

Occupational Violence Prevention in Queensland Health's Hospital and Health Services

Taskforce Report

31 May 2016

Occupational Violence Prevention in Queensland Health's Hospital and Health Services

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For more information contact:

Department of Health, GPO Box 48, Brisbane QLD 4001

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Contents

Executive summary	4
1. Recommendations	7
2. Occupational violence—definition and context.....	10
2.1 Definition	10
2.2 Causal factors.....	10
2.3 The Queensland Public Health System.....	11
3. Establishment of the Taskforce	14
4. Taskforce process (data gathering)	15
5. Occupational violence: the Queensland Health data perspective	17
6. Current policy framework	21
7. Snapshot of current strategies/initiatives in the Hospital and Health Services and Queensland Ambulance Service.....	23
7.1 Hospital and Health Services' occupational violence self assessment	23
7.2 Queensland Ambulance Service's Paramedic Safety Taskforce	24
7.3 Systems and data improvement.....	25
7.4 Case studies of contemporary good practice in Queensland Health	26
7.4.1 Occupational Violence Strategy: Metro South HHS	26
7.4.2 The 'Safewards' initiative	27
7.4.3 'Code Grey': Townsville HHS.....	28
7.4.4 Prepositioning nurses in the watchhouse—Gold Coast University Hospital	28
7.4.5 Peer support program: The Park - Centre for Mental Health, Wacol	29
7.4.6 Police and Ambulance Intervention Plans (PAIP)	29
8. Findings and recommendations	30
8.1 General issues.....	30
8.1.1 Occupational violence: a Queensland Health definition	30
8.1.2 Duty of care obligations	31
8.1.3 Societal context of violence	32
8.1.4 Organisational culture.....	34
8.1.5 Occupational violence strategic plans.....	40
8.2 Prevention strategies	40
8.2.1 Risk assessment and risk management	40
8.2.2 Training and capability development.....	43
8.2.3 Work practices.....	46
8.2.4 Workplace design	47
8.2.5 Information sharing.....	48
8.2.6 Data analytics	50
8.3 Protective interventions	51
8.3.1 Occupational violence as a clinical issue	51
8.3.2 Technology.....	53
8.3.3 Security services arrangements.....	54
8.3.4 Seclusion and restraint	55
8.4 Post-incident management	56

8.4.1 Focus on the wellbeing of the victim	56
8.4.2 Incident investigations	58
8.4.3 Prosecutions.....	59
8.5 The withdrawal of health care	61
9. Model of engagement	62
10. Implementation Issues	62
References	64
Appendix 1	66
Appendix 2	68
Paramedic Safety Taskforce Final Report April 2016	68
Summary of recommendations	70
Appendix 3	72
HHS Occupational Violence Self Assessment Summary	72
Key findings.....	72
Appendix 4	78
Occupational Violence Forum 21 March 2016: Breakout sessions.....	78
Background	78
Setting the context of occupational violence	78
Appendix 5	84

Executive summary

The Occupational Violence in Hospital and Health Services Prevention Taskforce was established by the Director-General, Department of Health, Michael Walsh at the request of the Minister of Health and Minister of Ambulance Services, Hon. Cameron Dick MP in January 2016 to:

- evaluate the effectiveness of current occupational violence intervention strategies and identify barriers and solutions to be considered
- review the findings and strategies implemented by other jurisdiction health services following the recent Victorian Occupational Violence against Healthcare Workers report
- propose an occupational violence intervention strategy and implementation plan to support Hospital and Health Services (HHSs).

Workers in the public health system provide a critical service in caring for the community. Healthcare workers are particularly vulnerable to occupational violence because they deal with people in stressful, unpredictable and potentially volatile situations. These situations include patients and mental health consumers whose clinical condition may lead to unintentional violent behaviour, concerned family and friends who may become upset and agitated as a result of the patient's condition, and individuals whose drug or alcohol-fuelled aggression threatens the safety of health professionals.

The causal factors of aggression and violence in health settings are complex and interconnected. They include medical conditions such as dementia, delirium, mental illness or head trauma. Some individuals have attributes such as a history of substance abuse or difficulty dealing with stressful situations. They may have poor communication skills. It may be frustration caused by the circumstances of their treatments or a reaction to those clinical treatments. Fear and uncertainty created by their condition can trigger aggression. The behaviour or attitude of staff can also be a catalyst for aggression. Hospital policy and procedures may not be understood and/or accepted.

Violence in health settings may also be related to broader societal factors in which violence and other anti-social behaviours are evident.

The issue of occupational violence in health environments is a serious issue with the potential for tragic outcomes; and one which is impacting on the health workers and paramedics nationally and internationally. The death of Gayle Woodford, a nurse in a remote Indigenous community in South Australia in March 2016 is a chilling reminder of just how tragic the consequences can be. Locally, the incident, in which a number of staff were assaulted at the Royal Brisbane and Women's Hospital on Sunday 15 May 2015, provides a serious and graphic example of the risks to personal safety of health workers.

Despite the considerable attention to occupational violence in Queensland Health since 2001, the incidence and impact of occupational violence against health workers remains problematic.

Queensland Health data from 2010-11 until March 2016 indicates that the number of reported incidents of occupational violence has ranged from 4500 (2013-14) to 5900 (2012-13) incidents. In 2014-15, about 3325 of the 5030 reported incidents were from the nursing profession, with nearly 10 per cent of that employment group impacted by aggressive or violent behaviour by patients or consumers. Interestingly, the number of reported incidents in the first three-quarters of 2015-16 has increased significantly. If the trend continues, the projected number of incidents for the 2015-16 year would be around 6700; an increase of over 30 per cent on the previous year. The reasons for this significant increase in the reporting of incidents requires further analysis.

Under the *Hospital and Health Boards Act 2011*, the HHSs are responsible for the delivery of health services to their local communities and the functions related to that obligation. In that context, human resource issues are central to the delivery of those services. Moreover, the prescribed HHSs are formally the employer of the health workers. The HHSs have clear and legally defined obligations under the *Work Health and Safety Act 2011* (WHS Act) for the safety of their staff.

Despite previous policy and campaign across the Queensland health sector around the theme of 'zero tolerance' for occupational violence, there is a high level of tolerance of workplace violence. Clinical and security staff are confronted by difficult ethical dilemmas; patient care obligations versus their personal safety. The issue is complex. The violence to which they are subjected includes unintentional actions such as post-operative responses, dementia patients and mental health patients with severe cognitive impairments, and from patients in severe shock. Other forms of violence are intentional and, in some cases, criminal acts of assault and other forms of aggression.

Queensland Health and the HHSs as employers have a legislative obligation under the WHS Act to minimise the risks to the staff through the identification of those clinical risks, and through the design and structure of the work environment and work practices, the provision of suitable training and other forms of support.

However, whatever the cause of the aggression, there is a victim; an employee who is potentially injured physically, psychologically or emotionally in the course of their work.

An agreed and commonly shared definition of occupational violence is a critical prerequisite for a comprehensive and integrated approach to the prevention and management of occupational violence in the public health system.

The philosophy underpinning a systematic and planned approach to workplace violence must be the right to be safe at work. Queensland Health and the HHSs need to promote a safety culture in which the commitment to the safety of individuals is paramount and where the safety of their workers and patients are valued equally.

Because the causal factors of occupational violence are complex and multi-dimensional, controls and intervention strategies to mitigate the incidence and impact of this violence must also be integrated and multi-faceted.

Critical to the success of any broadly focused intervention strategy is the workplace culture, which is based upon shared responsibility. The leadership of the system in all of its locations and functions must model a commitment to address this serious workplace issue with the same determination and commitment that they have to quality patient care. Health workers have an obligation to report incidents of occupational violence, and assist in the identification of risks and implementation of controls and

intervention strategies. Victims of aggression and violence need to feel supported. They must be encouraged to report incidents, even if there is no obvious or psychological injury.

Occupational violence needs to be recognised and promoted as a 'clinical issue' in the same way as patient care is. Essentially, workplace violence has the potential for adversely impacting on the quality of health services through increased costs related to sick leave, workers compensation, the refurbishment of facilities and the repair or replacement of critical equipment; and through losses of quality, experienced clinical staff, and the recruitment and training of their replacements. Adverse impacts on the quality of patient care are also a consequence of poor morale among staff. The redirection of staff from important clinical responsibilities to assist in the management of a threatening or violent patient can also impact on the quality of patient care of others.

If the response to incidents of occupational violence is based on clinical principles, the associated team approach could help overcome the fear, which some employees report, of feeling isolated and vulnerable.

A safety culture, determined to address the issue and support staff, accompanied by a clinical approach to threatened or actual incidents of violence, are likely to be critical success factors in an effective and sustainable response to occupational violence. They are inadequate in themselves. They must be accompanied by a suite of controls, supportive interventions and actions to prevent incidents and protect the health workers. These include risk assessments, targeted training and the involvement of staff in those processes. Workplace practices and design, including the use of technology are also important tools in promoting an effective response.

Incidents of aggression and violence need to be investigated, providing an important feedback loop to refine work practices and inform training.

Post-incident support, particularly in the workplace, is an obligation under the WHS Act and the response of a 'good' employer. The wellbeing of staff, who have been subjected to occupational violence must be the primary focus of post-incident activities. Peer support programs and support for staff where legal action is contemplated would reinforce the value that Queensland Health and the HHSs' place on the safety of their workforce.

Regrettably, while these forms of anti-social behaviours are becoming more prevalent in our society, strategies specifically targeted at occupational violence against health workers are unlikely to deliver sustainable outcomes unless considered as one element of a broader approach to all aspects of societal violence.

Occupational violence presents as a complex problem. There can be no simple solutions. Successful strategies will require sustained, comprehensive and integrated actions. Engagement and co-operation across the public health system will be important enabling strategies.

1. Recommendations

1. That the Director-General, Department of Health and System Leadership Team endorse the following definition of occupational violence and the associated clarifying statement for consistent use across Queensland Health and the HHSs.

Occupational violence is any incident where an employee is abused, harassed, threatened or assaulted by patients and consumers, their relatives and friends or members of the public, in circumstances arising out of, or in the course of, their employment, irrespective of the intent for harm.

Occupational violence includes, but is not limited to, verbal, physical or psychological abuse, threats or intimidating behaviour, racial vilification, harassment (including sexual harassment and stalking) or sexual assault. Physical abuse includes actions such as hitting, spitting, pinching, scratching and throwing objects.

Occupational violence impacts negatively, not only on physical, emotional and psychological wellbeing of health care workers, but on the overall quality of health care, through its impact on the individuals, their colleagues and other patients.

It can be perpetrated by patients and consumers, their relatives and friends and members of the public.

Common contributing factors linked to the incidence of occupational violence against health workers include:

- characteristics of some medical conditions (e.g. fear, pain, dementia, delirium and mental illness)
- characteristics of some individuals (e.g. patients with history of substance abuse and violence, and cognitive impairment)
- characteristics of relationships (e.g. daily routines, rules and limit settings, and practices around patient and visitor movements)
- organisational and environmental factors (e.g. wait times, community health services and services in remote and isolated locations)
- societal factors (e.g. community attitudes towards violence and service expectations).

As the contributing factors to workplace violence are complex and inter-related, intervention strategies should be evidence based, multi-faceted, integrated, participative, culture/gender sensitive and non-discriminatory.

2. That future Queensland Government and Queensland Health community awareness campaigns include themes such as the importance of 'respect' and 'respectful behaviours' and personal responsibility for unacceptable behaviour by recipients of health care services.
3. That Queensland Health and the Hospital and Health Services work cooperatively to promote a safety culture and the right to be safe at work across the public health system.
4. That the Service Level Agreement with each Hospital and Health Service includes a requirement for an Occupational Violence Management Strategy. The strategy should include measures or indicators of staff safety performance.

Further, the biennial audit requirements should include specific reference to the Occupational Violence Strategy.

5. That the Director-General, Department of Health and System Leadership Team initiate the development of a comprehensive training and capability framework to apply across the Queensland public health system, as a matter of urgency.
6. That each Hospital and Health Service be responsible for the application of the statewide capability and training framework by identifying local training and capability needs and implementing a training regime addressing:
 - occupational violence risk assessment and awareness and the specific capability requirements for health workers, executives, managers, supervisors, security co-ordinators and occupational health and safety/human resource professionals
 - customer service, empathetic communication, dynamic risk assessment/situational awareness skills and de-escalation techniques within a non-violence framework for all health workers
 - adequate resourcing of training and capability development
 - supportive intervention and targeted response training of clinically appropriate techniques for defined occupational groups
 - continuous improvement in the training program through effective feedback loops and regular reviews.
7. That working groups be established to develop a suite of evidence-based, clinical work practice interventions and controls for both unintentional and intentional occupational violence for identified high risk areas including emergency departments, mental health services, dementia and acquired brain injury facilities, drug and alcohol facilities, community health services, and services in isolated and remote communities. Each working group should be chaired by an executive leader from a Hospital and Health Service with relevant clinical experience. The working groups should report to the Occupational Violence Prevention and Management Implementation Taskforce (the Taskforce).
8. That interagency collaboration between the healthcare system, police and justice systems at both a system and facility level should be enhanced through formal protocols and procedures for providing information and facilitating cooperation.
9. That Queensland Health, in conjunction with the Queensland Police Service and the Queensland Ambulance Service, other relevant agencies, and advocacy groups undertake a project to investigate the opportunities which are available to share information to reduce the risks of occupational violence against health workers.
10. That the Taskforce notes the Queensland Integrated Safety Information Project system will improve the capture and reporting of incidents of occupational violence; however further work is needed to provide:
 - better electronic interfaces with the clinical reporting systems
 - consistent definitions
 - an agreed system-wide data set of staff safety indicators
 - training in the use of data on staff safety performance to inform processes to review intervention strategies.

11. That the preferred model to manage occupational violence incidents in medium and large facilities involve the use of trained, clinically led interdisciplinary teams (such as the 'Code Grey' and 'Safewards' models), and that best practice principles and standards to guide the clinical teams be developed to assist the Hospital and Health Services to effectively implement the models.
12. That a formal evaluation process be a requirement of the trialling of any clinically base initiative before that initiative is adopted in other Hospital and Health Services.
13. That, given the rapid technological advances in security systems, a standing committee be established to monitor and assess the suitability of emergency/duress alarm systems (including personal duress alarms). The committee should utilise the expertise of the Queensland Police Service, Queensland Ambulance Service, Queensland Fire and Emergency Services and Queensland Corrective Services. Priority should be given to communications and tracking devices for health workers in remote and isolated and community health settings.
14. That a working group reporting to the Occupational Violence Prevention and Management Implementation Taskforce be established to review the security service arrangements across Queensland Health. The review should include but not be limited to staffing levels, functions and roles, training and powers.
15. That the physical, emotional and psychological wellbeing of the health workers who have been subjected to occupational violence be the primary focus of post-incident activities.
16. That peer support programs be trialled in a range of settings including emergency departments, mental health services, community health services and isolated and remote health services.
17. That post-incident investigations have an explicit objective to develop and refine clinical practices, individual treatment plans and other controls and intervention strategies.
18. That investigation teams to review incidents of occupational violence be led by health workers who have specific training in investigation processes and techniques.
19. That organisational support be provided to health workers who have been subjected to occupational violence, where criminal proceedings have been initiated, through the establishment of small occupational violence support unit in the central office of Queensland Health.
20. That an Occupational Violence Prevention and Management Implementation Taskforce, chaired by a member of the System Leadership Forum, be formally established to lead the implementation of the recommendations of the Occupational Violence Prevention Taskforce.

2. Occupational violence—definition and context

Healthcare workers provide a critical role in caring for the community. Healthcare workers are particularly vulnerable to occupational violence because they deal with people in stressful, unpredictable and potentially volatile situations. These situations include patients whose clinical condition may lead to unintentional violent behaviour, concerned family and friends who may become upset and agitated as a result of the patient's condition, and individuals whose drug or alcohol-fuelled aggression threatens the safety of health professionals.

2.1 Definition

Queensland Health's Occupational Violence Prevention Staff Survey uses a definition of 'aggression':

Aggression is defined as the infliction, or threat, of harm or injury (either physical or psychological) upon another person. It includes verbal, physical or psychological abuse, threats or intimidating behaviour, intentional physical attacks such as hitting, pinching or scratching, aggravated assault, threats with an offensive weapon, sexual harassment or sexual assault..

(Queensland Health's Occupational Violence Prevention Staff Survey: qheps.health.qld.gov.au/safety/sms/index4.htm).

The current definition is not widely promulgated across the department and is deficient in that it does not specifically address occupational violence. This is considered further in Chapter 8.

It is important to note that the Taskforce's considerations are focused on violence directed towards Queensland Health's workforce by patients, consumers, their relatives and friends and intruders. While many definitions of occupational violence include violence within the workplace involving members of staff, this aspect is not included within the terms of reference of the Taskforce. It is a serious and significant issue for Queensland Health, which is being addressed separately.

2.2 Causal factors

The Victorian Audit-General in his 2015 report, *Occupational Violence Against Healthcare Workers*, identified the common inter-connected causal factors contributing to the incidence of occupational violence against healthcare workers under the following headings;

characteristics of some medical conditions—such as dementia, delirium, mental illness or head trauma, where violence or aggression is a potential clinical symptom

characteristics of individuals—such as the attributes of the aggressor who may have a history of substance abuse or difficulty dealing with stressful situations, or

the characteristics of the victims, such as their level of work experience or communication skills

characteristics of the relationship—such as the nature of the daily routine and relationships with the patient involving rules, limit-setting, practices around visitor and patient movements, and processes for undertaking caring duties

organisational and environmental factors—such as the physical layout of the environment, procedures and policies, wait times and staffing practices including access to security or other support

societal factors—such as community acceptance of violence, or attitudes towards authority.

(Victorian Auditor-General's Report: *Occupational Violence Against Healthcare Workers*, Victorian Government Printer. May 2015: pp. 2-3).

Arnetz et al have concluded from their research of documented incident reports in the United States of America (USA) that there are three clinically related causal themes: patient behaviour, patient care and situational events.

Patient behaviour...included two sub-themes: cognitive impairment and demanding to leave. Patient Care encompassed incidents that occurred in the course of providing care and/or working in close proximity with a patient. Patient Care had three sub-themes: needles, pain/discomfort and physical transfers. Situational events encompassed situations where patient freedom of mobility was infringed and included four sub themes: restraints, transitions, intervening and redirecting.

(Arnetz, Hamblin, Essenmaker, Upfal, Ager & Luborsky. *Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports*: Journal of Advance Nursing, Wiley & Sons. 2014. p. 342).

These complex and inter-connected characteristics are made even more difficult to manage by the presence of multiple factors which can increase the propensity towards violence, even against those whose training and overwhelming intentions are focused on the care of these people.

2.3 The Queensland Public Health System

The HHSs and Queensland Health are responsible for implementing appropriate controls to manage responses to workplace violence at a local level. Systematic risk management strategies aimed at improving staff and patient safety through early identification, prevention, protection and post incident management of occupational violence incidents have been implemented across Queensland Health.

With more than 65,000 employees, Queensland Health and the HHSs provide a vast range of services across the length and breadth of Queensland. Queensland Health's operations are varied and dispersed. Consequently the risk profile from occupational violence varies across and within its sites. However priority areas for risk include emergency departments, mental health (including community services), security, cash and drug handling, dementia and acquired brain injury units, drug and alcohol facilities, community health facilities and facilities in remote and isolated communities. In addition, risks can also be heightened when health workers are working alone or at night and when staff in general wards receive 'violent' patients from other parts of the facility.

Occupational violence is also a significant issue for Queensland Ambulance Service (QAS) where there were 170 physical assaults and 56 verbal assaults reported in 2014-5. (Paramedic Safety Taskforce Final Report, p. 4).

However, the issue of occupational violence in health environments is not limited to Queensland; it is a serious issue impacting on the health workers and paramedics nationally and internationally. According to Ahmad et al, "Workplace violence has been significant since 1980s." (M Ahmad, R Al-Rimawi, A Masadeh, and Atoum. *Workplace Violence by Patients and Their Families Against Nurses: Literature Review*. International Journal of Nursing and Health Science Vol 2, No. 4: 46-55 August 10, 2015. p. 46).

The public policy implications of occupational violence has troubled academics, health authorities and health professionals since that time.

Health workers are particularly vulnerable to occupational violence. A United States (US) report by the Department of Labor's Occupational Safety and Health Administration indicates that the rate of occupational violence for healthcare workers was 20 per cent (6.5 per 1000) higher than all other workers (5.1 per 1000). (Occupational Safety and Health Administration: *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. US Department of Labor, 2015. p. 3).

Despite the considerable attention which has been given to it, the incidence and impact of occupational violence against health workers, including those employed by Queensland Health, remains problematic.

