NHS

Security Management Service

‘Not Alone’
A guide for the better protection of lone workers in the NHS

Protecting your NHS

Contents

Executive summary

1. This guidance is designed to reflect the good practice that is in use throughout the NHS and other organisations to help protect lone workers, or staff who sometimes work alone. It is aimed primarily at lone workers, managers of lone workers and Local Security Management Specialists. It will also be of interest to risk managers, health and safety managers and human resource departments providing support to those who work alone on behalf of, but not exclusively for, the NHS.

2. The term 'lone worker' is used in this guidance to describe a wide variety of staff who work, either regularly or occasionally, on their own, without access to immediate support from work colleagues, managers or others. This could be inside a hospital or similar environment, or in a community setting; there is no single definition that encompasses those who may face lone working situations and, therefore, increased risks to their security and safety.

3. This guidance is designed to reflect good practice in relation to the protection of lone workers. It should also be used to develop or revise local policies, procedures and systems to protect lone workers, reflecting the local needs of staff and the environments within which they work.

4. Advice is given on what this means in terms of theoretical and practical action to help better protect lone workers. Information is provided on processes and physical measures that can be put in place to help prevent incidents from occurring.

5. The annexes include a short checklist, summarising the key points for line managers and their lone workers and a flow chart of what to do in the event of an incident of violence or abuse.

6. While lone workers may face higher risks, it is important that these risks are not over-emphasised, creating an unnecessary fear amongst staff that is disproportionate to the reality of the risks faced. It is therefore important that work to minimise the risks is based on fact.

7. A common-sense approach should be adopted and encouraged for the protection of lone workers. A balance needs to be struck between providing a high standard of care for patients/service users and the protection of lone workers where there are perceived or real risks.

8. Finally, the NHS Security Management Service would like to extend its thanks to all the stakeholders who have contributed to the guidance – in particular, the Health and Safety Executive and the NHS Litigation Authority.

1. Introduction

1.1. The NHS Security Management Service (NHS SMS) is part of the NHS Counter Fraud and Security Management Service (NHS CFSMS) and has overall responsibility for all policy and operational matters related to the management of security in the NHS. The NHS CFSMS is a business stream of the NHS Business Services Authority, a special health authority.

1.2 In December 2003, the NHS SMS launched its strategy document, *A Professional Approach to Managing Security in the NHS*, outlining its overall aims and objectives, as well as its distinctive approach to security management work. The strategy specifies priority areas of action for NHS SMS work, with an emphasis on tackling violence against NHS staff and professionals.

1.3 As part of this strategy, each healthcare organisation should have in place a nominated, trained and accredited Local Security Management Specialist (LSMS). LSMSs, supported by the NHS SMS nationally, are responsible for ensuring that the appropriate policies, systems, procedures and physical security measures for the protection of lone workers are developed locally, in conjunction with the relevant stakeholders, including staff representatives.

1.4 It is the responsibility of line managers of staff who work alone to ensure that the policies and procedures are developed, implemented, monitored and adhered to. Lone workers also have a responsibility to follow these policies and procedures for their own safety.

1.5 It is essential that staff feel safe and secure, so that they can undertake and perform their duties free from the fear of violence. They must also be confident that there is organisational commitment and support, backed up by strong management procedures, to ensure that effective action can be taken should they find themselves in a threatening environment and need help.

1.6 Due to the nature of their work, lone workers need to be provided with additional organisational support, management, training and instruction to deal with increased risks, as well as being enabled and empowered to take a greater degree of responsibility for their own safety and security.

2. Aim

2.1 This guidance is designed to advise NHS healthcare organisations and their staff on developing, implementing and disseminating local policies and procedures that address the needs of, and minimise the risks faced by, the many different groups of staff that may have to work alone in a diverse range of environments. It also provides lone workers and their line managers with practical advice to assist in preparing for a lone worker situation. Finally, this guidance will assist both NHS employers and their staff to meet their legislative responsibilities under the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. Guidance on this legislation is available from the Health and Safety Executive (HSE) website, **www.hse.gov.uk**.

2.2 The main aims of an NHS healthcare organisation's lone worker policy and procedures should be to:

- raise staff awareness of safety issues relating to lone working
- ensure that lone working is risk-assessed in an appropriate and
- dynamic way and that safe systems and methods of work are put in place to reduce the risk, so far as is reasonably practicable
- ensure that appropriate training is available to all staff to equip them to recognise risks and provide practical advice on safety when working alone, including, where appropriate, how to use technology
- ensure that there are the organisational structure, defined roles and responsibilities, communication links and support in place to help lone workers if they need assistance
- demonstrate to managers and their colleagues that lone working staff are safe and have procedures in place to protect them
- encourage full reporting and recording of any adverse incidents relating to lone working
- reduce the incidents of violence and abuse and injuries to staff related to lone working.

3. Background, statistics and definitions

3.1 Since 2004, the NHS SMS has collected and published figures on the number of physical assaults reported against NHS staff in England. There were 55,993 reported physical assaults against NHS staff in England in 2007-08. For a full year-by-year breakdown, **visit www.nhsbsa.nhs.uk/security**.

3.2 Although it is not known what proportion of these assaults relate to attacks on lone workers, it is widely recognised that this group of staff may face increased risks, because they do not have the immediate support of colleagues or others, such as security staff, if an incident occurs. For example, they may not be able to escape easily from a situation, particularly if they are in someone's home; they may be working in a high crime area or an isolated rural location; or they may be working at night, away from a main building, or where no one is around. Additionally, they may be in possession of equipment or drugs that might be attractive to thieves and who, in some cases, might use violence to achieve this.

3.3 Although there is no single definition, the NHS SMS defines lone working as:

any situation or location in which someone works without a colleague nearby; or when someone is working out of sight or earshot of another colleague.

The Health and Safety Executive (HSE) defines lone workers as:

those who work by themselves without close or direct supervision.

This could refer to those who routinely work in a hospital or general practice environment, where staff care for patients or service users on their own, without the support of line managers or other colleagues. It could also relate to those who work in the community where care is provided in the patient's home or in a non-clinical environment and away from a hospital setting. Lone working may be part of a person's usual job or it could occur infrequently, as and when circumstances dictate. Lone working is not unique to any particular group of staff, working environment or time of day.

3.4 Below is a list of some typical examples of NHS lone workers in primary care, acute, mental health and learning disability, ambulance and social care sectors:

- ambulance personnel, such as paramedics or emergency responders
- patient transport services
- a receptionist working alone in a clinic reception area
- community mental health workers and assertive outreach workers
- community psychiatric nurses, social workers and occupational therapists
- staff who see patients/service users for individual sessions in wards or clinics

- nursing and clinical staff on escort duty
- carers in the community and in community homes
- a technician working alone in a laboratory to provide an out-of-hours service
- those who provide primary care services, such as single-handed GP practices, community pharmacists and dentists or opticians (they may provide out-of-hours services, dispense controlled drugs/emergency medicines or make domiciliary visits)
- NHS security staff on patrols, particularly at night
- a hospital porter conveying medicines/samples etc to wards and departments, using corridors and public walkways where they might not come into contact with any other colleagues
- staff who have to travel between NHS sites and premises to provide a service
- on-call staff required to respond to clinical or non-clinical emergencies out of hours and off-site – for example, clinicians and estates engineers
- those who open (or reopen) and close NHS buildings either early in the morning or late at night
- smoke-stop coordinators or counsellors
- NHS staff who use areas off-site to smoke
- NHS staff travelling to and from vehicles/bicycles parked on NHS premises or in the community.

3.5 The problems that lone workers may face have been graphically illustrated by some high-profile incidents within the health and social care settings.

3.6 One recent case involved a nurse who was fatally injured after being attacked while she took a 10-minute cigarette break from duty in a hospital where she worked. Another involved a social care worker who was also fatally injured following an attack while on a routine house visit to a home for people with long-term psychiatric problems.

4. Legislation

4.1 Health and safety law applies to risks of violence, just as it does to other work-related risks. Staff and managers need to be aware of the following important pieces of relevant legislation:

- **Secretary of State Directions**

  NHS healthcare organisations have responsibilities to manage security, which includes the protection of lone workers in accordance with the *Directions to health bodies on measures to deal with violence against NHS staff* and *Directions to health bodies on security management measures*, 2003 and 2004 respectively and as amended 2006.

- **Health and Safety at Work Act 1974**

  NHS healthcare organisations have responsibilities under the Health and Safety at Work Act 1974, particularly in relation to employers ensuring, as far as is reasonably practicable, the health, safety and welfare of employees at work.

  Employers should have written policies setting out their arrangements for managing health and safety risks. These policies should be publicised and easily accessible to staff.

