



DRUGS AND CRIME PREVENTION COMMITTEE

INQUIRY INTO VIOLENCE AND SECURITY ARRANGEMENTS IN VICTORIAN HOSPITALS

DECEMBER 2011





PARLIAMENT OF VICTORIA
DRUGS AND CRIME PREVENTION COMMITTEE

**INQUIRY INTO VIOLENCE AND SECURITY
ARRANGEMENTS IN VICTORIAN HOSPITALS
AND, IN PARTICULAR, EMERGENCY DEPARTMENTS**

Final Report

December 2011

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Inquiry into Violence and Security Arrangements in Victorian Hospitals and,
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Drugs and Crime Prevention Committee — 57th Parliament

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Functions of the Drugs and Crime Prevention Committee

The Victorian Drugs and Crime Prevention Committee is constituted under the *Parliamentary Committees Act 2003* (Vic) as amended.

Section 7

The functions of the Drugs and Crime Prevention Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with:

- a. the use of drugs including the manufacture, supply or distribution of drugs;
- b. the level or causes of crime or violent behaviour.

Terms of Reference

Under s 33 of the *Parliamentary Committees Act 2003*, an inquiry into violence and security arrangements in Victorian hospitals and, in particular, emergency departments, be referred to the Drugs and Crime Prevention Committee for consideration and report no later than 30 September 2011, including:

- (a) the incidence, prevalence, severity and impact of violence in Victorian hospitals and, in particular, emergency departments;
- (b) the effectiveness of current security arrangements to protect against violence in Victorian hospitals and, in particular, emergency departments;
- (c) an examination of current and proposed security arrangements in Australia and internationally to prevent violence in hospitals and, in particular, emergency departments, including the appropriateness of Victoria Police Protective Service Officers in Victorian hospital emergency departments;
- (d) a recommendation of initiatives to enhance the overall security arrangements and safety in Victorian hospitals, particularly emergency departments, to ensure appropriate levels of safety for health professionals and the general public without compromising patient care.

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Chair's Foreword

Violence in hospitals is an ongoing problem in Victoria. Such violence can take the form of verbal abuse, threats and physical assault and in most cases is directed at health workers who have immediate contact with patients. Nurses are most at risk and particularly those who work in Emergency Departments of hospitals.

This Reference to the Drugs and Crime Prevention Committee allowed the Committee to examine, in detail, strategies to reduce the risk of violence and to best manage any violent incidents that do occur. The Committee was also able to investigate the most effective forms of security in a hospital environment.

Initially, the deployment of Protective Service Officers in Emergency Departments of hospitals was seen as a way to help combat violent behaviour. As is detailed in this Report, health clinicians, hospital staff in general and security personnel have unanimously opposed the placement of armed PSOs in hospitals. Conversely, there has been wide support for various mechanisms that help prevent antisocial behaviour and, consequently make hospitals a safer place for staff, patients and visitors.

The Committee also spent considerable time investigating the under-reporting of aggression and violence towards hospital staff and has made a number of recommendations aimed at encouraging the reporting of such incidents and improving the data collection system.

This is a comprehensive Report which examined all facets of security in Victorian hospitals. The Committee has made a number of recommendations which will help prevent and reduce the impacts of violence and provide a greater sense of security and safety in Victoria.

The Committee would like to thank the many people who provided verbal and written submissions to this Inquiry and who attended as witnesses at the public hearings in Melbourne, Geelong, Ballarat, Sydney and Perth.

The Committee would also like to thank the staff of the Drugs and Crime Prevention Committee — Sandy Cook, Pete Johnston, Danielle Woof and Mignon Turpin — for their dedicated and hard work and cooperation to deliver this Report to the Parliament.

I would personally like to thank my Committee members for their time and effort on this Inquiry.

A handwritten signature in black ink, appearing to read 'S Ramsay', with a horizontal line underneath the name.

Simon Ramsay M.L.C.
Chair

Executive Summary and Recommendations

The following principles are based on the deliberations on the Drugs and Crime Prevention Committee and the evidence it has received. These principles underlie and support the recommendations that follow.

Principles informing the recommendations

1. The Committee believes that all hospital staff are entitled to a safe and secure working environment that is free of all forms of violence.
2. The Committee recognises that, given the multifaceted environmental dynamics, hospital administrations face a complex challenge in reducing violence in especially in some large emergency departments (EDs).
3. The law should support clinical and security staff in their work environments.
4. The Committee believes that in addressing violence and security issues in Victorian hospitals:
 - a) A 'one size fits all' approach does not address the specific issues, needs and requirements of individual hospitals and health facilities.
 - b) Proactive policies based on *prevention* strategies are the key to addressing violence in hospitals.
 - c) A holistic and tailored approach is required that meets the specific requirements of each hospital. Such a holistic approach should draw upon strategies including:
 - strong leadership, support and encouragement by the senior management team at the hospital
 - appropriate policies and infrastructure that promote a 'zero tolerance' approach to violence towards hospital staff, allied health professionals such as paramedics, patients, visitors and all persons located in the hospital premises or environment
 - accredited comprehensive education and training programs to address violent behaviour in hospitals for both clinical and security staff, and public awareness programs for patients, their families and visitors
 - approaches that recognise the specific factors that contribute to hospital violence, such as clinical causes, alcohol and other drug use and mental illness, and promotes strategies to address these.
 - environmental and design strategies that address the situational factors that may exacerbate violence in the hospital setting, particularly the emergency department.
 - d) Strategies to prevent and address violence in hospitals are most effective when clinical staff, security staff, management and external workers such as paramedics and police work collaboratively as part of a team.

- e) Effective security strategies to prevent and address violence in hospitals are underpinned by a 'patient focused' approach that draws on interpersonal skills to defuse, minimise and manage aggressive behaviour.
 - f) Effectively addressing violence in the hospital setting requires uniform reporting procedures and data collection across the Victorian hospital system.
5. The Committee believes as a general principle that security staff should be licensed specialists in the area of hospital security and appointed by individual hospitals as determined by the hospital's specific needs.
 6. The Committee believes that firearms should not be used as a security measure in Victorian hospitals by security personnel.
 7. The Committee believes that as a general principle, capsicum spray and tasers should not be used as a security measure in Victorian hospitals, by security personnel. However, individual hospitals should have the power to decide what other forms of restraint and security mechanisms should be employed.

Recommendations

State-wide Recommendations

1. **The Committee recommends that the Victorian government ensure current policies and frameworks to prevent violence in Victorian hospitals such as the Department of Human Service's 'Preventing occupational violence in Victorian health services' and WorkSafe Victoria's 'Prevention and Management of Aggression in Health Services' are fully implemented and complied with in Victorian hospitals and health services.**

(Chapter 5)

2. **The Committee recommends that the Victorian government requires that hospitals complete the implementation of the recommendations emanating from the *Victorian Taskforce on Violence in Nursing: final report*.**

As a result of the research and deliberations of the Victorian Taskforce on Violence in Nursing, a comprehensive set of recommendations was delivered in the final report. The Government has implemented all but three of them in part or in full. This has resulted in the introduction of comprehensive frameworks to address violence in Victorian hospitals and health services. In particular, subsequent to the findings of the Report the Department of Human Services developed the 'Preventing occupational violence in Victorian health services' framework, a comprehensive document that gives clear direction to the state's hospitals and health services on ways to address violence occurring within their facilities. The Committee believes this framework and the subsidiary policies and documents that form part are a useful starting point for implementing best practice programs and procedures to deal with violence, not only against nurses but also against all people who work within, are treated at or visit Victorian health services.

The Committee agrees with the views of a number of stakeholders who gave evidence to this Inquiry that the remaining recommendations need to be expedited. Whilst the Department of Health may have progressively rolled out the policies, programs and initiatives that have emanated from the Taskforce recommendations, this does not mean that all Victorian hospitals have taken them up and implemented them in full or in part. The Department in conjunction with hospital management must ensure that any programs recommended by the Taskforce are effectively implemented in hospitals at local level. Moreover, all of the programs, procedures and policies that have been developed as a result of the Taskforce Report should be subject to independent evaluation.

(Chapter 5)

3. **The Committee recommends that within 12 months of the tabling of this Report there should be a fully independent evaluation of the policies, programs and other measures implemented as a result of the recommendations in the *Victorian Taskforce on Violence in Nursing: final report*.**

(Chapters 5 and 12)

4. **The Committee recommends that the Victorian government provides ongoing funding which is within the health sector budget which would provide funding for safety and security of staff in accordance with the particular needs of health services.**

A funding mechanism similar to the Occupational Violence Prevention Fund 2008–2011 may serve as a useful model to direct funding. It should, however, apply to all staff and departments in the hospital environment and not just nursing. Applications to the fund should also be subject to the completion of an occupational violence risk assessment.

How money is allocated from any funding mechanism should be up to the boards of individual hospitals. However, whatever resources are finally allocated to address this issue, it is absolutely paramount that this money is used for the dedicated purpose of addressing violence and security issues within public hospitals. Under no circumstances should this money be used for discretionary spending unconnected with the priorities of security and safety of the hospital.

(Chapter 12)

Law and Legal Issues

- 5. The Committee recommends that a specific offence of assaulting, obstructing, hindering or delaying a hospital or health worker or a licensed security guard or emergency worker in the execution or performance of their duties be considered in Victoria.**

It would certainly be possible under the current legal provisions of the Victorian Crimes Act and the Summary Offences Act to prosecute a person for assaulting a hospital or health worker under the general laws applicable to all members of the public. The Committee feels, however, that enacting specific laws applicable to assaulting personnel working in hospitals and health services including medical, nursing, social workers, other allied health professionals and security guards reinforces the message that violence towards such workers acting in accordance with their professional duties is totally unacceptable. As with police and ambulance officers, this is a particularly grave form of assault which requires severe penalties.

(Chapter 10)

- 6. The Committee recommends that individual hospitals develop strategies to manage violent behaviour that is appropriate to that hospital's environment.**

Banning notices, patient contracts and warning systems have been used successfully in some local and overseas jurisdictions including Britain. Nonetheless, the use of sanctions against patients, their families and visitors is a controversial issue. As such the Committee believes the use of such systems should not be mandatory. Each hospital should come to its own decision on the merits as to whether restricting access to the treatment and services it provides is appropriate. A caveat to this recommendation, however, is no patient should ever be refused treatment in circumstances where it is clear that the person is gravely ill and in need of immediate treatment.

(Chapter 10)

Hospital Policy, Management and Infrastructure

- 7. The Committee recommends that hospital executives and management promote policies endorsing the message that violence against health workers is unacceptable and will be proactively addressed. Such policies must encourage a culture of reporting violent behaviour and incidents.**

Increasingly in Australia and overseas it is being recognised that violence against staff, and to a lesser extent patients and visitors, is a serious problem in many hospitals and health services. As such, hospitals are developing and implementing 'zero tolerance' policies towards violence, usually at the direction of government health departments. The New South Wales government 'Zero Tolerance Response to Violence in the NSW Health Workplace' is a key example of a comprehensive 'no violence' framework. The Committee agrees with many of the sentiments and aspirations of this approach. However it endorses the approach of the 'Preventing occupational violence in Victorian health services' framework in not using this particular term. As discussed throughout this Report the use of the term 'Zero tolerance' arguably would result in patients who are not able to form the requisite intention to commit assault being asked to leave the hospital or being refused treatment. A common example would be an elderly patient with dementia.

A policy which addresses violence against health care staff in a holistic and proactive way is preferable to the narrowly prescriptive focus of 'zero tolerance'.

It is one thing, however, to have these frameworks and policies in place, it is another to make them enforceable. Hospital management must ensure that internal policies towards addressing occupational violence are developed and more importantly rigorously implemented as a priority. Hospital staff must be encouraged by management to report incidences of occupational violence whenever they occur and be supported in any efforts to prosecute the perpetrators of such violence.

(Chapter 5)

8. **The Committee recommends that hospitals should be encouraged to form security and aggression management committees and teams with representation from executive management, security staff, medical, nursing and allied staff including, where relevant, members of mental health and alcohol and drug teams.**

The Committee has received much evidence as to the importance of coordinated and integrated approaches across and between hospital departments and occupational groupings to address occupational violence in health care settings. Too often different parts of the hospital may work in 'silos' without sufficient communication between the various departments.

One way this 'siloesation' across departments can be overcome is through the use of management prevention committees and aggression management teams (AMTs).

(Chapter 8)

9. **The Committee recommends that hospitals form security liaison committees with representation from local police. Police liaison officers are recommended to facilitate relationships between hospitals and local police stations.**

Police clearly play an important role in addressing violence occurring in the hospital environment. They both transport patients with mental illnesses to hospitals and attend violent incidents at times when internal hospital security is unable to deal with the problem unaided. It is imperative therefore that hospitals form productive and complementary relationships and protocols with Victoria Police officers, particularly those in stations adjacent to their workplace. The use of regular meetings between police and a hospital security committee is one way in which this could be done. The establishment of dedicated police liaison officers for major Victorian hospitals, particularly those experiencing higher incidences of violent behaviour, may be another useful initiative.

(Chapter 8)

10. **The Committee recommends that hospital policies to address violence should utilise a risk management approach. Formal risk assessments should be conducted at each workplace, taking into account the times most likely to result in violent events. Continuous monitoring and evaluation of outcomes need to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.**

Many hospitals are recognising that the focus needs to be changed from incident management to risk management. Risk management, risk assessment and risk identification approaches to occupational violence are essentially about being pre-emptive and proactive to the potential for violence occurring in the hospital environment. Risk management is based on recognising and eliminating the hazards that may pose a risk to the physical and psychological wellbeing of employees and visitors to the workplace. The Committee agrees that risk management is an essential part of any approach to prevent violence in health care settings.

(Chapter 5)

Security Issues

11. **The Committee recommends that Protective Service Officers (PSOs) not be employed in Victorian hospitals and health services. Such a measure is inappropriate and contrary to the good management of security in hospitals and poses a greater safety risk.**

The overwhelming response to this Inquiry has been that under no circumstances should either armed or unarmed Victoria Police Protective Service Officers or any other armed officer be placed in Victorian Hospitals or emergency rooms to assist with security. This view has been repeatedly stated to the Committee by doctors, nurses, ambulance officers, and executive hospital management amongst others. The reasons for this position are many and are expounded in full in the relevant chapters of this Report.

In particular, however, hospital staff are concerned that the presence of armed guards would increase rather than reduce the potential for violence in the hospital environment. The introduction of armed officers has the potential for unintended serious consequences for the safety of staff and patients should firearms be discharged in close confines. This has certainly been the case in the United States of America. Moreover, according to many witnesses the sight of guns has the potential to unnecessarily intimidate patients or the public.

Secondly, there are concerns from hospital management that if Protective Service Officers were introduced the hospital 'chain of command' could be compromised. In particular, the issue of whom Protective Service Officers would be answerable to and take direction from would be blurred. This is particularly the case given that emergency risk management should be clinically-centred rather than security-centred according to most witnesses.

(Chapter 6)

12. The Committee recommends that hospital security guards should not possess, carry or utilise firearms, capsicum spray or tasers in the course of their duties.

Whilst the evidence to the Inquiry has emphatically been opposed to the introduction of armed PSOs or security officers, the arguments are less clear-cut for the use of other forms of weapons, restraint procedures or security equipment.

The use of capsicum spray and tasers is particularly contentious. Many witnesses to the Inquiry have given evidence that the deployment of such spray in the close confines of the emergency room can have a deleterious effect on staff and patients alike. At the very least its use would require the vacation of the immediate environs causing disruption to the smooth running of the emergency room. The evidence received by the Committee suggests that on balance it would be inappropriate for security officers to wear or use tasers or capsicum spray/foam.

As for other forms of restraint and security measures, for example handcuffs, physical restraints and metal detectors, the Committee believes each hospital should develop its own policies and procedures according to its own individual needs. In all cases however, hospitals must comply with and act according to the provisions of the state government policy 'Deter, detect and manage: A guide to the better management of weapons in health services'.

(Chapter 6)

13. The Committee recommends that all Victorian hospitals be assisted to comply with the provisions of Victorian firearms and weapons legislation and the state government policy *Deter, detect and manage: A guide to the better management of weapons in health services*.

The Department of Health in conjunction with Victoria Police have developed a comprehensive policy on weapons management in Victorian hospitals and health services. Recent legislation has also clarified the position of health care staff in receiving and handling weapons in the possession of patients, their visitors or any other person without authorisation to do so on hospital premises. It is essential that this policy is publicised and followed in all Victorian hospitals and health care settings.

(Chapter 6)

14. The Committee recommends that all security personnel employed in Victorian hospitals be fully licensed under the *Private Security Act 2004*.

Within the Victorian security licensing process, security staff engaged directly by hospitals are not required to hold appropriate security licences or meet minimal training requirements. Any security personnel engaged through a security firm, however, must be licensed and meet minimal training competencies and standards. In the Committee's view all security staff however employed should be appropriately licensed and trained before commencing employment in a hospital or health care setting. The current situation whereby different requirements apply depending on whether a security officer is 'in house' or contracted seems arbitrary and anomalous.

(Chapter 11)

- 15. The Committee recommends that each hospital be responsible for the employment of dedicated security staff with specialist training and skills in hospital security. Security staff may be either contracted through a security company or employed directly by the hospital.**

The Committee believes that hospitals should be able to choose whether security staff should be contacted from security agencies or employed on an 'in house' basis. However, this Report does make it clear that there is necessarily a close relationship between health care and security staff. Wherever possible it is preferable that there is continuity of staff placement in hospitals particularly where staff is employed through a security agency or company. Security officers with long-term experience of working in hospitals are ideally suited to being part of a dedicated security team that is clinically directed by the medical staff and hospital management.

The Committee acknowledges that dedicated and well trained specialist staff promote teamwork and ensure that security staff are equipped to deal with the specific challenges of the hospital environment.

(Chapter 7)

- 16. The Committee recommends that visible, uniformed, unarmed security staff should be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may have the potential to occur.**

The presence of unarmed security staff in visible locations of Emergency Departments may be an effective deterrent to violent behaviour. The presence of dedicated security officers with specialist training in health security supports health professionals in the management of violent behaviour and provides the resource of an immediate emergency response. In the bigger and busier hospitals witnesses have stated that ideally a minimum complement of security should include at least four officers stationed 24 hours per day.

It is essential according to the expert witnesses who gave evidence to this Inquiry that not only are security guards employed by the hospitals in sufficient numbers but they are deployed in areas which have the greatest risk of violence, most notably in and adjacent to emergency departments. Where it is impracticable to locate security officers in close proximity to the emergency area, security should always be complemented by electronic and other forms of surveillance monitoring.

(Chapter 7)

- 17. The Committee recommends that the Victorian Department of Health undertake a review of security requirements for rural hospitals that do not qualify for emergency department funding.**

Accident and emergency departments are categorised as 'primary care casualty' and do not qualify for emergency department funding. This may mean that some smaller, particularly rural, hospitals cannot provide even minimum staffed security, but are required to operate 24 hours daily. An analysis of the needs of rural hospitals and emergency departments may give some guidance on what the gaps are in security in rural health services.

(Chapter 7)

- 18. The Committee recommends that, as outlined in the Victorian Taskforce on Violence in Nursing: final report, standardised Code Grey (violence emergency) and Code Black (armed threat) responses be introduced into all Victorian hospitals. The St Vincent's Hospital security response may serve as an appropriate model.**

A problem in addressing occupational violence in hospitals has been that the definitions of the Codes have not been standard across the hospitals. This was one of the main criticisms coming out of a Melbourne University study into the use of the Codes (Department of Human Services 2005b) and the Victorian Taskforce on Violence in Nursing: final report (Department of Human Services 2005a). In particular, differences in what counts as an emergency or in defining responses to violent behaviour across hospitals had led to uncertainty, and in some cases hesitation, in calling codes, and has made a comparison across hospitals impossible. Both reports recommended that standardised categories and responses for codes dealing with violence in hospitals be developed and implemented across the public health care sector.

Specifically the Victorian Taskforce on Violence in Nursing: final report recommended that standardised Code Grey (violence and aggression emergency) and Code Black (armed threat responses) be introduced into Victorian hospitals.

Evidence to the Inquiry also commented on the need to address these anomalies and more importantly ensure all emergency department staff are sufficiently trained on the management of Code Grey and Black episodes.

(Chapter 8)

Communication, Education and Training

- 19. Accepting that long waiting times in the emergency department and triage rooms is one of the main contributors to frustration and aggression, the Committee recommends that the hospital explore options for the better communication of likely waiting times and alternatives sources for medical attention in cases of non-critical presentations.**

Evidence has been given to the Committee that in the volatile environment of the hospital emergency room frustration and aggression as a result of long waiting times or a misunderstanding of the triage process can often go 'hand in hand'. When people are receiving bad news violence can also erupt if this is not well handled. Time has to be given to providing careful explanation of administrative and medical procedures so patients and families can deal with these confronting circumstances. As one witness stated to the Committee, these issues are difficult but not impossible. There must be adequately trained staff available to approach the delicate communication issues associated with being a patient, family member or visitor to the emergency room.

(Chapters 9 and 11)

- 20. The Committee recommends that the Victorian government support non-government organisation such as the Jesuit Social Services and the Salvation Army to provide volunteers with appropriate training for Volunteer squads in emergency departments that could sit with patients and help keep them calm while the triage process is taking place.**

One strategy for defusing tensions amongst patients, visitors and members of the public in hospital environments is to use volunteers to sit with them and where necessary explain hospital procedures and policies or give updates on when they might be attended to or the progress of their treatment schedule. Evidence was given to the Committee that where volunteer schemes are in operation in hospitals they have been very successful. With appropriate resourcing a non-government organisation such as Jesuit Social Services or the Salvation Army would be able to provide both the volunteers and the training for such a program.

(Chapters 9 and 11)

- 21. The Committee recommends that in addition to holding a licence under the *Private Security Act 2004* (Vic), all hospital based security personnel must have received nationally accredited training in the specialised nature of providing security in a health setting. This will include culturally sensitive training in dealing safely with aggressive behaviours due to drug and alcohol abuse, mental health conditions, intellectual disabilities and other clinical conditions including dementia and acquired brain injuries. Training must also include communication skills and comprehensive instruction on safe restraint techniques and appropriate response to patients with various medical conditions and injuries that render usual restraint procedures inadequate.**

Security staff in hospitals play an important role in addressing violent incidents that occur. Their training varies depending on whether they are employed directly by hospitals or are contracted from commercial security firms.

Any security personnel engaged through a security firm must be licensed and meet minimal training competencies and standards. However, there are no licensing and minimum training competencies required when staff are employed directly by the hospital.

The Committee heard from many respondents that security training needed to be reviewed to make it more appropriate for working in a health care setting, and that a nationally accredited training course in

the specialised nature of providing security within a health care facility should be developed and made a necessary prerequisite for security personnel to work in health care settings.

It is the Committee's view that such a course should be developed and be a requirement for all staff employed as security personnel in health care settings, as well as being licensed, and on employment at a facility receive additional training relevant to the context in which they work.

(Chapter 11)

- 22. The Committee recommends that violence prevention including conflict management and techniques in de-escalating aggressive situations be included in the college or university curricula for health professionals' training, including medical, nursing, social work and allied health schools.**

In several studies based on nurse interviews, education and training in understanding factors contributing to incidents of violence, developing skills to de-escalate potential incident, as well as strategies to manage them were considered by nurses one of the most important ways in which to improve the ability, confidence and safety of medical staff.

Following up on the 2005 Victorian Taskforce on Violence in Nursing's finding that there was a lack of consistency in curricula for undergraduate nursing students with regard to preparing students to cope with occupational violence, the Committee reviewed the outlines of courses taught in Victorian Universities' clinical faculties. While some courses have incorporated aspects of occupational violence awareness and management in some subjects, there does not yet appear to be comprehensive student training in this area.

It is particularly imperative that students in medicine, nursing and allied health fields receive appropriate training in violence prevention and management long before they enter hospitals for their practical training or as part of the workforce.

(Chapter 11)

- 23. The Committee recommends that in-house comprehensive, induction and ongoing accredited education and training be provided to medical, nursing, allied health and security staff, especially emergency department staff, on violence and aggression prevention, procedures and practices. Such training should include but not be restricted to early recognition, restraint and de-escalation techniques along with reporting requirements and procedures. It should, wherever possible, be conducted jointly with health and security groups.**

Within all the various fields of work in health care settings, education and training was considered to be a core element of strategies to prevent and deal with occupational violence. Such training should then be supplemented with regular ongoing training during the working lives of health care staff. Although different levels of training may be required between and within hospital, all staff have the potential to become involved in aggressive or violent events. It is a regrettable oversight that no minimum established skill set for violence prevention training exists in Victoria.

Providing appropriate training in communication skills to de-escalate situations and strategies to manage violence gives staff confidence in their ability to deal with such incidents and a feeling of increased safety in their workplace. Doctors, nurses and security personnel all reported the benefits of training together to build teams and break down barriers to understanding each other's roles.

(Chapter 11)

- 24. The Committee recommends that where possible in-house training programs on violence prevention be made available to students on placement in the hospital.**

Appropriate levels of education and training must be made available to students on placement in hospitals in order that they understand what action they should take in the event of a violent incident, and how best to manage such an incident. It is especially important that training is provided on procedures to follow in the event of a code grey or code black being activated.

(Chapter 11)

- 25. The Committee recommends that the hospital should provide information to all health care staff, patients and visitors outlining the standard of behaviour expected of them within hospitals and other health care settings. In particular, hospital waiting rooms should have appropriate signage, posters and patient information sheets conveying the expected standard of behaviour and the possible ramifications for failing to adhere to them.**

It is important to make it clear to employers, nurses, other health service employees and members of the general public that occupational violence will not be tolerated. One of the key ways this is done is having signage displaying messages in prominent positions throughout the waiting rooms, emergency department and hospital generally that convey the expected standard of behaviour and the consequences of not adhering to these. These should be in a variety of languages or explained in some other way to people from non-English-speaking backgrounds who may not be able to read them.

(Chapters 9 and 11)

- 26. The Committee recommends that the state government develop and conduct a public health awareness campaign that promotes the message that violence in hospitals is unacceptable and subject to severe penalties.**

Government-run public health awareness campaigns promoting the message that violence in hospitals is unacceptable and will have severe consequences need to be conducted on a regular basis. Other such campaigns could include public health education campaigns informing the community about alternatives to presenting to emergency departments for non-critical health services so that numbers and waiting times in hospital waiting rooms are reduced.

It is important that such messages reach the public before they attend a health facility or come into contact with nurses at the hospital.

(Chapters 10 and 11)

- 27. The Committee recommends that Victoria Police receive specific education and training around security incidents in health care environments, including the management of aggression and violence in patients who may have a potential mental illness. Such training should be done in collaboration with health care professionals and experienced health care security officers.**

The Committee heard that while police are required under Victoria's mental health Act to apprehend a person they believe may have a mental illness and take the person to a place for urgent assessment by a medical practitioner, they are not required to have any particular clinical skills on which to base their judgement of potential mental illness.

Whilst police officers may be briefed at regular intervals by staff at hospitals that are in the areas where police are stationed, it is suggested that regular training sessions should be conducted where both emergency department staff and police officers attend. As well, the use of police liaison officers to facilitate relationships between hospitals and police needs to be further implemented to encompass more major Victorian hospitals.

(Chapter 11)

Situational, Environment and Design Issues

- 28. The Committee recommends that hospital management utilise the principles of crime prevention through environmental design (CPTED) in designing and fitting out existing emergency departments (including waiting rooms and triage areas) or in the designing and building of new hospital emergency departments.**

In relation to hospital design and particularly emergency departments evidence has been given to the Committee that suggests the carefully considered use of natural light, colour and art in the workplace has a calming effect on both staff and patients alike and decreases the incidence of violent and anxiety-related episodes. The layout of the hospital emergency department (entrances and exits, triage desks) should also be wherever possible designed in accordance with CPTED principles.

(Chapter 9)

29. **The Committee recommends that hospital management should consider establishing purpose built rooms or areas for isolating or assessing violent or potentially violent persons, particularly patients with mental health and drug and alcohol behavioural disturbance attending their hospitals. The Behavioural Assessment Rooms successfully trialled at St Vincent's Hospital may serve as an example of a measure to treat such persons in a manner that minimises the likelihood of harm to themselves or others.**

Evidence has been given to the Committee on the value and utility of isolation or behavioural assessment rooms. The evidence suggests that these specialist facilities are particularly useful in ensuring safe and appropriate care for aggressive and violent patients whilst protecting the health and safety of other patients, staff and visitors. This is particularly the case for mental illness related and drug related behavioural disturbance. Behavioural assessment rooms, it has been suggested, are an effective intervention for calming aggressive patients. Separating potential aggressors and removing sources of provocation has the potential to reduce violence. These specialised treatment rooms have been successfully trialled at St Vincent's Hospital and this should be considered as a model for the rest of the state.

(Chapter 9)

30. **Given that research indicates higher levels of patients presenting at emergency departments with a mental illness, the Committee recommends that greater efforts and resources are invested to ensure staff with training in psychiatric issues, such as nurse practitioners, be readily available to assist where necessary emergency department staff with mental health patients presenting to the emergency department.**

Given that many of the patients that exhibit aggressive, violent or antisocial behaviour in the emergency department have had a background of mental health disorders, many witnesses to this Inquiry have argued for much closer linkages between the emergency department and psychiatric assistance and expertise. A closer relationship between the emergency department and specialist resources such as mental health teams and nurse practitioners has been seen as one beneficial way of preventing or at least reducing occupational violence in the health care setting.

(Chapter 8)

31. **The Committee recommends that hospitals provide secure access and egress that are not accessible to members of the general public for emergency patients arriving or departing by ambulance.**

Many transport areas used by paramedics are open to the public, patients and relatives, frequently used as 'smoking areas' and have no security at all. While there are increased delays in admission of patients to emergency departments, there is ongoing potential for agitated patients to require aggression management even prior to ED admission.

(Chapter 9)

32. **The Committee recommends that hospitals install effective CCTV and electronic equipment in the emergency department, the triage area and other appropriate areas of the hospital to monitor at all times possible aggressive behaviour.**

The use of CCTV technology has become an increasingly popular and successful approach to crime reduction and community safety issues in areas particularly at risk including hospitals.

Many witnesses who gave evidence to the Inquiry supported the use of video surveillance in hospitals with appropriate safeguards. However, despite the support for its usage, it has been recognised that it is not enough for hospital management to simply install CCTV systems. Hospitals need to work in partnership with their security staff to develop and implement protocols on the usage of CCTV and other monitoring systems. Victoria Police should be encouraged to continue to work proactively with hospitals on using CCTV as a community safety and crime prevention tool.

(Chapter 9)

- 33. The Committee recommends that the hospital provide effective duress alarms for staff working in emergency departments and mental health facilities.**

The Committee has received considerable evidence particularly from clinicians working in emergency departments stating that there should be both fixed trigger point duress systems throughout the hospital and personal duress alarms worn by all staff potentially at risk. Such systems should be able to identify the location of the person in distress and detect if they are not moving.

(Chapter 9)

- 34. The Committee recommends that, as far as possible, waiting and treatment areas for paediatric patients within general emergency departments be separated to optimise the safety of children.**

It is important that emergency department layout should be designed wherever possible to have separate treatment and waiting areas for adults and children. It is clearly unsuitable to have children and their families being seen in the same environment as a potentially violent patient.

(Chapter 9)

Data, Reporting, Research and Evaluation Mechanisms

- 35. The Committee acknowledges the work that has been undertaken in developing and implementing the Victorian Health Incident Management System (VHIMS). The Committee recommends that an evaluation be undertaken of its performance, ease of use in capturing violent incidents in hospital settings and its effectiveness in promoting the reporting of these incidents by hospital staff. This evaluation should be undertaken 18 months after the roll out has been completed.**

In particular, the Committee believes it is essential that incident reporting systems, most notably VHIMS, is evaluated to ascertain whether violent incidents in Victorian hospitals are being reported and that the system through which this is done is readily accessible and user friendly. A centralised data system for incident reporting that is standardised across the state, easy to use and time-efficient is essential for determining the extent of violence in hospitals, the circumstances in which it occurs and developing effective prevention and management strategies.

(Chapter 2)

- 36. The Committee supports Recommendation 29 of the *Taskforce on Violence in Nursing: final report* that proposes the Department of Human Services make aggregated local data results available to health services. The Committee therefore recommends the expedition of the regular collation, analysis and dissemination of VHIMS data to Victorian hospitals and WorkSafe Victoria.**

A crucial aspect of collating any data is to be able to make use of it in a meaningful way to inform policy and practice. The provision of data to local hospitals would allow them to compare/bench mark their hospital against others and to inform their own risk management assessments.

(Chapter 2)

- 37. The Committee notes the importance of hospital staff recording the incidence of violent and potentially violent behaviour and recommends that hospitals encourage and train their staff to vigilantly report such incidents (on VHIMS).**

The underreporting of violence by staff is reported to be extremely high and is a significant barrier to addressing violence occurring in hospitals. Without this information hospitals are not able to have a clear picture of the nature or extent of occupational violence, the risk factors involved the high-risk patients or situations where staff might be vulnerable. It also means that it is difficult to develop targeted preventive interventions. There are numerous and completely understandable reasons why health care staff don't report. However hospitals should create an environment where reporting is encouraged and staff members are provided with training opportunities to use recording systems such as VHIMS.

(Chapter 2)

- 38. The Committee recommends that hospitals and other health care settings are regularly evaluated on their policy and progress around managing and reducing occupational violence. This could be included as a mandatory part of hospital accreditations.**

The introduction of the 'Preventing occupational violence in Victorian health services' policy framework in 2007 resulted in a range of programs and interventions to address violence occurring in hospitals and health care facilities. It is imperative that such programs be evaluated to assess the effectiveness of violence prevention and monitoring programs in health workplaces throughout Victoria.

(Chapter 12)

- 39. The Committee recommends the Victorian government commission research into the incidence, prevalence, nature and consequences of occupational violence in health care settings. Such research should be informed by a mixture of research disciplines including quantitative, qualitative and ethnographic methodologies**

There is still much that is unknown with regard to the issue of occupational violence in health care settings. This is particularly true with regard to how prevalent violence occurring in hospitals is, why it occurs and what the best ways are of addressing it. Evidence to this Inquiry has identified a need for better and more research studies to examine this form of violence.

(Chapter 12)

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List of Abbreviations

ACEM	Australian College for Emergency Medicine
AMA	Australian Medical Association
AMT	Aggression Management Team
ANA	American Nurses Association
ANF	Australian Nursing Federation
ANMC	Australian Nursing and Midwifery Council
APSF	Australian Patient Safety Foundation
ASIAL	Australian Security Industry Association Ltd
BAR	Behavioural Assessment Rooms
CAL/OSHA	California Occupational Safety and Health Administration
CPTED	Crime Prevention through Environmental Design
DHS	Department of Human Services (Victoria)
EASHW	European Agency for Safety and Health at Work
ED	emergency department
HCSA	Health and Community Services Union
HOHSE	Home Office and Health and Safety Executive (UK)
HSU	Health Services Union
ICN	International Council of Nurses
ILO	International Labour Office
JSS	Jesuit Social Services
NAO	National Audit Office (UK)
NESB	non-English-speaking backgrounds
NHMRC	National Health and Medical Research Council (Australia)
NHS	National Health Service (UK)
NIOSH	National Institute for Occupational Safety and Health (USA)
NOHSC	National Occupational Health and Safety Commission (Australia)
NSWNA	New South Wales Nurses Association
OH&S	Occupational Health and Safety
OHSA	Occupational Health and Safety Act 2004 (Victoria)
OSHA	Occupational Safety and Health Administration (USA)
PSD	Protective Services Division
PSI	Public Services International
PSO	Protective Service Officers
QGWB	Queensland Government Department of Industrial Relations Workplace Bullying Taskforce
RACS	Royal Australasian College of Surgeons
RCN	Royal College of Nursing (UK)
RMH	Royal Melbourne Hospital
SVHM	St Vincent's Hospital Melbourne
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VHA	Victorian Health care Association
VHIA	Victorian Hospitals Industrial Association
VHIMS	Victorian Health Incident Management System
VISU	Victoria Injury Surveillance Unit
VWA	Victorian WorkCover Authority
WHO	World Health Organization

PART A: Contextualising Violence in Victorian Hospitals

1. Introduction

Violence occurring within hospitals and health care settings has been a topic of increasing concern in Australia over the past decade. Much of the literature on this topic tends to concentrate on the experiences of health care staff, particularly nurses. Nonetheless, it should be stated from the outset that anyone present in the hospital environment, patients, their families and visitors can be the victim of an aggressive act occurring in these locations. Having made this observation, the primary although not exclusive focus of this Report concerns occupational violence against health care professionals — for it is they who are predominantly the victims of aggression in hospital settings, particularly emergency departments.¹

Violence against health professionals — a serious and increasing problem?

Violence against health care staff represents a continuum of aggressive conduct in the hospital or health care setting that, as Perrone (1999) comments, can range from passive aggressive behaviour to homicide. Fortunately the most physically violent acts such as beatings are rare compared to more common cases of verbal abuse.² Nonetheless, many studies have demonstrated that hospitals and particularly emergency rooms can be workplaces where staff, particularly nurses and doctors, are at risk of varying degrees of physical and verbal assault (Forster et al 2005; Department of Human Services (DHS) 2005a, 2005b, 2007a; Chapman 2011; Farrell & Shaffiei 2011).³

Many members of the community would rightly feel that health care workers — the ‘caring’ professionals — are the least deserving of being the recipient of violence and aggression whilst going about their duties. The irony, indeed the paradox, is that some medical staff have ‘put up’ with aggression and violence exhibited by patients and their visitors as being ‘part of the job’, a normal part of the culture of the hospital workplace. This has been one of the main reasons that significant levels of underreporting of occupational violence in hospital settings has occurred, which in turn leads to difficulties in establishing accurate benchmarks on the extent and prevalence of the problem.⁴ Official management policies that reject a culture of tolerance to violence in health care settings have only recently been developed.⁵ The difficult task for managers and policy-makers in the health field is to ‘balance occupational health and safety obligations to staff with the duty of care owed to patients’ (Forster et al 2005, p.357).

1 See discussion in Chapters 2 and 3.

2 See Chapter 3 for a discussion of the types of violence perpetrated on hospital staff.

3 As will be discussed throughout this Report it is recognised that health care staff are not the only victims of violence occurring in hospitals. To lesser degrees patients, visitors, security and other general staff may also be at risk. See discussion below and in Chapter 3.

4 This issue is discussed at length in Chapter 2.

5 Some of these policies such as those in place in New South Wales and the United Kingdom are officially called ‘Zero Tolerance’ policies. The Victorian Department of Health has not embraced the nomenclature of ‘zero tolerance’. Whilst not rejecting many of the precepts upon which zero tolerance is based, Victoria prefers to base its framework on ‘a systematic occupational health and safety hazard management approach’ (Department of Human Services 2005b, p.7). The concept of ‘zero tolerance’ as part of a policy approach to preventing occupational violence in the workplace will be discussed further in Chapter 5.

International recognition of hospital violence

Over the past two decades occupational violence against health workers has been viewed with increasing concern in both Australia and abroad. In 2002 the International Labour Organisation (ILO) in conjunction with the International Council of Nurses (ICN), World Health Organization (WHO) and the Public Services International (PSI), aware of the perceived rise of violent incidents against nurses and other health professionals, launched a joint international research project to address occupational violence in the health sector (ILO et al 2002). The WHO has noted that violence in the health sector is a global phenomenon which: '[C]rosses borders, cultures, work settings and occupational groups and is now epidemic in all societies, including the developing world'.⁶

Subsequently the World Health Organization made workplace violence prevention a major part of its public health program, issuing with the ILO a series of best practice guidelines for addressing occupational violence in the health and other sectors. The WHO defines (occupational) violence prevention policies and guidelines as:

Document[s] that sets out the main principles and defines goals, objectives, prioritised actions and coordination mechanisms for preventing intentional and unintentional injuries and reducing the health consequences (WHO 2006, p.5).

The ILO/WHO guidelines are very much based on a zero tolerance approach to workplace violence and have been instrumental in informing similar domestic policies around the world.⁷

An important aspect of the international studies undertaken by the ILO/WHO has been a call for better research in the area of occupational violence and particularly a need for better data to gauge the extent of violence in health sector workplaces. As will be discussed, whilst there have been some small-scale studies completed on violence against health professionals, there are limitations as to the extent they can be generalised, particularly in Australia (Mayhew & Chappell 2003). The ability to aggregate comprehensive data on the extent of violence against health care professionals has also been compromised by serious issues in underreporting of that violence by its victims, an issue discussed at length in Chapter 2.

Addressing violence in the health sector in Australia

In Australia some pioneering work has been done subsequent to the international studies by the ILO and WHO. In 2003 a comprehensive report on the occupational violence experiences of Australian health workers was conducted by Dr Claire Mayhew and Professor Duncan Chappell (Mayhew & Chappell 2003). This report not only reviewed the extent of violence against health workers in Australia, it was also influential in suggesting strategies to address the problem. Professor Chappell was also instrumental in chairing the *NSW Health Taskforce on the Prevention and Management of Violence in the Health Workplace*. Many recommendations from both the Mayhew and Chappell report and the Health Taskforce were taken up by the New South Wales government in formulating its policy *Zero Tolerance Response to Violence in the NSW Health Workplace*, one of the first comprehensive overarching frameworks to address violence against health professionals at a state level in Australia.⁸

6 New research shows workplace violence threatens health services. WHO. Geneva. Retrieved 2 November 2011 at www.who.int/inf/en/pr2002-37.html

7 Although the WHO in turn was influenced by the earlier zero tolerance policies of the National Health Service in the United Kingdom. These have also been particularly important in informing the development of local policies in New South Wales and Victoria. See National Health Service (1997).

8 The need for a comprehensive strategy to address workplace violence against health workers in New South Wales was raised as early as 1994 when a nurse working night shift alone in a small rural hospital was brutally raped and murdered by armed intruders. Subsequently the NSW Department of Health developed the first security policy and manual for health care facilities in that state. For a discussion of this issue and the development of security and anti-violence policy for NSW health facilities, see Kiedja and Butrej 2010.

The Victorian response

Concern about increasing levels of violence being exhibited to health care professionals in Victorian workplaces led to the DHS funding in 2002 a project to analyse the incidence of violence in four public hospitals.⁹ Partly as a consequence of this Report the Victorian Government established in 2004 the Victorian Taskforce on Violence in Nursing (hereinafter 'the Taskforce') to address the issues of violence against nurses in public sector workplaces. A key aspect of the Taskforce's work was the development and implementation of a state-wide *Survey of Violence in Nursing*. Some of the questions that arose during the Taskforce's deliberations that it hoped the survey would address included:

- Do health services have policy and procedures in place to address violence and bullying in the workplace?
- Is there consistency across health services to address the increasing number of incidents?
- What methods or reporting systems are in place to report and record potential or actual incidents of violence and aggression and bullying at the local level?
- Are written policy and procedures accessible to employees?
- Are policies and procedures fully supported and enforced by senior management at the health services?
- What training is provided for nurses and managers to deal with violence and aggression and bullying?
- What mechanisms are in place to support nurses who had experienced such incidents? (DHS 2005a, p.65).

The Taskforce made 29 recommendations in its Final Report¹⁰ aimed at addressing these questions and the general issue of violence against nurses in this state.

In particular, the work highlighted the need for a framework to effectively address occupational violence in health services and for clear and consistent messages that:

- Violence against nurses (or any health care worker) is unacceptable and must be proactively addressed
- There is not a culture of tolerance of violence in health care workplaces, and
- Encourage a culture of reporting occupational violence in health care (DHS 2007a, p.7).

One of the main results emanating from the Taskforce recommendations has been the establishment of an overarching policy framework for the prevention and management of occupational violence within Victorian public health services. The framework *Preventing occupational violence in Victorian Health Services*:

[p]rovides the policy principles to assist health services to:

- Implement occupational violence prevention and management programs at the local level
- Apply an integrated and systematic approach
- Enhance the capacity of health services to effectively meet their obligations as employers
- Continuously build on the evidence base and be informed by best practice
- Promote awareness and a 'no blame' approach to occupational violence and bullying (DHS 2007a, p.8).

⁹ See *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (Department of Human Services 2005b).

¹⁰ See Appendix 1 for a list and text of the Recommendations.

The Committee believes that this framework alongside the other policy frameworks, reviews, documents and legislation that have resulted from the Taskforce recommendations¹¹ serve as an excellent basis for addressing occupational violence against health workers, patients and others affected by violence in health care settings in Victoria. The problem is not that there isn't an effective policy base to direct procedure and practice in this area. Rather there needs to be concerted action to expedite the implementation of these policies on the ground.¹² In particular those recommendations from the Taskforce that have not yet been implemented need to be done so as soon as possible. Whilst the Department of Health may have progressively rolled out from central office the policies, programs and initiatives that have emanated from the Taskforce recommendations, this does not mean that Victorian hospitals have taken them up and implemented them in full or in part. Indeed a submission from the Australian Nursing Federation (Victoria) states that the implementation of the Taskforce recommendations is variable at best.¹³

It has now been seven years since the Violence in Nursing Taskforce was established and yet still much needs to be done. Recent research by nursing academics Farrell and Shafiei (2011) indicates that despite growing awareness of the problems of violence against health workers, half of the study's 1500 nursing respondents experienced some form of workplace aggression, with 46 per cent experiencing three or more instances in their previous four working weeks. Farrell and Shafiei also asked their respondents to rate the importance of a number of systems designed to prevent and manage occupational violence. The Table reproduced in Appendix 2 shows respondents' ratings of the importance of having available a number of factors related to their personal security at work. A majority of respondents thought that all of the factors were of 'high importance' in controlling risks to prevent and manage occupational violence. However, when asked which of these factors were actually present in their workplaces, wide discrepancies appeared between what respondents saw as being of high importance and what is available.¹⁴ The authors concluded that there is a pressing need for the policies and associated programs and procedures recommended by the Taskforce to be *fully* implemented and sufficiently resourced in Victorian hospitals.

Background to the Inquiry

Studies have shown that the experiences of Australian nurses and other health professionals with regard to occupational violence are similar to those of their overseas colleagues (DHS 2005a). Whilst data on the extent of such violence is far from robust, concerns have been expressed that such violence is increasing in Victoria. Certainly recent work such as that of Farrell and Shafiei (2011) has suggested that the problem is not only one of perception.

The genesis of this Inquiry reflects these concerns. The current Victorian Minister of Police fears that increasing levels of community violence may have spilled over into public hospitals and particularly emergency departments. On 29 April 2011 he confirmed the proposal to put armed protective service officers in public hospitals to address ongoing violence in emergency departments. The armed PSO proposal was publicly criticised by the Australian Nursing Federation (Victorian Branch) and the Australian Medical Association (Victorian Branch).¹⁵

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- 11 A full list of these policies is given in Chapter 5 and Appendix 8. Individual policies where relevant are discussed throughout the Report where appropriate. For example, the policy document *Deter, detect and manage: A guide to better management of weapons in health services*, is most usefully discussed in the section pertaining to the use of weapons in Chapter 6.
 - 12 Indeed, the Australian Nursing Federation (Victoria) in its submission to this Inquiry expressed frustration that 'another' Inquiry into the issue of health care violence was taking place. In their view what is needed is not 'further investigation' but full and comprehensive implementation of the 29 Taskforce recommendations throughout Victorian hospitals. (See Submission from Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011).
 - 13 Submission from Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.
 - 14 Some key examples included: good surveillance of waiting/reception areas; minimal public access points; effective duress alarm and communication systems; appropriately located CCTV at entrances/exits, car parks and other areas; alarms that are linked to security personnel and the police; on-site security guards in workplace 24 hours and a system of sanctions for aggressive clients, visitors or others. (See Farrell & Shafiei 2011.)
 - 15 The reasons as to why they were critical of these proposals is discussed in Chapter 6.

The concerns of the Police Minister with regard to rising levels of violence in emergency departments were shared and reiterated by the Minister for Health when he presented before the Victorian Public Accounts and Estimates Committee in May 2011.¹⁶ As such, the Minister believed that investigation by a Joint Parliamentary Committee would be the best means through which to provide bipartisan recommendations as to how safety and security in emergency departments could be improved.¹⁷ Consequently the Drugs and Crime Prevention Committee received the Terms of Reference listed below on 4 May 2011.

Terms of Reference

Under s33 of the *Parliamentary Committees Act 2003*, an inquiry into violence and security arrangements in Victorian hospitals and, in particular, emergency departments, be referred to the Drugs and Crime Prevention Committee for consideration, including:

- (a) the incidence, prevalence, severity and impact of violence in Victorian hospitals and, in particular, emergency departments;
- (b) the effectiveness of current security arrangements to protect against violence in Victorian hospitals and, in particular, emergency departments;
- (c) an examination of current and proposed security arrangements in Australia and internationally to prevent violence in hospitals and, in particular, emergency departments, including the appropriateness of Victoria Police Protective Service Officers in Victorian hospital emergency departments;
- (d) a recommendation of initiatives to enhance the overall security arrangements and safety in Victorian hospitals, particularly emergency departments, to ensure appropriate levels of safety for health professionals and the general public without compromising patient care.

Scope of the Inquiry

A number of challenges confronted the Committee when it was determining the nature and scope of the Inquiry. The topic of violence and security in health care settings whilst seemingly straightforward is also much more broad and far reaching than one would first have thought. Therefore there needed to be strict parameters drawn otherwise there was a risk that the Inquiry would lose focus and direction. The following section highlights some important matters that need to be mentioned from the outset whilst also briefly outlining issues that, although important, have been excluded from the scope of the Inquiry.

Occupational violence as part of a broader context of societal violence

A number of witnesses to this Inquiry have commented that perceived increases in violence against health care staff is a reflection of an increase in violence in the community generally, particularly that which is alcohol and drug related. For example, Mayhew and Chappell in their seminal research in this area have made the interesting observation that if the catchment area for a hospital is close to a number of licensed premises then the hospital may be subject to a higher incidence of external violence (Mayhew & Chappell 2003).¹⁸ Increased societal violence, according to Kennedy, results in increased visits *to* and possibly increased violence occurring *in* the emergency room (2005).

16 Hon David Davis, Minister for Health, Evidence given to the Public Accounts and Estimates Committee, Inquiry into budget estimates 2011–2012, Melbourne, 11 May 2011.

17 Hon David Davis, Minister for Health, Evidence given to the Public Accounts and Estimates Committee, Inquiry into budget estimates 2011–2012, Melbourne, 11 May 2011.

18 For a comprehensive account of societal violence generally, particularly that relating to alcohol and other drug use, see Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Assaults in Public Places in Victoria 2010*.

Another societal or situational theory of violence and aggression views health care settings as embedded in their local communities thus influencing the type and level of workplace violence experienced:

High levels of violent crime or gang activity within a community, low levels of community resources, and mistrust or miscommunication between minority residents and majority providers may contribute to violence in the health care setting. Larger societal factors, such as changing societal norms around the acceptance of aggression may have an impact on the risk of workplace violence. For example, there is a growing perception that acts of aggression within health care reflect similar findings within society, and that people are more ready to resort to such behaviour as a means of coping and getting what they want...Applied to the workplace, aggression and violence are seen as a possible outcome of negative interpersonal interactions, which are in turn embedded in the broader social and organisational context in which they occur (Linsley 2006, p.11).

Thus consideration also needs to be directed to addressing the causal factors of violence more broadly in the community (Paterson, Leadbetter & Miller 2005).

Certainly there is evidence in the international studies to suggest that the characteristics of perpetrators of violence against health care workers are similar to those of violent offenders generally (Mayhew & Chappell 2003; NSW Bureau of Crime Statistics and Research (BOSCAR) 2002; Kennedy 2005, p.363; Linsley 2006; Chapman 2011¹⁹). However, as one Victorian Report has stated, whilst this is a reasonable enough hypothesis it should also be noted that hospital staff, particularly nurses by reason of the work they do and 'the compromised circumstances of the people they care for', are *particularly* vulnerable to client initiated aggression (DHS 2005b, p.19).

Social context of the Inquiry

Managing violence and aggression in a health care setting is no easy task. As the Committee was told by one of the leading experts in the field, 'occupational violence rarely happens in a vacuum' but rather is often the outcome of interpersonal interactions that have gone wrong perpetrated by vulnerable and often seriously ill and damaged people.²⁰ Hospitals are emotionally charged environments that can bring out the worst (and best) in human behaviour. As the *Victorian Taskforce on Violence in Nursing: final report* commented: 'Recognising the socio-political facets of occupational violence allows for the adoption of prevention methods that move beyond introspective initiatives and permit committed interagency partnerships using evidence based interventions' (DHS 2005a, p.14).

Nurses at the vanguard

It is clear that nurses are one of the main professional groupings subject to occupational violence, not only in the health sector but generally (ILO et al 2002; Mayhew & Chappell 2005; DHS 2005a, 2005b; WHO 2006). Indeed nurses were identified by the Australian Institute of Criminology as the professional group *most* at risk of violence in the workplace (Graycar 2003). It is therefore not surprising that one of the most comprehensive documents on violence in health care settings is the *Victorian Taskforce on Violence in Nursing: final report*, a strategy document that not only has led to policy initiatives to address violence against nurses but also to interventions that support *all* health workers in the Victorian public sector.²¹

This Report does not restrict itself to a discussion of workplace violence against *nurses* only. It recognises that such violence occurs against all workers in health care settings including doctors,

19 Chapman's research involved surveys of 113 nurses and in-depth interviews with 20 of this group. Many respondents from both groups viewed violence against nurses as a reflection of society in general — 'sign of the times'. In particular, many of these nurses saw violence in the hospital setting as indicative of societal breakdown, a more aggressive society or an increasing lack of respect to fellow citizens. See Chapman 2011.

20 Professor Gerald A Farrell, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011

21 See in particular, *Preventing occupational violence in Victorian health services: A policy framework and resource kit*, Department of Human Services 2007a.

security officers, allied health and administrative staff, cleaners and maintenance workers. Violence in a health sector workplace can also be experienced by patients, their families, friends and visitors. It should be noted, however, that much of the academic and policy literature in this area does concentrate on the experience of the nursing profession, given that they are the professionals who are often in most direct contact with violent or potentially violent patients, their families or visitors.

Violence in other health care contexts

Similarly, despite the emphasis in this Report's Terms of Reference, the Committee recognises that health sector workplace violence is not restricted to hospital emergency departments. Occupational violence in the health sector may also occur in triage areas, on the wards or the general areas of hospitals. An increasing issue brought to the attention of the Committee is the issue of violence in non hospital health settings such as community health services, outpatient clinics, doctors' surgeries or residential settings such as aged care facilities. The Committee also acknowledges that occupational violence can and does occur in private hospitals and clinical settings. However, given the parameters of this Inquiry, unless the context requires otherwise the Report's discussion will be confined to the issue of occupational violence in Victorian (public) hospitals, with particular focus on emergency rooms.

Bullying and harassment

The Committee does not dismiss the fact that bullying and harassment may constitute a form of occupational violence. In particular it takes note of both the written and oral evidence of Professor Gerry Farrell that it is a particularly insidious and common form of occupational violence in the hospital setting.²²

The Committee also takes note that bullying and harassment have been specifically included as forms of occupational violence by the *Victorian Taskforce on Violence in Nursing: final report* (DHS 2005a). Whilst acknowledging the importance of recognising bullying as a form of occupational violence, the scope of this Report is limited to a discussion of violence generally. Nonetheless the interested reader is directed to the comprehensive discussions of bullying as a form of occupational violence in many policy and academic texts.²³

The work of the Committee

The Committee has embarked upon an extensive research process in order to canvass the issues and receive input and information from as many individuals, agencies and organisations as possible that have an interest in the issues raised in the Terms of Reference.

Literature review

A comprehensive review of the literature was undertaken to determine the prevalence, severity and impact of hospital violence. Current initiatives developed in Victoria, other Australian states and overseas to address the violence were also examined, as was their effectiveness. This review was constantly updated throughout the Inquiry. The research drew upon previously published research including statistical studies, surveys, prior academic and professional reviews and research, information and policy documents from government agencies, legislation, and other on-line sources of information.

22 See Submission from Professor Gerald A Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, La Trobe University to Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011. See also Professor Gerald A Farrell, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 29 August 2011.

23 See for example, Mayhew and Chappell 2003; Department of Human Services 2005a; 2005b; Linsley 2006; Department of Human Services 2007a; Farrell, Bobrowski and Bobrowski 2006; Farrell and Shafiei 2011.

Written submissions

Calls for written submissions were published on Saturday 28 May 2011 in the *Herald Sun* and *The Age*. Letters inviting submissions to the Inquiry were sent to every public and large private hospital, key stakeholders and government and non-government agencies in Victoria. The Committee received 32 written submissions, which came from a range of individuals and organisations.²⁴

The Committee also wrote to the Deans of clinical faculties in Victorian Universities requesting information on courses that address occupational violence in hospitals.

Public hearings and roundtable in Melbourne

Public hearings were held in Melbourne on 27 June 2011, 15 and 29 August 2011, 12 September 2011, and 10 and 24 October 2011. In total, oral evidence was received from 58 witnesses.²⁵

The Committee also held a roundtable with key representatives from the private security industry on 10 October 2011. The Committee thought it was essential to canvass the views of those currently providing security guards to some of Melbourne's largest public hospitals and that a roundtable would provide the best opportunity to gain greater insight into the range of issues confronting security services in hospitals.²⁶

Regional visits and public hearings

Through its research the Committee identified that Geelong and Ballarat Hospitals have been developing a range of initiatives to address hospital violence. The Committee travelled to these cities and conducted a series of public hearings with hospital staff from these areas.²⁷

Interstate visits

The Terms of Reference for this Inquiry require the Committee to examine current and proposed security arrangements in other states of Australia developed to prevent violence in hospitals and, in particular, emergency departments. New South Wales and Western Australia were considered to be particularly useful jurisdictions to visit as hospitals such as St Vincent's Hospital Darlinghurst, Royal Prince Alfred Hospital and Blacktown Hospital in Sydney and Royal Perth Hospital and Charles Gairdner Hospital in Perth have been trying to address the problem by developing innovative methods of providing a safe environment for its staff and patients. The Committee met and spoke to staff at hospitals and in public hearings and also undertook a comprehensive site visit of St Vincent's Hospital in Darlinghurst.²⁸

Community input into the Inquiry

In carrying out this Inquiry, the Committee has drawn upon the views and expertise of a broad range of people. The submissions, public hearings and interstate meetings have provided valuable insights into the excellent work of various community and government organisations and provided significant knowledge into what has turned out to be an extremely complex and challenging issue. The Committee is most appreciative of the time, effort and valuable contribution that all the individuals and organisations made during the progress of this Inquiry.

The importance of security in hospitals

At the outset it is thought the evidence received by the Committee requires an upfront and categorical statement that rejects the proposal for the deployment of armed protective service

24 For a list of the submissions received by the Committee see Appendix 3.

25 For a list of witnesses appearing at Public Hearings in Melbourne see Appendix 4.

26 For a list of witnesses appearing at the Private Security Industry Roundtable see Appendix 5.

27 For a list of witnesses appearing at Public Hearings in regional districts see Appendix 6.

28 For a list of people attending interstate meetings, Public Hearings and site visits see Appendix 7.

officers in hospital emergency rooms, departments or indeed anywhere in public hospital settings. As the reasons for this are canvassed thoroughly later in this Report,²⁹ it is sufficient to state at this point that the evidence given to this Committee particularly by emergency department and other hospital clinicians, hospital administrators, academics and security personnel is overwhelmingly against such a proposal.

Although the Committee does not believe protective service officers should be introduced into Victorian hospitals, it recognises the importance of, and the need for, good security systems and well trained staff in preventing violence and aggression in health care settings. It is quite clear that a specialist institution such as a hospital requires a specialist form of security to safeguard it and the staff, patients and visitors who form part of the hospital community. Hospitals have very distinctive features. They usually operate 24 hours a day; they have multiple entries; and a highly diverse and on occasion highly emotional client base. It is therefore arguably inappropriate to use on one night a security guard in a busy emergency room who the previous night has been acting as a crowd controller in a hotel. As Chapter 6 indicates, security personnel who work in the health care setting require comprehensive specialist training to equip them with the skills to do their tasks effectively. A question that needs to be considered is how security guards are to be deployed in hospitals — as full-time dedicated staff employed by the hospital or casual or contract employees hired through an agency?

Definitions and concepts

Occupational violence

One of the difficulties in addressing violence and aggression particularly in the hospital or health setting is that they are not easy to define:

Violence and aggression are subjective terms that mean different things to different people and groups. This means that the same kind of violent incident may have quite different impacts according to the individual involved. Because of this health care organisations and staff groups have defined violence and aggression in different ways for different purposes. However in order to recognise, address and prevent violence and aggression, health care staff must have a clear understanding as to what these terms mean. This requires a description that encompasses the different forms that violence and aggression can take while allowing for personal interpretation and understanding (Linsley 2006, p.1).

In Australia, Kennedy has argued that historically there has been no single, scientific or accepted definition of violence for use by the health industry (or elsewhere). Such a lack of clarity has consequences for reporting, grading or measuring violence for research and policy purposes (Kennedy 2005). At a macro level, different studies use different definitions of violence and aggression and different methods for collecting data.³⁰ For example, a verbal insult or a threat may be counted as an act of 'violence' by one hospital but not another. Is destruction of hospital property a form of violent conduct? Whilst property damage may not cause injury to staff it may be stressful and distressing to witness (Linsley 2006). Internal hospital violence characterised by bullying or harassment often perpetrated by a fellow worker is generally now viewed as a form of occupational violence but was not always counted as such (Farrell & Shafiei 2011; Mayhew & Chappell 2003). What if an individual health worker does not feel threatened by a particular form of 'violence' and therefore discounts it as such? What if a perpetrator does not *intend* to do harm but nonetheless causes significant injury?³¹ The issue as Mayhew and Chappell state is that the precise definition adopted will affect incidence and severity rates

29 See Chapter 6.

30 See, for example, Submission from Professor Gerald A Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

31 Some earlier definitions of occupational violence in the health sector seemed to exclude conduct or behaviour that inadvertently resulted in harm to a health care professional. See for example Krug 2002 quoted in Department of Human Services (DHS) (Vic) 2005b, p.1. A salient example is the case of the elderly patient with dementia who may lash out at a nurse without fully understanding the consequences of their actions.

of workplace violence and its reporting (Mayhew & Chappell 2005). Indeed the Taskforce on Violence in Nursing found that a 'significant barrier to addressing nurse violence is a lack of clear and consistent definitions [associated with] underreporting' (DHS 2005a, p.1).

Increasingly, however, standard definitions of what counts as violence are being developed and implemented in health care settings. This has particularly been the case since the ILO/WHO published their framework for violence in health settings in 2002 (ILO et al 2002). This framework defines occupational violence experienced by health workers as:

Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well being or health (2002, p.9).

An earlier ILO definition views occupational violence as 'All forms of violence which produce damaging or hurtful effects, physically or emotionally to staff in the course of their work' (Chappell & Di Martino 2000, p.9).

Such definitions have been supplemented by those in occupational health and safety legislation or policy and would generally include verbal attacks and threats in addition to physical violence. For example, WorkSafe Victoria defines occupational violence very widely as 'any incident in which a person is abused, threatened or assaulted in circumstances relating to their work'.³² These definitions are also preferable in that they discount the intention of the perpetrator.

Protective services officers

Protective services officers (PSOs) form part of the Protective Services Division (PSD), Victoria Police's specialist provider of security services. The PSD was established and formally commenced operations on 21 March 1988.

The *Police Regulation Act 1958* makes provision for the appointment of PSOs 'for the purposes of providing services for the protection of persons holding certain official or public offices and of certain places of public importance.'³³ PSOs perform general security at various official locations in the Melbourne city area, and suburban Magistrates Courts.

Under Section 118D of the *Police Regulation Act 1958* as amended by the *Justice Legislation Amendment (Protective Services Officers) Act 2011*, the powers of a protective service officer are as follows:

- (1) An officer who has taken and subscribed the oath has and may exercise, in the execution of his or her duties, the same powers, authorities, advantages and immunities, and is liable to the same duties and responsibilities, as a constable appointed under this Act has and may exercise, or to which such a constable is liable, by virtue of the common law.
- (2) In addition, an officer on duty at a designated place may exercise all the powers and has all the responsibilities given to or imposed on such an officer under this Act or any other Act.
- (3) In this section — *designated place* means a place prescribed by the regulations.

Security officers

Under the *Private Security Act 2004* the generic term for a security operative is a 'security guard' which is defined by Section 3 as follows:

security guard means a person who is employed or retained to protect, watch or guard any property by any means, which may involve one or more of the following –

- (a) the protecting, guarding or watching of any property by patrolling the property in person –

³² See Circular, *More information about occupational violence*, WorkSafe Victoria, Number MIA026. May 2011. See also, *Occupational Health and Safety Act 2004* (Vic).

³³ See Part VIA. *Police Regulation Act 1958* (Vic).

- (i) while exercising control over a dog; or
- (ii) while armed with a firearm; or
- (iii) while unarmed; or
- (iv) being the collecting, transferring or delivering cash or other valuables while armed with a firearm;
 - (b) the protecting, guarding or watching of any property by monitoring the property by operating a security system that utilises closed circuit television, a closed monitoring system, radio or other similar device –
 - (i) where the person may be requested to attend an activity; or
 - (ii) where the person cannot or does not attend an activity.³⁴

It should be noted that only security officers contracted to work usually from security companies are covered by the *Private Security Act 2004*. Specifically under Section 4 (h) of the Private Security Act 2004 (Vic):

A person is not required to hold a private security licence, a private security registration or a temporary permit issued under Division 6 of Part 3 or Division 5 of Part 4, if that person is –

a person (employee) who, in the course of his or her employment with an employer (who is not carrying on a business for which a private security business licence is required, or a business for which a private security business registration is required) is required:

- (i) to watch, guard or protect any property or do any inquiry work; or
- (ii) only in connection with the employer's business to:
 - (a) install, maintain, repair or service internal security equipment; or
 - (b) provide advice to the employer in relation to security and related services matters .

Conclusion

It is clearly regrettable that violence and aggression is a reality in Victorian hospitals, particularly emergency departments. It has also been recognised that health care and security staff, patients and their visitors should not have to tolerate such behaviour in any circumstances. Consequently a number of interventions have been introduced by Departments of Health and their hospitals to address occupational violence. In some cases however:

There seems to be an emphasis on the immediate reaction to violent episodes, for example security guards and duress alarms with little attention given to the prevention or long term management of such episodes (Pich et al 2011, p.18).

Whilst security responses are clearly important, to address occupational violence in health care settings effectively, a raft of holistic and systematic strategies that are both preventive and remedial are required. This Report discusses such strategies and where appropriate, the need for their immediate implementation.

³⁴ Section 3, *Private Security Act 2004* (Vic).

2. The Extent of Hospital Violence and the Need to Improve Reporting

It has been widely acknowledged in recent years that violence in hospitals has become an increasingly serious concern (Kennedy 2005; Chapman & Styles 2006) with Victorian doctors reporting that 'there is an epidemic of violence and aggression in EDs in our state's hospitals'.³⁵

It is well documented both nationally and internationally that it has been extremely difficult, if not impossible, to obtain an accurate picture of the extent of violence occurring in hospitals.³⁶ The reluctance on the part of hospital staff, particularly nurses, has been one of the main reasons that significant levels of underreporting of occupational violence in hospital settings has occurred. This in turn leads to difficulties in establishing accurate benchmarks on the extent and prevalence of the problem. Other reasons have included the lack of centralised hospital data reporting systems and problems associated with local reporting systems.

In order to gain further understanding of why violence in hospitals is not accurately measured it is important to explore the reasons medical staff, particularly nurses, are so reticent to report the violence they experience. The limitations of existing reporting systems also need to be acknowledged. As well as discussing these issues, this chapter analyses the data that does exist and the research that is currently available to gain a picture of hospital violence and whether it is increasing.

The underreporting of occupational violence

The low rate of reporting violent or potentially violent incidents in health services has consistently been identified as a major problem.³⁷ In a 2003 study, in which 54 per cent of violent events experienced by a range of health care workers were reported, the researchers concluded that:

Given the low proportion of violent events that are formally reported — and hence collated in official data banks — it would be difficult for any health service to have a clear understanding of the patterns of occupational violence, risk factors, high-risk clients, or scenarios where staff might be vulnerable. Most importantly, without comprehensive data it is virtually impossible to tightly target preventive interventions (Mayhew & Chappell 2003, p.36).

