CONFLICT RESOLUTION

HSE (Health and Safety Executive) Definition of violence at work:

‘Any incident where an employee is abused, threatened or assaulted in circumstances relating to their work’.

‘This includes physical attack whether visible injury occurs or not, including sexual or racial attack. Serious verbal abuse and threatening behaviour; an unacceptable threat has been made against a person including via the phone, electronically, social media and in person by a third party’.

What is the role and responsibilities of a worker in relation to managing violence and aggression?

You must ensure your own safety at all times. Follow the risk assessments laid down in the individuals care plan, ensuring they are updated when necessary and appropriate.

You must stay calm and use techniques to diffuse the situation and calm the other person down.

What are the legal requirements of a worker in relation to managing violence and aggression?

Employers have a legal duty to ensure the health, safety and welfare of their employees under the Health and Safety at Work Act 1974. In addition, the Management of Health and Safety at Work Regulations 1999 place specific requirements on employers to assess the risks to their employees, and to take appropriate measures to prevent or reduce the risks. These legal duties include protecting employees from exposure to reasonably foreseeable violence at work, both physical and verbal abuse.

What are the main aims of a worker in relation to managing violence and aggression?

• Allow time for a person to process and understand
• Allow for time to respond
• Be aware of body language
• Use short understandable sentences
• Think about the individuals needs

The ICS policy Violence and Aggression in the workplace states:

“ICS values its workers and will take reasonable steps to secure the health and safety of workers who may be exposed to the risk of aggression, violence or abuse in the work place”.

“ICS will not tolerate violent, aggressive, antisocial behaviour towards workers during the course of their duties. ICS will take action against offenders where there is no medical condition, or where the act is deliberate, which may result in withdrawal of treatment or care”.

“ICS acknowledge that some service users may display challenging behaviour which manifests in violence and aggression and will work alongside statutory services to manage such situations”.

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Definition of violence at work

The British Crime Survey (BCS) measures respondents’ experiences of crime related incidents and classifies these into offence types (including physical assaults and threats), and also collects detailed information about the nature of the victimisation.

Physical assaults include assault with minor injury, assault without injury, wounding and robbery; threats include verbal threats made to or against the recipient. Some addendums have been made to some definitions, to include electronic bullying and harassment via social networking sites and emails.

Section 2(2)*c* The Health And Safety at Work Act

‘The Employer has a responsibility to ensure that employees receive such information, instruction, training and supervision, as is necessary, to ensure the health, safety and welfare of staff by ensuring staff competence.

Employment Rights Act, Section 44

‘Prevents an employer from taking action such as dismissing or disciplining an employee who leaves their place of work because of danger, which they believe to be ‘serious and imminent’ and which they could not be reasonably expected to prevent. This includes taking any appropriate steps to protect themselves or others from the danger.

Legal framework

A person can face both a criminal and civil prosecution. It is not necessary that a criminal conviction is secured for a successful civil action to take place.

Assault

Assault is an act by any person/s that makes another fear the application of immediate personal violence/harm. It is not necessary that touch or actual harm takes place, nor is intention important. This could be eye contact, perceived physically aggressive gesturing or the use of verbal threats.

The ICS policy ’Managing Challenging Behaviour’ states:

“The term challenging behaviour has been used to refer to the ‘difficult’ or ‘problem’ behaviour, which may be shown by adults or children with learning disabilities’’.

“Challenging behaviour is not limited to service users with learning disabilities. Service users with acquired brain injuries and other conditions can also have challenging behaviour”.

“Challenging behaviour puts the safety of the service users or others (ICS workers) in some jeopardy or has significant impact on the service users and other people’s quality of life”.

“ICS acknowledges that some clients may display challenging behaviour with violence and aggression and will work alongside statutory services to manage such situations”.

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“ICS understands the importance of appropriate training for ICS workers managing challenging behaviour especially when physical intervention is required”.

**Challenging behaviour - Communication**

The most important form of intervention is the lowest level i.e. effective communication, active listening skills and diffusion strategies. We as health care staff who potentially face conflict should not embrace a culture of physical intervention as a primary strategy.

Tips for effective communication:

- Explore the reasons for the persons emotional arousal
- Identify possible positive outcomes
- Can you assist with the removal of the trigger?
- Would environmental change help?
- Validate the persons feelings
- Use active verbal/non-verbal approaches
- Appropriate proxemics (personal space awareness)
- Non-threatening attendance.

**Verbal** communication is made up of spoken word, phrases and content and equate to around 7% of the total message.

**Vocal** communication is made up of tone, volume, pitch and intonation and in heated dialogues (conflict) makes up around 38% of the overall message.