- **The Management of Health and Safety at Work Regulations 1999**

  These regulations require employers to assess risks to employees and non-employees and make arrangements for effective planning, organisation, control, monitoring and review of health and safety risks.

  Where appropriate, employers must assess the risks of violence to employees and, if necessary, put in place control measures to protect them.

- **Safety Representatives and Safety Committees Regulations 1977 (a) and The Health and Safety (Consultation with Employees) Regulations 1996 (b)**

  Employers must inform, and consult with, employees in good time on matters relating to their health and safety. Employee representatives, either appointed by recognised trade unions under (a) or elected under (b) may make representations to their employer on matters affecting the health and safety of those they represent.

- **The Corporate Manslaughter and Corporate Homicide Act 2007**

  This came into force in April 2008. This legislation creates a new offence under which an organisation (rather than any individual) can be prosecuted and face an unlimited fine, particularly if an organisation is in gross breach of health and safety standards and the duty of care owed to the deceased.

5. Roles and responsibilities

5.1 This section covers:

- Introduction
- the role of the organisation
- the role of the LSMS
- the role of the line manager (also see annex 2)
- the role of the staff member.

5.2 Introduction

5.2.1 To ensure that lone working security and safety policies, procedures and systems are accepted and implemented, it is necessary to communicate effectively to all relevant staff what their roles and responsibilities are in relation to lone working, whether they are managers or colleagues of lone workers or lone workers themselves. It is essential that staff at all levels are made aware of their responsibility to be familiar and compliant with lone working policies and procedures that are in place for their protection. This may be facilitated through:

- job descriptions
- staff handbooks
- clearly written policies and procedures
- induction programmes
- presentations by LSMSs
- awareness-raising sessions by risk managers and health and safety professionals
- training (such as when dealing with conflict resolution)
- team briefings
- the intranet or newsletters within a health or social care organisation.

5.2.2 The above list is not exhaustive and LSMSs and managers should consider using a combination of these and other options to achieve the desired outcome. In large healthcare organisations, LSMSs should consider conveying information to staff via line managers.

5.3 The role of the organisation

5.3.1 Under health and safety legislation (see section 4), employers have a legal duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees.

5.3.2 The overall responsibility for the protection of lone workers is that of the healthcare organisation's security management director (SMD). The SMD should actively lead

on important security issues and take responsibility for security management at an organisational and board level, including raising the profile of security management work and getting the support of the board for important security management strategies and initiatives. This should include ensuring the full backing and commitment of the board for all organisational strategies and initiatives to protect lone workers.

5.3.3 Although health and safety legislation does not apply specifically to lone workers and there is no specific legal barrier to prevent staff from working alone, as part of its duty of care the employer must assess risks to lone workers (including the risk of reasonably foreseeable violence) and take steps to avoid or control risk where necessary.

5.4 The role of the LSMS

5.4.1 The LSMS is responsible for ensuring that the healthcare organisation has robust and up-to-date policies and procedures in place to ensure the safety of lone workers. In liaison with line managers, the LSMS should ensure that these are disseminated to all relevant staff – including those responsible for their implementation and those whom they are designed to safeguard.

5.4.2 Such local policies and procedures should always be developed in consultation with relevant stakeholders. These include health and safety advisors, line managers, human resources representatives, risk managers and staff representatives (for example, trade unions and professional bodies).

5.4.3 The LSMS should also advise the trust on physical security measures, to improve the personal safety of lone workers and make sure that appropriate preventative measures are in place.

5.4.4 The LSMS should assist in ensuring that technology which is used to protect lone workers is appropriate, proportionate and meets the needs of the organisation and lone working staff. They should ensure that technology also meets the necessary legal requirements.

5.4.5 It is recommended that the LSMS plays an active part in the associated risk assessment and management process and advises on appropriate security provisions and technologies to protect lone workers.

5.4.6 When an incident occurs, the LSMS should carry out a full investigation and, where necessary, liaise with the police to allow follow-up action to be taken.

5.4.7 Once a thorough investigation and the appropriate action have been taken, the LSMS should conduct a full post-incident review to identify lessons that can be learned. They should work with line managers to ensure that appropriate remedial measures are implemented.

5.5 The role of the line manager

5.5.1 The line manager has a responsibility to ensure that all relevant policies and procedures are implemented and disseminated to lone working staff for whom they are responsible. They must ensure that these staff are appropriately protected before entering a lone working situation.

5.5.2 This includes ensuring that a suitable and sufficient risk assessment is conducted in consultation with the appropriate people (e.g. LSMS, health and safety manager, risk manager), thus ensuring that all risks from lone working are identified and appropriate control measures introduced to minimise, control or remove them.

5.5.3 These control measures will include ensuring that lone workers receive sufficient information, training, instruction and advice. The line manager must also ensure that any necessary physical measures are put in place, appropriate technology is made available and, where the safety of lone workers is threatened, that alternative arrangements can be made.

5.5.4 Regular reviews of arrangements should be overseen by the line manager to ensure that all measures are effective and continue to meet the requirements of the lone worker.

5.5.5 When an incident occurs, the line manager should ensure that the employee involved completes an incident reporting form as soon as possible, in line with local policy. They should also make sure that the incident is reported to the LSMS for follow-up action, including, where appropriate, contact with the police.

5.5.6 If someone is assaulted, the line manager should make sure that the individual has access to a list of relevant contacts or that they can be referred to the relevant person (e.g. LSMS, occupational health, staff support network, counselling or psychological services). This is to ensure that they undergo a debrief and a physical assessment, that any injuries are documented and that they receive access to proper post-incident support.

5.5.7 After an incident, the risk assessment should be revisited as soon as possible, the adequacy of existing control measures reviewed and the organisational risk register updated accordingly. This should take place before carrying out a formalised investigation, reviewing lessons learned and taking appropriate action taken to try to prevent a recurrence.

5.6 The role of the staff member

5.6.1 Staff members have a responsibility to take reasonable care of themselves and to cooperate with their employer under health and safety legislation. This includes making full use of conflict resolution training (see section 6.20), training in the use of technology and any other information, instructions, equipment and advice from their line managers regarding lone working.

5.6.2 Staff should plan appropriately and risk-assess before a visit and undertake continuous dynamic risk assessment of the situation they find themselves in, being aware of any changing circumstances and taking necessary action to minimise the possibility of an incident occurring.

5.6.3 Under no circumstances must an employee put themselves at risk. If a situation arises that they are unfamiliar with or in which they feel unsafe, they should withdraw and seek further advice and assistance.

5.6.4 If an incident occurs – even if it is considered a minor incident – the employee should complete an incident form as soon as possible and forward it to their line manager, in line with local policy, so that the appropriate risk assessment and follow-up action can be taken.

6. Preparing for lone working

6.1 This section covers:

- introduction
- policies and procedures
- risk management process
- identification of risks
- identification of risks for lone workers
- risk assessment
- managing risk
- before a lone worker visit
- violent patient scheme
- violent patient indicator
- information sharing
- low-risk activities
- high-risk visits
- scheduling visits
- emergency equipment
- lone worker movements
- the buddy system
- escalation points
- training – lone worker, personal safety, conflict resolution training
- managing behaviour – cultural sensitivity.

6.2 Introduction

6.2.1 Management instructions to staff should make it clear that they should not enter into lone working situations where they feel that their safety or the safety of their colleagues could be compromised. A commonsense approach should be adopted and encouraged. Staff who carry out an assessment of the risks that they face should not be penalised for not performing their duties if they perceive that their personal security and safety, or that of others, may be in jeopardy. However, this needs to be balanced against providing a good standard of care for patients/service users. Where there are perceived or real risks, alternative provision should be made, such as arranging treatment in secure premises or organising accompanied visits.

6.3 Policies and procedures

6.3.1 It is the responsibility of LSMSs to ensure that healthcare organisations have lone working policies and procedures in place. These could be standalone policies or form part of wider violence and aggression policies; this should be determined by local requirements. It should be recognised that lone working is not unique to community-based staff and professionals. Lone working can and often does occur within different healthcare settings and is not (or cannot always be) planned. For example, administrative/support staff and nursing staff based in the acute setting are often placed in a lone working situation despite their place of work being an acute ward or open-plan office. Due to their duties, these staff may find themselves either alone in a remote part of the building or escorting a patient/service user to another site. Therefore, policies and procedures need to reflect this.

6.3.2 Lone working policies and procedures should be developed in line with the organisational policy and procedure guidelines. In particular, equality impact assessments should be considered. Lone working policies should include equal opportunities legislation and need to take into account the principles of diversity to reflect the needs of the community that is served.

