Prevention and management of work-related violence and aggression in health services

Queensland Government

Contents

1. Introduction

The prevention and management of work-related violence and aggression (WVA) is a work health and safety (WHS) issue that requires a multi-faceted organisational approach. Employers have a primary duty of care to identify and control (eliminate and minimise) WVA risks in health service workplaces.

Health services include acute health services, mental health services and aged care services. They include public, private and denominational health services.

This handbook aims to help health service employers understand their duties under the *Work Health and Safety Act 2011* (WHS Act), however many parts may be applicable to other workplaces. It provides guidance on how to:

- identify hazards and risks related to WVA
- implement appropriate control measures
- respond to and learn from incidents to improve prevention.

Designed as a resource for managers, supervisors, health and safety representatives (HSRs) and others involved in developing strategies to control WVA, the handbook should be read in conjunction with the resources listed in section 7.

Health and community service workers can find practical advice in A guide to working safely in people's homes.

1.1 What is work-related violence and aggression?

For the purpose of this handbook, work-related violence is any incident in which a person is abused, threatened or assaulted in circumstances relating to their work. It includes a broad range of actions and behaviours that can create risk to the health and safety of workers.

WVA can result in a worker sustaining physical and/or psychological injuries, and can sometimes be fatal. Workers can be exposed to WVA from a range of sources including clients, consumers, patients, residents, visitors and members of the public.

Examples of work-related violence include, but are not limited to:

- biting, spitting, scratching, hitting, kicking
- pushing, shoving, tripping, grabbing
- throwing objects, damaging property
- using or threatening to use a weapon
- sexual assault.

Aggressive behaviour can include:

- verbal abuse and threats
- angry and hostile behaviour
- antagonism and jeering
- intimidation and insults
- shouting and swearing
- encroaching on someone's personal space, i.e. standing too close
- stamping feet
- banging, kicking or hitting items.

Threat may involve an actual or implied threat to health, safety or wellbeing. Neither intent nor ability to carry out the threat is relevant. The key issue is that the behaviour (as per the examples listed above) creates a risk of physical or psychological harm.

1.2 Leadership

Prevention and management of WVA requires active engagement from all levels of the health service, starting from the top level of the organisation, which may include board members, company directors, and those in executive and senior leadership roles.

Active and visible commitment to systematic prevention and management of WVA from the top down is critical in driving continuous improvement. Those in leadership positions can have a powerful influence in developing a positive safety culture where importance is placed on the health, safety and wellbeing of workers, as well as patients and residents. They should be accountable for the delivery of WHS improvement initiatives, including the prevention and management of WVA.

Leadership teams demonstrate a commitment to a culture where WVA is not accepted as part of the job by:

- setting health and safety objectives and accountabilities
- ensuring effective health and safe systems of work are in place to identify and control risk
- allocating resources to the prevention and management of WVA
- developing and promoting policy and key initiatives
- consulting with and supporting workers
- monitoring and reporting on performance outcomes and acting on issues and opportunities for improvement.

Refer to Section 27 of the *Work Health and Safety Act 2011* for further information on the duty of officers, workers and other persons.

2. Work-related violence and the law

WHS laws are designed to ensure the health and safety of workers and others in the workplace. 'Health' includes physical and psychological health.

A person who conducts a business or undertaking (PCBU) has the primary duty to ensure, so far as is reasonably practicable, workers and other people are not exposed to psychological health and safety risk from the conduct of the business or undertaking.

This duty requires the PCBU to manage risks to psychological health and safety arising from the conduct of the business or undertaking by eliminating risks from exposure to psychosocial hazards, including work-related violence and aggression, so far as is reasonably practicable. If it is not reasonably practicable to eliminate them, they must be minimised so far as is reasonably practicable.

WHS duties are designed to ensure the highest level of protection to workers, patients and others in the workplace from risks to their health, safety or welfare.

Managing WHS risks can ensure health services are effectively delivered and workers are protected.

When a WHS inspector is considering whether WHS duties are being met, they will look for evidence that a PCBU is:

- providing adequate work health and safety corporate governance and risk management systems
- providing and maintaining a work environment without risks to health and safety
- providing and maintaining safe systems of work
- providing information, training, instruction or supervision necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of a business or undertaking
- that the health of workers and the conditions at a workplace are monitored to prevent illness or injury of workers arising from the conduct of a business or undertaking.

A worker must take reasonable care of their own health and safety in the workplace, and the health and safety of others who may be affected by their actions. They must also cooperate with reasonable instructions given by the PCBU.

Others at the workplace, like visitors, must take reasonable care of their own health and safety and not to adversely affect other people's health and safety. They must comply with reasonable instructions given by the PCBU to allow them to comply with WHS laws.

2.1 Consultation

PCBU's must consult, so far as is reasonably practicable, with workers and HSRs, when, for example, identifying or assessing hazards or risks to health or safety at a workplace. Both workers and HSRs are a valuable resource in planning an effective and safe workplace design because they typically understand the work practices and workplace. Consideration should also be given to consulting patients and residents.

Consultation with workers and others about WVA should occur when:

- identifying risks in the workplace
- making decisions about ways to control WVA risks
- making decisions about information and training on WVA
- witnessing signs that WVA is affecting the health and safety of workers
- proposing change that may affect the health and safety of work.

Detailed information about consultation is available in the ***Work health and safety consultation, co-operation and co-ordination Code of Practice 2011***.

2.2 Other legislation

Circumstances involving WVA may be dealt with under criminal law as a criminal matter by the Queensland Police Service (QPS); however duty holders must still ensure health and safety by eliminating and minimising risks to health and safety.

Other legislation relevant to work-related violence in Queensland includes:

- *Criminal Code Act 1899*
- *Mental Health Act 2016*
- *Guardianship and Administration Act 2000*
- *Hospital and Health Boards Act 2011*

Further information on Queensland laws and compliance can be found at worksafe.qld.gov.au.

3. Risk management

Workplaces should have a solid foundation on which to build relevant, sustainable and continuously improving strategies to control WVA risks. These strategies should be based on organisation-wide WHS risk management. The recommended approach is cyclic and underpinned by consultation with workers and HSRs.

The risk management process for general psychosocial hazards, including work-related violence and aggression, can be used and this involves the four steps set out below and shown in Figure 1:

Step 1: Identify psychosocial hazards

Find out what psychosocial hazards could cause harm.

Step 2: Assess risks if necessary

Understand the nature of the harm that could be caused by the psychosocial hazards, how serious the harm could be and the likelihood of it happening.

Step 3: Control risks

Risk control measures should be selected on the basis of highest protection and most reliability. Determine and implement the most effective control measure/s that are reasonably practicable in the circumstances.

Step 4: Review hazards and control measures

Ensure controls are working as planned, and when necessary, improved.

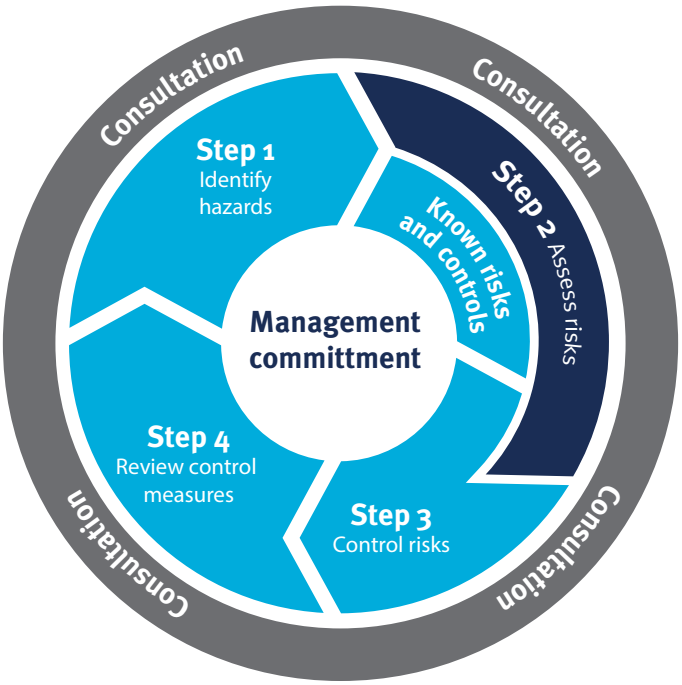

Figure 1. The risk management process

Remember:

Even if there is no history of incidents, it does not mean psychosocial hazards and risks do not exist.

Further information can be found in the Safe Work Australia national guidance material *Work-related psychological health and safety: A systematic approach to meeting your duties.*

3.1 Hazard identification in the context of WVA prevention and management

The nature and location of work, type of clients, business hours, services and facility access, staffing levels and varied employee skill set will affect the hazards present in a workplace and the risk of exposure to WVA.

The factors listed below may increase the likelihood and risks of worker exposure to WVA:

Workplace design:

- unrestricted movement of the general public throughout health service facilities to areas that are easy to access or are unsecured
- poorly lit areas of a facility or poor visibility (e.g. overgrown shrubbery) near entrances/exits
- limited access and exit points
- ease of access to telephone and toilet facilities.

Policies and work practices:

- isolated or remote working locations
- low or inadequate staffing levels and employee experience
- handling cash
- long waiting times
- poor customer service
- denying someone service
- noise
- visiting times (e.g. visitors may be aggressive, or may trigger aggression in clients)
- investigating and/or enforcing specific legal requirements (e.g. mandatory reporting of child abuse)
- activity at night.

Client related:

- distress or pain as a result of illness
- frustration
- physiological imbalances or disturbances
- substance misuse or abuse
- intoxication
- dementia and delirium
- acute and chronic mental health conditions.

These examples are not exhaustive and there may be other situations that expose workers to risks of WVA, particularly where there is direct interaction with the public.

3.2 Incident and injury record review or audit

Review of relevant records such as incident and injury records, first aid reports and workers' compensation claims is required in order to properly undertake risk management and decide upon control measures so far as is reasonably practicable.

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

Raising awareness of psychosocial hazards, including work-related violence and aggression, may result in increased reporting of incidents that may have previously gone unreported. Increased reporting improves the quality of data and creates increased opportunities for prevention through incident investigation. Increased reporting of WVA should be viewed as a positive outcome.

3.3 Walk-through inspection and checklist

A checklist is a useful way of identifying hazards and does not require expertise in WHS. It is a systematic way of gathering and recording information quickly to ensure hazards are not overlooked. A checklist may help identify issues to be considered during risk assessment.

Things to consider in a walk-through inspection are:

- security
- entry and exit points/options
- lighting
- methods of communication

- work schedules
- physical layout and natural surveillance points
- service delivery processes.