Queensland Health's concern about the impact of workplace violence on its workforce is not a recent development. Since 2001, the department has undertaken a range of activities to develop and refine strategies to reduce the risks to staff associated with occupational violence.

In response to a Queensland Nurses Union (QNU) campaign, the Minister for Health launched a 'zero tolerance campaign' in 2001. The following guidance materials were developed and promulgated:

- Occupational Violence Prevention Guidelines (2001)
- Aggressive Behaviour Management (ABM)—Instructor Training (Cert IV) (2003)
- Aggressive Behaviour Management—Staff Training (Cert III) (2003)
- Security Management Guidelines (2003)
- Restraint and Protective Assistance Guidelines (2003).

A Ministerial Taskforce on 'Violence against Nurses' was established in 2004. It made 60 recommendations which focused on a 'zero tolerance' policy, training, guidance materials, engagement with other agencies, including the Queensland Police Service (QPS), Corrective Services, Emergency Services and Child Safety, personal protection systems, security arrangements, risk assessments, work practices, post incident support, awareness raising and the data collection system. Many of these recommendations are still relevant, indicating the importance of ongoing attention to the issues around workplace violence.

Between 2007 and 2012 a range of actions were initiated including:

- the establishment of a corporate occupational violence prevention team to support HHSs and develop resource materials
- the development of the Occupational Violence Risk Assessment Tool (OVRAT)
- funding support for staff training, including a network of 108 qualified Aggressive Behaviour Management (ABM) instructors, 33 full-time ABM instructors funded to coordinate HHS activities, and staff training start-up funding of approximately \$12 million since 2005
- the release of security guidelines and risk assessment tools
- training on Crime Prevention Through Environmental Design (CPTED)
- mandated quarterly milestone reporting requiring the hospital districts to conduct gap analysis and to develop implementation plans and schedules of risk assessments of priority areas
- the introduction of External Safety Management System audits.

A criminal assault on a nurse in the Torres Strait in 2008 resulted in the imposition of an 'enforceable undertaking' by Workplace Health and Safety Queensland (WHSQ). As a result a corporate safety management system was developed which introduced performance reporting and auditing to validate the implementation and maintenance of safety systems in the hospital districts.

Since transition to the HHS model in 2012, HHSs hold the ultimate responsibility for identifying, developing, implementing and maintaining strategies to manage occupational violence. The department's position was to reduce the corporate role and related resourcing, to allow the HHSs the flexibility to structure their safety requirements to their individual risk profiles.

This resulted in the high level, specific mandatory requirements for occupational violence being converted to guideline materials, which the HHSs are able to adapt to meet their specific requirements. With its reduced role and accountability, the corporate Occupational Health and Safety (OHS) staffing levels and capability were reduced within the department.

The ABM training program was revised which reduced the training duration requirements. Other commercial training programs were reviewed to provide opportunities for the HHSs to determine their preferred training regime. Performance validation was through biennial External Safety Management System audits.

However, no comprehensive and independent evaluation across Queensland Health and the HHSs seems to have been undertaken and consequently it is difficult to ascertain the effectiveness of the various interventions which have been implemented.

This is not unique to Queensland Health.

...most workplace aggression research seeks primarily to examine the scale of the problem and secondarily to structure the problem according to demographics and locations of work.

(Dr. A Rae and Dr. P Cassematis: *Occupational Aggression against Healthcare Staff—Literature Review*, Griffith University (unpublished work commissioned by the Occupational Violence Prevention Taskforce. May 2016. p. 6).

There are few studies in the international literature “measuring the actual effect of the intervention on the prevalence or effects of violence”. (Rae and Cassematis, p.7).

The challenge for Queensland Health and the HHSs during the current review is to consider what strategies have been successful and which have not had the desired outcomes, and to assess the reasons for those outcomes. Its purpose should be to identify what strategies may result in effective and sustainable outcomes in the future.

3. Establishment of the Taskforce

The Occupational Violence Prevention Taskforce was established in January 2016 to provide a strategic oversight forum. Its objectives are to:

- evaluate the effectiveness of current occupational violence intervention strategies, and identify barriers and solutions to be considered
- review the findings and strategies implemented by other jurisdiction health services following the recent Victorian Occupational Violence against Healthcare Workers report
- propose an occupational violence intervention strategy and implementation plan to support HHSs.

The scope of the review was to:

- identify Queensland Health's approach to managing occupational violence including, but not limited to:
 - the implementation of work practices including occupational violence prevention training, technology, and counselling and support services
 - Queensland Health's *Occupational Violence Prevention and Management Framework* and related standards, procedures, protocols and guides
 - information and training materials provided to staff and instructors
 - other key documents and resources.
- evaluate the effectiveness of current occupational violence intervention strategies, identify barriers to their implementation and propose solutions to address these barriers
- review the findings and strategies implemented in the literature and in other jurisdictions following the Victorian Auditor-General's recent report *Occupational Violence against Healthcare Workers*
- consider any other matters connected with occupational violence in Queensland Health's facilities which the reviewer thinks necessary or appropriate
- make recommendations for the improvement of Queensland Health's occupational violence policies and procedures to minimise or eliminate the risk of occupational violence to Queensland Health personnel.

Jim McGowan AM was appointed to chair the Taskforce and lead the review. The membership of the Taskforce is Appendix 1.

The QAS has undertaken a review of occupational violence against its paramedics, which is being led by the QAS Commissioner, Russell Bowles. The QAS has established an Occupational Violence Taskforce and released an interim report of that Taskforce's findings on 29 January 2016. Its final report was presented in April 2016.

The Executive Summary and Recommendations of the final report are included in Appendix 2.

4. Taskforce process (data gathering)

The Queensland Health project team and the Taskforce Chair undertook a range of activities including:

- site visits, meetings and interviews
- a review of occupational violence related policies and guidelines including WorkCover Queensland's *Prevention and Management of Aggression in Health Services; A Handbook for Workplaces* (2009)
- a review of a range of relevant reports including the *Hunter Review of the Department of Health's Structure, Governance Arrangements and High Level Organisational Capability* (2015), the Victorian Auditor-General's Report, *Occupational Violence against Healthcare Workers* (2015), the NSW *12 Point Hospital Security Action Plan* (February 2016), the Department of Health (Victoria)'s *Progress on Occupational Violence Prevention in Victorian Health Services* (2012), the Queensland *Report on Violence Against Nurses* (December 2004), the Status Report on the Implementation of Recommendations (March 2010), and the QNU Submission to the Legal Affairs and Community Safety Committee (December 2015)
- a literature scan
- a range of Queensland Health workforce performance reports and reports on occupational violence in Queensland Health
- examples of 'good practice in Queensland Health and elsewhere.

In March 2016, the OHS team developed and distributed, on behalf of the Taskforce, a self-assessment proforma to capture the current policies, practices and initiatives in each of the HHSs. That information has been used to inform the findings and recommendation of the report of the Taskforce. (see Chapter 8).

The Executive Summary of the Hospital and Health Services Occupational Violence Self Assessment Report is included in Appendix 3.

On 21 March 2016, a Statewide Occupational Violence Forum was held involving a total of more than 100 participants including representatives from the QPS, QAS, QNU, Australian Workers Union, Together Union, WorkCover Queensland, Public Safety Business Agency, eHealth Qld, Children's Health Queensland, Darling Downs, Gold Coast, Metro North, Metro South, South West, Sunshine Coast and West Moreton HHSs and Queensland Health's Centre for Excellence and Human Resources departments. Additional people attended through videoconference sites in Townsville, Wide Bay, Cairns and Hinterland and Mackay HHSs.

The keynote address was provided by Associate Professor Dr. Jonathan Knott and Associate Professor Marie Gerdtz on the lessons from the Victorian Auditor-General Report and other Victorian experiences. Other presentations included the Princess Alexandra Hospital's Occupational Violence Prevalence Survey, QAS's Occupational Violence Taskforce Action Plan, the 'Safewards' trial and the Queensland Integrated

Safety Information Project (QISIP). Beth Mohle, Secretary of the QNU, Associate Professor Drew Rae from Griffith University and John McDonald of Proactive Resolutions made presentations from their different perspectives.

The objective of two breakout sessions was to understand the occupational violence in the Queensland public health system by testing assumptions against the reality of the experiences from people providing frontline services. The first session focused on the theme of defining occupational violence in relation to causes, prevalence and impact of violence. The second breakout session focused on three parallel themes of prevention, protection and post-incident strategies.

A summary of the outcomes of the forum is contained in Appendix 4.

Griffith University has been contracted to undertake a literature review. The aim of the literature review was to provide a clear picture of the nature of occupational violence against health care workers, what has been tried to address the problem and what has been known to work or not work, internationally.

Dr. Andrew Rae and Dr. Peter Cassematis, who conducted the literature review for the Taskforce, summarised their evidence-based conclusions as:

Policy and Messaging. 'Zero tolerance' and 'Violence is unacceptable' messaging may have a significant adverse impact on staff morale, behaviour and reporting, whilst having no impact on aggression. It is important that any messaging campaign has a clearly defined objective, with before-and-after measurement of the attitude or behaviour it seeks to change.

Design of work environments, and the systems that govern work. Aggression has complex causes, the situational factors that immediately precede aggression are most amenable to systematic intervention.

Training. Training should focus on the positive capacity of staff to reduce aggression, deal with aggression in progress, and support each other in the aftermath of aggression. Training should always be implemented in conjunction with other interventions.

Continuous Improvement. Given the current state of knowledge, evaluation should be an intrinsic part of intervention design. (Rae and Cassematis, p. 1).

Many of these observations are addressed in findings of the Taskforce (Chapter 8).

The views of Queensland Health staff are critically important. Griffith University has been contracted to conduct program evaluation of Queensland Health current initiatives and strategies. This will involve a series of structured interviews with health workers, which are designed to elicit information about successful (and unsuccessful) interactions with 'difficult' patients and consumers. Questions will address the perceived benefits, frustrations and gaps in current strategies and the identification of strategies, which have proven most helpful in these interactions. The results of this research will be an input into the working groups to investigate strategies and interventions for specific high risk groups and facilities across the public health system (see Recommendation 7). This research work will be supplemented by planned focus groups in other locations.

Taskforce meetings were held on 19 January, 11 February, 3 March, 4 April, 18 April, 3 May, 17 May and 30 May 2016.

5. Occupational violence: the Queensland Health data perspective

Table 1 provides data from 2010-11 until the March quarter 2016, on the number of reported incidents of occupational violence. It has remained within a relatively narrow range from 4500 (2013-14) to 5900 (2012-13) incidents annually. It is noteworthy that the number of reported incidents in the first three quarters of 2015-16 has increased significantly. If the trend continues in the fourth quarter, the projected number of incidents for the 2015-16 year would be around 6700; an increase of more than 30 per cent on the previous year.

The factors behind this dramatic increase require further analysis. As will be discussed in Chapter 8 of the report, there is significant under-reporting of occupational violence, which is evident across other jurisdictions in Australia and overseas. A further limitation in data is the inability to determine whether the nature of the violence has intensified over time. Anecdotally, it is claimed that the violence might be more serious as a result of greater patient acuity and nature of the drug and alcohol problem in our society.

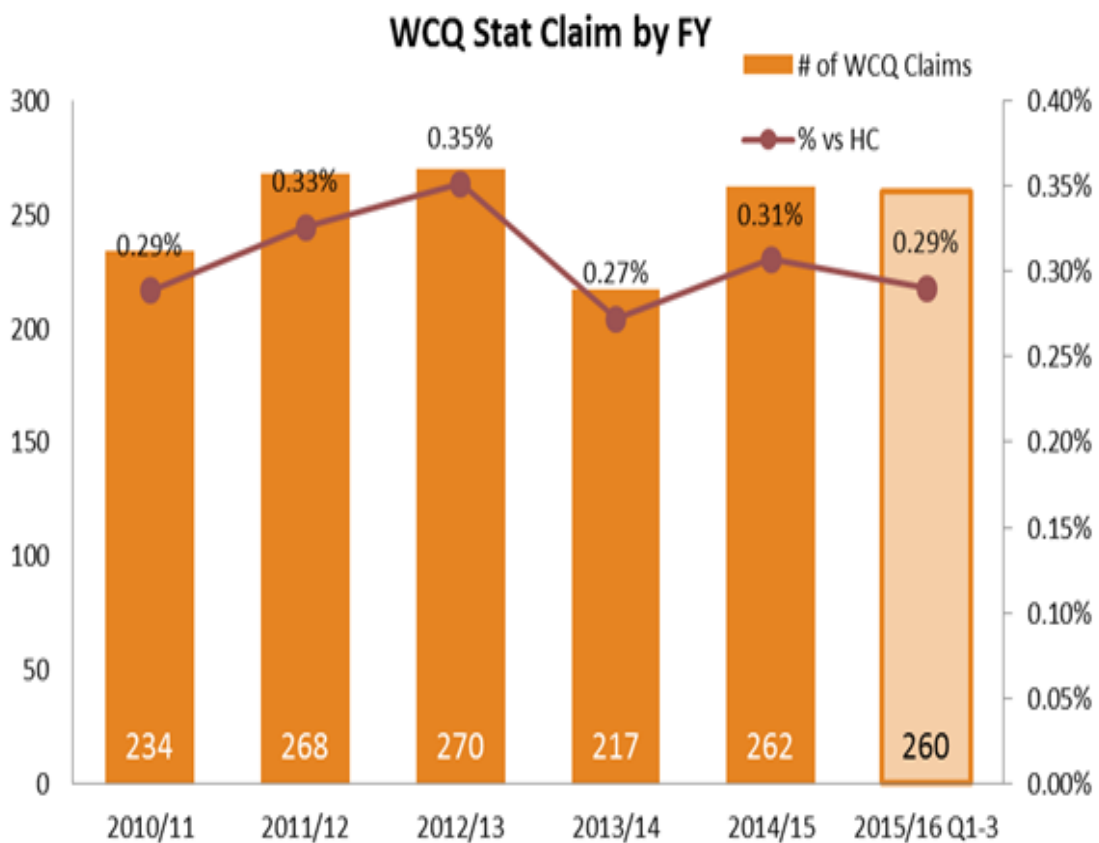


Table 1

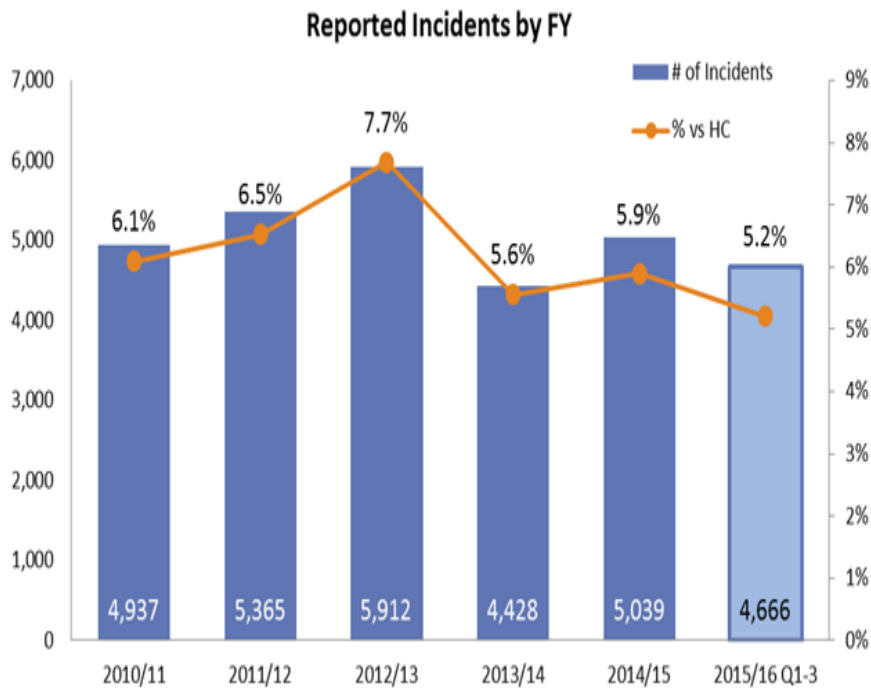


Table 2

Table 2 contains WorkCover data for the period 2010-11 until the December quarter in 2015-16. In contrast to the data on the number of incidents, the number of WorkCover claims from Occupational Violence is quite low with about 250 such claims a year. 2013-14 had only 217 claims. What is apparent from the Table 2 is that the about 5 per cent of the reported incidents become WorkCover claims. This has been also relatively stable over the period.

Occupational violence is the major contributor to WorkCover claims with about 30 per cent of all claims being related to occupational violence.

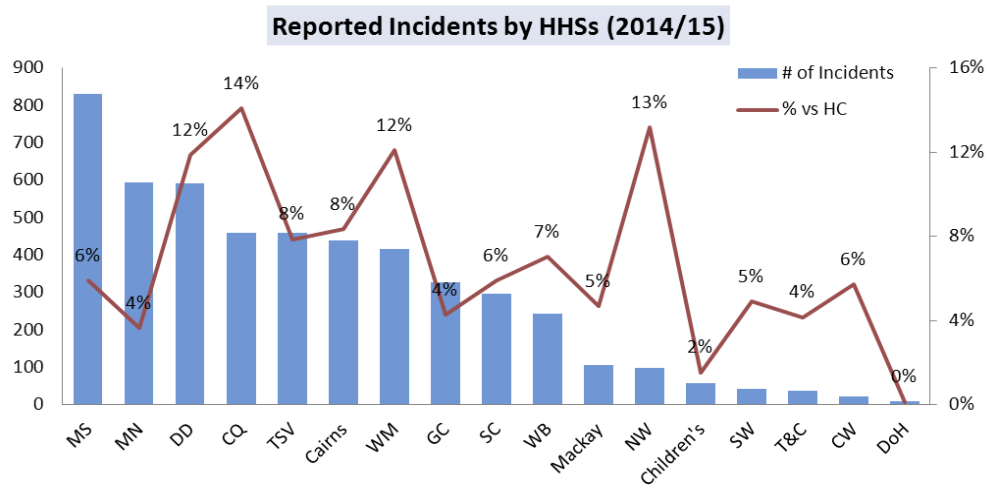


Table 3

Table 3 shows the number of incidents by HHSs along with the percentage of health workers who have reported incidents of workplace violence. As would be expected, the

number of incidents generally reflects the size of the workforce in each HHS with the largest number in Metro South and Metro North and smallest number of reported incidents in the Mackay, Children’s, South West and Torres and Cape and Central West HHSs. However, the Central Queensland (14%), North West (13%), Darling Downs (12%) and West Moreton (12%) HHSs report the highest percentage of staff impacted. The data does not enable the reasons for the higher incidence to be extrapolated but it does indicate a need for further investigation into those differences.

The data in relation to total and average costs of WorkCover claims in 2014-15 indicates the highest total costs being for Metro North (\$450k), West Moreton (\$260k), and Cairns and Hinterland, Sunshine Coast and Metro South (all with about \$250k). Average costs of claims were highest in Cairns and Hinterland (\$17,106), Sunshine Coast (\$13,532) and Central Queensland (\$11,795).

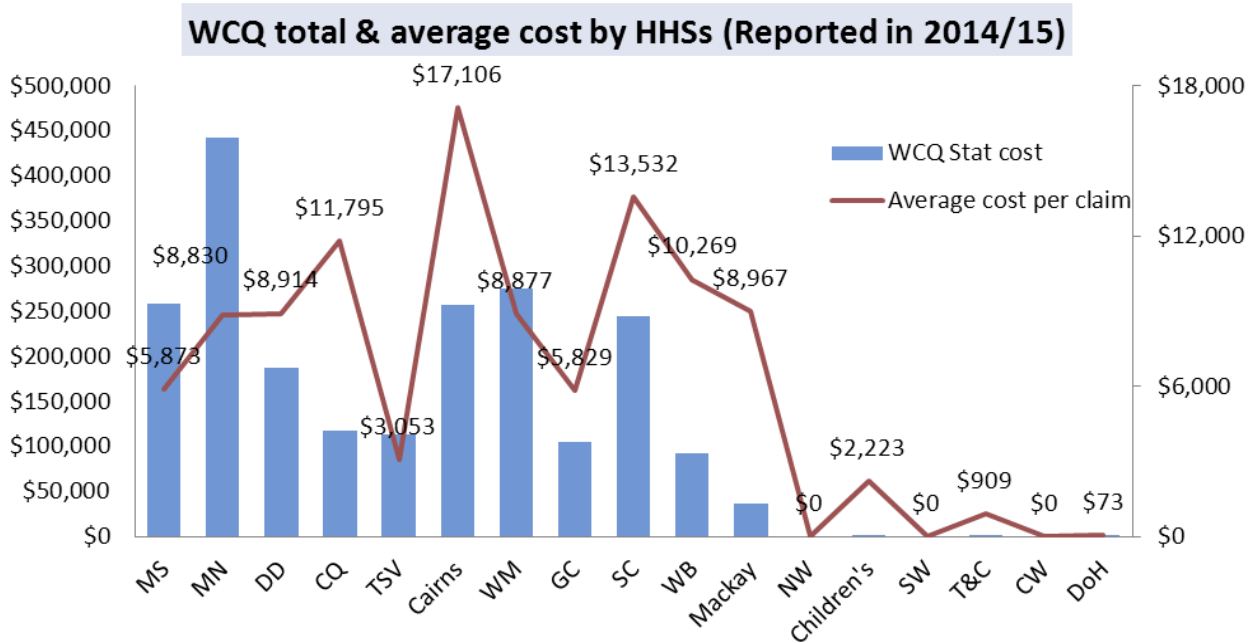


Table 4

While it is not possible or appropriate to draw conclusions from this aggregated data, it is important for each HHS to understand the reasons underpinning their performance whatever that performance outcome is.