6.3.3 Policies and procedures must be kept under constant review to take account of changes in the external environment, the introduction of new technologies and the lessons learned from the investigation of incidents that occur, where they cannot be deterred or prevented. They must offer a framework for the assessment of risks that NHS staff may face.

6.3.4 Local policies and procedures should address local views and needs, reflecting:

- the views of staff and their union or professional body and safety representatives
- advice from health and safety advisors and risk and human resources managers
- in mental health and learning disability environments, the views of service users on how they would like visits to their homes to be undertaken
- the use of positive reporting practices regarding appointments and movements
- clear links to other relevant procedures, risk assessment and healthcare organisation policies (for example, incident reporting, risk assessment, etc)
- a clear outline of responsibilities and lines of accountability in respect of any action required in ensuring compliance with monitoring and review of the policies, procedures and systems put in place.

6.3.5 Managers should contribute to a safer working environment for lone workers. They should identify roles and responsibilities and conduct suitable and sufficient risk assessments for lone working. This includes any assessment tools, matrices, systems, processes and procedures to follow before, during and after lone worker situations. Managers should also provide staff with clear lines of communication and reporting. It is important for there to be clear systems in place for the dissemination and use of these policies and procedures, which should be subject to regular

monitoring and review. This should follow the organisation's internal policy and procedure guidelines.

6.3.6 LSMSs should ensure that the implemented lone working policies and procedures are reviewed in line with the organisation's internal review process.

6.3.7 It is essential that all new employees are made fully aware of local lone working policies and procedures as soon as possible. LSMSs should ensure that lone working policies and procedures which are **specific to the working environment** are highlighted and discussed in new employee induction programmes.

6.4 Risk management process

6.4.1 Healthcare organisations will have their own risk models and policies in place to manage and mitigate risk. There should be a clearly documented risk assessment process in place in relation to lone workers within the healthcare or community setting:

- to identify risks in relation to lone working
- to assess the risks to lone workers
- to implement measures to reduce the risks to lone workers, including appropriate staff training to minimise these risks
- to evaluate the control measures and ensure that risks to lone workers are appropriately managed
- to feed into the corporate risk register and quality assurance framework where appropriate.

6.5 Identification of risks

6.5.1 The identification of risks relies on using all available information in relation to lone working to ensure that the risk of future incidents can be minimised. This includes learning from operational experience of previous incidents and involving feedback from all staff and stakeholders. It is therefore essential that staff are encouraged to report identified risks to managers, as well as 'near misses', so that a risk assessment can be carried out, appropriate action taken and control measures put in place.

6.6 Identification of risk for lone workers

6.6.1 The risk identification process should be carried out to identify the risks to lone workers and any others who may be affected by their work. This information is needed to make decisions on how to manage those risks and ensure that the action taken is proportionate. Arrangements also need to be made to monitor and review the findings[1].

[1] See Management of Health and Safety at Work Regulations 1999

6.6.2 This risk identification should consider:

- lone working staff groups exposed to risk
- working conditions: normal, abnormal and hazardous conditions, such as dangerous steps, unhygienic or isolated conditions, poor lighting
- particular work activities that might present a risk to lone workers, such as prescribers carrying prescription forms and medicines on their person, particularly controlled drugs
- staff delivering unwelcome information or bad news: whether they have received suitable and sufficient training to deliver sensitive or bad news and defuse potentially violent situations
- the possibility of an increased risk of violence from patients/service users due to alcohol abuse, or drug misuse in relation to their clinical condition or response to treatment, and the risk of violence from their carers or relatives
- the lone worker wearing uniforms when visiting certain patients/service users
- working in or travelling between certain environments or settings
- lone workers carrying equipment that makes them a target for theft or makes them less able to protect themselves
- evaluation of capability to undertake lone working – for example, being inexperienced or pregnant, or having a disability.

6.7 Risk assessment

6.7.1 The key to risk assessment is to identify hazards, understand how and why incidents occur in lone working situations and learn from that understanding to make improvements to controls and systems to reduce the risk to the employee. To achieve this, the following factors should be considered and documented[2]:

- type of incident risk (e.g. physical assault/theft of property or equipment)
- frequency/likelihood of incident occurring and having an impact on individuals, resources and delivery of patient care
- severity of the incident: cost to the healthcare organisation in human and financial terms
- confidence that the necessary control measures are in place or improvements are being made
- the level of concern and rated risk
- what action needs to be taken to ensure that improvements are made and risks reduced.

[2] For further information, see the Health and Safety Executive's *Five Steps to Risk Assessment*: http://www.hse.gov.uk/risk/fivesteps.htm

6.8 Managing risk

6.8.1 Healthcare organisations are required to implement measures to manage, control and mitigate risks to lone workers. The levels of follow-up action should be proportionate to the level of concern highlighted in the risk assessment.

6.8.2 These measures should be achievable, commensurate with the risk identified, and realistic. Any associated costs need to be included not only in terms of resources and purchasing equipment but also staffing, training and expertise.

6.8.3 Measures might include removing weaknesses or failures that have allowed these incidents to take place (procedural, systematic or technological), and identifying further training needs of staff in relation to the prevention and management of violence, or other training such as correctly identifying and operating the relevant technology.

6.9 Before a lone worker visit

6.9.1 Where it is practicable[3], a log of known risks should be kept. This should record the location and details of patients/service users/other people that may be visited by staff, where a risk may be present. This log should be kept secure and the information should be accurate and reviewed regularly. It should be available to lone workers to inspect ahead of any visit they make. Consideration should be given to requiring, as part of a lone worker's job description that they inform their manager or buddy (see 6.18) if they have to make a visit to an address or person on that log.

6.10 Violent patient scheme

6.10.1 Primary care trusts should utilise the violent patient scheme (VPS) to manage the risks to lone working staff. It may not be appropriate for lone workers to visit patients on the VPS in their homes, but if there is a clinical need, managers and staff should ensure that an appropriate risk assessment is conducted and the necessary measures are in place beforehand.

6.10.2 Lone working staff may need to come into contact with family members of a patient who is on the VPS when providing clinical care/treatment. Proper provisions should be made to deal with this scenario.

6.11 Violent patient indicator

6.11.1 NHS organisations may operate a violent patient indicator (VPI) process, whereby the records of patients who present a known risk of violence (or who have been identified as being potentially violent following an incident) are marked. The VPI or marker should outline the nature of the risk and practical advice for lone working staff. Such systems are usually based electronically, so their accessibility to lone

[3] If staff work from a variety of locations, a written log may be difficult to implement and maintain. Where this is in place, consideration should be given to placing it in a secure location that is only accessible to managers and lone workers – for example, on the organisation's intranet.

workers who are not based centrally or who do not have access to electronic systems is a consideration. Trusts should have their own protocols in place for the operation of any VPI scheme to make sure that it is fairly and consistently applied.

6.11.2 In primary care, patients on the VPS should also have their records marked.

6.12 Information sharing

6.12. 1 As part of the risk management processes outlined above, information concerning risks of individuals and addresses should, where legally permissible, be communicated internally to all relevant staff who may work with the same patients/service users. For this to work, organisations need to have, as an integral part of the process, an information sharing protocol that provides a clear explanation of what information can be shared, how and to whom.

6.12.2 Wherever possible and legally permissible, the healthcare organisation should also share information on known risks of addresses and associated individuals externally, within the health, social care and other public sectors. This should include social care services, the ambulance service, patient transport services and primary care where applicable. A means of achieving this should be built into a local information sharing protocol. Communication could also be facilitated through existing participation in crime and disorder partnerships, community groups and other health-care organisation forums, and liaison with the police.

6.13 Low-risk activities

6.13.1 There may be certain scenarios and activities that can be classified through a risk assessment as low-risk – for example, staff undertaking office work during normal daytime hours. Staff in this situation may be authorised to work alone without the agreement of their line manager. However, risk assessments need to consider not only safety while at work during normal office hours, but also issues of location and timing relating to personal safety (e.g. someone leaving an empty building, alone, at night).

6.14 High-risk activities

6.14.1 If there is a history of violence and/or the patient/service user, other friends/relatives who may be present or the location is considered high-risk, the lone worker must be accompanied by at least one colleague or security officer or, in some cases, by the police. Consideration should be given to whether the patient/service user should be treated away from their home, at a neutral location or within a secure environment.

6.15 Scheduling visits

6.15.1 Before visiting a location or patient/service user that is a known risk, colleagues who may have worked alone in the same situation previously should be contacted. This aids communication and informs the action taken to minimise the risks.

6.15.2 If there are known risks associated with a particular location or patient/service user, lone workers should consider, in consultation with their manager, rescheduling the visit so they can be accompanied by another member of staff or security or police presence. As part of the risk assessment process, consideration should also be given to whether they should, and can, be treated by attending a clinic or hospital.

