A handbook
for workplaces

Prevention and management of aggression in health services

Edition No. 1
June 2008

Contents

Foreword

WorkSafe Victoria (Worksafe) funded Melbourne Health and Northeast Health Wangaratta's Aggression Prevention and Management Project through its Safety Development Fund.

The three-year project was aimed at developing a sustainable and integrated system for managing occupational violence risks in the health services industry. This handbook is the project's main outcome.

The use of this handbook is intended to assist health services prevent and manage the increasing incidence and impact of aggression and violence in Victoria's health services. It is based on an occupational health and safety (OHS) risk management framework that will assist health service agencies comply with their legislative obligations and help provide a safer environment for staff and clients.

The resource should be used by managers, OHS committees and health and safety representatives (HSRs).

Broad industry consultation was undertaken throughout the project through an Industry Reference Group that represented the following organisations:

Aged & Community Care Victoria, Association of Hospital Pharmacists, Austin Health, Australian Medical Association (Victoria) Limited, Australian Nursing Federation (Victorian Branch), Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Department of Human Services, Eastern Health, Echuca Regional Health, Goulburn Valley Health, Health and Community Services Union, Health Issues Centre, Health Services Union, Kew Residential Services, Mercy Health & Aged Care Inc, Metropolitan Ambulance Service, Mt Alexander Hospital Castlemaine, Northern Health, Peninsula Health, Royal Children's Hospital, Rural Ambulance Victoria, South West Healthcare, Southern Health, Victoria Police, Victorian Hospitals Industrial Association, Western Health.

The contribution of a wide range of industry partners, particularly members of the Industry Reference Group, was essential to develop a document that has industry acceptance and ownership.

WorkSafe recognises and appreciates the time and expertise given by all professionals, organisations and associations who participated in the project and the handbook's development.

1. Introduction

1.1 Purpose

This handbook sees the prevention and management of aggression and violence as an OHS issue that requires a multi-faceted organisational approach. It provides a framework to identify, prevent and manage aggression and violence in health industry workplaces.

Based on risk-management processes, effective consultation, documentation monitoring and evaluation, this handbook will help health services establish and maintain an effective workplace aggression and violence prevention and management program.

It also emphasises the use of practical measures to prevent incidents and achieve a safe work environment. It's designed to be a resource for managers, supervisors, health and safety representatives (HSRs) and others involved in developing prevention strategies to address aggression and violence.

1.2 Scope

This handbook covers a broad range of situations in which health occupational violence can arise. The main focus is to prevent client-initiated violence; however, some measures and tools in this handbook are also suitable for aggression from family members or the general public.

This handbook is advisory in nature and will assist employers establish effective workplace prevention programs. It includes policy recommendations and practical methods to help prevent and mitigate the effects of workplace violence.

This handbook and its tools are available on-line at worksafe.vic.gov.au.

1.3 Definitions

For the purpose of this policy, occupational violence and aggression 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.

Within this definition:

- **Threat** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked. It may involve an actual or implied threat to safety, health or wellbeing, and
- **Physical attack** means the 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 threat is relevant. The key issue is that the behaviour creates a risk to health and safety.

Examples of occupational violence and aggression include, but are not limited to, verbal, physical or psychological abuse, punching, scratching, biting, grabbing, pushing, threats, attack with a weapon, throwing objects/furniture, sexual harassment or assault, and any form of indecent physical contact.

2. Legislative framework

2.1 Context

Victoria's health services operate within a complex legislative environment.

This guide has been developed in line with the requirements of the *Occupational Health and Safety Act 2004* (OHS Act) considering the following legislation:

– *Accident Compensation Act 1985*

– *Crimes Act 1958*

– *Equal Opportunity Act 1995*

– *Mental Health Act 1986*

– *Aged Care Act 1997*

– *Victorian Health Records Act 2001*

Occupational Health and Safety Act 2004

Health care employers have a responsibility to comply with Victoria's health and safety laws, including duties to ensure the highest level of protection to employees, patients and others in the workplace.

Managing OHS risks can ensure services are effectively delivered and employees are protected.

Under the OHS Act, employers are required to consult employees and health and safety representatives (HSRs) so far as is reasonably practicable. Both employees and HSRs are a valuable resource in planning an effective and safe workplace design because they know the work practices and workplace better than anyone. Consideration may also be given to consulting patients, but the importance of staff health and safety needs is given high priority.

To ensure work environments are safe and free from OHS risks so far as is reasonably practicable, the OHS Act imposes duties on those able to influence health and safety, including employers, those who have control of the workplace (e.g. an owner, director or manager), designers, manufacturers and employees (including contractors).

2. Legislative framework

Accident Compensation Act 1985

The *Accident Compensation Act 1985* regulates Victoria's WorkSafe compensation and rehabilitation system.

WorkSafe compensation is a statutory no-fault compulsory insurance scheme. Employers, where required, must take out a WorkSafe policy to insure themselves against compensation claims for workplace injuries and diseases. The scheme aims to insure employers against the impact of economic loss caused through injury to workers.

Employees are entitled to WorkSafe benefits if they suffer a work-related injury or disease. If an employee is unable to perform their normal duties because of a work-related injury, the employee may be entitled to weekly benefits. WorkSafe will also pay the approved costs of medical and like services required due to work-related injury or disease.

Crimes Act 1958

Criminal law in Victoria is a combination of common law and legislation. The key piece of legislation is the *Crimes Act 1958*, which punishes all forms of criminal behaviour.

The law recognises that aggression and violence – such as a sexual offence, stalking, a threat to assault, injure or kill a person, or damage property – in the workplace can be criminal offences. These offences are subject to investigation by the police, who may subsequently charge and eventually prosecute the offender.

Some examples of workplace aggression and violence in the health sector will not be offences under criminal law, such as where an employee is attacked by a person who is unable to form the necessary intent.

Mental Health Act 1986

The *Mental Health Act 1986* provides a legislative framework for the care, treatment and protection of people with mental illness in Victoria. The Mental Health Act emphasises clients' rights and requires that treatment is provided in the least restrictive environment and manner.

There is also a requirement that the individual be cared for properly in a safe environment. Mental illness can result in behaviour where the individual's rights may be reduced subject to restrictions for reasons of his or her health or safety, or the safety of others.

Aged Care Act 1997

The *Aged Care Act 1997* is a piece of Commonwealth legislation that relates to all aspects of the provision of residential aged care, flexible care and Community Aged Care Packages (CACPs) to older Australians.

The Aged Care Act directs service planning, approval of providers and care recipients, payments and subsidies and responsibilities of service providers to care recipients and employees.

Within the *User Rights Principles 1997*, each resident of a residential care service has the responsibility 'to respect the rights of staff and the proprietor to work in an environment free from harassment'.

2. Legislative framework

Information Privacy Act 2000

The *Information Privacy Act 2000* covers the collection, use, storage and disclosure of all personal information that could identify an individual (except health information) in the public sector in Victoria. The Information Privacy Act requires that any personal information used is accurate, relevant, up-to-date, complete and not misleading.

Health Records Act 2001

The handling of all personal information held by health service providers in Victoria is protected by the *Health Records Act 2001*. It creates a framework to protect the privacy of individuals' health information and regulates how to collect and handle health information.

The Health Records Act gives individuals a legally-enforceable right to access their health information records held in Victoria by the private sector. It also establishes health privacy principles that will apply to health information collected and handled in Victoria by both the public and private sectors.

3. Review, prepare and implement

3.1 Context

Organisations need a solid foundation to build relevant, sustainable and continuously improving aggression prevention and management strategies. These should be based on organisation-wide OHS risk management. The recommended approach is cyclic and underpinned by consultation as required by the OHS Act.

3.2 Preparation

Preparation should consider the operational and organisational impact of policies and procedures and any changes that need to be made to documents, building design or work practices.

Solid preparation should answer the following key questions:

- What data and other information need to be accessed?
- Who will lead the preparation?
- Who will be consulted?
- How will information be collected and analysed?
- How and to whom will outcomes be reported?

Answering these key questions will lead to an organisational self-assessment that provides a starting point for preparing **Tool 01** that:

- identifies an organisation's current situation related to compliance, governance, policies and procedures
- guides decisions about priorities for action to prevent and manage aggression and violence, and
- provides a baseline from which to review progress associated with implementing policy and practice changes and other control measures.

A staff survey could also be used to identify staff knowledge of organisational requirements and their needs in relation to continuing education and training.

A sample staff survey can be found at **Tool 02**. Alternatively, **Tools T1** and **T2** could be used as self-reporting risks associated with exposure to aggression or violence.

It is vital feedback is provided to employees from reports and surveys, particularly if any corrective action or changes to policy and/or procedures are necessary.

3. Review, prepare and implement

From the self-assessment, a preliminary hazard identification should be done to identify risks associated with:

- current compliance requirements
- organisational shortfalls (e.g. current governance structure, policies, procedures and training programs), and
- environmental impacts.

Risk management

The aim of OHS risk management is to eliminate or reduce the risk of injury and illness associated with work. It is a continuous process of hazard identification, risk assessment and control, and evaluation of control measures. Consultation between employers, employees, OHS and HSRs is required to determine the methods to be used in managing and controlling risks.

A comprehensive risk assessment forms part of the initial preparation stage of the OHS continual improvement cycle as it helps identify hazards in the workplace and the frequency of possible exposure to risks to guide the implementation of control measures.

Remember: just because there is no history of incidents, does not mean hazards do not exist.

Hazard identification in the context of aggression prevention and management

The nature and location of work, types of clients, business hours, service and facility access, staffing levels and skill mix all affect the risk of exposure to aggression or violence. These factors and the category they fall into are listed below.

Workplace design

- unrestricted movement of the general public throughout health service facilities to areas that are easy to access or unsecured
- poorly-lit areas of a facility, and
- limited access and exit points, privacy, ease of access to telephone and toilet facilities.

Policies and work practices

- long waiting times
- staffing levels and skill mix during times of increased activity, such as mealtimes
- visiting times
- poor customer service
- isolated or remote working locations
- denying someone service
- handling cash
- investigating and/or enforcing specific legal requirements
- noise, and
- activity at night.

Client related

- physiological imbalances or disturbances
- substance misuse or abuse
- intoxication
- acute and chronic mental health conditions, and
- distress or frustration.

These examples are not exhaustive and there may be other situations that expose staff to risks of occupational aggression or violence, particularly where there is direct interaction with the public.

Incident and injury record review or audit

Review of incident and injury records, first aid reports and workers' compensation claims helps analyse trends and identify patterns of aggression and violence.

The data should be analysed to establish a baseline for monitoring changes in reporting, measuring improvement, and to monitor and analyse trends. The data can also be used to support decision-making processes associated with setting priorities for further investigation, assessment, action or review.

Remember: raising awareness may result in increased reporting of incidents that may have previously gone unreported.

Walk-through inspection

A checklist is a useful way of identifying hazards that don't require expertise in OHS. It is a systematic way of gathering and recording information quickly to ensure hazards are not overlooked. A checklist helps identify issues to be considered during risk assessment.

Things to consider in a walk-through inspection are:

- security
- entry and exit points/options
- lighting
- methods of communication
- work schedules
- physical layout and natural surveillance points, and
- service delivery processes.

Risk assessments

Risk assessments determine if a hazardous situation may result in harm and assist employers make decisions about appropriate control measures.

When assessing the risks of occupational aggression and violence, the following questions should be asked:

- How likely it is that an act of aggression or violence will occur?
- How severe would the impact of such an act be?
- Is there any information regarding previous incidents of aggression or violence in the workplace?
- Do control measures exist and are they adequate?

A written record of risk assessments will assist with periodic reviews, whether done annually, when operations change or incidents of workplace aggression or violence occur. They also help assess the effects of change, provide a body of organisational evidence that will identify achievements and assist in further decision-making.

Tool T1 uses a risk matrix to self-report exposure to aggression and violence that might otherwise go unreported and could be used as part of the hazard identification and risk assessment process.

Incident and 'near miss' investigation

The organisational self-assessment tool **(Tool 01)** allows for the review of current systems, expectations and processes associated with reporting and investigations.

Incident and 'near miss' investigation is discussed in chapter 5.

3.3 Implementation

Risk control is a process of implementing effective measures to eliminate or reduce risks to health and safety. If risks cannot be eliminated, the OHS Act requires they be reduced so far as is reasonably practicable. Consider whether the hazard can be removed or if the activity that precipitates the risk can be discontinued or changed to eliminate the risk. One or more of the following control methods could be used to eliminate or reduce the risk of occupational aggression or violence:

- **Elimination** at the source of risks, e.g. utilising particular building design principles, such as calming or non-stimulating colour schemes, removing potential missiles/weapons or installing a direct taxi phone.
- **Substitution** of the hazard with something posing a lower risk, e.g. changes to client contact arrangements, such as telephone contact, video intercoms at night entrances.
- **Isolation,** e.g. security glass or metal screens to protect staff, secure retreat areas for staff.
- **Engineering control,** e.g. timely maintenance and repair of equipment or dual access and exit points to eliminate potential entrapment.
- **Administration,** e.g. signage, personal protective equipment, training and education, job rotation.

It is recommended that these control measures be considered and applied in descending order. A combination of measures may be required, but 'higher level' control options will always be more effective.

3.4 Review

When evaluating control measures, it is important to check if the introduced changes have reduced the risk from when it was previously assessed. This may require hazard identification and risk assessments to be repeated to ensure all risks to health and safety have been controlled so far as is reasonably practicable.

Where the evaluation of risk control measures reveals some remaining risk, the process continues until the risk is minimised so far as is reasonably practicable. Satisfactory control of risk is often a gradual consultative process, involving trialling and refining measures that consider employee feedback, new technology and changes in knowledge.

The review should also analyse data accessed in the initial preparation process, such as incident data to guide ongoing decisions about further actions.

References

Controlling OHS Hazards and Risks (WorkSafe 2007)

Prevention of Bullying and Violence at Work, Guidance Note (WorkSafe 2003)

4. Workplace design

4.1 Context

This part of the handbook provides guidance on how to establish and maintain staff safety and security by developing appropriate facilities, work spaces, building services and systems.

It will assist anyone involved in the design, development and management of health services to identify environmental risk factors for client-initiated aggression.

The objective is to reduce the likelihood of aggression or violence by using the design process that is identified as more effective in reducing risk than relying on work procedures or training alone.

4.2 Design process

Eliminating hazards by good design involves incorporating OHS into the design process from the beginning. Important decisions are made early in the design process, and as the project proceeds it becomes more difficult and costly to make changes.

It is important to specifically consider aggression and violence at all design stages for refurbishment or extensions to existing health services and for new purpose-built facilities.

Remember: it is easier to change a line on a drawing than to alter a finished building.

