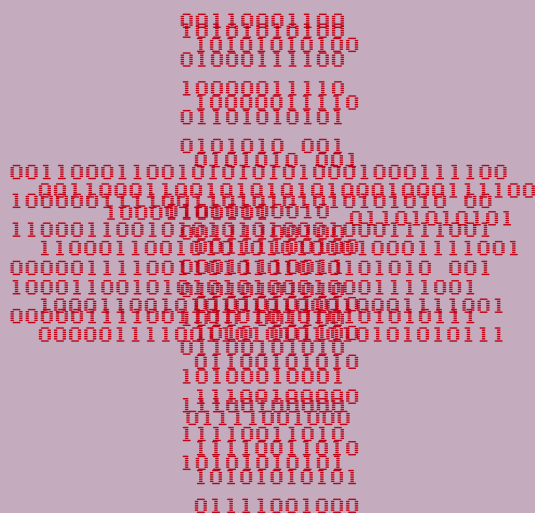


# Geweldsregistratie door ziekenhuizen

Procesevaluatie van de pilot 'Preventieve aanpak geweld'

Engelstalige samenvatting



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# Summary

Violent incidents affect the safety as well as the health of citizens. In the Netherlands, every year, 29,000 victims attend an emergency department (ED). The care costs add up to about 33 million euros a year, the costs of any absenteeism (74 million euros) are not yet included. Many violent incidents remain hidden to the police and municipalities. Since 2012, Amsterdam has started the pilot project 'Preventive approach to violence' where hospitals, municipality, police and other parties cooperate with the objective to reduce the number of victims of violence.

For the pilot project, seven hospitals in the Amsterdam region register data of patients who attend the ED with violence-related injuries. At the ED some characteristics of the violent incidents for which victims attend the ED are recorded. These data are sent to VeiligheidNL (organization for safety in the Netherlands) which makes a report based on these data. A reviewing committee checks these reports on non-traceability and verifies if the patients' privacy is sufficiently safeguarded. Next, the report is sent to municipality and police and they, in turn, must evaluate if the data give sufficient reason to take preventive measures in order to prevent violence.

## *Theoretical framework*

The theoretical background of the pilot can be traced back to the need to tackle safety problems more problem-oriented, information-directed and structured. More specific information regarding violent incidents is conducive to a better approach and can contribute to prevention. A similar initiative in Cardiff has led to various preventive measures such as an increase in surveillances on hotspots which came up from the recorded injuries. An effect evaluation points out that the number of hospital admissions in Cardiff due to violent incidents decreased by more than 40 percent, while in comparable cities in the United Kingdom the number has actually increased.

## *Methods*

This research concerns a process evaluation of the pilot. The research on which this process evaluation is based, involves the period from June 2013 until June 2014 inclusive. The key question in the process evaluation is to what extent the procedure is implemented as intended, and which adjustments are possibly needed to optimize the implementation process and to measure the effects. On behalf of the process evaluation several research methods have been applied: consulting and analyzing documentation, attending meetings, conducting case studies per hospital and interviews.

For the process evaluation, subjects to be evaluated were determined based on the documentation which was the basis of the pilot. These subjects refer to: contents, the objective and phasing of the pilot; the organization; legal context; the practical implementation and the violence registrations and reports.

The implementation of the pilot relates to the agreed arrangements which are included in various documents. When the pilot project was launched, not every detail was thought out. Actually, the pilot developed itself during the process. On the one hand this is inherent in such complex processes, on the other hand, broad outlines of how the pilot must be implemented give insufficient leads to the pilot partners in the case of difficulties. The pilot is still running. Therefore, it is possible that some findings as described in this report are not up-to-date anymore.

