



Royal College
of Nursing

RCN lone working survey 2011





Acknowledgements

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Contents

Background	4
Summary of methods, aims and results	5
The impact of...	7
RCN recommendations based on the survey findings	8
Survey methods	10
Survey findings	11
Discussion	35
References	37

Background

In 2003, the National Audit Office conducted surveys of NHS trusts in England on a range of health and safety issues which highlighted that violence was a significant issue for many NHS staff (National Audit Office, 2003). A subsequent report showed that incidents of violence and aggression had been increasing on a yearly basis since 1998. Following the publication of this report, the NHS Security Management Service was established (renamed NHS Protect in 2011) which has the operational and policy responsibility for security in the NHS, including reduction of violence.

In a survey conducted by the RCN in 2006, four in ten respondents reported that they had been harassed or assaulted by patients or relatives in the previous 12 months – an increase on an earlier report in 2000. Of these, 25 per cent were reported by nurses working in the community (RCN, 2006).

In 2007, the RCN commissioned a further survey which was conducted by independent consultants at Sheffield Hallam University's Centre for Research and Evaluation. The survey was sent out to 3,010 RCN members. The aim of this survey was to find out if the situation for nurses working in the community had improved since 2005, the extent to which these 'lone workers' felt at risk, their experiences of assault and abuse, whether they had been provided with technology aimed at reducing risk and how incidents had been handled (Smith, 2007).

The RCN used information from this survey to successfully campaign for government funding to improve the protection of nurses working alone. A number of employers across the UK have now invested in lone worker protection devices for their health care staff.

A new survey was commissioned by the RCN, supported by a grant from Reliance High-Tech Ltd and Connexion2 (the organisations awarded with government contracts to provide lone worker solutions to the NHS). The survey was undertaken jointly by the RCN and Sheffield Hallam University. The results from this 2011 survey are reported here and will be used to inform future RCN action and policy developments around improving lone worker safety.

Summary of methods, aims and results

Methods

The questionnaire was modified from a previous RCN survey which was conducted in 2007.

The link to the electronic survey was sent out by the RCN by email to 7,349 RCN members.

A reminder email was sent to non-responders after two weeks.

The questionnaire was completed online using Questback software.

SPSS for Windows (Version 18) was used to analyse results. Analysis of the survey data was mainly descriptive. Sub-group analyses explored the impact of factors such as gender, country of work and the existence of a lone worker policy using appropriate statistical tests.

Quotes from responses to open questions are provided for illustrative purposes only.

Aims

The aim of this survey was to explore the experiences and safety concerns of RCN members who undertake lone working as part of their employment.

This descriptive survey aimed to describe the respondents, their working patterns, their experiences of lone working and their perceptions of the associated risks.

Results

There were 766 completed questionnaires received, which gave a response rate of 10.4 per cent.

Respondents had a variety of job titles. The most common of these were community nurse (37.9 per cent, n = 290), community psychiatric nurse (13.6 per cent, n = 104) or district nurse (12 per cent, n = 92).

Respondents from England were in the majority with some respondents from Scotland, Wales and Northern Ireland.

The respondents had been in their roles for differing amounts of time. About a quarter had been in role for three to five years and just over a quarter for six to 10 years.

Most respondents were female (91.9 per cent, n = 692).

A wide range of age groups were represented but most were between 40 and 54 years old (58.9 per cent, n = 451).

The majority of respondents described themselves as White English/Scottish/Welsh/Northern Irish/British (89 per cent, n = 681).

The survey sample included respondents working in urban, suburban and rural areas in a variety of regions.

The results showed that 61 per cent (n = 465) of respondents spend more than 50 per cent of their time as a lone worker without immediate access to a colleague for support. In addition, 54.7 per cent (n = 418) of respondents worked outside normal working hours (9am to 5.30pm).

Only 19.1 per cent (n = 144) of respondents stated that their employer always knew their whereabouts and 44.2 per cent (n = 338) reported that their employer usually knew their whereabouts.

Most respondents (89 per cent, n = 680) reported that their employers had a lone worker policy. However, only 77.6 per cent (n = 527) had been provided with a copy of this policy.

There was a varied response to whether respondents carried out risk assessments ahead of making a visit. Only 18.3 per cent (n = 139) carried out a risk assessment on their first visit, with 19.3 per cent (n = 147) conducting a risk assessment on every visit.

Around half (53.7 per cent, n = 411) of respondents would wait for a colleague to accompany them if they felt there was a significant level of risk for a particular visit.

Few respondents (2.7 per cent, n = 21) felt quite unsafe or very unsafe when working away from colleagues.

Over half the respondents (57 per cent, n = 434) felt that the risk of verbal or physical abuse had stayed the same over the past two years while 38.5 per cent (n = 293) reported that the risk had increased.

Over half the respondents (60.3 per cent, n = 459) reported that they had been verbally abused by a patient, client or member of the public in the last two years while at work, and 10.7 per cent (n = 81) had been physically abused.

Less than half (42.5 per cent, n = 324) agreed or strongly agreed with the statement that “my employer has a better understanding of the issues associated with lone working now as compared to two years ago”.

Over half the respondents (59.9 per cent, n = 456) agreed or strongly agreed that their employers took action to manage the risks of lone working.

Around half the respondents (51.3 per cent, n = 390) agreed or strongly agreed that their employers would take action against patients/clients who verbally abuse staff. A higher proportion of respondents (73.2 per cent, n = 556) agreed or strongly agreed that their employers would take action against patients/clients who physically abuse staff.

Only a fifth (21.7 per cent, n = 166) of respondents had been offered the use of an Identicom device (or similar) by their employers. Of these, 69.5 per cent (n = 114) had gone on to use the device.

Most respondents (83.4 per cent, n = 636) had received training in managing conflict or other lone worker risks. Of these, 53.2 per cent (n = 339) received this training over a year ago. Of those that had training, only 36.1 per cent (n = 229) felt it addressed the risks that they face in their jobs ‘a lot’.

The impact of...

Urban/rural/suburban work setting

There were no associations between the proportion of time spent working alone and the work setting. However, there was a significant association between setting and out-of-hours working, with rural workers more likely to work out of hours than colleagues in suburban or urban. In all settings, over 45 per cent of respondents felt that the amount of time that they spend working out of hours had increased and this was particularly noticeable for those in suburban areas. Rural workers were less likely to work in the evening than colleagues in suburban or urban areas. There were no statistically significant associations between setting and the incidence of physical abuse, but there was an association between setting and incidence of verbal abuse. Over half of the respondents in all settings had been verbally abused, with suburban workers experiencing the highest levels of verbal abuse.

Gender

Of the 766 respondents, only 61 were male. There were no significant differences in proportion of time spent as a lone worker or the proportion of respondents who worked outside normal office hours between male and female counterparts. Females were more likely to state that their employers did not always know their whereabouts. There was no significant difference in feelings of safety while working alone. Females and males experienced a similar level of physical abuse over the last two years. Over 50 per cent of both groups had been verbally abused by patients, clients or members of public in the last two years. However, males had experienced higher levels of verbal abuse.

Country of work

It should be noted that some countries and regions had a low number of respondents. There were no significant associations between country of work and proportion of time spent as a lone worker, or the proportion of respondents who worked outside normal office hours. However, there were significant associations between country of work and evening and weekend work. In all areas less than 12 per cent of respondents felt that the amount of time they spend working out of hours had decreased over the last two years. In Scotland a smaller proportion of respondents reported an increase.

A lone worker policy

Those respondents whose employers had lone worker policies in place were more likely to state that their employer had all the details of their vehicle. Staff that had a lone worker policy in place were more likely to feel that their employer acted to manage the risks of lone working.

Working outside office hours

Those working outside normal office hours were no more likely to conduct a risk assessment ahead of making a visit, but there was an association between working out of hours and how safe respondents felt when working alone, with those who worked outside office hours more likely to feel unsafe in their work. Working outside office hours was also positively associated with how often respondents had felt unsafe in the last 12 months. Those working outside normal office hours were more likely to feel that the risks of verbal or physical abuse had increased over the last two years. There was a higher incidence of verbal and physical abuse in those who worked outside office hours.

Age

There were no associations between patterns of lone working, perceptions of safety, incidence of verbal or physical abuse and age.

RCN recommendations based on the survey findings

In 2007, the RCN called upon health care organisations to comply with their legal duty by implementing a five point plan of action to protect lone working nurses and health care assistants. This latest survey gives some indication that employers have an increased understanding of the issues of lone working, but raises serious concerns and identifies shortcomings in practice and legal compliance.

While the majority of respondents to the survey feel quite safe when working alone, just less than 40 per cent of respondents feel the risk of verbal or physical abuse has increased.

Health care is evolving and with an increasing number of patients being cared for in the community, some with very complex needs, there is more pressure on the community nursing team. Out-of-hours care is now routine with many community nurses working evenings, nights, weekends and being on call.

Increased patient expectations, efficiency savings and organisational changes (such as integration or mergers of community trusts in England), all have the potential to impact on lone worker safety. A lack of funding is not an excuse for ignoring the risks faced by lone working nurses. Employers have moral, legal, and with the cost of physical violence against an individual estimated at a minimum of £20,000 per incident, business reasons to do more. Staff that feel cared for and valued by their employer are also likely to deliver better quality patient care.

1. Risk assessments

Generic and dynamic risk assessments are key to identifying who is at risk and what the risks are. They will also inform the organisation, team and individual about what preventive measures need to be put in place to reduce the risk of abuse or injury.

Only 19.3 per cent of respondents in this survey made a risk assessment on every visit. However, it was unusual for respondents to receive adequate information on referral to inform them of any risks prior to making a visit. As one respondent put it: *“Staff feel very vulnerable entering a flat where there may be two or three men inside and very often you have no idea of the circumstances until you land in the middle of it.”*

Nurses must be provided with information to help them assess the risks and take steps to ensure their safety. Organisations must also carry out risk assessments to identify vulnerable staff, manage risk and reduce potential harm.

2. Prevention

Employers have introduced a number of strategies to prevent or reduce the risk of abuse or injury, some more successful than others. A significant number of NHS lone workers in England and Wales are benefiting from the roll-out of the government part-funded Identicom lone worker system, but there are many still without such protection. Only a fifth of respondents had been offered the use of an Identicom device (or similar).

Mobile phones are the most commonly used lone worker system, although NHS Protect (formerly NHS Security Management Service, 2009) recognised they are not as effective as a dedicated lone worker device when faced with a difficult situation, or compliant with the latest British Standard 8484 requirements. As one respondent to this survey stated: *“Identicom-type systems are easier to activate than a personal alarm at the bottom of a bag or trying to make a mobile phone call.”*

In reality there is no single solution and employers should prevent and manage the risks by implementing a number of measures including:

- having an effective means of raising the alarm
- a buddy system
- doubling up
- systems for ringing back to base
- equipment such as torches if working outside daylight hours.

A number of respondents in this survey commented on difficulties in obtaining a mobile phone signal in some areas. Lone worker devices are available using a variety of networks and, in cases where there is still no signal, other measures must be put in place to protect lone workers.

3. Lone worker policies

Lone worker policies play an important part in identifying roles and responsibilities and are a statement of commitment from the employer to protect lone workers. It is encouraging that in this survey there are a significant number of organisations with lone worker policies in place and the majority of respondents are familiar with the content of such policies. However, policies must be more than a paper or tick-box exercise and need to be implemented and included in all new staff induction programmes.

