

Preventing occupational violence in Victorian health services

A policy framework and resource kit



A Victorian
Government
initiative



Preventing occupational violence in Victorian health services

A policy framework and resource kit

October 2007

Acknowledgement

The Department of Human Services would like to acknowledge the members of the Victorian Taskforce on Violence in Nursing who shared their extensive and diverse knowledge and experience in the Victorian health sector to inform this work.

Professor Duncan Chappell has been involved in research and public policy development related to workplace violence for over a decade. He worked at the Australian Institute of Criminology (Canberra) and was the chair of the NSW Health Taskforce on prevention and management of violence in the health workforce. His contribution to this work requires special thanks.

Published by the Victorian Government Department of Human Services,
Melbourne, Victoria

© State of Victoria 2007

This publication is copyright. No part may be reproduced by any process
except in accordance with the provisions of the Copyright Act 1968.

This document may also be downloaded from the
Department of Human Services website:

www.health.vic.gov.au/nursing/promoting/noviolence

Authorised by the Victorian Government, 50 Lonsdale St, Melbourne
October 2007 (0010707)

Foreword from the Minister

Making workplaces safe and healthy places to be, and supporting and strengthening the health workforce, are key priorities for the Victorian Government.

Preventing and managing occupational violence in health care is a critical endeavor that requires a strong collaborative partnership between government and employers.

This document provides guidance and direction to public health services about the prevention and management of occupational violence in Victorian health care settings. It contains the guiding framework and rationale for health services to ensure that safe, healthy and productive workplaces are maintained. It is anticipated that health services will develop specific operational policies/procedures for managing and preventing occupational violence that give effect to the principles outlined in this framework. To assist health services in this process, a resource kit is included in this document, which contains tools that may assist in developing local policies or responses.

A safe and healthy working environment is inextricably linked to provision of quality care to clients, residents and patients and I believe that *everyone* has the right to be safe in our workplaces.

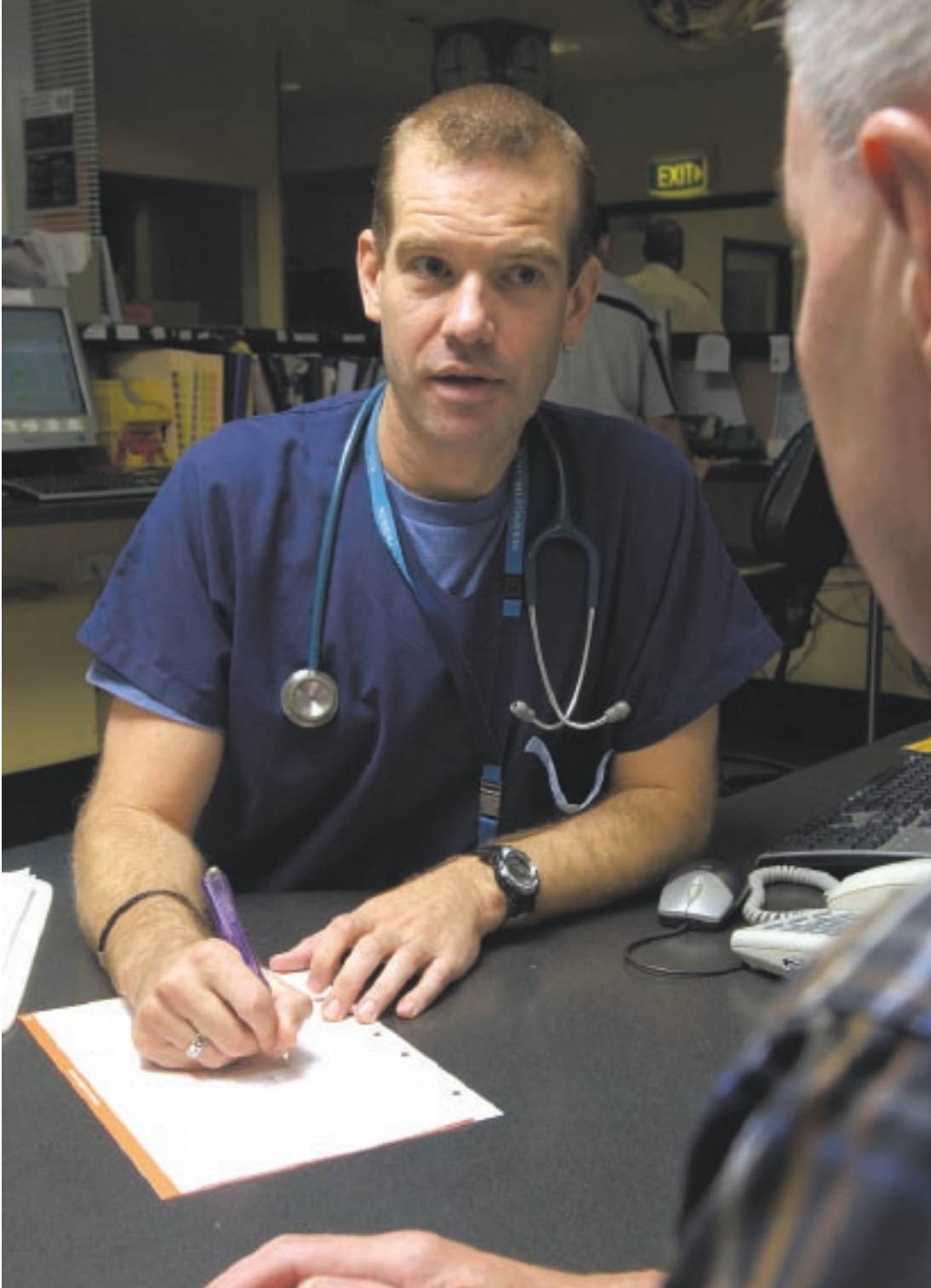
I commend this policy framework to you, and look forward to continued collaboration to improve health and safety outcomes for workers in the health sector.



HON DANIEL ANDREWS MP
MINISTER FOR HEALTH

Contents

Foreword	3
Introduction	7
The policy framework	7
The resource kit.....	8
The policy framework	9
Occupational violence prevention – strategic directions	9
Defining occupational violence.....	10
Policy context.....	10
Relevant legislation and regulation.....	11
Social context	14
Preventing occupational violence – applying an occupational health and safety framework.....	14
Monitoring and evaluation by the department	19
Key related policies or documents.....	20
Appendix 1 – Restraint, force and self-defence.....	21
The resource kit	23
1. Eliminate the hazard – Crime Prevention Through Environmental Design principles	24
2. Administrative controls – occupational violence measures and indicators	25
3. Administrative controls – checklist for occupational violence education and training.....	26
4. Administrative controls – occupational violence staffing considerations	27
5. Administrative controls – bullying prevention guidance (WorkSafe)	28
6. Administrative controls – occupational violence post incident response hierarchy.....	30
References	31



Introduction

Violence within the workplace is increasingly being recognised as an issue for health service providers. Concern about this issue within nursing led to the 2002 Department of Human Services funded project to analyse the incidence of violence within four Victorian public hospitals (Department of Human Services (Victoria) 2005). In 2004, the Victorian Government established the Victorian Taskforce on Violence in Nursing ('the taskforce') to examine key issues and recommend strategies to address occupational violence against nurses. The ministerial taskforce brought together government, industrial, regulatory, health service and clinical nursing representation to provide strategic advice to the government regarding violence and bullying in the workplace directed towards nurses and the strategies to reduce its occurrence.

The taskforce made 29 recommendations (Department of Human Services (Victoria) 2005) aimed at addressing the problem of violence against nurses in a more consistent and coordinated manner. In particular, the work highlighted the need for a framework to effectively address occupational violence in health services and for clear and consistent messages that:

- violence against nurses (or any healthcare worker) is unacceptable and must be proactively addressed,
- there is not a culture of tolerance of violence in healthcare workplaces and
- encourage a culture of reporting of occupational violence in healthcare.

