negative responses. The level of expertise was weighed towards the less experienced, i.e. SHOs and GP trainees, which reflects the usual proportions employed in general psychiatric hospitals. These juniors are the employees who are the most inexperienced in dealing with potentially violent situations. As the mean length of time in psychiatry or in this county was 2.5 years and 2.6 years respectively, we can be confident that respondents are reporting valuable information about what is occurring in this area.

A reassuringly high proportion of respondents had been able to attend induction courses as well as breakaway courses, which provided useful information regarding managing violent incidents. The picture changed when questions were asked regarding advice given and facilities available to prevent a violent incident occurring or escalating. Few knew of advice regarding private addresses and telephone numbers, personal alarms appeared to be rarely available and the availability of centrally placed, appropriately furnished interview rooms with carefully positioned panic buttons was limited. The questions regarding local arrangements for responding to, monitoring and reviewing assaults and violent incidents showed a very low level of awareness.

Few of those required to work in the community felt that their safety was of general concern. There was difficulty in obtaining assistance when visiting unknown and unpredictable patients and even availability of mobile phones to use in emergencies was limited to those expected to do night calls only. This will be of increasing importance as junior doctor's commitments become more community-orientated.

Perhaps most worrying was that over one-third had actually been involved in a violent incident (albeit subjectively defined), a similar figure to that found by O'Sullivan & Meagher (1995), and almost half reported that they often felt fearful or vulnerable in the workplace.

The CTC, in November 1995, suggested a revision to the current *Statement on Approval of Training Schemes for General Professional Training* for MRCPsych, emphasising certain areas of concern. They recommended all trainees should have access to mobile phones and bleeps, especially when in the community; unaccompanied trainees should not be required to visit potentially dangerous patients; breakaway technique courses should be mandatory and refresher courses should be available; the security of the hospital environment, both in the building and in the grounds, especially in the on call accommodation, should be ensured. The findings of this questionnaire, particularly the individuals' comments, suggest that junior doctors would support these revisions to the statement.

Conclusion

This survey indicates that the county in question (involving two trusts and one health authority) was making some progress in responding to the safety concerns of their junior employees but still had some way to go in specific areas. There was an unacceptably high level of trainees being subjected to violent incidents and, when it occurs, the trainees were not aware of the channels available for them to seek help. Many were still fearful for their safety.

There appear to be gaps in the provisions for safety of junior doctors according to the recommendations of the CTC and the Standards for approval for training schemes, and these need to be addressed. These figures have been presented to the Clinical Directors of each directorate for further discussion, with a view to possibly setting up standards suitable for audit review at a later date.

This questionnaire proved a useful tool in assessing the awareness of psychiatric trainees on safety issues, and could be used in a wider setting.

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