Policy Directive

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Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach

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Summary	This document outlines the requirements for identifying, assessing and eliminating or controlling violence related risks, and for providing an apporpropriate response when violence occurs.
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Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

PREVENTING AND MANAGING VIOLENCE IN THE NSW HEALTH WORKPLACE - A ZERO TOLERANCE APPROACH.

PURPOSE

For NSW Health staff to have the right to work in a safe workplace. Patients and visitors have the right to visit, or receive health care, in a therapeutic environment free from risks to their personal safety and from any exposure to acts of violence.

This document outlines the requirements for:

- Identifying, assessing, and eliminating as far as practicable or controlling, violence related risks, and
- Providing an appropriate response where violence does occur.

The intended scope of this document is to address issues of violence perpetrated by patients and others against staff, patients or visitors. Any incidents involving allegations of violence committed by staff must be managed in accordance with NSW Health policies for misconduct and criminal allegations.

MANDATORY REQUIREMENTS

NSW Health organisations must maintain a zero tolerance approach to violence, as well as establishing work systems and environments that enable, facilitate and support the zero tolerance approach.

As part of the ongoing management of work health and safety risks, all NSW Health organisations must have in place a violence prevention program that focuses on the elimination of violence related risks. Where the risks cannot be eliminated, they must be reduced to the lowest possible level using control strategies developed in consultation with staff.

NSW Health organisations must ensure that managers and staff have the skills to respond promptly, consistently and appropriately to effectively manage incidents of violence if they do occur and as far as possible, to prevent the recurrence of such incidents.

All incidents of violence must be reported locally using local reporting mechanisms. All physical assaults and serious threats of assault against individuals must be reported to the police.

ACCOUNTABILITY AND RESPONSIBILITIES

The Chief Executive is responsible for ensuring that the requirements of this Policy Directive are implemented within their Health organisation.

Managers must exercise their responsibilities in relation to preventing and managing violence, and encourage and support appropriate staff responses consistent with this document when violence occurs.

Staff must comply with violence prevention policies and strategies, report all incidents of violence, know their options when confronted with violence, exercise them consistently and know that they will be appropriately supported in doing so.

REVISION HISTORY

Version	Approved by	Amendment notes
December 2014 (PD2015_001)	Deputy Secretary, Governance, Workforce and Corporate	Replaces PD2005_315. Reflects changes to legislation and changes to a companion document, the Security Manual.
January 2005 (PD2005_315)	Director-General	*Zero Tolerance Response to Violence in the NSW Health Workplace* provides information on the overall process for Health agencies to have in place a violence prevention program that focuses on the elimination of violent behaviour.

ATTACHMENTS

1. Preventing and Managing Violence in the NSW Health Workplace: Procedures.

Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach

PROCEDURES

Issue date: January 2015

PD2015_001

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1 BACKGROUND

1.1 About this document

This document outlines the standards to ensure that all practicable actions are taken to prevent incidents of violence from occurring, and that following all incidents of violence, appropriate action is taken to protect NSW Health staff. The standards set out in this document are mandatory unless a local risk assessment carried out in consultation with staff determines that a different procedure would manage the risks more effectively.

A **Zero Tolerance Approach** means that as far as reasonably practicable action will be taken to prevent violence, and that in all incidents of violence, appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour, while ensuring clinical services continue to be provided in a way that maximises the safety of patients, staff and others. Action may include both clinical and / or non-clinical interventions as appropriate.

The standards outlined in this document should be reflected consistently in any local procedures which are specifically targeted at and adapted to local workplace cultures, situations and needs.

1.2 Key definitions

NSW Health organisation

For the purposes of this document the term **NSW Health organisation** is used to mean:

All public health organisations and all other bodies and organisations under the control and direction of the Minister for Health or the Secretary of the NSW Ministry of Health including:

- A Local Health District
- A statutory health corporation
- A speciality health network
- An affiliated health organisation
- Health Albury Wodonga in respect of staff who are employed in the NSW Health Service
- The Ambulance Service of NSW.

This policy does not apply to the NSW Ministry of Health.

Staff

For the purposes of this document the term **staff** is used to mean anyone who carries out work for a health organisation including:

- Employees
- Contractors, including visiting practitioners
- Sub-contractors

- Employees of contractors and sub-contractors
- An employee of a labour hire company
- Volunteers
- An apprentice or trainee
- Students.

Violence

For the purposes of this document, **violence** is defined as any incident, in which an individual is abused, threatened or assaulted.

Incident

Any unplanned event resulting in or with the potential for injury, damage or other loss. This includes a near miss.

Workplace

Means a place where work is carried out and includes any place where other staff go or are likely to be while at work, including vehicles, aircraft, mobile structures and domestic premises during home visits.

1.3 Relevant Legislative Environment

The Work Health and Safety Act 2011 and Regulation 2011 (WHS legislation)

WHS legislation imposes an obligation on a person conducting a business or undertaking to identify and eliminate or control all risks associated with violence as far as reasonably practicable.

Staff have a duty to take reasonable care to ensure that their acts are not harmful to the health and safety of themselves or others. Staff must also comply with any reasonable instruction given by their NSW Health organisation, and co-operate with any policies and procedures.

The Inclosed Lands Protection Act 1901

This legislation contains a number of provisions that give the owners or occupiers of 'inclosed lands' (which would include hospital premises) the right to control access to the land and provides certain powers and offences to support this right.

Crimes Act 1900* and *Civil Liability Act 2002

In the event of a complaint of assault following a restraint there is potentially a legal protection provided by relevant legislation (the Civil Liability Act 2002 and the Crimes Act 1900), when the restraint is used to protect the patient or others from imminent risk.

Wherever possible staff should take evasive action to escape from a violent situation, including removing themselves and others from the scene or isolating the violent individual.

Health Services Act 1997

Section 67J (1) creates an offence where a person intentionally hinders or obstructs an ambulance officer when the ambulance officer is providing or attempting to provide

ambulance services to another person. The maximum penalty for this offence is 50 penalty units or imprisonment for two years or both.

A more serious offence is set out at Section 67J (2) which applies where a person, by an act of violence against an ambulance officer intentionally hinders or obstructs the ambulance officer when the ambulance officer is providing or attempting to provide ambulance services to another person. This offence carries a maximum penalty of imprisonment for five years.

Crimes (Sentencing Procedure) Act 1999

Section 21A (2) is also relevant. It provides for aggravating factors to be taken into account in determining the appropriate sentence for an offence to include where the victim was a, emergency services worker, health worker, community worker, or other public official exercising public or community functions and the offence arose because of the victim's occupation or voluntary work.