Similarly, the *Victorian Taskforce on Violence in Nursing: final report* found that underreporting was 'a significant barrier' to addressing violence against nurses (Department of Human Services (DHS) 2005, p.1), and a retrospective survey of emergency department staff and directors showed that up to 70 per cent 'of episodes of violence are not formally reported through hospital incident reporting or other systems' (Kennedy 2005, p.363). Submissions and evidence to the Committee confirmed that underreporting remained a serious issue that needs to be addressed.³⁸

The following section outlines a wide range of reasons put forward to explain why such significant underreporting continues.

35 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

36 See for example Fry et al 2002; International Labour Organisation 2002; Forster 2005; Chapman 2006; Maguire and Ryan 2007;

37 See, for example, Mayhew and Chappell 2003; Kennedy 2005; DHS 2005a; and Linsley 2006.

38 For example, Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011; and Ms Kathy Chrisfield, Co-ordinator, Occupational Health Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

Reasons for not reporting violent or potentially violent incidents

- ◆ *Violent incidents are considered part of the job* — This may be due to episodes of violence being so frequent staff become ‘desensitised to its significance’ (Kennedy 2005, p.363) or be part of the workplace culture — ‘nurses get used to coping with difficult situations such as patient violence and are not encouraged to make a fuss’ (DHS 2005b, p.50). Unclear policies and protocols as to what is acceptable behaviour may also contribute to violence being thought of as ‘part of the job’ (Forster 2005).
- ◆ *Incident not thought to be serious enough* — If nurses do not incur an injury or feel adversely threatened then often the incident is not considered serious enough to report (DHS 2005a). One witness to the Inquiry said, ‘If somebody yells at you and abuses you we tend not to report it if we have been able to de-escalate the situation’.³⁹ Of course, individual staff will also have differing attitudes towards or tolerance levels to what constitutes ‘violence’. This may consequently have a bearing on whether they report an incident or not. For example, aggressive shouting by a patient may be viewed as unacceptable by one staff member but ‘laughed off’ by another.⁴⁰ Similarly, Mayhew and Chappell found that the greater the physical impact of an event, the more likely it is that staff will report it (2003).
- ◆ *Report will not be taken seriously* — The Committee heard evidence that at times when nurses try to report an incident to the police the health service will not support them in that process: ‘They then back off, and it does not get reported to police’.⁴¹ The Committee also heard from a nurse who was physically assaulted that the police were reluctant to lay charges, telling her that because the perpetrator was alcohol-affected and therefore had diminished responsibility there was no point in laying charges as he would get off anyway.⁴²
- ◆ *Nothing will be achieved by reporting the incident* — There is a widespread belief that nothing will come of reporting the event, in terms of prosecution or feedback from the health service and so reporting is waste of time. The Committee was told that ‘some of the registered nurses said they did not even know how to find the forms or documents [for reporting incidents] because they did not feel it was going to go anywhere’.⁴³
- ◆ *Frequency of aggressive and violent incidents* — Staff in certain areas of health services experience ‘so much lower-level aggression that they would never be able to complete their job tasks if they were continually filling in forms’ (Mayhew & Chappell 2003, p.7).
- ◆ *Not enough time* — Similarly, doctors listed the ‘paperwork and time-consuming nature of formal reports’⁴⁴ and the need to put patients before documenting incidents as the main reason they underreport aggressive and violent behaviour. As Dr Cruickshank told the Committee: ‘I can document this incident or I can go and see the next patient who

39 Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

40 See for example, Dr Laretta Luck, Associate Head, School of Nursing and Midwifery, University of Western Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011 and Dr David Eddy, Director, Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

41 Ms Kathy Chrisfield, Co-ordinator, Occupational Health Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

42 Ms Jodie Bourke, Associate Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

43 Dr Laretta Luck, Associate Head, School of Nursing Midwifery, University of Western Sydney, Meeting with the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Sydney, 20 September 2011.

44 Submission from Mr Geoff O’Kearney, Acting Chief Executive Officer, Australian Medical Association, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

might have — you know, that rash might be serious'.⁴⁵ One respondent also suggested that emergency departments are already understaffed and there is no time for employees to complete incident reports.⁴⁶

- ◆ *Embarrassment and sense of failure* — In some cases health workers fear that aggressive or violent behaviour from patients reflects their professional failure to manage challenging situations appropriately (Linsley 2006).
- ◆ *Being 'too forgiving'* — Dr Simon Young, Royal Children's Hospital, attributed underreporting by nurses to them being 'too forgiving' and tending 'to look through the fact that they have been subjected to violence in a forgiving way...and rationalise it in other ways'.⁴⁷
- ◆ *Fear of retribution* — According to witnesses to the Inquiry, staff members have a lot of aggression and threats directed at them. They are therefore reluctant to report threatening or violent incidents to the police that may lead to charges against the perpetrator for fear of retribution from that person.⁴⁸
- ◆ *Complicated reporting systems* — Several responses to the Committee suggested a complicated reporting process as a reason for not reporting incidents. One nurse manager said, 'Staff in the emergency department often play the incidents down basically because it is easier to do it that way'.⁴⁹ As Dr Marcus Kennedy observed:

'System blockers' to reporting injury and adverse events abound in most hospitals — there are complex forms to complete, lack of time to complete reports, unclear policies or protocols, systems that are not convincingly confidential, negative feedback through lack of system response capacity, peer pressure, and the stigma of victimisation (Kennedy 2005, p.363).

Similarly Forster et al 2005 made the comment that:

Under-reporting by staff of aggression and violence may be largely due to a lack of clear policy and procedure as to what is acceptable behaviour and the absence of systematic mechanisms to deal with unacceptable behaviour (p.360).

Whilst these observations by Kennedy and Forster et al were made in 2005 the evidence received by the Committee suggests that the situation in some hospitals is still the same.

It would appear that the reasons for not reporting aggressive and violent incidents are many and complex. However, unless the rate of reporting incidents improves from the current 'widely accepted estimate of 1 in 5 incidents'⁵⁰ there will continue to be a lack of adequate data on occupational violence in health care settings.

45 Dr Jaycen Cruickshank, Director, Emergency Medicine, Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

46 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

47 Dr Simon Young, Director, Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

48 Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

49 Ms Jodie Bourke, Associate Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

50 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

A snapshot of the current available data and research

In Victoria a centralised data collection system, the Victorian Health Incident Management System (VHIMS) has been developed and rolled out progressively to all Victorian hospitals between 2006 and February 2011.⁵¹ At the time of undertaking this Inquiry, however, data from the system was not available for analysis. Without centralised state level data, the Committee sought to gain the best possible picture of the prevalence and nature of hospital violence recorded in Victoria through specific data from the Victorian Injury Surveillance Unit (VISU) at Monash University, Worksafe Victoria and Victoria Police. These organisations maintain data bases that record various aspects of incidents of hospital violence. VISU and WorkSafe data provide some insights into the harm created by the violence whilst Victoria Police data record the assaults reported to and investigated by police on hospital premises.

The Committee also reviewed research conducted by academic researchers in specific hospitals or with nurses working in various hospitals across the state or the nation. The following discussion draws on the information that has been received. The data and analysis on Emergency Department presentations are provided by VISU.

Emergency department presentations related to violence (assaults) occurring in hospitals, Victoria 2001–2010 (10 years)

The Victoria Injury Surveillance Unit (VISU) at Monash University holds two hospital injury surveillance datasets: the Victorian Admitted Episodes Dataset (VAED) that includes injury hospital admissions to all public and private hospitals and the Victorian Emergency Minimum Dataset (VEMD) that includes injury presentations (including admitted cases) to the 38 hospital emergency departments (EDs) in Victoria which provide a 24-hour ED service.⁵²

Hospital admissions for in-hospital assaultive injury could not be identified on the VAED as the relevant location (place of injury) code is too broad ('Health Service Area' includes admissions to day procedure centres, health centres, hospice, hospital and outpatient clinics). ED presentations for in-hospital assaults were able to be extracted from the VEMD as there is a specific location (place of injury) code for 'hospitals' on the dataset that excludes the other health services. Data quality varies across hospitals contributing to the VEMD. Case identification is reliant on good data being provided. Data is collected in the busy emergency department, so detailed data collection is not always achieved because of work pressures. Hence these data are likely to be an underestimate of the true number of cases so the size of the problem is underestimated in this Report.⁵³

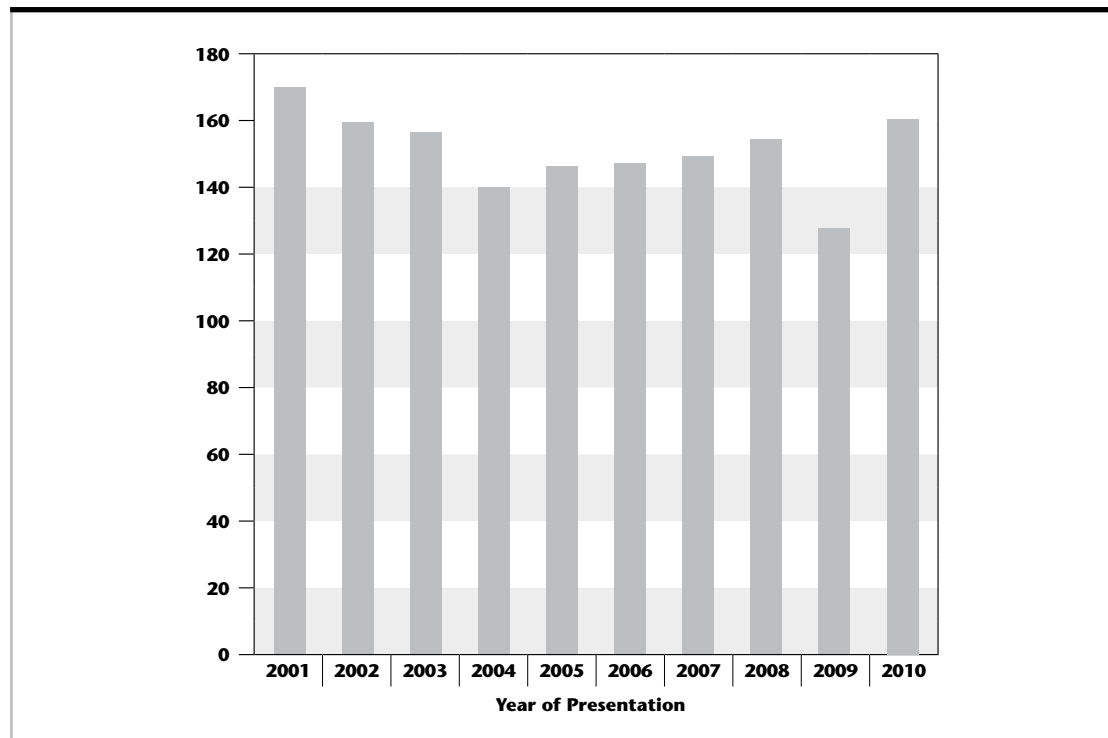
Frequency of presentations

In Victoria there were at least 1,512 ED presentations for in-hospital assaultive injury over the decade 2001 to 2010. Figure 2.1 shows the distribution of cases by year of presentation. There was a downward trend in the number of cases from 2001 to 2004 then a steady upward trend to 2010 (except for 2009 which recorded the lowest count of the decade).

51 VHIMS is discussed later in the chapter.

52 Victorian Emergency Minimum Dataset (VEMD). Variables collected include: age, sex, injury cause, location, activity, nature of main injury, body region, human intent, birth place, preferred language, address postcode, departure status, referral on departure and a 250 character text description of the injury event.
Submission from Ms Erin Cassell, Director, Victorian Injury Surveillance Unit, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

53 Submission from Ms Erin Cassell, Director, Victorian Injury Surveillance Unit, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

Figure 2.1: Frequency of ED presentations for in-hospital assaults, Victoria 2001–2010

Source: Victorian Emergency Minimum Dataset (VEMD).

Gender and age

Fifty-four per cent of the ED presentations were males (n=818). Table 2.1 shows the distribution of ED presentations by five-year age groups. ED presentations were concentrated in young and middle aged adults from ages 25 to 54, probably reflecting the age structure of hospital staff (the victims of most in-hospital assaults). Only a small proportion of cases were children and young people aged 0–19 years (1%, n=16). The five children were assaulted by a family member, another child or a patient.

Table 2.1: Distribution of ED presentations for in-hospital assaults by age group, Victoria 2001–2010 (n=1,512)

AGE GROUP	N	%
0-4yrs	2	0.1
5-9yrs	1	0.1
10-14yrs	2	0.1
15-19yrs	11	0.7
20-24yrs	110	7.3
25-29yrs	235	15.5
30-34yrs	189	12.5
35-39yrs	199	13.2
40-44yrs	220	14.6
45-49yrs	211	14.0
50-54yrs	192	12.7
55-59yrs	86	5.7
60-64yrs	41	2.7
65-69yrs	9	0.6
70+	4	0.3
	1,512	100.0

Source: Victorian Emergency Minimum Dataset (VEMD).

Activity of injured person (victim) at time of injury

The activity of 90 per cent of victims at the time of the assault was ‘working for an income’ (Table 2.2). Case narratives were analysed to identify the specific activity of the injured person at the time of the violent incident. There was no further information in the narratives of 63% (n=856) of ‘working for an income’ cases, 32% (n=432) were working as medical and nursing staff (mostly doctors and nurses), 5% were security staff (n=66) and 1% were police officers (n=12). Based on the distribution of cases where the specific activity is given in narrative data, it is probable that a high proportion of persons (around 85%) presenting to the ED with injuries due to in-hospital assaults are likely to be medical and nursing staff.

In 2% of cases (n=27) the injured person was not working for an income at the time of the assault. They were either visitors to the hospital or patients. In a further 8% of cases (n=119) the activity of the injured person was unspecified.

Table 2.2: Activity of victim at the time of the in-hospital assault, Victoria, 2001–2010

ACTIVITY WHEN INJURED	N	%
Working for an income	1,366	90.3
Medical and nursing staff	432	31.6
Security officer	66	4.8
Police officer	12	0.9
Working for an income, unspecified	856	62.6
Not working for an income	27	1.8
Visitor	16	59.3
Patient	11	40.7
Unspecified activity	119	7.9
TOTAL	1,512	100.0

Source: Victorian Emergency Minimum Dataset (VEMD).

Causes (mechanisms) of injury

The mechanism of three-quarters (n=1,136) of ED presentations for in-hospital assaultive injury was being 'struck by a person' including being punched, pushed to the ground or kicked.

'Struck by an object' was the next most common mechanism of injury (7%, n=106) involving a variety of objects such as items of furniture and technical and medical equipment, followed by cutting/piercing by objects including needlestick stabs and human bites (5%, n=70).

Perpetrator of in-hospital assaults

Case narratives were also analysed to identify the perpetrator of the assault (Table 2.3). The perpetrator was not identified in 31% of cases (n=462). In two-thirds of cases the perpetrator was a patient (67%, n=1,005). No further information was given on the type of patient perpetrating the assault in 74% (n=723) of these cases. Twenty-six per cent (n=258) of patient perpetrators were identified as psychiatric patients and 2% (n=24) as either 'Hepatitis C', Intensive Care Unit, Nursing Home, Coronary Care, Acquired Brain Injury or drunk patients. In the remaining 3% (n=45) of cases the perpetrator was a hospital visitor, family member of patient, a member of the hospital staff or hospital security staff or an intruder.

Table 2.3: Perpetrator of in-hospital assaults, Victoria 2001–2010

PERPETRATOR	N	%
Patient		
Psychiatric patient	258	25.7
Other specified type of patient	24	1.6
Unspecified patient	723	74.3
Other specified person		
Hospital visitor	23	51.1
Family member of patient	11	24.4
Security staff	6	13.3
Staff member	3	6.7
Intruder	2	4.4
Unspecified person	462	30.6
TOTAL	1,512	100

Source: Victorian Emergency Minimum Dataset (VEMD).

Location in the hospital where the injury occurred

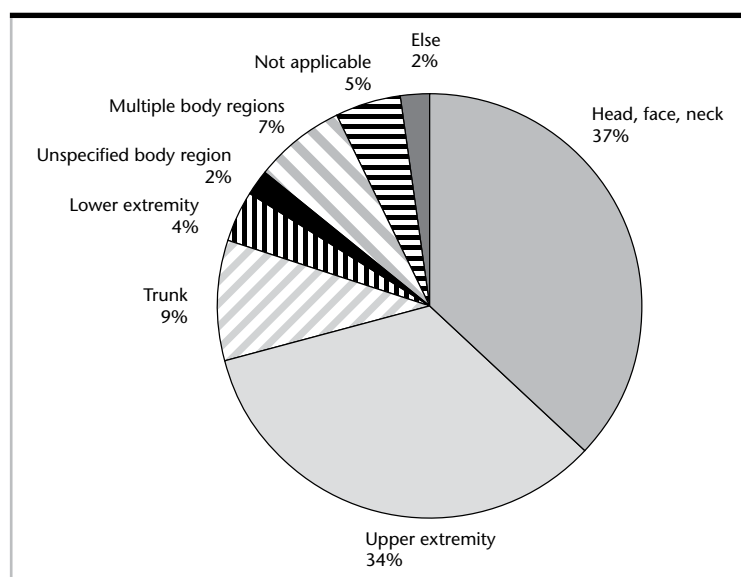
Case narratives were analysed to identify the specific location in the hospital where the violent incident occurred. This was unspecified for most cases (78%, n=1,179).

Of the cases where the location was specified (n=333), 47% occurred in a psychiatric ward of a hospital (n=156), 35% occurred in an 'other or unspecified' hospital ward/unit (n=115), 13% occurred in the ED (n=42) and 6% (n=20) occurred in the hospital grounds, for example in front of the hospital or the ED or in the hospital car park.

Body region injured and nature of injury

As shown in Figure 2.2, the head, face and neck (37%) and the upper extremity (34%) were the most commonly injured body regions. The specific body sites most frequently injured were the face excluding eyes (23%, n=349), the hand including fingers (12%, n=183) and the forearm (10%, n=150).

Figure 2.2: Body region injured: emergency department presentations resulting from violence in hospitals, Victoria 2001–2010



Source: Victorian Emergency Minimum dataset (VEMD).

Superficial injuries were the most frequent injury type (34%, n=507) followed by sprains or strains (16%, n=240), open wounds (10%, n=147) and injury to a muscle or tendon (7%, n=108).

Injury severity

Admission to a hospital ward is used as a proxy for injury severity as there is no severity score or scale on the VEMD. Only 2% of injured persons were admitted to a hospital ward (n=22); 98% were discharged home after treatment in the ED (n=1,487).

Workers' compensation claims

The following information is provided and analysed by WorkSafe Victoria. It is derived from workers' compensation data which is stored in a data warehouse. Information is used primarily to direct the activity required for resolution of these claims. Information regarding the type of incident/injury is also used to direct strategic program development, and some inspectorate activity.

From July 2006–June 2011 (as at October 2011), there were 3796 standardised⁵⁴ compensation claims lodged with WorkSafe Victoria which were coded with mechanisms of injury 'being hit by a person accidentally', 'being assaulted by a person or persons', and 'exposure to workplace or occupational violence'.

For these 3796 claims over this period, approximately 270,877 calculated days' compensation was recorded. This is calculated by taking the amount of weekly compensation paid and dividing it by the applicable daily compensation rate.

Of these claims 422 (or just over 11% of all occupational violence claims during this period) are recorded as occurring to 'nurses', where this includes the following occupations: enrolled nurses, nurse managers, nurse educators and researchers, registered nurses, registered midwives, registered mental health nurses, registered development disability nurses.

⁵⁴ Standardised claims are those that have exceeded the employer excess (days or dollars) or are registered as a standard claim and are open with no payments at the time of extraction.

It is not possible, within the data, to be confident of accurate agency⁵⁵ of injury in each case. The vast majority of claims list the agency as ‘person’.

Claims made by hospital staff

Table 2.4 covering the period July 2006 to June 2011 (as at October 2011) provides a breakdown between nurses and all other occupations at private and public hospitals. These are ‘raw’ workers compensation claim numbers only, and thus do not reflect all injuries occurring over this time in this population.

The second code of Personal Care and Nursing assistants has been included as a separate code because although they do not fit neatly into the definition of ‘nursing’, it was felt by WorkSafe that they could be considered similar in terms of risk of exposure to occupational violence at work.

The table does not look at injury types other than occupational violence.

Table 2.4: WorkSafe Claims lodged by workers at Victorian Hospitals (private and public) for occupational violence by grouped occupation of claimant

Occupation	Hospitals-Private		Hospitals-Public		Total hospitals	
	Claims	Calculated Days compensated to Oct-11	Claims	Calculated Days compensated to Oct-11	Claims	Calculated Days compensated to Oct-11
Nurses	36	2995	255	19668	291	22663
Personal Care and Nursing Assistants	1	23	10	784	11	807
Other occupation	8	1478	54	2601	62	4079
All	45	4497	319	23053	364	27550

Source: WorkSafe Victoria.

Claims made by nurses

A submission from Professor Gerald Farrell and Dr Touran Shafiei cited a 1995/96 report that stated, ‘Australian registered nurses recorded the second highest number of violent-related workers compensation claims, higher than prison and police officers’.⁵⁶ In light of concern expressed in submissions and evidence to the Inquiry, as well as more recent research academic research, it would seem there is still greater likelihood of nurses experiencing violence in the workplace compared with other health care workers and other occupational groups. As a consequence it was decided to compare workers compensation claims and those of other occupational groups over a five-year period.

Table 2.5 shows all occupational violence standardised claims made across the scheme from July 2006–June 2011 (as at October 2011).

55 This is defined as the ‘agency which concerns the object, substance or circumstances which was the direct cause of the most serious injury or disease’. In terms of occupational violence, the agency is often listed as person, client or patient or similar because this is what has most directly ‘caused’ the injury to occur.’ Correspondence from Maria Batchelor, Acting Director, Public Sector and Community Services Program, WorkSafe Victoria, 28 November 2011.

56 Grealy 2005 and Perrone 1999, cited in the submission from Professor Gerald Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, Faculty of Health Sciences, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011. The study looked at NSW Workers’ Compensation Claims.

Table 2.5: WorkSafe Claims for occupational violence across the scheme from July 2006–2011 by year and grouped occupation

Occupation	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011
Nurses	94	91	80	66	65
Other Occupation	669	623	656	623	626
All	763	714	736	689	691

Note: Data is extracted as at 30 October 2011. WorkSafe cannot do annual trend data on the calculated days compensated because some claims from earlier years are still receiving compensation. If these numbers were presented by year they would appear to be decreasing but claims reported in 2006/2007 have got 5 years of data and 2010/2011 only has 1 year.

Source: WorkSafe Victoria.

Table 2.6 shows the occupational violence standardised claims made within hospitals from July 2006–June 2011 (as at October 2011).

Table 2.6: WorkSafe Claims made by all occupational groups within hospitals from July 2006–2011

Occupation	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011
Nurses	58	60	58	49	45
Other Occupation	11	17	18	14	10
All	69	77	76	63	55

Note: There may yet still be claims submitted which result from an injury during the period 2010/11, so care needs to be taken not to over-interpret the slight 'dip' in the last year as meaning that less injuries or risk existed.

Source: WorkSafe Victoria.

As the numbers of claims made during the period of review are small, some care should be taken regarding the extrapolation of these figures to 'trends'. However Table 2.6 shows that nurses in Victorian hospitals are more likely than are their colleagues to make a workers compensation claim for injuries where the mechanism of injury was coded as 'being hit by a person accidentally,' 'being assaulted by a person or persons' and exposure to workplace or occupational violence. The number of claims made by nurses over the period has remained relatively stable.

Victoria Police data

Victoria Police provided the Committee with data on the number of assault offences at hospital locations, with or without weapons. This information was drawn from the Victoria Police's LEAP database. There are numerous limitations with LEAP database and these are well documented in previous reports of the Drugs and Crime Prevention Committee.⁵⁷ Victoria Police point out, however, that in viewing the following specific hospital violence data it is important to note the following limitations of the data:

- LEAP reporting of locations identifies hospitals, but cannot determine if an incident occurred in an emergency department of that hospital;
- These statistics record the assaults reported to and investigated by police as recorded on hospital premises;

57 See for example, Drugs and Crime Prevention Committee 2002, *Inquiry into Crime Trends — Fifth report*; Drugs and Crime Prevention Committee 2008, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People — Discussion paper*; Drugs and Crime Prevention Committee 2010, *Inquiry into Strategies to Reduce Assaults in Public Places in Victoria — Final report*.

- These statistics do not record all the incidents where police have attended a hospital and used a level of force, by example, assisting in the restraint of a psychiatric patient where there is no intention to proceed with any criminal charge. An attendance of this nature would not result in a LEAP report being submitted, but instead, police members are required to submit a Use of Force Form (UOF), whereby details of the use of force are recorded on a separate data base being the Use of Force Register;
- In incidents where force is used and a criminal charge is proposed, both a LEAP and UOF report would be submitted.⁵⁸

Table 2.7 shows that in the three years under review there has been an upward trend in assaults in hospitals, particularly assaults where weapons have not been used.

Table 2.7: Assault offences with or without weapons at hospital locations recorded by financial year 2007/08–2009/10

Victim type	2007/08		2008/09		2009/10	
	Weapon used	No weapon	Weapon used	No weapon	Weapon used	No weapon
Police	0	13	0	14	0	26
Civilian	5	56	4	80	6	87
Security Guard	5	3	3	1	0	12
Unknown	2	66	0	62	1	71
Total	12	138	7	157	7	196

Note: Modus Operandi location of ‘Hospital’ includes all areas within Hospital premises.

Source: The Victoria Police Corporate Statistics Unit records total assault offences.

The limitations of the data available to the Committee for analysis have made it difficult to give a complete picture of the current level of violence occurring in hospitals. Nevertheless, there are indications that such violence appears to be increasing and is more likely to be perpetrated by male patients aged between 25 and 54 and be directed towards nurses.

Recent research and anecdotal evidence

In addition to analysing the data, the Committee heard the views of many people working in the health care field on the current rate of violence in their workplaces. It also reviewed research conducted by academic researchers in specific hospitals or with nurses working in various hospitals across the state or the nation.

Anecdotal evidence

Throughout the Inquiry the Committee received considerable anecdotal evidence from health care workers, union officials and representatives from professional associations that violence was very much a part of the working lives of staff in hospital settings. Although little robust data exists to support or refute their view, they believed this violence was increasing.⁵⁹

As Dr Georgina Phillips from St Vincent’s Hospital in Melbourne explained to the Committee:

58 Correspondence from Acting Deputy Commissioner Tim Cartwright, Crime and Operations Support, Victoria Police, 28 November 2011.

59 See for example, Dr Jaycen Cruickshank, Director, Emergency Medicine, Ballarat Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011; Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

It is a very difficult question to answer because it relies mostly on anecdotal feeling. I do not think it has been studied enough to say that it is increasing, although the number of security incidents in our hospital is increasing. That could be a preparedness to call (for assistance) rather than actual events. My general impression as a clinician who has worked in this environment over about 10 or 15 years is that it is increasing...I think there are many more vulnerable and complex people out in the community who are not able to access the services that they need [such as mental health services], and there are a lot of substances out there in the community [that affect behaviour adversely], so my impression is that it is increasing. However, my caveat is that I have not really got good evidence behind that and I am speaking from one institution.⁶⁰

Ms Danielle McNamara, a Registered Nurse in the emergency department of the Geelong Hospital who has experienced physical assault at work, told the Committee that violence 'is increasing, violence and threats — probably threats of violence and verbal assault in the emergency department has definitely increased over the years'.⁶¹

Conversely, Ambulance Victoria reported that their members were experiencing only minimal violence against them, which did not appear to be increasing. As Mr Simon Thomson, Acting Regional Manager of Ambulance Victoria, explained to the Committee:

...our experience indicates that violence against paramedics either inside the emergency department or areas associated with emergency departments, at or nearby, appears to be minimal. We were unable to ascertain significant amounts of evidence that supported that this was a significant issue for Ambulance Victoria and for our staff. Our experience and the feedback from our front-line staff is that where violence occurs the response from hospital security and hospital staff has been acceptable up until this point and that the staff from the relevant hospitals have managed those incidents in a professional manner and in an effort to defuse the situation.⁶²

Recent research

Over the last decade in Australia numerous research projects have sought to examine the nature and prevalence of hospital violence, particularly violence that is unreported and directed at nurses. A review of the literature reveals that much of the research has been undertaken in specific hospitals or across a particular cohort of hospitals, using voluntary sampling and survey based methodologies.

However, criticism has been directed at the methodology of some of the work that has been undertaken. As Dr Marcus Kennedy explained:

Unfortunately, health workplace violence and its impacts have not been studied scientifically. This unscientific approach is not limited to the health industry. For instance, there is no single, accepted definition of violence, and, similarly, there are no clear definitions of measurement tools, or any agreement about grading of violent acts for the purpose of reporting or research.

Most published reports about ED violence are retrospective and survey-based, and use voluntary convenience sampling, creating significant risks of observer recall bias (Kennedy 2005, p.362).⁶³

Similarly, others have observed that the lack of consistency in definitions of violence creates a significant problem in understanding the nature, scope and prevalence of occupational violence.

60 Dr Georgina Phillips, Emergency Physician and Coordinator of International Programs, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

61 Ms Danielle McNamara, Registered Nurse, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

62 Mr Simon Thomson, Acting Regional Manager, Ambulance Victoria, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

63 Marcus Kennedy's 2005 research article provides extensive detail from Australian, Australasian and UK studies on occupational violence in emergency departments, particularly with regard to the extent of violence that had been occurring up to the time of publication.

Without such an understanding it is difficult to compare findings, identify meaningful trends and evaluate the impact of strategies to prevent and manage violent events (see for example, DHS 2005a; Chapman et al 2010).

Notwithstanding these concerns there has been some recent research in Australia that does provide some interesting insights into the nature and extent of hospital violence.

Nursing academics Professor Gerald Farrell and his colleague Dr Touran Shafiei informed the Committee in their submission that:

Although there are a limited number of large-scale studies conducted in Australia, the indications are that the situation here mirrors that of other developed countries. A recent survey of nursing staff from 94 wards from 21 hospitals in two Australian states found that physical violence, threats of violence and emotional abuse were experienced by 14%, 21% and 38% of respondents respectively during their last five shifts worked (Roche *et al.* 2009).

A recent NHS staff survey in England reports that 15 % of frontline staff experienced physical violence from patients (or their relatives), whereas bullying, harassment and abuse from patients (or their relatives) was reported by 21% of frontline staff (Health Care Commission 2009). The results from a Canadian National Survey of the Work and Health of Nurses (2005) found that 34% of nurses providing direct care to patients reported physical assault and 47% reported emotional abuse (Shields & Wilkins 2009).⁶⁴

Professor Farrell and Dr Touran Shafiei also recently completed a study drawn from a random sample of nearly 1,500 Victorian nurses. The study used the Department of Health's definition of workplace aggression, 'which included Occupational Violence (OV), i.e., aggression from patients or their relatives or others, but not from colleagues; and Workplace Bullying (WB) — between colleagues'.⁶⁵

Their findings indicated that:

[h]alf of the respondents experienced some form of workplace aggression in their previous four working weeks, with 46% of them experiencing three or more instances. Over one third of participants (36%) reported experiencing OV. And 32% experienced WB.⁶⁶

The major types of OV experienced were verbal abuse (90%), physical abuse (45%) and threat of harm (27%). Physical abuse mainly took the form of punching/striking, pushing, scratching and grabbing.

Patients and their visitors were identified as the main perpetrators of OV — 85% and 38% respectively. More than half of the perpetrators (54%) were male and aged over 50 years old. Patients were the most distressing to cope with, followed by their visitors.⁶⁷

The results of his study will be of particular interest to those in the field when they are published.⁶⁸

Professor Rose Chapman and her colleagues found in their 2008 study of nurses in non-tertiary hospitals in Western Australia that 75% of the 113 nurses who participated in the study reported having experienced workplace violence in the previous 12 months.

64 Submission from Professor Gerald Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, Faculty of Health Sciences, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

65 Submission from Professor Gerald Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, Faculty of Health Sciences, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

66 Submission from Professor Gerald Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, Faculty of Health Sciences, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

67 Correspondence from Professor Gerald Farrell and Dr Touran Shafiei, School of Nursing and Midwifery, Faculty of Health Sciences, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 28 November 2011.

68 The results from this study are currently under review for publication in the International Journal of Nursing Studies (Farrell & Shafiei 2011).

Twenty-five percent of the respondents reported that they had experienced WPV [workplace violence] in the last week, 27% monthly and 25% once every six months and 23% had never experienced such an event. Staff in ED and mental health reported the highest mean number of incidents per staff member (46-43 and 40-39 respectively) followed by those in the medical and restorative area. Ninety-two percent of the nurses reported experiencing verbal abuse, 69% had been physically threatened and 52% had been physically assaulted in the 12 months prior to the survey (Chapman et al 2010, p.482).

It is noteworthy that when asked about their most recent incident of violence only 50 per cent of nurses had reported it verbally, primarily to senior staff, whilst only 16 per cent had filled in an incident report.

Analysing code/grey/black databases to determine prevalence

An important study undertaken in 2005 by the Department of Health was the *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (DHS 2005b). This was the first study to describe the incidence of code grey/black events across three major regional hospitals and one regional health care agency. According to the authors:

The most noteworthy findings of this research relates to the prevalence within the acute hospital setting. Over a six-month period, 2,662 potential or aggressive events occurred across the four settings. That is an average of 14.6 events per day. Mean code duration was 23.3 minutes. Based on these figures and using a calculation of two nurses per code, this equates to 680 minutes (11.3 hours) of nursing time per day across the four sites' (p.58).

Since this study was undertaken other hospitals have analysed their code grey/black databases to gain an understanding of the prevalence and characteristics of incidents that occur.⁶⁹

Royal Melbourne Hospital: An audit of code grey events

The Royal Melbourne Hospital undertook a 12 month audit of code grey events at the hospital from 1 January 2010 to 31 December 2010. The code grey database, which is maintained by hospital security, was established at Melbourne Health in 2006. The data provides a 'description of the internal security response to actual and potential episodes of visitor and patient aggression when an internal security response is initiated violence'.⁷⁰

According to the Royal Melbourne Hospital's submission to the Committee:

These data provide the most comprehensive information about patient violence at Melbourne Health and are extensively used to inform incident monitoring, safety and quality initiatives and training on the prevention and management of patient aggression.⁷¹

The results of the audit are revealing:

A 12 month audit of Code Grey events at Royal Melbourne Hospital determined that the incidence of all Code Grey responses was 34.8 codes per 1000 patient visits. Of these 19.9 per 1000 patient visits were Planned Code Grey events and 15.7 per 1000 patient visits were Unplanned Code Grey events. The median duration of all Code Grey events was 15 minutes. Of all Code Grey events, 25% occurred at point of entry to the service (triage, ambulance, and waiting areas). Of all individuals for whom a Code Grey was activated, 12% of patients accounted for 32% of events.⁷²

69 See Chapter 8 for a discussion of the Code Grey and Code Black system.

70 A planned code grey is activated when: "staff anticipate a risk due to an unarmed threat including aggressive behavior where any (patient, visitor, intruder) could potentially threaten injury to others or themselves". An unplanned code grey is activated when: "staff perceives an immediate risk due to an unarmed threat including aggressive behavior where any person (patient, visitor or intruder) threatens injury to others or themselves." Submission from the Royal Melbourne Hospital. to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

71 Submission from Royal Melbourne Hospital. to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

72 Submission from the Royal Melbourne Hospital. to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

The submission explains the importance of the data and how it can be used to identify particular problems and then stimulate new interventions.

The audit data shows that a significant proportion of Code Grey events occur on, or shortly after, arrival in the ED and that there is a small group of individuals repeatedly attend the ED for medical treatment and subsequently become violent. These findings highlight the need to develop a method for identifying individuals who are at risk for violence at point of entry to the service and to implement targeted preventative interventions for those at risk.⁷³

The incidence of security responses at the Emergency Department of St Vincent's Hospital in Melbourne (SVHM) is considered to be quite high due to its location and demographics. As Dr Georgina Phillips and her colleagues explained in their submission, 'the incidence of security responses is at the higher end of the scale, and has been estimated to be around 2%, equating to around 2 Code Grey episodes in the ED per week (up to 6 per day hospital-wide). The aetiology breakdown is consistent with evidence from around Australasia, however SVHM receives a disproportionately higher number of aggressive and violent patients'.⁷⁴

A short summary

The above discussion on anecdotal evidence and academic research has shown it is extremely difficult to estimate with any degree of accuracy the true incidence of violence in hospitals. Factors such as the differences in definitions of workplace violence make the task of calculating the extent almost impossible. However, recent research undertaken in Australia has indicated that those working in hospitals, particularly nurses, are vulnerable and that nurses are disproportionately at risk of workplace violence compared to other occupational groups. This assessment has been confirmed by many of the views expressed to the Committee in submissions and at public hearings.

The need for a recording system

Health care workers and academics have acknowledged for some time that 'the first priority in developing a workplace violence prevention policy is to establish a system for documenting violent incidents in the workplace' (Lee 2006, p.5). Without a robust state-wide data set it is not possible to collate this information and identify state-wide patterns and trends relating to incidents. It also makes evaluating the effectiveness of initiatives that have been introduced extremely difficult (Mayhew & Chappell 2003; Lee 2006).

Background to the current system

Prior to 2006 there was no mechanism for the Department of Health to gauge the extent of incidents affecting patients, staff and others within Victoria's publicly funded health services (Department of Health 2011g). Responding to the 2005 *Taskforce on Violence in Nursing: final report* the Victorian Government accepted its recommendation 27 that the DHS develop a consistent state-wide minimum data set that gathers information on occupational violence occurring in Victorian hospitals:

The DHS Victorian Health Incident Management System (VHIMS) project will deliver a system for collection and review of state-wide incident information including OHS incident types (inclusive of occupational violence and including data elements identified by the Taskforce). The full implementation of VHMIS is anticipated to be 2010.⁷⁵

73 Submission from Royal Melbourne Hospital. to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

74 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager and Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital Melbourne to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

75 See <http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-5>

Victorian health incident management system⁷⁶

The Victorian health incident⁷⁷ management system (VHIMS) is a data set and methodology for health services, standardised across the state, for incident and consumer feedback reporting, management and analysis.

Roll out of VHIMS

In 2009 RiskMan International Pty Ltd was awarded the tender for a state-wide incident management system and subsequently incorporated VHIMS into its application. Existing RiskMan clients received a system upgrade that included the VHIMS data collection. Health services that were not existing RiskMan clients received, without cost, a central hosted system from the Department of Health, which is maintained by RiskMan on the Department's behalf. RiskMan is also contracted to provide help desk support for clients using a central hosted system. The state-wide roll out was completed in February 2011 (Department of Health 2011g).

Education and training in use of the system

As part of the roll out, the Department of Health provided training, education resources and funded locally based project officers. The Department developed the trainer program and contracted training delivery to RiskMan. A series of help/reference guides are included in VHIMS (RiskMan application) and E-Learning modules have been developed to support health services with incident management (Department of Health 2011g).

Scope of the health services required to use VHIMS

All publicly-funded Victorian health services and some agencies must use the VHIMS data set and prescribed system/s to record details of clinical incidents. This includes:

- 88 public health services (and all services auspiced from these services)
- 39 registered community health centres
- Ambulance Victoria
- Royal District Nursing Service
- Ballarat District Nursing and Health care
- 14 bush nursing centres
- Forensicare
- 5 Incorporated Residential Aged Care Services

Private health services however are not included in the VHIMS project scope (Department of Health 2011g, p.2).

Staff access to VHIMS

VHIMS is loaded onto health services' network drives so that staff can access it directly through their IT network log in or a specific VHIMS (RiskMan) log in. A specific template that dictates what information is captured by the user is allocated to each user to report incidents (Department of Health 2011g).

Once an incident is recorded, the staff member's line manager receives an alert email and is then responsible for reviewing the incident to make sure the information is accurate. Health

⁷⁶ The following information is paraphrased from Department of Health 2011g.

⁷⁷ 'Incident' in this context is defined as: 'An event or circumstance which could have, or did lead to, unintended and/or unnecessary harm to a person and/or a complaint, loss or damage' and comprises 'Adverse Events' and 'Near Misses' directly related to individuals, as well as incidents involving infrastructure, facilities and security (cited in Department of Health 2011g, p.1).

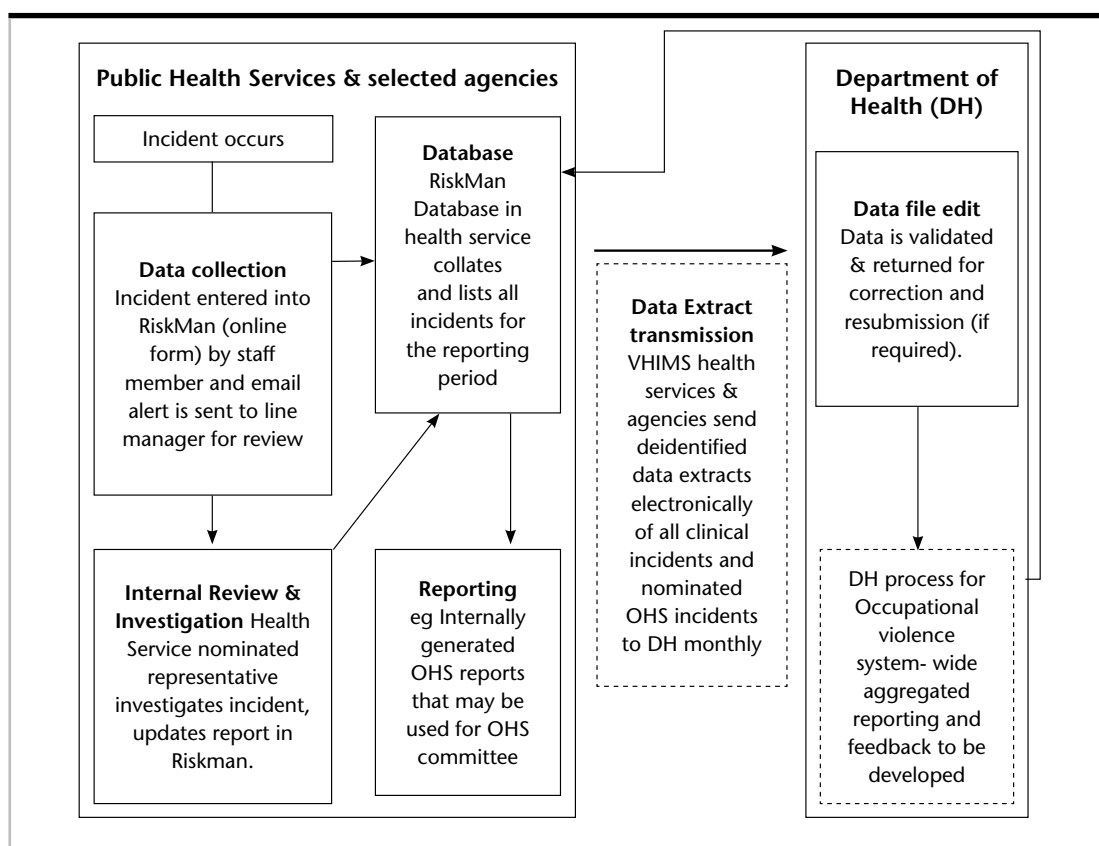
services can create alerts on a variety of data fields, which enables relevant staff to be notified of particular types of incidents when reported; for example, an OHS manager could receive an email notification each time an OHS incident is reported.

When the review is completed by the relevant staff member it is closed off by either the line manager or the nominated administrator who then creates a master copy of the incident that is included in the reports module of the system.

Transfer of data to the Department

A subset of the VHIMS data set for clinical incidents and occupational health and safety (OHS) incidents pertaining to violence against nurses in the workplace, without identification, is sent to the Department of Health. The health service holds the complete data record in its management system (Department of Health 2011g).

Figure 2.3: Flow diagram showing the process of recording incidents on VHIMS



Source: Department of Health 2011g.

This information can then be used at the local level to monitor trends, identify areas of risk and develop policy and new initiatives. The de-identified data is sent to the Department via an electronic secure data exchange process that allows for data encryption. Data transmission is mainly coordinated by the health service or agency’s nominated RiskMan administrator. The system then collates and lists on a dedicated screen ‘all incidents for the reporting period that meet the Department’s reporting requirements’ (Department of Health 2011g, p.4).

Concerns with RiskMan and VHIMS

Whilst it is only nine months since the roll out of RiskMan was completed, there have been complaints by health care personnel and hospital administrators that RiskMan is already falling short of its initial aims and expectations. Concerns have been expressed that the system is time consuming and difficult to manage for health care staff who are already extremely busy.

According to a submission from the Royal Melbourne Hospital, there is widespread reluctance among staff to record every incident on RiskMan. It suggests this is due to the following three factors:

1. Staff consider emergency responses to manage violent behaviour are routine practice and not an incident unless there is an adverse outcome.
2. Studies have shown that the expectation of workplace violence has become embedded among staff.
3. Staff report the usability of RiskMan is a barrier, in particular the time required to complete a single report.⁷⁸

The Health Services Union East Branch submission described the RiskMan system as ‘complex and tedious, requiring unnecessary detail’. It also pointed out that all incident reports must be done via a computer and some workers do not have access to computers.⁷⁹

Mr Tim Reinders, Occupational Health and Safety Manager, Ballarat Health Service, thought that whilst in the main the system works well, ‘in the ED...where it is time critical, it (RiskMan) is time-consuming and onerous...to add data in’.⁸⁰ With regard to the database he added that:

There is a range of issues around reporting and one of them we think may be the actual database itself. It might be difficult to use and to put the data on there. We did try another trial database to see if there was a greater incidence of reporting and it did increase — a simple database that went with RiskMan, to see if it increased the incidence of reporting and it did. We found it increased them quite substantially. We would like to have more reporting and we do encourage our staff to report constantly.⁸¹

The Committee acknowledges the work that has been undertaken in developing and implementing VHIMS. However, given the importance of having comprehensive, centralised and local level data readily available to hospitals, and the concerns expressed, the Committee believes an evaluation should be undertaken of its performance, ease of use in capturing violent incidents in hospital settings and its effectiveness in promoting the reporting of these incidents by hospital staff 18 months after the roll out of the last RiskMan.

Conclusion

Comprehensive and accurate information related to the prevalence and circumstances of aggressive and violent events in health care settings is essential for developing and implementing prevention and management strategies. Central to this being achieved is the need to report such incidents via the hospital system and have the details registered in databases of the relevant authorities. While progress has been made in this regard, improvements and changes appear to be required still in two main areas. First, improvement is needed in reporting systems to make them more user-friendly and consequently more time-efficient. Second, a change is required in the culture of health care workplaces with regard to reporting occupational violence incidents from one of dissuasion to one of encouragement.

78 Submission from Royal Melbourne Hospital. to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

79 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

80 Mr Tim Reinders, Occupational Health and Safety Manager, Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

81 Mr Tim Reinders, Occupational Health and Safety Manager, Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

Recommendation

- 35. The Committee acknowledges the work that has been undertaken in developing and implementing the Victorian Health Incident Management System (VHIMS). The Committee recommends that an evaluation be undertaken of its performance, ease of use in capturing violent incidents in hospital settings and its effectiveness in promoting the reporting of these incidents by hospital staff. This evaluation should be undertaken 18 months after the roll out has been completed.**

In particular, the Committee believes it is essential that incident reporting systems, most notably VHIMS, is evaluated to ascertain whether violent incidents in Victorian hospitals are being reported and that the system through which this is done is readily accessible and user friendly. A centralised data system for incident reporting that is standardised across the state, easy to use and time-efficient is essential for determining the extent of violence in hospitals, the circumstances in which it occurs and developing effective prevention and management strategies.

Recommendation

- 36. The Committee supports Recommendation 29 of the *Taskforce on Violence in Nursing: final report* that proposes the Department of Human Services make aggregated local data results available to health services. The Committee therefore recommends the expedition of the regular collation, analysis and dissemination of VHIMS data to Victorian hospitals and WorkSafe Victoria.**

A crucial aspect of collating any data is to be able to make use of it in a meaningful way to inform policy and practice. The provision of data to local hospitals would allow them to compare/benchmark their hospital against others and to inform their own risk management assessments.

Recommendation

- 37. The Committee notes the importance of hospital staff recording the incidence of violent and potentially violent behaviour and recommends that hospitals encourage and train their staff to vigilantly report such incidents (on VHIMS).**

The underreporting of violence by staff is reported to be extremely high and is a significant barrier to addressing violence occurring in hospitals. Without this information hospitals are not able to have a clear picture of the nature or extent of occupational violence, the risk factors involved the high-risk patients or situations where staff might be vulnerable. It is also means that it is difficult to develop targeted preventive interventions. There are numerous and completely understandable reasons why health care staff don't report. However hospitals should create an environment where reporting is encouraged and staff members are provided with training opportunities to use recording systems such as VHIMS.

3. The Nature of Violence in Health Care Settings

Introduction

The occurrence of violence generally, and in health care settings particularly, is a multi-faceted phenomenon. The academic and scientific literature indicates that ‘the patterns of violence experienced by Australian health care workers are complex and that, overall, the specific risk factors for violence largely unknown’ (Mayhew & Chappell 2003, p.37).⁸²

Prior to the landmark study by Mayhew and Chappell and the work of nursing academics such as Professor Gerry Farrell,⁸³ little (Australian) empirical research had been conducted that established baselines for the extent and types of violence being experienced by health care workers or the settings in which they take place. This chapter, drawing from the work of Mayhew and Chappell, subsequent research studies and the evidence given to the Inquiry, looks at the types of violence being experienced by health care workers, the settings in which they take place, the factors that contribute to the violence occurring, profiles of perpetrators and victims and the consequences of that violence for those who experience it.

The nature and types of violence experienced by people in a hospital setting

Violence experienced by health care workers, patients and other members of a ‘hospital community’ is clearly a real and significant concern. The following sections examine the types, patterns and settings of violence that takes place in a hospital environment.

Violent acts experienced by health workers and others in the health care setting can take one of two major types — acts of *physical* and acts of *psychological* violence.⁸⁴ Physical violence can take a great variety of forms. Such aggressive conduct can include beating, slapping, punching, sexual assault, throwing of objects, the tearing of clothes, kicking, biting, pinching, shaking and in the most serious cases the use of weapons including guns, knives, blunt instruments and/or the opportunistic use of hospital equipment such as chairs, medical instruments (syringes, cannulas, scalpels) or other types of hospital equipment. At the extreme end of the spectrum, violence can result in homicide, thankfully a relatively rare occurrence in Australian health care settings.⁸⁵

A graphic example of the type of violence being experienced in one busy Melbourne hospital was given to the Committee by an emergency nurse:

Behind the doors and inside the cubicles, depending on what type of patient you are dealing with, along with verbal aggression we also get bitten, punched, slapped and have objects thrown at us. They

82 This raises the complex issue of *predicting* violence, an aspect of the process of risk identification and risk management more suitably discussed in Chapter 5 of this Report.

83 See for example, Farrell and Gray 1992; Farrell 1997, 1999.

84 Other typologies have also been canvassed including that of ‘economic violence’. A detailed discussion of these peripheral forms of ‘violent’ behaviour is however beyond the scope of this Report. See generally discussion in Department of Human Services (DHS) 2005a, p.22 and the references listed therein.

85 Mayhew and Chappell 2003 note that homicides as a form of occupational violence in the health setting are relatively rare in Australia compared to jurisdictions such as the United States. However, a work related fatalities study that examined trauma related deaths between 1989 and 1992 showed that compared with other industry sectors, whilst health workers had an overall low risk of death (from any cause), health workers were disproportionately represented in the homicide figures: ‘it was found that 38 per cent of all work related homicides over this four year period were committed by clients or patients’ [or one Australian health worker murdered at work per year] (Mayhew & Chappell 2003, p. 6).

pull their IVs out and throw bloodstained cannulas, sharps — any kind of weapon they can get their hands on, such as chairs — at the nursing staff.⁸⁶

The term psychological (or emotional) violence ‘encompasses all violent activities that are not classified as acts of physical violence’ (Department of Human Services (DHS) 2005a, p.22). These include verbal abuse, swearing, threats (particularly with regard to the use of force), acts of neglect, insults, bullying, demeaning or belittling a person or questioning their skills or competence, intimidation and harassment. Acts of physical force will almost invariably be accompanied by psychological violence, particularly verbal threats; however verbal or emotional abuse need not and often will not be accompanied by physical aggression (ILO et al 2002). Physical acts of violence may be intentional or unintentional. They can range from a parent who punches a medical officer for what he considers is an unduly long time in attending to his child to an elderly and confused dementia patient who strikes out at a nurse without fully appreciating the consequences of her behaviour.⁸⁷

As the previous chapter has indicated, it is difficult to accurately measure the extent of violence in health care settings, including a breakdown of the types of violence that occurs. It is generally agreed in both the academic literature and in the experience of the many witnesses who gave evidence to this Inquiry, however, that the more extreme examples of physical violence are relatively uncommon whilst psychological abuse, particularly verbal violence, is much more prevalent. (Di Martino 2002; Mayhew & Chappell 2003; Hegney et al 2006; Chapman 2011; Behnam et al 2011).⁸⁸ Indeed Mayhew and Chappell noted in their study that verbal abuse could be viewed as ‘endemic’ in the health care setting (2003, p.27). The important thing to heed as Mayhew and Chappell note is that whilst physical assaults, particularly those at the more violent end of the spectrum are comparatively infrequent, they are nonetheless totally unacceptable. The task for hospital management and health bureaucracies is to prevent or minimise their occurrence without excluding or compromising patient care.

The settings of occupational violence in the health care sector

A number of studies examining occupational violence in health care settings have found that most incidents occur in emergency departments, followed by general wards and psychiatric units⁸⁹ (DHS 2005a). This was certainly true of the nursing audit conducted for the 2003 Melbourne University study that analysed code greys and blacks in four Victorian hospitals (hereinafter the ‘Code Black’ study). This study found the percentage of incidents for these three sites to be 68, 21 and 6 per cent respectively.⁹⁰ Reasons given for the high incidences in the emergency room include the levels of stress, pain and vulnerability of the patient (and/or their families/visitors); the belligerent nature of patients being brought to the emergency room by police or ambulance officers, the high numbers of patients with mental health and/or drug and alcohol conditions and the fact that emergency rooms are usually open 24 hours

86 Ms Leslie Graham, Registered Nurse, Dandenong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

87 A range of examples that demonstrate the enormous variance in the way violence can be exhibited in the health care setting are outlined in a variety of Victorian policy and research documents. In particular see those listed in *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (DHS 2005b).

88 When the Committee met with Curtin University nursing academic Dr Rose Chapman she stated that 75 per cent of the incidents in her study of violence against hospital nurses were verbal. According to Professor Chapman the international research shows that the effects of this ‘are as significant as physical contact’. See Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011. See also Chapman and Styles 2006; Chapman 2011.

89 In fact the *Violence in Nursing Taskforce* report makes the salient warning that one needs to be wary of the literature on violence against nursing in as much as many studies into patient aggression are derived from psychiatric settings and therefore not necessarily transferable to the general hospital setting: ‘In order to gain a complete picture of the prevalence of occupational violence in nursing, more information is required into how patient aggression manifests in a range of environments, particularly within the general hospital setting’ (DHS 2005a, p.19).

90 See *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (DHS 2005b).

a day, seven days a week. 'All of these factors increase the possibility of violent acts occurring' (Behnam et al 2011, p.566).⁹¹

However, an Australian Patient Safety Foundation (APSF) study analysing data from the Australian Incident Monitoring System (AIMS)⁹² over the period 2000–2002 found that the proportion of violent incidents in mental health units compared to emergency rooms was much higher (28 per cent to 16 per cent respectively). The authors also found that a high percentage of rural practitioners, outside the hospital setting, reported experiencing some form of violent and aggressive behaviour towards them. Seventy-three per cent of doctors in rural New South Wales, Victoria and Western Australia reported aggressive behaviour from patients and 20 per cent of that group reported being physically assaulted (Benveniste, Hibbert & Runciman 2005, p.349).

Mayhew and Chappell's study in 2003 highlighted some settings and contexts as being consistently at higher risk for occupational violence. Based on the responses of the 400 in-depth interviews with health care personnel, the high risk sites identified were:

- Emergency Departments
- Drug and alcohol clinics/units
- Mental health or psychiatric units
- Uncontrolled environments in which ambulance officers work
- Maternity/delivery wards
- Intensive care units and other areas where 'high stress' events occur frequently
- Child/paediatric wards
- Remote rural sites at night where there are few staff
- Outpatient or emergency facilities which have long waiting times and where explanations were perceived as inadequate (Mayhew & Chappell 2003, p. 25).

The authors commented that these responses were consistent with patterns reported in a number of international studies.

Settings other than the emergency department

One surprising result from the Mayhew and Chappell research was that workers in the aged care industry reported relatively high levels of violent incidents — 'a pattern that may escalate as the level of care for residents in facilities rises over times and the proportion of clients/patients with dementia and other cognitive disorders increases' (2003, p.37).⁹³ In one United Kingdom study the authors drew from studies that 'have shown that the vast majority of occurrences of violence are in departments other than the assumed "front-line" areas of accident and emergency' (Wells & Bowers 2002, p.231; see also Hegney et al 2006).

Much evidence given to this Inquiry stressed the need to consider that violence is experienced in other areas of the health care system as well as the emergency room. For example, some academic studies have identified the radiology department (Caruana 2005 (Australia); Ng et al 2009 (Hong Kong) or even the maternity suite (Mayhew & Chappell 2003) as being settings for verbal and

91 Certainly the views of those who work in emergency medicine believe the levels of violence occurring in emergency rooms is the highest of all health care settings and is underreported. See for example, Australasian College for Emergency Medicine (ACEM) 2004, *Policy on violence in emergency departments*, ACEM, Melbourne, Victoria. Website: http://www.acem.org.au/media/policies_and_guidelines/violence.pdf Accessed June 2011.

92 AIMS was a national incident reporting system that reported 'any events or circumstances which could have led or did lead to damage, loss or harm' (Benveniste, Hibbert & Runciman 2005, p.348). The weakness of the system has been that reporting has always been voluntary and dependent on hospitals deciding to participate in the scheme across Australia and New Zealand.

93 Indeed very high rates of violence against aged care nurses and carers were found in the United States and Queensland. See Hegney et al 2006 and the studies discussed therein.

physical abuse. This is particularly the case when the parents of the baby may be subject to impending care and protection proceedings from child protection services (Mayhew & Chappell 2003).

On this point a representative of Ballarat Hospital told the Inquiry that issues pertaining to parenting and children could be flashpoints for violent behaviour:

'[t]here are a number of mothers who have babies removed from them straight after birth; there will be families where restraining orders apply in terms of access to children; there will be tensions around families where parents may be separated. Custody issues are certainly an issue'.⁹⁴

Nursing academic Dr Rose Chapman, Curtin University, told the Committee that the violence occurring in emergency rooms can often spill over to the general and even the paediatric wards:

Lots of places do focus on just accident and emergency but I wanted to look at OK this is happening in ED, those same patients are going to the wards, what's it looking like there. And it's very similar on the wards and in fact on the medical wards it was even higher than in the Emergency Department.

Paediatrics where you think everybody is going to be really nice and lovely, it's the parents that get really stressed and upset and if you have kids and you have them in hospital you are quite anxious. You may not bash someone but some people have no other skills. It seemed to be the best place to work was maternity, it was very low in the maternity area. It still existed but not as high.⁹⁵

Similarly, Dr Stephen Parnis, Australian Medical Association (AMA), told the Committee:

This is not something that I would want to restrict to just emergency; I think it is a focus, but this is certainly an issue for every aspect of a hospital department. It is quite common that you have a so-called Code Grey or a violent incident being called in a ward, in a recovery area of a theatre or in an outpatient department; I heard one just two weeks ago in oncology, in the cancer chemotherapy ward. These things are not by any means exclusive to the emergency department.⁹⁶

Indeed as was indicated to the Committee, in some respects the situation can be worse on the general wards as there isn't the same level of security and auxiliary staff readily at hand that can be found in the emergency room environment.

Other witnesses to the Inquiry stressed that much violence against health practitioners can take place *outside* the hospital setting. A submission to this Inquiry from the AMA stated:

It is also important to note that high levels of violence within health settings are not only confined to EDs and hospital services. A UK study has found that 10 per cent of general practitioners included in the study had been assaulted and 5 per cent threatened with a weapon. Another survey of general practitioners found 11 per cent had been assaulted and 91 per cent had experienced verbal abuse.⁹⁷

Similarly, the Victorian Health care Association (VHA) has argued that whilst it is important to look at violence occurring in a hospital setting this should not mean that external locations such as community health care settings are ignored:

The VHA recommends that the committee also considers the violence and security arrangements for Victoria's group of community health services. These services are open to all members of the community and often see a similar cohort of clients as emergency departments, such as people who are substance-affected or experiencing mental health issues... The VHA is aware of violent incidents at

94 Mr Andrew Rowe, Chief Executive Officer, Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011

95 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

96 Dr Stephen Parnis, Vice-President, Australian Medical Association (AMA), Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

97 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

community health centres that have led to the installation of barriers between reception and the waiting room, as well as the addition of CCTV cameras in an attempt to identify perpetrators of violence. One community health centre has reported a loss of a number of staff over recent years who are simply too frightened to work in this environment. For example, there are some mental health clients who are unable to be seen by the mental health system without police presence. However, these same clients are able to walk into any community health centre with potentially negative consequences.

Many services generally have no security arrangements and the first point of contact a client usually has will be with a receptionist behind an open window. Any safety concerns subsequently require mitigation through community health service staff and the request for police intervention. Similarly, a rural hospital reports that it is difficult to have community services seen as a legitimate security risk area.⁹⁸

Whilst the results from the data is variable and inconclusive as to the exact settings of violence in the health care workplace, it is clear that policies and protocols to protect the interests of *all* workers, patients and other people in the health care setting must cover all potential situations and locations. The duty of care does not stop at the door of the emergency room or psychiatric unit.

Who are the victims of violence in health care settings?

In short, the answer to this question is that victims can be anyone present in the hospital setting. The majority of victims, however, will be hospital staff, although patients, their friends, families and visitors can and are also subjected to occasional aggression and violence.

Staff working in hospitals and health care settings

Whilst in a hospital or health care setting violence can be experienced by everyone from surgeons to security guards and cleaners, a number of international and local studies suggest that nurses are the group most susceptible to both physical and psychological abuse (Leather 2002; DHS 2005a and the references listed therein). A major reason for this is that nurses tend to be the 'frontline', spending more face-to-face time with patients and their relatives, particularly during the acute phases of illness. Whittington et al found that:

[P]roviding direct patient care and treatments was a major precursor to staff being assaulted. This includes actual 'hands on' delivery of treatment as well as verbal statements by the employee relating to the delivery of care (for example, questioning, persuading or arguing with the patient). Physical contact with a patient such as that associated with dressing or moving a patient, taking blood glucose or giving an injection was also found to be an important trigger for aggression (Whittington et al 1996 in DHS 2005a, p.25).

This is by no means to discount the experiences of violence other health care staff experience — some studies have found that ambulance officers were most at risk (closely followed by nurses) especially at the time of picking up patients (when no other supports were in evidence) (Mayhew & Chappell 2003). Although allied health staff experienced the least number of violent episodes, they were also at heightened risk in certain circumstances. In particular, allied health personnel such as social workers were at greater risk if they worked in drug and alcohol, domestic violence or child protection settings and particularly when working alone (Mayhew & Chappell 2003). Medical staff such as doctors experienced relatively fewer episodes of violence compared to nurses but the risk was heightened when they worked in high pressure environments such as the emergency room, intensive care or when treating patients affected by drugs or alcohol (Mayhew & Chappell 2003).

98 Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association (VHA) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

The impact of inexperience

In addition, within particular groups of health care staff some workers may be more vulnerable to violence than others. In particular, some studies have shown that health care workers with the least amount of experience, such as students or first year nurses, may be at greater risk of violence (Fisher 2002; Pich et al 2011; DHS 2005a, and the references listed therein). This finding is indicative of not only the need for comprehensive management protocols to prevent violence in hospitals and health care settings but also the need to ensure that all staff but particularly new or inexperienced staff, including students, are properly trained in dealing with violent and aggressive patients. As Petit states: 'Studies have shown that educational programs can help to reduce the number of violent events especially when the events are focused at staff who are less experienced' (2005, p.702).⁹⁹

Patients, families and visitors

Finally, it should be borne in mind that whilst this section has focused on the experience of health care staff, patients and their families and visitors can also be the victims of verbal and physical violence in the health care setting. One witness to the Inquiry stated that anyone in the vicinity of violence in a hospital setting, particularly the emergency room or triage setting, could be classified as a victim: 'The victims would be the other patients and visitors; reception staff; nursing staff; medical staff. Anyone else that is present who is not the perpetrator is a victim'.¹⁰⁰ This is particularly true of children or elderly people who are being treated in close proximity to the actions of the violent perpetrator.

The Victorian Health Services Commissioner has stated that whilst the number of patients complaining in relation to security issues in hospitals is relatively low (25 complaints out of a total of 2500 in 2010/2011) this does not mean that the experiences of patients should be discounted. Examples of complaints by consumers/patients include rough handling, too much force, inappropriate use of security, verbal insults or demeaning attitudes from staff etc.¹⁰¹

Whilst data on the experience of patients as victims is scarce, evidence given to the Committee indicates that particular groups of patients are especially vulnerable to aggression and violence. These include young people, particularly from disadvantaged backgrounds, patients of non-English-speaking backgrounds (NESB) and elderly patients.¹⁰²

In the case of young people a submission from Jesuit Social Services (JSS) to the Inquiry argues that disenfranchised young people can be as much victim as perpetrator of aggression in hospital settings. In JSS experience some young people have had very negative experiences of emergency departments in Victoria including being subject to verbal abuse by hospital staff. One reason that a young person may get abusive or aggressive in a hospital setting is that security officers in emergency departments do not always have the skills to deal with young people, particularly those ill, in crisis or suffering a mental health disorder.¹⁰³

For a discussion of the experience of patients from non-English-speaking backgrounds (NESB) as both victims and perpetrators of violence, the academic work of Professor Megan Jane Johnstone and Professor Olga Kanitsaki is especially useful.¹⁰⁴ At a meeting with the Committee, Professor Johnstone stated that whilst NESB patients could definitely be viewed as victims of aggression, particularly verbal abuse by mainstream treating staff, NESB *patients* were not the only ones to

99 For a discussion of education and training issues, see Chapter 11.

100 Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

101 Submission from Dr Beth Wilson, Health Services Commissioner to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

102 Abuse of elderly patients in both general and aged care settings and by health care staff and fellow patients is clearly a matter of great concern. A comprehensive discussion of this issue is however beyond the scope of this Inquiry.

103 Submission from the Jesuit Social Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

104 See the relevant listings in the bibliography of this Report.

suffer violence in the health care sector as a result of their ethnicity. Professor Johnstone told the Committee there have been several examples of patients from anglo-celtic or mainstream backgrounds who have been unhappy with the idea of being nursed by a worker from a non-English-speaking, particularly Asian, background. In some cases this had erupted in racially motivated violence. More often than not nurses (and other health workers) from NESBs were subject to verbal violence including insults, racist epithets, demeaning comments and questioning of their professional competence. In extreme cases staff from NESB backgrounds had been punched, had scalding cups of tea thrown over them or physically abused in other ways.¹⁰⁵

Who are the perpetrators of violence in health care settings?

Just as there are a range of types of occupational violence suffered by health workers and others in a hospital setting, so too there are a range of perpetrators associated with hospital violence. For example Mayhew and Chappell's 2003 study broke down perpetrators into four main groups:

- ◆ clients/patients
- ◆ relatives/visitors (of patients)
- ◆ staff
- ◆ other.

Of these groups 77 per cent of violent events were committed by patients, including the vast majority of physical assaults and threats. Relatives or visitors were responsible for nearly one-third of verbal abuse but few assaults. Fellow staff members were responsible for the majority of bullying events (Mayhew & Chappell 2003, p. 29).¹⁰⁶ These findings were generally confirmed by expert witnesses to the Inquiry and for the most part still represent current trends.

Patients as perpetrators

In the Mayhew and Chappell study there were some interesting variations as to whom the violence was directed. With regard to nursing staff, physical assaults were most commonly perpetrated by aged care (often dementia affected) or mental health clients, whereas verbal threats to nurses were inflicted by a wide spectrum of perpetrators including patients, visitors and relatives. Medical and security staff most commonly received assaults and threats in the emergency room or intensive care context particularly from patients with drug and alcohol or mental health conditions. Ambulance officers similarly were subject to verbal and physical violence from patients with drug and alcohol problems or mental health conditions (Mayhew & Chappell 2003).