**Non-verbal** communication has been proven to be the most influential form of resolve when dealing with challenging situations, this makes up around 55% of the conversation. (Mehrabian’s communication model)

‘**Windows of the soul**’ Our eyes will be very expressive during conversations and give off messages sometimes without our awareness

- Joy
- Happiness
- Sadness
- Fear
- Anger

**Facial Expressions** Our eyes and mouth are powerful communicators, our facial expressions when dealing with an angry person can alternate as quickly as our thoughts.

**Duty of Care linked to personal safety:**

The Manchester NHS and Social Care Trust state in their 2007 service governance directorate entitled ‘The prevention and management of violence and aggression at work against NHS staff policy’:
Every employee has a duty of care to ensure the safety of themselves and others during an incident of violence.

Employees will co-operate with the measures provided for their safety both in terms of the risk assessment process, the development and implementation of control arrangements.

Employees should attempt to minimise a potentially violent situation by withdrawing from the situation if the opportunity arises.

Employees should attempt to minimise a potentially violent situation by responding appropriately as a member of the MVA (Restrictive Physical intervention) team or withdraw.

**Duty of care**

We have a duty of care to those around us, we should always endeavour to ensure that we identify risks and inform others of the risks and danger. We should also where possible try and prevent harm coming to those around us, but this should not be at the cost of our own safety.

From a non-risk situation, we have a great duty of care to the individuals we care for and ensure we provide the highest possible level of care. These individuals may rely on us for the promotion of independence, self-care and awareness of health and safety.

**P A C E**

Identify the **Problem** and validate if necessary.

Know your **Audience** history, potential and impact factors

Recognise **Constraints**, law, rules and policies

Remember **Ethical** presence, duty to remain professional

**Leaps Communication tool**

- Listen – to what is being said
- Empathy – try to show we understand
- Ask – if we need more info, let the person know you’re trying
- Paraphrase – show you’re genuinely interested
- Summarise – the facts, and inform of your actions, action plan

**During an exchange**

Distraction may be an option, as the trigger is causing accelerating escalation, change the subject to a topic that may ease the situation. It’s imperative that wherever possible we get to know the individuals we are caring for, as this will give us much more de-escalation options.

**Understanding Behaviours**

**The typical Assault cycle** (Kaplan and Wheeler 1984)

**Trigger Phase** - The cause or a catalyst to start the behaviour
Escalation Phase - When a person’s emotional state starts to rise from maybe slightly agitated, confused or upset to higher state of anger.

Crisis Phase - During this phase, there are many things going on: threat of physical harm, throwing of objects, risk to all involved, the person/s may have lost their impulse control, and are far removed from their base line behaviour (norm).

Recovery Phase - This is where physical intervention may have been used, individuals start to resettle. It is important at this stage that effective communication is utilised as the person, although calming, is still way off his/her base line.

Post Crisis Depression Phase - at this point after an assault incident (crisis) the aggressor or those involved may become regretful, remorseful and ashamed or even on some occasions become suicidal, depressed or prone to self-injurious behaviour. Our role as the caregiver should be that of support, nurturing and reassurance.

Even though in certain situations we may be the victim during the assault cycle, where possible we should still maintain a good ethic and professionalism.

After an incident its takes approximately 90 minutes to physically regain some composure for the adrenaline to leave, and our physiological presence to go back to normal.

Things we can do:

- Allow time for a person to process and understand
- Allow for time to respond
- Be aware of body language
- Use short understandable sentences
- Think about the individuals needs
- Physical comfort

Things to avoid:-

- Signalling your anger or potential aggression at the situation
- Being negative or un-interested in their problem
- Stereotyping
- Being contrary
- Criticism
- Shouting
- Unwanted touch

The Adrenaline Reaction - Fight/Flight/Freeze

Before, during and after an incident the adrenaline reaction may be present, it enables us to respond adequately to some risk incidents. It gives us certain abilities to detect, observe and react with instinct.

Physiological change

- Glucose and adrenaline is released by the body to help muscles work.
• The heart beats faster, as it needs to work harder to carry extra oxygen in the blood to the muscles
• Respiratory rate quickens, to transform the glucose into energy

Blood is diverted from the digestive system to compensate for the above so symptoms such as churning stomach and dry mouth appear.

• Muscles tense to prepare for a response
• Skin changes colour due to the increased activity of the body e.g. sweating to cool the body
• The pupils of the eyes dilate and widen to make clearer vision

Fight/Flight/Freeze

• Pounding heart
• Dry mouth
• Jelly legs
• Gasping
• Muscular tension
• Facial tics
• Churning stomach (butterflies)
• Nausea
• Sense of panic
• Loss of control
• Confusion
• Paralysis or freezing
• Feeling of indignation or anger.

