



PARLIAMENT OF VICTORIA

DRUGS AND CRIME PREVENTION COMMITTEE

**Inquiry into Violence and Security
Arrangements in Victorian Hospitals**

Transcript of Evidence

December 2011

CONTENTS

MELBOURNE — 27 JUNE 2011.....	5
Ms E. CASSELL, DIRECTOR, AND	5
Ms A. CLAPPERTON, DATA MANAGER, VICTORIAN INJURY SURVEILLANCE UNIT (VISU), MONASH INJURY RESEARCH INSTITUTE (MIRI).....	5
GEELONG—8 AUGUST 2011.....	15
Mr P. MUNCASTER, DIRECTOR, HUMAN RESOURCES AND ORGANISATIONAL SAFETY;	15
Ms K. ACKLAND, NURSE UNIT MANAGER, EMERGENCY DEPARTMENT;	15
Mr P. DUNN, DIRECTOR, OPERATIONS, MENTAL HEALTH;.....	15
Mr D. EDDEY, DIRECTOR, EMERGENCY MEDICINE;	15
Ms D. MCNAMARA, REGISTERED NURSE, EMERGENCY DEPARTMENT; AND	15
Ms J. BOURKE, ASSOCIATE NURSE UNIT MANAGER, EMERGENCY DEPARTMENT,	15
GEELONG HOSPITAL/BARWON HEALTH.	15
MELBOURNE — 15 AUGUST 2011.....	43
Mr A. WAY, CHIEF EXECUTIVE OFFICER, ALFRED HEALTH; AND	43
Mr B. O’ SHEA, GENERAL COUNSEL, THE ALFRED HOSPITAL.	43
MELBOURNE — 15 AUGUST 2011.....	57
Mr S. THOMSON, ACTING REGIONAL MANAGER, METROPOLITAN REGION, AMBULANCE VICTORIA.	57
MELBOURNE — 15 AUGUST 2011.....	67
Mr T. CARR, CHIEF EXECUTIVE, AND	67
Mr M. CAMERON, RESEARCH AND POLICY OFFICER,	67
VICTORIAN HEALTHCARE ASSOCIATION.....	67
MELBOURNE — 15 AUGUST 2011.....	77
Dr S. PARNIS, VICE-PRESIDENT,	77
Mr B. PROSSER, DIRECTOR, POLICY AND PUBLIC AFFAIRS, AND	77
Ms E. MUHLEBACH, POLICY OFFICER, AUSTRALIAN MEDICAL ASSOCIATION.	77
MELBOURNE — 29 AUGUST 2011.....	91
Ms K. CHRISFIELD, COORDINATOR, OCCUPATIONAL HEALTH AND SAFETY UNIT (VICTORIAN BRANCH) ...	91
Mr P. GILBERT, ASSISTANT SECRETARY, AUSTRALIAN NURSING FEDERATION (VICTORIAN BRANCH);....	91
Mr P. SLOMAN, CLINICAL NURSE SPECIALIST, EMERGENCY DEPARTMENT, ROYAL CHILDREN’S HOSPITAL;	91
AND Ms L. GRAHAM, REGISTERED NURSE, EMERGENCY DEPARTMENT, DANDENONG HOSPITAL.....	91
MELBOURNE — 29 AUGUST 2011.....	105
Dr S. YOUNG, DIRECTOR, EMERGENCY MEDICINE, ROYAL CHILDREN’S HOSPITAL.	105
MELBOURNE — 29 AUGUST 2011.....	113
Professor G. FARRELL, PROFESSOR OF NURSING AND	113
Dr T. SHAFIEI, RESEARCH FELLOW, FACULTY OF HEALTH SCIENCES.....	113
LA TROBE UNIVERSITY.	113
MELBOURNE — 29 AUGUST 2011.....	123
Dr B. WILSON, HEALTH SERVICES COMMISSIONER, AND	123
Dr G. DAVIES, DEPUTY HEALTH SERVICES COMMISSIONER,	123
OFFICE OF THE HEALTH SERVICES COMMISSIONER.....	123
MELBOURNE — 12 SEPTEMBER 2011.....	131
Dr G. PHILLIPS, EMERGENCY PHYSICIAN,	131
Ms S. COWLING, NURSE UNIT MANAGER, AND	131
Mr P. CUNNINGHAM, SECURITY MANAGER,	131
ST VINCENT’S HOSPITAL.	131
MELBOURNE — 12 SEPTEMBER 2011.....	147
ASSOCIATE PROFESSOR M. GERDTZ, ASSOCIATE PROFESSOR OF EMERGENCY NURSING, AND.....	147
ASSOCIATE PROFESSOR D. HEINJUS, EXECUTIVE DIRECTOR, NURSING SERVICES,.....	147

THE ROYAL MELBOURNE HOSPITAL	147
MELBOURNE — 12 SEPTEMBER 2011.....	155
PROFESSOR M. JOHNSTONE, DIRECTOR, CENTRE FOR QUALITY AND PATIENT SAFETY RESEARCH, DEAKIN UNIVERSITY.	155
MELBOURNE — 12 SEPTEMBER 2011.....	165
SERGEANT P. RYLE, OPERATIONAL SUPERVISOR, VICTORIA POLICE.....	165
SYDNEY — 20 SEPTEMBER 2011.....	169
PROF GORDIAN FULDE, DIRECTOR, EMERGENCY DEPARTMENT;	169
MR ROSS JUDD, SECURITY MANAGER;	169
MS MEL KELLY, A/NURSE MANAGER EMERGENCY DEPARTMENT; AND	169
MR BEAVER HUDSON, NURSE MANAGER, PSYCHIATRIC EMERGENCY CENTRE,	169
ST VINCENT’S HOSPITAL, SYDNEY.	169
SYDNEY—20 SEPTEMBER 2011.....	189
MR B. DE CAIRES, CHIEF EXECUTIVE OFFICER; AND	189
MR P. JOHNSON, MANAGER, COMPLIANCE AND REGULATORY AFFAIRS, AUSTRALIAN SECURITY INDUSTRY ASSOCIATION LTD.....	189
SYDNEY—20 SEPTEMBER 2011.....	205
PROFESSOR D. CHAPPELL, SYDNEY INSTITUTE OF CRIMINOLOGY.	205
SYDNEY—20 SEPTEMBER 2011.....	219
DR L. LUCK, ASSOCIATE HEAD, SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF WESTERN SYDNEY.....	219
SYDNEY—20 SEPTEMBER 2011.....	229
MS J. EDWARDS, DIRECTOR, NURSING MIDWIFERY SERVICES;.....	229
DR R. DONNELLY, DIRECTOR, MEDICAL SERVICES;	229
MR J. JEWITT, DIRECTOR, CORPORATE AND FINANCE SERVICES; AND	229
MS T. ZARKOS, EXECUTIVE OFFICER TO EXECUTIVE DIRECTOR,	229
ROYAL PRINCE ALFRED HOSPITAL.	229
SYDNEY—20 SEPTEMBER 2011.....	241
MR D. GRUBISIC, SECURITY MANAGER;.....	241
MR D. DAWSON, GENERAL MANAGER; AND.....	241
MS S-A. REDMOND, DIRECTOR, CLINICAL GOVERNANCE, BLACKTOWN HOSPITAL.....	241
MELBOURNE — 10 OCTOBER 2011	253
MR K. MCNAMARA, GENERAL MANAGER, VICTORIA AND TASMANIA, ISS SECURITY;.....	253
MR S. MCINTYRE, GENERAL MANAGER, HEALTH SECTOR, AND	253
MS J. NICHOLSON, PROJECT MANAGER, SPOTLESS; AND	253
MR J. ROGERS, NATIONAL OPERATIONS MANAGER, AND	253
MR B. McDONALD, NATIONAL INTEGRATED SECURITY MANAGER, WILSON SECURITY.	253
MELBOURNE — 10 OCTOBER 2011	271
MR D. VAN LAMBAART, SENIOR CONSULTANT, JAKEMAN BUSINESS SOLUTIONS PTY LTD.....	271
MELBOURNE — 10 OCTOBER 2011	283
MS F. DIVER, EXECUTIVE DIRECTOR, DEPARTMENT OF HEALTH, AND	283
MR T. SYMONDS, ACTING DIRECTOR, PERFORMANCE, ACUTE PROGRAMS AND RURAL HEALTH, DEPARTMENT OF HEALTH.	283
BALLARAT—18 OCTOBER 2011	297
MR A. ROWE, CHIEF EXECUTIVE OFFICER;.....	297
DR J. CRUICKSHANK, DIRECTOR, EMERGENCY MEDICINE;	297
MR T. REINDERS, OCCUPATIONAL HEALTH AND SAFETY MANAGER; AND	297
MR R. DEKLEVA, SECURITY MANAGER, BALLARAT HEALTH SERVICE.....	297

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 27 June 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Ms E. Cassell, Director, and

Ms A. Clapperton, Data Manager, Victorian Injury Surveillance Unit (VISU), Monash Injury Research Institute (MIRI).

The CHAIR — I would like to open the public hearing and welcome our two guests, Erin Cassell and Angela Clapperton. I would like to introduce the committee. Sandy Cook is the executive officer and Pete Johnston is the senior research officer. Danielle is admin, and we have our Hansard staff.

Ms CASSELL — Taking down my every word, including my grammatical mistakes. I was very worried about that.

Mr SCHEFFER — What is worse is that they are taking down our every word!

The CHAIR — On that basis I will just read a document we have to read, given that we are recording the hearing. Welcome to the public hearing of the Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege that is provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege.

We assume you have received and read the guide for witnesses presenting evidence to parliamentary committees. We are recording evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. In finishing, we would like to invite you to provide us with a verbal submission. You can let us know whether you have a preference for us asking questions as you go through your document, which we have copies of, or going through your submission to the end and then having the committee ask questions.

Ms CASSELL — I do not mind. Whichever way suits you.

The CHAIR — We might just work through it, and if committee members have questions, perhaps they can take the opportunity to ask you. Over to you, Erin.

Ms CASSELL — I am Erin Cassell, the director of the Victorian Injury Surveillance Unit. We are funded by the Department of Health to provide reports like this on injury surveillance data in the state. We do about 300 of these kinds of reports a year for anybody who asks. It is basically a free service, but if we are asked to do something special and more extensive, we then charge out our time.

We hold two hospital injury surveillance datasets, as you see in the first paragraph of the handout — the Victorian admitted episodes dataset, which includes injury hospital admissions to all public and private hospitals, and the Victorian emergency minimum dataset, which includes injury presentations, including admitted cases, to the 38 hospitals that have a 24-hour ED service. The 38 hospitals are itemised on the back page.

We looked at both datasets and found that the hospital admissions dataset was not of much value because the code that would pick up hospitals was too broad. It is called 'health service areas', so it would pick up admissions for violent injuries to day procedure centres, health centres, hospices, hospitals and outpatient clinics. We did look at that data, but it was not hospital specific. Then we looked at our emergency department dataset, which was from the 38 major public emergency departments,

including St V's. It has the specific code for hospitals, so we could identify the assaultive injuries that occurred in hospitals. So that is the data that you have in front of you. It is only from the 38 major hospitals, not from the couple of hundred hospitals that are in the state.

The first section is on the case counts, and we found that there were 1512 ED presentations for in-hospital assaultive injury over the decade 2001–10. This would be an underestimate, because the data is collected in emergency departments and some of those 38 hospitals are good data collectors and others are not. We know that it is an underestimate. It could be as high as a 50 per cent underestimate. Unfortunately some of our bigger hospitals are not so good at data collection in the emergency department.

If we look at the table there, we can see that there is not much change over the decade. In 2001 there were 171 cases, and that went down to 140 in-hospital assaultive cases in 2004. From then on, it gradually works up again until we get to 2009, when there is a dip. We did investigate this dip in more detail: one major hospital was changing its data system and usually has about 13 or so cases a year and it only reported 1, but the rest of the difference is really just variations from one hospital to the other — random variations. There is no real reason for that dip. Then it has gone up to 159 cases in 2010. We have an average of about 150 cases a year, and there has not been much change over time. The situation according to this data is not getting any worse.

The CHAIR — But you said you have a possible variation of about 50 per cent.

Ms CASSELL — We look at the data quality from each hospital every six months, and most of them continue to provide us with roughly the same quality of data over time. Some of them improve for a little while and then they might go backwards, and so on. There was not much done to improve the hospital data in a concentrated way in those 10 years. We have not got the funding to do it. The department is more concerned with other aspects of the VEMD, which are associated with casemix funding, so they concentrate on the quality of the funding-related items on the VEMD, not the injury-surveillance items. I think it shows that the trend has not really changed much over time. When we did look at the admissions, again that did not show much change over time either, even though data are from a wider variety of health services.

Mr SCHEFFER — Sorry, do you mean overall admissions to the emergency department?

Ms CASSELL — Over the 10 years, all violence-related injuries that happened in all health services.

Mr SCHEFFER — I am not sure what the comparison is there.

Ms CASSELL — These are assaultive injuries that happened in hospitals; the other admissions dataset, not in this report, covers assaultive injuries that happened in health services, not confined to hospitals. That number did not show much variation over the 10 years either. Those pieces of evidence suggest that there has not been much change, but it is an underestimate.

Mr McCURDY — But it is probably an underestimate all the way through?

Ms CASSELL — Yes. In relation to the gender and age of the patients, about 83 per cent of the victims of assaults were aged between 25 and 54. Because of the fact that most, as you will see on the next page, are staff, that is the age range you would find of staff in a hospital. Fifty-four per cent were males and 46 per cent were females, so there is a pretty even gender balance.

If we turn to the next page, which is page 3 — —

Mr SCHEFFER — Could I just ask, in that centre column, ‘N’, what is — —

Ms CASSELL — That is the number.

Mr SCHEFFER — Right. Is that comparable to the number of people in that age cohort?

Ms CASSELL — No, it is not a rate.

Mr SCHEFFER — Yes, but what I mean is that in the 35-to-39 range there are 199 people, but if there are a lot of people employed by the hospital in that age range, does that mean there are fewer of them employed? For the age range of 60 to 64 there are only 41.

Ms CASSELL — They are not all staff. As you will see on the next page, some of the assault victims are patients being assaulted by other patients, visitors or security staff employed by the hospitals and so on. They could be older, and particularly the victims who are older have probably been assaulted by other patients. We had a look at the code, which is ‘working for an income’, to see how many of these victims were working at the time of the assaultive injury, and 90 per cent of them were working for an income. If you look at table 2, you can see the ones not working for an income — it is 1.8 per cent, so a small number were visitors and a small number were patients. Then there were 7.9 per cent where their status in terms of work was unspecified.

Each of the cases in the emergency department dataset have a narrative. It is a one-line description of what happened. Say, a nurse asked at triage, ‘What happened?’ Patients say ‘Fell down stairs’ or whatever, and then ED Staff type that into the narrative. So the narratives vary in quality also. Sometimes they just tell us what we already know: ‘assaulted’, ‘hit’ or whatever, but sometimes they are much better than that and they provide us a bit more information about what is going on.

There was no further information in the narratives of 63 per cent, of ‘working for income’ cases, telling us who the person was who was assaulted, but of those that told us, 32 per cent were working as medical and nursing staff, mostly doctors and nurses. In the narrative it says something like, ‘Patient hits nurse’ or whatever, ‘punched nurse’, ‘stabbed nurse’, ‘bit nurse’. Five per cent were security staff, mainly the security staff of the hospital, but 1 per cent were police officers who were obviously escorting the patient to the hospital or who may have been called to the hospital because of the incident.

We conclude, based on the distribution of the informative cases, that probably a high proportion of the persons presenting to the ED with assaultive injuries were medical

and nursing staff. We draw that conclusion from the percentage that we know of and applying that to the working for income cases we do not know about and the cases that are unspecified for activity.

In terms of the causes of injury, three-quarters of the patients who were assaulted were struck, including being punched, pushed onto the ground or kicked. The second major category were struck by an object, where they were hit by an item of furniture or piece of equipment — 7 per cent. Then you have a small proportion, 5 per cent, who were stabbed or bitten, so it was a cutting/piercing injury.

The next page reports the perpetrators of the in-hospital assaults. We again have to use case narratives for that, so of course the data quality is variable. In 31 per cent of cases the perpetrator was not identified. In two-thirds of cases the perpetrator was a patient; it was actually identified in the narrative that the patient was the person who committed the assault. No further information was given on the type of patient in 74% of cases. We went through all the 1500 narratives and tried to work out what kind of patients they were. Of the ones that are actually identified, psychiatric patients are obviously the major group that are committing these assaults. Then there are other specified types of patients, and those that were identified were hep C patients, usually drug-related cases; intensive care unit patients; nursing home patients; coronary care and acquired brain injury cases and people who are intoxicated (these are often in the emergency department).

Mr LEANE — Of the unspecified patients, is there a percentage known for how many of the assaults were reported to the police?

Ms CASSELL — No.

Ms CLAPPERTON — We don't have that information.

Mr LEANE — So there are no statistics about any reports or police action taken against the perpetrator?

Ms CASSELL — No, it would have to be in the narrative. The patient comes in; they write a short narrative about what happened and that is the end of the record in terms of the emergency department. There is nothing that tells us what happened after.

Mr LEANE — Whether there was any action.

Ms CASSELL — The odd narrative might have 'police called' or something, but usually it is the hospital security staff and we do not know whether they take any action afterwards.

Mr LEANE — That is interesting. Thanks.

Mr BATTIN — So the hospital does not have any record other than that one-line narrative?

Ms CASSELL — They might. They would not have it on this dataset, though. They may have their own internal dataset, because if it is staff, it would be a WorkCover case. You would probably have a WorkCover file, particularly if it is a nurse or doctor

who has been assaulted or an other staff member. No, we do not know very much more about them and what happens afterwards.

There are only a few intruders, and sometimes a staff member assaulted either another staff member or a patient — very few thankfully. The security staff were the perpetrator in a few cases, but that could be in terms of a scuffle or something that happened when they were trying to subdue a patient or whatever.

Where did the injury occur? Again, we are relying on case narratives. I am down at the bottom of the page now. It was unspecified for most cases (78%), but where it was specified around half occurred in a psychiatric ward or hospital ward, 35% occurred in other unspecified hospital wards, 13 per cent occurred in the ED and 6 per cent occurred in the hospital grounds. It is for only 333 cases out of the 1500 cases that we know this information so it could be biased. However, it does suggest that the psychiatric ward is the area where most assaults are happening. Then there are some that are out in the hospital car park.

What is the injury? About one-third of them are to the head, face and neck.

Mr SCHEFFER — So the sample could include a person who had been admitted, say, to the psych ward and they had been there for a period of time and then an assault occurred. That would not be just a person coming in fresh?

Ms CASSELL — That is right.

Mr SCHEFFER — Okay.

Ms CASSELL — Most of them are in the hospital, but it might not necessarily be the hospital where they come into the emergency department, though. They could be in a psychiatric centre or some other place. We are talking about the injured people, so they might come to the emergency department to be treated. But I would say that probably most of the people who are hurt in the hospital are members of staff of the hospital in which they are injured, so they go to the emergency department.

A third of the injuries are to the head, face and neck, and 34 per cent are upper extremity, that means the arm — they are injured in the arm. With defensive wounds in assaults you often find that it is the arm because people put their arms up to defend themselves. Then there are sprains, strains, open wounds and injuries to muscle or tendon. The only severity measure we have for those cases is whether or not they are admitted to the hospital following their injury. About 2 per cent of them were admitted, so only a small number of the 1522 were admitted to hospital. Generally speaking, the injuries are minor.

Mr LEANE — It would be hard to break down too the severity in the number of people who were admitted. You could be admitted overnight or you could be admitted for a longer stretch of time.

Ms CASSELL — Yes, that is all we know. From the admissions database we know how many days they spent in hospital, but not for the emergency department.

Mr LEANE — Okay.

Ms CASSELL — That is about all we can give you. It is the best we can do with the data that is available.

The CHAIR — Thank you. Does Angela wish say anything?

Ms CASSELL — She was here as my backup in case you asked too-hard questions. She is the data manager. I thought there may have been some technical questions.

Mr SCHEFFER — What? From us?

The CHAIR — We have a few minutes left. Do any members of the committee want to ask a question?

Mr SCHEFFER — I just want to ask about this data. Did you put this together just for the committee?

Ms CASSELL — Yes.

Mr SCHEFFER — So you have the data there. Do you feed that back to hospitals at all? Is there a conversation that goes on?

Ms CASSELL — We give them a data report on the quality of data and comparing them to like hospitals every six months. We get the data quarterly — mostly quarterly; here you are, Angela — usually.

Mr SCHEFFER — Technical question.

Ms CASSELL — From the Department of Health — de-identified — and then we have got our own datasets that we hold. We add them into our dataset and run our own checks on them. Every time we get a new lot of data — every six months — we will send back to each of the hospitals contributing data a data report which compares the quality of their data from one half of the year to the next. I write them a letter pointing out, ‘We would just love you to improve your data, and this is how you could do it’. The good hospitals are very concerned if their data deteriorates. The hospitals that provide us with poor data do not really improve it. It is to do with the culture in the hospital.

Mr SCHEFFER — Do you design the format in which the data is gathered? When you were speaking I got the impression that you had to deal with a dataset that was not ideal for you.

Ms CASSELL — Yes, that is correct.

Mr SCHEFFER — So how could you remedy that?

Ms CASSELL — The data collection system started in the late 1980s in one hospital — the children’s hospital — and it just kind of grew organically up till about 1996 when the department started to collect it in most of the 38 hospitals. They did not give hospitals any money to do that, and they allowed them to create their own software or buy off-the-shelf software, so we had a situation with all the hospitals having different software and so on. They were not really paid to collect it, so it was kind of grace and

favour. Really the Department has never been willing to put pressure on the hospitals. VISU get \$300 000 a year. We have had the same grant for 10 years. We are quite poor, and we have not really got the resources to do a lot of education in the hospitals, so what we do is send this feedback report back to them and ring them. We also send a poster that can go up in the staffroom of the emergency department so all the staff can see how good they are at collecting data. We just got a little grant from the ACCC, which is interested in product-related injuries. That has allowed one of the VISU staff to spend the last three or four months going around to hospitals and working with our worst performing hospitals and our best performing hospitals. The ACCC wants more data on products, as narratives might just say, 'Fell off trampoline'. We do not know what kind of trampoline or whatever, and there are a lot of injuries on trampolines, for example. The VISU staff member has also gone to the worst performing hospitals to present to staff and try to sort out why we are getting bad data. We have only been able to do this in the last three to six months. The data is variable. We are not satisfied with it.

Mr SCHEFFER — So you say the variation in the case of hospital assaults averages out at 150 a year.

Ms CASSELL — Yes.

Mr SCHEFFER — You do not know whether any of those fluctuations are related to changes in practice.

Ms CASSELL — I have got a table here that you did not get, which analyses each of the hospitals over time and reports how many cases they have been giving us each year, and they tend to be around about the same number of cases a year. When we looked to see why the number of assaults went down in 2009 — the number of cases went down — I found that one hospital had new software, but the rest of it was just normal variation.

Mr BATTIN — I have a minor query. You have got here the location in the hospital where the injury occurred. We have been going around to the hospitals, mainly interstate at the moment but I am sure we will see some here. The figures there, you have got 47 per cent occurred in psychiatric wards, but only 13 per cent occurred in the ED.

Ms CASSELL — Yes. Of the 333 we have got information on.

Mr BATTIN — This is all factual evidence — numbers. Have you had any information anecdotally speaking when you go out and speak to these hospitals or if they say anything different to that?

Ms CASSELL — We have never investigated particular problems with hospitals. It is sort of a research study really; it is not injury surveillance. I did not look up the literature to see if there has been any research on that issue in Australia. You could do a search and find out if there are studies in single hospitals or other groups of hospitals.

Mr BATTIN — Was that quite consistent across the hospitals that you researched where these percentages were pretty much — —

Ms CASSELL — The number of cases a year just seemed to fluctuate up and down — one or two more or less — from year to year. There were only two outstanding

differences. One was this one hospital that had fewer in that year, and the year before there was another hospital that had about 10 more than they usually record two or three and they ended up having 12 that particular year. But the rest of them did not change much. I could not find anything that suggested that there was something going on in all the hospitals.

Mr LEANE — I am going to ask the same question as Brad, in line with that. On page 4 that 333 being part thereof of the 1512, statistically speaking is that a fair enough — —

Ms CASSELL — What is it? It is about a fifth of cases, so it could be biased.

Mr LEANE — So it is hard to say that you could pin the overall results on that sort of snapshot, or it is a fair portion to give you an indication of where these assaults might have occurred.

Ms CASSELL — I would love to have half or more than half. This is a fifth.

Mr LEANE — Fair enough.

Ms CASSELL — I would be treating it with caution.

Mr McCURDY — Has the definition of an assault changed over those years?

Ms CASSELL — No, it has not. It is not a legal definition. It means the patient says that they have been assaulted by somebody.

Mr McCURDY — It is the severity. I suppose I am trying to see whether there have been any fluctuations as opposed to just raw numbers, but I do not suppose we can capture that.

Ms CASSELL — No. I only can look at the severity in the admissions dataset and the identifying code on that dataset covers a broader range of health services. We could look at that and see if that has changed over the 10 years.

The CHAIR — Are there any other data sources that you could direct us to that might help the committee?

Ms CASSELL — The only one I can think of is WorkCover, but you are with WorkCover because it is an insurance dataset. I think that the hospital staff come under WorkCover, don't they? Most or all of them do. Doctors would be included by the hospital, but if they were not employed by the hospital, they would not be covered by WorkCover; they are independent. You could contact WorkCover and find out. They might not be able to identify cases, it depends on what codes they have got on their datasets. They might have a broad code for health services or something like that. That is the only source I can think of.

The CHAIR — All right, Erin, we will investigate that and see what we come up with. Thank you both very much for your time and for presenting to the committee here today. Thank you.

Ms CASSELL — Thank you.

Witnesses withdrew.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Geelong—8 August 2011

Members

Mr S. Ramsay Mr B. Battin
Mr S. Leane Mr T. McCurdy
Mr J. Scheffer

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Mr M. Roberts
Administration Assistant: Ms D. Woof

Witnesses

Mr P. Muncaster, Director, Human Resources and Organisational Safety;
Ms K. Ackland, Nurse Unit Manager, Emergency Department;
Mr P. Dunn, Director, Operations, Mental Health;
Mr D. Eddey, Director, Emergency Medicine;
Ms D. McNamara, Registered Nurse, Emergency Department; and
Ms J. Bourke, Associate Nurse Unit Manager, Emergency Department,
Geelong Hospital/Barwon Health.

The CHAIR—Can I give a warm welcome and a thank you to those attending this public hearing. This a joint parliamentary committee of the parliament of Victoria, the Drugs and Crime Prevention Committee. We do have three registered witnesses on our list this morning. However, as I have indicated previously, we hope to have scope to also include others that wish to speak. I understand I have three extra names. Hopefully we can accommodate all six of you in relation to the two hours of time frame that we have. The committee do like to ask questions. I understand you wish to provide us with information in relation to your expertise in this reference, but also we are trying to pull out, as we go along in these hearings, information that will provide us with recommendations to parliament in relation to this reference. We do traditionally allow for the witnesses to speak and then the committee to engage in some question and answer session to draw out what we are looking for, as well as you telling us what you would like to provide for us. If you are happy with that—and Perry you are first off the rank—if we allow you time to make a presentation, given that we only have two hours and six speakers at this time, if we can perhaps ask it to be as condensed as possible in relation to your presentation and that allows us then as a committee to raise some questions about your presentation.

I do have—and I understand each of the witnesses are providing information to this hearing—that they have been given an information sheet in relation to the way the evidence is treated at these hearings. Bear with me, I have to read it out, it is part of the process. You also understand that everything that is being said at this hearing is being recorded and will be used in relation to our work as a committee in providing recommendations to the parliament. I do welcome our first witness to this hearing, Perry Muncaster who is director of human resources, as I understand. Thank you, Perry, for making your time available, and also welcome to this public hearing. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I assume you have received and read the guide for witnesses presenting evidence to parliamentary committees. As I said, we are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. I would like to invite you, Perry, to make a verbal submission and, as I said, we will ask questions as we go on.

Mr MUNCASTER—Thank you. I am here in relation to my role as the director of human resources. I have overall responsibility for security at Barwon Health as part of that role. Barwon Health is quite a comprehensive health service. Over 6,000 people are employed at Barwon Health and in 21 locations. The focus on the submission I am putting up is around the acute setting and by far over-representative, as far as security incidents or both violence and aggression incidents, is the emergency department. We, as most health services, do not tolerate violence and aggression in any form in the workplace, whether that be from patients or patients families to staff, to one another, or even staff to staff. We have a comprehensive policy which I have included in the pack.

I will briefly try and explain the process that we use for managing violence and aggression, but I need to say right now that I will leave the details of what happens in the workplace and their feelings to my colleagues who will follow me. Basically, we

have a violence and aggression policy, a comprehensive procedure process, a reporting process which is also comprehensive—and we are a very high reporting culture—and we have a large number reported. That does not mean that every incident will be reported. We also have emergency procedures and included in the pack is the extract from our emergency procedures manual, covering what are code grey and code black responses—code grey being unarmed threats, and code black being either an armed response or people that should not be in the hospital.

The process that we use to manage the violence and aggression is a progressive approach and it really starts with care plans and assessing patients, and the likelihood of violence or aggression from those patients. It is really important that we get that right because the dilemma that our clinical staff face—while we do not want them getting hurt, and they do not want to get hurt or subjected to violence and aggression, they are also there to care for these same people, and quite often those people are violent. The reasons for them being violent or aggressive can be drug and alcohol related. It could be a medical condition. Certainly once you get out of ED and into the wards, the majority of the cases there are really linked to people with some form of dementia or other mental illness. These people still need to be cared for. The way in which they are managed is all important. It is key to having a good care plan. That is the first part of it.

Then if there is any form of incident taking place, we first approach it in a calming and diffusion process to try and calm down the situation and move on. There is also a breakaway or retreat from the situation that staff are trained to do so they can get out of harm's way. The last resort is restraint. We have a program that was introduced in the 1990s by our mental health unit that is now used across the health service. It is called [MOVAIT] and we will use that name for ease. That basically takes through—trained staff—calming, withdrawal and then, if necessary, restraint techniques, to make it as safe as possible for both the staff and the patients. That is really the key to our response to a security incident.

Where an incident occurs or is likely to occur the code grey is called, which is the unarmed threat, or if someone is armed indeed it is code black. Barwon Health, in order to respond to that, has a security presence of one guard 24/7. That is a contracted in-service. That is based in the ED but covers the whole of the site. On Saturday evenings there is an additional guard employed that is based purely in ED. The security guard is backed up by an internal response team—nursing attendants—who are specifically trained for the role. They are called where violence or threat of ongoing violence occurs.

We also collect data as there is a large number of incidents reported. Within the pack there is a copy of a list of all the incidents that have been reported in the 2010-11 year with a summary. The summary is de-identified to give you some idea of what is being addressed. It can be anything from someone refusing to move from one place to another, to physical violence. There were three code black calls within the last year, and 549 code grey incidents. That is in the acute hospital alone. There were others in mental health and in other locations. The emergency department has by far the greatest number, followed by general medical wards that have older patients with medical conditions, as I said before, that can lead to this. The incidents do not occur in any particular pattern and are consistent across the days of the week. There is no real trending about when they occur. The time of day the incidents occur reflects

really the throughput of the hospital and the ED as well. There is not a magic hour where everyone goes mad. The figures do not show that anyway.

As I said, Barwon Health has a high reporting culture and we use the statewide Riskman incident reporting system to cover that. We also have backups to follow an incident in regards to supporting staff who may have been subject to this. That is completely voluntary on their part. We have in-house and we also outsource, if necessary, psychological help et cetera where the person deems that necessary.

The CHAIR—Thanks very much, Perry. I will invite the committee to ask questions. You talked about one security guard during the off-peak period, if you like, and two on the weekends, on the Saturday.

Mr MUNCASTER—Two on Saturday afternoon. As I say, there is no real off-peak period. Saturday nights are the traditional alcohol and drug times. We also put an additional one on where there are any major events, like the Cats winning or losing a grand final or whatever. Where there is some major event happening where there is likely to be an influx into ED we will put on an additional guard.

The CHAIR—The question I wanted to ask though, are they carrying any devices—weaponry—or anything to help control any violent behaviour? Are the guards armed in any manner or form?

Mr MUNCASTER—No.

The CHAIR—You talked about some of the behavioural incidents. Are they generally alcohol fuelled or drug fuelled?

Mr MUNCASTER—Kathryn can probably answer that better than I can, having worked in the environment. But drug and alcohol play a big part of the incidents in ED.

The CHAIR—I will go back to my original question and then I will move on to the other committee members. Do you see any need for a security officer being armed in any fashion in relation to helping to alleviate the risk of violence in emergency wards of hospitals?

Mr MUNCASTER—I suppose I can only give a personal view of that. I think that would pose as much risk. We still have to deal with that person in the end and as long as we can restrain that person that would be our preference. We would prefer any armed response to come from those well trained to do it, being the police.

Mr SCHEFFER—Coming back to the contracted people, the one person who is there 24/7, you said, and then an additional one on every Saturday afternoon, first of all what is the training of those people—that is one question—and how do they link in with the emergency department staff? Is that something you talk about or is that one of your colleagues?

Mr MUNCASTER—Part of it I can talk about, and part of it Kathryn can cover. We use a private security firm. They come to us trained. It is fair to say that at times there are varying degrees of effectiveness with some of those guards.

Mr SCHEFFER—Sorry to interrupt you, is it the same person? Well, 24/7 it would not be the same person obviously.

Mr MUNCASTER—No, it is not the same person.

Mr SCHEFFER—Are they the same group that are regularly assigned to you?

Mr MUNCASTER—They are but you have to take turnover of those people into account. We have guards assigned to us and we train them in MOVAIT. They are trained in that so they can link in with our techniques. They are based in ED and people in ED can get to know them, and they get to know the people in ED. I think it is best that I leave it to Kathryn to say how effective that is.

Mr SCHEFFER—Thank you.

Mr McCURDY—The incidents, the three blacks and the 540 greys, is that the last 12 months?

Mr MUNCASTER—That is right.

Mr McCURDY—Is that changing greatly from the last few years?

Mr MUNCASTER—Their numbers have increased. We used to call all those code black, and there was code black and code black AT. They were all reported as code blacks. We moved to the national standard of grey and black in May 2010, and with that we undertook a fair bit of training. We have much higher reporting as a result of that.

Mr LEANE—I think most of the questions I have probably relate to your colleagues.

The CHAIR—I want to clarify. When you said they came trained, they came trained as security guards and then you apply your MOVAIT over those security guards so that they are trained for emergency department or hospital security.

Mr MUNCASTER—That is right.

The CHAIR—Welcome, Kathryn. I am going to have to go through this information sheet in relation to the conditions around your presenting to this hearing, for the record and for Hansard. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I assume you have received and read the guide for witnesses presenting evidence to parliamentary committees. Obviously we are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. Welcome to this joint parliamentary committee and we look forward to hearing your presentation.

Ms ACKLAND—I am the ED nurse unit manager at Barwon Health Emergency. I will be speaking about the emergency department which includes our 33 staff beds and eight short stay beds. Obviously we know that the emergency departments are the highest known risk area for violence within any health care industry, and providing a safe environment is paramount to not only our staff but also patients and visitors that present to the department. Over the period from 1/6/10 to 30/6/11, we had 216 documented incidents of violence and aggression and that was documented through our Riskman system. Despite the fact that we have very good documentation on violence and aggression there is a lot of unreported incidences, for a number of reasons, mainly because staff felt intimidated to report. They feel that there would be retribution by the individual if they did report and that they are wasting people's time.