New South Wales and United Kingdom policy development has focused on a zero tolerance approach to violence and bullying. The Victorian taskforce, while it concluded that it would 'be informed by the NSW framework', has not formally adopted the nomenclature of zero tolerance. Clearly, what may be 'branded' as zero tolerance may have an underlying sound framework that is embedded in occupational health and safety principles of risk identification assessment and control. A systematic occupational health and safety hazard management approach, which includes proactive input from the occupational health and safety representative committee, has demonstrated benefits for preventing occupational violence and has formed the foundation stone of this policy framework.

The policy framework

The World Health Organisation (2006) defines injury and violence prevention policy as:

'a document that sets out the main principles and defines goals, objectives, prioritised actions and coordination mechanisms for preventing intentional and unintentional injuries and reducing the health consequences.'

The value of developing injury and violence prevention policies is that it provides the basis for effective joint action.

This document explains the overarching policy framework for the prevention and management of occupational violence and bullying within Victorian public health services. It contains the guiding framework and rationale for health services to ensure that safe, healthy and productive workplaces are maintained. In this context, the workplace is more than just the health services' 'bricks and mortar'; it includes all settings where health services provide care or services, such as in community and residential settings.

This policy framework is a visible commitment to the prevention of occupational violence in Victorian health services and makes explicit the expectation that health services will be committed to the implementation and support of occupational violence prevention in their workplaces. It also recognises the department's duty of care to staff and clients and that of health services to their staff and clients.

Policy principle:

Health services must have an integrated health workforce policy that acknowledges the imperative to provide safe and healthy workplaces and that specifically recognises the prevalence of occupational violence in health care.

The Department of Human Services is committed to providing all employees with a healthy and safe workplace free from violence. While this policy framework provides the strategic direction and guiding principles, it is anticipated that local health service policies and procedures will give effect to this framework.

The framework provides the policy principles to assist health services to:

- implement occupational violence prevention and management programs at the local level
- apply an integrated and systematic approach
- enhance the capacity of health services to effectively meet their obligations as employers
- continuously build on the evidence base and be informed by best practice
- promote awareness and a 'no blame' approach to occupational violence and bullying.

This framework has been informed by existing knowledge and literature. It is not intended to replace existing policies and documents, such as those referenced in the key related policies. Rather, it recognises issues of implementing occupational violence and bullying prevention measures within an occupational health and safety framework, with specific reference to a health care context.

The resource kit

In documents such as this, it can be difficult to achieve a balance between broad, general guidelines and a level of practical information that can be applied and implemented. To assist health services, a resource kit is included, which contains tools that may assist in developing local policies or responses.

Policy principle:

An overarching framework is important; however, each health service setting will need to consider customisation and local solutions/implementation strategies.



The policy framework

This framework applies to all public funded health workplaces in Victoria, including those in the community, as listed in Schedule 1–5 in the *Health Service Act 1988*. It is, however, expected that the same issues and responses will be appropriate for other sectors, including private health, aged care, community and welfare services.

Although the development of this framework originated from the recommendations of the Taskforce on Violence in Nursing, the framework applies to all staff employed by public health services. Further, the obligations of health services to provide a safe workplace for all those who enter the workplace are clearly defined in the relevant legislation. This means that elements of this framework apply to visitors, clients¹, volunteers and contractors as well as all employees (including nurses).

Occupational violence prevention – strategic directions

Effective management and prevention of occupational violence in health care requires an integrated systems approach. The key strategies underpinning this framework and the activities to progress the implementation of the taskforce recommendations have been clustered around five areas of effort. Those areas are:

Strategy 1	Setting the policy framework – this document forms the major plank of strategy 1
Strategy 2	Raising awareness of the importance of violence and bullying prevention – this will include the development of a communication strategy and public awareness campaign through engaging a variety of partners
Strategy 3	Enhancing the interface between health services, the police and the justice system
Strategy 4	Ensuring that education and training for the prevention and management of aggression reflects the organisational context and the needs of the employee
Strategy 5	Developing effective reporting and monitoring systems, including a standardised minimum data set that will enable health services to report, monitor and compare incidence of bullying and violence

Policy principle:

Although nurses are particularly exposed, it is recognised that occupational violence has the potential to affect all health workers. Therefore, it is important that health services develop whole-of-workforce health policies.

1. In this document, the term 'client' is used inclusively to refer to all those who are the recipients of services provided by health, community and aged care providers.

Defining occupational violence

Without consistent definitions, the true nature, extent and impact of workplace violence cannot be fully understood within the health care sector. The taskforce's work summarised the issues and inconsistencies arising from the different language and definitions applied to workplace violence and bullying. In this framework, the term 'occupational violence' is used and has been broadly defined to include threats and actual violence. As recommended by the Victorian taskforce, the department has adopted the following definition for use in all Victorian health services:

Occupational violence is defined as:

Any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment. (Adapted from *WorkSafe guidance note*, 2003)

Within this definition of occupational violence:

- 'threat' means a statement or behaviour that causes a person to believe that they are in danger of being physically attacked, and may involve an actual or implied threat to safety, health or wellbeing
- 'physical attack' means a direct or indirect application of force by a person to the body of, or clothing or equipment worn by, another person, where that application creates a risk to health and safety.

Neither intent nor ability to carry out the treatment is relevant, the key issue is that the behaviour creates a risk to health and safety.

Examples of occupational violence include, but are not limited to, verbal, physical or psychological abuse, threats, throwing objects, sexual harassment (Department of Human Services (Victoria) 2005).

Sometimes a distinction is made between bullying and harassment; sometimes it is included in definitions of workplace violence. The taskforce's recommended definition of occupational violence is broad enough to encompass aspects of behaviour such as bullying and harassment, while recognising that the relevant legal framework may include anti-discrimination legislation. The agreed definition of bullying is aligned with the WorkSafe definition and is: Workplace bullying is repeated, unreasonable behaviour directed toward an employee, or group of employees, that creates a risk to health and safety. Further detail is provided on page 28.

Policy context

In relation to health and health service provision, there are significant health and safety issues, including occupational violence and bullying, that need a systematic and coordinated approach. Providing a safe and healthy working environment is a key policy objective of the Victorian Government and the link between healthy and safe workplaces and workforce is critical.

National and state policy frameworks

This framework aligns with the key national and Victorian policy frameworks, including:

National OHS Strategy 2002–2012

Sets out the basis for nationally strategic interventions that are intended over the coming decade to 'foster sustainable safe and healthy work environments; and reduce significantly the numbers of people hurt and killed at work'.

National Health Workforce Strategic Framework

Articulates the direction in which national health workforce effort should be focused. Principle three requires that 'All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration'. (Australian Health Ministers' Conference 2004)

Growing Victoria Together – a vision for Victoria to 2010 and beyond

Expresses the Victorian Government's vision and challenges for the future of Victoria. One of the objectives in *Growing Victoria Together* is the vision of quality health and education and the goal includes 'high quality and accessible health and community services'.

Victoria – a better state of health

Articulates the government's vision for health and is underpinned by five principles, including 'A better place to work'.

Role of the Department of Human Services

The Department of Human Services is responsible for planning and funding a wide range of services, including health, community and housing services, to diverse client groups across Victoria. The department is committed to creating a safe and productive workplace through improving health, safety and wellbeing at work.

Considerable work on occupational health and safety (including management and prevention of occupational violence) has already been undertaken by the department in specific health care settings or in relation to working with specific client groups (Department of Human Services (Victoria) 2004; Department of Human Services (Victoria) and Police 2004; Department of Human Services (Victoria) 2005). These policies provide direction and guidance to health services about the specific management and prevention of occupational violence in those care settings.

Further, an occupational health and safety management framework model has been developed for Victorian health services. The model provides the basis for health services to develop a comprehensive approach to managing health and safety obligations, including meeting legislated obligations to provide a workplace free of risk and continuously improving health and safety performance (Department of Human Services (Victoria) 2003).

This framework is aligned to those documents and provides a complementary framework focused on preventing and managing occupational violence and bullying within health services. The department has a role in monitoring and evaluating policies that affect health services. (Refer to page 19 monitoring and evaluation by the department).