With regard to violence exhibited to health care staff by NESB patients, Professor Johnstone gave evidence to the Committee that it was necessary to look beyond the seemingly aggressive behaviour. She outlined a number of scenarios where conduct by NESB patients, including refugees or their visitors, was largely a result of miscommunication and misunderstanding of the patient's cultural background or customs:

In terms of some of the tensions, and I guess what we would call bad behaviours, mostly what came through was that there was a misunderstanding of basic communication not so much from patient to staff but from staff to staff and staff to patient. For example, you might have someone of non English-speaking background speaking loudly, and that could be perceived as being aggressive. People would then start to escalate what was not a tense situation in the first place.

We uncovered situations where mainstream staff still viewed migrants as jumping ahead of the queue. We found instances of people, for example, presenting at outpatients, waiting for an interpreter that

¹⁰⁵ See Professor Megan-Jane Johnstone, Director, Centre for Quality and Patient Safety Research, Deakin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

¹⁰⁶ An issue not discussed in this Report.

had been booked and the chart had been designated as being booked for an interpreter, but some staff, concerned that they were jumping the queue, would remove their file to the bottom of the pile — little instances like that.¹⁰⁷

There have also been cases where hospital staff excused or at least understood the behaviour of the perpetrator because of the patient's underlying condition or illness. This may also have resulted in the staff member not reporting a violent incident:

Client/patient-initiated violence was reported to be most common when people were “not themselves” because of injury, illness, brain injury, dementia or a semi-comatose state, or while recovering from anaesthesia, suffering from a range of mental health problems, or affected by drugs or alcohol. Although physical assaults were commonly reported from dementia clients, the behaviour was frequently “explained away” by their medical condition. The absence of malicious intent by the perpetrator was an obvious factor that mitigated staff interpretations (Mayhew & Chappell 2003, p.30. See also Chapman 2011).

Violence from visitors and families

Relative/visitor-initiated violence was reported from across health occupations and hospital sites, and was directed to both female and male workers.

It was also frequently reported that many relatives and visitors were anxious and fearful of the health outcomes for their loved ones, and some may have believed that assertive behaviour towards staff might improve attention and treatment. A number of reported perpetrators were the parents of child patients (Mayhew & Chappell 2003, p.30).

In Mayhew and Chappell's study, verbal abuse from relatives and visitors occurred during five types of situations:

1. In ward situations when nursing staff (in particular) did not respond immediately to a request for attention.
2. When relatives and visitors were refused admission or asked to leave a ward when visiting hours were over.
3. When there were long waiting times in emergency or outpatient departments, or if appointments with health care specialists had been delayed or cancelled.
4. In paediatric wards when parents were fearful about the health of their child, etc.
5. Significant levels of aggression in some maternity and delivery wards were reported, with the perpetrators commonly identified as husbands and other family members (Mayhew & Chappell 2003, p.30).

Similar findings were posited in a Queensland study by Hegney et al. For example, an increase in the violence perpetrated by visitors/families could be attributed to a nurse or other staff member's 'inability to provide the expected level of care to a patient' (2006, p.13).¹⁰⁸

Antecedents of perpetrator's aggressive behaviour

In examining the characteristics of the perpetrators of violence in hospital settings there are a range of antecedent factors that need to be considered.

A past history of violence

A Melbourne University study commissioned by the DHA on Code Greys and Blacks in Victorian hospitals reviewed the literature in this area and found that, with regard to violent patients, particularly those who had been physically aggressive:

¹⁰⁷ See Professor Megan-Jane Johnstone, Director, Centre for Quality and Patient Safety Research, Deakin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011. See also in this regard, *An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context* (Johnstone & Kanitsaki 2007a).

¹⁰⁸ Other reasons included the frustration with waiting times felt by patients and visitors alike. See discussion in Chapter 4.

Significant patient characteristics identified from the study data included diagnosis of psychosis with active impaired thinking or other neurological abnormality, a past history of violence and a diagnosis of substance abuse. Increased incidents of violence also occurred in patients who were younger, male and psychotic. Significant staff characteristics included sex (male employees were more often recipients of violent behaviour from clients) and appointment level (less senior workers with lower levels of education were more likely to experience violence at work). In respect to situational variables, Flannery and co-workers (1994) reported significant triggers for violent behaviour as denial of services or benefits, and sensory overload induced by high levels of work activity. Environmental variables also played an important role, in particular location and time of day were associated with violent behaviour (DHS 2005b, p.13).

With regard to the violent occurrences in the four Victorian hospitals that were the subject of the study, of the 261 code episodes of violence recorded most were patients (239 or 90%) with the remaining 25 cases (9.5%) being relatives or friends of the patients. Of all violent episodes recorded, 188 (72%) of the aggressors were male with fewer than one-third female.

Importantly, most aggressors were known to have a history of aggressive behaviour and 43 per cent appeared to be under the influence of drug or alcohol:

What stands out from the text of the transcripts is that there are a number of individuals who frequently present to emergency services and are violent or aggressive on each presentation. However, there seems little handover of these individuals and each new presentation seems to be addressed as a one off. One nurse participant calls this knowledge of patients who are violent when they present as 'corporate knowledge' but expresses frustration that this can not be handed on to others (DHS 2005b., p.44).

Certainly much evidence given to this Inquiry was to the effect that many perpetrators do have a history of violence and many were known to hospital staff.¹⁰⁹ Clearly this fact has important implications for preventing violence in hospitals and raises the possible need for computer registration systems at triage or reception that may 'flag' a potentially violent offender with a propensity for violent behaviour.¹¹⁰

Drug and alcohol use and abuse

People with underlying drug and alcohol conditions or simply people who are intoxicated usually by alcohol are often perpetrators of aggressive conduct (Di Martino 2002; Leather 2002; DHS 2005a). Again this fact was testified to by many witnesses appearing before the Inquiry and in many of the submissions received by the Committee.

The unpredictability of behaviour of people affected by alcohol and other drugs was of particular concern for hospital staff:

The drug and alcohol-affected clients were reported by many staff members to be quite unpredictable and often irrational, and posed a high risk. Another specific group of people who were frequently cited as higher risk were those receiving services from methadone clinics or collecting needle "health packs". Many interviewees also commented on the additional strain of having to be constantly alert for the unpredictable and potentially severe forms of violence from these perpetrators (and some of their visitors) (Mayhew & Chappell 2003, p. 30).

Location or catchment area of the health service

It is also certainly true that the type of patient or visitor and their propensity for violent, aggressive or antisocial behaviour will vary depending on the location of the health care facility where he or she attends. For example, the Committee received evidence from clinicians at both St Vincent's Hospital Melbourne and St Vincent's Hospital Sydney. In both cases the hospital serves a particular demographic that includes people from highly disadvantaged backgrounds:

109 What some witnesses to this Inquiry from a hospital background have termed 'frequent flyers'.

110 See discussion in Chapter 9.

The incidence and impact of and institutional response to behaviourally disturbed and violent patients differs significantly in hospitals across the state, and we acknowledge that. St Vincent's Hospital [Melbourne] has a high number of security incidents per day and is a preferential site of care for many vulnerable, unwell and violent patients who are often brought to the hospital by police and ambulance officers...

We sit right on the cusp of the CBD. We are surrounded by an environment of public housing, so you get individuals who are living in these boarding house type establishments who do frequent the organisation for health care for whatever reason...

In relation to the demographics of the patients we see, there are a lot of people in police custody, people with drug and alcohol problems and people with mental health issues (Witnesses from St Vincent's Hospital, Fitzroy, Melbourne).¹¹¹

When you look at St Vincent's it is important to see it in context and this particular catchment area has a high number of vagrants and homeless. There are nine refuges in the local area counting about 2,000 beds. There are high levels of mental illness associated with those sorts of refuges. High levels of criminality at Kings Cross. Prostitution and drug abuse which is quite significant around here and then on top of that you also have the tourist population (Witness from St Vincent's Hospital, Darlinghurst, Sydney).¹¹²

It is no accident then that St Vincent's hospitals in both cities have developed some of the most comprehensive best practice systems to address and prevent violence occurring in their respective locations.¹¹³

The implications of gender

The single most important variables that are apparent from nearly all international and national studies of violence in the health sector is that perpetrators have been disproportionately male and often have a history of violent behaviour and poor coping skills, attributes mirrored in studies of violence in the general community (Di Martino 2002; Fry et al 2002; Chou, Lu & Mao 2002; Leather 2002; Mayhew & Chappell 2003; DHS 2005a, 2005b; Hegney et al 2006). Such a finding has important implications for the way in which boys and men are socialised and strategies that can be developed to address men's violence in both the health sector and society generally.

Conclusion

This chapter has identified that occupational violence in health care settings is by no means an insignificant problem. Although the great majority of violent incidents may be verbal in nature, they still have the ability to cause great pain and distress to those who are the recipients of such aggression and even those who 'merely' witness the conduct.

Whilst the focus of this Inquiry is on violence in the emergency department, this chapter has also highlighted that violence directed towards health care workers and others is not restricted to this setting.

In examining the profiles of perpetrators (and victims) of occupational violence this chapter discussed some of the antecedent factors that may lead to the occurrence of that violence. Some of these factors also are relevant in any discussion of the 'cause' of occupational violence in hospitals and other health care environments. This along with a discussion of the consequences of such violence for those who suffer or witness it is the subject of the following chapter.

111 Dr Georgina Phillips, Emergency Physician and Coordinator of International Programs, Mr Paul Cunningham, Security Manager and Ms Susan Cowling, Nurse Unit Manager, St Vincent's Hospital respectively, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

112 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

113 See Chapter 8 for a discussion of the models used in these hospitals.

4. The Causes and Consequences of Violence in Health Care Settings

Introduction

The question, what *causes* violence in the hospital setting, as with any discussion of the causes of violence and crime, is complex. It is important to avoid explanations of violence that are attributed to single or uni-linear causes. What 'causes' violence is a complex and multifaceted phenomenon. Rather than discuss causes it is perhaps better to ask, what are the *contributory* factors that may result in violent or aggressive conduct in a hospital setting? Some of these may be more common than others. Those highlighted in this section are:

- ◆ drug and alcohol use/abuse
- ◆ mental health conditions
- ◆ organic or other medical conditions/illness
- ◆ situational or environmental factors
- ◆ organisational culture.

Each of these factors will be discussed in turn. It should be pointed out, however, that the factors contributing to a violent episode may differ depending on which part of the hospital the incident has occurred in, for example the emergency room, maternity ward or mental health unit. As Benveniste, Hibbert and Runciman rightly point out, 'Incidents in these [three] areas have their own characteristic patterns of contributing and precipitating factors (2005, p.349).

Before discussing each of the above factors individually it may be useful to present an overarching explanatory theory that examines why violence against health care workers may occur.

Chapman's ecological theory of violence

Nursing academic Rose Chapman has presented an 'ecological' theory of the factors that may explain why (nurses) are subject to violence in a hospital setting based on the views and responses of nurses themselves.¹¹⁴

Chapman explains that the multiple contributory factors that help account for violence against nurses can be grouped into four areas — societal, organisational, victim and perpetrator 'causes'. The ecological model therefore allows for 'the examination of both the immediate and more distant factors that contribute to an event of workplace violence' (Chapman 2011, p.5). Acts of occupational violence can be examined at an ontogenic, microsystem, exosystem and macrosystem level:

At the first level (ontogenic) individual factors include characteristics that increase the chance of a person becoming a victim or a perpetrator of occupational violence. The second level (micro or mesosystem) incorporates the proximity of social relationships as a factor for an increased risk of

114 A mixed method approach was used based on surveys (113) and in-depth interviews (20). Although the project focused on the experiences of nurses it could be argued that the theory could be applied to other workers in a health care setting. Chapman's work draws from earlier ecological models that have been used in the field of human development; see for example Bronfenbrenner 1979.

violence. The third level (exosystem) represents the community context in which relationships are embedded and the final level (macrosystem) includes the larger societal influences that may contribute to the experience of occupational violence (Chapman 2011, p.5).

Thus an ontogenic factor may include a nurse's inexperience¹¹⁵ or lack of communication skills or authoritarian manner or a perpetrator's drug addiction or mental health problems. Micro or meso system factors (level 2) refer to the general way a person's professional role as a nurse and their immediate daily relationships/routines with the patient may be a contributing factor to aggression or violent behaviour — for example, requesting a patient to change rooms, refusing access to visitors, attempting to take blood, deciding to discharge (or not discharge) a patient from the hospital etc. Micro factors are illustrative of the findings in the literature that jobs requiring close face-to-face contact with clients are inherently more dangerous than those that do not require such contact (Mayhew & Chappell 2003). Exo factors (level 3) are those referable to the hospital environment, rules and policies — they may include the physical layout of the wards or emergency room,¹¹⁶ long wait times, rigid hospital policies, and even a change from a traditional nurses' uniform.¹¹⁷ Macro system (level 4) factors are those that relate to the broader societal perspective, for example a more aggressive society, disrespect, and breakdown.

The strength of Chapman's model is that it can be used to develop interventions to prevent or reduce occupational violence at different 'nodal points' within the system, thereby contributing to an overarching strategy to address violence. Thus hospital management can simultaneously provide training to nurses to improve their experience or communication skills, (level 1 interventions) review hospital policies to achieve a better balance between staff and patient interests (level 2) and address any problems associated with emergency room design and function (level 3). Both immediate and more distant factors that contribute towards occupational violence within the hospital are addressed. It is only the level 4 societal factors that are arguably beyond internal intervention.

Having looked at this broad explanatory theory to understand the contributing factors in (hospital) occupational violence, the rest of this section will examine some individual variables.

Drug and alcohol issues

In addition to a voluminous research literature on this topic, almost all clinicians (doctors, nurses), health administrators/managers and security personnel who gave evidence to the Committee pointed out the strong nexus between ingestion of alcohol and other drugs by patients, and to a lesser extent family members or visitors, and their violent conduct in the hospital.

The research evidence is consistent that people, particularly young males, affected by alcohol or other drugs are higher risk perpetrators of violence. This may apply to someone with a chronic substance dependency or as a result of a one-off drunken binge. Indeed Mayhew and Chappell have put forward the example of injured parties involved in a drunken pub brawl ending up as patients in emergency departments and even wishing to continue their fights in the hospital environment (Mayhew & Chappell 2003).

Kennedy has argued that up to 50 per cent of hospital episodes of violence are associated with alcohol or drugs and 'the timing of violence is almost certainly related to the social patterns of

115 Conversely a very experienced nurse may be able to defuse a situation before it gets out of hand.

116 See Chapter 9 for a discussion of these types of environmental and design factors.

117 Many of the nurses in Chapman's study suggested that a change from the 'traditional' type of 'sister's' uniform to a more corporate or casual look sent the wrong signal to patients:

'I don't think they [patients] recognise us as professionals. I don't think the [corporate] uniform does a lot to promote professionalism...and I find that a lot of people get quite aggressive because they ask the wrong person questions [because they are unable to identify the nurse]' Nurse interview (Chapman 2011, p.15).

The literature has also indicated that the traditional white uniform in the past 'distinguished and symbolised the nursing profession and imparted both group pride, identity and respect' (Houweling 2004 in Chapman 2011, p.15).

use of such substances, with violence occurring more commonly during the evening shift and at weekends' (2005, p.363, see also Knott et al 2005).¹¹⁸

In terms of the type of drug giving rise to violent behaviour in the hospital precinct, most witnesses told the Committee the overwhelming and consistent problem was alcohol. For example, Beaver Hudson, Nurse Manager at St Vincent's Sydney told the Committee:

[a]lcohol in communities is much more prevalent and when I say more prevalent it's not just the 20 something's; we are talking about much younger people getting completely smashed, getting into altercations on the street; getting injured and then being brought in and then in the context of that injury management, [staff] having to deal with the level of perceived threats...[associated with] "I don't want to stay here", "you can't keep me here". We are talking about individuals in that age group of somewhere between 17 and 25 but certainly not restricted to that age group. So alcohol use is certainly contributing much more to some of the behavioural problems we have around here. ...the difficulty with people's abuse of alcohol and other substances [is] that it complicates the picture and on top of that it delays the amount of time in getting the individual out of the department.¹¹⁹

Professor Duncan Chappell of the Australian Institute of Criminology, on the issue of how best to address violence in hospital settings, put at least part of the blame on excessive alcohol consumption and indicated that addressing this was a major component of reducing hospital related violence:

I think I would put my money, frankly, into the control of alcohol, alcohol reduction.¹²⁰ Much of what comes into the hospital setting in the form of violence is fuelled by alcohol. It is something that we still do not have a grip on and we do not have any clear answers to, but if we are going to reduce violence further I think we have to take strong measures to deal with alcohol-related matters.¹²¹

This is not however to suggest that other drugs such as illicit substances are not contributing to occupational violence in the hospital setting — they certainly are (Mayhew & Chappell 2003; Kennedy 2005; Forster et al 2005). For example, in terms of its intensity and potential for causing severe violence, one clinician from Geelong Hospital told the Committee that crystal methamphetamine or 'ice' had caused real problems for doctors and nurses in the emergency room.¹²²

Problems pertaining to the ingestion of alcohol and/or other drugs can also be complicated and exacerbated when a person presents with mental illness.

Mental health issues

Whilst it is problematic and incorrect to suggest a simplistic nexus between mental illness and the occurrence of violent or aggressive behaviour, it is true that mental health problems can be a significant contributory factor to patients committing acts of violence in hospital

118 Although, according to one witness to the Inquiry, in city or inner city hospitals, particularly those that serve entertainment precincts, all nights can be 'party night' and consequently the emergency room will see many alcohol related cases whether it is a Saturday or a Monday (Mr Luke Roscoe, Head of Security, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011).

119 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Sydney, 20 September 2011.

120 For a comprehensive account of the issues associated with problematic alcohol consumption and violence and the strategies that can be employed to address this see Drugs and Crime Prevention Committee *Inquiry into Strategies to Reduce Harmful Alcohol Consumption*, Final Report, March 2006 and Drugs and Crime Prevention Committee *Inquiry into Strategies to Reduce Assaults in Public Places in Victoria*. Final Report, August 2010.

121 Adjunct Professor Duncan Chappell, Sydney Institute of Criminology, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

122 Dr David Eddy, Director of Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

settings.¹²³ In one study the mental health problems of patients accounted for over half of the violent incidents in an *emergency department* setting (Benveniste, Hibbert & Runciman 2005 and references listed therein).¹²⁴

The emergency department is increasingly and often the ‘initial point of contact, entry and treatment for patients with acute mental illness’.¹²⁵ Yet:

[m]ost EDs are not secure environments for such patients who are at risk of self-harm or harm to others.

Compounding these problems is the fact that there are often lengthy delays in processing patients with a mental illness. ED staff must wait for members of the psychiatric review team to assess patients, and Victorian doctors’ experience suggests that systems and paperwork burdens prevent psychiatric workers from seeing these patients promptly, particularly within two hours of handover.¹²⁶

Dr Stephen Parnis of the Australian Medical Association (AMA) elaborated on these problems when he gave evidence to the Inquiry:

I think it is important to recognise that among the causes of violence in emergency, the two biggest ones are people with mental illness and people who abuse drugs or other substances... Mental health, it is a recurring theme, clearly because of the nature of the problems, if the person is a threat to themselves or a threat to other people, but one of the things that compounds that is because of the pressure on limited mental health resources, and by that I mean staffing and mental health beds, these people spend longer times in emergency departments than they should. Yes, they need to be there for initial assessments, stabilisation if need be, but once those issues are sorted out, if it is deemed that they need to be admitted to a mental health unit, those beds need to be available and available quickly. A fair amount of the time that is not the case, so what happens is they spend time in probably the place that they should not be — a place that is chaotic, a place that is noisy, a place that has easy access in and out. These people may need to be supervised, cared for, they may be at risk of self-harm or a flight risk, but emergency departments need to be accessible. They are always on the ground floor of an emergency department near wide-opening doors. These people can get out very quickly, as well as be agitated and made worse by the sort of circumstances that you would appreciate occur frequently in emergency.¹²⁷

The link between mental health issues and violent or aggressive behaviour can take many forms. Often there may be a co-existent mental health and substance dependence issue (co-morbidity), As Philip Dunn, Geelong Hospital, told the Committee:

In Mental Health, Drugs and Alcohol Services, violence occurs, somewhat understandably, in the context of often altered states of perception. These states create fear and confusion in people. It is also

123 The problem will usually be more pronounced in hospitals that are in catchment areas with high levels of homeless, disadvantaged and mentally ill people — for example, St Vincent’s Melbourne and St Vincent’s Sydney. At St Vincent’s Sydney, for example, mentally ill patients account for at least 16 per cent of patients attending emergency whereas according to Nurse Manager, Beaver Hudson the average in other hospitals is more likely to be in the area of 3–4 per cent. See Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent’s Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

124 The figure could be higher or lower in a dedicated psychiatric hospital or mental health unit or setting. Higher because of the greater number of people with psychotic symptoms who may be present, or lower because there are especially trained mental health staff present who may be able to better deal with the precipitating factors. This issue, however, is beyond the scope of this Inquiry.

125 Submission from Mr Geoff O’Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

126 Submission from Mr Geoff O’Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

127 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

Similar evidence was given to the Committee by a senior clinician from a major hospital. He commented that without good reason it was appalling for both staff and the patient to have psychiatric patients in emergency for four hours or more. It is crucial that facilities are available to move psychiatric patients from emergency to a dedicated unit as soon as possible.

consequent...to drug-induced mental illness, often related to illicit drug use which is sometimes quite transient but often quite intense. It also arises in our circumstances in mental health where the client's liberty is temporarily suspended when they are being cared for involuntarily. As you could understand, many clients do not understand that and certainly at times do not accept that. But unfortunately violence can also be perpetrated on staff in circumstances where there is no understandable or defensible reason... Therefore the management of violence in a health service requires a very comprehensive approach.¹²⁸

The impact of deinstitutionalisation

According to some commentators one of the reasons for the increase of mentally ill patients presenting to emergency departments and the potential for violence stems from earlier policies of deinstitutionalisation:

Violent incidents in *mental health* settings are not uncommon. However in recent years deinstitutionalisation and mainstreaming of psychiatric services within *acute care hospital settings* have meant that the staff resources and level of experience available to manage violence have been reduced. Further, as mental health treatment and care continue to move towards a community focus, patients needing inpatient treatment are sicker with the result that violence towards health care practitioners is increasing (Forster et al 2005, p.359). (Committee emphasis).

Lyneham, in her earlier study of emergency department violence, also raised the issue of deinstitutionalisation as having at least some bearing on the issue. Many of her respondents commented that deinstitutionalisation *had* increased the number of psychiatric patients presenting to emergency departments:

Whilst these patients are mostly distressed and not violent or aggressive, there are times when an acutely psychotic, aggressive person arrives in the department. In such situations interacting with the person is not the only problem but also the lack of a suitable room in which to assess them adds to the difficulty (Lyneham 2000, p.15).¹²⁹

The Victorian Department of Health also raised this issue in its Code Black study in 2005. Whilst not resiling from the official policy of deinstitutionalisation it did acknowledge that 'emergency has now become the front door to psychiatry' and that 'emergency [nurses] are ill prepared for this'. Chapman has recently acknowledged this latter point in her study of nurses' responses to violent behaviour in the hospital:

The participants in this study recognised that there is a change in the demographics within our society. One of the major changes is the deinstitutionalisation strategies in the treatment of people with mental illness and the consequent mainstreaming of psychiatric patients into the general hospital system. Therefore it is not surprising that nurses in this study identified that one of the causes of occupational violence is the increase in community based mental health patients becoming aggressive in the hospital setting. ...One of our major concerns is that nurses working in the general wards areas rarely have the skills or knowledge to manage the increasing number of psychiatric patients admitted to their hospitals and as a result these patients are inevitably mismanaged (Chapman 2011, pp.25-26) and the references listed therein).

There have been many best practice initiatives and strategies established to address the problems of patients, particularly those with mental health problems, acting violently in Victorian hospitals. These are discussed in Chapters 8, 9, 10 & 11 dealing with strategies to address hospital violence.

128 Mr Philip Dunn, Director of Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

129 The issue of the need for dedicated isolation or behavioural assessment rooms is discussed in Chapter 9.

Organic illness and other medical reasons

A lesser but still significant number of violent incidents in hospitals may be attributed to organic illnesses and medical conditions such as head injuries, dementia and delirium.¹³⁰ Other evidence has been given that certain drugs and pharmacotherapies may result in violent episodes by patients. One school of thought argues that this may particularly be the case with regard to certain anti-depressant and anti-psychotic drugs. For example a submission to this Inquiry by consultant psychiatrist Dr Yolande Lucire states:

Some patients taking psychiatric drugs develop extra pyramidal side effects including akathisia. Some persons who develop akathisia kill themselves and kill others. Most persons who develop akathisia have violent thoughts, homicidal and suicidal ideation. Many people with akathisia have personality changes towards becoming aggressive.

In my experience of making visits to see clients in NSW Jails, 9 out of ten persons I see are suffering from drug induced akathisia and many have come into prison following acts of violence committed in that state and akathisia violence is not being recognised and they get more drugs that make them more violent and suicidal. This is tragic, as they are doubly mistreated.¹³¹

As has been pointed out earlier in this chapter a surprising number of incidences of aggressive and even physically violent conduct are perpetrated by elderly patients with dementia and related conditions (Mayhew & Chappell 2003; Department of Human Services (DHS) 2005a; Chapman 2011). As Dr Chapman told the Committee an elderly patient with dementia, frightened and confused can often lash out without full understanding of the consequences of their actions:

The ageing population, we are getting more and more patients coming in with dementia, and they are already really upset and nervous and concerned because you have taken them outside of their usual place to somewhere they don't know. So they are just fighting back.¹³²

Other forms of illness, particularly acute illnesses for which emergency admission is required can result in aggression and verbal and physical violence especially if accompanied by pain, which reduces people's ability to contain their frustration, particularly when waiting for treatment.

Even the pain and emotional trauma associated with childbirth may make the delivery room a setting of aggression and violence.¹³³ Professor Duncan Chappell told the Committee that when he conducted his research into violence in health care settings he was surprised at the violence that could take place in the maternity suite. This was particularly the case where there was a history of family friction with partners/fathers coming in acting belligerently or otherwise creating significant problems for staff.

Understandably, family members or visitors may also react emotionally when a health professional has to announce bad news such as the actual or imminent death of a loved one. Whilst this does not excuse violence, health care staff should be aware that delivery of bad news could result in an emotional or aggressive reaction. For example, Health Services Commissioner, Dr Beth Wilson told the Inquiry:

130 Evidence from St Vincent's Hospital, Melbourne, puts the figure at approximately 10 per cent of all such incidents. See Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

131 Submission from Dr Yolande Lucire, Forensic Psychiatrist, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011 and the academic articles cited therein.

132 Dr Rose Chapman, Director of Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

133 Professor Duncan Chappell, Sydney Institute of Criminology, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

We have got to take into account when we are giving people really bad news the way they are going to take it and offer them some support and a proper dialogue around that. Family members should not be given that information around a bedside or in an emergency situation.¹³⁴

Finally, whilst evidence has been given to the Committee that the levels of violent conduct by juveniles in paediatric hospitals and emergency rooms is relatively and comparatively low in relation to adult health care settings, it does occur.¹³⁵ Yet the contributory factors can be quite different from those in adult hospitals. As doctors from the Royal Children's Hospital (RCH) explained:

The antecedent conditions associated with children's hospital violence vary from those identified in adult services: neuro-developmental disorders (for example, developmental delay, autistic spectrum disorder) and mixed psycho-social morbidity (for example street kids, children known to protective services) play a much greater role in ED violence at the RCH than in other hospital settings. Conversely, substance intoxication and major mental health illnesses are less commonly seen than in adult services.¹³⁶

Another fairly common contributory factor to aggression in both paediatric and some adult hospitals where children attend is the tension and anxiety felt by parents with sick children:

Parents, caregivers and relatives contribute to violent 'incidents. Parents who come to the paediatric ED are commonly anxious and fearful about the health of their child. Sleep deprivation and frustration with previous health care encounters are also frequently seen. These factors all contribute to an increased risk of aggressive behaviour from parents/carers.¹³⁷

Thus any strategies to address violence in hospital settings must also take into account issues particular to paediatric patients.

Situational factors

There are number of factors that may contribute towards patients and others exhibiting aggressive, violent or antisocial behaviour that could be said to be situational in nature; that is, referable to the experiences of patients in seeking or receiving treatment for their conditions. These include waiting times, communication problems and environmental issues such as the inappropriate design of emergency departments or other physical aspects of the hospital environment.¹³⁸

Waiting times

Some studies have shown a strong link between waiting a long time to be seen in emergency departments or other parts of the hospital and violence. Other studies have been equivocal or have refuted this link (see Kennedy 2005; Linsley 2006). Waiting times in turn may be linked to staff shortages and a lack of resources that limit the amount of time staff can spend with individual patients (DHS 2005a). Evidence was also given to the Committee that waiting times are exacerbated by more people attending the emergency room for illnesses that once

134 Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

135 Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

136 Submission from Dr Sandy Hopper, Dr Simon Young and Ms Jayne Hughan, Emergency Department staff, Royal Children's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

137 Submission from Dr Sandy Hopper, Dr Simon Young and Ms Jayne Hughan, Emergency Department staff, Royal Children's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

138 The concept of using crime prevention through environmental design to ameliorate design features that may give rise to crime and violence is an important aspect of any strategy to address violence in the hospital setting. As such it is discussed separately in Chapter 9 of this Report.

would have been treated by their local GP. In rural areas particularly, some doctors may be cutting back on their times of availability thus leaving some patients with no alternative other than going to the emergency room or casualty of the local hospital — the only place that may be open particularly at night. For example, Mr Andrew Rowe, Chief Executive Officer, of the Ballarat Health Service told the Committee:

One of the contributing factors [to hospital violence] is that we have seen a substantial increase in patients seen in our emergency department. When I first started at the hospital we saw 35,000 patients that year, and in the last financial year that had increased to 52,000. Obviously where you have patients who may be anxious and who are waiting significant periods of time that in fact may well escalate some of the behaviours. I think that the numbers being seen and at times delays in being seen can certainly impact as well.

Understaffing also has the potential to jeopardise staff safety, particularly at night or in isolated rural hospitals (see Nabb 2000; DHS 2005a).

Certainly many clinical staff have given evidence to the Committee that waiting periods are one factor that may account for belligerent behaviour in the emergency room. This behaviour may be heightened if it is a result of frustration with waiting times on behalf of an ill partner, child, parent etc. Anger then may be seen as a 'rational' means for the perpetrator to get what he or she wants, for example have his sick child seen to (Linsley 2006, p.5).¹³⁹

Dr Rose Chapman commented to the Committee that some patients' frustration during the waiting process may stem from two causes. First, the general societal need for instant gratification that would seem increasingly prevalent in modern society:

People don't know how to wait anymore...I think society's expectations of 'now', so I don't have to wait for anything, I can get what I want at the click of a finger, and the fact that I might have to wait to see somebody is not good enough. I get angry and anxious because I have to wait for somebody.

Second, Dr Chapman believes people today have greater knowledge or at least pseudo knowledge of medical conditions and may think they know what is required without going through lengthy interviews or diagnostic tests:

OK, I've got a belly ache and my leg is a bit sore so I'm going on the internet to see what is wrong with me, the internet will tell me what will happen when I go in. So I go in with that knowledge, only we do a whole stack of other stuff, we are going to ask you a whole lot more questions but why can't you just deal with that now like it said on the internet. So some people have a lot more knowledge than they used to and that makes them more anxious and aggressive.¹⁴⁰

Anger can also arise because some members of the public do not understand *why* they have to wait or the intricacies of admission process, particularly the triage system:

Waiting times include the initial wait to see medical staff, waiting to have tests done, waiting for senior medical staff, waiting for results, and waiting for a bed to be available. A number of respondents commented on the public's lack of understanding of the triage categories and that clients did not accept that others required more immediate attention (Lyneham 2000, p.15).

Unmet expectations and subsequent violence may result from misunderstandings about what the public health system can, and cannot, deliver to prospective clients/patients:

139 Lyneham argues this is an example of Berkowitz' 'frustration-aggression' hypothesis:

'This theory postulates that a situation that becomes frustrating has the potential to result in aggression. In an emergency department this frustration may arise when a patient or their relative does not get the attention they expected or wanted such as immediate pain relief' (2000, p.9).

140 Dr Rose Chapman, Director of Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

Everyone that presents feels they should be seen straight away or in short period of time [in emergency]... They don't understand how the public hospital system works and that they are not seen in order of arrival but in order of priority ...Sometimes it can have a snowballing effect. When one person become abusive, they rile up the rest of the waiting room. They'll ask each other, 'how long have you been waiting for?' They don't ask, 'what are you waiting for?' (respondent in Mayhew & Chappell 2003, p.26. See also DHS 2005b).

Evidence given by the Health Services Union (HSU) underscored these observations made in the research literature:

Tempers and tolerance are set to fray when patients experience long waiting times. There are rarely staff to explain triage to patients so many patients see people arriving after them being treated first as an affront. HSU East members report that aggression and threat of violence invariably increase as waiting times increase.¹⁴¹

Other evidence has been given to the Committee by a number of witnesses that testifies to the problems caused by long waiting times at admission, triage or during the treatment process. For example, a submission from Ambulance Victoria states that aggression can flare as a result of such waiting long before a person is seen by the emergency room, for example in the ambulance bays:

While there are increased delays in admission of patients to emergency departments there is ongoing potential for agitated patients to require aggression management even prior to emergency department admission... It should be also noted that where there is extended delays for patients in accessing the emergency department due to emergency department bed shortages, patients can become agitated and aggressive, and on occasions this does require intervention by hospital security staff.¹⁴²

Ambulance Victoria elaborated on this issue when they gave oral evidence to the Inquiry:

[i]f you went to any emergency department in Melbourne, perhaps on a weekend, I think you would find that people who are required to wait become increasingly impatient over time. We are currently experiencing — as recently as last night — paramedics standing in emergency departments for 3 or 3½ hours with patients waiting to access a bed in that department and the patients and their family members becoming agitated about the wait to access the emergency department. It is in that context that we suggest that there is a potential for violence and aggression as the level of frustration increases with people who are required to wait.¹⁴³

It has also been brought to the Committee's attention that emergency departments are not necessarily the most 'peaceful' or relaxing of environments¹⁴⁴ in which to wait — for either patients or their loved ones:

[p]atients commonly spend many hours in the emergency department whilst being treated, or may experience delays in transfer from the emergency department to a place of definitive inpatient treatment. Prolonged exposure to the noise and activity in an ED can contribute to the patient's pain or fear, and heighten relatives' anxiety.¹⁴⁵

A number of witnesses have also commented that the frustration with long waiting times is particularly noticeable amongst parents who are anxious or angry with regard to a perceived lack of attention being shown to their sick children:

141 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

142 Submission from Mr Greg Sassella, CEO, Ambulance Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

143 Mr Simon Thomson, Acting Regional Manager, Ambulance Victoria, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

144 For a discussion of how the environmental design of the emergency department may impact positively or negatively on patient behaviour and suggested strategies to address this, see Chapter 9.

145 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

In [a paediatric hospital] a lot of violence and aggression will come more from parents. You do get paediatric patients who will be violent and aggressive as well, but a lot of it is at triage, with parents getting frustrated and upset around waiting times and that sort of thing.¹⁴⁶

Finally, more than one witness to the Inquiry commented that the frustration with waiting to be seen by medical staff can be exacerbated in those patients who would like to smoke cigarettes but given the clinical surroundings are clearly not able to. Indeed Professor Gordian Fulde of the emergency department at St Vincent's Hospital Sydney told the Committee that one of 'the most common reasons why people go ballistic suddenly is that they can't have a cigarette'.¹⁴⁷ This is part of a broader situation where people who may have limited tolerance for being told what to do find themselves being asked to constrain their behaviour in certain ways:

In the emergency department especially I think, you have got staff telling people 'no' a lot of the times which raises people's anger levels whether it is a nurse, a doctor or security, a lot of the times we are telling them 'no', we are telling them what they don't want to hear, we are telling them ways they need to behave and they don't always appreciate that.¹⁴⁸

Communication problems

Anger or aggression may also result from a *lack* of communication from medical staff to patients and families. It may also arise from misunderstandings or *miscommunication* as to what the 'system' can or cannot deliver. This is particularly true where a patient or family member has not had the triage system explained to them (Lyneham 2000; Mayhew & Chappell 2003; DHS 2005a, 2005b). Dr Simon Young, Royal Children's Hospital told the Committee that whilst it was not always possible given the demands of the system to give patients or their families up-to-date information on the process of their case, it was nonetheless important to keep patients in 'the loop' as much as possible:

Our problem is giving them accurate information because the emergency departments are a moving feast. One minute it can be a 2-hour wait and the next minute it is a 4-hour wait because the ambulance has just brought somebody in who takes up the time of three doctors for X period of time, so the waiting room times immediately blow out. Then the next shift comes on and the waiting times are back to 2 hours again. It is really difficult to provide that accurate information.¹⁴⁹

Moreover, a Melbourne University study into code black emergencies found that one issue that gave rise to great frustration amongst patients and their families was when appointments were cancelled by the hospital, sometimes time and time again. This was particularly the case when it was felt that no, or an inadequate, explanation was given for the postponement or cancellation of their appointments (DHS 2005b).

Even where information *has* been given it may have been communicated in an authoritarian, patronising, uncaring, dismissive or otherwise inappropriate style, which can also lead to aggressive or inappropriate behaviour (Chapman 2011). Often inadvertent provocation may be given by overworked staff who do not necessarily have the time or patience to be 'sensitive'.¹⁵⁰ Taking the smoking example in the last section into account, it may not necessarily be the ban

146 Mr Peter Sloman, Clinical Nurse Specialist, Emergency Department Assistant Secretary, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011. See also the comments of Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

147 Prof Gordian Fulde, Director Emergency Department, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

148 Mr Luke Roscoe, Head of Security, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

149 Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

150 See for example Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

on smoking (or the use of mobile telephones etc) per se that angers the patient as much as the peremptory way in which he or she perceives the 'order' being given.

Beth Wilson, Victorian Health Commissioner, told the Committee that a lack of proper communication between medical personnel, security staff and patients and their families can have serious consequences:

We have had cases where anxious parents very worried about their children have tried to get through to triage nurses in emergency that the child needs urgent care. However, they have not been listened to and instead security has been called in with disastrous results... we [need to take] a softly softly approach, if you like, and point out that simple things like a cup of tea, a volunteer, a nice chat and an explanation for what is going on — all of those things — can help to reduce rather than escalate violence.¹⁵¹

Similar evidence was given by Trevor Carr of the Victorian Health care Association:

People are sitting around for long periods of time. It is hard enough for the best of us to retain our patience without continually questioning, and I think communication is the key to some of that. Some of the anecdotes that I am aware of from the ward situations are also about breakdowns in communication. Often it can be unresolved grief — for example, big family gatherings where a parent may be about to die and where some of the family members feel they have not been clearly communicated with or where there are issues within the family that they need to deal with.¹⁵²

Clearly appropriate forms and styles of communication need to be taken into consideration in the training and education of health personnel. This is especially the case when the health care worker is interacting with a patient or family member from a non-English-speaking background (Johnstone & Kanitsaki 2008b, 2008c).¹⁵³

For example, Professor Megan-Jane Johnstone, an expert in culturally appropriate delivery of health care services, told the Committee that problems with communication or miscommunication between 'mainstream' health care workers and patients and their families from non-English-speaking backgrounds can be endemic. The problems are cultural as much as linguistic so the mere use of interpreters is not going to be the whole answer to resolving misunderstandings between patients and health care providers or security staff:

Communication is the quintessential tool of the therapeutic relationship. If you cannot communicate, it is hard. It is difficult enough for English speakers to communicate well. We can struggle even with people we know well. So communication is the key tool to effective therapeutic relationship. It does not take much imagination to see that if that breaks down, you have a risk of not assessing people properly; if you do not get proper assessment, you get misdiagnosis; and if you get misdiagnosis, you get wrong regimens prescribed... Families might be a little bit full on, if I might use that term, because they are anxious and worried, and sometimes the health professionals might take exception to that and then respond back, so they become provocateurs rather than mediators. That can escalate tension. The other thing that I am hearing from my colleagues is again about miscommunication basically, misreading behaviours and also not always understanding that people, particularly if they have come from traumatic backgrounds in their countries of origin, may see anybody in a uniform as being potentially a threat, so they get very triggered.¹⁵⁴

151 Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

152 Mr Trevor Carr, Chief Executive, Victorian Health care Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

153 For a discussion of education and training issues in the health care context see Chapter 11.

154 Professor Megan-Jane Johnstone, Director, Centre for Quality and Patient Safety Research, Deakin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

Organisational culture

Exposure to violence has been seen as a fact of life by [nurses]. Key messages have been that nurses have to be 'available', that they should provide care at all costs or risk being seen as negligent or not fulfilling a duty of care. Nurses have seen violence and aggression as being 'all in a day's work' and subsequently have conceptualised it as a work related risk, tolerating it as part of being a nurse (DHS 2005a, p.35).¹⁵⁵

Whilst the above quote is specifically referable to the position of the nursing profession, it is arguably true of most personnel working in the hospital and health care sector. Indeed Dr Stephen Parnis, AMA, gave evidence to the Inquiry on the importance of hospital management improving the culture of the hospital so that personnel, be they nurses, ward clerks or cleaners, do not feel 'inadequate' for reporting incidences of violence.¹⁵⁶

Culture has been suggested as a key variable in influencing behaviour.¹⁵⁷ In the context of hospital violence, both the organisational culture of staff and the individual culture of the patient may be relevant. For example, the cultural background of the patient may be such that impatience, anger or violence is the only way he or she knows to respond to frustration, pain and stress. Conversely the organisational culture of nurses and doctors characterised by care and service may, as was discussed previously, be a reason staff choose not to report instances of violence against them and even joke about them in the tearoom¹⁵⁸ — 'It's just part of the job'.¹⁵⁹ For example, Dr Simon Young, Royal Children's Hospital testified to the incredible forgiveness of health care staff:

[m]ost [nurses] are incredibly forgiving about the behaviours that they see. They put it down to, 'Oh, it is the alcohol'. The fact that they have just been verbally or physically abused manifests as, 'I'm sure he's a nice bloke, but it's just the alcohol that's causing the problem'; 'It is the child's mental illness'; or it is this or it is that. They tend to look through the fact that they have been subjected to the violence in a forgiving way. They are caring people coming from a caring profession. They are amazingly understanding of what is happening in front of them, and they tend to rationalise it in other ways, so they end up putting up with an enormous amount.¹⁶⁰

155 Conversely when nursing academic Dr Laretta Luck gave evidence to the Inquiry she stated that none of her research indicated that nurses were prepared to put up with violence as 'part of the job'. This may indicate a generational, policy, organisational and cultural shift whereby hospital staff are in fact proactively encouraged to report violence. See Dr Laretta Luck, Associate Head, School of Nursing and Midwifery, University of Western Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011. See also discussion in Chapter 5.

156 See Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

157 'Culture' is clearly relevant in a wider sense. For example a culture of greater acceptance of the use of guns in the United States may result in more incidents of violent patients using weapons in American hospitals. On this point, see Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

158 See Dr Rose Chapman, Director of Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

159 For a more detailed discussion of organisational culture in this context, see Department of Human Services (DHS) 2005a, 2005b. Of course organisational cultures can and do change. Today's hospital environment is far less tolerant of patient violence, in part due to policies which encourage reporting of violence and promote violence-free workplaces. See DHS 2007a and the discussion in Chapter 5.

160 Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

Numerous other witnesses made this same point about the non-judgemental attitudes of health care staff. See for example, Mr Bill O'Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011; Dr David Eddey, Director of Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011; Dr Rose Chapman, Director of Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011; and Professor Gordian Fulde, Director Emergency Department, and Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

Ironically, this 'incredible forgiveness' can be seen as both a positive and a negative attribute. Positive, because one would obviously hope doctors and nurses do view their professions as ones characterised by care and compassion. Negative, in as much as it may be these very attitudes that prevent them from reporting or dealing proactively with cases of violence directed towards them. Such reluctance to act accordingly may particularly be the case if hospital management does not actively encourage the reporting of such incidents or a cultural climate in which violence is totally unacceptable (Hegney et al 2006).¹⁶¹ It could therefore be argued that organisational culture is not so much a cause of violence in health care settings as a reason why the problem may continue, be unreported or not resolved.¹⁶²

The consequences of violence in health care settings

The consequences of violence and aggression for those working or present at hospitals and the health care setting can be many and serious, tangible and intangible. Apart from the obvious results of physical aggression (injury, pain, illness, incapacitation) health care workers, security staff, patients and/or their friends and families may suffer psychological and emotional trauma. The hospital or health care setting may also be subject to economic loss through absenteeism or inability to retain staff who have been injured, and society as a whole may be adversely affected through the costs associated with the care and treatment of the injured party and any associated insurance claims. Each of these broad areas, physical injury, psychological trauma and economic consequences, will be examined in turn.

Physical injury

The physical consequences of attacks on health care personnel, patients and others are fairly self-evident. These can range from the thankfully rare occurrence of death, to serious injury (broken limbs, burns, scalds, knife wounds), disability and ongoing or chronic conditions such as headaches or nausea (DHS 2005a, 2005b). See Chapter 2 for WorkSafe data.

Psychological and emotional consequences

The psychological trauma associated with occupational violence can be immense and far-reaching. Feelings of ongoing fear, anger and the occurrence of loss of memory, sleeplessness, lethargy, decrease in libido or sexual activity, drug and alcohol problems and even suicide may be the result of the violent conduct (DHS 2005a).

For example, one English study found that:

Staff who are victims of violence tend to distance themselves from patients. They may experience recurrent depression and anxiety, guilt and self-doubt, feelings of powerlessness and low self-esteem. Emotional reactions can take the form of rage, anxiety, a sense of helplessness, irritation, fear of returning to the location of the incident, and feelings and thoughts that something should have been done to prevent what happened. Reactions such as anger, disappointment, shock and ambivalence have also been reported. A survey of members of the Royal College of Nursing showed that nurses who were assaulted had poorer psychological wellbeing than those that were not assaulted. They were also twice as likely to have acute psychological problems, with frequently assaulted individuals most affected. There is also a possibility that exposure to violence and aggression could lead to an increased risk of post-traumatic stress disorder (PTSD), psychological burnout or other stress reactions. The reaction of individuals usually depends on the nature of the incident, the person's own experiences, skills and personality, and the extent to which they were directly or indirectly involved.

161 For the importance of managers being encouraging of their staff reporting violent incidents or otherwise supporting anti-violence initiatives, see discussion in Chapter 5.

162 Sometimes the non-judgemental or tolerant attitudes may be easier to display towards some angry patient compared to others. For example, a staff person may be more willing to accept abuse from someone with a serious illness than someone who is simply intoxicated. See for example Dr David Edey, Director of Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

Exposure to physical violence is also associated with behavioural reactions and change, such as social withdrawal. This may affect social relationships at work, as well as relationships outside of work. Those frequently exposed to violence at work have higher rates of absenteeism and provide a lower standard of care than those who are not exposed. Marital problems and inability to become involved in social activity are not uncommon (Linsley 2006, p.9).

Similar findings have been established in the Australian context. As the Victorian *Violence in Nursing Taskforce: final report*, drawing on the extensive research literature in the area, found:

Nurses experience an array of emotional responses following violent incidents. These include fear, anger, shock, disbelief, anxiety, worry, frustration, distress, sadness, confusion, embarrassment, guilt, annoyance (with self for not anticipating the incident), loss of self-esteem, emotional exhaustion and insecurity...Of these the most frequently reported emotional symptoms are fear, worry, anxiety, depression and anger (DHS 2005a, p.23).

Ordinarily, the greater and more severe the initial act of violence is the greater will be the psychological consequences, although this is not necessarily always the case. Trauma may also be felt as a result of a (serious) one-off incident or build up over time as a result of many continuous acts of verbal and physical aggression from a variety of patients or other perpetrators (Linsley 2006; Mayhew & Chappell 2003; DHS 2005a, 2005b).

A recent study of violence in Victorian hospitals found that the impact of workplace violence on nurses and midwives can have significant and long-term effects. For example, respondents indicated that occupational violence made them feel stressed or angry (37%) and anxious or depressed (16%). Respondents also indicated that their personal life was affected by occupational violence (16%) and others indicated weight gain or loss (10%) (Farrell, Shafiei & Gaynor 2010).

Interestingly, however, Mayhew and Chappell (2003) have speculated that some victims of violent conduct may feel less post-event stress than others depending on the presence or absence of intent or malice in the perpetrator. For example, if a patient had a condition such as dementia or a mental health disorder over which he or she had limited control the impact of violence may have been mediated by compassion for the perpetrator.

It is not just the direct recipients of violence who may suffer traumatic consequences. Research has shown that witnessing incidents of violence and aggression can also have detrimental effects. 'It [witnessing aggression] may lead to a fear of violent incidents and as such has similar negative effects to being personally assaulted or attacked' (Linsley 2006, p.9). Witnesses may be fellow workers or indeed patients or visitors on the ward or in the emergency department, as a submission from the AMA pointed out:

Violence in hospitals and emergency departments also regularly affects other patients and their visitors, commonly children. Patients should not have to endure abusive behaviour from other patients — whether directed at them or at other parties. This not only flies in the face of hospitals as a therapeutic environment, but also has the potential to antagonise other patients in a waiting room.¹⁶³

Economic, organisational and social consequences

The effect of occupational violence on hospital productivity, reputation and safety can be profound, as the AMA explained:

Several commentators have argued that violence and the threat of violence has had a significant effect on employees who work in Australasian emergency departments. Employers and employees can be affected in a number of ways, including by high levels of anxiety, depression, stress-related illness, as well as absenteeism and turnover amongst victims. There may be resultant diminished productivity, job

¹⁶³ Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

satisfaction, decreased morale, decreased employee engagement, and difficulties with staff recruitment and retention. The cumulative effect of violence may also result in clinician 'burnout'.¹⁶⁴

A submission from Alfred Health agrees that absenteeism is a significant factor but it isn't necessarily *on the surface* relatable to the incidents of violence experienced by the worker:

Alfred Health records show very few staff days lost as a result of injuries sustained from violence in the workplace. It should be noted however that in most cases staff will take sick leave which masks the cause of their absence. These records also mask the occasions when staff fear for their safety in the workplace as a result of aggression or violence even if they are not attacked or injured. This impacts on morale and the ability of The Alfred to retain staff in these key frontline clinical roles.¹⁶⁵

The *Victorian Taskforce on Violence in Nursing: final report* found that there are significant financial and economic consequences as a result of occupational violence, not only for the hospital but also, by extension, the health industry and the government:

Both the tangible effects of occupational violence and the intangible effects, such as motivation and commitment, loyalty to the enterprise, creativity, working climate, openness to innovation, knowledge building and learning, and emotional and social consequences result in significant financial implications for health services...The financial implications are [also] potentially significant for the industry and the government and include the impact on workers compensation and insurance premium costs for health care agencies, and the administrative costs associated with managing injuries, rehabilitation and return to work. Other legal and financial implications relate to potential prosecutions under the Occupational Health and Safety Act,¹⁶⁶ and the impact on the reputation of the health care agency (DHS 2005a, p.13).

The effects may also be felt by the families of the victim of violence either socially (marriage break ups, family tension and discord, transfer of job to another area of the city or state¹⁶⁷) or economically (resignation, reduction in income).¹⁶⁸

In the study by Farrell, Shafiei and Gaynor (2010) it was noted that the effects of workplace violence went well beyond effects on the individual with over one-quarter of respondents (26%) indicating that occupational violence affected their productivity and increased work related errors (8%). Hospital staff may become 'hardened' to the job, cynical or 'stale' and the quality of their care may deteriorate with staff taking on negative attitudes towards their patients (Lyneham 2000, p.8; DHS 2005a). As a submission from the Australian Nursing Federation drawing attention to the Farrell, Shafiei and Gaynor study notes:

These impacts are even more disturbing when put into the context of the need for nursing and midwifery workforce growth, when:

- About a third (32%) indicated they were thinking of leaving their current employment
- Almost a quarter (23%) thought of leaving nursing altogether.¹⁶⁹

Similarly, a study by the University of Ballarat found that 'Failure to address occupational violence in an appropriate manner may result in lowering professional nurses' competence

164 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

165 Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

166 And indeed under the general criminal law.

167 Or transfers to a different post or shift that is perceived as less threatening, for example from emergency room work to general wards. Nabb cites some cases where nurses have asked to be transferred to night shift as 'they won't have to deal with visitors and patient families' (Nabb 2000 in Hegney et al 2000, p.221).

168 See Adjunct Professor Duncan Chappell, Sydney Institute of Criminology, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

169 Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

levels with significant implications for patient care'.¹⁷⁰ Such consequences pose a significant risk not only for retaining health care staff but also for recruiting them in the first place (DHS 2005a). As will be discussed in Chapter 5 it is therefore imperative that hospital management take a lead role in assisting staff to recover from an incident of occupational violence.

Conclusion

Nursing academic Rose Chapman argues that violence against health care staff is a significant issue of great concern. This is at a time when a shortage of a skilled, experienced and knowledgeable workforce is crucial to address the needs of an ageing population (Chapman 2011). People who have been the recipients of occupational violence must be given the opportunity for formal counselling, debriefing sessions, employment assistance schemes and ongoing and follow-up support, not just informal 'debriefing' in the tearoom with fellow workers.¹⁷¹

It is therefore incumbent on hospital management to put in place policies that protect and support both health care staff, patients and their visitors alike. As Chapman notes the:

[c]oncern for governments, organisations and the general public alike is the risk that these events will cause nurses [and other staff] to leave the health care system and the profession...unless organisations address the issues surrounding workplace violence and publicly acknowledge that [nurses] working in all areas of the hospital setting are a valued asset they will continue to leave the profession (2011, p.24).

170 Research Paper, *Nurses and Occupational Violence: Support in Moderating Professional Competence* 2003, University of Ballarat, Victoria, cited in submission from Ms Sharon McNulty, Director, Support Services, Southern Health Group to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

171 Whilst the importance of support for post-incident experiences of violence including de-briefing are discussed in Chapter 5, it is illustrative at this point to outline the experience of the following witness with regard to post incident support or rather in this case its absence. This nurse from Geelong Hospital testified to the importance of *compulsory* post-event support:

'I had an incident where myself and another nurse had to physically remove a knife from a person who was holding a knife to a Red Cross volunteer's throat. We were assisted in the end by a nursing attendant because there was no security present. A code black was called. It takes a while for those people to get down to the department. She eventually was charged but we did not get follow-up through that. I never found out whether she went to court or anything like that. It is important for us to be able to feel safe in our department, and feeling safe and perceived as being safe are different things. We need to feel that we are safe and supported by the department. The incident follow-up which was mentioned to say that there is support and it is offered, it should not be offered, it should be compulsory. I was diagnosed with post-traumatic stress disorder but I did not know what was going on. Here I am a nurse with all this experience, I did not know what was going on. It was down the track that all this happened. It should have been compulsory. It should not be that I need to volunteer for those things' (Ms Jodie Bourke, Associate Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011).

The Committee was told that at the Royal Prince Alfred Hospital in Sydney, in any debriefing session of a person affected by a violent incident their manager must also be involved: 'both as a learning opportunity [for the manager] and also as an opportunity to identify any staff that may be particularly distressed as a result of the incident' (Mr Joseph Jewitt, Director of Corporate Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011).

Part B: Strategies to Address Violence and Security in Victorian Hospitals

5. Legal, Policy and Management Considerations for Addressing Hospital Violence

Introduction

Occupational violence in the health care sector has clearly been recognised as an issue of great concern for many years. However, it has arguably only been since the publication of the *Victorian Taskforce on Violence in Nursing: final report* that a coordinated and dedicated effort to address the issues has been undertaken in Victoria. This has largely been through the implementation of the recommendations arising from that report. One of the key developments has been the implementation of an overarching policy framework for the prevention and management of occupational violence in Victorian public health services.¹⁷² The policy framework *Preventing occupational violence in Victorian health services* (hereinafter the Framework) takes as its guide policy principles from the World Health Organization (WHO), most importantly the principle that:

Health services must have an integrated health workforce policy that acknowledges the imperative to provide safe and healthy workplaces and that specifically recognizes the prevalence of occupational violence in health care (Department of Human Services (DHS) 2007a, p.7).

The policy framework in association with other departmental policies, laws and guidelines¹⁷³ provides the overall strategic direction, coordination mechanisms and guiding principles to assist individual health services to:

- Implement occupational violence prevention and management programs at the local level
- Apply an integrated and systematic approach
- Enhance the capacity of health services to effectively meet their obligations as employers
- Continuously build on the evidence base and be informed by best practice
- Promote awareness and a ‘no blame’ approach to occupational violence and bullying (DHS 2007a, p.8).

Subject to the overall strategic framework and direction of the Department of Health, the Framework expects that each health care organisation will customise the policy to its own particular needs and provide local implementation strategies.¹⁷⁴ Moreover, despite much of the

172 As recommended in Recommendations 2, 3 and 4 of the Report (Department of Human Services (DHS) 2005a).

173 A comprehensive list of departmental policies and guidelines directly or indirectly relevant to the issue of occupational violence is attached as Appendix 8.

174 In Victoria, there is joint responsibility for health security arrangements in public health services. As Frances Diver, Executive Director of the Department of Health explained to the Committee:

‘The Department of Health has a role in terms of policy setting, planning, funding and monitoring service delivery but... health services operate in Victoria under a devolved governance arrangement. In that case they have boards appointed by the minister. Those boards and the health service management are responsible for the day-to-day operational matters at each health service, including the security arrangements for staff and patients’ (Ms Frances Diver, Executive Director, Department of Human Services, Department of Health, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011).

provenance of the Framework coming from the *Victorian Taskforce on Violence in Nursing*, it is not a document that is restricted to the nursing sector. Rather it is a document that applies to all Victorian public health services and all staff working within that sector.

This chapter examines the Framework and where applicable other policy documents and their application to the Victorian public health sector. It commences with a brief discussion of the legal basis of violence prevention policy in Victoria — the *Occupational Health and Safety Act 2004*. It then examines some of the key approaches that may underscore a violence prevention framework. These include:

- ◆ zero tolerance approaches
- ◆ the importance of managerial support and encouragement.
- ◆ risk management.

The legal basis

The duty of care of employers to their employees is governed by the common law as developed over the last 150 years and strengthened by progressive occupational health and safety legislation over the past 40 years. The current key legislation that underlies the principles of occupational health and safety and duty of care upon which the Framework is based is the *Occupational Health and Safety Act 2004* (Victoria), hereinafter the OHSA. Other legislation which is relevant to the issue of violence prevention in Victorian hospitals can include:

- ◆ *Accident Compensation Act* and *Accident Compensation (Workcover Insurance) Act 1993* which regulates Victoria's Workcover scheme for compensation and rehabilitation in relation to workplace injuries.
- ◆ *Mental Health Act 1986* which provides for the care, treatment and where necessary detention of mentally ill people in Victoria.
- ◆ *Crimes Act 1958* and *Summary Offences Act 1966*. These are the key acts pertaining to criminal law in Victoria. Where appropriate and depending on the seriousness of the offence a person may be charged with a criminal offence under either or both of these acts for acts of violence committed in the health care setting.¹⁷⁵

The purpose of the OHSA is to:

- (f) to secure the health, safety and welfare of employees and other persons at work; and
- (g) to eliminate, at the source, risks to the health, safety or welfare of employees and other persons at work; and
- (h) to ensure that the health and safety of members of the public is not placed at risk by the conduct of undertakings by employers and self-employed persons; and
- (i) to provide for the involvement of employees, employers, and organisations representing those persons, in the formulation and implementation of health, safety and welfare standards.¹⁷⁶

The principles of occupational health and safety upon which it is based include:

- (1) The importance of health and safety requires that employees, other persons at work and members of the public be given the highest level of protection against risks to their health and safety that is reasonably practicable in the circumstances.
- (2) Persons who control or manage matters that give rise or may give rise to risks to health or safety are responsible for eliminating or reducing those risks so far as is reasonably practicable.

¹⁷⁵ A discussion of these subsidiary laws is beyond the scope of this Report with the exception of the possibility of laying criminal charges under the relevant criminal laws, which is discussed further in Chapter 10.

¹⁷⁶ Section 2, *Occupational Health and Safety Act 2004* (Victoria).

- (3) Employers and self-employed persons should be proactive, and take all reasonably practicable measures, to ensure health and safety at workplaces and in the conduct of undertakings.
- (4) Employers and employees should exchange information and ideas about risks to health and safety and measures that can be taken to eliminate or reduce those risks.
- (5) Employees are entitled, and should be encouraged, to be represented in relation to health and safety issues.¹⁷⁷

The key responsibility for employers such as the state Department of Health¹⁷⁸ is to, so far as is reasonably practicable, provide and maintain a working environment that is safe and without risks to health and personal safety.¹⁷⁹ Employers in breach of these requirements can be prosecuted accordingly for breach of duty of care.¹⁸⁰ Moreover, the Act applies to *all* employees of a health service (from surgeons to cleaners) and in all types of health setting (hospital, clinics, aged care centres, psychiatric units, off site settings and even home care that is linked to a public health service).

The legislation is clearly only one aspect of an overall policy framework to prevent or reduce occupational violence in the workforce. What is important to note, however, is that it provides the basis and direction for health care employers such as the Department of Health and its hospital executives and managerial staff to *proactively* ensure the health and safety of health care workers, and to do so in consultation with the health care workers. As a judge ruling in a case of breach of duty of care by a hospital in Kempsey, New South Wales, stated:

The existence of a system on paper is clearly not sufficient to comply with the obligations imposed under the Occupational Health and Safety Act. The employer is required to ensure that its 'paper systems' are implemented and maintained in its daily operations.¹⁸¹

The role of WorkSafe

In situations where violence has taken place, the employer and their managers must also ensure that adequate systems of support, rehabilitation and care are provided to the injured worker and where necessary anyone else affected by the perpetrator's actions (DHS 2005a, 2007a). WorkSafe Victoria plays an important role in this regard. WorkSafe inspectors have been trained to identify occupational violence risks and where necessary will audit hospitals if they believe an occupational health and safety risk is present:

WorkSafe has built the industry's knowledge of, and compliance with, their legal obligations in relation to occupational violence over four previous Inspectorate based intervention projects (focussed on risk of exposure to occupational violence in emergency departments and adult acute inpatient mental health services, community mental health services, and Hospital in the Home programs). Results from these projects showed that there was already a reasonably high level of knowledge and understanding of preventative occupational violence systems and practices demonstrated in some of the services visited. Many services have implemented comprehensive strategies, however there was considerable variation observed in services where occupational violence has not been experienced first-hand, with a number of areas for improvement noted by inspectors and followed up as appropriate with each employer.¹⁸²

177 Section 4, *Occupational Health and Safety Act 2004* (Victoria).

178 Most occupational health and safety laws are state based. There is, however, currently an effort at Commonwealth level to legislate for uniform occupational health and safety laws across the country. National legislation will require the consent and cooperation of the state governments.

179 Section 21, *Occupational Health and Safety Act 2004* (Victoria).

180 And indeed there have been numerous prosecutions of hospitals for breaches of occupational health and safety laws, particularly under the NSW equivalent legislation. 'In many instances the hazards were known to management, the potential for violence was foreseeable or known and prior to the incidents [of injury to staff] reasonable action had not been taken to address risks' (Kiedja & Butrej 2010, p.8).

181 Justice Staff quoted in Kiedja and Butrej 2010, p.5. The judge found that in this case Kempsey Hospital was responsible for a number of security breaches including:
 – Absence of clearly documented security policies and procedures
 – Staff working regularly alone in isolated parts of the building
 – Training in duress response was provided to some but not all staff.

182 Mr Greg Tweedly, Chief Executive, Worksafe, Correspondence to the Drugs and Crime Prevention Committee, 16 November 2011.

To assist hospitals meet their occupational health and safety obligations, WorkSafe Victoria has produced a number of fact sheets and handbooks outlining strategies for managing aggression and violence in health care settings. The most comprehensive of these, *Prevention and management of aggression in health services*,¹⁸³ outlines a number of approaches and interventions for addressing occupational violence including workplace design, alarm systems, security and access, risk control and management policies.¹⁸⁴

Australian Standards

Security in health care facilities is also governed by the provisions of Australian Standard—*Security for health care facilities* [AS 4485.1/1997 and AS 4485.2/1997] prepared by Committee HT/8 Health Care Facilities –Security. These standards set out the requirements for health care facilities in developing policies, principles and standards for the protection of:

- (a) patients, staff and others who are required to work at or attend such a facility;
- (b) drugs, other controlled substances, and other dangerous goods;
- (c) information; and
- (d) other property, including money, owned by, or in the control of, the facility, and the property of patients, staff and others at the facility.¹⁸⁵

Part One of the Standard sets out the essential requirements needed to provide a safe and secure environment for staff, patients and visitors in hospitals and health care facilities whilst Part Two is a comprehensive guide to the implementation of security services:

Both documents cover facilities ranging from major hospitals to small, remote outposts, but each facility will need to undertake [a] security risk assessment process...to produce a program suited to its particular requirements and environment.¹⁸⁶

The Standard sets out a number of fundamental principles regarding the need for a ‘sound security regime’ in place in Australian health care facilities. These include:

- (a) Everyone has a right to be safe and secure at their place of work. Occupational health and safety legislation requires employers to provide a safe and secure environment for staff, and for others who, for whatever reason, work at or visit that facility.
- (b) Organizations such as health care facilities are required by law to protect the personal and private information they hold about their employees and patients.
- (c) It is necessary to protect other forms of information and valuable and attractive property for which the facility is responsible. It may also be important for insurance reasons to have a sound level of security.
- (d) In many cases there will be contractual requirements for sound security practices to be in place.
- (e) There may be a moral obligation to have sound security arrangements in place.¹⁸⁷

183 See WorkSafe Victoria 2008, *Prevention and management of aggression in health services — a handbook for workplaces* (June).

184 Other WorkSafe Victoria policies relevant to the issue of occupational violence in hospital settings include:

- A Health and Safety solution: ‘Pharmacies — Employees being confronted’ (November 2008) <http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/worksafe/home/forms+and+publications/health+and+safety+solution/pharmacies+-+employees+being+confronted>
- A Health and Safety solution: ‘Health services — Aggression in emergency departments’ (July 2008) <http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/worksafe/home/forms+and+publications/health+and+safety+solution/aggression+in+emergency+departments>
- Working Safely in Visiting health services including such as ‘Hospital in the home’ (June 2006) http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/worksafe/home/forms+and+publications/publications/import_working+safely+in+visiting+health+services

185 AS 4485.1/1997. Section 1.1.

186 AS 4485.1/1997. Preface.

187 AS 4485.1/1997. Section 1.2.1.

The administration of the Standard is usually the responsibility of the Chief Executive Officer, Governing Board or senior management of the hospital. It is premised on each hospital or health service undertaking a comprehensive risk management audit and analysis. Furthermore, the protective security services provided cannot be applied indiscriminately. They: 'must harmonise with other operational requirements of the facility, and in some cases be tailored for specific areas within the facility [for example, the emergency department]'¹⁸⁸. Moreover, security procedures are not 'to impinge on the quality or effectiveness of patient care services'.¹⁸⁹

Whilst the Standard provides a comprehensive coverage of the security requirements for Australian hospitals and health care services, some health care staff and security experts have commented that after almost fifteen years it needs to be updated. For example, the CEO of the Australian Security Industry Association [ASIAL] stated to the Committee:

The Standard is historical and whilst robust would benefit from a review.

AS 4485.1/1997 would benefit from a review to reflect currency and best practice within the areas of security risk assessments, information management and protection, access control and incident procedures.

AS 4485.2/1997 as a procedure guide does not reflect current requirements and is not a relative benchmark document.¹⁹⁰

Security Expert, David Van Lambaart has also commented that it may be time for a review of AS 4485. In particular he told the Inquiry that

As [standards] become more and more distant from reality - they become a perfunctory reference document with no real impact on the day to day operations of security managers or those charged with the responsibility of managing security within a health care setting. Hospitals as entities have evolved and the Standard has failed to evolve with them... Standards provide little or no insight into the effective implementation of [their provisions]- a section concerning 'How to Implement' the standards would be useful. How is a risk assessment of, for example, - Out Patients or Emergency Department to be undertaken? How does this provide direction for the identification of a suitable, appropriate and proportionate security solution?

How do you monitor the effectiveness of the solution? The Standard would benefit from a review in the context of the "current operational environment" within which it is to be applied.¹⁹¹

Finally, a submission to this Inquiry from Southern Health, observed that 'the standard is deemed to be outdated and does not support security requirements aligned to 21st century needs'.¹⁹²

Whilst the Committee notes the concerns raised by these experts in the field, it does not feel it can make a recommendation for a review of the Standard. First, Standards Australia comes under the jurisdiction of the Commonwealth Government and is therefore not properly part of this Inquiry's focus. Second, the Committee does not feel it has received sufficient evidence on which to make an informed judgement in this area.