Preliminary hazard identification may be done via an organisational self-assessment. Tool 1 – Organisational self-assessment provides an opportunity to review:

- organisational structures, work health and safety corporate governance and processes
- policies and procedures that support workers in the prevention and management of violence and aggression.
- incident recording and reporting processes
- human resource management and employee assistance service processes
- risk management
- measurement, evaluation and risk management system enforcement processes.

3.4 Risk assessments

A risk assessment involves considering what could happen if someone is exposed to a hazard and the likelihood of it happening. A risk assessment can help you determine:

- how severe a risk is
- whether any existing control measures are effective
- what action you should take to control the risk
- how urgently the action needs to be taken.

A risk assessment can be undertaken with varying degrees of detail depending on the type of hazards and the information, data and resources that you have available. It can be as simple as a discussion with your workers or involve specific risk analysis tools and techniques recommended by safety professionals.

When assessing the risks of WVA and the severity of harm that it could result in, the following questions should be asked:

- How likely it is that an act of violence or aggression will occur? Could the hazard cause death, serious injuries, illness or minor injuries?
- How severe would the impact of such an act be?
- How many people are exposed to the hazard and how many could be harmed in and outside the workplace?
- Could one failure lead to other failures? For example, could the failure of a duress alarm make any control measures that rely on that control ineffective?
- Could a small event of aggressive or violent behaviour escalate to a much larger event with more serious consequences?
- Is there any information regarding previous incidents of violence or aggression in the workplace?
- Do control measures exist and are they adequate?

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

A worker survey could also be used to identify knowledge of organisational requirements and their needs in relation to continuing education and training. A sample worker survey can be found at Tool 2 – Worker survey.

Alternatively, Tool 12 – Exposure to risk calculator and Tool 13 – Aggression risk calculator could be used for self-reporting risks associated with exposure to WVA that might otherwise go unreported. This could be used as part of the hazard identification and risk assessment process. Feedback should be provided to workers from reports and surveys, particularly if any corrective action or changes to policy and/or procedures are necessary.

3.5 Risk control

The most important step is managing risks associated with WVA. PCBUs must work through the hierarchy of control when managing risks. This means the PCBU must always aim to eliminate the hazard, which is the most effective control. If elimination is not reasonably practicable, the PCBU must minimise the risk so far as is reasonably practicable.

How to manage work health and safety risks Code of Practice 2011 refers to the management of both physical and psychosocial hazards. The code groups the hierarchy of controls into different types that can be applied when eliminating or minimising WHS risks.

Eliminating the risk means completely removing the psychosocial hazard and associated risks. This is the most effective control measure and you should always consider it before anything else. Where a risk cannot be eliminated you must minimise it so far as is reasonably practicable.

Work design is used to minimise the risks by substituting the hazard, isolating the hazard from the person or putting in place engineering controls. This must be done so far as is reasonably practicable.

For psychological health and safety, substitution means changing the hazardous design of the work or the system of work and replacing will less hazardous alternatives. Isolation and engineering controls may also be used to control physical and psychological risks.

3.6 Reviewing control measures

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

Satisfactory control of risk is often a continual consultative process that involves trialling and refining control measures and considering worker feedback, new technology and changes in knowledge.

The review of risk controls should also analyse data such as incident data to guide ongoing decisions about further actions.

4. Workplace design

Establish and maintain worker safety and security by developing appropriate facilities, work spaces, building services and systems.

The most effective design process begins at the earliest opportunity during the conceptual and planning phases. During the early stages of workplace design, there is an opportunity to find ways to design-out hazards, incorporate effective risk control measures and design-in efficiencies.

Effective design of good work considers:

The work:

- how work is performed, including the physical, mental and emotional demands of the tasks and activities
- the task duration, frequency, and complexity
- the context and systems of work.

The physical working environment:

- the plant, equipment, materials and substances used
- the vehicles, buildings, structures that are workplaces.

The workers:

- physical, emotional and mental capacities and needs.

Effective design of good work can radically transform the workplace in ways that benefit the business, workers, clients and others in the supply chain.

Failure to consider how work is designed can result in poor risk management and lost opportunities to innovate and improve the effectiveness and efficiency of work.

The principles for good work design support duty holders to meet their legal obligations and also help them to achieve better business practice generally. The objective is to eliminate or minimise the likelihood of WVA occurring by using safe design, as this may be more effective in reducing risk than relying on work procedures or training alone.

4.1 Design process

Design can be used to set up the workplace, working environment and work tasks to protect the health and safety of workers.

When designing a new health service workplace or altering an existing workplace, design processes should follow a risk assessment and involve consultation with workers and HSRs.

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

It is also important to monitor the progress of any refurbishment/extension work as changes made to designs during implementation may create additional safety risks.

It is easier to change a line on a drawing than to alter a completed construction build.

The *Safe design of structures Code of Practice 2013* provides practical guidance to PCBUs who design structures that will be used, or could reasonably be expected to be used, as a workplace.

The Safe Work Australia handbook Principles of Good Work Design outlines ten principles for good work design and is relevant to those with a role in designing work and work processes.

Strategies for ensuring good consultation and design can include:

- creating user groups - user groups should be made up of a mix of managers, workers, HSRs and designers. External users, such as Queensland Ambulance Service, when designing an emergency department, should also be involved
- training the user group in design awareness including skills and knowledge in relation to the design process
- establishing a transparent consultation process – clearly document and conduct the process in a language and style suitable for all participants
- visualising the design – use tape or chalk on the floor to do a simple mock-up of an area, computer mock ups, layout plans etc.

Stages of the design process

Involve key stakeholders, including workers, during the whole design process to achieve the best result. An integrated approach to considering safety (and, in particular, the threat of WVA) should occur at each design milestone. Safe work design can eliminate or minimise the risk of WVA, enhance quality of care and optimise workflow and communication.

Tool 4 – Violence and the design process outlines issues that should be considered at each stage of the design process.

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

Stage	Activities/considerations
Design brief preparation	Establish consultation structures. Brief user groups. Develop design awareness.
Feasibility	Map out and cost design proposal to determine if the scope is realistic given available resources. Focus on issues that may influence the potential for WVA to occur such as the location of key entries and exits. Consider the location of key departments that may influence the potential for WVA to occur (e.g. locate emergency department so that access is limited and separate from core hospital areas).
Contract documentation	Select and cost materials. Consider WVA-related design issues such as colours and lighting.
Construction	While the building is being constructed, there may be some issues relating to WVA that need to be considered, such as construction noise or the closure of some areas, which should be communicated to clients, residents and visitors.
Post-occupancy evaluation	Evaluate any design shortcomings that may impact on worker, client, resident, or visitor safety. Collect, review and analyse data on WVA and the impact of design.

4.2 Crime prevention through environmental design (CPTED)

CPTED can be used to address WVA. Principles should be applied to health service environments and incorporated into the work of architects, engineers, builders, maintenance staff and landscape gardeners.

CPTED principles fall into three broad categories:

1. **Territorial reinforcement** which aims to create a strong sense of ownership of a space. It is promoted by features that define property lines and distinguish staff areas from public spaces, such as landscaping, signs, gateways and fences. Ongoing maintenance and housekeeping are key aspects of territorial reinforcement to show the space is cared for.
2. **Access control** should be provided through physical and symbolic barriers to prevent unauthorised access to an area, such as locks and signage. It will attract, restrict or channel movement by making it clear where people can and cannot go.
3. **Surveillance** aims to ensure key areas, such as interview rooms, waiting areas and pathways to car parks, are clearly visible to workers. It can be electronic (e.g. CCTV) or natural (e.g. windows or by strategically positioning buildings, access-ways and meeting places and lighting).

4.3 Design controls

General high-risk areas

Reception and waiting areas

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

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

The reception desk serving the main entrance should allow for surveillance of everyone entering the hospital. A high and wide desk increases the distance between a receptionist and visitor, offering some level of protection. Height differentials can contribute to a person's ability to exhibit intimidating behaviours. Therefore, workers should be seated at eye level with visitors (or higher). The desk should be clear of items that could be used as weapons and separation windows can also be used to enhance worker protection.

Ensure worker consultation during the design stage to ensure new hazards (e.g. the risk of a musculoskeletal disorder) are not introduced.

Treatment and interview rooms

High visibility and controlled access to interview rooms can assist in reducing the risk of WVA, and having two entry/exit doors can allow for appropriate means of escape by workers should it be required. The layout should not permit obstacles between workers and the door, and furniture should be arranged to prevent workers from becoming trapped or cornered.

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

Rooms should be square-shaped, have two doors, secured/controlled access, and fitted with duress alarms. Glass windows should be made of safety/laminated glass. Windows that are one-way or that can be switched between opaque and transparent can be helpful for maintaining visibility without disturbing clients. Doors should be outward opening with peep holes if required. Door handles should move in a downward motion or be anti-ligature.

Staff/nurses station

The staff/nurses station is the primary space where visitors will engage with workers and the main hub where workers will congregate to undertake administrative duties. The following should be considered:

- a high and wide reception desk
- desk based duress alarms, which are regularly tested and maintained, that can be used in times of distress
- a second exit/door from the office area or a 'safe' secure room that workers can escape to, which should have phone to call for help and a vision window/panel on the door to see when it is safe to exit
- reflective mirrors if corner vision is required from the nurses station
- desk space should be kept clear of any items that could be used as a weapon such as vases, staplers, pamphlet holders or scissors.

Pharmacy and drug rooms

Pharmacy and drug room design should incorporate a secure physical separation between pharmacy operations and the public. Integrated security systems should also be used for access and audit functions. Design considerations should be applied to medication distribution points and medication rooms.

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

The design of pharmacy locations should start with the perimeter barrier to the space and include infiltration-resistant protective measures that start from a solid floor to a solid ceiling or roof. Design should prevent access from suspended ceilings through air ducts, cable or utility infrastructure, roof hatches, skylights, and unprotected external windows or doors.

To prevent customers coming into direct contact with workers, the pharmacy counter should be high and wide and the floor behind it should be raised if workers prefer a seated position.

Screens should be made out of laminated glass. Ideally, there should be a transaction drawer or alternatively, a security window which has an opening large enough to permit communication and transactions only. A fully opening window should be avoided. A duress alarm should be fitted behind the counter and there should be natural surveillance and CCTV coverage of the pharmacy area. Controlled drugs, such as narcotics, should be secured in lockable storage cupboards and toilets should not be located in or near the pharmacy or drug rooms.

Workers and others authorised to access the pharmacy should do so through one primary entry point that has restricted access. An audit trail should be kept of all entries through this and any other entry points. Delivery and receipt of goods should be channelled through a designated controlled entrance that allows for screening of personnel prior to entry. A video intercom or other visual mechanism should be installed to allow workers to view and communicate with those requesting access.