The WorkSafe publication *Designing Safer Buildings and Structures* provides guidance and tools for use in the design process and to help follow the recommended process to address OHS issues.

Strategies to improve the effectiveness of user consultation include:

- Getting the right people around the table – an effective user group should include a mix of managers, employees, health and safety representatives (HSRs) and designers.
- Training the user group in design awareness – skills and knowledge in relation to the design process.
- Establishing a transparent consultation process – clearly documented and conducted in a language and style suitable for all participants.
- Help to visualise the design – use tape or chalk on the floor to do a simple mock-up of an area.

Stages of the design process

Involving key stakeholders, including direct care staff, during the whole design process achieves the best result. An integrated approach to considering safety (and, in particular, the threat of aggression) should occur at each design milestone. Good design will eliminate many aggression issues, enhance quality of care, and optimise workflow and communication. **Tool D2** outlines issues that should be considered at each stage of the design process.

The table below outlines some of the key stages in the design process and the associated activities and considerations.

Stage	Activities/considerations
Design brief preparation	• Establish consultation structures. • Brief user groups. • Develop design awareness.
Feasibility	• Map out and cost the aim of determining if the scope is realistic given available resources. • Focus on issues that may influence the potential for aggression and violence, such as the location of key entries and exits. • The location of key departments may influence the potential for aggression (e.g. locating the emergency department).
Contract documentation	• All materials are selected and costed. • Aggression-related design issues, colours and lighting, are considered.
Construction	• While the building is being constructed, there may be some issues relating to aggression that need to be considered, such as construction noise or the closure of some areas, which needs to be communicated to clients.
Post-occupancy evaluation	• An evaluation should establish any design shortcomings that may impact on staff and client safety. • The collection, review and analysis of incidence data on aggression and violence should consider the impact of design.

4.3 Crime prevention through environmental design (CPTED)

CPTED can be used to address violence and aggression.

Its principles can be applied to health service environments and incorporated into the work of architects, engineers, builders, maintenance staff and landscape gardeners.

CPTED principles fall into three broad categories:

1. Territorial reinforcement aims to create a strong sense of ownership of a space. It is promoted by features that define property lines and distinguish private from public spaces, such as landscaping, paving, gateways and fences. Ongoing maintenance and housekeeping are key aspects of territorial reinforcement to show the space is cared for.

2. Access control can be provided through physical and symbolic barriers to prevent unauthorised access to an area, such as locks and signage. It will attract, restrict or channel movement by making it clear where people can and cannot go.

3. Surveillance aims to ensure key areas, such as interview rooms, waiting areas and pathways to car parks, are clearly visible to staff. It can be electronic (e.g. CCTV) or natural (e.g. windows or by strategically positioning buildings, access-ways and meeting places, and lighting).

4.4 Design controls

General high-risk areas

Reception and waiting areas

As areas of first public contact, receptions and waiting rooms should provide security and protection for employees, while still allowing good communication with clients. They should be designed to prevent unauthorised entry and also provide staff with good visibility of clients and visitors entering the area and using the waiting room.

The reception area should be easily identifiable, accessible and properly staffed to prevent client impatience and irritation. Clear signs should indicate where clients should report, particularly if they are to undergo triage before they register.

The reception desk serving the main entrance should allow for surveillance of everyone entering the hospital. A high and wide desk increases the distance between the receptionist and the visitor, offering some level of protection.

Treatment and interview rooms

High visibility and controlled access to interview rooms may reduce the risk of violence, and two exits allow for appropriate means of access and exit. The layout should not permit obstacles between staff and the door, and furniture should be arranged to prevent employees from becoming trapped or cornered.

The decor should have a calming effect on the client, with comfortable but minimal furniture in interview rooms or crisis treatment areas. Furniture and fittings that are difficult to use as weapons (e.g. hard to lift, without sharp corners and edges) should be used.

It remains important that these rooms – that should be square-shaped – should have two doors, controlled access, safety glass windows (so staff can be seen while retaining client privacy) and duress alarms.

Pharmacy

The pharmacy is a vulnerable part of the building and should have a separate alarm zone within the main alarm system.

To reduce the likelihood of a break-in, the pharmacy should not form any part of the external structure and should be located within easy reach of the main entrance. The walls should be masonry and built up to the underside of the floor above. It is important the staff entrance be access-controlled and inaccessible to the public.

To prevent customers coming into direct contact with staff, the counter should be high and wide and the floor behind it should be raised if staff prefer a seated position. It is also important the platform is balanced against the trip/fall hazards that may be introduced by any steps used to access the workstation, and that staff cannot rotate to a standing position.

Screens should be made out of laminated glass and be no thinner than 7.5 millimetres. A personal attack alarm should be fitted behind the counter and should have natural surveillance and CCTV coverage. Controlled drugs should be secured in a lockable storage cabinet and regular drug audits conducted. Toilets should not be located in or near the pharmacy.

Car parking

Onsite car access should be restricted to the minimum required and only for areas necessary. Parking should be limited to designated areas where cars can be more easily supervised.

Safe parking areas should:

- have limited and controlled access
- a defined perimeter
- natural surveillance over the whole area
- be well lit
- have low-level defensive planting
- traffic-calming measures
- one-way systems, and
- separate footpath/vehicle routes.

Other

The cash office is another vulnerable part of the building and should also have a separate alarm zone within the main alarm system. It should not form any part of the external structure, but be within easy reach of the main entrance. The walls should be masonry and built to the underside of the floor above and the office should be fitted with a laminated glass screen.

4. Workplace design

High-risk areas

Emergency Department (ED)

Why high risk	Examples of design control measures	Supporting measures
• Factors that may increase the risk of aggression, violence and challenging behaviour: – waiting times – other people – providing care to people who are in distress, afraid or under the influence of drugs and/or alcohol – substance abuse, and – volatile emotional situations.	• Ways these factors can be controlled through design measures: – limited public entry points – access control to treatment areas – comfortable, spacious waiting area with enough seating for peak demand times – safe rooms/secure area for staff to retreat to during emergencies – clear signage – private areas for separation of distressed or disturbed people – wide and screened reception counters – strategic CCTV and monitoring – queuing system – bollards to restrict vehicle access near doorways – designing out of narrow underpasses or lanes leading to car parks and public transport – separate staff car parks from visitor/client parking, and – duress alarms (desk based and personal).	• Security staff have authority to grant or refuse entry. • Duress and emergency response procedures are in place. • Security and reception staff are able to see all areas of the ED through the use of security cameras and/or mirrors.

Maternity and Paediatric Wards

• Factors that may increase the risk of aggression, violence and challenging behaviour: – volatile emotional situations – family disputes – family violence, and/or – child protection issues.	• Areas should not be located on the ground floor of the hospital include: – access control between public areas and nursery, and – entrances actively under observation by staff and CCTV.	• Visitors should be identified before entering. • Visitors' movements should be actively monitored. • Staff should be clearly identified. • Duress and emergency response procedures should be in place.

High-risk areas (cont)

Aged Care

Why high risk	Examples of design control measures	Supporting measures
• Factors that may increase the risk of aggression, violence and challenging behaviour: – change in routine – disinhibition – dementia – anxiety, and – fear.	• Control stimuli (e.g. noise, pedestrian traffic). • Safe walking circuits. • Adequate space – areas uncluttered. • Good lighting with access to natural light. • Appropriate floor coverings – smooth, no trip hazards.	• Provide a set routine with regular permanent staff. • Provide activities. • Maximise independence.

Mental Health

• Factors that may increase the risk of aggression, violence and challenging behaviour: – client mix – overcrowding – inadequate staffing – substance misuse – boredom, and – delirium.	• Good visibility, especially for entrances and exits. • Provide appropriate space (including outdoors) so patients have adequate personal space to retreat when threatened or do not want to interact with others. • Secure storage for potentially dangerous items (such as kitchen and occupational therapy equipment). • Safe isolation room. • Fixtures and fittings are flush mounted (i.e. not just mounted on a wall, but inset) and unbreakable. • Provide good ventilation and acoustics (e.g. soundproofing).	• Provide a set routine with regular permanent staff. • Provide activities. • Maximise independence.

Other considerations

Area	Risk/problem	Control/solution
Noise	• Noise can be a source of irritation, stress and aggression. • Sounds can be overwhelming and exacerbate stress and aggression.	• Avoid loud volumes on television and radio. • Use soundproof walls or double-glazed windows to reduce noise from the external environment. • Natural sounds and background music can be relaxing and help reduce stress.
Light	• A lack of natural light can cause distress and have negative effects on mental health, including social withdrawal and general unhappiness. • Glare can have a similar effect on behaviour.	• Natural light (through windows or skylights) is preferable to artificial light. • Avoid harsh overhead lighting – diffuse and glare-free lighting contribute to a relaxed environment.
Colour	• The colours of walls, buildings, signs and uniforms have been found to impact on human behaviour.	• Soft shades of pink have been found to reduce anxiety, blood pressure, arousal and time taken to return to a calm state. • A bright room with light colours is preferred over a room with dark colours, to minimise anxiety.
Temperature and climate	• The likelihood of aggression increases as the temperature does.	• Install climate control systems. • Ensure adequate ventilation, especially when rooms are at maximum capacity.

4.5 Security and access

Effective building security requires:

- securing perimeters, including doors and windows
- appropriately controlling access to the facility
- safe access and exit, especially after hours and during emergencies
- controlling access to vulnerable areas
- clear signage, and
- systems that allow staff members to be identified.

Furthermore, the operating system needs to be:

- secure enough to resist attempts to breach it
- able to effectively differentiate between those who have authorised access and those who don't
- able to prevent unauthorised entry but not prevent exit
- reliable, regularly maintained and tested, and
- designed to include a back-up system or process for providing access in the event of failure.

4.6 Alarm systems

The choice of an alarm system depends on the nature of the workplace, the activities undertaken and the level of risk. Staff working in the relevant areas should be consulted when determining alarm system requirements, where it should be located and protocols for its use.

When identifying appropriate alarm systems, health services should consider if:

- the alarm system complements other security/protective measures
- the alarm system's features and configuration suit the facility's needs and risks (expert advice should be sought)
- staff training in the use of the alarm system and response procedures is needed, and
- what ongoing maintenance and testing of the system (e.g. schedule of replacement of batteries for mobile duress alarms) is needed.

Duress alarms

A duress alarm emits a signal to call for assistance when a person is under attack or feels threatened. When installing a duress alarm, identify the features required by ensuring:

- fixed alarms with duress buttons are strategically located throughout the facility
- mobile duress alarms are worn by staff members inside and outside the facility, and
- an electronic global positioning system (GPS) is used.

Fixed alarms

Fixed alarms or panic buttons should be hard-wired and operated by strategically placed and easy-to-reach buttons installed throughout the area where a potential threat exists.

Mobile alarms

Mobile duress alarms may be used where the staff member is 'mobile' in the course of their work. For example, in wards or emergency departments where there is a risk of being confronted by aggressive behaviour. They should be attached to an employee's clothing, but not worn around the neck.

Training

Suppliers of any alarm system should train staff in how to use the equipment. A duress alarm is only a means of indicating that someone needs assistance – the response to the signal is the important part of the duress process. It is essential to establish a reliable and timely response system to an alarm that includes security and/or police back-up (see chapter 5). Alarm drills are a good way to test if the duress response system is working.

4.7 Resources

Australian Standard – AS 4485.1 – 1997 – Security for Health Care Facilities – General Requirements

Protecting People and Property: NSW Health Policy and Guidelines for Security Risk Management in Health Facilities, NSW Health Policy Directive, 2005

5. Policy, procedures and practice

5.1 Aggression prevention policy

Developing and implementing an aggression prevention policy clarifies expectations relating to behaviours and demonstrates a commitment to health and safety. The policy should be developed as a result of consultation across the organisation with health and safety representatives (HSRs), employees and managers.

A policy should include the following elements:

Purpose statement

- Intent to provide a safe and healthy workplace where employees are not subjected to aggression and/or violence.
- Commitment to support employees who are exposed to, or have witnessed, aggression and violence.

Definition of scope

- Definition of aggression and violence.

Objectives

- Aggression and violence are not acceptable and will not be tolerated.
- Appropriate action will be taken if aggression and violence occur.
- Reporting incidents is mandatory and based on a no-blame approach to investigation.
- Training and educating employees in the prevention and management of aggression and violence is tiered and based on exposure to risk, following OHS principles that are updated and ongoing.

Responsibility

- Roles and responsibilities of relevant staff.
- Appropriate authority is given to staff with responsibilities under the policy.

Risk management

- Proactive hazard identification and risk assessment of situations and sources.
- Risk control of violent or aggressive behaviour.
- System for communicating information about potentially violent situations for clients who have a history of exhibiting violent or aggressive behaviour, including triggers and management strategies.

References and related documents

- Documents and sources used in the formulation of the policy and related organisational documents.

Authorising committee/position in the organisation

- Policy is endorsed by authorised committee or senior manager.

Dates of approval and review date

- Regular monitoring and review of the policy to ensure it remains in line with changes in legislation and organisational needs.

The policy should be displayed in a prominent place for all employees to view.

A sample policy is attached to this document **(Tool P1)**. If the template is going to be used, consultation must occur with health and safety representatives (HSRs) and employees, and adapted to the organisation's specific requirements.

5.2 Organisational procedures

Health services should communicate that aggression and violence will not be tolerated, and that appropriate action will be taken if such behaviour occurs. This needs to be supported by the organisational policies, procedures and codes of conduct.

An organisation can develop a staged approach to the management of aggression and violence that may include:

- warnings
- file flagging and care planning
- restriction of visiting rights
- alternate treatment arrangements
- contracts of acceptable behaviour
- conditional treatment agreements
- refusal of service (except for treatment of life-threatening conditions), and
- prosecution.

The options in the staged approach should be applied in descending order that takes account of:

- the level of risk
  - frequency and severity of the behaviour, and
  - extent of exposure of staff
- ability of the client to understand the issues associated with the behaviour
- capacity to modify behaviour
- previous attempts to resolve the matter, and
- the ability to read and understand English.

Warnings

A written warning should:

- focus on the behaviour and the possible effects this may have on staff and other clients, not on the person or the intent
- be drafted in consultation with key stakeholders (e.g. relevant clinicians)

- clearly identify the matter of concern and the expected behaviour
- be polite, respectful, non-judgemental and informative
- use plain English
- clearly indicate the consequences of failing to behave in an appropriate manner
- include information about how to appeal or complain, and
- be signed by a senior manager with an appropriate level of authority.

Treatment agreements

Some circumstances may need a conditional treatment agreement to be established, such as where the client repeatedly comes for treatment:

- under the influence of alcohol and/or drugs
- with disruptive friends, relatives or others with a history of violence
- late at night or at change of shift times, and/or
- in a manner that threatens, attempts or perpetrates violence against staff.