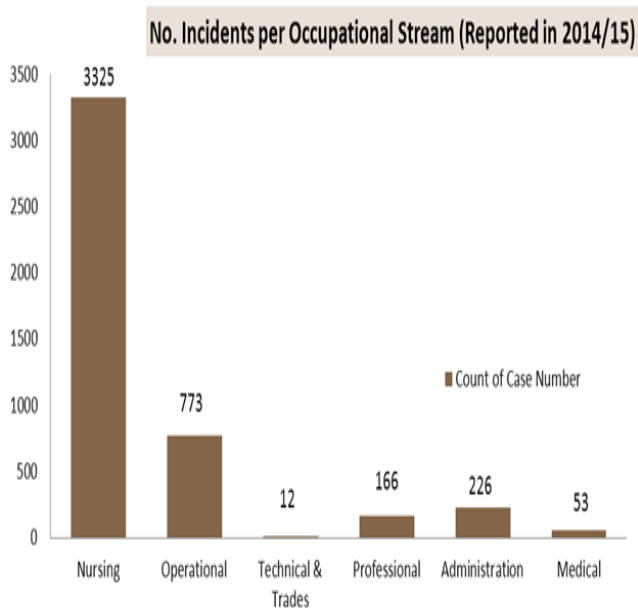


Table 5

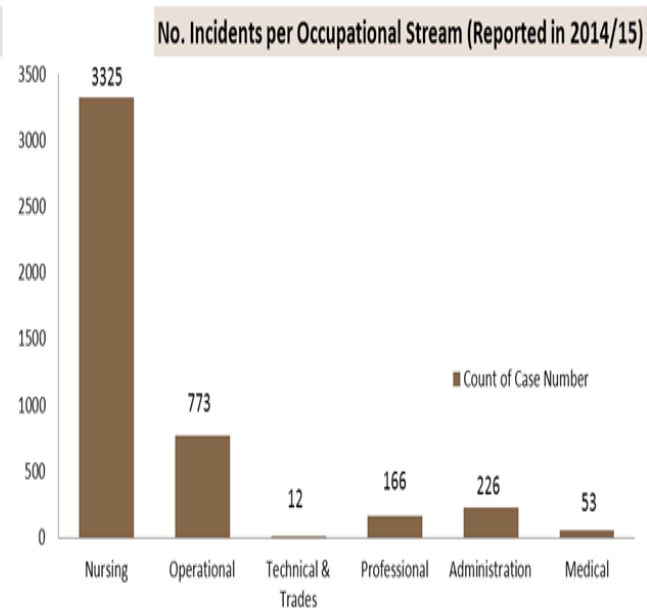


Table 6

Tables 5 and 6 confirm that nurses and midwives are the most vulnerable occupational group. In 2014-15, about 3325 of the 5030 reported incidents were from the nursing profession, with nearly 10 per cent of that employment group impacted. Operational staff including security and wards staff were the next most vulnerable group with more than 700 reported incidents. There was a relatively small number (53) and low proportion of medical staff (0.6%), who were the subject of occupational violence.

The proportion of physical to verbal assaults has been consistently 63% to 37% since 2012-13, until this financial year when there has been a slight increase in the reporting of verbal assaults. This is in contrast to the data from the literature review, which found that incidents of verbal abuse were more prevalent. (Rae and Cassematis, pp. 8-9).

The data may reflect that health workers in Queensland Health are more likely to report incidents of physical assault than verbal assaults.

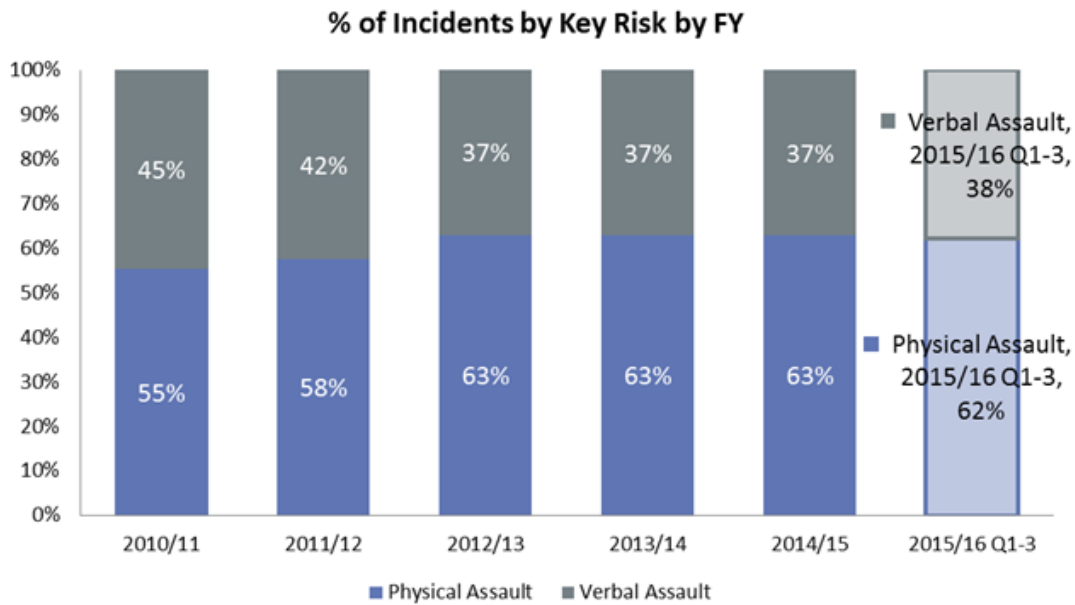


Table 7

Assaults against health workers are deemed to be serious assaults under section 340 of the *Criminal Code, 1899*. However, there is no systematic mechanism to capture data on the number of incidents, which are reported to the Queensland Police Service (QPS) or which proceed to court. Anecdotally the number is very small.

6. Current policy framework

Under the *Hospital and Health Boards Act 2011* (HHB Act), Queensland Health has a statutory responsibility for the state’s health system. This involves setting strategic policy priorities, funding negotiations with government, and assuring that health services across the state deliver quality health services. All HHSs and Queensland Health have clear and defined obligations under the WHS Act for the safety of their staff. Moreover, the prescribed HHSs are formally the employer of the health workers.

Given Queensland Health’s role as the ‘system leader; and ‘system manager’ (*Hunter Report: Review of the Department of Health’s Structure, Governance Arrangements and High Level Organisational Capability*, June 2015. p. 61), it is possible to require the HHSs to establish and maintain a quality staff safety system if occupational violence is seen as a key organisational priority. This requirement could be given effect either through the triennial service level agreements or through a health employment directive under the HHB Act. Alternatively and arguably more effectively, the prevention and management of occupational violence could be prioritised through a decision of the System Leadership Forum of Queensland Health and HHS leaders, and implemented through a networked model.

In relation to occupational violence, corporate office is responsible for the policy and accountability framework and for the provision of information technology systems, centralised performance data and advice on management tools such as risk assessment tools and training regimes. Corporate office can also assist the HHSs by acting as a coordination point and clearinghouse to share ‘good practice’.

Under the HHB Act, the HHSs are responsible for the delivery of health services to their local communities and the functions related to that obligation. In that context, human resource issues are fundamental to the delivery of those services.

In relation to occupational violence, these obligations extend to operationalisation of the broader departmental policy framework and guidelines and the development strategies based upon that framework. They are expected to undertake risk assessments in line with obligations under the Act, particularly at the work unit level, to provide appropriate and targeted training, report on and assess performance on a regular basis through a participative approach involving representative occupational health and safety committees, dedicated workplace violence committees, boards of management and/or the HHS boards. Importantly they have a legislative responsibility to support staff subjected to, or threatened by aggression and violence.

The department has developed a Framework on *Occupational Violence Prevention and Management*, which is to provide guidance to the HHSs in relation to occupational violence in their workplaces. That framework is Appendix 5. It is based upon contemporary literature and research around the prevention and management of occupational violence.

It stresses the need for hazard identification and risk assessments, risk control strategies and for performance monitoring and review.

Risk control strategies include:

- work area design
- work systems design
- community engagement
- patient violence assessment
- de-escalation, escape, defence and control techniques
- training and awareness
- documentation.

The framework is accompanied by three guidance notes from corporate Queensland Health.

The guidance note, *Occupational Violence Prevention and Management Framework* provides a framework for the early identification, prevention, protection from and post incident management of occupational violence and aggressive behaviour.

The importance of a risk management approach and the need for occupational violence-specific risk assessments at the facility or individual work unit level is articulated through the guidance note on *Occupational Violence Risk Assessment*.

The third guidance note is on *Occupational Violence Prevention Fundamentals Training, (OVP fundamentals)* and outlines the Queensland Health owned *OVP fundamentals* competency-based modular training program, which is based upon 'the principles of early intervention, prevention, de-escalation and avoidance.' This supersedes the ABM program.

WHSQ published the *Prevention and Management of Aggression in Health Services: a Handbook for Workplaces* in December 2009. That handbook provides very

comprehensive advice, which is aimed at OHS professionals. It was developed by WorkSafe Victoria and has been adapted by all the Australian jurisdictions.

While it is important that the framework and the guidance materials be reviewed following the report of the Taskforce, an ongoing limitation remains that the materials are for the guidance of the HHSs. Expectations of the HHSs by Queensland Health on their strategies to address occupational violence should be clearly articulated.

7. Snapshot of current strategies/initiatives in the Hospital and Health Services and Queensland Ambulance Service

7.1 Hospital and Health Services' occupational violence self assessment

In March 2016, the Occupational Health and Safety (OHS) team developed and distributed, on behalf of the Taskforce, a self-assessment proforma to capture the current policies, practices and initiatives in each of the HHSs. The data from this self assessment exercise has been consolidated into the Hospital and Health Service Occupational Violence Self Assessment Report (Appendix 3) which was prepared for the Taskforce.

Key successful strategies identified by the HHSs include:

- online resources such as the Occupational Violence Prevention Awareness Module (developed by the Department of Health, available on iLearn@QHealth and DVD)
- safe haven/staff refuge (place of safety for staff to retreat to)
- verbal de-escalation and communication training
- 'Code Black/Grey' response teams
- 'Safewards' model within mental health
- governance within organisational structures such as an occupational violence committee
- occupational violence risk assessment (facility static assessment)
- security officer presence
- duress alarms
- CCTV monitoring
- OVP training
- access controls such as swipe card access (Hospital and Health Service Occupational Violence Self Assessment Report. Appendix 3, section 1.15a)

There were a number of key challenges, which have been identified by HHSs as part of the self assessment including;

- resourcing occupational violence training and associated issues
- inconsistent training models within different HHSs

- use of occupational violence data and risk assessments informing environmental change
- development of staff skill sets to recognise and respond to emergent aggression
- expansion in staff knowledge of mental health issues
- workplace bullying and harassment (staff against staff)
- executive leadership and direction of occupational violence initiatives
- capability and resourcing skills sets such as security services
- Occupational Violence Risk Assessment process being time consuming and labour intensive (Hospital and Health Service Occupational Violence Self Assessment Report. Appendix 3, section 1.15b).

The Taskforce accepted that the key themes, which were identified to better manage occupational violence risk, were:

- communication and de-escalation training for frontline staff
- risk awareness training
- police beats
- staff support alternatives
- user friendly incident reporting mechanisms
- mandatory occupational violence training programs or support from Queensland Health regarding training programs
- increase security officer presence
- cultural change in relation to the 'tolerance of occupational violence'
- integration of clinical and non-clinical practices in the management of occupational violence (Hospital and Health Service Occupational Violence Self Assessment Report, Appendix 3, section 1.15c).

7.2 Queensland Ambulance Service's Paramedic Safety Taskforce

In December 2015, the Commissioner for the QAS established a Taskforce to

... investigate this issue of occupational violence being experienced by paramedics and provide practical strategic recommendations to reduce occupational violence against QAS officers.

(Queensland Ambulance Service: Paramedic Safety Taskforce, Final Report. Queensland Health. April 2016. p. 4).

The need for the Taskforce was the result of concerns particularly from paramedics on the level of aggression and violence with which paramedics were being confronted in the course of their duties. The data for 2014-5 showed that there were 247 reported assaults on QAS staff of which 170 were deliberate physical attacks staff. (Paramedic Safety Taskforce, Final Report. p. 4). Of concern was that data for 2015-16 suggested that if:

The current trend continued.....total assaults may exceed 370 (i.e. a potential increase of nearly 50 per cent on the 2014-15 financial year..

(Paramedic Safety Taskforce Final Report; p. 4).

The final report was presented in April 2016. Its recommendations were centred on:

- education and training
- media and communication
- internal QAS and external processes including:
 - data analysis
 - internal structures and models
 - linkages to staff support
 - post incident response and support
 - clinical practice and patient safety
 - research and development
 - technology options.

(Paramedic Safety Taskforce, Final Report. p. 4).

7.3 Systems and data improvement

The need to improve the usability, quality and reliability of information systems and data has been recognised by Queensland Health. Queensland Health currently has disparate processes and systems for the management and reporting of patient incidents, staff incidents, and consumer feedback, involving multiple systems such as PRIME CI (Clinical Incident), IMS.Net (Occupational Health and Safety Management) and CF (Consumer Feedback).

Frontline and managerial staff all commented upon their frustrations with the cumbersome and often duplicated data entry requirements of the current systems, which also lack the capacity to integrate information across those systems.

Queensland Health has committed to the Queensland Integrated Safety Information Project (QISIP). The project is designed to implement an integrated safety system that addresses clinical and workplace health and safety incident management, consumer and staff feedback and risk management.

According to the project plan, its objectives are to deliver:

- an integrated safety information system encompassing both patient and staff incidents, consumer and staff feedback and risk
- a user friendly and easy system to encourage increased entry of staff and patient incidents, feedback and risks
- improved efficiencies in management of reported incidents, feedback, and risks
- potential cost efficiencies in a robust single integrated safety solution rather than three systems (PRIME CI/CF and IMS.net)
- increased transparency of incidents and feedback information which will lead to decision making capability through more timely, comprehensive and trusted data
- information to demonstrate compliance with national and state legislation and National Commission on Safety and Quality in Health Care Standards
- a configurable, modular solution that can, in the future, seamlessly form part of a clinical governance safety management system.

(Queensland Integrated Safety Information Project: Project Initiation Document, version1.3).

It is proposed that the new information system will allow the collection of mandatory statewide data items. Its functionality will provide flexibility for each HHS to configure the system to collect additional data items of particular interest to their own HHS.

Under the structural arrangements in Queensland Health, the new system will not be mandated but:

The new system will also have the ability for HHSs to upload their local data should they select an alternate system.

(Queensland Integrated Safety Information Project: Project Initiation Document, version1.3).

Queensland Health is also rolling out the integrated electronic Medical Record (ieMR) system, which will replace the paper based patient information system with a secure electronic record. An additional potential benefit of being able to access a patient's full medical history is that history may include details of previous aggressive behaviour and the causes of that behaviour.

7.4 Case studies of contemporary good practice in Queensland Health

It is apparent from field visits, discussions at the Taskforce meeting and particularly the data in the HHS Occupational Violence Self Assessment Report and the statewide Occupational Violence Forum, that there are many examples of good practice in relation the occupational violence across the hospitals and other facilities of Queensland Health. The level of occupational violence, its impact on health workers and a desire to improve staff safety performance is a concern held widely and genuinely. The gap is the sharing of the good practice and in the evaluation of the strategies and interventions.

The examples below are simply indicative of what is being implemented and, is in no way an exhaustive list. It is intended to inform the risk-specific working groups (see Recommendation 7) on strategies and interventions arising from the implementation of the recommendations from this report.

7.4.1 Occupational Violence Strategy: Metro South HHS

Princess Alexandra Hospital's (PAH) Occupational Violence Against Staff Survey is a good example of an integrated strategy to address occupational violence at the hospital through a philosophy of engagement with the workforce.

The strategy is predicated upon the views and perceptions of staff of the factors associated with occupational violence from patients, relatives and visitors through a structured and comprehensive survey in 2015. The survey was preceded by a communication strategy which included the explicit endorsement of the senior leadership of the PAH. A total of 1853 responses were received.

Consistent with research nationally and internationally, the following themes emerged:

- Systems issues—healthcare system creates environment of frustration.

- Societal problem—increased violence a reflection of society.
- Common occurrence—staff believe occupational violence now occurs more frequently.
- Challenge to fix—complex multi-faceted problem.
- Exposure breeds acceptance—now considered routine and accepted as the norm.
- Illness related—can be related to patients' health status

(Garrahy and Stanford: presentation to Occupational Violence Forum, 21 March 2016).

While only in its first phase, its initial recommendations include the importance of raising awareness of the issue and the importance of reporting and the provision of targeted training. The team involved in the strategy have prioritised the need for a *'cultural shift to ensure staff feel safe and supported.* (Garrahy and Stanford: presentation to Occupational Violence Forum. 21 March 2016).

The next phase will involve the development of a set of evidence-based interventions to assist staff to recognise, prevent and manage challenging behaviour and more effectively manage clinical assault risks. The ongoing engagement with staff will be pivotal in building on the gains to date.

7.4.2 The 'Safewards' initiative

The 'Safewards' pilot project involves mental health facilities at the Royal Brisbane and Women's Hospital (RBWH), Prince Charles Hospital and Ipswich Hospital. Other facilities including Mackay HHS, Caboolture Hospital, Gold Coast University Hospital and The Park – Centre for Mental Health have also initiated the 'Safewards' model. The program, which was developed in the United Kingdom (UK) by Professor Len Bowers, is designed to improve safety in wards for patients and consumers by ten interventions, including:

- clear and mutual expectations
- soft words
- talk down (de-escalation)
- positive words
- bad news mitigation
- know each other
- mutual help meeting
- calm down methods
- reassurance
- discharge messages

(Niall Higgins & Thomas Meehan: Presentation to the Occupational Violence Forum Statewide Forum. 21 March 2016).

The Safewards model involves a move away from the traditional approach involving education and training and clinical supervision and proposes an alternative approach,

which focuses on potential flashpoints. Flashpoints emerge when staff interact with patients in an authoritarian and/or disrespectful manner and can lead to practices around seclusion or restraint. The interventions involve better ways to manage those flashpoints.

Associated with this initiative is use of *Brøset Violence Checklist*, which is an instrument for predicting inpatient violence within a 24 hour period. It considers six variables, which relate to the risk of aggressive behaviour. They are:

- confused
- irritable
- boisterous
- physically threatening
- verbally threatening
- attacking objects,

(Higgins & Meehan: Presentation to the Occupational Violence Forum. 21 March 2016).

It is argued that the *Brøset Violence Checklist* is more reliable than clinical assessments, takes less than a minute to complete and provides a standardised risk assessment tool.

The project team in Queensland will oversee an evaluation at Ipswich, RBWH and Prince Charles. That evaluation is expected to be completed in mid-2016.

The Safewards model has been adopted in Victoria.

7.4.3 ‘Code Grey’: Townsville HHS

The Emergency Department at the Townsville HHS is trialling the ‘Code Grey’ process, which is being adapted from Victoria. The initiative is being implemented after communication strategies aimed at de-escalation have been deemed not to be effective in defusing a situation, which has the potential to lead to violence. A trained ‘Code Grey’ team is deployed to re-establish a safe clinical environment. While the team is clinically led, it consists of clinical and security personnel. This model is discussed further in section 8.3.1.

7.4.4 Prepositioning nurses in the watchhouse—Gold Coast University Hospital

The Queensland Emergency Medicine Research Foundation and the Gold Coast Hospital Foundation have funded a program in which emergency department (ED) nurses from the Gold Coast University Hospital were prepositioned at the police watchhouse. The 2013 trial was a response to a coronial inquiry, which found that it was inappropriate for police officers to make medical decisions about prisoners who were being detained at the watchhouse. Associate Professor Julia Crilly identified the following advantages:

During the trial the addition of ED nurses with specialist skills meant that there was a 24-hour nursing presence in the watchhouse. They could detect and treat more health issues on site, in conjunction with forensic medical officers who were on-call. This means fewer transfers to hospital.

and

Every prisoner who needs to be transported to an ED requires two police officers and two ambulance officers, as well as hospital resources.