188 AS 4485.1/1997. Section 1.2.3.

189 AS 4485.1/1997. Section 1.2.3.

190 Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd, Correspondence to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 16 November 2011

191 Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty, Correspondence to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 21 November 2011.

192 Submission from Ms Sharon McNulty, Director, Support Services, Southern Health Group Security to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Zero tolerance

The concept of zero tolerance in the context of occupational violence in its simplest form is taken to mean that 'violence is not accepted as part of the job and that action will be taken to prevent and minimise the frequency and severity of violence in the health sector' (Kiedja & Butrej 2010, p.6).

Zero tolerance policies or their equivalents have been steadily developed over the last 10 years in response to: the increasing numbers of health care workers being injured in the workplace; taskforces that have investigated the occurrence of violence; and agitation from health professionals that more needs to be done to protect health care workers in their place of employment.¹⁹³ A zero tolerance policy seeks to counter the historic attitudes that violence in the hospital is simply 'part of the job'.¹⁹⁴ It also seeks to counter the lack of institutional support that has in the past, at least in some hospitals, been given to address the occurrence of violence against staff and others (Lyneham 2000, p.16).

A comprehensive zero tolerance policy was first enacted in the United Kingdom through the National Health Service (NHS). Under this system all NHS trusts (effectively hospitals and health services) were directed to reduce incidents of violence against health workers by 30 per cent over a three-year period (Hegney et al 2006). A particular feature of the British model was that it promoted mandatory organisational and police reporting of violent acts (NHS 1997; Kennedy 2005). More controversially, some of the NHS trusts, as part of their zero tolerance policies, in certain circumstances could refuse non life-saving treatment to belligerent patients. In effect a patient who continued to misbehave may be 'red carded'.¹⁹⁵

It is New South Wales, however, that has been the trail-blazer in terms of developing and implementing zero tolerance policies towards violence in health care settings.

The zero tolerance response to violence in the New South Wales health workplace — Policy framework and guidelines

In 2005 New South Wales Health, as a result of a key recommendation from the *NSW Health Taskforce on the Prevention and Management of Violence in the Health Workplace*, adopted a specifically named zero tolerance policy to address violence in the health sector. Its primary aim is to reduce and prevent 'all forms of violence by any person towards any other person on health service premises, or towards any NSW Health staff working in the community' (NSW Health 2003a, p.8).

The NSW guidelines are comprehensive and it is mandatory for them to be applied in all public health services in NSW. They state:

NSW Health staff have the right to work in a violence free workplace. Patients and others have the right to visit, or receive health care, in a therapeutic environment free from risks to their personal safety.

All Health Services must have in place a violence prevention program that focuses on the elimination of violent behaviour. Where the risks cannot be eliminated, they must be reduced to the lowest possible level using control strategies developed in consultation with employees.

The zero tolerance response means that in all violent incidents, appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour.

Health Services must ensure that managers and staff are appropriately trained and equipped to enable them to respond promptly, consistently and appropriately to effectively manage violent incidents if they do occur, and as far as possible, to prevent their recurrence.

193 For example, in the past calls for zero tolerance policies in hospitals and other health care settings have been made by the Australian Medical Association, Australian Nursing Federation and Australian College of Emergency Medicine. Zero tolerance as a guiding principle has been enshrined in these organisations position statements. See also Kennedy 2005.

194 See discussion in Chapter 3 of this Report.

195 For a discussion of sanctions against violent patients including the use of 'red' and 'yellow' cards, see Chapter 10. For a discussion of the Luton and Dunstable (UK) Hospital's yellow and red card schemes, see *Safety and Security*, Luton and Dunstable Hospital, NHS Foundation Trust (14 July 2011). <http://www.ldh.&s.us/Safetv and Securitv.htm>

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

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

Health Services will work towards establishing and maintaining a culture of zero tolerance to violence, as well as work systems and environments that enable, facilitate and support the zero tolerance response (NSW Health 2003a, p.8).

The zero tolerance policy is based on the principles that health care staff:

- know how to report a violent incident and are encouraged and supported in doing so
- have access to training, work environments, equipment and procedures to enable them to respond confidently in violent situations
- know that their response will be supported by management
- know that management will respond appropriately after an incident (NSW Health 2003a, p.8).

The guidelines include key messages, obligations and responsibilities for both managers and staff. The messages for managers are outlined in Figure 5.1.

Figure 5.1: NSW Zero Tolerance Policy: Guidelines for managers

- Putting up with violence in the health workplace IS NOT an acceptable part of your job
- lead by example (if you don't take violent incidents seriously, neither will your staff, patients or visitors)
- make sure your 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 your staff in utilising these options (staff need to feel confident in the decisions they make when confronted with violence and that their decisions will be supported, particularly when police are involved and during any resulting legal process)
- know and exercise your responsibilities as a manager in dealing with violence (both short-term and long-term)
- ensure that all violent incidents are reported (keep it simple to encourage a culture of reporting)
- investigate all violent incidents (this is the only way to ensure that risk management strategies continue to be effective), respond promptly to all reports of bullying (if you don't, staff will not take 'zero tolerance' seriously)
- keep 'zero tolerance' on the agenda (include violence risk management on staff meeting agendas, operational reviews and debriefings after violent incidents, communicate incident investigation results and remedial actions to your staff, encourage staff to feed back on how local protocols and procedures are working).

Source: NSW Health 2003a, p.9.

Staff are also advised of their rights and responsibilities as outlined in Figure 5.2.

Figure 5.2: NSW Zero Tolerance Policy: Guidelines for staff

- Putting up with violence in the health workplace IS NOT an acceptable part of your job (if you don't get the message, neither will patients and visitors)
- know your options when confronted with violence and exercise them consistently (the most effective way of protecting yourself AND getting the message to patients and visitors)
- management will support you in utilising these options (that is part of their responsibility)
- report all violent incidents (problems that don't get reported don't get fixed)
- be aware of violence as an occupational risk (it is just as real as other more recognised OHS risks eg manual handling, exposure to hazardous substances etc)
- be vigilant of factors contributing to the risk of violence (prevention is better than cure).

Source: NSW Health 2003a, p.9.

The ways in which the 'zero tolerance message' is disseminated, publicised or implemented are varied and include:

- information for staff summarising local procedures for getting assistance in an emergency and response options eg 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
- provision of similar information for community health staff
- ensuring that violence risk management is a regular item for discussion at staff meetings
- pamphlets that are provided 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
- placing copies of related materials in all bedside lockers and patient information kits (including 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
- managers positively reinforcing appropriate zero tolerance behaviour by staff (in line with local policies and procedures)
- posters placed on display in emergency departments and other relevant areas clearly stating that violence will not be tolerated. (NSW Health 2003a, pp.9–10).

The NSW zero tolerance guidelines and the policy from whence they derive are clearly comprehensive and all encompassing. They have generally been viewed as a good model on which to base an anti-violence strategy in public hospitals, particularly where implemented flexibly at the local level. There has, however, been some disagreement with some of the more rigid aspects of a zero tolerance policy and indeed the use of the nomenclature itself.

Alternative approaches to zero tolerance

It is important to note that a strict zero tolerance policy/approach is not universally favoured. As noted in Chapter 1, the *Victorian Taskforce on Violence in Nursing: final report*, and consequently the Victorian Framework has not adopted a strict policy of zero tolerance in the same way as have the United Kingdom or New South Wales. Rather the Framework promotes an approach that is centered in proactively and systematically taking an occupational health and safety/risk management focus yet is simultaneously based on principles that:

- Violence against nurses (or any health care worker) is unacceptable and must be proactively addressed
- There is not a culture of tolerance of violence in health care workplaces¹⁹⁶
- Encourage a culture of reporting occupational violence in health care (DHS 2007a, p.7).

There are some commentators who are critical of strict or inflexible zero tolerance policies, particularly those based on prosecuting, punishing, banning or otherwise sanctioning the perpetrator. One reason is that not all acts of violence in a hospital setting are done with the necessary *mens rea* or criminal intent. For example Mayhew and Chappell point out that alongside, or as part of, a zero tolerance policy alternative strategies need to be developed to take into account violent patients who lack the requisite intention or capacity to understand their actions and their effect on the victim, for example patients with mental illness or dementia (2003). Professor Chappell reiterated this concern when he gave evidence to the Inquiry stating, 'things like zero tolerance do not make much sense [in these circumstances] because you are not going to whip someone off who is an aged, demented person to court and prosecute them for being violent'.¹⁹⁷

As was discussed in the previous chapter in the context of *reporting* violence, some health care staff may differentiate between a client who is ill and violent and one who is belligerent as a result of intoxication. Some staff, therefore, would like the flexibility as to whether or not they should implement punitive measures particularly in the case of verbal aggression or less serious antisocial behaviour. For example, nursing academic Dr Laretta Luck told the Committee that most of the respondents to her surveys on violence against nurses told her they were unlikely to report cases of verbal violence by patients. The reasons for this were twofold.

First, some nurses did not view swearing or abusive language as violence but simply part of who that person was. Secondly, many nurses did not necessarily think 'zero tolerance' was an effective mechanism to stop violence and reporting as it would achieve nothing:

[s]ome of the registered nurses said they did not even know how to find the forms or documents because they thought there was no point doing it because nothing would change, nothing would happen. Rather than do that they managed it together.¹⁹⁸

Similar evidence was given to the Committee by a clinician from Geelong Hospital:

Personally I would not report somebody who had become upset and a bit angry if they are stressed or unwell, or having a specific mental health issue. I would report someone who assaulted me or threatened me simply because they are drunk and unhappy. That is the tolerance we would have in the course of medical practice; people we would accept as having behavioural disturbances. That is part of the problem they have come to have treated. There are people who are unpleasant and violent and put our staff and our patients at risk, and we would be keen to have those people put in a separate group. Most of my colleagues would consider that we would tolerate things from unwell patients, as opposed to intoxicated patients.¹⁹⁹

Thirdly, a rigid or punitive zero tolerance policy may be counter to the ethos of caring that medical institutions claim to represent. Nursing academic Professor Gerry Farrell acknowledges that the concept of a zero tolerance policy is a 'really tricky one'. He told the Inquiry:

I know in some places people talk about having a zero tolerance policy, but my view is that as part of the job you should not go to work thinking you are going to get hit or whatever. On the other hand, being distressed when you are ill is a fact of life. Getting drunk, falling over, cutting yourself and doing

196 Which is not the same as saying the health care workplace are zero tolerance zones.

197 Adjunct Professor Duncan Chappell, Sydney Institute of Criminology, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

198 Dr Laretta Luck, Associate Head, School of Nursing and Midwifery, University of Western Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

199 Dr David Eddey, Director of Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011

damage where you need some treatment is a fact of life as well. It is how you help staff think through some of these issues, because they are moral issues as well, and whether or not these people are deserving of this care. That is something to be addressed with the staff concerned...

There is not an easy right or wrong in terms of making the judgement, because it has got to be the judgement at the time, and each case is usually pretty complex. We often do have to deal with some issues that most people probably would not want to deal with — some serious forensic issues, some domestic violence issues. Both the victim and the perpetrator may be involved and may need treatment...

...we are in danger of stigmatising some people, because they may have been repeat offenders, but on this next occasion they may not be like that at all, and then how do you manage that situation? For the odd time that this is going to happen there is a bigger issue out there more generally around managing people who can sometimes be aggressive.²⁰⁰

The inquiry also heard evidence from Professor Duncan Chappell of the Australian Institute of Criminology who was a key adviser to the New South Wales and Victorian Taskforces on violence in the health care sector and has undertaken his own research into this area. It is interesting that Professor Chappell has distanced himself from his initial support for the use of term 'zero tolerance' in the context of violence prevention policy:

[a]lthough I have to admit I was in favour of the zero tolerance title that was given to the New South Wales guidelines at the time, I now feel it is not appropriate to use that terminology. The National Health Service, who obviously picked it up before we did in New South Wales, have now dropped it as well in favour of the view that, 'Violence is unacceptable, the workplace should be free of it, and if it occurs we will deal with it in an effective way but not using the language of zero tolerance', which from some of the training experience, I understand, has also been shown probably to be less successful in dealing with the management of violence. It makes health workers and others less able to cope with violent situations and less able to probably deal with them in an effective way.²⁰¹

Pich et al also make the valid point that:

It should be remembered that the concept of zero tolerance has its origins in crime reduction and so its transference to the health care setting must come with some modifications to take into account the unique therapeutic nature of the setting if its to be successful (2011, p.18).

Certainly whether policies are couched in terms of 'zero tolerance', risk management or some other rubric, contemporary anti-violence policies, including the Victorian framework, recognise the need to advertise to people entering the workplace that violence and aggression is totally unacceptable. This may take the form of leaflets given to patients, contracts or memoranda of agreement between patients and the hospital on admission²⁰² or posters circulated around the hospital's walls. The point is that 'all persons entering an [acute] health care facility should receive clear information outlining what is acceptable behaviour' (DHS 2005b, p.vii).

Policies that address violence in the (health) workplace must above all be systematic, coordinated and inclusive. In effect, there is little to distinguish the formal zero tolerance approach taken in New South Wales from the Framework in place in Victoria. Both are based in principles of occupational health and safety and both rely on risk management principles to deliver optimal outcomes. Whatever the nomenclature, as Mayhew and Chappell state:

The first and most important step in prevention [of workplace violence] appears to be an unequivocal top management commitment to a zero tolerance policy or related strategy which is clearly stated and enforced (2003, p.11).

200 Professor Gerald A Farrell, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 29 August 2011.

201 Adjunct Professor Duncan Chappell, Sydney Institute of Criminology, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Sydney, 20 September 2011.

202 For a discussion of patient 'contracts' as a 'disciplinary' measure, see discussion on sanctions in Chapter 10.

The need for management encouragement and support

A common theme throughout much of the policy and academic literature on strategies to address violence in the health care sector is that no matter how comprehensive policy/framework documents may be on paper, they count for little if the outlined strategies are not fully supported and promoted by senior management:

Chief Executive Officers should demonstrate commitment to zero tolerance of workplace violence. They should encourage cultural change and show enhanced concern for workers' safety. Strong encouragement should be given to formal reporting of workplace violence, including the removal of covert penalties and the excessive filling out of forms (Mayhew & Chappell 2005, p.346).

Management have an important leadership role to play not only in disseminating and promoting departmental and hospital policy but also in ensuring individual workers are supported in cases where they have been subjected to occupational violence. This means supporting workers to report claims of violence in the workplace and ensuring those reports are recorded, forwarded and taken seriously. Where appropriate, workers should also be offered police intervention and legal support (Lyneham 2000).

Support for reporting violence

As the *Victorian Taskforce on Violence in Nursing: final report* stated:

It is critical that nurses have confidence in the justice system and in their own employer to support them to report attempted or actual assaults to police and, where appropriate, to request that charges be laid. In NSW, a written Memorandum of Understanding between NSW Health and NSW Police underpins police response and support for health care workers when reporting violent incidents, including laying charges and pursuing prosecutions where appropriate.

A presentation was given to the taskforce from a clinical nurse who had experienced an assault during a home visit to a patient suffering from mental illness. The taskforce heard that while assault is a criminal offence and may be persecuted under the Victorian *Crimes Act 1958*, nurses can experience a lack of response when they report matters to police; action is rarely taken and prosecutions are rarely pursued (ANF 2002). The taskforce heard that this is due to a number of factors, including reluctance by police to pursue charges against patients with a medical condition due to the belief that such prosecutions will not succeed. It was also submitted that police resources at the local level influence the response.

Some nurses also report a lack of support from their own employing institutions to pursue charges, particularly against patients. This is often evidenced by the absence of any formal protocol or procedure to provide information and to assist staff with this process (DHS 2005a, p.44).

Equally important is the ongoing support given by management to the victim of the violence or anyone else affected by the perpetrator's actions.

Post-incident support

The *Victorian Taskforce on Violence in Nursing: final report* recognised the enormously important role executives and senior management have in assisting staff to manage and recover from an incident of violence and aggression:

An individual's response is usually related to both the incident itself and the perception of how they have been 'looked after' by the health organisation. This feature is represented by the actions taken by the manager.

It is the manager's role to create a climate for recovery within the workplace. This includes activities such as organising defusing, debriefing and/or counselling for nurses and follow-up in the immediate period post-incident. The manager is also responsible for establishing an operational review of the incident, which aims to determine an immediate risk assessment and actions to prevent the recurrence of further episodes of violence and aggression (DHS 2005a, p.46).

The importance of post-incident support for workers by management was also stressed by witnesses to this Inquiry including representatives from Geelong Hospital:

Staff reporting, support and follow-up: it is really not good enough to focus only on managing the incident itself. It is crucial for both the wellbeing and sustainability of the workforce that staff are well supported in the immediate and longer-term post-incident period to avoid any residual, psychological or physical impact. We are like plumbers with drippy taps at home. There is sometimes a belief that it is part of the job, it happens, we can cope, we can manage and we can get on with it. It may not be for a month later, post an incident, where circumstances arise that may be similar to an incident that occurred previously, that staff members can feel anxious and distressed at that particular time. It is really important the organisation follows staff up. ...we have an in-house medical and psychological support service and we can outsource that. Certainly my managers are very conscious of these issues and will follow up staff, obviously post an incident, within a month, within three months, and again within six months, even despite the fact that staff maybe all through that period are reporting that they are fine.

Clearly, in terms of workforce it is really important that we do that because in particular as a learning organisation, as a training facility, we have many, many students in the service in ED, in mental health, all across the service. If the organisation does not handle an incident well and handle the aftermath of that incident well, it is not the most attractive element of the profession. It is important that students see that the organisation takes this very seriously.²⁰³

Even 'just' emotional support in the sense that the hospital is behind you is important to individual workers and especially for emergency department staff who may feel particularly pressurised:

Unsupported? It is a very lonely place out at triage. You are there and there is the waiting room in front of you and there is this big stream of people coming in the door. You are the public face of the hospital. You are taking it on the chin. I think that feeling of being unsupported is very real. We put some of our most experienced nurses out there because they have good pattern recognition; they can see what is coming in and they can deal with it quickly. They do not have any power to deal with the things that are building up. What is going on in the main department behind them is a little bit out of their control. They are not fully engaged with that at the time because all their powers are engaged with the waiting room in front of them and keeping that waiting room informed and keeping people busy doing something. It is a really tricky job. You are very alone.²⁰⁴

Arguably the approach taken by management to occupational violence *has* changed greatly in recent years. In the New South Wales context, Professor Gordian Fulde, Director of Emergency at St Vincent's Hospital Sydney, told the Inquiry that the support of management for policies of zero tolerance and the reporting of violence was a fantastic turnaround from previous times when violence was seen a 'part of the job'. This was particularly the case since the NSW zero tolerance guidelines were implemented:

There used to be an attitude that it goes with the job, people in the mental health wards would get beaten up, abused, all that sort of thing. My staff would also regularly get beaten/punched and verbal abuse. I've done a lot of work on this and published that sort of thing. It was just accepted. The systems including our own superiors were not interested, the courts weren't interested, and the whole system was basically that goes with the turf. This has now fantastically changed. The first thing from above, change from above, no tolerance. In other words, occupational health and safety, everyone should have the right to go home in the same shape that they arrived.²⁰⁵

203 Mr Philip Dunn, Director of Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011. See also Kennedy 2005; Chapman 2011.

204 Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

205 Prof Gordian Fulde, Director Emergency Department, St Vincent's Hospital Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011

There have also been positive changes in Victoria particularly since the implementation of the Victorian Framework. Under the Framework, for example, managers must ensure employees are aware of their rights to complain to the police and file a report, apply for compensation or be given support if they take a case to court (DHS 2007a).

A need for further improvement?

Nonetheless, the Inquiry has heard evidence that there are still instances where health workers do not feel supported by the 'system' or management and are discouraged from either reporting a case of violent conduct or initiating legal procedures. For example, Farrell and Shafiei's recent survey of 1500 Victorian nurses found that many of their respondents 'had received no training in regard to occupational violence. Staff wanted better and more realistic training. They also wanted managers to take their concerns seriously when they reported incidents'.²⁰⁶

Similarly, a representative of the Australian Medical Association (AMA) indicated to the Committee that whilst hospital management may not *discourage* the reporting of occupational violence, the culture, administration and management in some hospitals did not necessarily encourage reporting or make it easy:

The culture needs to be encouraged whereby all health workers who have been associated with or exposed to these things are given the time, the opportunity, the skills to do these reports and the systems that they use become more user friendly — that you do not have to jump through hoops to get this stuff into the administrative area of the hospitals.²⁰⁷

The Health Services Union has been even more critical of the ways in which management deal with occupational violence. In a submission to this Inquiry it stated:

Reports of violence and hospitals' capacity to respond to it vary across the state. Some locations respond much more effectively than others.

Hospital workers consider that their safety is not a priority for hospital management. Repeated attempts to have the issues addressed have fallen on deaf ears. Employees consider that their personal safety is rated as less important than presenting a perception that 'hospitals are safe for the public'. Different hospitals have different levels of engagement with workers about worker and patient safety...

Members at one hospital in south-eastern Melbourne were so concerned about personal and patient safety that they commenced a survey to document experience of violence at the hospital, particularly in the emergency department (ED). Members commenced the survey, collecting 100 responses before being ordered by management to cease. The survey was stopped before ED staff had an opportunity to respond.²⁰⁸

Despite the development and implementation of policies such as the Victorian Framework it is disturbing that the Inquiry could still receive evidence that there are occasional examples of staff being discouraged or at least not encouraged to report incidents of quite serious violence. The following testimony from an emergency nurse recounting the case of a serious physical attack on a colleague and friend is illustrative:

If I had a serious issue that affected me I would report that to the police, but I know that a lot of people are afraid of management in different hospitals. The nurse who was strangled did not report it to the police and we were not allowed to make the public aware of the violence we come up against because we could end up in court.²⁰⁹

206 Submission from Professor Gerald A Farrell and Dr Touran Shafiei, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011. See also Farrell and Shafiei 2011. It should be stated however that despite these concerns a majority of staff who experienced occupational violence reported their handling of incidents overall as 'Very good' or 'Good', and felt 'Very safe' or 'Safe' at work. See Farrell and Shafiei 2011.

207 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

208 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

209 'Jim'. Emergency Department nurse. The name and the identity of the witness have been kept confidential to protect his anonymity.

Risk management approaches

Risk management, risk assessment and risk identification approaches to occupational violence are essentially about being pre-emptive and proactive to the potential for violence occurring in the hospital environment, be that in the emergency room, on the wards or elsewhere (Forster et al 2005).

The concept of risk management is taken from occupational violence and actuarial processes. Risk management guidelines also form part of the Australian and New Zealand Standards.²¹⁰ Risk management is based on recognising and eliminating the hazards that may pose a risk to the physical and psychological wellbeing of employees and visitors to the workplace: 'to be effective risk management needs to be incorporated into the culture of the organisation and become part of the overall philosophy, practices and business plans rather than be viewed as a separate program' (DHS 2005a, p.42). Moreover, 'as conditions in the workplace frequently change, hazard identification and risk control needs to be a continuous process' (DHS 2007a, p.14). Under Department of Health occupational health and safety guidelines²¹¹ risk management consists of three basic steps:

Hazard [or risk] identification — the process of identifying occupational violence hazards in the workplace that could cause harm to staff or others.²¹²

Risk assessment — the process of assessing the risks associated with the hazards, including the likelihood of injury or illness being caused by that hazard, and identifying the factors that contribute to the risk.

Risk control — the process of determining and implementing measures to eliminate or minimise workplace violence (DHS 2004 in DHS 2007a, p.14).²¹³

Risk control measures usually employ some form of risk assessment checklist or appraisal. A schematic representation of risk control measures used in the health care setting is reproduced in Figure 5.3.²¹⁴

210 In particular see AS/NZS ISO 31000. This new international standard on risk management was released by the International Organisation for Standardisation (ISO) on 15 November 2009. It provides guidance on the attributes of enhanced risk management. These attributes represent a high level of performance in managing risk and can be used to compare an organisation's own risk management performance.

The key attributes are:

Continual Improvement: through the setting of performance goals against which the organisation or its managers are measured;

Full Accountability of Tasks: designated individuals fully accept accountability, are appropriately skilled and have adequate resources to check controls, monitor risks, improve controls and communicate effectively about risks;

Risk Management Application in all Decision Making: no matter the level of importance or significance, explicit consideration of risks and risk management needs to take place;

Continual Communications: contact with internal and external stakeholders including the frequent reporting of risk management performance;

Full Integration with the Organisation's Governance Structure: the organisation's governance structure and process should be based on the management of risk.

See <http://www.safetyrisk.com.au/2010/05/03/new-risk-management-standard-asnzs-iso-31000/> See also Australian Standards in Security in Health care Facilities AS4485 and The Australian Council on Health care Standards Evaluation and Quality Improvement Program (EQuIP) at <http://www.achs.org.au/equip4/>

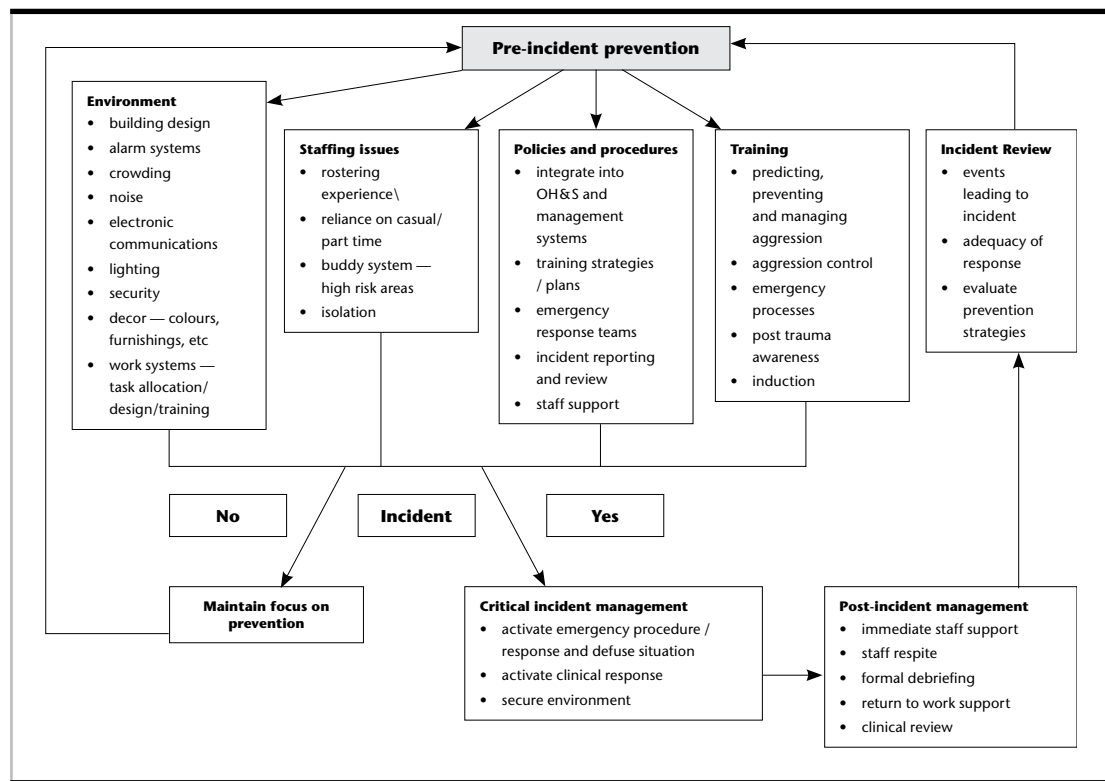
211 An approach that is fairly standard in government departments and private workplaces and mandated through WorkSafe Victoria. See WorkSafe 2011.

212 Risk identification in the context of health care violence is however easier said than done. This raises the complex issue of *predicting* violence. This is a subject that is beyond the scope of this Report, except to state that whilst there are few if any *diagnostic* tools that can be employed to predict violence in a hospital (or other) setting, a *history* of violence is usually the best predictor of future violence. Thus 'promptly recognising patients with histories of violence (if the patient is known to the hospital) at triage or registration is important' (Petit 2005, p.703). Certainly to this end some hospitals are now using computerised alert systems to flag potentially difficult patients on arrival. Moreover, whilst predicting violence may not be diagnostically possible, writers such as Harris and Rice 1997 argue that certainly variables such as gender (male), substance abuse, mental illness and aggressive childhood behaviour can be used actuarially to predict violence in certain circumstances. Evidence given to the Committee from clinicians also indicates that experienced staff can usually get a sense or 'feel' for when a situation may escalate into potential violence. See for example, Dr Harry Patterson, Deputy Head, Emergency Department, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011; and Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

213 There is voluminous technical and other material on risk management processes utilised in health sector workplaces, much of which is too detailed for mention here. In particular, see Public Sector OHS Management Model in *Preventing occupational violence in Victorian health services* (DHS 2007a, pp. 17ff).

214 See also Appendix 9 for an example of a generic risk control assessment sheet developed by WorkSafe Victoria that can easily be adapted for the health care setting.

Figure 5.3: Schematic representation of risk control in health care settings



Source: Department of Human Services 2007a, p.16.

A risk management approach has been specifically endorsed as the approach to take in addressing occupational violence in the current Victorian Framework. This differentiates the Victorian approach from the strict zero tolerance policy applied in New South Wales.²¹⁵ An essential aspect of the risk management model is to ensure that strategies, processes, procedures and programs implemented to address occupational violence are formally monitored and evaluated, both by the internal health service where relevant and by the Department of Health. The need for and importance of such evaluation has been specifically mandated by the *Preventing occupational violence in Victorian health services* Framework (DHS 2007a).²¹⁶ Most health care associations, peak organisations and bodies have endorsed risk management as the most appropriate approach to preventing and reducing occupational violence. For example the comprehensive *Position Statement* released by the AMA based on the three tiers of risk identification, risk assessment and risk control states that:

Violence risk management needs to take into consideration the work environment as a whole. To be successful it requires the commitment of management through sufficient investment of time, money and personnel. This includes commitment to regular audits of the organisation's vulnerability to violence to inform risk management planning. Consultation with staff is essential for violence risk management planning to be effective. A risk management methodology can be used in conjunction with the detailed knowledge of staff in the local work environment to develop tailored solutions to violence problems. It may be appropriate to assemble a working group of staff to develop a violence risk management plan (AMA 2005, p.1).

Support for risk management

The Committee received considerable local evidence stressing the importance of risk management in health care settings. According to some submissions and witnesses some hospitals are better at implementing risk management approaches than others:

215 Although the New South Wales policy certainly includes risk management as part of its overall approach.

216 This is particularly true in terms of reporting systems, models and protocols. See Chapter 2 in the context of the VHIMS reporting system.

It is a recommendation that the focus needs to be changed from *incident management* to *risk management*. Proactive prevention is the key. The physical and practiced strategies currently in place within the Emergency Departments should remain, however more needs to be done in relation to the early identification of high risk indicators occurrences and active physical and behavioural screening.²¹⁷

Some witnesses felt that more support should be given to health care facilities to comprehensively incorporate risk management procedures into their operations. For example, the Australian Nursing Federation (Victoria), whilst generally commending the current Framework, told the Committee:

Our [third] recommendation [in its written submission to the Inquiry] is that the government actually ensure that WorkSafe Victoria's guide *Prevention and Management of Aggression in Health Services — A Handbook for Workplaces*, is fully implemented and complied with in all health services. This guide was developed in conjunction with the health industry. It takes a full risk management approach whereby it looks at eliminating the hazards and reducing the risk so far as is practical. It looks at training, and it looks at the design of facilities, policies, procedures, staffing and patient management. It looks at implementing ways of reducing repeat offenders — for example, by putting in processes for behavioural contracts, if you like, for people who are repeat offenders with regard to these kinds of behaviour. It is a great guideline, and it is very easy to use. We feel that, combined with the VIN [Violence in Nursing] task force recommendations, should they both be fully implemented, we may not even need to be having this discussion in the detail we are having it today.²¹⁸

Some hospitals and health care services clearly *have* put in place comprehensive processes that aim to assess the potential for risk and then control that risk through management and control. For example the Royal Melbourne Hospital has established a governance structure to prevent and manage patient violence through risk identification and risk control:

At RMH, the Management of Clinical Aggression Steering Committee aims to promote a comprehensive and therapeutic approach to the prevention and early management of violence across all acute care areas. The Violence in ED Action Group is responsible for the monitoring of all incidents of patient violence in the ED. This is a multidisciplinary quality improvement committee which has nursing, medical, occupational health and safety, carer, security, police, mental health and education representatives.²¹⁹

Royal Melbourne Hospital has also developed a very sophisticated risk screening project for dealing with potentially violent individual patients, the genesis of which was examining the best practice models and literature to identify the early warning signs of aggression, conducting a clinical audit on past occurrences of patient violence, assessing nurses interaction with patients in assessing for the risk of violence and then developing that into a workable risk assessment and management model:

It is not about asking people direct questions, but rather looking at their behaviour and how they are presenting and then looking at what their risk factors might be. The logical follow-on from that is looking at the ways we might de-escalate that. That might be early contact with case management if the person is a frequent attender who has some issues that need to be worked through that way. Earlier liaison with the emergency crisis assessment team is another example. In some instances they will be moved to an environment that is less noisy, where they can be spoken to and individually managed in a private environment.²²⁰

217 Submission from Mr Brendan Gardner, Executive Director Frankston Hospital, Peninsula Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

218 Ms Kathy Chrisfield, Co-ordinator, Occupational Health & Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

219 Submission from the Royal Melbourne Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011

220 Associate Professor Marie Gerdtz, Associate Professor of Emergency Nursing, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

There are also examples of the idea of risk management being incorporated into everyday practice on the wards and in the emergency department. Wherever possible, St Vincent's Hospital tries to build risk identification and assessment procedures into its admission processes in emergency with potentially violent patients on the basis that such preventive action will not result in a problem later down the track:

We will do a very brief risk assessment — what are the risks, what are the possible causes for this person's violence, aggression or behavioural disturbance and do we need to keep them in a health-care environment or can we say to the police, 'You can take them away to a lock-up, and we do not need to have a role'. That does happen, but not commonly.

It is much more likely that we will treat them in a health-care framework because of an issue we believe needs to be explored a bit further or because of risks that are more suitably managed in a health environment rather than a police cell.²²¹

Similarly, Geelong Hospital's mental health team build risk assessment into their everyday practice:

Assessment... is another key component of our capacity to manage violence in mental health, and I am sure in other parts of the organisation there are a whole range of assessments made, risk assessments. This is both in the inpatient area and in the community. In mental health we also do what is called a home visit risk assessment. We are trying to assess whether we will be bitten by a dog; whether the visitors of a particular client potentially can create some potential for violence towards us as well. That is assessed every 90 days or ad hoc as required...[Risk assessment guidelines are] designed really to take the 'ifs, buts and maybe' and any delay in the decision-making out of the circumstances, that medical staff clearly have a capacity to refer to something that gives them a lot of good information, and quickly.²²²

The four 'gold standards' of risk management — risk identification, risk assessment, risk control, and monitoring and review are increasingly being promoted through departmental policy and subsequently being followed in 'micro' procedures, standards and protocols within hospital environments. But assessing and controlling for risk is not only the province of hospital administrators and clinicians. As will be discussed in Chapter 7 risk management is also a cornerstone of the approach of security personnel in interacting with potentially or actually violent people in the hospital environment.

Conclusion

The need for comprehensive strategies to address occupational violence in the (health care) workplace is incontestable. What has been, until relatively recently, contentious is how such a policy/strategy should be developed (see Paterson, Leadbetter & Miller 2005). Based on the examples of New South Wales and Victoria, some of the elements that are required to ensure such a policy can be successfully implemented include first and foremost an explicit commitment to a policy that categorically states occupational violence is totally unacceptable and that is supported by executive management of the health care facility. Other components of such a policy must necessarily include:

- ◆ a strict compliance with the occupational health and safety laws applying to the employing facility and understanding and observation of their duty of care obligations
- ◆ a risk management and identification process that incorporates regular violence vulnerability audits

221 Dr Georgina Phillips, Emergency Physician and Coordinator of International Programs, St Vincent's Hospital Melbourne, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

222 Mr Philip Dunn, Director of Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

- ◆ easily accessible/useable reporting systems
- ◆ comprehensive processes for workers who have experienced violence to be supported throughout the process
- ◆ formal and systemic evaluations of anti-violence interventions and procedures (paraphrased in part from Mayhew & Chappell 2003).

An overall policy to address occupational violence needs to contain each of these elements and be supported and proactively encouraged in practice as well as in theory.

Recommendations

1. **The Committee recommends that the Victorian government ensure current policies and frameworks to prevent violence in Victorian hospitals such as the Department of Human Service's 'Preventing occupational violence in Victorian health services' and WorkSafe Victoria's 'Prevention and Management of Aggression in Health Services' are fully implemented and complied with in Victorian hospitals and health services.**
2. **The Committee recommends that the Victorian government requires that hospitals complete the implementation of the recommendations emanating from the *Victorian Taskforce on Violence in Nursing: final report*.**

As a result of the research and deliberations of the Victorian Taskforce on Violence in Nursing, a comprehensive set of recommendations was delivered in the final report. The Government has implemented all but three of them in part or in full. This has resulted in the introduction of comprehensive frameworks to address violence in Victorian hospitals and health services. In particular, subsequent to the findings of the Report the Department of Human Services developed the 'Preventing occupational violence in Victorian health services' framework, a comprehensive document that gives clear direction to the state's hospitals and health services on ways to address violence occurring within their facilities. The Committee believes this framework and the subsidiary policies and documents that form part are a useful starting point for implementing best practice programs and procedures to deal with violence, not only against nurses but also against all people who work within, are treated at or visit Victorian health services.

The Committee agrees with the views of a number of stakeholders who gave evidence to this Inquiry that the remaining recommendations need to be expedited. Whilst the Department of Health may have progressively rolled out the policies, programs and initiatives that have emanated from the Taskforce recommendations, this does not mean that all Victorian hospitals have taken them up and implemented them in full or in part. The Department in conjunction with hospital management must ensure that any programs recommended by the Taskforce are effectively implemented in hospitals at local level. Moreover, all of the programs, procedures and policies that have been developed as a result of the Taskforce Report should be subject to independent evaluation.

Recommendation

3. **The Committee recommends that within 12 months of the tabling of this Report there should be a fully independent evaluation of the policies, programs and other measures implemented as a result of the recommendations in the *Victorian Taskforce on Violence in Nursing: final report*.**

Recommendation

- 7. The Committee recommends that hospital executives and management promote policies endorsing the message that violence against health workers is unacceptable and will be proactively addressed. Such policies must encourage a culture of reporting violent behaviour and incidents.**

Increasingly in Australia and overseas it is being recognised that violence against staff, and to a lesser extent patients and visitors, is a serious problem in many hospitals and health services. As such, hospitals are developing and implementing 'zero tolerance' policies towards violence, usually at the direction of government health departments. The New South Wales government 'Zero Tolerance Response to Violence in the NSW Health Workplace' is a key example of a comprehensive 'no violence' framework. The Committee agrees with many of the sentiments and aspirations of this approach. However it endorses the approach of the 'Preventing occupational violence in Victorian health services' framework in not using this particular term. As discussed throughout this Report the use of the term 'Zero tolerance' arguably would result in patients who are not able to form the requisite intention to commit assault being asked to leave the hospital or being refused treatment. A common example would be an elderly patient with dementia.

A policy which addresses violence against health care staff in a holistic and proactive way is preferable to the narrowly prescriptive focus of 'zero tolerance'.

It is one thing, however, to have these frameworks and policies in place, it is another to make them enforceable. Hospital management must ensure that internal policies towards addressing occupational violence are developed and more importantly rigorously implemented as a priority. Hospital staff must be encouraged by management to report incidences of occupational violence whenever they occur and be supported in any efforts to prosecute the perpetrators of such violence.

Recommendation

- 10. The Committee recommends that hospital policies to address violence should utilise a risk management approach. Formal risk assessments should be conducted at each workplace, taking into account the times most likely to result in violent events. Continuous monitoring and evaluation of outcomes need to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.**

Many hospitals are recognising that the focus needs to be changed from incident management to risk management. Risk management, risk assessment and risk identification approaches to occupational violence are essentially about being pre-emptive and proactive to the potential for violence occurring in the hospital environment. Risk management is based on recognising and eliminating the hazards that may pose a risk to the physical and psychological wellbeing of employees and visitors to the workplace. The Committee agrees that risk management is an essential part of any approach to prevent violence in health care settings.

6. Security Issues Around Violence Prevention: Putting weapons and protective service officers in hospitals

Introduction

As stated at the outset of this Report, the government's concerns with regard to violence in hospitals and particularly emergency rooms led to this Inquiry being conducted and in particular the following term in the Terms of Reference:

- (c) an examination of current and proposed security arrangements in Australia and internationally to prevent violence in hospitals and, in particular, emergency departments, including the appropriateness of Victoria Police Protective Service Officers in Victorian hospital emergency departments.

Protective Services Officers (PSOs) form part of the Protective Services Division (PSD), Victoria Police's specialist provider of security services. PSOs perform general security at various official locations in the Melbourne city area, and suburban Magistrates courts. Whilst not fully sworn police officers, they receive a truncated version of the training police officers at the Police Academy undertake.

This chapter analyses stakeholder views as to the appropriateness of stationing armed PSOs in Victorian hospital emergency departments as a deterrent and means of reducing hospital violence. It also looks at the general issue of firearms and other forms of weapons and restraint being used as security measures.

The reaction to the proposal

The evidence received by this Committee, in written submissions and oral testimony, was *overwhelmingly* against any introduction of PSOs in emergency rooms or other areas of Victorian hospitals.²²³ This was especially the case if such officers were to be wearing firearms.²²⁴

This view was held equally by doctors, nurses, hospital administrators, medical peak bodies, unions, security officers and security organisations. Indeed, some organisations such as the Australian Medical Association (AMA) and Australian Nursing Foundation (ANF) had indicated their reservations and objections prior to the Inquiry commencing.

Reasons for rejecting the deployment of PSOs

There have been a number of reasons given by various witnesses as to why the deployment of PSOs is not a good idea. In summarising these arguments, however, the objections fall into five main categories:

223 The Inquiry received submissions from 32 individuals and organisations and oral evidence from 58 witnesses. The issue of PSOs was mentioned in nearly all submissions and by most witnesses. In *all* but one case where the issue was raised it was viewed as an unsuitable strategy. The one witness that did not reject the proposal outright was equivocal as to its merit, saying further investigation would be required before she could be convinced of its suitability. See Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011. See Appendices 3 and 4 for a list of submissions and witnesses respectively.

224 See discussion later in this chapter as to the suitability of other types of weapon or restraint devices.

- ◆ PSOs with firearms add an extra layer of risk to what is already a volatile and chaotic setting.
- ◆ The wearing of firearms in particular is counter to the principles of risk management and occupational violence (outlined in Chapter 5 of this Report).
- ◆ It is unclear as to where PSOs 'loyalties' would lie. To whom would they be answerable and from whom would they take direction?
- ◆ There is a lack of clarity as to the actual scope of their role.
- ◆ Hospitals want the option to hire their own staff either directly or through a security contract.²²⁵

It should be noted with regard to the criticisms mentioned above that some clarification is required. First with respect to the issue about the loyalties of the PSO, it is clear that under the *Police Regulation Act 1958*, PSOs are answerable and accountable to the Chief Commissioner of the Victoria Police not hospital management. Second it is premature to argue there is a lack of clarity with respect to the role of the PSO, when that role has not been finalised or established yet.

It is not necessary to repeat at length the detailed reasons given by witnesses as to why PSOs are unnecessary and unsuitable. The following accounts therefore are selected to give a cross-section of the main concerns held by stakeholders.

The views of clinical staff

Some organisations representing medical and allied staff had already objected to the PSO proposal prior to the commencement of this Inquiry. The two peak bodies representing doctors and nurses — the AMA and ANF (Vic) — followed up their initial concerns with submissions and evidence to the Inquiry.

The dangers of guns in hospitals

The ANF was particularly concerned about the dangers the wearing of firearms by PSOs would bring to the emergency department and the occupational health and safety implications of this:

Government's proposal to spend \$21 million to put 120 armed Protective Services Officers (PSOs) in the emergency departments in Victorian Hospitals should not go ahead as this is in contravention of the risk management principles enshrined in the Occupational Health and Safety Act 2004, i.e. eliminating the hazard, as the employer will be directly introducing a firearm into the hospital, and thus introducing a hazard.²²⁶

The AMA took a similar line:

AMA Victoria opposes the use of armed guards in hospitals — in particular the placement of armed security staff into EDs. This measure has the potential for unintended serious consequences for the safety of staff and patients should firearms be discharged in close confines. More so, the sight of guns has the potential to unnecessarily intimidate patients or the public.

Also, the presence of weapons in EDs may lead to conflicts escalating into more serious incidents. The presence of guns may induce patients or their visitors to bring weapons of their own into EDs. Additionally in the close confines of the ED a gun could be appropriated by a patient (we are aware of at least two examples). Most concerning though are the consequences of guns being used inappropriately by the guards themselves. A patient who could be subdued through alternative means may end up being shot. We are [aware] of a Victorian case which supports this contention.

²²⁵ For further discussion of this point, see discussion in Chapter 7.

²²⁶ Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

AMA Victoria recommends that all armed personnel who attend EDs (such as police officers and security guards) be required to place their weapons in an appropriate weapons locker prior to entering an ED.²²⁷

There are other effective means of controlling aggressive patients in a health care setting which do not require the presence of guns and will not have such potentially dire consequences.²²⁸

The AMA's viewpoint was emphatically reiterated when Dr Stephen Parnis, the Vice-President gave evidence to the Committee. He stated that 'We are absolutely, 100 per cent against the possibility of armed guards in hospitals. To us that is a black-and-white issue'.²²⁹ He also referred to an incident in 2002 when a person died as a result of a shooting in the St Vincent's Hospital emergency department. According to Dr Parnis staff who were present at the time are still feeling the traumatic effects of that incident.

The effect of armed PSOs' presence on vulnerable people

The Australian College for Emergency Medicine (ACEM) was particularly concerned about the effect the presence of armed PSOs may have on vulnerable people in or near emergency departments, particularly people with drug and alcohol or mental health problems:

The suggestion that security officers in emergency departments might be armed with guns causes us much concern. Guns are lethal weapons, so risk of death with their use is high. Given that most behavioural issues in Emergency Departments are due to drug intoxication or mental health issues, the patient may not have the insight to see a gun as a deterrent; rather it may escalate the situation. Behaviourally disturbed patients in emergency departments are rarely armed, so an armed response is not commensurate with the threat posed. It is our view that arms, in particular guns, add a level of risk for staff and patients that is unacceptable.²³⁰

These views were endorsed by the Australasian College of Physicians.²³¹

The Health Services Union (HSU) was also concerned about how the presence of armed PSOs might affect people with mental health conditions:

At present, security guards are armed with "nothing but a pair of latex gloves". HSU East does not support the introduction of firearms into hospitals as this would only lead to an escalation of violence. Mentally ill and drug affected patients will not respond rationally - they will see firearms as an additional threat and will respond with heightened aggression. It is even possible that they will seek to arm themselves with firearms to respond to what they perceive as an additional threat.²³²

Other witnesses were worried about the effect an armed guard might have on people in the waiting rooms of the emergency department, particularly elderly people or children. For example, a nurse from the Royal Children's Hospital told the Committee:

We feel that providing security with weapons will only provide more anxiety to a waiting room. Very rarely would we need to call in police to use weapons in our department, so I think providing weapons would not actually benefit us at all. It would actually, like I said, just increase anxiety.²³³

227 The issue of the storage of weapons is discussed later in this chapter.

228 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

229 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

230 Submission from Dr Simon Judkins, Chairman, Victorian Faculty, Australasian College for Emergency Medicine to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

231 Submission from Professor John Kolbe, President and Professor Peter Ebeling, Chairman, Victorian State Committee, The Royal Australian College of Physicians to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

232 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

233 Mr Peter Sloman, Clinical Nurse Specialist, Emergency Department, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

The roles and management of the PSOs

Questions were also raised about the scope of the PSOs' role should they be stationed in Victorian hospitals. For example, whether they would have 'a responsibility to help with the day-to-day management of patients such as an agitated elderly patient or would be expected to[deal] only with criminal/dangerous behaviour'.²³⁴

It is not only peak bodies who have raised these concerns. Similar misgivings were expressed by representatives of individual hospitals. Staff from St Vincent's Hospital Melbourne were particularly concerned about how the deployment of PSOs might blur the lines of responsibility in the hospital hierarchy and established protocols that were working well:

Should an armed guard or protective service officer be stationed in the ED, critical questions arise. Who would develop their job description and who would they report to? What would be their key result areas and key performance indicators? When would it be deemed acceptable (if ever) to produce the weapon? Would they be part of the Code Grey team, would they answer to the Manager of Security or the Hospital Emergency Coordinator? How would the introduction of an armed officer not disrupt an already highly developed and effective team response? How would staff and patient safety be protected by the introduction of a lethal weapon into a volatile situation?²³⁵

Similar points were made in submissions from inter alia, the Royal Melbourne Hospital, Mercy Health, the Alfred Hospital, the Royal Children's Hospital and St Vincent's Hospital Sydney.

The views of health care academics

Health care academics were also very much opposed to the idea of PSOs or indeed as discussed later in this section *anyone* bearing weapons in an emergency department context. Dr Rose Chapman, for example, told the Committee:

I wouldn't have an armed person anywhere near in the hospital if I had my way... if I walked into a hospital and had people standing there with guns, it is just giving the wrong message I think. Plus would they ever use it? There is oxygen. If someone shot someone in the department, god forbid, what is the consequence of all that? So in reality would they use it, and if they aren't going to use it then why have it. If they are going to have people with guns, let's put coppers in there because at least they are trained.²³⁶

Professor Megan-Jane Johnson's response was even more emphatic. She saw the proposal as:

Very provocative in a dangerous way, particularly if you are dealing with already [agitated] people. Guns do not exactly symbolise peace and harmony. I think they are symbols of threat, fear and terror. Personally I would like to see a lot more evidence justifying the introduction of arms into casualty departments before such a step is taken. Frankly, my visceral response is one of horror.²³⁷

The views of security staff

Clearly from a commercial viewpoint it is not in the interests of security firms and companies to want government employees (PSOs) to replace or add to the complement of private security officers in public hospitals. Nonetheless, the views of representatives of security firms and

234 See Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

235 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

236 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

237 Professor Megan-Jane Johnstone, Director, Centre for Quality and Patient Safety Research, Deakin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

organisations do appear to be considered and sincere. For example, a submission from the peak body for the security industry — Australian Security Industry Association Ltd (ASIAL) — stated:

ASIAL considers the utilisation of Victoria Police Protective Service Officers in Victorian hospital emergency departments inappropriate and contrary to the good management of security in hospitals. The introduction of such a scheme would be costly, introduce additional management levels of control and command of personnel, organisational management conflict and the removal of hospital management responsibility and good governance.²³⁸

Peter Johnson, from ASIAL was even more emphatic about the unsuitability of PSOs when he gave evidence to the Inquiry in Sydney. He saw their deployment as abrogating the responsibility of the hospital, arguing that ASIAL does ‘not feel it is appropriate [deployment of PSOs] and we believe that police protective service areas would not recognise appropriately hospital management, and the status of hospital management’.²³⁹

David Van Lambaart, an expert on hospital security also gave a considered opinion to the Inquiry that the use of armed PSOs in emergency departments and other areas of the hospital would be counterproductive and inappropriate:

Should armed PSOs be employed in hospitals? Personally I am not in favour of utilising armed protective services officers in hospitals. I believe there is a range of other strategies that could be implemented to reduce the likelihood of aggression and violence. The employment of protective services officers may in itself be problematic, in that the use of protective services officers would be in contradiction to and inconsistent with the current [hospital] codes of practice. There is the potential to increase the likelihood of...weapons being used in an aggressive manner when it is widely known that protective services officers are carrying weapons themselves. Knowledge amongst the wider community will move quite quickly, I would suggest. It is not unusual to have uniformed security personnel in blue uniforms in particular aggravate certain individuals who have a history with law enforcement. The use of armed protective services officers would, I believe, serve to heighten rather than alleviate the potential for harm and tension. Protective equipment such as batons, handcuffs, capsicum spray and side-arms — or handguns — may well become dislodged or unlawfully removed from protective services officers during physical altercations, heightening the wider risk to staff, patients and visitors in proximity to the incident at hand. An escalation of an incident of this nature would have dire consequences within what is a relatively confined area.²⁴⁰

Finally, those responsible for implementing security within hospitals such as in-house security department heads were also concerned about how PSOs would fit into existing governance arrangements. For example, the head of Security at St Vincent’s Hospital Melbourne told the Committee:

To be armed as far as carrying a gun, a firearm, is definitely a no-no. I can never see when would be the right time to pull out a firearm and brandish it at someone to try to use it as a controlling mechanism. We have had incidents in the emergency department that could have gone horribly wrong. We have had a shooting. It just does not work when you are trying to work within the guidelines of health care. My guys and I carry nothing. We carry ourselves, our physical stature, and our mouthpiece, and that is it.

... To have protective services officers or someone from a different stream working in our environment, I find it hard to see what relationships we would have. Who would be in charge of what they do? Who would set out their operating procedures? Would they answer to me as the manager? Would they

238 Submission from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

239 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

240 Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011. Mr Van Lambaart also considered the costs of deploying and training PSOs may be prohibitive comparative to other methods of employing security. See Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

answer to the emergency department manager? Would they be the first respondent? At the moment we are the first respondent.²⁴¹

Do PSOs have a role outside the emergency department?

The one submission that did not reject the proposition outright was that of the Victorian Health care Association (VHA). This organisation, whilst not endorsing the proposal, believed it needed greater examination to determine 'the cost impact and feasibility of the approach'. The VHA also argues that it is not only emergency departments that may require heightened security:

Metropolitan hospitals with emergency departments provide care for thousands of Victorians per year. In addition, there are seventeen regional and subregional health service agencies that provide emergency services through funded emergency departments. All but one of the remaining fifty-two local health services provide 24 hour emergency services using the general funding provided for all of their health services. These Urgent Care Centres (UCCs) and Primary Care Services (PCS) manage their unplanned presentations with nurses, on-call General Practitioners (GPs) and urgent ambulance transfers to emergency departments. Many of these services could be equally in need of PSOs.²⁴²

The use of weapons and restraint generally

The bearing of firearms by police and security staff other than PSOs

The views of clinical staff

Whether PSOs, police officers or general security officers are employed in hospital settings, many of the witnesses who gave evidence to the Inquiry were very concerned about the presence of firearms and to a lesser extent other weapons on hospital premises. As Kathy Ackland, Nurse Unit Manager from the Geelong Hospital emergency department stated:

My personal view is I do not want security staff armed. It is a hospital and we need to go back to the fact that we are there to help people. If you start arming people there is a risk that one of the security staff are not trained or if they become disengaged that they might cause harm to a visitor or a patient, that a visitor or patient could get hold of the weapon and use it against other people. That would be my fear about having security armed.²⁴³

There is even some reluctance to have the presence of armed *police officers* within the hospital environment. For example, David Eddey, Director of Emergency Medicine at Geelong Hospital told the Committee:

The issue of police in the emergency department, they come in armed. We do not have a gun safe. When we built our emergency department recently they were reluctant to have a gun safe. Admittedly I have never had a problem with the police with a firearm in my presence, but it is a risk certainly in a location where there are specifically mental health patients.²⁴⁴

241 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

242 The following categories of health service that may be required to give emergency or trauma assistance in Victoria are:
 a) Emergency departments (ED): department of a health service that is funded by the Victorian Department of Health to provide emergency services
 b) (Urgent Care Centre (UCC): designated area in a local hospital providing emergency resuscitation and limited stabilisation prior to early transfer, otherwise providing limited definitive care depending on local resources
 c) Primary Care Centre (PCC): similar to an UCC but have either significant resource limitations for trauma resuscitation or are within close proximity of a higher-level trauma service. They are expected to transfer all self-presenting trauma patients'

See Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

243 Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

244 Dr David Eddey, Director, Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

St Vincent's had similar reservations about the presence of armed *police*:

Whilst we commonly work well together, Victorian Police officers and health workers, including security staff that work in hospitals have a fundamentally different approach to aggression and violence in an ED environment. Indeed, we rely on the assistance of the police during a 'Code Black' event, yet police presence in the ED can escalate agitation and led to increased aggression. When faced with a violent patient, police can react rapidly and forcefully — sometimes against the wishes of ED staff and in conflict with our principles of patient care and safety. De-escalation techniques are rarely employed. They do not answer to our SVHM Security staff nor to the Hospital Emergency Coordinator and therefore are not able to work effectively in a Code Grey team response. At times, a patient will calm down and become cooperative only after police have left the ED environment.²⁴⁵

Other witnesses acknowledged that there may be some (extreme) situations when the presence of police with firearms is regrettably necessary. For example, Dr Gordian Fulde, Director of St Vincent's Hospital Sydney whilst first decrying the general use of firearms in no uncertain terms admitted sometimes police action may be necessary:

People come to a hospital because they perceive they are sick or they are sick. To have someone shot in a hospital, I've worked a lot in America, I've actually been there when someone woke up in an operating theatre, had a gun and started shooting and had a security guard shot in the theatre. It's horrible...It's inexcusable.

If there is an issue that supersedes all that, in other words you have armed gangs, we have motor bike gangs/drug dealers, someone has come in, and then it's a police issue. The police come in and have to shoot somebody, so be it. It's not a health issue...[It] is a police issue, we ask the police in, we work with the police, and they have guns. Society accepts them to have guns and they are highly trained.²⁴⁶

Other medical staff have drawn attention to the chaotic nature and physical layout of the emergency department; oxygen cylinders, overcrowding and relatively small spaces in conjunction with armed security personnel could be a 'recipe for disaster'. As one highly experienced emergency doctor told the Inquiry:

I can't ever remember an experience where I thought it would be useful if someone had a gun in the emergency department, particularly a crowded place like an emergency department. I imagine that if someone has a gun, the only reason to have a gun is that you might need to use it sometime and I can't imagine a situation in the past where I thought that would have been an appropriate thing to do.²⁴⁷

The views of security staff and managers

The security industry is also generally opposed to its members being armed with guns except in exceptional circumstances. Bryan de Caires, Executive Officer of ASIAL told the Committee that:

There is only a very small proportion of the industry that uses firearms. Typically the majority of those are in the cash transit area. It is a very specialised area where they are moving significant amounts of cash and they are obviously clear targets...huge targets. There is a strong move away from firearms with most operators in the industry.²⁴⁸

His colleague Peter Johnson added that in pressured environments such as the emergency room, volatile patients and guns were a bad mix:

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- 245 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.
- 246 Professor Gordian Fulde, Director, Emergency Department, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.
- 247 Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 22 June 2011.
- 248 Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

Even in the most threatening situation let's train our people to know about the situation, withdraw, secure and contain. Do not have a firearm. I think putting firearms in there is more emotive than anything in this world. People see it and they see authority, the next minute you have aggression before you even start... 'What are you going to do, shoot me? I've already got a stab wound, what are you going to do?' It is emotive and it is unnecessary, in my opinion... In all the hospitals I have dealt with I can say it would create so many stress claims for health care workers by having a person standing around them with a firearm on, you will not have people wanting to work in an emergency department in the first place, and it is a tough gig already. Why make it any tougher?²⁴⁹

In Victoria, a forum of private security company managers convened by the Committee was unanimously of the opinion that arming security personnel was not a good idea. The views of Jennifer Nicholson of the Spotless group were fairly representative in this regard:

Again, should our security officers be armed? Spotless believes, in line with the hospital, that the presence of a firearm itself could incite aggression from patients and create further risk to staff and patients, particularly those who are known to self-harm...Firearms, tasers and other weapons such as batons are regarded as unnecessary in an environment where the key outcome really is a calm resolution.²⁵⁰

Security officers working in hospitals and their managers also have expressed no interest in being armed. Dunko Grubisic, Security Manager for the Westmead Hospital in Sydney, an area in which crime and violence is not unknown, expressed great concern that firearms would ever be used by security personnel in New South Wales:

I would say that would not be a practice that we would be in favour of in New South Wales whatsoever. I mean, we have had serious debate of even having batons and handcuffs issued to the officers, let alone a handgun or capsicum spray. The reason for that is the risk in losing that implement in an incident and having it used upon — the actual person holding the weapon. That is probably the biggest fear we have as an employer to offer these implements to our staff and have them used against them in the line of duty. From our point of view we always use the risk management approach. If the threat is too great, then we retreat and call for additional back-up and try and remove the risk by either closing the door to walking away or handling it in a manner that would be as safe as possible.²⁵¹

Other weapons

Mr Grubisic's comments quoted above suggest that some hospital staff are even wary of weapons other than firearms being used by security personnel. This includes the use of capsicum spray, tasers, batons and other types of non-firearm weapon. However, the consensus seems to be that although all weapons are unsuitable in hospital settings, if some force or restraint is necessary, non-firearm weapons are less objectionable than firearms.

Capsicum spray and tasers

With regard to the use of capsicum spray the major objection was the propensity for it to come into contact with not only the aggressor but also anyone in the immediate vicinity. This is because an environment such as the emergency department is a relatively small and contained unit and/or because of the ability of the spray to be dispersed through air conditioning and ventilation systems:

249 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

250 Ms Jennifer Nicholson, Project Manager, Spotless @ The Alfred, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Roundtable Meeting, Melbourne, 10 October 2011.

251 Mr Dunko Grubisic, Security Manager, Westmead Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

The use of capsicum spray in a confined environment can result in collateral damage, with staff, patients and visitors in close vicinity. The use of capsicum spray can reduce the capacity of emergency departments to meet the needs of patients.²⁵²

Concern was also expressed that capsicum spray may have the tendency to make an angry person even angrier.²⁵³

Victorian Health Commissioner, Dr Beth Wilson stated that she had spoken to health service providers in the lead-up to giving evidence to this Inquiry:

I have said there is an inquiry that is looking at security arrangements in hospitals, including armed guards. These are people who work in emergency, and they just stare at me and say, 'Armed guards? What are they going to do — shoot our patients?'. Or if you mention capsicum spray, they say, 'That sounds like a great idea for people who have respiratory distress', for example. If you sprayed it you would then have to evacuate the whole of the ward, which is not going to help seriously ill people.²⁵⁴

The objections of Bryan De Caires to capsicum spray was not so much the inherent attributes of the substance itself but that its deployment could lead to the 'ramping' up of more extreme forms of security:

It is an escalation. Once you start then the next thing is people will say, 'We want more than capsicum, we want batons'. Then you have batons and then firearms. It does start to escalate because people realise you are going to have capsicum — it ramps the whole thing up. If you have the approach to security where you can plan it with your access control, physical barriers, you start to get some way of containing things, rather than go to any form of arms, whether it is capsicum or tasers. I mean, it is a hospital. Obviously if people are not behaving you have to have a process to manage that. We resisted more security officers having arms because we think you start the whole process, and once you start there is no going back. The next step they will be fully armed with armour plate and Kevlar vests and where do you stop?²⁵⁵

Luke Roscoe, the head of security at Royal Perth Hospital, whilst opposed to the use of capsicum spray was less antagonistic to dispersing capsicum foam:

Our security staff do carry hand cuffs and OC foam, capsicum spray that comes out in a foam form. The reason for that with the actual pepper spray it can spread to quite a wide area, so in the situation of ED especially if you were to spray someone in one of the cubicles you would have to shut down half the department while it is decontaminated. This comes out in a foam form so it is a lot more controllable.²⁵⁶

Wilson Security has given cautious approval to the use of capsicum spray but only in outside areas; 'a discharge inside the hospital would affect other wards potentially causing unjustifiable harm' and if 'sufficient and regular training' was available (Wilson Security 2011, p.10). Their preferred option is the use of tasers, which:

[h]as the most potential for effect with most minimising harm potential to others. Again rigorous and regular training is the key but in realistic environments, not online or in a sterile classroom (Wilson Security 2011, p.11).

252 Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

253 See for example, Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

254 Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

255 Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

256 Mr Luke Roscoe, Head of Security, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011. Other hospitals also noted their use of foam in controlled circumstances where other methods had failed. See for example, Ms Lisa Gray, Co-ordinator of Nursing, Sir Charles Gairdner Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 22 June 2011.

Professor Duncan Chappell, however, was more ambivalent about the use of tasers when he gave evidence to the Inquiry:

I think the more contentious issue, certainly in the United States now, is in relation to the use of tasers in hospitals, and also I should say in correctional institutions. They obviously are non-lethal — in emphasis, question mark — control mechanism. Quite a number of psychiatric hospitals, I understand, in the United States have allowed them to be used in management of violent people. Here again in Australia there is a widespread view that that is inappropriate deployment of these weapons and indeed there is controversy still about whether they should even be deployed across the board to police officers.²⁵⁷

Other restraint mechanisms

Despite some cautious endorsement of capsicum from a minority of security personnel, almost all clinical staff were opposed to its use, even in its foam form. Tasers were also opposed by most health care workers. On the other hand most witnesses to the Inquiry also recognised the need for security officers to be able to use some mechanisms or techniques of restraint when other non-invasive methods such as 'talking down' or calming the aggressor had failed. For example, the Health Services Union supported the use of handcuffs in certain circumstances:

Security officers do need to be equipped appropriately to enable them to defend themselves or others (especially in situations with armed or violent offenders)...

Members are very clear that equipping and training in the safe and appropriate use of handcuffs is essential. Currently, guards can be holding a violent offender in a prone position for up to 45 minutes, while waiting for police to arrive. Police then handcuff the offender. This greatly increases the risk of positional asphyxiation or injury to the offender. A particularly powerful offender poses a threat to workers and other patients as well. The correct use of handcuffs in these situations would greatly minimise these risks.²⁵⁸

The need for occasional mechanical restraint and seclusion of violent patients has also been recognised by hospitals but as an intervention of last resort:

It is clear that the use of restraint and seclusion has a limited though important role in the management of violent behaviour when less restrictive methods of containment have failed. In such situations attention needs to be focused on the safety of patient and the staff involved. In the longer term, nurses must review the ways in which the patient may be encouraged to learn more socially acceptable ways of adapting to the stress of illness and hospitalisation and to taking responsibility for their actions (Department of Human Services (DHS) 2005b, p.18. See also DHS 2005a, p.48).²⁵⁹

Indeed some witnesses have indicated that without proper training the use of restraint techniques, particularly by security officers, can be as dangerous as using weapons and result in death or injury through restraint asphyxia.²⁶⁰

Overall, security staff said they were opposed to the use of weapons or restraint mechanisms and tried to avoid them wherever possible. They preferred to rely on techniques of persuasion and calm resolution that well trained security officers should have at their disposal.²⁶¹

257 Professor Duncan Chappell, Institute of Criminology, University of Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

258 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

259 For a discussion of the use of separate seclusion or behavioural assessment rooms (BAR), see Chapter 9.

260 See Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

261 See Chapter 11 for a discussion of education and training issues for security officers and others.

Firearms, tasers and other weapons such as batons are regarded as unnecessary in an environment where the key outcome really is a calm resolution. Our current strategy for resorting to numerous strengths seems to work effectively for more violent patients within the hospital.²⁶²

Indeed, Peter Johnson of ASIAL told the Committee that for the most part the best ‘tool’ a good security officer can have in a hospital is his or her ‘mouth’:

[t]he way you handle it, the way you talk to people and the way you calm them down. You have that manner, and you realise they are under pressure and you do not take anything personal, because if you did that you would not work. If you took it personally you probably would not be a nurse too long in ED either, or a doctor. There are a lot of other tools of the trade before you get to those. You spend your money on your training and it could be those people with good tools in their tool bag, the phrases to use, calm them down, the recognition and the acceptance of the position they are in. You have a lot of good things to do before you put something on your hip and you start to walk funny because you are carrying a gun — then you are a cowboy.²⁶³

Handling and storing weapons

Whilst hospital staff are generally opposed to the wearing and use of weapons, particularly firearms, in hospital premises they realise that on occasion there are reasons why authorised personnel such as police may need to carry them. Some hospitals have dedicated storage units for weapons (gun safes) and ask authorised officers to check those weapons in on arrival at the hospital. Some hospitals also have weapons screening processes.

There have been problems in the past, however, where medical staff may discover a weapon on a patient’s person and be reluctant to give that weapon to the police because of privacy issues pertaining to their patients. Another related problem is that by taking a weapon from the patient, the health care professional may have been theoretically in illegal possession of a prohibited item.

This issue is arguably indicative of a clash of professional values — the clinician’s need to protect his or her patient’s confidentiality and trust — and the police officer’s need to uphold the law and investigate any potential crimes.

