



Esperienze di prevenzione nelle aziende sanitarie

Le aggressioni. I disturbi muscolo-scheletrici.

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Aggressions



- Aggression against nurses and ancillary personnel is a major, albeit underreported, occupational problem in long-term psychiatric health-care.
- Assaults may represent a problem also in social-sanitary facilities for psychiatric and demented patients.
- In such residences, staff is mainly constituted by unskilled caregivers.

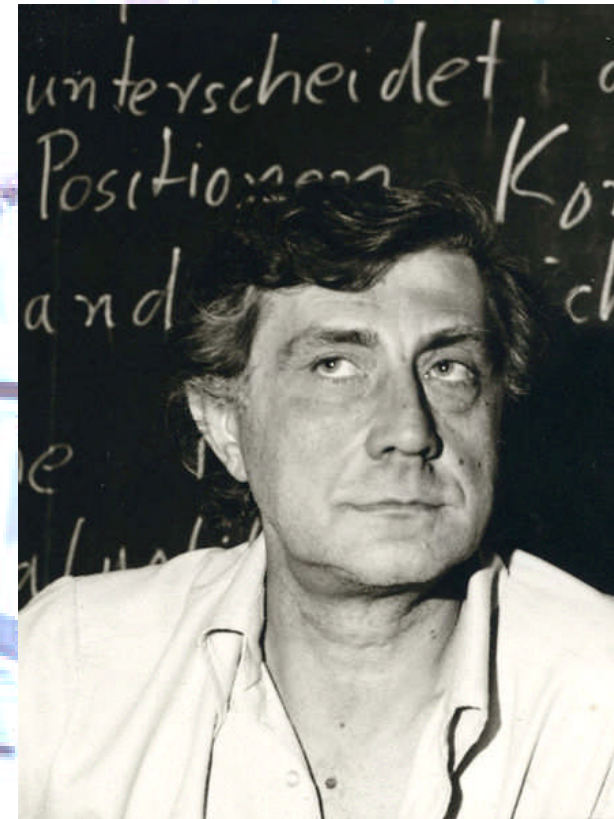
A gift from Innocenzo IV

- The studied facility was a psychiatric non-intensive rehabilitation unit near Rome
- The Institute, placed in a convent of the XII century, had been founded in the sixties in order to accommodate female patients affected by mental retardation.



