Managing the Risk of Workplace Violence to Healthcare and Community Service Providers: Good Practice Guide

newzealand.govt.nz

Department of Labour
TE TARI MAHI

Department of Labour
TE TARI MAHI

Managing the Risk of Workplace Violence to Healthcare and Community Service Providers: Good Practice Guide

newzealand.govt.nz

MANAGING THE RISK OF WORKPLACE VIOLENCE TO HEALTHCARE AND COMMUNITY SERVICE PROVIDERS

The Department of Labour recognises the excellent work of the Counties-Manukau District Health Board, the Australian Faculty of Occupational Medicine and the Australasian Society of Occupational Medicine in producing this Best Practice Guideline. It is a comprehensive document that provides practical guidance on managing the risk of violence to healthcare and community service providers.

Occupational violence is causing increasing concern across a variety of workplaces. Apart from the serious and long-lasting physical and psychological effects on individuals, their families and colleagues, it impacts on productivity, the quality of care provided to patients, and the industry's reputation.

Adopting the safe work practices in this Guide will assist employers, the self-employed and others with duties to understand their responsibilities under the Health and Safety in Employment Act 1992. The Guide will also make employees aware of the hazards of occupational violence that they may encounter at work, and see the range of practicable steps that can be taken to ensure their safety and that of others who could be affected by their work.

The Department of Labour thanks all those who were involved with the development of this Guide, and encourages its adoption by everyone involved in the healthcare and community service providers sector.

Maarten Quivooy
Group Manager, Workplace Services
Department of Labour

MANAGING THE RISK OF WORKPLACE VIOLENCE TO HEALTHCARE AND COMMUNITY SERVICE PROVIDERS

This is an industry-developed guideline that will fulfil health and safety obligations to healthcare staff while enhancing patient care.

Released on 22 January 2009

This document was developed by a professional group lead by the Occupational Health Unit of the Counties Manukau District Health Board in conjunction with representatives from the Australian Faculty of Occupational Medicine (AFOM) and the Australasian Society of Occupational Medicine (ANZSOM). It draws on material from a draft Code of Practice developed by the Department of Labour (NZ) and with further input from Austin Hospital (NSW), Barwon Health (Victoria), and various Occupational Physicians, other doctors and healthcare workers with an interest in mental health care and occupational medicine.

As such, this document represents a "best practice" approach developed by an industry group – an industry-based "Code of Practice". It provides a basis for units to compare their practice and to join together in developing effective solutions.

This is not a medical document, it takes the format of a "Code of Practice" that healthcare workers and their managers can refer to when discussing management methods to mitigate this risk to their wellbeing. It is primarily focused on the community care situation rather than the larger hospital with inpatient beds and staffing levels, although the principles of risk assessment and risk management are applicable.

Comment and suggestions for improving the document are welcome. Ideally alternative formats will be developed and units can adapt the various documents to suit their needs.

- Comments, amended or new self assessment templates or further case material can be posted to travisp@middlemore.co.nz.

- This document uses the Health and Safety in Employment Act 1992 (HSE Act) as a model of legislative requirements, and should be adapted by individual users to their local legislation.

- It applies risk management principles and procedures, and then attempts to demonstrate these principles through a number of scenarios (not every scenario in the best practice document is relevant to every organisation).

- Included are a number of self-assessment templates. These are but one mechanism that can be used. Mental Healthcare providers may wish to develop their own self-assessment tools or modify these tools to their own environment.

Employers and employees will not need to be reminded that workplace health and safety is part of the wider employment environment, and in this sector, patient treatment relationship. As such, the suggested policies and procedures outlined in this document need to be grounded in good employment and patient care practice.

The development group thanks all those organisations and individuals who have helped in the development of this best practice document, and invites submissions on amendments throughout the life of the publication.

> "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving explicit of implicit challenges to their safety, well-being or health."
>
> Framework Guidance for Addressing Workplace Violence in the Health Sector. – ICO/ICN/WHO/PS1 General 2002.

TABLE OF CONTENTS

1. FOREWORD

Acts of violence and aggression are an increasing threat to healthcare employees and community service providers. While many violent acts result in physical injury, threats or intimidating behaviour can cause just as profound damaging psychological effects, including loss of morale, confidence and long-term psychological stress.

Permitting violence towards staff is simply bad business.

Investigations have shown that all parts of the healthcare sector experience incidents of violence against staff, and that the issue is common to all international jurisdictions.

Therefore, violence against healthcare workers is a predictable occupational health and safety issue, and should be managed in the same manner as any other workplace hazard.

In New Zealand, the Health and Safety in Employment Act 1992 applies to all sectors of the workforce, and provides a framework for employers and employees to work together to lessen the risk of harm to those in the workplace. Similar legislation imposes similar duties in all the Australian states.

Although elimination of the risk of violence is not likely to be achieved given the nature of care provided, there are many practical steps available to employers and employees to identify and manage these risks without compromising patient care. Such interventions will reduce the financial and social costs of work-related injuries, and will also help retain skilled and motivated staff.

This document draws on the NZ Department of Labour's data, from best practice documents of the United Kingdom, the USA and Australia, and from such sources as the World Health Organisation and the International Labour Organisation. Particular use of the policy documents from Austin Hospital, New South Wales, is made to provide examples for organisations to base their own policies upon.

2. INTRODUCTION

Violence and aggression in the healthcare and community service setting are serious occupational health and safety issues. In New Zealand, Australia, UK, Canada and the USA, workplace violence results in a significant number of days off work each year.

It would appear that the majority of incidents involving violence or aggression at work go unreported, and many employees feel unsafe at work.

As such, violence and aggression are both workplace hazards.

This document describes the risks of physical and mental harm faced by staff in healthcare, residential, social service and community settings. It proposes a range of mechanisms to manage those risks and protect staff from harm arising from violence.

The effective management of violence must be undertaken in the context of the particular workplace. It should be done in a way that takes account of the effect on the quality of patient care, and be consistent with good employment practice.

This is intended to be a 'living' document. We look forward to your input to update this document.

3. THE SCOPE OF THIS GUIDE

This document will provide practical guidance for workplaces where people may be exposed to various forms of workplace violence including:

- physical assault
- verbal abuse
- threats, intimidation and harassment.

It focuses specifically on healthcare and related parts of the social services and community sectors. These are sectors where the physical proximity of care providers to clients, and the lack of an institutional environment with other attendant staff close at hand, means violent or verbally abusive behaviours of some clients can result in serious harm to staff.

The guide is intended to:

- raise general awareness among employers and staff about workplace violence in their sectors; and
- provide a generic list of mechanisms for developing effective management plans in particular work settings. These are based on the hierarchy of management detailed in the various Australian States and New Zealand Health and Safety Acts (elimination, isolation and minimisation).

This guide will sit alongside and help inform the development of guidance, codes and standards developed under (in the NZ context):

- health and disability service contracts
- health and disability sector standards (e.g. NZS 8134, NZS 8141:2001- *Restraint, minimization and safe practice* etc)
- legislation such as the NZ Mental Health (Compulsory Assessment and Treatment) Act 1992 and NZ Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR); and
- The NZ *Health Information Privacy Code.*
- Australian states will have similar guiding legislation.

The advice and information provided is made available in good faith and is from sources believed to be accurate and reliable at time of publication.

4. THE NATURE OF THE PROBLEM

The Range of Employees at Risk

Health facilities are high-risk situations for violence due to the presence of multiple risk factors. This best practice document will have application for people working in the following settings:

- hospitals and clinics
- accident and medical clinics
- drop-in centres
- general practice
- all-night shelters
- day programmes
- aged care facilities
- community-based residential services
- home-care services
- vocational services such as community participation, supported employment and sheltered workshops
- private homes
- alcohol and drug services
- youth offender homes
- services provided under Intellectual Disability Community Care legislation.

The document is not intended to cover the work of police or employees in the Department of Corrections, although similar issues exist in these occupations and the same principles of risk management apply.

Risk Factors

Risk factors associated with health care and social service providers being exposed to violence have been identified. Some occupational groups are at higher risk than others. These include:

- caregivers and support workers
- social workers, allied health and social professionals & needs assessors; etc
- and teachers in these environments
- health professionals and community health workers
- family members
- volunteers
- support staff
- mental health assistants
- security, porters
- telephonists, receptionists and secretaries, etc.

Defining Violence

Violent episode: means any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing or health. The violent episode can be instigated by a patient, another staff member or a member of the public.

Physical assault: means an assault which results in actual physical harm.

Physical threats: means attempted physical assault that does not result in actual harm.

Verbal/written threats: means verbal or written communication where the individual perceives a risk of harm to their person or property.

Damage to property: means items damaged that belong to a person or an organisation.

Examples of violence occurring to employees include:

- violence with the potential to result in *harm* such as pushing, pinching, hair pulling, obscene language and verbal abuse (sometimes highly personalised) including threatening behaviour, sexual and racial assaults
- stalking, intimidation, invasion of privacy, which have also been recorded as precursors to incidents of serious harm
- incidents with the potential to cause *serious harm* such as kicking, biting, spitting, scratching, strangleholds, the use of knives, knitting needles and other weapons, head butting and punches to all parts of the body.

The injuries sustained by caregivers within the NZ context as investigated by the Department of Labour include lacerations, puncture wounds (from bites and weapons), fractures and head injuries. Psychological harm has also occurred, including quite severe mental health problems for the staff member, such as post-traumatic stress disorder.

Some of the injuries sustained by caregivers, nurses and community service providers, have required weeks for recovery. In other cases, a full recovery has not occurred, or staff have chosen to leave the sector because of their fears and/or concerns. In New Zealand, some cases have proven fatal.

5. THE LEGISLATIVE BACKGROUND

Health and Safety in Employment Act 1992

This section uses the Health and Safety in Employment Act 1992 (HSE Act) as a generic piece of legislation to underpin the following discussions. Australasian States and Territories have broadly similar health and safety legislation, so this discussion is pertinent to most readers.

Introducing the Health and Safety in Employment Act 1992

The HSE Act contains general duties and responsibilities placed upon people to ensure their own safety at work, and the safety of others who are at the workplace or who might be injured at work.

These duties extend to the prevention of workplace violence and aggression.

The HSE Act requires employers to identify hazards, assess their likelihood and severity and then to control hazards. The Act applies to all people in paid work and certain classes of volunteers.

Key sections of the Health and Safety in Employment Act 1992 as applied to workplace violence

Hazard

(a) means an activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and
(b) includes—

> (i) a situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person; and
> (ii) without limitation, a situation described in subparagraph (i) resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour**.**

All practicable steps: Sections 6-10 of the Health and Safety in Employment Act 1992

Employers must take all practicable steps to mitigate risk and protect employees, especially those at potentially higher risk, such as healthcare staff, support staff and first responders (i.e. fire, police, ambulance and other emergency workers) from harm.

Employers need to plan actively to cover their risks and the risks to their workers and the public.

"All practicable steps" applies to the general duties that must be carried out by employers, employees, self-employed, people in control of workplaces and "principals", who are people who engage contractors to carry out work for them.

These people are required to take all steps that are **reasonably** practicable.

A step is practicable if it is possible or capable of being done.

Whether a step is also reasonable takes into account: the nature and severity of any harm that may occur, the degree of risk or the probability of harm occurring, how much is known about the hazard and the ways of eliminating, isolating, or minimising it, and the availability and cost of the available controls.

The degree of risk and severity of potential harm must be balanced against the cost and feasibility of the control measure. The cost of providing the control protection has to be measured against the consequences of failing to do so. It is not simply an assessment of whether the employer can afford to provide the necessary control protection. Where there is a risk of serious or frequent harm, a greater cost in the provision of protection may be reasonable.

Any judgement about whether a control measure is "reasonably practicable" is to be made taking common practice and knowledge throughout the industry into account.

Section 6 of the HSE Act (extract): "All practicable steps" - "Every employer shall take all practicable steps to ensure the safety of employees while at work; and in particular shall take all practicable steps to–

> (a) Provide and maintain for employees a safe working environment; and
>
> (b) Provide and maintain for employees while they are at work facilities for their safety and health;"

Hierarchy of Management Controls

Sections 7-10 describe a hierarchy of action for managing hazards. Where a significant hazard is identified, the Act sets out the steps an employer must take.

> 1. When practicable, **eliminate** the significant hazard (section 8). This may involve removing the hazard or hazardous work practice from the workplace.
>
> 2. If elimination is not practicable, **isolate** the significant hazard (section 9). This may involve isolating or separating the hazard or hazardous work practice from people not involved in the work or the general work areas. It could mean changing work practices or effecting building changes (see pages 23-24).
>
> 3. If it is impracticable to eliminate or isolate the hazard, **minimise** the likelihood that the hazard will harm employees (section 10).

Duties of Persons who Control Places of Work (Section 16)

This section provides guidance on the responsibilities of those who control places of work to transfer information on hazards arising that may have a detrimental effect on those in the vicinity of the place of work. The place of work in the healthcare sector can and does include acute (hospitals) and primary care (delivery of healthcare services to the community).

The overarching principal of section 16 is to ensure that persons in control of a place of work take all practicable steps to ensure that no hazard that is or arises in the place of work harms people in the vicinity of that place. For specific application of section 16 and its subsections refer to the *Guide to the Health and Safety in Employment Act 1992* on the Department of Labour website www.dol.govt.nz.

Section 19B Employee Participation

Section 19B of the Health and Safety in Employment Act 1992 says every employer must provide reasonable opportunities for the employer's employees to participate effectively in ongoing processes for improving health and safety in the workplace.

Section 28A Employees may Refuse to Perform Work Likely to Cause Serious Harm

Section 28A of the Health and Safety in Employment Act 1992 says employees have the right to refuse to perform work if they believe it is likely to lead to their suffering serious harm. However, their belief must be on reasonable grounds, and they must have attempted to resolve the matter with their employer before they can continue to refuse.

The right to refuse unsafe work does not apply unless the understood risks of the work have increased materially. Therefore, the right of an ambulance worker or a nurse to refuse is different to that of, say, a carpenter. It is also different to that of a sworn staff-member of the police, fire service or armed forces.

Independent contractors and volunteers have the right to withdraw their labour or services at any time, including when they feel the work environment presents an unsatisfactory level of risk.

6. RISK ASSESSMENT AND MANAGEMENT – ASSESSING AND MANAGING THE RISKS ARISING FROM VIOLENCE

Risk assessment requires identifying the hazards and assessing and controlling those risks.

Although individuals are sometimes unpredictable, violent episodes or incidents in this industry happen with sufficient frequency in certain settings to make them a predictable event.

In certain healthcare situations, management of violence may be best achieved through the application of a 'process'. In other situations, redesign of the physical work environment will be more productive.

Community homes where care occurs are workplaces and should be subject to the same hazard identification and management.

Recognising and Responding to the Risk

Once actual or potential violence is recognised, the most appropriate response is by means of "work practice" interventions, for example calming and de-escalation, and this is an integral part of mental health training. In this instance personal safety and good practice are synonymous.

Conscious Violence

Column 1 of Table 1 describes a variety of potential warning signs or cues that may indicate that a patient may be about to respond violently. Column 2 describes suggested responses to each warning sign that the caregiver can use to try and diffuse the potentially violent situation.

Table 1: Warning signs of conscious violence

Warning signs/cues of violence	**Responses that may help diffuse aggression**
Repeated succession of questions	Appear calm, self-controlled and confident, confirming that you are addressing their concerns.
Using another language in an aggressive manner	Identify language origin and locate interpreter to assist. A list of interpreters could be held in an Accident and/or Emergency Department.
Using obscenities or sarcasm	Do not match their language.
Shouting	Ask for information with a calm voice.
Replying abruptly or refusing to reply	Calmly confirm the received information back to the assailant.
Rapid breathing	Breathe slowly and evenly
Pacing	Attempt to sit them comfortably
Clenched fist or pointing fingers	Do not fold your arms or clench your fists in reaction.
Invading your personal space	Maintain a comfortable distance.
Staring	Maintain normal, but broken eye contact.
Tight jaw with clenched teeth	Open hands to the assailant
Shoulders squared up and dominating	Stand to the side.

Unconscious Violence

This guidance is not intended to assist in the diagnosis of the patient, but to identify that there may be a different trigger and management process necessary when responding.

For example, it would be unwise to call for police assistance to a patient who has hit an employee following a general anaesthetic, as they will have had no intention of harming the staff member and probably have no recollection of events once the effects of the anaesthesia have worn off.

Unconscious violence may occur as a result of the assailant experiencing:

- acute head injury
- post-operative effects of anaesthesia
- blood level of toxins, glucose, septicaemia, electrolytes and oxygen.

The purpose of identifying these situations is all about risk identification so that appropriate thought and planning can go into care plans. In this way, staff safety is preserved while appropriate standards of patient care are supported.

Identify the Hazard, Assess the Risk and Control the Hazard

After identification and risk assessment (the likelihood of injury or harm occurring, assessing the consequences and rating the risk) hazard control or management involves a preferred hierarchy of risk control measures, the most effective being elimination followed by isolation and finally the least effective, minimisation. Work practice interventions, for example, are a form of minimisation, engineering solutions usually fit into the isolation category and are more effective and cheaper in the long run.

There are a number of self-assessment templates at the end of this best practice document which can be used, and adapted to particular workplace settings, as aids to practical implementation.