There are also incidences that are not recorded because we have been able to de-escalate the situation. If you are being abused and have managed to control the situation, we tend not to report that. The 216 are ones where we have had to have the code grey team or code black team come into the department. In terms of our emergency department we have duress alarms located throughout the area. We also have an alert system on our computer that can identify patients that have a previous history of violence, but obviously that is identifying patients that have been violent, not visitors. We have a security staff member who is present 24 hours a day, but that is for the entire hospital. They are not located all the time down in the emergency department. We also have patient service attendants and they are trained in the management of violence and aggression, so the MOVAIT.

We have a code grey team that are located throughout the hospital, and they respond if we call the emergency button. They usually take only five minutes or less to present down to ED if we need them. We also have police that we can call. However, their response rates vary and that depends on what the incidence is. We have swipe cards to access the emergency departments. All staff need to carry them. That reduces the number of patients being able to enter into the department. We have also had education for all our nursing staff on MOVAIT and that is about de-escalation techniques and communication techniques to help in situations where the patients are aggressive or visitors are aggressive.

The most common reasons that we see for violence and aggression are related to drug and alcohol and mental health issues. There is a number of reasons why people are violent and that can be waiting times, even their personal views. The biggest thing we see is drug and alcohol and mental health issues. Essentially that is my presentation. If we are going to look at preventing violence and aggression I think we need increased security presence with a staff member present 24 hours a day; increased surveillance cameras in the emergency department; aggression management training for all staff. It should be mandatory. We need to look at ways of reducing the major issues—drug and alcohol—and trying to prevent individuals presenting to the emergency department for those reasons, and looking at legislative frameworks to support staff in prevent the incidences of aggression and violence.

The CHAIR—Thanks very much, Kathryn. You answered one of the questions we would like to ask and also like to hear is how can we improve it. This is what we are here for, trying to make recommendations to parliament that reduce the

risk to not only staff but visitors, all those people involved in emergency wards, particularly any violent behaviour or potential risk. I am glad to hear, at the end, you made some recommendations personally about how to improve that safety aspect. We would also like to hear from the other speakers how we can improve the safety issues. Can I identify a bit more in detail the type of drug we are talking about. We have been to Western Australia recently where we have talked to Western Australia police, and we visited Royal Perth and another hospital and we identified abuse of alcohol related to domestic violence. The mental health wards are quite closely related to emergency wards which is creating some risk. We heard about amphetamines being a particular type of drug that the young tend to use, particularly in going out to parties.

The Geelong Advertiser, almost on a weekly basis, has a front page of someone being bashed somewhere, and the emergency wards being quite busy on a Saturday night for a whole range of reasons. Geelong—and tell me if I am wrong—does tend to have a culture of quite antisocial behaviour, particularly Saturday nights. As part of our reference we are also looking at the issue around alcohol control. I am talking about liquor retail outlets, which is a bit removed from this reference but it relates to a second reference. Again I would invite some commentary from the speakers that maybe some of the venues around Geelong are creating that opportunity for antisocial behaviour, whether it is the late hours; the number of retail liquor outlets; why are the young congregating in the malls and creating antisocial behaviour, particularly in Geelong, we are hearing, where there seems to be a problem in the CBD which the City of Greater Geelong no doubt will tell us about this afternoon. I am very happy for you to spread out the thoughts you might have in relation to antisocial behaviour in Geelong generally that might relate to our two references. Back to our original question: is the drug amphetamines an issue?

Ms ACKLAND—Amphetamines seems to be the drug of choice at the moment. There is certainly an outbreak of amphetamines. Alcohol would be the biggest one that we see. Though we see drug-related incidences, it tends to be alcohol that we see. I agree that Geelong has antisocial behaviour. This is my personal opinion. I do not know whether you need to look at closing clubs earlier or stop serving alcohol at a period of time. It is not only on a Saturday. Clubs are open Thursday, Friday, Saturday, Sunday. Some are even open at other times and that is going to continue. People will continue to behave this way because there is no retribution or no penalties associated with it, especially when they get to the hospital system they can behave in that manner because they think it is their right to behave in that manner or because they are affected in such a way by the alcohol. Because we have a duty of care to look after these people, we do not know whether it is alcohol or drug-related, or whether there is something medical going on. We treat them because we need to. Unfortunately it is only later on that you might determine that it is drugs or alcohol that has made them behave in that way.

That is fine, we have done our duty of care by giving them the best health care system but it is disappointing that it stops people reporting it. We do not feel safe in the emergency department, and certainly that is the biggest thing that staff report is that they do not feel safe, and we should be able to come to work and do our job and perform that ability. There are people coming in that stop us from doing that, and also take our attention away from other sick individuals. When they are coming in with drugs or alcohol on board they tend to be noisy and aggressive and loud, and you do

need to de-escalate the situation but also manage them and make sure that they are safe. They take a lot of our time up.

Mr SCHEFFER—I want to come back to the figures you gave—I heard them orally so I might have them wrong. I thought Perry said that over the last 12 months there was one code black and 540 code grey, and in your presentation you talked about the June to June 2010-2011, 216 incidents. Could you reconcile that for us?

Ms ACKLAND—I have had two code blacks in that period of time that I have mentioned, and 214 code greys.

Mr SCHEFFER—Is that the emergency—

Ms ACKLAND—The emergency compared to the rest of the hospital, sorry.

Mr SCHEFFER—I see, okay. Moving on from that—and thank you for clarifying that—you talked about a low incidence of reporting, and you touched on it again there about the fear that your staff have of retribution. Could you talk about how the reporting process operates and how it would be that a person who has been aggressive in the emergency department would then know about that staff person reporting?

Ms ACKLAND—Essentially the person who has been aggressive would not necessarily know that we have reported them through our Riskman system. It would only be if we decided to press charges and go through the police that they would be aware. There tends to be a lot of aggression and threats made to us that we tend not to report to the police because of that retribution.

Mr SCHEFFER—So you are talking about reporting to the police?

Ms ACKLAND—The police, but also reporting in general. We do not do it because of timing. It is time-consuming to fill out the report. Also as I mentioned before, if somebody yells at you and abuses you we tend not to report it if we have been able to de-escalate the situation.

Mr SCHEFFER—I guess the question inside that then is what is the purpose of reporting if the value of the report outweighs the time invested in making that report?

Ms ACKLAND—You can certainly identify patterns and that is very useful. We encourage our staff to report so that we can look at strategies to improve the processes. Obviously we hope to gain additional security staff. From that point of view you want to encourage your staff to make those reports.

Mr SCHEFFER—I agree with that. You are telling us that in fact the number of incidents in the report, it is under-reported, and therefore it does not give an accurate picture of the very things you are wanting the reporting to show.

Ms ACKLAND—Yes.

Mr SCHEFFER—I am putting to you, is that a concern for the emergency department that you are looking at improving both the time outlaid for staff to be writing these reports so they are not taken away from their other work, that you have a good picture?

Ms ACKLAND—They are looking at changing the Riskman reporting system at the moment to make it easier for staff to report. It comes down to personal views that you can only encourage staff so much that if they do not want to report then that is their choice not to.

Mr SCHEFFER—I guess that is debatable.

Ms ACKLAND—Yes. At this stage it is not mandatory.

Mr SCHEFFER—All right. The other thing I wanted to ask you too is that you said that in terms of possible recommendations you talked about an increase in security. What do you mean by that—increased security guards up from the one plus the Saturday, 24/7.

Ms ACKLAND—I would like to have security staff based in emergency 24 hours a day.

Mr SCHEFFER—Isn't that what happens?

Ms ACKLAND—There is one security for the whole hospital.

Mr SCHEFFER—Yes, okay. One in emergency 24/7, you think that would be a good thing. The last thing on that was that you also cited security cameras. What do you think they might do?

Ms ACKLAND—At this stage, because we do not have a security staff member based in emergency 24 hours a day, if you had security cameras, at least security would be able to view those incidences or keep an eye on potential patients or visitors that might become aggressive.

Mr SCHEFFER—It might increase the response rate, do you think?

Ms ACKLAND—Yes.

The CHAIR—Before we go on, has this been addressed to the board in relation to the extra security or the 24-hour security?

Ms ACKLAND—I do not know to be honest. That was a while ago. I am new to the nursing unit manager position.

The CHAIR—I was wondering if there was a financial concern in relation to that or some other matter that is impeding that.

Ms ACKLAND—I am sorry, I do not know.

The CHAIR—That is all right.

Mr BATTIN—Part of the focus obviously for this is we are looking—I think there was a mention of armed guards and we are getting a view on that one. If you had your security guards—at the moment they are outsourced, a company that comes in, or would you prefer trained officers who are consistently in your facility, trained for working in hospitals?

Ms ACKLAND—I think both options are good. 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. As to whether they are trained in hospital or outside, I do not have an opinion at this stage. I would like more security.

Mr BATTIN—I know in WA they had officers who were dedicated to the hospital, trained in mental health, as well as handling patients with drug issues within that environment. Would that be a preference?

Ms ACKLAND—I think that would certainly fulfil the need.

Mr BATTIN—One of the things mentioned over there was uniform or not uniform.

Ms ACKLAND—I think uniform. 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.

Mr McCURDY—There is being safe and there is feeling safe in hospital. We have heard a bit from you about the staff. I am looking for an opinion. What about the other patients in the emergency departments, how are they feeling or what is your feeling towards the atmosphere for those other patients there?

Ms ACKLAND—Certainly if there has been an incident or if we suspect that there is going to be an incident, we can move patients away. We do have an isolation room that if we needed to restrain someone that we could take them into that area which is more quiet. However, if someone is abusing you, often you do not have time to react in that manner. Ours is more a reactive strategy post the incident where we would go and apologise to the patients with closed curtains to maintain their privacy, that they are not viewing the incident. That is essentially all we can do.

Mr McCURDY—On Saturday nights and that sort of thing, is there a greater increase of incidences, for example, that there are more people that would feel uncomfortable in the waiting room, for example, and really do not want to go to the hospital because of that?

Ms ACKLAND—The violence that we tend to see is generally directed at one person, the nursing or medical staff. If we felt that it was escalating, if it happens in

the waiting room, we would not allow them access to the emergency department, and we would move the patients that are waiting to a safer area, and we can bring them into the emergency department so they are not in harm's way. I have done that before.

Mr McCURDY—That waiting room or that other room is—

Ms ACKLAND—We have two waiting rooms—three, actually. We have a paediatric waiting room and we can put patients in there with the door closed.

Mr McCURDY—It is for after-hours obviously?

Ms ACKLAND—No, it is in-hours as well.

Mr McCURDY—Okay. Thank you.

Mr LEANE—That was a good recommendation that you touched on that all staff should have some form of conflict management training and it be ongoing.

Ms ACKLAND—Yes.

Mr LEANE—In original nurse training, is there any form of that?

Ms ACKLAND—It has been a long time since I did my nurse training. Things may have changed, they may do that but, no, I do not think there is.

Mr LEANE—It is surprising there is not, considering—

Ms ACKLAND—I agree.

Mr LEANE—I thought that was a good recommendation because what you have described to us is there is more of a holistic approach that needs to be taken. You could throw in an extra security guard but that might not be the only answer.

Ms ACKLAND—For the most part we do de-escalate situations and I think nurses and medical staff are very good at doing that. Often it is about listening to the patient or to the visitor and hearing what their concerns are. Where you want the extra security staff is for those times that you cannot de-escalate the situation and they tend to be reactive straightaway.

The CHAIR—Can I quickly ask, the code grey, can you identify the type of incidents we are talking about? We talk about violent or aggressive behaviour. Are we talking about a shake of the fist or a punch in the nose?

Ms ACKLAND—I would probably say a punch in the nose would warrant a code black. A fist, I would say, is a weapon. I had a recent code grey myself at the start of the year where I was threatened to be killed with a shotgun and that was a type of code grey that I called on that patient.

The CHAIR—You call that a code grey?

Ms ACKLAND—Yes.

The CHAIR—What is a low level code grey? I thought that might have been a code black.

Ms ACKLAND—No. I would call that a code grey. That is what we would report.

The CHAIR—Someone threatening you with a shotgun?

Ms ACKLAND—Did not have a shotgun; just threatened to shoot me with the shotgun.

Mr SCHEFFER—Following on from Simon's question, what is the range? Would it be rough language? When does it move into code black?

Ms ACKLAND—It tends to be mainly swearing, and I guess body language can impact it. If you felt that things were not quietening down; if you had done everything you could to try and prevent the code grey or code black, whichever it was, and you could not de-escalate it yourself, you would call it. Sometimes we have had patients have been brought in by police as aggressive but no weapons on them. That could be because of drug and alcohol or mental health issues, and we would call a code grey immediately on them.

Mr SCHEFFER—One of the questions that we wanted to tease out was who the victim is of behaviour, such as those you are describing, and who are the offenders. You have talked about offenders being, largely, people who are affected by alcohol, in general. But in terms of the victims of that—and I am not familiar with how an ED department operates—who would be the links that would cop it?

Ms ACKLAND—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.

Mr SCHEFFER—Okay, thanks.

The CHAIR—Thanks very much, Kathryn. I was listening to the radio this morning about heroin injecting rooms. Now, I know this is a little bit off centre and you might not wish to comment. There has been some discussion in Geelong: is heroin an issue? We talked about amphetamines or alcohol. But is that a drug that is impacting on antisocial behaviour?

Ms ACKLAND—I have not seen a lot of incidences of heroin use in emergency. The ambulance staff are very good at treating it at the moment where they give the antidote as such, then the patient tends to wander off. They respond quite quickly. I have not seen a lot of heroin incidences recently but I have been off the floor for a few months. I will let David Eddey speak to you about that.

The CHAIR—Thanks very much, Kathryn. I call on Phillip Dunn who is the director of operations for mental health. I will run through this because Hansard does not recognise if you have been in the hearing or not. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and

further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have received and read the guide for witnesses presenting evidence to parliamentary committees. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. Welcome to this joint parliamentary committee and we look forward to hearing your presentation.

Mr DUNN—Thank you for the opportunity to present to this inquiry in support of my written application. I understand the inquiry's focus is very much on violence in public hospitals, in particular in ED, but Perry asked me—and I hope the inquiry panel accepts that violence does occur outside of ED. As Perry indicated this is a very large organisation, and staff work both in in-patient areas and in community based services and can sometimes be quite vulnerable in those circumstances. My name is Phillip Dunn and I am a registered psychiatric nurse. My role for approximately the last 10 years has been in management of mental health and drug and alcohol services. My title at the moment is director of operations. Among other things, I also convene and chair the Community and Mental Health, Drug and Alcohol, Occupational Health and Safety Committee for Barwon Health.

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 consequent—as the point has been made previously—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. Violence, after all, occurs in all elements of society unfortunately. Therefore the management of violence in a health service requires a very comprehensive approach. That approach certainly has to be underpinned by the values of the organisation and how those values relate and align to the policies and procedures and operational guidelines that the organisation enacts.

Also what environmental features the organisation has developed and built will contribute to the success or the undermining of the management of violence. Knowledge, attitude and skills of staff and how they relate to training, culture and the organisational values is also very important; assessment, clearly, what can be understood and predicted and how that mitigates a violent incident occurring; data collection, a point others have made also, and the analysis of that data give us the capacity to assess the reasons why that violent incident may have occurred, and also gives us the capacity to look at the information and try to improve our processes; staff reporting, staff support and also the follow-up for staff—points have been made previously, how do we encourage staff to report every incident that we can clearly use the data to understand our circumstances. Another issue I think is very important is relationships that this organisation has, both internally and externally, and valuing good communication and shared processes and commitment from all stakeholders. In particular I refer to police and emergency services in that respect.

Obviously in my written statement I have given you more detailed data but the data snapshot, I suppose, in Mental Health, Drugs and Alcohol Services—and this is not data that is ED related, this is data that is either in our inpatient services or in our community services, which is the great bulk of Mental Health, Drugs and Alcohol Services. In the last 12 months we have had 116 code grey incidents and as I have indicated we constantly also battle with an element of under-reporting. To some extent there is under-reporting because there may well be concern for retribution, as Kathryn has indicated. But also I think there is a sense at times in some staff members in particular—particularly the older staff member—that there is a degree of complacency about, 'This is part of the job and there is an element of work and extra activity required.' We constantly try to encourage them not to take that view, and analyse that and monitor that as much as we can. There are 116 incidents in the last 12 months. Half of those involve physical violence and two-thirds of those incidents were patient to staff. There were a significant amount of incidents that were either patient to patient, or patient to visitor, or patient to property, I suppose. But two-thirds of it certainly involve physical violence. The problem is real and I commend parliament for looking at it carefully.

I want to work through some of those elements. The values of Barwon Health: the stated and enacted values of an organisation provide the foundation from which the response to any issue can be understood. In this context you can expect the values that Barwon Health has of respect, compassion, commitment, accountability and innovation to be applied to the care of its staff and clients or patients as it relates to the management of violence. I want to make a point at this stage that although my statement really from this point onwards, both written and now, has a focus on the implications of violence on staff, I know that Barwon Health is very aware and active in managing violence in a manner that is very respectful and is designed, not only to protect staff but also to ensure the safety and dignity of clients and visitors. As Kathryn has indicated we sometimes do not know why somebody has been violent and would not wish to make a presumption that that violence is related to an issue that if we overlook it may lead to their physical wellbeing not well managed.

Policies and procedures: you have in your pack, I understand, a variety of policies and procedures that have the management of violence and aggression related to them; some very specifically, some less specifically. These are designed to cover the incident itself and the post-related organisational requirements. In my view they enact a value to the organisation, they aim to provide a framework that supports staff and clients. Another point I have made is environment, tools and resources we have. 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 WiFi 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.

Community staff have mobile phones. They also have operational guidelines that are designed to protect them, such as any new client unknown to the service on an initial assessment is not ever assessed by one staff member, always by two. Also staff who are working alone in evening shifts or on weekends have to call in to an on-call system to ensure that we know they are safe and well when they are knocking off. In Mental Health, Drugs and Alcohol we consider the staffing resources we have,

particularly in our inpatient areas, are adequate for care delivery. However, increasingly staff consider that despite being well trained and have good policies and procedures, and an environment that is designed for their safety and resources et cetera, that we should not presume that they are best placed and able to manage all violent occasions without the need for dedicated and specific support to call upon.

You have heard about MOVAIT. It is a very well regarded and considered training program, but it does not avoid the necessity for us to consider all other avenues to provide support for staff. The code grey and black response in Barwon Health again has been mentioned. This is a critical component of Barwon Health's capacity to manage violence. Increasingly, mental health is using these resources and this capacity to call upon those resources in what we are informally calling a pale grey response which is where we assess the likelihood or the evolving nature of circumstances, and 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. Although this approach is currently well supported in Barwon Health, the code grey and the black team are not sitting around waiting for the code to occur, they are otherwise active in important duties across the services. This requirement can be disruptive. We are conscious of that but we do feel that in certain circumstances we are justified in calling them to us to assist us.

Knowledge and skills: we have mentioned MOVAIT and I will not go over that again. Basically MOVAIT has a number of modules. The focus is very much on understanding violence, why it occurs, the triggers, how to assess it, how to de-escalate it, as Kathryn has indicated, and then in circumstances where that is not required, there are certain modules that staff can utilise to skill them in the capacity to defend themselves, break away and secure the situation and support other people in the vicinity. There are more advanced skills that the mental health staff, particularly in the inpatient unit, are all trained in and have an annual refresher which is about safely and securely and in a dignified way securing a particular client and transporting that client internally into a facility within our inpatient unit where they can be more securely managed.

Assessment, as I mentioned earlier, 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. In mental health we also use a set of guidelines called the rapid sedation guidelines. These are well considered, evidence based guidelines to support, in particular, medical staff where they are trying to make decisions about which medication would be most appropriate and effective in certain circumstances. I think it is on draft 5 but it is still operational in the sense that we are using it. It escalates up, depending on the nature of the behaviour. This is 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. In ED these guidelines may well be used by the mental health triage staff to

advise staff, but in ED the capacity to use a wider range of medication is there because of the nature of the medical resources at that particular point.

Data Collection and Review: it is really critical to collect data. We have talked about the under-reporting, but even the current reporting gives us a lot of information about the nature of the aggressive incidences and how we are managing them. It is critical to collect this and to analyse it, because in doing so you remain vigilant to the issue and you are always looking to learn and try to adapt. It is also important to compare with others in mental health. I am not sure about ED but in mental health we benchmark, we have statewide reporting and some elements of information about, say, seclusion rates, are shared on a statewide basis.

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. Perry mentioned 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.

I also mentioned relationships. Kathryn mentioned police and ambulance services who are often involved in circumstances with our client group in particular where the potential for violence or actual violence has occurred. As I have said in my statement, in the main our local experience is that their care, compassion and professionalism is exemplary. Where issues arise there are good liaison and communication processes to ensure that we both work together on examining a particular incident that may not have gone as well as we would have liked, and to learn from that experience. It is important this inquiry consider this, as the experience of the client before their delivery or arrival to our services does influence their potential for violence, particularly in the first 15 or 20 minutes. If the policeman says, 'You're only popping in to see the doctor,' and we have to tell them, 'You're staying,' you quite often get a violent incident occur. But if the police are giving them good information, accurate information, then it is less likely to occur. In the main that occurs.

The other critical relationship obviously with mental health is internally with the emergency department itself. In Barwon Health I certainly believe this relationship is very highly effective and professional, and results in a timely service, good

communication. Of course, this is very important in assessing and being responsive in a timely fashion to circumstances, to mitigate any violent incident.

In conclusion, the management of violence in a public hospital, whether it be in an ED or a mental health facility, or any other area of health service, requires a very comprehensive and service-wide response and approach. Although having specific and immediate resources at hand to respond to an incident, such as further security guards, et cetera, as it unfolds is important, and arguably fundamental, it is just as important to invest resources, time and money and supporting health service to train, equip and support their workforce to better assess and avoid violent incidences occurring where possible. This systemic investment is likely to have a greater impact on the management of violence over time and in a sustainable way, in my view, than simply in only having a reliance on additional security resources. Although, as I said, they are fundamental. Thank you.

The CHAIR—Thanks very much, Phillip. You identified the training needs. Do you see an opportunity for the state to invest in a state based program for hospital employees in relation to dealing with antisocial behaviour, or does each hospital have its own training program, or does the Nurses Federation have their particular training programs?

Mr DUNN—Certainly each hospital generally has its own training program. I do not know of any hospital that does not. There would be a great variety of the emphasis and focus on those training programs. There are specific training programs in some mental health services within those other hospitals that are not generally offered to the rest of the hospital, whereas here in Barwon Health we have adopted MOVAIT across the service, so there is consistency and an understanding from all staff who have had the training, what is happening and the responsibilities they had within that incident. Certainly I would not dispute there is an argument to have a consistent approach across the state, but probably more importantly a consistent approach and comprehensive training program within a facility that is well understood within the staff of that facility would be more important. In the event that we could sell MOVAIT to the rest of the state at an exorbitant cost we would probably be quite happy to do that.

The CHAIR—You have the IP, do you? Thanks very much.

Mr BATTIN—One thing everybody has mentioned and spoken about so far that I have heard—and I missed the first part—was the lack of reporting or the amount of the unreporting of these incidents. That obviously is a concern to get the exact figures of what is going on. In your view, why has it happened that we do not get it? I know you said the older or more experienced staff tend not to because it is part of the job. What can we get in place to get these people to report? Are they not reporting because of the lack of action over the last however many years within the hospital? Are they saying, 'We keep reporting and nothing happens, so why bother?' How can we change that view.

Mr DUNN—As I said, I think there is probably a variety of reasons. It might well be work demands at a particular time which are high, which distracts people away from doing the reporting. It may be the retribution thing at times, depending on the circumstances. It is probably likely to be a sense of complacency at times in some

staff. As I said, we do encourage staff to report. We are trying to monitor those circumstances in which they do not. I do not think staff would take the view in Barwon Health that there has been lack of action, but I do think we could probably do better, sharing information with staff. It is probably likely for them to take a greater interest in that. Making sure as an organisation—because the Riskman system, you are probably not familiar with it, but it is an electronic based system and when somebody puts an incident in, generally in a violent incident, and particularly if the staff member has been injured or believes that they may have had some psychological damage occur, usually there is an incident and it is related to the client.

The circumstances of that incident is written down, 'Joe Bloggs did this in ED, and did this in mental health.' The occupational health and safety department are monitoring those particular incidences. When they see an incident like that they will contact the staff member directly, or the supervisor, and ask them to put an incident form in for themselves. In this way the organisation can track the individual, rather than look at the circumstances of the incident itself. I think that is a very powerful, supportive, symbolic initiative from the organisation to make sure that, 'We are interested in you putting in some details about yourself and what has impacted, and we are interested in following up supporting you through that process.' I think we can do better as an organisation, perhaps sharing more information, but I do not think it would be the dominant reason why people are under-reporting.

Mr SCHEFFER—Thank you for your presentation, Phillip. I want to come in on data as well, but take the other side of it. Many of us are in workplaces where we are required increasingly to enter data about a whole range of things and you often wonder what value it serves in the end. You spoke about the importance in analysis and forming a picture that can inform and improve future practice. Can you share with us, if you know, what the data is telling us, what is going on?

Mr DUNN—In my written statement I provided some data. Maybe I will start answering that question by saying where does the data go and who looks at it, I suppose.

Mr SCHEFFER—Yes, please.

Mr DUNN—Clearly the data, in mental health, is looked at by a number of forums and committees. We have a Clinical Governance Committee that looks at the data. We obviously have an Occupational Health and Safety Committee that looks at the data in a de-identified way. We are looking at trends, we are looking at peaks and troughs, unexplained trends, those things. I have given you in the written statement 18 months of data but we have many years of data. It is difficult sometimes to assess that data because of the nature of reporting, and when Riskman was implemented obviously we had a better way to capture incidences. You could look at the next month and the data may have doubled, but it may not have indicated a particular doubling of the particular behaviour or circumstances. It tells us where the incidents are occurring. Where we see a trend what we do generally—certainly the Occupational Health and Safety Committee will do—we will look at the incident in detail and try to understand was there anything that we did or did not do that could have had an impact on the incident itself.

In mental health we encourage people to indicate in their incident reporting whether they used any MOVAIT techniques. In doing so we are trying to analyse whether we should tweak or in some way review or enhance our training. Recently we undertook a fairly comprehensive review of MOVAIT, and we surveyed staff and asked them what procedures and what theoretical base they used in their interactions with people. In doing so we were able to narrow down our training. We used to train a huge amount of physical techniques for breakaway and protection, and we have narrowed it down to a top 10 or 12 that are most commonly used. That will help us—and did help us—refocus our training program to emphasise those particular technique.

Mr SCHEFFER—In all that is there anything at all to suggest that there might be value—and I accept their values are that we should not have security people operating in hospitals. That is a value position. But is there anything in the evidence that suggests that that might in some way improve the security in the hospital?

Mr DUNN—I could only answer that in terms of my experience here in the mental health inpatient unit. In my experience I certainly have not had a situation with a patient with a weapon—and there has been many—that our training and our resources were not able to adequately manage that situation. In fact, I am wrong, I had one occasion where we had to call in police. A person had barricaded themselves in a room. That is only one occasion in over 20 years of experience. When police enter our facility we have a gun safe. We require them to remove their guns and put them in a gun safe before they enter our facility—for the same reasons Kathryn was talking about. We feel the risks are greater with a weapon being brought into our facilities than it being used in whatever way to deter or manage a particular situation.

Mr LEANE—I want to touch on two things in your presentation. What is the breakdown of personnel on the code grey team? Who are they and their roles?

Mr DUNN—The members of the code grey team here, I do not ask them what—

Mr LEANE—No, what professions are in the breakdown?

Mr DUNN—They are mostly nursing attendants.

Mr MUNCASTER—General hospital orderlies, in the old term.

Mr DUNN—The code grey team are considered experts in the technique in MOVAIT, and on occasions act as trainers in MOVAIT. The code grey team, I suppose, in orderlies—and no disrespect to orderlies—there is a capacity to perhaps remove them from their rostered and normal duties to attend to a code grey, more than there would be in other circumstances potentially. You could not necessarily have a registrar or nursing staff who have other specific duties, to be relieved of those to attend a code grey situation; whereas you can, in most circumstances, with nursing attendants or orderlies.

Mr LEANE—How many orderlies are on a code grey team?

Mr MUNCASTER—Generally there are three per shift and they would work alongside the security, depending whether it was an inpatient or an external visitor.

The CHAIR—It is difficult when we are recording Hansard when we have information coming from somewhere else. You might have to repeat what has been said in the auditorium so we can have it on record.

Mr MUNCASTER—Usually three and they will work with the security guard if he is available, and also the nursing staff and other staff at the time.

Mr LEANE—It is not necessarily the fact that the security guard will be with the code grey team if they get called for a code grey?

Mr DUNN—Sometimes it depends on timing, sometimes it depends on availability of the security guard.

Mr MUNCASTER—If it is an inpatient, generally it comes down to the internal people to handle the situation and the security is there as a backup. If it is external or whatever it is a role reversal.

Mr LEANE—It is with the internal people and working with the security guard sometimes. The other thing I wanted to touch on, you touched on—in ED—the mental health triage team. When we were in Perth one of the Western Australian doctors, one of his wish lists to improve the security at his particular hospital to perhaps have a different area separate to the ED where suspected mental health patients would be assessed and admitted or not. Do you see a potential in Victorian hospitals for that to be a good way forward in improving security?

Mr DUNN—There may well be various opinions in the organisations, and on occasions they have been debated in the organisation, but there are two places or rooms in the current ED. There is an isolation room, there is a mental health room. On most occasions we are trying to assess and protect the dignity of our clients in those particular areas, and also conscious of the impact that perhaps a noisy, disturbed, fear-ridden person may well have to the rest of the ED. Fundamentally, from my point of view, we do not believe there should be a separate mental health area in ED. We apply that rationale and that principle in the rest of our services. Our mental health community service is located with our community health services to de-stigmatise clients. Although we have clearly a zero tolerance to aggression, as Perry indicated, it is also my view that the environmental triggers can also contribute to violence. If clients feel that they are being segregated in some way or treated differently in some way, in some circumstances that may well contribute to their belligerent attitude at the particular time. I would rather, certainly some dedicated space to properly care for, without disturbing the rest of the ED, but not a segregation scenario. As I said, there may well be some different views about that in the organisation.

The CHAIR—Thank you very much for your time, Phillip. We have half an hour approximately. The committee is required to be in the City of Greater Geelong chambers from 12 to 12.30. We have made provision for three extra speakers that indicated they wanted to speak, prior to the formal part of this process. I do invite those three in order and I do so on the basis if you could make your presentation to the committee fairly brief to allow the three speakers that wanted to speak to us, that we can fit them in, in the next half hour, because there might be some questions also. We cannot take commentary from the audience. This is a parliamentary hearing that

has evidence from a witness that is under the code of parliamentary privilege. Anything said outside that is not recorded and we cannot use it. I do ask you, if you have something to say you can register with us and you can quickly come to the table and provide that information. David Eddey, your position is?

Mr EDDEY—I am director of emergency medicine.

The CHAIR—Thank you, David. I inform you that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I assume you have received and read the guide for witnesses presenting evidence to parliamentary committees.

Mr EDDEY—Yes, I have.

The CHAIR—Thank you. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. Again, bearing in mind the constraints of time, David, I will ask you to briefly provide evidence to this joint parliamentary committee.

Mr EDDEY—Thank you for the opportunity to speak. My name is David Eddey, I am the director of emergency medicine at Geelong Hospital. I have held that position for the last 15 years. I have been an emergency physician in full-time practice for at least the last 20 years. I might give my perspective on these things. I would reiterate I would support what the previous witnesses have said. I will keep this brief because I do not want to go over old ground but you might like to ask me questions to clarify. To put things in perspective, the demographics of Geelong Hospital emergency department, we had 53-odd thousand attendances last year. In the overall scheme of things, 216 code greys are relatively small incidents.

However, the main groups of patients, as we have heard, are mental health patients, drug and alcohol affected patients or combinations of the two. Also there is a group of people who are unpleasant people with personal issues or poor coping skills who find it stressful in the ED or have unrealistic expectations of our staff. You asked particularly about drugs. Alcohol is by far and above the biggest problem that we would see. However in recent weeks especially there has been an incidence of severe behavioural disturbance due to what we believe is crystal methamphetamine in the community, that is ice. On one occasion it required at least six policemen to restrain. That gives you an overall view of the issue.

Fortunately armed incidences are extraordinarily rare. I cannot recall a firearm being used in the emergency department but certainly there are incidences of knives being used against staff. The issue of who is offending, they are not only patients. Often relatives or friends are the problem because they often have unrealistic expectations of us. You did ask Phillip Dunn about having separate areas. I would concur with what he said. Although we have a specific service for mental health patients with drug and alcohol and behavioural issues, often the line between mental health and medicine is very indistinct. To have mental health patients with severe behavioural issues taken aside and out of the mainstream emergency department is full of medical risks. I am

sure you have been aware there has been incidences of patients having bad outcomes, including death, from being managed in inappropriate locations. That is one of the reasons that police no longer routinely lock up drunks because of the medical risks of having people severely intoxicated without medical care.

I think we need to define what we are looking at. Lots of incidences are purely people that are angry and upset. We would encounter those in our normal day-to-day life regardless of working in a hospital. The severe incidences which could be called criminal need to be isolated. We were talking about why people under-report. 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.

The issue of police in the emergency department, we do not have a gun safe. They come in armed. 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. We were talking about reporting, and the reluctance of people to report things, certainly at the severe end of the scale where people have been assaulted—and you need to consider what is an assault. The perception that you are at risk or going to be assaulted is an assault. Some of the reluctance is the perception of going through a court process if it happened to come to that. Personally I have pursued it, and along with some of my nursing staff, successfully.

By and large, if people realise they are going to go to court and get tied up in that process, that is a deterrent to reporting. 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.

We have talked about security presence. There is a limited security presence in our hospital some days. Certainly it is a big campus to cover for a single security person. Security presence is a deterrent and as such need to be uniformed and identified. However, I think the essence of security is that they have to be extremely well trained. This is not like standing outside a bank stopping armed robbers coming in. This is a different environment where there are a lot of people. They have to be extraordinarily well trained and sympathetic. Certainly I think the quality of security personnel varies across our experience, even to the point where some are overtly inflammatory by their presence, if not by their actions and their words. Security staff need to be well trained and handpicked for this role because it is not a standard security operation.

The other issues that the security presence might help mitigate, there are not only violence issues, there are issues of theft and other bad behaviour around hospitals from staff and also by visitors and patients. Certainly a security presence is important for that as well. Lastly, 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. That is all I want to say. Thank you for your time.

The CHAIR—Thanks very much, David.

Mr SCHEFFER—I have one quick question. You talked about on the one hand there are patients who come in who are unwell, and there is another group you described who are intoxicated and generally unpleasant. As an individual I can probably appreciate the distinction, but as a professional is that distinction easy to make, given that you are suggesting there are different ways of dealing with them.

Mr EDDEY—Alcohol masks a lot of personality traits which otherwise might not be evident, but certainly some people do not require alcohol to mask that and they are just unpleasant people. Our duty is to make sure, when they come to the emergency department, their medical or mental health needs are attended to. Up to a point though, once we have done that, you sometimes wonder why they need to stay around an emergency department. If there are legal or forensic issues that need to be addressed then the police are probably the best people to do that. Sometimes we are stuck with them because it is extraordinarily difficult to tease out what is going on. The last thing we would want to do is send someone who is physically unwell or at risk of severe illness to police cells or a mental health ward where the medical supervision is at a much lower level. Unfortunately the emergency department is the place where that gets sorted out, and the worst outcomes we would have would be for people to die in police lock-ups and mental health wards because of lack of medical care and premature discharge from the emergency department.

Sometimes alcohol accompanies patients, that is not the presenting problem. It is sometimes difficult to talk people into receiving treatment. In our experience, after-hours, Thursday, Friday, Saturday, Sunday, alcohol is, for these things, the major problem that has resulted in their behaviour.

The CHAIR—Thanks very much, David. Dani.