## *Results*

The pilot knows a phased structure which starts with setting up a project organization and must result in determining the effect of the taken measures to prevent violence. In accordance with the agreement, a project organization was set up, consisting of a project group and a steering group. The latter spent a lot of time on creating a support at the hospitals in Amsterdam in order to let them register violent incidents. The managements of the seven hospitals in Amsterdam pledged their official cooperation. A reviewing committee monitors, as agreed by the pilot partners (municipality, police, hospitals and VeiligheidNL), the legal standards where the reports have to comply with (non-traceability of the data). According to the agreement there was an exchange of information between the hospitals and police and municipality. At the time of the process evaluation, the last two mentioned have not taken preventive measures based on reports which were provided by VeiligheidNL and approved by the reviewing committee. Monitoring the measures and determining the effect on the level of violence in Amsterdam therefore still has to take place.

As for the stages of the pilot, the implementation is behind on schedule. There are a number of causes. One cause is that two hospitals, for several reasons, started later with the registration of the violent incidents. Another cause for being behind

on the planned implementation of the pilot is related to the indistinctness about the form and contents of the reports between police and municipality on the one hand and VeiligheidNL on the other. These reports consist of tables and not of an analysis of hotspots and hot-times and an interpretation of the results. As yet, police and municipality are not able to manage the tables well. About form and contents of the reports, no (clear) arrangements have been made beforehand. Bringing the world of care and safety together has cost a lot of time, which made that other for the pilot important issues, such as the wishes and expectations regarding the reports, have been pushed somewhat into the background.

There are big differences between the hospitals regarding the quality of the registrations. These vary from a hospital which (practically) records every victim of violence to, according to the hospital itself, a hospital that only records a small part of the victims. The percentage of 'missings' in - for violence prevention - important variables such as time, location and offender-victim relationship, is rather high (about 30%). Attempts from the project group to increase the quality of the registrations have had little effect at the time of this process evaluation. During the pilot, next to the project group and steering group, a working group was set up in which representatives of the hospitals participate with the primary goal to involve the hospitals more in the pilot. This did not result in considerable quality improvements of the registrations.

The differences in quality of the registrations between the hospitals depend, for the most part, on the fact if the registration procedure is part of the workflow, who takes care of the registrations, and if the quality control is safeguarded at the hospitals by points of contacts, who want and are able to commit themselves to the pilot. Hospitals which are doing well with regard to the registrations, have integrated the violence registrations well in the work and registration process. Nurses take care of the registrations immediately after contact with the patient. Coordinators periodically verify the entered registrations and complete these where possible. They stimulate ED-employers to continue the registrations. The hospitals that are behind in the quality of the registrations, have not arranged it, or less well, on one or more of above mentioned matters (integration in workflow, safeguarding quality control etc.).

At the shop floor there is indeed support for the pilot but practice shows that the registration discipline can slacken in the hectic situation of an ED if not regularly a feedback of their efforts is given. In a number of hospitals this feedback by a concerned coordinator lacks on the shop floor.

The respondents endorse the goal of the pilot, namely reducing the victims of violence at the ED. The research provides a number of points for improvement which must be applied, for instance so that all hospitals register the victims of violence as complete as possible, so that – considering the legal framework - target

group analyses, hotspots and hot-times analyses are made possible and police and municipality can take preventive measures based on these analyses. These possible measures must be given time to take shape. Determining the effects early is not desirable.

### *In conclusion*

In order to give the pilot in Amsterdam the opportunity to prove itself, it is necessary that in the short-term attention will be paid to two essential aspects: the quality of the registrations by the hospitals and the reports of VeiligheidNL. The commitment of the hospitals should lead to actively encouraging the quality of the registrations. Judging by the quality of the hospitals that register correctly, it should be possible to identify and register at least 85 percent of the violence victims. The registrations must then be as complete as possible (>80%) with regard to the key variables (location, time, offender-victim relationship). The second aspect concerns the form and contents of the reports. The reports should be immediately usable for police and municipality, which means that in the reports hotspots and hot-times are presented in an orderly way with an interpretation of the results.

Should the pilot result in measurable preventive measures, than a number of points requiring attention are important for an effect evaluation. Autonomous developments, such as the decrease in crime in general, fewer ED visitors because of alterations in the national health insurance system and the role of the GP emergency post, must be included in this. Furthermore it is important to determine the added value of the hospital data next to what is already known to the police and to take ongoing initiatives in the area of violence prevention into account.



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