

"We didn't even record it in the notes!" Investigating dog bites to veterinary professionals

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BVNA British Veterinary Nursing Association

Introduction

Although veterinary nurses face comparable bite risk due to similar handling exposure (Owczarczak-Garstecka et al., 2018), existing research predominantly focuses on veterinary surgeons and emphasises injury frequency and severity, often aggregating species and injury types, which limits species-specific and contextual interpretation (Lucas et al., 2009; Kabuusu et al., 2010; Fritschi et al., 2006; Gabel and Gerberich, 2002). Outcomes such as lost work time are prioritised over situational context, offering limited guidance for bite prevention (Nienhaus et al.,2005; Epp and Waldner, 2012).



Methods

203 surgeons and 124 nurses completed an online questionnaire advertised via social media, investigating experiences of dog bites or near-misses while on duty.
Bites were defined as any attempt by a dog to place its teeth on a person or clothing, regardless of injury.
Incidents were classified using the modified Dunbar Bite Scale from Level 1: growling / lunging without contact to Level 5: multiple puncturing and tearing wounds (Dunbar, n.d.). To further explore lived experiences, eight randomly selected participants were interviewed regarding a single bite incident. Transcripts were thematically analysed to identify patterns and emerging themes (Braun & Clarke, 2006; Clarke et al., 2015).

Results

Accident Reporting & Documentation

63% did not report bites in clinic accident records due to: no injury, lack of time, complex / unknown protocols.
Accident reporting training increased reporting likelihood ($p < 0.009$).
78% documented bites in patient records; no professional difference ($p = 0.146$).
Non-documentation attributed to not thinking about it, no injury, or lack of encouragement.
Accident debriefs reported in 22% of clinics; 32% conducted morbidity & mortality rounds.
Career-to-date bite exposure: 6–10 bites - 36%; **15+ bites - 20%**

Specific Bite Incidents

Most common location: Consultation room (50%); Procedural area (22%); Ward (16%).
Dogs were typically on-lead, on the floor, or on a table. Incidents also occurred during sedation (n=23), and anaesthetic recovery (n=12).
Other people present in most cases: owner (58%), colleagues (40%); 9% alone.
Prior concern expressed: owner (17%), colleague (19%).
Only 20% reviewed previous bite history; 57% had no safety concerns beforehand.

Training & Confidence

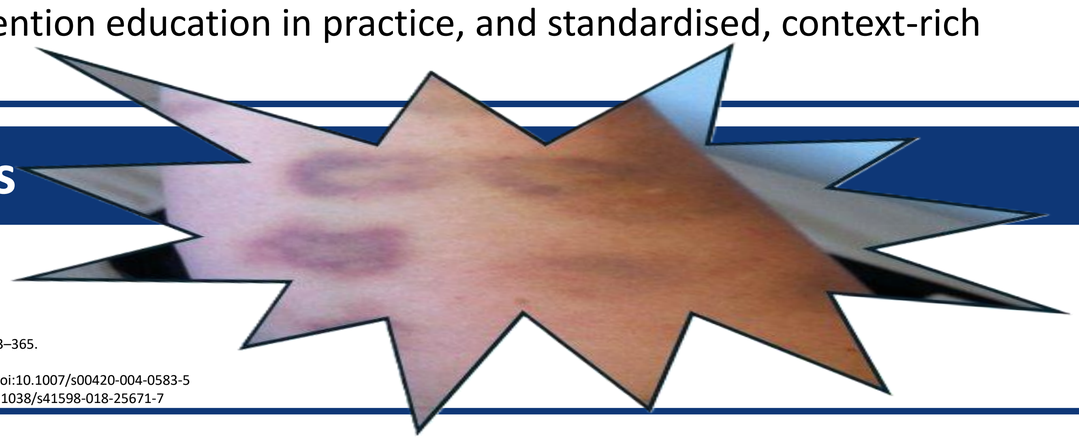
82% received no in-house bite prevention training; 12% did so at induction, 5% did so annually.
Academic qualification focus on dog behaviour was minimal:75% reported <5% curriculum focus.
66% undertook optional self-directed CPD on dog behaviour.
Lack of dog behaviour training significantly increased risk of Level 3+ bites ($p < 0.001$).
Bite severity was not influenced by whether one was a surgeon Vs nurse ($p = 0.159$).
Self-confidence increased with experience from career start to present: 24% → 80%

Interview Data: Six themes and one sub-theme were identified:

Theme / sub-theme		Example
Bite reporting procedural challenges		"…the process is really boring. The actual document is not great. It's got various things that are a little bit vague on it"
Bite severity influence upon reporting behaviour		"I probably wouldn't have thought about reporting any near miss, but a bite definitely"
Bite incident recording in patients' medical notes	**'CARE' labels**	"we either wrote on the dog's notes 'CARE' or didn't even put what happened"
Being compelled by a sense of 'need'		"we wouldn't have known how to proceed if we didn't do the exam in the first place…"
Perception of the dog's emotional experience		"…he was, like, petrified of me"
Self-blame		"…and it was probably a really silly thing to do, yeah"

Discussion / Conclusion

These findings demonstrate that dog bite risk in veterinary practice is shaped by more than procedural factors alone, reflecting complex interactions between animal behaviour, situational context, and human decision-making. Incidents frequently arose during moments perceived as low risk, including non-clinical interactions or postprocedural care, where cognitive biases and assumptions reduced vigilance. Although professionals often recognised potential danger, clinical urgency and limited alternatives led to continued exposure, highlighting structural constraints within practice environments. Inconsistent communication regarding behaviour and underreporting of near misses further restricted opportunities for shared learning and risk mitigation. Limited formal training in dog behaviour places responsibility on individuals to seek additional education, contributing to uneven competence and confidence. Bite reduction measures therefore require integrated reforms, including behavioural training within veterinary curricula, mandatory bite prevention education in practice, and standardised, context-rich reporting systems.



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