Ms McNAMARA—Thank you. My name is Dani McNamara, I am a registered nurse. I have worked in the Geelong Hospital emergency department for 22 years. I have been assaulted as of this year in the department.

The CHAIR—Before you go on, Dani, I am sorry to stop you. I know this is tedious but for the record, all evidence taken at this hearing—particularly in relation to this reference where obviously it has perhaps more implications than the other reference—is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have read the guide for witnesses presenting evidence to parliamentary committees. We are recording the evidence, which you understand, and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. Thank you for your time and your verbal submission to this committee.

Ms McNAMARA—Thank you. I have been physically assaulted in the emergency department and I have been very well supported by both the organisation and the police. I charged the girl that assaulted me. This is seven months ago. The court case is still pending. I encourage people to charge now. It is increasing, violence and threats—probably threats of violence and verbal assault in the emergency department has definitely increased over the years. I think it has been difficult for the police. People do not tend to go forward with reporting and charging because of the time involved, the fact that you have to do statements, you maybe had to go to court, but it is time that we all supported one another now and we did take the measures forward. I would love to see some appropriate penalties arising. I think it can be the only way that people are deterred from coming into our domain and threatening us literally. David fairly covered most other things that I was going to mention.

The CHAIR—Thank you very much. I would invite members of the committee to ask questions if they wish but we have to be mindful of the fact that this is within the courts, as we speak. We do not want to prejudice any matters before the court. I would invite the committee on that basis to ask any questions.

Mr SCHEFFER—I am a bit uncertain now that the chair has alerted us to that. My question was operational around hospital policy. I will restrict it to that, not to the immediate circumstances. What process did you go through to make your decision that you wanted to charge? You said you were well supported. How did that work?

Ms McNAMARA—I was well supported. At the time I charged this immediately. I was one of the code blacks. My incident was one of the code blacks. Police were present and I charged her personally.

Mr SCHEFFER—Because of the hospital policy it was clearly a code black category.

Ms McNAMARA—Yes.

Mr SCHEFFER—Therefore it was open to you to make the decision to press charges.

Ms McNAMARA—That was a personal decision of mine, yes.

Mr McCURDY—In your opinion, would more security in the hospital have prevented the incident?

Ms McNAMARA—Yes.

Mr McCURDY—We are all suitably chastised.

Ms McNAMARA—If we had a security guard in our department they could have possibly seen that escalation from this visitor and intervened long before it reached the assault stage.

The CHAIR—Thanks very much, Dani.

Ms McNAMARA—Thank you.

The CHAIR—Jodie Bourke. While you are getting seated, I will quickly go through this again. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have received and read the guide for witnesses presenting evidence to parliamentary committees. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. I would invite you to make your statement. Thank you. Welcome to this joint parliamentary committee and we look forward to hearing your presentation.

Ms BOURKE—Thank you. My name is Jodie Bourke, I am an associate nurse unit manager in the emergency department. I have worked in emergency departments for over 20 years. I am not really prepared, I only found out about this on the weekend, but I made some notes today. First of all, complacency about incident reporting. I think the reporting process is quite complicated and at times confusing, and while you are stressed it is difficult to do. Staff in the emergency department often play the incidents down basically because it is easier to do it that way. As David mentioned, going to court and whether you are going to be supported, you have to do all that on your own time. It is very difficult and sometimes you wonder is it all worth it. I think the staff have also lost faith in the reporting system. There is often not a lot of feedback about what happens and what comes of the reporting process.

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 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.

I had another 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. They are the points I wanted to mention.

The CHAIR—Thanks, Jodie.

Mr SCHEFFER—Given your experience, how do you provide feedback to hospital management? How do you formally as staff improve what is happening around you?

Ms BOURKE—How do I, as staff?

Mr SCHEFFER—Yes, because you have talked about the fact that staff have lost faith in outcomes and you have given us some very strong examples of what happened to you, to explain the background to that. What I am asking you is, formally speaking—I am not saying whether you are happy with it—what is the process for registering your experience to attempt to effect a change in procedure?

Ms BOURKE—With my personal experience I wrote a letter to the heads of the departments to express my shock at the lack of support I was given and I never received an answer back from any of them, I am afraid. I took my problems to my unit manager and left it with her. It is line management, and that is what I am encouraged to do. As I said, there is no follow-up, I do not know what happened from there. That is the process, you take it to your unit manager, your line manager, and they take it further. What happened from there, I do not know.

The CHAIR—Thanks very much, Jodie. Thank you all very much, the six witnesses that presented at this hearing this morning. I appreciate both the time and effort you went to, to make yourself available, and also those that put in written submissions. I am pleased that we were able to accommodate everyone that wanted to speak this morning. I thank the committee for their indulgence in allowing us to do that as well. As you know, this second reference is almost at the drafting stage. We still have a bit of work to do but I would certainly reinvoke anyone who believes we have not covered off on some of the points you wanted to raise, those of you that were not able to speak today, to provide a written submission to Danielle who is here this morning, or make contact with our office in St Andrews Place. I am sure you have the

address there, or we can give it to you. It is important we cover off on all the points you want to raise, or have raised this morning, or perhaps think we should be informed about as part of our work in taking the recommendations to parliament at a later stage. Again on behalf of the committee, thank you all very much for making your time available and we look forward to your ongoing input as we take this reference forward.

Witnesses withdrew.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 15 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Mr A. Way, Chief Executive Officer, Alfred Health; and
Mr B. O'Shea, General Counsel, The Alfred Hospital.

The CHAIR — Thank you both very much for coming here this afternoon to give evidence to this inquiry of the joint parliamentary Drugs and Crime Prevention Committee. Just before you start I will read you the witness information in relation to your providing evidence today and the grounds on which you do so. Perhaps you will bear with me for a moment while I get through this. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in the other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have read and received the guide for witnesses presenting evidence to parliamentary committees, and I see a nodding of heads. We are recording the evidence and we will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate.

Thank you both very much. I have read your submission, and I thank you for the second reference, which relates to security in emergency wards of public hospitals here in Victoria. We look forward to your evidence. I am not sure who is going first.

Mr WAY — I am Andrew Way, and I am the chief executive of Alfred Health, which incorporates the Alfred, Sandringham and Caulfield hospitals. Bill O’Shea is my legal counsel. We had hoped to have some clinicians with us this afternoon, but with clinical and educational duties they have left us to hold the fort.

The first thing to say is that Victorian hospitals — there is no such one thing; there are many, many different sorts of hospitals within Victoria that face different problems for their communities and with their communities, and I think the hospitals we have within Alfred Health are good examples of some of those differences. But with your particular interest in violence and security, we have chosen to focus predominantly on The Alfred hospital for the evidence that we are submitting, as that is where the greatest amount of potential for violent activity and violence itself occurs within our main campuses.

We start from a position that says, ‘Why is it and what is it about hospitals that create that sort of environment?’. Undoubtedly those of you who have already come into contact with hospitals during your life will agree that they are stressful times when people are attending hospitals. Even visiting a sick relative can be very stressful. Individual patients and their relatives have quite a different response to the way in which that stress affects them. Most patients manage it in a variety of completely unharmed ways. Most relatives manage it and visitors manage it in a way that does not impact on others at all. Some people find it very difficult to react to that stress without acting out in some particular way. What we have tried to do at The Alfred is to manage that — to recognise it early and to put in place strategies with our staff that mean that early recognition can create early intervention and, hopefully, dissipate the stress and the anxiety before violence actually occurs. That is a key principle of the way in which we think hospitals should work — that is, prevention is far better than cure.

What we have sought to do with our clinical staff — and the basis of our submission is to understand from the clinical staff how the things we do work for them and how the things that we do do not work for them in relation to some of the ideas that we know are floating around the system. Our clinical staff, particularly those that work in

the emergency department and the mental health services, which are the two services that have the most acute impact from violent and aggressive visitors and relatives, see the interrelationship between our in-house security service, although it is contracted out, and themselves as being an essential part of that, and they see the security service as part of the team in both instances.

Having a regular and known presence of a security team on site they would cite as being one of the key success factors to managing a violent event or a potentially violent event. The sorts of things they would cite are that the team knows what each other's responsibilities are — how the event will be handled — and also that there is a common understanding that prevention is the aim of the intervention, not holding somebody down and managing the violence once it has occurred. That is not always the case with all outsourced security services, but with ours we have managed to create that environment and that is very successful.

It is true to say that any single event of violence is more than anyone would want, and we do have more than one event of violence in our hospitals in any given period, and of course that is more than our staff are entitled to expect. We think there are things that could be done, and we have suggested some of those in our submission in terms of alternative legislative frameworks but also alternative approaches that might need some underpinning legislation to support them. We would cite the red carding system that is used quite widely in the UK as a good example of managing the expectations and experiences of patients but also protecting staff whilst managing potentially life-threatening conditions when those occur at the same time. There is a clear understanding by everybody as to what their rights and responsibilities in this regard are.

We have experience of an in-house service. We do not have experience of police or community service officers working in our environment. I personally have worked in hospitals where that has been the case; we funded the local constabulary in the UK to provide on-site police in a very different way than has been the case here in Victoria — or actually in most hospitals within England. It worked because, again, there was a consistent, known group of faces around the system that the staff were ready to work with. 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.

I am going to stop at that point in terms of adding content to the submission we have already made. I will be happy to take any questions or discussion items from you.

The CHAIR — I just have a couple of quick ones, then I will open it up to the committee. One is: are the security guards armed?

Mr WAY — No.

The CHAIR — I mean by any armoury at all?

Mr WAY — Absolutely not.

The CHAIR — Are they highly visible in uniform?

Mr WAY — Yes, they are in uniform. Those are provided by our non-clinical support service provider, and that happens to be Spotless at the moment, so they wear a Spotless security uniform, as they could do in any other part of the Spotless set-up.

Mr O'SHEA — Their office is right beside the emergency department, so it is quite visible when you check in. The security office is visible.

The CHAIR — Do they have any specific training that is quite different from normal security guard training in relation to working in hospitals?

Mr WAY — In relation to working with the Alfred staff, there is an expectation that people have gone through a range of induction activities to understand both the way in which we declare violence and prevent it and also what their role is in supporting the clinical team in dissipating violence. If it is an activity outside the clinical areas, then they are left to deal with it in a much more normal, public arena, but if it is in any of our clinical areas — so virtually anywhere inside our buildings — then they would be expected to respond to the clinical staff, who usually take the lead.

The CHAIR — This is the same question again, I know, but I need to be quite clear: would you support any security officers being armed, regardless of training, in an emergency ward of a hospital?

Mr WAY — No. Absolutely not.

Mr O'SHEA — We have consulted with the staff in preparing our submission, and the staff are adamant that they would see any arming of security guards, or indeed any elevation from the current level, as potentially making the situation worse. They are very confident in the partnership arrangements they have with the current security staff — they work hand in glove and they understand each other. I might add that the security team takes direction from the hospital. Whoever is in there, it is really important that they operate under the direction of the hospital itself.

Mr WAY — There is a general sense amongst the clinical staff that by not having armed staff on the premises you have a degree of respect that you might not otherwise get, whereas I think if we had armed staff on the premises, staff would feel that others might come in armed and ready to do battle as opposed to having some consideration for the premises they are on. There is a greater fear about staff being armed than not armed.

The CHAIR — So just in relation to the police that come in and out at the hospital, what are the requirements in relation to their revolvers there?

Mr WAY — We place no restriction on the police and their equipment coming into the environment at all.

Mr O'SHEA — They are subject to the privacy laws. The police are frequently in the hospital inquiring over fatal accidents or assaults, but they have to comply with the Health Services Act requirements on privacy. We have some guidelines between us and the police, which the former commissioner refused to sign, but we will endeavour to get the new commissioner to sign them, which is a protocol for operating within the hospital and when they need information.

Mr WAY — Most of that is to do with —

Mr O'SHEA — Investigation.

Mr WAY — consideration in investigation, as opposed to the management of violent assault.

Mr O'SHEA — They have no role, really.

Mr WAY — It is rare that we use the police in that way. They may well be called into the emergency department because we have discovered something illegal in the way in which a person has arrived at the hospital — drug dealing might be an obvious one. If it is obvious that we have a dealer on our hands, we would notify the police and then they would attend as normal. We would not take other reasons for informing the police. If the situation gets out of hand and we cannot control it — and that is extremely rare — then of course we would call the police and expect the sort of response that you would expect.

Mr SCHEFFER — Is Bill going to talk more about the amendments to the Wrongs Act and the card system?

Mr O'SHEA — I am happy to, yes.

Mr SCHEFFER — Is that something you were going to do?

Mr O'SHEA — Yes. I should say that I am merely here as the hospital's lawyer, not as Andrew's adviser. I just wanted to make that clear. We have an interest. I am Andrew's adviser, but I am here because I think there is a bit of legal input to this submission that I thought I should come and speak to.

Mr SCHEFFER — Yes. While you do, if you could talk about that a bit as part of your submission — —

Mr O'SHEA — Sure.

Mr SCHEFFER — The question I was going to ask is: the system appears to be premised on making an initial distinction between a person who is causing trouble in the way they would on the street or somewhere and a person who may be behaving in certain ways as a consequence of a condition or a circumstance that relates to why they are in the hospital for treatment. You make a primary distinction between those two categories, so just in response could just address that a bit?

Mr O'SHEA — Yes. We would say that the situation in a hospital should not be any different to the situation on the street. If someone is on the street and they are having an epileptic seizure and they are flailing around and engaging in what appears to be violent behaviour, no-one would criticise that violent behaviour. If they were on the street and they were psychotic and they were behaving the way a mentally ill person would behave on the street, no-one would criticise them or regard them as committing assaults. The same should apply inside the hospital. If they are intoxicated on the street, either by drugs or alcohol, and they misbehave on the street — for example, they hit somebody — then they are usually held accountable for that behaviour, and our submission quotes the relevant section of the Crimes Act that says that you judge them by the standard of somebody who is not intoxicated. Therefore if they are in the hospital and they are in the

same position, our view is they should be treated the same as they would be if they were on the street.

The staff at The Alfred feel that there seems to be some cone of immunity when they 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. Therefore, you have got to carefully exclude any actions that occur due to a physical illness or a mental illness, as you would out on the street.

Mr SCHEFFER — Yes, and that is really the point I am asking about — when you say ‘carefully exclude’. Out on the street people, bystanders, who are involved would be exercising a general duty of care and the police would do what the police do with their call to that incident.

Mr O’SHEA — But they would not charge someone over it.

Mr SCHEFFER — No, but they would operate under their own regulations or whatever they are required to operate under. But in a hospital, presumably the person is specifically there for treatment of some sort, so it must make the situation a bit different, and when you said you have got to carefully distinguish, that is the bit that I just wanted to invite you to unpick a bit for us.

Mr O’SHEA — I think there are a number of cases where, for example, psychiatric patients will assault nursing staff and nursing staff will want charges pressed against the psychiatric patient because they feel violated or they are off work — some of them never work in mental health again because of the injuries they sustain or the trauma that that causes them. There are cases where they have sought to bring charges. Now, when the police investigate those charges, it is pretty clear that any charge is unlikely to arrive at a conviction because of the circumstances of the mental illness and the lack of the person’s ability to form an intention to harm. You have got to look at that, and staff sometimes have to accept that it is not really feasible to charge someone in that situation because of the condition they were in.

The real issue we are looking at, I guess, is the intoxicated patient, which is the Friday night patient or the Saturday night patient who comes in and causes mayhem in the emergency department, not just to the staff but to other patients. That is a situation where you have got to say, ‘Well, is that something like someone who is psychotically ill or is it something like someone having an epileptic seizure or is it someone in a self-induced state of intoxication that they ought to know before they take that intoxicating substance could lead to a situation such as a violent episode, whether it is on the street or in a hospital?’. And if that is the case, that person should be held responsible for their actions. If they get themselves into a position where they are intoxicated, they should be held accountable for their actions. At the very least the police should be prepared to charge those people. It might be that at the end of the day there is a view that they cannot be convicted because of diminished responsibility, but let us at least put that to the test. We would like to see the police more willing to take those patients on and to put them on charges and not use the excuse that they are in a hospital seeking treatment to avoid their responsibility for the situation they have caused.

Mr WAY — I think the immediate response does not shift from the hospital based on whether the patient is obviously intoxicated or may have some underlying organic or mental illness. What we are trying to take from our staff is that they will deal with that as they can deal with it at the time. What they feel at the moment is that the balance has shifted very much towards preferring that there is no further investigation undertaken or prosecution mooted because the preference is for an underlying problem. We are thinking it should move the other way a little bit, in assuming that the person is in control unless there is obvious evidence that they are not. That is one of those balance issues for the prosecuting authorities, but our staff feel undermined in trying to manage some of the violent behaviour because there is no comeback, as they see it, from some of the events that take place.

Mr SCHEFFER — Thank you.

Mr WAY — Do you want to say something about the Wrongs Act?

Mr SCHEFFER — That is part of your submission.

Mr O'SHEA — The red card, yellow card system is a little bit different. 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. That is the situation in Luton and Dunstable that we quoted in our submission, which quotes the rules about how they operate that hospital in terms of violent behaviour. I think they can exclude them for up to a year. If you were to do that — let us suppose you put someone under a ban and said, 'You are not coming back here unless you have a life-threatening injury or illness' — does that expose the medical team to liability under common law?

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.

The staff's view would be that medical treatment is something that should be respected. Staff should be respected and the fellow patients should be respected. If they are going to come in and misbehave in that way, not due to any underlying medical condition or mental health condition, then they forfeit the right to that treatment.

Mr BATTIN — I have had a look through your submission and you talk about the red card and yellow card there, and one of the things you were talking about is prevention. Obviously that is still a reactionary process and we have got the security and everything that can remove people. Can you give us just an idea of how we could work that into a prevention method with the yellow and red card? What is the best way to get the message out there?

Mr WAY — The way that the Luton and Dunstable example takes that on is that it is very much part of the overall information that is given to patients and their visitors about how the organisation works. In addition to having a number of posters and displays saying, 'We will not tolerate violence towards our staff' it appends an issue about, 'And you may not be able to have treatment in this organisation if you continue', or words to that effect. That has got a widespread English response to the issue, but it cannot be used in isolation; it is part of an overall program. The problem with emergency departments is that you do not get much chance to create an environment in which prevention is a big opportunity. What you have to do is create an environment around the community that understands that the hospital has a way of excluding you if you misbehave. In the way that other public sector organisations have started to put the messages out that violence towards our staff is unacceptable, we would want to do the same sort of thing and include this in that information.

We have a lot of information that goes out to patients directly and to visitors. We have got public websites where you would start to incorporate this sort of information so that it became clear that you are never going to get excluded if you have a life-threatening condition, but if you have misbehaved badly, particularly if you have assaulted a member of staff, you may be excluded for a period of time. I would say the Luton and Dunstable system is well governed, so that it is not an arbitrary decision by any doctor any day. There is actually a process that has to be gone through. It is recorded very clearly and very carefully. All of the red cards are reviewed. It is quite a well-governed and risk-managed process to ensure that only the patients who are likely to be impacted are red carded or yellow carded.

Mr BATTIN — Has the program over in Luton been analysed?

Mr WAY — There has been analysis, but I cannot find a published report. We had a quick look, but I am sure the NHS will have something around that. In itself it is based on systems that are in use in other parts of Europe. It was not the first place in Europe to come up with that idea.

Mr O'SHEA — 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.

Mr LEANE — It depends on which code, doesn't it?

Mr O'SHEA — Yes. But everyone knows what red cards are. It has the beauty of simplicity. It is not a long contract you have to read; it is just yellow or red. They all know yellow does not mean you are sent off, but they know red means you are.

Mr WAY — But it can only be part of a system, it cannot be the whole system.

Mr BATTIN — That leads to the next part. You were talking about security as well. The Alfred said they are quite happy with their security structure at the moment. I believe there are other hospitals around Victoria that are not as happy with their structure at the moment because they do not have the same set-up.

When you give someone a red card, looking at the Luton example, do people just walk out? I watched Arsenal on the weekend, and they got a red card. He did not leave in a hurry.

Mr O'SHEA — But someone will help him off the field if he doesn't.

Mr BATTIN — That is what I mean. What is the element of security, and what is their involvement once the red card has come in.

Mr O'SHEA — They are not calling the legal office, I will tell you that.

Mr WAY — The rules around constraint and some of the legalities in the English system are a little different to the Victorian system. At Luton and Dunstable and others, if you are red-carded you are escorted off the premises. If you do not go, you are taken off the premises. You are then creating a trespass if you come back and can be picked up by the police.

Mr O'SHEA — And that has to be in the medical file. It is a discharge effectively against medical advice in a way, so it is tricky legally, which is why I think we need some sort of amendments to — it might not be the Wrongs Act, but it seems to me that is the logical place to do it. You will have to excuse the attempt at drafting a section of the Wrongs Act, but it does need some legislative protection. And I think the medical file would record the fact that the person was escorted off the premises for misbehaviour.

Mr LEANE — I suppose this is directed to Andrew. I want to put a personal overview about what we are talking about today and then put to you a potential acceptable end point and ask you to unpick it or not, as far as the end point is concerned. Your verbal submission was that all hospitals are different and need to be considered as different. The incoming new government had a commitment — \$50 million I think it was; I am happy to be corrected on the amount — to implement PSOs into the EDs of public hospitals, which was not accepted well in the health community. Your submission says that you do not support the PSOs going into your hospital, at least your hospital. There is \$50 million. The minister did say that if the \$50 million through this process was not used for that purpose, it would still be used for safety in EDs of staff, patients and visitors. The acceptable endpoint I want to bounce off you is that if that amount of money, if I am right, or whatever it is — —

The CHAIR — Twenty-two, I think.

Mr BATTIN — Twenty million dollars.

Mr LEANE — Twenty million dollars. All right. I have inflated it by two and a half.

Mr WAY — If you could do that with the rest of my budget, I would be very happy.

Mr O'SHEA — You can tell it is not his budget!

Mr LEANE — If that sizeable amount of money was actually made available as something that hospitals could draw on as, say, a grant application-type scenario where — just reading some of your ideas — your purpose might be around some money to maybe implement the card system or the signage that you speak about, you might apply for this particular amount of money and say, 'The Alfred would like to put in for a grant of \$1 million' — or whatever it is — 'to implement this'. As we said, it could be an improvement in safety. Another hospital might put in an application and say, 'We are asking you on the ground for our in-house security. We would like to see an extra security guard on Friday and Saturday nights, which will cost us X ongoing, so we would like to apply for a grant for that amount of money'. Some of the staff from hospitals we have already spoken to spoke about how there maybe could be improved staff training on conflict management, so they might apply for that amount of money — 'We want half a million dollars to get this education for our staff'. Do you see that as an acceptable end point of what we are talking about today?

Mr WAY — In terms of the use of the dollars, yes. I think it 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 — we could see the numbers go up because we suddenly record a lot more — so there is some clarity about what it is we are actually trying to do. I think that would be a good way forward.

My own view is that you have picked out the three things there that we would probably go for. One is around signage and communication with patients. Another one would be around training, particularly training of staff and the whole community team, and then something probably much more about this particular hard-to-manage group that we would probably want to try to do something directly with.

Mr O'SHEA — And isolation rooms. We mentioned isolation rooms as a good initiative, but it is patchy across hospitals. The Alfred has 24/7 cover. Caulfield does too, but it is aged care, and it is more about dementia and violence that might arise from dementia. Sandringham has an ED that is not quite anything like — it is a community ED, nothing like the Alfred's emergency department. The levels of security there are different. Every hospital is going to be different. I would have thought that it has to be hospital driven, not imposed from the top. One size does not fit all.

Mr WAY — Our staff would be very uncomfortable with PSOs on site as a matter of routine.

Mr LEANE — I suppose the beauty of having a pool of money that externally you can apply to and draw on is that if there was half a million, not necessarily at The

Alfred, freed up in a budget, would health professionals — not CEOs, but health professionals — be saying to you, ‘We would love an extra bed in this ward’ or ‘We would love an extra bit of equipment.’? Because of the way they are, they are driven towards the patients, and sometimes that is why in some areas of their own personal wellbeing they may put their patients first — if that is a fair thing to say.

Mr WAY — I think my experience in dealing with these sorts of issues in our clinical staff is that if you give them all the information, they will make very rational decisions. If you only give them part of it, then they will make irrational decisions. We know that our staff face aggression from patients and relatives and visitors more often than we would wish. We have an investment in that area, because we have quite a good security service, but they recognise some of the shortfall. There is a range of things that we did not fund in this year’s budget internally, so this would be part of those. If government priority is to secure the environment for staff and patients, then clearly that is where you put a bit more investment than some of the other things, where there is an opportunity to make a choice.

Mr O’SHEA — The other thing I thought I might say, which we have not said in the submission, is that our staff are incredibly non-judgemental. One of the things you notice when you work in public health, as I have for nearly eight years now, is that they accept all comers. We are not coming here today talking about red and yellow cards because we think health services should only be delivered to some Victorians and not others. They are incredibly tolerant and non-judgemental in the way they treat people. Someone could come in with a knife in their ribs and they might be one of the most undesirable individuals in the criminal world, and they would treat them just as they would treat the Governor of Victoria, if he happened to be there. It is completely non-judgemental, and I think it is important to note that.

They work in this environment where they treat anyone who walks in. The question is, ‘Should they have to do that when they are faced with self-induced violent behaviour?’. That is the issue, and I think it is probably time — given the incidence now of the use of recreational drugs and alcohol — that they should not have to put up with that in non-life-threatening situations. It is not something they are crying out for, but I think from the point of view of administering the hospital and the view of the government that is funding it, if we are looking at staff retention and staff safety, it is something we should offer them as a return for what they are offering the community.

Mr SCHEFFER — I just wanted to bounce off the suggestion there of the secure isolation rooms and just reflect for a moment on the design of emergency departments. The Alfred, down in Prahran, I am very familiar with; I go there more often than I would like to. It seems pretty well designed, except for the fact that it is incredibly boring in the waiting area — with the TV with the sound off and a water cooler and a drink dispenser, and that is it. It is an environment for people to get agitated in if they are upset in some way. I have never seen anything terribly bad happen there, but I am not there often on Saturday nights. That is one scenario.

The other scenario is at another hospital that will remain nameless, where I ended up very early in the morning, in the emergency area. The patients that came in were asked to queue up, so they were actually all standing in a row. There is a desk across a white line on the other side, and then doing a handover on the other side — the staff

that were leaving already had their coats on. It looked to the untrained eye as if they were chatting, but in fact they were doing a quick handover, which would have been better done down the back, because it just added to that sense. So design and the way staff communicate when they are very visible, which they often forget — do you have comment on that general space?

Mr WAY — Yes, it is interesting. We have been talking within The Alfred — its main ED physician group — about the use of the waiting room and what it is used for. Traditionally you come as a patient, you check in and you might be triaged or not. You sit in the waiting room. The view clinically is that that is really not what we should be doing and that the triage process should get you straight into the department, so we have been trialling off and on for some time using the waiting room as a place where relatives 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. In response exactly to what you are saying, the impression of the clinical staff leaving the service is that if patients are in the treatment area, they can see how busy everybody is and they are more comfortable waiting.

Mr SCHEFFER — Yes, exactly.

Mr WAY — An alternative response is to say — other departments have put up signs saying, ‘Your wait will be 2 hours and 45 minutes; there are 120 people ahead of you’. Those sorts of things, although very dispiriting — —

Mr SCHEFFER — Or you just need a TV monitor that shows them what is going on in the other area.

Mr WAY — Yes, so giving those sorts of cues is increasingly important in an age where people have an expectation of an immediate response to an immediate request.

Mr SCHEFFER — What about design of space that is used for — —

Mr WAY — Design is much more difficult to deal with. Most Victorian hospitals do not have the most modern of designs. That is consistent with most public health services around the world. Making those adaptations is generally very difficult in a well-established building. The Alfred is relatively lucky, because it had a major extension some years ago as part of the former program in the state, but there are things we would like to do differently with the space that we have. We are constantly reorganising it, which means that in order to get a bit more here in order to do something, you have to move three people three times in order to get this room available. It can become very expensive to make those sorts of changes, but they are necessary, and we need to think about how we make the environments we create more flexible. Isolation rooms, we think, are worth putting through that.

Mr BATTIN — Just on that, talking about design, which was brought up there, I am a former police officer from Prahran and quite regularly visited The Alfred hospital.

Mr WAY — I hope we treated you well.

Mr BATTIN — We were called down there. Sometimes it was good. Sometimes it was for my own injuries! One of the things I will say, and I think Johan brought it up perfectly there, is that when you get into a waiting room — without being rude — if you are feeling okay it is quite boring, but if you are in a position of being stressed, there is nothing to take your mind away from what you are doing. I think it was said that there is a TV with no volume, whereas the Casey Hospital has a small children's area. It still has the TV with no sound on. Is there anything that is looked at regarding hospitals to try to stimulate people's minds? Do you give them something else to think about? If you are going to wait for 2 hours, is there something else to do during those 2 hours, rather than sitting and waiting? Two hours is a long time.

Mr WAY — It is an interesting point. I am not aware of any published reports on diversion activity during waiting periods. The only thing I have seen — and I am sorry I do not have a clinician here who would be better read — is that actually a calm and quiet environment is the most important. I suspect that is the reason the sound on the TV is turned down. Whether or not that is right I think is an interesting question that we should put back to the clinical staff to ask, 'Are there things we can do to make the environment easier to wait in?'. Although, the ambition with the state and federal governments' targets in this area should be that there should not be a long wait. If you are in and out of the service in 4 hours, which is pretty much where we are headed, your wait to be seen should be minutes, not hours. If that is the case, then planning for a waiting facility, when actually you might wait for only a few minutes, is probably the wrong plan. I agree with what you are saying, but maybe the challenge is to get the wait down to something that is much more acceptable.

The CHAIR — In closing I will quickly raise an issue that has been canvassed by the other committee members. The reason the government saw fit to invest in or make provision in the budget for security in emergency wards was that there was a view at the time that there was an escalation of antisocial behaviour in emergency wards of hospitals. It was clear to the now government that some extra security or extra funding for security would have to be put in place, hence both PSOs at train stations between 6 in the evening and 6 in the morning and also additional funding for security arrangements in emergency wards. We can discuss what is best for that, but do you have data that identifies an increase, decrease or stabilisation of antisocial behaviour in emergency wards, in The Alfred in your case?

Mr WAY — We certainly have the data. Off the top my head I cannot tell you what it tells us. What I do know is that staff are much more confident in reporting the events now than they were even two or three years ago. What is difficult to ascertain is how much of any increase, if there is an increase, is an artefact of reporting as opposed to a real increase in violence. There is a perceived increase, absolutely. Through media coverage the general community believes there is an increase in violence. I suspect, if the figures show anything, that it will be a very small increase and that some of that will undoubtedly be a reporting artefact.

The CHAIR — It has been suggested to us that some of the medical staff are not comfortable about reporting incidents or they tend to underreport rather than report or overreport. Is that fair?

Mr WAY — I think that is fair.

The CHAIR — Consequently we are not seeing the true picture of antisocial behaviour in emergency wards.

Mr O'SHEA — They put up with it.

Mr WAY — We have been doing a lot of work with our staff to get them to understand why we want to know about it. It is not so that we can prosecute individuals, necessarily; it is actually so that we can understand the sorts of stresses and the environment they are working in. Giving people a clear understanding of why we want the information is helping them report it, but I am sure that we do not report 100 per cent of events at The Alfred.

Mr O'SHEA — The other issue is, though, if you look at the raw figures of, for example, the number of times security is called, it is not a measure of violence. In fact what it does is head off violence. It is not a true indicator of actual incidence. Often staff will call security because they know, for example, that the ambulance is bringing in someone who is floridly psychotic and is difficult to manage so that security will be there when that psychiatric or mental health patient arrives. There may be no incident of violence at all, but that would be recorded as a call-out of security, but it is preventive rather than responding to something that has already happened, so the data can be quite misleading in terms of a measure of actual violence that is going on. Our staff tend to be more preventive than reactive — more proactive.

Because of the partnership they have with the security staff, where they work hand in glove and their office is right next to the emergency department, they tend to head off episodes. That would be shown, for example, as the involvement of security, but it actually has not led to violence; it has prevented it. The figures are not always what they appear to be.

Mr WAY — I am more than happy to share with the committee whatever data we have, if that would be of help.

The CHAIR — Thank you both very much for providing that evidence to us.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 15 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witness

Mr S. Thomson, Acting Regional Manager, Metropolitan Region, Ambulance Victoria.

The CHAIR — Welcome, Simon, to the joint parliamentary Drugs and Crime Prevention Committee. Thank you for coming and providing evidence to this inquiry. I understand that you are very familiar with the terms of reference in relation to security arrangements in Victorian hospitals. Before you provide evidence, I need to read you the conditions under which you do so. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand that you have sighted the guide for witnesses presenting evidence to parliamentary committees; we have copies here. We are recording the evidence and will provide a proof version of the transcript at the earliest opportunity so that you can correct it as appropriate.

Once again, thank you, Simon. We are looking forward to hearing your evidence.

Mr THOMSON — I will start by giving an overview of the letter we provided to the committee. In compiling that letter we asked for feedback from our front-line operational staff via the local-level managers, so the evidence we have to offer today is derived from our front-line service delivery staff. In doing that we hope we have a relevant submission for the committee to consider.

The first of the criteria we provided the response to with regard to the incidence, prevalence and severity of violence in Victorian hospitals with particular reference to emergency departments, 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 most 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.

One comment we would make is that we are currently confronted with some significant delays in emergency departments across metropolitan Melbourne and in some major urban centres and we anticipate that that may potentially increase the occurrence of aggression expressed towards paramedics, as patients may express that frustration to the staff who are looking after them while they wait.

With regard to the effectiveness of the current security arrangements to protect against violence, with particular reference to the emergency departments, our staff report that again they find a level of satisfaction in the security arrangements at the emergency departments and that interventions from the security staff and the clinical staff within those areas has been appropriate. However, it was suggested that there may be an opportunity to consider increased staffing during peak times when we know that drug, alcohol or other substances may influence the behaviour of individuals, with specific reference to Friday, Saturdays, during the evenings and public holidays.

With regard to the arrangements for security across Australia internationally and the appropriateness of the Victoria Police protective services staff, ambulance paramedic staff report that the arrangements from our perspective appear to be satisfactory in an overall sense and that other than the things we have mentioned in terms of potentially increasing security presence during periods of peak demand and periods when we know that persons will present affected by alcohol or other drugs, there were not any significant advantages to having protective services officers or other staff available to manage it. We did receive feedback relating to the fourth area we responded to that there is a particular team at the Alfred hospital that deals with an aggression management response to those types of incidents. That had proven particularly successful in that facility, and the paramedics provided positive feedback from their experiences with that particular group. Some of our staff expressed concern that the addition of protective services officers may in turn be counterproductive to the management of aggressive or violent patients, although they did not provide any further comment as to why that might be the case.

The other comment we had was around emergency department design and potential opportunities we may have to ensure we do not create situations where our paramedic staff might be by themselves and not be easily viewed while they are preparing the ambulance to respond again while their partner and the patient is inside the facility, be that via CCTV or by other staff, and potentially be exposed to aggressive behaviour on the part of any person who might come into that area. There are a number of emergency departments across metropolitan Melbourne that have enhanced security measures, including CCTV. I am aware that the Royal Melbourne Hospital, for example, has a duress alarm as well within its ambulance bay area. Our staff have reported that they have found those arrangements to be quite successful.

In areas where the emergency department ambulance interface point is very open to the public they report that they see members of the public wandering into that area and that often it is used as a redundant smoking area for patients at the hospital because for the most part it is under cover to protect people from the elements. That constituted our submission in writing to the committee.

The CHAIR — Thank you very much.

Mr LEANE — From an uneducated generalist view, is it fair to say that as far as safety is concerned, ambulance paramedics feel more exposed at the pick-up end of the journey compared to the end of the journey where they are at a hospital and where it is a bit more of a controlled environment?