Policy principle:

All staff are entitled to work in safe and healthy workplaces and the Department of Human Services is committed to ensuring that public health services are healthy and safe workplaces, free from occupational violence and bullying.

Relevant legislation and regulation

Victoria's health services are required to reflect the requirements of State and Federal law, and the community's expectations about health, safety and quality. A number of legislative Acts, regulations and industry standards define and detail how health services manage the provision of health care/ services while also ensuring the safety and health of all those involved (directly or indirectly) in the provision of care, as well as clients and their families.

Legislation

The following section contains information about some key legislation that is central to this policy. It is not an exhaustive list.

Occupational Health and Safety Act 2004

The purpose of the Act is to secure the health, safety and welfare of employees and other persons at work, to ensure that the health and safety of members of the public is not placed at risk, and to provide for the involvement of all parties in the formulation and implementation of health, safety and welfare standards. Specifically, the Act:

- covers wherever staff are employed to provide health service (not just hospitals), for example, day centres, clinics and home care settings and residential aged care
- defines a workplace as 'a place, whether or not in a building or structure, where employees or self employed persons work' (s. 5)
- mandates that the department's duty, so far as is reasonably practicable, is to provide and maintain a working environment that is safe and without risks to health (s. 21)
- requires employees, while at work, to: (a) take reasonable care for their own health and safety; (b) take reasonable care for the health and safety of persons who may be affected by the employee's acts or omissions at the workplace; and (c) cooperate with their employer with respect to any action taken by the employer to comply with a requirement imposed by or under the *Occupational Health and Safety Act 2004* or its associated regulations (s. 25)
- imposes duties on employers to consult with employees and health and safety representatives 'so far as is reasonably practicable' when undertaking certain tasks. These include, but are not limited to, identifying or assessing hazards or risks and making decisions regarding measures to be taken to control risks to health and safety (s. 35).

(Refer also to page 18–19 of the Taskforce Final report.)

Mental Health Act 1986

The objectives of the Mental Health Act are to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection, to facilitate the provision of treatment and care to people with a mental disorder. This Act has implications for wherever clients with mental illness are treated.

The five criteria for involuntary treatment that need to be met are that the person: appears to be mentally ill; requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order only; it is necessary for the person's health or safety or the protection of members of the public; the person has refused consent or is unable to consent to the necessary treatment; and the person cannot receive adequate treatment in a less restrictive manner. The care of clients with mental health issues can be very challenging and raises specific issues in relation to occupational violence.

Criminal law

The criminal law in Victoria is a combination of common law and legislation. The key piece of legislation is the *Crimes Act 1958 (Victoria)*, which aims to punish all forms of criminal behaviour.

In the context of occupational violence, consideration of criminal law is relevant as most forms of occupational violence will be criminal offences and, as such, subject to investigation by the police. Relevant offences include assault, threats to kill and threats to cause physical injury. *The Summary Offences Act 1966*, which relates to behaviour in public places, including, but not limited to, obscene, threatening and abusive behaviour, may have a bearing in cases of occupational violence in health services.

However, there are some examples of occupational violence that will not be offences under criminal law, such as where an employee is physically attacked by a person, such as a psychiatric patient, who is incapable of forming the necessary intent. This may well require a careful appraisal of individual cases to decide if criminal liability may or may not be relevant (Worksafe, Victoria, 2003).

Aged Care Act 1997

The *Aged Care Act 1997* governs all aspects of the provision of residential care, flexible care and Community Aged Care Packages (CACPs) to older Australians. The Act sets out matters relating to planning of services, approval of service providers and care recipients, payment of subsidies, and responsibilities of service providers including occupational health and safety requirements. There are also principles made under the Act that provide further detail regarding the matters set out in the Act. In relation to occupational violence, Part 4.2: User Rights Principles 1997 states that:

Each resident of a residential care service under section 10.13 of the user rights principles is required to: respect the rights of staff and the proprietor to work in an environment which is free from harassment.

Anti-discrimination legislation

State and Federal anti-discrimination legislation prohibits behaviour that amounts to discrimination or sexual harassment. Bullying and violence that occur within the workplace could also be covered by such legislation if it amounts to discrimination on the basis of a prescribed attribute and meets the legislation's definition of unlawful harassment. The relevant legislation includes:

- *Equal Opportunity Act 1995 (Victoria)*
- *Racial and Religious Tolerance Act 2001 (Victoria)*
- *Human Rights and Equal Opportunity Act 1986 (Commonwealth)*
- *Racial Discrimination Act 1975 (Commonwealth)*
- *Sex Discrimination Act 1984 (Commonwealth)*
- *Disability Discrimination Act 1992 (Commonwealth)*
- *Age Discrimination Act 2004 (Commonwealth)*

Compensation legislation

The Accident Compensation Act 1985 and *Accident Compensation (WorkCover Insurance) Act 1993* in relation to the regulation of Victoria's WorkCover compensation and rehabilitation system may be relevant to some cases of occupational violence.

Duty of care

The department is mindful of the complexities and issues that arise in health care in relation to providing care and services to clients. The paper, *Duty of Care* (Department of Human Services (Victoria) 2000), provides a broad understanding of the law governing the duty of care owed by the department and, in some cases, by agencies engaged by the department. Health services are directed to this resource as a useful summary of the key issues.

Consideration of matters such as the use of restraint, force and self-defence are also important. Work done by the department in relation to staff working in youth justice can give some guidance in these matters (see Appendix 1).

In addition, work is currently being undertaken by the Victorian Quality Council (VQC) and Chief Psychiatrist's Quality Assurance Committee (QAC) to support the development and implementation of the *Creating Safety: Addressing Seclusion Practices* project to enable clinicians to apply best available evidence to clinical practice. The project aims to strengthen and support safety in adult acute mental health inpatient units and to minimise, wherever possible, the frequency and duration of the use of seclusion and restraint. These matters are of interest and relevance for all health services.

Accreditation and industry standards

Health services are required to comply with or consider accreditation and industry standards and a number of these standards have specific requirements that relate to the management and prevention of occupational violence. These include:

Aged Care Act 1997: requires approved providers of residential aged care homes to comply with the accreditation standards. The accreditation standards are set out in the quality of care principles and comprise four standards and 44 expected outcomes (The Aged Care Standards and Accreditation Agency Ltd. 2006). These outcomes include an obligation that management is actively working to provide a safe working environment that meets regulatory requirements.

The Australian Council on Healthcare Standards: has set standards for health services called Equip 4, which includes requirements relating to clinical, support and corporate functions (Australian Council on Healthcare Standards 2006). A key corporate standard (3.2) is that 'The organisation maintains a safe environment for employees, consumers/patients and visitors'.

There are two mandatory criteria that encompass issues including occupational violence:

- 3.2.1 Safety management systems ensure safety and wellbeing for consumers/patients, staff, visitors and contractors
- 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

Policy principle:

The Department of Human Services and employers must comply with relevant legislation and regulation relating to workplaces.



Social context

Violence is unacceptable and must be proactively addressed. Recent views argue the necessity for ‘comprehensive proactive organisational strategies to reduce workplace violence and assert the need for these to be complemented by wider social initiatives to address the roots of violence in our communities’ (Paterson 2005). These comprehensive strategies include adequate attention to physical and procedural security without compromising relational care. This requires the utilisation of clinical decision making processes that are professionally rational, while integrating risk assessments into care processes. (Middleby-Clements and Grenyer 2007. Secker et. al. 2004, Rew and Ferns, 2005).

Clearly, managing violence and aggression in health care is a complex and sensitive issue where illness and highly charged emotional states impact on the environment. Recognising the socio-political facets of occupational violence allows for the adoption of prevention measures that move beyond introspective initiatives and permit committed interagency partnerships using evidence-based interventions.

The interface of health care, police and the justice system

The interface between the justice system, police and health services in relation to occupational violence is an area in which the Department of Human Services is undertaking further work.

The taskforce highlighted a requirement for health services to support health workers in pursuing charges by having formal protocols and procedures to provide information and assistance to staff with this process. The taskforce also noted a requirement for this issue to be promoted to Victoria Police. The resource kit outlines a hierarchy of response guidelines, which may assist health services in formulating their own protocols.