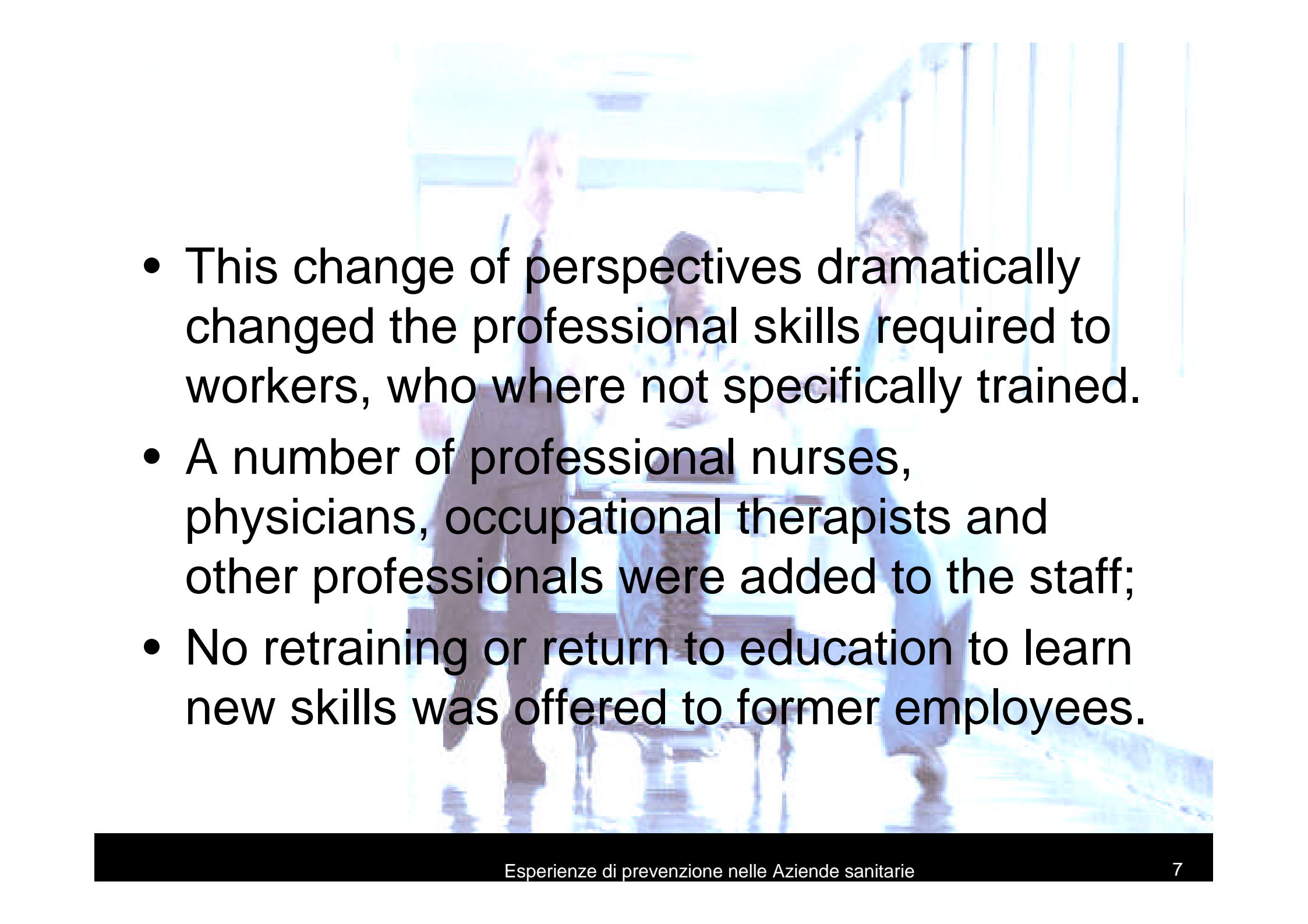


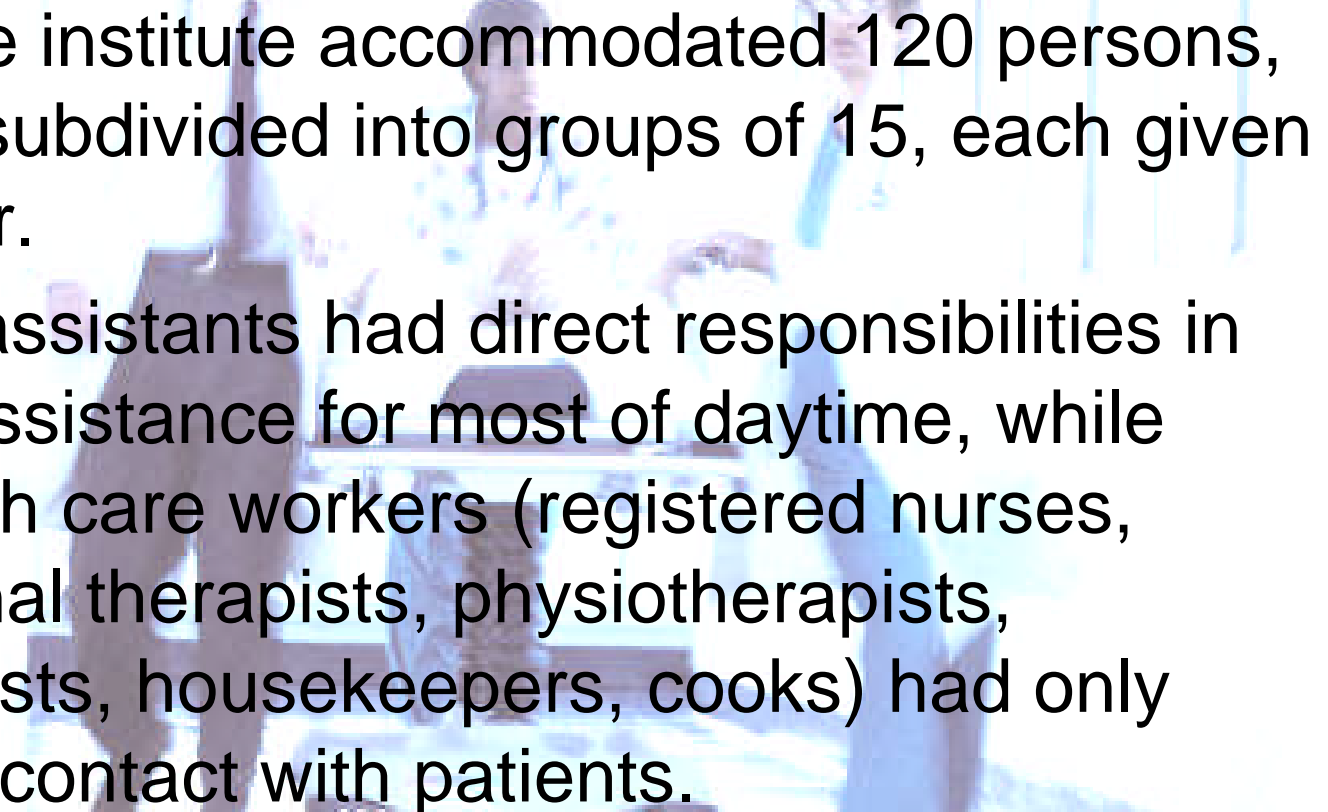
- Initially, its mission was internment and custody of patients. After the adoption of the Law 180/1978 (so called "Basaglia Law"), the institute gradually changed its mission to the supply of appropriate intervention to improve or completely eliminate the condition of mental handicap of patients.



