



The Sustainable Volunteering Project

Policy Report

Identifying and Mitigating Risks in Professional Voluntarism: Lone Working, Competency and Risk

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Introduction

Increasing interest in Professional Voluntarism coincides with a new risk environment. This Policy Report outlines the risk assessment processes involved in the setting up and management of the SVP project.¹

It takes a holistic view identifying all forms of risk involved in these kinds of placements but focusing in particular on key human resource management issues around lone working and 'co-presence.'

It presents important opportunities to share ideas and increase the efficacy and safety of international clinical placements in developing countries.

¹ A version of this paper was presented at the International Association for Risk Management in Medicine, Annual Conference, Heidelberg, September (2013) and is currently under review.

1. Risk Identification

The first stage in operationalizing the SVP was to commission a Professional Risk Assessment.²

The authors had been aware for some time of the serious risks associated with international professional voluntarism. Furthermore, often inflated and misguided perceptions of risks amongst potential volunteers, their families and supervisors constituted a major obstacle to medical voluntarism.

The SVP was fortunate to have the opportunity to commission a very experienced risk specialist to undertake the risk assessment (Moore and Surgenor, 2012). The risk analysis was undertaken on location in Uganda by Paul Moore, Chief Risk Officer at the University Hospital of South Manchester NHS Foundation Trust. Initial discussions encouraged a broader understanding of risk in the specific context of medical voluntarism in Uganda.

The Risk Assessment defines risk very positively as follows:

The primary goal of risk management is to achieve objectives. Risk is the effect of uncertainty on the achievement of objectives. Effective risk management requires anticipation of opportunity, but also what could stop the achievement of the objectives, and through adaptation increase the level of resilience of the project maximising benefit for stakeholders and investors.

It distinguishes 'inherent' from 'residual' or mitigated risk:

Inherent risk represents the estimated level of risk exposure without taking any further steps to mitigate or neutralise the threat (i.e. what it would be if nothing was done); whereas residual risk represents the estimated level of risk exposure after taking additional steps to control the risk. Estimates of residual risk are therefore lower because they take into account the controls applied (Section 3 and 4).

²The full risk assessment is available on the LMP website: www.LMPcharity.org

The completed risk assessment identifies the following key areas of risk associated with professional voluntarism in clinical settings in Uganda and ranks them on a scale from 'very low' to 'significant' risk:

| Risk | Mean Score |
|--|------------|
| Personal Accident or Injury including Road Traffic Accident | 15.00 |
| Terrorist Attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage) | 15.00 |
| Exposure to infection / tropical disease | 12.00 |
| Assault (verbal, physical, sexual) | 10.00 |
| Access to safe supply of food and drinking water at location | 10.00 |
| Lost (in unfamiliar and/or dark surroundings) | 10.00 |
| Needle Stick Injury (including provision of emergency HIV post-exposure prophylaxis) | 10.00 |
| Civil unrest / violent public disorder | 10.00 |
| Lone Working | 6.25 |
| Slips, Trips or Falls on uneven, wet and/or muddy ground | 5.77 |
| Unsafe or Unsupervised Clinical Activities | 5.25 |
| Sun Exposure | 4.00 |

Table 1: Risks Associated with Professional Voluntarism in Clinical Settings in Uganda

| VERY LOW RISK | | | LOW RISK | | | MEDIUM RISK | | HIGH RISK | | SIGNIFICANT RISK | | | |
|---------------|---|---|----------|---|---|-------------|---|-----------|----|------------------|----|----|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |

| Hazard Profile | Overall Residual Risk Exposure (Taking Control Into Consideration) | | | | | | | | | |
|--|--|-----------|------------------------------|---------|-------|-------|--------|--------------------|------|----|
| | Kabubbu | Kasangati | Mulago | Kawempe | Mbale | Hoima | Kisizi | Mbarara | Gulu | |
| Access to safe supply of food and drinking water at location | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Assault (verbal, physical, sexual) | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Unsafe or Unsupervised Clinical Activities | 3 | 9 | 15 | 3 | 3 | 3 | 3 | Unable to Evaluate | 3 | |
| Civil unrest / violent public disorder | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Exposure to infection / tropical disease | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| Lone Working | 5 | 5 | 15 | 5 | 5 | 5 | 5 | Unable to Evaluate | 5 | |
| Lost (in unfamiliar and/or dark surroundings) | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Needle Stick Injury (including provision of emergency HIV post-exposure prophylaxis) | 10 | 10 | 10 | 10 | 10 | 10 | 10 | Unable to Evaluate | 10 | |
| Personal Accident or Injury including Road Traffic Accident | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Slips, Trips or Falls on uneven, wet and/or muddy ground | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 4 |
| Sun Exposure | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Terrorist Attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage) | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Are all risks acceptable (i.e. controlled as low as reasonably practicable (Y/N)? | Y | Y | N Co-presence & Lone working | Y | Y | Y | Y | N | Y | Y |