Treatment might be deferred until the risks can be better controlled – for example, when more staff (or more experienced staff) are on duty. It may also be necessary to arrange for treatment in a safer location.

Clear behavioural expectations and the consequences of failing to comply (e.g. treatment at a different location or the banning of visitors) should be considered.

Agreements should always be:

- developed in consultation with the client and other relevant stakeholders (e.g. carer, relatives, clinicians, security staff)
- objective and focused on the behaviour not the person
- reviewed regularly
- completed in a safe and therapeutic environment, and
- have an appeal or complaint mechanism.

Sanctions

When other strategies are not appropriate, treatment may have to be refused except in life-threatening circumstances. This option should only be considered after other control options have been explored to their full capacity.

Relevant templates for decision-making and communication with respect to sanctions can be found in ***Tool P6.***

Staff should be aware of procedures for requesting police or security assistance and filing charges. It is advisable to maintain regular communication with local police.

5.3 Procedure to practice

The prevention and management of aggression and violence can be integrated into day-to-day practice through relevant work procedures that need to be documented. Describe details of the organisational arrangements to identify, assess and control hazards specific to aggression and violence, including responsibilities of clinical and non-clinical staff. It is important regular reviews are undertaken.

Work procedures need to:

- describe circumstances in which they are to be followed
- define roles and responsibilities
- describe specific risk controls and monitoring of the controls
- include emergency response arrangements, and
- provide guidance on reporting of incidents and near misses.

Clinical protocols should also be implemented to manage clinical aggression arising from a client's medical or psychiatric condition. Clinical aggression requires a clinical response for prevention and management.

Examples of procedures and practices relevant to the prevention and management of aggression could include:

- reporting incidents and near misses
- limiting the number of client support people/visitors
- communicating with clients and visitors to detail expected waiting times, client condition, treatments or treatment delays
- cultural awareness and the appropriate use of interpreters
- exchange of relevant information within and external to the organisation
- use of lanyards with a safety breakaway
- supply of security equipment such as duress alarms, and
- searching clients and visitors for weapons, illegal drugs or alcohol.

A procedure will be required to determine how to search an individual for weapons and other dangerous objects. The facility should determine conditions of entry and clearly define weapons, alcohol and illegal drugs that are not to be brought into the facility.

Searching individuals and removing dangerous items creates a potential risk to staff safety and should be undertaken by trained security personnel or, in some circumstances, by police, but not clinicians.

5.4 Behavioural risk factors

The most reliable predictor for the likely occurrence of violence is previous violent behaviour. To prevent the risk of injury to staff and others, clients with a history of aggression or violence should be identified, risk assessed and the resultant information effectively communicated to staff and other service providers as required.

Staff should be provided with the resources to identify and assess behavioural risks and to determine if any violent or aggressive behaviour has occurred in the past.

At presentation, the following risk factors should be considered:

- current status (e.g. under influence of alcohol and/or drugs)
- current level of aggressive behaviour
- unwelcome treatment, pain and/or anxiety
- long waiting time
- information provided by family, friends or other service providers, and
- history of aggression and violence.

A risk assessment should be conducted if conditions change or if there are any other indicators the behaviour might be a problem.

An example of a high-risk screening tool for the point of entry (triage) can be found in **Tool P2**, and a tool for combined violence risk identification and assessment is included in **Tool P3**.

Risk factors should be noted and highlighted in a care management or treatment plan, after completing a behaviour assessment worksheet **(Tool P4)**.

5.5 Client alert systems

Information known about any risks of violence or potential violence that may pose a threat to health and safety should be provided to staff who may come into contact with the client or to another health service to which the client is referred. Where a health service is aware of a risk of aggressive or violent behaviour, there is an obligation to inform other parties of the risk if the client is referred to another service, department or facility.

Alert systems, or 'file flagging', are used for a variety of clinical risk management and client safety reasons (e.g. to identify clients with life threatening allergies) and can also be used to identify client behaviours that could create a risk to health and safety. Criteria for flagging should be carefully developed and linked to safety issues that arise from a client's behaviour, rather than personal characteristics.

An example of a client alert can be found at **Tool P5**. Alternatively, a chart tag or log book may be used. The information needs to be objective, reviewed regularly and kept up-to-date.

A client alert procedure should cover the following issues:

- Clearly defined purpose for the flag, such as focus on behaviour and risk.
- Person to whom the flag refers (e.g. client only, family, regular visitors).
- Behaviour management planning.
- Delegated responsibility for initiating, reviewing, removing flags, and reviewing and updating associated management plans.

5.6 Care planning

Care planning requires a clinical understanding of aggressive behaviour. Some common causes include:

- pain
- medication-related issues
- drug withdrawal
- fatigue, or
- change of environment, routine or care giver.

Clinical reasons can include:

- delirium
- perception of loss
- response to overwhelming stimuli, or
- some psychological states.

If a client file has an alert flag it should be supported by an up-to-date management plan. Care plans can be developed through a multi-disciplinary team approach. Case conferences can be an opportunity to prepare a multi-disciplinary care plan that could include health and safety representatives (HSRs) or OHS staff.

5.7 Incident management

If an incident occurs or escalates, it is important staff have immediate response options, which may include calling more senior staff for assistance, a duress response team, security or the police.

The response approach selected needs to be appropriate to the situation and skills of staff and may include:

- review by a clinician
- calm verbal and non-verbal communication
- verbal de-escalation and distraction techniques
- support from other staff
- request that the aggressor leave
- withdrawal to a safer location
- internal emergency response
- external emergency response
- evasive self-defence, or
- initiating a duress response.

It should be possible for any member of staff to initiate a duress response at *any* time.

Where facilities have more than one high-risk area (e.g. emergency departments and mental health facilities), consider a secondary duress response protocol, in case two incidents occur at the same time.

Evasive self-defence

Evasive self-defence assists staff to safely remove themselves from a violent situation and minimise the risk of injury to themselves and others. The degree of force used must be proportionate to the degree of potential harm faced and must not be applied for longer than is reasonably required to control the risk.

Evasive self-defence strategies may provide staff with a controlled physical response when retreat is blocked; all other non-physical strategies have failed; the staff member is under threat of attack; or is being attacked.

Restraint

Restraints can be physical, mechanical or chemical and are designed to safely restrict a person's freedom of movement. Organisations need clearly written policies and procedures related to client restraint, which should include:

- a method for evaluating situations where restraint might be needed
- safe and proper application of safety devices
- client monitoring and review, and
- documentation.

Duress response

As part of an overall risk-management approach and to complement other risk controls, duress alarms should be considered during design and facility redesign as well as post-incident. The following characteristics should be features of any duress response:

- one call or trigger to activate response
- standardised response
- tailored to local needs, and
- covers all staff.

Duress response team procedures need to consider the following:

- numbers required
- delegated tasks
- response leader/coordinator
- training requirements (refer to chapter 6)
- documentation
- police involvement
- operational review and debriefing, and
- testing and maintenance of the duress alarm system.

Post-incident response

Priorities following an incident are:

- safety for all concerned
- medical attention
- psychological support, and
- reporting.

Incident investigation and review

Investigations need to be conducted in a systematic way to identify risks and hazards inside and outside the facility. Investigations also provide learning opportunities and should be conducted without seeking to blame individuals or groups.

An investigation needs to capture:

- the type of incident
- date and time of incident
- site of incident
- people involved – including witnesses to the incident
- the outcome of the incident
- injuries sustained by staff and/or clients, and
- contributing factors – clinical, workplace design, equipment failure/ maintenance, human resources and any other risks or hazards.

As well as speaking with staff involved or witnesses to an incident, it may also be necessary to consult other agencies or service providers (e.g. police, ambulance officers or general practitioners) to obtain detailed background on an incident, further actions or other relevant information.

Reporting the findings, recommendations and outcomes of an investigation should enable control measures to be introduced and practices reviewed to minimise the risk of future incidents. Staff directly affected should receive feedback about the outcomes and recommendations from the investigative process.

Page 5 of 10 of **Tool 01** (page 43) provides an organisational self-assessment of incident documentation, reporting and investigation processes aimed at identifying potential gaps in associated current organisational systems.

Additional support and follow-up

A follow-up program for people exposed to workplace aggression and violence is necessary. Several types of assistance can be incorporated into the post-incident response, such as trauma-crisis counselling, critical incident stress debriefing, peer support and employee assistance programs.

As well as debriefing, counselling and peer support after an incident, staff may also need assistance with police and judicial processes, WorkSafe Compensation claims and return to work.

6. Training and education

6.1 Context

Training and education is considered an administrative control measure.

Training can complement and support higher order measures, such as design, policy and work practices. Training that is based on comprehensive needs analysis will be more effective than training that is not.

6.2 Principles

Training programs need to be relevant to the workplace and based on organisational needs, appropriate to the needs of staff and the client group involved. They should be practical and accessible.

Such programs should also be based on principles of adult education to ensure relevance and support for programs. Special needs of staff, such as skills, gender, disability, literacy and first language, also need to be considered.

6.3 Needs analysis

A comprehensive training needs analysis should be completed before any training programs are introduced. A needs analysis can be conducted using questionnaires, staff surveys **(Tool 02)** or focus groups in specific work areas. Training needs can also be identified through incident analysis, OHS systems reviews and the use of risk calculator matrixes. Risk calculators at **T1** and **T2** of this handbook relate to a tiered approach to staff training and education.

6.4 Tiered approach

A tiered approach to training is recommended to ensure the right people get the right training, based upon their identified risk of exposure to incidents, and their roles, responsibilities and expectations within the organisation.

Programs should help staff understand:

- risk factors for aggression and violence
- clinical and non-clinical causes
- signs of escalation and imminent violence
- communication strategies
- prevention measures
- workplace policies and procedures
- emergency and post-incident responses, and
- the right to withdraw to safety at any time.

6. Training and education

The table below is one example of content that would build in a tiered approach.

Content	Level 1	Level 2	Level 3	Response Team Member	Manager
OHS duties of employers and employees *(OHS Act 2004)*	✓	✓	✓	✓	✓
Reporting mechanisms for incidents and near misses	✓	✓	✓	✓	✓
Policy framework related to client-initiated occupational violence	✓	✓	✓	✓	✓
Definition of client-initiated aggression and violence	✓	✓	✓	✓	✓
Policies, practices and procedures – emergency codes	✓	✓	✓	✓	✓
Patient rights and responsibilities bill/charter	✓	✓	✓	✓	✓
Identification of triggers to aggression and violence		✓	✓	✓	✓
Recognition of signs of escalating aggressive behaviour		✓	✓	✓	✓
Environmental scanning for actual or potential hazards and exit points		✓	✓	✓	✓
Management of an aggressive situation, including de-escalation/diffusion		✓	✓	✓	✓
Negotiation skills			✓	✓	✓
Evasive self defence, including use of reasonable force			✓	✓	✓
Restraint techniques, use of mechanical and other forms of restraint			✓	✓	✓
Risks of restraint to the client (e.g. positional asphyxia)			✓	✓	✓
Roles and responsibilities of clinical staff			✓	✓	✓
Roles and responsibilities of response team members, including team leadership				✓	✓
Incident management					✓
Implementation of staff support during recovery phase of an incident					✓
Conducting systemic investigations following an incident					✓

6.5 Additional considerations

The content of the level 1 program might be included in the organisational orientation program as part of an OHS overview.

This level of training might be sufficient for a person employed in human resources.

Level 2 could be suitable for a person working in environmental services, while level 3 would be geared to clinicians. The organisational context and the expectations placed upon staff should be considered when making these decisions. For example, in a small hospital where non-clinical staff may fill multiple roles, such as payroll, accounts payable and reception, the level 2 program would be valuable.

Within the staffing skill mix, key members of each shift team should have demonstrated skills, training and experience in the management of behaviours and conditions relating to that environment (e.g. dementia care, cognitive deficit, or challenging behaviours).

Code grey/code black response team members require theoretical and practical components with regular updates and opportunities to practice techniques and strategies as part of a team.

Evasive self defence training

Evasive self defence training should only be provided after all other possible risk control strategies have been implemented and the level of risk warrants such a response.

Where evasive self defence training is to be provided, it should:

- emphasise retreat and self-protection
- cover relevant legal issues, such as the concept of reasonable force and dangers and precautions when using evasive self-defence
- be developed and delivered by appropriately experienced and accredited experts
- provide techniques relevant to staff group, the risks they face and environments they work
- include the requirement for, and provision of, regular practice, and
- consider the physical characteristics of the staff group and those of the perpetrators of violence where possible.

Security staff

The needs of an organisation should be considered before employing security staff or subcontracting a security firm. Security personnel should have completed an industry approved program, such as Certificate III in Security Operations, ensuring they are appropriately qualified for the role.

Their inclusion in organisational training will assist in clarifying roles within response teams.

Managers

Tailored training for managers should ensure they:

- understand the adverse impacts of occupational violence on employees, patients and the workplace
- develop skills to prevent occupational violence within the health service setting
- understand the obligations of the employer to provide a safe workplace for employees and clients
- understand and manage their own behaviours, including the capacity to shape behaviour of others through role modelling, setting clear standards and effectively managing incidents
- understand their role in facilitating, supervising and supporting the implementation of organisational policies and procedures
- implement the organisation's staff support processes during any recovery phase of an incident, and
- are able to undertake systemic investigations following an incident.

Managers at all levels should participate in the consultation that informs the training needs analysis and in the implementation of training modules.

6.6 Providers and programs

Trainers can be recruited from the existing workforce if there are members of staff appropriately skilled in meeting the needs identified by the training needs analysis. Alternatively, external providers could provide the training program.

The training needs analysis and organisational review (chapter 3) should inform the choice of training provider and program. Considerations when making these choices include:

- What mode/s of program delivery would best meet our needs – self directed learning packages, face-to-face, online, internal or external providers?
- Does our organisation have the staff skills, knowledge (Certificate IV in Workplace Training and Assessment, postgraduate qualifications in education, OHS or psychology) and capacity to design, structure and deliver a tiered program in-house?
- Are there areas of the organisation that need to be targeted as a high priority?
- When, where and how will the program be delivered?
- What costs will be involved – venue, equipment, trainers, staff release and backfill?
- Who will co-ordinate the program?
- How will the program be evaluated and by whom?

6.7 Evaluation

Training and education evaluation determines if a program has achieved its stated objectives. Information is gathered at various stages of the design and delivery processes to:

- determine the effectiveness of training
- support decision-making about current and future training
- enable documentation of information and program improvements, and
- help determine the overall quality of the training provided to staff.