The current situation



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- This change of perspectives dramatically changed the professional skills required to workers, who were not specifically trained.
 - A number of professional nurses, physicians, occupational therapists and other professionals were added to the staff;
 - No retraining or return to education to learn new skills was offered to former employees.

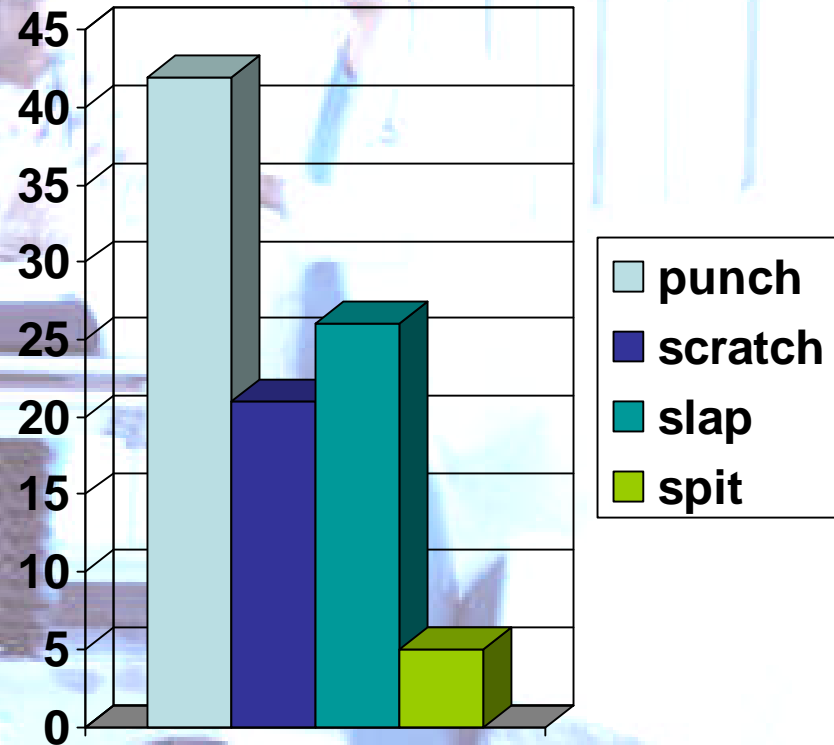
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- In 2001 the institute accommodated 120 persons, randomly subdivided into groups of 15, each given a caregiver.
 - Unskilled assistants had direct responsibilities in patients' assistance for most of daytime, while other health care workers (registered nurses, occupational therapists, physiotherapists, psychologists, housekeepers, cooks) had only short-time contact with patients.

2001 survey

- In 2001, assistants reported 26 incidents of aggression. The findings revealed that the majority (66,7%) of them had been subjected to physical aggression over time; 48,7 per cent of respondents had encountered at least several episodes of aggression within the last 12 months.
- No assaults were reported by registered nurses, housekeepers, cooks, occupational therapists, psychologists, and other health care workers, who had only limited contact with agitated patients.

Form

- The form of physical assault ranged from punching (42%), to scratching or hair pulling (21%), and to slapping or pushing (26%), spitting or restraining (5%). Verbal aggression, and intimidation, was also reported.