Drug rooms should be secured (swipe card/code access) with only authorised access allowed. Doors should be self-closing and a viewing window should be in place to allow natural surveillance.

Car parking

Staff parking should be within safe, designated areas and include:

- limited and controlled access
- a defined perimeter
- CCTV surveillance and signage
- ample lighting
- low-level defensive planting
- traffic-slowing measures
- one-way systems
- separate footpath/vehicle routes.

Cash office

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

Emergency Department (ED) or Emergency Room (ER)

Factors that may increase the risk of WVA	Examples of design control measures	Supporting measures
• waiting times • overcrowding • providing care to people who are in distress, afraid or under the influence of drugs and/or alcohol • substance abuse • volatile emotional situations • mental health conditions • cognitive impairment etc.	• limit public entry points • control access to treatment areas • provide comfortable, spacious waiting areas with enough seating for peak demand times • transparent barriers in reception and waiting areas • provide safe rooms/secure areas for workers to retreat to during WVA emergencies • separate paediatric and adult waiting areas • ensure clear signage for way finding • provide private areas for separation of distressed or agitated people • install wide and screened reception counters • use strategic CCTV and monitoring • consider the queuing system used (e.g. use a ticket/number system) • install bollards to restrict vehicle access near doorways • remove narrow underpasses or lanes leading to car parks and public transport • separate staff car parks from visitor/client parking and ensure they have ample lighting • install desk based duress alarms and/or provide personal alarms • ensure direct/separate access for high violence risk clients • where possible, affix items (e.g. chairs and tables) to walls or floor • provide secure storage for potentially dangerous items • provide a gun safe for the temporary storage of emergency services firearms (i.e. for when armed police officers present with a patient) • flush mount fixtures and fittings (i.e. not just mounted on a wall, but inset) and unbreakable.	• give workers authority to grant or refuse entry • ensure duress and emergency response controls, including Code Black and other measures, are in place • ensure lockdown procedures are in place • ensure security and reception workers are able to see all areas of the ED through the use of security cameras and/or mirrors • ensure workers are clearly identified (e.g. use ID badges with triple-break lanyards or retractable key/ID fobs that clip to pockets/belt loops) • identify visitors upon entry • install computer systems that support retrieval of patient information including alerts for aggressive behaviour • implement a weapons management policy • locate security staff close to the ED.

Maternity and paediatric units

Factors that may increase the risk of WVA	Examples of design control measures	Supporting measures
• volatile emotional situations • family disputes • family violence • child protection issues.	• control access to treatment areas • ensure workers can actively monitor entrances using natural surveillance and CCTV • install desk based and personal duress alarms.	• identify visitors before they enter these units • actively monitor visitors' movements using natural surveillance or CCTV • ensure workers are clearly identified (e.g. use ID badges with triple-break lanyards or retractable key/ID fobs that clip to pockets/belt loops) • implement duress and emergency response procedures • locate meetings related to child protection issues away from other clients • implement clear communication processes between the unit and child protection officers.

Aged care and disability care

Factors that may increase the risk of WVA	Examples of design control measures	Supporting measures
• change in routine • disinhibition • dementia • anxiety • fear and inappropriate placement of clients into unsuitable facilities • inadequate staffing and skills mix.	• control stimuli (e.g. noise, pedestrian traffic) • provide safe walking circuits • allow clients sufficient personal space in bathrooms, bedrooms and dining areas and provide unobstructed travel paths to these areas • use access control to specialised wards and exit doors/lifts where required • ensure workers can actively monitor entrances using natural surveillance and CCTV • provide adequate space and ensure living and common areas are uncluttered • install ample lighting and provide access to natural light • install appropriate floor coverings with no trip or slip hazards.	• provide a set routine with regular permanent workers • provide clients with activities, distractions, sensory modulation and choice • maximise resident independence • carry out risk assessment and screening of residents prior to admission • communicate behavioural expectations to client and family prior to admission • be flexible in timing of care tasks • develop a communication system that alerts workers to client behaviour/mood (e.g. use of a traffic light system).

Mental health

Factors that may increase the risk of WVA	Examples of design control measures	Supporting measures
• client mix • overcrowding • inadequate staffing • substance misuse • boredom • delirium • restrictions on smoking • involuntary admission and absconding • psychological state of patient.	• ensure good visibility, especially for entrances and exits • provide appropriate space (including outdoor areas) so patients have adequate personal space to retreat to when threatened or do not want to interact with others • transparent barriers in reception and waiting areas • provide secure storage for potentially dangerous items, such as kitchen and occupational therapy equipment and/or visitor belongings • provide a safe isolation room • flush mount fixtures and fittings (i.e. not just mounted on a wall, but inset) • fix furniture to walls, floors or ceilings where appropriate • install outward-opening doors • provide good ventilation and acoustics (e.g. soundproofing) • create direct access routes to the facility from other areas such as the ED • create gender sensitive areas or single sex treatment environments.	• provide a set routine with regular permanent workers • provide clients with activities, distractions, sensory modulation and options • maximise client independence.

Other considerations for health services

Area	Risk/problem	Controls
Noise	Noise can be irritating and/or overwhelming and can exacerbate stress and aggression, particularly in people with cognitive impairments.	• avoid loud volumes on communal area televisions and radios • use teletext/captions on waiting room televisions • decrease the number and volume of overhead paging and bells • use soundproof walls or double-glazed windows to reduce noise from the external environment • natural sounds and background music can be relaxing and help reduce stress.
Light	A lack of natural light can cause distress and have negative effects on mental health, including social withdrawal and low mood. Glare can have a similar effect on behaviour.	• install windows or skylights to provide natural light • avoid harsh overhead artificial lighting. Instead, use diffuse and glare-free lighting which can contribute to a relaxed environment.
Colour	The colours of walls, buildings, signs and uniforms have been found to impact on human behaviour.	• soft shades of pink have been found to reduce anxiety, blood pressure, arousal and time taken to return to a calm state • to help minimise anxiety, a bright room with light colours is preferred over a room with dark colours.
Temperature and climate	The likelihood of aggression increases as the temperature does.	• install climate control systems • ensure adequate ventilation, especially when rooms are at maximum capacity.
Space	Lack of space can increase agitation.	• provide indoor and outdoor spaces where clients can be alone or spend time with visitors • consider furniture on wheels that can be safely moved to clear a path for clients with limited mobility and their carers • design waiting areas to minimise crowding of clients.
Safe zones	There are times when a situation cannot be defused and workers must retreat for personal safety.	• provide a safe area for workers to retreat to in case of WVA.

4.4 Security and access

Effective building security requires:

- secure perimeters, including doors and windows (e.g. through controlled access, self-closing doors, air locks)
- safe access and exit, especially after hours and during emergencies
- controlled access to vulnerable areas (e.g. through swipe card access and elevator control)
- clear signage
- systems that allow workers to be identified.

Furthermore, the security operating system needs to be:

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

4.5 Alarm systems

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

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

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

Duress alarms

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

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

Fixed alarms

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

Personal alarms

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

Training

Workers should be trained in how to effectively use equipment and security features (e.g. alarm systems and access control systems) at induction and refresher training.

5. Policy, procedures and practice

5.1 Work-related violence and aggression policy

Developing and implementing a WVA prevention policy clarifies behaviour expectations and demonstrates a commitment to WHS. The policy should be developed through consultation across the workplace with HSRs, workers, managers and other relevant stakeholders.

A policy should include the following elements:

Purpose statement

The purpose statement should reflect:

- an intention to provide a safe and healthy workplace where workers are not subjected to WVA
- a commitment to support workers who are exposed to, or have witnessed, WVA.

Definition of scope

- The policy should include a definition of WVA.

Objectives

Objectives of the policy should outline that:

- WVA is not acceptable and will not be tolerated
- appropriate action will be taken if WVA occurs
- reporting incidents is mandatory and based on a no-blame approach to investigation
- incidents will be investigated with a view to prevention and continuous improvement
- training and educating workers in the prevention and management of WVA is tiered and based on exposure to risk, following WHS principles that are updated and ongoing.

Responsibility

The policy should outline roles and responsibilities of relevant workers and give them appropriate authority to carry out their responsibilities under the policy.

Risk management

The policy should address:

- proactive hazard identification and risk assessment of situations and sources of risk
- risk control designed to eliminate or minimise the risk of violent and aggressive behaviour
- systems for communicating/sharing information internally and externally about clients or visitors who have a history of, or are currently exhibiting violent or aggressive behaviour, including triggers and management strategies
- references and related documents.

The policy should include documents and sources used to formulate the policy and related organisational documents.

Authorising committee/senior management commitment

The policy should be endorsed and actively supported by senior leadership and any authorised committees.

It should be regularly monitored and reviewed to ensure it reflects changes in legislation and workplace needs.

The policy should be formulated in consultation with HSRs and workers and reflect the workplace's specific requirements. The policy should also be displayed in a prominent place for all workers to view.

Tool 5 – Violence prevention policy. If this example is going to be used as a starting point, consider how it may need to be adapted to the workplace's specific requirements following consultation with HSRs and workers.

A sample work-related violence prevention policy can also be found in the guide Preventing and responding to work-related violence 2014.

5.2 Workplace procedures

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

Health services should develop a staged approach to the management of WVA and outline the approach taken in a WVA policy and accompanying procedures. A staged approach may include:

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

The options in the staged approach should be applied in descending order taking into account:

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

Warnings

A written warning should:

- focus on the behaviour and possible effects the behaviour may have on workers, other clients and visitors and not on the person or their intent
- be drafted in consultation with key stakeholders such as relevant clinicians
- clearly identify the matter of concern and expected acceptable behaviour
- be polite, respectful, non-judgmental and informative
- use plain English
- clearly indicate the consequences of failing to behave in an acceptable manner and include information about how to appeal the warning
- be signed by a senior manager with an appropriate level of authority.

Treatment agreements

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

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

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

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

Agreements should be:

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

Sanctions

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

Workers should be aware of procedures for requesting police or security assistance and how to make a report to police about an assault following the incident.

Regular communication should be maintained with local police after an incident has occurred. Warnings, treatment agreements and sanctions for clients and visitors should be integrated into an organisation-wide alert system. A record should be made of any conversations held with clients or visitors explaining the nature of warnings, treatments or sanctions that may be in place.

An example warning notice is available at Tool 10.

5.3 Procedure to practice

The prevention and management of WVA should be integrated into day-to-day practice through relevant documented work procedures. Procedures should describe details of the workplace arrangements to identify hazards, assess and control risks specific to WVA, including responsibilities of clinical and non-clinical staff. It is important regular reviews of procedures are undertaken.