6.15.3 If practical, the time of day and day of the week for visits should be varied when visits are frequent

6.15.4 If a lone worker has been given personal equipment, such as a mobile phone or a lone worker device, this is safety protective personal equipment supplied in support of providing a safe working environment as required by health and safety legislation. All due care should be taken by the lone worker to maintain the equipment in good working order and ensure it is fully charged and ready to use (see section 9).

6.16 Emergency equipment

6.16.1 As part of the planning process, the emergency equipment that may be required should be assessed. This might include a torch, map of the local area, telephone numbers for emergencies (including local police and ambulance service), a first aid kit, etc.

6.17 Lone worker movements

6.17.1 Lone workers should always ensure that someone else (a manager or appropriate colleague) is aware of their movements. This means providing them with the address of where they will be working, details of the people they will be working with or visiting, telephone numbers if known and expected arrival and departure times.

6.17.2 Lone workers should leave a written visiting log, containing a diary of visits, with a manager and colleague(s). This information must be kept confidential. Details can be left on a whiteboard or similar, if it is in a secure office to which neither patients/service users nor members of the public have access.

6.17.3 Arrangements should be in place to ensure that if a colleague with whom details have been left leaves work, they will pass the details to another colleague who will check that the lone worker arrives back at their office/base or has safely completed their duties. For office-based staff, if details have been left on a whiteboard, they must not be erased until it has been confirmed that the lone worker has returned safely or completed their duties for that day.

6.17.4 Details of vehicles used by lone workers should also be left with a manager or colleague, for example, registration number, make, model and colour.

6.17.5 Procedures should also be in place to ensure that the lone worker is in regular contact with their manager or relevant colleague, particularly if they are delayed or have to cancel an appointment.

6.17.6 Where there is genuine concern, as a result of a lone worker failing to attend a visit or an arranged meeting within an agreed time, or to make contact as agreed, the manager should use the information provided in the log to locate them and ascertain whether they turned up for previous appointments that day. Depending on the circumstances and whether contact through normal means (mobile phone, pager, etc) can be made, the manager or colleague should involve the police, if necessary (see escalation process in 6.19).

6.17.7 If it is thought that the lone worker may be at risk, it is important that matters are dealt with quickly, after considering all the available facts. If police involvement is needed, they should be given full access to information held and personnel who may hold it, if that information might help trace the lone worker and provide a fuller assessment of any risks they may be facing.

6.17.8 It is important that contact arrangements, once in place, are adhered to. Many such procedures fail simply because staff forget to make the necessary call when they finish their shift. The result is unnecessary escalation and expense, which undermines the integrity of the process.

6.18 The buddy system

6.18.1 It is essential that lone workers keep in contact with colleagues and ensure that they make another colleague aware of their movements. This can be done by implementing management procedures such as the 'buddy system'.

6.18.2 To operate the buddy system, an organisation must ensure that a lone worker nominates a buddy. This is a person who is their nominated contact for the period in which they will be working alone. The nominated buddy will:

- be fully aware of the movements of the lone worker
- have all necessary contact details for the lone worker, including next of kin
- have details of the lone worker's known breaks or rest periods
- attempt to contact the lone worker if they do not contact the buddy as agreed
- follow the agreed local escalation procedures for alerting their senior manager and/or the police if the lone worker cannot be contacted or if they fail to contact their buddy within agreed and reasonable timescales.

6.18.3 The following are essential to the effective operation of the buddy system:

- the buddy must be made aware that they have been nominated and what the procedures and requirement for this role are
- contingency arrangements should be in place for someone else to take over the role of the buddy in case the nominated person is unavailable, for example if the lone working situation extends past the end of the nominated person's normal working day or shift, if the shift varies, or if the nominated person is away on annual leave or off sick.

6.19 Escalation process

6.19.1 It is important for NHS organisations to have an escalation policy and process, outlining who should be notified if a lone worker cannot be contacted or if they fail to contact the relevant individual within agreed or reasonable timescales. The escalation process should include risk assessment and identification of contact points at appropriate stages, including a line manager, senior manager and, ultimately, the police. Any individual nominated as an escalation point should be fully aware of their role and its responsibilities.

6.20 Training – lone working, personal safety and conflict resolution training

6.20.1 It is essential that staff are given the appropriate training in identifying, preventing, managing and de-escalating potentially violent situations. This must be done within a legal and ethical framework where the rights and needs of the patient/service user are balanced against the rights and safety of lone workers. Lone workers should be given the necessary training and awareness to enable them to carry out their duties in a positive, confident and caring manner. In all situations, they should try to attend to the needs of the individual involved and recognise their particular sensitivities and concerns.

6.20.2 As a key preventative measure to tackle violence against NHS staff and to ensure that staff and professionals are given the necessary skills to be able to recognise, de-escalate and manage potentially violent situations, a national syllabus in conflict resolution training for the NHS was introduced in 2004. A separate syllabus, specially adapted for mental health and learning disability settings, was introduced in 2005 and training standards for ambulance settings were introduced in 2007.

6.20.3 Conflict resolution training should be delivered to meet the needs of lone workers and should include modules covering risk assessment, de-escalation techniques and post-incident support. The training should also be scenario-based specifically for lone workers.

6.20.4 Ensuring that NHS staff and professionals receive appropriate training in risk assessment is a key element in building skills for dealing with lone working. Such training can raise awareness and encourage the sharing of information about identified risks that they and their colleagues may face.

6.20.5 Training should be delivered for any specific equipment or devices that may be issued to lone workers. This should include scenarios which are likely to be encountered when lone workers are equipped with devices and with support services fully in place.

6.20.6 A training needs analysis (TNA) should be undertaken by the relevant staff. This should determine which lone working staff in the organisation require training, who should be prioritised for training and in which subject, and how often this training is to be refreshed. Subject areas which may be included within the TNA are:

- conflict resolution training

- training in disengagement techniques
- training on health and safety encompassing employee responsibilities
- cultural awareness, diversity and racial equality training
- specific equipment training, including lone worker protection devices
- conducting a risk assessment
- first aid training.

6.21 Manage behaviour – cultural sensitivity

6.21.1 All lone working staff should be appropriately trained so that they are both aware and mindful of cultural issues (e.g. gender issues) and can manage behaviour before entering a lone working situation. This will ensure that lone workers do not add to or exacerbate the risks faced in a lone working situation.

7. When in a lone working situation

7.1 This section covers:

- dynamic risk assessment
- recognising warning signs
- managing a violent or abusive incident
- dealing with animals
- escorting patients/service users
- lone working and vehicles
- lone working and taxis
- lone working and travelling by foot
- lone working and public transport.

7.2 Dynamic risk assessment

7.2.1 During a lone working visit or a site visit, a dynamic risk assessment focuses on reducing the prevalence of a problem. This is done by minimising known or suspected risk factors and by early intervention (when violence is perceived to be imminent, while it is occurring or immediately post-incident).

7.2.2 A dynamic risk assessment can be defined as a continuous process of identifying hazards and the risk of them causing harm, and taking steps to eliminate or reduce them in the rapidly changing circumstances of an incident. The dynamic risk assessment involves staff:

- being alert to warning signs as covered in conflict resolution training
- carrying out a '10-second risk assessment'; if staff feel there is a risk of harm to themselves, they should leave immediately
- placing themselves in a position to make a good escape, i.e. where possible, being the closest to an exit
- being aware of all entrances and exits
- being aware of the positioning of items, including those belonging to the lone worker (scissors, scalpels, etc), that could be used as a weapon
- making a judgement as to the best possible course of action – for example, whether to continue working or withdraw
- utilising appropriate physical security measures (e.g. triggering panic buttons to call assistance from staff nearby/security/the police or using a lone worker device to raise an alarm)
- ensuring that when they enter a confined area or room, they can operate the door lock in case they need to make an emergency exit
- avoiding walking in front of a patient/service user, and not positioning themselves in a corner or in a situation where it may be difficult to escape

- remaining calm and focused during an incident in order to make rational judgements
- being aware of their body language (as well as that of the patient/service user), as there is a risk of exacerbating the situation.

7.3 Recognising warning signs

7.3.1 Lone workers should be able to recognise the risks presented by those who are under the influence of alcohol/drugs or are confused, or where animals may be present. Being alert to these warning signs will allow the lone worker to consider all the facts to make a personal risk assessment and, therefore, a judgement as to the best course of action (for example, to continue with their work or to withdraw). At no point should the lone worker place themselves, their colleagues or their patients/service users at risk or in danger.