Mr THOMSON — I think that would be a fair representation. It is very much contingent on the type of case you attend. The nature of the work of paramedics is that they work in a very dynamic environment. We encourage them to be very cognisant of their own safety, so I think that impacts on the dealings they may have. Obviously it might also depend on the type of the case they may attend; some cases have a propensity to violence more than others. I am sure that if it was an elderly patient who had a fractured NOF, they would feel less anxious about that patient than they would about a patient who maybe was drug or alcohol-affected and was known to have violent tendencies. But in a general sense ‘Yes’ would be the answer to your question. In an emergency department, where there are other people around and certainly security staff

and other clinical staff to assist in managing aggressive people, we would feel safer in that environment.

Mr SCHEFFER — You said in the submission that there is not really an issue around violence as far as your part of the work is involved. Why do you think that is the case?

Mr THOMSON — I suppose we are saying there is an issue around attendances at the emergency department. Obviously there is another conversation about violence —

Mr SCHEFFER — That is when it is off your hands, though, isn't it? Yes.

Mr THOMSON — The feedback we had from our front-line staff is that the current arrangements are adequate.

Mr SCHEFFER — What is good about them, though — to drill down into that?

Mr THOMSON — I think there are a number of points. One is obviously the strength in numbers. You are in an environment where there are other people. I think the response from the security staff generally in the hospitals across Victoria has been positive; they have been of assistance. Paramedics are also trained to deal with violent and aggressive people; that makes up a portion of their normal work environment in many senses. De-escalating someone who may be becoming aggressive or violent is something we would expect them to be engaged in, and having additional people to assist them with that could only be advantageous.

Mr SCHEFFER — How do you do that?

Mr THOMSON — In terms of how you de-escalate?

Mr SCHEFFER — Yes. If someone is presenting to you, as you mentioned before, with an alcohol-related condition where they are not stable, how would your people manage that?

Mr THOMSON — I suppose it is on an escalating scale. Verbal de-escalation, encouraging people to be calm; and looking for strategies in terms of taking them away from stimulants that might be encouraging them to be aggressive or violent. Often other people can contribute to behaviours, so removing them from that environment. We need to help them, so often our mantra is, 'We're here to help you. We'd like to help you. If you don't want us to help you, then we won't'. We want to make sure that that patient understands we are there to assist them, to an end point where, if the patient became aggressive and there was a clinical need, we would administer sedation essentially to chemically restrain them to prevent them from continuing if it got to that point. That is very much an end strategy, but there are occurrences where we have to do that in an effort to safely transport patients to hospital. For the same reason, if that behaviour then occurred in a hospital, we would expect the clinical staff within the hospital to assist us in doing that. We will sometimes do that before unloading them in an effort to make it safe, or if they escalate their behaviour in the emergency department we would expect the clinical staff within the department to intervene and assist.

Mr BATTIN — I just have a query that came out because you are wearing your uniform in here today. You are saying that ambulance drivers tend to have less issues

with patients once they get to the hospital and you do not see that at the moment there is a need to change the security setup at the hospital. Do you think part of it is that — I suppose I am asking your view here — all ambulance drivers wear a uniform, whether it is the blue one or the green for the students you see out there, whereas hospitals over the years have gone away from uniforms and more to corporate or even sometimes casual clothing for staff whilst they are working in the emergency departments and other parts of the hospital? Can you see that that would have an effect on the authority figure?

Mr THOMSON — Potentially. Paramedics wear a uniform and undergraduate students when they are observing wear the green. It depends which hospital it is, of course. A lot of the clinical staff within hospitals wear scrubs these days, which is a single-coloured, theatre-type garment. It tends to be a shirt and pant, which will often have the logo of their department on it. My experience would indicate that the security staff in most emergency departments do wear the uniform and are identifiable as being security personnel. Obviously it would vary according to which hospital it is, but for the most part in the emergency departments, particularly the larger metropolitan hospitals, the clinical staff wear scrubs, so it does make them identifiable. I suppose then they are also identifiable to the patients in that they belong to and work within that department; they are not a member of the public.

The CHAIR — From your viewpoint do you get the feeling that there is an escalation in the level of antisocial behaviour in emergency wards? Could you perhaps identify the types apart from alcohol — that is, drug related — heroin or any other substances that are creating an increase in it, if you see an increase?

Mr THOMSON — I think we are looking specifically at narcotic overdoses like heroin. Our experience would indicate that if those patients are managed well, we very rarely ever take them to an emergency department, so not many of those patients would present there. For the most part our experience is that those patients are reasonably compliant. It is very much contingent on how you deal with them and how you manage them.

I think that one thing we probably need to be mindful of is the growth within the health sector in terms of the number of patients who present. The growth in the number of cases that our ambulances go to sits at around 6 per cent annually. We are certainly seeing more instances. I think there is a question about whether on a percentage basis that is dramatically more than 10 years ago, and I do not have that answer. My feeling would be that there seems to be a heightened level of awareness and probably less tolerance of poor behaviour. Certainly from our industry's point of view we encourage our staff to be clear about their expectations around behaviour, and I think for the most part hospitals have done the same thing as well.

In terms of occupational violence, I think there is a lower level of tolerance among staff who work in the industry and in the emergency departments. Consequently I think we see that reporting has increased, and we have a heightened awareness of making sure we manage those circumstances well. As an organisation we are certainly very aware of occupational violence and the implication that has for our staff. I think the emergency departments certainly have a heightened level of awareness as well.

The CHAIR — What would be the main activity or the main stimulant in relation to antisocial behaviour? Is alcohol the main cause of antisocial behaviour?

Mr THOMSON — My experience would suggest that yes, that is the case. We know that the weekends are considerably worse. When people do not have to work the next day they tend to be more inclined to party. We see a variety of other substances that are used that can result in those types of behaviours. Some of them are illicit and illegal substances like amphetamines and stimulant drugs. Certainly the chance of having someone who would escalate their behaviour is much higher in those circumstances — people who may be taking depressant-type drugs like benzodiazepines; Valium is an example. Again, I think we have a heightened level of awareness around those patients and tend to be very cautious and make sure we do not put ourselves in a position where their behaviour might escalate.

I think alcohol probably remains the biggest single factor in terms of the prevalence of antisocial behaviour. My experience operationally would suggest that is the case. Certainly the feedback we have from our staff would indicate that alcohol is a considerable factor in terms of antisocial behaviour.

The CHAIR — Just on that, if I may, and then I will open it up to the committee: we are dealing with another reference in relation to community safety programs and looking at a number of issues that occur in an unsafe environment. Alcohol seems to be the factor all the way through the submissions we have had, and also the use of amphetamines, particularly by the young. They tend to fuel up before going out, and then they use amphetamines to, I guess, create a high. In your experience, is the use and overuse of amphetamines and alcohol as a mix trending upwards, particularly for the young? How do we control that? We have a responsibility to report back to Parliament with some recommendations to try to reduce the risk to the community in relation to the abuse of substances, and alcohol and amphetamines seem to be the ones that are a continuing factor.

Mr THOMSON — I think poly-substance abuse is something that is very common. From an ambulance point of view, I often give this advice to patients: if you are going to use something, perhaps just one at a time would be somewhat helpful. It makes it a little bit easier for us in terms of determining what you may or may not need to do with somebody. I think access to stimulant-type drugs has perhaps improved. One of the things we have certainly noticed with narcotic drugs is that there are obviously various mechanisms to restrict access to them through customs and policing, and that has meant that the amount of time we spend dealing with those types of overdoses in the community has decreased significantly. I started in the ambulance service in 1999 at the height of the heroin scourge. I worked in Footscray. One day we ran out of Narcan, which is the antidote drug that we use for heroin overdoses. That certainly does not seem to be the case now. I think the prevalence of the use of that drug has decreased as other options and other drugs have become more in vogue.

The stimulant-type drugs are certainly there. I am mindful that there would be a lot of people in the community who may very well be taking them, but obviously we still only see a small portion of people who may be having issues with them. The addition of alcohol, stimulant drugs and depressant drugs in many senses becomes a balancing act for that person physiologically, and I think that contributes to some of the behaviour that we see. One starts to work, but the other is not effective, so they take more, and it goes on like that to the point where we see patients who perhaps have been taking both sorts of substances for a number of days and have not been to bed. I think all of those factors contribute to potentially poor behaviour and bad judgement.

It may be violence related or it may be about choosing to get into a car or maybe it is about choosing to walk across a train track, all of which end up with fairly poor outcomes for that individual.

To that end I think we would agree that there is an increased prevalence. I do not have the data in front of me. Turning Point, that we do some research with, produced a report yesterday, which was reported in the media. It talks about the prevalence of drugs in the community based on ambulance presentations. I am sure the committee would have access to that if they wished to review it.

The CHAIR — One last one. We had a presentation last week from a city council that was concerned about the increasing use of heroin particularly, in the streets in the daytime. There was some discussion about whether a vehicle for turning it around would support legalised heroin injecting rooms to try to remove the traffic from the streets into areas of some control. In fact I had a discussion with a doctor over the weekend who strongly supports the use of legal heroin-injecting rooms. He used as an example the prohibition on alcohol back in the dark days of the Mafia. The moment it became legal of course a lot of that traffic went away. Do you have a view, or does your association have a view about legal injecting rooms for heroin in particular?

Mr THOMSON — I think we would always have a view and rather than talking about legal injecting rooms, as an agency we would support harm minimisation. That is obviously one of the opportunities that exists around how you minimise harm in the community. I think we consider it a travesty that anyone may die when associated with a drug overdose. We should consider mechanisms by which we can reduce the risk associated with that. In itself heroin appears at this juncture to be less of an issue than perhaps it has been historically, and we would be supportive of exploring any options and opportunities that exist in terms of minimising the risk to individuals and to the community in terms of behaviour.

It is devastating for family members and the community generally to see that people might die as a result of a drug overdose, which is relatively simple to reverse with an antidote called Naloxone. The advantage of concentrating people in a place is that, potentially, you can improve their access to it and if they do happen to overdose, there is someone around who can help them. We are very fortunate; ambulance response to life-threatening cases in Victoria on average is still around 8 or 9 minutes, so we certainly do reverse lots of heroin overdoses we are called to.

If the government was to consider injecting rooms, I would suggest that the benefit would be around the harm minimisation aspect of it and potentially being able to make lifesaving interventions available to those individuals at the time they overdose. Ensuring they are with other people is the other catalyst. If someone was to use heroin and not have anyone with them who might be able to call for assistance, then their chance of survival, should they overdose, would be very low.

Mr SCHEFFER — Simon, can I just bring you back to your submission and to the remarks you made in your introduction? I refer to the last part, where you talk about the possibility of developing what you call ‘specific aggressive management teams’. Could you explore a bit more with us how that might be structured, what it might do and what its benefits might be, if that has been worked through at all?

Mr THOMSON — My understanding, which I must admit is at a fairly macro level, is that the Alfred hospital has a strategy — and I think Barwon Health has a similar strategy — whereby they specifically train staff within that hospital to deal with aggressive and violence incidents. That involves, as I said before, an escalation process whereby we attempt to talk people down.

Mr SCHEFFER — Is that over and above their security people? Is it separate to that?

Mr THOMSON — I think it is in addition to. I do not know whether the security staff at the Alfred hospital are trained in it. I do not have that level of detail. The experiences that were offered by paramedics who responded to our request for information for the committee were that where that it been deployed, they had found that to be very successful and a more safe way to deal with someone who was escalating their behaviour within an emergency department. I believe the program at Barwon Health might be called MOVAIT, which involves a set of strategies to deal with escalation and then physical intervention. My understanding is that the arrangement at the Alfred is somewhat similar to that, but I do not have the detail. Should the committee desire it, I think the Alfred would be in a far better position to talk to it.

Mr SCHEFFER — Moving back from there, in your submission you say, ‘While there are increased delays in admission of patients to EDs’ — and you have mentioned that before — ‘there is ongoing potential for agitated patients to require aggression management even prior to ED admission’. You have said that overall it is pretty stable and that as far as your colleagues are concerned and the service you provide, it is pretty low and things are under control. But a few times in your submission you have said that there is a potential for increase. What do you base that on — that you are hovering on something around the corner?

Mr THOMSON — I think what we are referring to is that if 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.

Mr SCHEFFER — So in relation to the policies of the government to minimise or to reduce the turnaround time to a matter of minutes — I cannot remember exactly what it is, but it is a very short turnaround — you do not see evidence of that taking effect? And do you think it is possible?

Mr THOMSON — The current situation in terms of ramping — which is the expression that we use in hospitals in Victoria, particularly in metropolitan Melbourne — is that that has continued to deteriorate over the last three years. Our average time waiting to access beds in hospitals is currently continuing to deteriorate. There are facilities in Melbourne where that average is in excess of 40 minutes, during which time the paramedics are delayed waiting to access a bed for a patient they have. There are examples that run into the hours. We continue to work with — —

Mr SCHEFFER — You do not mean that you are unable to move the patient?

Mr THOMSON — Yes, that is exactly what I mean. The patient may be in the emergency department but waiting on an ambulance trolley with two paramedics attending to them while we wait for access to a bed within the emergency department.

Mr SCHEFFER — So during those 40 minutes are your colleagues able to keep the patient calm?

Mr THOMSON — Yes.

Mr SCHEFFER — But are you saying that that is potentially not controllable?

Mr THOMSON — We see that that example I was giving of 3 hours adds risk, and there are examples of longer. I think there is a potential for patients and their families to become increasingly agitated about the wait they are confronted with. If they become agitated, there is obviously an increased risk of aggression.

Mr SCHEFFER — Do you see that wait time or that ramping, as you call it, as continuing to escalate now, even as we speak?

Mr THOMSON — Absolutely, and the minister and the government have implemented measures. There is a new performance measure of 40 minutes at the 90th percentile to transfer patients from the ambulance service care to the care of the hospital. However, we continue to experience significant pressure associated with ramping and delays at hospitals.

Mr SCHEFFER — Despite that requirement, you have seen no change?

Mr THOMSON — It has deteriorated.

Mr SCHEFFER — Got worse. Thank you.

The CHAIR — Thank you very much, Simon. We appreciate your time in presenting to the committee this afternoon.

Witness withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 15 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Mr T. Carr, Chief Executive, and
Mr M. Cameron, Research and Policy Officer,
Victorian Healthcare Association.

The CHAIR — Welcome to you both, and thank you for making a submission to our second reference in relation to security arrangements in Victorian hospitals. Prior to you giving evidence I will quickly read the conditions under which you will be providing evidence to this committee today. All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975. It is further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege.

I understand that you have, or have at least sighted, the guide for witnesses presenting evidence to parliamentary committees. We are recording the evidence, and you will be provided with a proof version of the *Hansard* transcript at the earliest opportunity so that you can correct it as appropriate. Thank you again, and we look forward to hearing your evidence.

Mr CARR — Thank you for the opportunity, and thank you for the interest of the Parliament in this topic. Violence and security arrangements are terribly important issues for us to consider and take some action to prevent to the extent that we can. In terms of the terms of reference there is a focus on emergency departments, and I will start our conversation with an indication that our belief is that this is much broader than just emergency departments and that if the committee has any opportunity to reflect upon that at any stage, it might like to consider that the issue is genuine throughout the health-care system.

You have received our written submission, and I do not propose to go through that in any length and bore you to tears but rather to cover off a number of the matters we think are really important to highlight. One is the need to make sure that we retain as many health-care professionals as we can within our industry. Obviously, amongst other issues security arrangements and the sense of protection that staff have within hospitals are important elements in our overall retention strategies and are things I think we need to remain very mindful of.

We do not collect specific data in regard to this matter, so the information we are providing is in response to an invitation we gave to our members to contribute their own experiences to us through a voluntary process. We then wrapped those contributions up into our formal submission. The Victorian Managed Insurance Authority and WorkCover probably have more specific data in terms of the prevalence of security breaches and violence in hospitals; we do not have that specifically. Suffice to say that anecdotally our members indicate to us that these issues are on the increase, and we are therefore very happy to see the interest of the Parliament in addressing violence in the workplace in terms of hospitals.

The reason I said before that it is not just an emergency department issue is that we hear of many examples of situations within the hospital wards where codes are called on a regular breach — that is, security breach code calls for assistance. That can be in any environment from a medical ward, to a mental health unit, to a critical care unit, to goodness knows what. The issues are not always directly patient to staff; they can be family to staff and they can be family-to-family skirmishes. There can be a whole range of different indicators that bring about a sense of breach of the secure environment, if you like.

Our members also raised with us that from time to time there are patients who are escorted by police for hospital services, and a matter that might need to be considered is the communication arrangements or whether there is a specific protocol required in those instances. I am not suggesting that this is characteristic of every single occurrence, but our members have indicated to us that from time to time there is a failure of communication that occurs whereby a police escort arrives and the agency is quite unprepared for that. It can plan for that arrival and deal with the presentation in a different way if it knows it is coming.

Training is a significant issue. 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. Even if you have security 24/7 on site, you might have a site that covers several acres of ground mass and has wards spread across all of that ground mass. You cannot have security on every single ward — we accept that — but we think there is a need to consider volume and likelihood and therefore provide some funding to support the range of activities that an agency might be providing.

Mr McCURDY — Is that for the security staff or the other staff?

Mr CARR — For security staff to support other staff. At the moment, you cannot expect a nurse to undertake security duties. You cannot necessarily expect an administration person to undertake them, but in a lot of instances they are the ones who end up needing to deal with a situation in response to a code call. At the moment a nurse will call a code if there is a breach of the propriety or the security in the area. They do not know whether the security support will come straightaway or not, so they just need to continue to deal with the environment they have right in front of them and make the rest of the area as secure as possible for the staff, patients and visitors in that area. I think training is an issue in having the right mix of training for non-security staff, but we also need to have security staff who are purposely trained for the environment of hospitals. We do not want people to feel like they are criminals every single time they might breach security, so it is a fine balance.

I was up in Mildura last week, and I will not quote the organisation — it is probably self-evident now because I mentioned Mildura — but I was at a dental clinic that is quite new. One of the unexpected advantages that it received from this new infrastructure was that the violence or verbal aggression demonstrated by its patient group dropped. The only thing they can put that down to is the new environment; going from an old facility to a new facility, people are obviously feeling better about themselves. The verbal aggression at reception has dropped quite significantly for them. These sorts of issues around infrastructure — for example, video monitoring equipment or the presence of people who look like they are authority figures from a security point of view — all build together, I think, to sort of get the message across that, ‘This place is well monitored, and you need to behave yourself and in an appropriate manner’, but it does not always quite work that way.

The other issue that was raised with us was that sometimes there is an inconsistent approach as well. We had a story told to us about mental health clients who might

actually have restraining orders on them from the point of view of receipt of care, where they need to actually receive care in the company of an officer. They can then go to another facility and receive a completely different sort of care. They are just as much at risk of causing a violation within that facility as they would be in the one in which they needed to be accompanied. I am not sure how we overcome the privacy issues around knowledge and what sort of constraints might be placed upon a person who needs to be accompanied, but it is inconsistent at the moment. Certainly some of our community health service members, who do not provide emergency services so much but provide a broad range of drug and alcohol services, mental health services and so forth and are therefore exposed just as frequently to issues of security breach and violence, are very aware of these issues occurring from time to time.

That is probably as much as I need to say in terms of providing a quick encapsulation of the points we had in our submission. I am quite happy to take questions.

The CHAIR — Thanks, Trevor. Is Matt here to speak, or is he just providing support?

Mr CARR — Matt facilitated the survey for me, so during the Q and A he may be in a better position than I to answer questions.

Mr LEANE — I asked this question of the previous witness, so the other committee members will probably be bored by it. I want to take advantage of your expertise in relation to your representation of your members. The genesis of the current reference of this committee was that the new government had a budget line of \$20 million to introduce PSOs into ED wards to help make things more secure. Your submission asks a lot of questions around the feasibility of that, but in your introduction you touched on the idea that there is no single approach. The evidence we have been getting is in line with what you are saying.

The government has said that this \$20 million is going to be there in some form. Would it be an advantage to look at that money as a facility — that is, as if it were a pool of money that could be drawn down from some sort of grant application system whereby one of your members might apply for it and say, ‘We could really do with half a million dollars for more training, for security and for the medical staff’? Another of your members might apply for a closed-circuit television system in the waiting room. We had a previous witness who spoke about a duress alarm in a certain area of a hospital. Do you see that as a good approach or an end point for this committee?

Mr CARR — Yes, I think that would be quite appropriate. The minister is establishing the Health Innovation and Reform Council, and this may be something that could be further considered by that council in terms of having some pilots. There are a range of different approaches, just as you have suggested. It would need to be submission based, but with \$20 million you would have a reasonable amount of money to test a range of different solutions in a range of different service modalities and then get some evidence behind the value of each intervention. That would be where you would need to go back to the data, have a look at an organisation that does not have these interventions and find another organisation that does have them and see if there really is anything going on qualitatively that we can show the value proposition of. To my thinking that is going to be how we could perhaps extract some best value; \$20 million across 86 hospitals is

not going to go very far, and then you have another 38 community health services. You end up with nine-tenths of not a great deal.

The real issue we have at the moment is that fiscal imperative and that fiscal tightness around how much we can afford. It is always a value judgement around the risk versus investment proposition as to each agency saying, 'We have not got a high number of these things going on, therefore we do not think we need to invest that way', and then something disastrous happens and all of a sudden they need to find money for a whole range of things.

Mr LEANE — I suppose the work of your members is geared towards care, so for any money that is in a particular organisation, sometimes the priority might be care rather than other things like security. I suppose the good thing about this particular money, if it is earmarked for safety in hospitals, is that the argument could be that it should not only be used in EDs, as you said. It could be a grant system to improve the security of a whole hospital, but at least it is there and it is targeted for that particular purpose.

Mr CARR — Yes, absolutely. It will not be just for EDs. In my view it needs to be looking at things beyond ED. ED is perhaps at the front of the problem. People become disgruntled about sitting around for 4 or 5 hours, so you end up with ED rage. Also you get quite psychotic presentations and so forth that have not actually even been dealt with. You may have somebody come in who has an underlying mental health condition but is presenting for an acute episode. They may not expect to be there for 4 or 5 hours and may miss taking medication, and then things can spiral out of control very quickly. We have to be careful, though, not to make it a police state type of environment. There is ubiquity of technology in terms of the monitoring approach. From a staffing point of view, having the confidence that the monitoring is working and the response is going to come when they can see things getting out of control is the key.

Mr SCHEFFER — You said in your oral presentation just now that the VHA does not collect data and that the work Matt has done was gathering information from your membership base to see what perceptions are, rather than hard data, yet you concluded that issues were on the increase. I would like you to talk about that. To contextualise that, you also said that this is an issue that is much broader than just ED and that it goes into other areas of health service delivery. Could you build that into your response?

Mr CARR — Yes. I will give you a bit of pillow talk as well. My wife is a nurse.

Mr SCHEFFER — We do not need to go there.

Mr CARR — There are quite a variety of different units, so I am very aware of the frequency and nature of the sorts of risks that present on a regular basis from the floor as well as from the information we gathered from our members.

Mr SCHEFFER — Matt, how did you do the consultations with your members?

Mr CAMERON — We sent out a range of email communications to our members seeking responses. We got around 15 responses through that process and then others just through informal communications, phones calls and those sort of things.

Mr SCHEFFER — What was their sense? I do not want to put it as anything more than that. Was it that there was an increase or a potential increase? Was there a high level of concern? How did they pitch it?

Mr CAMERON — It was probably a mixture in that there was an increase in terms of frequency, but people also responded with an increase in terms of volatility. I suppose some of that is perception, but some of it is also just an increase in the types of incidents that are happening.

Mr SCHEFFER — What are the types of incidents? Did they talk about that?

Mr CAMERON — Not necessarily. Quite a few responses highlighted mental health incidents and alcohol and drug-related incidents. I suppose a lot of the incidents they communicated to us were symptomatic rather than criminal.

Mr SCHEFFER — The VHA works right across Victoria in rural and regional settings as well as urban and outer-urban settings. Do you deal with community health centres?

Mr CARR — Yes.

Mr SCHEFFER — There are a range of other kinds of areas. I know that 15 is a small base, and perhaps this is not a fair question, but was there any sense of what the distribution of feelings about these issues is?

Mr CARR — I think all sectors were represented in that response. There were large regionals, smaller rurals, community health services and metropolitan health services in the responses. Our board structure is representational and when we have these things we talk about them at the board level too, so you have a metropolitan chief executive, a metropolitan director of a service and rural, regional and community health. We gather it informally through that mechanism as well as through the formal mechanism that Matt applied.

Mr SCHEFFER — You used the term ‘ED rage’ just before. It may be a bit flamboyant, but nonetheless it is quite a strong term. Could you talk about that a bit — about what that means and where it comes from?

Mr CARR — I think that is probably representational of the majority of issues we confront that are seen to be potentially violent. Normally it is verbal aggression that is received, obviously, as aggression, and for that reason it is intimidating to the person receiving it. 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.

Similarly in ED, if you are sitting there waiting for 4 or 5 hours, your problem will be appropriate triaged. If you are there for that long, it will be triaged to say you do not

need immediate care, but to you, you need immediate care because you are experiencing some discomfort. It is a sense of patience.

Mr SCHEFFER — How does that square with the government's commitment to reducing waiting times? Is it that they are already being dealt with but they are not being told they have been dealt with or is it that they are not being dealt with?

Mr CARR — Up until recently the targets have only been about 85 per cent for a lot of categories, so at the busiest times there are still 15 per cent who are sitting for quite a long time. The target is within 4 hours, but 4 hours is still a fairly lengthy period of time. I do not think it is all going to be overcome. It depends on the personality type. If you are an agitated personality, it is a lot to expect you to sit there quietly for that period of time, particularly when you are in a non-smoking environment. I should not characterise it, as you are possibly a smoker. There are going to be a range of factors that impinge on the way in which you might normally manage yourself, and it becomes more and more difficult the longer people are sitting there.

Mr SCHEFFER — Would it be fair to say, as one of our previous witnesses said, that once the policy of reducing the waiting times starts to have effect it will, to some extent, take care of the problem?

Mr CARR — I do not believe it will. I mean really, if you go into an ED environment and you are deemed to be the least needy of the people presenting, then you are always going to be at the bottom of the line. Somebody else might walk in; you do not know what their problem is, but you might think, 'They do not look like they are very unwell, at least no more unwell than I am. Why are they being treated before me?'. Then the next person might walk in and be treated before you as well, just because of the triaging system. I do not see there is a strong correlation in that necessarily leading to a reduction. I think 4 hours is still a long time.

The issues in regard to the way in which we deal with people in ED by triage category are still going to be there if you are at lowest end. If you have not fully disclosed your underlying medical conditions to the staff at the ED as well, who often have a qualified mental health nurse to deal with an underlying mental health condition if in fact that is what you have as well, then they are not going to know the reasons for your agitation. Your body language is going to start sending out signals, and people are going to feel a little intimidated by that.

Mr SCHEFFER — In an emergency department like that, is it feasible to give patients who are waiting updates on where they sit?

Mr CARR — Yes, I think that would be useful. I think an hourly update would be useful, but that still does not overcome it completely.

Mr SCHEFFER — No.

Mr CARR — Just the fact you are communicated with would help. I have sat in an ED for 5 hours, and nobody says anything to you until they call your name. It is very frustrating.

Mr SCHEFFER — By that stage you have gone through all the *Home Beautiful* magazines.

Mr CARR — You are sort of getting very sick of yourself by then, particularly if you have not taken enough decent reading with you. It is a tough thing, because even if you are getting an hourly update, it might not satisfy everyone. But I think that level of communication would be helpful.

The CHAIR — A previous witness raised with us that the government may well have to look at legislation to remove liability from medical staff in relation to treating repeat offenders in relation to antisocial behaviour. Do you have a view about that — a sort of red and yellow card system?

Mr CARR — 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 yellow 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.

The CHAIR — I think it was in relation to one hospital and one hospital only in that respect.

Mr CARR — Right. I do not have a view on it; it is too difficult to make a call on — to say that you would refuse treatment on the basis of that. If the resources were available to have an attendance that was a supported attendance by your own security, then you might be able to look at having a right to have it as a supported attendance, but then it gets down to the resourcing and the availability of those staff as well. It is a very difficult area because refusing treatment on any basis is quite fraught with a whole lot of moral risk.

The CHAIR — I am not venturing an opinion. I am merely suggesting —

Mr CARR — I know you are not. I am searching my mind and trying to see whether is a way that that could be facilitated. The only way I can think of is if you were aware of who they were and you had some trained security staff available, then you might have the right to have a supported attendance.

The CHAIR — Which is a little bit different.

Mr CARR — Yes.

The CHAIR — Thank you. Are there any more questions?

Mr SCHEFFER — Yes, I have one more. In your submission under the heading 'Protective services officers' you said at the outset that protective services officers working in emergency departments requires further investigation — that is one proposition. Then further down under the three points you say:

Having firearms on the premises adds additional layers of risk to running a health service. Many VHA members highlighted their concerns with the use of firearms within the facility and recommended the consideration of non-lethal means of control. To me that sounds a bit like you could be persuaded. Is that a fair assessment of what your position is?

Mr CAMERON — They certainly recommended a non-lethal means of control, but they also — —

Mr SCHEFFER — Sorry, they certainly recommended?

Mr CAMERON — Non-lethal. They certainly recommended no firearms, from the responses we received, but they also, as you will see in the point above, were not too keen on the use of capsicum spray either. I am not sure that we received any suggestions on what other means you would use. I am not sure.

Mr SCHEFFER — I do not want to put words in your mouth; that is why I am asking in an open-ended way. But is this saying that it could be entertained — to have firearms there — or are you absolutely ruling it out?

Mr CAMERON — I do not think so, no.

Mr SCHEFFER — No?

Mr CAMERON — No.

Mr SCHEFFER — Okay.

Mr CAMERON — Not from the responses we have received.

Mr SCHEFFER — Okay. I just wanted clarification on that. Thanks.

The CHAIR — Thanks, Trevor, and thanks, Matt.

Mr CAMERON — It might also be worth just pointing out that other point of clarity on page 4 where we have provided a list of some of the measures that one service is looking at. That relates to the regional service on the page before and not the group C hospital in the paragraph above.

Mr CARR — A larger regional provider.

Mr CAMERON — Yes. That should be associated with the regional.

Mr SCHEFFER — Okay, thank you.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 15 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Dr S. Parnis, Vice-President,

Mr B. Prosser, Director, Policy and Public Affairs, and

Ms E. Muhlebach, Policy Officer, Australian Medical Association.

The CHAIR — Welcome, and thank you for your submission. We look forward to hearing your evidence this afternoon. Before you start — and I suspect, Stephen, you are going to be the leading witness — I have to remind the three of you of some conditions around your evidence this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975. It is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees? For Hansard's benefit I note three nods. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We look forward to your verbal submission.

Dr PARNIS — Good afternoon everyone, and thank you for the opportunity to give a verbal presentation on top of our written submission. As you may already be aware, I am the vice-president of AMA Victoria. My full-time job is that of an emergency physician. I have been a consultant for 5 years but prior to that I worked for over 10 years in emergency, and I have been a doctor for almost 20 years now — it goes quickly.

This is a topic which I and my colleagues, and I think the entire medical profession, feel very strongly about. It is a big issue and something that I think anyone who has practised medicine for more than a brief period will have personal experience of. What I would like to do is maybe illustrate some of the issues that we have already raised in that written submission, and I would say to you that what we have presented in written form is based on the best available evidence. I say 'best available', because it is not an area that has a huge amount of evidence in it. For in some respects obvious reasons I would say these things are very much underreported. Having said that, I think this is a great opportunity because there are opportunities not only to highlight the incidence and nature of this problem but to present some really useful and reasonably evidence-based solutions. Some are common sense, some are costly, but I have no doubt they will save lives.

It is fair to say that the issue of violence in the hospital system is an increasing problem. I can say that from my personal experience, from the experiences of the many colleagues who I have spoken with about this and from my discussions with emergency physicians across the country, and in fact across the world. 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. It is something that clearly not just doctors experience. We lead the health-care team, but it is very much our colleagues in nursing and allied health or clerical and administrative officers or, particularly importantly, the patients and their families who can bear the brunt of this stuff. To give you an example, 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 — we had that dealt with, but for the family and the poor child next to us — and thinking, ‘Maybe there are ways of dealing with this’. Things like the design of emergency departments come to mind.

Why do these things happen, and why is it often the patient or the person who comes through the door who is, if you like, at risk of causing violence? It is because we often see people at their worst. We see people when they are tired, emotional and in pain. They can have something called a delirium, where, for example, an elderly person has pneumonia and instead of presenting with a cough and fever they present with aggression and their wife of 50 years suddenly becomes a victim of domestic violence. These are the reasons hospitals have that happen, and it is not helped by the fact that we are overcrowded, that we suffer access block and that we do not have the space to deal with things that we would like, and I think that is without doubt the biggest single problem affecting health care in this country.

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. This is, I suppose, just an acknowledgement of what reality is, but they are not the only groups. I think it is important that what we do as doctors and nurses who work in these sorts of areas is to try to look at these things as a health issue, not a punitive issue. We need to control the violence, we need to help the person and we need to protect them from themselves and others. It is not meant to be a punitive exercise, and I think that is very important in the context of some of the solutions.

There are many times when I need to get a person who is violent or aggressive under control, for their own sake particularly. An example would be another case from a couple of weeks ago: a person brought in by police, demonstrating violent behaviour and abusing and threatening people with a knife in the front yard of their home. The question the police had — and it was a legitimate one — was, ‘Was this person mentally ill, or was this just criminal action taking place?’. In order to get this person under control to assess them, we needed physical restraint. We needed it in a safe environment — in other words, a room separate from the rest of the department, without things that could be grabbed or turned into weapons. I needed to sedate this person, and I was able to do that, get them under control, examine them, investigate, look for tests, look for these other things, liaise with the mental health workers and find out about the person’s past psychiatric history. Those things all took a lot of time, a lot of effort, but by the end of that, we had come to some conclusions, we had sorted the issues out, and the person, to be honest, was a very different person at the end of all of those things.

That was quite satisfying from my perspective, because it was a case of safety being satisfied for the people in the community, for the staff managing this person, for the person themselves and also getting the answers that we needed to get. That was the system working well. I looked after that person at one of my hospitals — that is, St Vincent’s Hospital. I mention that because it has a good example of a place that you can care for these people called a behavioural assessment room — something I have alluded to in the submission. I am not sure that many, if any, other departments in Victoria have such a facility. It 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.

As to 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.

In relation to underreporting, I have seen some evidence, and I would, off the top of my own experience, suggest that it is about right, that for every incident of violence — be it verbal, physical, threatened — about four episodes are unreported. I think that is a figure that sounds right to me, so I think in many respects we are dealing with the tip of an iceberg.

Talking about the sorts of recommendations that I believe are needed, I think that the reporting systems for violent incidents or near violent incidents need to be made easier. 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.

As to education, I would say as a rule that health professionals are inadequately educated, including the medical profession, 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 emergency departments — that could be turned into 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.

I think the opportunities for that training should be at a lot of levels, not just undergraduate training, but as an occupational health and safety requirement, and that is something that would not be too hard to implement.

What regard to security staff, I want to make a few points. We are absolutely, 100 per cent against the possibility of armed guards in hospitals. To us that is a black-and-white issue. That would escalate rather than mitigate the problem. To show how that has led to some serious issues, I will give you three examples. In 2002 a

prisoner who was in the emergency department at St Vincent's Hospital — this will be on the coronial record — was shot dead by a prison guard while attempting to escape. It is nine years on but the implications not only for the person who lost their life but for all the staff who are still traumatised by that event are quite something. Within a number of months of that particular episode there was another occasion where a patient, and I am not aware of their demographics, got their hand on a gun from either a prison guard or a policeman who was focusing on another patient in the department. That was dealt with by half a dozen people basically landing on top of this particular individual and holding the gun down, but, again, the senior doctor who brought that example to my attention said they remembered that because it was only a matter of months after the earlier occasion.