As part of the implementation of the taskforce recommendations, a justice, police and health service interface working group has been formed to develop strategies to implement the taskforce’s recommendations. This group has representatives from WorkSafe, criminal law policy, justice policy, Victoria Police, directors of nursing, directors of human resources, occupational health and safety managers and the Department of Human Services. The work being undertaken by this group includes policy analysis relating to complex legislative and operational issues that require further consideration by the department and health services.

A number of health services may have existing policies or procedures that relate to these issues and it is anticipated that

such policies will inform the work currently being undertaken by the department.

Preventing occupational violence – applying an occupational health and safety framework

It is vital that there are prioritised actions and coordinated mechanisms for preventing injuries and their health consequences arising from exposure to violence and bullying hazards in a health care setting. This policy provides the overarching context and direction for all of the work being undertaken to ensure the recommendations of the taskforce are implemented.

Occupational health and safety involves recognising and managing any risk to the psychological and physical safety and wellbeing of employees, contractors, volunteers and visitors in the workplace. Hazards are present in every health care workplace and are a threat to everyone’s health and safety. While not always recognised as such, occupational violence and bullying are a risk to an individual’s mental and physical safety and wellbeing.

The risk management process represents the basic preventative philosophy of occupational health and safety legislation and regulation. It also reflects the key responsibilities placed on employers to provide a healthy and safe workplace. As conditions in the workplace frequently change, hazard identification and risk control needs to be a continuous process (Department of Human Services (Victoria) 2003).

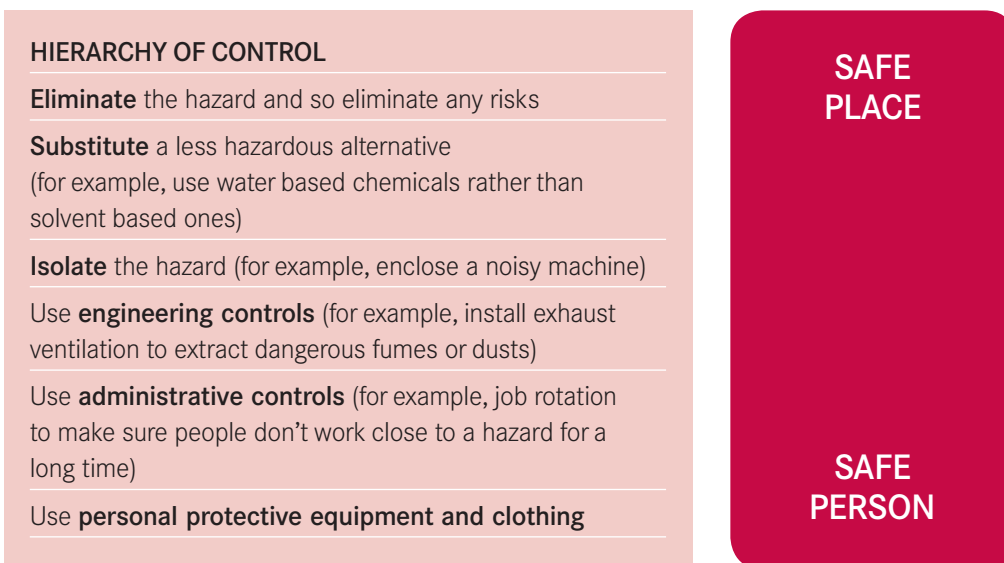
Under the legislation and supporting guidelines, there are three steps that should be followed:

- **Hazard identification** – the process of identifying occupational violence hazards in the workplace that could cause harm to staff or others.
- **Risk assessment** – the process of assessing the risks associated with the hazard, including the likelihood of injury or illness being caused by that hazard, and identifying the factors that contribute to the risk.
- **Risk control** – the process of determining and implementing measures to eliminate or minimise workplace violence. (Department of Human Services 2004, p. 13)

Occupational health and safety principles are that either the hazards should be eliminated or the risks they pose must be controlled so that people remain safe and healthy. One framework for conceptualising risk control is the preferred order of control model (also referred to as the ‘hierarchy of control’).

Figure 1 – Risk control

Once hazards have been identified and their level of risk assessed steps must be taken to control the risk. Risk controls are usually identified in the form of a hierarchy:



The hierarchy of risk control reflects the philosophy of prevention, in that the best approach is to eliminate risks, if this is possible. That way people have a safe workplace so they don't have to be concerned about risks and their own safety. The least desirable risks controls are those which require people to always do the right thing by following set procedures or using personal protective equipment.

Source: Occupational health and safety management framework model (Department of Human Services 2003).

Figure 2 – Schematic representation of risk control measures

Below is a schematic representation of risk control measures targeting occupational violence that were identified as part of the body of work *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (Department of Human Services (Victoria) 2004).

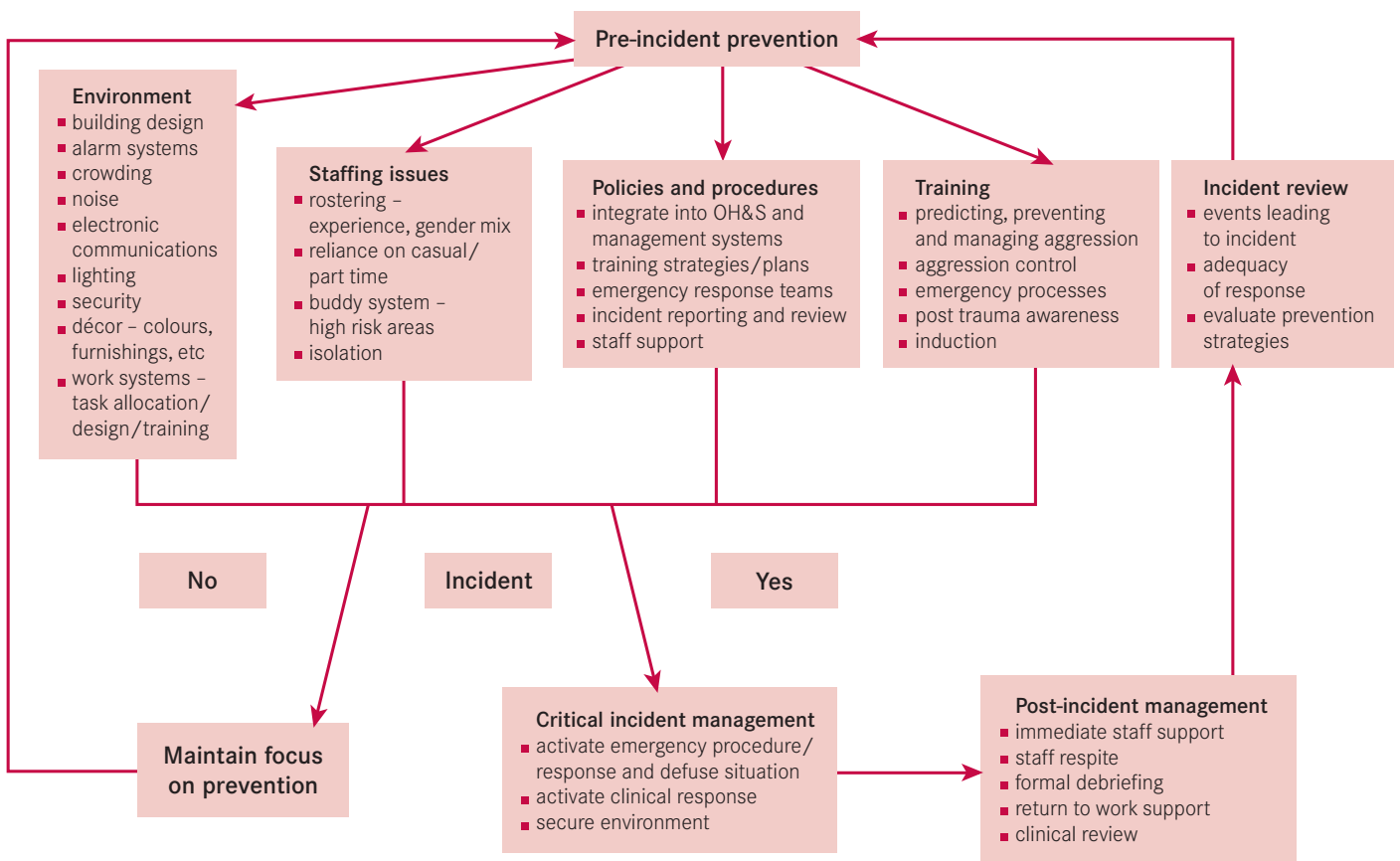


Figure 3 – Risk management model (Department of Human Services 2003)

The *Public hospital sector OHS management framework model* (Department of Human Services (Victoria) 2003) provides an excellent basis for conceptualising the implementation of the recommendations from the taskforce. The framework uses a simple, comprehensive three level systems approach – occupational health and safety system structure, activity and review. Table 1 uses this framework and identifies some of the issues related to occupational violence prevention programs that health services should consider.