- Appendix 1 includes an organisational self-assessment tool
- supported by Appendix 2 which includes the framework for assessing an individual's propensity for violence or conducting an area assessment
- Appendix 4 includes some completed examples for reference purposes.

As part of workplace risk identification and management, employers/managers may:

- investigate and identify those patients or clients who have been involved in assaults/ incidents in the past (or who fall into a recognised risk situations such as acute 'P' intoxication);
- review the triggers or circumstances relating to the incident; and assess whether the person's behaviour is still a risk to staff
- identify situations where clients are likely to respond adversely and investigate the likelihood of serious harm
- consult with staff to develop management plans, including adequate training, which may be included in the 'daily care plan', support plan or client's personal plan.
- Communicate these to all staff potentially at risk
- put into place strategies to support each individual client to manage their his or her own behaviour
- ensure clients are adequately matched to services/activities/programmes.
- Involve referring agencies/agents where appropriate
- have adequate emergency response routines in place
- monitor the results of these management solutions.
- Make long term plans to ensure adequate facilities, properly engineered to isolate or minimise the risk.

For community-based social service organisations in the disability and mental health sectors:

- identify situations where clients may be likely to react adversely

- put strategies in place that will mitigate these circumstances and assist the clients to manage his or her own behaviour
- ensure clients are appropriately matched to services and to activities or programmes within services.
- Involve referring agencies where appropriate.

Employee Participation and Responsibilities

Effective workplace health and safety management is strongly dependent on the involvement of staff in identifying hazards, and on the sharing of information.

This can be achieved by a number of methods, including: employee surveys, hazard identification by teams, regular weekly meetings where work is reviewed and systems discussed, or a health and safety committee including both elected employee and management representatives.

Under the HSE Act, employees have a duty to take all practicable steps to avoid harming themselves or any other person. This general duty implies the following:

- behaving appropriately
- taking care to avoid behaviours that generate inappropriate responses from others (including bullying or being dismissive of the needs of others)
- co-operating with the employer and providing constructive feedback in matters of health and safety
- a duty to follow care plans and to bring to the attention of the supervisor/ employer any difficulties with those care plans
- attending training and implementing the health and safety objectives of the training as far is possible
- fully participating in communication programmes
- reporting hazards and incidents (including stress and fatigue)
- taking part in incident investigations and debriefing exercises.

Transfer of Information

A number of incidents of violence in recent years have resulted from the non-transfer of information between agencies and to individual employees. For example, a health provider or social agency has not transferred information to a home-based or residential care organisation. Two such cases were:

1) a patient killed a home-based healthcare worker during a violent assault. The caregiver had not received the information that her client was potentially dangerous

2) a home-based caregiver took a client into her home. The organisation knew but did not tell the caregiver there was a history of violence. The person became violent towards the caregiver.

A number of reasons were cited for the failure to warn of the risk. These included:

a) inadequate or not regularly updated clinical assessment or patient history

b) inadequate documentation at inception of care, e.g. an acute psychiatric admission may lead to a dangerous patient going to an inappropriate environment

c) referral agencies reported they were too busy or 'could not be bothered'

d) staff in some health care organisations did not believe that it would be responsible to pass on certain information on the grounds that the 'downstream' caregivers were either

   i) 'not equipped' (presumably it is thought that they are not adequately trained or experienced) to handle it or

   ii) there is no need for them to know

e) staff feared repercussions from the misapplication of the Privacy Act and the Health Information Privacy Code (HIPC)

f) the organisation may have wished to place a patient/client with another organisation and therefore did not pass on information seen as likely to compromise the placement

g) the 'upstream' care-giving organisation may not have taken steps to obtain patient/client consent (when the information was initially being gathered) for subsequent passing on to 'downstream' caregivers

h) emergency admissions without the right skill mix, appropriate care provider or understanding of client needs.

The normal care and precautions concerning the supply of patient or client information apply but information relevant to the safe and proper care of patients or clients, including information concerning risks posed to employee wellbeing, is a necessary part of quality patient care and adequate employer health and safety management.

This information should be made available to caregivers consistent with provisions of the Health Information Privacy Code (HIPC):

- Referring agencies need to provide adequate information to permit comprehensive risk identification and ongoing support plan development.
- Where a group of providers are involved in the provision of support to a client, ensure mechanisms are in place to enable exchange of relevant information.
- Advise incidents of violence leading to physical or psychological harm (deliberate or not) by a patient or client to downstream caregivers so that staff safety and high-quality patient care can be provided for.

7. TRAINING, EDUCATION AND INFORMATION FOR STAFF, SUPERVISORS, MANAGERS AND OTHERS

Training and Staffing Issues

Well-trained and experienced staff are essential to deliver quality patient or client care.

All employees entering this sector should receive relevant and adequate training both at entry (induction) and at regular intervals as relevant. Training should also reflect the nature of incidents reported in that unit (see monitoring) and should cover aspects of self-protection and self-preservation, including reminding the employee of their right to refuse dangerous work.

Staff rosters should be made up of adequate numbers of trained staff to cover needs, including emergency response planning, for all shifts. Staff considerations such as physical strength, fitness and gender mix should also be considered. It is strongly recommended that such training occur initially (on induction) and at regular intervals thereafter.

Suggestions – Training for All Staff

Training in the management of workplace violence should be undertaken before exposure to potential hazards and followed by refresher training within the first year. (New employees are most at risk of workplace injury).

Provide training for all staff that covers:

- The workplace violence prevention policy
- Risk assessments, including identification of risk factors
- Non-injurious break-away techniques
- Grievance management, processes and techniques
- Self-defence, for use in extreme circumstances where there is no alternative response
- Recognition of early warning signs and appropriate ways to respond to them
- Ways to diffuse volatile situations or aggressive behaviour
- Responses to violent situations need to be tailored to individuals and specific circumstances
- Progressive behaviour control methods and safe methods of applying restraints, ensuring that practices are consistent with (for example) NZS 8141: 2001 *Restraint Minimisation and Safe Practice* and any related sector standards
- Summoning emergency help
- Policies for reporting incidents and events and taking part in investigations
- Discussion about how employee behaviour may promote violence
- Information on treatment facilities for injured workers

- Responsibilities and rights under the Health Information Privacy Code (HIPC).

Training for Supervisors, Managers and Health and Safety Representatives

Provide information, education and training for supervisors, managers and health and safety representatives that covers:

- Competency in policies and procedures to do with violence
- Identifying when employees' performance or behaviour indicates the presence of stress or likelihood of violence
- Support for injured employees, including providing advice and assistance as necessary which may include counselling, alternative duties, Employee Assistance Programme, etc
- Creation of a supportive environment
- Give staff knowledge of specialist support resources for difficult situations and provide peer support
- Provision of debriefing systems
- Staff rostering issues and emergency response planning.

8. TAKING ALL PRACTICABLE STEPS TO MANAGE RISK SITUATIONS

All Practicable Steps

Employers are required to take 'all practicable steps' to keep their employees safe. The steps described here are examples only, they are not applicable in every circumstance in every organisation and need adapting to each situation to follow the order of priority of *elimination*, *isolation* and *minimisation*.

Given the nature of many patients or clients, elimination of the hazard in the healthcare sector is often difficult or impossible. However, there are a few options which include:

- changing the system of work to completely eliminate the trigger for workplace violence or aggression
- Identifying and addressing underlying clinical influences that are having an effect on the individual's violent behaviour.

Isolation is often not the most practicable solution for those front-line staff caring for individuals. However, those who are in the vicinity of the place of work could be protected by isolation. In practical terms this could mean the use of a side room on a ward or a triage room in an emergency department.

If the opportunities to eliminate and/or isolate violence have been exhausted, minimisation may be the most practicable management mechanism. The principles of minimisation may include:

- issuing a clear policy statement
- designing and building for safety
- implementing work organisation controls
- implementing work practice controls
- ensuring the correct use of personal protective equipment; e.g. appropriate uniforms, appropriate footwear, shin guards etc.
- implementing an adequate emergency response plan
- the monitoring of management mechanisms
- having mechanisms in place to ensure an adequate response by suitably trained staff is in place for violent episodes.

In all situations, a combination of management methods systematically managing for all eventualities is likely to be the most successful.

Clear Policy Statements

Employers should have clear policies and procedures in place to inform staff, patients and clients that violence towards staff, and indeed anyone in the workplace, is unacceptable, and detail the procedures required when violence occurs.

- The principles of such policies are detailed by the World Health Organisation (WHO) at www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf
- A range of examples of such policies exist as part of the United Kingdom's NHS "zero tolerance" programme such as: http://www.dvh.nhs.uk/downloads/documents/ZCQ3ZSEKLJ_Zero_Tolerance_to_Violence_2006.pdf

Designing For Safety

Most of the following best practice documents concerning the safe design of premises are taken from Occupational Safety and Health Administration (OSHA) advice supplemented by the WHO/ILO document.

This is supplemented by the Australasian experience with respect to the necessary requirements of psychiatric facilities (residential and inpatient).

This section applies to in-patient care services and is not necessarily applicable to community-based service providers.

The principles of such advice include:

Access

- provide safe access and quick egress from the workplace
- minimise multiple areas of public access to healthcare facilities
- locate security services at the main entrance, near the visitors' transit route in emergency departments
- locate staff parking areas with close proximity to the workplace if possible
- ensure the reception area is easily identifiable by patients and visitors, and easily accessible to other staff
- restrict access to staff areas (changing rooms, rest areas and toilet facilities) to personnel of the facility.

Space

- provide enough space per person to reduce interference with personal space
- design waiting areas to accommodate all visitors and patients comfortably – provide adequate seating, especially if long waiting periods are a possibility
- provide employees with separate rest areas and/or meal rooms away from patients/clients, particularly when doing night work or dangerous work

- install protective barriers for workers at special risk and to separate dangerous patients/clients from other patients and the public consistent with assessment of therapeutic needs.

Fixtures and Fittings

- Provide good lighting
- Provide an environment with an appropriate temperature, humidity and ventilation
- Where high-risk patients are cared for, ensure that the wall coverings are sufficiently robust to withstand assault
- Ensure fixtures and fittings cannot be used as weapons.

Premises

When the opportunity presents itself for new premises or redesign:

- Design facilities with the potential for emergencies in mind
- Address the issue of "black spots". These are the areas that either promote violence by tunnelling people into confined spaces, or by restricting egress from a hostile situation
- Ensure interview rooms have two exits (to avoid a staff member becoming trapped) and viewing window(s) so that other staff can intervene if necessary
- Ensure treatment rooms in emergency service areas are apart from public areas
- Keep levels of noise to a minimum to reduce stress, irritation and tension
- Provide facilities for waste management i.e. soiled linen, clothing etc
- Provide extra services of facilities and equipment where needed, e.g. where a patient/client is know to be hepatitis B positive
- In problematic areas, and where proven need exists, introduce facilities to ensure that weapons or mood-altering substances are not smuggled to patients/clients
- Ensure weapons removed are stored off site by police or security
- Ensure that windows and doors are secure so that patients/clients can be cared for in an environment safe for them, the staff and the public at large
- Isolate potentially dangerous equipment, chemicals or medication supplies (i.e. locked cupboards where appropriate)
- Consider the use of closed-circuit TV where oversight may be required in geographically difficult or distant parts of the building
- Where appropriate, install security devices such as metal detectors to prevent armed persons from entering the facility
- Test these security devices and personal/other alarm procedures regularly
- Where appropriate, provide adequate security lighting and security escorts for evening or night staff.

Work Organisational Practices

Every workplace is unique; therefore a combination of different factors and management tools will apply. Principles taken from the World Health Organisation, International Labour Organisation and the National Health Service (UK) documents include:

Risk Assessment Routines

- "Isolate" the risk of violence by ensuring that clients are appropriately placed in organisations with the ability to cope with them and with people within those organisations who have adequate training and experience
- Obtain a current medical report from the referral agency, a general practitioner, psychologist or psychiatrist
- Ensure that clients with a history and likelihood of violence are identified beforehand
- Obtain information from those with recent responsibility for the patient/client (e.g. caregivers, family)
- Rule 11 of the Health Information Privacy Code makes it clear that personal health information must be transferred to downstream caregivers – recognising the possibility that a patient or client will be violent towards a caregiver.
- Develop a procedure for assessing changes in patient/client behaviour, communicating them to staff (via patient/client profiles) and implementing the changes in the way care is given
- Assess the risk of harm to employees that may result from contact with the patient or client .e.g. if the person has an infectious disease or where the infection causes the client to have an increased risk of behaving violently.

Communication

- Prepare care plans that address issues of actual or potential violence
- Ensure that the staff member has knowledge of the way the patient/client may respond to medication that they are receiving (i.e. the caregiver's knowledge is matched to the person's needs and circumstances)
- Consider the client's behaviour as it changes with time, record those changes on the client profile and report them to staff
- Assess accidents and incidents and make changes to the patient/client profiles as indicated.

Appropriate Staff Skills for the Demands of the Job

- Use best practice selection methods and pre-employment procedures to identify people who are suitable or unsuitable for this work
- Identify people who require training and their specific training needs before they begin the work
- Assess employee skills in relation to dealing with patients/clients and assign employees accordingly.

Other Factors that Impact on Staff Safety and Client Care

- Rotate jobs to reduce the period of exposure (with respect to long-term mental fatigue)
- Remove potentially dangerous weapons (e.g. scissors, knives) within the boundaries established by the law and management policies
- Assess the physical safety of the facilities in which patients and clients live and learn

Work Practice Procedures

Suggestions include:

- provide feedback on performance and opportunities for the development of skills
- patient/client notes should include a section which assesses the risk to caregivers. In particular, the nature of the risk should be specified by asking the following types of questions:
    - is there information in the patient/client record that suggests violence has occurred to staff in the past?
    - if you are aware of such incidents, from the information available, how frequent are they?
    - do family members or support people report a history of violence or abuse in the recent past?
- A procedure similar to this (risk assessment of patients/clients and situations) is required by most jurisdictions and professional associations.

Work Practice Procedures

- Define tasks and vary them if possible
- Assign tasks to people who have the skill and ability to do them – consider general abilities and things that may impact in the short term such as pregnancy, fatigue and/or fitness
- Rotate staff who do dangerous and/or unpleasant tasks or who are new to the job
- Introduce team care or buddying in situations where risk is unknown or high
- Consider the cultural factors (e.g. culturally inappropriate behaviour of employee) that may escalate or de-escalate client aggression
- Provide clear messages to patients/clients and their visitors that violence is unacceptable and has consequences
- Consider the use of appropriate models and techniques for managing different situations and client groups (for instance the 'yellow/red card system' as applied to those consenting to violence in the United Kingdom, has been used with marked success)
- Use behavioural techniques to promote non-violence

Personal Protective Equipment

Where appropriate:

- Ensure that clothing is appropriate to the level of risk encountered
- Ensure that emergency response devices cannot be used as a weapon (e.g. a personal alarm used as a garrotte)
- Instruct staff not to wear jewellery or carry tools or pens in at-risk situations
- Provide staff in hazardous environments with personal communication devices

Adequate Emergency Response

Where appropriate:

- Signpost areas for staff, patients and visitors
- Use signage to identify areas of special risk or restricted areas
- Ensure that areas where people may be assaulted are visible through windows
- Provide easy egress from areas where violence may occur
- Install other security devices such as cameras and good lighting in hallways
- Provide emergency exits

Allowing Staff to Summon Help Easily

Where appropriate:

- Develop emergency signalling, alarm and monitoring systems as appropriate, and test periodically (make sure that other staff are available to respond to alarms)
- Have a mixture of personal and wall-mounted alarms so that staff have a variety of options to summon assistance
- Test these systems regularly and measure the response time to ensure that intervention occurs before serious harm can be inflicted
- Have a system in place to treat and monitor employees who report suffering harm, serious harm or have been in an incident that could have lead to such harm (i.e. 'first aid' response and monitoring as required by the HSE Act)
- Have a 'check-in system' whereby staff are all accounted for at the end of each shift (refer to section 7, subsection *Community Service Providers*)

Further Guidance on Managing Violence

Communication

Use a variety of communication methods as covered in the training programme to ensure that clear information is given to the person in a manner that does not inflame (if the person has insight appropriate cognitive function) the situation.

Positioning the Individual

Having a clear communication link does not guarantee that a person who displays violent behaviour will not strike you. Maintaining a safe distance at all times is still very important. In some cases the use of a padded cot side as a physical

barrier is enough to prevent repeated kicks and strikes while the individual remains in bed.

Never place yourself in a vulnerable position.

Always ensure you have a clear line of retreat.

Remember the right to refuse dangerous work.

Community Service Providers

Community service providers are a particularly vulnerable group. They often work in isolation and within premises that cannot be designed with the safety of the service provider in mind.

What can Employers Do?