An evaluation tool should be developed or adopted during the needs analysis phase of training design. Methods for using the evaluation tool may vary depending on organisational needs and resources. To make it meaningful, attention must be given to when it is used as well as how it is designed. Best-practice principles indicate that ideally, evaluation of an education intervention for the prevention and management of aggression and violence should be conducted before, during and after the training.

Pre-training evaluation provides a baseline measurement that the effectiveness of the training, once completed, can be measured against. Pre-training evaluation could involve processes referred to in this chapter as well as staff surveys.

Evaluation during the training can inform the process and highlight any specific needs for a group or individual. It is a technique used by trainers and educators to ensure they are meeting the needs of participants rather than a specific tool for information gathering.

Post-training evaluation provides valuable information about design and delivery, but does not measure learning transfer or medium-to-long-term benefits of a program in the workplace. **Tool T3** could be used immediately after training to evaluate program relevance and key learnings for participants. In the context of aggression prevention and management, immediate post-training evaluation is a minor part of the evaluation process.

Post-training evaluation in the medium-to-long-term can involve ongoing monitoring as described in chapter 3. A learning needs analysis could be conducted 6–12 months after the training to identify ongoing deficits in skill or knowledge. An example of a medium-to-long-term post-training evaluation can be found at **Tool T4**.

Competency-based assessments could also be conducted. A sample competency-based assessment can be found at **Tool T5**. It is recommended for use by those with a solid OHS knowledge who have completed a Certificate IV in Workplace Training and Assessment.

Findings from the application of **Tool T4** should be fed back into the overall evaluation of control measures for the prevention and management of aggression and violence in the workplace.

References

All Wales NHS Violence and Aggression Training Passport and Information scheme

Certificate III in Security Operations Crowd Control (PRS03) International Security Training Academy Pty Ltd Training. Student manual, Version 6-060805

Protecting People and Property: NSW Health Policy and Guidelines for Security Risk Management in Health Facilities NSW Health December 2003

Violence and aggression management training for trainers and managers. A national evaluation of training provision in healthcare settings. Zarola, A. and Leather, P., 2006, University of Nottingham, Health and Safety Executive, United Kingdom

7. References

7.1 Related Documents

The following documents should be consulted when using the handbook:

Zero Tolerance: Response to Violence in the NSW Health Workplace – Policy and Framework Guidelines, NSW Health, 2003

Industry Occupational Health and Safety Interim Standards for Preventing and Managing Occupational Violence in Victoria's Mental Health Services, Department of Human Services, 2004

Victorian Taskforce on Violence in Nursing, Final Report, Department of Human Services, 2005

Occupational Violence in Nursing: An Analysis of the Phenomenon of Code Grey/ Black Events in Four Victorian Hospitals, Department of Human Services, 2005

Protecting People and Property: NSW Health Policy and Guidelines for Security Risk Management in Health Facilities, NSW Health, 2003

Information Pack for WorkSafe Victoria's Intervention on Occupational Violence in Hospitals, WorkSafe, 2005

Prevention of Bullying & Violence at Work, WorkSafe, 2003

Zero Tolerance (Occupational Violence & Aggression): Policy and Interim Guidelines, Australian Nursing Federation (Victorian Branch), 2002

Framework Guidelines for addressing Workplace Violence in the Health Sector, International Labour Office, World Health Organization, 2002

Other documents to be considered in conjunction with this handbook include:

Risk Management – Australia and New Zealand Standard 4360-2004.

Occupational Health and Safety Management Systems – Australia and New Zealand Standard 4801-2001

Security for Health Care Facilities (Part 1: General Requirements) – Australian Standard 4485.1-1997

Security for Health Care Facilities (Part 2: Procedures Guide) – Australian Standard 4485.2-1997

7. References

7.2 Bibliography

All Wales NHS Violence and Aggression Training Passport and Information Scheme (2004). Prepared by All Wales NHS Steering Group for the Management of Violence and Aggression

Personal Safety and Privacy for Doctors. Position statement. AMA (2005). Australian Medical Association

Zero tolerance (occupational violence and aggression) policy and interim guidelines and industry resource package. ANF (2002). Australian Nursing Federation (Victorian Branch)

Aggression Management Policy and Procedures. Occupational Health and Safety Manual. Austin Health (2006)

Decision-Making Tool: Responding to Issues of Restraint in Aged Care. Australian Government Department of Health and Ageing (2004)

Identification of compliance requirements and tools for an effective risk management process for the National Standard and Code of Practice for manual handling 2003 in Part B: Issues Papers prepared by consultants, the NOHSC Office and Government Ergonomists Network for the Report for the Manual Handling Review. Bottomley, Bryan and Associates (2003). Issues Paper 4. February 2003

Violence, Aggression and Bullying at work: draft code of practice for prevention and management. Commission for Occupational Health and Safety Western Australia (2005)

Occupational Health and Safety Management Framework Model. DHS (2003). Victorian Government Department of Human Services. Public Hospital Sector

Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services. DHS (2004). Victorian Government Department of Human Services. Metropolitan Health and Aged Care Services Division

Occupational violence in nursing: An analysis of the phenomenon of code grey/ black events in four Victorian hospitals. DHS (2005a). Victorian Government Department of Human Services. Policy and Strategic Projects Division

Victorian taskforce on violence in nursing. Final report. DHS (2005a). Victorian Government Department of Human Services. Policy and Strategic Projects Division

Emergency. Signage Improvement Initiative/Emergency Departments. Final draft. DHS (2006). Victorian Government Department of Human Services

Workplace Violence in the Health Sector – Country Case Studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand, plus an additional Australian Study: Synthesis Report; Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector. Di Martino, V. (2002)

Evaluation of Education and Training of Staff in Dementia Care and Management in Acute settings. Lincoln Centre for Ageing and Community Care Research. Latrobe University for the Aged Care Branch, Department of Human Services. Foreman, P.; Gardner I. (2005)

Know workplace violence: developing programs for managing the risk of aggression in the health care setting – Policy and strategy. MJA 2005; 183 (7): 357-361. Forster, J.; Petty, M.; Schleiger, C.; Walters, H. (2005)

7. References

Reporting incidents of violence and aggression towards NHS staff. Nursing Standard 19, No. 38: 51– 56. Ferns, T., Chojnacka, I. (2005)

The Recognition, Prevention and Therapeutic Management of Violence in Mental Health care. Prepared for the UK Central Council for Nursing, Midwifery and Health by the Health Services Research Department. Institute of Psychiatry, London. Gournay, K. (2001)

Differences Between Patient and Staff Perceptions of Aggression in Mental Health Units. Psychiatric Services 54:389-393. Ilkiw-Lavalle, O.; Grenyer, B. (2003)

Framework guidelines for addressing workplace violence in the health sector. Geneva: International Labour Office. ILO (2002). International Labour Office/International Council of Nurses/World Health Organization/Public Services International

Certificate III in Security Operations Crowd Control. (PRS03) Student manual, Version 6-070805. International Security Training Academy Pty Ltd Training

Violence in emergency departments: under-reported, unconstrained, and unconscionable. MJA 2005; 183 (7): 362-365. Kennedy, M (2005)

Preventing client-initiated violence: a practical handbook. Research and Public Policy Series No. 30, Australian Institute of Criminology, Canberra. Mayhew, C. (2000)

Prevention of Occupational Violence in the Health Workplace. Working Paper Series 140. School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre, The University of New South Wales, Sydney. Mayhew, C.; Chappell, D. (2001)

Violence In Health Care – Editorial*. Violence in the workplace.* MJA 2005; 183 (7): 346-347. Mayhew, C.; Chappell, D. (2005)

OHS and public sector workers: the risk of aggression from clients. The Australian and New Zealand Journal of Occupational Health and Safety 2005; 21 (6): 511-550. Mayhew, C.; McCarthy, Paul (2005)

Melbourne Health Management of Clinical Aggression (MOCA) Pre-Training Manual Part 1. Melbourne Health (2006)

A Safer Place to Work. Protecting NHS hospital and Ambulance Staff from Violence and Aggression. Report by the Comptroller and Auditor General HC 527 Session 2002-2003:27. London: The Stationery Office. National Audit Office (2003)

Zero Tolerance. Response to violence in the NSW Health workplace. Policy and Framework Guidelines. NSW Health (2003). NSW Department of Health

Protecting People and Property: NSW Health Policy and Guidelines for Security Risk Management in Health Facilities. NSW Health (2003)

The effect of the built and natural environment of Mental Health Units on mental health outcomes and the quality of life of the patients, the staff and the visitors. NSW Health (2005)

7. References

Guidelines for working with people with challenging behaviours in residential aged care facilities – using appropriate interventions and minimising restraint. NSW Health (2006)

Health Care Facility/Service Safety Management System. Queensland Government Department of Industrial Relations (2004)

Clients who use Violence. Better Practice Guide. South Australian Government Department of Human Services (2002)

Attitudes toward patient aggression amongst mental health nurses in the 'zero tolerance' era: associations with burnout and length of experience. Journal of Clinical Nursing; 11: 819-825. Whittington R. (2002)

Employee Representation. A comprehensive guide to part 7 of the Occupational Health and Safety Act 2004. WorkSafe (2006)

Information Pack for WorkSafe's Intervention on Occupational Violence in Hospitals. Health and Aged Care. WorkSafe (2005)

Managing Safety in your Workplace. A step-by-step guide. WorkSafe (2005)

Officewise – A Guide to Health and Safety in the Office. WorkSafe (2006)

Prevention of bullying and violence at work. Guidance Note. WorkSafe (2003)

Working Safely in Visiting Health Services. WorkSafe (2006)

Prevention of violence: a public health problem. 49th World Health Assembly Resolution WHA49.25: Geneva: WHO. World Health Organization

Violence and aggression management training for trainers and managers. A national evaluation of the training provision in healthcare settings. Part 1: Research Report 440. Institute of Work, Health & Organisations (I-WHO) The University of Nottingham. Zarola, A.; Leather, P. (2006)

Tools

Organisation

Tool 01 Organisational self-assessment

Tool 02 Staff survey

Design

Tool D1 Design and aggression

Tool D2 Violence and the design process

Prevention

Tool P1 Violence prevention policy

Tool P2 High-risk screening

Tool P3 Violence hazard identification and risk assessment

Tool P4 Behaviour assessment

Tool P5 Client alert

Tool P6 Warning notice

Tool P7 Conditions and agreement

Training

Tool T1 Exposure to aggression risk calculator

Tool T2 Aggression risk calculator

Tool T3 Post-training evaluation tool – short term

Tool T4 Post-training evaluation tool – medium to long term

Tool T5 Competency-based assessment

Organisational self-assessment

This organisational self-assessment has been designed to enable staff to complete specific sections of the document. The major components for organisational self-assessment can be divided easily for targeted assessments within organisations. They are as follows:

- Organisational structures, governance and processes.
- Policy content.
- Procedures that support staff in client management.
- Risk management.
- Measurement and evaluation.
- Documentation, reporting and investigation.
- Human resource management, training and education.

The aim of this self-assessment is to enable organisations to obtain an overview of current systems, policies and procedures that support aggression prevention and management strategies.

Tool 01 – Organisational self-assessment

Organisational structures, governance and processes

This template looks at the generic organisational structures that are in place to support occupational health and safety activities.

	Yes	No	N/A	Comments
Our organisation has an occupational health and safety (OHS) committee.				
Our OHS committee has current terms of reference that are reviewed every three years.				
The terms of reference reflect reporting/communication requirements and processes to executive and board/committee of management levels.				
Our documentation reflects a consultative and cooperative approach to OHS.				
Policies and procedures are consistent with current legislative and statutory requirements.				
Policies and procedures are reviewed every three years.				
Our health and safety representatives (HSRs) have received the training required to fulfil their roles within the organisation.				
Our policies and procedures support staff in implementing the aggression prevention and management policy of our organisation.				
Our organisation has a documented client charter/bill of rights.				
Our organisation client charter includes 'client responsibilities'.				

Tool 01 – Organisational self-assessment (cont)

Policy content
This template provides an opportunity to review policy content related to aggression prevention and management of client-initiated occupational aggression and violence.

	Yes	No	N/A	Comments
Our organisation has a formal written aggression prevention and management policy for the prevention of occupational aggression and violence.				
The policy:				
• applies to all staff				
• acknowledges the employer's responsibility to provide a work environment free from risk of aggression and violence				
• includes a clear statement that staff should not tolerate, or put themselves at risk of exposure to, aggression or violence				
• includes a statement about identification of risk factors associated with aggression and violence				
• states provision of training for all staff who have contact with the general public, appropriate to their identified level of exposure and risk				
• requests all incidents, 'near misses' and threats of aggression and violence are reported.				

Tool 01 – Organisational self-assessment (cont)

Policies and procedures that support staff in client management

This template provides an opportunity to review policies and procedures related to client-initiated occupational aggression and violence.

	Yes	No	N/A	Comments
There are easy-to-see and accessible public displays that advise clients this is a 'violence-free' workplace.				
Our organisation has an incident/aggression/ security response team.				
Our organisation has security staff.				
Written policies and procedures for staged client warning notices, treatment contracts and refusal of treatment have been reviewed in the past three years.				
Requesting security assistance:				
Our organisation has a written procedure for requesting assistance from security staff that identifies situations that could require assistance and communication channels when assistance is required.				
Requesting police assistance:				
Our organisation has a written procedure for requesting assistance from police that identifies situations that could require assistance and communication channels when assistance is required.				
The procedure has been written in consultation with local police.				
There is an organisational procedure for reporting aggressive or violent incidents to the police.				

Tool 01 – Organisational self-assessment (cont)

Policies and procedures that support staff in client management (cont)

	Yes	No	N/A	Comments
Physical and chemical restraint and seclusion.				
Our organisation has documented policies and procedures on restraint and seclusion of clients.				
The documents include:				
• the use of defusing/de-escalation techniques as preventative measures in the first instance				
• how to access additional support if situations continue to escalate				
• responsibility and accountability for the decision to physically restrain a client				
• responsibility and accountability for the decision to chemically restrain a client.				
The documented procedures reflect actual resource availability for client restraint.				
The client seclusion policy and procedure are compliant with legislative requirements.				
The seclusion procedures reflect actual resource availability for safe client care.				

Tool 01 – Organisational self-assessment (cont)

Documentation, reporting and investigation

This template provides an opportunity to review documentation and reporting and investigation processes following an incident or 'near miss'.

	Yes	No	N/A	Comments
Our organisation has a system for reporting incidents of aggression and violence.				
Staff are aware of their obligation to formally report incidents of aggression or violence (e.g. at orientation or unit meetings).				
All incidents of aggression and violence are reported within 12 hours of occurring.				
Our system for reporting incidents is accessible to all staff.				
Our system captures the following information:				
• type of incident				
• date and time of incident				
• site of incident				
• people involved in the incident				
• outcome of incident				
• injury to staff member				
• injury to client				
• mitigating circumstances.				
All incidents of aggression or violence are systematically investigated to identify:				
• clinical contributing factors				
• workplace design contributing factors				
• work practice contributing factors.				