4. Training

The survey found that while most respondents had received training, the effectiveness of the training was variable. Only 36.1 per cent felt that the training they received addressed the risks that they face in their jobs ‘a lot’.

While training on its own may not reduce the incidence of violence, it is an essential part of an organisation’s approach to managing the risks of violence and aggression. It must be appropriate and meet the needs of the particular group of workers.

5. Support from employers

Only around half of respondents agreed or strongly agreed that their employers would take action against patients/clients who verbally abuse staff. Slightly more (73.2 per cent) agreed or strongly agreed that their employers would take action against patients/clients who physically abuse staff.

Some respondents’ comments identify a perceived lack of support from senior management with many developing their own strategies or team strategies to address the issues faced.

Employers must change that view by: taking action to put preventive measures in place; taking action to manage abusive patients or relatives; creating systems that provide immediate support in the event of an incident and having good police liaison.

One respondent said: “*We had a recent episode whereby our team leader was very concerned about the potential threat to staff members and tried to implement a two-nurse visit every time, but was told by senior management that it was not cost effective. She fought to implement the above to protect her staff.*”

Survey methods

Sampling

RCN members who on the basis of their job title were likely to undertake lone working and, for who the RCN had an email address, formed the sampling frame for this survey. This included individuals with the following titles:

- community children's nurse
- community matron
- community nurse
- community psychiatric nurse
- district nurse
- health visitor
- midwife
- school nurse.

This resulted in a sample size of 7,349 individuals.

Ethical approval

Ethical approval to undertake the survey was obtained from the Sheffield Hallam University, Faculty of Health and Wellbeing Research Ethics Committee.

Instrumentation

The questionnaire was based on the questionnaire used in the 2007 RCN postal survey (Smith 2007). The questionnaire was modified for the purposes of this study to include questions which asked respondents to reflect on whether their perceptions of risk had changed over the intervening period. The questionnaire included ordinal scales, closed and open questions and collected demographic information about respondents. The questionnaire was developed using Questback software.

Data collection

Evidence-based data collection strategies were used throughout in order to maximise the response rate (Edwards et al, 2009). A link to the online survey (which used a white background) was sent to participants (n = 7,349) by the RCN by email. The link was sent with an introductory letter, signed by the Head of Employment Relations at the RCN, outlining the purpose and importance of the study and providing assurance to participants regarding anonymity and confidentiality. Respondents who completed the survey by the deadline date were included in a prize draw to win one of three £100 shopping vouchers. An email follow-up to non-responders was sent two weeks later to maximise response rates.

Data analysis

Responses to closed questions were pre-coded for computation and all questionnaire responses were then exported to SPSS (SPSS Windows version 18) where checks were carried out to expose possible errors in coding.

Analysis of the survey data was mainly descriptive. Sub-group analyses explored the impact of factors such as gender, country of work and the existence of a lone worker policy using appropriate statistical tests.

Survey findings

A descriptive overview of the findings is presented, followed by the sub-group analyses.

Cross tabulations where the significance of the test statistic was 0.05 or less are reported. This level of significance means that there is a less than five per cent possibility (or a one in twenty chance) that these results occurred purely by chance and they are therefore 'statistically significant'. The significance of the test statistic is referred to as 'p' throughout this report.

As the exact response rate for each question varies, due to either non-response or some questions not being applicable to all respondents, the exact sample size varies from question to question. The sample size is therefore quoted for each finding and is referred to as 'n' throughout the report.

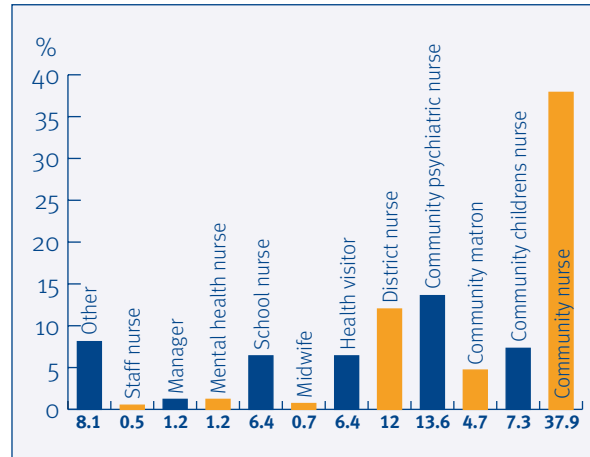
Response rate

Responses were received from 766 nurses. This represents a response rate of 10.4 per cent.

The respondents

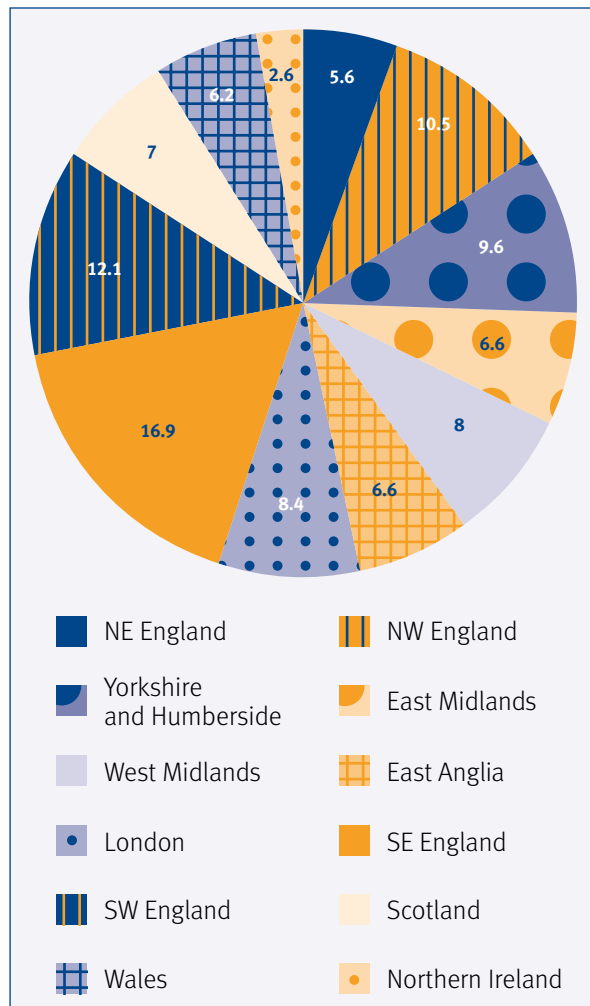
The largest group among the respondents were community nurses (37.9 per cent, n = 290). The breakdown of respondents' jobs is given in Figure 1.

Figure 1 Current roles of respondents



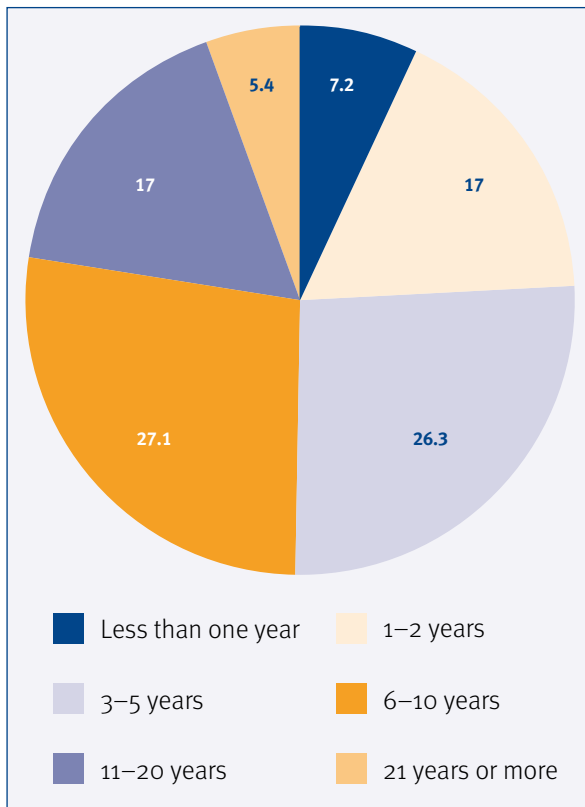
The majority of respondents (84.3 per cent, n = 642) were based in English regions with smaller numbers from Scotland, Wales and Northern Ireland.

Figure 2 Country/region of work



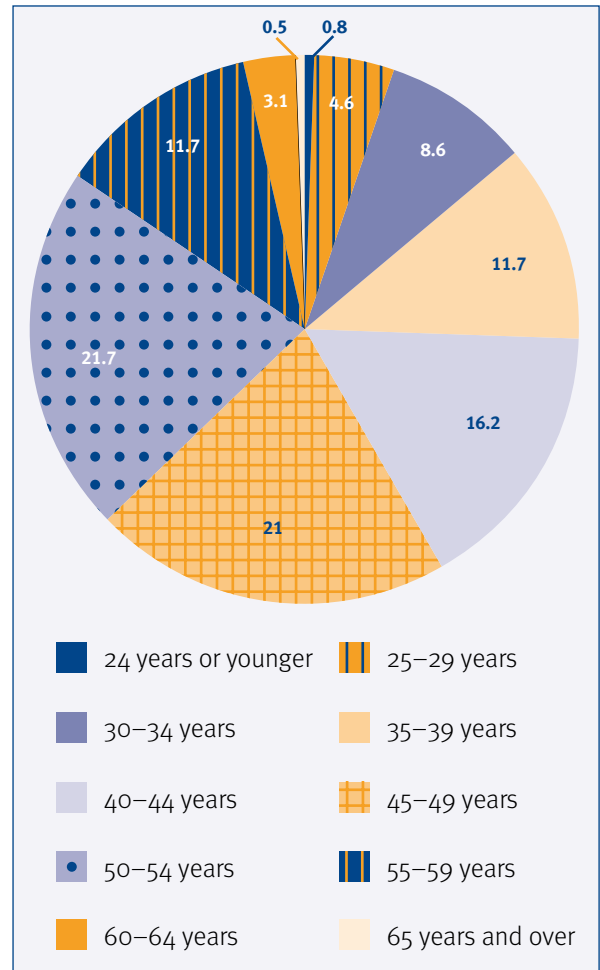
Over half the respondents (53.4 per cent, n = 408) had been in their current role for between six and 10 years.

Figure 3 Length of time in current role



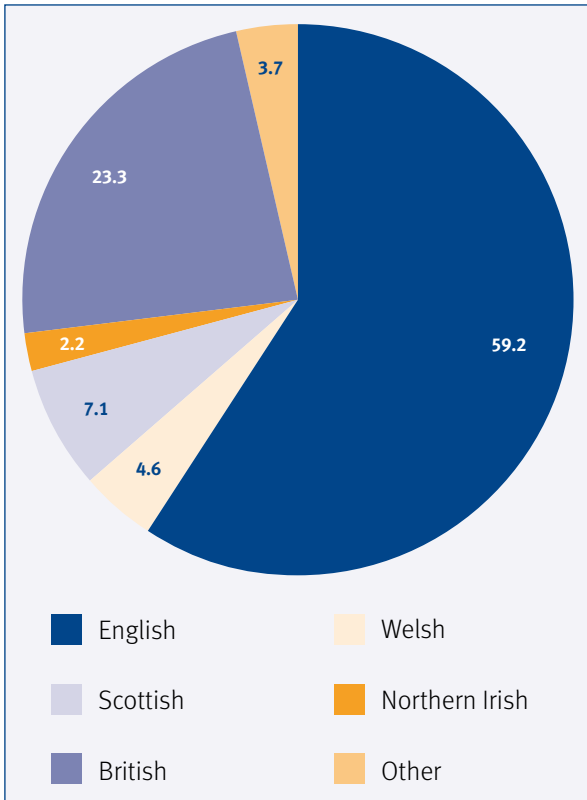
Most respondents (91.9 per cent, n = 692) were female. Over half the respondents (58.9 per cent, n = 451) were aged between 40 and 54. The distribution across age ranges is demonstrated in the figure below.