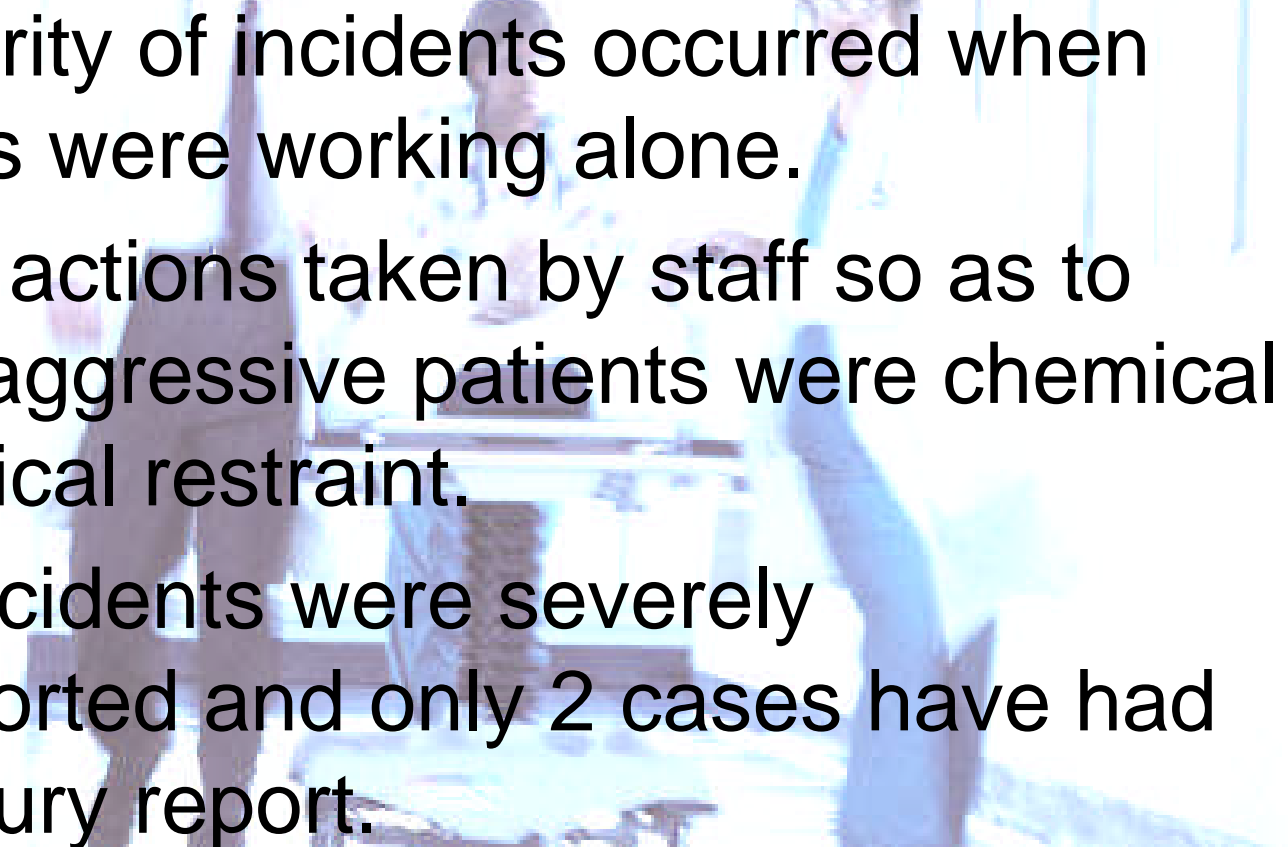


Consequences

- In almost all cases, vivid description of the psychological consequences of assaults comprised fear, anxiety, humiliation, helplessness, and sometimes avoiding reactions.
- In a minority of cases assaults had determined permanent physical impairment to the assaulted person.

Causes

- Violence in this sample was perceived as occurring principally in connection with unmet demands for such things as prescriptions and referrals, or with worker's attempt to put down aggressive behaviour of the patient.
- Assistants identified lack of aggression management training as potential determinant of incidents.

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- A blurred photograph of a hospital hallway. In the foreground, a person in a white lab coat is walking towards the camera. In the background, another person in a white lab coat is standing near a patient who is seated in a chair. The hallway has a tiled floor and a white wall with a door in the distance.
- The majority of incidents occurred when assistants were working alone.
 - Frequent actions taken by staff so as to manage aggressive patients were chemical and physical restraint.
 - Violent incidents were severely underreported and only 2 cases have had formal injury report.

Minimisation program.

- The aggression minimisation program was part of a wider program of improvement of health care quality.
- It included
 - educational,
 - organisational/structural,
 - medical measures.

Education

- Eight hours of training were divided into specific modules addressing: general aggression and violence minimisation competence, reporting procedures, specific safety strategies, communication skills and management options.
- A reporting procedure for aggressive incidents and near-miss events was developed and implemented.

Architecture and organisation (1)

- Lighting was improved
- Working rooms were enlarged, in order to contain an increased number of patients, who were assisted by a team of assistants.
- Working alone was avoided.