7.4 Management of a violent or abusive incident

7.4.1 Line managers should discuss with their lone worker staff what actions they should take in the event of an incident. Managers should check whether this is already covered by local lone working and/or violence and aggression policies and amend them as necessary. The flowchart in annex 3 outlines suggested action for individuals during an incident of violence or abuse.

7.5 Dealing with animals

7.5.1 If there is a known problem with animals at a particular address or location, the occupants should be contacted and politely requested to remove or secure the animals before arrival of NHS staff (bearing in mind that this could provoke a negative reaction). All possible efforts should be made to ensure that the situation is managed and de-escalated, should hostility become evident. If this is not possible, alternative arrangements should be made to carry out the visit.

7.5.2 Even if there are no known problems with animals, the request should still be made for them to be secured, as clinical procedures may provoke an unforeseen reaction from an animal. Alternatively, the animal's presence may be disruptive, so it may be prudent to request that it be removed or placed in a different room.

7.5.3 If a lone worker is confronted by an aggressive animal on a visit to a patient/service user's address, they should not put themselves at risk. If necessary, they should abandon the visit and report the incident in accordance with local procedures. This information should then be disseminated to all relevant internal (and, where possible, external) parties, including social care and ambulance staff.

7.6 Escorting patients and vehicles

7.6.1 Before a decision is taken to escort a patient/service user, a full risk assessment should take place. This should consider the safeguards that need to be in place before and during the escorting process.

7.6.2 Consideration should be given to the physical and mental state of the patient when planning an escort, and to whether they are capable of being transported.

7.6.3 The level of staff experience and their qualifications, and the number of staff needed to manage the patient during the transfer should be taken into account.

7.6.4 The type of transport to be used (e.g. ambulance, patient transport service, contracted taxi service or lone worker's vehicle such as ambulance fast responder car) should also be considered. Staff who escort patients using a contracted taxi service should still be considered lone workers and the necessary precautions taken.

7.6.5 If there is a need for a lone worker to escort a patient, they should always seat the patient behind the front passenger seat and ensure that their seat belt is fastened. This will enable the lone worker to operate the vehicle safely. There have been reported incidents of patients seated as front-seat passengers grabbing at handbrakes and steering wheels while being transported.

7.6.6 Lone workers should not escort a patient by car if there are any doubts about their safety in doing so and alternative arrangements should be made. Lone workers should not agree to transport a patient's animals.

7.6.7 If a conflict arises (or a patient becomes aggressive), the lone worker should pull over into a safe place and exit the vehicle – if possible, ensuring that the keys are removed. They should follow local procedures, which may involve calling the police, their manager, a colleague or their buddy.

7.6.8 Appropriate planning and provision should be made for the safe return of a lone worker to a familiar place, once the patient has been dropped off. This is particularly important if the lone worker has to return from an unfamiliar place late at night and travel to their place of work alone.

7.7 Lone working and vehicles (other than escorting patients/service users)

7.7.1 Before setting out, lone workers should ensure that they have adequate fuel for their journey.

7.7.2 They should give themselves enough time for the journey to avoid rushing or taking unnecessary risks.

7.7.3 Items such as bags, cases, controlled drugs and other equipment should never be left visible in the car. These should be out of sight, preferably stored in the boot of the vehicle.

7.7.4 Lone workers should always hold the vehicle keys in their hand when leaving premises, to avoid being distracted by searching for them when outside.

7.7.5 A visual check should be made of the outside of the vehicle. The inside of the vehicle should also be checked for possible intruders before entering.

7.7.6 Once inside the vehicle, all doors should be locked, especially when travelling at slow speed, when stationary at traffic lights and when travelling in high-risk areas. Some staff may understandably feel that a locked door may prevent them from escaping or receiving help in the event of an accident. However, modern vehicles and rescue techniques make this less of a factor than it may seem.

7.7.7 Lone workers should always try to park close to the location that they are visiting and should never take short cuts to save time. At night or in poor weather conditions, they should park in a well-lit area and facing the direction in which they will leave. They should ensure that all the vehicle's windows are closed and the doors locked.

7.7.8 Lone workers should avoid parking on the driveway of the property they are visiting as their vehicle may be blocked in, delaying or preventing escape. The Health and Safety Executive's safe driver training programmes advise that lone workers should reverse into car parking spaces so that the door can act as a barrier

7.7.9 Lone workers driving alone, especially after dark, should not stop, even for people who may appear to be in distress or require help. The lone worker should stop in a safe place and contact the emergency services as appropriate.

7.7.10 If followed, or concerned that they might be being followed, lone workers should drive to the nearest police station or manned and well-lit building, such as a petrol station, to request assistance.

7.7.11 In case of vehicle breakdown or accident, lone workers should contact their manager, colleague or buddy immediately. If they need to leave the vehicle to use an emergency telephone, they should put their hazard lights on, lock their vehicle and ensure that they are visible to passing traffic.

7.7.12 Lone workers should not display signs such as 'doctor on call' or 'nurse on call' as this may encourage thieves to break in to the vehicle to steal drugs, for example.

7.7.13 Lone workers should avoid having items in their vehicle that contain personal details, such as their home address.

7.8 Lone working and taxis

7.8.1 Whenever possible, a taxi should be booked in advance from a reputable company (NHS organisations should have an established contract or arrangement) and the driver's name and call sign obtained.

7.8.2 If a taxi has not been booked, the lone worker should use the number of a reputable cab company – ideally saved on fast dial in their mobile phone – and find a safe place to wait. As a last resort, they should go to a taxi rank to hail a cab.

7.8.3 They should never use a minicab, unless it is licensed or a registered hackney carriage. When travelling, they should sit in the back, behind the front passenger seat.

7.8.4 They should be aware of child locks and central locking (although most black cabs will have locked doors while in transit) in the taxi.

7.8.5 They should not give out personal or sensitive information to the driver (either through conversation with them or while talking on a mobile phone).

7.9 Lone working and travelling by foot

7.9.1 Planning before a journey should include determining the safest route for lone workers, highlighting known areas of concern, including any crime hotspots. Planning should include the actions lone workers should take if they require assistance, how to safely carry personal possessions and equipment and what to do in the event of a theft.

7.9.2 When setting off, lone workers should walk briskly, if possible, and not stop in areas that are unknown to them (for example, to look at a map or ask for directions). If they require assistance, they should go into a safe establishment, such as a police station, petrol station or reputable shop and ask for directions or, if necessary, to call for assistance from their manager, colleague or buddy.

7.9.3 They should avoid using mobile phones overtly in any area (before a visit, they should make a note of the phone's SIM number in case of theft) and, if carrying equipment, should ensure that this is done using bags that do not advertise what they are carrying.

7.9.4 Lone workers should stay in the centre of pavements, facing oncoming traffic. They should remain alert to the people and environment around them, staying on well-lit paths and areas if possible. They should avoid waste ground, isolated pathways and subways, particularly at night.

7.9.5 If someone attempts to steal what they are carrying, they should relinquish the property immediately without challenge. If carrying a handbag or similar, they should consider carrying their house keys and mobile phone separately.

7.9.6 It is important that any theft, or attempted theft, is reported both internally and to the police as soon as is practicable and safe to do so. The lone worker should make a note of the date, time and descriptions of events and attacker(s), as soon as they are in a position to do so and retain it safely until it is requested by the police or LSMS.

7.10 Lone working and public transport

7.10.1 Before using public transport, lone workers should have a timetable for their route. They should give their manager, colleague or buddy details of their intended route and mode of transport. If they have to vary their route or experience a significant delay, they should inform the relevant individual.

7.10.2 Lone workers should ideally wait for transport at a busy, well-lit stop or station. If they have to wait in areas that are not well lit and/or deserted, they should be vigilant at all times

7.10.3 They should always try to sit near the driver while on public transport, preferably in an aisle seat.

7.10.4 They should also familiarise themselves with the relevant safety procedures and sit near the emergency alarm.

7.10.5 They should avoid empty upper decks on buses and empty train compartments (and also avoid these situations if there is only one other passenger).

7.10.6 If threatened by another passenger, they should alert the driver/guard as soon as possible and follow pre-planned procedures for ensuring their own safety.

8. In the event of an incident

8.1 This section covers:

- reporting
- post-incident support
- post-incident action
- post-incident review
- sanctions
- publicity.

8.2 Reporting

8.2.1 It is important that staff are encouraged and supported by their organisation (and in particular by their line manager) to report all incidents of physical and non-physical assault to the LSMS, using the organisation's incident report form. This will enable the LSMS to conduct a thorough investigation and to ensure that all appropriate cases of physical assault are reported to the police **as soon as possible** for appropriate action to be taken (also, see 8.6 on sanctions).