Table 2: Residual Risk Exposure in 9 Hub Locations

Table 2 applies the risk assessment procedure, illustrated in Table 1, to the 9 placement locations. The results underline the priority attached by many organisations responsible for volunteer management to road traffic accidents.

Road Traffic Accidents form the greatest risk for volunteers.

In Uganda the risks associated with routine travel on the roads are both the most prevalent and are often associated with very serious outcomes. The Induction Pack and Volunteer Agreement urge volunteers not to use local motorcycle taxis (boda bodas) which are the most common form of cheap transport in Uganda and facilitate faster travel during the appalling rush-hour ('jam') in Kampala.

Volunteers are transported in their first visit to the placement location by private taxi. However within country travel (which we actively encourage) would be prohibitively expensive by this mode of transport. Alternatives are listed in the Induction Pack and discussed with volunteers when making travel plans.

Needle Stick Injury is another real risk for volunteers working clinically. Details on HIV prophylaxis are included in the Induction Pack and kits available at all volunteer accommodation. This area of risk is closely associated with lone working that forms the focus of this paper.

Whilst Terrorist Attacks are far less prevalent, the consequences are grave. The Induction Pack includes details of who to contact (including the UK Foreign Office) and how to behave if there is a high alert.

The risk assessment did not draw specific attention to the risks to volunteers arising from outbreaks Ebola /Marburg. These are rare but have taken place since the project commenced. High level specialist advice has been sought on this and a protocol is in place requiring volunteers to immediately stand down from clinical work for the duration of the outbreak and a subsequent incubation period. A special report on this is in the Induction pack and available as a separate document.

The SVP has invested considerable time in the production of a detailed Induction Pack and associated processes to reduce the risks associated with all of the categories listed above.

All volunteers working clinically are required to have full medical indemnity insurance, to be clinically registered to work in Uganda and a comprehensive 'bespoke' travel insurance policy is in place.

The remainder of this paper focuses on an important but often neglected dimension of risk and one which is inherently linked to sustainability and development impact. Namely, lone working.

³Available on the project website.

2. Lone Working and Risk ⁴

The last row in Table 2 assesses the acceptability of ‘controlled’ risks (i.e. current risk identification and mitigation processes). In one location lack of information resulted in a negative return. Only in one location (Mulago) did the risks associated with lone working tip the balance resulting in unacceptable residual risk.

Lone working is rarely conceptualised in terms of risk. ⁵ However, lone working is a very common feature of international voluntarism and the risks associated with it are complex and multi-faceted. At one level it links to other more ‘standard’ concepts of risk.

If a volunteer is working on their own they will face difficulties in complying with risk mitigation procedures following a needle stick injury, for example. Good practice in relation to HIV prophylaxis suggests that anyone suffering a needle stick injury should commence treatment within 2 hours. ⁶ If an obstetrician is working on their own in theatre this may not be possible.

Equally, exposure to risks associated with the various forms of assault are much higher when a person is on their own.

Lone working also presents serious challenges in terms of clinical competency. The SVP has developed a ‘competency algorithm’ to try to guide and empower volunteers pressurised into situations that test their competency often through a lack of access to supervision.

Risks associated with potential litigation or more broadly ‘blame’ are also closely linked to lone working.

Finally, and this is where risk is most closely associated with development impact, lone working fails entirely to deliver the objectives of projects like the SVP focused on knowledge transfer and capacity-building.

⁴Some of the material presented here is also contained in the Policy Report on Co-Presence’.

⁵University ethics committees have begun to recognise the risks associated with lone working in a research context and produce guidelines on the management of this aspect of risk (see for example <http://www.liv.ac.uk/researchethics/>)

⁶A section of the Induction Pack deals specifically with HIV prophylaxis.