Tool 01 – Organisational self-assessment (cont)

Documentation, reporting and investigation (cont)

	Yes	No	N/A	Comments
• equipment failure, maintenance, requirements that may have contributed				
• human resource contributing factors				
• personnel involved in the incident (to ensure they receive support and have an opportunity to be consulted)				
• previously unidentified risks or hazards.				
Comprehensive reports of incident data are tabled at relevant meetings.				
Outcomes of investigations are made known to the staff involved and health and safety representatives (HSRs).				
Summaries include:				
• follow-up risk assessments				
• recommendations for control measures				
• any other recommendations.				
Data associated with all incidents is maintained to enable analysis, tracking and identification of trends over time.				

Tool 01 – Organisational self-assessment (cont)

Human resource management and development

This template provides an opportunity to review human resource management and development processes related to client-initiated aggression and violence.

	Yes	No	N/A	Comments
Our organisation has a documented code of conduct for employees.				
All position descriptions refer to an employee's obligation in relation to OHS.				
There is a process for determining staffing levels in known high-risk areas of the organisation.				
All areas have appropriately qualified and experienced staff available/rostered to cover all hours of operation.				
The mix of casual/agency staff on duty is balanced by permanent staff known to the clients.				
There is capacity to rotate staff into alternate duties to reduce exposure to aggression.				
Our organisation has procedures in place to provide staff with backup and support when working alone or in isolation.				
Support is offered to staff following a serious/critical incident:				
• in the immediate aftermath of an incident				
• within 24 hours of an incident				
• one week after an incident.				
Support is offered and provided with respect for individual needs and personal support mechanisms.				
Our organisation has access to skilled debriefing personnel/services.				

Tool 01 – Organisational self-assessment (cont)

Human resource management and development (cont)

	Yes	No	N/A	Comments
Our organisation has an employee assistance program (EAP) available to all employees.				
Our staff are guided through all WorkSafe processes by experienced staff.				
In the event of a WorkSafe claim being accepted and processed staff are supported in the development of a return to work (RTW) program that aligns with input from health professionals involved in their care, treatment and management.				
Informal debriefing and peer support are available on an ongoing basis.				
Staff are encouraged to and supported in reporting incidents of aggression.				
Support is offered to staff through police and legal processes following incidents of aggression or violence.				
OHS education is provided to all new employees during orientation and induction to the organisation.				
Our organisation has/accesses a tiered education and training program related to aggression prevention and management.				
Staff who receive skill-based training are provided with updates for skill maintenance on an annual basis.				
Emergency response team (ERT) members are provided with opportunities for skill maintenance with other team members at least every six months.				
ERT members are provided with updates on education and training annually.				

Tool 01 – Organisational self-assessment (cont)

Hazard identification, risk assessment and management

This template provides an opportunity to review hazard identification, risk assessment and management processes related to client-initiated aggression and violence.

	Yes	No	N/A	Comments
Our organisation has a formal documented process for reporting risks/hazards.				
Any member of staff is able to report a risk/hazard.				
Identified risks/hazards are formally assessed and documented by appropriately trained and/or experienced people.				
Documented risk assessments include possible control measures to eliminate or minimise risks as far as reasonably practicable.				
Control measures are introduced proportionate to the identified risk.				
Control measures are reviewed within three months, or sooner, to evaluate their effectiveness.				
Identified risks/hazards and assessments are reported at OHS meetings.				
Reviews are conducted following an incident of aggression or violence to identify hazards that had not previously been identified.				
Reviews of the working environment are conducted following a significant change in function.				
Reviews lead to:				
• further risk assessments when a hazard is identified				
• implementation of risk controls to prevent injury or recurrence of an incident				
• changes to the working environment				
• new/changes to existing work practices				
• updates or development of new written procedures.				

Tool 01 – Organisational self-assessment (cont)

Measurement and evaluation

This template provides an opportunity to review measurement and evaluation processes related to client-initiated aggression and violence.

	Yes	No	N/A	Comments
Reports received at OHS committee meetings relate to:				
• security breaches				
• aggressive/violent incidents				
• injuries to staff and clients				
• hazard reports				
• risk assessments				
• control measure implementation/action				
• control measure reviews/outcomes				
• recommendations for further actions				
• review of policies, procedures and work practices.				
Minutes of meetings reflect responsibility and accountability for further actions.				
Executive/board of management meeting minutes reflect:				
• WorkSafe insurance premiums are monitored six monthly.				
• WorkSafe claims are reported quarterly.				
• Impacts of the implementation of control measures.				

Tool 02 Staff survey

Staff survey – aggression and violence

We are committed to maintaining the health and safety of all of our staff. This confidential survey will be used to help us identify occupational aggression and violence risks within our work environment and develop prevention strategies.

Please take a few minutes to complete the survey and return it to _____ by _____/_____/_____

The results of the survey will be provided to _____ on _____/_____/_____

General information

Ward/work unit/division_____ **Male** ☐ **Female** ☐

Age range (years): < 30 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ > 60 ☐

Occupational group, please tick one of the following:

Allied health professional	☐	Clerical/administration	☐
Nurse	☐	Environmental/food services	☐
Medical	☐	Other (please specify)	☐
Clinical assistant	☐	_____	
Coordination	☐		

Years of experience: < 5 ☐ 5–10 ☐ 11–20 ☐ 20–30 ☐ > 30 ☐

Policies and procedures

	Yes	No	Don't know
Does our organisation have a non-tolerance of violence policy?	☐	☐	☐
If 'yes' have you ever seen a copy?	☐	☐	☐
Are there written procedures that deal with aggression and violence in your work area?	☐	☐	☐
If 'yes' have you ever seen a copy of them?	☐	☐	☐
If 'yes' are they easy to follow?	☐	☐	☐
Is there a violence contact person within your work area?	☐	☐	☐

Working environment and systems

	Yes	No
Do you feel safe at work?	☐	☐
Have you been provided with all necessary controls and measures to protect your safety?	☐	☐
Do you believe you are prepared to manage an aggressive or violent situation?	☐	☐

If you answered 'no' to any of the above please mark the areas you consider require improvement.

☐ Lighting	☐ Security staff	☐ Security devices
☐ Work/treatment spaces	☐ Police liaison	☐ Information about devices
☐ Restricted access	☐ Patient/client transfers	☐ Incident reporting
☐ Education and training	☐ Communication about client history/behaviours	☐ Incident follow-up

Other (please specify): _____

_____

_____

Incidents, reporting and follow-up

	Yes	No	Don't know
1. Is there a system for accessing additional support if a client becomes aggressive or violent?	☐	☐	☐
2. Are you required to report threats of aggression or violence in your work area?	☐	☐	☐
3. Are you required to report actual incidents of aggression or violence in your work area?	☐	☐	☐
4. Do you feel you can make reports without fear of reprisal?	☐	☐	☐
5. Is there a system for reporting threats and incidents of aggression or violence in your work area?	☐	☐	☐
6. If 'yes' is it easy to follow?	☐	☐	☐
7. Does the supervisor/manager investigate reports without undue delay?	☐	☐	☐
8. Does the supervisor/manager take corrective action without undue delay?	☐	☐	☐
9. Are all co-workers formally briefed about an aggressive or violent situation before commencing duty or attending to a client?	☐	☐	☐

Staff survey (cont)

Incidents, reporting and follow-up (cont)

	Yes	No	Don't know
10. Is there a program to provide support for staff directly and indirectly affected by incidents of workplace aggression and violence?	☐	☐	☐
11. Are police and other emergency services called immediately after a criminal act occurs?	☐	☐	☐

Barriers to reporting

	Yes	No	Don't know
12. Are there particular obstacles to you formally reporting incidents of aggression or violence?	☐	☐	☐

If 'yes' please tick the barriers for you:

- ☐ Lack of access to reporting forms/mechanisms
- ☐ Don't know the process for reporting
- ☐ Don't know what constitutes an incident
- ☐ The reporting form is too complicated
- ☐ The reporting tool is geared to clinical incidents
- ☐ Time constraints
- ☐ Lack of feedback/visible change
- ☐ Concern about retribution/blame
- ☐ Concern about how colleagues will perceive me

Other (please specify): _____

_____

Who do you tell and how?

13. Who do you report incidents of aggression or violence to and how do you report it? *(Please mark as many boxes as are applicable to you.)*	Verbal	Written
Line manager	☐	☐
Health and safety representative (HSR)	☐	☐
Colleague	☐	☐
OHS staff	☐	☐
Friend/family member	☐	☐

Other (please specify): _____

_____

_____

Staff survey (cont)

Education and training

Have you ever attended any of the following, either at work or privately:	Yes	No	Don't know
• Customer service training	☐	☐	☐
• Communication skills training	☐	☐	☐
• Assertiveness training	☐	☐	☐
• OHS training Length of program: _____	☐	☐	☐
• Self-defence training To what level: _____	☐	☐	☐
• Aggression prevention and management training Name and length of program: _____ When did you attend? _____	☐	☐	☐
Have you ever attended an education or training program that has covered the following topics:			
• Recognising, preventing and dealing with workplace aggression and violence	☐	☐	☐
• Communication and care strategies to prevent aggression or violence	☐	☐	☐
• Psychiatric, behavioural and psychological conditions associated with aggressive or violent behaviours	☐	☐	☐
• Respectful self-defence measures related to clients	☐	☐	☐
• Do you believe you have adequate education and training related to aggression prevention and management for your current position?	☐	☐	☐

Are there particular barriers to you attending 'in-house' education and training programs that would need to be considered in planning education and training programs related to aggression prevention and management? *(Please tick as many boxes as are applicable to you.)*

- Too difficult to take time away from daily duties ☐
- Inconvenient location ☐
- Inconvenient time in relation to other work activities ☐
- Fatigue/'burn out' ☐
- Lack of support/encouragement to attend ☐
- Other (please specify): _____

  _____
- Any other comments: _____

  _____

Thank you for your time and input.

Tool D1

Design and aggression

Design and aggression – generic audit

Health facility:	**Department/work area:**
Persons involved in the audit (manager, health and safety representative (HSR), staff members, designer):	
Name:	
Title:	
Name:	
Title:	
Date of audit:	

Audit objective

To identify aggression risks that may relate to the design of an existing or planned workplace, with reference to *Prevention and management of aggression in health services*.

How to use the audit checklist

This checklist is designed to be used within a patient care department/work area so you may need to complete several checklists to cover your whole health facility.

- Existing workplaces – talk to staff and observe work being done to complete the checklist.
- Planned workplaces – use the scaled drawings of your proposed facility, a scaled ruler and a tape measure and work through the checklist.

Pre-questions

Prior to completing the audit, you need to have an understanding of what patient-care activities are likely to occur in the work area. The following questions will help to explore these issues:

- What types of patients/residents/clients will occupy the department/work area (both now and in the future)?
- What special patient-care activities will be undertaken?
- What types of equipment and furniture will be used in the work area?
- How will this department/work area interact with other departments/work areas in the health facility?

Design and aggression (cont)

Design and aggression – generic audit	Yes/No or N/A	Comments	Action
1. Strategic location			
1.1. Location – internal interactions			
• Does the location of the department facilitate easy interaction between related departments within the organisation?			
• Does the location of the work area facilitate natural surveillance, allowing staff to view and monitor the area?			
1.2. Location – external interactions			
• Does the location of the department facilitate any external interactions (e.g. suppliers)?			
1.3. Way-finding			
• Is the department easy to find for clients?			
• Is the way-finding signage suitable (e.g. language, size of text) for all clients?			
2. Design of the space			
2.1. Entry/exit			
• Is the location of the entry/exit doors suitable for staff to retreat to safety?			
• Does the design of the entry/exit door facilitate clients' independent use?			
• Does the design and location of the entry/exit door facilitate surveillance of people entering/exiting?			
2.2. Workspace (size and layout of area)			
• Is the workspace adequate for staff needs – consider equipment used and tasks?			
• Is the workspace adequate for clients needs (e.g. personal space)?			
• Is the workspace adequate for storage needs so that clutter is minimised?			

Design and aggression (cont)

Design and aggression – generic audit	Yes/No or N/A	Comments	Action
3. Furniture, fixtures and facilities			
3.1. Seating			
• Is the seating for clients comfortable?			
• Does the seating promote independence for clients?			
• Is the layout of the seating suitable for clients (consider fixed versus moveable)?			
• Is the seating easy to maintain/keep clean?			
3.2. Counter design			
• Does the design of the counter mean that clients cannot easily jump over the counter?			
• Does the design of the counter mean that clients cannot easily strike a staff member across the counter?			
• Does the design of the counter mean that clients cannot easily get behind the counter?			
• Is there an emergency response system (e.g. duress button, personal alarm) appropriately positioned and monitored?			
• Is CCTV in place and functional?			
3.3. Client facilities			
• Are appropriate toilet facilities available and easy to access?			
• Are appropriate refreshment facilities (e.g. water, food) available and easy to access?			
• Are appropriate entertainment facilities (e.g. magazines, TV) available and easy to access?			
• Is there a specially designed waiting area to entertain children?			
3.4. Cash and pharmaceuticals			
• Does the design limit client viewing of cash and pharmaceuticals?			
• Does the design limit client access to cash and pharmaceuticals?			

Design and aggression – generic audit	Yes/No or N/A	Comments	Action
4. Environment			
4.1. Noise			
• Are the noise levels in the area suitable for clients?			
• Are the noise levels in the area suitable for staff? *(Loud or persistent noise should be avoided.)*			
4.2. Lighting			
• Does the area have some natural lighting from external windows?			
• Is the space free from glare? Consider reflective surfaces, need for adjustable window coverings, etc.			
• Does the level of illumination suit the client activities (e.g. reading, sleeping) to be undertaken?			
• Does the level of illumination suit the staff activities (e.g. reading, use of a computer) to be undertaken?			
• Where necessary, is the lighting adjustable or is task lighting provided?			
4.3. Colour			
• Is the colour of the room relaxing for clients and staff? *(Large expanses of strong and dark colours should be avoided).*			
4.4. Temperature and odours			
• Is the area well ventilated so that the temperature remains fairly constant?			
• Can the temperature be maintained at an appropriate level for the type of activities being performed by clients?			
• Can the temperature be maintained at an appropriate level for the type of activities being performed by staff?			
• Is the area free from cold draughts where people are sitting?			
• Does the area have a pleasant/neutral odour without any persistent unpleasant smells (e.g. urine, faeces, vomit, disinfectant).			