- The best protection an employer can offer is to establish a zero-tolerance policy towards workplace violence
- Establish a workplace violence prevention policy. Ensure all employees know the policy and understand that all claims of workplace violence will be investigated and remedied promptly
- Provide safety education for employees so they know what conduct is not acceptable, what to do if they witness or are subjected to violence, and how to protect themselves
- Equip field staff with cell phones and hand-held alarms or noise devices
- Establish a daily work plan for field staff that requires employees to keep a designated contact person informed of their location throughout the day. Have the contact person follow up if an employee does not report in as necessary
- Keep employer-provided vehicles properly maintained
- Instruct employees not to enter any location where they feel unsafe
- Introduce a 'buddy system' or provide an escort service or police assistance in potentially dangerous situations or at night
- Develop policies and procedures covering visits by home healthcare providers. Address the conduct of home visits, the presence of others in the home during visits and the worker's right to refuse to provide services in a clearly hazardous situation
- Develop methods for rapid response back-up to community workers. Workers need to be able to access rapid support, which has implications for both the issue of communication devices and plans that enable the rapid deployment of assistance
- Advise staff to take extra care in lifts, stairwells and unfamiliar residences; leave the premises immediately if there is a hazardous situation or request police escort if needed
- It may be necessary on some occasions, where there is a history of violence, for the client to be brought to the office or clinic for treatment.

What can Employees Do?

- Attend personal safety training programmes to learn how to recognise, avoid and diffuse potentially violent situations
- Alert supervisors to any concerns about safety or security and report all incidents immediately in writing
- Raise any ongoing safety issues with health and safety representatives and/or union delegate
- Avoid travelling alone to unfamiliar locations or situations whenever possible
- Carry only minimal money, prescription medication and required identification into community settings.

Monitoring

When employees are exposed to a significant hazard, and when an employer can only minimise the hazard, the employer must monitor the employees' exposure to the significant hazard and, with the employee's informed consent, the health of the employee in relation to the hazard. This includes the physical and mental aspect of any actual or threatened violence.

Such apprehension, ("near misses") should be reported, investigated and managed rather than waiting for the "big event" to occur.

A system to report violence and/or its effects and a system to ask staff from time to time about their perceptions of the potential for violence (using a paper questionnaire, for example) would be a useful way of fulfilling these legal and best practice obligations.

Under-reporting of incidents is a particular problem with occupational aggression/violence. Reporting an incident does not reflect on the individual caregiver's treatment standards, but it is important to help identify and manage such situations. A positive culture to encourage reporting is therefore required.

Maintain an up-to-date and accurate incident/accident reporting system. Ensure that such reports are considered in the development of care plans, and are communicated to involve staff.

Investigate all incidents of violence and, where appropriate, make changes to practice. Such changes may include:

- Regular training programmes and retraining of the staff member
- Reassessment of the risk status of that client or patient
- Changes to the relevant care plans, including clinical reassessment
- Changes to the management measures for that unit
- Rotation of staff in certain areas
- Complaints being laid with the Police and the Police laying charges
- Procedural steps regarding the right to refuse to carry out work likely to cause serious harm
- A long-term plan to address facility needs, e.g. funding.

9. DEALING WITH INJURED OR ASSAULTED CAREGIVERS

Caregiver Reports

When a caregiver reports being assaulted and/or injured in the course of his or her work, the employer should assess the injury, provide first aid treatment if required, and facilitate any short- or long-term medical treatment that is necessary.

First Aid and Subsequent Medical Care

Provision for first aid should be made.

In addition:

- provision needs to be made for employees to be able to summon help quickly
- plans/arrangements may be necessary with local medical care facilities for urgent consultations in cases of injuries.
- A treatment plan or provider network should be established in advance, not only to deal withy any physical injuries but also to provide a treatment plan for any psychological or mental health issues that might arise from a workplace incident.

Rehabilitation

Best practice rehabilitation policies, procedures and responsibilities include:

- early intervention
- a strong management commitment to rehabilitation including the provision of safe modified duties during the recovery phase.
- appropriate (insurance and work fitness) certification by the treating doctors
- consideration of training and vocational needs
- the early development of rehabilitation plans in face-to-face interviews with the injured employee
- a supportive and consultative workplace culture for injured employees, including the provision and support for modified work and reduced hours of work in the short term
- the feedback into hazard management of issues arising out of the rehabilitation process
- return to work in a safe environment.

Supporting People who have been Injured or Assaulted

Employers have a duty of care towards employees to ensure that they are not harmed in any way by work activity. If violent incidents occur the effects should be minimised.

Long-term affects may include reduced morale, impaired performance, absenteeism, increased sick leave and the psychological trauma suffered by the people involved in the incident. The employer should have:

- documented procedures for prevention and early intervention strategies, as soon as an assault or the potential for an assault is identified
- procedures in place to be followed for an effective immediate response that controls and diffuses the situation
- access to a debriefing session if required (providers need to be aware of the deleterious effect on the individual of "traumatic incident debriefing" regimes - http://www.nice.org.uk/nicemedia/pdf/CG026fullguideline.pdf
- a rehabilitation assessment that considers:
    - time frames for interventions
    - the responsibilities of those involved
    - the methods for assessing needs
- A process to ensure that referrals are made to the relevant service providers for the appropriate treatment.

Dealing with Injured or Assaulted Employees

- When a caregiver reports being assaulted and/or injured in the course of his or her work, provide first aid treatment if required, and facilitate any short or long-term medical treatment that is necessary
- Make provision for employees to be able to summon help quickly
- Allocate a safe place to retreat to
- Control media access to those involved
- Provide communication with families and arrange transport home
- Make arrangements, if necessary, with local medical care facilities for urgent consultations in cases of injuries
- Be aware of different people's reaction to a stressful situation. These may include: feelings of anger, frustration, anxiety, guilt, embarrassment and of being "out of control". They may respond inappropriately and have physical symptoms such as vomiting. Longer term, they may suffer with sleeplessness, "reliving the event", and a fear of returning to work. These reactions should be recognised and managed quickly after the episode to reduce the risk of psychological harm
- Have best practice rehabilitation and support policies and procedures in place for employees who have been assaulted or injured
- Liaise with the insurer or ACC regarding medical treatment and any other entitlements, for example, earnings-related compensation or rehabilitation support
- Consider referral to employee assistance programmes to provide psychological first aid support.

10. MONITORING AND FOLLOW-UP POLICIES

A comprehensive set of policies should be available to ensure that the process for managing violence is clear to all staff.

Adequate monitoring and evaluation systems should be in place to ensure that policies remain appropriate and actually prevent violence and aggression in the workplace by identifying new hazards and updating management (control) options.

In determining the frequency of the monitoring and review processes, consider such things as:

- the level of risk (see the Risk Table in Appendix 2)
- the type of work involved
- whether the work environment has changed.

Such monitoring must be followed by meaningful analysis and appropriate investigation recognising the chronic under-reporting of these incidents evident internationally.

Monitoring and Follow-Up Policies

- set up adequate monitoring systems that will record not only incidents and assaults but also 'near-misses' and events which indicate a review of the management system may be necessary
- undertake meaningful analysis and appropriate investigation of all such incidents and events
- have a policy on when complaints should be laid with the Police, which is agreed with local Police.

It is useful to break the management of workplace violence into three phases, using a 'before, during and after' approach.

Before

Planning and Implementation. Plan to eliminate or reduce the impact of workplace violence.

During

Immediate response. Follow the plans and procedures that are in place.

After

Recovery and review. Return things to normal as soon as possible. Provide support to minimise the impact of the incident. Review incident to identify areas in need of improvement.

APPENDIX 1: ORGANISATIONAL SELF-ASSESSMENT OF THE PREVENTION AND MANAGEMENT OF VIOLENCE IN A HEALTHCARE SETTING

What: This self assessment is a 'gap analysis' across 12 factors, that can be used to identify the practicable steps that could be taken to prevent violence to employees in healthcare settings.

Who: It should be completed by the workplace health and safety committee and health and safety representatives.

When: It can be used to (a) identify gaps, thus leading to an action plan, and (b) compare situations before and after interventions.

How: Discussion between the workplace health and safety committee and management of the need for action and the practicable steps to be taken is seen as a sensible and inclusive way of reaching agreement.

Action plan: The selection of the actual steps that will be taken in the particular setting will be determined by the concept of 'all practicable steps' — the ones that are 'reasonably practicable in the circumstances and are proportionate to known and avoidable risks'.

1. Name of organisation

.....

2. Assessors

.....

Date ..... / ..... / .....

Summary of Results

3. Important recommendations stemming from this assessment may be summarised here.

.....
.....
.....
.....

Client Information

4. For each patient, is there a care plan that includes:

a) State of mental and physical health – including the diagnosis
☐ Yes ☐ No

b) Known tendencies to challenging or violent behaviour
☐ Yes ☐ No

c) Effective calming techniques that work with the person
☐ Yes ☐ No

d) Early warning signs for the person — for both violence and return to calm
☐ Yes ☐ No

e) The strength and size of the person
☐ Yes ☐ No

f) The person's mobility level
☐ Yes ☐ No

g) Any handling aids required
☐ Yes ☐ No

h) Presence of infectious diseases
☐ Yes ☐ No

i) The person's social situation — contact with/ influence of family/ relatives/ friends

☐ Yes ☐ No

j) Healthcare needs — including, for example, medical conditions that predispose to confusion (and possible consequential violence) such as oxygen deficiency.

☐ Yes ☐ No

5. Have the patient's/client's relatives been asked about any triggers for violence (and its reverse) that are individual to the patient/client?

☐ Yes ☐ No

6. Is each patient/client care plan updated as circumstances/conditions change — e.g. after an incident investigation?

☐ Yes ☐ No

7a. Are caregivers given enough information on changes to care plans as they occur?

☐ Yes ☐ No

7b. Are changes to care plans communicated to staff on shift changeover?

☐ Yes ☐ No

8. Is there a system for identifying and documenting hazards that may be associated with violence in the patient's/client's place of residence, education and/or care? (For example, items that may be used as weapons.)

☐ Yes ☐ No

9. Are these hazards and the required controls notified to caregivers and /or support people before they start work with the patient/client?

☐ Yes ☐ No

9a. Are hazard controls put in place before the support person or caregiver begins work with the patient/ client?

☐ Yes ☐ No

9b. Is the effectiveness of the control assessed from time-to-time?

☐ Yes ☐ No

10. Does the employer have access to the patient's/ client's GP when necessary?

☐ Yes ☐ No

11. These questions are about steps the employer has taken to identify the risk to employees **and must be answered before the support person or caregiver begins work in the patient's/ client's home.**

a) Do referral agencies provide an accurate profile with the referral?

☐ Yes ☐ No

b) Does the employer refuse to accept new patients/clients until full information is supplied?

☐ Yes ☐ No

c) Does the employer accept only those patients/ clients whose needs are within the ability of the organisation to meet?

☐ Yes ☐ No

d) Has the employer decided on the conditions where services might be withdrawn?

☐ Yes ☐ No

e) After a decision is taken to withdraw services, are employees, supervisors and management clearly aware of their responsibilities to the patient/ client?

☐ Yes ☐ No

f) Have the referral agencies been told of the conditions when services might be withdrawn?

☐ Yes ☐ No

g) Is there a means to meet with the patient's/ client's family, friends or representatives to discuss and negotiate realistic levels of service?

☐ Yes ☐ No

h) Have caregivers been instructed on:

i) When they might reasonably refuse work they perceive as dangerous?

☐ Yes ☐ No

ii) The sequence of events that should follow if they make the decision?

☐ Yes ☐ No

Job Design

12. Are the following elements of healthy work present?

a) Tasks are clearly defined

☐ Yes ☐ No

b) Tasks are assigned to people who have the skills to do them

☐ Yes ☐ No

c) There is a variety of tasks

☐ Yes ☐ No

d) There is good communication in the workplace

☐ Yes ☐ No

e) There are appropriate rewards

☐ Yes ☐ No

f) The workplace is supportive — for example through a team climate and buddying

☐ Yes ☐ No

g) Staff are rotated around unpleasant or dangerous tasks/jobs

☐ Yes ☐ No

h) Feedback on performance is provided

☐ Yes ☐ No

Comments

.....
.....
.....
.....
.....
.....
.....

Facility Design

13. Are the following features of safe facility design present?

a) The lighting is adequate

☐ Yes ☐ No

b) There is enough space per person — to avoid crowding and possible interference with 'personal space'

☐ Yes ☐ No

c) Noise is reduced to a minimum

☐ Yes ☐ No

Security Arrangements

14. Are the following security arrangements in place, where appropriate:

a) Areas of special risk are labelled

☐ Yes ☐ No

b) Restricted areas are labelled

☐ Yes ☐ No

c) Areas where assaults may occur are visible through windows
☐ Yes ☐ No

d) Emergency exits are provided
☐ Yes ☐ No

e) Easy egress is available from areas where violence may occur
☐ Yes ☐ No

f) Cameras and good lighting in hallways where appropriate
☐ Yes ☐ No

g) Emergency signalling, alarm and/or monitoring systems are installed and tested regularly
☐ Yes ☐ No

h) Ability to summon help promptly — e.g. by using personal alarms
☐ Yes ☐ No

i) Weapons — and items that can be used as weapons — are removed where necessary
☐ Yes ☐ No

j) Prompt emergency response.
☐ Yes ☐ No

Best Practice Selection and Pre-employment

15. Best practice selection techniques are in use.
☐ Yes ☐ No

16. Is pre-employment screening for MRSA, hepatitis A and B and influenza offered?
☐ Yes ☐ No

Note: These measures are valid pre-employment, but cannot be required post-employment.

17. Is information from the employee's pre- employment screening (including skill level) and the patient/client profile considered when assigning staff to clients?

Comments .
.....
.....
.....
.....
.....

Enough Staff to Work Safely

18. Are the following aspects of work allocation present?

a) Adequate procedures to assess the number of staff required
☐ Yes ☐ No

b) Adequate staff numbers
☐ Yes ☐ No

c) Adequate cover available for staff who are suddenly not able to attend work
☐ Yes ☐ No

d) Adequate rest periods
☐ Yes ☐ No

e) Shift work arrangements are safe
☐ Yes ☐ No

f) Night workers can summon emergency assistance promptly
☐ Yes ☐ No

g) Hours worked are not excessive
☐ Yes ☐ No

h) Ability to request extra help when early warning signs of violence are evident.
☐ Yes ☐ No

Comments

.....
.....
.....
.....
.....

Employee Monitoring

19. Does the employer have a system for monitoring the personal health of employees in relation to the hazards of:

    a) Violent behaviour by patients/clients
    ☐ Yes ☐ No

    b) Patient-handling injuries
    ☐ Yes ☐ No

    c) Infectious diseases
    ☐ Yes ☐ No

Describe the monitoring methods used

.....
.....
.....
.....
.....
.....

Education, Training and Supervision

20. Is information and training given about the following topics?

    a) The nature and use of patient/client profiles
    ☐ Yes ☐ No

    b) Recognition of the precursors and triggers of both violence and calm and appropriate responses to same
    ☐ Yes ☐ No

    c) Appropriate verbal and physical responses — given the different conditions patients and clients may have (for example, autism, schizophrenia)
    ☐ Yes ☐ No

    d) Calming techniques to minimise the risk of violence from patients/clients
    ☐ Yes ☐ No

    e) Dealing with pressure/bullying from relatives of clients/patients
    ☐ Yes ☐ No

    f) Emergency response procedures (e.g. after an episode of violence)
    ☐ Yes ☐ No

    g) Hazard identification — for identifying hazards in the client's home and behaviour
    ☐ Yes ☐ No

    h) Use of personal protective equipment
    ☐ Yes ☐ No

    i) Infection control
    ☐ Yes ☐ No

    j) First aid/reporting procedures after injury
    ☐ Yes ☐ No

21. Is expert training or advice for difficult or unusual cases available?
    ☐ Yes ☐ No

22. Is both induction training and refresher training given?
    ☐ Yes ☐ No

23. Are individual training records kept?
    ☐ Yes ☐ No

24. Is there adequate supervision* of employees on the job?
    ☐ Yes ☐ No

***Note**: supervision ensures the ability of staff to put the intent of training into

practice accurately and consistently. In the safety context this means:

(a) The use of the correct techniques to do the work and
(b) The ability to use the appropriate control measure for the hazards.

25. General comment on training:
.....
.....
.....
.....
.....

Relationships

26. Referral agencies have a good knowledge of the ability of the organisation.
☐ Yes ☐ No

27. There are discussions and negotiations with stakeholders over the levels of service that can be expected/provided with the available resources.
☐ Yes ☐ No

28. Good relations exist with neighbours.
☐ Yes ☐ No

Employee Participation

a) Employees have the opportunity to participate in hazard management
☐ Yes ☐ No

b) The process for documenting hazards and raising issues is well communicated and accessible to employees
☐ Yes ☐ No

Employee Responsibilities

29. Staff recognise their responsibilities to other staff and management.
☐ Yes ☐ No

a) Staff co-operate with the employer and provide constructive feedback in matters of health and safety
☐ Yes ☐ No

b) Attend training and implement the health and safety objectives of the training as far as is possible
☐ Yes ☐ No

c) Report hazards and incidents (including stress and fatigue)
☐ Yes ☐ No

d) Take part in incident investigations
☐ Yes ☐ No

Injury Management

30. Does the hazard identification procedure provide comprehensive coverage of infectious hazards from violence, including specific infectious risks (e.g. dog bites, hepatitis B and C, tuberculosis?)
☐ Yes ☐ No

31. Are procedures for the following situations prepared and in use?

a) Prompt help from trained people is available in an emergency alarm response
☐ Yes ☐ No

b) Adequate provisions for first aid
☐ Yes ☐ No

c) Transport for injured employees to a suitable treatment facility
☐ Yes ☐ No

33. General comment on the emergency response preparedness of the organisation.
.....
.....
.....

.....
.....
.....
.....
.....