1.4 Related Policies / Documents

The following documents should be read in conjunction with this Policy Directive:

- PD2013_050 Work Health and Safety: Better Practice Procedures
- NSW Health Security Manual Protecting People and Property NSW Health Policy and Standards for Security Risk Management in Health Facilities 2013
- Mental Health for Emergency Departments, 2009 (Red Book)
- PD2014_004 Incident Management Policy
- Memorandum of Understanding between NSW Police and NSW Health, 2007
- GL2006_014 Aged Care Guidelines on Working with People with Challenging Behaviours in Residential Aged Care Facilities
- PD2012_035 Aggression, Seclusion and Restraint in Mental Health Facilities in NSW
- PD2010-075 Emergency Department Patients Awaiting Care
- PD2009_039 Risk Management - Enterprise-Wide Policy and Framework, NSW Health.

1.5 Creating a Zero Tolerance Culture

In order for strategies for the prevention and management of violence to be successful every Chief Executive, manager and staff member needs to recognise and acknowledge that violence is not acceptable and that NSW Health is committed to addressing this issue.

1.5.1 Management Commitment

The operational success of the zero tolerance approach is based on the principles that:

- All practicable strategies to reduce the likelihood of violence occurring are identified and implemented

- Staff know how to report an incident of violence and are encouraged and supported in doing so
- Staff understand and are aware of violence prevention measures
- Staff have access to management support, training, work environments, equipment and procedures to enable them to respond confidently in violent situations
- Managers acknowledge and act on staff concerns in a way that is consistent with local procedures and with work health and safety obligations.

These matters are discussed in more detail in later sections.

Senior managers need to take a visible and active role in establishing a zero tolerance culture and importantly lead by example.

Appropriate actions and responses to all forms of violence need to be developed in consultation with staff, clearly articulated, systematically communicated, actively supported and consistently enforced.

Staff should be provided with appropriate feedback following investigations into reported incidents of violence.

1.5.2 Key messages to managers and staff

In order to promote a zero tolerance culture in NSW Health, certain messages need to be communicated to managers and staff, and regularly reinforced. NSW Health organisations should implement targeted local communication and education strategies to ensure that managers, staff, patients and visitors 'get the message'.

Key messages to all **managers** are:

- Putting up with violence in the health workplace is NOT an acceptable part of the job and NSW Health is committed to zero violence (i.e. taking action to prevent and manage the risk of violence)
- Lead by example. Demonstrate (1) support for strategies such as wearing duress alarms and incident reporting, and (2) support for staff during and after a violent event, (if incidents of violence are not taken seriously by managers, neither will staff, patients or visitors)
- Consult with staff including when investigating violence related incidents, conducting security audits, identifying hazards, assessing risks and determining the most effective risk control strategies
- Make sure staff know their options when confronted with violence (there are options and it is important that all staff know what they are)
- Encourage and support staff in utilising these options (staff need to feel confident in the decisions they make when confronted with violence and confident that their decisions will be supported, particularly when police are involved and during any resulting legal process)
- Ensure that all incidents of violence are reported utilising the local mechanism for reporting

- Investigate all incidents of violence and take action based on investigation findings (which is the only way to ensure that risk management strategies continue to be effective)
- Provide staff with feedback, as appropriate, on findings arising from investigations into reported incidents of violence
- Keep 'zero tolerance' on the agenda (talk about factors that affect the risks in staff meetings, run operational reviews and debriefings after violent incidents, communicate incident investigation results and remedial actions to staff, encourage staff to provide feedback on how local procedures are working).

Key messages to all **NSW Health staff** are:

- Putting up with violence in the health workplace is NOT an acceptable part of the job
- Know your options when confronted with violence and exercise them consistently
- Managers will support you in utilising these options
- Managers will support you if you are the victim of violence in the workplace
- Report all incidents of violence (problems that do not get reported do not get fixed)
- Be vigilant about factors contributing to the risk of violence (prevention is better than cure).

These messages can be conveyed to staff by:

- Providing staff (including community health staff) with information summarising local procedures for getting assistance in an emergency and response options e.g. small pamphlets or laminated cards in patient reception areas, nurses' stations and other relevant areas reminding staff of their options including key phone numbers, response codes etc.
- Ensuring that violence risk management is a regular item for discussion at team meetings and during handover.

1.5.3 Communication Strategies for patients and visitors

The message that violent behaviour towards NSW Health staff is not acceptable can be conveyed in a range of ways including:

- Providing pamphlets to patients (including patients receiving care in the community) and visitors clearly outlining their rights AND behavioural responsibilities when in, or visiting, hospital or receiving health care in the community, and the consequences of non-compliance
- Placing copies of related materials in bedside lockers and patient information kits (including for patients receiving care in the community) and keeping supplies in waiting areas, emergency departments, public health units and other areas based on local needs
- Encouraging local media to promote health service initiatives aimed at providing violence free health care environments

- Placing information on display in emergency departments and other relevant areas clearly stating that violence will not be tolerated.

2 A RISK MANAGEMENT APPROACH

2.1 Violence and the Risk Management Approach

Workplace violence is a significant workplace hazard. Work Health & Safety legislation requires NSW Health organisations to take all practical steps to eliminate or control as far as reasonably practicable workplace violence risks. If an incident of violence does occur, there should also be response procedures in place to minimise the impact of the event, investigate the incident and as appropriate improve controls.

A broad approach to violence management that focuses on prevention strategies and considers individual, environmental and clinical variables is more effective.

2.2 The Risk Management Process

The NSW Health *Work Health and Safety - Better Practice Procedures* outlines the steps involved in risk management which are summarised below, to assist with identifying, assessing, and eliminating or controlling, risks associated with violence.

Risk assessments relating to violence, should be documented.

Risk management aims to:

- Tease out complex issues with multiple contributing factors
- Determine factors contributing to the risk. These factors then act as pointers concerning where risk controls can be applied to reduce the risk
- Determine the severity of the risk and the urgency of the required response
- Determine whether standard risk control measures are appropriate for the specific circumstances
- Determine which alternative risk control measure would be the most effective with the aim of always implementing the highest order of control
- Review the effectiveness of existing risk control measures.

All steps of the risk management process must be carried out in consultation with staff. More complex risk assessments may require the input of security and clinical experts. Further, where there are shared duties, consultation must occur with the other duty holders e.g. car park contractors, security contractors, referring agencies.