Work procedures need to:

- describe circumstances in which the procedures are to be followed
- define roles and responsibilities
- describe specific risk controls
- outline steps to monitor and evaluate effectiveness of controls
- include emergency response arrangements
- provide guidance on incident reporting and near misses
- provide guidance on post-incident response including incident investigation.

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

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

- reporting incidents and near misses
- limiting the number of client support people/visitors
- identifying WVA risk in admission criteria and admission screening processes
- communicating expected waiting times, client condition, treatments or treatment delays with clients and visitors
- cultural awareness and the appropriate use of interpreters
- exchange of relevant information within and external to the workplace
- use of lanyards with a safety breakaway
- supply of security equipment such as duress alarms
- use of up to date behavioural management plans, and communication of client and visitor responsibilities and expected behaviours e.g. through communication of client code of conduct.

5.4 Behavioural risk factors

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

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

At pre-admission or presentation, the following risk factors should be considered:

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

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

Risk factors and control measures for particular clients should be noted and highlighted in a care management or treatment plan, after completing a behaviour assessment worksheet.

Tool 6 – High risk screening

Tool 7 – Violence hazard identification and risk assessment

Tool 8 – Behaviour Assessment

Transfer of information

Information about any known risks of WVA that may pose a threat to health and safety should be provided to workers who may come into contact with the client or to another workplace/ward/unit to which the client is referred.

Transfer of information should take place when a client is transferred:

- internally between wards or units at a health service
- between two campuses of a health service
- between two health services
- from a critical assessment team (CAT) to a health service
- between a residential care facility or a group home and a health service
- between Queensland Ambulance or Queensland Police and a health service.

Where a health service is aware of a risk of violent or aggressive behaviour, there should be a requirement to inform the service, department or facility the client/patient is being transferred to, of this risk.

The receiving service, department or facility should also request this information as part of their admissions process.

Sending workplace/ward/unit	Admitting workplace/ward/unit
Provide information as part of discharge process including: • clinical notes • behavioural history including WVA incidents • WVA triggers • management plan.	Request information as part of the admissions process including: • clinical notes • behavioural history including WVA incidents • WVA triggers • management plan.

5.5 Alert systems

Alert systems, or 'file flagging', are used for a variety of clinical risk management and client safety reasons (e.g. to identify clients with life threatening allergies) and can also be used to identify client behaviours that could create a risk to health and safety.

Alerts can be electronic or placed on hard copy files and should be accessible to any health service worker who may come into contact with the client. Client alert systems should be integrated and aligned to allow for transfer of alerts across a health service.

Workplaces should have an alert policy covering governance including how frequently alerts are reviewed. Criteria for alerts should be carefully developed and linked to safety issues that arise from a client's behaviour rather than the client's personal characteristics.

A client alert procedure should:

- clearly define the purpose for the alert and focus on behaviour and risk
- identify the person to whom the alert refers (e.g. client only, family, regular visitors)
- include steps for behaviour management planning
- identify who has been delegated responsibility for initiating, reviewing, removing alerts, and reviewing and updating associated management plans.

Alternatively, a visual prompt such as a sticker on the client's record may be used. The information should be objective, reviewed regularly and kept up-to-date. If a client file has an alert flag, where appropriate it should be supported by an up-to-date management plan.

Multi-disciplinary care plans can be developed to deliver a consistent care approach. In addition to HSRs or WHS staff, family members can also provide valuable input into care planning and their involvement can assist in ensuring clear standards of expected behaviour are set. When an alert is identified, workers should be prompted to complete an assessment of the client's current behaviour. The management plan should be reviewed and updated to ensure that care is provided in a safe manner.

Tool 9 – Client Alert

5.6 Incident management

If a WVA incident occurs or escalates, it is important workers have immediate response options such as a code black response.

The response approach selected needs to be appropriate to the situation and worker training/skills and may include:

- review by a clinician
- calm verbal and non-verbal communication
- verbal de-escalation and distraction techniques
- support from other resources such as more senior workers attendance by a duress response team, security or the police
- a request that the aggressor leave the workplace
- withdrawal to a safer location
- an internal emergency response
- an external emergency response
- evasive self-defence
- initiating a duress response
- the use of the least restrictive restraint practice.

Note: workplaces should have a clear policy on the use of restraint and seclusion.

Any worker can initiate a duress response at any time. Health services should consider a secondary duress response protocol in case multiple incidents occur at the same time.

The Australian Standard 4083-2010, Planning for emergencies – Health care facilities assists effective planning for internal and external emergencies.

Incident and 'near miss' investigation

Tool 1 – Organisational self-assessment allows for the review of current systems, expectations and processes associated with reporting and investigations.

Post-incident response

Workplaces should have a formal incident management and post-incident response policy and/or procedure.

Priorities following an incident may include:

- safety for all concerned including people such as workers, clients or visitors who may have witnessed the incident
- medical attention for anyone injured during the incident
- psychological support such as mental health first aid, peer support and Employee Assistance Program (EAP) support
- assistance with police and judicial processes (e.g. giving evidence in court about an incident)
- assistance with workers' compensation claims and return to work planning
- reporting
- investigation
- implementation of outcomes
- review of risk controls.

5.7 Reporting

Incidents of WVA should be reported immediately by workers, or by management on their behalf, to facilitate post-incident response and investigation. The workplace should have an incident reporting system to facilitate reporting.

Reporting allows for appropriate investigation and collection of data to assist in understanding and responding to emerging trends and issues in particular units or across the health service. Data on WVA reporting and incident trends should be presented to senior leadership and the Board of the health service.

External reporting may also be required, including the Regulator in the case of notifiable incidents. Visit worksafe.qld.gov.au for further information about notifiable incidents.

It is an offence to assault a health care professional. Workers may choose to make a police report following an incident. Health services should have a process to support workers make a police report. Making a police report assists police build profiles for repeat offenders, identify crime trends and support prosecutions.

5.8 Incident investigation and review

Incident investigations should be undertaken by a suitably trained worker, such as a Health and Safety Advisor, Nurse Unit Manager or Facility Manager.

The investigation process should be documented and conducted in a systematic way to identify risks and hazards inside and outside the facility. Investigations provide learning opportunities to improve risk controls to prevent future incidents and should be conducted without seeking to blame individuals or groups.

An investigation should document the:

- type of incident that occurred
- date and time of incident
- site of incident
- people involved – including witnesses to the incident
- outcome of the incident
- injuries sustained by workers and/or others
- recommendations to prevent future incidents occurring.

An investigation should also include a comprehensive review of the client's journey including behaviours and triggers (i.e. what has taken place in the days and hours leading up to a WVA incident/s).

Contributing factors to the incident should be identified including:

- clinical factors
- client care or client/visitor concerns
- work design, policies and work practices
- equipment failure/ maintenance
- communications
- human resources
- health and safety management system
- any other risks or hazards.

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

Reporting the findings, recommendations and outcomes of an investigation should enable control measures to be introduced and practices reviewed to minimise the risk of future incidents. Information about the outcomes and recommendations from the investigation should be communicated to the relevant people in a timely manner. This could be through a discussion at shift handover, a copy of the investigation report being provided to relevant workers, reporting through committees, or reporting to boards, senior leadership and managers.

Recommendations should be implemented using action plans. Actions plans should assign dates to review and assess whether revised control measures are effective.

Tool 1 – Organisational self-assessment can help to identify potential gaps in workplace systems related to incident documentation, reporting and investigation.

6. Training and education

6.1 Context

Training and education is considered an administrative control measure. It can compliment and support higher order control measures, such as design, policy and work practices. Training that is based on a comprehensive needs analysis will be more effective than training that is not.

6.2 Principles

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

Such programs should be based on principles of adult education to ensure relevance and support for programs. Special needs of workers, such as skills, gender, disability, literacy and first language need to be considered in the development and delivery of these programs.

6.3 Needs analysis

A comprehensive training needs analysis should be completed before any training programs are introduced. A needs analysis can be conducted using questionnaires, worker surveys or focus groups in specific work areas. Training needs can also be identified through incident analysis, WHS systems reviews and the use of risk calculator matrices.

Tool 2 – Worker Survey

Tool 12 – Exposure to aggression risk calculator

Tool 13 – Aggression risk calculator

6.4 Tiered approach

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

Programs should help workers understand:

- risk management approach for WVA, including risk factors, how to assess them, how to contribute to the development of controls, how to operate or implement controls and how to report issues with ineffective controls
- clinical and non-clinical causes
- signs of escalation and imminent violence
- communication strategies
- prevention measures
- workplace policies and procedures
- emergency and post-incident responses
- the right to withdraw to safety at any time.

6.5 Additional considerations

The content of a basic level program might be included in the workplace orientation program as part of a WHS overview.

This level of training might be sufficient for a worker employed in an area such as human resources.

A more detailed program could be suitable for a worker working in environmental services, while an even more extensive program would be needed for clinicians. The organisational context and the expectations placed upon workers should be considered when making these decisions. For example, in a small hospital where non-clinical workers may fill multiple roles, such as payroll, accounts payable and reception, a mid-level program would be valuable.

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

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

Evasive self-defence training

Evasive self-defence training should be provided as an adjunct to other initiatives to those most at risk. It should be considered after all other possible risk control strategies have been implemented and the level of risk warrants such a response.

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

- emphasise retreat and self-protection
- cover relevant legal issues, such as the concept of reasonable force and dangers and precautions when using evasive self-defense
- be developed and delivered by appropriately experienced and accredited experts
- provide techniques relevant to the worker group, the risks they face and environments they work in
- include the requirement for, and provision of, regular practice
- consider the physical characteristics of the worker group and of the clients or others demonstrating aggressive behaviours where possible.

Security staff

The needs of the health service should be considered before employing security staff or subcontracting a security firm.

Security personnel should be appropriately qualified for the role. Their inclusion in workplace training will assist in clarifying roles within response teams.

Managers

Tailored training for managers should ensure they:

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

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

6.6 Providers and programs

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

The training needs analysis and organisational review of control measures should inform the choice of training provider and program.

6.7 Evaluation

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

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

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

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

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

Post-training evaluation provides valuable information about design and delivery, but does not measure learning transfer or medium-to-long term benefits of a program in the workplace. In the context of WVA prevention and management, immediate post-training evaluation is a minor part of the evaluation process.

Post-training evaluation in the medium-to-long term should involve ongoing monitoring. A learning needs analysis could be conducted 6-12 months after the training to identify ongoing deficits in skill or knowledge. Competency-based assessments could also be conducted.