There is another case that I think is a useful example because it illustrates a number of points. About 20 years ago a colleague of mine who was very happy for her details and named to be given to this committee, Professor Anne-Maree Kelly, a professor of emergency medicine, was working as a relatively junior doctor in emergency at Albury hospital. There was another occasion where a patient, who had assaulted a senior nurse, had assaulted police officers and had been brought in either because of the reality or the suspicion of mental illness, got hold of a gun, pointed it at her and was about to pull the trigger. The quick thinking of a police officer in doing something to disable the weapon somehow — and this is something I have no expertise in — was the difference between something terrible happening. I asked Professor Kelly how she could remember this stuff and she said 20 years on if you have had a gun pointed at you, you still remember it like it was yesterday. The point about that example is that it was in the evening, it was in a country area, the security facilities within the hospital were relying on five or six police officers on that particular occasion and it was almost an instantaneous thing. She had just walked in to see the patient and found herself facing a gun. Some of the points are that this is not something that is restricted to the centre of Melbourne. This is something that is an issue for every hospital of every size to varying extents.

The CHAIR — Are you just referring to firearms when you talk about being armed?

Dr PARNIS — On those three occasions I meant firearms.

The CHAIR — Regarding your initial statement about opposing PSOs being armed, is that purely in relation to firearms or is that including all other devices they might have?

Dr PARNIS — We would be uncomfortable about them using any form of weapon, but I would couch that in the context that my and our experience of 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. In the 15 years or so that I have seen these things work well I have never seen them ever have recourse to a weapon of any sort, be it a baton, capsicum spray or any of these other things. I hope that answers your question.

The CHAIR — In the previous hearing in Geelong I think they indicated they had one security staff on Friday — and the committee will correct me I think — and two staff on in a high-risk time frame on the weekend. You have just indicated at least half a dozen in-house security staff are needed. Geelong is quite a busy municipal hospital with one, perhaps two.

Mr BATTIN — That is for the whole hospital not just the emergency department, or two for the whole hospital, which has included the Saturday nights or, as they say, when Geelong win or lose a grand final. Other than that you get one.

Dr PARNIS — The two examples that I have personal experience of, where I am talking the equivalent of the rugby front row, are the Royal Melbourne Hospital and St Vincent's Hospital. Those systems work very well, but there are examples not so far away from either of those hospitals where there is inadequate staffing. It is inadequate in either numbers, availability or training. Also I think there may be issues in relation to having security staff who come from outside, from a large company, and the first one that comes to mind is something like Group 4. 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.

Clearly in a number of hospitals there needs to be an interaction between the hospital and the police. As an example, I spent 10 years working at Werribee Mercy Hospital. The police station would have been maybe a kilometre along the road. The security was maybe one guard in the hospital and police were called for those violent incidents. One episode that affected me personally was a patient who was high on inhalants — I think some paint sniffing or something like that — who I managed to have under some degree of control but his aggression was such that he looked at my badge and he said to me, 'I know your name; I am going to find where your wife and kids live, and I am going to find them and I am going to kill them'. He looked at me in such a way that I thought he meant what he said. Again this is over 10 years ago, but I do not forget those sorts of things. I was almost hysterical. I mentioned this very quickly to the police, because we had called them, and I do not know that I was taken particularly seriously. That was my feeling at the time. So I would hope and think that those sorts of things become exceptions rather than the rule.

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 as to say respect their property, respect their body, respect their lives, respect their families. The AMA has advocated that position for some time.

Mr BATTIN — Just on that, you have said with reporting — it was 10 years ago in relation to your particular incident — from the research you have done, is that still a feeling through the hospitals where if a member of staff from an emergency department reports an assault or anything, the seriousness or the nature of the incident is taken from Victoria Police?

Dr PARNIS — No, I would say that in terms of other practice, both personal experience and daily liaison with the police, it is a very positive and good relationship.

Mr BATTIN — I just wanted to clarify that.

Dr PARNIS — Absolutely, and I hope I did not give the wrong impression. Thanks for the question.

I would like to make a couple of other points. 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. 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.

I mentioned already the behavioural assessment room at St Vincent's Hospital. It is an example that all new emergency departments should have some experience of. There needs to be a serious reason as to why it is not incorporated. In all new emergency departments that purport to treat both children and adults there should be a physical separation of children's and adults' facilities, rooms and resuscitation space. I think more emphasis can be made by putting mental health beds in place, because this is a highly vulnerable group.

We have talked about the penalties. We do not believe metal detectors are necessary. It is usually the case that if someone has been brought in by police, they would have been searched for weapons in that context. We would not want to go to that situation. I think it is anecdotal, I have not seen it myself, but I am told in an emergency department in the United States, I have forgotten where — it is Chicago I think — that it has an honour board for members of that department who have been murdered by firearms. We do not need to be the 51st state in that regard. We think the availability of the weapon is one of the things that contributes to the severity of the violence.

The CHAIR — Which is interesting given my understanding is that somewhere in the US they actually allow firearms for security guards in emergency wards in hospitals.

Dr PARNIS — We are talking, I hope, of a very different culture. For example, if people want to train in penetrating trauma, they go to the United States because the incidence of firearm injury is just well and truly above anything else in the western world. It really stands out. That certainly is mimicked in the exposure of doctors here. I have seen one gunshot wound in 20 years, and I have worked in major trauma centres in Australia, whereas I have a colleague in Los Angeles who sees one gunshot wound a week. The incidence of firearm injuries is proportional to the incidence of the availability of firearms.

The other thing that I think is worth acknowledging, and I think is an issue we have had problems with — it is not spoken about much — is that some emergency departments have a locker, a specific facility, for people who carry arms in the course of their work to put the gun away. How often it is used is a matter of contention. Anecdotally I am told the police use it sometimes and prison officers do not. That is a feeling. Clearly the question is: what is the need for it? I would not presume, nor would the medical profession presume, to tell people who work in the police or prison service about their use of firearms. My father-in-law is a farmer; he needs a firearm. But in the hospital setting I think we have expertise. We would contend and argue that that is the wrong place to have a firearm, but I do not want that to take away the attention I think should be given to all of those other things that we talked about that are not as, maybe, sensational but play a role in mitigating the angst that a lot of people have when they come to emergency.

Thank you very much for the opportunity to present. I hope if you have any questions or comments, I might be able to answer them.

The CHAIR — Would either of your supporting people here wish to make a comment?

Dr PARNIS — If I could mention, Elizabeth Muhlebach is our policy officer, and Bryce Prosser is the director of policy and public relations.

Mr PROSSER — We are here to support Dr Parnis today.

Mr McCURDY — I am just a little bit confused about something. It is definitely ‘no’ to the arms — we understand that. I am just trying to get the difference between the security staff and a PSO. Are you saying no to PSOs? I agree with the education. Is it whether it should be in-house security that does that, or are we saying that unarmed PSOs would be appropriate if they were trained in that? I suppose it is about building a bank of people who can do security in hospitals as opposed to being just PSOs who come off the train stations today and go into a hospital tomorrow.

Dr PARNIS — It entirely depends on what ‘PSO’ means. I think it is more helpful for us to say what these people’s attributes and skill sets need to be and then whatever label or system is used to employ them and use their skills is, I think, for others to decide. I think that hospital security is a specialised area, so I think your analogy is a good one — that you would not be able to have people who could do justice to the hospital job if they have just come straight from a previous shift as a security officer on a public train station.

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. By the same token, if they know me, they take confidence too because if you do something wrong as a doctor — for example, you give someone the wrong medication or do something like that — these are serious things. You are depriving a person of their liberty. You are giving them medication against their will. You are exposing them to the risks of those things. Similarly if you are a security officer of some sort and you are not doing it the right way, you could break someone’s arm, you

could crush their airway, you could kill them if you are not careful. This is why it is high stakes.

Mr LEANE — I would like to give an overview, as I have to other witnesses today about this reference, how it came to the committee and where it could lead. This reference came to the committee because it was highlighted that there was a budgeted amount of money that was proposed to be used for PSOs in ED wards in Melbourne or greater Victoria. It was then highlighted that that might not be the best way to go forward and so the reference then came to this committee. Your submission is in line with a lot of other submissions. It seems to be that this is an issue that requires a tailored response to each particular hospital.

Dr PARNIS — Absolutely.

Mr LEANE — Going forward it was stated that \$20 million is going to be there for hospitals whether it is used on PSOs or not; it is going to be there. Could one of the best recommendations we make be that the \$20 million be accessed by different hospitals as far as the grant system where one hospital might say, 'Look, we see the value in more education for the medical staff.' Another hospital might say, as you pointed out, 'Look, we have six security staff; we really need another one or two around security.' Another hospital might say, highlighting some of your recommendations, 'Our waiting room needs to look different.' Do you think that could be the best way forward for us? I do not think \$20 million is enough but I suppose it is a start. Do you think that is a good way for us to go?

Dr PARNIS — I think avoiding the one-size-fits-all approach is a very sensible thing. My feeling is that of the myriad measures that need to be considered looking at employment of increased numbers and better trained specialist security staff is a big issue. I certainly have had close contact with a number of my colleagues who work further out from the centre of the city and who say, 'Look, we are in desperate need of better security arrangements.' So my feeling is that that should be one of the highest priorities to come out of that \$20 million.

Mr LEANE — Do you think that part of that \$20 million could be used in identifying the different needs?

Dr PARNIS — You could. As a hospital clinician, I am always sceptical about scoping things out and spending more money and time and delaying that.

Mr LEANE — So it would be more that it would be better for a particular hospital to go, 'Look, if we could have \$1 million of that 21, we would do this and it would improve vastly and we could prove that down the track'?

Dr PARNIS — Again, the administrative processes are something that I would leave for others better qualified to work out, but I would not want to see much time or money wasted on working out whether there is a problem. It is a big problem; it is there, and it is ubiquitous. I think it is time to start getting some solutions out there.

Mr LEANE — That is pretty much in line with a lot of other submissions that have come through.

Mr PROSSER — Just to add to that point, I think you need a bit of a framework around what you are actually applying for. What works at St Vincent's, for example, may not work in a rural setting such as in Bendigo, Ballarat or a small country town. It needs a framework of what you are prepared to achieve, and then you can apply for the grant money. That would probably work.

Dr PARNIS — Clearly the clinicians, and hopefully the senior people at each of those hospitals, would be the best placed to say that. It is not hard to get access to the number of patients that come through the door, for example. It would be much harder to find out the number of violent incidents.

Mr BATTIN — I think it would be fair to say that security in hospitals throughout Victoria is a bit ad hoc, as you say. One has an internal and others have external agencies. I think you have looked at the PSOs that the government is looking at putting on railway stations as well. They will obviously be in a whole different role, and part of that is that they have adjusted their training through the academy. When they go through the academy they will actually be adjusting their training to suit that particular role.

I will go back to what Tim said. Whether they are PSOs or security, do you think the way forward with the \$20 million is to have a training program, whether it is through the police academy or an alternative, which is specific to hospitals so you can move those people around Victoria? Obviously the aim would be to have continuity within each hospital, but if they did move from hospital to hospital, they would have the training to deal with people with mental health issues and the circumstances they are in within the hospitals.

Dr PARNIS — I can only speak for myself in that regard, and 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.

My feeling is that the system would be diminished by having people who train out of one centre and just go to various bits. Sure, there could be some instances where they train in common, but my feeling is that we should pick the best bits of what happens in the hospitals that do it well. I would say those places include the Royal Melbourne, St Vincent's and the Alfred. Without wanting to denigrate any of the other hospitals, I do know those hospitals do it well. Let us take those examples, because this, to me, is a health issue. It is not a justice issue, it is a health issue. That changes the whole way you manage these people. I think that is the beginning and the end point for security arrangements in hospitals.

Mr BATTIN — Focusing on that part, as I said, the preference is to have each employed by each hospital, if comes from this funding and if that is the way it works with the \$20 million, but to have them with a training program. At the moment, as I think you just said, you could get someone down in Geelong who has done one lot of training at

St Vincent's, and they have got the sort of training they are very happy with. It is about finding a program for training specific security staff for hospitals around Victoria. At the moment we do not have that.

Dr PARNIS — Yes, absolutely. The answer is that I do not know. We are talking about the security guards. What I can say is that it is my feeling that, from the point of view of health professionals such as doctors and nurses, there is inadequate exposure to training. Probably the most highly trained people in assessing and dealing with violence among the medical profession would be my craft group, emergency physicians. Even then I think a lot of that is on-the-job training — the apprenticeship model — with our colleagues. It was very disconcerting when I started seeing that. Seeing the way that my seniors did it taught me a great deal, and I am sure a lot of my colleagues have not had exposure to those sorts of experiences.

Mr SCHEFFER — Thanks for your presentation. I just wanted to start at the very beginning of your written submission, where you begin by saying there is limited accurate information available — accepted. Then you go on to say that there is epidemic of violence and aggression in E-departments in our hospitals — which is very high up — and in your oral presentation you talked about the high level of violence and aggression in, I think you said, every aspect of the hospital. So a major issue comes out, and yet that is to some extent premised on a lack of accurate data. Can you link that up a bit?

Dr PARNIS — I will use the example of another thing I do. It is important, but we do not have a huge amount of evidence. An example would be cardiopulmonary resuscitation, which is basically heart massage and chest compressions. You cannot design a system where you can get a case study of 10 000 people and try either a particular type of resuscitation or another. The idea of getting level 1 evidence, the randomised controlled trial, just does not exist. In the meantime, people are still having cardiac arrests. You have to treat them with what you have got and the best available information at the time.

I suppose in this context what we are saying is that yes, we want better evidence, and that the way to do that is twofold: make the reporting systems better but improve the culture so that people do not feel reluctant to mention these things and so that they do not think that somehow they are inadequate as a doctor, nurse or clerk if they report that they have been harassed or even assaulted by a patient. I have plenty of examples of those. So we need to get better information, but let us not make that a reason to delay implementing some of these other things which we know will make a difference to the incidence and severity of violence that is already there. Does that answer your question?

Mr SCHEFFER — Yes, okay.

Mr McCURDY — If you give more resources to a hospital for security, will they spend it on security?

Dr PARNIS — I was going to say that earlier, but somehow we got sidetracked. 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. It is well outside the scope of terms of this particular inquiry, but I would like to see robust, transparent ways in which that money is used and

to see that 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.

The CHAIR — Bearing in mind that we have to close fairly shortly, I am still not clear about this aspect. You indicated that there is an aspect of violence in hospitals. In the same breath you have indicated that the major hospitals in Melbourne have reasonably good security arrangements in place and that they use in-house security — or some do, while some use external contractors. I have also been told that the first approach, the triage, is where many of the medical staff are quite well trained in dealing with antisocial behaviour at the front line. At the same time you are telling me that the state government should look at investing in, perhaps, more training in relation to dealing with the escalation of antisocial behaviour. The feeling I am getting is that unless we get the dollars the state government should not be investing in providing security as such but more in the education and training of medical staff.

My question would be: why are the hospitals not doing that? They are responsible for their employees, and I am reminded of people working at Centrelink employment agencies where there is a risk to themselves in relation to job seekers coming in. They actually have a very clear process whereby they have to have officers sight where there is easy access in and out the door so that they do not get wedged et cetera. I suspect that is the same for medical staff, whereby they are trained to deal with aggressive and violent behaviour by people that are obviously under some duress. Why does the hospital not incorporate a plan for their employees to provide that education and training, and where and why should the state actually be investing in that?

Dr PARNIS — The state health system is extremely variable. Performance, incidents and the resources they have, depending on where you are, are extremely variable. I have had some people say, ‘Yes, we’re very happy with what we have’, and other people say, ‘No, we’re dreadfully underdone in this regard’. You can have an example of an outer suburban hospital where you may have an emergency specialist — because in many places we are the exception rather than the rule — and you have people who are less skilled in dealing with these sorts of things, but even then you do not have the security resources. By and large the biggest thing I have heard is that even with the best training in the world, if I have someone in the back of a police divisional van who is rocking around, who weighs 80 kilograms and who is high on speed, I need some people who have the skills, training and strength to get that person under some control so that I can do my job, otherwise my life is at risk. There is a role for education, but I still think we need security guards.

The CHAIR — Is it actually security people on the ground that you are talking about?

Dr PARNIS — Yes.

The CHAIR — More so than the training aspect?

Dr PARNIS — This is a difficult question in terms of priorities. I think they are both of equal priority. There are hospitals — for example, on the Mornington Peninsula — where on Friday and Saturday evenings there are a fair number of people coming through, but they do not have any security presence or they have one person. I

have been in some places where the security guard needs to be protected. These are the sorts of things that are not acceptable.

Regarding your question about why hospitals do not do it, over my 20 years in the system I have seen improved processes, but like so many other things, while you would ideally be proactive, so often it is reactive. We got glass doors securing access to emergency at St Vincent's, and after that a prisoner was shot dead. The hospitals do not necessarily go looking for ways to enhance something. It is almost as though if you do not know about it, you do not go looking. It is going to cost a lot of money, and hospital budgets are under a huge amount of duress. They discourage people from claiming overtime.

The CHAIR — You are telling me that violence is escalating in hospitals?

Dr PARNIS — Yes, I am.

The CHAIR — So wouldn't you expect hospitals to react to that?

Dr PARNIS — Not if it is underreported.

The CHAIR — That is a common theme.

Mr SCHEFFER — I realise we are over time, but I have one more question. You said that fundamentally this is not a justice issue but a health issue. One of our previous witnesses talked about making a separation between those people who come into the hospital and misbehave in a way that is analogous to the way they may misbehave on the street and another category of patients whose misbehaviour has to do with a condition that needs treatment and arises out of that. The witness said it is fairly possible and easy to make that distinction.

Dr PARNIS — Sometimes it is difficult, actually.

Mr SCHEFFER — I appreciate that; that is what I want you to comment on. In that first category, where they are acting up in a way they may on the street, they could be presented with a card, a notification or a tag that would mean they were not welcome in the hospital and would be moved off. If they had a scratch on the head — I think that was the example — they could go to a local GP and get it dealt with. Basically the hospital did not feel that it should expose its staff to dealing with people behaving in ways that were not directly related to a medical condition. How do you negotiate that, given what you said before?

Dr PARNIS — 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.

There is no single, black-and-white answer to that. It is something where after 20 years I still see the risks. Luckily I think I have the training, and I teach my juniors the signs of a problem. An example: the older a person who comes in with aberrant

behaviour is, the more likely it is to be an organic or medical problem rather than a behavioural issue. There are all of these others. Part of the complexity of medical training is sorting those things through.

It has been a practice in the past — I have not seen it as much lately — to have awareness or a list of people who attend frequently with a view to abusing the system, such as someone who is looking for narcotics or someone who tries to manipulate staff to get access to certain equipment or this or that. I do not see that as much as I used to, say, back in the 1990s, but that is something that each emergency department certainly becomes aware of. I am not sure that it is a huge issue, because most people want to be away from emergency departments — with good reason — so we would err on the side of caution there.

The CHAIR — Thank you very much to the three of you for providing evidence to the committee today. We will be in touch with your submission as well.

Dr PARNIS — We appreciate your time. Thanks.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 29 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Witnesses

Ms K. Chrisfield, Coordinator, Occupational Health and Safety Unit (Victorian branch), and
Mr P. Gilbert, Assistant Secretary, Australian Nursing Federation (Victorian branch);
Mr P. Sloman, Clinical Nurse Specialist, Emergency Department, Royal Children's Hospital;
and Ms L. Graham, Registered Nurse, Emergency Department, Dandenong Hospital.

Overheads shown.

The CHAIR — In opening the proceedings I thank our witnesses for giving evidence at this hearing of the Drugs and Crime Prevention Committee. I should warn you that we have media here. I understand we have representatives from Channel 9, the *Age*, AAP and the ABC.

Just before I ask you as witnesses to present to the committee I have to read some conditions around this afternoon's hearing. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in the other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege.

Have you received and read the guide for witnesses presenting evidence to parliamentary committees? I will take that as a yes. We are recording the evidence, and you will be provided with a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. I invite you to make your verbal submission. Just before you do, I suspect that you, Paul, will be the leading witness.

Mr GILBERT — Correct.

The CHAIR — Thank you very much for your written submission. We have had a lot of interest in this second reference of the committee, and obviously we are looking forward to your presentation and evidence today.

Mr GILBERT — Thank you very much for inviting us here today. With me is Kathy Chrisfield, our occupational health and safety unit coordinator; Peter Sloman, who is an emergency nurse at the Royal Children's Hospital; and Leslie Graham, who is an emergency nurse from the Dandenong campus of Southern Health.

I am in charge of the slideshow today, amongst other things, but I did want to make a couple of quick points. Obviously the issue of armed guards has created some concerns amongst our side of the industry, and we will go into some detail as to the reasons for that. The other thing I would like to say is I think it is wonderful that a government has been prepared to commit an amount of money like \$21 million, which is a lot of money, but it also would buy about 235 full-time nurses across our emergency departments, which would go a long way towards treating one of the prime causes of frustration and violence in emergency departments, which of course is the time taken waiting to be seen for treatment. It would obviously have added benefits in terms of release of ambulances from ramping and hospitals and related issues.

What Kathy will go into is that it is certainly our preference to fix the cause of the problem rather than treat the symptoms of it. There will always be some degree of unanticipated activities in emergency departments where you need well-trained people to deal with a situation, but a lot of what we and our members experience arises from the frustration of long waiting times and frustration over people apparently believing they are not being treated in the order they believe they should

be treated. I am probably not telling you anything you do not know, but I would ask you to look at it in context. I think 235 full-time nurses in emergency departments would go a long way to fixing it.

We have already got in most emergency departments some level of security. The question is as to whether the people should be armed and limited only to the area of the emergency department and also the time at which they should be in the department. I think they are all issues that need to be explored further. We are also aware that, rightly or wrongly, hospitals have a lot of budgetary pressure placed on them, and in our experience if you say you must have one security guard 24 hours a day, they will quickly forget that they have already got one security guard 24 hours a day. You can pay them the money that they need to have a security guard 24 hours a day, but you will not have one more security guard than you had 5 minutes before. It is the nature of the beast. That is exactly what will happen, We have experienced it many times. 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. I will hand over to Kathy and teach myself how to use this computer.

Ms CHRISFIELD — As Paul said, thanks for the opportunity to present here today. I am going to go through our recommendations from our submission and talk in a little bit more detail about what they are and why we put them forward as our recommendations. Recommendation 1, in particular, is that armed guards of any description — whether security or protective services officers — not be put into emergency departments in any way, shape or form. As Paul mentioned, I am the OHS unit coordinator at the ANF. From strict risk management principles, we look back at treating the cause. We do not look at trying to treat the symptoms. If we can in any way, shape or form eliminate the risk or the hazard that we are dealing with, we would much prefer to do that rather than just treat the symptoms of the problem.

The Occupational Health and Safety Act 2004 in Victoria very clearly states that you must look at eliminating the hazard. By bringing armed guards of any nature, whether they be security guards or protective services officers, into emergency departments, we are actually introducing another hazard in the form of another weapon. We already have the problem that there are undisclosed weapons coming into emergency departments, and there are particular ways of dealing with those. We do not want to be bringing another weapon into an already potentially inflamed situation and potentially causing more problems with that weapon that has been brought in.

Additionally, we feel that there have been a lot of studies and a lot of research into this issue. The violence in nursing task force set out 29 very specific recommendations, and it is our strong belief that if these recommendations were fully implemented and evaluated, the majority of the causes of these issues could be dealt with, and then we would not be looking at whether we need armed protective services officers or not. We feel that the causes would have been treated in much more detail.

As I mentioned, the VIN task force identified 29 recommendations. The recommendations are current; they are relevant. Whilst they have gone some way to being implemented in some of the emergency departments, they have not been fully implemented, and they will treat the causes of the problems. The fact that they have not been fully implemented, we believe, is part of the reason that occupational

violence has not adequately been decreased in emergency departments and health facilities, and therefore our nurses and midwives are still being exposed to this risk.

As I said, there are 29 recommendations yet to be fully implemented in a lot of circumstances. Research undertaken in 2010 looked at a number of factors that nurses believed were present in their workplaces. Fifteen hundred nurses and midwives were interviewed. I apologise for the colour on the slide. There are a number of factors that are not fully implemented, and had they been implemented, these would be close to 100 per cent. For example, currently only 54 per cent of nurses surveyed felt that there were appropriately designed reception counters to protect staff — a relatively simple answer to reducing violence and exposure of nurses to violence in their emergency departments.

Only 60 per cent of those surveyed believed or were aware that the alarms in their emergency departments were linked to security personnel and police. That in itself is a security measure that can be put in place to reduce the need for even a consideration of armed protective services officers. Significantly, only 54 per cent of those surveyed have on-site security guards in the workplace for 24 hours, and 28 per cent only have security in the workplace after hours. Whether this is from the mistaken belief that incidents only happen after hours or whether it is a budgetary factor or that they do not want security in there all the time, it makes a big dent. Just the security presence alone can make a big difference as to whether there is likely to be an escalation of violence and aggression in emergency departments.

Our third recommendation 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 practicable. 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 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.

Our fourth recommendation is that the government ensure that there is dedicated project funding for any capital works being provided to address shortcomings. There has been funding provided under the VIN task force for some works where it has been applied for by health services. There have been a number of different capital works projects under that funding, but that has far from captured all emergency departments and facilities, and there is a long way to go. We would see that being able to dedicate the funding to put in place the physical design capabilities in emergency departments that can reduce the risk and the exposure would also go a long way to addressing the problems. Because there are shortcomings, there are places that have not applied and there are places that have not been successful in their application, so if we can address those gaps, then we are going to reduce the incidence of violence and aggression.

We also recommend dedicated ongoing funding to employ security guards specifically for EDs, in addition to security that is already in place, and this goes back to Paul's previous comments. Many facilities have security, but they might operate across the entire campus and not be dedicated to the emergency department. So when they are needed, they might have to come right across the campus to get there, and there can be a significant time delay between when they are called upon and when they actually get there. In order to make sure that this recommendation would be implemented we would need to see what is already in place, get a full audit of what is already there and make sure that what is being funded is additional to that to ensure that some of those gaps are being addressed.

The CHAIR — Can I ask for clarification there? In here you are arguing that you are not supportive of armed PSOs in emergency departments, which I understand, but in recommendation 5 you are perhaps opening the door to see if the government is willing to invest in extra security in hospitals that may need it. So you are actually supportive of having additional security in hospitals — security as in PSOs?

Ms CHRISFIELD — We are supportive of security where they are appropriately trained, whether that is PSOs or another form of security — —

The CHAIR — So it is really just the armed issues, not so much having the extra security?

Ms CHRISFIELD — Absolutely, it is the armed issues that we have — —

The CHAIR — Do many hospitals provide their own security in house?

Ms CHRISFIELD — Yes, they do.

Mr BATTIN — Just to clarify that when you say 'armed' you are talking firearms?

Ms CHRISFIELD — Yes.

Mr BATTIN — Or are you talking batons, handcuffs, OC spray and foam? There are all these different options that police carry now. Tasers are a new one coming in. So could you just clarify whether it is just firearms or is it tasers and foams?

Ms CHRISFIELD — It is particularly firearms. However, we have had situations where there has been, for example, OC spray used in emergency departments, and it causes the whole emergency department to be evacuated and a whole lot of other issues. We are saying that before we even need to go down the track of looking at that, there are so many other options that we should be looking at first in terms of addressing the cause and preventing and reducing the risks. Once all of that is done I think that is when we are in a better position to make a judgement about what is actually required from that perspective. I think at this point it is actually too early to even go down the track of looking at those kinds of recommendations.

Our recommendations touch a little bit on the question there. We are talking about consistent training for nurses, midwives and others, including security personnel. It is really important that security personnel are trained to deal with the situations they

face, particularly when they are volatile. We know that people are often at their lowest when they are presenting to emergency departments, whether that is because they have been injured or are ill themselves or because they have a family member or a friend — whatever the circumstances, when they are at a low point in their lives due to the very fact that they are there. So there is a specific level of training that needs to be undertaken to make sure that they are appropriately trained for the circumstances and can deal with the circumstances that they are faced with.

As I say, this is not just security personnel, but it extends to nurses, midwives and anyone else in the emergency department. They also need to have a consistent level of training so that everyone is on the same page and knows how to deal with the situation and you do not have people dealing with it in different ways, which can confuse the situation and potentially further inflame it.

The CHAIR — Do you think the hospitals should have responsibility for providing security in their own departments, or are you suggesting that the government take away the budgetary item in relation to armed PSOs and have some stake in providing security for public hospitals?

Ms CHRISFIELD — Whether it be provided by the government or the health service, as long as there are fairly strict criteria around how it is done, I think it can go either way, honestly. As Paul mentioned earlier with regard to whether it should just go into the budget for the health service — into the big bucket as such — we find that it can very quickly be reallocated elsewhere and not dedicated to the purposes for which it was originally intended. It is the importance of making sure that the funding, whether the security is provided directly by the government or whether it is provided through the health services themselves, as long as it is dedicated and there are criteria around how it is allocated, that is the important part of the process.

Mr LEANE — Can I ask a question in line with that answer, because it is a question I was going to ask at the end anyway. The government has a line commitment in its budget for \$21 million for PSOs in emergency wards, which has been referred to this committee to see if that is the best way to spend that money. But the minister did say that that money was there, the \$21 million, and I would imagine that could be ongoing, because if the PSOs were in there, you would have to pay them every year; you would not pay them for just one year, so I imagine that is ongoing. As far as making sure that it is there and is dedicated to security, one of the best ways for hospitals to access that is through some sort of application to that pool of money, so that if a particular hospital really needs training and that hospital puts in X million dollars, or whatever it is, for training. Another hospital might come back and say, ‘We do need an extra in-house security guard, and that is going to cost us X hundred thousand dollars ongoing’. Do you see that as the best way for us to recommend the best use of this money?

Ms CHRISFIELD — As per the health services’ self-determined needs?

Mr LEANE — Yes.

Ms CHRISFIELD — Possibly, but it depends; I will come back a step. In terms of the violence in nursing task force recommendations, there are a number of recommendations in there that are reliant on the health services implementing them themselves. Our position is that they have not implemented them fully. Various health

services have implemented them to varying degrees, but there has been no follow-up as to who has implemented them and who has not implemented them.

There was money associated with the task force. There were grants available. People did apply for funding, but again it is not always necessarily the ones that we would say needed it the most who might have applied for the funding; it is those who were aware that they had issues. Not every health service may be aware that they have issues or may not actually recognise those issues and the way they can deal with them. I do not necessarily think that you can leave it 100 per cent to the health service to apply for the money, because I do not think it is always recognised, and it is not always on the top of their priority list.

If we come back, included in the recommendations is evaluation of those recommendations. Once you have got that in place, part of that evaluation would identify where the gaps are, and then we can target better how that money could be spent in the various facilities.

Our recommendation 7 comes back again to treating the cause of the problem. A lot of the causes, contributing factors, to violence and aggression in emergency departments, are about waiting lists, treating times and the waiting that goes along with those. Obviously should you be able to prevent those waiting times and that situation escalating, you go a long way to treating the cause. We would suggest that additional nursing resources would go part way to addressing that cause and therefore reducing the violence and aggression that we see.

Recommendation 8 is legislating for an increase in penalties for the perpetrators of violence against nurses and midwives. This was again raised in the task force's recommendation 12 and also in the government's pre-election commitments. We see this as a good deterrent for those who currently exhibit violence and aggression in the emergency department. It is another prong to the holistic approach that needs to be taken to address the issues that we are talking about.

Mr SCHEFFER — How do you know it is a good deterrent?

Ms CHRISFIELD — It has had some benefits in terms of the ambulance service, in terms of the reduction in the violence that they face.

Mr SCHEFFER — That is the evidence there?

Ms CHRISFIELD — I believe so, yes, anecdotally.

Mr SCHEFFER — Could you provide that to us.

Ms CHRISFIELD — I could look and see, absolutely.

The CHAIR — When you say the government must legislate for an increase in penalties, is that to suggest that the present penalties are not sufficient or that they are not being enforced? Our understanding is that a lot of the violence happening in public hospital emergency departments is being underreported by nurses. I suspect we are having this inquiry and that the minister has allocated funding for security because there has been an escalation of violence in hospitals, and probably more nurses now are

reporting incidents that they would not have reported before. Is that a fair assumption? One of your recommendations asks for a change in legislation to enforce greater penalties, but again I ask if you could provide some evidence of where penalties might be sufficient but they are not being enforced by the police or others.

Ms CHRISFIELD — I can certainly look for and get that evidence for you. In terms of underreporting, there is significant underreporting of violence and aggression in nursing. A report by Gerry Farrell and his colleagues which was published last year estimates that approximately 50 per cent of incidents are being reported. We suggest there are a number of reasons for this lack of reporting, one of which may be that reporting is not always supported internally within health services. We also have anecdotal evidence whereby when a nurse tries to report an incident to police the health service does not want to support them in that process. They then back off, and it does not get reported to police. Underreporting is absolutely a significant issue.

The CHAIR — Are you suggesting to us that nurses or those who have been subject to some antisocial behaviour or violence are fearful of reporting the incident because there has been a lack of support from the health service?

Ms CHRISFIELD — In a lot of circumstances, yes, that is the case. That is what we hear from members when they call us.

Mr GILBERT — They feel fearful, or there is a perception that there is no point in progressing the incident any further, as the support will not be there to ensure there is a proper outcome. That includes the hospital supporting staff through that process, through to the police and through to the courts.

Ms CHRISFIELD — Our final recommendation asks the government to deliver on a pre-election promise, being its commitments to insist that the safety of nurses in and near hospitals is a key focus and to demand an evaluation of existing antiviolence measures in operation in our hospitals and health-care facilities. This comes back to one of the points we made earlier — that is, if 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.

Legislation is needed to ensure that physical violence is met with the full force of the law, that sentencing reflects that and to ensure proper occupational health and safety protection for nurses. That is a summary of our recommendations, but if you have any more questions for me, please feel free to ask them. As Paul mentioned we also have Peter and Leslie, who are nurses in emergency departments at the children's hospital and Dandenong respectively.

The CHAIR — We only have about 15 minutes more allotted to this evidence, so unless there is a question from any members of the committee, perhaps we could ask Peter and Leslie to provide any evidence they wish. I suspect then we will have a number of questions for you. Peter, perhaps you would like to add as you see fit, and then Leslie.

Mr SLOMAN — I come from the emergency department of the children's hospital, which is a large tertiary hospital. Of course we are paediatric, so our population and the violence that we see is quite different to Dandenong in that 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. Luckily we have recognised that in the past and have a security guard permanently in emergency. Anecdotally this seems to have reduced some of the aggression in the waiting room. We are not seeing that from tests — we have not researched it to see if it has made a difference — but it definitely feels like it has helped.

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.

At the Royal Children's Hospital, as it is a paediatric population, all our code greys — which are aggressive incidents — are dealt with by a clinical-led response. It is not security leading the response. We have a doctor, five nursing staff, two security and an executive to attend. If it is a family member or a visitor, then it is a different type of response; it is led by executive and security. If it is a patient, then it is led by the medical and nursing staff. In saying that, having extra security will be a benefit in that it will help bolster that. However, training is probably of more benefit to us providing adequate services. Yes, security is always handy, but really we need more training and more medical nursing staff to deal with the situation.

Ms GRAHAM — My name is Leslie. I work at Dandenong emergency department. We have a security guard who stays in our department with the triage staff from 7.00 p.m. till 3.00 a.m. every night. It is not funded for 24 hours but just for that period of 8 hours. In that time if anyone needs the help of the security guard, that security guard will be first on the scene but then has to call for backup, because there is only one of them. The other security personnel that will be around may not even be on campus because we have a lot of community houses that they also look after as well as our psych units, which they are often called to.