Advice should be sought from the NSW Health organisation Risk Manager on any local risk assessment tools adopted for use by the NSW Health organisation.

Assessment of risk should occur:

- Before changing premises, work practices, procedures (including clinical procedures) or the work environment; e.g. new models of care or redesigning a nurses station, or ensuring the absence of concealment points when designing premises
- Before purchasing equipment e.g. providing duress alarms or using new substances

- Before planning to improve productivity or reduce costs
- When new information about workplace violence risks becomes available
- When responding to past violent incidents (even if they have caused no injury)
- When responding to concerns raised by staff, health and safety representatives or others at the workplace about risks arising from potential violence
- As required by the WHS regulations for specific hazards.

Risk management must also be part of the process for designing and planning products or services, processes or places used for work. It is more effective to eliminate hazards at the design stage, e.g. ensuring that new buildings do not have concealment points, implementing standard procedures for after-hours access control in emergency departments, or implementing assessment procedures prior to staff visiting a patient in the community.

Generally the risk management process is made up of the following steps:

Step 1 Establish the context

In establishing the context consideration needs to be given to:

What type of workplace is it?

For example an emergency department, a mental health ward, an ICU ward, a patient's home (for staff who work in the community), or a public space (for NSW Ambulance staff), or where staff escort patients in the community e.g. mental health patients on escorted leave.

Who are the stakeholders, internal and external, who will be affected?

Consider staff and other businesses or organisations liable to be impacted by hazards in the workplace, such as visitors to the workplace, and patients.

What is the task?

For example clinical treatment of patients with high medical dependency or home visits to monitor post discharge progress.

What is the work process?

What are the activities making up the work processes? Who are the staff? What is their knowledge and experience? What equipment and systems of work are used?

Step 2 Violence Hazard Identification

Identify what violence related hazards have potential to cause harm or injury in the workplace and consider the level of harm that may result. A hazard is something that could cause harm. Risk is how serious the harm could be and the likelihood of it happening from exposure to the hazard. Hazard identification must be conducted in consultation with those performing the activity and, where appropriate, other persons with relevant knowledge, such as security and risk managers.

How people could be harmed?

First there needs to be consideration of how people could be harmed. This should consider both physical and psychological harm.

How could violence hazards be identified?

The following should be reviewed:

- Formal workplace inspections, security / violence / aggression audits observing:
  - The nature of the work being undertaken
  - The use of systems or work and equipment to minimise aggression risks.
- Incident, first aid and workers compensation statistics, incident reports, hazard reports security reports and any other relevant available data
- Results of recent violence / aggression incident investigations
- Results of recent duress response reviews
- Consulting with staff in the workplace to determine what they consider are the hazards
- Consulting with other stakeholders other duty holders as appropriate
- Developing scenarios about what could happen during or as a consequence of a violent / aggressive incident
- Considering all possible contributing risk factors, e.g. staffing and skills, work environment / building design; equipment; training; clinical procedures.

Decide who might harm or be harmed and how?

What potential violence hazards arise from the unit / service's patients / clients or others, for example:

- Alcohol and drug affected
- Medical / Psychiatric conditions
- Known as against unknown clients
- Socio-economic factors in the local area
- The type of ward / unit or in the community.

Who are potential targets of the violence:

- Which staff?
- Which patient / clients?
- Which other people?

What systems are in place to manage violence aggression risks from patients/clients:

- Assessment protocols
- Treatment protocols
- Systems for review of the above

- Access to response services in the event of an emergency, for example availability of security response.

Once it is clear who has the potential to cause or be harmed by violence, consider:

- Particular requirements of the staff member e.g. young or new staff, older staff, staff with a disability, staff working in the community, pregnant staff, staff with English as a second language
- Particular requirements of different patient groups – diagnosis and treatment to reduce risk of violent behaviours
- People who may not be in the workplace all the time e.g. cleaners, visitors, contractors, maintenance staff
- Visitors who could be confronted with a violent patient and / or witnesses.

Step 3 Assess / Analyse the Violence Risks

Risk is the probability, high or low, that somebody could cause harm or be harmed by an identified hazard, considered in conjunction with a consideration of how serious the harm could be. Risk is judged or assessed in terms of likelihood (how likely it is that the event will happen?) and consequence of impact (how bad will an event be if it happens?). A simple example of a risk assessment action is where the likelihood of a patient brandishing a pair of scissors left lying around may result in a staff member being injured.

While a hazard and its control(s) may be well known or specified in Work Health & Safety legislation or Codes of Practice and be suitable to the workplace, the risks may differ in different contexts. The focus is on the outcome, i.e. risk elimination and control, and not the process.

NSW Health organisations use local risk matrices, however broadly speaking assessing or rating the level of risk involves the following stages:

Assess / analyse how dangerous the hazard is

- Judge the potential **severity** of the risk associated with the hazard
- Is the risk of injury or illness high or low?

Assess / Analyse the likelihood that someone would be injured by the hazard

- What is the **likelihood** that someone could get hurt, either physically or psychologically, or killed
- To determine the level of risk also consider:
  - The **range of possible effects** or outcomes e.g. the range of possible effects increases the level of risk
  - Exposure e.g. the number of people in contact, how often and for how long?
  - Staff member differences e.g. skill level, experience, training and physical capabilities. The level of knowledge, experience and training can increase or decrease the risk of injury when dealing with potentially violent people.

Plan and prioritise

It may not be possible to fix all hazards immediately, so there may be a need to plan and prioritise your actions to make a workplace safer. The worst hazards should be dealt with first, including the hazards that are simple to fix. Interim risk controls should be implemented while final risk control measures are being developed and are awaiting implementation.

Step 4 Control the risks

Section 3 of this document provides further more detailed guidance on violence controls.

Having identified the hazard and the risk, it is then necessary to decide how to deal with the risk.

Level 1 - Elimination

Elimination is not always possible when dealing with risks that arise from human behaviour – e.g. health care still needs to be provided to patients.

An example of where elimination might be possible would involve securing a storage area. This may mean that opportunistic thieves cannot enter the area. This in turn eliminates the risks associated with a staff member being assaulted if they find somebody in the act of stealing property.

Level 2 - Substitute the hazard with something safer

Examples of substituting a hazard with something less hazardous include:

- Transferring a client to a unit that is better able to manage disturbed behaviour
- Attending to a client in a community health centre rather than in the client's home.

