



BRITISH GERIATRICS SOCIETY  
SPECIALIST MEDICAL SOCIETY FOR HEALTH IN OLD AGE

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Submission by the British Geriatrics Society to the NHS Security Management Service on:

**Marking the electronic care records of violent patients**

**The British Geriatrics Society**

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

**Geriatric Medicine**

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society is delighted to be given the opportunity to contribute to this debate.

1. Whilst we fully support the desire to protect health and social care staff from abuse and harm we have reservations about the proposed measures.
2. This is a complex issue that might, on balance, be associated with more harm than benefit for older people. Unless there are specific safeguards, there is a danger that such a system will include patients with episodes of delirium (acute confusion due to an acute medical illness) that may have caused them to act in an aggressive or violent manner. To characterise such patients on their health record as aggressive would be misleading and unfair. Indeed, marking the care records of such patients might be counter-productive in causing them to be regarded as potentially "difficult" patients by health staff, so jeopardising their care.
3. Despite being the commonest complication of hospitalisation delirium is currently poorly diagnosed and managed and so it is highly likely that an episode of aggression in the context of delirium will not be recognised as such. This will lead to un-necessary stigmatisation of the vulnerable person (many patients who suffer delirium have dementia as a predisposing factor). Should the care records of such individuals be electronically flagged, we see immense potential for this to become a disservice to them with resultant discrimination of older people with any form of cognitive impairment (chronic, i.e. dementia, or acute, i.e. delirium) and result in them receiving inadequate care.
4. Any person who is ill, but particularly an older person, is at risk of delirium, which may lead them to be violent to staff when they lack capacity. Such aggression within an episode of delirium may be completely out of character for that individual and should not warrant their notes being labelled as their being aggressive / violent. Their behaviour is best dealt with by treating the cause of their delirium, training of staff to recognise and manage delirium, attention to their basic care needs and will not be helped by labelling.

5. As delirium is so poorly recognised we are not convinced that this would always be recognised as the underlying cause of behavioural disturbance and therefore be adequately represented at the panel which determines whether VPI is appropriate or not.
6. As age, dementia, and multiple complex medical problems are all associated with 'frequent flyer' status (recurrent hospital admissions) and are also risk factors for delirium, such individuals are at risk of both being readmitted to hospital and further episodes of delirium. Therefore, we are not reassured that the intention to revoke a VPI within 6-12 months will occur for these patients. If a VPI is seen to be in force for any length of time this will inevitably result in further stigmatisation of that individual.
7. We all have a right to un-prejudiced non-judgemental healthcare, previous bad behaviour should not be held against us, and bears no relation to our requirement to equal access at the point of need.
8. Potentially aggressive people are always best approached with open-minded respect and calmness i.e. there is no need for special treatment of such people.
9. Conflict will escalate when staff are not trained in conflict management or managing confused people, when there are not enough staff to adequately care for the patients in their care and when the environment is not conducive to the care of sick elderly patients. These 3 areas should be improved before we consider stigmatising people by labelling their care records.
10. The document states the purpose is 'not to stigmatize but manage risk' and that is laudable, so too is the statement that a VPI will enable staff to seek professional advice on how best to handle the individual - but the process of full reports and investigation etc is going to be extremely bureaucratic and time consuming. The current system of incident reporting is probably underused for recording violent actions and different staff have varying tolerance levels e.g. pinching might be ignored by one person and amplified by another. If **all** examples **were** reported the scale of the problem would be enormous

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President  
For and on behalf of British Geriatrics Society  
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