The population we deal with is: mental health; geriatrics; head injuries, so people with acquired brain injuries who might not have any idea of what they are doing; and patients who are affected by drugs and alcohol, who have no mental health issues — it is just that they may have had a three-day binge on ice or something. Those patients may have had no sleep over the last three days, and they come in looking for fights. We may put them in a bed or we may not. The issues with putting them in the beds is that we may have children in the bed next to them, they can be physically aggressive, they can be verbally aggressive and there have been many incidents in the department where we have had staff being chased by patients. We have had instances where staff have been backed into corners, because of the layout of our department. However, introducing weapons is not the answer we need to help us; we need more security guards. Their presence can completely calm a patient and prevent the escalation of violence.

Mr BATTIN — Straight to that one, you just made a point there. You said more security is one thing, but just before that you mentioned staff being put into corners because of the environment. Is the environmental design of the actual emergency department one of the big issues with security for staff and nurses?

Ms GRAHAM — Absolutely. We have just had a brand-new emergency department designed and built but not by anybody who has ever worked in an emergency department, so we have a lot of corners and big spaces. We had a patient who was found strangling a nurse in a corridor that is not monitored. This nurse was only found by another staff member who was lost and found them.

Mr BATTIN — So the design layout was a big issue, and the lack of consultation with the professionals that work in there in design?

Ms GRAHAM — Yes.

Mr SLOMAN — I have seen the designs of the new department as we are getting a new home, which is almost complete. We are moving in two months. We have similar issues. Our department has some major flaws in that currently we are the only department, from my understanding, in Victoria that is completely open. We have no screens or anything — nothing protecting nursing or medical staff. Our new department has more protective measures so it is more locked down. There are fewer entrances and it is more secure. However, again we still do have corridors. Our safe room or seclusion room, which is used for an aggressive patient or person, is down a little corridor and tucked away at the back. Again, the design is thought through, thinking about these sorts of issues, but again there are still lots of problems with it. We will find most of those when we move in. If we can build that sort of thing into a new design, then fantastic, but I think unfortunately it does not always occur.

The CHAIR — A suggestion was made at a crime prevention meeting in Geelong last week about visitors waiting, isolation rooms, TVs and so on. I guess with the 4-hour rule, hopefully, we are overcoming some of these long waits for patients to be received by the nursing staff, but it was about getting things active around the waiting rooms so people are actually doing something or feeling engaged in something rather than just sitting there pondering what might or might not be happening. So I guess just adding on to Brad's comments is the importance, particularly in new constructions, of providing some form of engagement for those waiting, whether it be a patient or a visitor, to distract them from perhaps antisocial behaviour; is that fair?

Mr SLOMAN — I think that is definitely the case in a paediatric hospital where you are not only trying to entertain, say, the parents. They are concerned about their child and if you can somehow engage them and entertain that child during that 3-hour wait, that is going to reduce their stress and anxiety. How do you do that? TVs, playground — I do not know what the best option is there, but that would definitely help reduce it in some sense.

Mr McCURDY — My question is along the same lines as what Simon was talking about. Kathy, you were talking about addressing the cause, and I was thinking along the same lines about the waiting times. There are people of genuinely aggressive and violent nature in hospitals, people who are drug affected or alcohol affected, or neither but just who are aggressive by nature. Then you get this frustration. If I have been sitting there with my six-year-old son for 3 hours and all I ever see is people coming in and jumping the queue and getting in before me, that turns me into what I was not when I first came in. Is communication something that might be just as useful, as Simon was talking about, as opposed to more security? I agree that more nurses or emergency nurses would certainly help those waiting queues, but as we were talking about communication with patients, that might stop those people who are very frustrated by the time they leave.

Ms CHRISFIELD — Communication is key, absolutely. It is communication with the patients, communication when you are looking to design and build new facilities and communication with staff. Communication is absolutely the key to all of it, but yes, that can absolutely help reduce some of those frustrations that go along with that, 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 that there are adequate people coming through 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 is a significant part of what needs to go into the whole approach.

Mr SLOMAN — I think communication is the key, but again you try and tell a family that has been waiting 4 hours that they have potentially got another 2 hours to go, you can communicate all you like; it might reduce some of their anxiety, but they still might be verbally aggressive to you. You have got no answers for them. I can say, ‘You have got 2 hours to wait’, and they might wait 4 hours, so communication is a key component, but there are many other issues.

Ms CHRISFIELD — Absolutely.

Mr GILBERT — I just wanted to raise one other thing before we finish. 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 number of treatment areas in emergency departments not keeping up with demand is that we have hospitals asking nurses to treat patients in the waiting room. You will see more and more in the media about these waiting room nurses, which is obviously a significant irony in circumstances where there is an obvious recognition of the risk of unaccompanied staff outside that secure treatment area, yet 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.

Mr LEANE — At the start of your submission you had a bit of concern about corraling any money that may be allocated. Have you got any suggestions about how it could be done?

Mr GILBERT — Ironically if they were PSO positions, they would be employees of the Crown, and the government, or the chief commissioner, would determine where they were and how many of them there were and how they were trained. There is a lot of attractiveness to that from the point of view of ensuring that you have well-trained people in the right places not being able to be taken away. Do not take it that we are saying that there should not be CPOs — —

Mr LEANE — PSOs.

Mr GILBERT — PSOs. It is one of my *Star Wars* days, I think. That has a lot of attractiveness to it. It is the weapons issue that makes that difficult. It is pretty unclear from what we have heard whether you can have one without the other. Maybe you can. The alternative to that is that it is a departmental directive from the secretary of the department, ‘This is the money,

this is what it will be used for and you will report that you are meeting these objectives', and that there is some mechanism for raising non-compliance and ensuring that it is dealt with swiftly.

The CHAIR — Leslie, just one quick question. What is the most frequent type of violence that nurses face in an emergency department?

Ms GRAHAM — It depends which part of the emergency department. If it is at triage, we have a big protective glass screen that no hands can even get through. That is just a lot of verbal violence coming through, where patients raise their voices, yell, scream, throw themselves on the floor — things to make us go out to them. 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 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. You just press your duress alarm and run away.

The CHAIR — And security is called in then? What is the process?

Ms GRAHAM — In our department we have these new duress alarms, so we can press our duress alarm and it will go straight through to security, and they come straight away. They then restrain the patient on the bed. If we have to recommend them, then security will be there and we can get division 2 nurses to come in and sit with the patient to make sure that they are not going to try to run off or anything, but there is a big difference with security between a recommended patient and non-recommended patient. Some believe if the patient is not recommended, then they are not allowed to do anything, so if the patient assaults someone and then tries to run off, there is nothing you can do except call the police and give the police a description and hope they can find them in the community.

The CHAIR — Does that happen often?

Ms GRAHAM — The patients running away? Not so much. I have just stood down from being full time to 0.8, which is four days a week. I would probably be prone to having some kind of violence against me every second day in Dandenong.

The CHAIR — Verbal and physical?

Ms GRAHAM — Verbal and physical.

Mr BATTIN — All reported?

Ms GRAHAM — Some of it. A lot of it is reported, but it all takes time. You have to have access to the internet, and Southern Health unfortunately takes those rights away from a lot of people. I have never reported anything to the police, and I am not allowed to discuss any of my work issues outside the workplace unless my unit manager is aware that I am doing so.

Mr BATTIN — Can I ask why it does not get reported to police?

Ms GRAHAM — I think it is because it is just going to cause more issues with your management.

The CHAIR — Sounds like a support issue.

Ms GRAHAM — 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.

The CHAIR — Thank you all very much for giving your time this afternoon.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 29 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witness

Dr S. Young, Director, Emergency Medicine, Royal Children's Hospital.

The CHAIR — Welcome to the Drugs and Crime Prevention Committee, which is a joint Parliamentary committee. All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Dr YOUNG — I have.

The CHAIR — We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. Before you provide your verbal submission I thank you for your written submission; we really appreciate it. I think we have had over 30 submissions for this second reference in relation to the security in emergency departments of public hospitals. It has created a lot of interest and this is, I think, our fourth or fifth day of hearings in Melbourne and there have been a number outside Melbourne so there has been a lot of interest in this reference. We thank you for your time this afternoon.

Dr YOUNG — It is my great pleasure to be here talking to members of the committee. The Royal Children's Hospital probably needs no introduction to the committee. We are Victoria's major paediatric teaching hospital and we provide all sorts of secondary and tertiary services to the children of Victoria. I think when people think about violence in emergency departments they may not immediately think that it is a problem that affects a paediatric hospital. They might think there is some reason that it is sort of excluded, but in fact we do have problems that arise in this area every so often.

It is not a common thing. I doubt whether it is as common as happens at the adult hospitals, but it happens in a slightly different context. If there is some strategy that comes out of this committee, we would like the paediatric dimension to be taken into account. Some of the things that cause violence in our emergency department are similar to those that happen in adult departments. I heard you talk about long waiting times and things like that with previous witnesses; maybe we will come back to that. There is a whole group of children of all ages who have difficult behaviour that leads to situations of violence towards staff members. We deal with children who have probably the most difficult behavioural problems: children with autism and children who cannot understand what is going on. When they are younger their parents can control those behaviours, but as they get older and move into adolescence they are capable of inflicting a lot more force — they do not realise what they are doing — and we have strategies in place to deal with that.

Drug and alcohol-affected children we see infrequently, but we do see them on Friday and Saturday nights. I think most of those adolescents identify themselves as adults, so they turn up to adult departments and might consider it a bit funny if they went to the paediatric department. They are not children. If you are 16 and you are out taking some recreational drugs, you do not think of yourself as a child, so if there is a problem you go to an adult department. We do not see anywhere near the number that

would go to other emergency departments around town, but they occur with enough frequency for us to meet to have things put in place so that we can deal with them.

Then there is the parental frustration that I heard you talking about earlier and that is a major issue, especially at triage and especially out the front of departments. People who are otherwise fairly rational and reasonable when they come in sort of lose it at some stage during their stay. We saw 70 000 children come through the emergency department at the Royal Children's last year. There are times when standing in our waiting room is a frightening experience as you watch people coming through the door. We sometimes get 20 new patients an hour, which is one every 3 minutes, walking in the door. To design a system that is going to cope with that adequately is very tricky. The peaks and troughs we experience are extreme peaks and troughs. We try to keep our parents engaged while they are waiting; we try to provide some sort of treatment in the waiting room with respect to rehydration, medications and things like that.

I heard one of your previous witnesses talking about the problems that nurses have when they are dealing with that environment, and indeed they are very exposed when they are out there amongst 30 or 40 people trying to dish out medical care. It is a real challenge. We found that if people are doing it they cannot do it for long periods of time because it is very threatening to them.

We have just designed a new emergency department which is being built 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.

One of the principles we have is that you never go back on yourself and sit down in the place where you just came from. Hopefully parents will get this feeling that they are getting through the system. You are being put into a different area each time and being given something a little bit different. What we are hoping is that that will engender the feeling that something is happening because I think it is this frustration that nothing is happening that causes a lot of the problems. Of course the amount of time that you spend in the emergency department waiting to be seen actually has very little to do with what is wrong with you. It has to do with the number of other people that present at the same time you are presenting or in close proximity to the time you walk in.

Sure, the triage nurse will select a few very serious patients who will go through the system very quickly, but if you have a more minor problem, how quickly you get seen depends upon who else presents at the same time as you do because if nobody else presents you will be seen quickly. If you are one of those 20 people who have presented in a really busy hour it will take you a while to get through the system. It is tricky to design that sort of thing.

We put a security presence in our emergency department seven or eight years ago now. We did not have one before that. I have been director of the Royal Children's now for 16 years, and I think things have changed materially over those 16 years. The department we are in at the moment has been there for about 12 years and when we designed it — and you heard Peter Sloman, who is one of our nurses, talk about this — we really did design it with very few physical barriers.

We had large benches so that people could not reach across the benches and things, but the anti-violence measures were very passive; and 15 years ago we thought that that was adequate. Ten or twelve years ago it became not adequate; people were reaching across the benches to the triage nurses; people were doing things that we would consider to be unacceptable. So just the presence of a security guard who sits there and most of the time does not do very much except just provide the feeling to everybody there that they are there has really taken the sting out of a lot of situations.

One member of the committee raised the issue of communication with parents. 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 a bank or some other situation; and if they are kept informed we find that that again helps to reduce the feeling of angst and the incidence of violence in the emergency department. 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.

I think that is probably all I really wanted to emphasise. Everything else is in the paper. Violence does happen at the Royal Children's. We are aware of it. We put some passive things in place and we have some active strategies. I am very happy to answer any questions.

The CHAIR — Can you just define a child as compared to an adult? What is the age group we are talking about?

Dr YOUNG — Up until their 18th birthday is what we and the Department of Health define as a child. We do see children after that age. There are some kids with developmental difficulties and some children who take longer to transition across to the adult services so we will see some who are 19 and 20 but not many.

The CHAIR — And there are a number of cases under that age that are alcohol-affected or drug-affected; they come through the Royal Children's for treatment or just for visiting or — —

Dr YOUNG — Largely for treatment. They are brought in by the ambulance service. They are found at Flinders Street station, they are found at the Royal Melbourne show or they are found in other instances. Alcohol is by far the largest drug that we have problems with, and generally it is adolescents who have discovered spirits for the first time. They drink half a bottle of vodka or something like that. Other drugs are less likely. It would be a fairly rare occurrence for us to see children or adolescents high on other drugs.

Mr LEANE — In your submission you mention a management of clinical aggression course.

Dr YOUNG — Yes.

Mr LEANE — Who facilitates that? Who runs that course?

Dr YOUNG — We run that internally now. When we were setting it up we got expertise from the adult hospitals, and specifically St Vincent's Hospital gave us a lot of assistance on how to set that up. That concentrates a lot on de-escalation, on how to talk your way out of situations.

Mr LEANE — So yours is unique to your hospital, but there are similar courses being conducted in other hospitals; is that right?

Dr YOUNG — Correct; that is right.

Mr LEANE — The in-house security which you introduced seven years ago, are they employed by the hospital or are they contractors.

Dr YOUNG — I think they are contractors. I am pretty sure they are contractors actually.

Mr LEANE — Are the individual contractors who turn up particularly contracted to be in your hospital, or could you have a case where some security company has a security guard who may stand in front of a nightclub one night and then come to the Royal Children's Hospital the next night? Are you contracted so that you get the same sort of people and you can train them as to what your expectations are of them?

Dr YOUNG — I am pretty sure they are the same people. I say that because when I turn up to work they are the same faces there so I see the same people each time.

Mr LEANE — Do you see that as an important thing?

Dr YOUNG — I do actually. 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. In reality we get very little time to practise these things apart from on a course like the MOCA courses that we run.

The CHAIR — Do you think it is fair that nurses are not having the appropriate support from the health system in relation to violent attacks on themselves? There seems to be an ongoing currency through the evidence that is being provided by witnesses in this inquiry where nurses have continually provided evidence to suggest that there has been significant underreporting of violence towards nurses and also there seems to be a lack of

support from the health system both to encourage reporting but also to provide that ongoing support. Do you have any view about that?

Dr YOUNG — I do. I think the underreporting comes from the fact that most 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.

Mr SCHEFFER — Rationalise it or understand it?

Dr YOUNG — Probably a bit of both. They are probably right. If this person does sober up and go home he probably is a person in the morning who would not dream of doing this sort of behaviour, so they sort of look through what has happened to them in the same way as they would if it were some other sort of illness. I am sure you will hear from everyone about this underreporting element as to what goes on.

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.

The CHAIR — Would you ever see a point where your hospital would refuse to treat a patient who has been a repeat violent offender, as in a case we have heard about in one hospital?

Dr YOUNG — It certainly has not happened to date that I know of, and I could not see that happening because I think again we would always rationalise it by saying, ‘They are only a child’, ‘They are only an adolescent’ or ‘They are growing up’. Our powers of rationalisation are probably very high — —

The CHAIR — This was not a Royal Children’s Hospital — —

Dr YOUNG — No, but I think we would try even harder to rationalise that this is a child and why we should be dealing with it. If we do not deal with it, who will? Nobody. The other hospitals to some extent are insulated by hospitals around them that will also deal with the same patient load, but if we cannot deal with the kids, who is going to deal with these people? So I do not think we would ever wash our hands of someone. We would have to be forced into it.

Mr McCURDY — Are you comfortable that hospitals would make the right choices if there were further resources allocated in terms of the emergency departments versus the rest of the hospital? You are obviously a director in the emergency service area. Would you have to fight for those resources for the emergency department; are you comfortable that hospitals generally make the right decisions across the board; or would you say, ‘We need to specifically look at these particular areas for our extra security?’.

Dr YOUNG — I think any system will work best when it is integrated into a security system for the whole hospital, but I also think in general people who run our hospitals need to be reminded of the emergency department and the fact that this is the front door of the hospital and they need to concentrate on us and then work out from there.

The CHAIR — If we actually had an open chequebook in relation to budgetary item 4, ‘Providing security in hospitals’, where do you think the best return on investment would be?

Dr YOUNG — The best return would be to create a group of people — I hesitate to call them security guards as it is the wrong term; you really want to come up with a better term than that — who could assist in the security within the emergency department, who had an understanding of the behavioural aspects of dealing with aggression and who could take an active role in assisting the triage nurses to identify situations, to talk down situations that were arising, and only if all of those things failed to actually intervene in a true ‘guard’ sense of the word. My experience of the people we have at the Royal Children’s Hospital at the moment is that we do know them quite well. We have trained them actively through MOCA, but also passively by the fact that they are there, they have seen the way that other clinicians act and even though they are not clinically oriented at all when they start they gain a good understanding with time. Yes, a group of people who had those skills would be the most useful.

The CHAIR — Thank you very much.

Witness withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 29 August 2011

Members

Mr B. Battin
Mr S. Leane
Mr T. McCurdy

Mr S. Ramsay
Mr J. Scheffer

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Professor G. Farrell, Professor of Nursing and
Dr T. Shafiei, Research Fellow, Faculty of Health Sciences
La Trobe University.

The CHAIR — I would like to welcome you on behalf of the Drugs and Crime Prevention Committee. Thank you for appearing as witnesses to provide evidence to this inquiry. We certainly appreciate the effort you went to in relation to your submission and look forward to your verbal submission. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have received and read the guide for witnesses presenting evidence to parliamentary committees.

Prof. FARRELL — Yes.

The CHAIR — We are recording the evidence and we will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We would like to formally invite you to make your verbal submission.

Prof. FARRELL — I supplied some additional information for our submission. If you are happy I will read that and then obviously I am happy to take any questions. Thank you very much again for the opportunity to present information to you. Firstly, I would like to say that any programs designed to prevent and manage occupational violence will require a multipronged approach. You realise, I am sure, there is no magic bullet. Occupational violence really occurs in a vacuum and often it is the outcome of interpersonal interactions that have gone wrong.

While there appears to be some useful initiatives already in place we are really in the dark as to their effectiveness. Indeed there has been little in the way of a systematic evaluation of them in terms of their implementation, their outcomes or their cost. In our own study conducted among Victorian nurses and midwives last year only 54 per cent of respondents had received training in occupational violence. Although there were similar levels of occupational violence experienced by nurses working in EDs, aged-care and mental health sittings, mental health nurses were much more likely to receive training, at 95 per cent, compared to nurses who worked in aged care, 52 per cent, and emergency departments, 54 per cent.

However, among those who had received training related to occupational violence, 43 per cent thought it was marginally or not effective. Interestingly those who had experienced occupational violence were significantly more likely to rate their training as marginally or not effective compared to those who did not experience occupational violence. In respect of the use of Victorian protective services officers, preliminary findings from our study indicate that on-site security guards had one of the lowest ratings, at 64 per cent, in terms of their importance for respondents. On the other hand, factors considered by respondents to be of high importance were training and awareness and emergency response procedures, 88 per cent; having appropriate physical environments for safe care of patients, 87 per cent; and efficient staffing levels to deliver safe care, 80 per cent, as well as appropriate staff skill mix to provide safe care, 82 per cent.

In addition respondents' suggestions to prevent and manage occupational violence focused mainly on training around occupational violence. Respondents asked for thorough training, training to be more interactive with real-life situations, compulsory,

regular in-service and for all staff. One respondent summed up the need for training thus: staff need regular, meaningful, practical refresher courses that are compulsory for all staff. This respondent went on to say that security staff are often the escalators of an incident. How widespread this latter view is among nursing staff is unknown.

We need clarity around what we want to achieve in respect of occupational violence. Are we striving for a reduction in the overall level of occupational violence, or is it that we want staff to start to feel safe at work and confident to manage patients and their relatives regardless of the clinical setting at work. Is it both, or is it something else? Without having quality baseline data on occupational violence we are unable to assess what we are doing in respect of its prevention and management, nor can we evaluate the effectiveness of any new initiatives. Already there is considerable financial investment in staff training which has led to great variety in the content and delivery of programs, even within the same sector, most of which is entirely untried or unproven. 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. I should probably add there that it is increasingly hard to obtain.

The next point should not be taken as a self-interest bid, but 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.

In conclusion, occupational violence in all its forms is a major health-care issue and needs a statewide, coordinated approach to its prevention and management, which is locally relevant and based on sound evidence. The small financial cost associated with the establishment of a centre for research, implementation and evaluation should be weighed against the large personal, financial, and organisational costs of ad hoc, untested approaches. Investment in such a centre, we believe, would send a clear message to all stakeholders that their needs and concerns around occupational violence were being addressed.

The CHAIR — Thank you, professor. Dr Shafiei, would you like to provide further evidence?

Dr SHAFIEI — Not at the moment.

Prof. FARRELL — It was a joint effort, so Touran can add anything to what I am saying.

Dr SHAFIEI — That is right.

Mr SCHEFFER — Thank you very much for your presentation and your submission. In your submission you said that the problems of workplace aggression in these settings was an international phenomenon as well.

Prof. FARRELL — Yes.

Mr SCHEFFER — But I do not think you implied that it was an increasing problem. What I wanted to ask you really jumps off what you said there. Is the situation of violence and aggression in those settings part of what it has always been, and what we need to be looking at is how nurses and other medical people and staff in hospitals address that as part of their profession, or do you think there is some sense that it is changing, and, if so, why?

Prof. FARRELL — That is a good question and it is very difficult to give you an unequivocal answer. The problem with comparing studies, even within Australia, to overseas studies is that different studies use different definitions of violence and aggression. They have different methods of collecting data so it is very hard to get a handle on it. Probably the best way — if you look at some of the research coming out of the UK where they have annual surveys of staff, because we know if you look at written documentation it tends to be underreported, to some extent massively — of getting a handle on just how prevalent it is simply is to ask staff. Having said that, it is either similar over the years or it is increasing; I do not think it is decreasing. There is some evidence to suggest that generally speaking in society perhaps the level of civility towards one another is not as great as it has been in the past. That might add some support to the thinking that the level of aggression across settings in hospitals is either the same or in fact increasing.

Possibly, too, there are a couple of other factors we should be aware of. Nowadays people are much sicker when they are in hospital. If you ask staff what is their greatest distress factor, it will be something around not being able to provide the care that they think patients should receive. That is probably because staff have a bigger workload and they are dealing with much sicker patients than they were a decade ago, so that is probably feeding in to a workplace and an environment that is not the most conducive to de-escalating a patient's frustration.

Mr SCHEFFER — So they are sicker and they are being processed more — —

Prof. FARRELL — They are much sicker, and they being processed quicker. There is no doubt about that. Then we have to look at the staff skill mix and at the level of casual appointments in hospitals adding to the mix.

Mr LEANE — Taking and giving weight to your point about the survey where you have come to the conclusion that the training in the management of aggression and constraint training needs to be more prevalent and more refreshed — —

Prof. FARRELL — More finetuned, I think.

Mr LEANE — As to your suggestion that there could be a centre developed that could refine that, who is currently developing and delivering any training that is prevalent at the moment?

Prof. FARRELL — As far as I am aware, individual organisations are doing their own training. Even within the sector — the sector I was thinking of was mental health, for example — different sectors are doing their own particular training which is likely to be different from next door and what they are doing.

Mr LEANE — Is there a reason it should be different? Is there a reason that it needs to be tailored?

Prof. FARRELL — I think we need tailored training. Front-line staff will need a different level of training to the staff a little bit more removed, compared to, say, people in personnel departments who may have to respond to people who have been injured or who might want support. I also think we could make much better use of online education if it is done well. We now have the means to be quite creative in what we can do online, but it would require some investment. But then that could be rolled out at a state level so you have a similar level of implementation across sectors. You could adapt it at a local level to meet local needs; we are not saying that one size fits all. I think that is badly needed. As I said, we do not have much baseline data at all. Our study in Victoria last year would have been the largest one done and the only one done recently — probably ever — in a systematic way. We are putting a lot of money and resources into training and other initiatives without evaluating their outcomes.

Mr SCHEFFER — Another question, putting it around the other way: do we know anything at all about what patients say, what their experience of it is? It is a bit of a loaded question because what I wanted to ask you to reflect on, if you could, is about the design of emergency departments and the way that patients perceive the process that they are involved in.

Prof. FARRELL — Again, another good question. We have not taken great notice of consumers, and that is why I was saying if there was a centre, it was a buy-in from consumer organisations, because, rightly so, we do need to be cognisant of what patients say as well as the relatives. When people are ill they are often very stressed and so are the relatives, and nurses are busy and the facilities may add to their frustration. Sometimes it is the little things such as not having access to a phone — although I know most people have mobiles these days — but there might be a need for somewhere quiet to receive often bad news about the condition of a relative. That can add to a patient's frustration, or not having access to tea and coffee-making facilities. So I agree with you, a study should look at relatives' needs. Violence rarely occurs in a vacuum, where people come in and are aggressive. There are complex stories around it.

Mr SCHEFFER — I think you said in the study that the respondents said that they ranked the security officers as a low need.

Prof. FARRELL — Yes.

Mr SCHEFFER — We have heard from other witnesses who, I think it is fair to say, regard them as a high need. Is there a range there that would throw some doubt on the response that you have just shared with us?

Prof. FARRELL — There could very well be.

Dr SHAFIEI — Compared to other factors it is of lower importance. We asked how important were these factors, and there were some other factors that were more important than having a security guard in the place. It was 60 per cent compared to 80 per cent of some factors that Gerry read, such as the appropriate physical environment, being safe, or training in communication skills or emergency response procedures.

Mr SCHEFFER — So those things are ranked higher?

Dr SHAFIEI — Yes. Then we asked about the importance in preventing violence and safety at work, and it was ranked as higher in importance than having a security guard. And as Gerry said, they believed that sometimes security guards escalated violence because they do not have enough training. It is acceptable among nurses that patients will be stressed — not that they are violent — and the nurses know how to de-escalate that, but sometimes intervening with security guards makes it worse.

Prof. FARRELL — I suppose, just to add to that, at the pointy end of course you need some protection from security personnel. If you bring in someone who is really in a bad way because of drugs or severe psychosis or something, then I think it is very important that there are people there to protect staff, but even in these situations it does require clinical decision making as to what is the next best option for the patient. I can give you an example of that. Some years ago when I was working in the UK a patient was brought in in a very distressed and aggressive state with police and dogs and the whole works. But it was the charge nurse of the ward, and the way he managed it was that he said he would be happy for the police to go — because the patient wanted the police to leave — but he said, ‘I’ll do that if you can put your pyjamas on and get into bed’. And I thought that that was clinical decision making that was very apt, because it is very difficult to be aggressive if you are in your pyjamas and in bed.

So we just have just have to think about it in the total context. At the very pointy end — yes. But just talking to people — for example, in the mental health department up at the Austin Hospital, they have their own security staff, which they can call on within the field if they need them.

But they are trying to address the problem in other ways as well by having a mental health nurse practitioner working in the A and E department. That person is there not just to see people who may be potentially aggressive or are aggressive but also to assist staff to build their confidence and capacity to manage such patients when he or she may not be there. As I say, it is a multipronged, fairly complex approach. If extra personnel — security officers or protective officers — were to be the main response, then I think we would be missing out on other important measures that we should be taking.

The CHAIR — In your submission, in relation to the issue of violence, you have also suggested it be extended to bullying. Can you expand on the bullying aspect?

Prof. FARRELL — Yes. My view is that that is an important consideration in hospitals, unfortunately. It is important we look at it, because if staff are not working cooperatively among themselves, it is likely to have knock-on effects on patient care as well. Certainly from research coming out from America and from the joint commission — which accredits, I think I put in my submission, 18 000 hospitals in

America — one of their fields when they come to assess the quality of a hospital is looking at what management is doing around staff behaviour in the workplace, because they realise that if doctors and nurses are not getting on together, potentially there are catastrophic knock-on effects on patient care in terms of, for example, mistakes being made, people not being as cooperative with each other as they might be, perhaps not giving others the information that would help them to do their job well. I think soon it will be part of hospital accreditation here in Australia, too. They recognise the importance of staff relationships in the workplace.

I do not think nursing, or medicine for that matter, has a particular issue around bullying. Other places have as well. I was just saying to Touran that in a weekend paper I note there is a case of bullying going through in the Pacific Dunlop brands where one of their former employees is suing for several million dollars. I think it will happen in other organisations. Good organisations have good policies and implement them to ensure that it does not surface. I think in health care, certainly from some of the research we have done previously, staff are much more concerned around staff relationships and feel less confident and safe in managing that aspect compared to patient aggression.

The CHAIR — Is that mainly between doctors and nurses?

Prof. FARRELL — And between nurses and nurses. Yes, unfortunately.

The CHAIR — We have not heard much about it.

Prof. FARRELL — I could give you some research on it.

Dr SHAFIEI — Even in our study we found bullying was very high and had a very differing impact on nurses, like them leaving nursing altogether or reducing their productivity. Bullying had lots of negative effects compared with violence from patients.

Prof. FARRELL — In a Tasmanian study we did a few years back, 2 per cent — it does not sound enough, but it is in the context of there being a nursing shortage — had completely left nursing because of conflict in the workplace. I think it was about 20-odd per cent that were thinking of leaving, so there was a lot of churn as well.

Mr SCHEFFER — Previous witnesses have talked about a continuum of the response that nursing staff have to an aggressive incident where, on the one hand, they can see it as part of the stress — that is, part of the condition — that the person is behaving that way and they have sighted a mental condition as a context, and, on the other hand, it is a person who has had too much to drink and they could be presenting in the same way as they might in the street outside a pub. One is part of their professional treatment; the other one is not something they are prepared to deal with because it is just not fair. Clearly there is a judgement in there and a lot of overlap. As well as that, what witnesses have said to us is that nursing staff often have a view that they can just manage it and they take a more benign view. It was described as rationalising the situation rather than taking a more hard-edged view that this is not right, this is unacceptable in terms of occupational health and safety. How do you negotiate that?

Prof. FARRELL — It is a really tricky one. 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 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. It may not apply to all situations — obviously we will factor in ED — but that to me would be part of the training, to think through some of these issues and then how best to resolve and manage them.

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. These to me are moral issues that need a fairly careful thinking through in terms of how best to manage them. I suppose I not trying to duck the response, but it would be worth looking at some cases in a bit more detail and then working through with staff what might be the best response to deal with them.

There was a nice article, I think produced by some of the medical staff at Austin Hospital, which addresses some of the issues you are talking about. I can leave it for you, if you like. It is called *kNOw Violence*, and they bring up some nice issues around I think what you are alluding to as to how you might respond to different situations. They look at both the circumstances of the patient admission and also the staff response to it and throw up what I would call moral issues around treatment and care.

Mr SCHEFFER — One witness suggested to us that patients who were repeat offenders should be prevented from access to treatment and sent off to maybe a local GP rather than coming to the hospital. You are laughing!

Prof. FARRELL — Who is the local GP?

Mr SCHEFFER — That is what we had put to us.

Prof. FARRELL — Okay. Where does the local GP send them? Is it acceptable for the local GP to have a patient? That is the sort of issue and the complexity that they 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 time that is going to happen there is a bigger issue out there more generally around managing people who can sometimes be aggressive.

The CHAIR — As there are no more questions, is there any summary you would like to present to us?

Prof. FARRELL — Just reiterating the point that we really do need some good quality data on what the issues are, and at the very least I would be suggesting a three-year survey of staff. Probably the best way to get some good data is by encouraging staff to tell you what their experiences are. That literature will grossly underreport the

issue and does not really give you the sort of information I think you want to be able to make an informed decision about where to from here.

I think you asked a question: is it getting worse or better? We do not know, because we have not collected the data, yet we are investing a huge amount of resources — financial and staff time in terms of training and other initiatives.

Mr SCHEFFER — We have been told that in some jurisdictions, like the United States, they do have armed guards in hospitals, and overwhelmingly witnesses have said to us that they do not think that is on. What is the basis for sophisticated countries, such as the United States, that have high-quality medical care and are part of the First World, taking a decision like that?

Prof. FARRELL — I think they have a different perspective on law and order there, even at the most marginal level. If you look at, for example, some of the TV series, they are much more likely to cuff a person for a minor offence than you would see in *The Bill* in the UK or even here. I think they have a different attitude to violence. There may be more violence there in certain parts, but I suspect it is hard to generalise about America as it is, or any country really. It may be some states go down that road a little bit more than others as well. I do not really know. But in some ways they are quite sophisticated, like with the joint commission being really on top of the issue around staff relationships in the workplace as being important, so they go the other way as well.

The CHAIR — We had evidence from the Australian Nursing Federation just prior. They alluded to the fact that the VIN task force has provided 30-odd recommendations of which only some have been fulfilled. You are talking about the need for a research centre to collect more data in relation presumably to statistics in hospitals. I am thinking how much more information do we need before we start implementing? Some of the recommendations are already out there in the public arena.

Prof. FARRELL — When I said a research centre, I would add to that research for implementation and evaluation. I think such a centre could look at what is happening now that seems to be making a difference and have some way of evaluating that perhaps, and maybe then rolling it out in other centres where the problem seems not to have been dealt with very well and see if that makes a difference. It would be more than a research centre; it would be implementation and evaluation. As I said, 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 — —

Dr SHAFIEI — Your evaluation to see which works or will not work in different places.

Prof. FARRELL — It does. Anecdotally, if you talk to people, there is a lot of money and time gone in to train you, and I think it should be looked at as to are we getting the best outcome for the investment we are making. I think it can be tiered. Front-line staff would want one sort of training, I think, compared to staff who are little removed from the day-to-day workings. I would be investing in the internet. I think you can do some very neat training through the internet, and we have got some evidence for

that in a different context — for example, we have used the internet to look at nurses communication skills, and that worked very well.

The CHAIR — Thank you very much for your time.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 29 August 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Dr B. Wilson, Health Services Commissioner, and
Dr G. Davies, Deputy Health Services Commissioner,
Office of the Health Services Commissioner.

The CHAIR — Thank you both very much for attending this joint parliamentary committee hearing of the Drugs and Crime Prevention Committee and for providing a submission in relation to our second reference, ‘Inquiry into violence and security arrangements in Victorian hospitals’.

Before you provide verbal evidence to this inquiry I need to acquaint you with some conditions surrounding your evidence. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of the reciprocal legislation of other states and Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms WILSON — Yes, thank you.

The CHAIR — We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. I have to advise you that we do have the media in the room.

Ms WILSON — Thank you very much for the opportunity to make a submission to this important inquiry. As you already know the health services commissioner exists to receive and resolve complaints from users of health services, hopefully learn from the problems that have been raised and therefore improve the quality of health services. I personally have never worked in an emergency department. Grant, have you?

Dr DAVIES — As a student a number of years ago, yes.

Ms WILSON — So we may seem to be a little bit naive in that respect, but what we do have and what our office is rich in is patient narrative. We hear the stories that people bring to us about what has gone wrong or what their experience has been.

We are not opposing the introduction of armed security guards into emergency departments per se; what we are saying is if that is the only approach and we do not look at the other very important issues, such as teaching hospital staff how to work with and communicate with security staff, if we do not make places like emergency user-friendly and if we in fact design them in ways such that they alienate and anger people and make them more likely to become violent, then we will escalate the problem. So we have taken a softly softly approach, if you like, and pointed 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.