Level 2 - Isolate the hazard from people

Examples include:

- Having secure staff areas that patients cannot easily enter
- Providing time out rooms for patients experiencing behavioural problems
- Designing counter heights / widths so that staff cannot be easily assaulted over the counter
- Physical barriers between staff and others, such as desks or screens.

Level 2 - Reduce the risks through engineering controls

Examples include:

- Access control systems like swipe access or automatic door locking / unlocking systems to limit areas to staff only
- Increased lighting on paths.

Level 3 - Reduce exposure to the hazard using administrative actions

Examples include:

- Supervision, information

- Ensuring staff have the skills outlined in *PD2012_008 Violence Prevention and Management Training Framework for the NSW Public Health System*
- Code Black response procedures
- Pre home visit risk identification checklists
- Effective clinical protocols for the diagnosis and treatment of patients with potentially violent expression of symptoms
- Staff escorts to vehicles at the end of evening shift
- Structured environmental scanning, where in a potentially violent situation e.g. paramedic assaults, and supported withdrawal from scene.

Level 3 - Use personal protective equipment

Examples include:

- Wearing a personal duress alarm
- Access to portable radio / mobile / satellite phones when working in the community

The NSW Health Security Manual, *Protecting People and Property* provides more comprehensive information on strategies for controlling violence related risks.

Step 4 - Monitor and review risks and controls

Risk management does not end with an initial investigation. Hazard identification, risk assessment and risk control steps must be repeated as part of an ongoing practice, especially before making changes to the workplace, systems of work, or equipment.

Once a control or range of controls are implemented, they need to be maintained and regularly reviewed for effectiveness / compliance.

It is necessary to keep checking to see if controls are working. It is desirable to talk to staff about whether control / s are working. Encourage staff to advise if there are hazards that should have been eliminated or managed. Workers compensation records and incident reports are a useful guide.

2.3 Local Incident Reporting

A core requirement of violence risk identification and assessment is access to good information and data. All NSW Health organisations have in place an incident information management system, IIMS, which must be used for reporting and recording incidents of violence, including near misses, regardless of whether or not the incident resulted in an injury or lost time.

The data available from reporting is required to ensure that:

- There is access to information necessary to the risk management process
- Information being used is an accurate reflection of the incidence of violence
- Incidents and near misses can be investigated, their causes and contributing factors identified, and their recurrence prevented

- Facilities are able to meet Work Health & Safety legislative reporting requirements and Ministry reporting requirements
- NSW Health organisations have in place processes for escalating data on violent incidents to senior managers and Boards.

Staff must be provided with information on reporting requirements, and be actively encouraged and supported in reporting all incidents of violence (see *PD2014_004 Incident Management Policy*).

2.4 Relationships with Local Police

NSW Health organisations need to establish relationships with the relevant Police Local Area Command. Appropriate liaison officers within both the NSW Police Force and NSW Health need to ensure that appropriate channels of communication are readily accessible. Police can provide valuable assistance with, and advice on, such issues as:

- Security risk assessments
- Security / violence vulnerability audits
- Placement of ATMs and retail outlets on hospital premises
- Crime prevention through environmental design (CPTED) principles
- CCTV placement, maintenance and monitoring.

Police can also provide information to community health staff on strategies to protect them in the broader community.

Similarly, NSW Health organisations should:

- Inform police of the location of internal and external existing and new CCTVs
- Report all crimes occurring on hospital premises e.g. assaults, cars broken into, wallets / bags / equipment stolen, damage to property etc
- Report suspicious activity
- Ensure that in regard to the design and location of gun safes (as outlined in *GL2013_002 Management of NSW Police Force Officers' Firearms in Public Health Facilities and Vehicles)* firearms legislation compliance standards are met
- Provide police with access to the facility, e.g. lock codes, key, for use if access is required in an emergency.

Issues related to the nature or timeliness of the police response to violent incidents should be escalated to the Chief Executive of the Health organisation so that the issues can be raised with the relevant Police Local Area Command and other appropriate forums, such as the Local Protocol Committee (usually made up of representatives from the Health organisation, the Police and the Ambulance Service), to ensure resolution of those issues.

A Memorandum of Understanding (MOU) exists between NSW Health, Ambulance Service of NSW and NSW Police Force. This MOU includes an Overarching Response Flow Chart that outlines the core roles of each organisation, at points in the flow chart,

which can provide more detailed guidance for the development of local protocols. The MOU is located at http://www0.health.nsw.gov.au/pubs/2007/pdf/mou_mentalhealth.pdf.

3 VIOLENCE RISK CONTROL

Risk control is the part of risk management that involves implementing preventive and management activities, standards, and procedures to eliminate or minimise the risks facing an organisation.

During the design process, and when identifying and implementing violence risk controls, consultation with staff involved in the delivery of clinical services, and security and work health and safety experts should occur.

Specific standards for violence risk controls can be found in the NSW Health Security Manual (http://www.health.nsw.gov.au/policies/manuals/Pages/default.aspx.)

3.1 Staff Skills

The development of skills in violence management for relevant staff is an important part of risk management, i.e. being able to de-escalate a potentially violent situation.

There is a balance between the need to prevent and manage violent behaviour so that staff, patients and clients are safeguarded, and the need to promote the health and welfare of patients and visitors in the least restrictive manner required for safety.

It is a requirement of Work Health & Safety legislation that any necessary training, information and supervision be provided to enable staff to do their work safely. However, while training is essential in terms of information provision and risk management, it is not effective as the sole risk control measure and must therefore be used in conjunction with other controls such as clinical protocols, facility design, access control and provision of equipment e.g. duress alarms.

PD2012_008 Violence Prevention and Management Training Framework for the NSW Public Health System outlines the minimum skills *for* staff across NSW Health. Training must always reflect the identified risk.

Staff need to be aware of their behaviour and its possible effect on others in relation to escalating or de-escalating conflict or confrontation. It is important that an appropriate work environment be maintained in which all staff, patients and visitors treated with courtesy.

3.2 Physical Environment

The physical work environment can play an important role in decreasing the risks associated with violence.

Physical security measures <u>on their own</u>, may not adequately address violence issues without appropriate supporting operational and clinical procedures. A simple example is the requirement that all doors and windows are lockable. This is of limited value without a supporting process for determining when they are locked, who is responsible for ensuring that they are locked and unlocked, and who is responsible for ensuring that all locks are regularly checked and maintained.