8.2.2 Furthermore, through more accurate and increased reporting by staff, more will become known about the nature, scale and extent of the issues affecting lone workers. This will allow LSMSs to improve further the local policies and procedures to minimise the risks that these staff face. It is important that there are robust reporting processes in place for staff to facilitate this process. Staff should be supported and encouraged to report an incident to the LSMS using the approved system, in the knowledge that it will be investigated and appropriate action taken. Staff should also report near misses that could have resulted in a serious incident.

8.2.3 This will also ensure that any lessons learned can be fed back into risk management processes to make sure similar incidents do not recur. It also means that further preventive measures can be developed, sanctions taken (where appropriate) and increased publicity generated, creating a strong deterrent effect.

8.2.4 In short, this fosters a pro-security culture amongst NHS staff and professionals, raising their awareness of how and why incidents should be reported to facilitate the prevention process and contribute to the future security and safety of staff.

8.2.5 If an incident causes more than three consecutive days' absence from work, there is also a legal requirement for it to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. This must be done in addition to reporting all physical assaults to the NHS SMS through its physical assault reporting system (PARS).

8.3 Post-incident support

8.3.1 Incidents that occur in lone working situations, whether they involve assaults on staff, theft or criminal damage to NHS property, have a direct impact on both the

human and financial resources allocated to the NHS to deliver high-quality patient care.

8.3.2 Employers should have measures in place to support any member of staff who has been subject to an abusive or violent incident. These might include a debrief following the incident, psychological support, counselling services, post-trauma support, peer support and access to the staff member's professional or trade union representative. The organisation's lone worker policy/procedure should provide information about what support is available and relevant contact details.

8.3.3 If assaulted, the individual will also need to undergo a physical assessment and receive treatment for any injuries, so they are well enough to return to work.

8.4 Post-incident action

8.4.1 Following an incident or threat in a lone working situation, the LSMS should make sure that there are effective arrangements to ensure that incidents and risks are reported and dealt with in accordance with the NHS SMS national frameworks for tackling violence and security management work[4,5]. Further information has been issued on the liaison arrangements to be adopted for incidents that will also be investigated by the Health and Safety Executive[6].

8.4.2 If the incident involves a physical assault on an NHS staff member, it must be reported and investigated according to the framework for tackling violence against NHS staff established in November 2003 and the guidance to underpin this. Where appropriate, it should also be reported to the police as soon as possible[7]

8.4.3 If the incident involves a non-physical assault, such as verbal abuse, it must be reported, investigated and dealt with according to the national framework for non-physical assaults against NHS staff established in April 2004 and the underpinning guidance[8]

8.4.4 For all incidents, irrespective of whether the police may be pursuing sanctions against offenders, LSMSs should conduct an investigation to establish the causes of the incident and whether any further action needs to be taken. This action might be aimed at creating a pro-security culture, deterrence, prevention or detection.

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[4] Department of Health, 2003, Directions to NHS bodies on measures to deal with violence against NHS staff (2003)

[5] Department of Health, 2004, Directions to NHS bodies on security management measures (2004)

[6] Concordat between the Health and Safety Executive and the NHS Counter Fraud and Security Management Service (March 2005)

[7] Tackling violence against staff: Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003 (March 2007)

[8] Non physical assault notes: A framework for reporting and dealing with non-physical assaults against NHS staff and professionals (November 2004)

8.4.5 Where lessons can be learned, it is essential that they are used in the revision of procedures and systems locally, as well as guidance nationally. This will ensure that lone workers are given the best possible protection and minimise the risks that they face.

8.4.6 For incidents where violence is not a factor, such as theft or criminal damage, healthcare organisations should ensure that staff report these to the police, where appropriate, and through their local incident reporting systems. Reporting has a significant effect, as it will determine the actions and investigation undertaken by the LSMS. The investigation will establish, if possible, who the offenders are and whether there are any trends or patterns that can be identified to prevent a recurrence and determine the actions required to control and reduce the risk. Such information can also be used to inform action that needs be taken to enhance pro-security culture, deterrence, prevention and detection and allow for solutions to be developed for specific problems.

8.4.7 Through effective investigative work by the LSMS, the healthcare organisation can identify resources lost as a direct result of an incident. This provides the information and evidence needed to attempt to recover that loss, whether through the criminal courts, by way of compensation or by seeking redress through the civil courts.

8.5 Post-incident review

8.5.1 Post-incident review will enable all available information to be used to ensure that lessons can be learned and the risk of future incidents minimised. The key to post-incident review, risk assessment and follow-up action is an understanding of how and why incidents occur in lone working situations and being able learn from that understanding. In order to achieve this, the following factors should be considered:

- type of incident (for example, physical assault/theft of property or equipment)
- severity of incident
- likelihood of incident recurring
- cost to healthcare organisation (human and financial)
- individuals and staff groups involved
- weaknesses or failures that have allowed these incidents to take place (for example, procedural, systematic or technological)
- training needs analysis of staff, in relation to the prevention and management of violence, the correct use and operation of lone worker protection technology or other relevant training
- review of measures in place to manage and reduce identified risks
- review of the effectiveness of support measures for the staff involved
- technology in place to protect lone workers.

8.5.2 LSMSs should ensure that the comprehensive and robust lone working policies and procedures developed and implemented are reviewed after an incident that exposes a fundamental weakness or failure.

8.6 Sanctions

8.6.1 There are various sanctions that can be taken against individuals (or groups) who abuse NHS staff and professionals, or who steal or inflict damage on its property. These range from criminal prosecutions and Anti-Social Behaviour Orders to civil injunctions.

8.6.2 Professional investigation of incidents by LSMSs will inevitably lead not only to more intelligence about the problems and possible solutions, but also to more sanctions being taken against offenders. This can be achieved by close working with the police, the Crown Prosecution Service and the NHS SMS's Legal Protection Unit.

8.6.3 If staff who report incidents are part of the investigation process, feel supported and see that improvements in working practices are made to reduce the levels of risk from violence and aggression, the more confident they will be in reporting future incidents. As a consequence, they will feel safer and more secure in their working environment.

8.6.4 More sanctions against offenders, where appropriate, will help develop a strong deterrent message: that the NHS will take firm action to protect its staff, particularly those who work alone to deliver vital healthcare to the most vulnerable in the community.

8.6.5 Advice, guidance and support on the range of sanctions that are available to deal with offenders can be obtained from the NHS SMS's Legal Protection Unit. The unit's contact details are available from the NHS SMS's website: **www.nhsbsa.nhs.uk/security**.

8.6.6 Finally, it is important to remember that following an incident and investigation, the LSMS should keep the victim (and any witnesses) fully informed of progress, supported and, where appropriate, involved in the process as the case progresses to court. LSMSs should refer to the Home Office website, where they can read the victim's charter and, more specifically, the code of practice for victims of crime, which sets out the services that victims can expect to receive from the criminal justice system: **http://www.homeoffice.gov.uk/documents/victims-charter**.

8.7 Publicity

8.7.1 Making use of the media, both nationally and locally, is a highly effective means of promoting what the NHS is doing to protect its lone workers – including the introduction of lone worker protection procedures, systems and technology.

8.7.2 Locally, LSMSs should establish good relationships with their healthcare organisation's press, media or communications officers to ensure the appropriate publicity for measures introduced to protect lone workers. Nationally, the media team at the NHS SMS will provide guidance to LSMSs who wish to promote such measures to their local press and other media. This is to ensure the correct balance between achieving the required deterrent effect and ensuring that staff are not put at further risk.

8.7.3 This can help to promote a pro-security culture amongst the general public by raising awareness of the systems in place to protect NHS workers and why they are needed. It also strengthens public disapproval of the small minority who present such risks to staff. It also makes clear to staff the commitment of the healthcare organisation to improving the security and safety of its lone workers.

8.7.4 Publicity of cases that clearly demonstrate the problems encountered by lone workers and the measures in place to protect them will ensure that equal publicity is given to the problems identified and the solutions implemented.

8.7.5 A true deterrent effect can only be achieved when:

- there is a strong chance that potential offenders will be apprehended
- they understand that they will be punished for their actions where appropriate
- the sanctions that may be applied against them outweigh any perceived benefit from their actions.

8.7.6 In addition to playing a key role in helping to protect staff from physical and non-physical assaults, appropriate publicity of the sanctions applied to those who have targeted lone workers may also deter others who may be minded to commit such acts.

8.7.7 See the NHS SMS website for posters, leaflets and other resources to raise awareness about the need to protect lone workers: www.nhsbsa.nhs.uk/security.