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. I know of one case where the baby died. That is the kind of story we hear.

We have looked at some good design, Dandenong Hospital being a case in point. We have raised issues in our submission about lighting — things that can be calming. It does not mean that we do not think that nursing staff need to be protected; They do, but we need a balanced approach. That is it, in summary.

Mr SCHEFFER — Have you looked at other emergency wards? You picked out Dandenong. Is there a reason for that?

Ms WILSON — Because it is such an excellent example.

The CHAIR — Comparing it with other emergency departments?

Ms WILSON — Old emergency departments, yes, where design factors have not been taken into account so much. A lot of the complaints we hear and the adverse events we deal with are very often design problems. Can I give you an example of what I mean?

The CHAIR — Yes, please.

Ms WILSON — This one is not necessarily about an emergency department but is a really good example of where design has contributed to a terrible outcome. It is the Columbine case from the United States. I heard about this at a conference of medical imaging people in South Australia fairly recently. The paper was given by a medical imaging scientist who is also an architect, so his perspective on it was very interesting. About 10 years ago a young child between six and eight years of age had a childhood accident and was taken in for paediatric surgery. The child was inside an MRI scanner when the anaesthetist found that he was running out of oxygen and started yelling for assistance. Nursing staff had to go a long way from where the child was, down to the other end of the building to get the oxygen. The cupboard was locked and they had to come back. They went back again, by which time the child's CO₂ levels were rising quite dramatically and the anaesthetist was getting very agitated indeed. An unfortunate nurse who had left for the day came back to get something she had left behind, heard the anaesthetist screaming out for help and for oxygen, saw an oxygen container in the kitchen, took it into the MRI room and straight into the magnet it went like a torpedo. The child subsequently died.

There were a lot of things that went wrong in that catastrophic case, but design was a very strong factor in ensuring a really bad outcome. We need to look at design factors. As we mentioned, the kind of lighting can be very important in dealing with people's responses, particularly if the person has a mental illness or is perhaps on the Asperger's spectrum. There are things we can do that than be calming just through design.

To go back to your question, there are other examples of good design. I think it is Ballarat where the waiting area is designed to be used. I am not sure if it is Ballarat or Bendigo. I am sorry, I always get those two mixed up, which is a terrible crime. The waiting area is specially designed so that people are not sitting in uncomfortable rows of white plastic chairs, herded up and waiting anxiously all together. It is designed so that there are some quiet spots, and it is a much calmer kind of atmosphere. I do not have any empirical research evidence to prove that that works — it is more intuitive — but I am sure there is some around. Grant did some research for me and came up with a whole bunch of papers that look at these kinds of issues.

Mr McCURDY — Where is it done very poorly? Are there any examples you can give off the top of your head to say, 'This is a place that is just not a great design'?

Ms WILSON — I am a bit reluctant.

Mr McCURDY — I can understand that.

Ms WILSON — It is partly because I do not have that information, but also to single out particular hospitals — —

Mr McCURDY — Probably older ones.

Ms WILSON — Older ones definitely, and I can remember more in the past. The Royal Melbourne Hospital is a good case in point in that it used to be terrible and now it has improved a lot; it is a much better hospital. The intensive care unit used to be like going into a war camp. People were all huddled around the beds; it was a very crowded and really uncomfortable space. It is now much better. There are offices for staff to go into. There is a world of difference just because of the renovation and rebuilding of the hospital.

Mr SCHEFFER — Thanks for your submission and your presentation. You are, I think, the only witness who has been able to talk to us from the point of view of the clients — I guess, the patients. I think that is true. Most people have talked from the other side of it, from the nursing/hospital side of it. But your sample, from what you say in your submission, is very small. You have 25 complaints.

Ms WILSON — Yes.

Mr SCHEFFER — You put that up-front, so I appreciate that we are operating from a small base. I gather from what you say that you have drawn your recommendations from, in part, that evidence of the 25, but could you share with us a little bit more about what those 25 said, what the spread of issues are that they raised with you?

Ms WILSON — Could I just say that the small sample of 25 is in itself evidence that we do not want to overexaggerate the problem.

Mr SCHEFFER — I appreciate that.

Ms WILSON — I know it is awful for hospital staff to ever be subjected to any violence — it is for everybody — but if it was a catastrophic problem, we would be seeing a lot more complaints than that. I have been in this job now for 14 years, and I have heard a lot of particular stories about where things have been done well and where things have not been done so well, and I have included those in here. There is the example of the hospital-based complaints liaison officer who saw a woman being marched out by security guards. She went out and said ‘What’s going on?’ and was able to talk calmly to the person, calm her down and get her the medical help she needed.

There are the end-of-life situations. I think I put one in about the young farmer who had had a heart attack, and when the family were told that they would have to turn off life support one member went home and came back with a gun. 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. They should be taken away to a quiet spot, sat down and allowed to absorb the information well. That is the kind of thing we are talking about.

Mr SCHEFFER — Generally what witnesses have communicated to us is that it is a major problem in emergency wards and hospitals and that we need more data, we need more approaches, we need better training and we need better design of facilities. There is a whole raft of issues that have fallen out of that experience of the hospitals, and here we have 25 complainants over a period of time. Would it be fair to say that overwhelmingly even patients who have gone into hospital and precipitated, for one reason or another, an incident that has had to be dealt with are themselves generally happy with the way they have been responded to and that is why you only have the 25 complaints? My point is: do you think that a reasonable construction of that is that hospitals are doing a good job in dealing with these very difficult issues?

Ms WILSON — I am not denying the experience of the health service workers and what they are telling you, and with our sample of 25 it may be that the people who have had the experience are not reporting to us because in fact their behaviour was very bad; I don't know. We are not seeking to minimise the problem or to exaggerate it; we are simply trying to say that armed guards alone are likely to accelerate the problem. I have spoken to health service providers in the lead-up to giving evidence to this committee. 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.

The CHAIR — I was just thinking when you were comparing other hospitals that Ballarat has an isolation room, which I see in some of your work here is identified as a need. That has been an underlying issue that has come before this committee in relation to the environment that people come into. Placing people who are at risk of potentially behaving in an antisocial and violent manner in an isolated room actually removes the threat fairly quickly.

Ms WILSON — Yes, it is, unfortunately, a luxury for a lot emergency places because space is at a premium, but it can really help to just isolate people so someone can talk to them, rather than have them get more and more angry and frustrated and the behaviours escalate.

The CHAIR — Dr Davies, do you want to provide any evidence to this committee?

Dr DAVIES — Not specifically, only to say that episodes of violence from anxious and distressed individuals in emergency departments in particular can be situational; it is not a sustained behaviour. It can occur, and with the appropriate intervention it can be managed appropriately.

Mr SCHEFFER — We have had one group of witnesses put to us a view that it is a possibility for hospitals to bar patients who have repeatedly caused violence in wards not as a consequence of a medical condition but because they have been intoxicated. They could be demonstrating that behaviour out on the street, but they have chosen to do

it an emergency ward, for example. They put to us that those repeat offenders should be prohibited from using the hospital and be referred to a GP or a local private clinic.

Ms WILSON — But I would feel a bit sorry for the GP!

Mr SCHEFFER — That has been observed too. What are the ethical parameters? How do you think about that ethically?

Ms WILSON — We have seen over the years a number of examples of people dealing with really difficult behaviours. Contracts can be used so that they can only come to the hospital if they agree by signing a contract to not exhibit those behaviours. That can be quite useful. The violence that we have experienced is not always just physical violence. I recall a patient who was quite debilitated and was not capable of hitting or hurting anybody but really knew how to make vicious threats against nursing staff and their children.

In fact a delegation of about nine people from that hospital came to see me, not because they wanted me to do anything but because they just wanted me to hear their perspective and their story and what that psychological violence, if you like, was like and what it was like living with that every day. They just wanted us to appreciate that, which of course we did. Banning people does not help, because they have to go somewhere. Just telling them to go to a GP or another service is putting the GP or the other service at risk. I have had a great deal of assistance over the years from the Office of the Chief Psychiatrist, particularly Dr Ruth Vine, in helping us to negotiate when we have a difficult patient who may have a mental illness and where the hospital is completely burnt out and cannot deal with it any longer — help in negotiating the terms where they might get their treatment elsewhere. We need to understand the behaviours and what motivates people to become violent.

Mr McCURDY — I am interested in any further information on those contracts.

Ms WILSON — 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.

Mr SCHEFFER — You said in your opening presentation that you are not opposed to armed security guards per se but you must take a holistic approach.

Ms WILSON — Absolutely.

Mr SCHEFFER — Just in the context of that, ‘holistic’ is a general concept, but what specific circumstances do you think might have to arise before you would be prepared to say that armed officers should be present in hospitals?

Ms WILSON — I would not like to enter an emergency unit having armed guards highly visible at the doorway or in the unit. I would rather have signage indicating that there are security guards around and they will be available if there is any poor

behaviour. I remain to be convinced that just the presence of them there is going to prevent violence.

Mr SCHEFFER — But what I am getting at is: do you think there could conceivably be a circumstance where an armed security person would be of benefit to patients and the hospital?

Ms WILSON — If a patient came in with a large knife and was brandishing it around the nursing staff or came in with a gun, then an armed security guard would be appropriate in that highly escalated, dangerous situation. I am not an expert in that.

The CHAIR — Is there anything you would like to add just in summary.

Ms WILSON — No, as you pointed out, our sample is a small one, but that is not necessarily a bad thing.

The CHAIR — Thank you both very much.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 12 September 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Dr G. Phillips, Emergency Physician,
Ms S. Cowling, Nurse Unit Manager, and
Mr P. Cunningham, Security Manager,
St Vincent's Hospital.

The CHAIR — Thank you very much for appearing to give evidence to the joint parliamentary Drugs and Crime Prevention Committee. Thank you also for your submission, of which we have all had briefing summaries over the last few days. We appreciate the work you have done, which I must say seems to be consistent with a number of other pieces of evidence we have had over several months. My name is Simon Ramsay, and I chair the committee. Georgina, are you going to be the lead speaker?

Dr PHILLIPS — Yes.

The CHAIR — Paul or Susan can interject or provide evidence as they see fit.

Dr PHILLIPS — Yes, Paul and Sue both have particular expertise they can speak to, depending on the questions you want to ask or the things you want to hear more about.

The CHAIR — Depending on the format you want to present, we allow witnesses to provide evidence and then we ask questions, or are you happy for us to ask questions as we go through?

Dr PHILLIPS — If it is okay with the committee, I will make a brief opening statement with the key issues, which is essentially a summary of our written submission, and then I will leave it to the committee to ask questions.

The CHAIR — That is fine. I must advise you that we have media representatives in the room, and I have to read you an address to witnesses who provide evidence to this parliamentary committee. Please bear with me while I read that, and then you will understand the obligations and conditions under which you are giving evidence. I will then ask you to present to the committee.

I extend a warm welcome. This is a public meeting in relation to our second reference in the inquiry into security arrangements in the emergency wards of Victorian hospitals. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and where applicable the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege, and I understand you have read or sighted a copy of the guide for witnesses presenting evidence to Parliamentary committees.

We are recording the evidence. Hansard is here and will provide a proof version of the transcript at the earliest opportunity so that you can correct it as appropriate. As I said, you are providing evidence in a public hearing at which media are attending today. I invite you to make your verbal submission to the committee.

Dr PHILLIPS — We thank the Parliament of Victoria for the opportunity to give evidence at the public hearings into violence and security arrangements in Victorian hospitals. Our written submission addressed all the terms of reference of the inquiry, both from a general knowledge and a specific St Vincent's Hospital, Melbourne, viewpoint.

Due to the unique nature of St Vincent's Hospital as the sole provider of inpatient care for prisoners as well as having possibly the highest number of security incidents

in Victoria per day, we believe our evidence speaks with particular authority about the issue of violence and the management of aggressive and disturbed patients. Additionally, St Vincent's Hospital's emergency department was the site of a fatal shooting incident in May 2002, when an armed security guard shot a potentially escaping prisoner inside the hospital building, who subsequently died despite resuscitation attempts in the emergency department. This significant and disturbing event triggered a detailed analysis of the role of weapons within an emergency department and enabled a clear and unambiguous conclusion that there was no place for guns or any other weapons, regardless of who was carrying them, in a hospital environment.

As a result of the particular situation of St Vincent's, we have developed a targeted and innovative security response system which we believe to be highly effective. This approach prioritises prevention and safety within a patient care focused framework. Our evidence seeks to showcase this St Vincent's response as a potential model for all hospitals and emergency departments throughout Victoria so that aggression and violence can be managed in a safe environment without compromising the care, privacy and dignity of all people who seek emergency and hospital care, regardless of their circumstances.

The key issues we wish to bring to the attention of the committee today are that acute behavioural disturbance and violence can be caused by acute mental illness, substance intoxication or a combination of both these factors, as well as primary organic illness such as head injury or delirium. Some environmental factors such as a long emergency department waits, poor communication and busy surroundings can trigger violence and aggression. 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 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.

St Vincent's Hospital has developed a security response which focuses on patient and staff safety, patient care, prevention and de-escalation. St Vincent's has also improved the emergency department environment, with a behavioural assessment room, which we call the BAR, to facilitate safe and secure containment of aggressive patients. The key components of the St Vincent's security response are prevention and early intervention, training and education, attention to the environment, the skilled actual containment of aggressive patients and then documentation, quality control and follow-up. St Vincent's Hospital's security teams work within a patient safety framework which is fundamentally different to a police response, as observed by clinicians.

Introducing weaponry and fortification into a hospital and emergency department environment increases risk. We can provide some examples if you wish, but they are in our written submission. The following recommendations formed part of our written submission and can be repeated here. They are: that a structured approach to violence be standardised throughout Victorian hospitals, focusing on the three key features of environmental improvements, staff recruitment, education and training, and structural supports to ensure appropriate follow-up and support; that the creation of a behavioural assessment room, a BAR, be considered as the most appropriate

environmental improvement to emergency departments in Victoria to ensure safe, timely and private care for aggressive and violent patients; that the St Vincent's model of a code grey team security response, as outlined in our written submission, be considered the gold standard of an appropriate security response for hospitals and emergency departments in Victoria and that adequate resources be provided to hospitals to allow for the adoption of such a model; that all Victorian hospitals and emergency departments be declared gun and weapon-free environments and that all armed police and security officers be encouraged or even mandated to leave their weapons in secure storage facilities provided by the hospital; that under no circumstances should armed Victoria Police protective services officers or any other armed officer be placed in Victorian hospitals or EDs to assist with security; and that hospitals themselves be responsible for the oversight, training and management of all security incidents within their institution under the auspices of an in-hospital security department.

The government should consider greater resources and the funding of solutions-based packages to assist health-care organisations in their training initiatives. Victoria Police should 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 to coordinate training sessions which both emergency department staff and Victoria Police officers can attend. Ongoing audits and critical reviews of violence and security incidents should be done across Victorian hospitals with the assistance of an expert panel comprising emergency department and mental health clinicians, hospital emergency coordinators and specialist health-care security officers so that continual development and improvement of security responses can occur.

A further recommendation can be made regarding the development of centres of excellence for the care of patients with acute behavioural disturbance. As trauma centres have become the accepted standard for the care of all patients with traumatic injuries requiring urgent care, there is an argument for similarly specialised centres within EDs to expertly manage patients with acutely altered behaviour, including aggression and violence. Timely and skilled care in appropriate environments is known to improve staff perception of safety and patient management. A behavioural emergency centre as part of an emergency department would strive to deliver optimum evidence-based care in the safest environment as well as offering the wealth of multidisciplinary services that these vulnerable and complex patients require. St Vincent's Hospital, Melbourne, already has expertise in this area and could provide a suitable environment for such a centre.

We now welcome your questions.

The CHAIR — I have gone into your submission in detail, as I am sure has the rest of the committee, and I congratulate you for the effort and also for the succinct recommendations, which as I said are certainly consistent with a lot of the evidence provided to us over the period of the inquiry. Thank you for the effort and the work you put into the submission and the evidence you have provided today. Susan and Paul, do you wish to make any comments at this stage, or are you happy for us to ask questions?

Mr CUNNINGHAM — I am happy to open the floor for questions. If you have anything you would specifically like to ask, I would be more than happy to try to answer it.

The CHAIR — I will quickly lead, because as the chair I have that opportunity! Your recommendations are able to be managed by larger hospitals, but I am wondering about the smaller ones where they do not have in-house security and they rely on either contracts or outside security. Do you see the messages within the recommendations as being attributable to those smaller hospitals that have external contractors for security — that is, the training and education process et cetera?

Dr PHILLIPS — Clearly it is a resource issue. I have worked in a small country hospital where they had to rely on external support for these kinds of incidents, but I think the education and training is certainly something that can be managed by smaller hospitals along with the liaison with police and the education and training of the police — that collaborative approach. I think those things can be applied in any environment. It then comes down to the resources of a hospital-based, in-house security team.

The CHAIR — Some do not have the luxury of being able to provide contained areas — your BAR rooms, if you like.

Dr PHILLIPS — I have worked at Warrnambool hospital, where they tried to create an environment a bit like the BAR room, but it was much more difficult because of the lack of the other components, which are having the team response, having the education and the ongoing training, having a hospital-wide system for follow-up and reporting of incidents, and all those other things that form part of the whole security response.

The CHAIR — You talked about the training being a state approach with all hospitals. Is there a training module that goes right across all hospitals in relation to security?

Dr PHILLIPS — I am going to get Paul to answer that question because there is not something, as far as I am aware, that goes across all hospitals. Paul will probably know more detail on the training modules we have developed at St Vincent's.

Mr CUNNINGHAM — Yes, they are very much in-house and specific to what your site's requirements are. The training that we deliver at St Vincent's has been about 12 years in the making now, and we have progressively improved it as we have gone along. It is all about establishing the right committees around the training so you can roll out the education for security. In St Vincent's security we work extremely closely with the medical officers and the nursing staff. I guess we are lucky in a way — or I see it as lucky — that we work for a Christian organisation. The values that underpin the work that we carry out on a day-to-day basis are seen in and channelled through our training.

For the major hospitals such as St Vincent's, the Royal Melbourne and the Alfred, I can see that there is a need for some continuity and some consistency in the training mechanisms that are delivered throughout those organisations. I currently sit on the security manager's forum that we have every six months, and we have discussed issues like this. It has been raised that there is a gap. There is a gap in what we do at St Vincent's. I believe we do it to a very high and exacting standard. You then look at

other organisations, and their delivery is probably dependent on what their set-up is. Some organisations may have more security officers.

We have two security officers who respond to our code greys with our support services staff, and then we have the medical staff as well. I know other organisations might send four security officers. We were introduced as a backup mechanism, which has evolved into more of a proactive approach of stepping in at the outset if there is violence. But it is always underpinned by what the health-care organisation stands for, and that is delivering a high standard of care to the patient. When it comes to security, that gets lost in a lot of responses because a lot of security officers go in with the mentality that it is all about trying to contain the aggression and violence purely because that person is acting out that way. You have to look at it more deeply than that and try to understand the mechanisms of why they are behaving that way. That is how we deliver our response.

We do theory base and practical base. We have an hour's session that runs through the theoretical and legislative requirements, and then we go into practicality, where we do scenario-based training. That is where we do restraints and scenarios in which patients become aggressive. We look at how we would effectively deal with and manage those situations as they arise as a team response. We had 3500 code greys last calendar year, so we are pretty experienced when it comes to handling and responding to those.

We have extremely close relationships with VicPol, the police. I know Pat extremely well. We have a police liaison officer in place. I meet monthly with that police liaison officer, and we discuss the issues in our surrounding demographics. I talk about the issues we might have with them on site or ways that we can improve their responses. St Vincent's, in conjunction with Victoria Police, is in the middle of developing a training DVD to try to marry the relationships even further so that they know exactly what their requirements are when they come onto the site and we know exactly what our responses need to be. It is so when they turn up we can work together, there is unity there, we can bring the patient in, we can deliver the care that is required and everyone knows what playing field they are on.

Mr SCHEFFER — Thanks very much for your presentation. You say in your submission that around 40 per cent to 50 per cent of behavioural disturbances in your hospital are due to primary health issues, and you detail those. You say another 40 per cent to 50 per cent are a result of acute substance intoxication — drugs and alcohol and so forth. Within that, there are cases where it is both. You then say about 10 per cent are due to organic illnesses, like dementia, delirium and so on. I will tell you what I am driving at. My question is: is there a category of person presenting that would not fall into any of those categories? The reason I am asking is because it has been put to us that there is a type of person who might present who would be the equivalent of a person acting up outside a club, and basically it would be within the hospital's gift to say, 'You are behaving in a way that is unacceptable to us. Could you go away, go to a GP and make other arrangements? When you learn to behave you can come back and we will treat you, but this is just not on'. When I look at that submission I do not see a space for where that kind of individual would exist. Is that just hypothetical?

Dr PHILLIPS — Those figures are based on a number of different papers that have looked at behavioural emergencies in an Australasian context. That is really looking

at all the evidence that is out there, and this is pretty much the breakdown. I think that breakdown would be true to St Vincent's. It is mostly a combination of mental illness and substance intoxication, and then there are others with a head injury or something like that. What you are describing is a person who is just a bad person or an angry person, who is neither intoxicated nor mentally ill.

Mr SCHEFFER — I am not saying I believe it; I am putting it to you as a proposition.

Dr PHILLIPS — I think that is a very small number, because there may be people who are angry and bad, but often they will come to us in the context of intoxication, which exacerbates all of those things. There are some very infrequent times when we have that kind of patient brought to us by ambulance or by the police. We will assess them in our BAR room, which is right next to the ambulance entrance, so it is away from the main department. This is where the response has to involve a fairly senior medical officer. 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. It certainly is the case that if we deem there to be no immediate health risk and the person is behaving in a dangerous or violent way, we will ask the police to take them away to their lock-up after that brief assessment in the BAR room. If another health issue emerges and the behaviour is different, then of course we can only deal with that.

Mr SCHEFFER — Do you have this kind of person coming to the hospital more than once, so you start recognising them — as in, 'Here they come again'?

Dr PHILLIPS — We certainly have frequent attenders.

Mr CUNNINGHAM — I think a lot of that falls back on where we are located demographically. 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, and they are always treated on merit as they come in. We do not live in a perfect world.

Dr PHILLIPS — Actually most of those frequent attenders do have complex health needs and are often quite vulnerable to illness or injury. There are many people who we recognise and in fact that improves our ability to contain them and respond to them because we know them. We would prefer to manage them in the emergency health-care environment rather than in a less safe and more risky environment.

Ms COWLING — We actually have systems that flag them, so those patients who come in frequently and are problematic when they present to triage or to the nursing staff or whatever — —

Mr SCHEFFER — But they are the ones I gather you are mainly talking about — the percentage break-ups that you have talked about. I was trying to hone in on what had been put to us. I do not want to put words into your mouth, but I was wondering whether there was ever a justification for sizing up a person who presents and saying, ‘Listen, this is not really for us as a hospital. Go away’.

Dr PHILLIPS — Yes.

Mr CUNNINGHAM — Of course there is.

Mr SCHEFFER — OK.

Mr CUNNINGHAM — You may get a mirror reflection of an incident that occurred at a nightclub where there had been a physical altercation. Those people have been brought in, and you may have a group of their friends who also come in. Again it comes back to the fact that most of them are intoxicated. You do not generally just get a person who arrives on the doorstep who does not have some sort of substance on board. They are intoxicated. It may be 2 o’clock in the morning and they act a little bit irrationally. I have often stepped in. It is all about the way you communicate and making sure you deliver the message in the right manner and in the right tone. Generally I can talk my way out of just about anything. I can quell and calm the situation as I see fit. Always having the support mechanism of Victoria Police just around the corner, you can generally come to a very peaceful outcome. It is just a matter of persuasion, really.

Mr McCURDY — Susan, I want to ask about challenges in relation to staffing. You are a nurse and unit manager. Paul has spoken about the security side of things. Have you seen a change over the years in the type of person you need to have in the emergency department or the type of person that is suitable to be in the emergency department? Do you have to be a bit more selective about who takes on those roles? Or is it just that whoever is on shift, regardless of their ability, will handle these situations?

Ms COWLING — At St Vincent’s we have had good retention of nursing staff. Considering all the incidents we have had at the hospital that you might have heard about, we have some long-standing nursing staff. When interviewing staff, especially nursing staff, it is extremely important that they are made aware of the profile of the patient that might enter the area. I am very up-front and open when looking at people coming on about the type of patients that they might see. We are not a trauma centre — I flag that first off. There are no incoming helicopters or anything like that. However, 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. We have a reputation with those services that pick up patients or pick up people in the streets — the ambulance services and the police — of being a place they can bring them to. I make sure they are very aware of all of that.

Most staff joining the team feel quite supported by the environment that they work in. I think one of the things about education for staff has been that it is a joint education. It is not nurses who are educated on their own or medical staff on their own. We do it as a team. It is a team approach, and it is seen as a clinical intervention. I have been involved with the colleges of emergency nursing of Australia and Victoria. In their response to aggression in EDs, a lot of nurses see it as a security approach rather than a clinical approach. For that reason we are able to filter out those people who do not

fit the role. Everyone goes in together at the one time — senior doctors, senior nurses and security. No-one should go in on their own in any of those situations, unless it is something that was not predicted. We try to determine whether there is a clinical need for the patient to stay in our department for their own safety. If there is not, then we look at what the other options are and move them on. However, because of that team environment and because of the environment we have created, staff feel very supported and secure.

In relation to the hospitals you were talking about — those rural and regional hospitals — and whether they could adapt the policies we have here, recently we have had a lot of EDs from Ararat and different areas come to look at our BAR room and see what they can provide in their hospital. Having the right environment is imperative to staff in helping them to feel safe. Having violence or aggression in an open floor plan where there are the patients there — the elderly lady with chest pain — and having staff on their own just does not work. It is too hard to contain, and it is too frightening. Staff need to feel in control when the person arrives. If they have pre-warning and they know that the person is coming or if they have a team, even if it is an all-female team or whatever, everyone knows what their function is and I think they can respond best to it. They feel supported in that environment.

Mr BATTIN — The one area we have not spoken about much is security. I just wanted to ask you to outline the three most important things from your perspective. There is about \$20 million in the budget allocated to security for hospitals, so what are the three things you would outline as being most important for that money? Also, is that your current uniform?

Mr CUNNINGHAM — Yes.

Mr BATTIN — So all of your staff wear a uniform?

Mr CUNNINGHAM — Yes.

Mr BATTIN — Could you just tell us about the importance of wearing a uniform for security staff in hospitals?

Mr CUNNINGHAM — 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.

The uniform is one part of it, but it is all about the criteria you put around your selection process when you actually hire individuals to come into the health-care industry. I have worked in the mainstream security industry for many years. I have worked doors at clubs and whatnot, and 95 per cent of the security personnel out there do not fit the mould you require in health care. If I had a budget of \$20 million — —

Mr BATTIN — That's for the state — it's not just for your hospital!

Mr CUNNINGHAM — I want that whole \$20 million! It would probably be about increasing my staffing levels just slightly. I have three staff members on every shift. That is adequate in a lot of situations, but one more officer would just tie it down beautifully.

I will break it down into two streams. For me it is about personnel and the right recruitment structure. It is also about your training mechanisms, which marry into your personnel. Then the other big thing for me is about physical security in the sense of electronic security, access control, closed-circuit television and whatnot. They complement each other beautifully — your duress alarms and so on. 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, your cameras and whatnot set 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. The two main streams are personnel, getting your recruitment right and then having funding for your access control and CCTV.

Mr BATTIN — Obviously part of this relates to armed officers. When you have armed officers, whether firearmed or not firearmed but with other tools, what is your personal view from a security point of view on the pros and cons of that?

Mr CUNNINGHAM — I would have to strike it right off the plate straightaway. 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.

Mr BATTIN — We have to note you are a fair size.

Mr CUNNINGHAM — I am probably one of the smaller ones there. Again it comes back to your recruitment process — about having guys who look the part, can articulate at all levels, can deliver the right message and can walk into a room and command a little bit of respect, and that delivers the right outcomes. 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 answer to the emergency department manager? Would they be the first respondent? At the moment we are the first respondent. We are the core and crux of the team when it comes to dealing with aggression. It would be about trying to fit all that in and to mould that into a package that would work for everyone. Personally, I would not particularly like to have someone working as a security officer who was not responsible

to me. I 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.

Going back to staff retention, it does not matter how much training you put out there; training offers you so much, but it is about the life experiences. 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. Then 10 years down the track you see how professional they have become. I am involved in the training of nurses, the support services staff and the cleaners, right across-the-board, with aggression prevention training. You see someone when they are extremely green, and then you see them 10 years later in the same sort of situation and they just know how to handle it. It is about retaining your staff and keeping the right people in place, and it goes a long way towards having positive outcomes.

Mr BATTIN — You were talking about how important it is to have that in-house training. Do you find it very important to have in-house training?

Mr CUNNINGHAM — I do.

Mr BATTIN — So you do it and deliver it to the specific needs of that — —

Mr CUNNINGHAM — That is exactly right. I have sat down with nursing staff and risk management, OHS and security people, and it has taken years to get it right. Twenty years ago when I came in there was limited training. Now we have a whole host of training packages, from code grey training to aggression prevention. It is online, it is face-to-face delivery — it is the whole gamut. Certain things work for certain individuals. I think we have covered all that off. The training is run by me and my deputy, Simon, and one of the emergency after-hours coordinators, so you are getting both facets. It is a select group that gets trained. We have a code grey team. They are your SSAs, your nurse unit managers and your emergency coordinators; it is about the people who you empower to do that job and who are able to handle those situations.

Mr BATTIN — Thank you very much, Paul.

Mr LEANE — I want to go on an exercise of looking at a number of your recommendations and joining the dots and for you to comment on whether it is a fair summation of an outcome that you would see as preferable. I refer to your recommendations 4, 5 and 6. I will start with recommendation 6 and take on board what Susan and Paul said about in-house security and the importance of having that team. In recommendations 4 and 5 you are pretty clear, as you are in your submission and in what you have said today, that you do not see a role for PSOs with guns in the ED ward. The genesis of this reference coming to us is the minister being asked about a line item for \$21 million to be put aside to put PSOs into ED wards in Victoria. The minister said the reference could come to this committee to explore the best outcomes and that money would be there for security in hospitals. Notwithstanding recommendations 4, 5 and 6, would it be fair to say that \$20 million should be put towards recommendation 1. If it were spent on your recommendation 1, would that be your preferable outcome?

Dr PHILLIPS — Recommendation 1 is really an overarching recommendation. With the staff recruitment, education and training and the structural supports, the implication is an in-house security-supported type of arrangement.

Mr LEANE — I understand that. Some hospitals might need environmental improvements, as Paul said, such as with closed-circuit television, which you see as a good thing. Some hospitals may be lacking in that area so they might like some of those dollars to go towards that.

Mr CUNNINGHAM — Yes.

Mr LEANE — With the training of staff, some might see they are lacking a little bit in that area and would like to spend some dollars in that area. And in other areas there might be the need for security. Some hospitals might need to beef up their actual numbers, as you said in your submission. If that \$21 million went towards recommendation 1, is it a fair summation for me to say that you think that would be a good place for it to land?

Dr PHILLIPS — As you have just outlined, every hospital will have different needs and a different emphasis. The three key features of recommendation 1 are improving the environment, whichever way we can — whether through a BAR, CCTV, limiting access to the environment, making waiting areas more comfortable and lighting; there are lots of things you can do and all those sorts of things can make a difference. Then the staff recruitment, education and training is really about having not just clinical staff but also security staff and the educational packages that go around that. Then the structural supports are really vital. You have to have institutional ownership of addressing violence and aggression in your hospital. I think we could use the model that Paul has talked about with the multidisciplinary committees that have oversight and follow-up. Every time there is a security incident we need to follow it up and analyse what went right and what did not and what we can improve. We need to have everybody involved at that follow-up stage, and institutional oversight is very important too. Recommendation 1 touches on everything.

Mr LEANE — Yes.

Dr PHILLIPS — And there are the specifics in recommendations 4, 5 and 6 about the security issues.

Mr McCURDY — Do you think there is any benefit in further external education for the community; or do you think a lot of that goes out the window when they hit the triage and what they have heard about or thought about before becomes not as important when they are thinking about the here and now? Is that where it needs to be handled?

Dr PHILLIPS — I think there is a lot of general public and community misunderstanding about what goes on in hospitals and emergency departments. There can be a fear factor that emergency departments are dangerous places or that there are a lot of violent and aggressive people there. I think that really needs to be damped down; actually they are not that kind of place at all. Also I think you meant educating people about the triage process and waiting times, what to expect and the communication issues that go on. I think it would be hard to have general public education about those things, but at the

point of triage within emergency departments issues of communication, and notification of what goes on and what is expected are the sorts of things that can always be improved.

Mr McCURDY — And it will help to de-escalate a few of those issues?

Dr PHILLIPS — De-escalation, yes. Paul's earlier comment was that de-escalation is absolutely crucial. The fact that he is a big bloke and has a uniform is often enough to defuse a situation that is building. The de-escalation is very important.

Mr CUNNINGHAM — 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 A and E 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 A and E department. They have this self-belief that they are the only sick one in there and they should be seen first, but they do not see the back-end and the ambulances bringing everyone in. They see just the waiting room environment and that is it. I have my doubts about educating the public.

Dr PHILLIPS — I think a lot of it comes down to communication at the entry point, because people in pain, people who are frightened or people not understanding — all of those things can make people angry.

Mr CUNNINGHAM — It would not normally.

Dr PHILLIPS — And it can trigger aggressive behaviour, so a lot of it comes down to that.

Ms COWLING — 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. I have sat at many a triage window where you open up very nicely with, 'How can I help?'. It just gets blurted out, and they start banging their fist because they are very frightened and upset. 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. Sometimes it might be that they do come through a lot quicker, but they are taken away from everyone else; the public do not need to see what is going on. Or it might mean that security walk them out the door and say that if their behaviour is not appropriate we cannot address caring for them. Not everything is acceptable in the waiting room and that starts to frighten people, and they frighten the staff who then struggle to care for them. It is very important that staff feel confident that if something happens they have the supports there to help them. 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.

Mr CUNNINGHAM — You have to be careful that you are not seen to be rewarding poor behaviour, because that message gets disseminated very quickly: ‘Go to St Vincent’s; if you act out, they are going to take you through’. Each case has to be judged on its own merit, and you have to do what is right for everyone at the time.

Mr SCHEFFER — We had a previous witness talk to us about the problem of ramping. In your submission you talk about the use of the behaviour assessment room and its value in moving patients quickly from an ambulance into that space, but with the ramping issue, how do you transact that?

Ms COWLING — Those patients would not be ramped. The principle around the BAR has always been that we respond to those patients who we are notified of, in a similar way that we would to any acute resuscitation. We see it as a resuscitation of their behaviour. We have made inroads and have a good relationship with the ambulance and the police. They will ring and notify us that they are bringing someone in. They wait at the ambulance bay doors. They do not let the person out or get out of the police divvy van until the team has responded. We meet them at the door, so they would not be ramped; they would be taken straight in.

The CHAIR — We are nearly at the end of our allotted time for this session. I have a couple of questions arising from evidence given to us earlier. One is a suggestion that there has been underreporting by nursing staff in hospitals about physical or verbal violence, and that is because of recriminations from management. I just need a quick answer: do you see that as an issue? The other is: has there been an escalation of violence of any description in hospitals, or is this just the norm, if you like, that different hospitals are dealing with in different ways? I know your data suggests there has been an increase. I am playing out here whether that is real, or is that perception? Also the in-house security is different for different hospitals. St Vincent’s can afford to do that, but other hospitals cannot.

Dr PHILLIPS — They have prioritised it. There is an opportunity cost for everything, but St Vincent’s has prioritised what it is doing.

The CHAIR — Some hospitals use external contractors from outside security firms. I guess the question is, if there is one firm that actually has a good program of external security and providing security for hospitals, is there an opportunity to rotate security through different hospitals?