Figure 4 Age of respondents



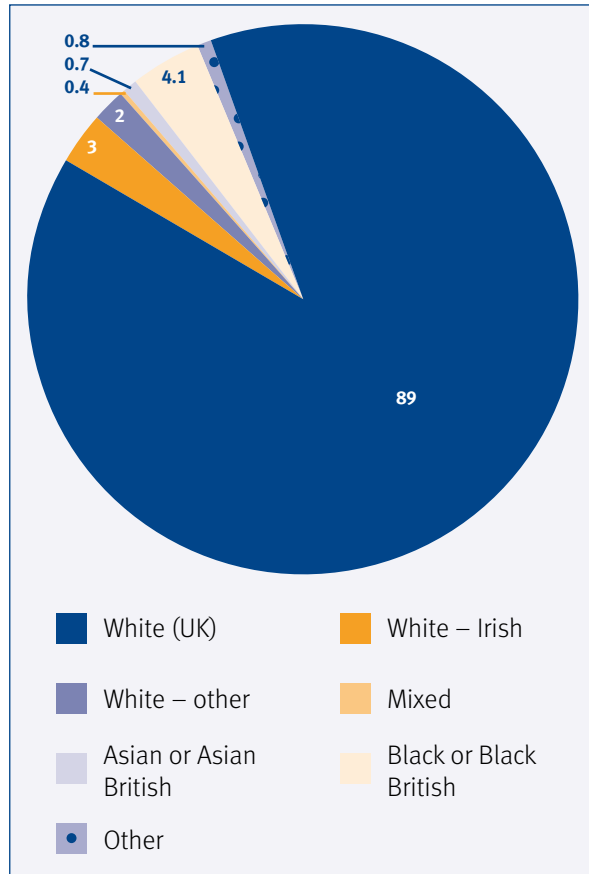
Most of the respondents (59.2 per cent, n = 451) described their national identity as English as demonstrated in the figure below.

Figure 5 National identity of respondents



Most respondents (89 per cent, n = 681) described their ethnic group as White English/Scottish/Welsh/Northern Irish/British as illustrated in the figure below.

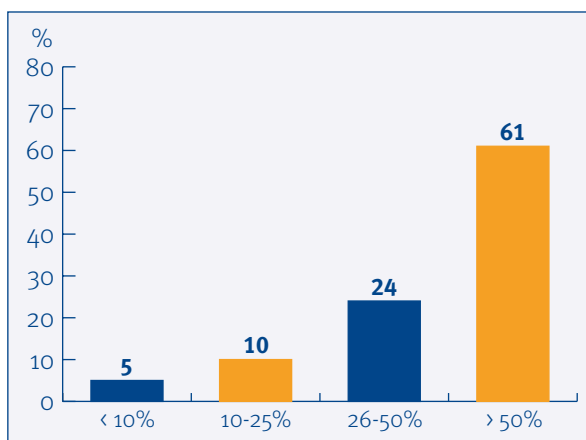
Figure 6 Ethnicity of respondents



Working lives of respondents

Almost two thirds of respondents (61 per cent, n = 465) reported that more than 50 per cent of their time is spent as a lone worker without immediate access to a colleague for support. Overall, 85 per cent (n = 648) spent more than 25 per cent of their time working alone.

Figure 7 Percentage of time spent as a lone worker without immediate access to a colleague for support

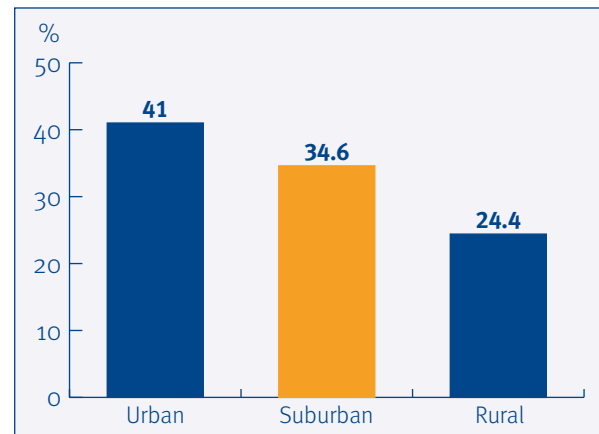


Just over half of respondents (54.7 per cent, n = 418) reported that their jobs involved working outside of normal office hours. Of those who worked outside of office hours, 69.7 per cent worked in the evening (n = 295), 77.1 per cent worked at weekends (n = 326) and 25.5 per cent (n = 108) worked on call.

For these respondents who worked outside office hours, 55 per cent (n = 230) reported that the amount of time that they spend working outside of normal office hours had increased over the last two years, while only 4.8 per cent (n = 20) reported that these hours had decreased.

The highest proportion of respondents (41 per cent, n = 313) worked in an urban environment. The working environments of all respondents are illustrated in the figure below.

Figure 8 Working environment of respondents



Only 19.1 per cent (n = 146) of respondents stated that their employer always knew of their whereabouts when they were working alone in the community, with 44.2 per cent (n = 338) stating that their employer usually knew their whereabouts. A significant number (16.4 per cent (n = 125)) of respondents reported that their employer rarely or never knew their whereabouts. Some respondents commented:

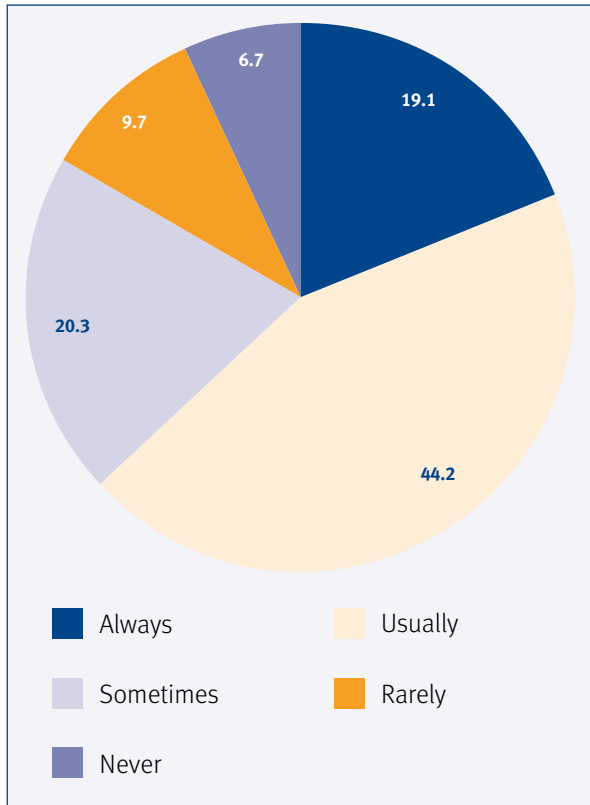
“We are often totally alone on Sundays so the only people that know where we are, are our spouses.”

Community nurse, urban setting.

“I think as a nurse working out of hours I often feel unsupported and alone, and issues regarding being out alone until after 11pm are not even recognised. If I didn't phone back into the base I really don't think anyone would notice and it would be down to my husband to realise I hadn't got home. Sometimes – quite frequently – we are covering the 5pm to 11pm shift alone due to staff shortages.”

Community nurse, rural setting.

Figure 9 Employer’s awareness of whereabouts of lone workers



Most respondents (81 per cent, n = 616) reported that their employers had all the details of their vehicles such as make, model, colour and registration.

Lone worker policy

The majority of respondents (89 per cent, n = 680) stated that their employer had a specific lone worker policy in place. Of those whose employers had a policy, 77.6 per cent (n = 527) had been provided with a copy of the policy and 71 per cent (n = 484) were either very or quite familiar with the policy.

Figure 10 Provision of lone worker policy

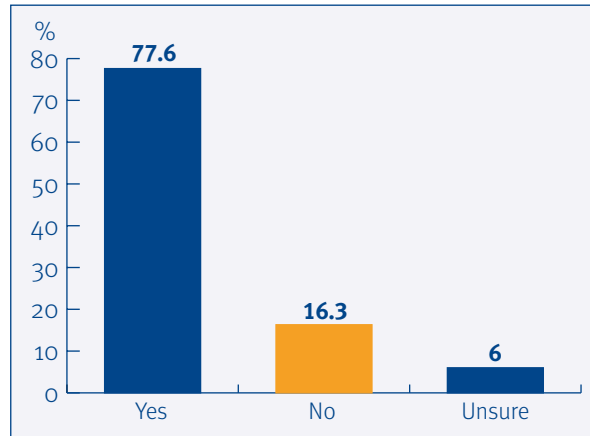
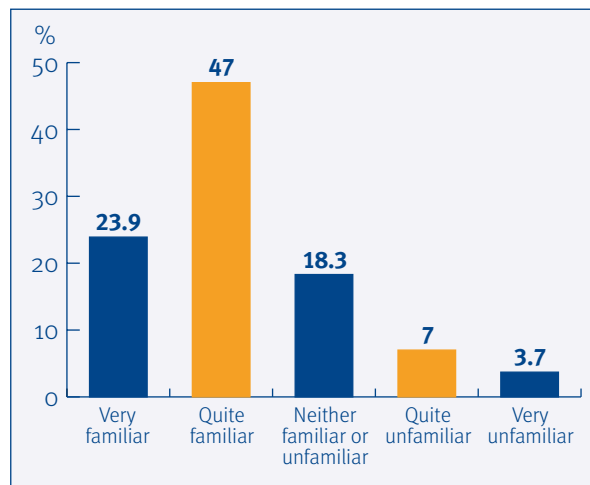


Figure 11 Familiarity with the content of lone working policy



Several respondents reported that while lone worker policies were in place, there were issues with implementation:

“My employer has a lone worker policy, which I think is in place largely to tick the boxes required as a ‘good employer’.”

District nurse, rural setting.

“We have a trust lone worker policy, but how well this is adhered to is debatable. In all honesty, teams are often so busy that this issue gets pushed down the list until there is an issue.”

Community nurse, suburban setting.

“My employer has a clear lone working policy, however to implement it effectively will require an increase in resources.”

Mental health nurse, rural setting

“Staff have no idea what they may face on a first visit. In rural areas staff are very isolated and often do not have mobile reception for use in emergency situations. Relatives can be aggressive if they are unhappy with the service. Staff feel very vulnerable entering a flat where there may be two or three men inside and very often you have no idea of the circumstances until you land in the middle of it.”

District nurse, rural setting.

“Many of the lone working procedures we have put in place ourselves locally and the written policy is a waste of paper. We are expected to visit patients in the evening that we have never met and have only very basic details.”

Community nurse, urban setting.

Risk assessment

There was a varied response to whether respondents carried out risk assessments ahead of making a client/patient visit. A significant number (18.30 per cent (n = 139)) of respondents only carried out a risk assessment on their first visit, while 41 per cent (n = 312) carried out a risk assessment always or usually prior to completing a home visit.