Building your occupational health and safety system structure

Developing policies, procedures and plans to establish the OHS management system

System elements	Occupational violence issues (as identified by taskforce and other department policies)
<ul style="list-style-type: none"> • OHS policy and commitments • OHS responsibilities • OHS consultation • OHS training • OHS procedures • Contractor management • OHS performance indicators and 	<p>Responsibilities</p> <p>Health organisations will establish an aggression management reference group, which will be responsible for developing policies and procedures around the management of aggressive incidents, primarily through a clinically led aggression management team.</p> <p>Physical workplace design</p> <p>The physical environment of public spaces and buildings can have a strong influence on behaviour. The principles of affecting behaviour through environmental design and management will be applied to all future building and refurbishment. Please refer to resource kit for a more detailed explanation of design principles.</p> <p>Systems of work</p> <p>Program specific policies and procedures designed to control occupational assault hazards will be developed and implemented, with priority to high-risk groups. When designing work, occupational violence hazards will be eliminated where practicable. Elements to be considered will include staffing levels, workload, work patterns, work plans and competence (Department of Human Services (Victoria) 2004).</p> <p>Information, instruction and training</p> <p>Staff will be trained in identifying, assessing and planning for control of occupational assault hazards. Priority will be given to workplaces where increased risk of occupational assault injury is present. Relevant information and training will be provided to contractors where appropriate.</p> <p>Clinical behaviour assessment and management</p> <p>Clients will be assessed using existing systems and behaviour management strategies will be developed and documented. Behaviour management strategies will be reviewed as required to maintain a working environment, which is safe, and without risk to health.</p> <p>Supervision</p> <p>Management will provide appropriate supervision in relation to the control of the hazard arising from exposure to occupational violence. Supervisors will monitor employee skills and competence in implementing aggression management strategies.</p>

Running your occupational health and safety system activity

Implementing the policies, procedures and plans to maintain the operations of the OHS management system

System elements	Occupational violence issues (as identified by taskforce and other department policies)
<ul style="list-style-type: none"> • Risk management processes • Inspection, testing and corrective action • Emergency response • Injury management and return to work programs • OHS document control 	<p>Responding to incidents (Post incident management)</p> <p>Responses will vary depending on the scale and severity of the incident, but a number of responses that may be appropriate are outlined below:</p> <ul style="list-style-type: none"> • Provide first aid and medical treatment if required. • Give any employees involved the option of being relieved of their duties. • Give the target of occupational violence the opportunity to talk through immediate issues with a counsellor and/or other employees. • Offer further debriefing or ongoing counselling to targets of violence and witnesses. • Ensure the incident is reported. • Review control measures and if necessary conduct further risk assessments and implement further risk controls to prevent a recurrence. • Notify health and safety representative and health and safety committee. • Notify the Victorian WorkCover Authority if required. • Notify the police in circumstances where criminal acts of violence have taken place.*

Reviewing your occupational health and safety system performance

Assessing the performance of the policies, procedures and plans to achieve improvements in OHS performance

System elements	Occupational violence issues (as identified by taskforce and other department policies)
<ul style="list-style-type: none"> OHS performance review OHS auditing and corrective action OHS continuous improvement 	<p>Data collection</p> <p>Incident report forms should:</p> <ul style="list-style-type: none"> • record factual information (for example, who was involved, when and where the incident occurred, whether a weapon was used, what injuries were sustained) • describe how the incident occurred and what the outcome was • allow staff to make suggestions or comments to management • be concise and easily understandable • provide for mandatory feedback to staff involved (Department of Human Services 2004, p. 35). • Notify the police in circumstances where criminal acts of violence have taken place.

*Refer to page 12 for information on criminal law.

Monitoring and evaluation

Monitoring and evaluation is critical to measure the performance and effectiveness of strategies designed to prevent and manage occupational violence. As part of their occupational health and safety programs, health services collect and analyse a range of specific, locally relevant data items on incidents that occur within their workplaces, including occupational violence.

The *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services (2004)* highlighted under-reporting as a common issue in health care settings.

The reasons include:

- lack of available guidelines or operational policy (or lack of knowledge of them)
- lack of staff confidence/training
- no (or inadequate) incident recording form
- time and effort required to complete the incident recording form
- a perception that violence is 'part of the job'
- concern that violent incidents represent professional failure
- lack of confidence that corrective action will be taken
- fear of litigation.

Monitoring and evaluation by health services

Encouraging incident reporting is critical to prevention and management of occupational violence and is integral to achieving culture change.

Individual health services should develop specific outcomes related to the local implementation and occupational health and safety frameworks, and these should aim to monitor different parts of the overall program. Some examples of different indicators or measures that could be used to monitor and evaluate the impact of local occupational violence prevention programs are provided in the resource kit in this document.

Accreditation standards, such as Australian health care standards and aged care standards, also place a requirement on health services in relation to data collection and monitoring of occupational health and safety including occupational violence.

WorkSafe

Health services may find it useful to receive information from the regulator. WorkSafe monitors compliance with the Act and its regulations, gives advice in relation to occupational health, safety and welfare, and engages in, promotes and coordinates the sharing of information to achieve the objects of the Act.

Monitoring and evaluation by the department

The level of detail needed by health services to effectively manage and continuously monitor events is different from that required by the department to monitor the health system. The Department of Human Services has a key role in system-wide monitoring of occupational violence in health care and is developing data collection and reporting processes to support this role.

The department will use an incident information system as the basis of the system-wide monitoring. A data set was proposed by the taskforce and has been revised with input from health services and data standards. This will be incorporated into the incident information system. When this data can be collated and analysed, the department will facilitate benchmarking across health services. The data related to occupational violence in health care will allow the department to:

- collate and analyse the data provided by health services
- produce and disseminate reports on system-wide aggregated data to assist health services to compare their reported levels of occupational violence with peers
- monitor system-wide trends over time to assess the impact of health services implementing the recommendations of the taskforce.

System-wide data will also be used to validate the classification system proposed by the taskforce to ensure it meets the needs of the health services and the department in relation to supporting the development of prevention strategies. As recommended by the taskforce, there will be preliminary analysis of the data set and strategies 12 months after implementation and a comprehensive evaluation of the same after three years.

Policy principle:

Reporting and measuring is important to be able to predict trends, assist with prevention and control measures and build an evidence base for future policy development.

Key related policies or documents

The following documents are some of the key related policies or standards, in addition to this policy, that health services should be mindful of as they discharge their responsibilities to provide a safe and healthy workplace free from occupational violence.