Findings from the application of Tool 15 – Post-training evaluation tool – medium-to-long term should be fed back into the overall evaluation of control measures for the prevention and management of WVA in the workplace.

Tool 14 – Post-training evaluation tool – short term could be used immediately after training to evaluate program relevance and key learnings for participants.

An example of a medium-to-long term post-training evaluation can be found at Tool 15 – Post-training evaluation tool – medium to long term.

A sample competency-based assessment can be found at Tool 16 – Competency-based assessment. It is recommended that individuals with solid WHS knowledge administer this kind of assessment to workers.

7. Further information

Workplace Health and Safety Queensland (worksafe.qld.gov.au)

Work Health and Safety Act 2011

Work Health and Safety Regulation 2011

How to manage work health and safety risks Code of Practice 2011

Work health and safety consultation, cooperation and coordination 2011

Safe design of structures Code of Practice 2013

Preventing and responding to work-related violence guide 2014

A guide to working safely in people's homes

WorkSafe Victoria resources (worksafe.vic.gov.au)

It's never ok: Violence and aggression in healthcare campaign

Prevention and management of violence and aggression in health services

Designing safer buildings and structures guide

Occupational health and safety in boards

Working safely in visiting health services: A handbook for workplaces

Safe Work Australia resources (safeworkaustralia.gov.au)

Work-related psychological health and safety: A systematic approach to meeting your duties

Principles of good work design: A work health and safety handbook

Victorian Department of Health and Human Services resources (health.vic.gov.au)

Guide for violence and aggression training in Victorian health services – Guiding principles

Preventing Occupational Violence: A policy framework including principles for managing weapons in Victorian health services, Department of Health and Human Services, (2011)

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

Queensland Health (www.health.qld.gov.au)

Occupational Violence Prevention in Queensland Health's Hospital and Health Services, Taskforce Report, May 2016

Queensland Health Capital Infrastructure Requirements, Volume 3, Architecture and health facility design

The Royal Women's Hospital

Strengthening hospital responses to family violence resource centre

Reports and inquiries

Violence in Healthcare Taskforce Report, June 2016

Occupational Violence Against Healthcare Workers, Victorian Auditor-General's Report, May 2015

Inquiry into violence and security arrangements in Victorian hospitals (Parliament of Victoria, Drugs and Crime prevention committee, 2011)

Violence in nursing final report, Department of Human Services, Victoria

Standards and guidelines

AS 4485.1 – 1997 – Security for Health Care Facilities – General Requirements www.standards.org.au

AS 4485.1-1997 - Security for Health Care Facilities (Part 1: General Requirements) www.standards.org.au

AS 4485.1-1997 - Security for Health Care Facilities (Part 1: General Requirements) www.standards.org.au

AS 4485.2-1997 - Security for Health Care Facilities (Part 2: Procedures Guide) www.standards.org.au

Emergency Department Design Guidelines, Australasian College for Emergency Medicine, 2014 www.standards.org.au

Australasian Health Facility Design Guidelines – www.healthfacilityguidelines.com.au/

AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines www.standards.org.au

AS/NZS – 4801: 2001 Occupational Health and Safety Management Systems – Specification with guidance for use www.standards.org.au

All standards available for purchase from www.saiglobal.com

Acknowledgements

The information presented in the Prevention and management of work-related violence and aggression in health services handbook is intended for general use only. It should not be viewed as a definitive guide to the law and should be read in conjunction with Queensland WHS legislation.

The information in this publication has been adapted with the permission of WorkSafe Victoria.

Document history

First published 2009, updated in 2019.

Tool 1 – Organisational self-assessment tool

This section of the template assesses the generic workplace structures that are in place to support work health and safety activities.

Organisational structures, governance and processes	Yes	No	N/A	Comments
Our workplace has a work health and safety (WHS) committee.	☐	☐	☐	
Our WHS committee has current terms of reference that are reviewed every three years.	☐	☐	☐	
The terms of reference reflect reporting/ communication requirements and processes to executive and board/committee of management levels.	☐	☐	☐	
Our documentation reflects a consultative and cooperative approach to WHS.	☐	☐	☐	
Policies and procedures are consistent with current legislative and statutory requirements.	☐	☐	☐	
Policies and procedures are reviewed every three years.	☐	☐	☐	
Our health and safety representatives (HSRs) have received the training required to fulfil their roles within the workplace.	☐	☐	☐	
Our workplace has a formal written policy for the prevention of work related violence and aggression (WVA).	☐	☐	☐	
Our policies and procedures support workers in implementing the prevention and management of WVA.	☐	☐	☐	
Our workplace has a documented client charter/bill of rights.	☐	☐	☐	
Our workplace client charter includes 'client responsibilities'.	☐	☐	☐	

Policy content

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

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

Policies and procedures that support workers in client management

This section of the template provides an opportunity to review policies and procedures related to client-initiated work-related aggression and violence.

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

This section of the self-assessment tool looks at physical and chemical restraint and seclusion.

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

Documentation, reporting and investigation

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

	Yes	No	N/A	Comments
Our workplace has a system for reporting incidents of WVA	☐	☐	☐	
Workers are aware of their obligation to formally report incidents of WVA (e.g. at orientation or unit meetings).	☐	☐	☐	
All incidents of WVA are reported within 12 hours of occurring.	☐	☐	☐	
Our system for reporting incidents is accessible to all workers.	☐	☐	☐	
Our system captures the following information:				
• type of incident	☐	☐	☐	
• date and time of incident	☐	☐	☐	
• site of incident	☐	☐	☐	
• people involved in the incident	☐	☐	☐	
• outcome of incident	☐	☐	☐	
• injury to worker	☐	☐	☐	
• injury to client	☐	☐	☐	
• mitigating circumstances.	☐	☐	☐	
All incidents of WVA are systematically investigated to identify:				
• clinical contributing factors	☐	☐	☐	
• workplace design contributing factors	☐	☐	☐	
• contributing factors related to patient care or patient/visitor concerns	☐	☐	☐	
• equipment failure, maintenance, requirements that may have contributed	☐	☐	☐	
• human resource contributing factors	☐	☐	☐	
• communications contributing factors e.g. handover	☐	☐	☐	

	Yes	No	N/A	Comments
• workers involved in the incident (to ensure they receive support and have an opportunity to be consulted)	☐	☐	☐	
• previously unidentified risks or hazards.	☐	☐	☐	
Comprehensive reports of incident data are tabled at relevant meetings.	☐	☐	☐	
Outcomes of investigations are made known to the workers involved and HSRs.	☐	☐	☐	
Summaries include:				
• follow-up risk assessments	☐	☐	☐	
• recommendations for control measures	☐	☐	☐	
• action plans for implementation of recommendations including dates for review and revised control measures.	☐	☐	☐	
Data associated with all incidents is maintained to enable analysis, tracking and identification of trends over time.	☐	☐	☐	

Human resource management and development

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

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

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

Hazard identification, risk assessment and management

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

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

Measurement and evaluation

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

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

Employee survey – identifying work-related aggression and violence risks

We are committed to maintaining the health and safety of all of our workers. Results from the survey will be used to help us identify work-related aggression and violence risks within our work environment and develop prevention and management strategies. The survey is confidential.

Please take a few minutes to complete the survey and return it to		by
The results of the survey will be provided to		on

General information

Ward/work unit/division

Male ☐ Female ☐

Age range (years): ☐ < 20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ > 60

Occupational group, please tick one of the following:

☐ Allied Health Professional

☐ Nurse

☐ Medical

☐ Clinical assistant

☐ Coordination

☐ Clerical/administration

☐ Environmental/food services

☐ Other (please specify)

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

Policies and procedures

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

Working environment and systems

Do you feel safe at work?

	Yes	No
Have you been provided with all necessary controls and measures to protect your safety? (e.g. personal duress alarms or dual exits in interview rooms)	☐	☐
Do you believe you are prepared to manage an aggressive or violent situation?	☐	☐

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

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

Incidents, reporting and follow-up	Yes	No	Don't know
1. Is there a system for accessing additional support if a client becomes violent or aggressive?	☐	☐	☐
2. Are you required to report threats of violence or aggression in your work area?	☐	☐	☐
3. Are you required to report actual incidents of aggression or violence in your work area?	☐	☐	☐
4. Do you feel you can make reports without fear of reprisal?	☐	☐	☐
5. Is there a system for reporting threats and incidents of violence or aggression in your work area?	☐	☐	☐
6. If 'yes' to question 5, is it easy to follow?	☐	☐	☐
7. Does the supervisor/manager investigate reports without undue delay?	☐	☐	☐
8. Does the supervisor/manager take corrective action without undue delay?	☐	☐	☐
9. Are all co-workers formally briefed about a violent or aggressive situation before commencing duty or attending to a client?	☐	☐	☐
10. Is there a program to provide support for workers directly and indirectly affected by incidents of work-related violence or aggression?	☐	☐	☐
11 Are police and other emergency services called immediately when an incident involving a criminal act occurs?	☐	☐	☐

Barriers to reporting

	Yes	No	Don't know
12. Are there particular obstacles to you formally reporting	☐	☐	☐

If 'yes' please tick the barriers for you:

Lack of access to reporting forms/mechanisms

- ☐ Don't know the process for reporting
- ☐ Don't know what constitutes an incident
- ☐ The reporting form is too complicated
- ☐ The reporting tool is geared to clinical incidents

Time constraints

- ☐ Lack of feedback/visible change
- ☐ Concern about retribution/blame
- ☐ Concern about how colleagues will perceive me

Other (please specify):

Who do you tell and how?

	Verbal	Written
13. Who do you report incidents of violence or aggression to and how do you report it?	☐	☐

Please mark all that are applicable to you.

- Line manager
- Health and safety representative (HSR) Colleague
- WHS staff
- Friend/family member

Other (please specify):

Tool 2 – Worker Survey

Education and training

Have you ever attended any of the following either at work or privately:	Yes	No	Don't know
• Customer service training	☐	☐	☐
• Communication skills training	☐	☐	☐
• Assertiveness training	☐	☐	☐
• Work health and safety training. Length of program:	☐	☐	☐
Self-defence training To what level:	☐	☐	☐
• Aggression prevention and management training	☐	☐	☐

Name and length of program:

When did you attend:

Have you ever attended an education or training program that has covered the following topics:

• Recognising preventing and dealing with workplace violence and aggression	☐	☐	☐
• Communication and care strategies to prevent violence or aggression	☐	☐	☐
• Psychiatric behavioural and psychological conditions associated with violent or aggressive behaviours	☐	☐	☐
• Respectful self-defence measures related to clients	☐	☐	☐
• Do you believe you have adequate education and training related to violence and aggression prevention and management for your current position?	☐	☐	☐

Are there particular barriers to you attending 'in-house' education and training programs that would need to be considered in planning education and training programs related to aggression prevention and management?

