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THE PREVALENCE OF VIOLENCE ENCOUNTERED BY COMMUNITY PHYSIOTHERAPISTS IN IRELAND

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This work was undertaken by Roisin Burns and Anna Magnier as a requirement for the BSc Physiotherapy degree. Professor Marie Guidon was the supervisor for the study.

Key Words

Violence, prevalence, community physiotherapy

Summary

The Health and Safety Authority of Ireland has recognised violence towards health workers as an occupational hazard. However no research examining the issue of violence against physiotherapists in Ireland exists. The aim of this study was to establish the prevalence of violence encountered by community physiotherapists in Ireland and to identify any influential factors.

A descriptive cross-sectional questionnaire was distributed to all 103 members of the Chartered Physiotherapists in Community Care (CPCC) group. Topic sections were: personal details and area of work, incidents of violence, reporting of incidents, workplace provisions and referrals.

The majority of respondents (94%) reported that they felt safe in their job as a community physiotherapist. However 73% (n=51) had experience of violent incidents whilst working in the community. All of these physiotherapists experienced verbal aggression and ten had also experienced physical assault. The fact that the physiotherapist was seen as a representative of the health system was the most common reason given for the aggression. Of the 51 physiotherapists who had experienced any incident of violence, only 17 (33%) had reported it to a member of staff. Only 24 physiotherapists (34%) had received specific training or education on how to deal with violent work situations.

Introduction

The Health and Safety Executive's (UK) definition of workplace violence is *any incident in which an employee is abused, threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment* (HSE, 1992). This was the definition used in this study to establish the prevalence of violence. Under the HSE (1992) definition, verbal aggression, threats to one's safety or

belongings and physical assault are deemed to be violent incidents.

Background

The Health and Safety Authority of Ireland issued a report in 1992 recognising violence towards health workers as a hazard (National Authority for Occupational Safety and Health, 1992). Research has demonstrated this hazard within the nursing (Rose, 1997) and radiography (Healy et al 2002) professions in Ireland. However no research examining the issue of violence against physiotherapists in Ireland exists and only limited studies have been undertaken in the United Kingdom.

A study conducted by the Chartered Society of Physiotherapy (CSP, UK) in 1996 surveyed 10% of CSP members working in a variety of settings in the United Kingdom. Results showed that verbal aggression from a patient was encountered, at least once, by 70% of respondents and from patients' relatives or members of the public by 54% of respondents. Occasional physical assault by a patient was reported by 21% of physiotherapists with 6.6% of these suffering physical injury as a result. Numerous areas of concern for physiotherapists were highlighted, in particular the substantial number of violent encounters, injuries sustained and the low rate of reporting. However no correlations were made between the occurrence of violence and other possible influential factors.

Prevalence of violence towards physiotherapists was reported by Whittington et al (1996) in a study which examined violence towards staff in a general hospital setting. Of the 29 physiotherapy respondents, 17% had encountered physical assault and 48% had experienced verbal aggression. Although nursing staff reported higher rates of physical assault (28%) than all other professionals, radiographers and doctors reported similar rates to physiotherapists (22% and 19% respectively).

Although violence against community workers has not been researched in physiotherapy, it has been studied in the nursing profession by Shacklady (1997), who found that 25% of community nurses had encountered violence. The violence occurred in the patients' own homes in 74% of all cases. Training in violence management had been received by 64% of the community nurses.

The levels of violence encountered by community healthcare workers may be influenced by many factors such as level of experience, geographical location, hours of work, presence of specific workplace policies and lone visits (Fazzone et al 2000). Other contributing factors, which have been highlighted, are visits to families previously unknown to the community healthcare worker and inadequate training and education for staff on coping with violence (Gellner et al 1994).

Aim

The aim of this study was to establish the prevalence of violence encountered by community physiotherapists in Ireland and to identify any influential factors pertaining to this issue.

Ethical Considerations

This study was approved by the Research Ethics Committee of the Royal College of Surgeons in Ireland. Participation in the study was voluntary, confidential and anonymous.

Methodology

A descriptive cross-sectional postal questionnaire was distributed to all 103 members of the CPCC an employment sub-group of the Irish Society of Chartered Physiotherapists, who work in a variety of settings including outpatient clinics and patients' own homes. The questionnaire comprised of 30 questions, divided into five topic sections: personal details and area of work, incidents of violence, reporting of incidents, workplace provisions and referrals.