Figure 12 Completion of a risk assessment ahead of making a client/patient visit

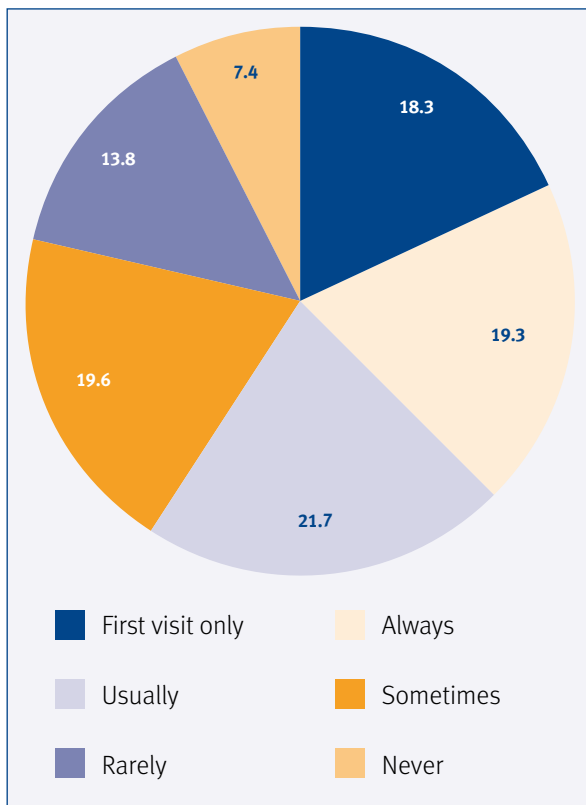
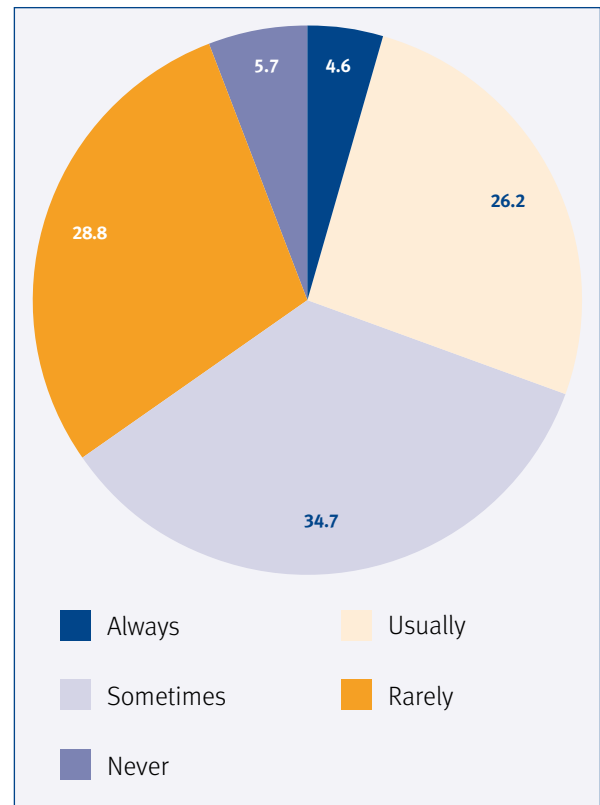


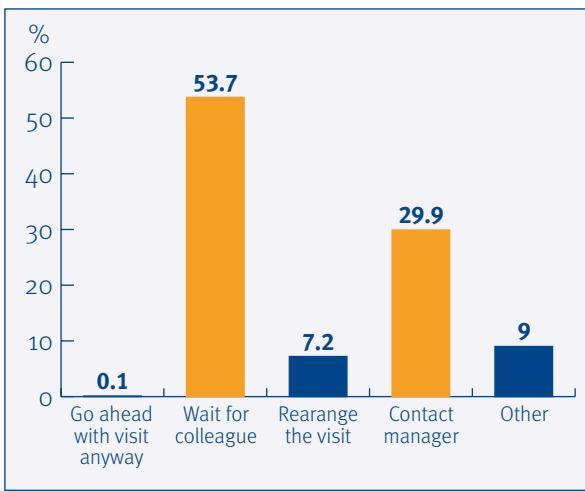
Figure 13 Provision of adequate information on referral



It was unusual for respondents to receive adequate information on referral to inform them of any risks prior to making a visit, with 34.5 per cent (n = 262) reporting that they rarely or never receive this information. Only 4.6 per cent (n = 35) of respondents stated that they always received adequate information. Some respondents articulated the risks that they face in practice:

If respondents thought that there was a significant risk of violence on a visit, most (53.7 per cent, n = 411) would typically wait for a colleague to accompany them. The full range of actions is illustrated in the figure below.

Figure 14 Typical actions if respondents thought there was a significant level of risk of violence



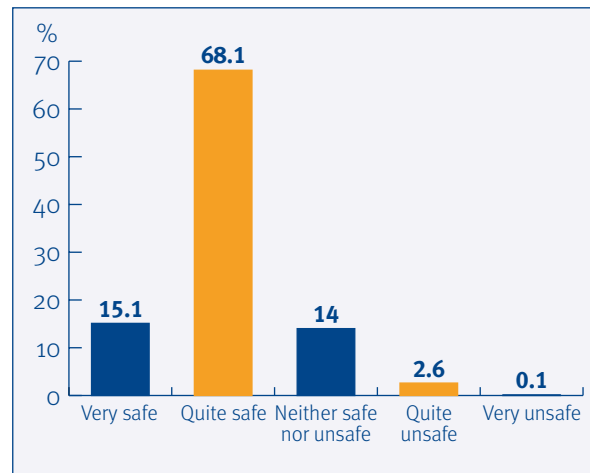
Of those who mentioned other strategies, these included arranging for the client to be seen in a clinic or Sure Start Children's centre or alternative public/safe venue. Six respondents reported that they considered asking the police to attend. Two respondents reported that if the violence had not been directed at workers previously then they would go on their own. One respondent commented:

"I don't have a problem with lone working in general. If I feel at risk I always take another nurse with me. If there are any complaints or abuse it gets reported to management and we leave the visit immediately."
Community children's nurse, urban setting.

Safety at work

Most respondents (83.3 per cent, n = 636) reported that they felt either very safe or quite safe at work when operating away from colleagues. Only 2.7 per cent (n = 21) felt very or quite unsafe.

Figure 15 Feelings of safety when working alone



Most respondents (69.2 per cent, n = 519) stated that they had either very rarely or rarely felt unsafe or at risk in the last 12 months. However, some individuals described feeling very vulnerable as illustrated by the following quotes:

"I feel very vulnerable and am highly visible in my uniform in the community. Parking is difficult so I usually have to walk some distance to my client and carry quite heavy equipment too, adding to my vulnerability. It makes me feel very uneasy but I am told I have no choice despite the fact I work in an area of high drug and alcohol addiction with a high crime rate."
Community matron, urban setting.

"I don't think it is safe for nurses to go out alone after dark as even the police go out in twos, but it seems that it is ok for nurses to go out alone!"
Community nurse, rural setting.

Figure 16 How often respondents felt unsafe in the last twelve months

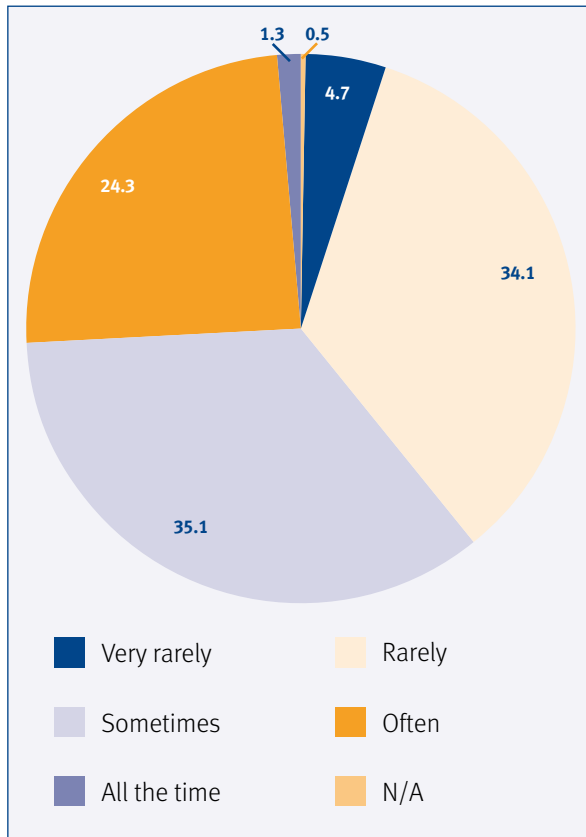
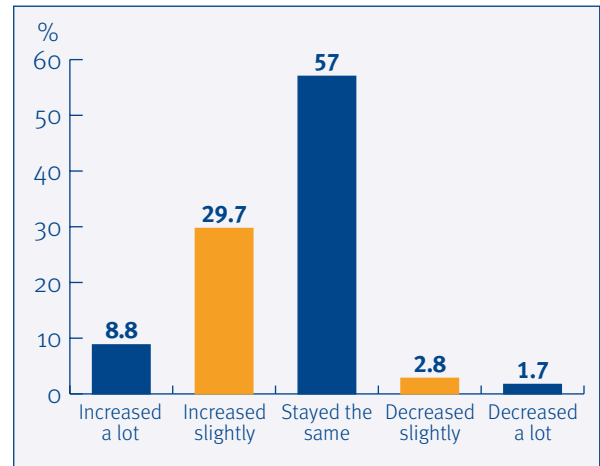


Figure 17 Risks of verbal or physical abuse in own role compared to two years ago



Just over half the respondents (57 per cent, n = 434) felt that the risks of verbal or physical abuse in their roles had stayed the same while just over a third (38.5 per cent, n = 293) felt that the risks had increased over the last two years.

Table 1 – Thoughts on why risks have increased

Reason	n	%
Increased expectations of patients’ relatives and/or carers	248	83.5
Increased patient expectations	217	73.1
Increased caseload	211	71.0
Increase in community based work and/or out-of-hours work	170	57.2
Increased patient stress	149	50.2
Increased incidence of substance misuse in patients that I see	110	37.0
Increased presence of dangerous animals eg dogs	98	33.0
Underlying medical conditions of patients visited	86	29.0
Other	29	9.7

Other reasons included:

- change in base location
- fewer hospital beds available
- financial reasons
- inadequate information on referral
- inappropriate discharges from hospital
- increase in bullying from senior managers
- increased expectations from managers to visit patients where I am at risk (n=2)
- lack of respect (n=3)
- mental health problems
- more complex cases and deterioration
- over reliance on bank staff
- promotion and redeployment (n=2)
- too much paperwork not enough patient contact time because of this
- work in CHC (NHS funded care).

Some respondents commented more fully on these issues:

“The risks as a lone worker have increased as beds are closed, clients have to now be treated in the community when they would have been deemed in need of admission before. They therefore present more risks to lone workers. The number of clients has also increased and the staffing levels available now cannot support working in pairs to visit all clients. I do feel that the risks to staff have not been adequately assessed and will continue to increase until a dangerous situation arises which would have legal implications for my employer.”

Community psychiatric nurse, suburban setting.

“Safety will decrease as staff levels are affected by cuts.”

Community psychiatric nurse, suburban setting.