Department of Human Services

- *Staff safety in the workplace: guidelines for the prevention and management of occupational violence for Victorian child protection and community-based Juvenile Justice staff* (Office for Children, 2005)
- *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (2004)
- *Public hospital sector occupational health and safety management framework model* (2003)
- *Creating safety; addressing seclusion practices, a literature review* (Victorian Quality Council and Chief Psychiatrist's Quality Assurance Committee 2007)
- *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (2004)

Other documents

- NSW Health, *Zero tolerance response to violence in the NSW health workplace – policy and framework guidelines* (2003)
- WorkSafe Victoria, *Guidance note for the prevention of bullying and violence at work* (2003)
- WorkSafe Victoria, *Information pack for WorkSafe Victoria's intervention on occupational violence in hospitals* (Health and Aged Care Team. Public Sector and Community Services Division November 2005)
- Australian Nurses Federation (Vic Branch), *Zero tolerance policy and toolkit* (November 2002)
- Victorian WorkCover Authority. *Labour hire agencies: managing the safety of on-hired workers* (June 2006)
- Health and Community Services Union, *Occupational assault: a health hazard...or is it 'just part of the job?'* Health and Community Services Union, Victoria Number 2 Branch of the Health Services Union. Undated



Appendix 1

Restraint, force and self-defence

The following is an extract from *Staff safety in the workplace: guidelines for the prevention and management of occupational violence for Victorian Child Protection and community based juvenile justice staff* (pages 35–36).

Restraint, force and self-defence

The department has a duty of care to ensure staff are provided with adequate training, resources and appropriate systems of work to enable them to respond appropriately to situations of assault. Mechanisms, such as restraint, time out and sedation, should not be the primary approach to minimising the risks of assault in departmental workplaces. Such mechanisms should only be used to provide the necessary protection for staff and clients where the process of risk assessment and control have identified and put in place the range of appropriate controls, but some risk of assault still exists.

Physical restraint should only be used where an immediate risk of injury exists and no other option for resolving the situation is available. The physical restraint used should be the minimum required.

Reasonable force is the force that is sufficient to stop the assaulting person causing injury or harm to themselves or others—and no more.

In addition to civil law where staff are provided with a duty of care to clients which justifies the use of physical restraint, staff owe a duty of care to protect clients from being assaulted or assaulting others. The use of reasonable force sufficient to prevent this is acceptable. This includes situations where there is an overriding necessity to protect someone.

The ‘emergency’ or ‘rescue’ powers given to departmental workers provide the right (and responsibility) to rescue a person from a dangerous situation. There are situations the law ‘excuses from being assault’, such as:

Implied consent

Everyday activities of caring for clients require some physical contact between individuals. The department’s clients have consented to the care provided and therefore to the physical contact involved in that caring. However, consent to such physical contact is not consent to restraint or seclusion.

Part 5, Division 3 of the Mental Health Act 1986, s. 44 of the Intellectually Disabled Persons’ Services Act 1986 [repealed], and ss. 256 (a), (b), and (c) of the Children and Young Persons Act 1989 [repealed] provide specific detail on the use of restraint and seclusion in those settings and should be consulted and complied with in relation to the use of restraint and seclusion for such clients.

Please note these Acts might have recently been amended and care should be taken to ensure the most recent version is consulted

Self-defence and defence of others

This is permitted where a direct care worker (or someone in care) is attacked or has a reasonable belief there is about to be an attack. Training in self defence techniques, including evasive self-defence, provides employees with controlled physical intervention when all other non-physical strategies have failed. Services and programs in which staff work with clients who might display aggressive behaviour should provide adequate training for staff in containment and self-defence techniques

Reasonable force

The person responsible might be liable for prosecution for assault if an incident of aggressive behaviour occurs under provisions set down in the Victorian Crimes Act 1958. The main defence against assault actions available to staff is self-defence. Staff behaviour should therefore be defensive rather than aggressive, controlling rather than punitive, and use no more force than is necessary in the given situation. The justification of ‘self-defence’ relies on the argument that the level of force used is reasonable given the threat faced. The level of force considered appropriate for self-protection or to ensure the safety of others will remain a matter of judgement, depending on the context of the specific persons and the situation involved.

Appropriate responses

Appropriate responses to aggressive incidents are:

- crisis communication and negotiation where staff are being verbally abused or verbally threatened
- evasive self-defence to the threat of assault and battery, such as where physical contact or injury might occur
- physical intervention and controlling self-defence to aggravated assault only where serious injury might be inflicted.

Use of restraints

General law provides that no person can be physically restrained against their will; however, in some instances it might be appropriate to place reasonable restraints on a client in a manner that is consistent with legal requirements. This applies only to the necessary and reasonable restraints or seclusion required to ensure the safety of the client and others, such as staff, other clients and visitors.

Medication and sedation

If medication is used outside the parameters of normal clinical practice and procedure and has no other clinical purpose or benefit other than sedation, then it is illegal and an assault against the person.

Post-incident issues

There are usually a number of relevant legal issues following incidents of occupational violence. These can include internal requirements, professional ethics, industrial issues, workers' compensation matters, and civil or criminal actions.

Management must ensure employees are aware of their rights (for example, their entitlement to claim compensation, and their right to report the assault to the police) and also the legal requirements and responsibilities placed on them under law by the organisation or with respect to professional ethics.

Management should also make provision for employees who are involved in giving evidence in court (if relevant). These provisions should advise on the format of criminal court procedure and also provide debriefing following the trial (preferably on an individual basis). Managers can seek advice and assistance from the legal unit in relation to these matters.



The resource kit

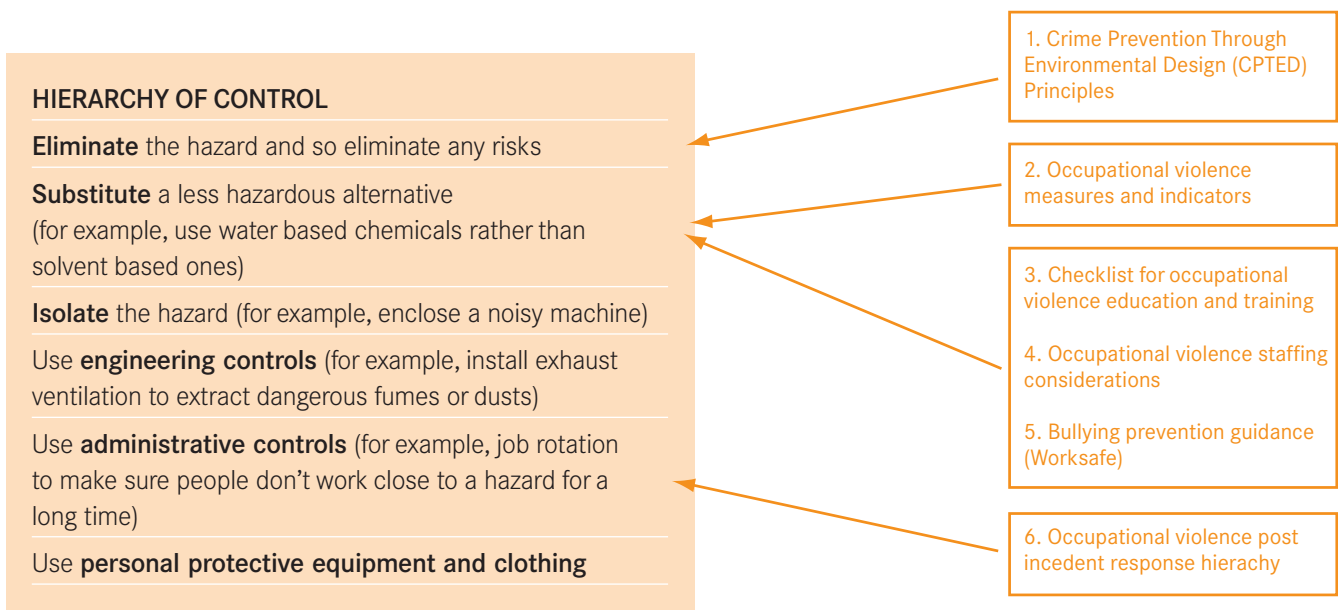
This resource kit is designed to provide practical guidance for health services to implement occupational violence prevention control measures. It should be used in conjunction with the *Preventing Occupational Violence in Victorian Health Services: A policy framework* (Department of Human Services 2007).

The 'hierarchy of control' illustrates the practical application of the guidance included in this kit.

The hierarchy of control prescribes an order of actions, that is: in the first instance, where practicable, hazards should be eliminated at the source. If that is not practicable, then substitution should be adopted. If this is not practicable, then design modifications are to be adopted. In turn, administrative controls may be adopted if it is determined that it is not practicable to adopt higher order controls.