Injury Causation Investigation

34. Is there a functional accident and incident reporting and investigation system?
☐ Yes ☐ No

35. Are steps taken to modify:
a) patient/client violent behaviour?
☐ Yes ☐ No

b) staff behaviour if provocation was indicated?
☐ Yes ☐ No

Miscellaneous

36. General comments
.....
.....
.....
.....
.....
.....
.....
.....
.....

Summary

37. Does this gap analysis indicate the need for action in any of the key topics below? Keep in mind that one 'yes' tick in each category does not necessarily indicate a 'need for action'. You will have to use your judgement as to the significance of the gap identified for each section and the bearing it has on the need to take all practicable steps.

Client/Patient information
☐ Yes ☐ No

Job design
☐ Yes ☐ No

Facility design
☐ Yes ☐ No

Security arrangements
☐ Yes ☐ No

Selection and pre-employment
☐ Yes ☐ No

Enough staff to work safely
☐ Yes ☐ No

Employee monitoring
☐ Yes ☐ No

Education, training and supervision
☐ Yes ☐ No

Relationships
☐ Yes ☐ No

Employee responsibilities
☐ Yes ☐ No

Injury management
☐ Yes ☐ No

Injury causation investigation
☐ Yes ☐ No

Table 2 is a summary sheet for the Organisational Self-Assessment on the Prevention and Management of Violence. Use this sheet to note what is required for items that have been rated poorly in the assessment.

Table 2: Organisational Self-Assessment Summary Sheet

Factor	Practicable Steps	Likely Impact	Plan for Actioning Steps	Who will Action	Deadline
Client/patient information		**H** **M** **L**			
Job design		**H** **M** **L**			
Facility design		**H** **M** **L**			
Security arrangements		**H** **M** **L**			
Best practice selection and pre-employment procedures		**H** **M** **L**			
Enough staff to work safely		**H** **M** **L**			
Employee monitoring		**H** **M** **L**			

Factor	Practicable Steps	Likely Impact	Plan for Actioning Steps	Who will Action	Deadline
Education, training and supervision		**H** **M** **L**			
Relationships		**H** **M** **L**			
Employee responsibilities		**H** **M** **L**			
Injury management		**H** **M** **L**			
Injury investigation		**H** **M** **L**			

APPENDIX 2: RISK ASSESSMENT OF WORKPLACE VIOLENCE

Risk Consequence Score - Step 1

Table 3 lists suggestions for a range of potential consequences for a specific descriptor relating to the outcome of workplace violence. This forms step 1 of the Risk Consequence score process.

Table 3: Step 1 of the Risk Consequence Score

Descriptor	1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
Injury	No injuries	First aid treatment	Medical treatment	Extensive injuries (hospitalisation)	Death
Human resources/ organisational development	Short term low staffing level temporarily reduces service (<1 day)	Ongoing low staffing level reduces service quality	Minor error due to insufficient training. Ongoing unsafe staffing level	Uncertain delivery of key objective due to lack of staff. Serious error due to insufficient training	Non-delivery of key objective due to lack of staff. Loss of key staff. High turnover. Critical errors due to training
Adverse publicity/ reputation	Rumours	Local media - short term	Local media - long term	National media < 3 days	National media > 3 days. Government interest.

Risk Likelihood Score - Step 2

1	Rare	only occurs in exceptional circumstances, <1%, 1-5 year strategic risk
2	Unlikely	could occur at some time, 1-5%, at least annually
3	Possible	should occur at some time, 6-20%, at least monthly
4	Likely	will probably occur, 21-50%, at least weekly
5	Almost certain	expected to occur, > 50%, at least daily

Risk Rating - Step 3

- Insert Likelihood and Consequence scores on your Hazard/Risk assessment (see Appendix 4) and consult the Risk Matrix to determine actions required.
- If a risk falls in one of the boxes numbered 15-25, immediate action is required, taking all practicable steps.
- If a risk falls in one of the boxes numbered 8-14, prompt action is required, taking all practicable steps.
- If a risk falls in one of the boxes numbered 4-6, risk reduction is required, taking all practicable steps.
- If a risk falls in one of the boxes numbered 1-3, further risk reduction may not be feasible or cost effective.

Risk Matrix - Apply Steps 1, 2 and 3 to the matrix to ascertain level of risk

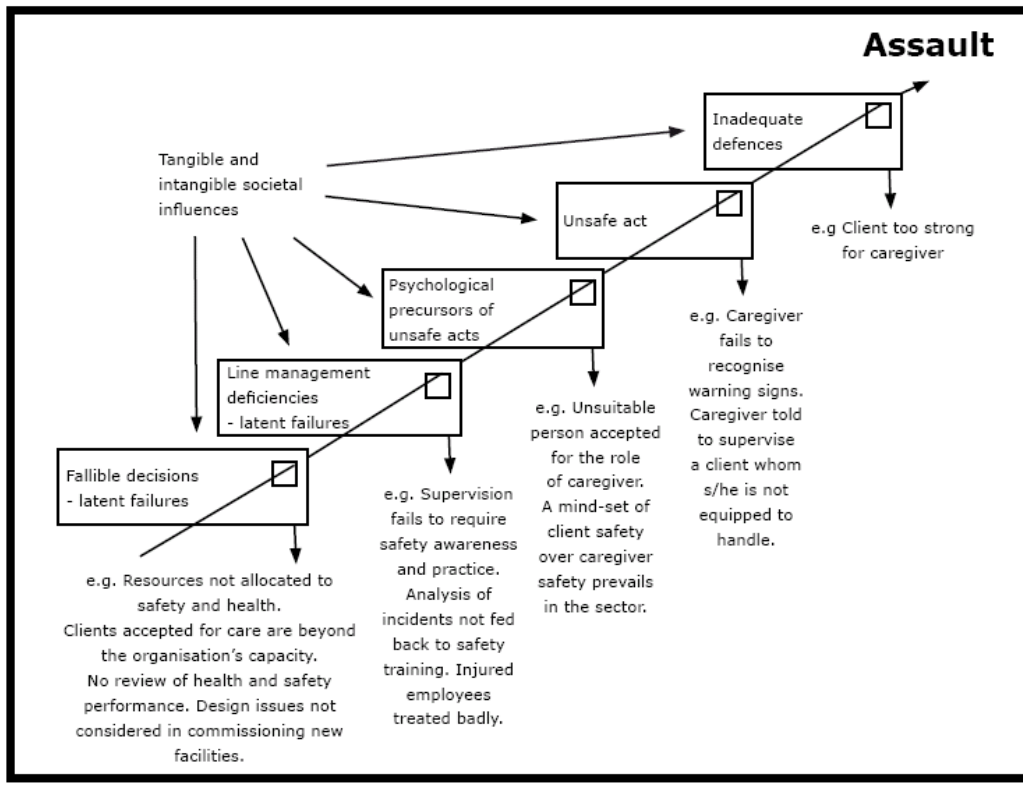
Table 4 combines the results of steps 1, 2 and 3 by applying the risk matrix for each identified hazard. A high score indicates that prompt or immediate action is recommended to effectively reduce the potential for negative outcomes of violence.

	Consequence				
Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1. Rare	1	2	3	4	5
2. Unlikely	2	4	6	8	10
3. Possible	3	6	9	12	15
4. Likely	4	8	12	16	20
5. Almost certain	5	10	15	20	25

APPENDIX 3: SUMMARY OF CAUSATIVE FACTORS

Figure 1, which is derived from *Reason's* work on accident causation, shows a general model of potential organisational defences, adapted for client/patient violence. The model illustrates that actions at both higher organisational and individual levels are needed to prevent violence. (Note: the diagram (a) may be misleading for the reasons noted below and (b) does not mention processes that should occur after an assault or that relate to wider societal issues.)

Figure 1: Model of Potential Organisational Defences



Note: The structure of this diagram casts a false inevitability over the situation - in that a straight line is used to describe the trajectory of an event (that results in an assault). Of course, many 'windows of opportunity' exist in each of the 5 panes, through which many different straight and curved arrows could pass.

The straight line therefore represents only one of many possible ways in which things could chain together to result in an assault.

This point may seem academic. However, when an assault has occurred people who look for a chain of causation may find a straight line and view it, with the 'benefit' of hindsight (and therefore probably falsely), as either inevitable or the only possible one that could represent the series of events.

And, again of course, there is no reason why one straight line should be used to represent the series of events - which could be likened to a web as much as a chain.

APPENDIX 4: WORKPLACE VIOLENCE - RISK ASSESSMENT FORM AND SAMPLES

Section 1: Context Description — setting the scene

Location	**Division**
Area/Activity/Person:	

Section 2: Identifying Hazards — what can go wrong and who will be affected

Hazard	**Something with the potential to cause harm**	**Persons at risk [√]**
A		**S [ ] V [ ] P [ ] O [ ]**
B		**S [ ] V [ ] P [ ] O [ ]**
C		**S [ ] V [ ] P [ ] O [ ]**
D		**S [ ] V [ ] P [ ] O [ ]**

S = staff; V = Visitor, P = Patient; O = Other

Section 3: Existing Control Measures —what practical steps are already in place

Hazard	**Existing Control Measures**
A	
B	
C	
D	

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	**Consequence (1 – 5)**	**X**	**Likelihood (1 – 5)**	**=**	**Risk Rating (1 – 25)**
				=	
				=	
				=	
				=	

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	**E /I/ M**	**Practicable Steps required to further control risk**	**Responsibility**

Section 6: Further Information: cross-sector safety responsibilities

Who is responsible for local monitoring?
Is further competent (clinical risk, manual handling) advice required? ☐ Yes ☐ No Comments:
Do third parties (agencies) require a copy of this risk assessment for their safety? ☐ Yes ☐ No Comments

Section 7: Assessment Sign-Off – assessment monitoring responsibilities

Assessor's name:
Date of assessment: ___ / ___ / ___
Assessor's signature:
Review: (tick one) daily ☐ weekly ☐ monthly ☐ yearly ☐
Reassessment date: ___ / ___ / ___
Manager's signature

Example 1: Care of the Elderly Unit

Section 1: Context Description — setting the scene

Location: Hillside General Hospital	**Division:** Care of the Elderly Unit
Area/Activity/Person: Mr Patient is currently in Bay 2 and is experiencing increasing terms of confusion and shortness of breath. During these occasions, Mr Patient has shown a strong desire to leave the ward, attacking staff who try and direct him to stay. Note – Mr Patient was a regular smoker prior to admission. Mr Patient wears a hearing aid in each ear as a calming measure, however, he is **unable to hear or lip read**.	

Section 2: Identifying Hazards — what can go wrong and who will be affected

Hazard	Something with the potential to cause harm	Persons at risk [√] S=staff, V=visitor, P=patient, O=other
A	Communication difficulties, leading to frustration; due to hearing deficit and his inability to lip read.	S[ ] V[ ] P[√] O[ ]
B	Absconding from the unit – possibly through lack of comprehension of the treatment being given.	S[ ] V[ ] P[√] O[ ]
C	Acute aggression towards staff who attempt to prevent patient leaving the ward.	S[v] V[ ] P[ ] O[ ]
D	Nicotine withdrawal resulting in adverse effects to the patient's stability and aggressive tendencies to staff.	S[v] V[ ] P[P] O[ ]

Section 3: Existing Control Measures — what practical steps are already in place

Hazard	Existing control measures
All	No control measures have been introduced at this time

Section 4: Evaluating Risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1 – 5)	X	Likelihood (1 – 5)	=	Risk Rating (1 – 25)
A	2	**X**	4	**=**	8
B	3	**X**	2	**=**	6
C	2	**X**	2	**=**	4
D	2	**X**	3	**=**	6

Section 5: Risk Prioritised Action Plan - applying the hierarchy of controls: =eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A+ B	**M**	As Mr Patient can read and write the most appropriate form of communication is through the use of note-pad and pen. *Oral communication should not be used as this aggravates Mr Patient.*	Ward matron
A+B	**M**	Attending employees including doctors, porters, nurses, x-ray staff need to be aware of Mr Patient's specific communication needs. On leaving the ward a pad and pen must accompany Mr Patient.	Ward matron
A+B+C	**I**	Do not prevent Mr Patient leaving the ward. Ensure at least one employee accompanies Mr Patient, bringing with them his pad and pen to ensure effective communications	All ward staff made aware at handover.
B	**M**	Consult with Mr Patient's wife to ascertain specific triggers for his aggression and suggested controls that can be implemented – ensure the findings are used to inform the review of this assessment	Division manager and ward matron.
D	**E**	The hospital ward is a 'no smoking' area. The use of nicotine patches during Mr Patient's inpatient stay should be communicated with him and trialled with his agreement. Remember to change the patches as per manufacturer's instructions.	Mr Patient's doctor.

Section 6: Further Information: cross-sector safety responsibilities

Who is responsible for local monitoring?: Ward matron
Is further competent (clinical risk, manual handling) advice required? ☐ Yes ☐ No Comments: Rehab team
Do third parties (agencies) require a copy of this risk assessment for their safety? ☐ Yes ☐ No Comments: When attending other internal departments.

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: Mrs Ward assessor
Date of assessment: 10 September 2005
Assessor's signature
Review: (tick one) daily weekly monthly yearly
Reassessment date: 11 October 2005
Manager's signature:

Example 2: Maternity Services

Section 1: Context description — setting the scene

Location: : Labour ward	**Division:** Maternity Services
Area/Activity/Person: Mr A Husband (also known under the alias Mr B Husband) previous partner of Mrs Patient (hospital number 03271) has threatened to 'snatch' her newborn child. Mr A Husband has previously assaulted Mrs Patient causing her to 'flee' to her parents' home accompanied by her other two children. Mr A Husband currently has a court injunction served on him ordering that he does not come within 200m of Mrs Patient. Mr A Husband is currently using Mrs Patient's name to secure accommodation in a nearby area.	

Section 2: Identifying hazards — what can go wrong and who will be affected

Hazard	Something with the potential to cause harm	Persons at risk [√] S=staff, V=visitor, P=patient, O=other
A	Mr A Husband accessing Mrs Patient while she is in labour	S[ ] V[ ] P[√] O[√]
B	Mr A Husband entering the Labour Ward and attempting to take the newborn baby by violent means	S[√] V[√] P[√] O[ ]

Section 3: Existing control measures — what practical steps are already in place

Hazard	**Existing control measures**
A	Planned admission to labour ward to avoid delivery at Mrs Patient's home
A and B	Security cameras & locked doors throughout the labour ward

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1 – 5)	X	Likelihood (1 – 5)	=	Risk Rating (1 – 25)
A	4	**X**	3	**=**	12
B	3	**X**	3	**=**	9

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A, B	**M**	Make copies of photo provided by Mrs Patient to ensure the labour ward staff, including receptionist, can readily identify Mr A Husband.	Ward manager
A, B	**I**	Liaise with hospital security personnel to review current security measures including changing the key codes on the locks accessing the labour ward.	Hospital security.
A	**M**	Video surveillance is in operation, however, the tapes are currently erased after a 48-hr period. Purchase additional tapes to increase capacity and retain data for a seven-day period in support of possible legal action against Mr A Husband.	Reception.
A, B	**I**	On admission to labour ward ensure the central records do not indicate Mrs Patient's name has been assigned to any beds. Local knowledge is all that is required.	Bed bureau
A, B	**I**	Discuss with the local police station this situation to agree a prioritised callout using either the 111 number or a direct dial to the station. On agreement this is to be conveyed with the receptionist who is authorised to call for police assistance and the subsequent removal of Mr Husband when in the proximity of the reception.	All labour ward staff.

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A, B	**I**	NO information pertaining to Mrs Patient is to be given over the phone. This includes confirmation that Mrs Patient is even on the ward. Only Mrs Patient's parents may have access to the ward.	All labour ward staff
B	**M**	Instigate early liaison with other agencies to plan for the safe transfer and continued support of Mrs Patient and child on discharge to her home; Child Protection, Community Services etc.	Community liaison team

Section 6: Further information: cross-sector safety responsibilities

Who is responsible for local monitoring?: Ward manager
Is further competent (clinical risk, manual handling) advice required? **Yes** No Comments: Hospital Security, Local Police
Do third parties (agencies) require a copy of this risk assessment for their safety? **Yes** No Comments: Hospital Security, Local Police.

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: Risk assessor
Date of assessment: 23 August 2005
Assessor's signature
Review: (tick one) daily weekly monthly yearly
Reassessment date: on discharge
Manager's signature:

Example 3: Northend Community Nursing Services

Section 1: Context description — setting the scene

Location: : Community Services	**Division:** Northend Community Nursing Services
Area/Activity/Person: Mr Patient is a self-administering type-2 diabetic. Following an assessment by the diabetes department, Mr Patient has been identified as requiring regular monitoring by a healthcare professional in his own home. Mr Patient is now ready for discharge to Northend Community Nursing Services, however there have been several recorded incidents of inappropriate sexual behaviour from Mr Patient; including stroking, gestures, forced embracing towards female attendees. Mr Patient is fully mobile, communicating both orally and in written form. This risk assessment sets in place those controls necessary to ensure an effective safe discharge to Community Services.	