The sections **Incidents of violence** and **Reporting of incidents** were based on questions used by the Chartered Society of Physiotherapy Questionnaire (1996).

The sections **Personal details and area of work**, **Workplace provisions** and **Referrals** were individually designed by the researchers. These sections included the following details:

Personal details and area of work: This section ascertained number of years working as a community physiotherapist, area of work (rural/urban), number of hours spent making home visits and various precautions taken while making these visits.

Workplace provisions: This section investigated the presence of specific workplace policies and training opportunities available to deal with the issue of violence.

Referrals: This section examined the source of community physiotherapy referrals and whether these referrals provided adequate information regarding the patient's social history.

The questionnaire comprised of both open and closed-ended questions. A cover letter in which workplace violence was defined as *any incident in which an employee is abused, threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment* (Health and Safety Executive, UK 1992) accompanied the questionnaire. A stamped addressed envelope was included with each questionnaire. Reminder letters were distributed by the researchers one week after the due date of the return of the questionnaire, to encourage a higher response rate.

Statistical Analysis

Data was analysed using the Statistical Package for Software Solutions (SPSS 11.0). For the purpose of statistical analysis respondents were divided into two groups based on whether or not they had experienced any violent incident. Unpaired t-tests and Chi-Square, Fisher's Exact and Kendall's tau-b tests were used to examine relationships between data. The significance level for all

statistical tests was $p < 0.05$. Responses to open-ended questions were entered into Microsoft Word and represented as text.

Results

Seventy questionnaires (68% response rate) were analysed. Of the 70 participants, 69 (98.5%) were female and one (1.5%) was male. Eighteen participants (26%) reported that they worked in the urban setting, 16 (23%) in the rural setting and the remaining 36 (51%) worked in both. Of the 67 respondents who made home visits, 60 (90%) reported always making these visits alone. Thirty-eight (57%) of community physiotherapists surveyed stated that they never wore a uniform while making home visits, with 20 (30%) reporting that they always did so.

The majority of respondents (94%) reported that they felt safe in their job as a community physiotherapist. However 73% ($n=51$) had experience of violent incidents whilst working in the community. All of these physiotherapists experienced verbal aggression and ten had also experienced physical assault. Of the ten physiotherapists who encountered a physical assault while working, one person sustained a physical injury which necessitated a visit to a doctor. None of those surveyed reported encountering physical assault with a weapon. Most of the violence experienced was perpetrated by a relative or friend of the patient and by patients themselves (Figure 1).

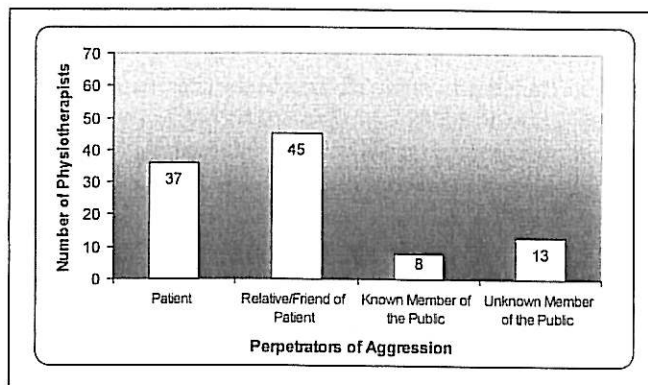


Figure 1: Number of Physiotherapists who Encountered Violence from Various Perpetrators

Of the 37 (53%) of community physiotherapists who encountered violence from a patient, 27 (73%) had not perceived the patient as a risk. The patient type involved in these incidents is indicated in Figure 2.

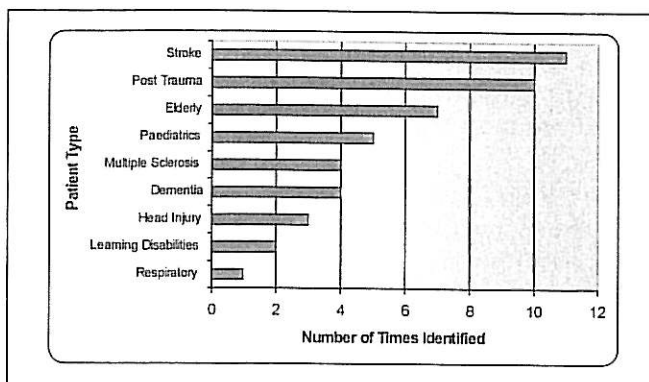


Figure 2: Patient Type Involved in Violent Incidents

The fact that the physiotherapist was seen as a representative of the health system was the most common reason ($n=26$, 38%) given for the aggression.