Please tick as many boxes as are applicable to you.

• Too difficult to take time away from daily duties	☐	☐	☐
• Inconvenient location	☐	☐	☐
• Inconvenient time in relation to other work activities	☐	☐	☐
• Fatigue/'burn out'	☐	☐	☐
• Lack of support/encouragement to attend	☐	☐	☐

Other (please specify):

Any other comments:

Tool 3 – Design and aggression

Design and aggression – generic audit

Health facility:

Department/work area:

Persons involved in the audit (manager, health and safety representative (HSR), staff members, designer):

Name:

Title:

Name:

Title: Date of audit:

Audit objective

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

How to use the audit checklist

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

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

Pre-questions

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

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

Design and aggression – generic audit	Yes	No	N/A	Comments	Action
1. Strategic location **1.1. Location – internal interactions**					
• Does the location of the work area allow easy interaction between related departments within the workplace?	☐	☐	☐		
• Does the location of the work area facilitate natural surveillance, allowing workers to view and monitor the area?	☐	☐	☐		
1.2. Location – external interactions					
• Does the location of the work area facilitate any external interactions (e.g. suppliers, paramedics)?	☐	☐	☐		
1.3. Directions					
• Is the department easy to find for clients?	☐	☐	☐		
• Is the directional signage suitable for all clients (e.g. language, size of text, positioning)?	☐	☐	☐		
2. Design of the space **2.1. Entry/exit**					
• Is the location of the entry/exit doors suitable for workers to retreat to safety?	☐	☐	☐		
• Does the design of the entry/ exit door facilitate clients' independent use?	☐	☐	☐		
• Does the design and location of the entry/exit door facilitate surveillance of people entering/ exiting?	☐	☐	☐		
2.2. Workspace (size and layout of area)					
• Is the workspace adequate for worker needs - consider equipment used and tasks?	☐	☐	☐		

Design and aggression – generic audit	Yes	No	N/A	Comments	Action
• Is the workspace adequate for clients' needs (e.g. personal space, movement)?	☐	☐	☐		
• Is the workspace adequate for storage needs so that clutter is minimised?	☐	☐	☐		
3. Furniture, fixtures and facilities **3.1. Seating**					
• Is there adequate seating for clients and is it comfortable?	☐	☐	☐		
• Does the seating promote independence for clients?	☐	☐	☐		
• Is the layout of the seating suitable for clients (consider fixed versus moveable)?	☐	☐	☐		
• Is the seating easy to maintain/keep clean?	☐	☐	☐		
3.2. Counter design					
• Does the design of the counter mean that clients cannot easily jump over the counter?	☐	☐	☐		
• Does the design of the counter mean that clients cannot easily strike a worker across the counter?	☐	☐	☐		
• Does the design of the counter mean that clients cannot easily get behind the counter?	☐	☐	☐		
• Is there an emergency response system (e.g. duress button, personal alarm) appropriately positioned and monitored?	☐	☐	☐		

Design and aggression – generic audit	Yes	No	N/A	Comments	Action
• Is CCTV in place and functional?	☐	☐	☐		
3.3. Client facilities					
• Are appropriate toilet facilities available and easy to access?	☐	☐	☐		
• Are appropriate refreshment facilities (e.g. water, food) available and easy to access?	☐	☐	☐		
• Are appropriate entertainment facilities (e.g. magazines, TV) available and easy to access?	☐	☐	☐		
• Is there a specially designed waiting area to entertain children?	☐	☐	☐		
3.4. Cash and pharmaceuticals					
• Does the design limit client viewing of cash and pharmaceuticals?	☐	☐	☐		
• Does the design limit client access to cash and pharmaceuticals?	☐	☐	☐		
4. Environment **4.1. Noise**					
• Are the noise levels in the area suitable for clients?	☐	☐	☐		
• Are the noise levels in the area suitable for staff? Loud or persistent noise should be avoided.	☐	☐	☐		

Design and aggression – generic audit	Yes	No	N/A	Comments	Action
4.2. Lighting					
• Does the area have some natural lighting from external windows?	☐	☐	☐		
• Is the space free from glare? Consider reflective surfaces, need for adjustable window coverings etc.	☐	☐	☐		
• Does the level of illumination suit the client activities (e.g. reading, sleeping) to be undertaken?	☐	☐	☐		
• Does the level of illumination suit the staff activities (e.g. reading, use of a computer) to be undertaken?	☐	☐	☐		
• Where necessary, is the lighting adjustable or is task lighting provided?	☐	☐	☐		
4.3 Colour					
• Is the colour of the room relaxing for clients and workers? *Large expanses of strong and dark colours should be avoided*.	☐	☐	☐		
4.4 Temperature and odours					
• Is the area well ventilated so that the temperature remains fairly constant?	☐	☐	☐		
• Can the temperature be maintained at an appropriate level for the type of activities being performed by clients?	☐	☐	☐		
• Can the temperature be maintained at an appropriate level for the type of activities being performed by workers?	☐	☐	☐		
• Is the area free from cold draughts where people are sitting?	☐	☐	☐		

Design and aggression – generic audit	Yes	No	N/A	Comments	Action
• Does the area have a pleasant/neutral odour without any persistent unpleasant smells (e.g. urine/ faeces, vomit, disinfectant)?	☐	☐	☐		
5. Security					
• Are worker only areas secure (e.g. door locks, swipe card, key pad access)?	☐	☐	☐		
• Is there an emergency call system (e.g. duress alarms, personal pagers, emergency buzzer) available for workers?	☐	☐	☐		
• Is client activity monitored (e.g. natural surveillance, CCTV, presence of security staff) in high-risk areas?	☐	☐	☐		
• Is the CCTV appropriately designed (e.g. overt or covert system) and located (e.g. view of the area)?	☐	☐	☐		

Tool 4 – Violence and the design process

Question	Consider	Yes	No	N/A	Comments	Action
Consultation structure						
Who to involve	• Designers • Managers • Health and safety representatives (HSRs) • Workers • External users (e.g. Queensland Ambulance) • OHS experts • Consumers (e.g. clients/residents)	☐	☐	☐		
When to consult	• At each key milestone/stage • Time allowance for consultation	☐	☐	☐		
How to consult	• Face-to-face meetings • Documentation of decisions • Feedback to participants	☐	☐	☐		
Master planning						
What aspects about the general location of the facility might create or influence aggression and violence risks/ outcomes?	• General demographics and socio-economic structure of the area • Access to public transport	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
What aspects about the neighbouring buildings or sites are likely to impact on aggression?	• Access to other agencies such as police/ambulance • Neighbouring residential/ industrial/business areas • Lighting and noise • Surrounding landscape	☐	☐	☐		
What aspects about the facility boundaries may contribute to aggression and violence risks?	• Entry and exit • Busy roads • Public transport	☐	☐	☐		
Where are the entry and exit points to the site and relevant departments, and how does this relate to security and surveillance?	• Entry and exit points in relation to security and surveillance	☐	☐	☐		
Where are the major departments located and do these facilitate work flow and client/ visitor flow?	• Location of departments serving clients and visitors • Pathways of travel	☐	☐	☐		
Is the space and location of parking appropriate to facilitate safe access for workers and visitors?	• Car park surveillance • Access control • Defined perimeter	☐	☐	☐		
What are the major paths of travel for vehicles, pedestrians and goods, and are these easy to navigate?	• Separate footpath/ vehicle route • Clear signage, directions and signs • Traffic feasibility study	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
What is the likely future site development? Have adequate areas been set aside for future growth and change?	• General demographics • Economic structure of area	☐	☐	☐		
Is it likely that the demographics of the client or visitor population will change?	• General demographics • Economic structure of area	☐	☐	☐		
Feasibility study						
What types of clients are likely to occupy the facility?	• Demographics of the local area such as potential for drug/alcohol-influenced clients • specific cultural groups	☐	☐	☐		
Are there any high-risk departments (such as emergency, mental health and aged care) that need special consideration?	• Cultural groups and demographics	☐	☐	☐		
What types of visitors may attend the facility?	• Access control	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
What special features does the facility need to meet organisational policies and procedures related to aggression and violence?	• Isolation rooms • Observation of clients • Garden areas	☐	☐	☐		
What security measures need to be installed?	• Duress alarms • CCTV	☐	☐	☐		
Who must be consulted in relation to identifying client aggression and violence risks during the planning process?	• Department managers • Health and safety representatives • Workers • WHS professionals • Designers	☐	☐	☐		
What user consultation process should be included and costed into the planning process?	• Training user groups • Briefing strategies • Design visualisation	☐	☐	☐		
Schematic design						
Where there is an interaction between workers and clients or visitors, there is a risk of aggression and violence. Have all functions been documented for all client/visitor areas?	• Quality documentation systems	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
Has adequate workspace been allocated to all areas to ensure tasks can be undertaken safely and is there enough room for all those likely to occupy the area?	• Feedback from consultation phase	☐	☐	☐		
Where there is the potential for the first interface between workers and clients (e.g. reception, interview rooms) has the potential for aggression and violence been taken into account?	• Second exit in interview rooms • Physical barrier in reception • Signage	☐	☐	☐		
Have the relationships between work areas been documented?	• Quality documentation systems	☐	☐	☐		
Does the location of different departments facilitate work and client/visitor flow?	• Access control	☐	☐	☐		
Does the layout facilitate compliance with aggression-related policies (e.g. observation of clients)?	• High visibility • Controlled areas	☐	☐	☐		
Have the entry and exit points of the facility and individual departments been planned to facilitate security systems?	• CPTED principles	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
What security measures and communication devices need to be installed throughout the facility?	• Duress alarms • CCTV • Telephones	☐	☐	☐		
Does the interaction between the building and the external environment maximise the therapeutic environment?	• Crime prevention through environmental design principles (CPTED)	☐	☐	☐		
Design development						
Is there adequate workspace for all equipment and fixtures?	• Feedback from consultation committee	☐	☐	☐		
Has adequate storage been planned to ensure clutter is avoided?	• Feedback from consultation committee • Consultation with department workgroup	☐	☐	☐		
Do the furniture and fixtures minimise the potential for aggression and violence?	• Fittings and furniture that are difficult to use as weapons, hard to lift and without sharp corners and edges	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
Is the lighting appropriately designed to minimise stress and fatigue and maximise feelings of relaxation?	• Natural light • Artificial light	☐	☐	☐		
Have unwanted noises been designed out?	• Soundproof walls or double glazed windows • Avoid loud volumes on TV and radio	☐	☐	☐		
Has an effective and consistent way-finding system been designed?	• Signage (directional and symbols)	☐	☐	☐		
Have positive distractions been provided to reduce stress and divert focus from pain?	• Gardens • Art • Views	☐	☐	☐		
Have systems for effective client communication been designed?	• Refer to consultation committee • Signage in reception areas	☐	☐	☐		
Has the ventilation system been designed to minimise unwanted smells and to facilitate comfortable temperatures?	• Provide good ventilation • Air-conditioning systems	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
Contract documentation						
Have appropriate colours been chosen to minimise stress and create a feeling of wellbeing?	• Lighter colours	☐	☐	☐		
Does the interior design facilitate feelings of relaxation and wellbeing?	• Natural light • Soft colours	☐	☐	☐		
Do the floor coverings minimise glare and noise?	• Type and impact of floor covering • Equipment interaction with floor surface • Person interaction with floor surface	☐	☐	☐		
Construction						
Will any services or spaces that workers or clients previously used be changed during the period of construction and if so what impact may this have?	• Consult with staff	☐	☐	☐		
Will there be an increase in noise that may increase the risk of aggression and violence?	• Noise sources • Floor surfaces • TV and radio	☐	☐	☐		