Section 2: Identifying hazards — what can go wrong and who will be affected

Hazard	Something with the potential to cause harm	Persons at risk [√] S=staff, V=visitor, P=patient, O=other
A	Indecent or sexual advances directed at attending female healthcare professionals and other organisations.	S[√] V[ ] P[ ] O[ ]
B	Periods of high blood sugar levels due to lack of appropriate insulin management	S[√] V[ ] P[√] O[ ]

Section 3: Existing control measures — what practical steps are already in place

Hazard	Existing control measures
A	Refusal by Northend District Nursing Services to accept discharge until all practical steps have been taken to ensure their continued safety when attending the patient. (Short term measure only.)
B and A	A Case management meeting held on 11 November 2005 to gather information and outline the issues – attended by Valley Acute Hospital, Northend District Nursing, Diabetes Department and community liaisons.

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1-5)	X	Likelihood (1–5)	=	Risk Rating (1–25)
A	2	**X**	5	**=**	10
B	2	**X**	4	**=**	8

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A	**M**	Ensure that, prior to discharge, suitable arrangements are in place to attend Mr Patient in pairs. Mobile phones will also need to be provided.	Community nursing manager
A	**I**	Should Mr Patient make further inappropriate advances he is to be informed that continuation will lead to escorted visits to an alternative venue for his insulin monitoring.	All attending to be aware of position..
B	**M**	Ensure that all community nurses managing Mr Patient's insulin dependency are made aware of how his particular insulin pen is used. New nurses to attend Diabetes Department if unsure on Mr Patient's pen model.	Community nursing manager/ Diabetes Department
B + A	**I**	In all cases communication is the key to maintaining a positive environment between the visiting professional and patient. Provided persons entering Mr Patient's home are made aware of the risks and ensure they continue to maintain a strict position of 'zero tolerance' to his sexual behaviour, the continuation of clinical care should not be an obstacle	Bed bureau

Section 6: Further information: cross-sector safety responsibilities

Who is responsible for local monitoring?: ASE manager
Is further competent (clinical risk, manual handling) advice required? **Yes** √ No Comments: ON review
Do third parties (agencies) require a copy of this risk assessment for their safety? **Yes** √ No Comments: Other known agencies whose female staff may be in a position of risk. Ensure you measure the balance between maintaining the confidentiality of the patient and the safety of others

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: Risk assessor
Date of assessment: 11 November 2005
Assessor's signature
Review: (tick one) daily weekly monthly yearly
Reassessment date: 11 April 2006
Manager's signature:

Example 4: Primary Care East

Section 1: Context description — setting the scene

Location: : After Hours Medical Centre	**Division:** Primary Care East
Area/Activity/Person: Assessment of the risk of violence to those employees currently working in the Community Hospital's After Hours Medical Centre (AHMC), focusing on the following elements: • Escape routes • Lone working, and • Response and de-escalation of violence	

Section 2: Identifying hazards — what can go wrong and who will be affected

Hazard	Something with the potential to cause harm	Persons at risk [√] S=staff, V=visitor, P=patient, O=other
A	Vulnerability of receptionist as patients can easily mobilise over the low-level reception counter.	S[√] V[ ] P[ ] O[ ]
B	A single point of access/egress to/from the consulting room. Current room design has resulted in positioning the patient between the consultant and the escape route (*records of previous incidents*)	S[√] V[ ] P[√] O[ ]
C	Incident records indicate that the last person to close the building at 22:00 hrs has been subject to harassment which could lead to future attacks.	S[√] V[ ] P[√] O[ ]
D	Employees are faced with aggressive situations on a weekly basis and find it difficult to identify early signs of aggression through lack of appropriate training (*records of serious harm exist*)	S[√] V[ ] P[√] O[√]

Section 3: Existing control measures — what practical steps are already in place

Hazard	Existing control measures
A, B and D	Staff have been issued with personal attack alarms which can readily be heard throughout the centre. This measure may introduce new risks as responding individuals are not equipped with the skills to de-escalate that violence.
B	Cardiac arrest pull cords are available to summon assistance, however the same limitations to those responding apply.

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1–5)	X	Likelihood (1–5)	=	Risk Rating (1–25)
A	3	**X**	2	**=**	6
B	4	**X**	3	**=**	12
C	2	**X**	4	**=**	8
D	4	**X**	2	**=**	8

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A	**I**	Submit Estates 'New Works' order to retrofit low-level area of reception with a shatterproof clear Perspex barrier. Ensure persons with disabilities are not disadvantaged by providing a suitable gap under the barrier to exchange paperwork.	AHMC manager to submit 'new works' form
B	**M**	Submit Estates 'New Works' form to provide additional outward opening door fitted with a push-bar to the consulting room. Positioning of this second egress route is critical to ensure it easily accessed in an emergency.	AHMC manager to submit 'new works' form
C	**M**	Develop a written 'lock-up'/opening protocol which ensures there are at least two persons when the centre is being closed or opened to avoid lone working.	AHMC manager in consultation with staff
D	**M**	Train all After Hours Medical Centre frontline staff in violence identification, de-escalation and non-injurious break-away skills and techniques.	Hospital manager/ AHMC manager
D	**M**	Ensure the roles and expectations of those employees attending emergency calls for assistance are clearly defined and communicated. This document should include guidance on when to call 111.	AHMC manager in consultation with staff

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
D	**I**	Develop a policy complete with screening mechanism to ensure other agencies/third parties do not introduce known violent patients to the After Hours Medical Centre without providing appropriate escorts/support. Example: Police may bring a member of the public in a drunken state into the centre for sutures. The screening of the patient should identify this and medical staff may insist that the patient remains under escort during treatment.	AHMC manager/ Receptionist Consult with local police station etc.

Section 6: Further information: cross-sector safety responsibilities

Who is responsible for local monitoring?: Hospital manager/After Hours Medical Centre manager
Is further competent (clinical risk, manual handling) advice required? **Yes** √ No Comments: Required for selection of appropriate training programme
Do third parties (agencies) require a copy of this risk assessment for their safety? **Yes** √ No Comments: Other agencies that use the after hours medical centre need a copy of this assessment and policy for the management of hazard D – Employees are faced with aggressive situations on a weekly basis and find it difficult to identify early signs of aggression through lack of appropriate training (*records of serious harm exist*)

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: After hours medical centre representative
Date of assessment: 25 November 2005
Assessor's signature
Review: (tick one) daily weekly monthly yearly
Reassessment date: 26 February 2006
Manager's signature:

Example 5: Mental Health and Social Rehabilitation

Section 1: Context description — setting the scene

Location: : Mental Health Unit	**Division:** Mental Health and Social Rehabilitation

Area/Activity/Person: Mr Citizen (hospital no. 1###12) is an in-patient in the Mental Health Unit awaiting a psychiatric assessment to determine an appropriate rehabilitation plan. During his extensive hospitalisation Mr Citizen has experienced chronic hepatisation and, as a result of contracted meningitis, he has also sustained limited brain injury. This has left Mr Citizen with a decreased ability for cognitive reasoning and a visual impairment. Due to his cognitive difficulties Mr Citizen has the potential to:

- Engage in self-harm
- Spit at attending staff
- Fall (*recorded incidents*)
- Grab and attempt to break others' fingers, and
- Present non-consented verbal and physical violence.

(*Recorded incidents including 17 cases of injury and 6 cases of serious harm to attending employees*)

Section 2: Identifying hazards — what can go wrong and who will be affected

Hazard	**Something with the potential to cause harm**	**Persons at risk [√]** S=staff, V=visitor, P=patient, O=other
A	Physical injury to attending persons; targeting recipient's hands.	S[√] V[ ] P[] O[√]
B	Hepatitis infection from sputum (spit) targeted at employee's face.	S[√] V[ ] P[√] [√]
C	Soft tissue injury resulting from falls and acts of physical aggression directed at inanimate objects	S[ ] V[ ] P[√] O[ ]
D	Inadequate diet due to any of the above factors (weight loss	S[√] V[ ] P[√] O[ ]

Section 3: Existing control measures — what practical steps are already in place

Hazard	Existing control measures
A,	Mental Health unit specific training (non – injurious break away techniques)
C	Sharp or hard objects removed from room including non essential medical devices
C	Ten millimetre high density foam provided beside bed and chair to reduce injury consequence when fall occurs
B + D	There are no controls in place for these hazards

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1 – 5)	X	Likelihood (1 – 5)	=	Risk Rating (1 – 25)
A	3	**X**	2	**=**	6
B	4	**X**	3	**=**	12
C	2	**X**	3	**=**	4
D	2	**X**	4	**=**	8

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
All		Take all steps to prioritise the completion of Mr Citizen's psychiatric review.	AUnit manager
B		Purchase splash protection spectacles for use by persons entering Mr Citizen's room. Ensure these are cleaned between uses.	Unit manager
D		Evaluate effectiveness of diet plan with dieticians and Mrs Citizen.	Unit manager /named nurse

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
A + D	**M**	**Violence triggers** - Mr Citizen will sometimes share personal thoughts (triggers to violence) following care episodes with Mrs Citizen. These have included: • Being confined to a small room • The desire to walk to the toilet regardless of need • Food falling from his plate – ensure plate guards are used • Being given beakers to drink from – give cup to drink from in future and ensure beverage does not pose a scalding hazard. It is therefore essential that communication with Mrs Citizen is an integral part of the review process.	Unit manager /senior in charge at each shift.
		Attending Mr Citizen - When Mr Citizen does become aggressive target areas that should be kept from reach include: hands, wrists and abdomen kicks from his bed. This is often accompanied by spitting during drug administration and blood letting. To manage these risks please implement the following when attending Mr Citizen: • Keep hands out of Mr Citizen's grasp – do not offer your hand to lead him as this is the opportunity seized on to break fingers. • If hands are grasped, withdraw sharply without delay. • On escalation of aggression give Mr Citizen 'space' assuring him of your continued presence. • At all times wear the splash guards provided to protect eyes from sputum – to be purchased.	Unit manager/senior in charge at each shift and all persons at

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
D	**I**	**Third parties** - When any other person outside of the mental health unit attends Mr Citizen they must be informed of the current risk. Examples of third parties include: • Physiotherapists and occupational therapists who may be scheduled to attend Mr Citizen. If unit staff are aware of an increased level of agitation the therapy should be cancelled as it may over stimulate Mr Citizen to a point of physical aggression. • Porters should not be sent in to collect Mr Citizen without being informed of the risks. They must also be advised **not** to engage Mr Citizen in idle discussion as this has been known to trigger his violent episodes.	Senior in charge of each shift
		The next shift - The next shift is always at risk if changes to Mr Citizen's care plan are not highlighted at hand-over. As a quick reference document the whiteboard on Mr Citizen's door should include a current record of: • Mr Citizen's current triggers of violence. • Actions to manage the hazards. • Special risks to Mr Citizen or employees.	Senior in charge of each shift.

Section 6: Further information: cross-sector safety responsibilities

Who is responsible for local monitoring?: Unit manager, senior in charge of shit
Is further competent (clinical risk, manual handling) advice required? **Yes** √ No Comments: Psychiatric review
Do third parties (agencies) require a copy of this risk assessment for their safety? **Yes** √ No Comments: All parties at risk

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: A unit assessor
Date of assessment: 17 July 2005
Assessor's signature
Review: (tick one) daily weekly monthly yearly
Reassessment date: 18 August 2005
Manager's signature:

Example 6: Independent Medical Examination in Private Rooms

Section 1: Context description — setting the scene

Location: : Specialist medical rooms	**Division:** Physician working both in private and within the hospital environment
Area/Activity/Person: Mr MJ is a 33 year old labourer. He was referred for an assessment of his work capacity following an injury. He presented with a variety of symptoms after having apparently fallen on stairs at a work-skills training course. Later the same day he was involved in a fight. Following this fight he reported experiencing pain of his head, left anterior chest, neck, buttocks, left elbow and wrist, bilateral anterior ankle and sole of foot pain. During this assessment he demonstrated those activities he was unable to perform (which included a one-handed push-up and a headstand). He reported that he was unable to work as a traffic controller (road repairs) due to his level of symptoms, but stated that appropriate vocational goals for him included: him working as an actor, a male model, a professional boxer, a bobcat operator or go to university to become a Mechanical Engineer. The physician considered Mr MJ to be physically fit for employment, but had concerns regarding his psychological fitness for employment recommending that he be referred for a psychiatric assessment. His rehabilitation provider provided Mr MJ with a copy of my report. He has a record of previous assaults on medical professionals, this history was unknown to the assessing physician at the time of the assessment.	

Section 2: Identifying hazards — what can go wrong and who will be affected

Hazard	**Something with the potential to cause harm**	**Persons at risk [√]** S=staff, V=visitor, P=patient, O=other
A	Physical injury to attending persons; targeting professionals who disagree with his perceptions	S[√] V[√] P[] O[ ]
B	Mental injury from intimidation to independent physician or their staff	S[√] V[ ] P[ ] O[√]
C	Soft tissue injury to self resulting from falls and acts of physical aggression directed at inanimate objects	S[] V[ ] P[√] O[ ]

Section 3: Existing control measures — what practical steps are already in place

Hazard	**Existing control measures**
A	Preventing the decision to commit violence: The doctor and their staff can reduce the risk by being courteous and professional (particularly in the face of provocation). Create a physical and emotional environment, which is calming and relaxing. This can be achieved through a variety of mediums, including the use of light, colour, music, pot plants and space. Not allowing clients free access to offices and consultation rooms. Maintain an attitude of not being intimidated by threats of violence. With a difficult client, give clear reasons why their demands cannot be met based on sound principles and logic. Make use of a chaperone or witnesses to conversations. Always retain the right to terminate the interview, or offer the client an "out" of the situation. It may be appropriate to re-schedule the assessment for a later time or alternatively advise the client as to the reasons for terminating and explaining the possible implications. Design for safety in private rooms, have a (potential barrier between you and the patient, have an escape route and a mechanism for summoning help. Require referrers to identify individuals with history of assault of intimidation towards professional staff.

Hazard	Existing control measures
B	Induct staff into appropriate responses and actions when confronted with potential violence. Have yourself and staff undertake calming and de-escalating training. Develop a protocol for staff to follow post incident based on the UK NICE recommendations[1]. Have access to appropriate treatment services for yourself or staff as per protocol.
C	Be able to offer independent treatment options to individual, warn provider of potential problems.

Section 4: Evaluating risk — not 'worse case scenario'; takes into account existing controls

Hazard	Consequence (1 – 5)	X	Likelihood (1 – 5)	=	Risk Rating (1 – 25)
A	4	**X**	3	**=**	12
B	4	**X**	3	**=**	12
C	2	**X**	2	**=**	4

Section 5: Risk prioritised action plan - applying the hierarchy of controls:

E=eliminate I=isolate M=minimise

Hazard	E/I/M	Practicable steps required to further control the risk	Responsibility
All	**M**	Identify individuals at risk Ensure environment is equipped to minimise risk and to provide options in the unlikely advent of behaviour deterioration	Specialist or practice manager
B	**M**	Consider such situations when employing staff and if such incidents are a significant hazard avoid employing staff with pre-existing anxiety or depressive disorders. Post incident provide a safe working environment while the staff member adjusts	Specialist or practice manager

[1] http://www.nice.org.uk/nicemedia/pdf/CG026fullguideline.pdf

Section 6: Further information: cross-sector safety responsibilities

Who is responsible for local monitoring?: Practice Manager, booking staff (when accepting individual from referrer)
Is further competent (clinical risk, manual handling) advice required? Yes **No** Comments: Psychiatric review
Do third parties (agencies) require a copy of this risk assessment for their safety? **Yes** √ No Comments: All parties at risk

Section 7: Assessment sign-off – assessment monitoring responsibilities

Assessor's name: Physician
Date of assessment: 17 July 2005
Assessor's signature
Review Policy: (tick one) daily weekly monthly **yearly**
Reassessment date: 18 August 2005
Manager's signature:

APPENDIX 5: VIOLENCE ASSESSMENT

Key Considerations

The following considerations have been included as practical examples of the questions one might ask as part of the Workplace Violence Assessment for those patients who, for a number of reasons, may be unaware of their violent actions.

- Is the client/patient alert, orientated, co-operative and co-ordinated?
- Should the patient be accompanied by a mental health professional? Some clinical settings are not equipped with the skills or facilities to safely manage patients `sectioned' under the Mental Health Act 1992
- What can immediate family/friends tell you about the patient in terms of specific likes and dislikes?
- Communicate with the patient's attending doctor
- Is it appropriate to include a psychiatric review as part of the action plan?
- Attach the risk assessment to accident forms resulting from the patient's continued violence.
- Have all items that can be used as weapons been removed?
- Has the area been assessed for clear escape routes?
- Is there a cumulative effect on the employees from a number of similar violent individuals on the same ward? (i.e. should that unit's potential "load" be reduced?)
- Where there is a potential for significant incidents, ensure you identify all those who may come into contact with the patient and are at risk of injury, documenting those findings on the assessment.

APPENDIX 6: SAMPLE POLICIES ADAPTED FROM THE AUSTIN HOSPITAL (NSW) POLICIES

Admission Guidelines for the Management of Aggressive Patients

Overview

These Guidelines should be read in conjunction with the Aggression Management Policies and Procedures in the Occupational Health and Safety Section, Human Resource Department on the intranet.