Table 3 shows the results of the risk assessment for one health facility in Uganda where the risks associated with lone working were particularly high (Mulago Hospital).

The risk assessment report takes a strong stance on lone and ‘unsupervised’ working suggesting that volunteers with draw from such situations ‘even if this leaves the patient at risk.’ Such withdrawal may be called for both to prevent UK volunteers becoming substitutes for local staff or working beyond their competency. The report also links the risks associated with lone working to out-of-hours working (at night and during weekends). Paragraph 3 of the report describes the situation reported to them by volunteer medical students in Mulago.

| HAZARD | CURRENT CONTROLS | INHERENT RISK | | | RESIDUAL RISK | | | ADEQUATE | FURTHER ACTION FOR UMNH CO-ORDINATOR |
|-----------------------------------|--|---------------|---|----|---------------|---|----|----------|---|
| | | S | L | RR | S | L | RR | Y/N | |
| | | | | | | | | | |
| Unsafe Clinical Activities | <ul style="list-style-type: none"> Withdraw from undertaking clinical work in the absence of professional Ugandan Peers, or should you become a substitute for Ugandan staff Never undertake clinical work beyond your competency In an emergency it is accepted that a volunteer may be compelled to act or intervene clinically according to their level of competency. If compromised clinically or professionally you are required to withdraw from the clinical activity and report to your mentor, even if this leaves the patient at risk. | | | | | | | N | <p>We were informed by volunteers that they were exposed to working without supervision & access to a suitably qualified doctor. Also, volunteers working night / weekend shifts</p> <p>Communicate controls and clarify understanding with volunteer(s) prior to departure.</p> <p>Establish and enforce the co-presence principle with officials at Mulago Hospital</p> |

Table 3: Lone Working, Co-Presence and Risk

As a condition of ethical approval by the Hospital Ethics Committee, we were told that medical students were required to work during the weekends and at night. Both the volunteer and medical students spoke about difficulties accessing senior medical colleagues during the night. We were informed of a particular night shift wherein there were 2 still births, a death on the Maternity HDU and an obstructed labour – obstetric and midwifery staff apparently refused to attend and assist because they were sleeping (which we were told is normal practice and they are not to be disturbed whilst sleeping). We understand it was left to the volunteers to work through the problems as best they could. Medical students explained how they were often goaded into carrying out clinical examination or diagnostic procedures they did not feel competent to perform, and whilst they declined to carry out the procedures, they explained how this created some tension with Ugandan medical students also working at the Hospital. We were concerned here about the level of clinical supervision and support, but also the security implications of working at night. (Source: Risk Assessment)

The concerns expressed in the Risk Assessment are identified in other studies of professional voluntarism and reported by volunteers working in Uganda. Hudson and Inkson cite a respondent in their research on voluntarism who experienced this situation: 'A bad day is filled with frustrations and lack of understanding... all staff will have mysteriously disappeared' (2006:312). Similarly, respondents in an evaluation of the International Health Links Scheme (Ackers and Porter, 2011) expressed concerns about UK volunteers being left to work in the absence of supervision:

"We should say that we wouldn't send over junior British staff unless there's a senior [local clinician] on the wards and I wonder if that might set a bit of an example because I know some people have felt very exposed to situations they've never had to deal with before. There's a lot of gains to be had for the NHS (UK National Health Service), but I think we need to do that in a much more structured way"

In this case the respondent is not questioning the potential value to the UK health service of this exposure but is concerned about the risk to the individual and the contribution of this form of input. Evaluation of the experiences of SVP volunteers echo these experiences.

In one example, a very experienced professional volunteer described in his post return report how, as soon as he arrived on the ward, the local consultant made an excuse that his partner was not feeling well and left – and then failed to return. The Consultant in this case explained how, in the time frame of his short (10 day) stay, he managed to clear the backlog of untreated patients and relieve congestion. Clearly the patients were direct beneficiaries of this process but it would be impossible to justify this kind of voluntarism from the perspective of skills exchange or sustainability as no co-presence took place. And as soon as the volunteer returned to the UK, the wards would rapidly re-congest.