Question	Consider	Yes	No	N/A	Comments	Action
Will temporary way-finding systems be required to facilitate navigation?	• Directional signage	☐	☐	☐		
Post-occupancy evaluation						
Review of incident and injury records related to work-related violence and aggression	• Review data regularly • Provide reports • Support a reporting culture	☐	☐	☐		
Consultation with the user group and workers regarding design issues impacting on aggression and violence	• Impact of aggression and violence during design phase	☐	☐	☐		
Walk-through inspection of the area	• Regular inspections	☐	☐	☐		
Documentation of design shortcomings and positive design features for future projects	• Quality documentation systems • Quality filing systems	☐	☐	☐		

Tool 5 – Example: Violence prevention policy

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing a violence and aggression prevention and management policy.

Name of workplace

Purpose

Name of workplace is committed to providing a safe and healthy working environment free of violence or aggression for all workers, clients and visitors.

This policy is intended to define behaviour that constitutes work-related violence and aggression and to guide workers in the management of aggression and violence in the workplace.

Definitions

For the purpose of this policy, work-related violence and aggression involves incidents in which a person is abused, threatened or assaulted in circumstances relating to their work. This definition covers a broad range of actions and behaviours that can create risk to health and safety of workers. It includes behaviour often described as acting out, challenging behaviour and behaviours of concern.

Threat may involve an actual or implied threat to safety, health or wellbeing. Neither intent nor ability to carry out the threat is relevant. The key issue is that the behaviour creates a risk to health and safety.

Examples of work-related violence include, but are not limited to:

- biting, spitting, scratching, hitting, kicking
- pushing, shoving, tripping, grabbing
- throwing objects
- verbal threats
- threatening someone with a weapon or armed robbery
- sexual assault.

Aggressive behaviour can also include:

- angry and hostile behaviour
- antagonism and jeering
- intimidation and insults
- shouting and swearing
- encroaching on someone's personal space, i.e. standing too close
- stamping feet
- banging, kicking or hitting items

Objectives

- Managers, in consultation with health and safety representatives (HSRs) will manage violence or aggression issues.
- All incidents and near misses of violence or aggression are reported via *<<reporting system>>* and followed up by the area manager or supervisor.
- In the event of exposure to violent or aggressive incidents workers are provided with support, such as psychological support including debriefing opportunities and follow up.
- All reports of violence or aggression are reviewed by *committee* and systems are investigated to identify control measures that will minimise future risk.
- An assessment is conducted and documented on all clients to identify any risk factors that may trigger an episode of violence or aggression.
- Information about clients who have a history of, or are currently exhibiting, violent or aggressive behaviour, including triggers and management strategies, is shared whenever the client is transferred internally or externally.

- Care plans will include behaviour management strategies to reduce risks of work-related violence and aggression. These plans will be reviewed as required. All reasonably practicable control measures will be implemented to eliminate or minimise risks to health and safety for workers and clients. However, name of *workplace* reserves the right to refuse treatment or entry to clients and visitors known to initiate violence and/or aggression towards its workers, clients and visitors.
- All workers will receive education and training in the prevention and management of work-related violence and aggression according to their levels of exposure to risk.

Roles and responsibilities

Name of workplace will:

- Promptly, objectively and sensitively review all reports or threats of work-related violence and aggression, including a review of all investigations associated with work-related violence and aggression incidents.
- Ensure critical incidents have been reported, as required, to Workplace Health and Safety Queensland, the police, the WHS Committee and the elected health and safety representative (HSR) and investigated.

Senior leadership should demonstrate a commitment to a culture where aggression and violence is not accepted as part of the job by:

- setting health & safety objectives and accountabilities
- ensuring effective health and safety systems are in place to identify and control risk
- allocating resources to prevention and management
- developing and promoting policy and key initiatives
- consulting with and supporting workers
- monitoring and reporting on performance outcomes and acting on issues and opportunities.

Managers and supervisors will:

- ensure policy and procedures are implemented
- in consultation with workers, conduct hazard identification, risk assessments and implement control measures to ensure risks are eliminated or minimised
- monitor worker compliance
- identify and alert worker to violent clients and hazardous situations
- follow up and investigate all incidents of work-related violence and aggression
- ensure debriefing is completed for those either directly or indirectly involved in the incident
- track and analyse incidents for trends and prevention initiatives.

Workers will:

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

Health and safety committee will:

- Be consulted about the development, establishment and implementation of work-related violence and aggression prevention measures and procedures.

Risk management

- Workplace hazards will be assessed and controlled appropriately and include consideration of work-related violence and aggression hazards.
- All reports of violence or aggression are investigated and risk assessments are conducted to identify control measures that will avoid similar situations arising in the future.
- Clients will be assessed for aggression risk factors and a documented plan of care will take those factors into account to reflect care aimed at minimising the risk of exposure to violence or aggression.

- Visitors to the service who are repeatedly violent or aggressive, or who provoke violent or aggressive behaviour, will be identified and removed from the facility.
- A staged education and training program is provided for workers based upon their risk of exposure to work-related violence and aggression.
- All new workers will receive both general and risk-specific orientation to preventing and managing work-related violence and aggression in their work area.

Endorsed by:	Committee on	(Date)
Responsible officer: Chairperson: (Committee/position within the organisation)		
Review date:	(Policy and procedures will be reviewed annually)	
Name:		
Signed:	Date:	

Consultation

The *WHS Committee* has considered the following legislation and guidance when establishing this policy:

- *Work Health and Safety Act 2011*
- Work Health and Safety Regulation 2011
- Work health and safety consultation, cooperation and coordination Code of Practice 2011
- How to manage work health and safety risks Code of Practice 2011
- Preventing and responding to work-related violence 2014

Tool 6 – Example: High-risk screening

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

High-risk screening (triage)

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

If no boxes are ticked, no risk identified, finish here.

Signed: Date:

Name: Position:

If 1-8 boxes are ticked, a potential risk/s has been identified, determine safety precautions

Apply safety precautions *(if any risk identified)*

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

Signed: Date:

Name: Position:

☐ Full assessment of aggression/violence risk completed

Signed: Date:

Name: Position:

Tool 7 – Example: Violence hazard identification and risk assessment

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

Combined violence hazard identification and risk assessment (clinical)

Name of person

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

Hazard identification	Yes	No	Don't Know	When and how identified, e.g. client, family, other agencies, clinical observation?
Withdrawn or fearful	☐	☐	☐	
Loss of control or independence related to disease or disability	☐	☐	☐	
Refusing treatment	☐	☐	☐	
Drug-seeking behaviour	☐	☐	☐	
In possession of dangerous items or weapons	☐	☐	☐	
(3) Social context				
Language barriers	☐	☐	☐	
Communication difficulties	☐	☐	☐	
Cultural misunderstanding	☐	☐	☐	
Complex/distressed family relationships	☐	☐	☐	
Friends or family who may place workers or other clients at risk	☐	☐	☐	
(4) Health service issues				
Restraint or seclusion	☐	☐	☐	
Refusal of requested drugs/treatment	☐	☐	☐	
Removal of privileges/belongings	☐	☐	☐	
Separation from family/friends	☐	☐	☐	

Hazard identification	Yes	No	Don't Know	When and how identified, e.g. client, family, other agencies, clinical observation?
No access to smoking areas	☐	☐	☐	
Treatment delays	☐	☐	☐	
Rigidly scheduled care routines (e.g. meal times, personal care)	☐	☐	☐	
Sleep disruption, noise	☐	☐	☐	

(5) Other relevant information

Is there a risk?

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

Risk assessment

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

Consequence *(tick one)* – ***How serious is the risk?***

Insignificant	Minor	Moderate	Major	Catastrophic
☐	☐	☐	☐	☐

Likelihood (tick one) – ***How likely is it to occur?***

Rare	Unlikely	Moderate	Likely	Almost certain
☐	☐	☐	☐	☐

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

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

Date prepared:

Risk controls				
Action required	**Person responsible**	**Completion date**	**Reviewed date**	**Action completed**
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Tool 8 – Example: Behaviour assessment

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

Behaviour assessment worksheet

Client name: ID No

Scorer am/pm on

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

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

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

Enter final comments here:

Tool 9 – Example: Client alert

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing a client alert.

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

Client alert

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

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

☐ Client (patient/resident)

☐ Carer

☐ Environment

☐ Other, as indicated

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

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

Signed Designation

Last updated

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

Tool 10 – Example: Warning notice

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing a warning notice.

<<NAME>>

<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<WORKPLACE>> on the <<DATE>> between yourself and a member of

<<THE PUBLIC / STAFF>>.

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

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

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

Yours faithfully

<<NAME>>

<<POSITION>>

COPIES: Addressee
Client file
Hospital alert system
Security

Tool 11 – Example: Conditions and behavioural agreement

Note: This is an example only and not intended as a template. Consider the needs of your workplace when developing a conditions and behavioural agreement

<<NAME>>

<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<WORKPLACE>> on the <<DATE>> between yourself and a member of

<<THE PUBLIC / STAFF>>.

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

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

If you wish to discuss the contents of this letter or the behavioural agreement with a representative from

<<WORKPLACE>> please phone <<PHONE NUMBER>>. A copy of our consumer complaints procedure is enclosed for your information.