The major obligation for the employer under the Occupational Health and Safety Act[2] is to ensure patient, visitor and staff safety by providing a safe work environment. The employer also promotes and fosters a culture where violence and aggression toward patients, visitors or staff is unacceptable.

Scope

Occupational aggression is defined as any incident where a patient, visitor or staff member (including agency and temporary staff) is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.

Aggressive behaviour, causing occupational aggression may include:

- Verbal, physical or psychological abuse (including bullying)
- Threats or other intimidating behaviours (e.g. spitting, gesticulating)
- Intentional physical attack (e.g. hitting, pinching, biting or scratching)
- Threats or attacks with weapons or objects
- Any form of indecent physical contact, including sexual harassment or sexual assault.

Objective

To provide a procedure for the management of patients demonstrating aggressive behaviour on presentation to the Emergency Department and/or requiring a ward admission.

References

Developed by the Occupational Health & Safety Unit in consultation with the Aggression Management Committee. Details of legislation, Codes of Practice and guidelines referred to are listed at the end of the document.

Policy

1. The employer is committed to preventing and managing risks associated with aggression to ensure a safe environment for staff, patients and visitors.

2. No aggressive behaviour or behaviour provoking aggression will be tolerated.

[2] Health and Safety in Employment Act 1992 in New Zealand

3. All managers, staff, patients and visitors must meet their responsibilities towards the prevention and management of aggression.

Process

The employer will attempt to achieve acceptable behaviour through a staged process of behaviour management, except in emergency situation such as a physical assault. Each step of the process should be recorded in the patient's file and in the incident reports. This will ensure that all staff are aware of previous incidents and that further responses are based on evidence.

The process will involve moving through the following steps as required. Each step must be recorded in the patient file and/or incident reports.

1 Verbal requests to the patient/visitor to modify their behaviour;
2 Development of a patient care plan if appropriate;
3 Development of a patient/visitor contract;
4 Not Welcome Notice/Eviction from premises;

The Police may be contacted at any point during this process if it is determined that an external emergency response is required or assistance is necessary in escorting a person from the premises.

The following three references detail the processes for managing aggression and should be referred to. They are:

- Emergency Procedures Manual, Section B6 *Pro-Active Management Strategies: Unacceptable Patient or Visitor Behaviour,* pages 11- 23.
- *Protocol for Early Intervention in Complex/Difficult Cases* (Dec 02).
- *Nursing Standard, Mechanical and Manual Patient Restraint.*

In the circumstances where the safety of staff, patients and/or visitors is at risk, patient or visitor restraint may be exercised to provide a safe environment.

When a patient demonstrates behaviour which is threatening, aggressive or abusive, and a staged process of behaviour management has been unsuccessful, and it is necessary to restrain a patient, "The Standard for Mechanical & Manual Patient Restraint" is implemented.

Where physical or mechanical restraint of a visitor has been required to provide a safe environment, it is necessary to:

- Explain the reasons for the restraint
- Ensure that the person's physical, comfort and emotional needs are observed and monitored whilst being mechanically restrained
- Ensure any adverse effects or complications are detected and acted upon immediately
- Ensure the use of restraint is reviewed and processes, which require attention or modification, are identified
- Request Police attendance.

In all cases, a documented patient care plan incorporating patient, visitor and staff safety considerations should be developed with reference to the team involved with the care of that patient. The plan should be reviewed every 24 hours or more frequently as required. Any changes should be documented on the plan.

Whilst the patient is demonstrating unacceptable behaviour, the initial focus of medical/surgical treatment will be to address potentially life threatening or permanently health threatening conditions, including psychiatric illness. Further treatment will be determined after taking into consideration the patient's competency and ability to exercise cooperation with the treatment required.

Where a competent patient:

- Expresses that they do not wish to participate in further treatment, or
- Refuses to modify non cooperative behaviour to an acceptable standard which allows staff to provide care,

They will be deemed to have self discharged.

Request from the Police OR Mental Assessment Service (MAS) to Bring a Patient Requiring a Psychiatric Assessment to the Emergency Department

Where Police or MAS contact The employer to request an assessment for a person who is acting in a way, which warrants a psychiatric assessment, and they have no other injury or evident illness requiring medical assessment, they shall be referred to the CAT unit for assessment on site (i.e. their residence or other appropriate location) or at a convenient Police Station.

Emergency Department Management of Aggressive Patients

Staff will attempt to achieve acceptable behaviour through a staged process of behaviour management:

- requesting cooperative behaviour
- discussion and counselling
- explaining consequences of non cooperative behaviour with patient care

In emergency situations where a staged process does not work or is impractical to follow and it is necessary to ensure patient, visitor or staff safety, the following procedure is applicable. Note that a verbal request to modify behaviour must be tried in all circumstances.

1. Any patient who is assaulting, or attempting to assault patients, visitors or staff, (unless there is a medical reason for the behaviour) should be manually restrained and then mechanically restrained, (consistent with *Nursing Standard, Mechanical and Manual Patient Restraint*) to facilitate medical assessment. A medical assessment should be performed, including competency status, and then develop a patient care plan

regarding further management. Consideration should be given to administering appropriate medication.

2. Patients who have assaulted or attempted to assault staff or others should be treated with caution, that is:
    - At least 2 staff members should attend the patient at all times
    - When attending these patients maintain an avenue of escape (i.e. do not allow the patient to obstruct the doorway).

3. Notify and consult with ED Director or Deputy as well as NUM regarding the patient's care plan.

4. Where a patient is competent and has committed an assault and the staged process has not worked, place an alert on the patient's medical record and make a note that readmission is to be only on the basis of the patient requiring urgent medical treatment. The CSU Director (or AHSM if out of hours) must be notified to endorse this action and discuss with the relevant Executive Director. If there is agreement that this is the appropriate course of action, the CSU Director or AHSM is responsible for ensuring that the patient is served with a Not Welcome Notice in accordance with the employer's Aggression Management Procedures. They are also responsible for ensuring the patient is informed of this decision.

5. If the Executive Director, CSU Director or AHSM does not endorse this action, the alert must be removed and the documentation in the medical recorded is amended. The CSU Director, in conjunction with other relevant staff, will develop a patient care plan to provide a safe environment, and which will manage either their behaviour or the risks arising form their behaviour to staff, visitors and other patients

6. Should the patient require admission to a ward and/or is being transferred to the Operating Theatre, the Nurse in charge must discuss the patient's behaviour and care plan with the Nurse in charge of the receiving area.

Management of Aggressive Competent Patients Requiring Hospital Admission

1. Patients who exhibit behaviour that is threatening to the physical well being of other patients, visitors or staff should only initially be treated for the presenting life threatening or permanently health threatening condition, including any psychiatric illness. Note that a verbal request to modify behaviour must be tried in all circumstances.

2. Any patient who has assaulted or attempted to assault patients, visitors or staff, (unless there is a medical reason for the behaviour) should be manually restrained and then mechanically restrained, (consistent with *Nursing Standard, Mechanical and Manual Patient Restraint*) to facilitate medical assessment. A medical assessment must be performed, including competency status, and also development of a patient care plan regarding

further management. Consideration should be given to administering appropriate medication.

3. While the patient continues to exhibit behaviour which is, threatening, aggressive and/or abusive they:
   - Should be accommodated in a single room, even if this means that an intra-ward or inter-ward patient transfers are required at the time of admission,
   - Should be admitted to the ward which has their specialty unit. If this cannot occur at the time of admission, the patient should be transferred to the appropriate ward as soon as possible.

4. Where patients cannot be accommodated in the ward allocated for their specialty, they remain the responsibility of that medical/surgical unit and must be reviewed by the medical staff every 24 hours or more frequently as required.

5. As part of the admission process, the Aggression Risk Assessment and Management form must be completed, including the development of a patient care plan.

6. Psychiatric assessments of patients posing a significant risk of aggressive behaviour are considered high priority and require the Psychiatric Registrar to review the patient within 4 hours following admission.

7. If a safe management plan cannot be provided by the unit's registrar, the patient's medical/surgical consultant should be contacted by the NUM/ANUM

8. When assessed as competent, the patient must be requested to modify their behaviour according to the staged process outlined above. It must be explained to the patient that if they remain non-cooperative with aggressive behaviour, they may be deemed non-compliant with their treatment plan and eligible for self-discharge.

9. Where a patient has assaulted a person (staff member or otherwise) and/or has demonstrated aggressive behaviour that has not been modified despite being requested to conform with the staged process, place an alert on their medical record and where a sanction has been implemented, record that readmission is to only be on the basis that the patient requires urgent medical treatment for a life threatening or permanently health threatening condition. The CSU Director or AHSM must be notified to endorse this action and discuss with the relevant Executive Director. If there is agreement that this is the appropriate course of action, the CSU Director or AHSM are responsible for ensuring that the patient is served with a Not Welcome Notice in accordance with the employer's Aggression Management Procedures. They are also responsible for ensuring the patient is informed of this decision.

10. If the Executive Director, CSU Director or AHSM does not endorse this action, the alert must be removed and the documentation in the medical record amended. The CSU Director, in conjunction with other relevant staff, will develop a patient care plan to contain their behaviour which must provide a safe environment.

11. Where a patient discharge becomes problematic because they have no discharge destination and it is considered inappropriate to discharge the patient in these circumstances, referral should be made in the first instance to the CSU Director or AHSM if after hours. The matter may be referred to the Executive Director Acute Operations or Chief Medical Officer if necessary.

Management of Aggressive Non-Competent Patients Requiring Hospital Admission

This section does not cover Patients being treated under the Mental Health Act 1986. Patients being treated under coverage of the Mental Health Act 1986 are to be treated in accordance with the provisions of that Act.

1. The treatment of non competent patients who exhibit behaviour that is threatening to the physical well being of staff should be aimed at containing the patient's aggressive behaviour to other patients, visitors or staff and/or preventing self harm. Any patient who has assaulted or attempted to assault patients, visitors or staff and where there is a continuing unavoidable risk of further assault of patients, visitors or staff, unless the patient is manually restrained, the patient should be manually restrained, to facilitate medical assessment and or relocation. A medical assessment must be performed, including competency status, and also development of a patient care plan regarding further management. Consideration should be given to administering appropriate medication (Guidelines for the Pharmacological Management of Behavioural Disturbance).

2. While the patient continues to exhibit behaviour which is, threatening, aggressive and or abusive they:
   - Should be accommodated in a single room, even if this means that an intra-ward or inter-ward patient transfers are required at the time of admission,
   - Should be admitted to the ward, which has their specialty unit. If this cannot occur at the time of admission, the patient should be transferred to the appropriate ward as soon as possible.

3. Where patients cannot be accommodated in the ward allocated for their specialty, they remain the responsibility of that medical/surgical unit and must be reviewed by the medical staff every 24 hours or more frequently as required.

4. As part of the admission process, an Aggressive Risk Assessment form must be completed, including development of a patient care plan

5. Psychiatric assessments of patients posing a significant risk of aggressive behaviour are considered high priority and require the Psychiatric Registrar to review the patient within 4 hours following admission.

6. If a safe management plan cannot be provided by the unit's registrar, the patient's medical/surgical consultant should be contacted by the NUM/ANUM

7. Where a patient has assaulted a person (staff member or otherwise) and /or has demonstrated aggressive behaviour that has not been modified despite being requested to conform with the staged process, place an alert on their medical record. Where a sanction has been implemented, record that readmission is to be only on the basis of the patient requiring urgent medical treatment for a life threatening or permanently health threatening condition The CSU Director or AHSM should be notified to endorse this action and discuss with the relevant Executive Director. If there is agreement that this is the appropriate course of action, the CSU Director or AHSM are responsible for ensuring the patient is served with a Not Welcome Notice in accordance with the employer's aggression management procedures. They are also responsible for ensuring the patient is informed of this decision.

8. If the CSU Director or AHSM does not endorse this action, the alert must be removed and the documentation in the medical record is amended. The CSU Director, in conjunction with other relevant staff, will develop a patient care plan to contain their behaviour which must provide a safe environment.

9. Where a patient discharge becomes problematic because they have no discharge destination and it is considered inappropriate to discharge the patient in these circumstances, referral should be made in the first instance to the CSU Director or to the AHSM if after hours. The matter may be referred to the Executive Director Acute Operations or Chief Medical Officer if necessary.

References

Legislation

Occupational Health and Safety Act 2001[3].

Information

- Guidelines for the Prevention of Workplace Bullying and Occupational Violence, WorkSafe

[3] Health and Safety in Employment Act 1992 in New Zealand

- The New Zealand 2003 Zero Tolerance (Occupational Violence & Aggression): Policy and Interim Guidelines, Australian Nursing Federation (The New Zealand Branch), 2002
- Framework Guidelines for addressing Workplace Violence in the Health Sector, International Labour Office, World Health Organisation, 2002

Related Employer Policies

- Occupational Health and Safety Policy and Procedures Manual
- Emergency Procedures Manual
- Protocol for Early Intervention in Complex Difficult Cases (Dec 02)
- Home Visit Risk Assessment Policy (April 02)
- Staff Incident Report Form (reviewed Mar 02)
- Support for Staff Injured at Work (May 02)
- Support for Staff who wish to report assaults to Police after being assaulted at Work (August 02)
- Risk Assessment for Patient Admission (Nov 02)
- Terms of Reference, Aggression Management Committee
- Patient & Visitor Aggression Response Protocol (Nov 2002)

Employee Relations

- Bullying (Prevention of in the Workplace): A&RMC Policy No: 75/02
- Discrimination and Harassment Prevention Policy: A&RMC Policy No: 48/00
- Visitor Access (Employee Invited): A&RMC Policy No: 45/02
- Equal Employee Opportunity, A&RMC Policy No: 47/98
- E-mail and intranet Equal Opportunity Policy, A&RMC Policy No: 71/02

Nursing

Mechanical and Manual Restraint No 77/03

Aggression Management Policy and Procedures

Overview

This Aggression Management Policy documents the process for the prevention and management of occupational violence and aggression (referred to as "aggression" throughout this document) at CMDHB Health.

Objectives

- to train staff to in recognising signs of aggression and preventive techniques
- to provide a procedure for the pro-active prevention and management of aggressive incidents
- to support staff following an aggressive incident.

Scope

Occupational 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.

Aggressive Behaviour may include:

- Verbal, physical or psychological abuse (including bullying)
- Threats or other intimidating behaviours (e.g. spitting, gesticulating)
- Intentional physical attack (e.g. hitting, pinching, biting or scratching)
- Threats or attacks with weapons or objects
- Any form of indecent physical contact, including sexual harassment or sexual assault.

At this hospital aggression includes aggressive behaviour that is demonstrated by patients, relatives, visitors, co-workers, supervisors or intruders into the workplace.

The policy applies to all employees (including labour hire/agency staff) and to independent contractors and their employees who carry out work under the control of this organization and all patients/residents and visitors to this hospital's facilities.

The policy also applies to CMDHB employees who are required to provide Home Visit or similar services outside a facility.

References

Developed by the Occupational Health & Safety Unit in consultation with the Aggression Management Committee. Details of legislation, Codes of Practice and guidelines referred to are listed at the end of the document.

Policy

1. The employer is committed to preventing and managing risks associated with aggression to ensure a safe environment for staff, patients/residents and visitors.

2. No aggressive behaviour or behaviour provoking aggression will be tolerated.

3. All managers, staff, patients/residents and visitors must meet their responsibilities towards the prevention and management of aggression.

Procedure

Roles and Responsibilities

a. Senior Management – are responsible for ensuring that appropriate risk controls for the prevention and management of aggression are in place and followed.

b. Department/Unit Managers – are responsible for ensuring that employees are aware of the organisational approach to managing aggression and for encouraging a team approach towards aggression management. Departmental Managers are responsible for incorporating pro active measures in dealing with patients and visitors and developing patient care plans which will reduce the probability of aggressive incidents. Following an aggressive incident Department/Unit Managers are to identify contributing factors and implement preventative action in consultation with the OH&S Unit.

c. Employees – are required to take care of themselves and others in the workplace. They must report all aggression-related incidents on the *Staff and Visitors Incident Report Form* and actively participate in procedures and initiatives aimed at preventing and managing aggression.

d. Patients/residents/visitors – are required to behave in an acceptable manner and to actively participate in relevant procedures and initiatives aimed at preventing and managing aggression.

Hazard Identification and Risk Assessment

a. Patient/resident aggression – on admission, information will be sought on aggressive risk factors. During care, patients' behaviour will be monitored for aggressive tendencies. This information and any resultant risk control actions will be highlighted in the patient care plan.

b. Home visit Risk Identification – Services will not be provided in people's homes or at other venues not on the hospital campus unless a risk assessment has been carried out which indicates that the service provision does not place any person in a position of unacceptable risk. (Home Visit Risk Assessment Policy April 03.)

c. Incident Reporting – all aggressive incidents (either actual or near miss) must be reported in line with the Incident Reporting Policy. (Section A 5.1 OH&S Manual).

d. Incident Investigation – all reports of aggression will be investigated by line managers, in consultation with the health and safety representative, to identify root causes and appropriate action taken to ensure the prevention of a recurrence.

e. Visitor aggression – repeat offenders are identified and flagged with Security and Department Managers. See Emergency Procedures Manual (Section B 6) for *Pro-Active Management Strategies* including *Warning* and *Not-Welcome Notices*.