Specific standards on all aspects of physical security can be found in the NSW Health Security Manual located at http://www.health.nsw.gov.au/policies/manuals/Pages/default.aspx.

Many risks can be effectively 'designed out' during the planning, design / redesign of refurbishments or renovations and construction of new health facilities.

Designing out workplace hazards during construction or refurbishment should be the highest priority for controlling workplace risks.

3.2.1 Australasian Health Facility Guidelines in NSW

NSW Health Guideline GL2008_017 *Health Facility Guidelines – Australasian Health Facility Guidelines in NSW* has been developed to assist health facility planners and designers minimise security and safety risks. The Guidelines provide standards for the design of facilities, Sections 2 and 3 of the Facility Guidelines specifically provide design standards to minimise safety and security risks.

The Guidelines are found at www.healthfacilityguidelines.com.au.

When designing facilities, ensure all relevant sections of Parts B and C are consulted and incorporated into facility designs. During the design stage consultation with staff and WHS / Security staff must also occur to ensure specific hazards and risks are identified and assessed

3.2.2 Specific Control Measures

Control strategies to restrict access, lighting for increased visibility, physical design and layout of rooms, appropriately designed and placed furniture and fittings, muted decor in waiting rooms, and the appropriate placement of surveillance and alarms can minimise safety and security risks in the health facility.

Areas within heath care facilities at particular risk of hold-up violence include shops, cash handling areas, pharmaceutical storage and dispensing areas. 'Target hardening' of these areas should be prioritised which involves architectural or engineering designs or redesigns to control access to specific areas and hence make violence more difficult.

Some key controls include:

Reception and waiting areas

- Areas of first public contact, including reception and waiting rooms, should be designed to prevent unauthorised entry and provide security and protection for staff members, while still allowing good communication with patients and visitors.
- Clear signage and explanations for delays in procedures and timing may reduce risk.
- The main entrance reception desk should allow for surveillance of everyone entering the facility.
- The design of desks, counters and screens must be determined by giving consideration to a range of factors including:
  - Their intended purpose
  - The identified risk of violence occurring

- The required security of records and information held in the area
- The confidentiality of the discussions that take place
- The equipment being used
- Whether the desk is always staffed
- The availability of escape routes
- Access to a fixed duress alarm and assistance in the event of an incident developing.

Treatment and Interview rooms

- High visibility and controlled access to interview rooms may reduce the risk of violence.
- Interview rooms must have two doors to allow for appropriate access and exit, with controlled access, include discreetly placed duress alarms, and have safety glass windows so staff can be seen while retaining patient privacy.
- Treatment rooms should be located in monitored / supervised areas ie not in a remote part of a building where immediate support cannot be provided.
- Treatment rooms should, where possible, have outward swinging doors.
- Furnishings should not be able to be easily moved and / or used as weapons. Patients or furniture should not be positioned between the staff member and the exit.

A balance needs to be achieved between creating a relaxed therapeutic environment and delivering services to patients while always ensuring the safety of staff and other patients.

Looking at the workplace and its fittings as part of the risk assessment process, can often identify relatively simple changes that will promote safety while retaining a therapeutic environment.

3.3 Patient Alert Systems

Patient alert systems or ‘file flagging’ can be used for a variety of purposes including identification of patients presenting a risk to the health and safety of staff and other patients.

Staff should receive clear information on the patient alert system operating in their NSW Health organisation especially during induction.

3.3.1 Patient Management Plans

If a patient file has a flag for any reason, there should be an up to date management plan that enables those managing the presenting patient to do so in a safe and appropriate manner.

3.3.2. Legal Issues

Anti-discrimination law does not specifically prohibit the flagging of files. In the present context obligations under Work Health & Safety legislation support as part of the risk

management process, processes to identify individual patients and clients with a propensity to violence, where such identification is undertaken in order to protect staff and other patients.

Under the *Privacy and Personal Information Protection Act 1998* (PPIPA), disclosure of personal information is permissible provided it is necessary 'to prevent or lessen a serious and imminent threat to the life or health of the individual to whom the information relates, or another person'. Any patient alert system therefore needs to incorporate these criteria.

Under Section 15 of PPIPA, NSW Health organisations have an obligation to ensure information used is 'relevant, accurate, up to date, complete and not misleading'. An active flag should not remain on a file once the risk is no longer current. A process to review and remove flags as appropriate is critical to any flagging system.

3.4 Clinical Initiatives

This could include implementing clinical protocols for:

- Diagnosis and treatment and early identification of escalating behaviour
- Seclusion reduction strategies
- The utilisation of clinical initiatives nurse
- Access to specialist advice after hours
- Mental health training for ED nurses.

3.5 Administrative Controls

Examples of other administrative controls include:

- Appropriate local procedures for violence prevention and management e.g. de-escalation, restraint and duress response arrangements
- Appropriate dress e.g. avoiding dangling jewellery (earrings, necklaces) or clothing (neckties) that could be grabbed during an attack and ensuring that identification tag necklaces are of the break-away kind to avoid injury if grabbed by an assailant
- Appropriately trained, available security staff
- Effective customer service processes and skills
- Appropriate communication systems
- Development of relationships and agreements with other key agencies eg Police, community services
- Communication strategies for ensuring that patients and visitors are aware of their behavioural responsibilities.

4 RESPONDING TO VIOLENCE

4.1 Immediate Response Options

Every effort should be made to prevent violence occurring. However, in the event that a violent incident does eventuate, it is important that staff have the necessary skills to respond. The response / s will depend on a number of factors, including the nature and severity of the event, whether it is a patient, visitor or intruder, and the skills, experience and confidence of the staff member / s involved. However, the response options available to staff should always be based on the obligation to ensure the safety of staff and others in the workplace and may include calling for backup from senior staff, duress response teams or local police.

When a patient becomes violent, consideration should always be given to the possible clinical aspects of the behaviour. A violent outburst by a patient may be secondary to a number of physical or mental medical conditions, and initial clinical assessment and prompt treatment, as well as protection of the patient, staff and others, should form part of any response. The management of risks arising from a patient's behaviour must occur concurrently with their clinical treatment.

NSW Health documents 'Mental Health for Emergency Departments' (Red Book) and 'Management of Adults with Severe Behavioural Disturbances' (Red Book 2009), provide information on clinical management of patients who may potentially become violent. They also send a clear message that functional cooperation and good working relationships between the emergency department, mental health and drug and alcohol services with clearly delineated responsibilities and local protocols, is crucial to the effective management of the clinical aspects of violence.