Yours faithfully

<<NAME>>

<<POSITION>>

COPIES: Addressee
Client file
Hospital alert system
Security

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

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

THE CONDITIONS

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

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

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

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

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

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

I understand that if I breach any of these conditions, security staff may evict me from the hospital and/or contact the police to enforce the eviction.

<ADD ADDITIONAL CONDITIONS IF WARRANTED>>.

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

Signed:

Tool 12 – Exposure to aggression risk calculator

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

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

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

For example:

- A survey of security staff might reveal exposure to 'physical aggression' on a weekly basis. This result would indicate this worker group require level 2 training. However, a review of their position descriptions might reveal they are required to participate in physical restraint of clients, removal of clients from the premises and isolated patrols of the facility that place them at risk of assault. This suggests that a level three training program would be more appropriate for security staff.
- A survey of clerical staff might reveal that ward clerks, switchboard and reception staff identify exposure to 'threat intimidation' on a weekly basis, while clerical staff with no day- to-day contact with the general public identify exposure to 'minor verbal aggression' bi-annually.
- A survey of an aged care work unit might reveal that nurses identify exposure to 'high aggression extreme threat' on a weekly basis while food services staff identify exposure to 'verbal aggression' on a monthly basis. However, far fewer incidents might be revealed if incident reporting data was reviewed in isolation.

In addition to identifying the level of training required by workers this simple survey can reveal some systemic issues within a workplace.

For example, it might identify:

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

To complete this tool:

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

Work area: (eg aged care) Position: (eg PSA)

Time Employed: (eg six years)

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

L = Low risk – 'Dealing with difficult customers' session is recommended

M = Medium risk – Level 1 training is recommended

H = High risk – Level 2 training is recommended

E = Extreme risk – Level 3 training is recommended

Tool 13 – Aggression risk calculator

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

It has been developed to enable workers to document the role they carry out in client care and the type of client contact they have within that role as a means of determining the level of training required by particular occupational groups. It could be used in conjunction with a worker survey, or in isolation to provide a snapshot of a current situation. It enhances the snapshot provided by the exposure to aggression risk calculator (Tool 1).

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

To complete this tool:

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

Work area: (e.g. acute)

Position: (e.g. physio)

Time Employed: (e.g. three years)

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

L = Low risk – 'Dealing with difficult customers' session is recommended

M = Medium risk – Level 1 training is recommended

H = High risk – Level 2 training is recommended

E = Extreme risk – Level 3 training is recommended

Tool 14 – Example: Post training evaluation tool – short term

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing post training evaluation tools.

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

Tool 3 could be used immediately after training to evaluate program relevance and key learnings for participants.

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

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

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

What would you have excluded from the program?

Key learnings

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

Employers:

Employees:

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

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

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

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

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

Tool 15 – Example: Post training evaluation tool – medium to long term

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing post training evaluation tools.

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

The tool has three components:

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

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

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

Please take a few minutes to complete the survey and return it to		by
The results of the survey will be provided to		by

Thank you for taking the time to complete this survey.

General information

Ward/work unit/division ☐ Male ☐ Female

Age range (years): ☐ >20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ >60

Occupational group, please tick one of the following:

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

Years of experience: ☐ 5 ☐ 5-10 ☐ 11-20 ☐ 20-30 ☐ >30

I have completed:	Yes	No	Date
Orientation	☐	☐	
Level 2 Prevention and Management of Aggression training	☐	☐	
Level 3 Prevention and Management of Aggression training	☐	☐	

1. The Work Health and Safety 2011 (WHS Act) applies to:

A. PCBU, contractors and visitors ☐
B. Patients and employees ☐
C. Visitors and patients ☐
D. PCBU and workers, including contractors and volunteers ☐

2. Our workplace has the following combination of policies and procedures related to work-related violence:

A. Restraint, seclusion, zero/non tolerance, code of conduct, incident reporting ☐
B. Work-related violence, WHS ☐
C. Hazard identification, risk assessment, Code Black ☐
D. All of the above ☐

3. Work-related violence occurs:

A. When a worker is threatened or physically attacked in the workplace ☐
B. When a worker is threatened or physically attacked in the street ☐
C. When a worker is threatened or physically attacked in their home ☐
D. All of the above ☐

4. Following an aggressive or violent incident I should:

A. Discuss it with my colleagues and family ☐
B. Complete a hazard report and advise my supervisor ☐
C. Report the incident to my supervisor and complete an incident report ☐
D. Advise the health and safety representative (HSR) and do a risk assessment ☐

5. If I am involved in an aggressive or violent incident related to my work and need some additional support afterwards, I should:

A. Discuss the issue with my colleagues ☐
B. See my general practitioner/local doctor ☐
C. Contact the human resources department ☐
D. Contact my supervisor for support and guidance ☐

6. The main reason clients become aggressive is because:

A. They are in pain ☐
B. They feel they have no choices ☐
C. They are thirsty and hungry ☐
D. They are substance affected ☐

7. In relation to aggression and violence at work:

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

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

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

(Low) (High)

Evaluation tool for participants post training for workers that have completed a level 2 Prevention and Management of Aggression training program

9. The Patient Rights and Responsibilities Bill/Charter:

A. Protects workers from aggressive and violent behaviours in the workplace ☐
B. Outlines the rights and responsibilities of patients and aims to support a partnership between patients and their health care providers ☐
C. Requires that all patients receive immediate attention ☐
D. Makes patients responsible for their actions ☐

10. 'Client-initiated aggression' means:

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

11. If a client is becoming aggressive I should:

A. Use distraction techniques to avert an incident ☐
B. Pacify the client by giving in to their demands ☐
C. Stand my ground ☐
D. Try to resolve the issue using good communication focusing on the actual cause for the aggression ☐

12. Risk assessments related to WHS:

A. Should always be done by the WHS committee chairperson or manager ☐
B. Must be completed following an incident that places a worker's health or safety at risk ☐
C. Occur following identification of a hazard ☐
D. All of the above ☐

13. Conflict can be verbal, physical and/or psychological. Which strategy is the most useful in conflict management?

A. Focus, listen and argue the point ☐
B. Focus, listen, be assertive and give ultimatums ☐
C. Focus, listen, be assertive and offer choices ☐
D. Give the client what they want ☐

14. Which combination of factors would contribute to escalation of a situation the most?

A. Willingness to resolve, poor communication, unsatisfactory solution, actual cause not addressed ☐
B. Unwillingness to resolve, poor communication, unsatisfactory solution, actual cause not addressed ☐
C. Unwillingness to resolve, good communication, satisfactory solution, actual cause not addressed ☐
D. Unwillingness to resolve, poor communication, satisfactory solution, actual cause not addressed ☐

15. I would know a situation was escalating because:

A. All workers would be fearful and clients would be anxious ☐
B. Voices would be raised and threats would be made ☐
C. The client would be becoming increasingly agitated, sarcastic and angry towards staff ☐
D. Staff would be arguing with the client and giving ultimatums ☐

16. Under the WHS Act I have a duty to:

A. Take reasonable care for my own health and safety ☐
B. Report unsafe practices and incidents ☐
C. Take reasonable care for the health and safety of others who may be affected by my acts or omissions at work ☐
D. All of the above ☐
E. None of the above

17. Under the WHS Act the PCBU has a duty to consult:

A. When determining membership of the WHS committee ☐
B. By sharing information with workers and giving reasonable opportunities to express views about the matter ☐
C. When making decisions about measures to be taken to control risks to health and safety ☐
D. All of the above ☐
E. None of the above ☐

18. Aggression and violence usually arise as a result of:

A. Pathophysiological changes for the client, anxiety, miscommunication and long waiting times ☐
B. Noisy environments that are brightly lit and intruders and drug seekers ☐
C. Mental health problems that require immediate psychiatric attention ☐
D. All of the above ☐

19. The term 'reasonable force' means:

A. An immediate code response is required ☐
B. A person must be secluded to prevent damage to people and property ☐
C. Action that is commensurate with the situation ☐
D. Physical action that will prevent injury or damage to people or property ☐

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

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

(Low) (High)

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

Any comments:

Tool 16 – Example: Competency-based assessment

Note: this is an example only and not intended as a template. Consider the needs of your workplace when developing this tool.

This competency-based assessment tool has been developed for use by those with solid WHS knowledge.

This competency assessment instrument has been developed to help identify individual needs in relation to client-initiated aggression prevention and management. It is recommended that for use by people with expertise and sound knowledge in WHS, beyond a common sense approach, and with a capacity to assess individual competence. It could be used to obtain information from a sample of workers across a workplace, or in a targeted way with a particular work unit/group within a workplace.

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

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

Criteria		Rating			Comments
		C	P	N	
Objective 1: The worker understands the importance of WHS and acts in accordance with aggression prevention and management policies and procedures					
1.1	The worker demonstrates an understanding of the PCBU's statutory duty of care.	☐	☐	☐	
1.2	The worker demonstrates an understanding of his/her own duty of care in relation to the *Work Health & Safety Act 2011*.	☐	☐	☐	
1.3	The worker demonstrates an understanding of the principles of zero tolerance to violence and aggression in the workplace.	☐	☐	☐	
1.4	The worker can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control.	☐	☐	☐	
Objective 2: The worker demonstrates an understanding of risk management in the context of the client-initiated aggression prevention and management within our workplace					
2.1	The worker can explain the process for reporting incidents in the workplace.	☐	☐	☐	
2.2	The worker is able to identify incidents or near misses that require reporting.	☐	☐	☐	
2.3	The worker understands the workplace's aggression and violence prevention and management policy and its implications.	☐	☐	☐	
2.4	The workers can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control.	☐	☐	☐	
2.5	The worker demonstrates an understanding of risk assessment principles associated with the physical environment, work practices and a client's ability to comprehend and communicate.	☐	☐	☐	
2.6	The worker understands the procedures involved for proper storage and maintenance of duress alarms and personal safety devices.	☐	☐	☐	

Criteria		Rating			Comments
		C	P	N	
Objective 3: The worker is able to identify and assess the aggression and violence risks associated with a client according to their needs and abilities.					
3.1	The worker is able to identify common causes of client-initiated aggression and violence in the workplace.	☐	☐	☐	
3.2	The worker is able to describe patterns of behaviour in clients that might indicate escalation to an aggressive or violent situation.	☐	☐	☐	
3.3	The worker is able to identify environmental hazards in relation to client initiated aggression or violence.	☐	☐	☐	
3.4	The worker is able to discuss diffusing techniques appropriate to the client's needs and abilities and to the workplace.	☐	☐	☐	
3.5	The worker is able to explain how to access further assistance if a situation becomes violent.	☐	☐	☐	

Key:

C = Competent: no prompting required

P = Competent: some prompting required

N = Not competent