(Associate Professor Julia Crilly: Queensland Health media release. 30 October 2015 <https://www.health.qld.gov.au/goldcoasthealth/news/2015>).

7.4.5 Peer support program: The Park - Centre for Mental Health, Wacol

A peer support program has been operating for more than a decade at The Park, as part of a multifaceted strategy to reduce both the incidence and impact of aggression toward staff. The peer support program is available to all staff who were involved in an incident of aggression or violence from consumers at the facility. There is a small team of peer support volunteers who undertook a short training program.

These volunteers were required to attend a two-day training program in peer support principles and stress debriefing techniques in preparation for the role.

(Meehan, Fjeldsoe, Stedman and Duraiappah: Reducing aggressive behaviour and staff injuries: a multi-strategy approach. Australian Medical Review: Vol 30 No. 2. p. 205).

Staff who had been assaulted are followed up on, on at least three occasions; the day of the incident and then three days and ten days later. On that last formal occasion, an assessment is made as to whether the person needs more professional counselling through the Employee Support Program (EAP).

Peer support programs are discussed further in section 8.4.1.

7.4.6 Police and Ambulance Intervention Plans (PAIP)

The Mental Health unit at RBWH, the QPS and QAS have recognised the benefits of maintaining open lines of communication in relation to consumers and/or vulnerable people who are considered to be at significant risk to themselves and/or others and/or property and/or engaging in serious risk taking behaviours. The avenue for sharing this information is through PAIPs.

It builds upon the information, which is shared on a daily basis as a component of the Mental Health Intervention Program (MHIP). The sharing of this information is enabled by the Authority for Disclosure and Publication of Information to lessen or Prevent Serious Risk to Life or Safety or Public Interest. The Authority is under the HHB Act, section 147 and the *Mental Health Act 2000*, section 526, and is supported by the Memorandum of Understanding (MOU) with Queensland Health, QPS and QAS.

The PAIPs are a standardised, two page document which gather information on the person's context, identified risks, contacts, what to expect when attending, interventions and strategies, clinical information and review details.

Principles informing this framework including an approach that:

- is proactive, supports timely early interventions and mitigating risks

- facilitates collaborative working relationships and builds capacity between service providers, consumers and carers, based on mutual respect and understanding
- standardises the documentation provided to the QPS and QAS in the form of a Police and Ambulance Intervention Plan
- demonstrates accountability and transparency by the QPS, QAS and mental health services through regular reviews and audits, and a framework that is consumer-focused
- establishes baseline expectations with a view to ongoing improvement activities.

It has the potential for broader application by providing a standardised process and documentation for the QPS, QAS and HHS mental health services across the state for the those consumers whom are assessed as having the highest risks to themselves and health workers.

8. Findings and recommendations

8.1 General issues

8.1.1 Occupational violence: a Queensland Health definition

The Occupational Violence Taskforce has identified the critical importance of a consistent definition across the entire Queensland public health system. Currently the only formal definition in Queensland Health is the one on 'aggression (see Chapter 2). There are a range of definitions used in legislation, other jurisdictions and by organisations including the World Health Organisation and the International Labour Organisation. However, it is important to clarify what is in scope and out of scope in the Queensland Health context. The value of a common definition was discussed at the statewide forum on 21 March 2015. A single Queensland Health definition, which is endorsed across Queensland Health and all HHSs would facilitate consistent messaging on the issue and avoid unnecessary duplication and confusion across the HHSs in those communications, and in the potential control and intervention strategies.

The definition of occupational violence requires the following minimum components:

- the type of offending behaviour (e.g. abuse, threats, physical assaults)
- the people to whom the behaviour is directed (e.g. health and hospital workers in the Queensland public health system)
- the scope (e.g. occurring as part of or arising from their employment with Queensland Health)
- the potential sources or perpetrators of the violence.

It is important to note that, while staff-to-staff aggression, bullying and harassment are important workplace issues for Queensland Health, this form of violence and aggression was not included in the Taskforce's terms of reference. Specific strategies to manage occupational violence between employees are available to managers and staff. Further activities are being undertaken by the Department of Health, separate to the deliberations of this Taskforce.

An agreed definition of occupational violence is a critical prerequisite for a comprehensive and integrated approach to the prevention and management of occupational violence in the public health system. An endorsed and commonly shared definition enables the quantification of the issue to be better understood with less likelihood of differing interpretations.

Recommendation 1

That the Director-General, Department of Health and System Leadership Forum endorse the following definition of occupational violence and the associated clarifying statement for consistent use across Queensland Health and the Hospital and Health Services.

Occupational violence is any incident where an employee is abused, harassed, threatened or assaulted by patients and consumers, their relatives and friends or members of the public, in circumstances arising out of, or in the course of, their employment, irrespective of the intent for harm.”

Occupational violence includes, but is not limited to, verbal, physical or psychological abuse, threats or intimidating behaviour, racial vilification, harassment (including sexual harassment and stalking) or sexual assault. Physical abuse includes actions such as hitting, spitting, pinching, scratching and throwing objects.

Occupational violence impacts negatively, not only on physical, emotional and psychological wellbeing of healthcare workers, but on the overall quality of healthcare, through its impact on the individuals, their colleagues and other patients.

It can be perpetrated by patients and consumers, their relatives and friends and members of the public.

Common contributing factors linked to the incidence of occupational violence against health workers include:

- characteristics of some medical conditions (e.g. fear, pain, dementia, delirium and mental illness)
- characteristics of some individuals (e.g. patients with history of substance abuse and violence, and cognitive impairment)
- characteristics of relationships (e.g. daily routines, rules and limit settings, and practices around patient and visitor movements)
- organisational and environmental factors (e.g. wait times, community health services and services in remote and isolated locations)
- societal factors (e.g. community attitudes towards violence and service expectations).

As the contributing factors to workplace violence are complex and inter-related, intervention strategies should be evidence based, multi-faceted, integrated, participative, culture/gender sensitive and non-discriminatory.

8.1.2 Duty of care obligations

Frontline health workers, particularly nurses and paramedics, are exposed to the threat of both verbal and physical violence on a daily basis with an unacceptable level of physical assaults. (See Chapter 5)

A consequence of the increasing level and scale of violence is that the 'duty of care' obligations of Queensland Health, HHSs including the HHS Board members and QAS to provide a safe working environment, are being compromised daily.

Despite previous policy and campaigns across the Queensland health sector around the theme of 'zero tolerance' for occupational violence, the reality is clearly different. There is a high level of tolerance of workplace violence. Clinical and security staff are confronted by difficult ethical dilemmas, with a demonstrable and legitimate focus on patient care. For clinical staff, this focus is derived from their professional training and is reinforced constantly. The violence to which they are subjected includes unintentional actions such as post-operative responses, dementia patients and mental health patients with severe cognitive impairments and from patients in acute pain or severe shock. Despite the fact that these types of actions may be unintentional, Queensland Health and the HHSs as employers have an legislative obligation under the WHS Act to minimise the risks to the staff through the identification of those clinical risks, and through the design and structure of the work environment and work practices, and through the provision suitable training and other forms of support.

However just as certainly, health workers are being increasingly subject to actions, which are, or border on criminal acts. The behaviour is absolutely unacceptable. This behaviour can include violent behaviour brought on by drugs and alcohol or by the failure of mental health patients to take their prescribed medications. Family members and friends can be perpetrators of this violence as well. These people have exercised a choice; a choice to get drunk, take illicit drugs or not to take medication. The society and its legal system should hold people to account when they opt for such choices and threaten or harm the wellbeing of those who are dedicated to helping them.

However, to further complicate the dilemma for health workers, the behaviour of patients and/or customers is often impacted by 'dual diagnosis' and 'co-morbidity' issues. This makes the distinction between 'unintentional' and 'unacceptable violent behaviour even more blurred. However, the cause and nature of behaviour needs to be addressed during the investigations resulting from any violent act against a staff member, so that personal responsibility for unacceptable behaviour is assigned to those who have made 'bad choices.

Duty of care obligations implies that individual health workers confronted with the threat of violence have the right to protect themselves, if that is possible, primarily through de-escalation, disengaging and extrication. Management and colleagues must give 'permission to' and support staff whose actions are consistent with this approach. It means that if attempts to 'de-escalate' the situation are unsuccessful, disengaging or extricating oneself from that situation until support is received, should be the preferred response.

8.1.3 Societal context of violence

Occupational violence against health workers must be seen in the broader societal context in which violence is a major concern. This is evidenced in alcohol and drug fuelled violence including the 'coward punch' phenomena, 'glassing', domestic violence, bullying (including cyber-bullying), road rage, child and elder abuse, sexual abuse, stalking and a range of mental health issues impacting in the community.

Aggression in society at large can translate to aggression against healthcare workers through the process of acculturation..

(Rae and Cassematis, p.15).

Regrettably, while these forms of anti-social behaviours are becoming more prevalent in our society, strategies specifically targeted at occupational violence against health workers are unlikely to deliver sustainable outcomes unless considered as one element of a broader approach to all aspect of societal violence.

The 2008 Report for Victorian Police, *Violence in Public Places: Explanations and Solutions* commented that:

There was general agreement across all jurisdictions—police, ambulance, hospitals, courts and education—that there had been, in the past years, a pronounced increase not only in the incidence of violence, but also in its severity.

(R Eckersley and L Reeder (Australia 21). *Violence in Public Places: Explanations and Solutions*. A report for Victoria Police on an Expert Roundtable. December 2008. p. 5).

It concluded that:

It is clear that the issue of antisocial behaviour is a multi-faceted problem requiring multi-faceted responses....it needed an integrate strategy. It is important that a whole of government approached is developed to achieve consistency on enforcement and preventative models..

(R Eckersley and L Reeder, p. 20).

Ad hoc and piecemeal responses to antisocial behaviour and public violence don't work.

(R Eckersley and L Reeder, p. 25).

Societal norms around violence are changing. Traditional taboos which, in the past, resulted in an intuitive reaction not to threaten or assault the 'caring professionals' or emergency services personnel have been weakened.

Societal violence requires a multi-faceted, multi-dimensional approach involving community awareness and education campaigns and public policy responses, which might include harsher penalties, when thresholds are crossed. The longer term objective must be to change attitudes and behaviours. In this context, changes to the closing times for hotels and nightclubs and strategies to reduce domestic violence in Queensland are welcomed as are harsher penalties for such violent behaviour.

In recognition of the importance of raising awareness of occupational violence prevention, the Queensland Government has allocated \$1.35M for a public awareness campaign through the media to highlight the issues of assaults on paramedics and health workers and the impact of that behaviour on those workers and their families. The campaign, which includes social media, consists of advertisements, community messages and signage in health facilities.

Part of our response must focus on education of the community and indeed those in the health system that violence is unacceptable and that there will be consequences for those who perpetrate violence.

(Beth Mohle, Secretary QNU. Presentation to Occupational Violence Forum. 21March 2015).

Consistent with the recommendations from the Victorian Auditor-General, the public messaging should “*highlight the need for appropriate and respectful behaviour when seeking medical treatment*”. (Victorian Auditor-General’s Report Recommendation 9, p 35). The themes of ‘respect’ and ‘respectful behaviour’ should be an element of signage in public spaces in the public hospital system. The messages can also assist to reinforce expected standards of behaviour of those seeking treatment. (Rae and Cassematis, p. 16 and p. 30).

While impact of community awareness campaigns on the actual perpetrators may be limited, if they engage health workers, other patients, visitors and community members so that they change from passive onlookers to active discouragers of anti-social behaviour, the investment should be worthwhile.

Public awareness campaigns should also be used to increase the public standing of health workers.

Recommendation 2

That future Queensland Government and Queensland Health community awareness campaigns include themes such as the importance of ‘respect’ and ‘respectful behaviours’ and personal responsibility for unacceptable behaviour by recipients of healthcare services.

Information to consumers should be displayed in public areas in health facilities in relation to expectations of acceptable behaviours.

Behavioural and attitudinal change does not occur easily or quickly; it requires a long-term commitment. In the case of societal violence there is a need to link with and reinforce the messages of anti-violence campaigns such as for domestic and family violence and child abuse. In this context, the community awareness campaign needs to be ongoing.

8.1.4 Organisational culture

Traditional approaches built around specific strategies related to risk assessment, workplace design, policy and procedures, and training and education are likely to be less effective and sustainable unless the importance of organisational and workplace cultures are recognised.

In this context, any approach which ignores the fundamental importance of organisational culture is doomed to fail. Queensland Health needs to promote a **safety culture**.

The philosophy underpinning an integrated and comprehensive approach to workplace violence in the public health system must be the **right to be safe** at work. The commitment to the safety of individuals must be paramount. A safety culture and the right to be safe at work requires Queensland Health and the HHSs to demonstrate that they value the safety of their workers and patients equally.

There were some concern expressed to the Taskforce, at the Occupational Violence Forum and through site visits, that previous strategies to reduce the impact of occupation violence have not had as much impact as was needed because the issue was seen to be issues for human resources (HR) and/or occupational health and safety (OHS) professionals. It needs to be recognised and promoted as a ‘clinical issue’ in the

same way as patient care is. Essentially, workplace violence has the potential for adversely impacting on the quality of health services through increased costs related to sick leave, workers compensation, the refurbishment of facilities and the repair or replacement of critical equipment. Additional costs are incurred through losses of quality experienced clinical staff and recruitment and training of their replacements. Adverse impacts on the quality of patient care are also a consequence of poor morale among staff and through the redirection of staff from important clinical responsibilities to assist in the management of a threatening or violent patient.

Implementing and achieving a culture of safety that integrates patient safety with worker safety requires changes in attitudes, beliefs and behaviors. It is not quickly nor easily accomplished. Understanding the key components of a safety culture that integrates patient safety with worker safety and assessing the current organisational culture are integral steps to achieving a culture of safety. Leadership and employee commitment are the hallmark of a true safety culture where safety is an integral part of daily operations.

(Health Research & Educational Trust, Illinois. Culture of Safety Change Package: March 2016 Update. Chicago. (accessed at www.hret-hen.org) p. 5).

The strong message from the Occupational Violence Forum was that this inappropriate behaviour not be 'normalised. Beth Mohle, Secretary of the QNU articulated these concerns.

Unfortunately and unacceptably it seems violence has been normalised, within broader society but also for both management and staff who far too often see violence as part of the job of health workers. Well it is not. Violence towards health workers is totally unacceptable and should not be tolerated. It destroys far too many lives and far too many careers. We need to tackle this normalisation of violence as a matter of urgency—it is a symptom of a gross under valuing of health workers by our health system and broader society.

(Beth Mohle, Secretary QNU. Presentation to Occupational Violence Forum. 21March 2015).

It is salutary to remember that, regardless of the cause of the aggression, **there is a victim**; a person who is potentially injured physically, emotionally or psychologically in the course of their work. There is a cost as well to the health worker in terms of their wellbeing, to the system, to other patients and consumers and often to the perpetrator as well.

Building a safety culture requires the explicit recognition that there is a victim of occupational violence regardless of whether the violence is intentional or unintentional.

Internationally and in Queensland, there is evidence of significance under-reporting of occupational violence in health settings.

While recent research studies show high levels of occupational violence against healthcare workers in Victoria, the true extent is unknown. This is partly because there is significant under-reporting of occupational violence incidents in Victoria—as there is nationally and internationally. It is also because health services' occupational violence data is not of sufficient quality and comparability to provide a statewide picture.

(Victorian Auditor-General's Report, p. xi)

A similar conclusion can be drawn in the Queensland context. Other explanations relate to the nature of work in the health system.

Staff may also excuse violence because they believe a client is ill or disabled in some way; because they may fear job loss if they do complain; or because violence is so prevalent they would never be able to do their jobs if they were continually filling in forms.

(Professor Duncan Chappell, Literature Review into Best Practice for Preventing and Managing Customer Aggression. Reprinted and de-identified by Comcare, Canberra. 2009 p. 6).

The QNU also noted these concerns in their submission to the Legal Affairs and Committee Safety Committee of the Queensland Parliament in December 2015.

Of some concern to the QNU is that nurses and midwives do not report many incidents of abuse or violence for various reasons including workloads and a view that this type of behaviour from patients, relatives or visitors is 'normal'. It is not 'part of the job...'

(QNU Submission to the Legal Affairs and Community Safety Committee: Tackling Alcohol-Fuelled Violence Legislations Amendment Bill 2015. December 2015).

The Victorian Auditor-General's made a number of observations on the reasons for under-reporting. These are detailed in Box 1.

Box 1. Reasons for under-reporting: Victoria Auditor-General's Report 2015

Incident reporting systems are cumbersome

The incident reporting system used by health services is not suitable for reporting occupational violence incidents, has multiple overlapping codes, insufficient relevant fields and a complex interface. It can take 40 minutes to report a single incident and involves scrolling through multiple redundant fields.

Staff have compassion and sympathy for patients whose aggression arises from a clinical condition—staff report feeling that the patient 'couldn't help it'.

There is a view that clinical violence is an inevitable part of the job—for example, interviews elicited repeated comments that the frequency of occupational violence incidents meant that if staff reported every incident 'you would be reporting all day'.

Staff perceive a lack of management action in responding to incidents—our analysis of incident reports highlights poor investigation and response for any but the most serious of incidents.

There are logistical and equipment barriers to reporting—including being required to complete a report after a shift ends and difficulty accessing computers. (Victorian Auditor-General's Report p. 14).

Staff interviewed across the audited agencies also reported:

- a lack of clarity regarding what constitutes occupational violence and what should be reported
- poor knowledge of policies and procedures
- staff safety not being as clearly and strongly promoted as patient safety that it was an individual's choice whether to report an occupational violence incident, rather than a requirement as part of a whole-of-organisation responsibility—this leaves the way open for staff not to report something because it is perceived to be 'unintentional' on the part of a patient or 'just part of the job'. (Victorian Auditor-General's Report p. 21).

In its comprehensive survey of 1853 health workers at the PAH, the reasons for not reporting incidents of occupational violence were consistent with the data from the Victorian Auditor-General's report, which showed both clinical reasons and ones related to concerns about follow up actions and workload. (see section 7.4.1)

Reason not to report	Frequency of response
Patient had Dementia	236
Patient had Brain Injury	184
Patient was Elderly	178
Patient Characteristic was of Aggressor	167
Respondent is accustomed to OV	155
Patient was under influence of drugs	155
Patient was drunk	118
Respondent believes nothing is ever done about OV	116
Aggressor was traumatised	85
Respondent was unconcerned by the OV	69
Respondent accepted aggressors apology	49
Patient was a minor	45
Respondent has no time to document	25
Respondent told not to report	23
Respondent Documented, not in incident report	14
Patient was suffering from Mental Health issue	12
A patient's relative	3
Threatened with Legal Action	1

(Source: Garrahy and Stanford. Presentation to Occupational Violence Forum 21 March 2016)

Whatever the reason for under-reporting, particularly of serious incidents, whether it be workloads, poor and time-consuming reporting systems, a belief that 'nothing will be done' or the ethical dilemmas referred to section 8.1.2, the impact of organisational culture on workplace violence must be considered as a priority.

The staff interviewed identified that the 'lack of adequate training' is frequently put forward by management when a serious incident occurs. However, they rightly identified that staff training in the management of aggression should be seen as only one component of a comprehensive aggression management plan. This is supported by an earlier study of patient aggression at the Park (Meehan et al. 2006), which found that staff training on its own might have a limited role in reducing aggressive behaviour. The effective management of aggressive behaviour in any health care facility, mental health or otherwise, requires an overall plan of action, a commitment from senior management, and a number of different strategies implemented simultaneously. As such, it is recommended that a plan for the management of aggression be developed for the HHS and this needs to be underpinned by a strong commitment from senior management.

(Evaluation of the Aggression Behaviour Management (ABM) Program: Final Report. Service Evaluation & Research Unit, The Park—Centre for Mental Health September 2015. p. 5).

There was much discussion at the statewide Occupational Violence Forum on workplace cultures across the public health system and the tolerance of aggressive behaviours.

A culture of blaming others for not effectively managing or addressing this workplace issue is likely to exacerbate the problem. 'Shared responsibility' is a useful concept in the context of occupational violence with leaders, managers and health workers having specific but different responsibilities. In commenting on the critical success factors for a violence prevention program, the Illinois Health Research & Educational Trust comments:

Management commitment and worker participation are essential elements of an effective violence prevention program. The leadership of management in providing full support for the development of the workplace's program, combined with worker involvement is critical for the success of the program.

(Health Research & Educational Trust, Illinois, p. 6).

They argue that 'effective management leadership' begins by recognising that workplace violence is a safety and health hazard. (Health Research & Educational Trust, Illinois, p. 6).