This kit provides some tools for implementing hazard controls. It is not intended to be an exhaustive tool kit. Tools and templates are being developed continuously. Further examples are provided in the related documents section of the policy framework.

Figure 4 – Hierarchy of control



1. Eliminate the Hazard – Crime Prevention Through Environmental Design principles

Crime Prevention Through Environmental Design (CPTED) has been defined as systematic processes of creating features within our built environments that influence social behaviour in a positive way. These concepts have evolved from use in shopping centres, residential zones and parkland, but the principles are applicable in health care settings to design for the prevention of violence (Department of Human Services (Victoria) 2005).

Key principles of CPTED that are applicable to the health care setting are:

- Territorial reinforcement: people assume and express feelings of ownership and possibly pay more attention to an area or note potential intruders or acts of violence.
- Access control: physical and symbolic barriers control access. Clearly identifying staff-only areas with physical or symbolic barriers makes it more difficult to reach potential victims or targets.
- Natural surveillance: as people often feel safe where they can be seen and interact with others, natural surveillance can be achieved by creating sightlines between public and private space.
- Space management: there is a belief that a well-maintained facility may reduce criminal activity, whereas a run down, empty, graffiti covered building may attract criminal activity and offenders.

Control strategies that are components of the key principles include:

- clear communication strategies to provide information and signs
- service delays are minimised
- activity or noise levels are minimised
- adequate lighting in waiting areas, entrances and car parks
- consistent, clear and concise signage that caters to the needs of clients who may be culturally and linguistically diverse
- fixtures are secured wherever possible, with sharp corners and edges eliminated
- staff identification is worn at all times

- access to buildings is restricted, staff-only access points are clearly signposted and access is reduced in times of reduced staffing, such as after hours in smaller health services
- legal implications with regards to weapons are specified
- computerised access control systems for locks and for recording of audit trails
- security/reception areas are protected through design
- closed circuit television (CCTV) monitoring clearly states whether monitors are staffed by security or not
- CCTV monitor is reversed, where the public watches themselves
- waiting rooms are comfortable, spacious, provide reading material, access to phones, water dispensers and so on.

To be effective, CPTED requires:

- cooperation from all staff
- chief executive officer and senior management endorsement and support
- an understanding of the impact of environmental design and its benefits, which should be included in education and training programs.

Before recommending or implementing any such strategy, it is important that contextual considerations and site risk are properly identified, measured and assessed by appropriately trained personnel, such as occupational health and safety representatives and risk managers. This particularly applies to health services that vary in their size, purpose, location and resources.

It is important to establish a balance between creating a safe environment for all and delivering care to the clients. Risk assessment and risk management are imperative in reducing environmental risks.

Security resources have been identified as a component for promoting a safe environment in some health care settings. The need for security officers will depend on a range of factors, including the size and needs of the health care setting and other locally implemented safe environment strategies, and should be considered by health organisations as part of their risk assessment and management framework.

2. Administrative controls - occupational violence measures and indicators

The following table uses the Public Hospital Sector OHS Management Framework Model (Department of Human Services (Victoria) 2003) to outline examples of the types of measurements and indicators that health services may use to monitor their systems of occupational violence prevention.

System structure

Proposed outcome	Types of measurements
OHS policy and commitments	The accessibility of policies and procedures
OHS responsibilities	Number of contract staff receiving training and orientation related to prevention of violence and bullying
Contractor management	Number of staff completed training
OHS performance indicators and targets	Frequency of OHS committee meetings
Prevention of violence and bullying training	Number/percentage of workplace changes that involved staff consultation
Improved consultation	Workplace grievance records

System activity

Proposed outcome	Types of measurements
Risk management processes	Number of risk assessments conducted
Inspection, testing and corrective action	
Emergency response	Staff satisfaction surveys, decrease in injuries
Injury management and return to work programs	Return to work rates

System review

Proposed outcome	Types of measurements
Prompt reporting of incidents	Hazard reports for example DINMA Incident reports on occupational violence WorkCover data.

3. Administrative controls – checklist for occupational violence education and training

Effective and worthwhile education and training for the prevention of violence in health care plays a significant role in the broader hazard management approach. The taskforce recommended that guidelines to ensure minimum standards of education be provided to health services.

The University of Melbourne is conducting an evaluation of the WorkSafe safety development fund project of aggression prevention and management in health services. As an adjunct to this evaluation, the project is collecting data relating to current training provided to health services on the prevention and management of occupational violence. It is anticipated that further guidance about training will become available as that work progresses. In the meantime, the following is a checklist to assist health services in their endeavours to provide education as part of an approach to prevent violence and bullying. As there are many training providers, it is important that health services become acquainted with the various courses on offer.

Current research provides advice in relation to what has been established as ‘effective training in violence management’:

1. The content tends to be broader rather than focusing on individual competence.
2. The content tends to be closely allied to perceived need.
3. The content needs to clearly demonstrate (include evidence) of a proactive organisational response to workplace violence (Zarola & Leather 2006).

Key training considerations

The following has been identified as important when health services are considering training in relation to occupational violence and bullying (Department of Human Services (Victoria) 2004, p 25). The key components should be:

- the policies and procedures of the workplace
- legal issues and legislative framework
- predicting, preventing and managing aggression and potentially assaultive situations
- system of emergency processes
- post-incident processes including access to support systems
- induction systems for all staff, including permanent casuals, part-time staff and students on commencement of work and regularly thereafter
- competency-based skills for all staff for the roles undertaken by them
- local practice issues that have an impact on response, such as access to support from others, sufficient staff available to respond to an incident, availability of emergency services and acceptable response times
- management personnel at all levels should be trained in emergency response
- training should be compulsory for all staff and be provided in paid time to ensure attendance.

Principles of training

Training should:

- be practical and relevant to the workplace
- be flexible enough to allow modification to address particular issues within a workplace to include direct and non-direct care staff
- be available in a way that facilitates regular updates
- emphasise both proactive and reactive responses
- address physical and psychological protective measures, such as follow-up after a critical incident and care of self
- ensure all temporary, casual and agency staff are trained to a competent level before being engaged
- consider local factors that have an impact on the type of response available to a consumer and staff member to support them.

Considerations

- Clinicians need to feel that training can assist them in everyday practice.
- Training should be competency-based.
- Training should incorporate the key components listed below and should be provided to all staff. Additional suitable modules should be provided according to whether staff participate in direct or indirect care.
- Training providers should be appropriately accredited.

More details on the key competencies of occupational violence response training are provided in the *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (Department of Human Services (Victoria) 2004).

4. Administrative controls – occupational violence staffing considerations

How staff are managed can be important in preventing and managing occupational violence (Department of Human Services (Victoria) 2004). The organisation's approach to risk control in relation to staffing should cover:

- rostering and staffing ratios, for example, ratio of staff to clients should be adequate for the level of care needed and also take into account range of required activities
- skill level, training and experience appropriate for duties
- where possible, staff should be permanent or regular employees who are known to the clients and workplace
- capacity to rotate staff into alternate duties to reduce exposure
- procedures and back up for staff working alone or in isolation
- regular support and supervision.



5. Administrative controls – bullying prevention guidance (WorkSafe)

The following is an extract from WorkSafe Victoria’s *Prevention of violence and bullying at work Guidance note* (2003).

Defining workplace bullying

Workplace bullying is repeated, unreasonable behaviour directed toward an employee, or group of employees, that creates a risk to health and safety. Within this definition: “unreasonable behaviour” means behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten; “behaviour” includes actions of individuals or a group, and may involve using a system of work as a means of victimising, humiliating, undermining or threatening; “risk to health and safety” includes risk to the mental or physical health of the employee. The following types of behaviour, where repeated or occurring as part of a pattern of behaviour, could be considered bullying:

- verbal abuse
- excluding or isolating employees
- psychological harassment
 - intimidation
 - assigning meaningless tasks unrelated to the job
 - giving employees impossible assignments
 - deliberately changing work rosters to inconvenience particular employees
 - deliberately withholding information that is vital for effective work performance

This list is not exhaustive. Other types of behaviour may also constitute bullying. Note: An employee may be a manager or supervisor.