“We are increasingly under pressure to see more people, with higher risks. When pushed for time, things get missed, risk assessments are more cursory, and the likelihood of serious incidents is greatly increased.”

Community psychiatric nurse, urban setting.

“We will be commencing new shift patterns later this year, from 8pm to 8am. Obviously this will present many new concerns particularly between 5pm and 8pm when we have been told there will only be two staff on at each base

and other bases are at least five miles away if support is required.”

Community nurse, urban setting.

“Excuses about lack of funding are getting in the way of providing safe working environments for my team and I deeply care about them!”

Manager, urban setting.

Verbal abuse

Over a half of respondents (60.3 per cent, n = 459) had experienced verbal abuse during the course of their jobs in the last two years.

For the respondents who stated the number of times this had happened (n = 362) the range was wide from 1 to 110 incidents, with a median (SD) of 2.0 (7.07). While the median number of incidents reported to managers was similar (2.0, SD 2.86, n = 349), 14.6 per cent (n = 51) of respondents failed to report any of these incidents to their managers.

Of the incidents of verbal abuse, few were reported to the police and 94.7 per cent (n = 342) of respondents failed to report any of these incidents to the police.

Of those who had been verbally abused, 6.4 per cent (n = 23) reported that some of these incidents involved verbal racial abuse and 6.4 per cent (n = 22) verbal sexual abuse.

Comments included: “... difficult to say as when faced with clients from my area of expertise it is not uncommon to have verbal remarks in relation to being Scottish ... ” and “... although I felt some were related to the fact that I wasn’t Muslim ... ”.

It is interesting to note in this question that there is a comment that introduces the concept of perception as one respondent stated: “I have had lots of sexual comments but none that I would consider abuse”.

One respondent commented:

“Verbal abuse seems to be accepted as part of our work and we are expected to continue visiting these patients as they have no one else to provide them care. If we go in

twos this will increase our already stretched workforce further, so we grin and bear it. In A&E at least they can evict those who are abusive. Our managers are not particularly supportive of us taking action against those who verbally abuse us. We just think it is part of our job. Nevertheless, it is a really stressful, upsetting and at times humiliating experience, often when we are only trying to do our best with our very limited resources. If you have a good team then we will support and look out for each other. Even so, we are often too afraid or just don't have time to tackle those who are verbally aggressive."

District nurse, suburban setting.

Few respondents (1.1 per cent, n=5) had taken time off as a result of verbal abuse in the past two years. One of these had one episode of time off and two respondents had two episodes of time off. One respondent had taken two days off, one had taken nine days off, and one had taken six weeks off as a result of verbal abuse.

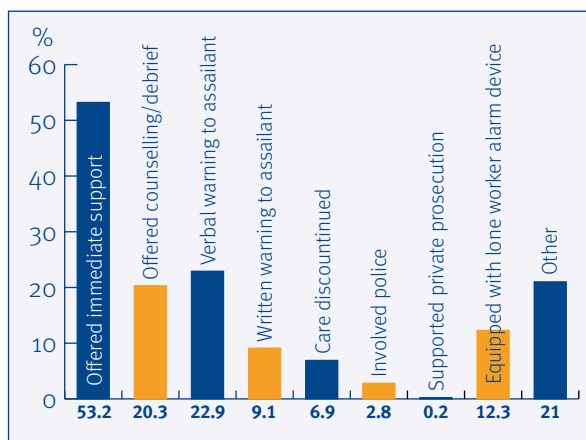


Figure 18 Strategies used by employers following verbal abuse

Of the respondents who have been subject to verbal abuse, the most common strategy used by their employer (53.2 per cent, n = 246) was to offer immediate support. The range of strategies used by employers is illustrated below.

Some of the other reported strategies included completing incident forms and support from colleagues. One respondent reported that no strategies were put in place and that *“this organisation offers no help and they would have to be extenuating circumstances for them to discontinue care, they would rather upset staff than relatives or patients”*. Several respondents reported that they had not reported the incidents. One respondent put *“you are joking!!!”* with regard

to the strategies instigated by their employers. In contrast, another respondent reported:

“My employers have been quickly proactive in assessing and managing verbal aggression and potential violence. We have had involvement of police and safety officers.”

Community nurse, suburban setting.

Physical abuse

10.7 per cent (n = 81) of respondents had been subject to physical abuse by patients, clients or a member of the public during the course of their job in the past two years.

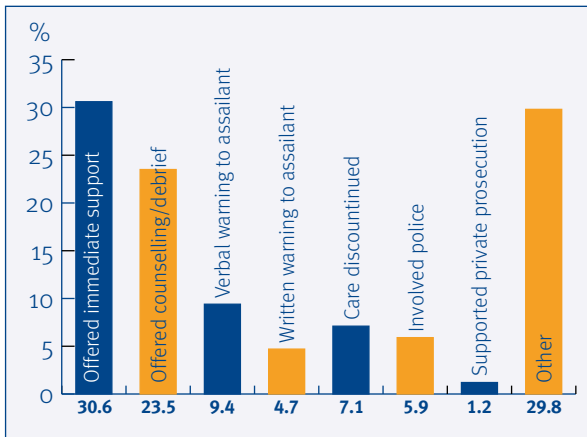
For the respondents who stated the number of times this had happened (n = 77) the range was from 1 to 15 incidents, with a median (SD) of 1.0 (2.35). While the median number of incidents reported to managers was similar (1.0, SD 2.70, n = 50), eight per cent (n = 4) of respondents failed to report any of these incidents to their managers.

Of the incidents of physical abuse, few were reported to the police, with 74.7 per cent (n = 37) of respondents failing to report any of these incidents to the police.

Of those who had been physically abused, four per cent (n = 2) reported that some of these incidents involved racial abuse and none involved sexual abuse.

Few (0.1 per cent, n=1) incidents involved sexual abuse, while 6.2 per cent (n = 5) of respondents had time off work as a result of physical abuse in the past two years. Most of these episodes off work were on one occasion, while one respondent had time off on three separate occasions as a direct result of one physical attack. Most of these respondents had one day off work (n=3), one respondent had 11 days off work and one had approximately 255 days off work. Strategies used by employers following physical abuse are detailed in figure 19 on the following page.

Figure 19 Strategies used by employers following physical abuse

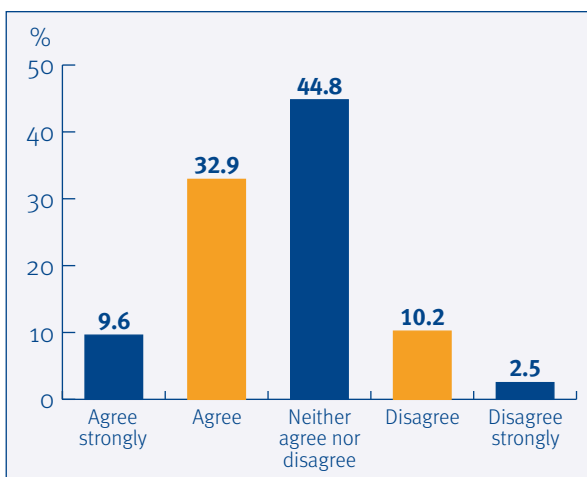


Of those who reported other strategies, some reported that there was no action taken, although some of these were due to the mental health of the patients and ‘unavoidable situations’.

Increasing lone worker safety

Compared to two years ago, 42.5 per cent (n = 324) of respondents agreed or strongly agreed that their employer had a better understanding of the issues associated with lone working now. The range of responses is illustrated in the figure below.

Figure 20 Responses to ‘My employer has a better understanding of the issues associated with lone working now as compared to two years ago’



Comments included:

“Our trust has thought a lot about this over the past few years and addressed areas of risk to a large extent. The unpredictable is always present but much has been done to keep us safer.”

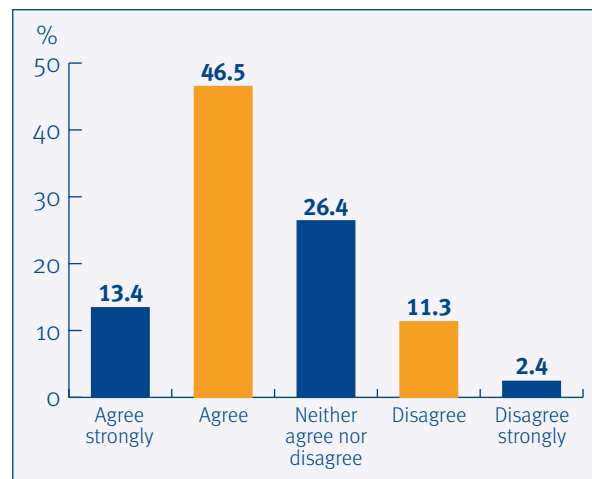
School nurse, urban setting.

“It has improved but feels at times like a lot of box ticking exercises rather than anything very robust.”

Mental health nurse, urban setting.

The extent to which respondents agreed with a series of statements regarding their employers’ actions are summarised in the figures below.

Figure 21 Responses to ‘My employer takes action to manage risks of lone working’



Comments included:

“I believe my employers would like to support the lone worker more fully but budgetary restrictions mean that they have to prioritise their spending and government targets tend to be uppermost due to the potential ‘fines’ if these targets are not met.”

Community nurse, rural setting.

“My employer has been very proactive encouraging the use of lone worker devices. I have felt safer travelling on the road, having been attacked previously, I also feel safer in clients’ homes knowing someone is listening in and will raise the alarm if I am in danger.”

Community children’s nurse, urban setting.

Figure 22 Responses to ‘My employer would take action against patients/clients who verbally abuse staff’

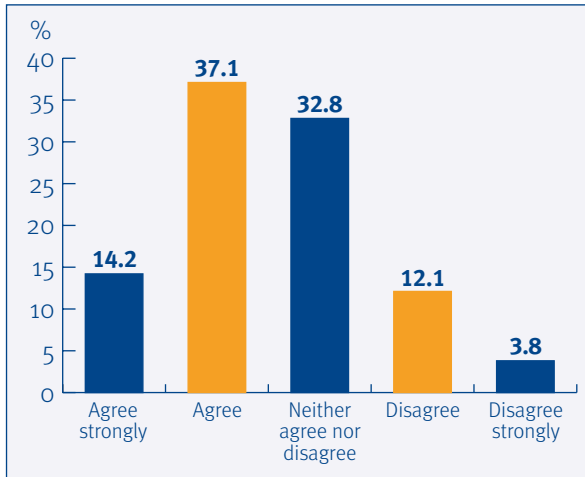
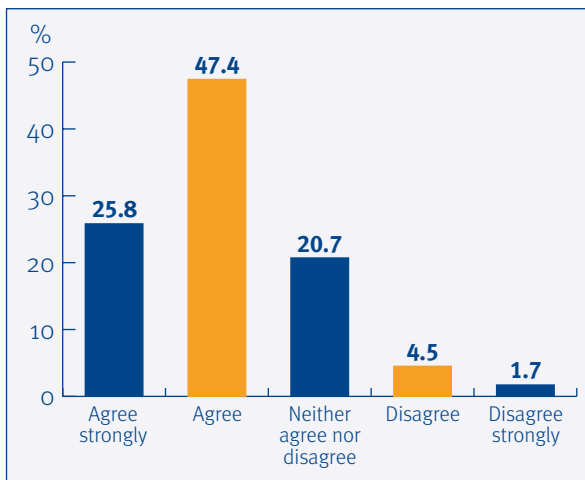


Figure 23 Responses to ‘My employer would take action against patients/clients who physically abuse staff’

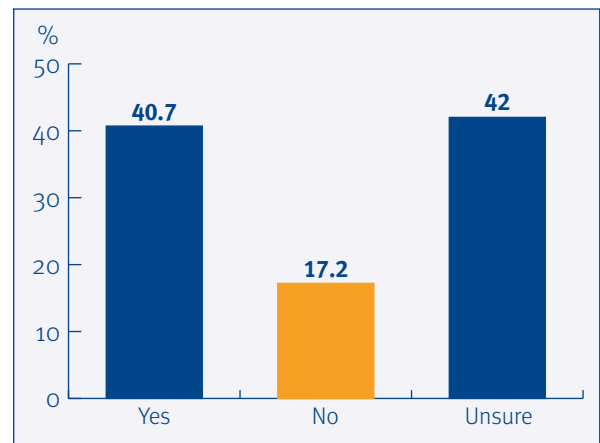


Strategies to manage risk

Around a fifth (21.7 per cent, n = 166) of respondents had been offered the use of an Identicom or similar device by their employers in the last two years. Of these, 69.5 per cent (n = 114) had used the device. Of those respondents who had used such a device, 55.3 per cent (n = 63) felt safer as a result.