Architecture and organisation (2)

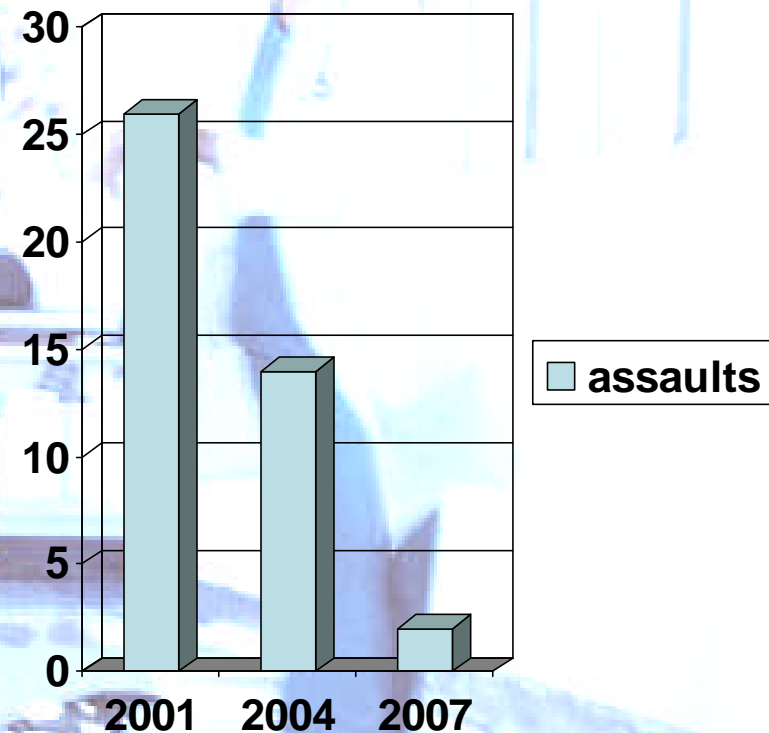
- Each team had to work with a specific kind of patients, with well-defined therapeutic objectives.
- Patients were divided into three assistance areas, depending upon the severity of mental illness: (1) profound/severe impairment, with associated motor impairment; (2) severe/mild impairment, with no motor impairment; (3) mild/slight impairment.

Clinical improvements

- The clinical homogeneity of patient working groups, lead to improvement of interpersonal relationship between patients and toward workers.
- Improvement of communication between therapists (psychiatrist, neurologist, psychologist, general physician) and other caregivers lead to early identification and control of aggressive patients, without restraints or seclusion.
- Training apparently gave the techniques to control patients and de-escalate violence.
- Violent incidents were monitored through spontaneous reporting (using the VIF) and direct interview during periodical medical examinations.

Results

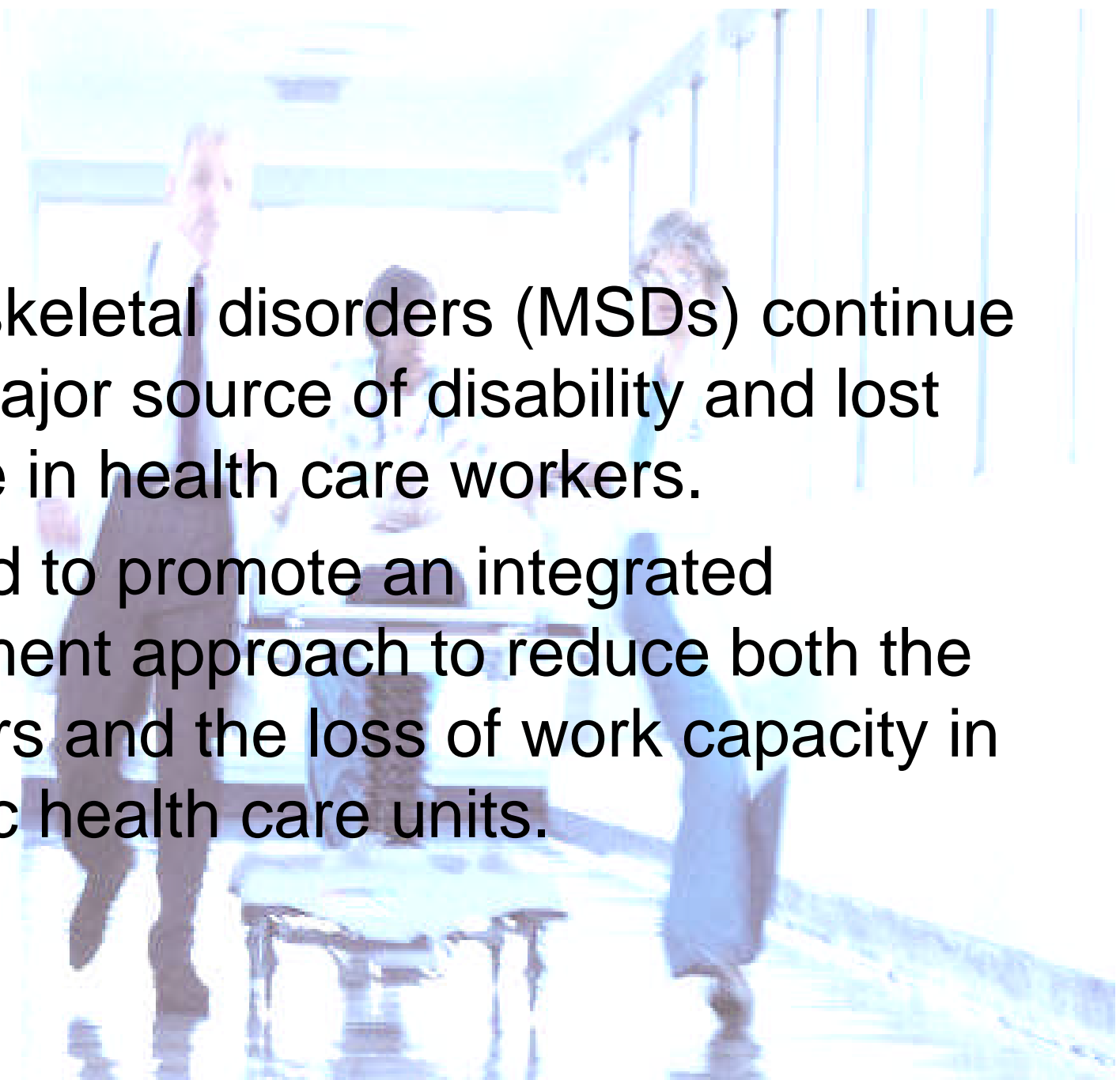
- At the completion of the program, assault rate was significantly reduced.
- In 2007, only two minor assaults were reported, plus one attempted assaults and four threats (near-miss cases). Staff members were satisfied and reported increased confidence for dealing with aggressive behaviour.