Local procedures must be in place to support the range of available options. Procedures need to be communicated to staff.

When considering options for responding to violence the following points should always be kept in mind:

- The possibility of an underlying clinical condition contributing to the violent behaviour
- Recognising contributing factors / warning signs, the need to remain calm and initiate early, appropriate action
- When confronted with escalating behaviour assess the level of threat, as far as possible, as this will allow decisions to be made as to the most appropriate action. However, if a staff member feels unsafe **at any time**, they should call for back up or retreat if appropriate
- Regardless of action taken, de-escalation and containment should always be considerations
- At all times the key priority is to prevent injury (to the staff member, the patient and others).

The response options available must be appropriate to the situation and may include the following:

- Verbal de-escalation and distraction techniques

- Issuing a verbal warning that the behaviour should cease
- Requesting that the aggressor leave
- Retreating to a safer location
- Seeking support from other staff to assist or step in if necessary
- Initiating internal emergency response in line with local protocols e.g. duress response team etc
- Initiating external emergency response in line with local protocols e.g. police
- Evasive self-defence / breakaway techniques
- Utilising restraint practices, as appropriate
- Utilising sedation practices, as appropriate
- Utilising seclusion practices, as appropriate
- Negotiating conditional treatment, or determining inability to treat under the current circumstances

Obviously more than one option may be appropriate.

Ministry Policy Directive *PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* outlines NSW Health policy and guidelines for use of restraint, sedation and seclusion in the mental health setting.

The Security Manual provides NSW Health policy and standards for the management of theft, bomb threat, violence and armed hold up incidents, as well as duress response planning and the role of security staff in NSW Health.

4.1.1 Verbal De-escalation / Distraction and Warning

When confronted with escalating behaviour, de-escalation may be sufficient to manage the situation. However de-escalation may not always be possible. Staff should feel able to call for back-up or leave the scene at any time they think necessary.

De-escalation techniques should form part of all violence minimisation and management training, along with techniques for identifying conditions and signs of impending violence.

In the face of verbally abusive behaviour, it may be appropriate to set limits on escalating behaviour. If a staff member feels unable to do this or that it is not appropriate to the situation or it will further inflame the situation, back up should be sought. If the situation does warrant issuing a warning, this should be done in a calm, respectful, 'informative' manner, possibly drawing the individual's attention to the patient information brochures outlining patient and visitor behavioural responsibilities.

4.1.2 Back-up

If the individual fails to respond to verbal warnings or the situation escalates, staff must seek back-up and / or retreat if necessary. As noted earlier, if staff feel unsafe at any time they must call for back up.

Depending on the level of perceived threat, imminence or actuality of violence, effects of the behaviour on others, availability of support and local protocols, this may include any / all of the following:

- Calling on a more senior staff member or clinician to step in
- Withdrawing to a safer location
- Initiating a duress call
- Calling police.

All staff must have access to appropriate emergency assistance in the event of threats or actual violence. Chapter 29 of NSW Health Security Manual provides specific standards on duress response arrangements.

All work areas must have a clearly articulated duress response. Facilities should have arrangements in place that take account of the possibility of multiple incidents occurring at the same time.

4.1.3 Evasive / Breakaway Techniques

No staff member should knowingly place themselves or others at unnecessary risk. However, effectively exercised evasive breakaway techniques may provide staff with a controlled physical response when retreat is blocked, when all other non-physical strategies have failed and the staff member is under threat of or actual attack.

The purpose of evasive techniques in these circumstances is to assist staff to separate or breakaway from an aggressor in a safe manner that does not involve restraint. When properly used, it may minimise the risk of injury and minimise the potential trauma.

NSW Health organisations may determine, via risk assessment, that evasive / breakaway techniques training is necessary for particular group / of staff at high risk of violence.

Evasive / breakaway techniques training should complement other risk control strategies (refer *PD2012_008 Violence Prevention and Management Training Framework for the NSW Public Health System*).

4.2 Longer Term Response Options

Longer term options to deal with repeated violent behaviour include:

- Written warnings
- Patient alerts in conjunction with supporting multi-disciplinary patient management plans
- Negotiating a collaborative care plan in consultation with the patient and / or their carer, setting behavioural requirements and outcomes for failure to comply with these requirements
- Conditional patient treatment agreements and / or alternate treatment arrangements eg as a clinic outpatient rather than home visits
- Conditional visiting rights or exclusion from the premises

- Formal recognition of inability to treat in certain circumstances
- Apprehended Violence Orders (AVOs) to protect staff – see Section 7.3.

The zero tolerance approach is only meaningful in an environment where appropriate, consistent action is taken in response to violence.

As referred to elsewhere in this document, it is not intended that inappropriate action be taken against those whose violence arises directly from a medical condition. However it should not be assumed that if a person is receiving treatment for a mental illness or is detained in a mental health facility that no action can be pursued regarding alleged criminal acts.

4.2.1. Written Warnings

It may be appropriate to issue a letter of warning to a patient or visitor who has exhibited repeated violent behaviour, and where verbal discussion with the patient or visitor has failed to resolve the situation, or a verbal discussion has not been considered appropriate given the risk an individual poses.

A number of factors will need to be considered in determining whether a letter is appropriate, or whether it is necessary to utilise other risk control strategies such as a conditional treatment agreement.

These factors may include:

- Frequency, nature and severity of the behaviour
- Circumstances surrounding the behaviour, such as the existence of a medical condition
- Extent of exposure of staff, visitors and others to the relevant behaviour
- Level of threat or risk the behaviour presents to others
- An individual's ability to comprehend the issues associated with their behaviour and capacity to modify their behaviour
- Previous attempts made by staff to discuss concerns with the individual.

Where it is determined that a letter is the appropriate first step, the correspondence should:

- Be drafted in consultation with the relevant level of management and clinical staff involved in determining and delivering care
- Have an informative tone, using clear plain language
- Focus on the behaviour and clearly articulate the matters / behaviour of concern
- Identify the possible effects their behaviour may have on staff and other patients, and that it may impact on the ability of staff to provide effective health care in a safe and therapeutic environment
- Identify the implications the behaviour has for the NSW Health organisation e.g. work health and safety responsibilities, duty of care to other patients
- Clearly identify the preferred or expected behaviour

- Seek the support of the individual in helping the NSW Health organisation meet its work health and safety and duty of care requirements
- Clearly indicate the consequences of failing to behave in an appropriate manner, e.g. conditional treatment agreement; refusal to permit entry to a facility, provision of service elsewhere and under different circumstances; calling the police
- Invite a response, where appropriate
- Be signed by a senior clinician, unit manager, facility manager or Chief Executive as appropriate.