Of the 587 respondents who had not had this option, 40.7 per cent felt that such a device would increase their confidence to work alone while 42.1 per cent (n = 247) were unsure. This is illustrated in the figure below.

Figure 24 Respondents views on the ability of the Identicom to increase confidence to work alone



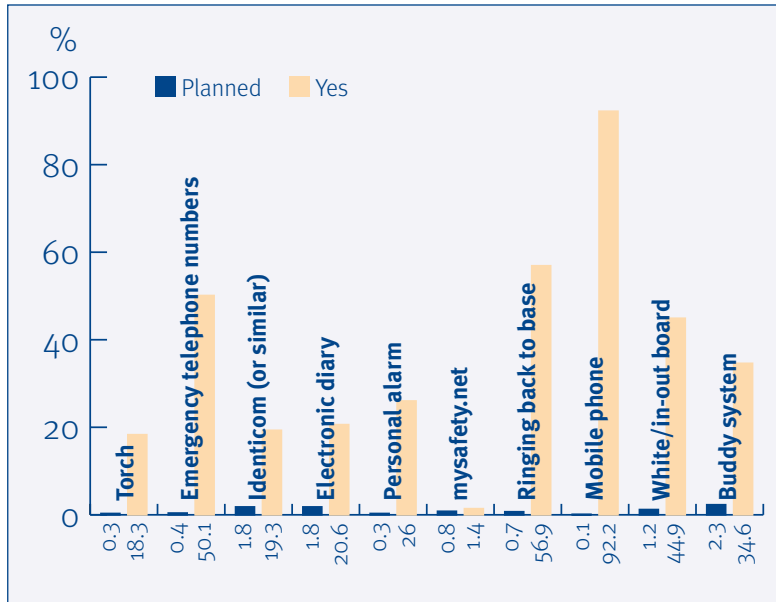
One respondent commented:

“Identicom-type systems are easier to activate than a personal alarm at the bottom of a bag or trying to make a mobile phone call.”

Community matron, suburban setting.

Other lone worker systems in place are illustrated in figure 25 below.

Figure 25 Lone worker systems currently in use

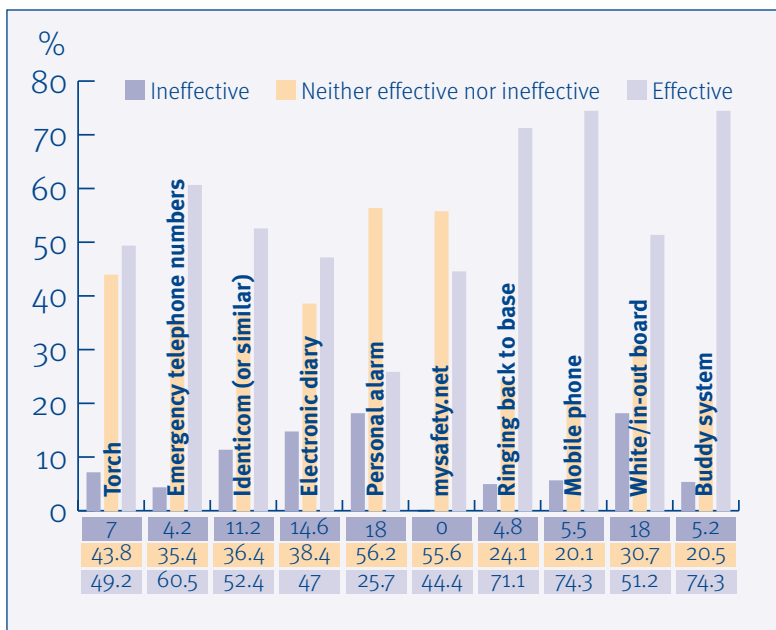


One respondent commented:

“My employer appears not to address the risk – I make sure one specific colleague knows where I am, we have our own buddy system. If there was an emergency I am not sure the processes in place would meet the risk appropriately.”
Community children’s nurse, rural setting.

The figure below illustrates how effective respondents felt these systems were.

Figure 26 Respondents’ views on the effectiveness of the strategies in use



Comments included:

“None of the nurses in my team have a work mobile. The white board works for recording, however, people often don’t notice or do anything if they notice that someone is not back when expected.”

Community learning disability nurse, rural setting.

“The in/out board is only effective during office hours when there is staff around to check on people’s whereabouts. The use of mobile phones is only effective if you are in a position to use it. You may not feel able to use the phone in certain situations or feel able to discuss the situation in front of a client. Ringing back to base is not mandatory and you could be in a situation where it was only noticed that you were missing towards the end of a shift, then your whereabouts are not necessarily known as we see several clients one after the other. An electronic diary or identicom would possibly ameliorate some of these problems, but not necessarily at night, when we are expected to go out and assess clients who may be totally unknown to us – although not alone, but there would not be anyone left at base to know that we were in trouble etc.”

Community psychiatric nurse, suburban setting.

“Our policy is, if you feel threatened in a person’s home, you ring your base and give a code sentence out which alerts the person on the other end of the phone to contact the police. I think if you were seriously being threatened you wouldn’t have the time to make the call, or get the code out, and it could antagonise the situation, as the code doesn’t make sense.”

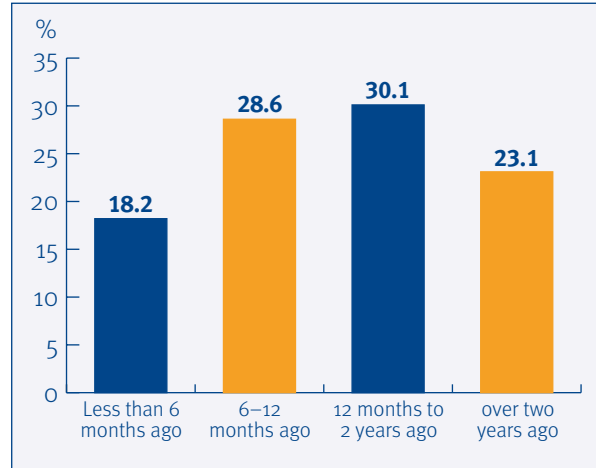
Specialist nurse, rural setting.

“My employer expects nurses to go to rural locations in the dark, while the doctors are driven or escorted by a male. Very often we are sent out to assess patients for the doctors. This sometimes makes me feel like a disposable commodity.”

Community nurse, rural setting.

Most (83.4 per cent, n = 636) respondents had received training in managing conflicts or other lone worker risks. The timing of the training varied, with nearly one half of respondents receiving their training over a year ago (53.2 per cent, n = 339).

Figure 27 Timing of training in managing conflict



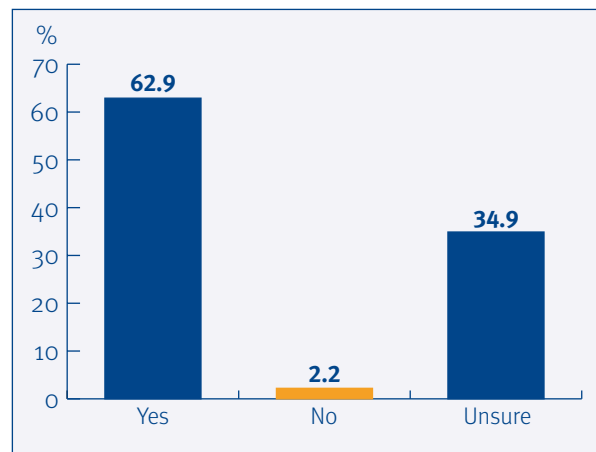
In relation to the most recent training they had undergone, 36.1 per cent (n = 229) of respondents felt that training addressed the risks they faced ‘a lot’ with most respondents (57.7 per cent, n = 366) saying it addressed the risks ‘a little’.

“I feel that my employer does not offer timely access to training for lone working, it is on offer but places are difficult to obtain. I have worked for six years and have not attended any training in relation to violence and aggression or lone working.”

Community staff nurse, urban setting.

Around two thirds (62.9 per cent, n = 478) of respondents felt that if evidential audio recordings of abuse were available, their employers would be better placed to take action against those responsible. Only 2.2 per cent (n = 17) felt that this would make no difference.

Figure 28 Responses to ‘If evidential audio recordings of abuse were available, would your employer be better placed to take action against those responsible?’



“I feel that the trust will always support the view of the patient/carer above that of the nurse, and that nurses who work alone are therefore left in a vulnerable position as they have no evidence to back them up, unless a recording of conversations have taken place.”

Community nurse, suburban setting.

Impact of urban/suburban/rural setting

There were no significant associations between the proportion of time spent working alone and the work setting. Over 50 per cent of workers in all settings worked outside normal office hours and there was a significant association between setting and out-of-hours working¹ with rural workers more likely to work out-of-hours than colleagues in suburban or urban areas.

These differences are illustrated in Table 2.

Table 2 – Proportion of respondents whose job involves working outside of normal office hours ie 9am to 5.30pm

	Yes n (%)	No n (%)	Total
Urban	157 (50.2)	156 (49.8)	313 (100)
Suburban	144 (54.8)	119 (45.2)	263 (100)
Rural	117 (62.9)	69 (37.1)	186 (100)
Total	418 (54.9)	344 (45.1)	762 (100)

In all areas more than 45 per cent of workers felt that the amount of time that they spend working out of hours had increased, this was particularly noticeable for those in suburban areas. The association between changes to out-of-hours working and setting was statistically significant².

Table 3 – Respondents views on changes to out-of-hours working over the last two years

	Increased n (%)	Decreased n (%)	No change n (%)	Total
Urban	73 (46.5)	11 (7.0)	73 (46.5)	157 (100)
Suburban	91 (63.2)	6 (4.2)	47 (32.6)	144 (100)
Rural	66 (56.4)	3 (2.6)	48 (41.0)	117 (100)
Total	230 (55.0)	20 (4.8)	168 (40.2)	418 (100)

1. ($X^2 = 7.65$, $df = 2$, $n = 762$), $p = 0.02$,

2. $X^2 = 10.42$, $df = 4$, $n = 418$, $p = 0.03$

While there were no associations between setting and on call and weekend work, there was a significant association between setting and working in the evening³ with rural workers less likely to work in the evening than colleagues in suburban or urban areas.