Legal and policy developments

The dilemmas associated with the handling and storage of weapons have been lessened to a significant degree by recent legislation and policy directives. The *Victorian Taskforce on Violence in Nursing: final report* recognised that there were serious problems associated with having weapons on hospital premises. The Report ‘identified the need for a coordinated approach to the management of weapons and dangerous articles within health care settings, including consideration of the issues of search, seizure, storage and disposal or return of such items’ (DHS 2009b, p.4). One result of the Taskforce was the development and implementation of *‘Deter, detect and manage: A guide to better management of weapons in health services 2009’*.

The guide and the policy enunciated therein marked a shift from ‘a reactive emergency-situational focus to one that systematically and proactively deters and manages firearms and non firearms weapons in health services’ (DHS 2009b, p.5).

The policy covers not only firearms but ‘non firearm weapons’ (for example knives, machetes and swords) and ‘dangerous articles’ such as legitimate or everyday items that could be adapted for use as a weapon (syringes, scalpels etc).²⁶⁴ The policy is premised on the establishment

262 Ms Jennifer Nicholson, Project Manager, Spotless @ The Alfred, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Roundtable Meeting, Melbourne, 10 October 2011.

263 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

264 See *Control of Weapons Act 1990 (Vic)*.

of good *formal* partnerships between hospital staff and Victoria Police.²⁶⁵ Whilst constructive partnerships have been formed between some health services and local police these have tended to be 'working in isolation and informal' (DHS 2009b, p.6).

Some selected guiding principles underlying the policy are as follows:

- Under the *Victorian Occupational Health and Safety Act 2004* and relevant Australian standards, the safety of clients, visitors and staff within health care settings is the overriding priority. Health service employees have an obligation to act based on a risk assessment, in a way that enables clients to receive medical or clinical care without endangering themselves or others. This may include delaying treatment until a risk assessment is undertaken, taking action to minimise the risk and contacting the local police for assistance or advice, and is in accordance with the Victorian Public Hospital Patient Charter (2002).
- The presence of firearms or non-firearm weapons in a health care setting poses an increased risk to the health and safety of the community (staff, clients, and visitors). Under occupational health and safety legislation and regulation, health services are required to manage such risks and provide a safe environment.
- Health services provide care to vulnerable groups (for example, confused, elderly and juvenile clients) in public spaces where illness and highly-charged emotional states coexist. In this context, the presence of weapons, including dangerous articles, poses an even greater risk to clients, visitors and staff alike. Health services need to manage such risks irrespective of a person's need for medical care, their authority to carry a weapon, or their competence to manage their own weapon.
- Health service providers, including ambulance services, have an obligation to keep each other informed (whether transferring clients into, out of, or within health care facilities) about any actual or potential risks a client may pose, because of identified or known dangerous behaviour, including use or possession of weapons.
- The best way to protect staff, clients and visitor is to deter individuals from bringing firearms and non-firearm weapons into health services. Health service weapons policies should apply equally to all those entering the workplace. The message that firearms and non-firearm weapons are not permitted on health services premises and that refusal of entry may result if a person is found in possession of a weapon, should be clearly communicated to all staff, clients and visitors, and reflected in local policies and procedures.
- Given that some officers, such as police and prison officers, are legally authorised to carry and use firearms (as well as prohibited weapons such as capsicum spray and batons) in the course of their duties, health services need to negotiate agreements with the relevant agencies regarding the *appropriate* authorised carriage and use of weapons within the different areas of the health service based on a risk management approach. The agreed procedures should form part of the local firearms and non-firearm weapons policy and be agreed by the local health service-police partnership.
- Police should be contacted immediately when the presence, or likely presence, of a firearm is detected in a public health service. Agreements should be negotiated to ensure that firearms are collected by Victoria Police, in accordance with agreed local procedures and timeframes. If necessary, the firearm should be safely stored, *only* for the purposes of making the health care facility safe, while awaiting collection by the police. After collection, Victoria Police should determine an appropriate course of action for the item.
- Health services need to recognise and manage the potential for everyday items such as furniture and crockery, as well as items used specifically in health care such as syringes and scissors, to be used as weapons. Assessing risk associated with dangerous articles and applying a risk management methodology requires a systematic, proactive approach that includes an awareness of and recognition that different contexts, settings and clients (or groups of clients) and their clinical needs will require different approaches to ensure a safe workplace (DHS 2009b, pp.7–8, 10–11).

265 See also the discussion in Chapter 8.

'Deter, detect and manage: A guide to better management of weapons in health services' is clearly a policy based on principles of occupational health and safety and risk management — in effect minimising and controlling weapons in health services. As such, some commentators have questioned whether the issue of PSOs as discussed above isn't counter-intuitive.²⁶⁶

Whilst the policy was certainly seen as a coordinated approach to weapons management, it did not and could not solve the problem of medical staff being (in theory) in possession of prohibited items should they handle a weapon retrieved from a patient or visitor. Subsequent amendments to the *Firearms Act 1996* and the *Control of Weapons Act 1990* have resolved this anomaly by exempting certain health workers under these Acts from committing an offence when possessing a firearm or controlled weapon, prohibited weapon or dangerous item.²⁶⁷ The main workers who are covered by the new provisions include health professionals (doctors, nurses, psychologists); ambulance officers and health service security guards.²⁶⁸

The circumstances under which the exemptions apply are that the health professional, health service security guard or ambulance worker,

- (f) is carrying out his or her duties as a health professional, health service security guard or ambulance worker, as the case may be; and
- (g) either—
 - (i) is given the firearm by a patient; or
 - (ii) removes the firearm from a patient; or
 - (iii) finds the firearm in the vicinity of the patient; or
 - (iv) is given the firearm by a health professional or ambulance worker who has taken possession of the firearm in the [same] circumstances.²⁶⁹

A health professional, health security guard or ambulance worker who takes possession of a firearm must notify a member of the police force as soon as practicable after having taken possession of the firearm.²⁷⁰

The provisions for the removal and disposal of weapons other than firearms are in the same terms under the *Control of Weapons Act 1990*.²⁷¹

Subsequent to these legislative changes the Department of Health has revamped its weapons policy directing public health services to ensure that:

- their local weapons management policies and procedures are developed and/or reviewed in consultation with their local police and legal counsel to ensure joint agreement about how weapons

266 See for example, Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Other witnesses to the Inquiry, whilst certainly applauding these policy and legislative developments as beneficial changes, argue that there are still considerable problems in addressing weapons management in hospital. For example in a Submission from the Royal Melbourne Hospital it was stated:

'Despite the implementation of policy changes, staff continue to report problems identifying and removing weapons at point of entry to the ED. Evidence of this problem was noted during 30 hours of triage observations conducted between June–August 2011. At triage there is limited privacy for performing weapons screening and it is clear that time constraints and high patient turnover in the waiting area represent significant barriers to the conduct of safe effective weapons screening. Indeed, many nurses report that they lack confidence and are fearful of performing weapons screening. In addition, security may not always be immediately available to assist with the process because they are attending to other duties within the hospital. Our observations confirm that triage nurses require the support of security staff to safely and effectively conduct effective weapons screening' (Submission from the Royal Melbourne Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011.

267 See Section 54AA *Firearms Act 1996* and Section 7A *Control of Weapons Act 1990* respectively.

268 Defined as 'a security guard licensed under the *Private Security Act 2004* when working in a health service facility as a contractor or employee' See Section 54AA (6)(c) *Firearms Act 1996*.

269 Section 54AA, subsection 3, *Firearms Act 1996*.

270 Section 54AA, subsection 4, *Firearms Act 1996*.

271 See Section 7A. *Control of Weapons Act 1990*.

will be managed within their specific environment, taking into consideration variables such as access to gun safes (or agreed alternatives) and proximity of police (particularly in rural environments)

- there are clear policies and procedures that identify which workers are specified as exempt in the Firearms Act and the Control of Weapons Act, including through contractual arrangements (for example, external security contracts or 'agency' staff), as well as the specific circumstances under which the exemptions apply
- relevant policies and procedures include information about what is meant by a 'prohibited person', as set out in section 3(1) of the Firearms Act
- employment processes are in place to keep the health service informed of any *current* or *potential* employees who are 'prohibited persons' (and therefore not exempt from the specific breaches of the Acts), and that these employees and their managers are aware that the exemptions do not apply to prohibited persons
- affected staff members are aware of their responsibilities under the Firearms Act and Control of Weapons Act and that policies and procedures reflect and support lawful actions
- these legislative changes and this factsheet are included on the agenda of the organisation's *Police and other key agencies collaborative committee* (however titled)
- joint agreements with local police are in place regarding the processes for safe storage of weapons while awaiting collection by the police and the safe disposal of weapons
- processes are in place for accurate reporting and reviewing of incidents where health care workers need to take possession of a firearm or other weapon in the course of carrying out their duties (Department of Health 2011a, p.1).

Conclusion

This chapter has examined the issue of whether it is appropriate to deploy Protective Service Officers in Victorian public hospitals. The evidence received by the Inquiry emphatically indicates that the government should not pursue such a policy direction. Similarly, the overwhelming weight of expert opinion suggests that it would be inappropriate, dangerous and counterproductive for firearms and to a lesser extent other forms of weaponry to be part of the security measures used in the hospital environment.

In summary, the attitude of hospital staff to PSOs or any type of security officer bearing arms and to a lesser extent other types of weapons is summed up in the medical maxim *primum non nocere* — 'do no harm'. It would seem to be the consensus that the specific proposal for PSOs and the general issue of weapons in the emergency room is counter to the patient focused ethos of most hospitals — in the words of one submission, 'Firearms increase *risk* not security'.²⁷²

The use of weapons however is not the only issue that needs to be considered in the context of hospital security. The next chapter examines a raft of issues pertaining to how security personnel and security measures should be best employed in Victorian health care settings.

272 Quoted in Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

Recommendation

- 11. The Committee recommends that Protective Service Officers (PSOs) not be employed in Victorian hospitals and health services. Such a measure is inappropriate and contrary to the good management of security in hospitals and poses a greater safety risk.**

The overwhelming response to this Inquiry has been that under no circumstances should either armed or unarmed Victoria Police Protective Service Officers or any other armed officer be placed in Victorian Hospitals or emergency rooms to assist with security. This view has been repeatedly stated to the Committee by doctors, nurses, ambulance officers, and executive hospital management amongst others. The reasons for this position are many and are expounded in full in the relevant chapters of this Report.

In particular, however, hospital staff are concerned that the presence of armed guards would increase rather than reduce the potential for violence in the hospital environment. The introduction of armed officers has the potential for unintended serious consequences for the safety of staff and patients should firearms be discharged in close confines. This has certainly been the case in the United States of America. Moreover, according to many witnesses the sight of guns has the potential to unnecessarily intimidate patients or the public.

Secondly, there are concerns from hospital management that if Protective Service Officers were introduced the hospital 'chain of command' could be compromised. In particular, the issue of whom Protective Service Officers would be answerable to and take direction from would be blurred. This is particularly the case given that emergency risk management should be clinically-centred rather than security-centred according to most witnesses.

Recommendation

- 12. The Committee recommends that hospital security guards should not possess, carry or utilise firearms, capsicum spray or tasers in the course of their duties.**

Whilst the evidence to the Inquiry has emphatically been opposed to the introduction of armed PSOs or security officers, the arguments are less clear-cut for the use of other forms of weapons, restraint procedures or security equipment.

The use of capsicum spray and tasers is particularly contentious. Many witnesses to the Inquiry have given evidence that the deployment of such spray in the close confines of the emergency room can have a deleterious effect on staff and patients alike. At the very least its use would require the vacation of the immediate environs causing disruption to the smooth running of the emergency room. The evidence received by the Committee suggests that on balance it would be inappropriate for security officers to wear or use tasers or capsicum spray/foam.

As for other forms of restraint and security measures, for example handcuffs, physical restraints and metal detectors, the Committee believes each hospital should develop its own policies and procedures according to its own individual needs. In all cases however, hospitals must comply with and act according to the provisions of the state government policy 'Deter, detect and manage: A guide to the better management of weapons in health services'.

Recommendation

- 13. The Committee recommends that all Victorian hospitals be assisted to comply with the provisions of Victorian firearms and weapons legislation and the state government policy *Deter, detect and manage: A guide to the better management of weapons in health services*.**

The Department of Health in conjunction with Victoria Police have developed a comprehensive policy on weapons management in Victorian hospitals and health services. Recent legislation has also clarified the position of health care staff in receiving and handling weapons in the possession of patients, their visitors or any other person without authorisation to do so on hospital premises. It is essential that this policy is publicised and followed in all Victorian hospitals and health care settings.

7. Roles and Responsibilities of Security Personnel in Hospitals

Introduction

A key focus of this Inquiry was to examine the security arrangements that have been implemented to prevent violence in hospitals and, in particular, emergency departments. As hospitals and health care settings are environments in which aggression and the potential for violence are common, it is essential that they are provided with good security services as one part of an overall approach to reduce that violence. Yet such a proposition is not as straightforward as it might seem. A number of questions and issues arise pertaining to the deployment of security services in (public) health settings. These include:

- ◆ How should security staff be deployed in hospitals — as permanent employees, contracted staff, casual staff? Should individual hospitals have the ability to choose which option is best for them?
- ◆ What should the *role* of security staff be in the emergency room and other parts of the hospital?
- ◆ Should security staff in hospitals be specialists with dedicated training on health related issues or generalists who can ‘switch’ between jobs?
- ◆ What should the relationship be between security staff and clinical staff?
- ◆ Who is responsible for leading responses to security incidents for example, Code Grey or Code Black emergencies — clinical staff, security staff or a combination of both?
- ◆ What should be the relationship between security services and external parties such as Victoria Police or Ambulance Victoria?

These questions and issues will be discussed throughout this chapter

Clearly hospitals have made important advances in security over the last 20 years. Nonetheless, there are still significant issues that require addressing with regard to the need for hospitals and health services to provide safe environments for staff, patients and visitors. Not the least is the different types of security staff that can be used by hospitals — in-house employees, contract or casual staff. Prior to examining these issues it is appropriate first to look at the legislation governing the deployment of security staff — the *Private Security Act 2004* (Vic) and then to briefly examine what some of the main tasks of security officers may be in a hospital setting.

Regulation of security staff — the Private Security Act 2004

The licensing, vetting, disciplining and general regulation of contracted private security officers is governed by the provisions of the *Private Security Act 2004*. Security staff who are employed directly by organisations such as hospitals or ‘in-house’ security are for the most part not covered by the Act.

Under the Act the generic term for a security operative is a ‘security guard’ which is defined by Section 3 as follows:

security guard means a person who is employed or retained to protect, watch or guard any property by any means, which may involve one or more of the following —

- (a) the protecting, guarding or watching of any property by patrolling the property in person —
 - i) while exercising control over a dog; or
 - ii) while armed with a firearm; or
 - iii) while unarmed; or
 - iv) being the collecting, transferring or delivering cash or other valuables while armed with a firearm;
- (b) the protecting, guarding or watching of any property by monitoring the property by operating a security system that utilises closed circuit television, a closed monitoring system, radio or other similar device —
 - i) where the person may be requested to attend an activity; or
 - ii) where the person cannot or does not attend an activity.²⁷³

Other types of security personnel covered by the Act include private investigators, bodyguards, crowd controllers and security trainers. In the hospital context however, only security guards are of relevance. Victoria Police members and protective service officers, as one would expect, are specifically excluded from the Act's ambit.²⁷⁴ Unlike some other states, particularly New South Wales, security staff who are employed by an employer such as a hospital as dedicated or in-house security are *not* required to be licensed.²⁷⁵

Both security officer companies or contractors and individual security guards must be licensed to provide contract security guards or act as individual guards respectively.²⁷⁶ To act in contravention of these requirements attracts monetary penalties.²⁷⁷ Under Section 172 of the Act the Chief Commissioner of Police may approve or authorise any security education, training or competency standards as a condition of licence. The issue of education and training of security officers will be covered separately in Chapter 11 of this Report.

The tasks of a security officer in a health care setting

The tasks that security officers may be called upon to perform in a hospital setting can include:

- ◆ Dedicated stationed positions in emergency department
- ◆ Patrol of hospital wards, emergency department, car parks and other areas of the hospital
- ◆ Patient, staff and visitor safety
- ◆ Weapons screening
- ◆ Monitoring of video surveillance equipment where applicable
- ◆ Participation in joint hospital committees and teams such as aggression management teams²⁷⁸

273 Section 3, *Private Security Act 2004* (Vic).

274 For a definition of a Protective Service Officer see Section 118 *Police Regulation Act* and the discussion in Chapters 1 and 6.

275 See Section 4 (h) *Private Security Act 2004* (Vic).

(4) A person is not required to hold a private security licence, a private security registration or a temporary permit issued under Division 6 of Part 3 or Division 5 of Part 4, if that person is –

(h) a person (employee) who, in the course of his or her employment with an employer (who is not carrying on a business for which a private security business licence is required, or a business for which a private security business registration is required) is required:

- (i) to watch, guard or protect any property or do any inquiry work; or
- (ii) only in connection with the employer's business to:

- a) install, maintain, repair or service internal security equipment; or
- b) provide advice to the employer in relation to security and related services matters –

276 Section 5 [Business licenses], Section 7 [Individual licenses].

277 Section 5. 120 penalty units for individual business licenses, 240 penalty units for corporate businesses. Section 7. 120 penalty units for an individual operating licence.

278 See discussion in Chapter 8.

- ◆ Emergency response such as Code Greys and Blacks
- ◆ Generally addressing aggressive incidents in all parts of the hospital
- ◆ Securing the entrances and exits of hospitals
- ◆ Addressing theft and other criminal activity in hospitals.²⁷⁹

How should security officers be deployed in hospital environments?

One of the issues raised throughout the course of the Inquiry is whether security officers should be contracted employees of the hospital on either a full-time or part-time basis (in-house staff) or employed on a sub-contractual or casual basis from security companies. Alternatively, is a mix of staff the optimal model; that is, a core of dedicated in-house security staff supplemented by casual employees on a needs basis?

Dedicated employed or 'in-house' security

Until relatively recently, security personnel have in the most part been employed by or directly engaged by hospitals.²⁸⁰

Witnesses to the Inquiry have expressed differing views on the most suitable way to deploy security staff, seeing advantages and disadvantages in both the in-house and the contracted staff models. Many of the 'big' hospitals such as St Vincent's or Royal Melbourne have dedicated in-house staff although some such as the Alfred Hospital rely on the services of a security company.

One point raised by security expert David Van Lambaart is that as full-time dedicated staff may be in some cases prohibitively expensive it may be against the (budgetary) interests of some hospitals, particularly smaller ones, to employ them. 'Security is not necessarily viewed as a revenue stream and is therefore relatively low on the scale following initial quality and compliance objectives'.²⁸¹ Alternatively, some particularly smaller or more remote hospitals might have 'multi-skilled' some of their employees to perform both security and other functions. Only relatively recently has an increase in the problem of hospital related violence made it apparent that this is an unsatisfactory and indeed dangerous option:

[Employing directly engaged security staff] did not necessarily mean however that dedicated security personnel were prevalent or 'the order of the day'. Finite budgets meant that in a number of hospitals there was a need to cross skill staff through the utilisation [extension] of existing resources such as male nurses, orderlies and in some instances cleaners [NSW] to undertake the emerging security requirement.²⁸² Their utilisation however continued to be ad hoc and reactionary and by extension presented a number of downstream consequences and difficulties associated with recognition of function, role definition, and prioritisation of tasks [ie. conflict in terms of focus and productivity].

As the incidence or prevalence of aggression increased it became apparent that there was a need for some hospitals to consider dedicated and purpose trained security personnel through specific and direct engagement. Due to finite budget resources however, many hospitals continued to use cross skilled resources and simply extended that resource base.²⁸³

279 This list is a synthesis of written and oral evidence given to the Inquiry by security and clinical staff in Victorian hospitals. See also Wilson Security 2011.

280 Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

281 Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

282 Certainly in 2000 Lyneham noted the prevalence of male cleaners doubling up as 'security' in rural and remote area hospitals. This 'questionable' practice was often made worse by local police often being out on other calls physically distant from the hospital (Lyneham 2000, p.15).

283 Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

Continuity and trust

Many of the witnesses the Committee heard from and certainly those working in public hospitals seemed to prefer the dedicated security model to having casually contracted staff. For example, Dr Stephen Parnis, emergency physician and vice-president of the AMA (Victoria), told the Inquiry:

Continuity is a good thing. When you are in a high-pressure environment, and I know the people I am working with, the senior nurses, the administrative people, even orderlies who can be trained to provide skills and help in these areas, if I know the people I am working with, that gives me confidence and makes a big difference....[i]n my and our experience the security that works very well in a hospital setting is with, for example, a team of six highly trained, unarmed in any way, shape or form, in-house-employed security personnel who have immediate access to the emergency department, who work closely with medical and nursing staff, and who are skilled in the use of physical restraint and of mitigation of aggression...my preference would be to have them as specific hospital employees. I say that because in many hospitals you have got people who have been working in the place for years. It is not just that they become part of the furniture, it is that point I made earlier that you have someone by your side and you know what they are good at, you know their strengths and weaknesses and you trust them. That makes all the difference. It is like a finely tuned team when you are dealing with one of these violent patients. If you have got locums or people there who do not even know where the toilets are, for example, the chances of their effectiveness being diminished is much higher.²⁸⁴

This view that dedicated security staff provide a sense of trust, intimacy and continuity that is lacking with contract or casual staff was fairly prevalent amongst witnesses from hospital settings. Susan Cowling, Unit Nurse Manager at St Vincent's Hospital Melbourne, told the Inquiry in this regard:

You need to build relationships with your security officers. The team need to know that when they step into that room and have to restrain that person to put in a needle, a cannula, or something like that, then they have to feel very sure about the people holding that person down. When different officers come on board, I know you are at first a little nervous because a lot of verbal abuse goes on. You have to stand there and listen to a lot of things, so that support and relationship between your officers is very important for the team.²⁸⁵

The Health Services Union also testified to the importance of in-house security who are prepared to work in conjunction with and where necessary under the direction of the clinical staff.

Moreover, some hospitals who use in-house security claim one of the benefits is that they can provide the specialist training that security staff need themselves and in conjunction with clinical and other staff.²⁸⁶ Training together and working together as a team provides staff with a level of collegiality and cohesive relationships that is arguably missing when casual or contracted staff are employed. As Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, from St Vincent's Hospital Sydney explained to the Inquiry:

You can't under estimate the value of a regular face, someone you know. When you have a contractor, he's wearing a uniform he must be security. But when you know that guy, then the level of informal information — that informal relationship really comes to the fore when you need a form of response to a situation. The aspect of corporate memory... that really helps. So that sense of ownership [of the job and

284 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

285 Ms Susan Cowling, Nurse Unit Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

286 See for example, comments of Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011. Further discussion of the training needs of security staff can be found in Chapter 11.

the role] means that the team is very cohesive and they look after one and other. It's not just seen as this is the police force of the hospital...They are very much a part of the entire team.²⁸⁷

Similarly, Dr Harry Patterson the Deputy Head of Emergency at Royal Perth Hospital told the Inquiry:

I can't see how [our system] could be better advantaged than [by having] the [in house] security staff that we have at the moment. I know a lot of guys who have worked in the hospital for a long time — I trust them they trust me. People coming in from outside, it takes a while to build up that sort of trust again. I think the security here are wonderful. They really are very good. I've worked at some of the other hospitals in this State and the security guards are sometimes no more than glorified car park attendants.²⁸⁸

The same considerations apply in a paediatric setting according to Dr Simon Young of the Royal Children's Hospital:

I think a security presence in the emergency department is incredibly useful, but they have to be trained in what we expect them to do. There are lots of differences in working in a clinical environment to working in an unprotected environment, and I think they do need an understanding of the behaviours that they are seeing. If they see an autistic adolescent for the first time the last thing you want is some heavy-handed person to deal with that. You want somebody with a bit of understanding and finesse of what is going on to assist you as part of the team. Ideally you would know them very well and you would practise going through these situations.²⁸⁹

Dr Stephen Parnis stated that the downside of using contracted staff is the risk that they are not sufficiently familiar with the clinical setting to be of optimal value:

I think there may be issues in relation to having security staff who come from outside, from a large company...So they have been working one day providing security for a public event and then the next they are providing security in a hospital department; the needs are completely different, and that reduces their ability.²⁹⁰

Even staff in hospitals that *do* employ contract staff, such as Perry Muncaster of Geelong Hospital, recognise that 'at times there are varying degrees of effectiveness with some of [those] guards.'²⁹¹

Responsibility and accountability

Advocates of in-house security also believe that such a system creates better lines of accountability and responsibility between clinical and security staff. For example, St Vincent's Hospital Melbourne is an organisation that uses a dedicated security staff team many of whom have been in their positions for at least 10 years, a system which according to Paul Cunningham, Security Manager, works very well:

We are the core and crux of the team when it comes to dealing with aggression. ...Personally, I would not particularly like to have someone working as a security officer who was not responsible to me. I

287 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011. Mr Hudson's colleague Mr Ross Judd, Security Manager of St Vincent's Hospital, Sydney also comments that having in-house security allows the hospital to offer security employees a career path with better conditions, remuneration and training. This in turn makes the security staff feel they are a valued part of a team unit. Mr Ross Judd, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

288 Dr Harry Patterson, Deputy Head, Emergency Department, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

289 Dr Simon Young, Director, Emergency Medicine, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

290 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

291 Mr Perry Muncaster, Director, Human Resources and Organisational Safety, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

need to be able to set out what they do, how they do it, what their job role is, right down to the nth degree, and that way I would know we would get it right. If you are going to have security, it all needs to be in-house.

As to my retention of staff, I have no-one who has not been there for less than 10 years now. When guys come to work in security at St Vincent's they stay, and that is how they become better at delivering the service. You see when they first come in, whether it be nursing staff or security staff, they are rusty; they are learning the ropes and they learn how we actually need to deliver the service...The only way you are going to get the level of care that you want is to have officers who have been there for a good period of time. That is one reason that we have never gone with contract security.²⁹²

St Vincent's 'sister' hospital in Sydney seems to have a particularly good collaborative model in which clinical and security staff work as equal partners under the overall direction of the emergency department team. For example, Ross Judd, Security Manager of St Vincent's Hospital Sydney, told the Inquiry:

My guys [security staff] definitely have the upmost respect of [the emergency clinical team] when they work with them. In terms of when we do the more serious things like restraints and they are violent and they can be very exceedingly so and dangerous, they still operate under these people's direction. These people appreciate my staff knowing what they can do, what they should do and give them the resources to be able to do what they need to do in those particularly violent incidents. But they still manage my staff; they are still clearly under a clinical direction when all these things take place. So if Gordian [the Director of Emergency] says "Boys you have to stop or do this or that" they will instantly respect his view. They might ask or put two bobs worth in and say that are not confident about this, we don't want to release this guy or whatever, so there is some input from the security team but they are still under very specific direction and management.²⁹³

A senior emergency department nurse from the Sir Charles Gairdner Hospital in Perth was emphatic that any responses to violent incidents on the floor need to be clinically led:

[Security staff] need to be led. Security is part of a team but ultimately the decision is a medical decision as to how that situation runs. So either senior nursing or senior medical is the lead on that team. There are situations where that doesn't go as well, security has no idea what direction to take, what to do, how to do it, what our expectations are and if they don't have the ability to ask and be that sort of assertive person through training and also knowledge base...there have been situations where it hasn't gone the right way...Someone has been injured or someone, the patient has not had the best outcome as such.²⁹⁴

Security managers who work in hospitals where there are dedicated in-house security staff tend to agree with such a viewpoint. For example, Dunko Grubisic, Security Manager at Westmead Hospital, Sydney told the Inquiry:

Through my experiences working as an officer and in a management capacity I have come to understand that there are a number of factors when dealing with aggressive situations... The internal factors for me are more of a clinical controlled environment where you work under a clinician, you are guided by their understanding of the clinical procedures, the type of patient you have and that type of

292 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

293 Mr Ross Judd, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

294 Ms Lisa Gray, Co-ordinator of Nursing, Sir Charles Gairdner Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 22 June 2011.

On the importance of teamwork between clinical and security staff and the need for both groups of workers to be given effective training to promote this, see the comments of Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

See also Mr Dominic Dawson, General Manager, Blacktown Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

thing. When you work with a clinician from a security point of view it becomes easier to manage the situation from a legislative view. It is easier to come up with a decision to best look after the patient, as well as care for the staff and the patient and visitors in the area.²⁹⁵

In Western Australia, Luke Roscoe, Head of Security at the Royal Perth Hospital agreed that generally an in-house model was much preferable for reasons such as accountability. He stated that whilst 'A few hospitals have trialled contract security, normally they come back to in-house security'.²⁹⁶

It may also be that contract staff, particularly those who have only relatively short stints in the hospital, may not be attuned to or sympathetic with the clinical approach to dealing with aggressive patients. As David Van Lambaart explained:

It is not uncommon for conflict to arise between security personnel who are trained, experienced and adept at physical restraint and clinical staff who hold the view that the restraint of an individual that requires overpowering is in direct conflict with their ethos of what constitutes reasonable force and a wider 'duty of care'. Conversely, this does not mean that at times security personnel may not be over zealous with an individual, escalating the associated risk factors for the individual being restrained and for hospital staff, patients and visitors in proximity to such an incident.²⁹⁷

Employed hospital staff, however, may be recruited on the basis of their willingness to train with, learn from and be led by clinical staff. For example, Paul Cunningham, Security Manager for St Vincent's Hospital Melbourne told the Committee that the security complement at that hospital were perfectly in accord and respected the Christian ethos of St Vincent's and their approach of respect and compassion for the patients in their care.²⁹⁸

Contract staff

The relationship between a security provider company and individual (hospital) clients can vary significantly according to the Australian Security Industry Association (ASIAL):

There is no security service model or minimum standard when dealing with the provision of hospital security services. The degree of service provided varies according to the client and the assessment of the client's site requirements and assessed risks.²⁹⁹

The use of external security service providers, however, has some advantages, principally according to David Van Lambaart, financial and budgetary ones. In particular the use of contract/casual staff has been:

[i]n a number of instances driven by the more obvious deliverables of: —

- managing and controlling of costs including human resources overheads
- shift in responsibility associated costs for recruitment

295 Mr Dunko Grubisic, Security Manager, Westmead Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

296 Mr Luke Roscoe, Head of Security, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Site Visit, Perth, 20 June 2011.

297 Contrary to much of the evidence received by the Committee from hospital staff, Mr Van Lambaart did not believe that a 'clinically led' response to a violent incident was always necessarily appropriate:

'Of concern moreover is the contention that clinical staff are best placed and skilled to lead a response to an aggressive or violent incident. While accepting that numerous aggressive and or violent incidents typically arise from a clinical setting (Emergency Department — Triage and Treatment, Mental Health, presenting 'Emotionally Disturbed' persons, Social Welfare) this does not necessarily lead to the conclusion that clinicians are best skilled, equipped or experienced to manage an effective or safe response, particularly one that may require physical restraint or intervention' (Submission (No. 1) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011).

298 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

299 Submission from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

- shift in exposure to WorkCover overheads in an area that has obvious and inherent risks.³⁰⁰

Mr Van Lambaart also indicated that one of the advantages of contract staff is that unlike in-house staff who are employed by the hospital, particularly over a long period of time, contract staff may be less resistant to changing entrenched work practices and more likely to embrace innovation and change.³⁰¹

Some witnesses to the Inquiry, whilst generally preferring a model of in-house security, did acknowledge that casual or contracted security staff could 'plug gaps' at times when flexibility was needed in deploying security staff. For example, whilst St Vincent's Hospital Melbourne employs only in-house staff in its main premises, some contract security are occasionally employed to monitor their smaller sites.³⁰² Similarly, Royal Prince Alfred Hospital in Sydney that has in-house security does 'at times use agency security but that is the exception and not in patient areas or high risk areas'.³⁰³

Security companies who provide staff argue that contract staff can provide flexibility to hospitals depending on their need. At the Security Forum convened by the Committee, representatives argued that in allocating staff to hospitals or other health services, management were always mindful to provide staff that were especially trained in health security and match the right type of staff to the hospital environment wherever possible. As Jennifer Nicholson, Project Manager from Spotless Security, explained:

We try to align the staff we recruit with the environment we are recruiting them for. We actively avoid employing officers who have come from a nightclub background, as the aggression management is quite different. We note that the security industry [could] improve[e] the diversity of its workforce by increasing the representation of female security officers; our experience is that the presence of female security officers can be advantageous when de-escalating or trying to calm an aggressive patient. A more even gender mix in the security team would allow for a more targeted response team to be used, depending on the type of aggression.³⁰⁴

Ms Nicholson also suggested that the role, function and training of the contracted security officers they allocate to the Alfred Hospital are little different from security officers working on an in-house footing:

The services for security that we provide at the Alfred cover the whole gamut of security, which is patrolling, managing the ID and access systems, and keys. We do the duress point attendance across the facility and testing of all the duress points across the hospital. We manage patient valuables and property with CCTV monitoring; locking down and opening up of the facility as required; screening visitors, who come through the emergency entrance only after hours; and we do mortuary. We also assist with all the codes: red being fire; brown being general emergency; code yellow, which is an internal emergency; and code purple, which are bomb threats. By far most of our time on codes is spent managing the code greys and, to a lesser extent, code blacks across the hospital. These are predominantly in our emergency department and now the psychiatry wards of the hospital. That is where most of our time is spent.³⁰⁵

300 Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 21 October 2011.

301 Submission (No. 2) from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 21 October 2011.

302 See Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

303 Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

304 Ms Jennifer Nicholson, Project Manager, Spotless @ The Alfred, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Roundtable meeting, Melbourne, 10 October 2011.

305 Ms Jennifer Nicholson, Project Manager, Spotless @ The Alfred, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011.

Bryan de Caires the Chief Executive Officer of ASIAL argued that it is not so much whether a security officer is employed by the hospital or is contracted that is important as much as the type of work they are engaged to do in the hospital. On whatever basis the person is employed he or she needs to have a role that is dedicated to security tasks and security only. In some ways it is more likely that an in-house employee will be expected to 'multi-skill' than someone contracted from a security company with the specific brief of supplying security services:

The multi skilling of emergency department security staff reduces the effectiveness of a physical security presence and the response ability of the resource. Multi skilling includes dual roles of security/orderly, security/cleaning or significant time away from the emergency department of dedicated security staff in the performance of other security response, patrol or delivery functions within the broader hospital environment.³⁰⁶

Peter Johnson, also from ASIAL, suggested that the idea that in-house staff were somehow more likely to be a cohesive and clinically led group than contract staff was somewhat questionable. Contracted staff can and do work as part of a close-knit team:

The problem does not exist to the degree of what you are suggesting...Our members contract in and they are already under a contract negotiated position of relationship and they are part of the team. In actual fact, in some hospitals you would not even know whether those people are contracted in or are employees of the hospital. They are moulded in as part of the team. You might see a different uniform being worn or you may see the uniform of the hospital being worn, you will not see the name of the contractor there but they are part of the response team...You get these health care workers and security people realising they are so dependent upon each other...They have good relationships. That is why we have permanent night shift people because those night shift nurses are permanent, the night shift security are permanent, and they really work so well together, they rely on each other and they trust each other.³⁰⁷

Similarly, Andrew Way, Chief Executive Officer of Alfred Health³⁰⁸ indicated it is not so much the model of security employed that is important but how those security officers are trained to work as a team with the other hospital staff:

Whether it is an in-house service, an outsourced service or a service provided by a third agency, the key message seems to be the way in which the teams work together to create an environment that manages the prevention of aggression and violence rather than the way they manage the event itself.³⁰⁹

Another advantage of using security company services is that, in Victoria at least, all contracted staff will have been provided with minimum training as part of their security contract and licensing requirements.³¹⁰ Whilst advocates of in-house security staff may argue that comprehensive and clinically oriented training can be provided by the hospital this will not always be the case:

Every security person in New South Wales is required to hold an appropriate security licence, whether they are an internal employee or are provided through a security contract. In Victoria that is not the case and it is something that should be considered as one of the requirements. Legislation in Victoria provides that an in-house security team does not have to be security licensed and therefore they do

306 Submission from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

307 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

See also comments from Brett McDonald, National Integrated Security Manager, Wilson Security. Mr McDonald indicated that in examples of security emergencies such as Code Black calls, security staff would always be guided by the clinical team, particularly where restraint needed to be employed. Mr Brett McDonald, National Integrated Security Manager, Wilson Security, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Roundtable meeting, Melbourne, 10 October 2011.

308 The Alfred Hospital uses contract security services through the company Spotless.

309 Mr Andrew Way, Chief Executive Officer, Alfred Health, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

310 See Submission from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

not have to meet the underpinning based requirements of training. Whether that training is suitable or not is irrelevant; they do not have to meet it.³¹¹

Security companies argue moreover that even contract staff can and do share joint in-house training with clinical staff in the hospital setting: For example, Wilson Security pointed out that many of their staff:

Under[go] the same training with hospital staff — they are all working in the same guidelines and also develop a more harmonious working relationship with hospital staff. This type of training definitely delivers a better outcome than generic outsourced training through a third party provider (Wilson Security 2011, p.7).³¹²

Finally, David van Lambaart, an expert in hospital security, stated that the problem is not so much whether security staff are contracted or fixed employees as that some hospitals do not have professional approaches to risk management either through the employment of a security risk manager or through actively seeking external independent security risk-management advice.³¹³ Other witnesses have also stated that whether security staff are fixed term, hospital employees, contracted through a security company and/or casually employed the important issue is that they are present in sufficient numbers to make a real difference.³¹⁴

A note on uniforms

One issue that has been raised throughout the course of this Inquiry is whether security staff, be they hospital employees or contract staff, should wear a uniform and if so what type of uniform that should be.³¹⁵ Most hospital security staff do wear a uniform of some type. This may be the corporate uniform of the security service company (Spotless, Wilson etc) or a uniform provided by the hospital that may or may not be indistinguishable from uniforms worn by clinical staff. Many if not most uniforms have a logo, insignia or nametag referring to their role as security staff.

Most clinical staff who presented to the Committee expressed the view that security and other staff should be differentiated by a uniform that indicated their role:

311 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

312 Conceivably, however, such a system could only work in cases where staff are contracted to the hospital for relatively long-term appointments.

313 Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011.

314 Although numbers vary, many witnesses have stated that in a reasonably busy hospital at least four qualified well trained security officers should be rostered on 24 hours a day, 7 days per week. This may need to be increased in hospitals that also staff and monitor video surveillance equipment. For example Mr Luke Roscoe, Head of Security at Royal Perth Hospital, told the Committee that whilst video surveillance was important there still needed to be sufficient numbers of visible security staff to patrol the hospital floors and grounds:

'We do have a security ED office that is separate from our main control room and normally we like to have at least one security officer there barring other duties. There was discussion a number of years ago about having full time security just for the emergency department. Unfortunately we are too under resourced to commit to have someone there 100 per cent of the time... At the moment we have got four security officers on duty at any one time, one of those security officers is in our control room, one of the cameras that they rotate, that leaves three out on the floor. We would like to have four on the floor so we have two teams of two; we don't like sending people in by themselves, so if you have two people dealing with an incident, one person is left basically by themselves. So we would like to have two teams of two' (Mr Luke Roscoe, Head of Security, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011).

On the adequacy of security staff numbers generally, see also Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011; And the evidence of Dr Harry Patterson, Deputy Head, Emergency Department, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011; Mr Perry Muncaster, Director, Human Resources and Organisational Safety, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

315 And not only security staff. The issue as to whether the abandonment of the traditional nurses' uniform has resulted in a decrease in respect for the profession is covered in Chapter 4.

I think uniforms [should be worn]. You need to identify to people who they are. It is the same with nurses: they wear a specific uniform to indicate that they are nurses. In emergency we wear scrubs but it says Nurse on it, and the doctors have Doctor on there. Our patient service attendants also wear a uniform. It is good for people to recognise who everyone is.³¹⁶

Witnesses were not only in favour of security officers wearing uniforms because they identified them as such but also because a 'smart' uniform gave security officers a presentable and professional appearance.³¹⁷ Security officers in identifiable uniforms could also give fellow hospital staff (doctors, nurses, ward clerks etc) a sense of reassurance that their safety was being taken into consideration. This would therefore increase their confidence.³¹⁸ Witnesses were generally however not in favour of uniforms that had 'militaristic' overtones. Certainly, in the context of PSOs, some Health Service Union members believed a police style uniform could have a negative effect on patients:

'As soon as they see uniforms they get attitude straight away. You can see them thinking "wanna be cop"' (HSU East member with 32 years experience in Victorian hospitals, comment on the effect of visible security staff on patients).³¹⁹

Paul Cunningham, Head of Security at St Vincent's Hospital Melbourne, made similar observations when he gave evidence to the Inquiry:

We are probably one of the few organisations that does not wear a uniform of the kind worn by the Victoria Police, the army, the navy or something like that. I went away from that look. We had that look when I first started at the hospital. I have been with St Vincent's for nearly 20 years now. We used to wear a tie, shirt and pants and whatnot, and we looked like the Victoria Police. That tended to bring out the wrong behaviours in people. Some people may see black as an aggressive colour, but what we find is that we tend to blend in. We do not have security written all over the back of us. We do not wear jackets that have security written all over them. Yes, we are seen. It is on the arms and the sleeves. We wear badges and whatnot.³²⁰

Ultimately, however, many hospital witnesses were of the view that the type of uniform worn by security staff was not as important as the fact that security must be *visible* and in close proximity to clinical and other hospital staff at all times.³²¹

The relationship between hospitals, security and the police

One of the issues that arose out of the *Victorian Taskforce on Violence in Nursing: Final report* was the need for a better interface between the police and health services, including their security forces, in relation to occupational violence. Some of the particular areas where it was felt there could be improvement were inter alia, the transport of mentally ill patients to hospitals, weapons management and better protocols to assist the victims of occupational violence to pursue criminal charges and support him or her through the process (Department of Human Services (DHS) 2007a).

Consequently a justice, police and health working group was formed to address some of these issues. Various memoranda of understanding were also initiated between hospitals and Victoria Police subsequent to the Taskforce reporting. One of the most important of these is the

316 Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

317 See for example comments of Dr Harry Patterson, Deputy Head, Emergency Department, and Mr Luke Roscoe, Head of Security Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

318 See comments of Ms Lisa Gray, Co-ordinator of Nursing, Sir Charles Gairdner Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 22 June 2011

319 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

320 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

321 See for example, Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

formal collaboration between Victoria Police and Department of Health (and through it most public health services) to support the implementation of policies and procedures on weapons management arising from *Deter, Detect and Manage: A guide to better management of weapons in health services* (DHS 2009b).³²²

Despite such progress there are still areas where Victoria Police in particular believes there is room for improvement. Police identified the following areas of concern with regard to hospital and security processes in relation to violent patients:

- Insufficient hospital staff, in particular over night-shift hours to deal with violent persons. This includes orderlies or security staff, either employed on contract or directly by the hospital;
- The lack of suitable training of security and equipment to deal with violent persons in an effective and lawful manner. This places an unacceptable risk of death or injury to ill-equipped security personnel and renders them potentially ineffective to resolve any threat that immediately presents;
- On occasions there has been a reluctance of security staff to offer practical assistance in the restraint/disarming or securing of a violent person;
- Police attendance for violence issues generally entails substantial time spent at the hospital by members who remain until it is safe and prudent to leave. This places a heavy burden on police resources, particularly for night-shift hours;
- Some hospitals have secure alternative entrances for the admission of patients with mental health issues but these are not always used. Admissions are facilitated through public areas such as triage and this exposes the public, other patients and staff to witnessing potential violence, physical arrests or becoming directly involved. Only a small number of hospitals have purpose built areas for appropriate treatment of violent/aggressive patients.
- Some hospital staff are adverse to armed police attending emergency departments if called to deal with violent person, however this is an unfortunate necessity for operational police and also a matter for an operational decision by attending members. A small number of hospitals have varying facilities for the safe storage of firearms. In more remote areas, a police response to an emergency may require an 'out of hours' call-out of an off duty police member. The issue is that there is no on-site security.³²³

In short, Victoria Police are concerned that 'significant differences between hospitals regarding levels of security [have been] identified.'³²⁴ As a way of addressing these issues it has been suggested that hospital managements develop appropriate relationships and protocols and meet regularly with local police³²⁵ concerning security issues. Certainly, some hospitals have stronger relationships with local police than others. Alfred Health and St Vincent's Hospital Melbourne are two health services that have mentioned very close links with their local police stations, in part due to the demographics of the local area. St Vincent's has a dedicated police liaison officer who meets monthly

322 See also discussion in Chapter 6

323 Submission from Acting Deputy Commissioner Tim Cartwright, Crime and Operations Support, Victoria Police, November 2011.

324 Submission from Acting Deputy Commissioner Tim Cartwright, Crime and Operations Support, Victoria Police, November 2011.

325 When the Committee met with representatives of the emergency department at Sir Charles Gairdner, Perth, they spoke of the strong and valuable assistance they received from WA Police when there was a police station adjacent to the hospital at Subiaco:

'[w]e had a fairly good relationship with Police stations close by, in particular Subiaco Police Station and a particular sergeant that was station officer at the time. They actually did walk throughs for us. Trying to do one per shift which made a huge amount of difference to the patients seeing two coppers walk through. Once per their shift. So every eight hours. You would see three different crews within a 24 hour period. If they weren't busy and we weren't horrendous they would sit and have a coffee and a chat with staff which also built that relationship up as well...We lost that fairly quickly when that Police sergeant moved on and they closed Subiaco since' (Ms Lisa Gray, Co-ordinator of Nursing, Sir Charles Gairdner Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Site Visit, Perth, 22 June 2011).

with hospital security and staff to discuss matters pertaining to hospital security.³²⁶ Alfred Health also told the Inquiry that a protocol for police operating within the Alfred Hospital had been drawn up by between the hospital and the police, but was still awaiting action and finalisation.³²⁷

In Sydney, St Vincent's Hospital emergency department and other units of the hospital together with hospital management and security meet quarterly with NSW Police Service and NSW Ambulance Service to discuss operational issues. Emergency department staff told the Inquiry that these meetings were of great value in terms of addressing possible security breaches in hospital security.³²⁸

Whilst these types of agreements are clearly of value, they tend to be ad hoc in nature. Some health bodies have suggested agreements and protocols governing the relationship between health services and police should be systematic. For example, the Health Services Union in a submission to this Inquiry recommended that 'hospital security personnel should meet at least monthly with local police'.³²⁹

The Victorian Health Care Association also indicated that the problems between police and hospitals are not all unidirectional. In particular, some rural health care services whilst generally having good local relationships with police note there are some shortcomings in the service provided due to budgetary constraints etc:

Whilst Victoria's rural hospitals have a good relationship with police services, some VHA members have noted that their service is considerably reliant on police assistance due to limited internal resources. Furthermore, there is often a delay in police arrivals in rural areas due to competing demands and distance. Health agencies generally have protocols in place to deal with security incidents in accordance with accreditation standards; however there is a need for benchmarks and standards to ensure this is systematised rather than dependent on local relationships. This requires significant funding and support.

Patients that require police escort can create difficulties for health services. One major regional health service reports that their service currently receives no notification as to who is being brought in, when they are to arrive, what potential risk is posed and what security resources will be needed to manage them. To mitigate potential risks, the VHA recommends prior notification to health service security staff of all police escorted patients and all correctional services patients being brought to the hospital for treatment.³³⁰

On the issue of reporting occupational violence and subsequently taking legal action, one senior nurse who gave evidence to the Inquiry was unimpressed with the way in which police dealt with her personal experiences of patient violence:

As for reporting to police we are often encouraged to do so, but my personal experience has been that on several occasions I have been physically assaulted. I have called the police to lay charges and the police have been reluctant to do that. On one occasion the person was alcohol affected and I was told that there was no point because he had diminished responsibility, and if I did lay charges he would

326 See Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011; and Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

327 The former Chief Commissioner of Police had not signed off on the protocol prior to his resignation. It was therefore still awaiting approval at a senior level. See Mr Bill O'Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

328 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

329 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

330 Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

get off anyway. So if I am going to waste my time, what is the purpose if the police are telling me he is going to get off. Another one was a patient who was drug affected and was chemically and physically restrained but was still very difficult to manage, threatened myself and my family and was lucid enough to say, 'I don't need to know where you live because I know where you work. I know how I can get you'. I called the police to make charges. That was a shift where I looked after him for 10 hours. The police came and were more than reluctant; they were encouraging me not to press charges because this man was drug affected and where would it lead. Basically you are not encouraged to do so.³³¹

It is hoped that the working party protocols referred to above will result in such experiences being relatively isolated occurrences.

Conversely, Ambulance Victoria spoke highly of their relationship with hospital security stating in a submission to this Inquiry:

Paramedics report satisfaction in the performance of current security staff at EDs. When required, their intervention appears appropriate, measured and well coordinated with the medical staff. There is a cooperative working relationship between hospital security staff and paramedics, where the ED has been alerted and the security staff meets with Paramedics on arrival.³³²

Ambulance Victoria, however, have recommended that the numbers of hospital security staff could be increased at times where violence and aggressive behaviour may be more prevalent such as Fridays, Saturdays and public holidays, from late evening until early morning.

Conclusion

Much of the research indicates that health care staff feel much safer in the presence of security officers deployed in adequate numbers, particularly at night and in high risk areas such as emergency departments (Mayhew & Chappell 2003).

As this chapter has discussed, security services come in a variety of forms (in-house, contract staff, casual) each with their advantages and disadvantages. It should be for hospitals and health services to choose the type of security that best meets their needs and requirements. However if the hospital does employ contract staff, it is essential that hospital management retain responsibility for the security policy and practice framework applying in that facility. In this respect security companies and their employees should always follow the hospital's lead. It is also essential that whatever model is chosen, security staff are licensed, well-trained and have the ability to work as part of a team led by clinical and other staff.

331 Nurse Unit Manager, Emergency Department, at a Victorian Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing. The name and hospital where this nurse works have been kept anonymous to protect the witness.

332 Submission from Mr Greg Sassella, Chief Executive Officer, Ambulance Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Recommendation

- 12. The Committee recommends that hospital security guards should not possess, carry or utilise firearms, capsicum spray or tasers in the course of their duties.**

Whilst the evidence to the Inquiry has emphatically been opposed to the introduction of armed PSOs or security officers, the arguments are less clear-cut for the use of other forms of weapons, restraint procedures or security equipment.

The use of capsicum spray and tasers is particularly contentious. Many witnesses to the Inquiry have given evidence that the deployment of such spray in the close confines of the emergency room can have a deleterious effect on staff and patients alike. At the very least its use would require the vacation of the immediate environs causing disruption to the smooth running of the emergency room. The evidence received by the Committee suggests that on balance it would be inappropriate for security officers to wear or use tasers or capsicum spray/foam.

As for other forms of restraint and security measures, for example handcuffs, physical restraints and metal detectors, the Committee believes each hospital should develop its own policies and procedures according to its own individual needs. In all cases however, hospitals must comply with and act according to the provisions of the state government policy 'Deter, detect and manage: A guide to the better management of weapons in health services'.

Recommendation

- 15. The Committee recommends that each hospital be responsible for the employment of dedicated security staff with specialist training and skills in hospital security. Security staff may be either contracted through a security company or employed directly by the hospital.**

The Committee believes that hospitals should be able to choose whether security staff should be contacted from security agencies or employed on an 'in house' basis. However, this Report does make it clear that there is necessarily a close relationship between health care and security staff. Wherever possible it is preferable that there is continuity of staff placement in hospitals particularly where staff is employed through a security agency or company. Security officers with long-term experience of working in hospitals are ideally suited to being part of a dedicated security team that is clinically directed by the medical staff and hospital management.

The Committee acknowledges that dedicated and well trained specialist staff promote teamwork and ensure that security staff are equipped to deal with the specific challenges of the hospital environment.

Recommendation

- 16. The Committee recommends that visible, uniformed, unarmed security staff should be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may have the potential to occur.**

The presence of unarmed security staff in visible locations of Emergency Departments may be an effective deterrent to violent behaviour. The presence of dedicated security officers with specialist training in health security supports health professionals in the management of violent behaviour and provides the resource of an immediate emergency response. In the bigger and busier hospitals witnesses have stated that ideally a minimum complement of security should include at least four officers stationed 24 hours per day.

It is essential according to the expert witnesses who gave evidence to this Inquiry that not only are security guards employed by the hospitals in sufficient numbers but they are deployed in areas which have the greatest risk of violence, most notably in and adjacent to emergency departments. Where it is impracticable to locate security officers in close proximity to the emergency area, security should always be complemented by electronic and other forms of surveillance monitoring.

Recommendation

- 17. The Committee recommends that the Victorian Department of Health undertake a review of security requirements for rural hospitals that do not qualify for emergency department funding.**

Accident and emergency departments are categorised as 'primary care casualty' and do not qualify for emergency department funding. This may mean that some smaller, particularly rural, hospitals cannot provide even minimum staffed security, but are required to operate 24 hours daily. An analysis of the needs of rural hospitals and emergency departments may give some guidance on what the gaps are in security in rural health services.

8. Coordinating Approaches to Address Violence: Management teams, prevention committees and specialist practitioners

Introduction

Whilst security services are essential components in the efficient and safe running of modern hospitals they cannot be the only answer to preventing and reducing violence in health care settings. Security must, as almost all evidence to this Inquiry indicated, be part of a raft or suite of approaches to reducing or preventing aggression and violence in hospital settings.

Some of the other strategies to address this complex issue include coordinating mechanisms such as management aggression teams or interdisciplinary committees, and the deployment of specialist staff such as nurse practitioners. These approaches are the subject of this chapter.

Coordinating mechanisms and approaches

The Committee has received much evidence as to the importance of coordinated and integrated approaches across and between hospital departments and occupational groupings to address occupational violence in health care settings. For example, Beaver Hudson, Nurse Manager, at the Psychiatric Emergency Centre, St Vincent's Hospital Sydney, explained to the Committee that one of the reasons St Vincent's was such a successful model for containing violence in an emergency department setting, despite its serving a particularly volatile demographic, was due to its promotion of the 'Three C's' — Collaboration, Coordination and Cooperation.³³³ In other words, different areas of the hospital need to be able to work collaboratively together to minimise the potential for patient and other forms of violence. This is especially true for the relationship between triage/emergency and mental health units, which according to Beaver Hudson have too often in the past been prone to working in silos:

If you go across the [country] you will find... some mental health services will refuse to see somebody until they have been medically cleared. A good example is what is going on in Victoria at the moment. I've just done a review of the Alfred Hospital Emergency Department and the problems they have over there. They have this very linear process which is, regardless of how you present you must be seen by a physician, you must be examined to determine if there is any physical cause for your behaviour and then you can be passed on to mental health.

In the good old days that was a really safe appropriate way of managing people but given that we have to move people through the department faster, we have to think a little more creatively.³³⁴

One way this 'siloesation' across departments can be overcome is through the use of management prevention committees and aggression management teams (AMTs).³³⁵

333 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

334 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

335 Sometimes referred to as Management Aggression Teams.

Violence Prevention Committees and Aggression Management Teams

The study by Melbourne University that examined Code Grey and Code Black emergencies in 2005 found that a 'cornerstone of violence prevention' in hospitals was the formation of multidisciplinary violence prevention committees and AMTs. Each of these is an important component of an overall strategy to prevent violence in hospitals.

Violence prevention committees

The idea of a violence prevention committee or equivalent is to ensure all violent incidents occurring in hospitals are:

Audited in a way that quantifies occurrence, identifies management problems, informs local policy and provides advice in respect to education and training (Department of Human Services (DHS) 2005b, p.17).

Violence prevention committees vary in their membership but usually will be comprised of senior hospital management, representatives from most medical, nursing and allied health teams, security representatives and occasionally external members such as police or ambulance officers. Some of the objectives of an AMT or equivalent may include:

- to facilitate the aggression management program and its continued development and implementation
- to further enhance a clinically led aggression management team as part of a process to effectively manage aggressive behaviour
- to ensure that security services (where applicable) are integrated into planning, operations, reporting and evaluation in a manner consistent with obligations
- to integrate training programs
- to develop and review protocols and procedures that are integrated into existing management systems
- to monitor trends through auditing, data collection and evaluation
- to recommend changes to existing systems through review of the current program and serious accidents (DHS 2005a, pp.47–48).

To assist with the audit process, St Vincent's Hospital Melbourne employs a specialist aggression coordinator whose role is to analyse information pertaining to violent incidents in the hospital and identify areas of risk. The Alfred Hospital also employs an Aggression Management Coordinator who reviews and analyses aggression and violence related data and advises Alfred Health's Violence Management Committee accordingly. The Royal Melbourne Hospital (RMH) has two similar groups:

The Management of Clinical Aggression Steering Committee aims to promote a comprehensive and therapeutic approach to the prevention and early management of violence across all acute care areas. The Violence in ED Action Group is responsible for the monitoring of all incidents of patient violence in the ED. This is a multidisciplinary quality improvement committee which has nursing, medical, occupational health and safety, carer, security, police, mental health and education representatives.³³⁶

Representatives of the Royal Melbourne Hospital spoke to the importance of coordinating committees and mechanisms when they gave evidence to the Inquiry:

Melbourne Health, as a result of work undertaken since 2006, has a very strong clinical governance framework for responding to the management of aggression in particular. At an organisational level it has an executive committee that looks at data that comes from various sources and it also looks at training that has been undertaken as well as actual incidents, so adverse incidents as well as overall information that comes from code grey responses. At the emergency department level we also have

336 Submission from the Royal Melbourne Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, November 2011

another committee, and that committee is really looking at what is happening in the ED, so we are looking more specifically at issues that arise at point of entry, which is a particular trigger point which I think we have highlighted in our submission, and in the emergency department, so we look at all events. We look at local training and specific kinds of issues that might pertain to security. On both of those committees we have a multidisciplinary representation. We also have a carer consumer rep on both levels, so it is important that we take into account the perspectives of users of the service as well as clinicians in the emergency department group. We also have representation from security and police. Basically those committees look at the issues at two different levels.³³⁷

Aggression management teams

Aggression management *teams* deal with problems at the 'coal face' rather than the more 'macro' issues of policy and planning. They are based on three underlying principles:

- The development and implementation of a written policy for job safety and security that is clearly communicated to all staff working with patients. Organisations should provide a clear definition of violence and aggression and clearly state policy response for workplace violence
- That all members of AMT are educated in respect to organisational policy and trained in techniques used to contain violent incidents
- That the management of patient violence both in policy development and in staff training be informed by a framework that conceptualises patient violence as a clinical problem requiring a clinically driven response (DHS 2005b, p.17).

AMTs may usually be comprised of doctors, nurses and a security representative. Often they will also have a specialist in mental health as a member of the team and indeed many AMTs may be especially established to deal with mental health issues. This is particularly the case given experience across the country has shown that many call-outs for AMT or their equivalents were related to patients with mental health disorders (DHS 2009b).

The establishment of aggression/violence management teams for all health organisations was a key recommendation of the *Victorian Taskforce on Violence in Nursing: final report* in 2005.³³⁸ The Taskforce's report envisaged AMTs in the following terms:

The AMT focus is to assist the local team to provide ongoing and appropriate care and treatment for patients, and optimise staff safety. In the case of visitors, similar principles are adopted, although security/police may have a more active role in eviction from the clinical area or hospital if this is required.

AMT members may be drawn from any area of the health service and undertake this role as part of their normal duties. Adequate training for the role is critical and AMT members should be trained to assess the incident and coordinate the appropriate responses to best resolve the incident in the least restrictive and safest manner. The AMT will assist the local staff response with the management of an aggressive incident. The senior clinician should have responsibility for escalating a Code Grey to a Code Black, and to engage the support of other personnel (for example, a psychiatrist or police), if required.

Where applicable and according to the needs of the organisation, security services should form part of the AMT or be accessible to the service. The effectiveness of the AMT can be enhanced by having clear policies and associated guidelines in place regarding the use of restraint and/or seclusion but, in any event, should be a temporary or last-resort action.

The appropriate number and skill of members of the AMT may depend on the size of the organisation and number of staff, hours of operation, geographical location and the types of clients that the service supports. For instance, a large public hospital with an emergency department that operates 24 hours per day, seven days per week will have different requirements of an AMT to a maternal and child

337 Associate Professor Marie Gerdtz, Associate Professor of Emergency Nursing, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

338 See Recommendation 11 (Department of Human Services (DHS) 2005a, p.9).

health service operating only on weekdays. Staff skill and availability of security personnel for the AMT should be determined according to individual workplace situations and requirements. A team should be available to respond to aggressive incidents for the entire duration that any facility is open to the public (DHS 2005a, p.47).

Submissions and oral evidence to the Inquiry from some witnesses³³⁹ also called for AMTs similar to those at St Vincent's to be established in hospitals.³⁴⁰

A note on Code Grey and Code Black teams

In addition or as part of their AMTs, some hospitals may have specialist Code Grey and Code Black teams. If these are separate teams from the AMTs they may nonetheless be comprised of the same types of staff (for example, doctors, nurses, mental health specialists, security), although they will usually be headed by the hospital emergency coordinator or equivalent position.³⁴¹

The definitions of Code Greys and Code Blacks vary across hospitals but as a rule Code Greys will usually involve a potentially violent emergency, usually associated with a patient who needs to be subdued because of violent or potentially violent, aggressive or threatening behaviour.³⁴² A Code Black emergency pertains to a higher level of seriousness and in some hospitals will mean that there is a threat of firearms or other weapons being used and/or is an emergency that requires police attention. In most cases if a Code Grey situation escalate in seriousness then a Code Black will be activated (DHS 2009b).

Increasingly, some hospitals are also incorporating informal 'pre or planned Code Grey' categories into their emergency responses that are based on a proactive reading of a potentially violent incident rather than 'waiting for it to happen'. The evidence of Philip Dunn, Director of Operations, Mental Health, Geelong Hospital, is illustrative in this regard:

The code grey and black response in Barwon Health...is a critical component of Barwon Health's capacity to manage violence. Increasingly, mental health is using these resources [code teams] and this capacity to call upon those resources in what we are informally calling a 'pale grey response'. This is where we assess the likelihood or the evolving nature of [potential violence]. We will not call a code grey per se across the speakers in the organisation but we will contact a code grey team informally and ask them to attend and support us to pre-empt and to create sufficient resources around the circumstances where we think aggression might occur.³⁴³

As indicated above, a major problem has been that the definitions of the Codes have not been standard across the hospitals. This was one of the main criticisms coming out of the Melbourne University study (DHS 2005b) and the *Victorian Taskforce on Violence in Nursing: final report* (DHS 2005a). In particular, variability as to what counted as an emergency or in defining response

339 See for example Submission from Mr Greg Sassella, Chief Executive Officer, Ambulance Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

340 See discussion later in this chapter.

341 Most of the hospital staff that gave evidence to the Committee noted that they have specialist Code Grey and Code Black teams. At St Vincent's Melbourne for example their Code Grey team comprises:

'2 security officers, 2 orderlies, at least 2 senior nurses, a senior ED doctor and is supervised by the Hospital Emergency Coordinator. Often an ED mental health clinician will also be present. The security officers and trained orderlies are responsible for the safe physical restraint of the patient if required until a sedating medication can be given and its effect commence' (Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011).

342 The study, *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (DHS 2005b) defined the terms as follows:

'Code Grey — A hospital wide internal security response to actual aggressive behaviour
Code Black — A hospital wide internal security response to actual or potential aggression involving a weapon or serious threat to personal safety'.

The study acknowledged, however, that these were not at the time consistent definitions used by hospitals or indeed the DHS.

343 Mr Philip Dunn, Director, Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

to violent behaviour across hospitals had led to uncertainty and in some cases hesitation in calling codes (DHS 2005a, 2005b).

Both reports recommended that standardised categories and responses for codes dealing with violence in hospitals be developed and implemented across the public health care sector.³⁴⁴ Specifically the *Victorian Taskforce on Violence in Nursing: final report* recommended that ‘The Department of Human Services introduces into Victorian health services standardised Code Grey (violence and aggression emergency) and Code Black response (armed threat)’ (DHS, p.9, Recommendation 10).

Evidence to the Inquiry also commented on the need to address these anomalies and more importantly ensure all emergency department staff are sufficiently trained on the management of Code Grey and Black episodes.³⁴⁵ As a response to the Taskforce’s final report and as part of the policy changes and responses in *Preventing occupational violence in Victorian health services: A policy framework and resource kit* (DHS 2007a), the Department of Health is currently in the process of reviewing the codes, with the aim of having a wider adoption of Code Grey across health services. It is estimated the review will be completed by May 2012 (Department of Health (Vic) 2011b).

The use of specialist mental health workers and/or nurse practitioners

Given that many of the patients that exhibit aggressive, violent or antisocial behaviour in the emergency department have had a background of mental health disorders, many witnesses to this Inquiry have argued for much closer linkages between the emergency department and psychiatric assistance and expertise.

Closer integration of the emergency and mental health teams

The strategy responses suggested by experts such as Chapman are: the better utilisation of specialist mental health nurse practitioners on call in general wards and emergency rooms; access to mental health teams; and the better training of staff in addressing violence and aggression. The Committee has received much evidence calling for a closer integration between mental health and emergency departments. For example, the Victorian Health Services Commissioner stated:

Emergency Departments are often the locale of violent or angry behaviours. Improvements have occurred when appropriately qualified psychiatric nurses or drug and alcohol counsellors are available to advise emergency staff. Poor management in hospitals may lead to inappropriate responses by clinical staff which, in turn, may lead to an escalation of violent behaviours. Appropriately skilled mental health clinicians need to be readily available in these situations; therefore, all Victorian hospitals should have mental health clinicians available. There was a marked improvement when trained psychiatric nurses were made available in emergency departments, particularly at night.³⁴⁶

Similarly the Australian Medical Association (AMA) (Victoria) noted that often emergency department doctors have to wait lengthy periods before a patient with a mental health condition is assessed by a psychiatrist. The AMA has therefore recommended that:

344 See also, *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals* (DHS 2005b, p.vii).

345 St Vincent’s Melbourne argues, moreover, that such training needs to be realistic with simulated scenario based training. At St Vincent’s Melbourne:

‘All Code Grey training [is] coordinated internally and designed specifically around the health care environment. Training includes theory based presentations with a large emphasis placed on role playing around scenarios that have actually occurred on site at SVHM. All members of our Code Grey team are required to attend refresher training annually and all training is carried out as collective groups to ensure that a total understanding and synergy is achieved across the board. Training is delivered at orientation, on-line and during regular in-person sessions’ (Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent’s Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011).

For further discussion on education and training issues, see Chapter 11.

346 Submission from Dr Beth Wilson, Health Services Commissioner, Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

[g]reater efforts and resources are invested to ensure more prompt disposition from the ED to an appropriate mental health bed for suitable mental health patients. In particular, additional resources should be allocated to employing more psychiatric workers in hospitals especially within regional and rural areas. This would facilitate prompt performance of mental health assessments of patients and ease the currently high congestion levels within EDs.³⁴⁷

Similar recommendations have come from other hospitals and health services.³⁴⁸

Two current innovative examples that have attempted to resolve the issues raised by the AMA deserve mention at this point. One approach, as indicated earlier in this chapter, is that of St Vincent's Hospital Sydney. St Vincent's Sydney has amalgamated its mental health services within its general services including the emergency department but ensured that sufficient specialist trained staff in mental health are on hand to deal with any mental health crises that may arise within the emergency department context.³⁴⁹ Nurse Manager Beaver Hudson explained the system to the Committee as follows:

What we have here at St Vincent's is a parallel assessment process. That is, we [emergency and psychiatry] work together. We don't necessarily always have to wait for someone to be medically cleared. We can have two doctors at the same time be part and parcel of the same assessment...I think the biggest advantage of that is we capitalise on each other's skill base and knowledge base. So there is not an expectation that emergency staff should know how to manage a mental health client and there is no expectation that mental health should be able to manage someone with a chest infection. We collaborate on these kinds of issues so the patient is the person who benefits from that relationship.