Another consultant clinician explained in her report how senior staff ‘walked off the ward’ the moment she arrived. These are common experiences in Uganda. The following excerpt from a blog written by a British obstetric volunteer illustrates the problem in more detail;

“The 2 weeks leading up to Christmas were perhaps the most intense two weeks that I’ve had at [the hospital]. Over these two weeks all of the SHOs [clinical trainees] were on exam leave and to make matters worse the interns [junior doctors] were on strike because they hadn’t been paid. During this period I was the only junior doctor on the rota to cover labour ward, theatre and admissions (there would normally be 3-4 SHO’s and 4 interns)! Two seniors were supposed to be covering labour ward during the exam period, however often only one would turn up and would go to theatre leaving me alone. On one day no specialists turned up at all, so I wasn’t able to open theatre when there were 8 women waiting for caesareans. A woman presented with cord prolapse so I had to take her to theatre but she was the only caesarean that got done. To say I felt vulnerable would be an understatement, and in true [hospital] style everything you could imagine happened: eclampsia, twins, breech deliveries, abruptions, ruptured uteri. One particular incident happened when I was alone in admissions. A woman arrived in a semi-conscious state following an eclamptic seizure, and was now having an abruption (premature separation of the placenta leading to heavy vaginal bleeding). It was very hard to auscultate a fetal heart beat and I feared the baby was dead. After delivering the baby with a vacuum it needed urgent resuscitation. I attempted to resuscitate the baby but it was futile, I didn’t have a towel to dry the baby and the resuscitation equipment was broken. A very frustrating and upsetting day”.

In another hospital, a HUB partner recounts the experience of a midwife they had placed in Uganda who,

“initially put herself on the staff rota. However, the local midwives stopped coming in because they thought, ‘Oh she is there so that’s OK’. So she took herself off the rota and started to come in at different times and did an assessment and made decisions about where her work was best needed. So she wasn’t on the rota because, especially when it came to the evenings, she was invariably the only midwife there. I had a long chat with some other doctors and they said they’d seen the same thing. Two young [volunteer] doctors turned up and all the senior staff went on holiday the next day and that’s unacceptable. It’s very difficult to extract yourself from that situation”.

The penultimate case illustrates the relationship between lone-working and competency with early career volunteers often under serious pressure to perform tasks that fall outside their experience and confidence.

3. Risk, Lone Working and Competency

An important component of the risk dynamic concerns competency. Competency is both a matter of clinical skills/experience (objective) and one of confidence (subjective). For insurance purposes, and to safeguard the individual from trauma or stress, all volunteers must operate within a competency framework. They should never be put in a position of having to perform procedures that they are not, or do not feel, competent to perform in unsupervised environments.

This presents serious challenges in the Ugandan healthcare system where the lack of senior staff or their failure to be present on the wards often leaves more junior staff in situations where they have to work out of the bounds of their competency. This is normalised for Ugandan healthcare staff and it is unsurprising within this culture that volunteers may be expected to do the same.

4. Risk Lone-Working and Blame

Another important dimension of risk concerns attribution of responsibility or 'blame'. In the UK risk is closely associated with litigation and defensive practice. Such concerns have, until recently, appeared to be less of a problem in developing countries where litigation remains unusual but by no means unknown.

The kinds of risk associated with what Ugandan colleagues have described as the 'blame culture' present in Ugandan healthcare (linked closely to the risks associated with lone working) remained theoretical until recently. However, in recent months one of the SVP volunteers experienced a maternal and neo-natal death. The deaths occurred following a period in which the volunteer was left to work totally on her own in very challenging circumstances and with poor equipment (a typical scenario for a Ugandan doctor). The following day local staff attributed blame to the British volunteer suggesting that her negligence contributed to the deaths. This situation has caused serious concern to the volunteer and her mentors. Indeed the Ugandan mentor subsequently emphasised to the volunteer the importance of not engaging in lone working. In this case co-presence is as much about having a witness as it is about knowledge transfer.

Following the risk assessment process, the SVP developed a series of measures to mitigate the risks associated with lone working and promote the efficacy of knowledge transfer processes.

5. Implementing Co-Presence in the SVP

The principle of 'co-presence'⁷ lies at the heart of operational practice. It embraces a number of key concerns shaping the management of the SVP:

- 1) Lone working represents a significant and uninsurable risk for UK Volunteers.
- 2) Working together with Ugandan mentors and peers is necessary for knowledge to be created and exchanged.
- 3) Reciprocal, bilateral contributions lie at the heart of genuine partnership.

