Comment

This survey looked only at drivers with clearly inadequate visual acuity; it did not consider those with disabilities in other aspects of visual function, such as the visual field. Additionally, it relied on honesty to admit driving with inadequate vision.

Despite this rather liberal assessment of what constituted inadequate visual acuity, and the potential for underreporting, 14% of drivers examined were classed as having inadequate vision. This is considerably higher than in previous reports and probably reflects the different populations examined. Though informed that they had no possibility of passing the visual standard and being strongly advised to stop driving, over half of this group admitted ignoring the advice. Analysis of the results suggested that it is not possible to identify people who will knowingly continue to drive illegally by the easily observable characteristics of age, sex, diagnosis, and visual acuity.

There is continuing debate over the importance of vision to a driver.[3-5] Whatever the outcome, this survey calls into question the efficacy of the current system for meeting visual acuity standards. Although generalisation is dangerous, it would seem that relying on drivers to stop driving of their own volition is not an adequate policy. Respect for the relevant law is outweighed for many people by personal and social pressures and they continue to drive, both against the law and against advice.

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Assaults on professional carers of elderly people

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Many residents in homes for elderly people have severe behaviour disturbance and mental illness.[1,2] The problem may become worse in future as the numbers of elderly people increase and continuing care beds in psychiatric hospitals are closed. This study aimed at establishing the rates of assaults on staff caring for elderly people in various residential settings.

Subjects, methods, and results

We collected data from four units in each of the following types of care environments for elderly people in Bristol: elderly people's homes; homes for elderly mentally infirm people; private nursing homes; and psychogeriatric hospital wards. Staff were invited to complete a questionnaire anonymously. The questionnaire included items on the staff's experience of aggression from elderly residents and demographic information. A physical assault was defined as physical contact made with the intention of causing harm. The physical assaults were categorised by severity of injury as mild (no visible injury), moderate (visible injury such as bruising but no treatment required), or severe (required medical treatment or time off work, or both).[3] We tested the significance of the differences between the mean number of assaults by modified t tests using the Bonferroni method.

Questionnaires were completed by 204 care staff, nurses, and managers (response rate 73%). Most staff, with the exception of hospital staff, were unqualified, and few had been trained in managing aggression.

The table shows the rates of reported assault in the week of study. Of the 468 physical assaults, 381 were classified as mild and 87 as moderate. Hospital staff were assaulted significantly more often than staff in nursing homes ($t=3{\cdot}92$, $p<0{\cdot}001$, df=92) and elderly people's homes ($t=5{\cdot}33$, $p<0{\cdot}001$, df=72) but not more often than those in homes for elderly mentally infirm people ($t=2{\cdot}14$, $p=0{\cdot}21$, df=106).

Thirty one staff had had an assault which required medical treatment or time off work, or both, at some time in their present post. Seventeen of the 31 had been punched or kicked, eight reported head or face injuries, and three had been strangled. Three members of staff had been bitten, and one had been threatened with a knife. Two staff reported permanent disability from hand injuries sustained during assaults and another had required 12 weeks' sick leave after falling because of being kicked.

Characteristics of staff and reported assaults

	Elderly people's homes (n=38)	Nursing homes (n=58)	Homes for elderly mentally infirm people (n=72)	Hospital wards (n=36)
No (%) of staff with formal qualification	8 (21)	23 (40)	20 (28)	22 (61)
No (%) of staff trained in managing aggression	6 (16)	13 (22)	20 (28)	14 (39)
No (%) of staff physically assaulted in the past week	6 (16)	34 (59)	47 (65)	29 (81)
Mean (SD) No of physical assaults/member of staff in the week	0·26 (0·68)	1·60 (2·17)	2·90 (3·35)	4·33 (5·41)
No (%) of staff severely assaulted in their present post	5 (13)	5 (9)	12 (17)	9 (25)

Comment

The rates of assault reported by staff suggest that aggression is common in elderly residential units. Although most assaults were mild, 49 staff had sustained a visible injury in the past week, and 31 staff had been severely assaulted at some time during their present post.

Traditionally the most aggressive elderly people have been cared for in long stay psychogeriatric wards.[4] High rates of assault were reported in all community settings but especially in homes for elderly mentally infirm people. This finding supports evidence that many elderly people in these homes are behaviourally disturbed and may require psychogeriatric care.[5]

Aggressive behaviour in an elderly person warrants specialist assessment and management. Our results indicate that numerous untrained staff have to manage behaviourally disturbed residents without any psychogeriatric support. Closer links between the psychogeriatric service and residential homes for elderly people are urgently needed.

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