Visible and genuine management commitment provides the incentive to report incidents of aggression. Management also must allocate resources consistent with the intervention plans, which are an essential element of a comprehensive and integrated approach to occupational violence.

To be effective, any intervention strategies must be accompanied by a commitment from organisational leaders within the public health system. A 'top down commitment' to local/work unit initiatives and the encouragement of reporting of, and investigations into workplace violence will demonstrate to frontline health workers that 'management' takes the issue of staff wellbeing seriously. A simple proposition of trusting that staff have 'done the right thing' unless subsequently established otherwise, would be viewed positively by many staff members, as would an interest in the support, which people need after an incident.

These comments are not to argue that leaders and managers are not concerned about the issue of occupational violence. Indeed the evidence from site visits and the statewide Forum on 21 March 2016 was that they were very concerned about the impact of violence on health workers. Evidence is reflected in the occupational violence committees in the HHSs and their initiatives and in the agendas of, and interest by the HHS Boards. However, some frontline staff expressed a desire to see this interest and support more explicitly displayed.

The May 2016 Occupational Violence Forum for the Metro North HHS is a commendable initiative which has enabled frontline staff to participate in discussions about an issue which affects their personal safety. This type of opportunity is important in building a safety culture through the engagement of health workers, managers and leaders.

Importantly, health workers have obligations. They need to report incidents. They are often more knowledgeable about the workplace and the systems and processes which enables them to identify risks and propose more effective controls and interventions. They can assist their colleagues under pressure.

Through involvement and feedback, workers can provide useful information to employers to design, implement and evaluate the program. In addition, workers

with different functions and at various organisational levels bring a broad range of experience and skills to program design, implementation, and assessment.

(Health Research & Educational Trust, Illinois, p. 7).

During the deliberations of the Taskforce and the Occupational Violence Forum, some expressed the view that the attitude and/or behaviour of some staff contributed to the aggression. Frustration with long waiting times, the lack of information and the language and manner of staff can trigger inappropriate responses. That is undoubtedly true. However, health workers are often under severe pressure due to high loads and the demands of patients and consumers. Frustration can be a factor for them as well. Support from other team members who notice this behaviour and training to manage this risk, can help to ameliorate the cause of patient aggression.

Shared responsibility is central to a safety culture.

Additionally, occupational violence requires an ongoing commitment. Strategies need to be evaluated for effectiveness and refined upon the basis of evidence. It is an issue impacting on all HHSs and requires a 'whole of organisation' focus. Successful interventions need to be shared across Queensland Health.

Data is important. Interventions and controls must be accessed regularly and refinements made where the evidence indicates that the measures are not effectively contributing to improvements in staff safety performance. Ironically, however, an increase in the reported number of incidents may be a leading indicator that the cultural change program is having some impact.

The safety culture program must be accompanied by messages and actions, which promote safe behaviours.

Changing the workplace culture is likely to be the single most critical success factor in a program to limit the impact of occupational violence. Organisational leaders must be advocates for an integrated and comprehensive approach to violence in the workplace. Importantly, the HHSs and individual facilities and work areas must acknowledge that 'static' approaches will have limited long term effectiveness. A culture, which is underpinned by a concern for staff safety and which has a continuous improvement philosophy is a prerequisite for successful implementation of effective control and interventions. Evidence from recent international literature review is that a focus on staff safety should also have a positive impact of patient outcomes. (M Ahmad et al., p. 2).

The Taskforce contends that Queensland Health and the HHSs should promote a 'safety culture' and the 'right to be safe' at work. The essential components include the need for Queensland Health and the HHSs to:

- demonstrate that they value the safety of their workers and patients equally
- recognise that there is a victim of occupational violence regardless of whether the violence is intentional or unintentional
- recognise that intervention strategies must be evidence based, multi-faceted, integrated, participative, culture/gender sensitive and non-discriminatory
- support the importance of a shared responsibility approach at all levels
- provide resources to support those strategies
- measure and act on staff safety performance

- promote safe behaviours.

Recommendation 3

That Queensland Health and the Hospital and Health Services work cooperatively to promote a safety culture and the right to be safe at work across the public health system.

8.1.5 Occupational violence strategic plans

The Occupational Violence Self Assessment report confirms that all HHSs have established committees to focus on occupational violence either as a dedicated standalone committee or as part of a broader workplace health and safety committee. In fact the HHSs acknowledged that governance arrangements around the issue had been strengthened through this focus. It was recognised as one of the key successful strategies. (HHS Occupational Violence Self Assessment Report, section 1.15a).

Strong governance arrangements will support the promotion of a safety culture. The development of an occupational violence strategy or plan by each HHS would reflect the importance of staff (and patient) safety. The occupational violence strategy should establish goals and objectives, governance arrangements and identify the potential controls and interventions within a framework of prevention, protection and post incident management. The current Queensland Health Framework on *Occupational Violence Prevention and Management* would be a useful reference (see Appendix 5). The strategy should identify the measures or indicators to assess the safety performance of the HHS. In the case of the large metropolitan and regional hospitals, there may be benefits in reporting on performance at the individual facility level. The strategy should be evaluated and reassessed on a regular basis.

Under the current service level agreements, biennial safety audits are required. These safety audits should make specific reference to the occupational violence management strategy.

Recommendation 4

That the Service Level Agreement with each Hospital and Health Service include a requirement for an Occupational Violence Management Strategy. The strategy should include measures or indicators of staff safety performance. Further, the biennial audit requirements should include specific reference to the Occupational Violence Strategy.

8.2 Prevention strategies

The best strategy for managing aggression is prevention. (Natisha Sands, An ABC Approach to Assessing the Risk of Violence at Triage, Australian Emergency Nursing Journal, No.10, 2007. p.107).

8.2.1 Risk assessment and risk management

Risk assessments are a primary tool in determining the nature and potential impact of risks within health services and facilities and the potential effectiveness of any planned control or intervention. There are multiple dimensions to a comprehensive risk

assessment framework. The first tier involves an assessment of the workplace risks. However, this element needs to be supplemented by clinical assessments based on the characteristics and needs of patients and consumers. The third tier is more complex. Dynamic risk assessments, in real time, involve assessments of the risks in an evolving circumstance.

Two fundamental questions need to be answered through this first step in the risk management process—what is the level and nature of risk within the working environment; and what policies, procedures or systems are already in place within an organisation that can assist in eliminating or minimising the risk of violence? Answering these two questions may not be a very time-consuming or complex task in a small enterprise but in larger organisations, a proper assessment of the risks involved may require a major commitment of time and resources. It cannot be stressed too highly that no two workplaces are alike, or confront exactly the same hazards or levels of risk. (Chappell, p. 4).

Queensland Health, the HHSs and individual facilities have had a significant history of the use of risk assessment tools with OVRAT and modifications of it, such as the Violence, Aggression Mitigation Management Plans (VAMP) being used across the system. The frequency, with which the assessments are reviewed vary from annually to triennially, although most HHSs advised that a significant incident might trigger a review within the normal cycle. (HHS Occupational Violence Self Assessment Report, section 1.5).

While the assessment of risk in smaller facilities might be able to be done across the whole facility, there is the potential for the aggregation of risk assessments to mask specific high-risk environments within those facilities. A similar consequence can arise from the aggregation of data. Risk needs to be assessment at the work unit level, especially in the larger regional and metropolitan hospitals. This is important because risk assessment need to inform procedural and training arrangements. Generic, whole-of-hospital arrangements can waste valuable resources for areas of lesser risk, while at the same time provide inadequate support in other areas of higher risk. To state the obvious, effective training and procedural arrangements in large emergency departments, mental health facilities and community health services will differ from those in general wards or indeed in geriatric facilities. Moreover, while the risk profile in the general wards might be lower, the consequences or impact when a 'violent patient' is moved to those workplaces may be greater as the experience, situational awareness and training may not equip those nurses and other health workers to deal with such situations as effectively as those who work with 'difficult' patients and consumers on a daily basis.

The second fundamental requirement for risk assessments in individual work areas is the involvement of the local staff. It is important the risk assessment process not be handed over to OHS 'experts'. Their role should be to assist with tools and the process but local input is important for two reasons. Work area staff are more knowledgeable about the nature of patients and consumers and the physical environment in which they work. Involving them in the process helps them understand the different risk treatments, which may be necessary. It also reinforces the notion of shared responsibility; that workplace violence is everybody's issue.

While workplace risk assessments are an important aspect of the prevention of, and protection from workplace violence, they reflect a static environment. In reality, hospital

environments are anything but static. They are busy, sometimes chaotic places with large throughputs of people with a myriad of needs and demands. Situations can and do change instantaneously and without warning. In such a context, staff need higher order skills and insights.

There are a range of tools, which are useful supplements to the more generalised risk assessments. These instruments are generally clinically focused and relate to specific work environments such as mental health units. Clinical risk assessments are used widely through the mental health services. The purpose of clinical risk assessments is outlined in the Work Instruction of the Cairns and Hinterland HHS.

Clinical risk assessment is a gathering of information and analysis of the potential outcomes of identified behaviours, including identifying specific risk factors relevant to an individual, understanding the context in which it may occur, and linking historical information to current, anticipated and possible future outcomes.

(Work Instruction, Clinical Risk Assessment. Cairns and Hinterland HHS).

Clinical risk assessments in mental health can utilise tools such Risk Screening Tool, which has been developed by Mental Health Services and the Brøset Violence Checklist. (See section 7.4.2)

There are a range of other tools including the 'ABC of violence risk assessment at triage' which 'aims to provide a practical framework for a systematic approach to violence risk assessment' involving assessment, behaviour and conversation. (Sands p. 108).

The working groups to identify clinical work practice interventions in high risk areas (see Recommendation 7) should identify, adapt or develop risk assessment tools suitable for their specific areas, in consultation with the representative groups, clinical networks and corporate office. These tools could then be shared across the HHSs.

In mental health and other settings, clinical risk assessments are important inputs to assist with individual behaviour and care planning.

It needs to be acknowledged that the new integrated electronic Medical Record (ieMR) system could assist in these clinical risk assessments through the capacity to view and share details of a patient's medical history, which may include details of previous aggressive behaviour and the context of that behaviour.

These first two tiers of risk assessment are necessary but not sufficient in effectively identifying and responding to threats in the workplace.

Dynamic risk assessments are necessary to reassess risks from people and situations continuously to enable actions to be terminated or modified in order to protect oneself or one's colleagues. Situational awareness by individuals and teams is a key to the identification of possible dangerous developments in the workplace.

Dynamic risk factors include the presence of active symptoms, stressors, intoxication, medication noncompliance, access to weapons, and interpersonal conflict.

(R Green, R Pedley and D Whittingham, 'A structured clinical model for violence risk intervention. International Journal of Law and Psychiatry No. 27, 2004. p. 350).

Unlike the other risk assessments, dynamic risk assessments are generally not able to be documented. The focus needs to be 'upon ongoing assessment, rather than prediction.' (Green et al. p 356).

Dynamic risk assessment is a skill, which requires training so that signals and/or thresholds are identified almost intuitively or instinctively.

8.2.2 Training and capability development

Education and training are important risk management controls.

Training is critical to building a robust safety culture that protects workers.

(Victorian Auditor-General's Report, p. 23).

There was significant feedback on training from the HHSs, which is highlighted in the HHS Occupational Violence Self Assessment Report. A concern was that many HHSs identified training as their primary prevention solution. (HHS Occupational Violence Self Assessment Report, section 1.6 and 1.11). It must be seen as important but is only one of a suite of prevention strategies.

Rae and Cassematis provide a useful summary of the role of training in the prevention of occupational violence.

Training is part of the solution to workplace aggression, so long as:

- it is part of a multi-factorial solution, rather than a single factor intervention
- it provides staff with increased capacity to do work safely, rather than imposing further constraints on their work
- it is seen as part of individual career and professional development, not a work requirement
- it is designed with and delivered by people who do the work, rather than outsiders
- it provides a range of tools that can be adapted and applied across different work contexts. (Rae and Cassematis, p. 31).

Concerns were also expressed at the costs of training and the capacity to deliver in-house training. Resourcing occupational violence related training was an issue and the Occupational Violence Forum in March and identified as the key challenge for the HHSs. (HHS Occupational Violence Self Assessment Report, section 1.15b).

There was also considerable variation in the training programs, which were being utilised. (HHS Occupational Violence Self Assessment Report, sections 1.13 and 1.14).

Training must be valued and this value consistently reinforced by leaders and managers across the public health system. It must be adequately resourced.

However, training has to be relevant to the workplace risk and derived from a robust workplace risk assessment processes. This point is well made in the 'Evaluation of the Aggression Behaviour Management (ABM) training program'. It recommended:

the development of a tiered approach to training that is based on both rates of exposure by clinical area and staff role....

and that

The content and delivery of training to meet the needs of the different disciplines and different work roles needs to be considered.

(Evaluation of the Aggression Behaviour Management (ABM) Program, p. 7).

Training in situational awareness, communication skills (including empathetic communications skills), de-escalation techniques, strategies and techniques around disengagement and extrication from a dangerous situation, risk assessments, incident investigations and supervisor training were identified as priorities at the March 2016 Forum. Training needs to incorporate the identification of ‘triggers’ or thresholds which signal when de-escalation is unlikely to be effective and disengagement and/or when support are required.

Clearly incident response teams, emergency department workers, community nurses, workers in the mental health sector, clinical staff in remote areas and occupational groups such as security officers have higher order training needs and skills development requirements, which are context specific, and may go to physical, mechanical or chemical restraint techniques and procedures.

An issue raised during consultation was the impact of the HHS model on the training. It would entirely consistent with the legislation and the outcomes of Hunter Review, that individual HHSs are and should be responsible for the provision and delivery of training around the safety of staff, generally and from threats or assaults from patients, consumers and other hospital visitors, specifically. Additionally the HHSs are accountable for staff access to training, the identification of modules suitable for individual work areas or groups of employees and the quality of that training. That training needs to be framed by the workplace risk assessments.

There needs to be flexibility in the delivery of training to include face-to-face, on line and modular options. These decisions are best made locally as the contexts and requirements of training are different.

A further requirement is for training programs to be reviewed regularly for relevance. That requires the establishment of clear goals with measurable outcomes for the training regime and its components. The quality of training opportunities needs to be tested against their impact in the workplace.

Training can and should be properly evaluated, according to changes in the knowledge, skills and behaviours of participants, and the ultimate effect that those changes have on the occurrence, management and reporting of aggression.

(Rae and Cassematis, p. 31).

The outcomes of investigations into incidents of violence is an important element of the feedback loop and is likely to provide a better review mechanism than a simple reliance on participant feedback.

Incident reviews and investigations are key controls for the prevention and mitigation of occupational violence incidents and are critical to continuous improvement.

(Victorian Auditor-General’s Report p. 29).

However, responsibility for the training and capability framework and the curriculum design is more contested. The Victorian Auditor-General commented that:

DHHS and WorkSafe—as system manager and regulator respectively—could help health services save time and money involved in developing their own training materials by providing sector-wide guidance and tools for training and evaluating training effectiveness. This would provide the basis for consistent, high-quality

training and support the evaluation of training effectiveness across the sector. (Victorian Auditor-General's Report, p. 24).

The Hunter Review, in the development of design principles for the public health system recommended that:

Design should support devolution of functions where doing so outweighs the impacts. (Hunter Report, p. 54).

It further explains that:

Frontline services should continue to be devolved to Hospital and Health Services unless there are demonstrable advantages in operating them on a statewide or regional basis, such as clear economies of scale (more efficient, higher quality, safer outcomes) or the need to standardise systems.

(Hunter Report, p. 54).

The training framework and curriculum schema or design in relation to minimising the impact of occupational violence provides an opportunity to test that design principle. The need for greater consistency was identified as an issue by some HHSs. (HHS Occupational Violence Self Assessment Report, section 1.15c) Queensland Health needs to consider the benefits of organisational-wide training and capability framework, which would provide quality assurance across the system and reduce potential inefficiencies related to 'multiple reinventions of the wheel'. That essentially is the rationale of the Victorian Auditor-General. If such a model was acceptable in the Queensland, the development of the framework and its curriculum schema would require a collaborative and consultative approach involving the HHS in order that it is seen as a Queensland public health services framework and not one imposed on the HHSs by corporate Queensland Health. The development of this framework should be considered a priority, as it is necessary to inform the review of training arrangements across the HHSs.

Queensland Health has a responsibility to assist the HHSs by developing guidance materials and identifying and evaluating suitable training programs and modules and assessment tools.

Recommendation 5

That the Director-General, Department of Health and System Leadership Forum initiate the development of a comprehensive training and capability framework to apply across the Queensland public health system, as a matter of urgency.

Recommendation 6

That each Hospital and Health Service be responsible for the application of the statewide capability and training framework by identifying local training and capability needs and implementing a training regime addressing:

- occupational violence risk assessment and awareness and the specific capability requirements for health workers, executives, managers and supervisors, security co-ordinators and occupational health and safety/human resources professionals
- customer service, empathetic communication, dynamic risk assessment/situational awareness skills and de-escalation techniques within a non-violence framework for all health workers

- adequate resourcing of training and capability development
- supportive intervention and targeted response training of clinically appropriate techniques for defined occupational groups
- continuous improvement in the training program through effective feedback loops and regular reviews.

8.2.3 Work practices

As discussed earlier the causes of occupational violence and its impacts are complex and multi-dimensional. Consequently, to be effective and sustainable, intervention strategies must also be multi-faceted, comprehensive, integrated and evidence-based. To the extent that it is possible, the approach needs to be pro-active to minimise the potential for a tragic outcome, rather than have a crisis driven reaction to a tragedy. There can be no simple solutions to a complex problem.

This is not to oversimplify the complexities that are inherent with this approach. While acknowledging the volatile environment, which is characteristic of health settings, particularly of emergency departments and mental health and dementia units, documented procedures and practices should reflect the increased risks to staff safety.

It is important to recognise the different contexts in which work is performed and consequently the need for specific strategies to be tailored to those contexts. A 'one cap fits all' approach will fail.

The different services with their differential risk profiles have clear implications for workplace design, policy and procedures, personal protection and training.

The development of service specific controls and inventions for high risk areas including emergency departments, mental health services, dementia and acquired brain injury facilities, drug and alcohol facilities, community health services and services in isolated and remote communities requires the input from those with relevant clinical expertise.

It is important for the working groups to identify possible catalysts of aggression and violence. Risk assessments, targeted training and the availability of information to enable an assessment of potential for violence of a patient or consumer are essential elements of the identification of appropriate controls and interventions.

Working groups need to be action-oriented and are likely to be more focused if they are relatively small (i.e. eight to 10 people from across Queensland Health and the HHSs). The QNU should be represented on the working groups. The effectiveness of clinical networks across the health system should instil confidence in this approach.

In order to reinforce the importance of a partnership between the HHSs and Queensland Health, and to demonstrate leadership commitment to the prevention and management of occupational violence, it is suggested that each working group be chaired by an executive leader from a HHS, with relevant clinical experience. The working groups should report to the Occupational Violence Prevention and Management Implementation Taskforce. That Taskforce should report to the System Leadership Forum (see Recommendation 20).

Recommendation 7

That working groups be established to develop a suite of evidence-based, clinical work practice interventions and controls for both unintentional and intentional occupational violence for identified high risk areas including emergency departments, mental health services, dementia and acquired brain injury facilities, drug and alcohol facilities, community health services and services in isolated and remote communities. Each working group should be chaired by an executive leader from a Hospital and Health Service, with relevant clinical experience. The working groups should report to the Occupational Violence Prevention and Management Implementation Taskforce.

Staffing levels are clearly an important factor in the mitigation of occupational violence as they are in patient care. However, it is not appropriate for this Taskforce to specifically address this issue, as it is a matter which is being pursued in other forums and through industrial relations processes.

An important related issue is the need to ensure that health workers are appropriately qualified or trained to undertake the tasks, which are required of them in specific health settings. Placing workers in facilities, areas or situations without the necessary qualifications, expertise or training puts those workers in unsafe situations and is not consistent with the legislated duty of care obligations of the HHSs or Queensland Health.

On a more specific issue, frustration caused by delays in receiving treatment cannot be eliminated but can be mitigated by informing patients and consumers of the likely period of waiting and by information related the prioritisation of care. Perhaps, somewhat self obviously Arnetz et al conclude:

For nurses, violence prevention programmes should emphasise the increased risks of physical assault when working with patients who are cognitively impaired, demanding to leave, or in pain; and when using needles, restraints, performing physical transfers, or redirecting patients in the course of patient care.

(Arnetz et al, p 346).

The working groups should consider the potential for diversionary programs such as the Gold Coast trial of nurses being located at police watchhouses (see section 7.4.4). Diversionary or alternative treatment models for mental health consumers could help to reduce the risks of workplace aggression and violence as well as having potentially better health outcomes for the patients and consumers. Diversionary programs could have an additional benefit of saving valuable resources. Such local initiatives should be encouraged with formal evaluations being required as part of the project plans.