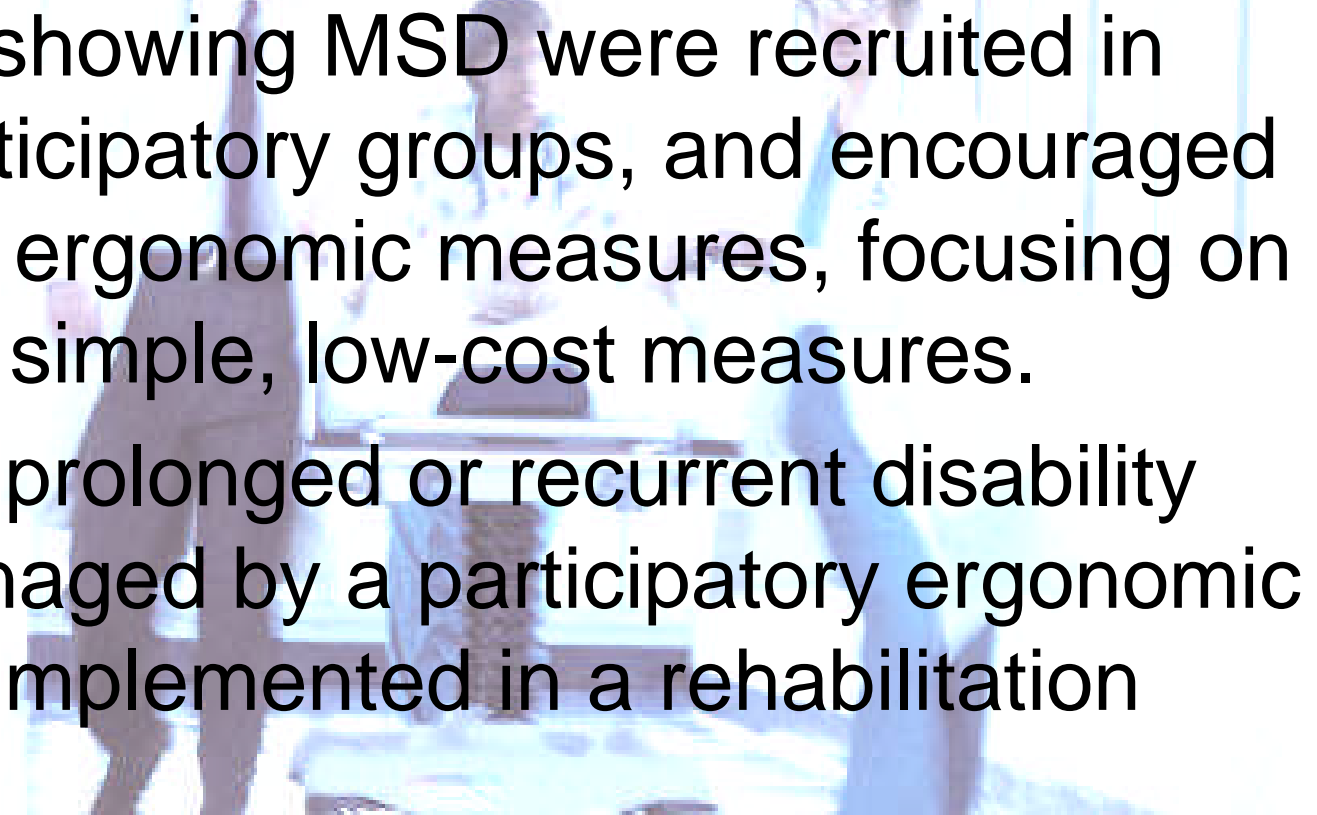


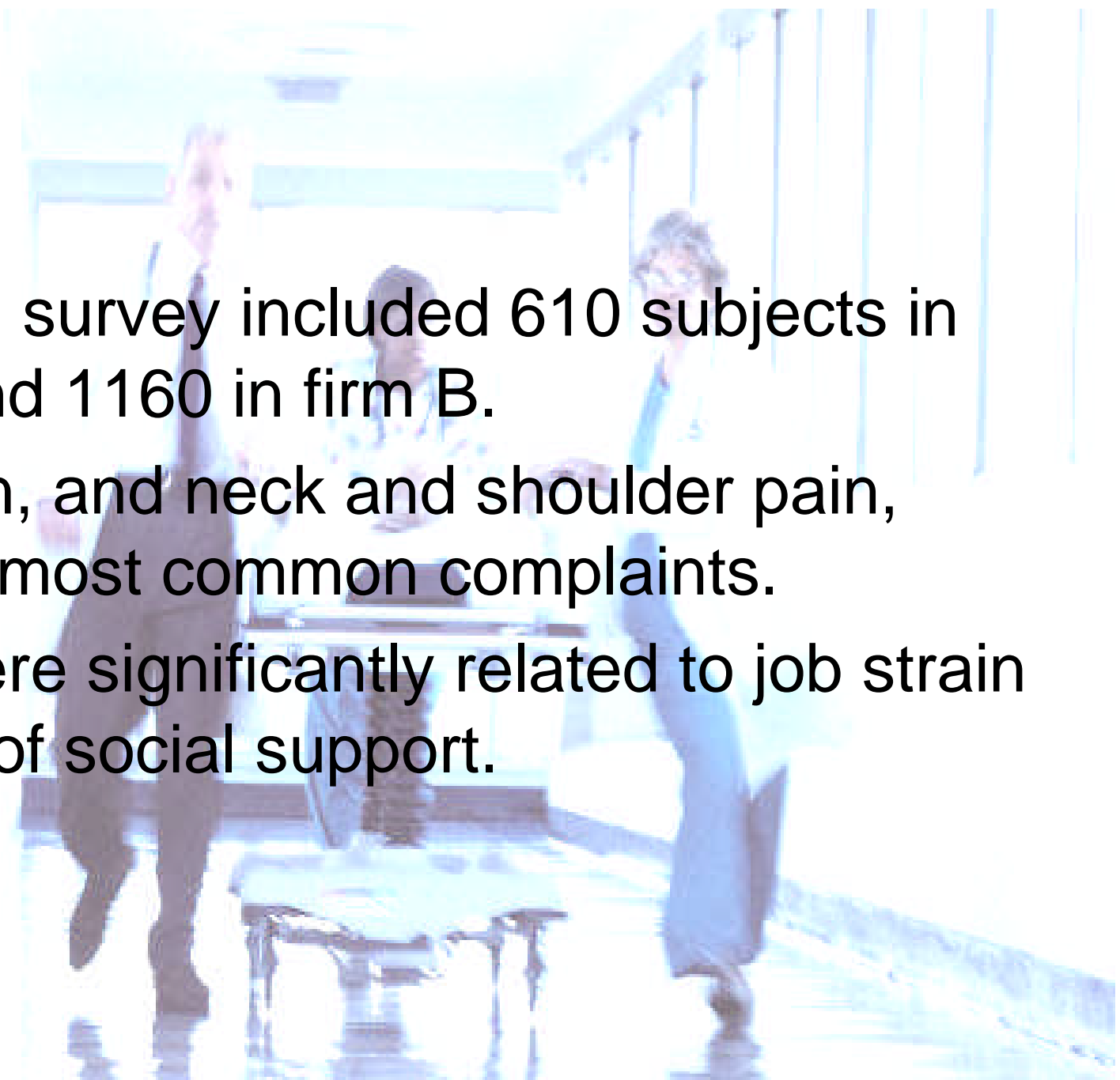
Disturbi muscolo- scheletrici

Ergonomia partecipativa



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- Musculoskeletal disorders (MSDs) continue to be a major source of disability and lost work time in health care workers.
 - We aimed to promote an integrated management approach to reduce both the risk factors and the loss of work capacity in two public health care units.

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- Workers showing MSD were recruited in small participatory groups, and encouraged to design ergonomic measures, focusing on practical, simple, low-cost measures.
 - Cases of prolonged or recurrent disability were managed by a participatory ergonomic program implemented in a rehabilitation context.