What is “unreasonable” behaviour?

“Unreasonable” refers to behaviour that a reasonable person, having regard to all the circumstances, would expect to humiliate, intimidate, undermine or threaten. In this context, a “reasonable person, having regard to all the circumstances” means a hypothetical reasonable person who has observed the situation. “...having regard to all the circumstances” does not mean that this hypothetical person has total knowledge of every aspect of the situation. Rather, this person knows as much as the alleged bully could reasonably be expected to know.

What is “repeated” behaviour?

“Repeated” refers to the persistent nature of the behaviour, not the specific form the behaviour takes. Behaviour is considered “repeated” if an established pattern can be identified. It may involve a series of diverse incidents – for example, verbal abuse, deliberate damage to personal property and unreasonable threats of dismissal.

What about a single incident?

According to the definition, a single incident of bullying-style behaviour does not constitute workplace bullying. However, since an employer has a general duty to provide his or her employees with a safe workplace and safe system of work, single incidents of bullying-style behaviour should not be ignored or condoned. If the behaviour displayed during a single incident of bullying-style behaviour involves a physical attack or threat of physical attack, it may be dealt with under the guidance note as an instance of occupational violence.

Bullying and the law

Employers have the primary legal duty for providing a healthy and safe workplace under Victoria’s *Occupational Health and Safety Act 2004*. The duty applies to their own employees and to others in their workplace. This includes someone employed by a labour hire company is seconded from another division, company or organisation, and sub-contractors.

Employees have a responsibility to abide by safety standards and to cooperate with their employers actions to ensure a healthy and safe workplace is maintained.

Preventing bullying

Like all workplace health and safety matters, bullying is best handled by prevention. It is prudent that all workplaces have policies and procedures to prevent bullying and manage it if it occurs. Policies should be developed in consultation between the employer, senior management, health and safety representatives and the general workforce. They must be used. All workers need to understand the procedures for reporting and managing any matters that occur. WorkSafe's prevention guide, *Bullying and Occupational Violence*, provides detailed information about dealing with bullying on your workplace.

Dealing with bullying in your workplace

Where alleged bullying has not yet been reported at the workplace, the person contacting WorkSafe will generally be advised to do so to ensure the appropriate workplace issue-resolution procedure can be followed. Work through the established procedures which are often found on organisations' websites and intranets.

If you're a worker, talk to your manager, Human Resources department, health and safety representative or union. If you are an employer, your industry association can often provide helpful information in relation to the prevention of bullying or actions to be taken to ensure bullying activity ceases. Employees and employers can contact WorkSafe's Advisory Service on 1800 136 089.

'No bullying' policy

A 'no bullying' policy outlines an organisation's standards of workplace behaviour and makes a clear statement that bullying will not be tolerated. The policy can be developed on its own, or it may be included in relevant existing occupational health and safety policies. Another option could be to include it in a policy that covers workplace behaviour.

Some organisations may want to include reference to occupational violence in their 'no bullying' policy, instead of having a separate policy on this issue. When developing a 'no bullying' policy, the employer should consult with elected health and safety representatives. It is a good idea to also consult employees directly on the policy.

The policy should be:

- written in plain language
- provided in languages other than English, where appropriate
- displayed where all employees can read it
- communicated to employees at relevant times.

The size of an organisation will usually determine the level of detail needed in the policy. In large organisations, a more detailed policy may be required to cover the range of situations that may arise. Smaller organisations may prefer a simpler policy.

Building commitment to the policy

An employer can create commitment to the policy by:

- developing a policy that is specific to the workplace
- consulting employees on the development of the policy and providing an opportunity to comment on a draft policy
- securing the commitment of the chief executive/employer to the policy and involving them in policy development, and
- ensuring the policy is adhered to and consistently applied.

Inform, instruct and train

Employers have a duty to make sure that their employees are provided with the information, instruction, training and supervision they need to do their jobs safely and without risks to health. The specific mix of information, instruction and training needed to reduce the risk of bullying in a particular workplace will depend on the specific needs of the employees and the workplace.

Administrative controls – occupational violence post incident response hierarchy

The following hierarchy of response guidelines has been adapted from the *Zero Tolerance: response to violence in the NSW Health workplace: policy and framework guidelines*.

Response	Possible interventions
Immediate	<p>Immediate response options</p> <p>Health services should have in place local procedures and protocols to support the range of available options. Procedures need to be communicated to staff, and staff should be provided with training to enable them to exercise the options appropriately and effectively, particularly those involving clinical restraint. Immediate and short-term options available to staff (in no particular order) include the following:</p> <ul style="list-style-type: none"> • issuing a verbal warning • using verbal de-escalation and distraction techniques • seeking support from other staff • requesting that the aggressor leave the immediate area • requesting review by a clinician • retreating • initiating code grey/code black as appropriate. <p>Options specifically related to clients/patients include:</p> <ul style="list-style-type: none"> • utilising clinical restraint policies as appropriate (violent client) • utilising sedation policies as appropriate (violent client) • negotiating conditional treatment, or determining inability to treat under the current circumstances
Long term	<p>Long-term response options</p> <p>Longer-term options to deal with repeated violent behaviour include:</p> <ul style="list-style-type: none"> • formal management plans • written warnings • exclusion from visits or conditional visiting rights • apprehended violence orders • requesting that charges be laid (via police). <p>Options specifically related to clients/patients include:</p> <ul style="list-style-type: none"> • conditional patient treatment agreements • patient alerts in conjunction with support management plan • alternate treatment arrangements e.g. a different facility • formal recognition of inability to treat in certain circumstances.

References

- Australian Council on Healthcare Standards (2006), *The ACHS EQUIP 4 Guide*, Sydney, Australia
- Australian Health Ministers' Conference (2004), *National Health Workforce Strategic Framework*, Australian Health Ministers Council, Sydney
- Department of Human Services (Victoria) (2000), *Duty of care*, DHS, Melbourne
- Department of Human Services (Victoria) (2003), *Public hospital sector occupational health and safety management framework model*, DHS, Melbourne
- Department of Human Services (Victoria) (2004), *Design guidelines for hospitals and day procedure centres* DHS, Melbourne
- Department of Human Services (Victoria) (2004), *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services*, DHS, Melbourne
- Department of Human Services (Victoria) (2005), *Occupational violence in nursing: an analysis of the phenomenon of code grey/black events in four Victorian hospitals*, DHS, Melbourne
- Department of Human Services (Victoria) (2005), *Staff safety in the workplace: 45*, DHS, Melbourne
- Department of Human Services (Victoria) (2005), *Victorian taskforce on violence in nursing: final report*, DHS, Melbourne
- Department of Human Services (Victoria) & Victoria Police (2004), *Protocol between Victoria Police and the Department of Human Services Mental Health Branch: 70*, DHS, Melbourne
- Middleby-Clements, JL & BFS, Grenyer (2007), 'Zero tolerance approach to aggression and its impact upon mental health staff attitudes', *Australian and New Zealand Journal of Psychiatry* 41: 187-191
- Paterson, DBL & Miller, G. (2005), 'Beyond Zero Tolerance: a varied approach to workplace violence', *British Journal of Nursing* 14(15): 810-815.
- Rew, Maggie and Ferns, Terry. (2005), 'A balanced approach to dealing with violence and aggression at work', *British Journal of Nursing* 14(4): 227-232.
- Schopper D, Lormand JD, Waxweiler R (eds). *Developing policies to prevent injuries and violence: guidelines for policy-makers and planners*. Geneva, World Health Organization, 2006.
- Secker et al (2004), 'Understanding the social context of violent and aggressive incidents on an inpatient unit', *Journal of Psychiatric and Mental Health Nursing* 11 (2): 172-178.
- The Aged Care Standards and Accreditation Agency Ltd. (2006), *Results and processes guide*, Paramatta, NSW.
- Zarola, A & Leather, P (2006), *Violence and aggression management training for trainers and managers. A national evaluation of the training provision in health care settings. Part 1: Research report*, Health and Safety Executive, United Kingdom.