8.2.4 Workplace design

The literature details comprehensive advice on the importance of workplace design in both the prevention of, and protection from workplace violence.

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

(WorkCover Qld., p. 11).

Crime prevention through environmental design (CPTED) is a well-established concept in the design of new and refurbished health facilities, involving control over access to specific areas, the provision of safe and secure areas, and visible and electronic surveillance.

Improved workplace design will not in itself reduce the incidence or impact of workplace aggression. It must be considered as one element of a suite of possible interventions.

The involvement of staff in the design stage is an important aspect of an organisational culture, which recognises the importance of staff safety and the engagement of staff.

8.2.5 Information sharing

Information sharing between HHSs, the QAS and the local QPS is seen as an important strategy. However, it continues to be problematic because of time pressures, logistical problems, technology interface issues and privacy concerns.

During the course of the Taskforce's deliberations, it was acknowledged that repeated perpetrators (particularly mental health patients/consumers) were known to hospital staff, local police and paramedics. The issue of information sharing was a significant issue at the statewide Occupational Violence Forum, not only between the HHSs, QPS and QAS and between different health facilities.

The Taskforce was informed on the recent revisions of the 2011 Memorandum of Understanding (MOU) between Queensland Health and the Queensland Police Service on Mental Health Collaboration. In that MOU, the parties:

agree to work collaboratively and cooperatively to prevent and resolve mental health incidents involving people with a mental health problem and vulnerable persons...

and

.acknowledge that any relevant confidential information must be shared without delay, to reduce the risk to life, health or safety of the person to whom the confidential information relates and/or to public safety.

Information on mental health consumers can be accessed electronically through the Consumer Integrated Mental Health Application (CIMHA). Where appropriate, it can be provided to other agencies including the QPS by mental health staff.

The PAIP initiative (see section 7.4.6) involving the Mental Health unit at RBWH, the QPS and QAS, builds upon the commitments in MOU between Queensland Health, QPS and QAS. It enables information on identified 'high risk' mental health consumers to be shared. It has the potential for broader application by providing a standardised process for mental health services across the state for those consumers whom are assessed as having the highest risks to themselves and health workers.

This partnership approach to information sharing in the mental health areas is to be commended.

The QPS and mental health staff commented that information sharing works best when patients and/or consumers are transported to, or present at the local hospitals. It is less effective when they present at a different facility.

Consideration should be given to the potential benefits of such a model beyond its current limited application to reinforce the importance of the partnership between Queensland Health, the HHSs, QAS and QPS more generally.

Local arrangements, which support and complement statewide arrangements, tend to have more direct and positive impacts. Local engagement between emergency departments and mental health facilities and the QPS and QAS is needed to develop formal protocols for the handover, particularly of potentially and actively aggressive or violent people.

Where information is shared in advance, staff can plan for the arrival and management of such patients and consumers. This works to everyone's benefit including, importantly, for the person in need of care and support.

Regional and metropolitan hospitals are large communities with daily populations larger than many towns. Police support is regularly required. Most large facilities have dedicated police liaison personnel. This is an important role and should be extended where appropriate. The Police Beat initiative at PAH was also seen as a very valuable model.

Recommendation 8

That interagency collaboration between the healthcare system, police and justice systems at both a system and facility level should be enhanced through formal protocols and procedures for providing information and facilitating cooperation.

Similarly within hospital and health facilities, full disclosure of relevant information on the patient should be available to a work area receiving the person. Ideally this would be both personal communication and the electronic transfer of those details. The ieMR is an electronic patient care system, which will enhance the capacity to share information of any episodes of aggressive or inappropriate patient behaviour within a hospital setting.

While the benefits of information sharing with the QPS, QAS and other government agencies are almost universally acknowledged, there are claims that it is 'too hard'. Privacy issues and the privacy legislation are often given as reasons. It seems that the privacy regime is like a strange and mysterious vortex. It is daunting to lay people, creating fear of doing something illegal or inappropriate. It can become an excuse for inaction.

Given the undoubted benefits of information sharing from both a patient care and workplace safety perspective, Queensland Health in conjunction with the QPS and QAS, other relevant agencies, and advocacy groups should undertake a project to investigate the opportunities, which are available to share information without compromising genuine and legitimate 'privacy' obligations. The project's perspective should be what is desirable and what is possible. It is recognised that this may require some legislative amendments to health or privacy legislation.

Recommendation 9

That Queensland Health, in conjunction with the Queensland Police Service and the Queensland Ambulance Service, other relevant agencies, and advocacy groups undertake a project to investigate the opportunities, which are available

to share information to reduce the risks of occupational violence against health workers.

8.2.6 Data analytics

Accurate, real-time and comprehensive data is fundamental to effective strategy development, decision-making processes and the evaluation of the performance and the effectiveness of strategies. Historically, the availability of and confidence in the Queensland Health data sets from PRIME CI (Clinical Incident), IMS.Net (Occupational Health and Safety Management) and CF (Consumer Feedback) and the inability to integrate information from those systems presented a major weakness. Users lamented the cumbersome and often duplicated data entry requirements.

These issues were raised in 2004 in the *Report on Violence against Nurses* and again in the *Implementation of Recommendations—Status Report* in 2010.

The Taskforce was made aware of QISIP, which is designed to implement an integrated safety system that addresses clinical and workplace health and safety incident management, consumer and staff feedback and risk management.

Staff and patient safety are inter-related. Health workers have high workloads. A consistent criticism is that the information systems, is that they do not ‘talk to one another’ and that imputing information is too time consuming and complex.

The QISIP project provides an opportunity to use data and other information more effectively to evaluate the effectiveness of controls in the support of the objective of reducing the incidence and impact of occupational violence on health workers in the Queensland public hospital system. It is important that this opportunity not be lost during the development and implementation of the new integrated safety management system. Electronic interfaces with the clinical reporting systems would reduce work demands and provide more comprehensive data. A further issue, which has been raised, is the need for consistent definitions. The differential reporting of ‘Code Grey’ and ‘Code Black’ incidents is a case in point. The Taskforce was also aware of differing interpretations of ‘single nurse posts’. Not only is this lack of clarity a cause of confusion, it also limits the capacity for comparisons on safety performance and the use of data to identify and support evidence based interventions.

A representative and senior group of users with high-level endorsement from Queensland Health and the HHSs should be established to ensure that the data analytical requirements of the system are realised.

Recommendation 10

That the Taskforce notes the Queensland Integrated Safety Information Project system will improve the capture and reporting of incidents of occupational violence; however further work is needed to provide:

- **better electronic interfaces with the clinical reporting systems**
- **consistent definitions**
- **an agreed system-wide data set of staff safety indicators**
- **training in the use of data on staff safety performance to inform processes to review intervention strategies.**

8.3 Protective interventions

8.3.1 Occupational violence as a clinical issue

If occupational violence is seen as a clinical issue and the response to incidents is based on clinical principles, the team approach could help overcome the fear of feeling isolated and vulnerable. There would give practical effect to a 'we are all in this together' message.

During the site visits and meetings including Taskforce meetings, and through the literature scan, a number of examples of how an 'emergency clinical' model could be applied were articulated.

According to the Victorian Auditor-General, the introduction of 'Code Grey' across their health services was seen as positive initiative.

In 2011, the [Parliamentary Inquiry into Violence and Security Arrangements in Victorian Hospitals and, in Particular, Emergency Departments] recommended establishing a standard for Code Grey responses in health services. In 2014, DHHS [the Department of Health and Human Services] released these standards for Code Grey responses which outline best practice principles and minimum practice standards for organisational responses to incidents of clinical aggression in Victorian health services.

The standards define a Code Grey response as a hospital-wide coordinated clinical and security response to actual or potential aggression or violence not involving a weapon. Code Grey activates an internal alert and a clinically led emergency response. This means an appropriate clinical response, in coordination with security as required, can be provided to manage the clinical conditions that can commonly result in violence. The standards also allow for the use of a Code Grey response to instances of non-clinical aggression, such as that enacted by visitors.

(Victorian Auditor-General's Report, p. 21).

In British Columbia (BC), Canada, a 'Code White' model has been prescribed. WorkSafe BC, in conjunction with the Health Association of BC and the Occupational Health and Safety Agency for Health Care in BC, has produced guidelines, which articulate the rationale:

'Code White' refers to a trained team response to a disturbance that is a behavioural emergency involving clients in healthcare settings...

One of the goals in the management of aggressive behaviours within the healthcare setting is to address this behaviour in a respectful, caring, safe manner. The focus of the Code White Team Response is to de-escalate a threatening situation before an individual(s) is injured or property is damaged.

(WorkSafe, British Columbia, Guidelines: Code White Response, A Component of Prevention and Management of Aggressive Behaviour in Healthcare. British Columbia. April 2002. P. 4).

The Townsville HHS is trialing a 'Code Grey' process, which is initiated after de-escalation strategies have been assessed as not being effective. The objective of the 'Code Grey' team is to establish a safe clinical environment. The 'Code Grey' process is clinically led, team approach, involving both clinical and non-clinical staff.

Such a model would seem to have merit, as it would utilise strategies well practiced in a clinical context to one in which colleagues were under threat.

It should be distinguished from 'Code Black' responses, which is used in Victoria, other Australian jurisdictions and many HHSs in Queensland. 'Code Black' should specifically refer to a threat, which involves actual or potential aggression involving a weapon or a serious threat to personal safety and where a security and/or police intervention is required.

However, the 'Code Grey' model is not a panacea and would need to part of a suite of strategies. It requires an investment in specific training of a team of experienced clinicians, security and other personnel in the larger hospitals. It requires endorsement from leaders at all levels of Queensland Health and the HHSs. There are a number of logistical and other practical issues, which would need to be addressed in the implementation of a 'Code Grey' model. Queensland Health would need to follow the Victorian example and develop a standard or guidelines and an implementation plan, in collaboration with the HHSs, professional associations and unions, and clinical staff, to support the implementation of a clinical approach.

The 'Safewards' model (see section 7.4.2) has been adopted in Victorian mental health services and is being formally trialled in the mental health facilities at the RBWH, Prince Charles Hospital and Ipswich Hospital. The program is designed to improve safety in mental health wards for patients and consumers, and as a consequence for staff 'through positive interactions between staff and patients'. (Rae and Cassematis, p. 22).

Other facilities including Mackay HHS, Caboolture Hospital, Gold Coast University Hospital and The Park—Centre for Mental Health have also initiated the 'Safewards' model. However, these sites are not part of the formal evaluation.

The broader implementation of the 'Safewards' model would be assisted by systemic guidelines, based upon the evaluation of the trial sites.

Many of the strategies have applicability for other services. The appropriateness of 'Safewards' strategies in other health settings is worthy of further investigation.

Clinical approaches to the response to an incident were identified as important at the Occupational Violence Forum, where participants also acknowledged the value of 'Code Grey' and 'Safewards' initiatives.

Recommendation 11

That the preferred model to manage occupational violence incidents in the medium and large facilities involve the use of trained, clinically led interdisciplinary teams (such as the 'Code Grey' and 'Safewards' models), and that best practice principles and standards to guide the clinical teams be developed to assist the Hospital and Health Services to effectively implement the models.

Innovation is important and initiatives should be encouraged. Queensland Health, in consultation with the HHSs and clinical networks, should develop a governance framework for the piloting or trialling of clinically based initiatives. Consideration should be given to the creation of an 'innovation' fund to be managed by the Implementation Taskforce. (see Recommendation 20).

The governance arrangements should include the need for formal evaluation processes.

Organisations seeking to reduce aggression have an individual and collective responsibility to rigorously evaluate the actions they are taking.

(Rae and Cassematis, p 32).

The formal evaluation of initiatives should be an essential element of their approval and funding. This will ensure that future adoption of those initiatives is based on the evidence of the effectiveness of interventions and the identification of those factors and elements, which have been fundamental to the success of the pilot program or trials. Such an approach can assist in ensuring public confidence and that public funds are being efficiently and effectively.

Recommendation 12

That a formal evaluation process be a requirement of the trialling of any clinically based initiative before that initiative is adopted in other Hospital and Health Services.

8.3.2 Technology

Technology has an important part to play, particularly with respect to access control, visible monitoring and surveillance systems (CCTV), emergency duress systems and personal duress alarms.

During site visits and information received from HHSs as part of the data gathering exercise, there was evidence of CCTV being not linked to surveillance systems and in some cases, inoperative. This situation is unacceptable and should be addressed urgently in the risk assessments and as part of planned maintenance to provide assurance that existing systems are fully operationally and fit for purpose.

In circumstances where the preferred approach is for individual health workers to try to remove themselves from the danger and seek assistance, emergency/duress alarms are an important protection. That has implications for the location of such alarms. In some facilities these alarms are at the head of the bed and access requires the staff member to go past the patient. It would seem that the duress alarms should be located near the egress point. Again having multiple egress points can provide more options to staff threatened by violent behaviour. Similarly many HHSs identified 'safe havens' (or a place of safety to which staff can retreat) as useful risk controls. (HHS Occupational Violence Self Assessment Report, section 1.15a).

There was a considerable divergence in the design and use of personal duress alarms. In some situations there were not worn regularly because they were considered too cumbersome or difficult to activate. Some personal duress alarms such as those on lanyards constituted a risk to staff as they could be "grabbed" by violent patients or consumers and used as a "weapon". In other situations such as the staff in the emergency department of PAH, voice activated personal duress alarms provided a safe, versatile and effective system of personal protection.

Staff in community health and in remote and isolated settings are subject to different and, often greater risks. They are vulnerable to occupational violence, particularly as their patients or mental health customers can also be affected by alcohol or drug

abuse. They operate without the support mechanisms, which are afforded to those who work in hospital or health facilities. These staff require different personal protection technologies.

In reality, emergency/personal duress systems are important to other emergency services. Corrective Services officers have similar, if not more acute needs in this area. The expertise of these agencies should be utilised.

In the modern world, the capacity and functionality of this type of protective technology is increasing rapidly. It is important that Queensland Health and the HHSs monitor these technological developments on an ongoing basis and invest in those technologies, which have been assessed as having the best potential to improve the safe working environments for employees, including those who work in community health and remote and isolated settings. In general terms, personal duress alarms are a relatively inexpensive but important device. Queensland Health in collaboration with the HHSs should establish a process to regularly review the design and functionality of these important personal protection devices.

Recommendation 13

That, given the rapid technological advances in security systems, a standing committee be established to monitor and assess the suitability of emergency/duress alarm systems (including personal duress alarms). The committee should utilise the expertise of the Queensland Police Service, Queensland Ambulance Service, Queensland Fire and Emergency Services and Queensland Corrective Services. Priority should be given to communication and tracking devices for health workers in remote and isolated and community health settings.

8.3.3 Security services arrangements

A range of models of providing security within the larger health facilities was apparent as part of the review into workplace aggression and violence. These range from 'in-house' security staff to the engagement of security contractors. In some places, the security model was a centralised and mobile one (RBWH and Ipswich), while in others security staff were located within emergency departments and mental health units where, presumably the risks were assessed as higher.

There was no evidence that any particular model was delivering better safety outcomes and the decision is rightfully one for each HHS based upon their particular needs.

What was a common theme was that the services, which security officers provide, were valued by clinical staff and that the demands on those security officers were great. A weakness was that when multiple incidents or even a second occurred, there were inadequate numbers to manage.

Training is of particular importance to these units. Again though, if a clinical model of response to incidents is the preferred model, the training regime for security staff, in addition to their specific skill requirements, must be facility-specific, derived from the risk assessments and involve clinicians. As is usually the case, the response must be under the direction of the clinicians.

Security officers are exposed to significant risks not only to their personal safety but also as a result of their interventions, particularly physical interventions, during assaults of other health workers. The initiative at Metro North HHS, in which security staff have personal cameras to capture the circumstances around an occupational violence incident, should be considered by other HHSs. This technology can act as a deterrent, while also providing evidence for use during investigations and prosecutions.

During the Taskforce's deliberations, the issue of the role, powers and qualifications/training requirements of security personnel was raised as a matter warranting further consideration. The Taskforce agrees. The Australian Workers' Union needs to be involved in any review of security arrangements.

In smaller country hospitals and remote health facilities, it was not financially viable to provide 24/7 security services, despite the fact that risks to staff, particularly at night when there was only one or two clinicians on duty is high. Other strategies including lockdowns and good relationships with local police go some way to mitigate this risk. Technology might provide some other opportunities.

In these smaller facilities, security in the form of visits from contracted security firms is provided. However, this type of service may serve to protect property or be some type of deterrent; it is not and should not be seen as part of an occupational aggression or violence strategy. A similar conclusion can be drawn when security staff are deployed to manage parking and smoking offences. The services do not and cannot support staff under threat.

Recommendation 14

That a working group reporting to the Occupational Violence Prevention and Management Implementation Taskforce be established to review for security services arrangements across Queensland Health. The review should include but not be limited to staffing levels, functions and roles, training and powers.

8.3.4 Seclusion and restraint

A reduction in the use of seclusion and restraint is a national safety priority in mental health.

The need to utilise seclusion and restraint [is] a failure of the mental health system to provide high quality care.

(National Mental Health Consumer and Carer Forum: Position Statement— Ending Seclusion and Restraint in Australian Mental Health Services, 2009).

The *Mental Health Act 2016* requires that

The use of medical constraint in an authorised mental health service must be approved by the chief psychiatrist. Mechanical restraint and seclusion may only be used if it is necessary to protect the patient or others from physical harm and there is no less restrictive way of providing treatment and care to the patient.

(Hon. Cameron Dick, Minister for Health and Minister for Ambulance Services Mental Health (Recovery Model) Bill 2015, Explanatory Notes. Queensland Parliament, 2015. p. 3).

While there was general recognition of importance of this objective, there was less clarity of what it means in practice. It was apparent that the use of physical and

mechanical restraint and seclusion for mental health consumers was differentially applied across the range of facilities and against the specific needs of the consumers.

This policy dimension does present a dichotomy with worker and consumer safety. Such practices unless carefully and thoughtfully managed can aggravate the aggressive behaviour of mental health consumers.

Current evidence suggests that preventive measures for managing aggression and violence in the mental health field at an organisational level are preferable to more restrictive practices. This is due to significant variation in local practices and therefore thresholds for the use of restrictive practice. Understanding what factors increase the likelihood of aggressive and violent events occurring is important to enable mental health clinicians to better predict and prevent them from occurring.... The provision of risk appropriate aggression management training to mental health staff is one such organisational approach.

(Evaluation of the ABM Program, p. 10).

Further clarification of the intent of the policy and its practical application is necessary. This needs to be accompanied by a specific education and awareness strategy and targeted training. This is a task for the working group on mental health intervention strategies. (see Recommendation 7)

8.4 Post-incident management

8.4.1 Focus on the wellbeing of the victim

It is important to reflect on the proposed definition of occupational violence and the essential elements of a safety culture. Regardless of whether the incident is intentional or unintentional, there is a victim; an employee of Queensland Health or a HHS who has been injured in the course of their employment. There is a legislative obligation, under the WHS Act, on Queensland Health and the HHSs to provide a safe working environment. That obligation extends to a requirement to support workers who have been injured at work.

Queensland Health and the HHSs need to be seen as 'good employers'. In that context, their support involves more than providing access to sick leave, workers compensation, rehabilitation and return to work programs and other industrial or legal entitlements.

The system response after any incident must focus primarily on prompt and effective support of the victim. Then the focus must be on the care they need, to treat the physical and emotional damage done.

(Beth Mohle, Presentation to the Occupational Violence Forum. 21 March 2016).

Ms Mohle added that:

It starts with making the violence visible in the system and then ensuring we immediately respond in a meaningful and supportive manner.

(Beth Mohle, Presentation to the Occupational Violence Forum. 21 March 2016).

Recommendation 15

That the physical, emotional and psychological wellbeing of the health workers who have been subjected to occupational violence be the primary focus of post-incident activities.

Central to the needs of staff affected by any incident is the opportunity for debriefing.

...it is important for nurses who have been involved in an aggressive incident to have the opportunity to debrief after an event, or seek counselling if further support is required. Exposure to violence is often extremely traumatic, and can impact negatively on confidence and clinical performance, as well as have ramifications for emotional health and well-being.

(Sands, p. 109).

Debriefings should occur after each incident especially reported incidents. Debriefings involving professional support such as through the EAP or through work teams are also important for physical and psychological welfare of those impacted by aggression or violence. They also have an important role in improving work practices and workplace design.

Peer support programs have the potential to both benefit victims of workplace violence and to assist to reduce such incidents in those workplaces. They provide a less formal, non-judgmental, immediate and ongoing support from colleagues who understand the workplace and its challenges. Victims are more likely to 'open up' about their feelings in the debriefing sessions.