These differences are illustrated in Table 4.

Table 4 – Proportion of respondents whose job involves work in the evening

	Yes n (%)	No n (%)	Total
Urban	115 (72.3)	44 (27.7)	159 (100)
Suburban	111 (76.0)	35 (24.0)	146 (100)
Rural	69 (56.0)	48 (48.0)	117 (100)
Total	295 (69.9)	127 (30.1)	422 (100)

There were no associations between whether employers knew of the whereabouts of lone workers or kept details of vehicles and whether the work setting was urban, suburban or rural.

There was a significant association between how safe respondents felt while working alone and the setting⁴. However, the exact reasons for this association are unclear, given the relatively small proportions who felt unsafe in all settings.

These differences are illustrated in Table 5.

Table 5 – Perceptions of safety when operating away from colleagues

	Very safe/quite safe n (%)	Neither safe nor unsafe n (%)	Quite unsafe/very unsafe n (%)	Total
Urban	250 (80.1)	54 (17.3)	8 (2.6)	312 (100)
Suburban	220 (83.3)	39 (14.8)	5 (1.9)	264 (100)
Rural	164 (88.2)	14 (7.5)	8 (4.3)	186 (100)
Total	634 (83.2)	107 (14.0)	21 (2.8)	762 (100)

3. $X^2 = 9.69$, $df = 2$, $n = 422$, $p = 0.01$,

4. $X^2 = 11.36$, $df = 4$, $n = 762$, $p = 0.02$

There were no statistically significant associations between setting and the incidence of physical abuse, but there was an association between setting and incidence of verbal abuse⁵. Over half the respondents in all settings had been verbally abused, with suburban workers experiencing the highest levels of verbal abuse.

Table 6 – Proportion of respondents who had been verbally abused in the last two years

	Yes n (%)	No n (%)	Total
Urban	186 (59.6)	126 (40.4)	312 (100)
Suburban	172 (65.9)	89 (34.1)	261 (100)
Rural	100 (53.8)	86 (46.2)	186 (100)
Total	458 (60.3)	301 (39.7)	759 (100)

There were no statistically significant differences regarding support offered by employers following incidents of verbal and physical abuse.

There were no significant associations between setting and the completion of risk assessments, attending training on conflict management, or having a lone worker policy in place. The only significant associations in terms of the safety systems in place were in the use of torches⁶ and electronic diaries⁷; with least use of torches in urban areas (13.7 per cent, n = 43) compared to suburban (20.1 per cent, n = 53) and rural (23.7 per cent, n = 44) areas. With the most use of diaries being in urban areas (24.9 per cent, n = 78) compared to suburban (19.3 per cent, n = 51) and rural (15.1 per cent, n = 28) areas.

5. $X^2 = 6.80$, $df = 2$, $n = 759$, $p = 0.03$

6. $X^2 = 8.46$, $df = 2$, $n = 763$, $p = 0.02$

7. $X^2 = 7.34$, $df = 2$, $n = 763$, $p = 0.03$

Impact of country of work

There were no significant associations between country of work and proportion of time spent as a lone worker or the proportion of respondents who worked outside normal office hours. However, there were significant associations between country of work and evening⁸ and weekend work⁹.

Respondents in Scotland reported less evening work and respondents in Northern Ireland reported less weekend work.

Table 7 – Proportion of respondents whose job involves evening work

	Yes n (%)	No n (%)	Total
England	247 (69.6)	108 (30.4)	355 (100)
Scotland	13 (52.0)	12 (48.0)	25 (100)
Wales	27 (87.1)	4 (12.9)	31 (100)
Northern Ireland	7 (70.0)	3 (30.0)	10 (100)
Total	294 (69.8)	127 (30.1)	421 (100)

Table 8 – Proportion of respondents whose job involves weekend work

	Yes n (%)	No n (%)	Total
England	267 (75.2)	88 (24.8)	355 (100)
Scotland	23 (92.0)	2 (8.0)	25 (100)
Wales	30 (96.8)	1 (3.2)	31 (100)
Northern Ireland	5 (50.0)	5 (50.0)	10 (10.0)
Total	325 (77.2)	96 (22.8)	422 (100)

In all countries, there were less than 12 per cent of respondents who felt that the amount of time they spend working out of hours had decreased over the last two years. In Scotland a smaller proportion of respondents reported an increase. The association between changes to out-of-hours working and setting was statistically significant¹⁰.

Table 9 – Respondents views on changes to out-of-hours working over the last two years

	Increased n (%)	Decreased n (%)	No change n (%)	Total
England	203 (57.7)	16 (4.5)	133 (46.5)	352 (100)
Scotland	6 (24.0)	1 (4.0)	18 (72.0)	25 (100)
Wales	16 (51.6)	2 (6.5)	48 (41.0)	31 (100)
Northern Ireland	5 (55.6)	1 (11.1)	3 (33.3)	9 (100)
Total	230 (55.2)	20 (4.8)	168 (40.2)	417 (100)

8. $X^2 = 8.17$ df = 3, n = 421, p = 0.04

9. $X^2 = 14.86$, df = 3, n = 418), p < 0.01

10. Likelihood ratio 12.58, df = 6, n = 418, p = 0.05

There were no associations between country and whether employers knew of the whereabouts of lone workers or kept details of vehicles.

Similarly, how safe respondents felt when working alone, perceptions of risks over the last two years and the incidence of physical or verbal abuse was not associated with country. There were no statistically significant differences in support offered by employers following incidents of physical abuse. For those workers who had been verbally abused there were associations between country of work and two interventions, however, these should be interpreted with caution due to the low numbers in each group:

- issuing a verbal warning to the abuser¹¹. The highest proportion of respondents who reported were from Wales (32.1 per cent, n = 9) and lowest from Scotland (3.8 per cent, n = 1)
- providing a lone worker alarm device¹². The highest proportion of respondents who reported were from Wales (32.1 per cent, n = 9) and lowest from Scotland n = 0).

There were no statistically significant differences between country and completion of risk assessments or having a lone worker policy in place. However, there was an association between country and attending training on conflict management¹³, with the highest proportion of respondents who had attended training from England (85.3 per cent, n = 546) and the lowest from Northern Ireland (50 per cent, n = 10). However, again, numbers from some countries were low, so these findings should be interpreted with care.

11. $X^2 = 8.67$ df = 3, n = 459, p = 0.0313. $X^2 = 20.84$ df = 3, n = 546, p = <0.01

12. Likelihood ratio = 14.69 df = 3, n = 459, p = 0.02

13. $X^2 = 20.84$ df = 3, n = 546, p = <0.01

Impact of gender

Of the total 766 respondents, only 61 were male. For this reason, findings on the impact of gender should be interpreted with caution. There were no significant differences in the proportion of time spent working alone and working outside normal office hours or on-call/evening/weekend work between male and female respondents. Females were more likely to state that their employers did not always know their whereabouts¹⁴.

Table 10 – Employers' awareness of workers' whereabouts by gender

	Always/usually n (%)	Sometimes n (%)	Rarely/never n (%)	Total
Male	47 (77.0)	11 (18.0)	3 (4.9)	61 (100)
Female	429 (62.1)	142 (20.5)	120 (17.4)	691 (100)
Total	476 (63.3)	153 (20.3)	123 (16.4)	752 (100)

There was no significant difference in feelings of safety while working alone. Females and males experienced a similar level of physical abuse over the last two years. Over 50 per cent of both groups had been verbally abused by patients, clients or members of the public in the last two years. However, males had experienced higher levels of verbal abuse¹⁵.

Table 11 – Proportion of respondents who have been verbally abused in the last two years by gender

	Yes n (%)	No n (%)	Total
Male	45 (73.8)	16 (26.2)	61 (100)
Female	409 (59.4)	279 (40.6)	688 (100)
Total	454 (60.6)	295(39.4)	749 (100)

There was an association between gender and the frequency of risk assessment¹⁶, although the reasons for this are difficult to interpret.

Table 12 – Frequency of risk assessment by gender

	First visit only n (%)	Always/usually n (%)	Sometimes or rarely n (%)	Never n (%)	Total
Male	10 (16.4)	35 (57.4)	16 (26.2)	0 (0)	61 (100)
Female	127 (18.5)	271 (39.4)	236 (34.3)	54 (7.8)	688 (100)
Total	137 (18.3)	306 (40.9)	252 (33.6)	54 (7.2)	749 (100)

14. $X^2 = 7.5$, $df = 2$, $n = 752$, $p = 0.02$

15. $X^2 = 4.82$, $df = 1$, $n = 749$, $p = 0.03$

16. $X^2 = 10.44$, $df = 3$, $n = 749$, $p = 0.02$

Although the numbers involved were small and therefore these results should be interpreted with caution, the following employer responses as a result of physical abuse were reported by more males than females in the survey:

- immediate support (males 66.7 per cent, n = 6; females 26.7 per cent, n = 20)
- counselling (males 66.7 per cent, n = 6; females 18.7 per cent, n = 14)
- police involvement (males 44.4 per cent, n = 4; females 1.3 per cent, n = 1).

Similarly, following verbal abuse, the males in the survey were also more likely to report counselling (males 42.2 per cent, n = 19; females 18.0 per cent, n = 74) and police involvement (males 11.1 per cent, n = 5; females 1.7 per cent, n = 7), although again, overall numbers are low.

There were no significant associations between gender and training in conflict management and the only significant differences in terms of the safety systems in place, were that more males reported:

- the use of whiteboards (males 68.9 per cent, n = 42; females 42.6 per cent, n = 295)¹⁷
- ringing back to base (males 78.7 per cent, n = 48; females 55.1 per cent,¹⁸ n = 381)
- use of electronic diaries (males 41 per cent, n = 25; females 18.8 per cent, n = 130¹⁹).

Impact of lone worker policy

Having a lone worker policy in place was associated with the frequency of completing risk assessments ahead of making client visits (likelihood ratio = 11.10, df = 3, n = 697, p = <0.01). However, the nature of this association is difficult to interpret with more respondents whose employers had a policy in place stating that they never do risk assessments, and more stating that they always or usually do risk assessments.

Table 13 – Frequency of risk assessment with a lone worker policy

	First visit only n (%)	Always/usually n (%)	Sometimes or rarely n (%)	Never n (%)	Total
Policy in place	122 (18.0)	286 (42.1)	229 (33.7)	42 (6.2)	679 (100)
No policy	4 (22.2)	9 (50.0)	1 (5.6)	4 (22.2)	18 (100)
Total	126 (18.1)	295 (42.3)	230 (33.0)	46 (6.6)	697 (100)

17. $X^2 = 15.59$, df = 1, n = 753, p = <0.01

18. $X^2 = 12.78$, df = 1, n = 753, p = <0.01

19. $X^2 = 16.90$, df = 1, n = 753, p = <0.01

Those respondents whose employers had lone worker policies in place were more likely to state that their employer had all the details of their vehicle²⁰.

There was no association between having a lone worker policy in place and employers being aware of lone workers' whereabouts, incidence of verbal or physical abuse, the nature of the safety systems in place, strategies used by employers following verbal or physical abuse or whether the respondents had received training in managing conflict. Staff that had a lone worker policy in place were more likely to feel that their employer takes action to manage the risks of lone working²¹.

Having a lone worker policy in place was not associated with the belief that employers would take action against patients/clients who verbally or physically abuse staff.