These are the symptoms to associate with when the adrenaline reaction manifests itself, if we are aware why they are happening then it gives us a sense of control.

When adrenaline turns to anger or aggression we associate certain behaviours of a negative nature:-

• Louder voice/shouting
• Silence
• Use of swearing
• Using threats
• Offensive gestures
• Negative body language (fist clenching, gritted teeth, staring, finger pointing)
• Crying
• Invasion of space
• Banging about
• Throwing objects
• Physical assault

Physical intervention, Safe holding and the risks

Consistently implementing positive behaviour supports has been shown to reduce the incidence and intensity of behaviours that may necessitate physical interventions. The adoption of guidelines and policies founded in evidence based practices will not only increase environmental predictability for
service user/patients, but will provide an essential systemic support for care staff, thus promoting a positive enhanced caring climate.

The use of physical interventions in care settings may cause strong reactions from some individuals, therefore it is essential that practices be grounded in a set of beliefs and are consistent with all applicable legal requirements and evidence based practices. Taken together, these three sources call organisations to (a) promote a positive and respectful climate for all service user/patients and staff; (b) use preventative and positive strategies even for service user/patients with the most harmful behaviours; and (c) resort to more restrictive practices, such as physical intervention only in extraordinary circumstances and when all other positive approaches have been exhausted.

The Care Quality Commission (CQC) declared we mustn’t endure another Winterbourne View culture. In 2011 BBC Panorama broadcast and exposed staff, working at the care home in Bristol, who were found guilty of physical and psychological abuse towards vulnerable adults.

**Risks in Restraint**

**Positional Asphyxia** - The term asphyxia is thought by some pathologists to be a vague and confusing one. But it refers to a state in which the body becomes deprived of oxygen while in excess of carbon dioxide i.e. hypoxia. This state can result in loss of consciousness or in extreme conditions death can occur, so asphyxia related death is therefore one in which the oxygen deprived state has been achieved unnaturally.

Some cases for further research:

The David ‘Rocky’ Bennett enquiry

Christopher Alder

Gareth Myatt

Adam Rickwood

All of the above individuals lost their lives linked to restraint.

**David Bennett** was killed in restraint at the Norvic Clinic on the 30th October 1998. He was restrained face down and died of positional asphyxia.

In April 1998 **Christopher Alder** died on the floor of a police station in Hull, he was face down. In 2000 a Coroner’s jury decided Mr Alder was unlawfully killed. In 2002 five Humberside police officers went on trial accused of manslaughter and misconduct in public office. They were cleared of all charges on the order of the judge. Four years later, a report by the Independent Police Complaints Commission said that four of the officers present in the custody suite when he died were guilty of the most serious neglect of duty.

**Gareth Myatt** was 15 years of age and he died in a seated restraint at the Rainsbrook secure training centre on April 19th 2004.
Adam Rickwood hung himself whilst 14 years of age, hours after being forcibly restrained for refusing to go to a cell. A painful restraint technique called “nose distraction” which has been described as a squeezing, tweaking, flicking, or karate chop to the nose was used in the incident.

Other contraindications:-

- Excited delirium
- Sickle cell disease
- Compartment syndrome
- Neuroleptic Malignant Syndrome (NMS)
- Pregnancy
- Respiratory problems
- Injuries
- Illnesses

All of the above should be researched if you are working within an environment where physical intervention is being used.

VIDEOS

Christopher Alder: http://www.youtube.com/watch?v=uWyrHEGuf9U

Winterbourne View Case Review: http://www.youtube.com/watch?v=hhCx3K8XJJM

USEFUL WEBSITES


DoLS: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Autism: http://www.autism.org.uk

Mental Health: http://www.mentalhealth.org.uk/help-information/

Depression: http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx

Sane: http://www.sane.org.uk

Rethink: https://www.rethink.org

Mind: http://www.mind.org.uk/information-support/types-of-mental-health-problems/schizophrenia/#.VnArkIR3au4

British Crime Survey: http://www.crimesurvey.co.uk/

HSE – Definition of Violence at Work: http://www.hse.gov.uk/violence/


The prevention and management of violence and aggression at work against NHS staff policy: http://www.mhsc.nhs.uk/media/53893/prevention%20and%20management%20of%20violence%20and%20aggression%20at%20work%20against%20NHS%20staff.pdf
REFERENCES


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