That kind of collaboration and cooperation is essential in being able to move rapidly from one form of investigation, physical or psychiatric to another.³⁵⁰

St Vincent's approach, in addition to a comprehensive range of other environmental, situational and educational strategies, has made for a holistic and coordinated model to address violence in the hospital setting.³⁵¹

Similarly Geelong Hospital has been innovative in utilising specialist mental health assistance in the emergency room when required. As Dr Eddey explained:

I think Barwon Health has enjoyed for many years the presence and the engagement of a good mental health team. In the 1990s the after-hours mental health service was a stand-alone service away from the emergency department. The amalgamation of that service integrated into the emergency department means that we have virtually 24-hour access to mental health professionals. It is possibly something that some of my colleagues in other hospitals do not enjoy; certainly in smaller hospitals. That helps us manage the mental health side of these things very well. I would encourage this model. Obviously it is not available to every small emergency department but certainly it is a model we think works very well, to the point where, when we did build our new emergency department, they have their own office and basically full-time presence in our department.³⁵²

347 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

348 See for example, Submission from Mr David Plunkett, Acting Chief Executive, Eastern Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

349 For example the employment of an emergency nurse practitioner who is a specialist in mental health issues in the emergency department of Royal Prince Alfred Hospital, Sydney. See Mr Joseph Jewitt, Director of Corporate Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

350 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

351 See comments of Professor Gordian Fulde, Director Emergency Department, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

352 Dr David Eddey, Director of Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

The use of nurse practitioners

The other related initiative that has often been suggested to overcome some of the problems associated with mentally ill, drug affected or dementia patients acting in aggressive or violent ways in the emergency room is the use of specialist nurse practitioners. Nurse practitioners may have specialised skills in addition to their basic nursing training; for example in mental health, gerontology or substance abuse:

Nurse practitioners have the capacity to work autonomously, have expert skills and knowledge and have extensive experience gained in their speciality. As such the nurse practitioner may use their expertise to assist nurses working in all areas of a hospital to care for patients with [dementia]... Many nurses are not adequately trained to effectively care for dementia patients which increases their risk of workplace violence. Providing staff with access to a nurse practitioner with specialised skills and knowledge could help ward nurses effectively care for dementia patients. Better care can reduce dementia patients' fear and confusion with the likely outcome that they will be less likely to become aggressive (Chapman 2011, p.20).

Although Chapman commends the use of nurse practitioners in the context of aggressive *dementia* patients her words could equally apply to other types of aggressive patient or visitor. Dr Chapman herself recognised this when she gave evidence to the Inquiry:

[m]ost EDs have a psychiatric liaison nurse but what you don't have are nurses with the education on how to deal with [violent patients]...These are general trained nurses, they are not mental health trained nurses, so they need not only education around workplace violence they need education around how do I deal with someone who is psychotic, who is a florid schizophrenic, someone who has "got the message" and been told to come in and kill people.

How do you deal with that, how do you manage that aspect? I think...we need nurse practitioners, mental health practitioners who can prescribe medication because while I'm trying to calm someone down I have to find a doctor to come along and prescribe something, and that takes time often. Whereas if you have nurses in place who can prescribe certain drugs that may reduce the timeframe from having someone highly psychotic to manageable.³⁵³

Such a model has been employed at Royal Prince Alfred Hospital, Sydney to great effect:

One of the things that has worked very well in our emergency department is we have an ED nurse practitioner who is a specialist in mental health, and that position not only provides senior clinical leadership in terms of the management of mental health patients coming into the ED, but also helps provide local in-service training and incident debriefing for the staff. That has helped us in terms of that team based approach that we have in our ED, and coordinating our procedures and processes for managing those patients coming through. Also it provides an important link...to the mental health service so that the patients, particularly patients who are high risk, are escalated and identified to the Mental Health Services that in fact they are high risk and not appropriately managed within our emergency department and need admission. In other words there is a mechanism to make sure those patients are placed in an appropriate facility at the earliest opportunity. That has helped I think in terms of that patient flow through the system.³⁵⁴

In Victoria, nursing academics Professor Gerry Farrell and Dr Touran Shafiei brought to the attention of the Committee a similar initiative at the Austin Hospital in Heidelberg:

At the hospital's emergency department, a nurse practitioner, with expertise in mental health nursing and in handling patients' 'challenging behaviours' has been employed. A major part of the nurse practitioner's role is staff training around the management of patients who are or can be aggressive

353 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

354 Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

and their 'difficult' relatives. Anecdotally, this initiative has been very successful in supporting staff and in increasing their capacity to respond therapeutically when incidents arise and to take proactive steps towards their prevention. The Austin hospital's initiative is part of a suite of initiatives it has implemented to prevent and manage aggression by patients or their relatives.³⁵⁵

Conclusion

Certainly a closer relationship between the emergency department and specialist resources such as mental health teams and nurse practitioners has been seen as one beneficial way of preventing or at least reducing occupational violence in the health care setting. Addressing the relationships between staff so they are all working towards reducing occupational violence is important. Initiatives such as aggression management teams have been extremely useful in drawing together a range of staff to address occupational violence in health care settings. But strategies that address the physical environment of the hospital are also important. An examination of how weaknesses in the design and layout of areas such as emergency departments may impact upon occupational violence is therefore necessary. It is the situational and environmental aspects of occupational violence and how these can be addressed that is the subject of the following chapter.

Recommendation

- 8. The Committee recommends that hospitals should be encouraged to form security and aggression management committees and teams with representation from executive management, security staff, medical, nursing and allied staff including, where relevant, members of mental health and alcohol and drug teams.**

The Committee has received much evidence as to the importance of coordinated and integrated approaches across and between hospital departments and occupational groupings to address occupational violence in health care settings. Too often different parts of the hospital may work in 'silos' without sufficient communication between the various departments.

One way this 'silosation' across departments can be overcome is through the use of management prevention committees and aggression management teams (AMTs).

Recommendation

- 9. The Committee recommends that hospitals form security liaison committees with representation from local police. Police liaison officers are recommended to facilitate relationships between hospitals and local police stations.**

Police clearly play an important role in addressing violence occurring in the hospital environment. They both transport patients with mental illnesses to hospitals and attend violent incidents at times when internal hospital security is unable to deal with the problem unaided. It is imperative therefore that hospitals form productive and complementary relationships and protocols with Victoria Police officers, particularly those in stations adjacent to their workplace. The use of regular meetings between police and a hospital security committee is one way in which this could be done. The establishment of dedicated police liaison officers for major Victorian hospitals, particularly those experiencing higher incidences of violent behaviour, may be another useful initiative.

³⁵⁵ Submission from Professor Gerald A Farrell, Professor of Nursing and Dr Touran Shafiei, Research Fellow, School of Nursing and Midwifery, La Trobe University to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Recommendation

- 18. The Committee recommends that, as outlined in the *Victorian Taskforce on Violence in Nursing: final report*, standardised Code Grey (violence emergency) and Code Black (armed threat) responses be introduced into all Victorian hospitals. The St Vincent's Hospital security response may serve as an appropriate model.**

A problem in addressing occupational violence in hospitals has been that the definitions of the Codes have not been standard across the hospitals. This was one of the main criticisms coming out of a Melbourne University study into the use of the Codes (Department of Human Services 2005b) and the Victorian Taskforce on Violence in Nursing: final report (Department of Human Services 2005a). In particular, differences in what counts as an emergency or in defining responses to violent behaviour across hospitals had led to uncertainty, and in some cases hesitation, in calling codes, and has made a comparison across hospitals impossible. Both reports recommended that standardised categories and responses for codes dealing with violence in hospitals be developed and implemented across the public health care sector. Specifically the Victorian Taskforce on Violence in Nursing: final report recommended that standardised Code Grey (violence and aggression emergency) and Code Black (armed threat responses) be introduced into Victorian hospitals.

Evidence to the Inquiry also commented on the need to address these anomalies and more importantly ensure all emergency department staff are sufficiently trained on the management of Code Grey and Black episodes.

Recommendation

- 30. Given that research indicates higher levels of patients presenting at emergency departments with a mental illness, the Committee recommends that greater efforts and resources are invested to ensure staff with training in psychiatric issues, such as nurse practitioners, be readily available to assist where necessary emergency department staff with mental health patients presenting to the emergency department.**

Given that many of the patients that exhibit aggressive, violent or antisocial behaviour in the emergency department have had a background of mental health disorders, many witnesses to this Inquiry have argued for much closer linkages between the emergency department and psychiatric assistance and expertise. A closer relationship between the emergency department and specialist resources such as mental health teams and nurse practitioners has been seen as one beneficial way of preventing or at least reducing occupational violence in the health care setting.

9. Environmental and Situational Strategies to Address Hospital Violence

Introduction

This Report has previously examined some of the situational and environmental factors that may contribute to occupational violence in the health care setting.³⁵⁶ These include such factors as poor communication between staff and patients, long waiting times to be seen by a health professional and poor design features in emergency rooms and other areas of the hospital. This chapter examines some of the strategies and initiatives that can address these issues. It commences with a discussion of the concept of crime prevention through environmental design (CPTED) and how that can apply to the health care setting to make hospitals safer work environments. It also examines how waiting times can be reduced in the clinical setting. Finally it discusses how communication between hospital staff, including security officers, patients and visitors can be improved.

Crime prevention through environmental design

Environmental crime prevention approaches are essentially pragmatic solutions which concentrate on the immediate problems confronting individuals and local communities (Lane & Henry 2004). In contrast to social crime prevention which concentrates on the reasons why offenders may commit crime, environmental prevention measures concentrate on the *targets* of criminal behaviour. Environmental crime prevention programs and projects specifically aim to modify the physical context in which crime occurs to minimise the extent to which these environments can give opportunity to engage in criminal activities. This approach has grown into a specific aspect of crime prevention planning called CPTED (Crime Prevention through Environmental Design). CPTED emerged in the 1960s and 1970s based on the idea that urban design such as the design of public buildings, streets, shopping centres or parks and the installation of measures such as improved street lighting could prevent crime by reducing opportunities. Supporters of such strategies argue the cost of installation of improved street lighting, or in the hospital context better designed emergency departments, is outweighed by the monetary benefits resulting from crime reduction (Painter & Farrington 2001).

Consistent with crime prevention research, CPTED based strategies emphasise enhancing the perceived risk of detection and apprehension and believe that the proper design and effective use of the built environment can reduce crime, reduce the fear of crime and improve the quality of life. CPTED incorporates urban planning and architectural design theory and practice to 'influence people's perceptions of the built environment and the way public space is defined and used' (Sutton, Cherney & White 2008, p.60).

CPTED in the hospital context

In health care settings CPTED can be used in a number of ways. Specific strategies can include *target hardening* or making it more difficult for a perpetrator to commit a crime, for example by putting up protective glass barriers at triage. Improved *surveillance mechanisms* such as video monitors and screening are also commonly used. CPTED can be incorporated into the

356 See Chapter 4.

design and construction of new buildings or the refurbishment of old ones.³⁵⁷ In the context of workplace violence in hospitals, Mayhew and Chappell state that:

While in the short term these interventions may appear costly, in the longer term such strategies may well be cheaper and have much greater preventive benefits (2003, p.10).

State government approaches

The *Victorian Taskforce on Violence in Nursing: Final report* specifically endorsed CPTED principles and concepts. In Recommendation 14 of that report it stated:

The principles of affecting behaviour through environmental design and management should be applied to all future building development and refurbishment (Department of Human Services (DHS) 2005a, p.9).

The Victorian government framework *Preventing occupational violence in Victorian health services* endorsed the following key principles of CPTED as being applicable to the health care setting:

- Territorial reinforcement: people assume and express feelings of ownership and possibly pay more attention to an area or note potential intruders or acts of violence.
- Access control: physical and symbolic barriers control access. Clearly identifying staff-only areas with physical or symbolic barriers makes it more difficult to reach potential victims or targets.
- Natural surveillance: as people often feel safe where they can be seen and interact with others, natural surveillance can be achieved by creating sightlines between public and private space.
- Space management: there is a belief that a well-maintained facility may reduce criminal activity, whereas a run down, empty, graffiti covered building may attract criminal activity and offenders (DHS 2007a, p.24).

In line with these principles the Framework mandates the following control strategies:

- clear communication strategies to provide information and signs
- service delays are minimised
- activity or noise levels are minimised
- adequate lighting in waiting areas, entrances and car parks
- consistent, clear and concise signage that caters to the needs of clients who may be culturally and linguistically diverse
- fixtures are secured wherever possible, with sharp corners and edges eliminated
- staff identification is worn at all times
- access to buildings is restricted, staff-only access points are clearly signposted and access is reduced in times of reduced staffing, such as after hours in smaller health services
- legal implications with regards to weapons are specified
- computerised access control systems for locks and for recording of audit trails
- security / reception areas are protected through design
- closed circuit television (CCTV) monitoring clearly states whether monitors are staffed by security or not
- CCTV monitor is reversed, where the public watches themselves
- waiting rooms are comfortable, spacious, provide reading material, access to phones, water dispensers and so on (DHS 2007a, p.24).

357 For example, the recent refurbishment of the Royal Children's Hospital and Royal Melbourne Hospital.

Some of these strategies are discussed in more detail throughout this chapter.

The Framework, whilst approving of these types of interventions, emphasised that merely having a checklist of CPTED principles did not ensure that hospitals would automatically become safer workplaces. In order to be effective:

CPTED requires:

- cooperation from all staff
- chief executive officer and senior management endorsement and support
- an understanding of the impact of environmental design and its benefits, which should be included in education and training programs

Moreover, before recommending or implementing any such strategy, it is important that contextual considerations and site risk are properly identified, measured and assessed by appropriately trained personnel, such as occupational health and safety representatives and risk managers. This particularly applies to health services that vary in their size, purpose, location and resources (DHS 2007a, p.24).

In response to the Taskforce on Violence in Nursing the Department of Health has also been working closely with WorkSafe Victoria to produce a range of guidelines and materials on incorporating CPTED principles into hospital design and practice. For example, WorkSafe Victoria in its comprehensive handbook *Prevention and management of aggression in health services* endorsed the aims of CPTED and outlined a range of design control principles for hospitals to employ to reduce occupational violence. These included guidelines for the design layouts of reception and waiting rooms, treatment and interview rooms, emergency departments, pharmacies and car parking areas (WorkSafe Victoria 2008, pp.13–14). In addition, the Department of Health has through its *Occupational Violence Prevention Fund 2008–2011* supported a number of health services to undertake refurbishment works consistent with CPTED principles (Department of Health 2011b, p.3).

Criticisms of CPTED implementation

Despite such initiatives, not all stakeholders believe enough is being done to implement environmental design strategies in Victorian health care workplaces. For example, a submission from the Australian Nursing Federation (ANF) (Victoria) outlines findings from recent research that suggests when it comes to environmental design only a relatively small percentage of the initiatives stemming from the Victorian Taskforce on Violence in Nursing has been implemented. In particular, Farrell, Shafiei and Gaynor's unpublished research study (2010) involving 1500 Victorian nurses found that the percentages of environmental protective measures that were present according to their respondents was relatively low. Table 9.1 indicates selected best practice environmental interventions and the degree to which the nurses in the study believed they had been implemented in Victorian hospitals.

Table 9.1: Environmental interventions and their implementation

Appropriate physical environment for safe care	83% present
Good surveillance for waiting/reception areas	64% present
Means for safe retreat when needed (e.g. escape doors)	47% present
Appropriately designed reception counters to protect staff	54% present
High standard patient facilities to reduce their frustration and anxiety	61% present
Minimal public access point	67% present
Minimal hiding spots	42% present
Effective duress alarms and communication systems	68% present
Personal protective equipment (e.g. personal duress alarm)	56% present
Appropriately located CCTV	51% present
Adequate external security lighting	72% present
Alarms are linked to security personal and police	60% present
Timely response of security/police	67% present
After hours access by swipe card only	63% present

Adapted from Farrell, Shafiei and Gaynor 2010 (unpublished).

Commenting on these findings, the ANF stated that:

[t]he results listed are indicative of what has (and consequently has not) been implemented in Victorian Hospitals — if all recommendations had been fully implemented, it is expected that these figures should be much closer to 100%.³⁵⁸

The importance of environmental interventions and workplace design

Chapman’s 2011 study of violence against nurses stressed the importance of good environmental design and layout in the health care workplace. Many of the nurses in her study felt vulnerable and at risk of violence because of poor environmental design, particularly in the emergency department:

One of the concerns of the participants was related to the physical layout of the wards and departments... The ED was reported to be a busy uncontrolled environment that was available to patients and their visitors 24 hours per day seven days per week. This was especially so at triage and one nurse explained ‘triage you get verbally abused by relatives out there big time. You get things thrown at the glass...’ (Chapman 2011, pp.13-14).

However, Petit argues that there are a number of environmental variables that can be manipulated to reduce the potential for violence or its escalation in hospital settings:

These include: patient comfort, relative isolation, decreased time of waiting — staff attitude and decreased stimuli...

Physicians should never place themselves or any other staff member in an unsafe situation (eg, in a closed room or where access to doors is blocked or other compromising locations). All items or objects that can be potentially dangerous should be removed or at least accounted for by the staff to prepare and minimize the danger of injury³⁵⁹ (Petit 2005, p.707).

358 Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

359 Although as Lyneham comments, in the emergency department ‘it would be inappropriate to lock down essential equipment for such equipment must be readily available for use’ (2000, p.15).

Linsley takes up this latter point stating how something relatively easy to control such as the accessibility of objects that can be used as weapons, is often so easily overlooked (2006).

CPTED improvements can be expensive and not all health services, particularly smaller or rural hospitals, may be able to comprehensively incorporate new design measures into their workplaces without extra budgetary assistance. For those hospitals such as the Royal Melbourne and Royal Children's Hospitals (RCH) that have recently done major structural refits and refurbishments the process is easier. Dr Simon Young, Director of Emergency at the RCH stated that virtually 'starting from scratch' enabled the hospital to incorporate many modern environmental design features into their new emergency department.

Environmental security interventions

Suggestions for improvements

A number of suggestions have been made to the Inquiry regarding the importance of supplementing security staff with a range of environmental and technological improvements. For example, a submission from the Victorian Health care Association stated that a range of further measures are required to assist security staff address the risk of violence associated with a hospital environment. These include:

- Two-way communication capability of the security cameras
- The ability to open and close doors electronically from the security control room
- The introduction of GPS tracking with Duress Alarm capabilities for all Fleet Vehicles and mobile staff with the capacity to be monitored by switchboard/security control office 24/7
- The creation of one main central command office by combining the security office with the switchboard
- A designated fleet vehicle for in-house security response which could also be used to perform nightly patrols of all sites
- Redevelopment of the patient/visitor search policy to include the use of metal detectors by the Duty Security Officers prior to Psychiatric interviews within the Emergency Department or where the condition of the patient or visitor raises the suspicion of the duty security officer or medical staff
- Designated security reporting system to allow identification of security risks and/or repeat offenders.³⁶⁰

St Vincent's Hospital Melbourne also outlined a raft of environmental security measures they believe are best practice measures in addressing occupational violence. Most of these are already utilised at St Vincent's. They include:

- Utilisation of security cameras within the ED waiting room and inside the ED work area to observe potentially violent patients
- Security staff are strategically located in the ED waiting area and the office is centrally located campus wide, allowing for quick responses to high risk areas such as ED and the Mental Health Unit. There are adequate staff numbers per shift to allow for security responses throughout the hospital, yet still prioritise the high risk areas
- Renovation of the ED waiting room to include more comfortable chairs, reading material, art on the walls and a large television screen
- Triage and administrative area protective features such as a reinforced, shatter-proof protective window, large desk separation and duress alarms. Effort was made to allow for staff protective features without compromising the ability of triage nurses to safely assess patients and offer comfort, and to minimise the impression of increased fortification

³⁶⁰ Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011. To this list one could also add a dedicated telephone line from the hospital to the local police (Lyneham 2000, p.16).

- Clear visibility between patients and carers in the waiting room and the triage staff.³⁶¹

St Vincent's also recommend the creation of a purpose built containment area for all patients with acute behavioural disturbance: the Behaviour Assessment Room (BAR). This is a subject that will be discussed separately later in this chapter.

In addition to these measures, Kiedja and Butrej believe it is also important to incorporate:

- Staff stations, consultation rooms and examination rooms with *two* doors
- Safety glazed and/or [hydraulic lift up] security screens
- Quarantined parking spaces for staff
- Electronic access to staff areas
- A single after hours entry point for staff (2010, p.7).

Beaver Hudson, Nurse Manager at the Psychiatric Emergency Centre, St Vincent's Hospital, Sydney told the Committee that wherever possible emergency department design layout should be open plan:

[o]pen plan means that there is a reduction of nooks and crannies. If you look at some of the other emergency departments they are like rabbit warrens which make it very difficult to see around corners... which makes it that much more dangerous.³⁶²

The Australian Security Industry Association (ASIAL) also stressed that electronic access control measures that have the ability to 'lock down' a hospital by securing and monitoring all doors is a 'must':

The after-hours control of visitors to a hospital and the emergency department is of paramount importance not only with regard to incident management but emergency management in the event of a fire or other incident requiring evacuation etc.³⁶³

Improvements to address light and noise

A number of research studies have stressed the importance of appropriate lighting in hospital environments (Linsley 2006). On this point the AMA states that:

[i]n relation to health facility design, there is growing evidence to suggest that the carefully considered use of natural light, colour and art in the workplace has a calming effect on both staff and patients alike and decreases the incidence of anxiety-related incidents and associated medication requirement.³⁶⁴

This is something that Health Services Commissioner, Dr Beth Wilson, has commented on:

Details like lighting are also important — fluro lights may play a part in sparking reactions and outbursts, particularly in children on the autism spectrum. More muted-natural light (readily available in modern light bulbs) may be a useful alternative in changing the artificial nature of ER lighting...³⁶⁵

361 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

362 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

363 Submission from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

364 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

365 Submission from Dr Beth Wilson, Health Services Commissioner, Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

In addition to lighting, Professor Marie Gerdtz from the Royal Melbourne Hospital told the Inquiry that noise is a factor that can aggravate a patient and increase the tension and potential for aggression in the emergency department:

That sort of sensory stimulation is an issue for people who are agitated. We know that noise is one of the biggest factors. What has changed between the old department and the new department is the increased use of single cubicles. In the other ED we had a lot of curtains and things; that has certainly been minimised. So the noise level is certainly down...[where] there are solid walls, as opposed to curtains, between groups of patients there is better privacy and less noise.³⁶⁶

Protecting ambulance officers

Ambulance officers and paramedics are often at the front line of occupational violence. It is therefore understandable that they would wish to minimise the risks associated with the transporting and admission of potentially violent patients. Ambulance Victoria is concerned, however, that some poor environmental design features can result in their members being more vulnerable to violence from patients and visitors. In a submission to the Inquiry they stated:

In relation to security for Paramedics, medical staff and the public, many Paramedics raised the issue of ED design. Their recommendations included secure access and egress for emergency patients arriving or departing by ambulance, and specialised areas within the ED to manage patients demonstrating aggression and/or violence. Many transport areas utilised by Paramedics are open to the public, patients and relatives, frequently used as 'smoking areas' and have no security at all. While there are increased delays in admission of patients to EDs, there is on-going potential for agitated patients to require aggression management even prior to ED admission.³⁶⁷

On the positive side, Simon Thomson from Ambulance Victoria stated that paramedics were pleased that some hospitals such as Royal Melbourne Hospital had installed duress alarms in their ambulance bay area and that such arrangements were proving to be quite successful.³⁶⁸ At St Vincent's Hospital Sydney, security for ambulance staff is enhanced by having video camera surveillance in the ambulance bays and hospital receiving areas. This also has the advantage of alerting any emergency department staff to any incidents happening outside their line of vision:

When the new emergency department was being designed, there was a lot of collaboration around the design of the ambulance entry area of the emergency department to ensure that safety was paramount. This demonstrates the CCTV which is a direct link back to the security office. That advantage means you can have clinical staff really involved in the clinical work but there might be something going on that they aren't necessarily aware of. That will be witnessed by security and certainly there have been more than one or two occasions where security has come into the emergency department because they have seen something for themselves [and need to inform staff]. A patient is escalating or there has been some kind of kerfuffle going on that we have not been immediately aware of. So that's really important.³⁶⁹

Other considerations

Lyneham's study of violence against health care staff, whilst not recent, did make some important points that sometimes security initiatives such as those mentioned in this section are not always 'foolproof' because they may have been inappropriately or incompletely implemented and therefore decreased the level of protection they were designed to afford:

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- 366 Associate Professor Marie Gerdtz, Associate Professor of Emergency Nursing, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.
- 367 Submission from Mr Greg Sassella, Chief Executive Officer, Ambulance Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.
- 368 Mr Simon Thomson, Acting Regional Manager, Ambulance Victoria, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.
- 369 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

Many respondents felt that security doors reduced the risk of violence from outside but did not prevent violence once the patients and the relatives/friends are admitted to the inner sanctum of the [emergency department]. Other security equipment was reported as being useful when situations occurred, but the time taken to repair broken equipment was an issue. If security equipment malfunctioned on the weekends it was often not repaired until the next week and even then only if the appropriate service person was available...The performance of equipment [particularly security doors and pagers] was often [negatively] commented on by respondents (Lyneham 2000, pp.14–15).

Whilst design features such as security doors and barriers to protect the emergency department have been increasingly used over the past decade, the ANF (Victoria), warned that the violence could simply be displaced to other, less secure, areas of the hospital:

You will have noticed over the last 10 to 15 years that emergency departments have become very physically segregated between waiting rooms and treatment areas, almost in a semi-banking kind of way with locked doors and glass and slide under the hand, and those kinds of things.

One of the things we are seeing now with the emergency departments not keeping up with demand is that we have hospitals asking nurses to treat patients in the waiting room...something we are now seeing re-emerge is an expectation that staff come out and treat people in the waiting room without the security we have come to expect. That is obviously something we will be monitoring very closely to ensure that people are not exposed to significant risk.³⁷⁰

Finally, evidence has been given to the Inquiry by a number of witnesses suggesting that emergency department layout should be designed wherever possible to have separate treatment and waiting areas for adults and children. Dr Stephen Parnis of the AMA recounted his own experience of the unsuitability of having children and their families being seen in the same environment as a potentially violent patient:

I have worked in a so-called mixed emergency department, which is where you treat adults, children and all comers coming through the door. I had a mentally ill patient who was aggressive and violent and in the cubicle next door was a young child with croup. You only have curtains separating them because you need access to these patients. I remember being quite distressed about the fact that I was dealing with this person and had the family and the poor child next to us...Things like the design of emergency departments come to mind [as a possible solution to this situation].³⁷¹

Health Services Commissioner, Dr Beth Wilson also stressed the need for a space for children (usually those accompanying the unwell patient). In her view this is useful in separating them from the waiting crowd and thus lessening the anxiety of others who may be waiting.³⁷²

There are some specific measures that may assist in improving the security environment in regard to violence in hospitals. These are the use of video surveillance technology, duress and personal security systems and metal detectors.

Video surveillance

The use of CCTV technology has become increasingly popular to address crime reduction and community safety issues in areas particularly at risk such as local government authorities, nightclubs and as a sad commentary on the times — hospitals.

370 Mr Paul Gilbert, Assistant Secretary, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

371 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

372 Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

Many witnesses who gave evidence to the Inquiry supported the use of video surveillance in hospitals with appropriate safeguards.³⁷³ For example, in a submission to this Inquiry the AMA stated:

Doctors working in Victorian EDs have indicated that visible TV monitoring should be in operation within all Victorian hospitals, in appropriate locations. A suggested system includes that which is currently being utilised in banks whereby a presenting patient can see themselves on a TV monitor.

These devices should be placed with the triage nurse at reception, so as to immediately convey to patients and visitors that they are being watched, and that their behaviour is being recorded.³⁷⁴

Dr Stephen Parnis from the AMA (Victoria) spoke to this submission and gave guarded support for the installation of video surveillance systems in public hospitals. He explained:

In relation to design, we think there is a role for security cameras, but clearly it also needs to be done very carefully, because we need to respect in the appropriate contexts the privacy of a patient. This is a difficult balance. You know curtains do not stop private details being conveyed, but if you cannot see or hear what is happening to an unstable patient, you cannot look after them. That is a continuing balancing act.³⁷⁵

Paul Cunningham, Security Manager at St Vincent's Hospital Melbourne, also testified to the importance of security surveillance systems monitored from a central position within the hospital:

Physical security in the sense of electronic security, access control, closed-circuit television... complement each other beautifully. You could have five or six officers on duty at any one given time, but you are still not going to be able to cover the demographics of a sprawling campus like we have. You introduce CCTV and access control and you are able to close your perimeters down to keep the mainstream populace out from areas that you do not want it to go into, and you control your emergency environment with your entry and egress and then you have your duress alarm, and your cameras up; it does the majority of your work for you. It is about where you station your security office. We are right in the heart of the emergency department. We are centrally located right in the middle of the campus so we can respond to our mental health unit, our emergency department, our detox area and everything else that we have on campus.³⁷⁶

Despite the support for its usage, it has been recognised that it is not enough for hospital management, or indeed any organisation installing CCTV systems to place the cameras and 'hope for the best'. State police forces and government authorities are increasingly working in partnership with local councils, hotel and entertainment establishments and hospitals to develop and implement protocols on the usage of CCTV and other monitoring systems. For example, in Western Australia the Office of Crime Prevention has produced documents that assist agencies and organisations with regard to the legal, ethical and technical aspects of installing and running a CCTV monitoring system.³⁷⁷ Victoria Police also work proactively, especially with local councils, on using CCTV as a community safety and crime prevention tool.³⁷⁸

373 See for example, Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

374 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

375 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

376 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

377 See Office of Crime Prevention 2009, Western Australia, Closed Circuit Television (CCTV) Guidelines, Office of Crime Prevention, Perth, November 2009; Office of Crime Prevention 2010, Western Australia, Closed Circuit Television (CCTV) Technical Advice, Office of Crime Prevention Perth, October 2010.

378 See Victoria Police 2011, Community Crime Prevention Program - CCTV Information, Circular dated 4 August 2011.

Duress and personal security systems

Many witnesses have told the Inquiry that duress systems are an essential part of any approach to hospital security. Bryan De Caires, Chief Executive Officer of ASIAL, noted that:

There are a number of commercial providers of duress locating systems. The use and requirements depends upon the risks assessed. Duress devices are used at many health facilities offering the ability to be a locator, communicator and emergency activator including mission critical and life critical messaging and man-down facilities. Such systems can incorporate site mapping facilities and escalation procedures if an emergency alarm is not acknowledged. The systems also have facilities to notify staff of specific patient alarms, fire and emergency situations.³⁷⁹

Clinicians working in emergency departments have argued there should be both fixed trigger points throughout the hospital and personal duress alarms worn by all staff potentially at risk (Kennedy 2005). They should be able to identify the location of the person in distress and detect if they are not moving (Kiedja & Butrej 2010). St Vincent's Hospital Sydney utilises fixed systems throughout the hospital and especially at triage:

One of the big advantages of the triage area is that if we have an altercation at that point, the triage nurse has the facility to isolate that area and she is able to do that, she is able to lock off the waiting rooms and that red button there (there are two of them on either side), she can press either of those two buttons, it blocks the front of the hospital, preventing people [from being] able to get into the emergency department and prevent[ing] people getting into the waiting room. It sends an automatic duress to security who will respond within 90 seconds if not sooner.³⁸⁰

St Vincent's emergency department staff also wear personal alarms which can be monitored throughout the hospital from a central surveillance monitoring centre.

Increasingly some hospitals are also examining the use of sophisticated personal telephone systems such as iPad phones and other wireless gadgetry to give an extra layer of protection to their staff at risk.³⁸¹

Geelong Hospital has sophisticated personal duress alarm systems that have proved quite effective, particularly for their mental health teams:

In mental health, staff in all inpatient areas are provided with a personal duress system. It is a very sophisticated, integrated system. Everybody wears one. It has a WiiFii capacity. It connects to every other one. It has voice capacity. It alerts certain PCs that are monitored and it also is connected to the security guard system. In our inpatient areas, if somebody presses the duress system, it does not take long for additional support to arrive.³⁸²

379 Correspondence from Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 21 November 2011.

380 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

381 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

382 Mr Philip Dunn, Director, Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

Problems associated with duress alarms

Whilst the use of duress technology in hospitals has become increasingly sophisticated it has not been without its problems. As hospital security expert David Van Lambaart explained:

Duress Alarm Management is an emerging area — Tracking an individual duress pendent is available here and now [but] they have challenges in terms of their accuracy and the need to saturate a given area with transmitters and receivers in order to locate an individual to say within a 5 metre area. The dilemma with this is that when you saturate [which is very expensive to implement and even more difficult to manage] an area there is a likelihood that you will have an overlap of signals being sent and received that has the propensity to confuse rather than clarify. Therefore a balanced approach is desired and should be assessed on a case by case basis.³⁸³

Finally, Dominic Dawson, General Manager of Blacktown Hospital, whilst agreeing that duress systems are a major part of hospital security, added that it is important that all duress alarms are standardised across the hospital and all staff know where they are located and how they work. As with any intervention, he notes that duress systems can only form one part of an overall strategy to minimise occupational violence.³⁸⁴

Metal detectors

Whilst increasingly used in the United States of America,³⁸⁵ not a great deal of evidence was given to the Committee as to the suitability, or otherwise, of using metal detectors or other forms of weapons searching in emergency departments and/or other areas of the hospital. One of the few hospitals that gave evidence to the Inquiry that does use metal detectors is St Vincent's Hospital in Sydney. Nurse Manager Beaver Hudson, however, stressed that their use was governed by strict protocols:

We have very clear safety protocols which relate to use of metal detector screening. So the individual is brought into the emergency room, it is a condition of entry that you submit to a search, you turn your pockets out, they get scanned by the metal detector by the security guards and that is before we start to do an intervention. Because our history has taught us that it is not uncommon, it has been known to happen, when you are sitting talking to a client or a patient and they pull out a big mess of hunting knives or you have left them for ten minutes while you go out and get them something to drink and you come back and they have taken their razor blade and sliced themselves. Or you go in there to talk to somebody and you discover that they have lots of syringes on them.³⁸⁶

Staff at St Vincent's can also request at any time that security officers perform a metal detector screening on patients or visitors whom they suspect may have weapons or other prohibited items on their person.

On the other hand the AMA (Victoria) does not support the introduction of weapon searches and/or metal detectors in hospitals, believing they are unnecessary given the relatively low incidents involving guns or knives in Victorian hospitals. Moreover they believe the introduction of metal detectors has the potential to 'undermine the therapeutic nature of a hospital'.³⁸⁷

383 Personal communication from Mr David Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 21 November 2011.

384 Mr Dominic Dawson, General Manager, Blacktown Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

385 See Petit 2005; Behnam et al 2011.

386 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

387 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Flag and alert systems

It has been suggested that as a past history of violence is the best predictor of future aggression, the files of serial perpetrators of violence should be 'flagged' to forewarn other staff of the propensity of the client to act aggressively (Mayhew & Chappell 2005, p.347). Some Victorian hospitals are trialling computer alert systems using hospital registration or medical/triage records to note those patients who are known to have exhibited past violent behaviour.³⁸⁸

St Vincent's Hospital Sydney has an innovative computer alert strategy that is linked into the wider security response of the hospital. Nurse Manager Beaver Hudson and Head of Security Ross Judd explained the system to the Committee as follows:

When an individual presents to the triage desk, it mainly provides us with cross referencing against existing hospital records and that is matched up to a MRN (Medical Records Number) and then if there is an alert placed in the emergency system telling us that person has the potential for violence, the alert comes up which allows the staff to either commence an intervention or to delay the individual coming into the department until we can have some security in place...It basically tells the triage nurse that security standby is required...³⁸⁹

The standby is a proactive strategy that we have adopted...the previous predilection of this patient to violence is known by staff and is recorded by staff. Staffs will then contact security and say we need a standby, which is the term we use. A security team will present themselves to the staff to assist/manage before any actual incident occurs. So it is a proactive strategy that tries to prevent things occurring up front. Over the years it has proved very successful; it's not 100% successful of course. But...obviously it supports the nursing staff with the management of that patient.

The security team are already there if it goes a bit pear shaped. It is a very good strategy we have adopted for years and it has worked very effectively, particularly in our high risk areas. We do a lot of those daily.³⁹⁰

Yet even hospitals that do have alert systems recognise that the placing of warning 'flags' need to be done with some caution. As Professor Denise Heinjus of Melbourne Health told the Inquiry:

We have an alert system that would alert the clinician at triage, and through that episode of care, around a number of things. It may well be around a history of violence, but it will also be around drug allergies, for example, or some other event that they would deem the attending clinician should be aware of. If it was somebody with a known history of violence, then I would expect that the clinician would note it. It needs to be applied with some caution. If somebody has had an acute episode and been violent as a one-off, you would not want that to be on an alert system for the rest of that person's life. So each episode of care does need to be refreshed.³⁹¹

Behavioural assessment rooms

Recognising that behaviourally disturbed patients are typically managed in an open emergency department setting, on view to others in the emergency department and potentially disturbing the delivery of health care, a novel approach to managing aggression in the emergency department was trialled at St Vincent's Hospital Melbourne:

388 See for example: Submission from Mr Brendan Gardner, Executive Director Frankston Hospital, Peninsular Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011; Submission from Mr Tim Reinders, Manager, Occupational Health & Safety, Ballarat Health Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011; and Ms Susan Cowling, Nurse Unit Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

389 Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

390 Mr Ross Judd, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

391 Associate Professor Denise Heinjus, Executive Director, Nursing Services, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

Using a purpose-built containment area or 'behavioural assessment room' (BAR), this system augments the typical Code Grey response by removing the patient from the public environment and into an allocated room external to the central ED. The BAR requires less space than conventional management strategies by containing and removing the disturbance from the ED proper. Consequently, this strategy offers a method of promptly restoring equilibrium to the ED and may increase patient and staff safety (Cowling, McKeon & Weiland 2007, p.296).

St Vincent's explained the operation of the BAR in a submission to this Inquiry:

This is a small room at the ambulance entrance and adjacent to the resuscitation cubicles of the ED which is bare but for concealed access to oxygen and suction as an emergency requirement. It is separate to the main patient and work area of the ED and separate to the triage and waiting area and permits ease of access and egress. Potentially violent patients delivered by ambulance or police have direct access to the BAR without passing through any other location in the ED, and agitated or aggressive patients within the ED work area are moved to the BAR during a Code Grey in order to contain their behaviour. By removing and containing a violent patient in the separate BAR, the therapeutic equilibrium of the main ED and other patient / carer safety is maintained, and the privacy and dignity of the agitated or aggressive patient is protected. Other benefits include a positive impact on clinical treatment times and ED length of stay. Most importantly, the BAR and associated Code Grey team response increases staff perception of safety and improved patient management.³⁹²

The advantage of the BAR being next to the ambulance bay is that, at least at the time of the initial entry, the aggressive patient need not have any contact with people in the main emergency department. The time in the BAR can then be used to calm the patient down before ongoing treatment is provided. As well,, other patients in the emergency department need not witness the aggressive conduct.³⁹³

In a research study and audit of the use of the BAR over a 12 month period (January–December 2003), the most important finding was that the BAR and associated team response increased staff's perception of safety and improved patient management:

The data provide[s] the first evidence that a dedicated area such as the BAR, with policy to support clinical practice and a coordinated team approach, may minimise the impact of disruptive behaviour on the emergency department. By creating a secure work environment, the safety and confidentiality of all patients and staff is maintained. In light of the increasing frequency of behavioural disturbance in EDs, the adoption of practical strategies such as the BAR is warranted (Cowling, McKeon & Weiland 2007, p.303).

St Vincent's recommended that the creation of a BAR 'be considered as the most appropriate environmental improvement to EDs in Victoria to ensure safe, timely and private care for aggressive and violent patients'.³⁹⁴

The use of a BAR such as that at St Vincent's has been endorsed by the AMA (Victoria):

Behavioural assessment rooms are an effective intervention for calming aggressive patients. Separating potential aggressors and removing sources of provocation has the potential to calm and relieve aggression. These specialised treatment rooms have been successfully trialled at St Vincent's Hospital and should be implemented in all public hospital EDs across the state.³⁹⁵

392 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

393 Dr Georgina Phillips, Emergency Physician and Coordinator of International Programs, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

394 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

395 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Further, Dr Stephen Parnis, Vice-President of the AMA (Victoria) explained that:

It [the BAR] is not an incredibly expensive addition to an emergency department, but the ability to care for people in this sort of environment safely is a good one, and there is some good evidence from the five or more years of this facility's use that it does help care for these people and get things sorted out.³⁹⁶

Similarly, a submission from Alfred Health also asks for consideration to be given to providing secure isolation rooms in all public emergency departments across the state.³⁹⁷ Victoria Police have also supported the introduction of purpose built BARs:

Such areas should contain equipment which would include mechanical and chemical restraints such as sedatives and furniture suitable for the restraining or temporary holding of such persons in a safe manner that minimises the likelihood of harm to themselves or others.³⁹⁸

Behavioural assessment or seclusion rooms are not universally favoured however. For example, Dr Jaycen Cruickshank, Director of Emergency Medicine at Ballarat Hospital, explained there are alternative ways of addressing aggressive patients within the emergency department:

We have two different places where we will look at [violent patients]. We have a resuscitation area and we also have bay 4, the area closest to our doctor in charge area, which is specifically designed with less sharp objects and various things like that. I personally have not ever been a fan of the seclusion rooms where you put someone in a padded room, because it is very hard to supervise those people. We try and treat it as a medical emergency rather than a behavioural emergency. In the medical emergency you can check someone's oxygen and blood sugar and pulse rate and all those things much better. I appreciate there are different models around the place but we have been fairly comfortable with our approach and our physical design.³⁹⁹

Situational factors

Addressing long waiting times

Long waiting times (perceived and actual) before patients and their visitors can be attended by staff contribute significantly to occupational violence in hospitals.⁴⁰⁰ Some strategies have been devised at various hospitals to address this problem. These may relate either to shortening the period the patient may be waiting and/or making the experience of waiting more pleasant and less boring. In the former category, interventions include improving the triage system, and the introduction of the 'four hour rule'. Strategies to make the experience of waiting more pleasant can include the offering of beverages or reading material.

Expediting the waiting period

A submission from St Vincent's Hospital Melbourne acknowledged that prolonged waiting times are sometimes beyond the control of the emergency department. It also noted, however, the importance of minimising the waiting period by expediting as soon as possible any tests, procedures or investigations that might be needed and by ensuring there is ongoing liaison

396 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

397 Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

398 Submission from Acting Deputy Commissioner Tim Cartwright, Crime and Operations Support, Victoria Police, November 2011.

399 Dr Jaycen Cruickshank, Director, Emergency Medicine; Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

400 See discussion in Chapter 4.

with a senior emergency department nurse. Explaining to the patient and family about any expected delays or waiting times can also be helpful.⁴⁰¹

Alfred Health has been trialling an innovative approach to defusing tension in waiting rooms. Andrew Way, Chief Executive Officer of Alfred Health, explained it to the Committee:

Traditionally you come as a patient, you check in and you might be triaged or not. You [then] sit in the waiting room. The clinical view is that the triage process should get you straight into the department. So we have been trialling using the waiting room as a place where people wait for their relatives who are being treated. The intention is to get the patient from the front door into the department — in a treatment area — immediately, not sitting in the waiting room, having been triaged, waiting for a cubicle to become available. The impression of the clinical staff is that if patients are in the treatment area, they can see how busy everybody is and they are more comfortable waiting...⁴⁰²

The Royal Children's Hospital is using a similar system in its new emergency department area:

We have just designed a new emergency department...and we have put in place things that we have found out from emergency departments around the world in order to try and deal with the security issues. We have separated our pre-triage waiting from our post-triage waiting. In a traditional emergency department you go up to the window, or you may have to stand in a line until you get to the triage nurse; you talk to the triage nurse and then you go and sit down again in the same waiting room where people who have not been triaged are walking through. We tried to design a flow-through system where people go to triage and then they go beyond that into another room. We hope that will help give parents the feeling that they are progressing through the system.⁴⁰³

Improving the waiting room experience

The atmosphere of the waiting room is also important. Petit states that within the constraints of a busy emergency department, efforts should be made to make the patient's experience:

...as comfortable and safe as possible. A quiet room or an individual examination room can decrease external stimuli, which in turn can assist in the de-escalation of a patient. Offering the patient a chair on which to sit or a stretcher on which to lie down or something to drink...conveys caring and respect and can improve a potentially volatile situation (Petit 2005, p.70).

Health Commissioner Dr Beth Wilson has also found that 'Simple things like the presence of a cooler, where people use a simple plastic cup to get a free drink of water, can also be useful'.⁴⁰⁴ Nursing academic Dr Laretta Luck also told the Committee not to underestimate the effect of offering a cup of tea or coffee. Some of the respondents to her research on violence against nurses told her there were cases where people could be in the emergency department for up to 16 hours without the offer of a cup of tea and this increased their anxiety and frustration levels. In Dr Luck's view it was the more experienced staff who picked up on these things and were more knowledgeable about the little 'tricks' that could be used to defuse violence.⁴⁰⁵

Dr Stephen Parnis, Vice-President of the AMA (Victoria) also suggested strategies that can make the experience of waiting more pleasant:

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- 401 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.
- 402 Mr Andrew Way, Chief Executive Officer, Alfred Health, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.
- 403 Dr Simon Young, Director, Emergency Medicine, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.
- 404 Submission from Dr Beth Wilson, Health Services Commissioner, Victoria, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.
- 405 Dr Laretta Luck, Associate Head, School of Nursing and Midwifery, University of Western Sydney, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

There are things that can make differences to people's experiences, at least in emergency. Even things like the waiting room — it should not look like a public toilet; it should be a relatively pleasant environment. It should have artwork. It should have a TV. It might even be worthwhile having some form of screen that says, 'Expected wait for category 1, 2, 3, 4 is this amount of time', because a long anticipated wait is usually a bit easier to digest than a long unanticipated wait.⁴⁰⁶

Finally, nursing academic Dr Rose Chapman suggested to the Inquiry that one strategy to address waiting room delays may be to televise what was happening in the triage and waiting areas to the public. Whilst this would not make the waiting experience any more *pleasant*, it could help in educating patients, families and visitors as to why they may be experiencing delays in being attended to:

I think it would be fabulous to have a television campaign around what really happens in emergency departments. Ordinarily if I'm sitting in a waiting room and I can't see anything behind that, all I see is these people coming in, nurses are just walking, chatting to triage, walking out, I can't see what is behind there. Whereas if we could do stuff around the patient journey, for example, where I come into triage, behind there I can see that the bays are full and everyone is really busy. There is no one just sitting around doing nothing. We have emergencies coming in through the ambulance bay which I can't see because I'm still sitting here and everything is happening over there. So if we had television campaigns around that and if it was in the waiting rooms on a constant loop or something, rather than watching 'Days of our Lives', people could look at that and see how busy they are and what is happening. They aren't just ignoring me because they hate me. They are ignoring me because people are really sick. It's about educating people I guess.⁴⁰⁷

The four hour rule

Long waiting times for patients to be seen at hospitals can be attributed in part to issues endemic to the overall health care system, including understaffing, badly designed, cramped and out-dated emergency departments and long patient lists. Whilst provisions have been put in place to improve parts of the system such as ambulance transport times, this doesn't necessarily mean the patient will be seen any quicker in the emergency department. As Simon Thomson from Ambulance Victoria told the Inquiry, ambulance staff still 'experience significant pressure associated with ramping and delays at hospitals'.⁴⁰⁸

One policy initiative in Western Australia to reduce waiting times in public hospitals has been the introduction of the 'four hour rule' program.

WA Health introduced the program in April 2009. Its aim is to ensure that patients arriving at emergency departments 'are seen and admitted, discharged or transferred within a four-hour timeframe, unless required to remain in the ED for clinical reasons'.⁴⁰⁹ The major Western Australian hospitals (Royal Perth, Sir Charles Gairdner and Fremantle) were expected to reach their targets of 85 per cent of patients seen within the four hour period by April 2011.⁴¹⁰ The four hour rule has had both its supporters and detractors amongst the witnesses that appeared before the Inquiry in Western Australia. On the positive side, Dr Harry Patterson, Deputy Head of Emergency at Royal Perth Hospital, stated that after some initial teething problems it has shown real benefits:

People have come to wait less time, they are getting seen earlier, they are getting seated earlier, getting moved out. So the level of unhappiness shall we say is much much less...

406 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

407 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

408 Mr Simon Thomson, Acting Regional Manager, Ambulance Victoria, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

409 See <http://www.health.wa.gov.au/fourhourrule/home/index.cfm>

410 <http://www.health.wa.gov.au/fourhourrule/home/index.cfm>

We do know it's not going to [work for] everybody, some people are unfortunately going to stay a little bit longer. It's really depending on what's wrong with them. But I think it has changed the way we have thought about things to give people an idea of how long they are likely to wait as opposed to we will just have to wait and see, which seemed to be the mindset before.⁴¹¹

Criticisms of the four hour rule

On the other hand, nursing staff at Sir Charles Gairdner Hospital in Perth saw it making little difference, in fact according to some staff it merely displaced acts of aggression from the emergency department to the wards:

What we saw from the 4 hour rule introduction initially we saw a drop of code blacks occurring in the emergency department shifting towards the ward, we have seen that change back now. It hasn't made any difference, I don't think, in the amount of violence and aggression.⁴¹²

Other witnesses noted the potential for aggression to move from the emergency department to the wards, so that whilst the patient may be seen by emergency in under four hours, there could still be a bottleneck resulting in a lengthy wait for a ward bed. Addressing waiting times in the emergency department alone therefore is only a partial solution.

The Royal Australasian College of Surgeons (RACS) has also been highly critical of the four hour rule and the way it has been implemented in Western Australia:

The four hour rule, as introduced in England and subsequently in Western Australia, requires the vast majority of patients presenting at a hospital's emergency department (ED) to be seen and either admitted, discharged or transferred within four hours from the time of triage.

Potential disadvantages include a reduction in the standard of emergency care delivered. There is an increased likelihood of adverse patient outcomes because of the risk of early discharge from the ED without a definitive diagnosis or appropriate treatment plan in place. Emergency care may be reduced to emergency triage.

There is a danger that clinical flow in the ED will become the gold standard, with excellence in flow being given higher priority than patient care. It is also possible that patient perceptions of faster care may lead to more presentations. Surgical registrars in many hospitals implementing the four hour rule report a substantial increase in the number of cases admitted to surgical teams. Sometimes these admissions are discharged that same day.

The issue of safe working hours is central to the welfare of patients. Where previously less urgent cases were often held over in ED pending the morning handover, surgical registrars are now being called throughout the night in order to facilitate an admission. They are then returning to work the next day significantly sleep deprived.⁴¹³

The RACS does not believe all the problems associated with hospital waiting times and delays can be attributed to emergency departments alone:

Delays in emergency departments cannot be attributed to emergency departments alone. Rather, they are a symptom of hospital-wide problems, most notably a shortage of beds in wards, a shortage of medical and nursing staff, a shortage of facilities, and inadequate diagnostic services. Unless there is a significant investment in these areas, a four hour rule simply forces more patients down an already choked bottleneck.

While promptness of care in emergency departments is an ideal to which we should aspire, this must not come at the cost of quality of care. If a four hour rule requires clinicians to work unsafe hours,

411 Dr Harry Patterson, Deputy Head, Emergency Department, Royal Perth Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

412 Ms Shari Kidd, Clinical Nurse Specialist, Violence and Aggression, Sir Charles Gairdner Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 22 June 2011.

413 The Royal Australasian College of Surgeons, Submission to the Council of Australian Governments Expert Panel. May 2011. Accessed 23 November 2011 at http://www.surgeons.org/media/433658/sbm_2011-05-24_four_hour_rule.pdf

or requires clinicians to discharge or admit patients without necessary tests being done or correct diagnoses being made, we run the risk of compromising patient safety.⁴¹⁴

In Victoria, Trevor Carr of the Victorian Health care Association told the Committee that whilst the four hour rule may assist in reducing waiting times to some degree 'Four hours is still a fairly lengthy period of time...if you are an agitated personality it is a lot to expect you to sit there quietly for that length of time.'⁴¹⁵

The four hour rule nationwide

It should be noted that the four hour rule is currently being reviewed in Western Australia by an expert panel convened by the Minister for Health. The review is, in part, a response to hospital staff in Perth's major hospitals who were concerned that the rule could possibly compromise patient care, particularly where hospitals are not adequately resourced to meet set targets.⁴¹⁶ Whilst Western Australia is the only state to date that has implemented the rule, the federal government has as part of its health reform package — the *National Partnership Agreement on Improving Public Hospital Services* committed to apply the four hour rule in the emergency departments of other states.⁴¹⁷

The implementation of a four-hour National Access Target in emergency departments (the four hour rule) was one of the subjects discussed by an expert panel chaired by Commonwealth Acting Chief Medical Officer, Professor Chris Baggoley. The membership of the panel was agreed to by all state and territory governments.

The Panel reported to the Council of Australian Governments and the Prime Minister in June 2011. With regard to the four hour rule it noted:

[t]he concern of some members of the Australian emergency medicine community that four hours is an inadequate period of time to undertake necessary medical assessment and treatment within an emergency care setting, and that rushed care does not equate to better care.⁴¹⁸

However, it found, that in light of the positive outcomes being achieved in reducing waiting times in Western Australia 'a four hour target, properly implemented and with an allowance for some patients to remain longer, is an appropriate target to drive necessary reform.'⁴¹⁹

It also stated that:

[m]eeting the emergency access target cannot solely or predominantly be the responsibility of emergency departments. Whole-of-hospital engagement in achieving the target will be essential, ensuring that all obstacles to effective patient flow are removed. We have noted in systems that have undergone such changes, the vast majority of the process change occurred at the 'back end' of the hospital rather than the emergency department. Without whole-of-hospital involvement, it will not be possible to meet the target. For example, effective patient discharge and ward transfer mechanisms

414 The Royal Australasian College of Surgeons, Submission to the Council of Australian Governments Expert Panel. May 2011. Accessed 23 November 2011 at http://www.surgeons.org/media/433658/sbm_2011-05-24_four_hour_rule.pdf

415 Mr Trevor Carr, Chief Executive, Victorian Health care Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

416 See 'Doctors welcome review of four hour rule', *ABC News* online. Posted 21 July 2011. Accessed 23 November <http://www.abc.net.au/news/2011-07-21/four-hour-rule-review/2804618>

417 See *Panel to Advise on Public Hospital Access Targets*. The Hon Nicola Roxon M.P., Minister for Health and Ageing. Media Release 10 May 2011 Accessed 23 November 2011, at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/.pdf>

418 Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services, Report, 30 June 2011. Accessed 23 November 2011 at Australian Government Department of Health and Ageing, National Health Reform at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report>

419 Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services, Report, 30 June 2011. Accessed 23 November 2011 at Australian Government Department of Health and Ageing, National Health Reform at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report>

are required to ensure that staff and beds are available to transit the emergency patient into a hospital bed in a timely fashion.⁴²⁰

It therefore recommended:

That the four hour National Access Target for Emergency Departments be retained but renamed the 'National Emergency Access Target' ('NEAT') to change the focus from being entirely on the emergency department to emphasise the whole-of-hospital changes that are required to improve emergency patients' access to care.⁴²¹

It also suggested a timetable for implementation with targets increasing over a four year period. For Victoria it has been suggested that 72 per cent of patients be seen within the four hour period in 2012 increasing to 90 per cent in 2015.

It is widely recognised, including by those people who support a formal commitment to reduced waiting times such as a four hour rule, that such a policy needs to be supplemented with other strategies to make the waiting room experience more bearable.

Communication issues

The need for better communication

Previous discussion has demonstrated that a lack of communication, miscommunication or poor communication were key contributors towards patients and visitors acting aggressively in hospital environments.⁴²² Kathy Chrisfield, Co-ordinator of the Occupational Health and Safety Unit at the ANF told the Inquiry that improving communications between staff and patients was an absolutely essential aspect of defusing any potential tension or violence:

Communication is absolutely the key to all of it, that can absolutely help reduce some of those frustrations that go along with [waiting for treatment], as long as there is an end in sight sometimes. That can be all that is needed. As long as you know that you have not been forgotten...and there are reasons that you are here while everyone else has been coming through, that can help; and in the scheme of things, absolutely, when you look at it in the big picture communication is a significant part of what needs to go into the whole approach.⁴²³

In particular, improved communication needs to concentrate on giving clear explanations about the triage system in order to counter the perception that some patients may have unfairly 'queue jumped' in having their conditions prioritised (Mayhew & Chappell 2003, p. 40).

The manner of some health care staff interacting with patients has also been commented upon. Whilst undoubtedly workers may have to tolerate some aggressive and unpleasant behaviour, some staff may inappropriately meet aggression with aggression. Whilst this may be related to the stresses of working in the emergency department, it may also be a product of 'burnout' or unsuitability for that particular role (Lyneham 2000, p.15; Chapman 2011).

A lack of or miscommunication may not just be a problem between health care staff and members of the public. There may also be problems of communication between staff. For example, a new program developed by Blacktown Hospital in Sydney emphasises the

420 Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services, Report, 30 June 2011. Accessed 23 November 2011 at Australian Government Department of Health and Ageing, National Health Reform at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report>

421 Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services, Report, 30 June 2011. Accessed 23 November 2011 at Australian Government Department of Health and Ageing, National Health Reform at <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report>

422 See discussion in Chapter 4.

423 Ms Kathy Chrisfield, Co-ordinator, Occupational Health & Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

importance of inter-staff communication, particularly in notifying the new shift staff as to any potentially violent or aggressive patients:

We at Blacktown have been implementing a program over the last few months called 'Improving patient and staff experience'. One of the parts of that program is about hourly rounding of our patients. If in fact we are looking at our patients every hour to pick up any change of what might be their mental status or capacity, then we have a much earlier chance of avoiding an incident. Clearly it is about getting staff attuned to that as well to be part of that assessment process. Communications again are the important thing that we have found because if someone is 'just not right' and that is not communicated to the next person — you often find that when they do a root cause analysis later on, then 'just not right' would have made the difference if someone had communicated that with the next shift or whatever.⁴²⁴

'How to deliver the message' — An effective communications strategy

Recognising that effective communication is an important part of any strategy to minimise occupational violence, in 2009 the DHS developed the handbook — *A workplace free of violence and bullying: How to deliver the message* (DHS 2009a). This guide gives advice to local hospitals and health services on how to develop an Occupational Violence Communication Plan, the overarching objectives of which should be to:

- Raise awareness about the impact of violence on its health care workers
- Promote the message that violence against its health care workers is unacceptable, and
- Discourage a culture of violence being accepted as 'part of the job' (DHS 2009a, p.3).

Whilst it is recognised that each hospital will have unique and individual features and requirements, the Communication Plan suggested for health services includes eight basic steps:

1. Identifying your target audience
2. Developing the key messages
3. Identifying key stakeholders
4. Develop your communications tools
5. Develop a plan for managing any issues
6. Setting tasks and timelines
7. Establishing a budget for communications
8. Evaluation (DHS 2009a).

The guide urges hospitals to incorporate standard promotional materials tested with community focus groups into their own occupational violence materials. These include poster messages such as:

- A workplace free of violence and bullying: Everyone has the right to be safe
- A workplace free of violence and bullying is a better place to care for you and your family
- A workplace free of violence and bullying: A better place for work, a better place for care (DHS 2009a, p.4).

In addition, health services are encouraged to incorporate and use other communication tools produced by the DHS in their promotional materials. These may include multilingual cards with the key messages and a DVD developed by DHS and hospital staff in conjunction with Victoria Police — *Every day's a challenge — Responding to violence in Victorian health services*.⁴²⁵

424 Mr Dominic Dawson, General Manager, Blacktown Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

425 For a discussion of the importance of training and education on communication skills, see Chapter 11 of this Report.

How effective is signage?

The Communications Strategy mentioned above places great emphasis on educative messages to the public that occupational violence will not be tolerated. One of the key ways this is done is having signage displaying these messages in prominent positions throughout the emergency department and hospital generally.⁴²⁶ Some of the witnesses before the Committee have agreed that such signage can be effective and have advocated that there should be more of it in their own hospitals.⁴²⁷

Other witnesses, however, have been less convinced of the effectiveness of signage as a deterrent or as part of a broader public education program. For example, Paul Cunningham, Head of Security at St Vincent's Hospital Melbourne, told the Committee:

We have often looked at signage and ways of improving our communication with the public that come in. We live in a very selfish society, and when people come in their expectations of the service that we can deliver is often not justifiable; we just cannot do it. They come in, and they sometimes think if they become a little bit loud or a little bit aggressive or stand up and puff out their chest that they are going to be seen more quickly. We have tried the signage thing, but accident and emergency departments are full of signage as it is. You come in and you are lost. You are looking, and you have got it in 17 different languages so that we are covering off the broader community. Some people just tend to lose their way when they come into an accident and emergency department ... I have my doubts about educating the public.⁴²⁸

His colleague, Nurse Unit Manager, Susan Cowling agreed, stating:

The staff need to feel confident. People are not going to read signs when they first come in. They are going to walk up to the first person behind glass and either demand to be seen or demand to go in and see their friend, or they say, 'I need care now. You are not taking notice of me'. It is important for the staff to feel confident in their approach, and I think that goes to education. It is about knowing that as soon as a person starts yelling at you, I have mechanisms or the staff have mechanisms where you get support straight away. Then that support makes you feel confident in going ahead with what you are going to say to the person and addressing it....I do not think that signage is going to do it. I have given people brochures about how to behave, and they just screw them up and throw them back at you.⁴²⁹

Certainly, the Committee agrees with the views of witnesses that signage in hospitals warning about the consequences of violent behaviour needs to be large, easily readable and prominently displayed if it is to be effective.

De-escalation

One particular aspect of the communication process between health care staff and patients and visitors is the ability of a health professional to de-escalate potentially violent situations. De-escalation is a technique that is discussed later in this Report in the context of education and training.⁴³⁰ However, it is useful to briefly mention it in this context. Petit explained de-escalation as follows:

Techniques of verbal de-escalation ('defusing' or 'talking down') should be used as the first approach with any agitated patient, including all of the verbal or non verbal responses used to defuse or reduce a potentially violent situation. The overriding interventional principles are that the staff conveys their

426 For an example of such a message in poster form, see Appendix 11.

427 See for example, submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

428 Mr Paul Cunningham, Security Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

429 Ms Susan Cowling, Nurse Unit Manager, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

430 See Chapter 11.

professional concern for the well being of the patient, their assurance that no harm will come to the patient and that they are in control of the situation...Staff should reinforce the feeling that the patient is in a safe environment and that everyone is there to assist in the patient's evaluation and treatment. At the same time, the limits on patient behaviour and consequences of present and future actions need to be verbalised (Petit 2005, p.708).

Petit added that these approaches are especially important for patients with mental health or dementia problems (2005).

Some clinicians acknowledged the importance of de-escalation as a technique to defuse violence. However, it was indicated to the Committee that optimally this should be done by a specialist such as a psychiatric liaison nurse.⁴³¹ Unfortunately, however, this was not always possible in a busy and understaffed emergency department.

Other witnesses believe that de-escalation should be a skill that all clinical security and even reception staff should possess to greater or lesser degrees. For example, Joseph Jewitt from Royal Prince Alfred Hospital, Sydney, told the Inquiry that:

It's a team based approach, [for example] reception staff are trained in terms of customer service to be able to de-escalate and manage people at that initial encounter with the service in an effective manner to avoid any kind of escalation intention, particularly people who are distressed or concerned about waiting times...⁴³²

Sometimes, in my experience, people feel they need to try and advocate very strongly on behalf of their loved one, and the way in which that is expressed is a manner that is quite aggressive and threatening to staff, but they feel as if they are trying to do the right thing. Our response is really about trying to understand what are the issues that underpin the cause of the aggression which is why there is such a focus on that team based response and first de-escalation because, in our experience, more often than not once you engage the person in a discussion you are better able to understand what are the issues that are underpinning it, and able to defuse and de-escalate the situation quite effectively.⁴³³

St Vincent's Hospital Melbourne has also testified to the importance of simple de-escalation techniques and effective communication strategies in its submission to this Inquiry:

Primacy is placed on de-escalation techniques, which can include establishing rapport, clear communication, prioritising specialist (including mental health) review, mitigating pain, offering simple sedative medications and setting clear boundaries whilst respecting as much patient autonomy as possible. At times it may be something as simple as taking the patient out for a cigarette; and the SVHM approach is to be as flexible and responsive as possible in order to maintain a calm environment and therapeutic relationship.⁴³⁴

In light of the observations of Professor Gordian Fulde, St Vincent's Hospital, Sydney,⁴³⁵ that a significant contributor to patient aggression can be not being able to smoke a cigarette, the

431 See discussion in Chapter 5 on the importance of psychiatric liaison nurses in emergency department contexts.

432 Dr Roy Donnelly, Director, Medical Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

433 Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

434 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

435 See Chapter 4.

suggestion from St Vincent's Melbourne might be an interesting approach for defusing potential aggression.⁴³⁶

The use of volunteers

One strategy for defusing tensions amongst patients, visitors and members of the public in hospital environments is to use volunteers to sit with them and where necessary explain hospital procedures and policies or give updates on when they might be attended to or the progress of their treatment schedule. For example, Health Services Commissioner Dr Beth Wilson has suggested employing volunteers to be with anxious patients, families and friends can be very beneficial:

The presence of volunteers can make a dramatic difference to the ER experience. The effect of a gentle voice of someone who has no agenda other than to say hello, listen and ask about your sick patient (child, mother, friend etc) can be a useful intervention in lessening anxiety and violence. These front line (generous and often elderly) people cannot be the solution to unexpected violent outbursts, but they certainly can play a role in calming the environment in an ER.⁴³⁷

Evidence was given to the Committee that volunteer schemes are in operation at both Royal Melbourne Hospital (RMH) and Royal Prince Alfred Hospital, Sydney. Professors Heinjus and Gerdtz from Melbourne Health have told the Inquiry that the RMH volunteer model has been very successful:

During our busiest times we have volunteers who have a presence in the emergency department waiting room...I think the volunteers can see they are adding real value as well...⁴³⁸

...The main role of the volunteers is comfort and care. When there is a perception that the nurses are engaged in addressing priorities of care, the volunteers can be directed by clinical staff to provide comfort and care, and communication; [but] they do not do anything without being carefully monitored.⁴³⁹

Royal Prince Alfred Hospital use their volunteers as a conduit between the waiting room and the emergency department, in effect acting as the 'eyes and ears' for emergency department staff who may be too busy to spend too much time in the waiting areas:

We are introducing volunteers into the waiting room to really be a liaison between what is going on out there and to provide some feedback from clinical staff, particularly when the emergency department is extremely busy. The people that are waiting there for a long period of time that could be potentially

436 The importance of de-escalation as an intervention for defusing patient aggression and the need for all staff to be trained accordingly was also mentioned by other witnesses. See for example:

- Mr Simon Thomson, Acting Regional Manager, Ambulance Victoria, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.
- Dr Georgina Phillips, Emergency Physician and Coordinator of International Programs, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.
- Ms Kathryn Ackland, Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.
- Ms Sue-Anne Redmond, Director, Clinical Governance, Westmead Hospital, Sydney West Area Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.
- Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre, St Vincent's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

437 Submission from Dr Beth Wilson, Health Services Commissioner, Victoria to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

438 Associate Professor Denise Heinjus, Executive Director, Nursing Services, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

439 Associate Professor Marie Gerdtz, Associate Professor of Emergency Nursing, the Royal Melbourne Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 12 September 2011.

neglected, if they have some contact and know what is going on and a bit of an estimation of how long it will be, the theory behind that is we will be reducing that tension out there.⁴⁴⁰

The community service charity Jesuit Social Services has also recommended the establishment of volunteer squads in emergency departments trained in mental health first aid. Such volunteers would be particularly useful in assisting young people. 'These volunteers could sit with patients and help keep them calm while the triage process is taking place'.⁴⁴¹ Jesuit Social Services claims that with appropriate resourcing a non-government organisation such as Jesuit Social Services would be able to provide both the volunteers and the training for such a program.

The Committee supports the establishment of such an initiative.

Conclusion

Environmental strategies clearly play a very important part in preventing and reducing aggression in health care settings. They form one component of a suite of interventions that are collectively necessary to effectively address occupational violence. However, many of the strategies discussed in this chapter such as de-escalation techniques and communication skills will not be effective without staff receiving comprehensive training on how to use them. This will be the area of focus in Chapter 11 of this report.

Recommendation

- 14. The Committee recommends that all security personnel employed in Victorian hospitals be fully licensed under the *Private Security Act 2004*.**

Within the Victorian security licensing process, security staff engaged directly by hospitals are not required to hold appropriate security licences or meet minimal training requirements. Any security personnel engaged through a security firm, however, must be licensed and meet minimal training competencies and standards. In the Committee's view all security staff however employed should be appropriately licensed and trained before commencing employment in a hospital or health care setting. The current situation whereby different requirements apply depending on whether a security officer is 'in house' or contracted seems arbitrary and anomalous.

Recommendation

- 19. Accepting that long waiting times in the emergency department and triage rooms is one of the main contributors to frustration and aggression, the Committee recommends that the hospital explore options for the better communication of likely waiting times and alternatives sources for medical attention in cases of non-critical presentations.**

Evidence has been given to the Committee that in the volatile environment of the hospital emergency room frustration and aggression as a result of long waiting times or a misunderstanding of the triage process can often go 'hand in hand'. When people are receiving bad news violence can also erupt if this is not well handled. Time has to be given to providing careful explanation of administrative and medical procedures so patients and families can deal with these confronting circumstances. As one witness stated to the Committee, these issues are difficult but not impossible. There must be adequately trained staff available to approach the delicate communication issues associated with being a patient, family member or visitor to the emergency room.