Risk Control

a. Staged Process for Achieving Acceptable Behaviour

Except in unusual or emergency situations for example physical assaults, The employer will attempt to achieve acceptable behaviour through a staged process of behaviour management. Each step of the process should be recorded in the patient's file and in the incident reports. This will ensure that all staff are aware of previous incidents and that later responses are based on evidence.

The process will include the following steps:

1 Verbal requests to the patient/visitor to modify their behaviour (recorded in the patient file/and /or incident reports).
2 Development of a patient care plan if appropriate.
3 Development of a patient/visitor contract.
4 *Not Welcome Notice*/Eviction from premises.

The Police may be contacted at any point during this process if it is determined that an emergency response is required or assistance is required in escorting a person from the premises.

The following two The employer references detail The employer processes for managing aggression and should be referred to for an expanded explanation of these processes where practicable.

- Emergency Procedures Manual Section B6 *Pro-Active Management Strategies: Unacceptable Patient or Visitor Behaviour,* pages 11- 23.
- *Protocol for Early Intervention in Complex/Difficult Cases* (Dec 02).

b. Training – Baseline *De-escalation and Violence Management training* will be available to managers and staff as appropriate for their potential to exposure and level of responsibilities. The Respond Grey Emergency Response Team members will be offered a second level of specialised Aggression Management Training.

c. Employee Relations – for aggressive incidents involving solely staff members, refer to the Employee Relations Unit and the Policies listed in the References to this document.

Post Incident Management

After the event interventions should be directed to minimise the impact of aggression and to prevent future occurrences. They should be targeted not only at the victim but also at the perpetrator, witnesses and any staff directly or indirectly concerned by an aggressive incident.

They may include, but are not limited to:

- Aggression Action plans including patient care plans
- Debriefing (Section C 5 OH&S Manual)
- Counselling or medical treatment
- Support to staff who wish to report assaults to the Police
- Grievance or disciplinary procedures
- Rehabilitation.

Monitoring and Evaluation

a. Key Performance Indicators – KPIs relating to aggression to be monitored by unit/ department heads and will include (but not be limited to):

i. Staff incidents and WorkCover claims relating to aggression
ii. Respond Grey Codes 1 and 2 statistics
iii Security Aggressive Incident Reports
iii. Debriefing Services provided by ITIM for aggressive incidents.

b. Aggression Management Policy evaluation – review of the Aggression Management Policy by the Aggression Management Committee will occur on a regular basis with appropriate action taken to correct or improve on non-compliance or poor outcomes.

c. Clinical Care Review – when patients repeatedly offend a comprehensive clinical care review should be undertaken.

References

Legislation

Occupational Health and Safety Act 2004.

Information

- Guidelines for the Prevention of Workplace Bullying and Occupational Violence, WorkSafe Victoria 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 Organisation, 2002

Related Policies

- Occupational Health and Safety Policy and Procedures Manual
- Emergency Procedures Manual
- Protocol for Early Intervention in Complex Difficult Cases (Dec 02)

- Home Visit Risk Assessment Policy (April 02)
- Incident Report Form (reviewed Mar 02)
- Support for Staff Injured at Work (May 02)
- Support for Staff who wish to report assaults to Police after being assaulted at Work (August 02)
- Risk Assessment for Patient Admission (Nov 02)
- Terms of Reference, Aggression Management Committee
- Patient & Visitor Aggression Response Protocol (Nov 2002)
- Admission guidelines for the management of aggressive Patients (April 2006)

Employee Relations

- Bullying (Prevention of in the Workplace): Policy No: 75/02
- Discrimination and Harassment Prevention Policy: Policy No: 48/00
- Visitor Access (Employee Invited): Policy No: 45/02
- Equal Employee Opportunity, Policy No: 47/98
- E-mail and intranet Equal Opportunity Policy, Policy No: 71/02

Home Visit Risk Assessment Policy and Procedure

Overview

Outlines measures that will maximise the safety of all employees when conducting home visits and track the return of employees following completion of home visits.

Objectives

To eliminate or reduce as far as practicable the risk to employees who make home visits.

Scope

All staff will observe the Home Visit Risk Assessment Procedure prior to conducting a home visit. These procedures are to be applied within the organisation in so far as is practicable/ Covers all staff who may make home visits.

Reference

Developed by Occupational Health and Safety Unit in consultation with the Aggression Management Committee and Home Visit Working Party.

Policy

The employer has a commitment to provide health care services which are best practice, cost effective and safe for staff. This includes providing services in people's homes or other appropriate locations. The employer has a commitment to the safety of its staff in all work locations including people's homes, other venues not on the hospital campus and safe travel to and from these venues.

The employer's services shall not be provided in people's homes or at other venues not on the hospital campus, unless a risk assessment has been carried out and which indicates that the service provision does not place any person in a position of unacceptable risk.

It is the responsibility of the employer, line managers and supervisors providing the service to ensure that this policy is observed.

It is the responsibility of employees to follow this policy and supporting procedures.

The Occupational Health and Safety Act (2001) states that the Employer must provide a workplace that is safe and without risks to health for employees. The Act also states that an Employee must take reasonable care of his or her own safety.

Procedure

Rationale

Home visits should only be conducted with consent, consistent with policies of CMDHB Health. When organising any home visit staff are expected to assess any potential risks prior to undertaking the home visit. If risks are identified this must be documented in the medical record and discussed with the manager/supervisor of the department.

The managers/supervisors responsible for providing these services will ensure that administrative procedures are in place which:

- Ensure risk assessments are carried out and acted upon
- Track and record the safe return of employees following completion of the home visit
- Ensure appropriate equipment is provided
- Provide an up to date record of the employee and recent photographs
- Establish police notification in the case where safe return of the employee can not be established.
- Ensure staff who provide home visit services are appropriately trained and conversant with these procedures.

Risk Assessment

The assessment of risk should be holistic and include points that may impact upon staff safety. This may include but not be limited to:

- Verification of location
- Access to premises
- Time of visit. This includes the consideration of circumstances after dark, taking into account the increased isolation and subsequent vulnerability that occurs when conducting visits after dark
- Persons present on the home visit
- Presence of potential dangerous animals and pets
- History of violence, aggressive behaviour or domestic violence
- Presence of fire arms
- History of mental illness, medical conditions or substance abuse
- Family conflict
- Cultural needs

The Risk Assessment is conducted by completing the risk assessment form (appendix 1) or by reviewing a previously completed risk assessment form and reassessing the current risks. Where this data is kept will be in keeping with Privacy Legislation.

Risk Management

The home visit will proceed when all identified risks have been addressed.

If the employee assesses a potential risk following completion of the risk assessment form, staff are required to document this in the medical history and

discuss these concerns/risks with their immediate manager/supervisor. If their immediate manager/supervisor is unavailable, contact should be made with another senior staff member.

If any risk is identified, staff should not proceed with the visit. The manager/supervisor are to be advised of the risk assessment and will take appropriate action.

If safety risks/concerns are raised with the manager/supervisor that can not be managed (removed or mitigated) to an acceptable level, then the manager/supervisor will arrange one of the following:

a) a second support worker or security officer to accompany the primary worker
b) cancel the home visit and consider other ways of providing the service.

If the service provision is assessed as an unacceptable safety risk to the employee, this needs to be documented. If the service provision has been discussed with the client, the client should be advised why the service will not be provided. Where a letter has been sent to the client a copy of this letter should also be sent to the Director of the service.

Each department who has staff that conduct home visits should as part of staff orientation collect information that may be used in the event of an emergency. This information will need to be updated annually by managers/supervisors and during the year by employees if changes occur with respect to contact details or they make significant changes to their personal appearance. It includes:

- Employee contact details (including Next Of Kin)
- A clear photograph (both sitting and standing) of employee
- A physical description of the individual (completed by the employee)

Prior to the Home Visit

Managers/supervisors responsible for providing services involving home visits shall establish a record system. Employees involved in providing home visit services are responsible for recording data related to the home visit. This data must include the following:

- Name of visiting staff member(s)
- Name of patient/ client
- UR number
- Address and phone number of destination
- Departure time
- Expected time of return
- Car type and vehicle registration
- Mobile phone number
- Completed Risk Assessment

Only take essential items with you are on a home visit.
This includes (but is not limited to):

- Identification badge
- Licence
- Mobile phone number with pre-programmed 000 emergency phone numbers. Select the emergency number prior to entering an unknown situation, for example, a first visit to an unknown address. If contacting emergency services, always begin by giving the address first and then the complaint/report.
- Confirm that there is mobile phone coverage in the area (ask patient and refer to the risk assessment form). If not is a GSM phone required?
- Torch and batteries
- Personal alarm ("screecher")

Managers are responsible for ensuring all staff undertaking home visits are orientated by taking them through the safety considerations incorporated in the Home Visit Staff Security Orientation Checklist (appendix 2) prior to undertaking any home visits.

Vehicle Guidelines

Prior to conducting any home visit all staff should refer to the "Guidelines whilst Driving" in the Home Visit Staff Security Orientation Checklist (appendix 2).

Prior to departure it is the responsibility of the staff member to ensure that all equipment is functioning and that:

- where mobile phone use is required for business purposes (staff are expected to answer or make calls whilst driving) the vehicle must be equipped for hands free operation
- the mobile phone is charged and turned on.
- that there is a recent Auckland Road Maps available (either country or metro depending on travel details)
- that there is adequate fuel in the car – minimum quarter tank
- petrol card
- the car contains a mobile phone charger, hands free car kit, fire blanket and any other necessary emergency equipment
- Do not leave equipment in full view in the vehicle.

Whilst Conducting the Home Visit

On arrival staff should park the vehicle in an appropriate and safe location. This should be considered in terms of loading/unloading equipment and /or patients, proximity of house to the street and how busy the street is including available parking.

In the evening park in a well lit area.

Upon arrival staff should assess the premises for potential risks. This may include but not be limited to:

- Listen for any conflict that may be occurring at the premises
- Observe the room that you will be located
- Identify potential exits
- Keep car keys on your person
- Staff are responsible for their personal property on a home visit

If at any time during the home visit there is an assessed risk to the staff member, remove yourself from the premises as quickly as possible. Secondarily ensure the safety of the patient if they are also at risk.

Leave and contact manager/supervisor immediately.

If it is not possible to leave immediately, attempt to diffuse the situation and leave at the first available opportunity. If staff are unable to leave the premises then they should attempt to use their mobile phone or landline to contact police.

Staff are not expected to provide a service if the environment is not safe. Staff are able to refuse service delivery in these circumstances.

Upon Return from the Home Visit

Record your return and/or inform appropriate accountable persons as per department procedure.

If any incidents occurred whilst on the home visit, these must be reported to the manager/ supervisor who will initiate the appropriate action required to assist the staff member following any incident/accident.

This includes:

- Access to first aid or medical assistance
- Access to critical incident/accident debriefing and counselling
- Advice regarding WorkCover
- Advice regarding appropriate reporting and direction on completing the incident forms and documenting the incident
- Review the patient risk assessment.

Failure to Return from Home Visit

In order to provide a safe service a management process needs to be in place to track the safe return of staff from home visits. If the staff member does not expect to return by the nominated time, it is the responsibility of the staff member to contact and leave a message with the manager/supervisor of a revised time.

If the staff member is returning after hours, arrangements should be in place to confirm safe return from the home visit. This can be either by contacting a direct manager/supervisor on return to the hospital or leaving a message with the on site manager that you have returned.

If the staff member has not returned and is ½ an hour later than their expected return time the Manager/supervisor or delegate should:

- Contact the staff member on their mobile phone
- If staff member does not answer the phone - Contact the clients listed for home visits to establish if the staff member arrived and/or left and at what time.
- In the event that the staff member is not contactable, notify the police and provide description and relevant details of the staff member. Also contact the Executive via the switchboard.
- Notify the Security Department
- Contact next of kin
- Complete incident form.

Employer Home Visit and Staff Security Risk Assessment Form

Home Visit Rating…… **Date:…….**	**1. Visit to proceed** **2. Conditional service - refer to A. B. C. D. E. F.** **3. Unacceptable risk**

The home visit will not proceed until all identified risks have been addressed, reducing risk to an acceptable level

Date of 1st home visit:	**Melways Ref**				
Patient UR		**D.O.B.**			
Name					
Address No. **Street** **Suburb**	…… …… **Patient's usual address Yes No** **Details:**				
Telephone Home **Work** **Mobile**	**…….** **…….** **……. Mobile Coverage Yes No**				
Nominated Contact person/NOK	**Name_____ Phone no._____**				
Name of staff member completing form.	**Signature**	**Dept**	**Today's Date (form completed)**		

QUESTION	**YES**	**NO**	**ACTION**
Has the occupant consented to the home visit/assessment?			Offer alternative avenue of service

A. ACCOMMODATION – please tick

House	High Rise Complex		Aged Care Facility
Flat / Unit	Floor or Level	…….	Specify …….
	Lift		Residential care Unit
	Stairs		Other …….

B. ACCESS TO PROPERTY

QUESTION	YES	NO	ACTION
Is the house visible from the street? Is it remote? Are there high fences?			Obtain specific directions &/or location
Is the house number visible from the street/road? Day & night?			Temporary sign. Investigate further.
Is there close vehicle access to the house?			Consider risks associated with difficult vehicle access situations
Is there easy and clear 24 hour access to the house via the driveway?			Can someone meet the health care worker at car?
Will the gate be easily opened at the time of the visit?			Make practicable arrangements
Which door is used for entry? Front Side Back			Assess the access for risks
Is the pathway leading to the entry In good condition? Are there slippery steps?			See Manager
Will someone be able to open door?			Specify Other Arrangements
Do we need to negotiate an alarm/lock up system?			Please list instructions

C. LIGHTING

QUESTION	YES	NO	ACTION
Is there operational external lighting? Porch? Driveway?			If yes – inform patient that light MUST be left on in poor light. If no – discuss with Manager re provision of service.

D. OCCUPANTS

QUESTION	YES	NO	ACTION
Is the patient the sole occupant?			List other occupants _____ _____
Are these occupants or visitors likely to come and go during the visit?			If yes – inquire who will be there? _____ _____

QUESTION	YES	NO	ACTION
			_____
Will this impinge on security, delivery or treatment of the patient?			If so, ask to reschedule visit
Are there any firearms in the house?			If so, are they securely locked away?
Is there significant alcohol or drug consumption from a patient/occupant /visitor that home visit staff should be aware of.			If so, please advise -Type: -Quantity: -Time of Day: Advise the patient that if at any stage a home visit staff member feels uncomfortable or threatened, the patient needs to be aware that the home visit service will be withdrawn.
Does the occupant/s have a history of aggressive/offensive behaviour?			If so, see Manager

E. ***ANIMALS***

QUESTION	YES	NO	ACTION
Does the patient have any animals? Type_____			
Can the animal be restrained or isolated during the healthcare worker's visit?			Place elsewhere
Are there any dogs that will bark when staff are entering the property?			
Will the animal be in the front garden?			Place elsewhere
Do we need to phone ahead of time to allow for removal of animals?			

F. ***HISTORY*** ***Please use patient file or other assessments for details.***

Please ask discreet questions only

QUESTION	YES	NO	ACTION
Are there any medical conditions that may impact on the patient's health?			If so, please list

Are there any other aspects that may impose a security risk?

Home Visit Staff Security Orientation Checklist

NB This orientation checklist must be completed in conjunction with the Home Visit Risk Assessment Policy and Procedure.

1. SUPERVISOR/ MANAGER RESPONSIBILITY

Prior to undertaking a home visit, it is essential for the manager/supervisor to establish a file containing:	**Checklist**
Personal contact details of staff member	
Sitting and standing photo of staff member - to be kept in department	
Physical description of staff member	
Contact name and number of Next Of Kin	

2. PRIOR TO STAFF LEAVING THE EMPLOYER FOR HOME VISIT

Collect as much information about the client to assess potential risks	
Contact the client and explain your role and purpose of home visit	
Complete the Home Visits Staff Security Risk Assessment Form If any risks or concerns are identified, discuss with departmental manager. Options include: 1. second staff member or hired security to accompany staff on visit 2. alternative service to be delivered If service is not provided, this needs to be documented and communicated to the client if service provision has been discussed with the client. If a letter has been sent to the client a copy should be sent to the Director of the service	
Explain the number of people that may be attending the home visit with you	
Organise a day and time for the home visit If possible, avoid visits out of working hours	

2.1 On day of visit, record information in your department on:

Name of visiting staff member(s)	
Name of patient / client	
UR number	
Address and phone number of destination	
Departure time	
Expected time of return	
Car type and registration number	
Mobile phone number that staff can be contacted on	
Ring the client if you are likely to be delayed.	