Of the 51 physiotherapists who had experienced any incident of violence, only 17 (33%) had reported it to a member of staff (Figure 3).

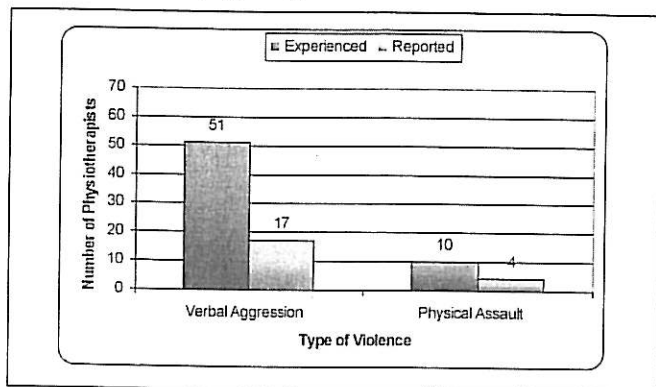


Figure 3: Levels of Violence Experienced and Reported

Four of these physiotherapists reported the event to a colleague only, while the remainder ($n=13$, 76%) reported it to a manager. Fifteen (88%) of those who reported violent incidents were satisfied with the outcome. Various reasons were given for non-reporting (Figure 4). Twenty-two (67%) of those who did not report incidents had workplace policies on violence in situ.

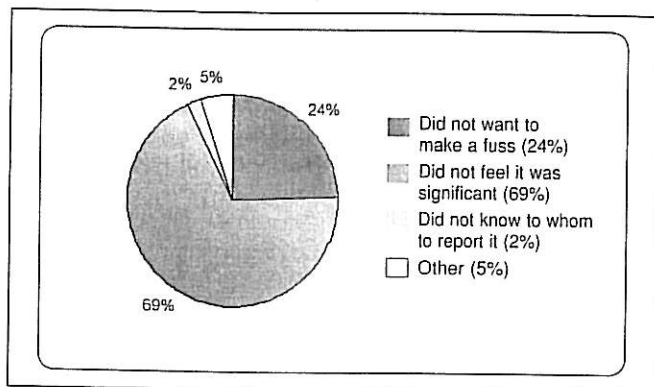


Figure 4: Reasons for Not Reporting Violent Incidents

Only 24 physiotherapists (34%) had received specific training or education on how to deal with violent work situations with 20 (83%) of these subsequently feeling prepared to deal with difficult situations. Responses to open-ended questions indicated that the extent of the training received varied from discussion in staff meetings to two-day courses.

Fifty-nine of all community physiotherapists, in this study, received the majority of their referrals from either a general practitioner or a public health nurse, and 98% of these physiotherapists reported that the referrals did not always provide sufficient information on patients' social history. With regard to the ability to refuse a referral which a physiotherapist may have felt was a cause of concern for his/her safety, 51 physiotherapists (73%) stated that they had the ability (Figure 5).

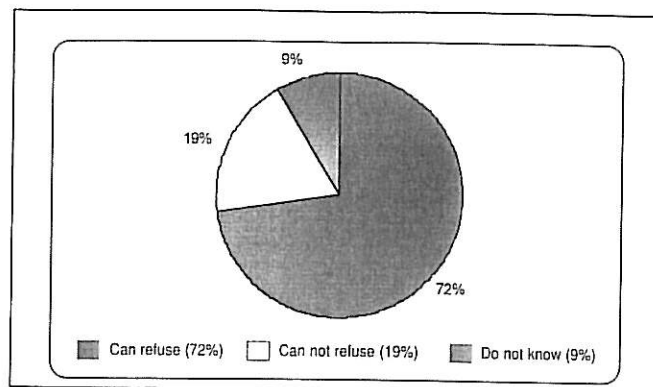


Figure 5: Community Physiotherapists Ability to Refuse Referrals

Respondents were divided into two groups – those who had experienced violence ($n=51$) and those who had not ($n=19$). Statistical analysis showed no statistically significant difference between the two groups for years working as a community physiotherapist, hours spent making home visits alone, wearing of uniform, area of work and ability to refuse referrals.