440 Ms Joanne Edwards, Director, Nursing Midwifery Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

441 Submission from Ms Julie Edwards, Chief Executive Officer, Jesuit Social Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

Recommendation

- 20. The Committee recommends that the Victorian government support non-government organisation such as the Jesuit Social Services and the Salvation Army to provide volunteers with appropriate training for Volunteer squads in emergency departments that could sit with patients and help keep them calm while the triage process is taking place.**

One strategy for defusing tensions amongst patients, visitors and members of the public in hospital environments is to use volunteers to sit with them and where necessary explain hospital procedures and policies or give updates on when they might be attended to or the progress of their treatment schedule. Evidence was given to the Committee that where volunteer schemes are in operation in hospitals they have been very successful. With appropriate resourcing a non-government organisation such as Jesuit Social Services or the Salvation Army would be able to provide both the volunteers and the training for such a program.

Recommendation

- 25. The Committee recommends that the hospital should provide information to all health care staff, patients and visitors outlining the standard of behaviour expected of them within hospitals and other health care settings. In particular, hospital waiting rooms should have appropriate signage, posters and patient information sheets conveying the expected standard of behaviour and the possible ramifications for failing to adhere to them.**

It is important to make it clear to employers, nurses, other health service employees and members of the general public that occupational violence will not be tolerated. One of the key ways this is done is having signage displaying messages in prominent positions throughout the waiting rooms, emergency department and hospital generally that convey the expected standard of behaviour and the consequences of not adhering to these. These should be in a variety of languages or explained in some other way to people from non-English-speaking backgrounds who may not be able to read them.

Recommendation

- 28. The Committee recommends that hospital management utilise the principles of crime prevention through environmental design (CPTED) in designing and fitting out existing emergency departments (including waiting rooms and triage areas) or in the designing and building of new hospital emergency departments.**

In relation to hospital design and particularly emergency departments evidence has been given to the Committee that suggests the carefully considered use of natural light, colour and art in the workplace has a calming effect on both staff and patients alike and decreases the incidence of violent and anxiety-related episodes. The layout of the hospital emergency department (entrances and exits, triage desks) should also be wherever possible designed in accordance with CPTED principles.

Recommendation

- 29. The Committee recommends that hospital management should consider establishing purpose built rooms or areas for isolating or assessing violent or potentially violent persons, particularly patients with mental health and drug and alcohol behavioural disturbance attending their hospitals. The Behavioural Assessment Rooms successfully trialled at St Vincent's Hospital may serve as an example of a measure to treat such persons in a manner that minimises the likelihood of harm to themselves or others.**

Evidence has been given to the Committee on the value and utility of isolation or behavioural assessment rooms. The evidence suggests that these specialist facilities are particularly useful in ensuring safe and appropriate care for aggressive and violent patients whilst protecting the health and safety of other patients, staff and visitors. This is particularly the case for mental illness related and drug related behavioural disturbance. Behavioural assessment rooms, it has been suggested, are an effective intervention for calming aggressive patients. Separating potential aggressors and removing sources of provocation has the potential to reduce violence. These specialised treatment rooms have been successfully trialled at St Vincent's Hospital and this should be considered as a model for the rest of the state.

Recommendation

- 31. The Committee recommends that hospitals provide secure access and egress that are not accessible to members of the general public for emergency patients arriving or departing by ambulance.**

Many transport areas used by paramedics are open to the public, patients and relatives, frequently used as 'smoking areas' and have no security at all. While there are increased delays in admission of patients to emergency departments, there is ongoing potential for agitated patients to require aggression management even prior to ED admission.

Recommendation

- 32. The Committee recommends that hospitals install effective CCTV and electronic equipment in the emergency department, the triage area and other appropriate areas of the hospital to monitor at all times possible aggressive behaviour.**

The use of CCTV technology has become an increasingly popular and successful approach to crime reduction and community safety issues in areas particularly at risk including hospitals.

Many witnesses who gave evidence to the Inquiry supported the use of video surveillance in hospitals with appropriate safeguards. However, despite the support for its usage, it has been recognised that it is not enough for hospital management to simply install CCTV systems. Hospitals need to work in partnership with their security staff to develop and implement protocols on the usage of CCTV and other monitoring systems. Victoria Police should be encouraged to continue to work proactively with hospitals on using CCTV as a community safety and crime prevention tool.

Recommendation

- 33. The Committee recommends that the hospital provide effective duress alarms for staff working in emergency departments and mental health facilities.**

The Committee has received considerable evidence particularly from clinicians working in emergency departments stating that there should be both fixed trigger point duress systems throughout the hospital and personal duress alarms worn by all staff potentially at risk. Such systems should be able to identify the location of the person in distress and detect if they are not moving.

Recommendation

- 34. The Committee recommends that, as far as possible, waiting and treatment areas for paediatric patients within general emergency departments be separated to optimise the safety of children.**

It is important that emergency department layout should be designed wherever possible to have separate treatment and waiting areas for adults and children. It is clearly unsuitable to have children and their families being seen in the same environment as a potentially violent patient.

10. Addressing Occupational Violence: Penalties and sanctions for perpetrators

Introduction

The Victorian Taskforce on Violence in Nursing in examining occupational violence in hospital settings believed there was a need for 'a hierarchy of consequences', including legal sanctions in addressing the actions of violent perpetrators:

Australian research by Mayhew and Chappell (2003) established that the majority of perpetrators of violence and aggression experienced no negative consequences following their inappropriate behaviour. Few perpetrators are prosecuted following violent acts and perpetrators of violence against nurses and medical officers are least likely to experience any negative consequences. For those perpetrators who receive a sanction, this is usually a verbal warning from a nurse unit manager or security officer. The taskforce considers that the current system, where few aggressors have any form of sanction imposed, is deficient (Department of Human Services (DHS) 2005a, p.43).

The Taskforce acknowledged, however, that there were circumstances where sanctions, at least those at the more severe end, would be inappropriate:

In determining sanctions and their application, it is relevant to consider the source/nature of the behaviour. It is not the intent that inappropriate action is taken against those whose violence arises directly from a medical condition. In these cases, the emphasis should be on prompt, effective clinical management and compassionate care of the patient, while at the same time protecting the safety of staff and others who may be affected by the behaviour (DHS 2005a, p.43).

This does not mean that the victim of the occupational violence should not seek redress for any pain or suffering he or she has experienced whether or not such conduct was intended. As the *Victorian Taskforce on Violence in Nursing: final report* explained:

[t]here has been a tendency by nurses to 'explain away' violent or aggressive behaviour by clients affected by a medical condition, with the absence 'of malicious intent by the perpetrator mitigating staff interpretations of aggressive incidents' (Mayhew & Chappell 2003). This has contributed to a 'culture of silence', which is perpetuated by the failure of nurses to assert their legal rights after they become the victim of a violent episode, and a lack of support systems at the institutional level (Forrester 2002) (DHS 2005a, p.43).

The following discussion reviews the sanctions already in place to address occupational violence in Victorian hospitals and examines the feasibility of enacting a new criminal offence specifically aimed at penalising the actions of perpetrators of hospital violence. It also examines strategies to strengthen and increase the penalties of current offences available to deal with assaults and other crimes in health care settings.

Sanctions available to address occupational violence

The types of sanctions that have been used in hospitals both in Australia and overseas have included the following:

- ◆ verbal and written warnings
- ◆ patient contracts

- ◆ managed visits
- ◆ exclusion or banning orders, including refusal of treatment and for visitors, restriction of visiting rights ('Red cards')
- ◆ criminal prosecutions.

It should be noted from the outset that the concept of a sanction in the context of occupational violence is premised on there being a Code of Conduct for patients and visitors in place in each hospital. Such Codes should include the rights and responsibilities of patients and visitors and clearly defined rules pertaining to the behaviour expected of them whilst in the hospital (Mayhew & Chappell 2003, p.39). In addition, there needs to be ample publicity on the behaviour expected of patients and visitors and the penalties that can be enforced should patients and visitors breach hospital rules and guidelines. Ideally, the rules of expected behaviour should be included in materials such as pamphlets/booklets on admission to the hospital and posters/notices should be displayed prominently in the public areas of the premises (DHS 2005a).⁴⁴²

Lower level sanctions — warnings and contracts

Verbal sanctions are at the lower end of the sanctions scale followed by written warnings or notices. Verbal warnings are most often given by nurse managers or a member of the security staff whereas written warnings would usually be issued by hospital management. For an example of a written warning notice issued in a Victorian health care setting, see the Barwon Health Warning Notice in Appendix 10.

In some United Kingdom hospitals, the National Health Service (NHS) issues clients who behave inappropriately with a series of 'yellow warning cards'. If a client continues to misbehave after a number of warnings, he or she will be issued a 'red card' that may result in withholding of treatment (Mayhew & Chappell 2003; DHS 2011a). Red card systems are discussed separately below.

Patient contracts

A number of hospitals have patient/visitor contract systems whereby patients or their visitors, who may already have received a warning about their behaviour, are asked to sign a written contract. In effect they contract to be of good behaviour and observe hospital rules during their stay at the hospital. A breach of the contract may result in being refused (non-life threatening) treatment or in the case of families and friends, withdrawal of visiting rights. It is also possible that a patient or visitor in breach of the contract could be charged with trespass and removed from the premises by police should he or she return to the hospital.

The Alfred Hospital is one of the health services that uses patient contracts, but Andrew Way, the Chief Executive Officer of Alfred Health explained that they are not a straightforward sanction to implement:

We currently have a patient contract system. If we have a patient on the ward who is behaving badly, for example, we will get them to sign a contract to behave, or if the relatives are misbehaving towards staff we will get them to sign a behaviour contract. But that is a very slow process. You have to draft it, you have to get the medical director to sign it and you have to get them to read it and explain it. A red and yellow card, they all understand. They all watch football and they know what it means.⁴⁴³

Health Services Commissioner Dr Beth Wilson told the Committee that behavioural contracts can be a really useful tool to prevent potential violence from escalating in a hospital setting, although they may need to be explained and negotiated simply and clearly, particularly for clients with psychiatric or intellectual disabilities:

⁴⁴² See also discussion in Chapter 11 with regard to education, training and public awareness programs.

⁴⁴³ Mr Bill O'Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

Contracts...can be quite useful...They can be very flexible. It can be just an agreement where somebody who is a skilled communicator at the hospital can sit down with the person and say, 'Okay, you have come here and have done this and that; you have shouted at our nursing staff and threatened violence. We cannot treat you in those circumstances, but we are willing to provide you with treatment if you will agree to A, B, C, D', and they sign it. I do not know how legally enforceable that would be, but sometimes quite angry, violent people can be very reasonable if you give them the opportunity.⁴⁴⁴

Patient contracts may or may not have conditions and stipulations attached to them. For example, they may limit the number of times a patient or visitor can access the health service, they may require a patient or visitor to report and register with security prior to entering the ward or emergency department. In some cases it may be a condition of visitation that security escorts are provided to and from the premises or that visits are supervised by a third party (DHS 2005a).

Red Cards, Banning Orders and Refusal to Treat Notices

A significantly more punitive sanction is the idea of the 'red card' or banning notice. Originating in the United Kingdom's NHS as part of its zero tolerance policy,⁴⁴⁵ the card system is drawn from football terminology whereby a yellow card or series of cards is given as a formal warning (or warnings)⁴⁴⁶ and a red card results in withdrawal of treatment or exclusion from the hospital for 'serial' perpetrators. Exceptions are made in the British system for patients who need life-saving treatment or have mental health conditions. The following example from the Luton and Dunstable NHS Trust is illustrative of the policy operable throughout the United Kingdom:

We pledge to treat our patients with care and dignity. To make sure we can do this, the L&D will not tolerate violent or aggressive behaviour towards members of staff and other patients.

Examples of unacceptable behaviour include:

- Verbal abuse which prevent staff from doing their job or makes them feel unsafe
- Significant threats or risk of serious injury to a member of staff, fellow patients or visitors. Actual violence towards a member of staff, fellow patients or visitors
- Serious destruction of hospital property
- Excessive inappropriate noise, e.g. loud or intrusive conversation or shouting
- Threatening or abusive language involving swearing or offensive remarks
- Derogatory racial or sexual remarks
- Malicious allegations against staff, other patients or visitors, whether in verbal, written or electronic form. Offensive sexual gestures or behaviours
- Abusing alcohol or drugs in hospital
- Drug dealing
- Wilful damage of hospital property
- Theft

People who behave in an antisocial manner may be taken out of the hospital and could face withdrawal of treatment under the Red Card scheme. A Red Card means that for purposes other than emergency treatment the person will not be allowed in the hospital for a period of 12 months. The person's GP will also be sent a letter.⁴⁴⁷

444 Dr Beth Wilson, Health Services Commissioner, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

445 See discussion in Chapter 5.

446 Each hospital may differ in the number of 'cards' that are given. See National Health Service 1997 and *Safety and Security*, Luton and Dunstable Hospital, NHS Foundation Trust (14 July 2011), <http://www.ldh.&s.ub/Safetv and Securitiv.htm>

447 *Safety and Security*, Luton and Dunstable Hospital, NHS Foundation Trust (14 July 2011) <http://www.ldh.&s.ub/Safetv and Securitiv.htm>

Merits of the red card system

In its submission Alfred Health stated that the red card system has merit as it is simpler and more easily understood by patients and visitors than contracts:

Alfred Health suggests that the Victorian Government investigate the “card system” used in the UK and other countries to warn and then exclude violent or aggressive patients or visitors. This would not apply if the patient is suffering from a life threatening condition.

The first step in the process would be to serve an offender with a yellow card which in effect is a final warning. A second yellow card is the equivalent of a red card and automatic eviction from the premises. Eviction could also mean the patient is banned from returning to the hospital for a period of up to six months unless suffering from a life threatening condition.

Such a system is well understood in sporting competitions and would be readily understood by most patients and visitors.⁴⁴⁸

Bill O’Shea, Legal Counsel for Alfred Health, expanded on the need for a red card system when he gave evidence to the Inquiry:

We are really saying that if a patient does not have a life-threatening injury or illness or a mental illness and that is the diagnosis and they are engaging in violent behaviour, they should be warned, and if they continue to engage in that violent behaviour, they should be evicted — basically, removed from the hospital, escorted out. If they have got a cut head, they can treat their cut head at home or they can go to a GP or they can go somewhere else, but they will not be treated in the emergency department if they are going to endanger the health and safety of staff or fellow patients. That would be the red card situation. Not only are they excluded, they can be excluded for a period of time, maybe six months, from coming back to the hospital for other than life-threatening treatment.⁴⁴⁹

Legal issues with using red cards

There may be some possible legal complications should a ‘red card’ system be introduced in Victoria. These were alluded to by Bill O’Shea in evidence to the Inquiry. He raised the example of the abusive patient with a cut head who is refused treatment because of his belligerent behaviour. He indicated that it was quite possible that the nurse or doctor who ‘red carded’ him could be liable in negligence if that patient subsequently became ill:

If someone goes home with a cut head and trips over on the way home and injures themselves, the Wrongs Act provided a number of exceptions to claims to personal injury against medical staff. For example, the good Samaritan provisions of the Wrongs Act say that if a person acts as a good Samaritan they will not be held liable if they are not the world’s greatest good Samaritan — in other words, they will not be held liable in tort. Our view would be that if the government were to think about introducing a yellow and red card system, there should be some virtual indemnity or some ability for the medical staff who make that decision to tell someone to leave so that they cannot then be sued for negligence as a result of that decision if it is made in good faith and the person who is evicted does not have a life-threatening injury. I think the health professionals, whoever they are, the allied health, nursing and medical staff would be nervous if they were to be asked to exclude people without some protection. I think that strengthens them. It goes hand in hand with the right to evict.⁴⁵⁰

In a submission to the Inquiry, Alfred Health recommended that the *Wrongs Act* be changed by legislative amendment to absolve medical staff for any actions in negligence for using a red card in good faith:

The Committee should consider an amendment to the Wrongs Act 1958 (Vic) that would absolve a health practitioner from liability when that health practitioner declines to treat a patient in circumstances

448 Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

449 Mr Bill O’Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

450 Mr Bill O’Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

where the patient has displayed violence or aggression towards the health practitioner (or any other person in the hospital) without a lawful excuse provided the person does not have a life threatening condition. A lawful excuse would not extend to a person affected by self-induced intoxication whether by drugs or alcohol.⁴⁵¹

Concerns regarding the red card system

Red card systems are not universally favoured, at least not without going through all other possible alternatives. As Forster et al stated:

The notion of 'Not welcome' notices and 'Refusal to treat' options in health care systems is contentious in view of the sometimes conflicting obligations of having a duty of care to patients and providing a safe workplace for staff. The tension arising from imposing sanctions on patients and/or visitors provides a challenge for clinical and administrative teams...The key message is that sanctions can be imposed on health care users who are deemed able to have responsibility for their action. They should be given a warning notice that violent behaviour will not be tolerated. A 'Refusal to treat directive' does not preclude patients from receiving care and treatment from the hospital, but implies that this will only be provided if their condition is life threatening (Forster et al 2005, p.359).

Evidence given by other witnesses to the Inquiry was equivocal at best about introducing a red card system, seeing both practical and ethical problems with it. For example, Trevor Carr of the Victorian Health care Association raised the following issues:

I do not really know how we could do that. We do not push people away because they are smokers when they present with lung cancer. I think it is hard to make hard and fast calls like that. I do not even know that you could have an ID system, because we just do not have the technologies available to facilitate it. And how would you know if they were on a...card? They might be at the Alfred today, the Austin tomorrow and Western Health the next day. We do not have any systems in place that would communicate that across those networks.⁴⁵²

Dr Stephen Parnis of the Australian Medical Association (AMA) told the Committee that there was 'no single black and white answer' to issues of patient violence generally or card systems specifically. He continued:

It is always a difficult issue. We have a duty of care to people, and I always have that in the back of my mind. I would rather have the person who is misbehaving under my roof than kick out the person whose behaviour is a result of a medical issue. It is almost like I would rather let nine guilty people off than convict the innocent. We have to watch that very closely. We treat that with the same level of respect as when we take a person's rights away by restraining them, sedating them, admitting them as an involuntary psych patient or whatever.⁴⁵³

Nursing academic Professor Gerry Farrell, whilst recognising that health care staff shouldn't have to put up with either actual or threats of violence, believed the card system proposal was flawed on ethical and moral grounds. He also said that the suggestion that patients who were banned from hospitals could attend a local GP for needed treatment was flawed:

Okay. Where does the local GP send them? Is it acceptable for the local GP to have the patient? That is the sort of issue and the complexity that they [red card proponents] will need to address. Then we are in danger of stigmatising some people, because they may have been repeat offenders, but on this next occasion they may not be like that at all, and then how do you manage that situation? For the odd

451 Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

452 Mr Trevor Carr, Chief Executive, Victorian Health care Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

453 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

time that is going to happen there is a bigger issue out there more generally around managing people who can sometimes be aggressive.⁴⁵⁴

The situation is somewhat different with regard to aggressive visitors however. Clearly in these circumstances the person is not in need of treatment, life-saving or otherwise. It may be that in such circumstances a card system is feasible. Certainly in some hospitals provisions have been made for security staff to issue banning or barring notices for persistently violent offenders to leave the hospital premises. If they fail to do so, they are liable to police action and prosecution.⁴⁵⁵

Prosecuting violent offenders

Threats and acts of violence against hospital staff are clearly actionable under Victorian criminal law.⁴⁵⁶ Historically, however, it would seem there have been few prosecutions of perpetrators for assaults or violent acts against hospital staff. This may have been because staff were reluctant to report such incidents and/or felt they wouldn't be supported by hospital management and/or police if they did. Moreover, until relatively recently there were few protocols in place in hospitals or between hospital and police that supported staff in laying criminal charges and through the process (DHS 2005a, 2005b).⁴⁵⁷ Added to this perceived lack of support, factors such as the time involved in going to court, the paperwork involved such as witness statements and the emotional stress of court proceedings may have all contributed to a reluctance to take further action.⁴⁵⁸

Notwithstanding these valid concerns the *Victorian Taskforce on Violence in Nursing: final report* stated it was critical:

[t]hat [nurses] have confidence in the justice system and their own employer to support them to report attempted or actual assaults to police and where appropriate to request that charges be laid (DHS 2005a, p.44).

It therefore made the following recommendation:

That the Victorian Government considers procedures for reporting to police, laying charges and prosecutions, including the potential for legislation for nurses similar to that developed for ambulance officers. (A Memorandum of Understanding, similar to that adopted between NSW Health and NSW Police, is a useful reference).⁴⁵⁹

The 2007 *Preventing occupational violence in Victorian health services* policy framework recognised the importance of reporting incidents of violence against hospital staff to the police, where appropriate. As part of its provisions on post-incident issues it stated:

Management must ensure employees are aware of their rights (for example, their entitlement to claim compensation, and their right to report the assault to the police) and also the legal requirements and responsibilities placed on them under law by the organisation or with respect to professional ethics.

Management should also make provision for employees who are involved in giving evidence in court (if relevant). These provisions should advise on the format of criminal court procedure and also provide debriefing following the trial (preferably on an individual basis). Managers can seek advice and assistance from the legal unit in relation to these matters (DHS 2007a, p.22).

454 Professor Gerald A Farrell, Professor of Nursing, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 29 August 2011.

455 See Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

456 In particular the assault and crimes against the person provisions of the *Summary Offences Act 1966* and *Crimes Act 1958*.

457 For a discussion of the reasons why staff may be reluctant to report violence to police and the lack of encouragement some hospital management to do so, see discussion in Chapter 5.

458 See Ms Danielle McNamara, Registered Nurse, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

459 Recommendation 12, *Victorian Taskforce on Violence in Nursing: final report*, DHS 2005a.

Notwithstanding these developments to encourage workers to report violence, some witnesses who gave evidence to the Inquiry feel that there still some problems in the way the 'system' handles complaints of violence. For example, Bill O'Shea legal counsel for Alfred Health told the Inquiry:

The staff at The Alfred feel that there seems to be some cone of immunity when [perpetrators] walk into The Alfred and engage in antisocial behaviour that would be unacceptable on the street. Their view is that if it is unacceptable on the street, it should be unacceptable in the hospital, so police should be prepared to take action for assaults that occur in the hospital that would not be put up with if they were outside the hospital.⁴⁶⁰

Alfred Health is emphatic that perpetrators shouldn't be immune from prosecution simply because they are patients unless there are medical reasons such as dementia or psychosis that may prevent them from forming the relevant *mens rea* or criminal intent. Certainly intoxication should not be a reason of itself not to charge a patient. As Mr Way explained:

An issue requiring consideration by the Committee is the extent to which persons who engage in violent or aggressive behaviour in a public hospital are not prosecuted by Victoria Police because allowances are made on the grounds they were intoxicated.

Alfred Health staff are concerned that there appears to be a reluctance on the part of Victoria Police to charge offenders who are violent or aggressive within the Hospital compared to when the same anti-social behaviour is displayed in a public area such as outside a nightclub or on public transport. Intoxication, whether from drugs or alcohol, should not be an excuse for tolerating aggression or violence or failing to charge those responsible.

Persons who engage in violent or aggressive behaviour in public places are usually charged with a relevant offence. It should make no difference that this behaviour occurs in a public hospital.

Section 9AJ of the Crimes Act 1958 (Vic) has changed the law on intoxication as a defence, by requiring that the conduct of a person whose intoxication is self-induced is to be judged against the standard of a reasonable person who is not intoxicated.

Thus intoxication should not be a barrier to Victoria Police charging a person with a relevant criminal offence wherever it is committed, including within a public hospital.⁴⁶¹

Similarly, Dr David Edey of Geelong Hospital told the Inquiry:

Often the police involved in these incidents are very junior police officers. In our experience they have not been overtly encouraging our staff to report assaults because they may use the excuse they are intoxicated or they are mentally ill and there will not be any penalty for them, they will get off. We have heard that before. Certainly in the event of serious assaults or extreme behavioural incidents, we would encourage our staff to report, and certainly report to police with a view to prosecution if that was appropriate.⁴⁶²

These types of experiences with the legal process have led some observers to call for changes in the way in which violent perpetrators are prosecuted.

The need for legal reform?

Increased penalties

Much evidence has been given to the Inquiry arguing that the penalties for assaulting health workers in the course of their professional duties should be considerably increased. For example, a submission from the AMA (Victoria) stated:

460 Mr Bill O'Shea, General Counsel, The Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

461 Submission from Mr Andrew Way, Chief Executive, Alfred Health to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

462 Dr David Edey, Director, Emergency Medicine, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

Treating doctors should not be subjected to violence, abuse or threats to their safety.

AMA Victoria supports enhanced penalties for those who are violent towards hospital staff. This could cost-effectively reverse the trend of violence towards doctors and nurses in EDs and the wider health care setting. Assaults on health workers should become an aggravated offence and carry more significant fines, and longer jail sentences. This would bring penalties into line with those for assaults on police officers.

Increasing penalties for assault would be an effective way to send the message to the public that doctors and nurses occupy positions of respect.⁴⁶³

Similarly the Australian Nursing Federation Victoria in its submission to this Inquiry requested the state government to implement Recommendation 12 of the *Victorian Taskforce on Violence in Nursing: Final report* legislating an increase in penalties for perpetrators of violence against nurses and midwives.⁴⁶⁴

Under existing laws pertaining to assault this would ordinarily involve an increase in penalties under the offences against the person or assault sections of the *Crimes Act 1958*. However, the provisions of the *Crimes Act* are generic and don't distinguish between different classes of victim. Therefore, theoretically an assault that is perpetrated against a nurse or doctor would be given no more weight than one against a member of the general public. A sentencing judge *might* possibly take the victim's status into account as one of the matters he or she could consider at the sentencing stage but this is a matter for each individual judge and would be by no means a uniform practice.

Dedicated offences

Treating medical and security staff in the same way police and ambulance officers who are assaulted in the course of their professional duties are treated is a possible alternative to increasing penalties.

Under Section 31(1)(b) of the *Crimes Act 1958* it is a crime to assault or threaten to assault a member of the police force (or person acting in aid of a member of the police force) in the due execution of duty. As with police officers, there are special provisions making it an offence to assault an ambulance officer or paramedic worker in the course of their professional duties. Section 51 (1) of the *Summary Offences Act 1966* states as follows:

- (1) A person must not assault, resist, obstruct, hinder or delay an operational staff member within the meaning of the Ambulance Services Act 1986 in the course of the operational staff member providing care or treatment or attempting to provide care or treatment to a patient.

A number of witnesses to the Inquiry have stated that not only should there be tougher penalties for perpetrators convicted of occupational violence under existing law but that as recommended by the Victorian Taskforce on Violence in Nursing a *dedicated offence* addressing violence against workers in health care settings should be enacted. For example, Dr Stephen Parnis, Vice-President of the AMA explained to the Committee:

I think it is timely to mention one solution that we believe is appropriate — that is, that health-care workers should be, as far as the law and the community are concerned, treated like other public servants, such as police or prison officers. The law says that if you harm one of those people, the penalties are more severe. We hope those laws are never used, but it is about the law sending a message. This is a powerful one that could be sent by the Parliament: that people who work in health-care professions, who are putting themselves at some degree of risk — though we cannot eliminate the risk, we are saying that these people need to be treated with respect, and that respect goes so far

463 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

464 Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

as to say respect their property, respect their body, respect their lives, respect their families. The AMA has advocated that position for some time.⁴⁶⁵

Peter Johnson from the Australian Security Industry Association believed that a similar dedicated offence should apply to security officers in the health care field, as they too are often assaulted in the course of their duties. He explained:

[We believe there should] be an offence created to prevent a security officer or a health care worker being assaulted, hindered or obstructed in the course of their duties. That has not been implemented in Victoria. We certainly recommend that it be implemented as a priority. In doing so you would strengthen the response to a security officer's handling of a situation if a person was hindering them in the operation of their duty, which a lot of visitors may do. Patients are hindering the ability to provide a health care response, a security response.⁴⁶⁶

The Committee acknowledges that it is certainly possible under the current provisions of the Victorian *Crimes Act 1958* and the *Summary Offences Act 1966* to prosecute a person for assaulting a hospital or health worker or security officer under the general laws applicable to all members of the public. The Committee has received evidence that enacting specific laws applicable to assaulting personnel working in hospitals and health services including medical, nursing, social workers, other allied health professionals and security guards reinforces the message that violence towards such workers acting in accordance with their professional duties is totally unacceptable. As with police and ambulance officers, this is a particularly grave form of assault which requires severe penalties.

Conclusion

For a variety of reasons health workers, and their employers, have been reluctant to prosecute or otherwise penalise perpetrators of occupational violence in hospitals. This has been the case particularly because of the strong service and caring ethos of nursing, medical and other staff working in Victorian health care. Yet, as has become increasingly apparent over the last decade, health care staff should not be expected to tolerate violence in their workplace nor should patients or visitors feel they are entitled to act with impunity. As such, the Committee believes that a dedicated offence to criminalise violence against health care workers similar to the provisions which protect police and ambulance officers should be considered. Such a change to the law will send a signal that aggressive and violent acts towards people working in our hospitals is totally unacceptable. Unless there is a sound reason to the contrary, such as a mental health or other medical condition that prevents the perpetrator from acting with criminal intent, patients or other clients who threaten or act in violent or aggressive ways should feel the full force of the law.

Sanctions, however, can only be, as a witness to the Inquiry put it, 'one prong to the holistic approach that needs to be taken' to address the behaviour of perpetrators of occupational violence.⁴⁶⁷ As the next chapter discusses, educating and training health care and security workers to recognise and address potential and actual aggression before it gets out of hand is equally if not more important.

465 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

466 Mr Peter Johnson, Manager, Compliance & Regulatory Affairs, Australian Security Industry Association Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Sydney, 20 September 2011.

467 Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Recommendation

- 5. The Committee recommends that a specific offence of assaulting, obstructing, hindering or delaying a hospital or health worker or a licensed security guard or emergency worker in the execution or performance of their duties be considered in Victoria.**

It would certainly be possible under the current legal provisions of the Victorian Crimes Act and the Summary Offences Act to prosecute a person for assaulting a hospital or health worker under the general laws applicable to all members of the public. The Committee feels, however, that enacting specific laws applicable to assaulting personnel working in hospitals and health services including medical, nursing, social workers, other allied health professionals and security guards reinforces the message that violence towards such workers acting in accordance with their professional duties is totally unacceptable. As with police and ambulance officers, this is a particularly grave form of assault which requires severe penalties.

Recommendation

- 6. The Committee recommends that individual hospitals develop strategies to manage violent behaviour that is appropriate to that hospital's environment.**

Banning notices, patient contracts and warning systems have been used successfully in some local and overseas jurisdictions including Britain. Nonetheless, the use of sanctions against patients, their families and visitors is a controversial issue. As such the Committee believes the use of such systems should not be mandatory. Each hospital should come to its own decision on the merits as to whether restricting access to the treatment and services it provides is appropriate. A caveat to this recommendation, however, is no patient should ever be refused treatment in circumstances where it is clear that the person is gravely ill and in need of immediate treatment.

Recommendation

- 26. The Committee recommends that the state government develop and conduct a public health awareness campaign that promotes the message that violence in hospitals is unacceptable and subject to severe penalties.**

Government-run public health awareness campaigns promoting the message that violence in hospitals is unacceptable and will have severe consequences need to be conducted on a regular basis. Other such campaigns could include public health education campaigns informing the community about alternatives to presenting to emergency departments for non-critical health services so that numbers and waiting times in hospital waiting rooms are reduced.

It is important that such messages reach the public before they attend a health facility or come into contact with nurses at the hospital.

11. Improving Education and Training

Introduction

One of the key components for addressing aggression and violence in hospitals effectively is the provision of specific education and training, including training in appropriate communication, for all people involved in health care settings. This includes clinical staff, managers and administrative personnel, security officers, police and the general public. While the degree of risk in terms of aggressive and violent behaviour may vary between hospitals, departments within hospitals and other health care settings, it is important that an appropriate level of training is provided for all personnel in those settings.

The following sections of this chapter examine the needs and availability of education and training for each of the above groups, beginning with health care undergraduates and students. While training staff in management systems is not the whole solution to the problem of occupational violence, it is a core element of strategies to prevent and deal with it and 'is likely to be the most effective tool in the longer term' (Kennedy 2005, p.364).

Education and training

Health care undergraduates and students

In 2005 the *Victorian Taskforce on Violence in Nursing: final report* identified a lack of consistency in curricula for undergraduate nursing students with regard to preparing students to cope with occupational violence (Department of Human Services (DHS) 2005a). The report stated further that:

It is the taskforce's view that an integral part of a nurse's undergraduate preparation for entry into practice is the inclusion of OH&S principles, particularly an introduction of occupational violence and bullying management principles and coping strategies. It is also argued that OH&S content should be undertaken by students before clinical placements and reinforced once they enter the nursing workforce (p.56).

To gauge what developments there had been in this regard the Committee wrote to the Deans of clinical faculties in Victorian Universities requesting information on courses that address occupational violence in hospitals.⁴⁶⁸ The outlines of courses received in response indicated that education and training in prevention and management of aggression and violence is being incorporated into clinical scenarios and integrated within the curricula in several courses, although the extent of this is not clear in many instances and seems minimal in some others.

Whilst heads of faculties acknowledged the importance of educating health care students about occupational violence, there appeared to be no separate and comprehensive programs covering the full gamut of knowledge and training necessary for equipping graduates with the skills to effectively prevent, manage and report aggressive and/or violent events.

The *Victorian Taskforce on Violence in Nursing: final report* had previously cited evidence suggesting that inexperienced nurses, particularly students, are at a greater risk of being victims of client-initiated violence (DHS 2005a). It stated that training staff about understanding and

468 The Committee received responses from Deakin University, La Trobe University, Monash University and Victoria University.

dealing with occupational violence 'requires ongoing education and support, which should commence at orientation to the organisation and be updated on a periodic basis' (DHS 2005a, p.36). Training students about code grey and code black events⁴⁶⁹ was also listed as a training requirement (DHS 2005a).

There were, however, some positive signs that the issue of student preparation for dealing with occupational violence is being improved. For example, La Trobe University's faculty of health sciences is:

...scoping the requirements for, and developing what will be an extensive Placement Safety Program for undergraduate students prior to clinical placement...[to] enhance undergraduate placement preparation and improve university policy aimed at reducing the risk and impact of aggression experienced on placement, including EDs and hospitals in general. It is hoped this training will also equip future health care professionals in identifying and managing violence in the workplace.⁴⁷⁰

As Mr Philip Dunn from Geelong Hospital pointed out, students also learn from example so it was important at teaching hospitals that the experienced staff they worked with were suitably trained in handling incidents and their aftermath well.⁴⁷¹

Health care professionals

It is clear from submissions and evidence to the Committee that individual organisations develop and implement their own occupational violence prevention and management training for medical staff, in many cases tailoring it to the context in which the practitioner works.⁴⁷² Such tailoring is consistent with a WorkSafe recommendation for 'a tiered approach to violence and aggression training...to ensure that staff receive training based upon their risk of exposure to aggressive incidents and difficult behaviours'.⁴⁷³ There is no requirement for in-house training and ongoing occupational violence prevention programs to be accredited. Among health care professionals, nurses are the group most exposed to the risk of violence in hospital settings.

Adequacy of training for nurses

In 2007 the policy framework *Preventing occupational violence in Victorian health services* listed components for consideration when developing education and training for nurses in relation to occupational violence. These were to apply to all staff — permanent, casuals, part-time staff and students, on commencement and regularly thereafter. The framework also stated that training providers should be appropriately accredited and that 'training should be compulsory for all staff and be provided in paid time to ensure attendance' (DHS 2007a, pp.26, 27).

Clearly many health care settings have followed DHS recommendations and implemented programs for training nurses and other medical staff in prevention and management of aggressive and violent behaviour. However, not all health care settings have done so.

469 A code grey incident involves the threat of potentially aggressive behaviour and a code black incident involves a weapon or serious threat of a weapon.

470 Correspondence from Professor Hal Swerissen, Executive Dean, Faculty of Health Sciences, Pro Vice Chancellor, Regional, La Trobe University to the the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 17 November 2011.

471 Mr Philip Dunn, Director, Operations, Mental Health, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

472 One such example is Barwon Health which uses the Management of Violence & Aggression International Training program (MOVAIT), based on training developed in England. All staff in at-risk areas are trained in MOVAIT, a comprehensive training course which 'provides staff with a high level of skills to confidently identify risk situations, and to prevent and manage any potential violent and aggressive incidents' (Mr Perry Muncaster, Director of Human Resources, Geelong Hospital and Mr Philip Dunn, Director of Operations, Mental Health, Geelong Hospital, material given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011).

473 The WorkSafe Victoria Handbook 2008, *Prevention and management of aggression in health services*, cited in the submission from Ballarat Health Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

Despite nurse practitioners having a high risk of exposure to aggressive and violent incidents, a recent study conducted among 1500 Victorian nurses and midwives found that only 54 per cent of respondents had received training in occupational violence management.⁴⁷⁴ It also found that while nurses working in emergency departments, aged care and mental health experienced similar levels of occupational violence, a much higher percentage of mental health nurses received training (95%).⁴⁷⁵ Of those nurses who had received training related to occupational violence, 43 per cent thought it was 'marginally or not effective'; however respondents' suggestions about managing and preventing occupational violence focused mainly on training, particularly training that is 'thorough', 'regular' 'compulsory' and 'interactive with real life situations'.⁴⁷⁶

Dr Rose Chapman's recent study analysing nurses' perceptions of the causes of violence reported that nurses listed lack of training and experiences as being a cause, with one nurse attributing a violent incident to inexperience and another saying: 'I certainly wasn't very well equipped to deal with verbally or physically aggressive patients. I felt really inadequate when it came to that, I didn't know what to do' (quoted in Chapman 2011, p.12).

The cost of supplying training in managing potential and actual violence may explain the inconsistency in the provision of nurses' training in this area. Mr Andrew Rowe, Ballarat Health Services, spoke about the cost of training in evidence to the Committee:

...we have over 3,000 staff and we constantly, obviously, have a turnover of staff and it becomes very expensive to ensure that appropriate training is provided. As new staff come on board we have to keep doing that. We have to take them out of the workforce to do that. We have to backfill to ensure they have the time to do it. That is a significant issue for us.⁴⁷⁷

Providing resources for staff training in effective management of threatening incidents in rural and smaller regional hospitals may be considerably more difficult than in large metropolitan hospitals.

A submission from Ballarat Health Services advocated that a government program to fund training for nurses be established to ensure that staff are provided with the knowledge and skills to better manage instances of violence and aggression, not only to prevent an incident escalating but also to reduce the potential risk of a physical or psychological injury.⁴⁷⁸

Adequacy of training for medical practitioners

While considerable research has been conducted into aspects of occupational violence in health settings from the perspective of nurses, including education and training to prevent and manage it, little information is available on this topic with regard to doctors and specialists.

Dr Jaycen Cruickshank, Director of Emergency Medicine at Ballarat Health Services, told the Committee the national curriculum framework for junior medical staff includes education in dealing with aggressive patients, so they 'should be qualified to deal with it'. He described the factors required to deal with aggressive patients as 'the medical factors, good communication skills and de-escalation'.⁴⁷⁹

474 Professor Gerald Farrell, Professor of Nursing, Faculty of Health Sciences, La Trobe University, Study conducted with Dr Touran Shafiei, referred to in evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

475 Professor Gerald Farrell, Professor of Nursing, Faculty of Health Sciences, La Trobe University, Study conducted with Dr Touran Shafiei, referred to in evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

476 Professor Gerald Farrell, Professor of Nursing, Faculty of Health Sciences, La Trobe University, Study conducted with Dr Touran Shafiei, referred to in evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

477 Mr Andrew Rowe, Chief Executive Officer, Ballarat Health Services, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

478 Submission from Mr Tim Reinders, Manager, Occupational Health & Safety, Ballarat Health Services, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, October 2011.

479 Dr Jaycen Cruickshank, Director of Emergency Medicine; Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

However, with regard to ongoing education and training, he added that:

We could have a better balance of on-site and off-site education. I get a continuing medical education allowance and study leave but I have to choose between resuscitation, ultrasound, paediatrics, violence and aggression. There are probably 50 different courses I could choose to attend. Attending violence and aggression courses is probably under-represented for emergency staff...I do not think there is the quality of courses [on violence and aggression] for medical staff to attend at the same level as resuscitation, when they really are quite similar in terms of patient risk.⁴⁸⁰

The vice-president of the Australian Medical Association, Dr Stephen Parnis, expressed the view that health professionals, including the medical profession, were inadequately educated on how to anticipate and handle potentially violent cases:

Things as simple as do not let a patient like this get between you and the door. Think about the potential for basic implements — and there are plenty of them in the emergency departments — that could be turned into basic weapons: syringes, scalpels, scissors, needles, all those sorts of things, drugs. These are the sorts of things that a lot of people do not give enough time and credence to, so I think at every aspect of education of health workers these things need to be considered.⁴⁸¹

The need for clear communication

The Committee received many suggestions with regard to aspects of education and training that could contribute to a decline in serious incidents of aggression and violence in hospitals and emergency departments. Underlying many of these were the need to provide information and to conduct communications skilfully.⁴⁸²

A recurring point made in the academic research and in evidence given to the Committee was the need for improved communication from medical staff to patients and relatives when there are lengthy waiting times, which may occur frequently in emergency departments (Mayhew & Chappell 2003). Clear explanations need to be provided about the triage process (why some conditions are prioritised), predicted waiting times and options for review if new concerns arise.⁴⁸³ To help prevent rising anxiety and aggression, volunteer squads in emergency departments trained in mental health first aid could sit with patients and help keep them calm while the triage process is taking place. With funding, a non-government organisation such as Jesuit Social Services or the Salvation Army could provide both the volunteers and the training for such a program.

Dr Simon Young, Royal Children's Hospital, spoke of the need to keep parents in the emergency department waiting room informed:

Most parents from our point of view are very understanding about what is going on and very tolerant about things they would not tolerate in bank or some other situation; and if they are kept informed we find that... helps to reduce the feeling of angst and the incidence of violence in the emergency department.⁴⁸⁴

Being skilled in communicating in a helpful and pleasant manner⁴⁸⁵ is also considered important in terms of keeping people calm and reducing the likelihood of antagonism, as research on characteristics responsible for provoking incidents of workplace violence indicates:

480 Dr Jaycen Cruickshank, Director of Emergency Medicine; Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

481 Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

482 For further discussion see Chapters 4 and 9.

483 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

484 Dr Simon Young, Director of Emergency Services, Royal Children's Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

485 For further discussion see Chapters 4 and 9.

...nurses who use authoritarian communication, exhibit an external locus of control, show incompetence and lack of caring, and display anxiety and fear can increase their chances of being abused...[a 2007 study] recognized those nurses that “stirred patients up” by their inflammatory behaviour as increasing patient aggression in the ED (cited in Chapman 2011., p.20).

Dr Rose Chapman also told the Committee:

Nurses will say “if there is an inexperienced nurse, I have to watch them because I know they are going to arc these people up”. Because they don’t know how to deal with it [‘hyper’ behaviour]...and I’m going to have to go and intervene and I can talk them down, I can do that.⁴⁸⁶

Appropriate communication skills were reported by many as being essential for de-escalating potentially violent situations. For example, in Dr Simon Judkin’s view, intervening when a patient or relative was exhibiting disturbed behaviour required a team of staff who could de-escalate the situation and make the person feel safe rather than threatened, and that the ‘majority of interventions will involve communicating in a way which reinforces these ideals’.⁴⁸⁷

Mr Geoff O’Kearney, Australian Medical Association, also referred to the importance of communication skills such as lowered voice tone, eye contact, and non-threatening body language being part of the training in preventative strategies.⁴⁸⁸

Other education/training factors that may reduce the incidence and/or severity of occupational violence

Submissions and evidence the Committee received, as well as the academic research, show clearly that effective education and training in occupational violence prevention and management in health care settings needs to cover a broad range of knowledge areas and skills. The following discussion outlines some such areas raised by respondents to the Inquiry.

Cultural diversity education

In their study exploring the process and implications of delivering workplace cultural diversity education for health service providers, Johnstone & Kanitsaki emphasised that such education is ‘of considerable importance to the development and maintenance of health service provider capabilities to deliver culturally and linguistically appropriate health care to patients from minority racial, ethnic and language backgrounds’ (Johnstone & Kanitsaki 2008, p.139). It is also important that other non-clinical staff who have direct contact with patients from non-English-speaking backgrounds and their friends and families, develop skills that help to avoid misunderstandings in communications.

Education to improve reporting of incidents

The Committee received evidence that incidents of aggression and violence have been underreported by medical and nurse practitioners. To rectify this, staff need to be educated about the prevalence of such incidents and about how reporting can lead to the development of strategies to reduce similar incidents, thus benefiting staff (DHS 2005a). Another factor in underreporting that was noted was the ‘complex and burdensome’⁴⁸⁹ reporting process. One witness told the Committee: ‘I think the reporting process is quite complicated and at times confusing and while you are stressed it is difficult to do’.⁴⁹⁰

486 Dr Rose Chapman, Director, Practice Education School of Nursing and Midwifery, Curtin University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Perth, 20 June 2011.

487 Submission from Dr Simon Judkins, Victorian Faculty Chair, Australasian College for Emergency Medicine to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

488 Submission from Mr Geoff O’Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

489 Submission from Mr Geoff O’Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

490 Ms Jodie Bourke, Associate Nurse Unit Manager, Emergency Department, Geelong Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Geelong, 8 August 2011.

Mixed training and working as a team

It was considered by several respondents to the Inquiry to be advantageous for health care providers and security personnel to undertake 'in-hospital' occupational violence training together to build teams and break down barriers to understanding each other's roles. For example, Dr Georgina Phillips, St Vincent's Hospital, explained that:

Staff training is ideally mixed, involving medical, nursing, hospital orderlies and security staff — who all have particular roles to play during a security response. Such multidisciplinary education sessions facilitate teamwork and clarify roles and responsibilities within the team so that a seamless response can occur during a real episode.⁴⁹¹

Practical training

The *Preventing occupational violence in Victorian health services* policy framework addressed the issue of self-defence and defence of others in the event of an attack or a reasonable belief that one is imminent. It stated that:

Training in self-defence techniques, including evasive self-defence, provides employees with controlled physical intervention when all other non-physical strategies have failed. Services and programs in which staff work with clients who might display aggressive behaviour should provide adequate training for staff in containment and self-defence techniques (2007a, p.21).

Similarly, Bowers et al (2006) argue that as well as theory sessions, education programs directed at nurses should also include practical sessions that provide training in use of restraint, breakaway techniques and pain-free holds (cited in Chapman 2011).

Evaluation of programs

The *Victorian Taskforce on Violence in Nursing: final report* describes as essential the need for all violence management programs to be evaluated in terms of cost, sustainability, skill and knowledge retention and effectiveness (DHS 2005a). Developing and continually reviewing hospital policies regarding 'patient aggression and management of both armed and unarmed threats, both within patient-care and legal framework', is a key component of St Vincent's Hospital's security response, which has been developed and refined over the last 20 years with continual evaluation for improvement.⁴⁹²

Continuing education and refresher training

To ensure that occupational violence incidents continue to be managed effectively and efficiently, ongoing education and training programs for health care providers need to be offered regularly to health clinicians (DHS 2005b). Similarly, in regard to security personnel, Ballarat Health Services recommended that security personnel receive ongoing skilling and compulsory regular refresher training.

The Royal Australasian College of Physicians also strongly supported the ongoing training of general hospital and security staff, stating in its submission that 'This will ensure staff are well equipped to address any instances of violence that may occur in Emergency Departments'.⁴⁹³

491 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

492 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

493 Submission from Professor John Kolbe, President and Professor Peter Ebeling, Chairman, Victorian State Committee, The Royal Australasian College of Physicians to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

Security staff

Adequacy of training

Security staff in hospitals play an important role in addressing violent incidents that occur. Their training varies depending on whether they are employed directly by hospitals or are contracted from commercial security firms.

Any security personnel engaged through a security firm must be licensed and meet minimal training competencies and standards.⁴⁹⁴ ⁴⁹⁵ However, there are no licensing and minimum training competencies required when staff are employed directly by the hospital;⁴⁹⁶ staff are given hospital-specific training in-house that reflects the facility's emergency response needs and policy.

It has been suggested that personnel trained in a commercial organisation to work in a variety of industry, retail and hospitality venues may not be appropriately trained for health care settings;⁴⁹⁷ and conversely, that staff employed directly by hospitals may be put on other duties in other parts of the hospital which could reduce the effectiveness of a physical security presence and the response ability of the resource.⁴⁹⁸

It is the Committee's view that both processes are necessary — that staff employed as security personnel in health care settings should be licensed, meet training competencies and standards and, on employment at a facility, receive additional training relevant to the context in which they work.

It would appear from submissions and evidence received that there are hospitals following this course, for example The Alfred Hospital and St Vincent's Hospital. Security officers contracted to The Alfred Hospital, are trained by Spotless and required to complete the nationally accredited competencies for security licensing.⁴⁹⁹ They then undertake courses run by The Alfred. In addition, each security officer attends an initial and then refresher training on:

- "De-escalation and minimisation of aggression" run by The Alfred's Psychiatry Nursing education (2 day course); and
- "Behaviours of Concern" run by The Alfred's Emergency & Trauma Centre Nursing Education (4 hour course).⁵⁰⁰

St Vincent's hospital recruits 'professional security officers who have as a minimum a certificate 111 in security guard/crowd control and hold a control room operator licence'.⁵⁰¹ In addition, regular education and training is conducted for all emergency department staff on managing

494 Submission from Mr Bryan de Caires, CEO, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

495 For legislation and regulation details pertaining to security officers see Chapter 1.

496 Submission from Mr Bryan de Caires, CEO, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

497 Submission from Ms Sharon McNulty, Director, Support Services, Southern Health Group Security to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

498 Submission from Mr Bryan de Caires, CEO, Australian Security Industry Association Ltd (ASIAL) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

499 The CPP07 Property Services Training Package is the endorsed benchmark which relates units of competency to national qualifications, and provides guidelines for assessment for the Security Sector. Training Packages are developed by industry to meet current and emerging skills needs. The Construction and Property Industry Skills Council represents the workforce training and skills development needs of the security industry.

Information provided by Mr Bryan de Caires, Chief Executive Officer, Australian Security Industry Association Ltd, Correspondence to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 4 November 2011.

500 Mr Stephen McIntyre, General Manager, Health Sector, Spotless, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011.

501 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

a code grey episode and aggression prevention management. Wherever possible, medical, nursing, orderlies and security staff participate in this training together.⁵⁰²

In a submission from the Health Services Union East Branch, security personnel highlighted the importance of training and working as a team with clinical staff. As well as learning how each person will respond, this enables a rapport to develop so that members can recognise and respond to cues from each other to de-escalate potentially dangerous situations.⁵⁰³

Despite such systems of licensing and training, the Committee has received adverse reports about the lack of skill some security staff have displayed. In its submission the Jesuit Social Services reported that: 'It is Jesuit Social Services experience that security officials in the emergency departments don't have the skills to deal with people who are experiencing a mental health crisis, such as a psychosis'⁵⁰⁴ and one Connexions staff member reported that 'clients end up leaving the hospital because of the attitude of the security officers'.⁵⁰⁵

Ms Sharon McNulty, Southern Health, expressed the view that: 'The challenges faced by security personnel entering the Health Care industry are highlighted at the time of their employment'.⁵⁰⁶ In particular, security staff must become aware of and accept the patient focused ethos of the hospital.

The need for additional training

Many respondents to the Inquiry commented that security personnel training needed to be reviewed.⁵⁰⁷ Ms Julie Edwards, Jesuit Social Services, recommended that a training package for security staff around mental health and drug and alcohol issues be developed and used, which 'should emphasise the importance of communication, including lessons/role play around defusing techniques with people in crisis'.⁵⁰⁸

Similarly Ms Kathy Jackson, Health Services Union East Branch, recommended that in addition to holding a licence under the *Private Security Act 2004* (Vic), all security personnel be trained in the specialised nature of providing security in a health setting. She suggested this should include:

...training in dealing safely with aggressive behaviours due to psychosis, drug and alcohol abuse, intellectual disabilities and acquired brain injuries. Training must also include appropriate response to patients with various ailments and injuries that render usual restraint procedures inadequate.⁵⁰⁹

There were also calls for a nationally or state accredited course/training qualification specialising in security within a health care facility.⁵¹⁰ For example, Mr Robert Dekleva, Ballarat Health Services, told the Committee, 'there is not anything in the industry that is nationally recognised

502 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

503 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

504 Submission from Ms Julie Edwards, Chief Executive Officer, Jesuit Social Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

505 Submission from Ms Julie Edwards, Chief Executive Officer, Jesuit Social Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

506 Submission from Ms Sharon McNulty, Support Services Director, Southern Health Group, to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

507 For example, in the submissions from Ms Sharon McNulty, Support Services Director, Southern Health Group (July 2011); Ms Julie Edwards, Chief Executive Officer, Jesuit Social Services (June 2011); and Kathy Jackson, Executive President, Health Services Union East Branch (August 2011) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals.

508 Submission from Ms Julie Edwards, Chief Executive Officer, Jesuit Social Services to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, June 2011.

509 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

510 For example, Mr Stephen McIntyre, General Manager, Health Sector, Spotless, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011; Mr Robert Dekleva, Security Manager, Ballarat Health Service, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Ballarat, 18 October 2011.

or within the state to be specifically designed for security personnel in the health sector to deal with violence and aggression'.⁵¹¹

The Committee agrees that in addition to holding a licence under the Act, all hospital based security personnel must have received accredited training in the specialised nature of providing security in a health setting.

Managers and administrative personnel

The research studies, academic literature and views the Committee has heard during the Inquiry suggest that education and training needs to be part of a broader organisational approach to be most effective. The *Victorian Taskforce on Violence in Nursing: final report* stated that: 'The taskforce believes that all managers, medical staff and team leaders of health services play an important role in establishing the health care environment' (DHS 2005a, p.55). Clearly then, managers can have an influence on the management of violence in the workplace and so require appropriate training (DHS 2005a).

In the *Handbook for Workplaces: prevention and management of aggression in health services*, WorkSafe recommended that tailored training for managers should ensure that they:

- understand the adverse impacts of occupational violence on employees, patients, and the workplace
- develop skills to prevent occupational violence within the health service setting
- understand the obligations of the employer to provide a safe workplace for employees and clients
- understand and manage their own behaviours, including the capacity to shape behaviour of others through the role modelling, setting clear standards and effectively managing incidents
- understand their role in facilitating, supervising and supporting the implementation of organisational policies and procedures
- implement the organisation's staff support processes during any recovery phase of an incident, and
- are able to undertake systemic investigations following an incident (WorkSafe 2008, p.31).

WorkSafe also advised that managers should participate in consultations that determine training needs and the implementation of training (WorkSafe 2008).

With regard to security risk managers specifically, Mr Van Lambaart, Jakeman Solutions, told the Committee the basic training level for these personnel in hospitals was a Certificate IV.⁵¹²

Front desk reception and administrative staff, particularly in emergency department reception areas, also require training in dealing with potentially aggressive or violent situations. The type of training and frequency appears to depend on the specific health care setting they work in. At the Royal Prince Alfred, Sydney, the Committee heard that reception staff 'are trained in terms of customer service to be able to de-escalate and manage people at that initial encounter with the service in an effective manner to avoid any kind of escalation intention, particularly people [who] are distressed or concerned about waiting times'.⁵¹³

Police

St Vincent's Hospital noted that while police are required under Victoria's mental health Act to apprehend a person they believe may have a mental illness and take the person to a place for urgent assessment by a medical practitioner, they are not required to have any particular

511 Mr Robert Dekleva, Security Manager, Ballarat Health Service, Evidence given to at, 18 October 2011.

512 Mr David van Lambaart, Senior Consultant, Jakeman Solutions Pty Ltd, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 10 October 2011.

513 Mr Joseph Jewitt, Director, Corporate and Finance Services, Royal Prince Alfred Hospital, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Meeting, Sydney, 20 September 2011.

clinical skills on which to base their judgement of potential mental illness, and aggression and violence is often involved in apprehension of the person before he or she is brought to the hospital. St Vincent's therefore recommended that:

Victorian Police receive specific education and training around security incidents in health care environments, including the management of aggression and violence in patients with potential mental illness. Such training can be done in collaboration with health care professionals and experienced health care security officers. Police liaison officers are recommended to facilitate relationships between hospitals and local police stations and coordinate training sessions where both ED staff and Victorian Police Officers can attend.⁵¹⁴

The Committee requested information from Victoria Police about any specific training police did receive in dealing with aggression and violence in health care settings and received the following response from Mr Tim Cartwright, Victoria Police:

Victoria Police policy, education and practices emphasise police responses that are necessary to address the needs of various members of the community. As such, members undergo extensive Operational Tactics and Safety Training (OTST) that focuses on police interactions with a number of unique clients — including violent persons and persons suffering from medical conditions and mental illness — as opposed to training that is specific to a location, such as a hospital.⁵¹⁵

The police officer also commented that members stationed in areas that encompass large hospitals are usually introduced to hospital staff, briefed about ongoing violence issues and security arrangements, and in some instances a police liaison officer attends regular meetings between local hospitals regarding safety and violence issues.⁵¹⁶

Improving public awareness

The *Victorian Taskforce on Violence in Nursing: final report* stated that the general public needed to be educated about 'the expectations of behaviours and the potential consequences of their own behaviour while engaging with the various health settings' (DHS 2005a, p.56).

The Taskforce suggested that media campaigns, similar to ones used nationally and internationally, be run to raise awareness about occupational violence, inform potential consumers of health care that aggressive and violent behaviours will not be tolerated and convey to the community their rights and responsibilities (DHS 2005a). To be successful, the public awareness campaign should:

- be part of a broader strategy to address violence against nurses
- include messages directed at employers, nurses, other health service employees and members of the general public
- ensure that information reaches consumers before they attend a health facility or come into contact with nurses
- have clear and easily understood messages that are widely disseminated (DHS 2005a, p.37).

Hospital waiting rooms should have appropriate signage, posters and patient information sheets conveying the expected standard of behaviour and the possible ramifications for failing to adhere to them.

514 Submission from Dr Georgina Phillips, Emergency Physician, Mr Paul Cunningham, Security Manager, Ms Sue Cowling, ED Nurse Unit Manager, St Vincent's Hospital to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

515 Correspondence from Mr Tim Cartwright, Acting Deputy Commissioner, Crime & Operations Support, Victoria Police to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 17 November 2011.

516 Correspondence from Mr Tim Cartwright, Acting Deputy Commissioner, Crime & Operations Support, Victoria Police to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 17 November 2011.

It has also been suggested that a public health education campaign be conducted to inform the community about alternatives to presenting to emergency departments for non-critical health services.⁵¹⁷ Evidence suggests that aggression and threats of violence increase as waiting times increase,⁵¹⁸ so with fewer patients waiting for treatment the risk of such behaviour occurring is likely to be reduced.

The over-reliance on education and training — a cautionary note

There appears to be little doubt that education and training ‘can play a valuable role in enhancing staff abilities to recognise and avert conflict situations and to deal more safely with physical violence’ as Paterson et al find in their 2005 study (p.748). However, the researchers also see as detrimental approaches to violence in hospitals that focus primarily on education and training of staff as the main response as that ‘frames the problem either solely or largely as a problem of staff skill deficits which are remediable by training in conflict management and/or physical intervention skills’ (p.746).

They also argue that such a focus takes the emphasis away from the health care agency’s central role and responsibility and ‘the structural dimension of care which lie outside the control of individual workers’ (Leadbetter & Paterson 2004 in Paterson et al 2005, p.746).

This 2005 study concludes that the role of education and training should not be emphasised to the extent that health care organisations ignore the need to look closely at the structural reasons which can give rise to such violence.

Conclusion

It is clear to the Committee that there is wide agreement between health care providers, security personnel and researchers that education and training is an essential component in preventing and managing incidents of aggression and violence in health care settings. With regard to health care providers, such education should be part of undergraduate curricula, with training in prevention and management of code grey episodes provided before they take up placements in hospitals. Additional training within individual workplaces and regular refresher courses are also necessary for effective handling of potentially violent situations. Consideration should be given to ensuring all staff who come into contact with patients, their friends and families have appropriate communication skills.

It is also apparent that there is considerable variation in the training and qualifications of security personnel and the suitability of that to employment in health care settings. As a consequence, the Committee believes that a state or national training course and accreditation should be developed and made compulsory for all security staff working in health care settings, in addition to that implemented by their specific health care settings.

As a 2003 study by Mayhew and Chappell found, many health care staff stated that an effective aggression minimisation training program gave them increased confidence in their ability to de-escalate incidents of aggression and potential violence and increased their feeling of safety in the workplace.

517 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

518 Submission from Ms Kathy Jackson, Executive President, Health Services Union East Branch to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, August 2011.

Recommendation

- 14. The Committee recommends that all security personnel employed in Victorian hospitals be fully licensed under the *Private Security Act 2004*.**

Within the Victorian security licensing process, security staff engaged directly by hospitals are not required to hold appropriate security licences or meet minimal training requirements. Any security personnel engaged through a security firm, however, must be licensed and meet minimal training competencies and standards. In the Committee's view all security staff however employed should be appropriately licensed and trained before commencing employment in a hospital or health care setting. The current situation whereby different requirements apply depending on whether a security officer is 'in house' or contracted seems arbitrary and anomalous.

Recommendation

- 19. Accepting that long waiting times in the emergency department and triage rooms is one of the main contributors to frustration and aggression, the Committee recommends that the hospital explore options for the better communication of likely waiting times and alternatives sources for medical attention in cases of non-critical presentations.**

Evidence has been given to the Committee that in the volatile environment of the hospital emergency room frustration and aggression as a result of long waiting times or a misunderstanding of the triage process can often go 'hand in hand'. When people are receiving bad news violence can also erupt if this is not well handled. Time has to be given to providing careful explanation of administrative and medical procedures so patients and families can deal with these confronting circumstances. As one witness stated to the Committee, these issues are difficult but not impossible. There must be adequately trained staff available to approach the delicate communication issues associated with being a patient, family member or visitor to the emergency room.

Recommendation

- 20. The Committee recommends that the Victorian government support non-government organisation such as the Jesuit Social Services and the Salvation Army to provide volunteers with appropriate training for Volunteer squads in emergency departments that could sit with patients and help keep them calm while the triage process is taking place.**

One strategy for defusing tensions amongst patients, visitors and members of the public in hospital environments is to use volunteers to sit with them and where necessary explain hospital procedures and policies or give updates on when they might be attended to or the progress of their treatment schedule. Evidence was given to the Committee that where volunteer schemes are in operation in hospitals they have been very successful. With appropriate resourcing a non-government organisation such as Jesuit Social Services or the Salvation Army would be able to provide both the volunteers and the training for such a program.

Recommendation

- 21 The Committee recommends that in addition to holding a licence under the *Private Security Act 2004* (Vic), all hospital based security personnel must have received nationally accredited training in the specialised nature of providing security in a health setting. This will include culturally sensitive training in dealing safely with aggressive behaviours due to drug and alcohol abuse, mental health conditions, intellectual disabilities and other clinical conditions including dementia and acquired brain injuries. Training must also include communication skills and comprehensive instruction on safe restraint techniques and appropriate response to patients with various medical conditions and injuries that render usual restraint procedures inadequate.**

Security staff in hospitals play an important role in addressing violent incidents that occur. Their training varies depending on whether they are employed directly by hospitals or are contracted from commercial security firms.

Any security personnel engaged through a security firm must be licensed and meet minimal training competencies and standards. However, there are no licensing and minimum training competencies required when staff are employed directly by the hospital.

The Committee heard from many respondents that security training needed to be reviewed to make it more appropriate for working in a health care setting, and that a nationally accredited training course in the specialised nature of providing security within a health care facility should be developed and made a necessary prerequisite for security personnel to work in health care settings.

It is the Committee's view that such a course should be developed and be a requirement for all staff employed as security personnel in health care settings, as well as being licensed, and on employment at a facility receive additional training relevant to the context in which they work.

Recommendation

- 22. The Committee recommends that violence prevention including conflict management and techniques in de-escalating aggressive situations be included in the college or university curricula for health professionals' training, including medical, nursing, social work and allied health schools.**

In several studies based on nurse interviews, education and training in understanding factors contributing to incidents of violence, developing skills to de-escalate potential incident, as well as strategies to manage them were considered by nurses one of the most important ways in which to improve the ability, confidence and safety of medical staff.

Following up on the 2005 Victorian Taskforce on Violence in Nursing's finding that there was a lack of consistency in curricula for undergraduate nursing students with regard to preparing students to cope with occupational violence, the Committee reviewed the outlines of courses taught in Victorian Universities' clinical faculties. While some courses have incorporated aspects of occupational violence awareness and management in some subjects, there does not yet appear to be comprehensive student training in this area.

It is particularly imperative that students in medicine, nursing and allied health fields receive appropriate training in violence prevention and management long before they enter hospitals for their practical training or as part of the workforce.

Recommendation

- 23. The Committee recommends that in-house comprehensive, induction and ongoing accredited education and training be provided to medical, nursing, allied health and security staff, especially emergency department staff, on violence and aggression prevention, procedures and practices. Such training should include but not be restricted to early recognition, restraint and de-escalation techniques along with reporting requirements and procedures. It should, wherever possible, be conducted jointly with health and security groups.**

Within all the various fields of work in health care settings, education and training was considered to be a core element of strategies to prevent and deal with occupational violence. Such training should then be supplemented with regular ongoing training during the working lives of health care staff. Although different levels of training may be required between and within hospital, all staff have the potential to become involved in aggressive or violent events. It is a regrettable oversight that no minimum established skill set for violence prevention training exists in Victoria.

Providing appropriate training in communication skills to de-escalate situations and strategies to manage violence gives staff confidence in their ability to deal with such incidents and a feeling of increased safety in their workplace. Doctors, nurses and security personnel all reported the benefits of training together to build teams and break down barriers to understanding each other's roles.

Recommendation

- 24. The Committee recommends that where possible in-house training programs on violence prevention be made available to students on placement in the hospital.**

Appropriate levels of education and training must be made available to students on placement in hospitals in order that they understand what action they should take in the event of a violent incident, and how best to manage such an incident. It is especially important that training is provided on procedures to follow in the event of a code grey or code black being activated.

Recommendation

- 25. The Committee recommends that the hospital should provide information to all health care staff, patients and visitors outlining the standard of behaviour expected of them within hospitals and other health care settings. In particular, hospital waiting rooms should have appropriate signage, posters and patient information sheets conveying the expected standard of behaviour and the possible ramifications for failing to adhere to them.**

It is important to make it clear to employers, nurses, other health service employees and members of the general public that occupational violence will not be tolerated. One of the key ways this is done is having signage displaying messages in prominent positions throughout the waiting rooms, emergency department and hospital generally that convey the expected standard of behaviour and the consequences of not adhering to these. These should be in a variety of languages or explained in some other way to people from non-English-speaking backgrounds who may not be able to read them.

Recommendation

- 26. The Committee recommends that the state government develop and conduct a public health awareness campaign that promotes the message that violence in hospitals is unacceptable and subject to severe penalties.**

Government-run public health awareness campaigns promoting the message that violence in hospitals is unacceptable and will have severe consequences need to be conducted on a regular basis. Other such campaigns could include public health education campaigns informing the community about alternatives to presenting to emergency departments for non-critical health services so that numbers and waiting times in hospital waiting rooms are reduced.

It is important that such messages reach the public before they attend a health facility or come into contact with nurses at the hospital.

Recommendation

- 27. The Committee recommends that Victoria Police receive specific education and training around security incidents in health care environments, including the management of aggression and violence in patients who may have a potential mental illness. Such training should be done in collaboration with health care professionals and experienced health care security officers.**

The Committee heard that while police are required under Victoria's mental health Act to apprehend a person they believe may have a mental illness and take the person to a place for urgent assessment by a medical practitioner, they are not required to have any particular clinical skills on which to base their judgement of potential mental illness.

Whilst police officers may be briefed at regular intervals by staff at hospitals that are in the areas where police are stationed, it is suggested that regular training sessions should be conducted where both emergency department staff and police officers attend. As well, the use of police liaison officers to facilitate relationships between hospitals and police needs to be further implemented to encompass more major Victorian hospitals.

PART C: The Way Forward

12. Conclusion

Introduction

Clearly the safety of health workers, their patients and visitors to the hospital is a fundamental aspect of the operation of the health system and the provision of quality health care. Innovative approaches to address violence in hospitals need to maintain a delicate balance. They must address the occupational health and safety obligations to staff whilst upholding their duty of care considerations to their patients.