NSW Health organisations should always keep in mind that as with any correspondence issued, such letters are essentially a public statement of the NSW Health organisation's position, and should be drafted with regard to the above considerations.

4.2.2 Conditional Treatment Agreements for Patients

In some circumstances it may be necessary to establish a conditional treatment agreement with a patient.

Such circumstances may include where a patient has a history of repeatedly:

- Presenting for treatment then behaving in a violent or disruptive way
- Being accompanied by groups of friends / relatives who significantly disrupt the treating environment
- Being accompanied by persons with a history of violent behaviour towards staff or others
- Regularly threatening, attempting or perpetrating violence against staff or other patients, including via phone or email.

Depending on the circumstances, the following conditions may be considered when developing conditional treatment agreements:

- Clearly articulated behavioural requirements (the patient and those accompanying him / her need to understand what behaviour is required)
- Setting out the consequences of the patient's failure to comply with those requirements, for example treatment may need to be provided in a different way or at different times, visitors may not be permitted
- Where the treatment will be provided e.g. at what organisation and at what location within that organisation
- Who can accompany the patient e.g. a friend / relative who is able to exercise a calming influence
- Who will not accompany the patient e.g. a friend / relative who is regularly threatening or violent towards staff or other patients
- The required condition of the patient and those accompanying the patient, for example not being under the influence of drugs or alcohol.

Not all conditional treatment agreements will include all of the above conditions, and some may be more straightforward. However, the conditional treatment agreement should:

- Be developed where possible in consultation with the patient and other relevant stakeholders e.g. guardian, relatives, treating staff, security etc
- Focus on the behaviours, not personal characteristics of the individual
- Be regularly reviewed according to an agreed timetable (from both a clinical and practical perspective)
- Be reviewed when there are changes in the patient's circumstances eg the person moves to a different residential location, or there is an improvement in the person's condition or behaviour
- Emphasise that treatment can only be provided in a safe environment
- Include a mechanism for having the agreement reviewed.

It is not the objective of patient treatment agreements to result in withdrawal of treatment. Such an outcome should only occur in exceptional circumstances after all other efforts have failed (see below).

Agreements should form part of broader risk control strategies aimed at protecting staff, patients and visitors from violence, while at the same time, as far as possible, allowing for appropriate treatment to be provided.

Conditional treatment agreements must be communicated to all relevant staff, and flagged on medical files.

4.2.3 Inability to Treat

Despite the options available for managing violent patients, there may be, on rare occasions and usually as a temporary measure, a situation where it is impossible to treat a patient without significant, unacceptable risks to those involved.

Depending on the circumstances surrounding this situation, options may include:

- Deferring treatment where possible (if not life threatening) to a time when the risks are better able to be managed e.g. when more suitably skilled and experienced staff are available, when the patient is more settled, or when back-up (e.g. police) can be obtained
- Arranging for treatment to be carried out in a different location, where the risks can be more appropriately managed.

The option not to treat (at a particular time, or under particular conditions or at a particular location) would only arise after all other options have been investigated. Decisions regarding an inability to treat must only be made following consultation with senior clinical staff and notification to senior managers. Decisions on inability to treat must be communicated to all relevant staff.

4.3 Duress Alarm Systems

Staff must be able to summon assistance. To enable assistance to be summoned staff must have access to a duress alarm that is fit for the circumstances and working environment. Duress alarms should not be considered as a single strategy, but rather should form part of an overall risk management process.

Whenever an alarm is installed or provided, there needs to be regular testing of the alarms and appropriate maintenance.

The features of duress alarms are outlined in Chapter 11 of the Security Manual.

4.4 Duress Response Planning

Acceptance by managers that staff are entitled to call for assistance in duress situations is an underpinning principle of NSW Health's approach to work health and safety and to violence prevention and management.

The nature of that response will vary from facility to facility depending on local conditions such as the size and nature of the facility or unit within the facility, the availability of support staff including security and clinicians, and access to external services such as police or private security firms.

Chapter 29 of the Security Manual outlines the standards for duress response arrangements.

4.5 Effective Incident Management

4.5.1. Post Incident Response

Staff involved, whether directly or as witnesses, will react in different ways regardless of the level of severity of the incident. It is important for management to be sensitive to how a staff member wants to be supported, particularly immediately after the incident when some staff may prefer to be alone rather than receiving more active assistance.

Managers must:

- Ensure any injuries are treated in the first instance
- Make certain the staff member is supported from the time of the incident – immediately after an incident can often be a period of vulnerability
- Remember the staff member is a victim and should be provided with any necessary support
- Ensure any witnesses to an incident are also offered appropriate support
- Be sensitive to the staff member in how the incident is communicated to other staff. For example, a staff member may not always want their experience repeatedly described, except where it is necessary for safety reasons to do so.

The types of support could include:

- Providing access to counselling. This could be in-house, through a local victim group support service, through the local Employee Assistance Program or through any service identified by the staff member
- Temporarily relocating the staff member or changing their role where feasible.

Reviews of patient management plans must occur and appropriate patient alerts documented, and communicated to other relevant staff. The suitability of the facility to manage the patient behaviour must also be assessed i.e. is more specialised care necessary or care provided in a larger facility.

4.5.2 Incident Investigation / Operational Review

The most effective way to prevent a recurrence of an incident is to determine why it happened and how it could be prevented from happening again. Investigations should be conducted in a systematic way. *PD2014_004 Incident Management Policy* provides standards for investigations and when they should occur. Reference must also be made to obligations to investigate incidents outlined in *PD2013_050 Work, Health and Safety: Better Practice Procedures.*

5 STAFF WORKING IN THE COMMUNITY

5.1 Risk Management

Chapter 16 of the NSW Health Security Manual provides detailed standards to manage risk arising from working in the community, including identifying appropriate communication devices.

NSW Health staff working in the community face a particular set of risks associated with being present in premises not under the direct control of a Health organisation and away from the immediate support of other staff. Work Health and Safety legislation equally applies to staff working in the community and all reasonable action must be taken to prevent such staff from being exposed to violence.