Providing support to victims of patient assault through a program of peer support has also been found to reduce the frequency of violence in mental health facilities. Peer support typically involves immediate and ongoing support for a staff member who has been traumatised as a result of assault. These peer support programs have been shown to aid return to work and reduce the symptoms associated with post-traumatic stress syndrome.

(Meehan et al., p. 204).

Importantly, peer support programs and their debriefing aspect help generate and/or support a team approach, consistent with a shared responsibility philosophy.

Staff at The Park—Centre for Mental Health, a forensic mental health facility in the West Moreton HHS, have initiated a peer support program. During the site visit, all staff spoke highly of the program and the benefits, which have accrued from it. Specific training for the staff who volunteer for the team is essential.

The peer support team is well placed to identify staff members who need more professional psychological support and encourage them to seek such counselling. The program needs to be seen as complementary to more formal EAP and other professional services.

Peer support programs were seen by participants of the statewide Occupational Violence Forum as beneficial. The literature review also identified peer support as an important aspect of post-incident care. (Rae and Cassematis, p. 29)

The model of peer support would seem to have applicability for all health workers in all high-risk situations and should be considered a key element of an integrated and comprehensive workplace violence prevention and management strategy.

Recommendation 16

That peer support programs be trialled in a range of settings including emergency departments, mental health services, community health services and isolated and remote health services.

8.4.2 Incident investigations

In the Framework for *Occupational Violence Prevention and Management*, the importance of formally investigating incidents of occupational violence is articulated. (See Appendix 5)

However, the Taskforce found that investigation processes were not consistent and often not rigorous. As indicated in section 8.1.4, one of the reasons for the under-reporting of incidents is that some health workers believe that it will not result in any significant managerial action and/or that the investigation are into the actions of the staff who have to defend themselves. Reporting can be seen as a bureaucratic activity. (Rae and Cassematis, p. 30 and p. 32).

The tolerance by clinical staff to unintentional aggression also results in decisions not to report the incident and hence no investigation ensues. Feedback loops were described by some at the Occupational Violence Forum as poor.

However, investigations are important for the development and refinement of intervention strategies.

Qualitative content analysis of documented incidents of workplace violence can provide a better understanding of determinants of patient-to-worker violence by providing insights into the nature of specific risk situations.....[It is] a critical factor in the development of data-driven, effective interventions.....Hospital staff can be trained to recognise these specific risk factors for patient violence and can be educated in how to best mitigate or prevent the most common forms of violent patient behaviour.

(Arnetz et al., p346).

If the culture becomes one in which reporting is genuinely encouraged, staff must be confident that managerial action, where warranted, will occur and where the outcomes will be used to develop more effective prevention and protection strategies.

Recommendation 17

That post-incident investigations have an explicit objective to develop and refine clinical practices, individual treatment plans and other controls and intervention strategies.

However, to provide an effective feedback and learning loop, investigators need to develop specific skill sets which supplement their clinical skills. The issue of inadequate investigation skills was recognised, at the statewide Forum as a deficiency across the system.

The Victorian Auditor-General noted that

Without investigation training, and with only limited documented guidance, those who complete investigations have limited knowledge of what is required, which may result in poor analysis and an ad hoc approach that compromises opportunities for improvement.

(Victorian Auditor-General's Report, p. 29).

This is not to argue that all incidents require the same intensity of investigation. Serious incidents require more rigour and consequently would benefit from the use of trained investigators. Indeed in the clinical area, serious incidents warrant a 'root cause analysis'; a technique, which health professionals have pioneered. Again the application of this process to serious incidents of aggression and violence against staff would have merit.

While all reported incidents should signal a workplace debrief or review, it would be useful to establish some guidelines, which would trigger a formal investigation. The guidelines should be consistent with the existing clinical investigation methodologies. Consistency of language is important.

The use of trained investigators involves costs to the health services and it is unlikely that such additional costs could be justified in smaller hospitals and other facilities or by training all those who may be involved in investigations at some point in their career. However, if a small group was trained in each HHS, they could lead investigations, provide advice to others involved in the investigation of workplace incidents or, where deemed appropriate, lead in the investigation into a serious incident in another facility or location within the HHS.

Recommendation 18

That investigation teams to review incidents of occupational violence be led by health workers who have specific training in investigation processes and techniques.

Where incidents involve police action, there has been some anecdotal commentary that some HHSs defer the investigation process to the QPS. That is inappropriate, because the QPS and Queensland Health investigations have different purposes. In some circumstances, formal investigation by the health service, including a 'root cause analysis may be warranted. That is appropriate because the person has been injured physically or psychologically in the course of their employment. It is not the same a person who is assaulted in the streets at night. In a case of occupational violence, Queensland Health has a primary obligation to the injured person. A thorough investigation by Queensland Health would provide additional and more detailed information to the QPS or Director of Public Prosecutions (DPP), which may assist in the prosecution of the perpetrator.

8.4.3 Prosecutions

While the number of incidents of workplace violence is high, the number of matters, which are referred to the QPS and/or the Office of the DPP for prosecution is extremely low. The precise number and the outcomes of those matters are unknown at the systemic level. Data was not available from the DPP or QPS.

This low number of prosecutions is despite assaults against public sector health workers being classed as 'serious assaults' and liable for up to 14 years imprisonment under section 340 of the "*Criminal Code 1899*". This followed amendments to the Code in 2007.

According to the DPP, matters are often dealt with summarily in the Magistrates Court and are managed by the DPP only when it has been determined that the 'serious assault' charge should proceed by indictment and following a separate review of the case by the office of the DPP. It seems that often perpetrators are charged with offences other than those under section 340 of the Criminal Code.

There are different arrangements for people with mental illness. The *Mental Health Act 2016* enables people to be diverted from the criminal justice system if they are found to have a mental illness at the time of an alleged offence. These diversions involve the Mental Health Court and the Mental Health Review Tribunal, where the person's 'unfitness' for trial is not considered to be permanent. (Hon. Cameron Dick, Minister for Health and Minister for Ambulance Services, *Mental Health (Recovery Model) Bill 2015*, Explanatory Notes. p. 1).

Even when matters, which fall outside the mental health jurisdiction, do come before the courts, judges and magistrates have typically imposed lenient sentences, often using drug or alcohol dependencies or the failure to take medication as mitigating factors. The public information campaign may help to shape community (and judicial) opinion that offences against public hospital workers are serious and warrant significant penalties.

Further complicating matter is that as these matters are under the criminal jurisdiction there is no formal role for, or acknowledgement of Queensland Health.

Queensland Health has recognised the need to support their staff who lodge complaints with the QPS through its brochure entitled *What can I do if I am assaulted at work?* which includes the following statement;

Queensland Health is committed to supporting SAFETY FOR ALL. In addition, Queensland Health managers and supervisors hold a responsibility towards providing subordinate staff with assistance in reporting assault to the police.

In the course of this review, Queensland Health has requested that QPS and the DPP review the contents of the brochure. That is an initial step but the issue requires a much more comprehensive support program when a staff member decides to proceed with a complaint.

An important element of a public awareness campaign is to inform the community of the potential consequences for this criminal behaviour.

Navigating the criminal justice system is complex especially for a person without experience in the courts and one who may be suffering physical injury or psychological distress. While health workers may be kept informed by the QPS and/or the DPP, Queensland Health is not. Queensland Health needs to provide demonstrable support to its staff. It also ought to be determined to ensure that the perpetrators of this violence are held accountable for the actions.

The purpose of the occupational violence support unit should be to provide support to a victim of an assault, which is to go before the court system. It would be a low cost but symbolically important initiative. That unit would be responsible for liaison with the QPS and the DPP, and if appropriate the Court, on behalf of the victim to ensure that all relevant information such as investigation reports and CCTV footage is available to them. It could monitor progress through the system and advise the complainant of that progress. It would be responsible for liaison with the relevant health facility and HHS. It

would provide data on the number of criminal matters and the outcomes of them. Most importantly it would provide demonstrable evidence of the concern, which Queensland Health has for the safety and wellbeing of injured workers.

The unit should not provide legal advice or legal representation.

The use of the term 'victim' in the title might have negative connotations, which might discourage some health workers from accessing the service. It could also be confused with existing victim support units in mental health services in some HHSs. It is suggested that the unit be named the occupational violence support unit.

Recommendation 19

That organisational support be provided to health workers, who have been subjected to occupational violence where criminal proceedings have been initiated, through the establishment of small occupational violence support unit in the central office of Queensland Health.

8.5 The withdrawal of health care

An issue, which has been raised during the deliberations of the Taskforce, is the question of whether there are any circumstances in which care can be withdrawn. This question raises very complex ethical considerations. Public health does not have access to the option of many other public and private services. Their ultimate sanctions can include the option to deny aggressive customers service either temporarily or permanently. The 'duty of care' obligations of those employers to their employees are more easily fulfilled.

It is noted that one approach, which is used in Queensland Health is the use of formal conditions on the delivery of services to patients and consumers with a history of inappropriate behaviour. These include requirements for the patient or consumer to be accompanied by another suitable person or to attend a particular facility for treatment.

However, there are examples with health sectors overseas where there are processes to withhold or deny services for a period of time based upon extreme or repeated violent behaviour of patients. The Dartford and Gravesham, Wirral Community and University Hospitals Birmingham NHS Trusts have formal policies on withholding care, which involve verbal and written advice to offenders outlining their behaviour and the period for which care is being withheld. The Birmingham University Hospital uses a yellow and red card system.

The appointment of an 'ombudsman' type position, similar to that to which complaints against clinical staff are referred, was canvassed to provide an avenue for hospital staff to make complaints against patients and consumers. However, it is not clear what sanctions would be available to the position and under what conditions sanctions would be imposed.

As previously indicated, this is a complex matter. For the policy of withdrawal of care to be advanced the questions of the authority to withdraw or withhold care and the conditions for such actions as well as the alternative treatment plans would require significant work and consultation. Additionally the value of such a strategy would be questionable as it is doubtful that the policy would be exercised.

9. Model of engagement

Queensland Health and the HHSs need to be seen to be working collaboratively to address the workplace issue of occupational violence, which impacts on health workers in every facility across Queensland.

There is the inconsistency of approaches to occupational violence across the 16 Hospital and Health Service. There is a lack of a whole of organisational focus and commitment to tackling this horrendous problem.

(Beth Mohle, Presentation to the Occupational Violence Forum. 21 March 2016).

A Queensland Health directed approach is likely to bring a negative reaction from the HHSs, which place a high value on their autonomy. It is also important to acknowledge that expertise exists across the system.

Equally, it must be acknowledged that HHSs are accountable in a legal sense for the safety of their employees. This accountability requires that they be also judged on the outcomes of their occupational violence interventions and their response to those outcomes. This accountability requirement can be enhanced by greater collaboration and information sharing.

Clinical networks exist across the public health system and are a highly valued collaborative mechanism. A similar approach to significant workforce issues could reinforce to staff the importance of a specific workplace issue, like occupational violence.

The Taskforce proposes a networked approach in which teams, with relevant expertise are established across the HHSs and Queensland Health to identify potential control and intervention strategies with a framework of prevention, protection and post-incident management. A similar approach can be used for other tasks.

Corporate Queensland Health staff would be expected to provide expertise and support to these cross agency groups.

In some cases, a particular task may be delegated to a HHS, which is seen as a leader in a particular area.

However, whatever approach is adopted, mechanisms to share information, initiatives and ideas must be promoted and sustained. This will not happen without leadership. The System Leadership Forum members have a specific obligation in this regard. They must model this collegiate behaviour and encourage and reward it within their spheres of influence.

10. Implementation Issues

The Taskforce notes the approach advocated in the Paramedic Safety Taskforce Report.

To facilitate ongoing collaboration, engagement and progression of the recommendations contained within the Taskforce Final Report, the Paramedic

Safety Implementation Oversight Committee will ensure the strategic oversight and coordination for the range of initiatives with the aim of ensuring that future strategies, systems and processes aimed at minimising the risk of occupational violence to QAS personnel are implemented.

(Paramedic Safety Taskforce Final Report. p. 5).

A similar approach is recommended through the Occupational Violence Prevention and Management Implementation Taskforce. Successful implementation of the recommendations will require leadership and ownership, which have been recurring themes in this report. The important stimulus provided by the establishment of the Taskforce must not be lost. The causes of occupational violence in the health system are complex and diverse. There can be no 'quick fix', 'silver bullet' or simple solutions. Successful strategies will require sustained, comprehensive and integrated actions. Engagement and co-operation across the public health system will be important enabling strategies.

It is for these reasons that the Occupational Violence Prevention and Management Implementation Taskforce should report to the System Leadership Forum and chaired by a member of that Forum.

Occupational Violence Prevention and Management Implementation Taskforce should be responsible for the implementation of the approved recommendations of the Occupational Violence Prevention Taskforce Report. It is important that the momentum created by this Taskforce is not lost. It should establish timelines for the reporting on progress and the completion of tasks. Working groups would report on the progress of their work and present their final reports for approval.

In all these matters, resourcing can be a 'make or break' factor. This was a significant issue addressed in self assessment report. (HHS Occupational Violence Self Assessment Report, section 1.15b). The Implementation Taskforce should be provided with a dedicated budget to manage the implementation process; as to require the implementation to be managed from the existing resources of HHSs or central office units will compromise the opportunity to promote a safety culture for patients and staff.

Recommendation 20

That an Occupational Violence Prevention and Management Implementation Taskforce, chaired by a member of the System Leadership Forum, be formally established to lead the implementation of the recommendations of the Occupational Violence Prevention Taskforce.

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Appendix 1

Occupational Violence Taskforce 2016	
Name	Position Branch/Division
Chair	
Jim McGowan AM	Executive Director, SNJ Business Solutions
Queensland Health	
Michael Nelson	Chief Human Resources Officer, Department of Health
Theresa Hodges	Senior Director, Workforce Performance and Assurance Unit
Queensland Health Representatives	
Michael Rice	Manager, Patient Safety and Quality Improvement Service, Clinical Excellence Division
Dr John Allen	Chief Psychiatrist, Mental Health, Alcohol and Other Drugs Branch Proxy–Janet Martin
Dr Darren Neillie	Director Community Forensic Outreach Service. Chair Clinical Collaborative
Deb Nizette	Office of the Chief Nursing and Midwifery Officer
Bob Green	Queensland Forensic Mental Health Service Proxy Darren
Paul Coffey	Queensland Ambulance Service (liaison only)
Terry Carrick	Team Leader, Safety and Wellbeing, Health Support Queensland
Daniel Vercoe	Media and Communications
HHS Representatives	
Lisa Fawcett	Director of Nursing, Mental Health, Metro North HHS
Dr David Rosengren,	Royal Brisbane and Women’s Hospital. Queensland Emergency Department Strategic Advisory Panel representative
Adam Lavis	A/Director Workforce Services, Workforce Services Metro South HHS. Chair Prevention of Occupational Violence Steering Committee Princess Alexandra Hospital
Julie Rampton	District Director Nursing Services, District Office Mackay HHS
Gail Cameron	A/Occupational Health and Safety Manager, Mackay HHS
Lawrie Usher	Manager Occupational Health and Safety, South West HHS
Greg Neilson	Nursing Director Acute and Community Mental Health, Acute Mental Health Unit, Darling Downs HHS
Chris Neilsen	Director Human Resources, Darling Downs HHS
Lissa Mcloughlin	Director of Nursing, Mount Isa Hospital Campus North West HHS (rural and remote)
Debbie Maclean	Manager Leadership & Learning, Learning Unit, Townsville HHS
Padraig McGrath	Nursing Director, Secure Services, The Park-Centre for Mental Health, West Moreton HHS
Dr Daniel Bitmead	Director of Emergency, Accident & Emergency Ipswich Hospital West Moreton HHS
Peter King	Manager, Protective Services, Facility Management Lady Cilento Children’s Hospital, Children’s Health Queensland HHS

Union Representatives	
James Gilbert	Queensland Nurses' Union
Gary Roberts	Together Union
Mark Raguse	Australian Workers' Union
Renee Lamont	Australian Salaried Medical Officers Federation
Inter-agencies	
Bob Gee	Assistance Commissioner, Brisbane North Region, QPS
Sam Thompson	Director Policy, Public Safety Business Agency
Colin Anderson	Director Safety and Wellbeing, Public Safety Business Agency
Secretariat	
Tony Johnson	Manager, Safety and Wellbeing
Garth Richards	Principal Advisor, Safety and Wellbeing

Appendix 2

Paramedic Safety Taskforce Final Report April 2016

Executive summary

Paramedics are committed to helping and caring for others and they deserve our respect and gratitude for the important work they do in our community. The increasing prevalence of assaults on paramedics and other health workers in the Queensland community is of significant concern.

Assaults, whether they be physical or verbal on paramedics is inexcusable, and represents reprehensible behaviour. There were 170 deliberate physical attacks and 56 verbal assaults on ambulance officers in the 2014-15 financial year. This represents an increase from the 160 physical assaults and 33 verbal assaults on ambulance officers in 2013-14 financial year.

In December 2015, [Queensland Ambulance Service] QAS and [United Voice Queensland] UVQ collaboratively established the Paramedic Safety Taskforce to investigate this issue of occupational violence being experienced by paramedics and provide practical strategic recommendations to reduce occupational violence against QAS officers.

The Taskforce chaired by the Commissioner QAS, maintained a key tenet in the review that the creation of a safe work environment for QAS officers to be of critical importance to ensure that our patients and the community continue to receive care that is timely, and adheres to the highest standards of clinical quality and patient safety.

The Taskforce's activities were assessed against the achievement of the following key initiatives:

1. **Education and training**—development of enhanced contemporary training modules combined with face-to-face practical sessions.
2. **Media and communication**—development and implementation a media and communication strategy directed at occupational violence. The strategy should include the utilisation of various media platforms, giving consideration to the internal communication requirements within QAS and an external communication strategy with the broader community.
3. **Data analysis**—analysis of assault data to develop best practices for occupational violence prevention strategies and policy development. This includes using quantifiable data sets such as WorkCover injury, Safety Health and Environment (SHE); current industry evidence base of best practice; and a consultative approach of frontline paramedic focus groups aimed at identification and recognition of practical workplace strategies and interventions.
4. **Internal structure and models**—mapping of technology and communications, procedures, guidelines and standard operating procedures (SOPs) to ensure occupational violence intervention strategies are accurately represented and adhered to by QAS supervisors.

5. **Linkages with staff support**—ensuring that a system is in place that provides effective and practicable early intervention strategies available to paramedics.
6. **Post incident response and support**—review of the current strategy undertaken by QAS Staff Support Service (in the context of a staff member encountering an incident of occupational violence pre and post incident) that provides a significant and multi-layered post critical incident response.
7. **Clinical practice and patient safety**—functional and relevant clinical practice and patient safety guidelines and appropriate response and support being provided to staff involved in incidents to minimise the risk of occupational violence.
8. **Research and development**—undertaking occupational violence related literature reviews including the identification of the latest developments and information on managing challenging issues related to occupational violence in the context of positive interventions.
9. **Technology options**—identification of the latest developments and information regarding technology that can assist frontline paramedics in the context of positive interventions.

To facilitate ongoing collaboration, engagement and progression of the recommendations contained within the Taskforce Final Report, the Paramedic Safety Implementation Oversight Committee will ensure the strategic oversight and coordination for the range of initiatives with the aim of ensuring that future strategies, systems and processes aimed at minimising the risk of occupational violence to QAS personnel are implemented.

The 'Paramedic Safety Taskforce Final Report' provides the direction and ongoing commitment to reducing the risk of occupational violence against QAS front-line paramedics in the performance of their duties and to raise awareness for the creation of a safer working environment.

It is therefore recommended that the Minister for Health and Minister for Ambulance Services:

- Notes the outcomes achieved from the nine initiatives that have been completed by the Paramedic Safety Taskforce.
- Consider the fifteen final recommendations contained within *Paramedic Safety Taskforce Final Report* for implementation in QAS.
- Note the role of the Paramedic Safety Implementation Oversight Committee, which will be responsible for the implementation of the recommendations of Paramedic Safety Taskforce endorsed by the Minister for Health and Minister for Ambulance Services.

Summary of recommendations

Taskforce recommendation: Education and training

- That QAS implement the outcomes of the Taskforce review of the 'Situational Awareness for Everyday Encounters' (SAFE) training program through the rollout of the revised SAFE2 training course to all frontline paramedics across Queensland by December 2016.

Taskforce recommendations: Media and communications

- That QAS develop a media and communication strategy aimed at minimising violence against paramedics, including internal messaging to all staff by April 2016.

Taskforce recommendations: Data analysis

- Working with Department of Health and UVQ, QAS will implement a public awareness campaign through mainstream and social media aimed at minimising violence
- That QAS undertake a detailed demographic modelling review of all QAS datasets pertaining to occupational violence against paramedics to determine the situational factors by April 2016.
- That QAS implement the outcomes of the review by June 2016 ensuring that:
 - the investigations of occupational violence incidents are fulsome and insightful in all circumstances
 - QAS internal structures and initiatives are responsive to ongoing data collection and analysis.