2.2 Take only personal items of identification with you

Identification badge	
Licence	
Mobile phone	
Torch and batteries	
Personal alarm	
Avoid taking a diary that may contain personal information about staff worker or family members	

2.3 Turn on the mobile phone and ensure:

It is fully charged	
Contains pre-programmed emergency numbers, i.e 000	
Identify whether the mobile has reception in the area you are visiting. If not take a GSM phone	

2.4 Ensure the car contains:

Recent street directory (country or metro depending on trip details)	
Mobile phone charger	
Hands-free kit for mobile if determined by the manager to be necessary for business purposes	
Fire blanket	
Adequate petrol /petrol card Fill up when car contains ¼ tank petrol	

3.0 IN-VEHICLE SAFETY

3.1 Before driving the car

Keep car and house keys separate and do not label them with your name or address.	
Be aware of weather and road conditions and have adequate maps	
Have accurate directions to the street, building, and apartment. If the area is unfamiliar to you, check with a colleague for more detailed information. Always know exactly where you are going.	
Always keep in the glove box, a torch, pen, paper and coins for emergency calls.	
When possible, avoid parking in deserted, poorly-lit areas.	
Prior to entering the vehicle check inside for people, especially the rear	
Approach car with keys in hand and disarm alarm when close to the vehicle. If possible, use keyless remote that opens only the front drivers car door rather than opening all doors of the vehicle	
If strangers are around the car, do not approach the vehicle	

3.2 Driving the car:

Once inside, lock all doors and roll up windows to within 3cm of the top	
Be wary of strangers approaching your car while you are stationary. Stay in gear and be prepared to sound the horn or drive away if threatened.	
Be alert at all times for potentially dangerous situations. If asked for help stay in the vehicle and use the mobile phone. When travelling never pick up hitchhikers. If annoyed by another driver, or think you are being followed, keep driving and drive to a place where people are visible, for example, petrol station, shop, or police station. Obtain the registration number and report incident to police as soon as possible.	
Only use the phone when necessary and use the car kit only.	
If the hospital car breaks down or you are involved in an accident, follow the procedure in the glove box. Upon return to the hospital complete an incident form	

3.3 Leaving the car:

Always remove the key from the ignition and lock up. Valuables should be out of sight, as should any papers with your name and address.	
Never hide a spare key in the car.	
Park the car in the street or if you have to assist the client into the home or take equipment, then park the car in the driveway	
In the evening, park the car as close as possible to a well lit area	
Don't get out of the car immediately - take a look around and make mental notes about areas that could present a risk.	

3.4 If Caught in a Bushfire (Australia)

Do not leave the car	
Park in a cleared area	
Ensure windows are up and vents closed, turn air conditioning off	
Cover yourself with a woollen blanket and clothing	
Put the hazard lights and headlights on and keep the engine running	
Crouch below window level	
Wait until fire front passes	
In the event of a bushfire, do not continue to drive into the fire zone, but do a "U" turn to safety if the road conditions permit you to do so	

4.0 WHILST CONDUCTING HOME VISIT

After knocking on the door, stand to one side and not in a position where opening the screen door can trap you.	

4.1 Do not enter the premises if:

No-one answers the door and it is unusual for them not to do so	
The door is left open	
Evidence of a break-in	
There are conflicts/arguments or extraordinary noises coming from the home	
The client does not know who you are and why you are there	
The person answering the door gives any cause for concern, make an excuse and do not go in.	
The client is alcohol or drug impaired. If so, do not enter – terminate the visit and return another time, with security if necessary	

4.2 Upon entering the premises:

Follow the client into the home – never walk ahead of the client	
Choose carefully where you sit – identify potential escape routes. Try to maintain a position closest to exits and escape routes.	
Be alert for items that may pose a risk, such as walking sticks or kitchen knives	
Treat clients courteously- remember you are a guest in their home	
Avoid reacting to home e.g. smells, surroundings, untidiness	
Do not spread belongings around so that if you need to leave quickly, you don't need to collect your belongings	
Contact supervisor/manager if expected delay greater than 30 minutes	

4.3 Remain alert to sudden changes in client's mood. Does the client:

Indicate a heightened level of anxiety or depression?	
Have hostile or aggressive body language?	
Complain about the provision of services?	
Refuse to cooperate?	
Display suicidal tendencies or cries for help?	
Have rapid breathing, clenched fists/teeth, appear restless or talk loudly?	
Swear excessively or use sexually explicit language?	
Disregard organisational policies and procedures?	
Make verbal threats?	

4.4 If the client becomes aggressive, abusive or sexually suggestive:

Stay calm and don't panic	
Leave as quickly as possible – suggest you have something for the client in your car	
If you are unable to remove yourself from the situation, attempt to diffuse the situation	
Prepare to hit the speed dial on the mobile – contact the police	

5. UPON RETUNING TO CMDHB HEALTH

Ensure there is adequate petrol in the car for the next staff member	
Ensure mobile is fully charged	
Sign in and record time of return	
Return car keys and mobile	

5.1 If incident occurs during home visit:

Report incident to manager / supervisor	
Access First Aid or medical assistance if necessary	
Complete Incident Report	
Access to critical incident debriefing and counselling	
Seek advice regarding Workcover	
Notify police if appropriate	

6.0 FAILURE OF STAFF TO RETURN FROM HOME VISIT

If the staff member is half an hour later than their expected return time:

6.1 Department manager / supervisor needs to:

Contact staff member via mobile number	
If staff does not answer the mobile, contact the clients listed for home visits to establish if staff member arrived or time left the premises	
If staff member still not contactable, contact police and provide description and relevant details of missing staff member. Photos and personal description should be made available to police.	
Contact staff Executive via CMDHB switch board	
Notify CMDHB Security department	
Contact staff member's Next Of Kin	
Use *Missing Home Visit Staff Member Action Sheet* (Appendix 3).	
Complete the incident report form.	

Action Sheet: Missing Home Visit Staff Member

To be completed in the event that a Home visit staff member does not return to The employer in accordance with the policies and procedures in place for the outreach area.

Report date:_____ Report time:_____

Missing at or between the following hours_____ on _____

Details of Missing Staff Member

Name:_____ Date of Birth:_____ M / F

Address:_____ Telephone No.: _____

Work Location_____

Description

*Photograph available: Yes / No

Height:_____Build:_____Eyes:_____

Hair:_____ Complexion:_____

Clothing: Colour or Type of

Dress:_____ Skirt:_____

Trousers_____ Cardigan / Jumper:_____

Shirt / Blouse_____ Jewellery_____

Coat / Jacket:_____ Footwear_____

Other distinguishing features_____

Vehicle Details:

Vehicle Type_____ Model_____

Colour _____Registration _____

Mobile Phone Details

Mobile phone: Yes / No Number:_____

Home Visit Location Details

DATE	TIME	DESTINATION	CONFIRMED

Last known destination:_____

Next of Kin Details

Name:_____ Telephone No_____

Relationship to missing staff member:_____

NOK contacted: *Y / N Time:_____

Comments:_____

Site Manager/AHSM

Site Manager / AHSM contacted: *Y / N

Name:_____Time:_____

Comments_____

Police

Police Contacted: *Y / N Time:_____

Officer_____Station_____

Comments:_____

Outcome

Time:_____

Date:_____

Details:_____

Reporting Person

Name:_____ Position:_____

Signed:_____ Date: _____

Protocol for Early Intervention in Complex/Difficult Cases

Overview

Provides guidance for identifying the need for early intervention, the first actions to be taken, and staff roles.

Objectives

To ensure early recognition of complex/difficult patient cases and prompt effective reducing action.

Scope

Protocol covers all patient situations on all campuses.

Reference

Developed by the Aggression Management Committee in consultation with OHS Unit.

Identification of Serious Cases

These cases can be identified by any member of the Support Team in consultation with clinical staff. Triggers for identification of these patients include:

- Repeated incidents of aggressive behaviour eg assaults, threats, abuse
- Numbers of staff incident reports relating to the one patient /visitor/family member
- Lack of cooperation with treatment plans
- Issues with medical power of attorney/guardianship
- Refusal to participate in residential care planning
- A pattern of complaints and/or extensive liaison with Patient Representative
- Threats of medico-legal action

Education and Aggression Management Committee

Education of staff about early intervention and prevention of further escalation is an important step in preventing cases progressing or escalating to Serious Case status.

The Aggression Management Committee is responsible for actioning a medical centre wide approach including involvement of the Psychiatric Liaison Nurse.

First Steps After Identification of Complex/Difficult Patient Case

- Patients and/or their families who present with complex or difficult management issues should be identified as early as possible.
- The Nursing staff should undertake a Risk Assessment and then develop and implement an action plan in consultation with patient and family. This action plan should be discussed with the CSU Manager or their delegate in the first instance.
- If staff or other patients or visitors or families are threatened, OH&S or Security should be contacted immediately.

- The Support Team which is available to assist in the management of difficult and complex cases includes the CSU Manager, Psychiatric Liaison nurse, Social Worker, OH&S Unit, Site Nursing Manager, Patient Representative and Security.
- Staff support can be provided to check that protocols are in place and are working on a regular basis.

Protocol for Managing Serious Cases

- The CSU Manager or delegate identifies a Serious Case and convenes a meeting of representatives as appropriate from OH&S, Patient Representative, Nursing Services, Social Work, Acute Services/Medicolegal, Corporate Counsel, Psychiatric Liaison Nurse, Registrar/Resident/Consultant and NUM from the area.
- The Support Team can provide assistance with reviewing the plan, identifying additional protocols and processes that may be required to obtain adherence to the plan and provision of support to staff. A Case Manager is nominated by this group.
- The Case Manager (usually the CSU Manager/ delegate) is responsible for
    - ensuring the plan is in place and proceeding as agreed.
    - liaising with the Care Team and Support Team, including Corporate counsel.
    - allocating roles /responsibilities to Team members
    - identifying any barriers or additional resources or staff support required to implement the plan
    - ensuring that a communication plan is in place to inform security staff, after hours supervisors and other relevant staff.
    - escalating issues to Director of CSU or Executive Director as appropriate.
- The Case Manager and Registrar involved will liaise with the consultant and convene family meetings as required. This may involve members of the Support Team

Risk Assessment

Area **Process**

Risk Assessment Conducted With Staff and NUM (Name): **Date**

Risk assessment undertaken using Worksafe Victoria, Prevention of Bullying and Violence at Work, February 2003, Risk Assessment Checklist, page 23, Part 2: Preventing Occupational Violence.

Describe task/s or area being assessed

Risk Areas to Assess		No ✓	Yes ✓	If Yes Adequate Controls Y/N	Recommendation
Incident/ Injury records	Have there been any incidents of occupational violence in the past 12 months?				
	Have employees been threatened in the past?				
	Have the recorded incidents of occupational violence resulted in serious injury or impact?				
Work environment	Is work performed in unfamiliar environments?				
	Are employees working in isolated locations?				
	Is it easy for an aggressor to get physical access to an employee?				
	Is it difficult for an employee to retreat to a safe place?				

	Is it difficult for employees to communicate when threatened?				
	Is the environment uncomfortable for clients?				
	Does the physical layout fail to provide privacy for clients?				
	Would it be easy for an aggressor to break into the work place after hours?				
	Is access to alarms difficult or too obvious?				
	Does the building have multiple access points?				
	Is visibility impaired for awareness of potential threats to safety?				
	Is external lighting inadequate?				
Work Practices	Are there likely to be service delays?				
	Are there likely to be circumstances that would frustrate clients?				
	Are staffing numbers **insufficient** at demand times?				
	Do employees have the responsibility for cash or other valuable items?				
	Are employees providing community outreach services?				
	Do employees ever work alone?				

	Would it be difficult for an employee to seek assistance if threatened or attacked?				
	Does the workplace lack security and emergency procedures?				
	Does the work place fail to regularly check and test emergency procedures?				
Employee training	Are there inexperienced employees in front line positions?				
	Are there employees who have not received training in how to deal with aggressive clients?				
	Are there employees who do not have the appropriate knowledge and skills to deal with clients?				
	Are any employees unaware of the policy on occupational violence?				
Client behaviour	Are clients likely to be distressed or aggressive?				
	Is the behaviour of clients unpredictable?				
	Is the aggressor likely to have a weapon?				
	Is there likely to be more than one aggressor?				
	Is the aggressor likely to be under the influence of alcohol or drugs?				
	There is no method to review patient aggression or violence?				

Policy on Support for Staff Injured or Assaulted at Work

Overview

The employer will assist and support staff members who have been injured or assaulted during the course of their employment.

Objective

To ensure staff are provided with appropriate medical assistance, relevant support following assault or injury and defusing/debriefing as required.

Scope

Policy covers all staff at all sites.

Reference

Developed by the OH&S department in Conjunction with the Aggression Management Committee.

Policy

Where a staff member has been injured during the course of their employment, it shall be the responsibility of their manager or of the most senior management representative available to take reasonable steps to ensure the care and welfare of the employee.

If an employees injuries are of such a nature that they do not require urgent medical attention (ambulance or Respond Code Blue), they will be assisted as follows:

- Offered to be accompanied when going to Emergency Department (ED) for assessment of their injury.
- If attention is not provided in ED within one and a half-hours, staff are to be offered the option of going to a Medical Clinic of their choosing. ED will facilitate an off-site appointment if desired.
- If injury assessment is to be undertaken by a Medical Clinic, to be offered transport to the Medical Clinic.
- To be offered to be accompanied in visiting the Medical Clinic.
- To be offered assistance in getting home, if assistance is required.
- To be offered defusing and debriefing.

Where an employee suffers more severe injury requiring the calling for an ambulance or activation of Respond Blue; either their manager or the most senior management representative available, will initiate the most appropriate action. That is they will dial 7777 and activate Respond Blue or request ambulance attendance.

APPENDIX 7: REFERENCES AND FURTHER READING

1 *Best practice documents for Preventing Workplace Violence for Health Care and Social Service Workers*. US Department of Labor, Occupational Safety and Health Administration, OSHA 3148-01R, 2004.

2 *Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units*. Royal College of Psychiatrists Council Report CR 41, March 1995.

3 Wykes T (ed). *Violence and Health Care Professionals*. Chapman & Hall, 1994.

4 Gerberich SG *et al*. An epidemiological study of the magnitude and consequences of work related violence: the Minnesota nurses' study. 4 O*ccupational and Environmental Medicine*, 2004, 61: 495 - 503.

5 Mayhew C, Chappel D. *The occupational violence experiences of 400 Australian health workers: an exploratory study*. Journal of Occupational Health and Safety Australia and New Zealand, 2003, 19(6).

6 *Best practice documents for Preventing Workplace Violence for Health Care and Social Service Workers*, OSHA 3148-01R, 2004. World Health Organisation http://www.who.int/health-services-delivery/nursing

7 *Trainee Safety in the Workplace*. Royal Australian and New Zealand College of Psychiatrists, Position Statement No 48, 2002.

8 *The Guide to the Handling of Patients*. Revised 4th Edition. National Back Pain Association and the Royal College of Nursing, Middlesex, UK, 1998.

The following is a selection of references covering violence to caregivers. It is not meant to be an exhaustive list.

1 *A Guide for Employers and Employees on Dealing With Violence at Work.* Occupational Safety and Health Service, Department of Labour, Wellington, 1995.

2 Bensley L *et. al. Injuries due to assaults on psychiatric hospital employees in Washington State*. American Journal of Industrial Medicine, 1997, 31: 92- 99.

3 Brunton W. *Colonies for the mind: The historical context of services for Forensic Psychiatry in New Zealand*. Psychiatry and the Law. Brookers, 1996.

4 Carr B. *Nurses' experiences of patient violence in a rehabilitation and extended care setting: OHS implications.* Journal of Occupational Health and Safety Australia and New Zealand, 2000, 16(2) 15 -162. Judge M. Personal communication, 2003.

5 Mayhew C and Chappel D. *The occupational violence experiences of 400 Australian (public) health care workers: an exploratory study*. Journal of Occupational Health and Safety Australia and New Zealand, (19) 6, 2003. There are 7 sections: (1) Introduction and background; (2) Methodology; (3) Findings: patterns of occupational violence; (4) High risk settings for occupational violence; (5) Perpetrators of occupational violence; (6) Reporting of occupational violence; (7) Conclusion.

6 Morrison E F. *The evolution of a concept: Aggression and violence in psychiatric settings.* Archives of Psychiatric Nursing, 1994, Vol. 8 No. 4, 245-253.

7 Ore T. *Differences in assault rates among direct care workers*. Journal of Occupational Health and Safety Australia and New Zealand, 2003, 19(3): 225-233.

8 *Preventing Violence in Health Care - Five Steps to an Effective Program*. 2000. Workers' Compensation Board of B.C. PO Box 5350 Stn Terminal, Vancouver, BC V6B 5L5, Fax: 604 279-7406, E-mail: pubvid@wcb.bc.ca

9 *Preventing Violence in the Accommodation Services of the Social and Community Services Industry*. New South Wales Department of Community Services, April 1996.

10 *Prevention and Management of Workplace Aggression: Best practice documents and Case Studies from the NSW Health Industry*. Prepared by Jim Delaney on behalf of Central Sydney Area Health Service, December 2001. WorkCover NSW Injury Prevention, Education and Research Grants Scheme Grant No 97/0050. Reason J. Human Error. Cambridge University Press, 1990.

11 *Violence - Occupational Hazards in Hospitals*. NIOSH, 2002. Department of Health and Human Services, Centres for Disease Control and Prevention DHHS (NIOSH) Publication No. 2002-101

12 United Kingdom National Health Service Counter Fraud and Security Management Service (CFSMS) http://www.cfsms.nhs.uk.

13 Reason, J. (1990) *Human Error*. Cambridge, England. Cambridge University Press

FOR MORE INFORMATION ON HEALTH AND SAFETY VISIT **WWW.DOL.GOVT.NZ**
OR CALL **0800 20 90 20** DURING BUSINESS HOURS

PLA10726 JULY 08