Design and aggression (cont)

Design and aggression – generic audit	Yes/No or N/A	Comments	Action
5. Security			
• Are staff only areas (e.g. door locks, swipe card/key pad access) secure?			
• Is there an emergency call system (e.g. duress alarms, personal pagers, emergency buzzer) available for staff?			
• Is client activity monitored (e.g. natural surveillance, CCTV, presence of security staff) in high-risk areas?			
• Is the CCTV appropriately designed (e.g. overt or covert system) and located (e.g. view of the area)?			

Tool
D2

Violence and the design process

Consultation structure

Question	Consider	Yes/No or N/A	Comments	Action
Who to involve	• Designers • Managers • Health and safety representatives (HSRs) • Employees • OHS experts • Consumers (e.g. clients/ residents)			
When to consult	• At each key milestone/ stage • Time allowance for consultation			
How to consult	• Face-to-face meetings • Documentation of decisions • Feedback to participants			

Master planning

Question	Consider	Yes/No or N/A	Comments	Action
What aspects about the general location of the facility might impact on aggression?	• General demographics and socio-economic structure of the area • Access to public transport			
What aspects about the neighbouring buildings or sites are likely to impact on aggression?	• Access to other agencies such as police/ambulance • Neighbouring residential/ industrial/business areas • Lighting and noise • Surrounding landscape			
What aspects about the facility boundaries may have an impact on aggression?	• Entry and exit • Busy roads • Public transport			
Where are the entry and exit points to the site and relevant departments, and how does this relate to security and surveillance?	• Entry and exit points in relation to security and surveillance			
Where are the major departments located and do these facilitate work flow and client/visitor flow?	• Location of departments serving clients and visitors • Pathways of travel			
Is the space and location of parking appropriate to facilitate safe access for staff and visitors?	• Car park surveillance • Access control • Defined perimeter			
What are the major paths of travel for vehicles, pedestrians and goods, and are these easy to navigate?	• Separate footpath/ vehicle route • Clear signage, directions and signs • Traffic feasibility study			
What is the likely future site development? Have adequate areas been set aside for future growth and change?	• General demographics • Economic structure of area			
Is it likely that the demographics of the client or visitor population will change?	• General demographics • Economic structure of area			

Violence and the design process (cont)

Feasibility study

Question	Consider	Yes/No or N/A	Comments	Action
What types of clients are likely to occupy the facility?	• Demographics of the local area such as potential for drug/alcohol-influenced clients, specific cultural groups, etc			
Are there any high-risk departments, such as emergency, mental health and aged care, that need special consideration?	• Cultural groups and demographics			
What types of visitors may attend the facility?	• Access control			
What special features does the facility need to meet organisational policies and procedures related to aggression?	• Isolation rooms • Observation of clients • Garden areas			
What security measures need to be installed?	• Duress alarms • CCTV			
Who needs to be consulted in relation to identifying client aggression issues during the planning process?	• Department managers • Health and safety representatives • Employees • OHS professionals • Designers			
What user consultation process should be included and costed into the planning process?	• Training user groups • Briefing strategies • Design visualisation			

Schematic design

Question	Consider	Yes/No or N/A	Comments	Action
Where there is an interaction between staff and clients or visitors, there is a risk of aggression. Have all functions been documented for all client/visitor areas?	• Quality documentation systems			
Has adequate workspace been allocated to all areas to ensure tasks can be undertaken safely and is there enough room for all those likely to occupy the area?	• Feedback from consultation phase			
Where there is the potential for the first meeting between staff and clients (e.g. reception, interview rooms) has the potential for aggression been taken into account?	• Second exit in interview rooms • Physical barrier in reception • Signage			
Have the relationships between work areas been documented?	• Quality documentation systems			
Does the location of different departments facilitate work and client/visitor flow?	• Access control			
Does the layout facilitate compliance with aggression-related policies (e.g. observation of clients)?	• High visibility • Controlled access			
Have the entry and exit points of the facility and individual departments been planned to facilitate security systems?	• CPTED principles			
What security measures and communication devices need to be installed throughout the facility?	• Duress alarms • CCTV • Telephones			
Does the interaction between the building and external environment maximise the therapeutic environment?	• CPTED principles			

Violence and the design process (cont)

Design development

Question	Consider	Yes/No or N/A	Comments	Action
Is there adequate workspace for all equipment and fixtures?	• Feedback from consultation committee			
Has adequate storage been planned to ensure clutter is avoided?	• Feedback from consultation committee • Consultation with department workgroup			
Do the furniture and fixtures minimise the potential for aggression?	• Fittings and furniture that are difficult to use as weapons, hard to lift and without sharp corners and edges			
Is the lighting appropriately designed to minimise stress and fatigue and maximise feelings of relaxation?	• Natural light • Artificial light			
Have unwanted noises been designed out?	• Soundproof walls or double glazed windows • Avoid loud volumes on TV and radio			
Has an effective and consistent way-finding system been designed?	• Signage (directional and symbols)			
Have positive distractions been provided to reduce stress and divert focus from pain?	• Gardens • Art • Views			
Have systems for effective client communication been designed?	• Refer to consultation committee • Signage in reception areas			
Has the ventilation system been designed to minimise unwanted smells and to facilitate comfortable temperatures?	• Provide good ventilation • Air-conditioning systems			

Contract documentation

Question	Consider	Yes/No or N/A	Comments	Action
Have appropriate colours been chosen to minimise stress and create a feeling of wellbeing?	• Lighter colours			
Does the interior design facilitate feelings of relaxation and wellbeing?	• Natural light • Soft colours			
Do the floor coverings minimise glare and noise?	• Type and impact of floor covering • Equipment interaction with floor surface • Person interaction with floor surface			

Construction

Question	Consider	Yes/No or N/A	Comments	Action
Will any services or spaces that staff or clients previously used be changed during the period of construction and if so what impact may this have?	• Consult with staff			
Will there be an increase in noise that may impact on aggression?	• Noise sources • Floor surfaces • TV and radio			
Will temporary way-finding systems be required to facilitate navigation?	• Directional signage			

Violence and the design process (cont)

Post-occupancy evaluation

Question	Consider	Yes/No or N/A	Comments	Action
Review of incident and injury records related to violence and aggression	• Review data regularly • Provide reports • Support a reporting culture			
Consultation with the user group and staff regarding design issues impacting on aggression	• Impact of aggression during design phase			
Walk-through inspection of the area	• Regular inspections			
Documentation of design shortcomings and positive design features for future projects	• Quality documentation systems • Quality filing systems			

Violence prevention policy

Name of organisation

Purpose

<<Name of organisation>> is committed to providing a safe and healthy working environment free of aggression or violence for all staff, clients and visitors.

This policy is intended to define behaviour that constitutes workplace aggression and violence and to guide staff in the management of aggression and violence in the workplace.

Definitions

For the purpose of this policy, occupational violence and aggression 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.

Within this definition:

- **Threat** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked. It may involve an actual or implied threat to safety, health or wellbeing, and
- **Physical attack** means the 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 threat is relevant. The key issue is that the behaviour creates a risk to health and safety.

Examples of occupational violence and aggression include, but are not limited to, verbal, physical or psychological abuse, punching, scratching, biting, grabbing, pushing, threats, attack with a weapon, throwing objects/furniture, sexual harassment or assault, and any form of indecent physical contact.

Objectives

- Managers and health and safety representatives (HSRs) will manage aggression and violence issues through the organisation's consultative processes.
- All incidents and near misses of client initiated aggression or violence are reported via *<<reporting system>>* and followed up by the area manager or supervisor.
- In the event of exposure to aggressive or violent incidents staff are provided with debriefing opportunities and follow-up.

- All reports of aggression and violence are reviewed by *<<committee>>* and systems are investigated to identify control measures that will minimise future risk.
- An assessment is conducted and documented on all clients to identify any risk factors that may trigger an episode of aggression or violence.
- Care plans will include behaviour management strategies to reduce risks of aggressive or violent incidents. These plans will be reviewed as required.
- All reasonably practicable control measures will be implemented to eliminate or minimise risks to health and safety for staff and clients. However, *<<name of organisation>>* reserves the right to refuse treatment or entry to clients and visitors known to initiate aggression and/or violence towards its staff, clients and visitors.
- All staff will receive education and training in the prevention and management of aggression and violence according to their levels of exposure to risk.

Roles and responsibilities

Name of organisation

- Promptly, objectively and sensitively review all reports of violence or threats of violence, including a review of all investigations associated with aggressive or violent incidents.
- Ensure critical incidents have been reported, as required, to WorkSafe, the police, the OHS committee and the elected health and safety representative (HSR) and investigated.

Managers and supervisors

- Enforce policy and procedures and monitor staff compliance.
- Identify and alert staff to violent clients and hazardous situations.
- Follow up and investigate all incidents of workplace aggression and violence.
- Ensure debriefing is completed for those either directly or indirectly involved in the incident.
- Track and analyse incidents for trends and prevention initiatives.

Employees

- Formally report all incidents of aggression, violence or threats, including near misses.
- Participate in education and training programs to be able to respond appropriately to any incident of workplace aggression or violence.
- Understand and comply with this policy and all related procedures.
- Contribute to risk assessments and incident investigations.

Health and safety committee

- Be consulted about the development, establishment and implementation of violence measures and procedures.

Violence prevention policy (cont)

Risk management

- Workplace hazards will be assessed appropriately and include consideration of violence hazards.
- All reports of aggression or violence are investigated and risk assessments are conducted to identify control measures that will avoid similar situations arising in the future.
- Clients will be assessed for aggression risk factors and a documented plan of care will take those factors into account to reflect care aimed at minimising the risk of exposure to aggression or violence.
- Visitors to the service who are repeatedly aggressive or violent, or who provoke aggressive or violent behaviour, will be identified and removed from the facility.
- A staged education and training program is provided for staff based upon their risk of exposure to aggression and violence.
- All new employees will receive both general and risk-specific orientation to the Violence Prevention Program.

Endorsed by: _____ *Committee* on ____/____/____ (Date)

Responsible officer: *Chairperson,* _____ *Committee/position within the organisation*

Review date: ___/____/___ (Policy and procedures will be reviewed annually)

Name: _____

Signed: _____ Date: ____/____/____

Related documents

Occupational Health and Safety policy	Critical Incident Debriefing policy
Staff Orientation policy	Critical Incident Debrief procedure
Privacy policy	Risk Management policy
Risk Management policy	Employee Support and Assistance program
Incident/near miss report form	

Consultation

The OHS Committee has considered the following Victorian legislation when establishing this policy:

- *Occupational Health and Safety Act (2004)*
- *Accident Compensation Act (1985)*
- *Accident Compensation (WorkCover Insurance) Act (1993)*
- *Crimes Act (1958)*
- *Equal Opportunity Act (1995)*
- *Mental Health Act (1986)*
- *Victorian Health Records Act (2001)*

Tool
P2

High-risk screening

Handbook key	High-risk screening tool
Link to handbook	Client-risk factors (section 5.4)
Purpose/aim	Screening of **all** clients upon point of entry (triage) to identify high-level risks
Description	Brief screening tool to identify clients presenting to triage (emergency) who may be at high risk of violence or self-harm Tick boxes when potential risk identified
User(s) – area/department	Emergency
User(s) – Position	Triage nurse
Time required to complete	More than one minute
Source(s) of information	Observation, client response(s)
Review	N/A

High-risk screening (triage)

Name: _____

☐ Tick if any of the following are observed/identified:

1	☐	History of violence
2	☐	Presenting with injuries inflicted by self or others
3	☐	Substance or alcohol affected
4	☐	Behavioural disturbance
5	☐	Stating intention to harm self or others
6	☐	Hyper-vigilance
7	☐	Suspected of having weapons

High risk screening (cont)

No ☐ 1 to 7?	No risk identified *Finish here*

Signed: _____ Date: _____

Name: _____ Position: _____

Any ☐ 1 to 7?	Risk identified *Apply safety precautions*

Apply safety precautions *(if any risk identified)*

☐	Refer to senior clinician
☐	Initiate security back-up if needed
☐	Consider treatment environment
☐	Minimum of two staff during client contact
☐	Communicate identified risk (e.g. file flagging, wrist band identifier)
☐	Monitor of behaviour/situation
☐	A full assessment of aggression risk required

Signed: _____ Date: _____

Name: _____ Position: _____

☐	Full assessment of aggression risk completed

Signed: _____ Date: _____

Name: _____ Position: _____

Tool P3

Violence hazard identification and risk assessment

Handbook key	Combined violence hazard identification and risk assessment (clinical)
Link to handbook	Client-risk factors (section 5.4)
Purpose/aim	Identify hazards to clinicians' workplace safety Assess the degree of risk and Determine appropriate controls
Description	Hazard identification and risk assessment tool to be used for clients at high risk of violence or self-harm Tick boxes when potential hazard identified and conduct basic risk assessment Consider risks to staff and other clients The risk factors are not intended to be added up or used to produce a numerical score
User(s) – area/department	Admissions/inpatient areas
User(s) – position	Only to be completed by senior staff member upon admission
Time required to complete	Less than 30 minutes
Source(s) of information	Client, family, other agencies, medical records, clinical observation
Review	To be advised (TBA)

Violence hazard identification and risk assessment (cont)

Combined violence hazard identification and risk assessment (clinical)

Name of person_____

Hazard identification

	Yes	No	Don't know	When and how identified, e.g. client, family, other agencies, clinical observation?
(1) Client history				
History of violence in a health care setting	☐	☐	☐	
Any history of escalating behaviours, aggression or violence to self or others	☐	☐	☐	
Police involvement	☐	☐	☐	
History of substance or alcohol misuse	☐	☐	☐	
(2) Behaviour				
Drug and/or alcohol affected	☐	☐	☐	
Agitated, frustrated or distressed	☐	☐	☐	
Verbally abusive or raised voice	☐	☐	☐	
Hostile, threatening or intimidating	☐	☐	☐	
Expressing violent thoughts or plans	☐	☐	☐	
Concern from others regarding aggressive behaviour	☐	☐	☐	
Hitting furniture, banging fist, throwing things	☐	☐	☐	
Self-harming behaviour	☐	☐	☐	
Pacing, staring, hyper-vigilance	☐	☐	☐	
Withdrawn or fearful	☐	☐	☐	
Loss of control or independence related to disease or disability	☐	☐	☐	
Refusing treatment	☐	☐	☐	
Drug-seeking behaviour	☐	☐	☐	
In possession of dangerous items or weapons	☐	☐	☐	

Violence hazard identification and risk assessment (cont)

Hazard identification

	Yes	No	Don't know	When and how identified, e.g. client, family, other agencies, clinical observation?
(3) Social context				
Language barriers	☐	☐	☐	
Communication difficulties	☐	☐	☐	
Cultural misunderstanding	☐	☐	☐	
Complex/distressed family relationships	☐	☐	☐	
Friends or family who may place staff or other clients at risk	☐	☐	☐	
(4) Health service issues				
Restraint or seclusion	☐	☐	☐	
Refusal of requested drugs/treatment	☐	☐	☐	
Removal of privileges/belongings	☐	☐	☐	
Separation from family/friends	☐	☐	☐	
No access to smoking areas	☐	☐	☐	
Treatment delays	☐	☐	☐	
Rigidly scheduled care routines (e.g. meal times, personal care)	☐	☐	☐	
Sleep disruption, noise	☐	☐	☐	
(5) Other relevant information				

Violence hazard identification and risk assessment (cont)

Is there a risk?