Table 14 – Relationship between whether employers take action to manage risks of lone working and existence of a lone worker policy

	Agree strongly agree n (%)	Neither agree nor disagree n (%)	Disagree/disagree strongly n (%)	Total
Policy in place	425 (62.9)	170 (25.1)	81 (12.0)	676 (100)
No policy	7 (38.9)	5 (27.8)	6 (33.3)	18 (100)
Total	432 (62.2)	175 (25.2)	87 (12.5)	694 (100)

Impact of working outside of office hours

There was no association between whether respondents worked outside office hours and employers having details of respondents' vehicles. However, there was an association with respondents working outside normal office hours and employers knowing of their whereabouts²².

Table 15 – Relationship between employer knowledge of whereabouts and out-of-hours working

	Always/usually n (%)	Sometimes n (%)	Rarely/never n (%)	Total
Outside office hours	253 (60.5)	101 (24.2)	64 (15.3)	418 (100)
Not outside office hours	230 (66.7)	54 (15.7)	61 (17.7)	345 (100)
Total	483 (63.3)	155 (20.3)	125 (16.4)	763 (100)

20. $X^2 = 43.11$ $df = 2$, $n = 693$, $p = <0.01$

21. Likelihood ratio = 6.33 $df = 2$, $n = 694$, $p = 0.04$

22. $X^2 = 8.51$ $df = 2$, $n = 763$, $p = 0.01$

Those working outside normal office hours were no more likely to conduct a risk assessment ahead of making a visit, but there was an association between working out of hours and how safe respondents felt when working alone, with those who worked outside office hours more likely to feel unsafe in their work²³.

Table 16 – Perceptions of safety when operating away from colleagues and out-of-hours working

	Very safe/quite safe n (%)	Neither safe nor unsafe n (%)	Quite unsafe/very unsafe n (%)	Total
Outside office hours	355 (80.1)	67 (16.0)	16 (3.8)	418 (100)
Not outside office hours	300 (87.0)	40 (11.6)	5 (1.4)	345 (100)
Total	635 (83.2)	107 (14.0)	21 (2.8)	763 (100)

Working outside office hours was also positively associated with how often respondents had felt unsafe in the last 12 months²⁴.

Table 17 – Frequency of feeling unsafe in last 12 months and out-of-hours working

	Very rarely/rarely n (%)	Sometimes n (%)	Often/all the time n (%)	Total
Outside office hours	272 (68.3)	115 (28.9)	11 (2.8)	398 (100)
Not outside office hours	247 (77.9)	67 (21.1)	3 (0.9)	317 (100)
Total	519 (72.6)	182 (25.5)	14 (2.0)	715 (100)

Those working outside their normal office hours were more likely to feel that the risks of verbal or physical abuse had increased over the last two years²⁵.

Table 18 – Perceptions of changes to risks over last two years and out-of-hours working

	Increased a lot/slightly n (%)	Stayed the same n (%)	Decreased a lot/slightly n (%)	Total
Outside office hours	198 (47.5)	201 (48.0)	18 (4.3)	417 (100)
Not outside office hours	94 (27.4)	233 (67.9)	16 (4.7)	343 (100)
Total	292 (38.4)	434 (57.1)	34 (4.5)	760 (100)

There was a higher incidence of verbal abuse in those who worked outside office hours compared to those who did not work outside office hours 68.1 per cent (n = 284); 51 per cent (n = 175)²⁶. There was also a higher incidence of physical abuse in those who worked outside of office hours compared to those who did not work outside office hours; 13.3 per cent (n = 55); 7.6 per cent (n = 26)²⁷.

23. $X^2 = 7.59$ df = 2, n = 763, p = 0.02

24. $X^2 = 7.38$ df = 2, n = 715, p = <0.01

25. $X^2 = 32.62$ df = 2, n = 760, p = <0.01

26. $X^2 = 22.97$ df = 1, n = 760, p = <0.01

27. $X^2 = 6.39$ df = 1, n = 757, p = 0.01

Those who work outside normal office hours were less likely to have a whiteboard or in/out board in place²⁸ or use electronic diaries²⁹ than those who work during office hours. Those who work outside normal office hours were more likely to have a mobile phone³⁰, a torch³¹ and use emergency telephone numbers³².

There were no differences in any aspects of training in conflict management.

Those working outside normal office hours were less likely to agree that their employers:

- had a better understanding of the issues associated with lone working compared to two years ago³³
- would take action against patients/clients who had verbally³⁴ and physically³⁵ abused staff
- take action to manage the risks of lone working³⁶.

Impact of age

There were no associations between patterns of lone working, perceptions of safety, incidence of verbal or physical abuse and age.

28. $X^2 = 16.98$, $df = 1$, $n = 764$, $p = <0.01$

29. $X^2 = 22.52$, $df = 1$, $n = 764$, $p = <0.01$

30. $X^2 = 11.18$, $df = 1$, $n = 764$, $p = <0.01$

31. $X^2 = 43.35$, $df = 1$, $n = 764$, $p = <0.01$

32. $X^2 = 11.09$, $df = 1$, $n = 764$, $p = <0.01$

33. $X^2 = 7.83$, $df = 2$, $n = 762$, $p = 0.02$

34. $X^2 = 11.27$, $df = 2$, $n = 762$, $p = <0.01$

35. $X^2 = 14.50$, $df = 2$, $n = 762$, $p = <0.01$

36. $X^2 = 7.35$, $df = 2$, $n = 762$, $p = 0.03$

Discussion

There are a number of issues to take into account when looking at the survey findings. Although the report reflects the views of over 700 RCN members, this represents a response rate of only 10.4 per cent. Therefore, it should not be assumed that the views of respondents are representative of all the RCN members who were invited to participate in the survey. The findings may reflect some selection bias; those RCN members who responded are those who feel particularly concerned about the consequences of lone working.

In addition, comparisons with the previous RCN survey in 2007 (Smith, 2007) should be made with care, since the sampling strategy used for the earlier survey is not known.

The respondents (most were female and described themselves as White English/Scottish/Welsh/Northern Irish/British) undertook a variety of jobs; the most common was community nurse. While most respondents were from England, there was representation from Scotland, Wales and Northern Ireland. This is not dissimilar to the demographics of the respondents to the 2007 survey.

Out-of-hours working was common, with over half the respondents working outside of normal hours. The majority of those who worked out of hours did so at evenings or weekends, with a quarter working on call. Over 60 per cent of respondents spent more than half their time as a lone worker without immediate access to a colleague for support. Although this compares to the figure of 64.9 per cent reported in the 2007 survey, there are strong indications that for these respondents, out-of-hours working had increased over the last two years.

Less than 20 per cent of respondents stated that their employer always knew of their whereabouts, but only 6.7 per cent stated that their employer was never aware. The majority of respondents' employers had details of their vehicles and this was also the case in the 2007 survey.

The vast majority of respondents' employers (89 per cent) had a lone worker policy and, where one existed, more than 70 per cent had a copy. In addition to this, most (71 per cent) respondents who had been provided with a copy were familiar with its content. This contrasts sharply with the

respondents in the 2007 survey, where although a similar proportion had a policy (82.4 per cent), less than 18 per cent had been provided with a copy.

Less than 20 per cent of respondents always carried out a risk assessment before client/patients visits. The equivalent figure from the 2007 survey is 13.9 per cent. This should be interpreted alongside the fact that in the current survey, it was unusual for respondents to receive adequate information on referral to inform them of any risks. Strategies to manage high-risk visits were very similar to those reported in the 2007 survey.

Despite the reported inadequacies in information and the low incidence of routine risk assessment, most respondents felt safe at work as did those in the 2007 survey. However, respondents who worked outside normal office hours were more likely to feel unsafe. In common with the respondents to the 2007 survey, over one third of respondents felt that the risks of verbal or physical abuse had increased over the last two years for a variety of reasons, including raised expectations on the part of patients or relatives/carers.

Being subject to verbal abuse was common among respondents, although most incidents did not involve racial or sexual content. Few were reported to the police and not all were reported to managers. Reluctance to report verbal abuse to the police was also reflected in the 2007 survey. Few incidents of verbal abuse led to time off work, although it should be noted that for those who did need time off, this could be for a prolonged period. Employers' strategies consisted of offering immediate support, but seldom involved counselling for those employees who reported verbal abuse. It was rare for employers to issue any kind of warning to abusers and even rarer for matters to be escalated to the police or to result in prosecution. Only 12.3 per cent of respondents were subsequently issued with a lone worker safety device.

As in the 2007 survey, physical abuse was much less common, although some individuals had experienced a high number of incidents. Few incidents involved racial or sexual abuse and most were not reported to the police. Respondents did not always report these incidents to their managers. Again, only a small proportion of incidents resulted in time off work, although for some individuals a substantial period of time off was needed. Although more incidents involving physical abuse were reported to the police than for verbal abuse, this was still in a small minority of cases.

In the 2007 survey, the proportion of incidents of abuse which were reported to the police was also small. In both surveys, most respondents thought that evidential audio recordings would help employers take action against abusers.

The findings regarding verbal and physical abuse in this current survey are echoed in the RCN's employment survey, conducted in 2010. This showed that across all respondents working in all settings, acute, primary and community, 30 per cent had personally experienced harassment or violence from a patient/client or member of their family over the previous 12 months (RCN, 2011).

Among those nurses surveyed in the employment survey who work in community settings, 31 per cent report having personally experienced harassment or violence from a patient/client or member of their family over the previous 12 months. Community psychiatric nurses (42 per cent) and health visitors (35 per cent) were most likely to report having experienced harassment or violence from a patient or client. Overall, 16 per cent of nurses working in the community stated that violence or harassment from patients or clients or their family has increased over the last 12 months, with district nurses (23 per cent) most likely to report an increase (RCN 2011).

Respondents' experiences of physical or verbal abuse in this survey makes it surprising that over half of them agreed, to some extent, that their employers took action to manage the risks of lone working and would take action against those who verbally or physically abused staff.

There was also some indication that respondents felt their employers' understanding of the issues of lone working had increased over the last two years.

A minority of respondents had been offered the use of an Identicom or similar device in the last two years, although of these, most have used the device and around half felt safer as a result.

The most common strategies in place for lone workers were mobile phones, ringing back to base, in/out boards and emergency telephone numbers. In contrast the incidence of more technologically advanced solutions such as a web-based buddy system, electronic diary or Identicom device was much lower.

Low tech solutions such as a buddy system, in/out board, mobile phones or ringing back to base were also seen as the most effective strategies to use, however the extent to which perceptions of effectiveness are influenced by respondents' experiences of using these strategies in practice is not clear.

In common with the respondents in the 2007 survey, the majority had received some training in managing conflict. In this 2011 survey, less than half had received training in the last year, with the value of this training seen as very variable.

In summary, RCN members who responded to this survey spend a substantial proportion of their time working alone. Most respondents worked outside normal office hours and felt that this was increasing. Although lone worker policies existed, routine risk assessment was uncommon and information to assess risk was often inadequate. Although most respondents did not report feeling unsafe, they felt risks were increasing over time and verbal abuse was particularly common in practice. Those who worked outside normal office hours felt less safe and more at risk. Incidents of verbal and physical abuse were not always reported to managers and few incidents were reported to the police. The most common strategies in place to manage the risks of lone working were low-tech solutions, rather than more advanced technological solutions.

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