

Lone working

An increasing number of NHS staff work alone in community settings such as patients' homes or on outreach work. Lone workers can be vulnerable and at increased risk of physical or verbal abuse and harassment from patients, clients, their relatives or members of the public, simply because they don't have the immediate support of colleagues or security staff.

Over 2009/10, 30,000 NHS lone workers are receiving personal security alarms following a commitment made by former Health Secretary Alan Johnson to improve the safety and security of staff.

The lone worker alarm system is designed for nurses and other healthcare staff who work in isolation from colleagues and may need to call for assistance if their personal security is threatened. The Partnership for Occupational Safety and Health in Healthcare (POSHH), working closely with the NHS Security Management Service, has produced this chapter to help employers, managers and staff deal with the important issue of staff working on their own, and in particular to stress the need for robust risk assessment and risk management in lone worker situations.

Who is at risk?

The risk factor most strongly associated with assaults at work is the occupational group in which a person is employed (Budd, 1999). However, exposure to violence at work not only depends on a person's occupation but also on the circumstances and situations in which they perform their job. Working alone, for example, increases the vulnerability of workers (Chappell & Di Martino, 2000).

Definition of a lone worker

The Health and Safety Executive (HSE) defines lone workers as "those who work by themselves without close or direct supervision" (Working alone in safety: controlling the risks of solitary work, HSE, 1998) and lists a number of examples, including those who:

1. work from a fixed base, such as one person working alone on a premises (for example estates staff)
2. work separately from others on the same premises (for example security staff) or outside normal hours (for example on-call staff)
3. work away from a fixed base (for example community nurses)
4. work at home (for example various non-clinical staff)
5. mobile workers (for example first responders).

Lone working does not automatically mean a higher risk of violence, but it is generally understood that it does increase workers' vulnerability. This vulnerability will depend on the type of situation in which the lone work is being carried out.

The NHS Security Management Service 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”

Below are 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 staff
- 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 or clinical staff on escort duty
- carers in the community or in community homes
- a technician working alone in a laboratory.

The law

An employer's responsibilities for lone workers are governed not only by the common law duty of care but also by the following specific pieces of legislation:

[Health and Safety at Work Act 1974](#)

NHS 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.

[Secretary of State Directions](#)

NHS 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, amended 2006).

[The scale of the problem](#)

Up to 100,000 healthcare professionals are working on their own in the NHS every day. More than half of those taking part in a Royal College of Nursing (RCN) survey said they thought the risk of violence or abuse had risen over the last two years

The RCN and other staff-side organisations have now called on employers to comply with their legal duty to protect nurses, by implementing a five-point plan of action covering:

1. risk assessments
2. prevention
3. policy
4. training
5. support from the employer.

To ensure staff safety, it is important that employers support them by undertaking to:

- provide information to help healthcare professionals assess risks and ensure safety
- invest in technology and services that help staff to summon help discreetly
- provide a clear policy on lone working
- provide training, for example on conflict management

They should put preventative measures in place as well as creating systems that provide immediate support in the event of violence. The following section on the roles of local security management specialists, line managers and staff is taken from guidance on lone working published by the NHS Security Management Service (*Not Alone: A guide for the better protection of lone workers in the NHS*. NHS Security Management Service, 2009).

The role of the local security management specialist (LSMS)

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.

Such local policies and procedures should always be developed in consultation with relevant stakeholders. These include health and safety advisers, line managers, human resources representatives, risk managers and staff representatives such as trade unions and professional bodies.

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.

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.

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. 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 taken.

The role of line manager

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.

This includes ensuring that a suitable and sufficient risk assessment is conducted in consultation with the appropriate people (for example LSMS, health and safety manager, risk manager), to ensure that all risks from lone working are identified

and appropriate control measures introduced to minimise, control or remove them.

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.

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.

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.

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 (for example 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.

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 to try to prevent a recurrence.

The role of the staff member

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, training in the use of technology and any other information, instructions, equipment and advice from their line managers regarding lone working.

Staff should plan appropriately and risk assess before a visit. They must 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.

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.

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.

Risk management process

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

Identification of risks

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.

Identification of risks for lone workers

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.

For more information on identifying risks, see the Management of Health and Safety at Work Regulations 1999 and the Health and Safety Executive's *Five steps to risk assessment* at www.hse.gov.uk/risk/fivesteps.htm

The 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
- lone workers wearing uniforms when visiting certain patients/service users
- those working in or travelling between certain environments or settings
- lone workers carrying equipment that makes them a target for theft or less able to protect themselves
- evaluation of capability to undertake lone working, for example being inexperienced or pregnant, or having a disability.

Risk assessment

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:

- type of incident risk (for example physical assault/theft of property or equipment)
- frequency/likelihood of incident occurring and having an impact on individuals, resources and delivery of patient care
- likely 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.

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.

Managing risk

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.

These measures should be achievable, proportionate to 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.

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.

Before a lone worker visit

Where it is practicable, a log of known risks should be kept. This should record the location and details of patients/service users/other people who 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 if they have to make a visit to an address or person on that log.

Violent patient scheme

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.

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.

Violent patient indicator

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 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 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.

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

Information sharing

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.

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 healthcare organisation forums, and liaison with the police.

Low-risk activities

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, for example someone leaving an empty building alone at night.

High-risk activities

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.

Scheduling visits

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. 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 arrange a police presence. As part of the risk assessment process, consideration should also be given to whether the patient/service user is able to, and should, be treated by attending a clinic or hospital.

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

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.

Emergency equipment

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, and so on.

Lone worker movements

Lone workers should always ensure that someone else, for example 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.

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.

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.

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

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.

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 can be made (mobile phone, pager, and so on), the manager or colleague should consider involving the police.

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.

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. This can result in unnecessary escalation and expense, which undermines the integrity of the process.

The buddy system

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'.

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.

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

- The buddy must be made aware that they have been nominated and the procedures and requirement for this role.
- 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.

Training – lone working, personal safety and conflict resolution training

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.

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.

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.

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 lone workers and their colleagues may face.

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.

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.

Recognising warning signs

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.

More information

POSHH Improving safety for lone workers online leaflets
www.nhsemployers.org/HealthyWorkplaces/StaffHealthAndWell-Being/Pages/POSHHViolenceandAggressionWorkingGroup.aspx

Health and Safety Executive's Five Steps to Risk Assessment
www.hse.gov.uk/risk/fivesteps.htm

Not Alone: A guide for the better protection of lone workers in the NHS
NHS Security Management Service, 2009
www.nhsbsa.nhs.uk/2460.aspx