This Report has indicated throughout that a broad array of holistic strategies is required to comprehensively address occupational violence. These strategies range from initiatives addressing the physical environment of hospitals, to education and training for health care workers in preventing violence on their 'watch', to mechanisms for the better reporting of occupational violence. As the submission from the Victorian Health care Association succinctly observed:

No single approach will eliminate all security risks within the hospital environment. These risks are caused by a range of issues and therefore a broad range of measures are required to prevent and manage client aggression and potential violence within the Victorian health sector for all workers, patients and visitors.⁵¹⁹

Yet such strategies must also be flexible enough to address local problems and customise local solutions. For example, the needs of a small 'bush' hospital may be quite different to those of the large metropolitan institutions. One size most certainly does not fit all in addressing these issues. The need for a 'tailored fit' of interventions to individual circumstances has been recognised and endorsed in the *Preventing occupational violence in Victorian health services* policy framework (Department of Human Services (DHS) 2007a, p.8). It is also the position of the Australian Medical Association (AMA) (Victoria):

Prevention strategies must be customised within each health care setting...It should be recognised that while some workplaces, such as major hospitals, are able to provide formal protective measures, others, such as small hospitals, cannot provide the same sorts of formal protective measures. In lower volume lower acuity workplaces the risk of violence may be lower, but the impact of it is likely to be higher when it does occur because of the lack of immediate response and assistance from security staff or police. Both settings should incorporate underlying policies which promote the personal safety and security of all staff.⁵²⁰

At the same time, strategies need to be uniform where appropriate. This is particularly true of reporting violence and collating and analysing the data from these reports. A standardised

519 Submission from Mr Trevor Carr, Chief Executive, Victorian Health care Association to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

520 Submission from Mr Geoff O'Kearney, Acting Chief Executive Officer, Australian Medical Association (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

approach to protocols for emergency response teams such as Code Grey and Code Black responses is also necessary.

Finally, strategies need to be driven by an overarching set of principles and a coordinating framework. The Committee believes the *Preventing occupational violence in Victorian health services* policy framework, in conjunction with subsidiary policies and procedures, such as those implemented by WorkSafe, is a good model. The tools provided in the associated Resource Kit are also useful when adapted to individual circumstances.

However, as discussed previously in this Report, it is imperative that the recommendations of the *Victorian Taskforce on Violence in Nursing: final report* on which the Framework is largely based, are fully implemented in hospitals as soon as possible. The Department of Health and hospital managements must work closely and cooperatively to ensure that the initiatives developed as a result of that report are put into operation at the local level.

Key principles and findings informing the Recommendations

As a result of the evidence gathered by the Committee and the research undertaken, the Committee takes the following positions with regard to strategies that could be employed in order to reduce occupational violence in Victorian hospitals and health services.

1. The Committee believes that all hospital staff are entitled to a safe and secure working environment that is free of all forms of violence.
2. The Committee recognises that, given the multifaceted environmental dynamics, hospital administrations face a complex challenge in reducing violence, especially in some large emergency departments.
3. The law should support clinical and security staff in their work environments.
4. The Committee believes that in addressing violence and security issues in Victorian hospitals:
 - a) A 'one size fits all' approach does not address the specific issues, needs and requirements of individual hospitals and health facilities.
 - b) Proactive policies based on *prevention* strategies are the key to addressing violence in hospitals.
 - c) A holistic and tailored approach is required that meets the specific requirements of each hospital. Such a holistic approach should draw upon strategies including:
 - ◆ strong leadership, support and encouragement by the senior management team at the hospital
 - ◆ appropriate policies and infrastructure that promote a 'zero tolerance' approach to violence towards hospital staff, allied health professionals such as paramedics, patients, visitors and all persons located in the hospital premises or environment
 - ◆ accredited comprehensive education and training programs to address violent behaviour in hospitals for both clinical and security staff, and public awareness programs for patients, their families and visitors
 - ◆ approaches that recognise the specific factors that contribute to hospital violence, such as clinical causes, alcohol and other drug use, and mental illness, and promotes strategies to address these.
 - ◆ environmental and design strategies that address the situational factors that may exacerbate violence in the hospital setting, particularly the emergency department.

- d) Strategies to prevent and address violence in hospitals are most effective when clinical staff, security staff, management and external workers such as paramedics and police work collaboratively as part of a team.
 - e) Effective security strategies to prevent and address violence in hospitals are underpinned by a 'patient focused' approach that draws on interpersonal skills to defuse, minimise and manage aggressive behaviour.
 - f) Effectively addressing violence in the hospital setting requires uniform reporting procedures and data collection across the Victorian hospital system.
5. The Committee believes as a general principle that security staff should be licensed specialists in the area of hospital security and appointed by individual hospitals as determined by the hospital's specific needs. For example, security staff could be either contracted through a security company or employed directly by the hospital as 'in house' staff.
 6. The Committee believes that firearms should not be used as a security measure in Victorian hospitals by security personnel.
 7. The Committee believes that as a general principle, capsicum spray and tasers should not be used as a security measure in Victorian hospitals by security personnel. However, individual hospitals should have the power to decide what other forms of restraint and security mechanisms should be employed.

Some final comments

There are two substantive matters that have not hitherto been addressed, but are important in the prevention and management of occupational violence in health care settings. The need for research and evaluation in addressing occupational violence is paramount. In addition, the issue of funding any initiatives developed and implemented to address occupational violence must also be taken into account.

Research and evaluation

When Mayhew and Chappell conducted their comprehensive research study on occupational violence in the health sector, they identified a need for better and more research studies that examined this form of violence. Specifically, they noted that 'Comprehensive data on the incidence of occupational violence in the Australian health care setting do not exist' (Mayhew & Chappell 2003, p.11). In particular:

A need was identified for substantive empirical risk factors and high risk settings, estimate incidence and severity patterns across different health occupational groups, identify reporting/non-reporting ratios, distinguish possible perpetrator characteristics, and provide information about the effectiveness of prevention strategies. Close examination of the contexts of violent events could also assist with recommendations for the redesign of workplaces and work processes to reduce the risks (Mayhew & Chappell 2003, pp.11–12).

Certainly since Mayhew and Chappell published their findings in 2003 there has been a great deal more research undertaken on the issue of occupational violence against health care workers. There have also been comprehensive Inquiries undertaken such as that of the Taskforce on Violence in Nursing which have led to a multitude of policy documents — most importantly the *Preventing occupational violence in Victorian health services* policy framework in 2007. Of great importance too has been the development of a new data reporting and recording system on violence in the health care workplace — the Victorian Health Incident Management System (VHIMS).

However, despite such positive advances, there is still much that is unknown. This is particularly true with regard to how prevalent violence occurring in hospitals is, why it occurs and what the best ways are of addressing it.

More and better research

One of the problems facing researchers has been that many of the studies used to assess the problems associated with occupational violence have been from overseas and not readily able to be generalised or compared, particularly when different methods of collecting data and defining and analysing violence and aggression have been used. To this end nursing academic Professor Gerry Farrell has called for more 'home grown' research to be undertaken. He believes the establishment of a local research centre in the area would be appropriate:

Essentially we need a sophisticated, statewide approach if we are to seriously advance the agenda around the prevention and management of occupational violence. Critique and advice for improvement are called for. While individual researchers can provide some of the necessary data, it is at best likely to occur piecemeal as its availability relies on the interests and initiatives of individual researchers and on research funding that is hard to obtain...

It is our view that targeted government funding would be required to establish a centre for research, implementation and evaluation covering all aspects of occupational violence including staff conduct around intimidating and disruptive behaviours that undermine a culture of safety in an organisation. Such a centre would have buy-in from professional associations, consumers and the government. Centre staff would draw on the best available evidence to advise on the design and delivery of educationally sound programs that are attuned to resource limitations that inevitably constrain training. Further, centre staff would be able to compare outcomes and successes across sectors over a long time frame. Such a centre would be hands-on and not remote from the everyday realities of staff who work in health care.⁵²¹

It has also been suggested that far more qualitative research needs to be undertaken that examines the experience of violence from the victim's (and perpetrator's) perspectives (Mayhew & Chappell 2003).

Finally, with the exception of aged care facilities, there has been a dearth of research regarding violence towards *patients* in general hospitals and emergency departments. This is despite anecdotal reports that suggest it is more common than otherwise would be suspected. As such, there is a need for research to be undertaken in this area.

Evaluation

The introduction of the *Preventing occupational violence in Victorian health services* policy framework in 2007 resulted in a range of programs and interventions to address violence occurring in hospitals and health care facilities. It is imperative that such programs be evaluated to assess the effectiveness of violence prevention and monitoring programs in health workplaces throughout Victoria. As Professor Farrell told the Inquiry:

We should be looking at what is happening now that seems to be making a difference and have some way of evaluating that and then rolling it out in other centres where the problem seems not to have been dealt with very well. I think there are some good initiatives already in place — and we should look at them — but we do not really know, because each setting is working in isolation from what is happening elsewhere. Again, at the very least it might be you put on a one-day conference to bring people together from different settings to say what they think they are doing well. It would be one way of sharing and evaluating what works.⁵²²

A submission from the Australian Nursing Federation (Victoria) to this Inquiry has also recommended that the government undertake a comprehensive evaluation of existing anti-violence measures in operation in all Victorian health care facilities to determine their

521 Professor Gerald A. Farrell, Professor of Nursing, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 29 August 2011.

522 Professor Gerald A. Farrell, Professor of Nursing, La Trobe University, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, 29 August 2011.

effectiveness.⁵²³ Speaking to this submission at a public hearing, Occupational Health and Safety Coordinator Kathy Chrisfield told the Committee that such an evaluation is absolutely essential:

[i]f we look at what is currently in place, then we can look at where the gaps are and address those by dealing with the causes of violence and looking at ways we can prevent violence from occurring... Once you have got the evaluation in place, then we can target better how that money could be spent in the various facilities.⁵²⁴

In particular, the Committee believes it is essential that incident reporting systems, most notably VHIMS, is evaluated to ascertain whether violent incidents in Victorian hospitals are being reported and that the system through which this is done is readily accessible and user friendly.

Funding and resourcing

Many witnesses to the Inquiry have observed that the types of best practice strategies that are or should be in place to address occupational violence 'do not come cheaply'. Moreover, hospitals do not necessarily prioritise funding for security initiatives. It is understandable that hospital managements have competing claims to consider in balancing their budgets, however funding for security issues should never be regarded as an 'add on' extra.

The Occupational Violence Prevention Fund 2008–2011

One way of financing projects to address violence in the health workplace has been through the *Occupational Violence Prevention Fund*. This fund initiated in 2008 invited public health services to submit yearly applications for funding to assist the highest priority occupational violence risks in their workplace. Many of the successful applications involved crime prevention through environmental design (CPTED) projects.⁵²⁵ Some examples included improvements to emergency security systems, mobile and static duress systems and alarm systems. However, funding was also made available for staff to take education, training and support courses in preventing occupational violence; for hospitals to conduct occupational violence audits or for health services to establish police/health service partnerships to better manage occupational violence.

A Department of Health panel reviewed and rated the applications according to a set of pre-determined criteria based on occupational health and safety guidelines and criteria. One of the beneficial aspects of the process was that organisations were expected to include an occupational violence risk assessment in their applications.

The Fund has expended four million dollars over four years with 144 high priority risk projects being financed across 65 health services.⁵²⁶ The fund is due, however, to cease operating in 2011.

Flexible and dedicated funding

In April 2011 the Victorian Minister of Police committed to fund protective service officers in emergency departments. At the time he also indicated that subject to a number of considerations including the outcomes of this Report, funding could be provided in other ways for the safety and security of staff in accordance with the particular needs of health services.

If such funding was available for measures to address occupational violence, most witnesses to the Inquiry have stated that above everything else they would like the flexibility to use

523 Submission from Ms Kathy Chrisfield, Occupational Health and Safety Unit Co-ordinator, Australian Nursing Federation (Victoria) to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, July 2011.

524 Ms Kathy Chrisfield, Co-ordinator, Occupational Health & Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

525 See chapter 9 for a discussion of CPTED.

526 See http://www.health.vic.gov.au/__data/assets/pdf_file/0019/660214/Occ-Violence-Project-Status-Report2011.pdf

those funds as best meets their particular needs. In effect, a continuation of the occupational violence fund of its equivalent would best meet these requirements. For example, Andrew Way, Chief Executive of Alfred Health told the committee:

I think [such a system] gives flexibility for health services to decide the most appropriate investment to make, provided we are clear about what the outcome should look like: a reduced amount of violence to staff or reduced incidence of violence or better recording of violence.⁵²⁷

Other witnesses to the Inquiry have commented that the most important issue pertaining to funding is that any monies set aside to address occupational violence in hospitals *must* be dedicated to that purpose only. For example, Mr Paul Gilbert, Assistant Secretary of the Australian Nurses Federation (Victoria) told the Inquiry:

We are also aware that, rightly or wrongly, hospitals have a lot of budgetary pressure placed on them... If the government is going to dedicate funding for security in emergency departments, it must be dedicated for that purpose and that purpose alone. Once it goes into the general revenue of hospitals it will not be the priority that it needs to be.⁵²⁸

Occupational Health and Safety Coordinator Kathy Chrisfield also expressed the view that with regard to security issues health care staff would be somewhat anxious that any allocated funding didn't go into the 'big bucket'; that is, the general health budget for hospitals:

We find that it [funding] can very quickly be reallocated elsewhere and not dedicated to the purposes for which it was originally intended. It so important to make sure that the funding, whether the security is provided directly by the government or whether it is provided through the health services themselves, is dedicated and there are criteria around how it is allocated.⁵²⁹

Trevor Carr, Chief Executive of the Victorian Health care Association, noted that the issue of dedicated funding is extremely important given that historically security was not necessarily high on the list of all hospitals' budgetary priorities:

We do not have a funding stream specifically for security elements; they are to be funded out of the activity-based funding mechanisms that we principally have here in Victoria in terms of hospitals and outpatient attendances. That sometimes leads to a value judgement on the part of agencies as to whether or not they can even afford those security arrangements and to what extent they can afford them.⁵³⁰

Finally on this issue, Dr Stephen Parnis, Vice-President of the AMA (Victoria) believes that security staff should be 'one of the highest priorities' to come out of any monies allocated, however that hospitals should also have the flexibility to expend that money as they see fit according to their particular needs. As to a dedicated fund, he is in total agreement with the views previously expressed:

I would be watching that money like a hawk. I think it is fair to say that hospitals are, by and large, not adequately funded to do what they do, and I think the premise is to go for those areas where they can cut costs...I would like to see robust, transparent ways in which that money is used and to see that

527 Mr Andrew Way, Chief Executive Officer, Alfred Health, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

528 Mr Paul Gilbert, Assistant Secretary, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

529 Ms Kathy Chrisfield, Co-ordinator, Occupational Health & Safety Unit, Australian Nursing Federation, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 29 August 2011.

530 Mr Trevor Carr, Chief Executive, Victorian Health care Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

there are people employed as a result of that and not hived off to some other area that clinicians would regard as the last place they would be of any use.⁵³¹

Closing remarks

Most patients and their visitors deal with the stress of being in the hospital environment in ways that do not negatively impact upon those around them. A minority, however, may find it difficult not to behave in an antisocial, inappropriate or even violent manner. Ultimately addressing occupational violence in health care settings is about developing and implementing ways to prevent such behaviour before it has taken place. Early intervention policies and procedures must be put in place that can recognise potential violence long before it happens. Victoria's health care staff are a valued resource that should expect no less. It is hoped that this Report and the recommendations therein will assist in this regard.

Adopted by the Drugs and Crime Prevention Committee

55 St Andrew Place

Melbourne 3002

5 December 2011

Recommendation

3. **The Committee recommends that within 12 months of the tabling of this Report there should be a fully independent evaluation of the policies, programs and other measures implemented as a result of the recommendations in the *Victorian Taskforce on Violence in Nursing: final report*.**

Recommendation

4. **The Committee recommends that the Victorian government provides ongoing funding which is within the health sector budget which would provide funding for safety and security of staff in accordance with the particular needs of health services.**

A funding mechanism similar to the Occupational Violence Prevention Fund 2008–2011 may serve as a useful model to direct funding. It should, however, apply to all staff and departments in the hospital environment and not just nursing. Applications to the fund should also be subject to the completion of an occupational violence risk assessment.

How money is allocated from any funding mechanism should be up to the boards of individual hospitals. However, whatever resources are finally allocated to address this issue, it is absolutely paramount that this money is used for the dedicated purpose of addressing violence and security issues within public hospitals. Under no circumstances should this money be used for discretionary spending unconnected with the priorities of security and safety of the hospital.

⁵³¹ Dr Stephen Parnis, Vice-President, Australian Medical Association, Evidence given to the Drugs and Crime Prevention Committee, Inquiry into Violence and Security Arrangements in Victorian Hospitals, Public Hearing, Melbourne, 15 August 2011.

Recommendation

- 38. The Committee recommends that hospitals and other health care settings are regularly evaluated on their policy and progress around managing and reducing occupational violence. This could be included as a mandatory part of hospital accreditations.**

The introduction of the 'Preventing occupational violence in Victorian health services' policy framework in 2007 resulted in a range of programs and interventions to address violence occurring in hospitals and health care facilities. It is imperative that such programs be evaluated to assess the effectiveness of violence prevention and monitoring programs in health workplaces throughout Victoria.

Recommendation

- 39. The Committee recommends the Victorian government commission research into the incidence, prevalence, nature and consequences of occupational violence in health care settings. Such research should be informed by a mixture of research disciplines including quantitative, qualitative and ethnographic methodologies**

There is still much that is unknown with regard to the issue of occupational violence in health care settings. This is particularly true with regard to how prevalent violence occurring in hospitals is, why it occurs and what the best ways are of addressing it. Evidence to this Inquiry has identified a need for better and more research studies to examine this form of violence.

Appendices

Appendix 1: Victorian Taskforce on Violence in Nursing — Recommendations

Occupational violence and aggression

Recommendation 1

The Department of Human Services and health care facilities adopt a uniform definition of occupational violence consistent with the definition and classifications developed by the Taskforce on Violence and Aggression Subcommittee in this report.

Recommendation 2

That the Department of Human Services and health care facilities adopt a policy statement that has key messages including:

- ◆ violence against nurses is unacceptable and must be proactively addressed
- ◆ there is not a culture of tolerance of violence in the workplace
- ◆ encouraging a culture of reporting amongst nurses.

Recommendation 3

That the Department of Human Services develops a framework for the prevention and management of occupational violence and aggression for adoption in Victorian health care settings and that this work be informed by:

- ◆ NSW Health, *Zero tolerance to violence in the NSW health workplace — policy framework guidelines* (2003)
- ◆ Department of Human Services, *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (2004).

Recommendation 4

That the Department of Human Services will:

- ◆ establish a hierarchy of response guidelines for a uniform system of sanctions in response to violence and aggression against nurses. The response should include warning systems, contracts of acceptable behaviour, and the enforcement of sanctions/consequences.
- ◆ develop guidelines that include the duty of care and legal responsibilities of all parties. Case study examples should be provided to highlight the issues to be considered in determining strategies and responses to occupational violence and aggression against nurses in the workplace.

Contin. over

Recommendation 5

That the Department of Human Services develops education and awareness programs for the community, police and the judiciary, to promote a greater understanding of occupational violence in nursing.

Recommendation 6

That the Department of Human Services requests the Department of Justice to consider the issues of occupational violence in nursing and consider legislative mechanisms and strategies that will improve the safety of nurses and other health care workers.

Recommendation 7

That the Department of Human Services consider the development of statewide guidelines with respect to weapons and dangerous articles within the health care setting. This may include introducing legislation or guidelines in health services that relate to the search and removal of weapons and/or dangerous articles, the storage, disposal or return of such articles, and to allow police to receive and hold such property, regardless of whether it is to be used as evidence in relation to a crime or that charges are to be laid. This matter should be considered together with other legislative issues referred to the Department of Justice.

Recommendation 8

That the Victorian Government and health services develop, pilot and implement a public awareness campaign that:

- ◆ promotes an expectation of behaviour and consequences for unacceptable violence and aggression
- ◆ clearly states the message that violence towards nurses is unacceptable.

Recommendation 9

That the Department of Human Services, in consultation with health services, adapts for broad use: *The industry occupational health and safety interim standards for preventing and managing of occupational violence and aggression in Victorian mental health services* (Department of Human Services 2004) for post-incident management.

Recommendation 10

That the Department of Human Services introduces into Victorian health services, standardised Code Grey (violence and aggression emergency) and Code Black response (armed threat).

Recommendation 11

All health organisations will:

- ◆ establish an aggression management reference group which will be responsible for developing policies and procedures around the management of aggressive incidents, primarily through a clinically led aggression management team
- ◆ ensure that all clinical areas undertake a risk assessment and give consideration to a number of strategies, including the development of guidelines to address the needs of each different setting and reviewing the need for appropriately trained security personnel
- ◆ establish, in all high-risk departments, security measures that include a response by staff who are trained in the prevention and management of violence and aggression during hours of operation

- ◆ consider how to address the broader issues of physical restraint and seclusion within non-designated mental health areas
- ◆ develop guidelines for emergency responses during operating hours in smaller health facilities or for those nurses working in community, rural and remote settings.

Recommendation 12

That the Victorian Government considers procedures for reporting to police, laying charges and prosecutions, including the potential for legislation for nurses similar to that developed for ambulance officers. (A Memorandum of Understanding, similar to that adopted between NSW Health and NSW Police, is a useful reference.)

Recommendation 13

The Department of Human Services and health services commit resources to support:

- ◆ the implementation of strategies to prevent and manage violence and aggression against nurses and other health workers
- ◆ strategies developed in areas that include design, personnel, equipment, publications and training
- ◆ the evaluation of the strategies following their implementation
- ◆ preliminary analysis of the data set and strategies 12 months after implementation and a comprehensive evaluation of the same after three years.

Recommendation 14

The principles of affecting behaviour through environmental design and management should be applied to all future building development and refurbishment.

Education

Recommendation 15

Health services develop a clear statement of expected behaviour, outlining acceptable and unacceptable behaviour, for both staff and consumers.

Recommendation 16

The Department of Human Services develops guidelines to ensure a minimum standard of education is provided to all nurses.

Recommendation 17

Health services:

- ◆ provide education and training for nurses to prevent and manage occupational violence and bullying. The education and training will be consistent with DHS guidelines and address the key elements identified by the Education Subcommittee, including prevention and management of occupational violence and bullying
- ◆ provide nurses, including part-time and casual bank nurses and other health care employees, with education and training as part of the orientation process to a new organisation
- ◆ ensure all nurses in the workplace undertake continuing education and training programs that address occupational violence and bullying at least on an annual basis

Contin. over

- ◆ provide additional specific training to staff working in identified high risk areas
- ◆ maintain a database of all nurses who have completed education, and develop systems to ensure the adequate education of casually employed nurses in relation to occupational violence and bullying and that these systems meet the requirements of the *Occupational Health and Safety Act 2004*.

Recommendation 18

Providers of agency nurses ensure nurses receive education and training in the prevention and management of occupational violence and bullying prior to undertaking casual employment with any health care facility. This education is to include all key elements identified as a minimum educational and training requirement.

Recommendation 19

Health services develop specific education programs for all managers, covering:

- ◆ the impact of occupational violence and bullying on the workforce
- ◆ the organisation's expectations of the managers, inclusive of policy and procedures for prevention and management of incidents
- ◆ the importance of supporting staff to report incidents
- ◆ the obligations of the manager
- ◆ techniques and available support mechanisms for staff and managers.

Recommendation 20

That the Minister for Health requests:

- ◆ the Nurses Board of Victoria to require, through accreditation processes, nursing courses leading to registration to include OH&S principles, particularly those that address occupational violence and bullying
- ◆ the Australian Nursing and Midwifery Council to consider the development of competency standards pertaining to OH&S principles and require the inclusion of OH&S components of occupational violence and bullying.

Recommendation 21

Higher education providers and health services create a mechanism for monitoring and evaluating the prevalence of bullying and violence experienced by students in the workplace during clinical placements.

Bullying

Recommendation 22

That the Department of Human Services and health services accept an agreed definition of bullying that is aligned with the WorkSafe definition and use it consistently.

Recommendation 23

That health services establish consistent management strategies that include:

- ◆ clear organisational policy with 'safe' reporting to an objective, senior, listener
- ◆ timely and consistent response from management
- ◆ support for realistic outcomes.

Recommendation 24

That health services establish management education strategies that:

- ◆ explore and articulate mechanisms to assist organisations to manage situations where, despite investigation, no clear resolution to bullying is obvious and/or possible
- ◆ emphasise positive behaviours in the workplace
- ◆ raise nurses' awareness of the differences between bullying behaviours and legitimate business practices, for example, legitimate and reasonable performance management and organisational change
- ◆ minimise ambiguity so that bullies and victims are aware of the subtleties and trivialities that comprise bullying in nursing.

Recommendation 25

That the Department of Human Services develops and disseminates a statewide 'tool kit' containing bullying prevention strategies (adapted from *WorkSafe Victoria Guidance Note 2003*) that:

- ◆ includes examples of policies, procedures and suggestions for culture change
- ◆ ensures consistency in the approach to managing bullying
- ◆ provides a useful resource that contributes to quality improvement processes
- ◆ includes readily accessible policies, procedures, case studies and customised pamphlets for nurses
- ◆ uses innovative ways to convey messages about bullying behaviours that are relevant to nursing.

Recommendation 26

That the Department of Human Services:

- ◆ promotes management of bullying in accordance with the *WorkSafe Victoria Bullying and Violence at Work Guidance Note* (February 2003)
- ◆ further researches nursing culture to identify key factors that may trigger bullying behaviour by nurses, thereby enabling a more targeted approach to prevention
- ◆ considers sponsorship of innovative strategies to prevent bullying and disseminate ideas and outcomes to health services.

Reporting tools

Recommendation 27

That the Department of Human Services:

- ◆ develops a statewide minimum data set that includes key critical fields, with reference to the critical fields identified by the Reporting Tools Subcommittee
- ◆ develops guidelines to assist health services to understand the significance of data collection related to violence and bullying and to collect critical field information
- ◆ pilots the data set across a sample of Victorian health services prior to implementation.

Contin. over

Recommendation 28

All health services submit a minimum data set to the Department of Human Services on a biannual basis.

Recommendation 29

That the Department of Human Services makes aggregated local data results available to health services and WorkSafe Victoria to compare local prevalence and nature of events and create statewide benchmarking.

Appendix 2: The Importance and Presence of Safe Systems at Work to Prevent and Manage Occupational Violence

	High Importance %	Present at workplace %
Appropriate physical environment for safe care	87	83
Good surveillance of waiting/reception areas	75	64
Means for safe retreat when needed (e.g. escape doors)	67	47
Appropriately designed reception counters to protect staff	69	54
High standard patient facilities to reduce their frustration and anxieties	76	61
Minimal public access points	71	67
Minimal hiding spots	57	42
Effective duress alarm and communication systems	80	68
Personal protective equipment (e.g. personal duress alarms)	65	56
Appropriately located CCTV at entrances/exits, car parks and other areas	66	51
Adequate external security lighting	81	72
Alarms are linked to security personnel and the police	72	60
Timely response of security/police	72	67
On-site security guards in workplace 24 hours	64	54
After hours access by swipe card only	76	63
Protocols to assess clients with aggressive or violent behaviour	76	69
Incorporating of clinical assessment of behaviour in patient care plans	75	69
Systems in place for client alerts in relation to aggressive and violent behaviour	77	68
Early intervention and effective clinical management of clients who are aggressive	72	56
System of sanctions for aggressive clients, visitors or others	70	57
Effective enforcement of policies, including sanctions by management	68	51
Staff screen visitors after hours	76	68
Sufficient staffing levels to ensure safe care	80	61
Appropriate staff skill mix to provide safe care	82	69
Training in communication skills, including de-escalation skills	71	52
Training and awareness in emergency response procedures	88	85

Source: Farrell, GA & Shafiei, T 2011, Scoping workplace aggression, including bullying (SWAB) in nursing and midwifery, *International Journal of Nursing Studies* (under review).

Appendix 3: List of Submissions

Submission No.	Name of Individual/Organisation	Date received
1	Confidential submission	29 May 2011
2	Mr Danny Hills PhD Student Monash University	30 May 2011
3	Mr Gordon Weber Director Australian Security Emergency and Safety Services	23 June 2011
4	Ms Erin Cassell Director Victorian Injury Surveillance Unit (VISU) Monash Injury Research Institute (MIRI)	24 June 2011
5	Ms Julie Edwards Chief Executive Officer Jesuit Social Services	28 June 2011
6	Dr Yolande Lucire Forensic Psychiatrist	1 July 2011
7	Professor Gerald A Farrell Professor of Nursing Dr Touran Shafiei Research Fellow School of Nursing and Midwifery Faculty of Health Sciences La Trobe University	4 July 2011
8	Dr Beth Wilson Health Services Commissioner, Victoria	4 July 2011
9	Mr Brendan Gardner Executive Director Frankston Hospital, Peninsular Health	4 July 2011
10	Mr Trevor Carr Chief Executive Victorian Health care Association	4 July 2011
11	Mr Bryan de Caires Chief Executive Officer Australian Security Industry Association Ltd (ASIAL)	4 July 2011
12	Ms Kathy Chrisfield Co-ordinator, OH&S Unit Australian Nursing Federation (Victoria)	4 July 2011
13	Mr Greg Sassella Chief Executive Officer Ambulance Victoria	5 July 2011
14	Mr David Plunkett Acting Chief Executive Eastern Health	8 July 2011

Submission No.	Name of Individual/Organisation	Date received
15	Dr Georgina Phillips Emergency Physician Mr Paul Cunningham Security Manager Ms Sue Cowling ED Nurse Unit Manager St Vincent's Hospital, Melbourne	8 July 2011
16	Dr Simon Judkins Chairman, Victorian Faculty Australasian College for Emergency Medicine	11 July 2011
17	Professor John Kolbe President The Royal Australasian College of Physicians Professor Peter Ebeling Chairperson Victorian State Committee The Royal Australian College of Physicians	12 July 2011
18	Mr Geoff O'Kearney Acting Chief Executive Officer Australian Medical Association	14 July 2011
19	Ms Sharon McNulty Director, Support Services Southern Health	15 July 2011
20	Mr Andrew Way Chief Executive Alfred Health	18 July 2011
21	Mr Jim Fletcher Chief Executive Officer Western District Health Service	28 July 2011
22	Dr Simon Young Director Emergency Medicine, Dr Sandy Hopper Paediatric Emergency Physician Ms Jayne Hughan Nurse Unit Manager Emergency Department The Royal Children's Hospital	4 August 2011
23	Ms Kathy Jackson Executive President Health Services Union (HSU) East Branch	5 August 2011
24	Confidential submission	8 August 2011
25	Mr Wayne Sullivan Chief Executive Officer Bairnsdale Regional Health Service	9 August 2011
26	Mr Stephen Cornelissen Chief Executive Officer Mercy Health	10 August 2011

Submission No.	Name of Individual/Organisation	Date received
27	Confidential submission	28 August 2011
28	Mr David Van Lambaart Senior Consultant Jakeman Business Solutions Pty Ltd (JBS)	10 October 2011
29	Mr David Van Lambaart Senior Consultant Jakeman Business Solutions Pty Ltd (JBS)	21 October 2011
30	Mr Tim Reinders Manager — Occupational Health & Safety Ballarat Health Services	31 October 2011
31	Acting Deputy Commissioner Tim Cartwright Victoria Police	28 November 2011
32	The Royal Melbourne Hospital	28 November 2011

Appendix 4: Witnesses Appearing at Public Hearings — Melbourne

Hearings in Melbourne — 27 June 2011

Name	Position	Organisation
Ms Erin Cassell	Director Victorian Injury Surveillance Unit (VISU)	Monash Injury Research Institute (MIRI)
Ms Angela Clapperton	Data Manager Victorian Injury Surveillance Unit (VISU)	Monash Injury Research Institute (MIRI)

Hearings in Melbourne — 15 August 2011

Name	Position	Organisation
Mr Andrew Way	Chief Executive Officer	Alfred Health
Mr Bill O'Shea	General Counsel	The Alfred Hospital
Mr Simon Thomson	Acting Regional Manager	Ambulance Victoria
Mr Trevor Carr	Chief Executive	Victorian Health care Association
Mr Matthew Cameron	Research and Policy Officer	Victorian Health care Association
Dr Stephen Parnis	Vice-President	Australian Medical Association (AMA)
Mr Bryce Prosser	Director, Policy and Public Affairs	Australian Medical Association (AMA)
Ms Elizabeth Muhlebach	Policy Officer	Australian Medical Association (AMA)

Hearings in Melbourne — 29 August 2011

Name	Position	Organisation
Mr Paul Gilbert	Assistant Secretary	Australian Nursing Federation
Ms Kathy Chrisfield	Co-ordinator, Occupational Health & Safety Unit	Australian Nursing Federation
Mr Peter Sloman	Clinical Nurse Specialist	Royal Children's Hospital
Ms Leslie Graham	Registered Nurse	Dandenong Hospital
Dr Simon Young	Director, Emergency Services	Royal Children's Hospital
Professor Gerald A Farrell	Professor of Nursing School of Nursing and Midwifery	La Trobe University
Dr Touran Shafiei	Research Fellow School of Nursing and Midwifery	La Trobe University

Dr Beth Wilson	Health Services Commissioner, Victoria	Office of Health Services Commissioner
Mr Grant Davies	Deputy Health Services Commissioner	Office of Health Services Commissioner

Hearings in Melbourne — 12 September 2011

Name	Position	Organisation
Dr Georgina Phillips	Emergency Physician and Coordinator of International Programs	St Vincent's Hospital
Ms Susan Cowling	Nurse Unit Manager	St Vincent's Hospital
Mr Paul Cunningham	Security Manager	St Vincent's Hospital
Associate Professor Marie Gerdtz	Associate Professor of Emergency Nursing	Royal Melbourne Hospital
Associate Professor Denise Heinjus	Executive Director, Nursing Services	Royal Melbourne Hospital
Professor Megan-Jane Johnstone	Director, Centre for Quality and Patient Safety Research	Deakin University
Sergeant Pat Ryle	Operational Supervisor, Melbourne West	Victoria Police

Hearing in Melbourne — 10 October 2011

Name	Position	Organisation
Ms Frances Diver	Executive Director, Hospital and Health Service Performance.	Department of Health
Mr Terry Symonds	Acting Director, Performance, Acute Programs and Rural Health.	Department of Health
Mr David Van Lambaart	Senior Consultant	Jakeman Business Solutions Pty

Appendix 5: Roundtable Meeting — Security Industry

Melbourne — 10 October 2011

Name	Position	Organisation
Ms Kerry McNamara	General Manager (Vic/Tas)	ISS Security
Mr Stephen McIntyre	General Manager, Health Sector	Spotless
Ms Jennifer Nicholson	Project Manager	Spotless @ The Alfred
Mr John Rogers	National Operations Manager	Wilson Security
Mr Brett McDonald	National Integrated Security Manager	Wilson Security

Appendix 6: Regional Visits and Public Hearings

Public Hearings in Geelong — 8 August 2011

Name	Position	Organisation
Mr Perry Muncaster	Director Human Resources and Organisational Safety	Geelong Hospital
Mr Philip Dunn	Director, Operations, Mental Health	Geelong Hospital
Dr David Eddey	Director of Emergency Medicine	Geelong Hospital
Ms Kathryn Ackland	Nurse Unit Manager, Emergency Department	Geelong Hospital
Ms Jodie Bourke	Associate Nurse Unit Manager, Emergency Department	Geelong Hospital
Ms Danielle McNamara	Registered Nurse, Emergency Department	Geelong Hospital

Public Hearings in Ballarat — 18 October 2011

Name	Position	Organisation
Mr Andrew Rowe	Chief Executive Officer	Ballarat Health Service
Dr Jaycen Cruickshank	Director, Emergency Medicine	Ballarat Health Service
Mr Tim Reinders	Manager, Occupational Health and Safety	Ballarat Health Service
Mr Robert Dekleva	Manager, Security	Ballarat Health Service

Appendix 7: Witnesses Appearing at Interstate Meetings, Site Visits and Public Hearings

Meetings in Perth — 20-22 June 2011

Name	Position	Organisation
Dr Rose Chapman	Director, Practice Education School of Nursing and Midwifery	Curtin University
Dr Harry Patterson	Deputy Head, Emergency Department	Royal Perth Hospital
Mr Luke Roscoe	Head of Security	Royal Perth Hospital
Ms Lisa Gray	Co-ordinator of Nursing	Sir Charles Gairdner Hospital
Ms Shari Kidd	Clinical Nurse Specialist, Violence and Aggression	Sir Charles Gairdner Hospital
Assoc Professor Roger Swift	Emergency Physician	Sir Charles Gairdner Hospital

Meetings in Sydney — 20 September 2011

Name	Position	Organisation
Prof Gordian Fulde	Director, Emergency Department	St Vincent's Hospital
Mr Beaver Hudson	Nurse Manager	Psychiatric Emergency Centre St Vincent's Hospital
Mr Ross Judd	Manager, Security	St Vincent's Hospital
Ms Mel Kelly	A/Nurse Manager Emergency Department	St Vincent's Hospital
Mr Bryan de Caires	Chief Executive Officer	Australian Security Industry Association Ltd
Mr Peter Johnson	Manager, Compliance & Regulatory Affairs	Australian Security Industry Association Ltd
Professor Duncan Chappell	Adjunct Professor, Institute of Criminology	University of Sydney
Dr Lauretta Luck	Associate Head, School of Nursing and Midwifery	University of Western Sydney
Ms Kristina Zarkos	Executive Officer to Executive Director	Royal Prince Alfred Hospital
Dr Roy Donnelly	Director, Medical Services	Royal Prince Alfred Hospital
Ms Joanne Edwards	Director, Nursing Midwifery Services	Royal Prince Alfred Hospital
Mr Joseph Jewitt	Director, Corporate and Finance Services	Royal Prince Alfred Hospital
Mr Dunko Grubisic	Security Manager Westmead Hospital	Sydney West Area Health Service
Mr Dominic Dawson	General Manager Blacktown Hospital	Sydney West Area Health Service
Ms Sue-Anne Redmond	Director, Clinical Governance Westmead Hospital	Sydney West Area Health Service

The staff at St Vincent's Hospital provided the Committee with a comprehensive tour of the Emergency Department at the hospital.

Appendix 8: Department of Health Policies and Guidelines Relevant to Occupation Violence

Document/resource name	Format	Availability/URL
Original Taskforce on Violence in Nursing documents		
Victorian Taskforce on violence in nursing Final report 2005	Report	http://www.health.vic.gov.au/__data/assets/pdf_file/0007/17674/victaskforcevio.pdf
Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals 2005	Report	http://www.health.vic.gov.au/__data/assets/pdf_file/0008/17585/codeblackgrey.pdf
Implementation of recommendations documents for public hospitals		
Preventing Occupational Violence in Victorian Health Services- A policy Framework and resource kit	Policy Guidance / document	http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-1
Deter, detect and manage — A guide to better management of weapons in health services (DHS 2009)	Policy/ Guidance document	http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3
Every day's a challenge: Responding to violence in Victorian health services (DHS, WorkSafe & Victoria Police)	DVD multimedia resource	http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3
New Weapons legislation: implications for Victorian Health Services	Fact sheet	http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3
Occupational Violence Incident Resolution Action Pack	Document	The document is currently being piloted by health service demonstration sites in the <i>Building Better Partnerships</i> project. Copy available on request.
Other relevant Departmental documents for public hospitals		
Management of clinical aggression- Rapid emergency department intervention.	Training manual/ research project	Final draft of the research paper is in progress. Copy of manual and DVD available on request.
Victorian Health Incident Management System data specification	Document	http://docs.health.vic.gov.au/docs/doc/B0D77F3F1FA7C558CA257902000F6406/\$FILE/VHIMS-overview-data_spec.pdf
Ambulance transport of people with a mental illness Protocol 2010	Policy	http://www.health.vic.gov.au/mentalhealth/publications/amb-transport0910.pdf
Department of Health and Victoria Police: Protocol for Mental Health	Guidance Document	http://www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910.pdf

Document/resource name	Format	Availability/URL
Improving the Patient Experience Program in Victoria's public hospital emergency departments	Guidance Documents	<p><i>Improving the Patient Experience Program Summary Report</i> http://www.health.vic.gov.au/emergency/improving-experience0507.pdf</p> <p><i>Wayfinding and signage guidelines for emergency departments</i> http://www.health.vic.gov.au/emergency/emerg_sign.pdf</p> <p><i>Improving the patient experience for Aboriginal people in the emergency department</i> http://www.health.vic.gov.au/emergency/ipe_aboriginal_ed.pdf</p> <p><i>Improving the environment for older people in Victorian emergency departments</i> http://www.health.vic.gov.au/emergency/patient-xp-audit-0509.pdf</p>
Better faster emergency care: improving emergency care and access in Victoria's public hospitals (2007)	Policy	http://www.health.vic.gov.au/emergency/better-faster-report07.pdf
Victorian Health Priorities Framework 2012-2022	Policy	http://docs.health.vic.gov.au/docs/doc/8CB17E5E28C07CDCCA257884007D275D/\$FILE/1104014%20VHPF_2012-22_FA7%201%20June.pdf
Victorian Health Incident Management Policy guide (June 2011)	Policy/ Guide	http://docs.health.vic.gov.au/docs/doc/C466CF49CDAS28DCA2578A90080F6C5/\$FILE/110402_DoHVHIMS%20policyguide%20WEB%20v2.pdf
Victorian Health Incident Management data Specifications	Manual	http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Incident-Management-System-(VHIMS)-data-set-specification---An-overview

Appendix 9: WorkSafe Risk Control Assessment Checklist

More information about Occupational violence

Occupational violence: Risk assessment checklist

All employers should carry out a regular check of the workplace in consultation with health and safety representatives and workers to identify if there are signs that occupational violence is happening or could happen (risk identification), and take steps to implement solutions to control risks.

This checklist is designed to help employers meet their legal obligations to manage risks associated with occupational violence.

Follow the checklist to assess the risks and list possible solutions to be implemented.

This checklist is not exhaustive. You may need to consider other factors that are unique to your workplace. Add these to the 'additional factors' section of this checklist. There are also other tools found in the publication, *Working safely in visiting health services* that you may use to assess risks of occupational violence in your workplace (see the example checklists for referral information and initial safety assessment information).

If you tick YES to any of the questions below, implement risk control measures such as those mentioned under 'solutions for occupational violence' in this document. Retain a copy of this document if you use it to identify a risk of injury or risk control.

Incident/Injury records	Yes (risk control needed)	No	Solutions	Comments
Have there been any incidents of occupational violence in the last 12 months? Have workers been threatened or assaulted in the past? Have these incidents resulted in serious injury or impact?				
Work environment	Yes (risk control needed)	No	Solutions	Comments
Does the building have multiple access points? Is access to alarms difficult or too obvious? Is work done in unfamiliar environments? Is the environment uncomfortable for clients? Does the physical layout fail to provide privacy for clients? Is it easy for a client to get physical access to a worker? Are workers working in isolated locations? Is it difficult for workers to go to a safe place if in danger? Is it difficult for workers to communicate when threatened? Is visibility impaired? Is visibility of the working environment from outside the building inadequate? Is external lighting inadequate?				

More information about Occupational violence

Work practices	Yes (risk control needed)	No	Solutions	Comments
<p>Are there likely to be service delays that are not communicated to the client?</p> <p>Are there likely to be circumstances that would frustrate clients?</p> <p>Are staffing numbers insufficient at demand times?</p> <p>Are workers providing community outreach services?</p> <p>Do workers ever work alone or in isolated locations?</p> <p>Would it be difficult for a worker to seek assistance if threatened or assaulted?</p> <p>Would it be difficult for another person to see that assistance was needed if an incident occurred?</p> <p>Does the workplace lack security and emergency procedures?</p> <p>Does the workplace fail to regularly check and test security and emergency procedures?</p> <p>Does the workplace lack a clear process for dealing with conflict and aggression?</p> <p>Does the workplace lack procedures to deal with violence during and after an event?</p>				
Worker training	Yes (risk control needed)	No	Solutions	Comments
<p>Are there inexperienced workers in front line positions?</p> <p>Are there any workers that have not received training in how to deal with aggression and/or challenging behaviour?</p> <p>Are there any workers that do not have appropriate workplace knowledge and skills to deal with clients?</p> <p>Are any workers unaware of policies or procedures about occupational violence?</p>				

More information about Occupational violence


Behaviour	Yes (risk control needed)	No	Solutions	Comments
Are clients/service users likely to be distressed or aggressive? Is the behaviour of the client(s) unpredictable? Is an aggressor likely to have a weapon? Is there likely to be more than one aggressor? Is an aggressor likely to be under the influence of alcohol or drugs? There is no method to assess or identify potential for aggression or violence				
Additional factors				

This fact sheet provides information in relation to your health and safety obligations under the Occupational Health and Safety Act 2004 (OHS Act) only. It should not be viewed as a definitive guide to the law, and should be read in conjunction with the OHS Act. You should seek advice about other legal duties that may apply to your organisation.

Whilst every effort has been made to ensure the accuracy and completeness of this fact sheet, the advice contained herein may not apply in every circumstance. Accordingly, the Victorian WorkCover Authority cannot be held responsible, and extends no warranties as to the suitability of the information for your specific circumstances; or actions taken by third parties as a result of information contained in this fact sheet.

Appendix 10: Barwon Health Warning Notice

(Please reword if appropriate)



WARNING NOTICE

Patient's / Resident's / Visitor's Name: _____

Date of Admission / Offence: _____

This is to formally notify you that you have previously displayed aggressive and/or violent behaviour towards the employees and other patients of Barwon Health.

This behaviour will not be tolerated and if this is displayed in future presentations or visits then security and police will be informed immediately.

Barwon Health has a responsibility to care for all people who present to this Organisation for medical treatment.

Please note that all persons entering are expected to display courteous and respectful treatment to all staff, patients and visitors.

Threats, intimidating behaviour, verbal abuse and physical violence are not acceptable.

Signed By: _____

Position: _____

Date of Issue: _____

(Copies to: Patient, Patient's File, Crisis Plan Folder ED, Security, OH & S Department)

Source: Barwon Health, Material presented to the Drugs and Crime Prevention Committee at the Public Hearing, Geelong, 8 August 2011.

Appendix 11: Poster informing patients that violence is unacceptable



Source: Forster et al 2005, 'kNOw workplace violence: Developing programs for managing the risk of aggression in the health care setting'. Copy of an A3 size poster on the Triage door at the Austin Hospital, Heidelberg.

Bibliography

- Australasian College for Emergency Medicine (ACEM) 2004, *Policy on violence in emergency departments*, ACEM, Melbourne, Victoria. Website: http://www.acem.org.au/media/policies_and_guidelines/violence.pdf Accessed June 2011.
- Australian Medical Association (AMA) 2005, 'Personal safety and privacy for doctors', *AMA position statement*, AMA, Canberra, ACT.
- Behnam, M, Tillotson, RD, Davis, SM & Hobbs, GR 2011, 'Violence in the emergency department: A national survey of emergency medicine residents and attending physicians', *The Journal of Emergency Medicine*, vol. 40. no. 5, pp.565–579.
- Benveniste, KA, Hibbert, PD & Runciman, WB 2005, 'Violence in health care: The contribution of the Australian Patient Safety Foundation to incident monitoring and analysis', *The Medical Journal of Australia*, vol. 183, no. 7, pp.348–351.
- Bronfenbrenner, V 1979, *The ecology of human development: experiments by nature and design*, Harvard University Press, Cambridge.
- Caruana, E 2005, 'Radiographers at risk of assault', *The Radiographer*, vol. 52, no. 2, August, pp.15–17.
- Chapman, R 2011, Perceived causes of workplace violence among nurses working in a non-teaching setting: An ecological approach (unpublished manuscript).
- Chapman, R & Styles, I 2006, 'An epidemic of abuse and violence: Nurses on the frontline', *Accident and Emergency Nursing*, vol. 14, pp.245–249.
- Chapman, R, Styles, I, Perry, L & Combs, S 2010, 'Examining the characteristics of workplace violence in one non-tertiary hospital', *Journal of Clinical Nursing*, vol. 19, pp.479–488.
- Chappell, D & Di Martino, V 2000, *Violence at work*, 2nd edn, International Labour Organisation, Geneva.
- Chou, K, Lu, R & Mao, W 2002, 'Factors relevant to patient assaultive behaviour and assault in acute psychiatric units in Taiwan', *Archives of psychiatric nursing*, vol. 16, no. 40, pp.187–195.
- Cowling SA, McKeon MA & Weiland TJ 2007, 'Managing acute behavioural disturbance in an emergency department using a behavioural assessment room', *Australian Health Review*, vol. 31, pp.296–304.
- Department of Health (Vic) 2010a, *Management of clinical aggression — Rapid emergency department intervention*, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/clinicalnetworks/emergencyactivities.htm>
- Department of Health (Vic) 2010b, *Preventing occupational violence in Victorian health services: Implementing the Taskforce recommendations*, Nurse Policy Branch, Department of Health, Victorian Government, Melbourne. Website: www.health.vic.gov.au/nursing/promoting/noviolence Last updated 23 November.
- Department of Health (Vic) 2010c, *Ambulance transport of people with a mental illness Protocol 2010*, Mental Health, Drugs & Regions Division, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/mentalhealth/publications/amb-transport0910pdf>
- Department of Health (Vic), 2010d, *Department of Health and Victoria Police: Protocol for mental health*, Mental Health & Drugs Division, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/mentalhealth/publications/police-mh-protocol0910pdf>

- Department of Health (Vic) 2011a, *New weapons legislation: Implications for Victorian Health Services*, Fact sheet, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3>
- Department of Health (Vic) 2011b, *Status report on the implementation of the Victorian Taskforce on Violence in Nursing (2005) recommendations*, Department of Health, Victorian Government, Melbourne.
- Department of Health (Vic) 2011c, 'Occupational violence incident resolution pack', part of the *Building Better Partnerships* project, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3>
- Department of Health (Vic) 2011d, *Victorian health incident management policy guide*, Quality, Safety and Patient Experience Branch, Department of Health, Victorian Government, Melbourne. Website: www.health.vic.gov.au/clinrisk/vhims/
- Department of Health (Vic) 2011e, *Victorian health priorities framework 2012–2022*, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/healthplan2022/>
- Department of Health (Vic) 2011f, *Victorian health incident management data specifications*, Department of Health, Victorian Government, Melbourne. Website: [http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Incident-Management-System-\(VHIMS\)-data-set-specification---An-overview](http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Incident-Management-System-(VHIMS)-data-set-specification---An-overview)
- Department of Health (Vic) 2011g, *Victorian health incident management system (VHIMS)*, Department of Health, Victorian Government, Melbourne.
- Department of Health (WA) 1998, *Guidelines for developing protocols on intervention and management of family and domestic violence for hospitals in Western Australia*, Department of Health Western Australia, Perth.
- Department of Human Services (DHS) 2005a, *Victorian taskforce on violence in nursing: final report*, State Government of Victoria, Melbourne.
- Department of Human Services (DHS) (Vic) 2005b, *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals*, Policy and Strategic Projects Division, DHS, Victorian Government, Melbourne. Website: http://www.health.vic.gov.au/_data/assets/pdf_file/0008/17585/codeblackgrey.pdf
- Department of Human Services (DHS) (Vic) 2007a, *Preventing occupational violence in Victorian health services: A policy framework and resource kit*, DHS, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/nursing/promoting/noviolence>
- Department of Human Services (DHS) (Vic) 2007b, *Improving the Patient Experience Program in Victoria's public hospital emergency departments*, Metropolitan Health and Aged Care Services Division, DHS, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/emergency/improving-experience0507.pdf>
- Department of Human Services (DHS) (Vic) 2007c, *Better faster emergency care: Improving emergency care and access in Victoria's public hospitals*, Metropolitan Health and Aged Care Services Division, DHS, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/emergency//better-faster-report07.pdf>
- Department of Human Services (DHS) 2007d, *Victorian taskforce on violence in nursing — Implementation of recommendations — Reference group: terms of reference*, State Government of Victoria, Melbourne.
- Department of Human Services (DHS) 2008a, *Victorian taskforce on violence in nursing — Implementation of recommendations — Update on occupational violence prevention fund 2008–2011, Rounds 1 & 2*, State Government of Victoria, Melbourne.

- Department of Human Services (DHS) (Vic) 2008b, *Victorian health incident management system (VHIMS): data set specification*, Rural and Regional Health and Aged Care Service Division, DHS, Victorian Government, Melbourne.
- Department of Human Services (DHS) (Vic) 2009a, *A workplace free of bullying and violence: How to deliver the message*, DHS, Victorian Government, Melbourne.
- Department of Human Services (DHS) (Vic) 2009b, *Deter, detect and manage: A guide to better management of weapons in health services*, DHS, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3>
- Department of Human Services (DHS) 2009c, *Victorian taskforce on violence in nursing — Implementation of recommendations — Update on occupational violence prevention fund 2008–2011, Round 3 Summary*, State Government of Victoria, Melbourne.
- Department of Human Services (DHS) (Vic), WorkSafe & Victoria Police 2011, *Every day's a challenge: Responding to violence in Victorian health services*, Fact sheet, Nurse Policy Branch, Department of Health, Victorian Government, Melbourne. Website: <http://www.health.vic.gov.au/nursing/promoting/noviolence/strategy-3>
- Di Martino, V 2002, 'Relationship of work stress and workplace violence in the health sector', *Joint programme on workplace violence in the health sector*. Informal technical consultation documents, ILO/ICN/WHO/PSI, Geneva.
- Drugs and Crime Prevention Committee 2002, *Inquiry into Crime Trends — Fifth report*, Parliament of Victoria, Melbourne.
- Drugs and Crime Prevention Committee 2006, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption — Final Report*, Parliament of Victoria, Melbourne.
- Drugs and Crime Prevention Committee 2008, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People — Discussion paper*, Parliament of Victoria, Melbourne.
- Drugs and Crime Prevention Committee 2010, *Inquiry into Strategies to Reduce Assaults in Public Places in Victoria — Final report*, Parliament of Victoria, Melbourne.
- Farrell, G 1997, 'Aggression in clinical settings: nurses' views', *Journal of Advanced Nursing*, vol. 25, no. 3, March, pp.501–508.
- Farrell, G 1999, 'Aggression in clinical settings: nurses' views — a follow up study', *Journal of Advanced Nursing*, 1999, vol. 29, no.3, pp.532–541.
- Farrell, G & Gray, C 1992, *Aggression: A nurses' guide to therapeutic management*, Scutari Press/Harcourt Brace Jovanovich, London.
- Farrell G, Bobrowski, C & Bobrowski, P 2006, 'Scoping workplace aggression in nursing: findings from an Australian study', *Journal of Advanced Nursing* vol. 55, pp.778–787.
- Farrell, G & Shafiei, T 2011, 'Scoping workplace aggression, including bullying (SWAB) in nursing and midwifery', *International Journal of Nursing Studies* (under review).
- Farrell, G, Shafiei, T & Gaynor, N 2010, 'Relationships at work (RAW): Occupational violence and bullying in nursing and midwifery (unpublished manuscript).
- Fisher, J 2002, 'Fear and learning in mental health settings', *International Journal of Mental Health Nursing*, vol. 11, pp.128–134.
- Forster, JA, Petty, MT, Schleiger, C & Walters, HC 2005, 'kNOw workplace violence: Developing programs for managing the risk of aggression in the health care setting', *Medical Journal of Australia*, vol. 183, no. 7, pp.357–361.
- Fry, A, O'Riordan, D, Turner, M & Millis, K 2002, 'Survey of aggressive accidents experienced by mental health staff', *International Journal of Mental Health Nursing*, vol. 11, pp.112–120.
- Graycar, A 2003, 'Violence in the workplace: personal and political issues', Paper presented at the 2003 Security in Government conference, Canberra, 30 April–2 May.

- Harris G & Rice M, 1997, 'Risk appraisal and management of violent behaviour', *Psychiatric Services*, vol. 48, no. 9, pp.1168–1176.
- Hegney, D, Eley, R, Plank, A, Buikstra, E & Parker, V 2006, 'Workplace violence in Queensland, Australia: The results of a comparative study', *International Journal of Nursing Practice*, vol. 12, no. 4, pp.220–231.
- International Labour Organisation, International Council of Nurses, World Health Organization & Public Services International 2002, *Joint programme on workplace violence in the health sector — Framework, guidelines addressing workplace violence in the health sector*, ILO/ICN/WHO/PSI, Geneva.
- Johnstone, Megan-Jane & Kanitsaki, O 2006, 'Culture, language, and patient safety: Making the link', *International Journal for Quality in Health Care*, vol. 18, no. 5, pp.383–388.
- Johnstone, Megan-Jane & Kanitsaki, O 2007a, 'An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context', *Journal of Transcultural Nursing*, vol. 18, July, pp.247–256.
- Johnstone, Megan-Jane & Kanitsaki, O 2007b, 'Health care provider and consumer understandings of cultural safety and cultural competency in health care: An Australian study', *Journal of Cultural Diversity*, vol. 14, no. 2, pp.96–105.
- Johnstone, Megan-Jane & Kanitsaki, O 2008a, 'Cultural racism, language prejudice and discrimination in hospital contexts: An Australian study', *Diversity in Health and Social Care*, vol. 5, pp.19–30.
- Johnstone, Megan-Jane & Kanitsaki, Olga 2008b, 'The politics of resistance to workplace cultural diversity education for health service providers: An Australian study', *Race, Ethnicity and Education*, vol. 11, no. 2, pp.133–154.
- Johnstone, Megan-Jane & Kanitsaki, Olga 2008c, 'The problem of failing to provide culturally and linguistically appropriate health care', in S Barraclough & H Gardner (eds), *Analysing health policy: A problem-oriented approach*, pp.176–187, Churchill Livingstone/Elsevier, Sydney, London.
- Johnstone, Megan-Jane & Kanitsaki, Olga 2009a, 'Ethics and advance care planning in a culturally diverse society', *Journal of Transcultural Nursing*, vol. 20, no. 4, October, pp.405–416.
- Johnstone, Megan-Jane & Kanitsaki, Olga 2009b, 'Encouraging patients as safety partners: Some considerations for ensuring a culturally and linguistically appropriate approach', *Health Policy*, vol. 90, pp.1–7.
- Johnstone, Megan-Jane & Kanitsaki, O (forthcoming, online) 'Safety', Springer Science + Business Media, LLC.
- Kennedy, M.P. 2005, 'Violence in emergency departments: Under-reported, unconstrained, and unconscionable', *The Medical Journal of Australia*, vol. 183, no. 7, October, pp.362–365.
- Kiejda, J & Butrej, T 2010, 'Evolution of a multi-faceted violence prevention and response strategy in public hospitals in New South Wales, Australia', Paper presented at the 2nd International Conference on violence in the health sector, Amsterdam, 27–29 October.
- Knott, JC, Bennett, D, Rawet, J & Taylor DM 2005, 'Epidemiology of unarmed threats in the emergency department', *Emergency Medicine Australasia*, vol. 17, pp.351–358.
- Lane, M & Henry, K 2004, 'Beyond symptoms: Crime prevention and community development', *Australian Journal of Social Issues*, vol. 39, no. 2, May, pp.201–213.
- Leather, P 2002, 'Workplace violence: Scope, definition and global context', in C Cooper & N Swanson (eds), *Violence in the health sector*, pp.3–18, International Labour Organisation, Geneva.
- Lee, DTF 2006, 'Editorial', *Hong Kong Medical Journal*, vol. 12, no. 1, February.
- Linsley, P 2006, *Violence and aggression in the workplace: A practical guide for all health care staff*, Radcliffe Publishing, Oxford.

- Lyneham, J 2000, 'Violence in New South Wales emergency departments', *Australian Journal of Advanced Nursing*, vol. 18, no. 2, pp.8–17.
- Mayhew, C & Chappell, D 2003, 'The occupational violence experiences of 400 Australian health workers: an exploratory study', *The Journal of Occupational Health and Safety Australia and New Zealand*, Special issue, vol. 19, no. 6, December, pp.3–43.
- Mayhew, C & Chappell, D 2005, 'Violence in the workplace', *The Medical Journal of Australia*, vol. 183, no. 7, pp.346–347.
- Nabb, D 2000, 'Visitors' violence: The serious effects of aggression on nurses and others' *Nursing Standard*, vol. 14, no. 23, pp.36–38.
- National Health Service (NHS) 1997, 'We don't have to take this' Reference Pack, NHS Zero Tolerance Zone, National Health Service, United Kingdom.
- Ng, K, Yeung, J, Cheung, I, Chung, A & White, P 2009, 'Workplace violence — a survey of diagnostic radiographers working in public hospitals in Hong Kong', *Journal of Occupational Health*, vol. 51, no. 4, pp.355–363.
- NSW Bureau of Crime Statistics and Research (BOCSAR) 2002, *Who are the offenders?* BOCSAR, Sydney.
- NSW Health 2003a, *Zero tolerance response to violence in the NSW health workplace: Policy and framework guidelines*, Circular, NSW Department of Health, North Sydney.
- NSW Health 2003b, *Zero tolerance response to violence in the NSW health workplace, Policy directive*, Circular, NSW Department of Health, North Sydney.
- NSW Health 2003–2007, *Protecting people and property: NSW health policy and guidelines for security risk management in health facilities*, NSW Department of Health, North Sydney.
- Painter, K & Farrington, D 2001, 'Evaluating situational crime prevention using a young people's survey', *British Journal of Criminology*, vol. 41, pp.266–284.
- Paterson, B, Leadbetter, D & Miller, G 2005, 'Beyond zero tolerance: a varied approach to workplace violence', *British Journal of Nursing*, vol. 14, no. 14, pp.746–752.
- Perrone, S 1999, *Violence in the workplace*, Australian Institute of Criminology, Canberra.
- Petit, JR 2005, 'Management of the acutely violent patient', *Psychiatric Clinics of North America*, vol. 28, pp.701–711.
- Pich J, Hazelton M, Sundin D & Kable A 2011, 'Patient-related violence at triage: A qualitative descriptive study', *International Emergency Nursing*, vol. 19, no. 1, January, pp.12–19.
- Sutton, A, Cherney, A & White, R 2008, *Crime prevention: Principles, perspectives and practices*, Cambridge University Press, Port Melbourne.
- Victorian Injury Surveillance Unit (VISU) 2011, *Emergency department presentations related to violence (assaults) in hospitals, Victoria 2001–2010 (10 years)*, VISU, Monash University Injury Research Institute, Melbourne.
- Wells, J & Bowers, L 2002, 'How prevalent is violence towards nurses working in general hospitals in the UK?', *Journal of Advanced Nursing*, vol. 39, no. 3, pp.230–240.
- Wilson Security 2011, Presentation to the Drugs and Crime Prevention Committee — written notes, 10 October.
- WorkSafe 2008, *A handbook for workplaces: Prevention and management of aggression in health services*, 1st edn, WorkSafe Victoria, Melbourne.
- WorkSafe 2011, *More information about occupational violence*. Website: http://www.worksafe.vic.gov.au/wps/wcm/connectWS_MIA_OCCUPATIONAL+VIOLENCE_WEB.pdf Accessed 2 November.
- World Health Organization (WHO) 2006, *Developing policies to prevent injuries and violence: guidelines for policy-makers and planners*, WHO, Geneva.

Extract from the Minutes of Proceedings

The Minutes of the Proceedings of the Committee show the following Divisions which took place during the consideration of the Draft Report and Recommendations.

A summary of the Proceedings follows.

Monday 5 December 2011

Executive Summary and Recommendations

1. The Committee divided on the question:

That Recommendation 4 is replaced with the following alternative recommendation:

The Committee recommends that the \$21 million the Government committed to improving security in hospitals, as confirmed by Minister Ryan, be allocated over the term of this government for access by public hospitals for security improvements and that the Department of Health should administer this component of the general dedicated fund as recommended.

These Strategies include, but are not restricted to, the employment of specialist security guards, capital works, appropriate environmental and design measures, and education and training opportunities for staff.

Each hospital should determine how this money is spent according to their specific needs. However, it should be mandatory for hospitals to complete an occupational violence risk assessment before applying for such funding.

Moved: Mr S Leane M.L.C.

Seconded: Mr J Scheffer M.L.C.

The result of the Division was:

Ayes: 2 ***Noes: 3***

Mr J Scheffer M.L.C. Mr S Ramsay , M.L.C.

Mr S Leane , M.L.C. Mr B Battin M.P.

Mr T McCurdy M.P.

The question was resolved in the negative.

Chapter 1

2. The Committee divided on the question:

That the following paragraph including footnote on page 4 be deleted

The Minister was reported as saying that 'the \$21 million dollar package would be directed to easing emergency room violence, however it was not guaranteed that Public [sic] Service Officers would still form part of the final plan'.¹

Moved: Mr T McCurdy M.L.C.

Seconded: Mr B Battin M.P.

The result of the Division was:

Ayes: 3

Noes: 2

Mr S Ramsay M.L.C.

Mr J Scheffer M.L.C.

Mr B Battin M.P.

Mr S Leane M.L.C.

Mr T McCurdy M.P.

The question was resolved in the affirmative.

3. The Committee divided on the question:

That the following words, comprising the last sentence of Chapter 1, page 4, paragraph 2, *Background to the Inquiry*, be deleted:

After these media reports, the armed PSO proposal was publicly criticised by the Australian Nursing Federation (Victorian Branch) and the Australian Medical Association (Victorian Branch).'

And that the following words be inserted into page 4, second paragraph after the first sentence:

Media reports indicated that, while the Coalition had not made it a formal election commitment, it did list a \$21 million plan in its pre-election costings to place 120 armed security officers in emergency departments of hospitals. Following public criticism of the proposal from the AMA and the ANF, the Minister for Police announced that the matter would be referred to the Drugs and Crime Prevention Committee.

Moved: Mr J Scheffer M.L.C.

Seconded: Mr S Leane M.L.C.

The result of the Division was:

Ayes: 2

Noes: 3

Mr J Scheffer M.L.C. Mr S Ramsay M.L.C.

Mr S Leane M.L.C. Mr B Battin M.P.

Mr T McCurdy M.P.

The question was resolved in the negative.

1 Grant McArthur, 'Alarm on plan to put gun-carrying Protective Services Officers in hospitals', Herald -Sun 29 April 2011.

4. The Committee divided on the question:

That the following words be inserted after the first sentence of the first paragraph of the section *Scope of the Inquiry* in Chapter 1, page 5 of the Report:

In scoping the work entailed in the terms of reference, the Committee formed the view that, owing to the permanent research team being fully occupied with its Inquiry into Locally Based Approaches to Community Safety and Crime Prevention, it did not have the resources to properly conduct the new Inquiry into Violence and Security Arrangements in Victorian Hospitals and, in Particular, Emergency Departments.

The Committee agreed to approach the Speaker to seek funds to enable it to engage a consultancy but the Speaker was unable to comply with the request but permitted the Committee to employ an additional researcher. It was difficult to find an appropriately qualified researcher and the delay placed the Committee's research team under considerable pressure.

By way of example, the Committee was unable to give any attention to international evidence relating to current and proposed security arrangements in international jurisdictions, which term of reference (c) required.

The Committee was granted an extension, moving the reporting date from the 30th September to the 6th December.

As the December reporting date drew closer, the Committee sought agreement from the Cabinet Secretary to enable the Final Report to be tabled out of session to give the research team a little more much needed time to complete some aspects of the report. The Cabinet Secretary was unable to meet the request.

Consequently, the scope of the Final Report was narrower than would have been the case had the Committee been provided with adequate resources and more time.

Moved: Mr J Scheffer M.L.C.

Seconded: Mr S Leane M.L.C.

The result of the Division was:

Ayes: 2 **Noes: 3**

Mr J Scheffer M.L.C. Mr S Ramsay M.L.C.

Mr S Leane M.L.C. Mr B Battin M.P.

Mr T McCurdy M.P.

The question was resolved in the negative.

Appendices

5. The Committee divided on the question:

That the article by Grant McArthur, appearing in the Herald Sun on the 29th April 2011, headed *Alarm on plan to put gun-carrying Protective Services Officers in hospitals* be included as an appendix to the final report.

Moved: Mr J Scheffer M.L.C.

Seconded: Mr S Leane M.L.C.

The result of the Division was:

Ayes: 2 ***Noes: 3***

Mr J Scheffer M.L.C. Mr S Ramsay M.L.C.

Mr S Leane M.L.C. Mr B Battin M.P.

Mr T. McCurdy M.P.

The question was resolved in the negative.