Discussion

Although a large number of community physiotherapists (73%) had experience of violent incidents, the incidence of physical assault ($n=10$, 14%) experienced was lower than in other studies (CSP 1996; Healy et al 2002). Of the 10 physiotherapists who encountered a physical assault, none reported that time off work was required as a result of the assault.

Healy et al 2002) reported that radiographers with only one to three years experience were more likely to experience violence and Fazzzone et al (2000) highlighted that young female community healthcare staff had an increased perception of personal risk. However this study found no statistically significant difference in mean number of years experience between physiotherapists who had and had not experienced violence. A possible reason for this may have been that having worked as a community physiotherapist for a greater number of years could have influenced the prevalence of violent incidents in two ways: it could have increased exposure to violence, yet it also could have increased the working experience of physiotherapists and made them aware of the risk of workplace violence (Shacklady 1997), thus increasing their ability to avoid violent situations.

Seventeen (33%) of the community physiotherapists who had experienced any incident of violence had reported it to a member of staff. This is a higher rate of reporting than that found in the CSP study (1996) in which 20% of physiotherapists had reported their incidents. Despite differences in outcomes of reporting (from no action taken to patient transfer to another therapist), the majority of physiotherapists who reported incidents were satisfied with the outcome (16 out of 18 respondents) which indicated that reporting was of some benefit. The most common reason (69%) for non-reporting of incidents was that it was not felt to be significant which was also the most common reason given for not reporting

in the CSP (1996) study. This suggests that physiotherapists did not perceive all violent incidents to have been important similar to Shacklady (1997) who reported that 21% of community nurses felt that violence against them was part of their job. This may also explain why 94% of respondents in this study felt safe in their job as a community physiotherapist although 73% had experienced violent incidents. Although all had experienced verbal aggression, only 10 had experienced physical assault. Verbal aggression alone may not have been perceived as a significant threat to personal safety.

Twenty-four physiotherapists (34%) had received specific training or education on how to deal with violent work situations but it was evident that such training was not standardised as the extent of training received varied from discussions in staff meetings to two-day courses. Training was received by a higher percentage of community workers (64%) in the Shacklady (1997) study and interestingly a lower prevalence of violence (25%) was found among these community workers. The relationship between training and prevalence of violence was not explored in this current study and it was not known as to whether training had been received pre or post incident(s). However, 20 (83%) of those who had received training reported that they subsequently felt prepared to deal with difficult situations. The lack of standardisation of training or education on how to deal with violent work situations was a cause for concern.

Although the large majority (94%) felt safe in their job numerous issues were raised by respondents. Guidelines on safety were not standardised throughout the country and in many cases were drawn up by individual employers. It was commonly felt that safety policies should be introduced in anticipation of and not as a result of violent incidents. Although satisfaction with workplace policies was not investigated in this study, the fact 67% of those who did not report incident(s) had workplace policies in situ implies that many of them inadequate. Many physiotherapists stated that paired home visits were possible if it was known in advance that a situation posed a risk to their safety. However it was widely acknowledged that community physiotherapists were very vulnerable when working alone especially in unknown areas. Furthermore it was felt that this vulnerability was enhanced when inadequate social history of the patient was known. Many of the respondents highlighted the increasing risk posed by dangerous domestic animals.

Limitations and Recommendations

Although this study established the prevalence of violence encountered by community physiotherapists in Ireland, the number of incidents encountered by each physiotherapist was not investigated. The study did not attempt to ascertain the extent of psychological damage (if any) that had been sustained and this may be a topic for further investigation. Although the health system was identified as the main reason for the aggression encountered by physiotherapists, the specific aspect of the health system responsible was not investigated. This study focused on community physiotherapists, as it was thought that they may have been a particularly vulnerable group. However, further study on violence against

physiotherapists in other work settings in Ireland is required, to establish if, in fact, the prevalence of violence is higher in any one setting. A concern regarding insufficient training was highlighted in this study. Further research on the effectiveness of different training programmes is required before recommendations regarding appropriate training can be made.

Conclusion

The results of this postal survey established that violence was encountered by 73% of the members of the Chartered Physiotherapists in Community Care employment group. However the majority of respondents (94%; n=66) reported that they felt safe in their job as a community physiotherapist. Other areas highlighted in this study were the low levels of reporting (33%) and training received (34%) among respondents. No influential factors relevant to the prevalence of violence encountered were found.

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