Implementing co-presence has been and continues to be a challenging process. It has met with resistance from UK supervisors and mentors, from individual volunteers and from local Ugandan staff. Professional voluntarism has a long history often linked to forms of colonial or missionary-style interventions or 'character-building' (in-at-the-deep-end) approaches to internationalisation. These attitudes persist among UK clinicians and donor organisations. One senior British clinician expressed the view that 'clinical' mentoring should and could be distinguished from risk assessment (or co-presence principles): *Risk assessment are really issues for [sending organisations] rather than clinical mentors and I would not like to [get involved] [Senior UK clinician]*

In this case the clinician was unable to see the importance of linking clinical mentoring to notions of co-presence viewing his role more as one of clinical advice-giving (on a particular procedure or patient condition) and perhaps replacing the role of a local supervisor/mentor than on a more holistic development principle.

A UK NGO funding volunteers in Uganda expressed a similar response to the risk assessment process suggesting that risk assessment in itself was an expensive and unnecessary process:

The nature of difficulties facing health professionals in Africa is very different to anything that most trainees would experience in the UK. Problems present in their most extreme form and tragically can result in maternal death. If a doctor is unwilling or unable to operate in this environment [...] then he or she should not go to Uganda.

⁷For more details see the SVP Annual Report 2013 <http://www.lmpcharity.org/images/documents/SVP%20Annual%20Report%202013.pdf>

A more common concern expressed by potential volunteers prior to placements was that the implementation of the co-presence principle (and potentially withdrawing from a situation in which their competency is seriously challenged and no supervision/back-up is available) amounts to professional negligence. Indeed, for many clinicians the logic of 'co-presence' may lie in direct tension with the values enshrined in the Hippocratic Oath which UK General Medical Council guidelines explain as follows: *'Our first duty is to our patients, not to the Trust (employer), the NHS, or to Society ... we must do what is in the best interest of our patients.'*

Certainly the recommendations embodied in the risk assessment report requiring clinical volunteers to withdraw from clinical work at any time they are left to act as substitute labour and/or work beyond their competency raise clear tensions for clinicians trained in the culture of the Hippocratic Oath to prioritise patient needs above all else (including their own health and safety). Volunteers often express concern that complying with such risk mitigation procedures places them in a difficult relationship with local staff who are expected to work without supervision and outwith their competency on a daily basis.

The SVP has emphasised the importance of not becoming involved in these practices as volunteers are not the employees of Ugandan facilities and are in breach of their professional indemnity insurance if they do so. A team of volunteers spent some time developing a 'competency algorithm' to try to manage such situations.⁸ This is very much a work in progress.

⁸ This group was led by Drs Helen Scholefield and Kim MacLeod of the Liverpool Mulago Partnership