Taskforce recommendation: Internal structures and models

- That QAS implement the outcomes of the Taskforce review of supervisory models and process through the revision of Standard Operating Procedures relevant to reducing the risks and impacts of occupational violence and improving paramedic safety by June 2016.

Taskforce recommendation: Linkage with staff support

- That QAS implement the outcomes of the Taskforce review involving the intervention strategies available to paramedics who are exposed to occupational violence through the development of a Directive and Guideline specific to 'Local Incident Management Practices' by June 2016. The Directive and Guideline will be incorporated into QAS on-line education and the SAFE2 training program

Taskforce recommendations: Post incident response and support

- That QAS conduct a review by April 2016, of current post-incident response and support strategies available to paramedics who are exposed to occupational violence during operations.
- That QAS implement the outcomes of the review by June 2016, and ensure post incident response and support services remain available to all paramedics.

Taskforce recommendations: QAS clinical practice and patient safety

- That QAS will introduce chemical sedation medication (Droperidol) into clinical practice for all Advanced Care Paramedics by October 2016 ensuring contemporary therapy is available for the treatment of patients presenting with acute behavioural disturbance.
- That QAS implement the outcomes of the Taskforce review of clinical practice and patient safety guidelines regarding the management of acute behavioural disturbances by October 2016. These guidelines will ensure a graded approach to the management of acute behavioural disturbances, including the application of minimal painful stimuli in the patient neurological assessment.

Taskforce recommendations: Research and development

- That QAS conduct a preliminary review of occupational violence related literature, with input from external stakeholders to identify the latest developments and positive interventions with respect to the management of occupational violence in ambulance services, by April 2016.
- That QAS deliver a final research paper regarding the management of occupational violence in Ambulance Services, by December 2016.

Taskforce recommendation: Technology options

- That QAS will further develop the findings of the Taskforce examination of potential technology options that will minimise the risk of occupational violence by November 2016.

Taskforce recommendation: Establishment of oversight implementation committee

- That QAS establish a Paramedic Safety Implementation Oversight Committee by April 2016 to lead the implementation of the recommendations. The implementation of all recommendations will be completed by December 2016.

Appendix 3

HHS Occupational Violence Self Assessment Summary

Key findings

1.1 All Hospital and Health Services (HHSs), responding to the occupational violence self-assessment indicated that occupational violence was identified as a risk within the HHS.

Responses to this question varied from a Yes response, to those HHSs demonstrating an awareness of the extent and magnitude of the problem evidenced by data from a number of sources.

Cairns and Hinterland, Sunshine Coast and West Moreton HHSs identified inclusion of occupational violence in Queensland Health risk or strategic and operational risk registers demonstrating a higher level of organisational awareness, responsibility and accountability.

There is variation across the HHSs submitting a self-assessment, evidencing differing degrees of quantification of the risk and a limited awareness in some HHSs of occupational violence risk dimensions. Without a complete assessment of dimensions there are consequences which may limit the effectiveness of proposed solutions. By example HHSs which have identified 'hotspot' locations which require specific interventions compared to generic interventions which may dilute available resourcing and may have limited effectiveness in locations which have lower occupational violence risk profiles.

HHSs evidencing best practice in governance of the occupational violence, which dedicate resources specific to the risk in the form of occupational violence committees and occupational violence trainers/coordinators include: Metro North, Mackay, Townsville, Sunshine Coast, Gold Coast.

HHSs, predominately rural and remote, demonstrated that existing structures such as workplace health and safety committees were utilised effectively in the review and escalation of occupational violence issues. North West HHS was evidenced.

1.2 Uniform responses across all HHSs included the monitoring and use of Incident Management System (IMS) data. A variety of reporting systems (staff/patient/security based) are present in the HHSs' self assessment, with variations in collation and analysis of data available.

A significant system wide issue is evident in the variation and quality of occupational violence data being collated and reported to executive within different HHSs.

The quantification of incidents being reported versus occurrence is not able to be clearly demonstrated and evidences the viewpoint that an undefined number of incidents occur and fail to be recorded in some HHSs. Very limited awareness of

incident occurrence is evidenced in HHSs where reliance solely on IMS data alone is reported to Health Service Executives.

Best practice evidence of comprehensive collation of data is demonstrated in Gold Coast and West Moreton HHSs, which utilise data from a variety of sources.

1.3 All HHSs responding to the self-assessment indicated widespread occurrence of occupational violence. Key areas identified include:

- Accident and Emergency (Emergency Departments)
- Mental Health units (all specialities).

All HHSs identified occupational groups having contact with patients/consumers and relatives, highest identified groups being:

- nursing
- clinical staff
- security.

Main types of violence identified:

- verbal aggression (in person and by phone)
- physical aggression
- threats and intimidating behaviours.

Perpetrators identified:

- patients/consumers
- patients/consumers family members/carers

Commonly identified contributing factors:

- pain
- fear
- altered states
- intoxication
- frustration (waiting times and enforcement of rules such as smoking)

1.4 All HHSs have a process in place conducting occupational violence risk assessment. Time between risk assessments and review (up to three years) provides a static risk assessment of the facility and environment. Health Support Queensland is reliant on risk assessments conducted within respective HHSs.

1.5 All HHSs conduct occupational violence risk assessments of workplaces as part of a continuing audit cycle. 13 out of 16 self-assessments submitted noted that occupational violence risk assessment utilise the Queensland Health developed OVRAT (Occupational Violence Risk Assessment tool). Sunshine Coast HHS has developed a shorter tool Violence Aggression Mitigation and Prevention (VAMP) Risk Assessment, which Townville HHS is currently reviewing with planned adoption of a

variation of the VAMP/OVRAT tool. Children's Health Queensland has developed a further variation combining security and occupational violence risk assessment.

All HHSs conduct occupational violence risk assessment in a multi-disciplinary team consultative approach, the results are provided to decision making functions such as OHS committees and HHS executive.

All HHSs utilise the information from occupational violence risk assessment for occupational violence training needs analysis under categories of risk from low to high.

1.6 A variety of mechanisms related to the management of change are utilised by HHSs according to localised business rules and practices. Demonstration of risk management practices are in place however some HHSs do not articulate information gathered during occupational violence and workplace health & safety risk assessments in revising or reviewing models of care across the organisation. Evidence provided by some HHSs indicate that information may be held within a silo of the organisation and not utilised across all aspects of the organisation. Limited application of the risk management process is evident when training as a solution to issues is seen as the primary or solo risk control.

Best practice HHSs that integrate information through formal processes indicate a greater potential of utilisation within business processes and executive decision making.

1.7 Date range of completed security risk assessment and management plans from HHSs range from 2014 to 2016. All HHSs indicate plans to progress further activity. Knowledge and capability to perform security risk assessments varied from in-house to external contractor.

1.8 Variation in approach across all HHSs is evident in all aspects of security risk assessment. Responses to this question evidenced a spectrum of responses from a lack in conformity to industry standards and best practice to clear demonstration of skill and expertise related to security risk assessments.

A number of HHSs have utilised external consultants to perform security risk assessments (Cairns and Hinterland, Central Queensland, Metro South, Sunshine Coast, Torres and Cape Hospital and Health Services).

The majority of HHSs did not identify tools or indicate an adaption of tools.

The Department of Health provides HHSs with a guidance note 'Security for work health and safety' which does not detail specific requirements or provide HHSs with up to date tools, reference to relevant legislation and codes of practice such as Australian Standard (AS4485) Security of Health Care Facilities (part 1 and 2), and Australian Standard (AS 4083-2010) Planning for emergencies—health care facilities.

1.9 and 1.10 All HHSs evidenced that policies/procedures and guidance material were available for staff.

Non-prescribed services were noted as utilising Department of Health guidelines, whereas prescribed services have developed documentation in alignment to local safety management systems.

The majority of HHSs demonstrated an extension of strategic documentation into local procedural/operational guidance for staff. HHSs with a perceived low exposure to occupational violence hazards evidenced minimal documentation.

1.11 Responses to the question of a summary of controls grouped under three headings:

Prevent violence: the majority of HHSs interpretation of prevention identified concepts such as environment, equip and training interventions.

- occupational violence risk assessment processes (facility/unit based)
- training was identified as a primary prevention solution
- Mackay HHS and PAH MSHHS demonstrated a multi-modal preventative approach demonstrated by use of the work area design, work system practices and equipment.
- All HHSs which have security officers identified the presence of uniformed officers as a preventative effect.
- patient/consumer violence risk assessment and identification by alerts in medical chart of persons with a past history of violence with communication of same during handover.
- signage and wayfinding
- diversionary activities in waiting areas.

Protect workers during violent events:

- the use of uniformed security to intervene and manage occupational violence all hours was identified in most HHSs as a key protective control
- safe refuge rooms and communication by duress devices or alternative
- patient/consumer clinical management care plans
- Code Black/Grey intervention teams
- protective equipment
- withdrawal of staff from incident
- emergency response plans
- assistance from Queensland Police Service.

Post-incident management significant post incident controls identified included:

- debriefing and defusing of employees involved
- clinical supervision
- modification to patient/consumer treatment plan
- access to the Employee Assistance Program
- post-incident investigation and reporting to inform change in a variety of formats (clinical, work health and safety and executive)
- incident data
- persons of interest (identification of patients/consumers/others).

1.12 Limited comments across a number of different themes were made by some HHSs in relation to general comment regarding controls utilised. Key elements within comments related to organisational commitment and structures, dedicated resources and interagency communication.

1.13 Three different training programs were identified within HHSs for healthcare staff (OVP/ABM, NCI, MAYBO). Further variation is reported in relation to security officer training (OVP/ABM, MAYBO and VAST). OVP/ABM is utilised in eleven HHSs with MSHHS utilising a mixed model of some staff trained in OVP/ABM and others in MAYBO. Adaptation of the OVP/ABM program has occurred with differences in duration and content. Non-violent Crisis Intervention Training program (Crisis Prevention Institute) is utilised in CHQHHS. Capacity to deliver training through in-house instructors/facilitators noted as problematic by some HHSs. HHSs which do not provide physical restraint training as the intervention of physical restraint of patients/consumers is not endorsed: Central West HHS, HSQ, Metro South HHS (Logan and Beaudesert, QE II, Redlands Hospital & Wynnum Health Service), North West HHS, South West, Torres and Cape HHS. In other HHSs training in physical restraint is restricted to security and mental health staff.

1.14 Significant variation in responses is apparent across all HHSs which may indicate limited understanding of how the multi-modal approach to recognising and managing aggression can be expressed. Complementary programs exist across the Queensland Health system especially within clinical arenas; however in many instances the reporter for the HHS demonstrated limited understanding of complementary access or information by indicating “nil”.

Programs that provide communication skills such as CAPS and cultural awareness have direct translation in complimenting and expanding staff skill sets in the management of difficult and challenging behaviours.

Safewards as a new program initiative (described in detail by Mackay HHS) demonstrates potential application across specialty areas with a focus on staff client/consumer communication and interaction.

1.15 Significant variation in responses were recorded by HHSs, key strategies, challenges and identified potential actions include the following:

Summary of self-assessment 1.15a

Key successful strategies identified by HHSs include:

- online resources such as the Occupational Violence Prevention Awareness Module (developed by the Department of Health, available on iLearn@QHealth and DVD)
- safe haven /staff refuge (place of safety for staff to retreat to)
- verbal de-escalation and communication training
- Code Black/Grey response teams
- Safewards model within mental health
- governance within organisational structures such as a an occupational violence committee
- occupational violence risk assessment (facility static assessment)
- security officer presence
- duress alarms
- CCTV monitoring

- OVP training
- access controls such as swipe card access.

Summary of self-assessment 1.15b

Key challenges identified by HHSs include:

- resourcing occupational violence training and associated issues
- inconsistent training models within different HHSs
- use of occupational violence data and risk assessments informing environmental change
- development of staff skill sets to recognise and respond to emergent aggression
- expansion in staff knowledge of mental health issues
- workplace bullying and harassment (staff against staff)
- executive leadership and direction of occupational violence initiatives
- capability and resourcing skills sets such as security
- Occupational Violence Risk Assessment process, time consuming and labour intensive.

Summary of self-assessment 1.15c

Key themes identified in what could be done better to manage occupational violence risk include:

- communication and de-escalation training for frontline staff
- risk awareness training
- Police beats
- staff support alternatives
- incident reporting mechanisms (ease of use)
- mandatory occupational violence training program or support from Department of Health regarding training programs
- increase security officer presence
- cultural change to zero tolerance of occupational violence
- integration of clinical and non-clinical practices in the management of occupational violence.

Appendix 4

Occupational Violence Forum 21 March 2016: Breakout sessions

Background

Breakout sessions conducted in the course of the Occupational Violence Forum were planned to understand the depth of the problem by testing assumptions against the reality of the lived experience with staff engaged in the delivery of clinical care. A total of 115 staff registered to attend the forum with 103 attending on the day with an additional six videoconference sites attending from Townsville HHS, Wide Bay HHS, Cairns and Hinterland HHS, Mackay HHS.

Staff attending the forum contributing to breakout sessions included representatives from the following: Australian Workers Union, Children's Health Queensland HHS, Department of Health CED/HRS, Darling Downs HHS, eHealth Qld, Gold Coast HHS, Metro North HHS, Metro South HHS, Public Safety Business Agency, Queensland Ambulance Service, Queensland Police Service, Queensland Nurses Union, South West HHS, Sunshine Coast HHS, WorkCover Qld, West Moreton HHS.

Breakout sessions ran for approx. 45 mins in separate locations. Smaller groups composed of between six to eight persons from diverse occupational groups and agencies, with an additional group composed of videoconference attendees. A butcher paper exercise was utilised with focus questions on each table, information was recorded.

Setting the context of occupational violence

Session 1 focused on the theme of defining occupational violence in relation to background and impact. Key elements that were examined were identification of occupational violence by asking key questions related to prevalence, severity and contributing factors.

1. Where did the incident occur?

Occurrence of occupational violence was commented by groups as being a hazard within most healthcare environments. Areas of occupational violence incidents that were commented as having a higher incidence were:

- Emergency departments
- Mental health
- Front-line services
- Waiting rooms/areas.

2. What types of violence occur?

Types of violence occurring that the groups commented on included:

- Verbal violence either directly or by verbal threat

- physical violence
- emotional or psychological abuse
- threats with weapons
- bodily fluids such as spitting and blood.

3. Is there a frequency?

The frequency of occupational violence in different facilities groups identified as being as high as four to five physical incidents per 24-hours in some major facilities; to daily in relation to client groups and presentations. Groups did not differentiate the frequency as being verbal or physical. Comments such as continuous may indicate high levels of verbal violence and threat.

4. What triggered the aggressive incident?

Commonly recorded themes that groups identified as triggering an occupational violence incident were:

- communication issues and patient/staff attitudes
- waiting times
- frustration and dissatisfaction
- nicotine, drugs and alcohol including withdrawal
- patient or relative unrealistic expectations of care
- dissatisfaction with service, quality, delay or lack of care
- emotional and stress responses by patients/relatives included trauma.

5. How did the recipient respond?

The responses that groups identified for how staff members responded to occupational violence was noted as being accumulative and impacting on worker performance and productivity. Responses included:

- stress and personal distress
- physical injury
- anxiety and depression
- absenteeism from workplace
- frustration.

Groups additionally identified that there was a consequent impact to organisational goals, productivity and performance.

6. How did the organisation respond?

Groups stated a perception of Queensland Health organisational responses being poor in comparison to QAS. Additional comments:

- patient role and safety was greater than staff (as a cultural issue)
- a need for a statewide alert for aggressive patients
- follow through (after incident) noted as a need
- issues raised around reporting.

7. On a spectrum from intentional acts to non-intentional acts how is that decision made by clinicians?

Decision-making was not clearly articulated by groups. Statements made included:

- that the outcome of violence whether intentional or not was the same
- training and experience
- empathy towards mental illness
- based on history diagnosis and interactions.

8. Additional comments during the first breakout session

- Thoughts—mandatory support—to overcome the 'we can do it all' over-empathetic stance and 'part of the job'.
- No smoking and search policies; No central management of security services; Lots of ED unreported; reporting is time consuming; if reports rely on staff (downward arrow); better is supplemented by security.
- IRS does not allow multiple types.
- Ability to share information across jurisdictions/services e.g. HHS and QPS having a platform to combine inputs and share.
- Concern regarding report to police will escalate subsequent actions.
- Police bring to ED versus Police bring to cells; action on penalties.
- High risk needs to be converted to alerts.

Prevention, protection and post-incident strategies

Session 2 focused on three parallel themes of prevention, protection and post-incident strategies. Breakout groups were assigned one of the three themes broadly divided across the number of representatives.

Prevention

9. What key strategies could be followed to prevent incidents?

Responses from the groups focused on dynamic risk assessment of violence (patient assessment, facility wide assessment. Prevention strategies included:

- highly visible security
- training
- alerts
- risk assessment tools such as Broset.

10. What facility approach could prevent incidents (changes to environment/CPTED)?

Groups commented on a number of environmental factors that if remedied could reduce incidence. Examples of approaches included:

- nicer waiting areas (distraction such as TV)
- a more proactive organisational culture (currently reactive)

- greater input of staff (versus management) in decisions and managing changes including staff
- better policies regarding occupational violence
- lighting and security in car parks
- auditing with a view to make improvements
- colour and signage
- actioning recommendations of OVRAT
- Police beat
- adequate staffing.

11. What individual approaches would assist resolution of aggression?

Groups commented from both an organisational and individual perspective, examples included:

- consistent approach by management to zero tolerance
- talking to patients about waiting times (reassurance)
- treat people like you want to be treated
- training (appropriately resourced) e.g. your behaviour can affect other peoples behaviours
- greeter (person to meet and greet patients/relatives)
- communication—let them know what’s going on
- be proactive not reactive
- de-escalation skills.

12. What interagency protocols would provide prevention strategies?

All groups commented on a need for stronger interagency protocols in relation to the exchange of primary information on persons at risk of perpetrating occupational violence being shared between QAS, QAS and Queensland Health.

13. How can information regarding past history and violence potential be shared?

Responses to this question indicated that the question was insufficiently understood, responses made were from the perspective of providing information to patients to deescalate situations. Examples included:

- providing information to patients on likely waiting times
- supports available
- information being provided in a non-identifying way
- generic respectful behaviour was commented by one group.

Protection

14. What changes to work practice provide protection?

Group responses demonstrated that there is a close connection between prevention and protection evidenced in comments made, in general comments related to communication, treatment, planning and protocol:

- QAS advising patients name so we can access databases (protocol)
- explore appropriateness of mandatory 1-7 day follow-up of all discharges (MH) especially NFA not wanting follow-up, non ITO (community orders)
- new workers mentoring, shadowing, coaching. Allow to build confidence and skills
- appropriateness? of single officer responses/contact (QAS and rural/remote)
- easy access to shared information (QAS/QPS/Health)
- communication skills
- situational awareness/ proactive identification of triggers/ professional awareness/alertness
- mobile access to CIMHA (outreach teams)
- mobile phones for all staff
- scheduling appointments
- initial assessments in pairs
- a clear searching protocol between Health and police
- agreed framework prior to home visits (risk assessment)
- rights of people to withdrawal (change in protocol)
- withdraw services – community
- alerts and care planning
- review work practices/clinical practices
- pre-warning other health providers/handover. Not isolated—be visible
- situational awareness
- information sharing—handover—previous history, specially on increased risk patients
- MDT approach.

15. What practical elements of technology would assist protection?

Primary responses to this question included:

- duress and communication alarms (local and personal)
- use of CCTV
- alert systems within electronic systems such as Riskman and Hibiscus.

16. What type of training would provide the best protection?

Groups commented on the question strongly endorsing face-to-face training over on-line training with a focus on communication and de-escalation, additional comments

related to training in situational awareness. Comments included relevance and tailoring of the training with adequate resourcing.

17. What local protocols may provide greater protection?

Group responses included engagement with communities and providing information. Worker safe refuges were noted. A consistent approach by all staff additional was commented on.

18. What type of response should be available to call on for further assistance?

Group comments focused on incident response teams inclusive of security

Post-incident management

19. What additional strategies can be implemented to support staff?

Comments in relation to additional strategies focused on:

- incident investigation
- cultural change
- direct support through a dedicated support unit for injured workers
- increasing communication across the system.

20. Additional comments

- Police focus on target hardening to stop them (victims) from being victims again
- reluctance in environments to state the reality – the chance of assault is high
- we culturally forgive because people are “unwell” – contributes to tolerance
- trust across the system particularly at handover points between services (Police to hospitals)
- withdrawal—nicotine, alcohol and other drugs a substantial issue.



Framework Summary of Guidance Note Occupational Violence Prevention and Management

Appendix 5