9. Technology

9.1 This section covers:

- introduction
- lone working devices
- practical suggestions on the use of a mobile phone
- practical suggestions on the use of a personal audible or screech alarm
- practical suggestions on the use of other lone working protection devices
- lone worker service
- definition
- before a visit
- escalation process
- training
- during a visit
- recording
- post-visit
- archiving
- marketing and publicity.

9.2 Introduction

9.2.1 Technology should not be seen as a solution in itself. Consideration must be given to the legal and ethical implications of its use, as well as to its limitations.

9.2.2 Technology, however, can play an important part in helping to protect lone workers, as part of a robust risk assessment process. This guidance provides advice to help healthcare organisations choose the right system, which is appropriate to their needs and the needs of their staff, as well as to minimise the risks that they face. However, it is also clear that technology can only be effective if it works alongside:

- a rigorous risk assessment process for managers and staff
- clear and robust management policies and procedures that put in place measures to address identified and potential risks and to deal with incidents when they occur
- managers and staff accepting responsibility for and supporting the need to operate systems, procedures and technology provided for their protection
- the sharing of information from within and outside the NHS on identified and potential risks
- support and proportionate response from the police and technology support services when a lone worker device is activated

- the provision of good-quality conflict resolution training to help staff prevent and manage violent situations
- device-specific lone worker safety training including scenarios that reflect the fact that lone workers have been issued with a device and that support services are in place.

9.2.3 The requirement for technology should result from risk assessments, pre-or post-incident reviews and analysis of relevant reports and operational information. It is essential that LSMSs and security management directors take responsibility for ensuring that technology is used appropriately and effectively and that it is proportionate to the problem it is intended to address.

9.3 Lone working devices

9.3.1 It is essential to recognise that lone worker devices will not prevent incidents from occurring. They will not make people invincible, nor should they be used in a way that could be seen to intimidate, harass or coerce someone. However, if used correctly in conjunction with robust procedures, they will enhance the protection of lone workers. Lone workers should still exercise caution even if equipped with such devices and continue to use the dynamic risk assessment process. Finally, lone workers should remember that a device will only be useful if checked regularly, properly maintained and kept fully charged.

9.3.2 The successful introduction of a lone worker alarm system relies on healthcare organisations employing a comprehensive and inclusive approach to determine the most appropriate system, involving staff, professionals and staff safety representatives. Where an evaluation has taken place, the following will be of value as a deterrent and to enable a response to an incident:

- internal alert systems that are activated from static panic buttons in treatment rooms, with clear procedures on when and by whom they are to be activated and what the response should be
- internal alert systems that are activated from portable panic attack devices and used by individual workers (some of these systems are connected to a central control room, which is alerted when an incident is occurring and can indicate its exact location and ensure an immediate response)
- fixed panic buttons that are linked to a switchboard and (following a risk assessment) can be linked to the police (for example, in some accident and emergency department settings and remote clinics, or clinics in inner city areas identified as high-risk)
- mobile human resource safety devices and systems that are operated using mobile technology or handsets; some may also incorporate global positioning satellites (GPS)
- personal attack alarms that emit a high-pitched noise on activation and may be battery or aerosol powered.

9.3.3 CCTV is widely used as a crime prevention measure within NHS organisations. It also has its place in the protection of lone workers inside and outside NHS premises.

9.3.4 When making a decision to invest in lone worker protection systems or devices, there are a number of issues that healthcare organisations should consider. An outline of the practical requirements when investing in lone worker systems will be issued by the NHS SMS in due course.

9.3.5 All the above devices can send a strong deterrent message to potential offenders. They may also improve the feeling of confidence amongst NHS staff, helping to reduce the fear of crime. However, physical security measures in the absence of appropriate policies, procedures, and training to prevent and manage violence may create a false sense of security. It is therefore important to adopt a holistic approach to the problem.

9.3.6 Lone working systems and devices must only be used for their intended purpose: to improve the safety of lone workers. To use them for other purposes will compromise the integrity of the system and may deter lone workers from using it. As well as jeopardising lone workers' safety, lack of use could result in monitoring services being withdrawn. In some cases, the police may refuse to attend incidents if there has been a history of misuse or false alarms.

9.3.7 If a lone worker protection device is misued frequently or maliciously, the matter should be referred to the LSMS for investigation.

9.3.8 It is essential that lone workers receive appropriate training and instruction in the use of such devices. They must be given sufficient time to become familiar with lone worker procedures, systems and devices before they are expected to use them in their day-to-day work.

9.4 Practical suggestions on the use of a mobile phone

9.4.1 Lone workers will inevitably carry mobile phones and they should always check the signal strength before entering a lone working situation. A mobile phone should never be relied on as the only means of communication. Lone workers should tell their manager or a colleague about any visit in advance, including its location and nature, and when they expect to arrive and leave. Afterwards, they should let their manager or colleague know that they are safe.

9.4.2 If provided, a mobile phone should always be kept as fully charged as possible.

9.4.3 The lone worker should ensure they can use the mobile phone properly, by familiarising themselves with the handset and instruction manual.

9.4.4 Emergency contacts should be kept on speed dial.

9.4.5 The phone should be kept nearby and never left unattended.

9.4.6 Lone workers should be sensitive to the fact that using a mobile phone could escalate an aggressive situation.

9.4.7 In some circumstances, agreed ‘code’ words or phrases should be used to help lone workers convey the nature of the threat to their managers or colleagues so that they can provide the appropriate response, such as involving the police. The decision to use code words or phrases should give due consideration to the ability of a member of staff to recall and use them in a highly stressful situation.

9.4.8 A mobile phone could also be a target for thieves. Care should be taken to use it as discreetly as possible, while remaining aware of risks and keeping it within reach at all times.

9.4.9 It is against the law to use a mobile phone while driving. Employers should consider providing staff with hands-free equipment if appropriate.

9.5 Practical suggestions on the use of a personal audible or screech alarm

9.5.1 These alarms are primarily designed to create a distraction to allow the member of staff to escape from a violent or threatening situation. The lone worker and line manager should ensure the alarm is fully operational through regular checks (away from the working environment to prevent false alarms). This is especially important before any situation in which they will or might be working alone.

9.5.2 The alarm’s battery (or aerosol) should also be checked regularly.

9.5.3 The lone worker should carry the alarm in their hand, or within easy reach in a pocket or clipped to a belt, ready for use and not concealed in a bag.

9.5.4 The devices should be used pointing towards the potential assailant, away from the lone worker.

9.5.5 The lone worker should also ensure that they are aware of the procedures for sounding a personal attack alarm and the expected response. The assumption must be that there is no certainty of assistance; car alarms, for example, are often ignored. Audible alarms are primarily to ‘stun’ an assailant for a few seconds, allowing the lone worker to make their escape.

9.5.6 It is also recommended that the lone worker discards the personal alarm so that the assailant’s attention is diverted to silencing it. Some experts do not like to advise the use of personal alarms indoors or where there are no clear escape routes because of the risk of escalating the situation. Their view is that these alarms are more suitable for outside use.

9.6 Practical suggestions on other forms of lone worker protection devices

9.6.1 Line managers should ensure that lone workers have received appropriate training on a particular product or device. They should be satisfied, as far as possible, that the lone worker is confident in handling it and familiar with the procedures and

systems in place to support its use. If in any doubt, instruction should be offered and the lone worker should feel comfortable in requesting such training.

9.6.2 Great care should be taken to ensure that the device is in good working order and that it is fully charged or its batteries are changed regularly. The lone worker should test the device as suggested in instruction manuals, in training or by their manager.

9.6.3 Agreed ‘code’ words or phrases should be used (see 9.4.7)

9.6.4 The device should be kept nearby so that it may be activated quickly.

9.6.5 The lone worker should be familiar with the response they can expect if an alert is raised.

9.7 NHS lone worker service

9.7.1 **Definition**

9.7.2 The NHS has a framework agreement which provides lone worker services. This has been negotiated centrally on behalf of the NHS in England. Under the agreement, a supplier provides services to those NHS organisations that wish to contract them. The overall service provides:

- helpdesk facilities
- training
- network services
- lone worker devices
- alarm receiving centre (ARC) services.

9.7.3 Through this service, a lone worker can use a device to record their location as they go about their work; this is called an amber alert. If they feel that their safety may be threatened, they can send a red alert to the ARC. The ARC can then listen to the lone worker’s incident and use technology to confirm their location. It can then notify the emergency services or the escalation point as required to provide an appropriate response. The service also records incidents in a format that can be used as evidence in court. Lone workers can only use this service if they give their prior consent to being located when they activate a red alert.

9.8 Before a visit

9.8.1 All NHS organisations have a legal responsibility to protect their staff from incidents of violence, threatening behaviour and verbal abuse. NHS organisations are now starting to utilise lone worker services to protect lone working staff by monitoring and recording incidents where staff feel their safety is threatened and providing an appropriate response.