NSW Health organisations must have in place procedures, developed in consultation with relevant staff, to assure as far as possible that staff are safe when working in the community. These procedures must be communicated and must cover:

- Conducting patient risk assessments and developing appropriate plans for the provision of care
- Obtaining relevant client information from the referring clinician / service, or control room
- Conducting violence risk assessment prior to each visit and implementing appropriate management measures
- Conducting environmental scans when at scenes to identify when danger may be present
- When to withdraw from a home or scene
- Communication devices including duress alarms and how to use them

- A means of tracking staff to ensure safe return and follow up if they do not return, including procedures for responding to duress alarms or triggered emergency beacons
- Appropriate on-going support for staff in the event of an incident
- Arrangements for developing and maintaining good communication and cooperation with local police and other local services
- Communication devices including duress alarms and how to use them.

Chapter 16 of the Security Manual outlines the standards to be implemented where staff are working in the community.

6 ISOLATED / REMOTE LOCATIONS

6.1 Risk Management

NSW Health staff working in remote areas, face particular challenges arising from isolation and limited support, which can make implementing risk controls and managing violent incidents particularly difficult. However, the risk of violence must be reduced to the lowest level practicable.

Risk assessment must take account of such factors as:

- The work being undertaken
- The type and characteristics of the community being worked in
- The degree of isolation of the community
- The number of available staff
- Facility design (including residences if applicable)
- Emergency communication devices and response protocols
- Access to emergency services (e.g. police), referral and other agencies
- Working arrangements such as on call and after hours services.
- Chapters 16 and 17 of the Security Manual provide further standards around working in isolated / remote locations.

7 THE NSW CRIMINAL JUSTICE SYSTEM

7.1 Legal Options

NSW Health organisations must provide all possible support for staff leading up to and during any legal processes that occur as a result of incidents of violence arising from their work.

7.2 Criminal Charges

All physical assaults and serious threats of assault must be reported to the Police by the facility, and a COPS event number obtained by the person reporting it. Should an

affected staff member wish to pursue Police charges they should be supported in doing so.

7.3 Apprehended Violence Orders

Where a staff member fears that there may be future violence, harassment or intimidation from someone they have been exposed to in the workplace or in the course of their work, regardless of whether charges of assault are being laid against the person, the staff member may seek to take out an Apprehended Violence Order (AVO).

An AVO is an order made by the court to protect people from abuse, violence or threats of violence. They can also be applied for if someone is being stalked, intimidated or harassed, or reasonably fears that they may be so in the future.

Where a staff member is successful in gaining an AVO, the NSW Health organisation must undertake a risk assessment to identify any additional security risks. The AVO may also have implications for provision of care to a specific person at that Health organisation.

Further detailed information on managing serious threats of violence to individual staff members is outlined in Chapter 26 of the Security Manual.

8 MONITORING, REVIEW AND CONTINUOUS IMPROVEMENT

8.1 Ongoing Monitoring

It is important that the working environment is monitored to identify any new or emerging violence related risks. Staff should be encouraged to monitor the working environment for relevant risk factors and take appropriate action, including reporting of any identified hazards. Managers have the lead role in responding to matters raised by staff and managing risk.

8.2 Formal Review and Evaluation

In addition to day to day monitoring of the working environment, there should be formal allocation of responsibility for monitoring, review and evaluation of violence prevention strategies. Those who are allocated such responsibilities need to have the appropriate skills, authority and resources to carry them out.

In particular, responsibility should be allocated for the following:

- Conducting regular security and violence vulnerability audits
- Implementing and monitoring recommendations from the audits
- Reviewing local procedures and protocols for continuing relevance and effectiveness
- Regular testing and maintaining safety equipment such as duress alarms and communication devices
- Ensuring safety equipment continues to effectively meet the needs / purposes for which it was initially provided

- Monitoring the incident reporting system / procedures for 'user friendliness' and compliance
- Investigating incidents and ensuring any recommendations from the investigation are implemented in a timely manner
- Ensuring that appropriate post incident support is provided to those involved in violent incidents
- Reviewing responses to violent incidents, including the duress response
- Implementing and monitoring recommended modifications to response protocols
- Ensuring staff have the appropriate skills, including induction / orientation of new staff.

All of the above should include consultation with staff and any other identified stakeholders involved in the process or affected by any potential changes.

NSW Health organisations should identify timeframes for formal review and evaluation that should reflect the level of identified risk of various workplaces.

8.3 Performance Indicators

The most obvious way of determining whether violence prevention and management strategies are working effectively is looking for any trends in the frequency and severity of incidents of violence.

It should be noted that encouraging staff to report incidents can lead to an increase in the number of reported incidents, as distinct from the number of actual incidents.

Other sources of quantitative data can be utilised as part of the evaluation process, such as physical assaults data.

Other examples could include:

- Work health and safety hazard reports
- Results of safety and security audits and vulnerability audits
- Workers compensation data
- Patients not treated / discharged from hospital due to aggressive incidents
- Near miss events and review of Root Cause Analysis reports
- First aid records
- Daily duress alarm checks – percentage occurring across site
- Frequency of duress response drills completed by department
- Percentage of staff trained in department specific duress response procedures
- Number of staff who have attended violence prevention and management training.

Qualitative data could include staff member interviews and / or surveys on their perceptions regarding their personal safety to ascertain how safe / unsafe they feel.

Another important aspect of the evaluation process is identifying those initiatives with the greatest potential for impact on frequency and severity, and evaluating / monitoring their implementation. Solutions most likely to reduce violence include implementing sound clinical protocols, adopting an appropriately supported zero tolerance approach, and developing staff skills in how to prevent and manage potential or actual violent situations.

Indicators could include:

- Number of violence vulnerability audits conducted and where
- Number of improvements instigated as a result of the audits
- Percentage of incidents that resulted in changes or additions to clinical protocols, staff training / orientation, the environment, incident response protocols or other existing risk control measures
- Proportion of staff who have attended violence prevention and management training
- Degree of implementation of key aspects of the Ministry's zero tolerance policy e.g. percentage of patients receiving information on their behavioural responsibilities, changes to frequency of violent incident reports, percentage of assaults reported to police.
- When identifying performance indicators to be used as part of an evaluation process, a balance of qualitative, quantitative, positive and negative performance indicators gives the clearest picture on the effectiveness of local violence prevention and management strategies.

8.4 Continuous Improvement

Review and evaluation of violence prevention and management activities are only of benefit if their findings and resulting recommendations are continuously fed back into the relevant components of the system.

This approach allows risk control strategies to be dynamic and responsive to changing systems, technologies and environments, and ensures that they remain up to date and continue to be effective.