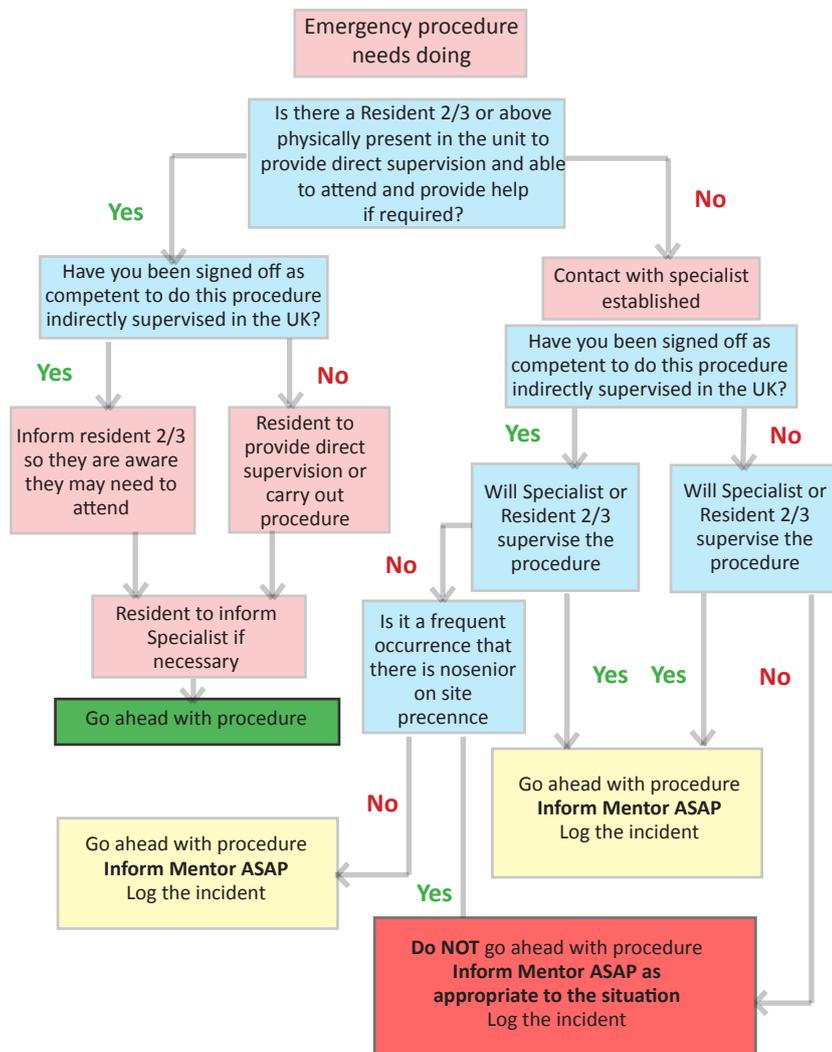


Figure 1: The SVP Competency Algorithm

Risk forms a critical component of the volunteer Induction Process; and routine night working is prohibited for volunteers, as working at night is associated with a high risk of lone working.

Advocacy is also extremely important. Bi-annual volunteer/mentor workshops are held in Kampala involving all volunteers and their mentors, complemented by workshops in the UK at regular intervals and frequent presentations at professional and academic events. This is augmented by regular site visits involving discussions with senior staff and mentors and revised negotiations during the placement of every volunteer.

Mentoring processes are also closely linked to co-presence. Each volunteer is allocated a mentor in the UK (someone in their broad area of specialism with experience of working in Uganda and often an ex-volunteer) and a Ugandan mentor. Mentoring is monitored and supported through monthly reporting mechanisms which require each volunteer to provide a detailed report of their activities that month.

The report includes specific questions on volunteers' relationships with their mentors and both the Ugandan and the UK mentors are required to sign off the monthly report. The 'Monthly Reporting Template' also requires volunteers to record the following:

Co-Presence

- Have you been working alongside Ugandan colleagues at all times?
- Can you describe who you have mainly been working with this month?
- Are there times when you have been left to work on your own? If so can you explain?
- Do you have any concerns about this?

The reports are reviewed by the project manager and action taken where necessary to support co-presence and mentoring processes and mitigate risk.

Conclusions

This paper has outlined the risks associated with the international placement of volunteers in healthcare settings in the developing world. Until very recently this area of risk has been neglected and volunteers (including medical elective students) left to 'fend for themselves'.

This practice is both risky but also fails to comply with sustainability principles encouraging a 'gap-filling' approach to professional voluntarism.

The risks associated with working in developing countries are real and risk assessment in itself cannot eradicate those risks. However, it enables us to move from 'inherent' to 'residual' risks and, most importantly to increase awareness and encourage a reflexive and attentive approach to risk.

Enforcement, as Moyo (2009) indicates, is critical to the embedding of the co-presence principle and to the preservation of relationships grounded in mutual respect and trust. Increasing awareness of risk and embedding the co-presence principle will, we hope, avoid the dangers identified by Moyo where the deployment of aid through volunteering perpetuates dependency and patronage. The onus is on all stakeholders to ensure that human resource management policies and practices ensure co-presence.

References

Ackers, H.L. and Porter, C. J. (2011) Evaluation of the NHS Perspective of Health Links with Developing Countries, International Health Links Centre, School of Tropical Medicine, University of Liverpool.

Ackers, H.L., Lewis, E., and Ackers-Johnson, J. (2014) Identifying and mitigating risks in medical voluntarism to support maternal and infant wellbeing in Uganda, *Journal of Medical Safety*.

Moore, P. And Surgenor, M. (2012) The Ugandan Maternal and Newborn Hub Sustainable Volunteering Programme Risk Analysis July 2012, University Hospital of South Manchester NHS Foundation Trust

Moyo, D. (2009) *Dead Aid. Why Aid is not working and how there is another way for Africa'* London: Penguin.

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