9.9 Escalation process

9.9.1 NHS organisations need to have an escalation policy and process in order for lone worker services to be effective (see section 6.19) This information will be held securely by the service supplier and used to trigger an appropriate response once an alert has been activated.

9.10 Training

9.10.1 It is important that lone workers who use a device fully understand the service that supports it and the policies they need to adhere to in order for the service to be effective.

9.10.2 All lone worker users are expected to attend a minimum of one training course provided by the supplier before they use the service. The supplier will ensure that face-to-face training is the preferred option.

9.10.3 This is in addition to any other essential training (e.g. conflict resolution training) designed to protect lone workers.

9.11 During a visit

9.11.1 During an incident, if a lone worker activates their device, the supplier's ARC monitors their red alert and last amber alert and uses technology to locate them. If necessary, the ARC will then communicate directly with the emergency services to obtain assistance. They will also continue to listen to the incident until they receive confirmation that the lone worker is safe.

9.11.2 ARC staff monitor and manage escalations relating to red alerts. As soon as they have confirmed a red alert, they will follow the escalation path. If they assess the threat levels as high, they will immediately contact the relevant emergency service.

9.11.3 ARC staff will have sufficient information on the user's location from both the amber alert and the device technology, where GPS information is available. They will also be able to obtain regular updates on that position.

9.12 Recording

9.12.1 When a lone worker activates the device, the ARC will record the incident. The lone worker is under *no* obligation to inform the alleged assailant that a device has been activated or that the incident is being recorded.

9.12.2 Information obtained through this service during an incident is admissible as evidence in criminal proceedings. All or relevant parts of a recording may be transcribed and used as evidence to progress criminal, civil or local sanctions against an alleged offender.

9.13 Post-visit

9.13.1 If an incident is recorded, the NHS organisation's LSMS will be informed by the supplier. The LSMS will listen to the recording and, if necessary, take appropriate action to progress criminal, civil or local sanctions. Access to recordings of incidents must only be given to the police or the LSMS through the defined process.

9.13.2 Where possible, the alleged assailant will be informed that the incident has been recorded.

9.14 Archiving

9.14.1 False red alerts

If a red alert is false and no incident has occurred (for example, accidental activation), the recording is securely deleted.

9.14.2 Genuine red alerts

Genuine red alerts are retained for use in criminal, civil or disciplinary sanctions and are securely destroyed by the supplier after 12 months.

9.14.3 Amber alerts

Amber alerts will be kept for a maximum of three months, at which point they will be securely deleted by the supplier. Amber alerts relating to a genuine red alert (i.e. those created on the same day) will be retained for 12 months, after which they will be securely deleted by the supplier.

9.15 Marketing and publicity

9.15.1 The NHS organisation has an obligation to promote the lone worker services used by its NHS staff to patients, service users, stakeholders and the public. This is to publicise and raise the profile of the services, act as a deterrent by highlighting the benefits of the service to better protect lone workers and explain the important features of the lone worker services to all interested parties.

9.15.2 The NHS organisation is expected to support the supplier's marketing and publicity strategy around lone worker services and ensure that NHS facilities to which the public has access contain information on the organisation's use of lone worker services.

10. Annexes

- **Annex 1 – References**
- **Annex 2 – Checklist for managers**
- **Annex 3 – Lone worker incident actions flowchart**

Annex 1 – references

The following documents should be read in conjunction with this guidance. All are available online and can help NHS organisations develop lone working policies and procedures.

- NHS Counter Fraud and Security Management Service, 2002. **The Policy and operational responsibility for the management of security in the NHS Statutory Instrument 2002/3039** [online] Crown copyright. Available from: **http://www.opsi.gov.uk/si/si2002/20023039.htm**
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- Department of Health, 2003. **Directions to NHS bodies on measures to deal with violence against NHS staff 2003.** [online] NHS CFSMS. Available from: **http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/vas_directions.pdf**
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- NHS Counter Fraud and Security Management Service, 2004. **Non-physical assault explanatory notes. A framework for reporting and dealing with non-physical assaults against NHS staff and professionals**.[online] NHS CFSMS.

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- NHS Counter Fraud and Security Management Service, 2005. **Prevention and management of violence where withdrawal of treatment is not an option**. [online] NHS CFSMS. Available from: **http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/prev_man_violence.pdf**

- NHS Counter Fraud and Security Management Service, 2006. **Offensive weapons. NHS Security Management Service guidance**. [online] NHS CFSMS. Available from: **http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/offensive_weapons.pdf**
- NHS Counter Fraud and Security Management Service, 2007. **Tackling violence against staff. Explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003**. [online] NHS CFSMS. Available from: **http://www.nhsbsa.nhs.uk/SecurityManagement/Documents/Tackling_violence_against_staff_2007.pdf**
- Criminal Justice and Immigration Act 2008 Part 8 (119-121) **Causing a nuisance or disturbance on NHS premises**. [online] Office of Public Sector Information. Available from: **http://www.opsi.gov.uk/acts/acts2008/ukpga_20080004_en_14#pt8-pb2-l1g121**
- NHS Security Management Manual. In particular, chapter 14 **Developing a policy for the management of security** – restricted document – available to all trained and accredited Local Security Management Specialists
- NHS Security Management Manual. In particular, chapter 15 **Developing a policy for the protection of lone workers** – restricted document – available to all trained and accredited Local Security Management Specialists

Annex 2 – checklist for managers

Are your staff –

1. *issued* with all relevant policies and procedures relating to lone working staff?

2. *trained* in appropriate strategies for the prevention and management of violence (in particular, have they received conflict resolution training)?

3. *given* all information about the potential risks for aggression and violence in relation to patients/service users and the appropriate measures needed to control these risks?

4. *issued* with appropriate safety equipment and the procedures for maintaining such equipment?

5. *trained* to be able to confidently use a device and familiar with the support service systems in place before being issued with it?

6. *aware of* how to report an incident and of the need to report all incidents when they occur?

7. *issued* with the necessary contacts for post-incident support?

Are they –

8. *aware* of the importance of doing proper planning before a visit, being aware of the risks and doing all they can to ensure their own safety in advance of a visit?

9. *aware* of the importance of leaving an itinerary of movements with their line manager and/or appropriate colleagues?

10. *aware* of the need to keep in regular contact with appropriate colleagues and, where relevant, their nominated 'buddy'?

11. *aware* of the need to carry out continual dynamic risk assessments during a visit and take an appropriate course of action?

12. *aware* of how to obtain support and advice from management in and outside of normal working hours?

13. *aware* that they should never put themselves or colleagues in any danger and if they feel threatened should withdraw immediately?

Do they –

14. *appreciate* the organisation's commitment to and support for the protection of lone workers and the measures that have been put in place to protect them?

15. *appreciate* that they have their own responsibilities for their own safety?

16. *appreciate* the circumstances under which visits should be terminated?

17. *appreciate* the requirements for reporting incidents of aggression and violence?

18. *understand* the support made available to lone workers by the trust, especially post-incident support and the mechanism to access such support?

Annex 3 – lone worker incident actions flowchart

Incident occurs

- The lone worker:
  1. activates lone worker alarm device if issued
  2. removes themselves from the situation/environment to a place of safety
  3. contacts:
     (a) police
     (b) manager/buddy

5. The lone worker returns to work base as soon as practicable to complete an incident report form or a serious untoward incident form.

6. If a physical assault, a completed PARS form is submitted to the NHS SMS.

7. The line manager initiates a post- incident review in conjunction with risk, health and safety and LSMS.

- Post-incident review process begins – including:
  - medical review (consultant/doctor)
  - LSMS investigation
  - security review (LSMS)
  - quantifying/regulating (risk management)
  - counselling/support as appropriate to employee or other individuals affected by incident
  - following up on all witnesses to the incident.
  - conduct risk assessment.

- Review process also provides feedback on processes/systems in place, identified weaknesses and lessons learned.

If NHS organisation uses the NHS lone worker service, the activity below is triggered

Lone worker device activated for a genuine alarm

- Alarm receiving centre (ARC) operator monitors the incident. A recording is made and the lone worker's location is identified.

- ARC operator conducts a full risk assessment of the incident and takes appropriate action, following the pre-determined escalation path.
- If risk is severe, they contact the emergency services.

- The LSMS listens to the recording. If no action by the police has been taken, the LSMS will, if necessary, take appropriate action to progress criminal, civil or local sanctions in conjunction with the police and Crown Prosecution Service.

For information

- If incident was a false alarm (i.e. accidental activation):
  1. recording is closed with user's agreement
  2. record is deleted.