Did you answer 'yes' to any of the above questions?	☐ Risk identified ☐ Risk assessment and control required.

Risk assessment

What could happen?	
How could it happen?	
Who is at risk?	

Consequence (tick one) – *How serious is the risk?*				
Insignificant	Minor	Moderate	Major	Catastrophic
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐

Likelihood (tick one) – *How likely is it to occur?*				
Rare	Unlikely	Moderate	Likely	Almost certain
☐	☐	☐	☐	☐

Tool P3

Violence hazard identification and risk assessment (cont)

Do you consider the risk to staff is low, moderate, high or extreme?				Consequence				
				Insignificant	Minor	Moderate	Major	Catastrophic
Risk Level		Likelihood	A Almost certain	High	High	Extreme	Extreme	Extreme
Low	☐		B Likely	Moderate	High	High	Extreme	Extreme
Moderate	☐		C Moderate	Low	Moderate	High	Extreme	Extreme
High	☐		D Likely	Low	Low	Moderate	High	Extreme
Extreme	☐		E Rare	Low	Low	Moderate	High	High

Current safety precautions ☐ Tick if completed

Safety precaution		Responsible	Comment
☐	Emergency response plan in place		
☐	Security back-up		
☐	Duty administrator, senior clinician, psychiatric consultant, nurse, patient advocate consulted/advised		
☐	Other staff are aware of the risk		
☐	Safety first (never engage if you have concerns for safety)		
☐	Safety tips reviewed		
☐	Personal protection, communication devices and duress alarms reviewed		
☐	Environment checked for safety hazards		
☐	Adequate staffing (assessment of client by at least two staff)		

Risk controls

Date prepared: _____

Action required	Person responsible	Completion date	Reviewed date	Action completed

Tool
P4

Behaviour assessment

Handbook key	Behaviour assessment
Link to handbook	Client-risk factors (section 5.4)
Purpose/aim	Identify and assess degrees of aggressive behaviour which impacts on clinicians' safety, inform care planning, and monitor behaviour
Description	Behaviour assessment worksheet to be used for clients identified at high risk of aggression and violence. Scoring for seven items The factors are intended to be added up and used to produce a numerical score, with one score for each item. Each item carries the same weight. Add scores in each column, and then add the four scores together
User(s) – area/department	Inpatient areas
User(s) – position	To be completed by a clinician upon admission
Time required to complete	Less than 3 minutes
Source(s) of information	Clinical observation
Review	Ongoing, TBA

Behaviour assessment (cont)

Behaviour assessment worksheet

Client name_____I.D. No _____

Scorer _____am/pm on _____/_____/_____

1 = absent	2 = present to a slight degree	3 = present to a moderate degree	4 = present to an extreme degree
The behaviour is not present	The behaviour is present, but does not disrupt others (e.g. staff and/or clients). The individual may redirect spontaneously	The individual needs to be redirected, but benefits from such cueing	The individual is not able to engage in appropriate behaviour even when external redirection is provided

	Absent	Slight	Moderate	Extreme
Impulsive, impatient, low tolerance for pain or frustration	1	2	3	4
Uncooperative, resistant to care, demanding	1	2	3	4
Violent and/or threatening violence towards people or property	1	2	3	4
Explosive and/or unpredictable anger	1	2	3	4
Rapid, loud or excessive talking	1	2	3	4
Self-abusiveness, physical and/or verbal	1	2	3	4
Current symptoms of alcohol or substance misuse	1	2	3	4
Add checks in each column:	_____+	_____+	_____+	_____=
Then add the four scores Total score:				

Total score:	10 or below	11 to 14	15 to 17	more than 17
Final assessment	Within normal limits	Mild occurrence	Moderate	Severe

Enter final comments here: _____

_____

Tool
P5

Client alert

Handbook key	Template client alert
Link to handbook	Patient alert systems (section 5.5)
Purpose/aim	Identify individuals with a propensity for violence in the context of protecting staff and other clients
Description	File flagging as used for a variety of other clinical risk management and safety reasons
User(s) – area/department	Inpatient areas
User(s) – position	To be completed by a senior clinician after risk assessment has been completed
Time required to complete	Less than 2 minutes
Source(s) of information	Risk identification and assessment
Review	Ongoing, TBA

Client alert

This page should be placed prominently in the front of the client's file to inform staff of potential risks to their health and safety.

Based either on assessment or past behaviour, the following potential areas or risks to staff have been identified:

☐ Client (patient/resident)

☐ Carer

☐ Environment

☐ Other, as indicated _____

Staff are advised to check current notes to familiarise themselves with these risks before contact, and to always use safe work practices themselves and with respect to others.

Client's file entries must inform others of any risks or potential risks.

Signed_____Designation_____

Last updated _____/_____/_____

Source: *Zero Tolerance (Occupational Violence and Aggression) Policy and Toolkit*, Australian Nursing Federation (Victorian Branch), 2002.

Tool P6

Warning notice

<<NAME>>

<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<ORGANISATION>> on the <<DATE>> between yourself and a member of <<THE PUBLIC/STAFF>>.

You have been made aware of our organisation's policy with regard to maintaining a violence-free workplace on <<DATES>> and have been provided with a copy of our policy.

This letter is to advise you that future incidents of aggressive or violent behaviour which you are involved in at this organisation will result in the development of a behavioural contract and could subsequently require police involvement, refusal to treat you through our services and legal action.

If you wish to discuss the contents of this letter with a representative from <<ORGANISATION>> please phone <<PHONE NUMBER>>. A copy of our consumer complaints procedure is enclosed for your information.

Yours faithfully

<<NAME>>

<<POSITION>>

COPIES: Addressee

Client file

Hospital alert system

Security

Conditions and agreement

<<NAME>>
<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<ORGANISATION>> on the <<DATE>> between yourself and a member of <<THE PUBLIC/STAFF>>.

You have been made aware of our organisation's policy with regard to maintaining a violence-free workplace on <<DATES>>; been provided with a copy of our policy; and received written warning of further actions in the event that you were involved in further incidents of aggressive or violent behaviour at this organisation.

Enclosed with this letter are two copies of a behavioural agreement for you to sign and return in the enclosed reply paid envelope by <<DATE>>.

If you wish to discuss the contents of this letter or the behavioural agreement with a representative from <<ORGANISATION>> please phone <<PHONE NUMBER>>. A copy of our consumer complaints procedure is enclosed for your information.

Yours faithfully

<<NAME>>
<<POSITION>>

COPIES: Addressee
Client file
Hospital alert system
Security

Conditions and agreement (cont)

ONGOING ACCESS TO AND USE OF <<ORGANISATION>> FACILITIES AND SERVICES

Staff, clients and visitors of <<ORGANISATION>> are entitled to a safe environment free of violence, threats and intimidation.

THE CONDITIONS

I, _____<<NAME>>_____ agree to treat all staff, clients and visitors courteously and with respect at all times.

I understand that threats, intimidating behaviour, verbal abuse, physical violence and other anti-social behaviour are unacceptable.

I accept that I will be restricted to the treatment area or ward where I am a client or visiting.

I agree to visit the hospital on <<DAYS>> only and between the hours of <<TIME>> and <<TIME>> and on every occasion I will report to the head of security at the reception desk on arrival before proceeding to the treatment area or ward.

I understand that in certain circumstances, a security guard will be based on the ward during my treatment or visit.

I am aware that a request for information about a relative (if I am the next of kin) from a member of staff may be made through the patient liaison officer or after-hours administrator.

I understand that if I breach any of these conditions, security staff may evict me from the hospital and/or contact the police to enforce the eviction and obtain a restraining order against my returning to this hospital.

<<ADD ADDITIONAL CONDITIONS IF WARRANTED>>.

I AGREE TO THE CONDITIONS ABOVE AND AM AWARE THAT FAILURE TO COMPLY WITH THESE CONDITIONS WILL RESULT IN MY EVICTION FROM THIS HOSPITAL. I HAVE BEEN GIVEN A COPY OF THIS AGREEMENT.

Signed: _____

Tool T1

Exposure to aggression risk calculator

This risk calculator can be used across an organisation, in a specific department or unit, or with staff from a particular work or professional group to determine the level of training required. The aim of this calculator is to identify the type of aggression staff are exposed to and the frequency of the exposure.

It has been developed to enable staff to document experiences and/or perceptions of their exposure to client-initiated aggression and violence in their work environment as a means of determining the level of training required by work groups or units in your organisation. It could be used in conjunction with a staff survey, or in isolation to provide a snapshot of a current situation.

The results of the compiled data from this calculator should be reviewed in conjunction with incident and near-miss data reported formally within the organisation, position descriptions and role expectations of staff and other organisational documentation, e.g. training and education records and health and safety control measures that have been implemented.

For example:

- A survey of security staff might reveal exposure to 'physical aggression' on a weekly basis. This result would indicate this staff group require level 2 training. However, a review of their position descriptions might reveal they are required to participate in physical restraint of clients, removal of clients from the premises and isolated patrols of the facility that place them at risk of assault. Clearly, a level 2 training program would not be appropriate for this group of staff.
- A survey of clerical staff might reveal that ward clerks, switchboard and reception staff identify exposure to 'threat intimidation' on a weekly basis while clerical staff with no day-to-day contact with the general public identify exposure to 'minor verbal aggression' bi-annually.
- A survey of an aged care work unit might reveal that nurses identify exposure to 'high aggression extreme threat' on a weekly basis while food services staff identify exposure to 'verbal aggression' on a monthly basis. However, far fewer incidents might be revealed if incident reporting data was reviewed in isolation.

In addition to identifying the level of training required by staff this simple survey can reveal some systemic issues within an organisation.

For example, it might identify:

- A workforce skilled in defusing/de-escalating situations before they become violent.
- A limited understanding of what constitutes an aggressive incident based upon the criteria used within the survey.
- Issues associated with incident reporting processes.
- Under-reporting of incidents.
- Work practice issues within a work area that require further investigation (e.g. staff skill mix).

Tool T1 – Exposure to aggression – risk calculator (cont)

To complete this tool:

1. Note your work area, position and length of employment.
2. Identify the type/s of aggression you experience in your work from clients/visitors/relatives across the top of the table.
3. Identify how frequently it occurs to you personally from the column on the left.
4. Mark the appropriate box in the matrix.

Work area (e.g. Aged care): _____ Position: (e.g. PSA)_____ Time employed: (e.g. six years)_____

Risk ☐	**Extreme aggression**	**Severe aggression**	**High aggression extreme threat**	**Physical aggression**	**Threat intimidation**	**Verbal aggression**	**Minor verbal aggression**
Exposure ☐	attack resulting in death attack with weapons	attack resulting in serious injury severe physical attack, including repeated kicking, punching, etc	attack possibly resulting in serious injury physical attack, including punching, kicking, etc specific threat to kill	attack resulting in minor injury pushing, grabbing, scratching, biting	specific threat to harm overtly physically aggressive	abuse, swearing directed at specific staff non-specific threat	heated disagreement, raised voices
Weekly	**E**	**E**	**E**	**H**	**H**	**M**	**M**
Monthly	**E**	**E**	**E**	**H**	**M**	**M**	**L**
Bi-annually	**E**	**E**	**H**	**H**	**M**	**M**	**L**
Annually	**E**	**H**	**H**	**M**	**M**	**L**	**L**
5 yearly	**E**	**H**	**M**	**M**	**L**	**L**	**L**
20 yearly	**H**	**M**	**M**	**M**	**L**	**L**	**L**
40+ yearly	**H**	**M**	**M**	**L**	**L**	**L**	**L**

L = Low risk – 'Dealing with difficult customers' session is recommended
M = Medium risk – Level 1 training is recommended
H = High risk – Level 2 training is recommended
E = Extreme risk – Level 3 training is recommended

Tool
T2

Aggression risk calculator

This risk calculator can be used across an organisation, within a specific department or unit, or with staff from a particular work or professional group to determine the tiered level of training required based upon occupational groups. The focus of this tool is staff who deal with clients by telephone or directly.

It has been developed to enable staff to document the role they carry out in client care and the type of client contact they have within that role as a means of determining the level of training required by particular occupational groups. It could be used in conjunction with a staff survey, or in isolation to provide a snapshot of a current situation. It enhances the snapshot provided by the exposure to aggression risk calculator **(Tool T1)**.

The results of the compiled data from this calculator should be reviewed in conjunction with incident and near-miss data formally reported within the organisation, position descriptions and role expectations of staff and other organisational documentation such as training and education records and health and safety control measures that have been implemented.

Tool T2 – Aggression risk calculator (cont)

To complete this tool:

1. Note your work area, position and length of employment.
2. On the table identify the type of work you do or the environment you work in from the eight options across the top of the table.
3. Identify the type of client contact you have in your work from the table at the bottom.
4. Mark the appropriate box in the matrix.

Work area: (e.g. Acute): _____ Position: (e.g. Physio) _____ Time employed: (e.g. three years)_____

		Occupational group							
		Isolated – secure switchboard	**Reception enclosed**	**Admissions**	**Triage and reception open**	**Hands-on care**	**Hands-on care – mental health**	**Part-time security**	**Full-time security**
Type/level of client contact	Telephone, physical contact, visitors/relatives, client handling, restraint and violence issues	**L**	**L**	**M**	**H**	**H**	**E**	**E**	**E**
	Telephone, physical contact, visitors/relatives, client handling and restraint	**L**	**L**	**M**	**H**	**H**	**E**	**E**	**E**
	Telephone, physical contact, visitors/relatives and client handling	**L**	**L**	**M**	**H**	**H**	**E**		
	Telephone, physical contact, visitors/relatives	**L**	**L**	**M**	**H**	**H**	**H**		
	Telephone and physical contact	**L**	**L**	**M**	**M**				
	Telephone and enclosed contact	**L**	**L**	**L**					
	Basic telephone response only	**L**	**L**						

L = Low risk – 'Dealing with difficult customers' session is recommended
M = Medium risk – Level 1 training is recommended
H = High risk – Level 2 training is recommended
E = Extreme risk – Level 3 training is recommended

Tool T3

Post-training evaluation tool – short term

Post-training evaluation provides valuable information about design and delivery, but does not measure learning transfer or medium-to-long-term benefits of a program in the workplace.