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- Symptom survey included 610 subjects in firm A, and 1160 in firm B.
 - Back pain, and neck and shoulder pain, were the most common complaints.
 - MSDs were significantly related to job strain and lack of social support.

Education

- Since it was observed that misconceptions and negative beliefs about musculoskeletal pain precede sickness behaviour and hinder recovery, the prime objective has been to create a positive and active attitude to the problem

Participatory ergonomics

- Small participatory groups were set up to study and try to find a solution to the ergonomic problems
- Identification of the problem was usually the first step. By the auto-confrontation method the worker was invited to explain his/her work.
- The group proposed low-cost solutions

Nurses (wards)

- Change of anti-bedsore mattresses.
- Modifications in modes of taking and transporting biological samples.
- Positioning and use of patient lifting devices.
- Ways of using minor aids: drawsheets with handles, belts with straps, easy-sliding cloths.
- Methods of using patient devices (lifting gear, etc.).
- Distribution and use of wheelchairs.
- Improvement of hospital bed design .

Nurses (surgeries and services)

- Change in cleaning hours.
- Modification in transport of material for home treatment.
- Modifications in instrument cleansing operations.
- Reorganization of medical records archives.
- Modification of test sampling station.
- Modification of reception station for test samples.

Ancillary personnel

- Modification laundry trolleys.
- Removal of architectural barriers.
- Modification of trolley for transporting liquids.
- Modification of transport, requests, sampling, response procedures.
- Modification of cleaning times and methods.

Technicians



- Ergonomic chairs.
- Modification in mode of collecting and disposing of effluent.
- Modifications in procedure for sample reception.
- Modification in organization procedures and information archives.
- Modification in procedures for loading chemical tanks.
- Modifications in work tops and work stations in medical imaging.

Workmen

- Belts to facilitate transport of objects.
- Modification of trolleys.
- Removal architectural barriers.
- Modification ladders.
- Replacement work tools.

Office workers

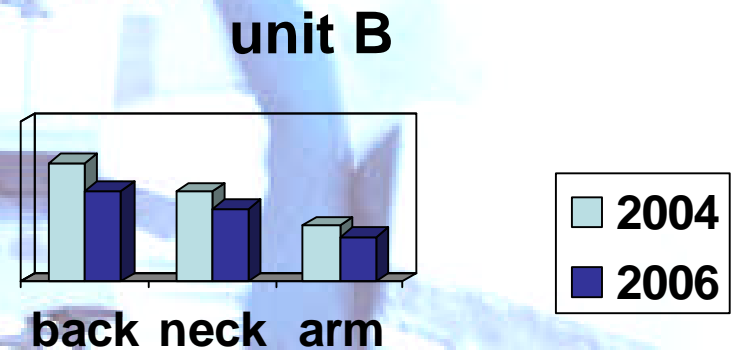
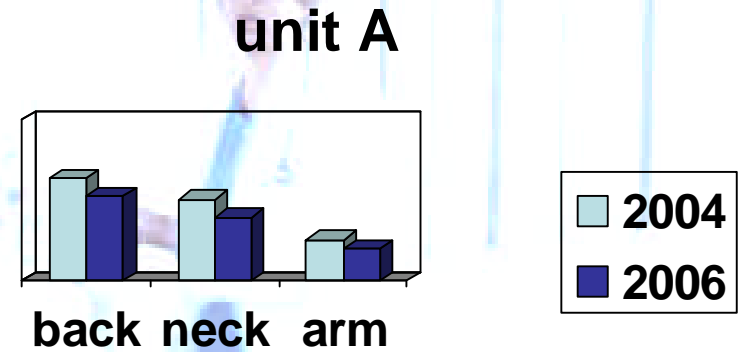
- Mini-pauses during continuous work at terminals.
- Planned intervals in window-counter work.
- Modifications in layout: position of display, keyboard, printer, telephone and other work articles; height and characteristics of work seat; natural and artificial light sources.
- Modifications in window-counters for general public.

Physicians

- Modification in dentistry surgery layout.
- Modification in endoscopy services layout.
- Digitalization of medical imaging.
- Modification in operating theatre structure.

Results

- After intervention, reported prevalence of musculoskeletal symptoms moderately, but significantly decreased in both health care units.



Results

- Workers who entered the on-site treatment program showed a significant reduction of work loss (-33%) if compared to workers who were treated outside by the National Health Service.
- The rate of workers with limitation of their work attitude fallen from 12% (firm A) and 14% (firm B) to 2.5% and 6.6%, respectively.

Conclusion

- In this longitudinal case study, participatory ergonomics proved to be effective in reducing the impact of MSDs in health care workers.