Tool T3 could be used immediately after training to evaluate program relevance and key learnings for participants.

Tool T3 – Post-training evaluation tool – short term (cont)

To assist us in providing relevant training please complete this evaluation and leave in the box provided.

Topics covered in this course	Very relevant	Relevant	Little relevance	Not relevant	Comments
1. Understanding the legal context, including the employer's duty of care, the right to protect yourself and the use of reasonable force					
2. Definitions of violence, and how it occurs					
3. Non-physical management of violence including: • customer service • verbal and non-verbal communication skills • cultural diversity • diffusion • de-escalation					
4. Organisational policy, procedures and practices in relation to work-related violence (including roles and responsibilities of management and staff, reporting and accountability)					
5. Post-incident reactions and support, including psychosocial follow-up, and internal and external support mechanisms					
6. Physical intervention and management skills, including withdrawal, breakaway, control and restraint techniques					

Are there any additional topics you would like to have covered during this training program? _____

_____

What would you have excluded from the program? _____

_____

Post-training evaluation tool – short term (cont)

Key learnings

1. List two new things you have learnt today about the legal duty of care pertaining to:

Employers

Employees

2. List three ways which you can change your current practices in your workplace to prevent and/or manage client-initiated aggression or violence:

3. What are three risk factors for aggression and violence?

4. What are three signs of a person becoming aggressive or impending violence?

5. A patient in your work area becomes agitated and you fear he/she may become aggressive or violent. What would you do?

6. Who should you notify if there is an episode of aggression or violence in your work area and how should they be notified?

Tool T4

Post-training evaluation tool – medium to long term

This evaluation tool has been developed and is to be used at least six months after training to assess knowledge and skill retention and the effectiveness of the training program.

The tool has three components:

- general information
- introduction (usually following orientation), and
- level 2 and 3 training.

The introduction questions are numbered 1–8. The evaluation could cease at that point or continue to question 21 for people who have completed aggression prevention and management training programs at levels 2 and 3.

Tool T4

Post-training evaluation tool – medium to long term (cont)

We are committed to maintaining the health and safety of all staff. This evaluation will assist us in determining the effectiveness of the **aggression prevention and management training and education** program.

Please take a few minutes to complete the survey and return it to _____ by _____/_____/_____

The results of the survey will be provided to _____ on _____/_____/_____

Thank you for taking the time to complete this survey.

General Information

Ward/work unit/division **Male** ☐ **Female** ☐

Age range (years): < 30 ☐ 30–39 ☐ 40–49 ☐ 50–59 ☐ > 60 ☐

Occupational group, please tick one of the following:

☐ Allied health professional
☐ Nurse
☐ Medical
☐ Clinical assistant
☐ Coordination
☐ Clerical/administration
☐ Environmental/food services
☐ Other (please specify)

_____

_____

Years of experience: < 5 ☐ 5–10 ☐ 11–20 ☐ 20–30 ☐ > 30 ☐

I have completed:	**YES**	**NO**	**DATE**
Orientation	☐	☐	____/____/____
Level 2 Aggression Prevention and Management training	☐	☐	____/____/____
Level 3 Aggression Prevention and Management training	☐	☐	____/____/____
I attended an *update* Aggression Prevention and Management training	☐	☐	____/____/____
I am part of a **Code Response Team**	☐	☐	____/____/____
I have attended an *update* training	☐	☐	____/____/____

Tool T4

Post-training evaluation tool – medium to long term (cont)

Please indicate your response to each question by marking the appropriate boxes

1. The *Occupational Health and Safety Act 2004* (OHS Act) applies to:
   - A. Employers, contractors and visitors ☐
   - B. Patients and employees ☐
   - C. Visitors and patients ☐
   - D. Employers and employees, including contractors ☐

2. Our organisation has the following combination of policies and procedures related to occupational violence:
   - A. Restraint, seclusion, zero/non tolerance, code of conduct, incident reporting ☐
   - B. Occupational violence, OHS ☐
   - C. Hazard identification, risk assessment, Code Black ☐
   - D. All of the above ☐

3. Occupational violence occurs:
   - A. When an employee is threatened or physically attacked in the workplace ☐
   - B. When an employee is threatened or physically attacked in the street ☐
   - C. When an employee is threatened or physically attacked in their home ☐
   - D All of the above ☐

4. Following an aggressive or violent incident I should:
   - A. Discuss it with my colleagues and family ☐
   - B. Complete a hazard report and advise my supervisor ☐
   - C. Report the incident to my supervisor and complete an incident report ☐
   - D. Advise the health and safety representative (HSR) and do a risk assessment ☐

5. If I am involved in an aggressive or violent incident related to my work and need some additional support afterwards, I should:
   - A. Discuss the issue with my colleagues ☐
   - B. See my general practitioner/local doctor ☐
   - C. Contact the human resources department ☐
   - D. Contact my supervisor for support and guidance ☐

6. The main reason clients become aggressive is because:
   - A. They are in pain ☐
   - B. They feel they have no choices ☐
   - C. They are thirsty and hungry ☐
   - D. They are substance affected ☐

7. In relation to aggression and violence at work:
   - A. I have a right to withdraw to safety at any time ☐
   - B. I am always involved in de-escalating/defusing incidents within my work area ☐
   - C. I should always call for assistance/a code response regardless of the situation ☐
   - D. All of the above ☐

8. Please rate your current level of anxiety at the possibility of dealing with an aggressive client on the scale below.

   ☐1 (Low) ☐2 ☐3 ☐4 ☐5 ☐6 (High)

Post-training evaluation tool – medium to long term (cont)

Evaluation tool for participants post training for staff who have completed a level 2 Aggression Prevention and Management training program

This brief evaluation will assist to determine the effectiveness of the **aggression prevention and management** training program. **If you have not completed a level 2 or 3 training program do not proceed.** If you have completed a level 2 or 3 Aggression Prevention and Management training program please take a few minutes to complete the survey and return it to _____ by _____/_____/_____

The results of the survey will be provided to _____ on _____/_____/_____

Please indicate your response by marking ONE box only

9. The Patient Rights and Responsibilities Bill/Charter:
   - A. Protects staff from aggressive and violent behaviours in the workplace ☐
   - B. Outlines the rights and responsibilities of patients and aims to support a partnership between patients and their health care providers ☐
   - C. Requires that all patients receive immediate attention ☐
   - D. Makes patients responsible for their actions ☐

10. 'Client-initiated aggression' means:
   - A. The client is looking for a fight ☐
   - B. Known or unknown circumstances have provoked an aggressive response from a client ☐
   - C. That staff should see aggression as 'part of the job' in the health industry ☐
   - D. None of the above ☐
   - E. All of the above ☐

11. If a client is becoming aggressive I should:
   - A. Use distraction techniques to avert an incident ☐
   - B. Pacify the client by giving in to their demands ☐
   - C. Stand my ground ☐
   - D. Try to resolve the issue using good communication focusing on the actual cause for the aggression ☐

12. Risk assessments related to OHS:
   - A. Should always be done by the OHS committee chairperson or manager ☐
   - B. Must be completed following an incident that places an employee's health or safety at risk ☐
   - C. Occur following identification of a hazard ☐
   - D. All of the above

13. Conflict can be verbal, physical and/or psychological. Which strategy is the most useful in conflict management?
   - A. Focus, listen and argue the point ☐
   - B. Focus, listen, be assertive and give ultimatums ☐
   - C. Focus, listen, be assertive and offer choices ☐
   - D. Give the client what they want ☐

14. Which combination of factors would contribute to escalation of a situation the most?
   - A. Willingness to resolve, poor communication, unsatisfactory solution, actual cause not addressed ☐
   - B. Unwillingness to resolve, poor communication, unsatisfactory solution, actual cause not addressed ☐
   - C. Unwillingness to resolve, good communication, satisfactory solution, actual cause not addressed ☐
   - D. Unwillingness to resolve, poor communication, satisfactory solution, actual cause addressed ☐

Post-training evaluation tool – medium to long term (cont)

Evaluation tool for participants post training for staff who have completed a level 2 Aggression Prevention and Management training program (cont)

Please indicate your response by marking ONE box only

15. I would know a situation was escalating because:
    - A. All staff would be fearful and clients would be anxious ☐
    - B. Voices would be raised and threats would be made ☐
    - C. The client would be becoming increasingly agitated, sarcastic and angry towards staff ☐
    - D. Staff would be arguing with the client and giving ultimatums ☐

16. Under the OHS Act I have a duty to:
    - A. Take reasonable care for my own health and safety ☐
    - B. Report unsafe practices and incidents ☐
    - C. Take reasonable care for the health and safety of others who may be affected by my acts or omissions at work ☐
    - D. All of the above ☐
    - E. None of the above ☐

17. Under the OHS Act my employer has a duty to consult:
    - A. When determining membership of the OHS committee ☐
    - B. By sharing information with employees and giving reasonable opportunities to express views about the matter ☐
    - C. When making decisions about measures to be taken to control risks to health and safety ☐
    - D. All of the above ☐
    - E. None of the above ☐

18. Aggression and violence usually arise as a result of:
    - A. Pathophysiological changes for the client, anxiety, miscommunication and long waiting times ☐
    - B. Noisy environments that are brightly lit and intruders and drug seekers ☐
    - C. Mental health problems that require immediate psychiatric attention ☐
    - D. All of the above ☐

19. The term 'reasonable force' means:
    - A. An immediate code response is required ☐
    - B. A person must be secluded to prevent damage to people and property ☐
    - C. Action that is commensurate with the situation ☐
    - D. Physical action that will prevent injury or damage to people or property ☐

20. Please rate your current level of confidence in managing an aggressive client on the scale below.

☐1 (Low) ☐2 ☐3 ☐4 ☐5 ☐6 (High)

21. How many times in the past six months have you used the knowledge and skills learnt at the training program you attended?_____

Any comments: _____

_____

Tool
T5

Competency-based assessment

This competency-based assessment tool has been developed for use by those with a solid OHS knowledge and who have completed a Certificate IV in Workplace Training and Assessment.

Tool T5 – Competency-based assessment instrument (cont)

This competency assessment instrument has been developed to help identify individual needs in relation to client-initiated aggression prevention and management. It is recommended that people with expertise and sound knowledge in OHS, beyond a commonsense approach, and with a capacity to assess individual competence, use it.

It could be used to obtain information from a sample of staff across an organisation, or in a targeted way with a particular work unit/group within an organisation.

This instrument is not recommended as a self-assessment tool

Rating	Criteria ALL of the following which are relevant to a particular assessment must be met:
Competent – no prompting required	• Demonstrates an understanding of 'non-tolerance of violence' principles. • Meets the stated criteria with no assistance. • Performs all essential steps correctly. • Demonstrates accuracy and safety in completing the required assessment. • Demonstrates sequential process in assessing the patient. • Performs the assessment within an acceptable time frame.
Competent with prompting – some prompting required and areas for improvement identified	• Demonstrates an understanding of 'non-tolerance of violence' principles. • Meets the stated criteria with minimal assistance (may require one or two prompts). • Performs all essential steps correctly. • Demonstrates accuracy and safety in completing the required assessment. • Demonstrates sequential process in assessing the patient. • Demonstrates sequential process in performing the task. • Performs the assessment within an acceptable time frame.
Not yet competent	• Unable to demonstrate an understanding of 'non-tolerance of violence' principles. • Requires three or more prompts to complete the assessment task. • Assessment task completed in an unacceptable time frame. • The patient assessment process lacks sequence or is disorganised. • The performance of the task lacks sequence or is disorganised. • A breach of safety occurs.

Tool T5 – Competency-based assessment instrument (cont)

Employee's name:	Signature:	Date:
Assessor:	Signature:	Date:

Criteria	Rating			Comments
	C	P	N	
Objective 1: The employee understands the importance of OHS and acts in accordance with aggression prevention and management policies and procedures.				
1.1 The employee demonstrates an understanding of the employer's statutory duty of care				
1.2 The employee demonstrates an understanding of his/her own duty of care in relation to the *Victorian Occupational Health & Safety Act, 2004*				
1.3 The employee demonstrates an understanding of the principles of Zero Tolerance to Violence in the workplace				
1.4 The employee can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control				
Objective 2: The employee demonstrates an understanding of risk management in the context of the client-initiated aggression prevention and management within our organisation.				
2.1 The employee can explain the process for reporting incidents in the workplace				
2.2 The employee is able to identify incidents or near misses that require reporting				
2.3 The employee understands the organisation's aggression prevention and management policy and its implications				
2.4 The employee can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control				

Key: **C** = Competent: no prompting required **P** = Competent: some prompting required **N** = Not competent

Tool T5 – Competency-based assessment instrument (cont)

Criteria	Rating			Comments
	C	P	N	
Objective 2: The employee demonstrates an understanding of risk management in the context of the client-initiated aggression prevention and management within our organisation.				
2.5 The employee demonstrates an understanding of risk assessment principles associated with the physical environment, work practices and a client's ability to comprehend and communicate				
2.6 The employee understands the procedures involved for proper storage and maintenance of duress alarms and personal safety devices				
Objective 3: The employee is able to identify and assess the aggression and violence risks associated with a client according to their needs and abilities.				
3.1 The employee is able to identify common causes of client-initiated aggression in the workplace				
3.2 The employee is able to describe patterns of behaviour in clients that might indicate escalation to an aggressive or violent situation				
3.3 The employee is able to identify environmental hazards in relation to client initiated aggression or violence				
3.4 The employee is able to discuss diffusing techniques appropriate to the client's needs and abilities and to the workplace				
3.5 The employee is able to explain how to access further assistance if a situation becomes violent				

Key: **C** = Competent: no prompting required **P** = Competent: some prompting required **N** = Not competent

WorkSafe

Advisory Service

222 Exhibition Street
Melbourne 3000

Phone 03 9641 1444
Toll-free 1800 136 089
Email info@worksafe.vic.gov.au

Head Office

222 Exhibition Street
Melbourne 3000

Phone 03 9641 1555
Toll-free 1800 136 089
Website worksafe.vic.gov.au

Local Offices

Ballarat 03 5338 4444
Bendigo 03 5443 8866
Dandenong 03 8792 9000
Geelong 03 5226 1200
Melbourne
(628 Bourke Street) 03 9941 0558
Mildura 03 5021 4001
Mulgrave 03 9565 9444
Preston 03 9485 4555
Shepparton 03 5831 8260
Traralgon 03 5174 8900
Wangaratta 03 5721 8588
Warrnambool 03 5564 3200

VWA 1158/01/06.08