Mr CUNNINGHAM — I could not see that as a viable option. Yes, hospitals represent the same thing in the overarching sense that we all provide health care, but they are very different. The dynamics are so different when you move between St Vincent’s, the Austin, the Alfred and Royal Melbourne. 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. We have some contract security that monitors our smaller sites at the moment, just doing drive-arounds and things like that.

Dr PHILLIPS — Do you mean smaller sites than St Vincent’s?

Mr CUNNINGHAM — Like Cambridge. They are within the inner eastern network, so they do not have the same issues that we have, but we do things very

differently from the Austin and the Alfred. We do. I see that at the security managers forums that I go to. Unless you were to have some overarching training package and some sort of mechanism in place that was from the top and then came down, which would pull everything together, then maybe it is a possibility. I think logistically it would be very hard to do. My executive team would have different ideas to those of another hospital's executive team about the way we respond to things, how we deal with them and what are our priorities and underpinning philosophies. Within a Christian organisation we do it very differently to what other organisations do.

Ms COWLING — 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.

The CHAIR — In closing, Susan, underreporting — yes or no?

Mr CUNNINGHAM — No, not at ours.

Ms COWLING — I think in some organisations there can be.

Dr PHILLIPS — Yes.

Ms COWLING — I believe physical assaults are probably getting reported more, although, if they have been physically assaulted, a lot of nursing staff would sometimes wonder about the outcome. From speaking to some of the nurses, I know some organisations do not provide a smooth way of reporting incidents. There is a lot of verbal aggression with which people are confronted on a daily basis that maybe does not get reported. But at the organisation where I work the reporting is very good, and people feel a code grey or code black is for any member of staff, whether clerical, cleaner or volunteer — anyone can call one of those and would be supported in reporting it. But that is not the case across all areas.

Mr CUNNINGHAM — And it is encouraged. We encourage people to call codes. We encourage having those mechanisms in place to make people feel safe. When you talk about reporting mechanisms, it depends on the individual's tolerance to violence. Georgina may see as needing to be reported something that I might not see as such an issue; so it depends on your tolerance levels. I can tolerate a lot. I do not go back and report every incident that I go to, because if I can handle it through communication lines, then for me that is a win. We report every code grey, every code black, every code yellow.

The CHAIR — I am not worried about security; I am more worried about the nurses. Georgina, I do not want to catch up with the past but I need to know whether violence is up or down in relation to emergency wards in hospitals.

Dr PHILLIPS — 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 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, and 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, and there are a lot of substances out there in the community, 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. As for the underreporting, that is a recognised thing that violence in general is underreported. There are papers that talk about that in the literature. Again from our environment it depends a lot on your structures that you have around and the institutional ownership issue as to whether it is being underreported or whether it is happening in an up-front way.

The CHAIR — Thank you all very much.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 12 September 2011

Members

Mr B. Battin

Mr S. Leane

Mr T. McCurdy

Mr S. Ramsay

Mr J. Scheffer

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Associate Professor M. Gerdtz, Associate Professor of Emergency Nursing, and
Associate Professor D. Heinjus, Executive Director, Nursing Services,
The Royal Melbourne Hospital.

The CHAIR — I welcome you both to this hearing of the Drugs and Crime Prevention Committee, which is a joint parliamentary committee. I am required to read you the conditions under which you are providing evidence to this committee today. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have read the guide for witnesses presenting. We are recording the evidence and will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate. Again, thank you very much for providing a verbal submission in relation to our inquiry on violence and security arrangements in Victorian hospitals. Who will be the lead speaker?

Assoc. Prof. GERDTZ — My position is a joint position with the University of Melbourne, which is my employer, and I hold an honorary appointment at Melbourne Health. I am an emergency nurse and my title is associate professor of emergency nursing. I am speaking on behalf of Melbourne Health, and we welcome the opportunity to present to this parliamentary inquiry. The work that we are presenting today in the management of clinical aggression is really informed by the mission of Melbourne Health to provide world-class health care to the community and also to respect the dignity and beliefs and abilities of every individual. It is also important to the strategic direction of Melbourne Health and in particular to implement continuous service improvements with strong clinical governance frameworks, so the innovative approaches and discussions in relation to the management of clinical aggression that we have outlined in our submission actually are informed by the recommendations from the final report of the Victorian Task Force on Violence in Nursing which was published in 2005, and in particular our submission really speaks to recommendation 11 of that task force, which was about establishing a reference group which is responsible for developing policies and procedures around the management of aggressive incidents.

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 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, but it is important that we also consider the evidence so we are also looking at research that might be done to point us to new initiatives.

As a result of constantly looking at the research evidence — and there is a lot of literature coming out all the time, and we discuss that at meetings and so forth — part

of the work we are doing, which is outlined in our submission, is looking particularly at point-of-entry screening for people who are at-risk individuals. What we do know from looking at the literature is that there is limited evidence about the effectiveness of any intervention beyond training to reduce episodes of violence in emergency departments. That does not mean that work has not been done — there has been some work in the US, for example — but it is not related to this particular context. However, we do consider that evidence. When we have our monthly and bimonthly meetings we talk about new initiatives. We have also undertaken an audit, which is outlined in our submission of 2010, to describe what is happening at Melbourne Health. That is part of a larger piece of work that we are doing around violence risk screening.

Mr SCHEFFER — Can you elaborate on that a bit more? Were you saying that there is no evidence that any initiative other than training makes a difference?

Assoc. Prof. GERDTZ — None that makes a difference to actual episodes — the actual occurrence and incidence of events — in the emergency literature. That is not to say that in other contexts that will be the case, but in the emergency medicine and emergency nursing literature that is the case. That does not mean that we do not support the idea that something could be done, and we would be interested in looking at what evidence could be gathered about the effectiveness of an increased security presence, including things such as risk screening. We feel very strongly about the fact that any interventions that are considered need to accord with the idea that they are evidence based and person centred. We want to focus on the idea that patient and staff safety at Melbourne Health occurs in the least restrictive environment possible to achieve that optimal outcome, which is the safety and quality of the working environment for staff as well as the patients who we care for.

Mr SCHEFFER — I want to come back to the issue of incidence and prevalence. First of all, what is the incidence? Then can you talk a bit about whether you think there has been an increase in the number of incidents that your hospital is being called upon to deal with?

Assoc. Prof. GERDTZ — The data capture we have at Melbourne Health has been improving remarkably since 2006, and that is in line with the work that was done through nursing policy and the occupational violence task force. One of the things was to improve data capture, and Melbourne Health has certainly done that. We talk in our submission about the two different ways that we get information about violence: the RiskMan and the code grey database. We have observed in the data we have that there has been an increase in the number of planned incidents. That means that staff are being more proactive in activating an early response to contain potentially aggressive incidents. We call those planned code greys. Certainly those have increased, but there is no evidence from 2006 to the present that the actual overall incidence of violence is increasing. There is no local evidence for that, but the proportion of planned events is increasing, which we would consider to be a good thing.

Mr SCHEFFER — Are there changes in the types of incidents and behaviours of people presenting that relate to difficulties?

Assoc. Prof. GERDTZ — Within that database there is no way of capturing the severity of events, and that is because there is no agreed classification for thinking about severity.

Mr SCHEFFER — Is severity the same as type?

Assoc. Prof. GERDTZ — No.

Mr SCHEFFER — Is there difference in the types of events that are occurring?

Assoc. Prof. GERDTZ — No.

Assoc. Prof. HEINJUS — The way it is reflected in the database is whether it is a planned code grey or whether it is a code grey. It does not go down to the detail. The database would be accurate because the event is entered into the database as soon as the event is completed, so we would be very confident that the database that the security team keeps is relatively accurate, but it does not drill down into type and severity.

Mr SCHEFFER — How do the systems relate to reporting? We have been told by a number of witnesses that there is underreporting because of a range of factors influencing hospital staff in that area; could you comment on that?

Assoc. Prof. HEINJUS — I think there is underreporting in the RiskMan, and that is primarily because emergency departments are very busy places. People who work in an emergency department over time probably build up a threshold for managing it. Having said that, I think actual events are relatively accurately captured in RiskMan. If there is an event where a staff member has been hurt or where there has been an event where they felt really threatened, I think they are relatively well documented in RiskMan.

Mr SCHEFFER — These are not your words; they are mine. When you referred to nurses or hospital staff being in a situation where they are getting used to these kinds of events, is there also — and it has been put to us — a culture within hospitals of ‘just deal with it’?

Assoc. Prof. HEINJUS — I do not think that would be reflected at the Royal Melbourne emergency department. I think the staff would know that we have put a lot of time into building up a values-based culture of working there. We would not ever expect any staff member to just manage it. Certainly I think that is the sort of event that we would see documented in RiskMan if there was a case, and I cannot recall that there ever has been.

Mr McCURDY — I have a question about PSOs as opposed to in-house security. Is there room for PSOs coming up through the system, or is the in-house system far better?

Assoc. Prof. HEINJUS — We have four security officers rostered on all shifts at Royal Melbourne, and I think that works well for us. They are well known to the staff, they are continually moving, they respond to planned code greys and they work with the clinicians. Again, referring to the values around teamwork and unity, I think it works well for us. There are times when we might bring in additional security staff if we have a particularly challenging patient who has moved from the emergency department into one

of the wards. We have been known to bring in additional security staff to work alongside that particular nurse.

Mr LEANE — This is a brief supplementary to Tim's question. Are security staff in-house?

Assoc. Prof. HEINJUS — Yes.

Mr LEANE — Have they always been?

Assoc. Prof. HEINJUS — I have been at Royal Melbourne for four and a half years, and I have only ever known them to be in-house during that time.

The CHAIR — Can I ask about the types of antisocial behaviour, if you like — for want of a better word — in emergency wards rather than the verbal violence? Alcohol, drugs and mental health seem to be the main components of antisocial behaviour. Are we talking about threatening or actual physical attacks? What sorts of violence are we talking about in relation to Royal Melbourne?

Assoc. Prof. HEINJUS — We would experience what you have already outlined. We are a major trauma centre for Victoria, so there are times when a patient who has a head injury, for example, may be behaving out of character during that period of time. They are likely to have a nurse caring for them one on one. If they are particularly aggressive, we might have a security officer close by as well during the acute episode. However, we would experience the behaviours you have outlined in a busy emergency department like Royal Melbourne.

The CHAIR — Are they more mitigated by waiting time?

Assoc. Prof. HEINJUS — I would not be able to confirm that. I think people are who they are and they can get aggressive at times, but I am not sure that it is always to do with waiting times. I think it can be the result of alcohol, drugs or an acute mental health episode. And, as I have said, sometimes through a head injury or acute trauma people can react differently from how they would in everyday life.

Mr SCHEFFER — I just want to come back to the point I asked you about in relation to initiatives other than training.

Assoc. Prof. GERDTZ — About the evidence?

Mr SCHEFFER — I was just trying to run through a bit of a check list of what I could think of that was not training. I must agree with you that a lot of things fit under training, so I can understand why you said what you said. But could I ask you to talk a little bit about the issues of design that a lot of witnesses have talked to us about — the design of waiting rooms — —

Assoc. Prof. GERDTZ — The environmental design?

Mr SCHEFFER — Yes, environmental design, and everything from wall colours to ambience to how people are communicated with — TVs, books, magazines, all that stuff. What are you doing at Royal Melbourne in relation to that?

Assoc. Prof. GERDTZ — The emergency department at Royal Melbourne was redesigned and has been occupied for just over two years now, so it is a relatively new facility. Certainly within the waiting room area there have been some changes from the old department, for example, with television and things like that in the waiting room itself. There is also the design feature of a security presence right at the front door. So from a monitoring point of view they are able to see the triage area directly from where they are sitting, as well as being able to see the ambulance bay. In terms of the inside, work has been done — not at Royal Melbourne, but generally — around noise levels. 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. I know from working as a clinician in other EDs, while they have very high throughput in that emergency department — they are seeing over 60 000 patients a year — the activity level does not appear that way because of the way the cubicles are laid out and also the fact that there are solid walls, as opposed to curtains, between groups of patients. There is better privacy and less noise.

Mr SCHEFFER — That is once the people have been seen. But when they first present and come up to the window and say who they are and are asked to sit down for a while, am I right to say that it is in that waiting period that incidents are likely to occur?

Assoc. Prof. GERDTZ — That things happen, yes. With some of the things that have been done we think of it in terms of addressing issues around the environment and interpersonal communication aspects, and dealing with individual patients as well. So we have a sort of a three-way model. For people who are queued to wait to come into the emergency department there is a designated nursing role, so those people do not have the perception that they are waiting as long, even though they are waiting to see a doctor. They will have contact with a triage nurse and then be queued to go inside, and they will still be seeing another nurse who may be initiating some other things for them. One of the important things about that nurse is that they will be communicating to the person about the wait. Mostly if people understand about why they are waiting and there is a perception that something is happening — for example, some X-ray has been ordered or they have been given some medication that has been ordered, such as Panadol for pain — then they will accept what is happening, as long as they are informed. We would think of the design aspect as being the people as well and how the roles are designed. That has happened fairly recently as well.

Mr SCHEFFER — I was going to ask you about the violence risk screening project. Are the kinds of environments and processes you have just described part of that project?

Assoc. Prof. GERDTZ — That is right. With the violence risk screening project we looked extensively at the literature to identify what the early warning signs are for aggression and what some of the observed behaviours are. 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.

Assoc. Prof. HEINJUS — During our busiest times we have volunteers who have a presence in the emergency department waiting room as well, and we also have a nurse working in the waiting room, just on the assessment of pain and letting people know where they are sitting in the waiting period. It has been very successful with the volunteers.

The CHAIR — The Alfred has a red card system for where there are repeat aggressive offenders in relation to any social behaviours that come before the department. St Vincent's Hospital had a different methodology to deal with those repeat offenders, if you like, in relation to aggressive behaviour. Does the Royal Melbourne have a methodology in dealing with repeat offenders, like refusing to provide medical assistance?

Assoc. Prof. HEINJUS — 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.

Mr McCURDY — I want to flesh out the volunteer side of things again. I suppose you are not the first one to tell us that in some instances, or many instances, it may be better value having somebody who roams around and keeps people informed rather than a six-foot-five burly security guard standing in the corner, and that there may be better usage of time that way. Have the volunteers been going on for long at the Royal Melbourne? Has it been measured, or is it a relatively new concept?

Assoc. Prof. HEINJUS — It is relatively new, probably — —

Assoc. Prof. GERDTZ — In 2008.

Assoc. Prof. HEINJUS — Yes, but it has been very successful, and I think the volunteers can see they are adding real value as well.

Assoc. Prof. GERDTZ — 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; so they do not do anything without being carefully monitored.

Mr McCURDY — Is this a 9-to-5-type arrangement, or still at midnight on a Saturday night?

Assoc. Prof. HEINJUS — No, it is not at midnight on a Saturday night. It is usually around the busiest hours, but it is tried to be mixed with availability of volunteers as well, so it is reasonable hours for them.

Mr SCHEFFER — I just want to get right down to the gory bit. Do you think there is a role for firearms or weapons in the emergency departments of your hospital?

Assoc. Prof. HEINJUS — I would not see that that would be something that we would take up at the Royal Melbourne Hospital emergency department, no.

Mr SCHEFFER — Then I want to ask why not?

Assoc. Prof. HEINJUS — I am not sure that there is evidence that it makes a difference, and in fact it could evoke the reverse reaction. I think what we have got with the trained security officers and the teamwork with the commissions works.

The CHAIR — Thank you both very much for your time this afternoon. We appreciate it.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 12 September 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witness

Professor M. Johnstone, Director, Centre for Quality and Patient Safety Research,
Deakin University.

The CHAIR — Professor Johnstone, welcome to the hearing of the Drugs and Crime Prevention Committee. It is a joint parliamentary committee so we have a bipartisan representation here. We understand you are just giving us a verbal submission. You are looking worried.

Prof. JOHNSTONE — A little bit.

The CHAIR — Before you say anything, I will advise you that we have media here. It is a public hearing; they have every right to be here and report what is being said. I need to read you the conditions around which you will be providing evidence. I am sure you are well versed in this, but we need to do that for the transcript. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comment you make outside the hearing may not be afforded such privilege.

I understand you have read the guide for witnesses presenting evidence to this parliamentary committee. We are recording the evidence, and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. I will leave it up to you to make your presentation.

Prof. JOHNSTONE — I understood that the principal driver for me being invited here today was because of some research that a colleague and I conducted some years ago. I will just scope that project, and then explain where I am positioned with that subsequently and its possible relevance to the proceedings today.

My colleague who has now retired is Olga Kanitsaki, who was a former head of school of nursing at RMIT. We were successful in getting a grant funded by the Department of Human Services for the public health research project of 2004–05. Essentially what we were looking at was the cultural safety and cultural competency in Victorian health services. Our project ended up being quite significantly larger than what we had originally intended mainly because of the extraordinary interest that was shown in it. All up we interviewed over 140 people which comprised both individual and focus group interviews. There were over 17 of what we would call field sites, if you like, which also included consumers in their own homes. We interviewed people in residential aged-care facilities right up to acute care services. It is solely a Victorian study.

The results of that study were published between 2006 and 2009. As far as I am aware there has not been a comparable study conducted in Victoria. The works we have published are just starting to be cited in the patient safety and quality care literature now. I think probably one of the distinguishing features of our work was that we were successful in substantiating the link between culture, language and patient safety. As extraordinary as it might seem, that link had not been formalised before, even though you can see our study was done in 2004–05 and was published in 2006. One of the articles was the first in international literature to formalise the link between cultural language and patient safety. Up until then it would be fair to say that the issue of cultural diversity was seen as a Cinderella issue — in other words, it is an issue we can give attention to if we have the resources.

Our experience was that after making that link and reframing the issue with a framework of clinical governance and showing that this was really not just an ethnic issue, if ever it was, but was fundamentally a patient safety and quality care issue, we got a lot of traction with that. We presented that paper over 20 times to different health services in Victoria, which was quite astonishing. On the basis of that article we also were invited to make a significant contribution on safety to a forthcoming *Encyclopaedia of Immigrant Health*. I feel perhaps what may be of interest to you is the reframing of issues and tensions that can exist between patients and staff, staff and staff, and staff and management around the so-called ethnic issue.

What was of particular interest to us was that Victoria is one of the most multicultural states in Australia, so the field was really ripe for our investigation. We found in some of the health services we accessed, and I am sure you are aware, that sometimes one in every four, one in every three and sometimes one in every two patients presenting to an emergency department was of a non-English speaking background. If you add into that the complexity of people's terror of illness and injury and all sorts of other issues, as well as it often being an environment that is very foreign and unfamiliar to them, in terms of patients presenting that are foreign and unfamiliar to staff there can be a mix for accidents waiting to happen.

I will just put a caveat around publications between 2006 and 2009. I have not been involved in any robust research since that date, so I really wish to make it clear that in terms of research it is dated, but then I am not aware of other work that has been done. My reading of the literature since then is basically reaffirming what we found in other cultural contexts.

The other thing that we found was that while some individuals and health services were doing extremely well in ensuring the delivery of culturally responsive health care which helped mitigate tensions and stop situations escalating, others were not doing it quite so well, and it seemed to us that what was being done well was very much a matter of work being done by conscientious individuals and conscientious institutions.

I should also say that I am mindful that following the publication of our study the department did put out a *Cultural Responsiveness Framework — Guidelines for Victorian Health Services*. We were invited to consult on that framework, and it is my considered view that that is a very comprehensive framework and really a good example for the country in many ways.

One of the things that I think has been difficult for Victoria, and we would base this on our study, is the absence of robust national standards and frameworks for culturally responsive health care. We do not yet have anything to compare with what the US has done, for example, where they do have national standards for culturally and linguistically appropriate services.

Things may have improved with this, although again in the work that we did around the time this was published we would say that you can have the best policy in the world, but if people do not understand that at the coalface, then that policy can be prevented from being realised, either intentionally or unintentionally.

The summary of what we found was that overall most of the people we interviewed had not had any formal education in caring for people from diverse cultural backgrounds. There had been a bit of a mix of — —

Mr SCHEFFER — The 140 interviews that you conducted — —

Prof. JOHNSTONE — We conducted interviews with 145 participants.

Mr SCHEFFER — What was the break-up of the participants.

Prof. JOHNSTONE — Yes, I can give you that break-up. Can I give it to you later, or do you need it now?

Mr SCHEFFER — Yes, just roughly, so we know who they were, because you went on to talk about what they told you, so I want to know who told you what.

Prof. JOHNSTONE — Yes, actually I do have that here. The categories were: nursing staff; patients and families; ethnic liaison officers; health interpreters; allied health professionals, which included speech pathologists and occupational therapists; ethnic welfare organisations; health service managers; and what we loosely term cultural trainers or educators.

In terms of the individual interviews, from the nursing staff there were 16 total interviews comprised of 11 focus groups and 5 individuals, so 51 nurses; for the patients and families, a small sample of 8 consumers; for ethnic liaison officers, 18 with 16 individual interviews; health interpreters, 3 groups with 6 health interpreters all up; allied health, 4 and 4; ethnic welfare officers 5 interviews but 11 people; health service managers, 20 interviews of 32 people; and cultural educators, 13 interviews with 15 people all up. It was quite a comprehensive sample, and that was spread out across 17 sites.

What we found all up was that only two had heard of the term ‘cultural safety’, which was interesting, and although not having had formal training in cultural competency, they were able to make a link between cultural competence and clinical competence. Few had thought about the relationship between cultural language and patient safety, but at the end of the interviews you could see there was a change in thinking, saying, ‘It makes sense’.

What we also identified through the study was that health service strategies and interventions backed by good government strategies and policy was really critical, and leadership from the top was really critical. If there was no support from the top, then strategies to help improve cultural competency and organisations would be lacking. Infrastructure support, education and training — and I would just say that it is really important to recognise that education and training are not the panacea but only part of the process, there needs to be good infrastructure support as well. What we found was that among those who were leading education and training, and certainly ethnic liaison officers at that time, there was a high turnover because they burnt out. The work was so demanding that they would burn out.

Definitely there is a need for research and evidence-based practice, and I can tell you it is actually quite difficult to get funding for that area, because it is not seen as a

priority at NHMRC level. There is also the usual issue of funding and human resources. What we found at that time was that interpreting services were grossly underfunded and that health services were having to dig deep and engage in very creative strategies to meet people's basic communication needs.

At this stage we are still finding examples, even though it contravenes state government policy, of using children as interpreters. This is particularly so with newly arrived refugee groups and asylum seeker groups. I just clarify that there is a difference between immigrants, refugees and asylum seekers. Not only is there a cultural difference but they also tend to bring a whole baggage of trauma with them, which adds another layer of complexity in providing responsive care.

I think the other thing about the new arrivals in the last five or so years is that they are very different from previous rounds of migration. People from the Horn of Africa in particular are physically and culturally very different, and in many ways what I am hearing through my networks is that there are the same issues that were occurring in the 1950s and 1960s with Greek and Italian migrations: things like not having good resources with interpreting services because they have yet to build them up and the need to really develop strong outreach and community liaison and so forth in order to reach people and also help disarm them of their terror when they may have had very traumatic experiences in their countries of origin.

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 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.

In other instances, war veterans, obviously in their older age, with unresolved post-traumatic stress, did not want to be cared for by Asian nurses. We captured incidents such as, in one case, where an elderly veteran screamed that he did not want this Asian nurse near him, and at one stage threw a hot cup of tea over her back. There were quite difficult situations like that.

I think that is probably about it in a nutshell, but I am happy to take questions. One more thing we found that I probably overlooked, which is fairly confronting and which we published, is language prejudice and discrimination in a hospital context. We really linked this particularly to equality and patient safety, and it did occur right through the health system, that people who had so-called 'thick' or 'heavy' accents or who were not seen to be speaking the English language proficiently were sometimes treated as also being rationally incompetent and were treated in demeaning ways, which also escalated difficult communication between staff and patient, family and staff and sometimes between family members as well.

The CHAIR — You did say, but can you just remind me again when that research was done?

Prof. JOHNSTONE — Yes, 2004 to 2005 — it was completed at the end of 2005.

The CHAIR — I am just wondering if conditions have changed in relation to the interface between migrants and staff.

Prof. JOHNSTONE — I cannot comment on that with authority because I have not really done any follow-up research on that. We did do a little bit of trawling subsequently through the health services commission report to see whether there were complaints around communication. One of the difficulties is that it is difficult to capture so-called ethnic datasets, so you would have communication problems. We know communication contributes to a majority of adverse events in health care, but there was no mechanism for distinguishing whether that was due to a failure to use interpreters. I know at one stage the health services complaints commission was distinguishing that and had identified some cases as being due to failure to use interpreters, but I have not looked at those documents recently, so I cannot comment on that.

The CHAIR — I was really thinking of the nursing staff now, who are quite multicultural. They are obviously bilingual; a lot of them have different languages and could provide that interface fairly quickly without the need to go and seek interpreters.

Prof. JOHNSTONE — Yes, no and maybe.

The CHAIR — I am not saying that it happens all the time; I am just saying in that period from 2004 — —

Prof. JOHNSTONE — Again I cannot comment. I would like to think it has improved. Certainly since the guideline document has come out I know anecdotally that health services have been working very hard to operationalise this framework. I know this because of still being invited to present the cultural language and patient safety as part of health services' attempt to be rolling in the operationalising of the framework. The stories that I get during that seem to be or are obviously anecdotal, and I really do not feel I am in a position to comment one way or the other.

The issue of bilingual staff is an interesting one and one that I am familiar with. I guess I should make the point that staff, whatever their cultural background, are just as vulnerable to misreading their patients and fellow staffers as anybody, so it is not just a problem of patients; it is also a problem of staff. Secondly, I think we need to be careful in assuming that just because a health professional is an immigrant they have cultural knowledge and are culturally competent. In fact I would say quite the reverse. There are two reasons for this. We found instances where, because of their desperate need to fit in, they really sometimes want to try to disguise their backgrounds, or they feel too embarrassed to use their language and are sometimes made to feel that they should not be using their language. There is that aspect, and we have captured case studies of that in our findings.

The other thing is really about competency. Health interpreting is a highly skilled strategy for improving communication. Certainly we would see family as having an

obvious role in day-to-day stuff — and doctors, nurses and allied health professionals who are bilingual in terms of their own work. But in terms of doing proper health assessments, it is really vital that a qualified health interpreter is used for that purpose. There is no way of knowing just what the level of competency is for bilingual staff. They are not qualified health interpreters. Secondly, even if they were, there is a risk that that would take them away from their designated duties; and thirdly, you might get someone who speaks Italian, but there are many dialects in Italian, and it is the same with the African languages; there are many dialects. There is always a risk of misinterpretation, particularly when using specialised medical and nursing language.

The CHAIR — I will stand corrected.

Mr SCHEFFER — I have a question. You mentioned the framework guidelines. I am not sure what they are. What I want to ask you — you may have done it in your presentation and I lost focus; and if you did, forgive me — what is in that document, and how does that relate to standards in the USA, which you referred to. I just wondered what the framing of that was.

Prof. JOHNSTONE — When we did our study we discovered that the US has really, I guess, seized the moment, if you will, and developed a national standard for culturally and linguistically appropriate services. They have a very large document on standards that are mandatory, standards that are required and standards that would be good to do if it was possible.

Coupled with that they also have a national research agenda, so that it is backed by evidence — you know, a whole agenda of research that is providing evidence for the strategies that are being implemented. The other thing is that they have gone considerably further than we have in Australia in also making the link with patient safety and quality care. Since we have done the report the Joint Commission on safety in the US has now also rolled out a very substantial work on the link between cultural language and patient safety. It is right out there: there is no avoiding it.

Mr SCHEFFER — So that is mandatory, is it?

Prof. JOHNSTONE — They have mandatory standards.

Mr SCHEFFER — In all states?

Prof. JOHNSTONE — It is a national framework, so they have a list of standards that are mandatory. There are those that are required — I actually have our major report, which I can leave for you, if you like, and the information is there — and those that would be nice to have if you had the resources to follow them.

This cultural responsiveness framework, I guess, went a considerable way in Victoria to really identify what was critical in terms of ensuring the responsiveness of Victoria's health services to its culturally diverse population and also made the link to the clinical governance aspect of it. It is not just an ethnic issue; it is also most profoundly a quality and patient safety issue. Although there was limited research, and I might say there is still limited research internationally, there is enough to join the dots to show that failure to be culturally responsive to patients can lead to a

trajectory of what we would call accident opportunity: they are accidents waiting to happen.

Mr SCHEFFER — Okay. That was the next bit I wanted to link into.

Prof. JOHNSTONE — You know, misdiagnoses if you cannot communicate. 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. Certainly we captured some of that in the context of our study.

Through my other work at our centre I am also privy to and have seen similar situations. We know communication breakdown is a major contributor to adverse events in health care, so it is no surprise. What we did in our landmark article was actually trawl through legal cases, primarily overseas. We certainly do not have precedent for Australian jurisdictions, but the Canadian cases in particular were of great relevance to Australia because of the cultural similarities and the cultural diversity. They really helped underscore the importance of ensuring a quality and safety approach to cultural diversity and not just marginalising it as an ethnic issue. I would say that link is now firmly established.

Mr SCHEFFER — Earlier in your presentation you talked about ‘accidents waiting to happen’ in the context of people from non-English-speaking and culturally diverse backgrounds sometimes having a one in four, sometimes a one in two, frequency in presentations, so clearly the dimensions of the issue are large. Most of what you have talked about in terms of patient safety has been in the kind of clinical area, and that is very serious, but what we are talking about here under our terms of reference are acts of violence or aggression, mainly in emergency department settings but also in other parts of the hospital. Do you have any information at all, or did you in your study come across that relationship with those types of incidents at all?

Prof. JOHNSTONE — The main thing was miscommunication at triage. 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.

Mr SCHEFFER — What I am going to say might sound very provocative, but it is actually part of our terms of reference. It is about firearms and other weapons in those kinds of settings. You have probably answered it, but could you respond to it for the record?

Prof. JOHNSTONE — Would you formulate the question?

Mr SCHEFFER — Touché. The question is: do you think there is any justification for having firearms or other weapons in hospital settings with particular reference to emergency departments?

Prof. JOHNSTONE — I can offer you a personal opinion on that. I do not have evidence, but I would see it as being very provocative.

Mr SCHEFFER — You agree with me.

Prof. JOHNSTONE — Very provocative in a dangerous way, particularly if you are dealing with already triggered 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.

The CHAIR — Thank you very much, Megan. We appreciate your time and the work you have done in your research.

Witness withdrew.

Proceedings in camera follow.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 12 September 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witness

Sergeant P. Ryle, Operational Supervisor, Victoria Police.

The CHAIR — I welcome Sergeant Ryle. Thank you for giving us your time. We respect your request for part of your evidence to be taken in camera. I would like to read you the conditions around your evidence. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you read the guide for witnesses presenting evidence to this parliamentary committee?

Sgt RYLE — Yes, I have.

The CHAIR — We are recording the evidence and will provide you with a proof version of the transcript at the earliest opportunity so you can correct it as appropriate. Thank you for providing us with your verbal submission.

Sgt RYLE — First of all I would like to give you some background about my involvement in police and health services. I was the liaison officer at St Vincent's Hospital for an eight-year period from early 2001 to 2009. As a result I was asked to speak at a number of conferences externally and I visited a number of hospitals as well, I suppose to spread the message of the successes we had at St Vincent's from a partnership approach, including at the Australian Nurses Federation, emergency department conferences and an up-and-coming conference in October which I have been asked to speak at.

I wanted to relay some of the experiences at St Vincent's and the establishment of the emergency services liaison committee, the issues that arose and the policies adopted. We developed policies in relation to the speedy and efficient transition of mental health patients who were taken to the hospital by police. We wanted to try and do it in a timely manner; and you have heard from St Vincent's about their response of a code grey. I have noted in other forums that code grey is not common. It is not an Australian standard, and that is being addressed by the department. Some hospitals do not even have that response at all, let alone a different response. There was also the use of a behavioural assessment room to take people who were violent and aggressive. We dealt with a lot of issues of absconding patients, particularly from mental health facilities, which become issues of violence.

The difficult issue for the police in general was trying to deal with the overarching policy of the Mental Health Act in treating people in a less restrictive environment. Police would take patients to the hospital who were quite violent and quite ill and they would see them on the street in a very short period of time thereafter and would wonder why they were out and were then listed as missing persons. We addressed that. We raised a number of issues in a working party in conjunction with the hospital to address that. When I took over in 2001 we were averaging one person a day being reported missing and they were missing for an average of four and a half days, so you can imagine that it created a lot of work. I have moved on from Fitzroy, and I recently spoke to the police liaison officer there now and it is down to about 105 per annum.

There have been some fantastic moves there from a police perspective. The working parties have helped. They have addressed issues of environmental factors, security and the police response to code grey, and how those things would intertwine. That was supported by a police handover sheet that I developed. When the ambulance

brings a patient in they have a handover sheet. The police now also have a handover sheet for the people they bring in, and that documents the circumstances that caused the police to detain someone under section 10 of the Mental Health Act 1986, which in essence refers to those who are likely to cause harm to themselves. Police detain those people on observable behaviours. We are not there to make a clinical judgement about whether that person suffers from mental illness or not, but that authority allows us to take them there. The police handover sheet would not lose anything in transformation. If someone was speaking to that patient later, they would be fully aware of the circumstances in which that patient was presented.

After a period of time I suggested to the hospital that they have a proactive, early intervention and intelligence-led model — that is, all of the information they get from their code greys that they put into RiskMan and are now putting into VIMS should be analysed. More recently that has led to St Vincent's appointing what they call an aggression prevention coordinator, whose sole task is to analyse information that comes in and to identify areas of risk. We decided that all of our new recruits or new arrivals at the police station should spend a day at the hospital for orientation. They spent half a day in mental health in plain clothes and that gave them a better understanding of the dealings and the philosophies of the hospital.

It is probably not particularly related to what we are talking about here, but we do emergency management exercises as part of our critical infrastructure for counter-terrorism matters. We are involved with the fire brigade and the ambulance services in relation to those emergency management exercises. I did some training for their staff for bomb threats and suspicious packages for their telephone and mailroom staff to make them feel more at ease. At the police level, St Vincent's would come to our station and deliver a package on how they deal with patients. Conversely I have received training from all the nurses and doctors there. We have a lot of policies in place to address issues that come up in relation to provision of statements relating to police matters, the service of subpoenas and the handling of exhibits. We have a trial there in relation to reports of death that are required by the coroner where the police would take reports. It saves a lot of angst that the reports are now completed by hospital staff. That saves a lot of angst for the families and staff.

As a result of my eight years as a liaison officer and the work of the violence in nursing task force we made 29 recommendations. A large number of those related to the justice interface. As a result of that and after a lot of consultation with myself, the Department of Health put forward the Building Better Partnerships project. I will not go into a great amount of detail, but out of that they developed the occupational violence prevention policy. That resulted in the delivery of an action pack to hospitals that outlined what they needed to do if they were subjected to violence or assaults.

There were misapprehensions about what the legal process was in regard to reporting matters to the police. The pack gave them some idea of the process they had to go through. We also had a training and awareness video that you have seen. With the Building Better Partnerships program there were 11 test sites throughout the state that became part of that project both from a metropolitan point of view and a country point of view. A lot of things came out of that. There were consistent messages about building an excellent relationship and having proper policies in place, and that related to the CPTED environmental principles, and first and foremost the training and implementation of all of those.

Other police projects that I am aware of in this area include the PACER project. I do not know if you are aware of that. Essentially it involves a mental health clinician working with a police member. When there is a mental health incident out in the field, the police division will be able to attend. When it is deemed to be safe, the mental health clinician moves in. There were a lot of issues that had to be dealt with. The delays in assessment and presentation to emergency departments were overcome because they were dealt with out in the field. That has been extremely successful and hopefully that will be expanded shortly.

Part of the mental health training for police, which I was involved with at the police academy in the first half of 2010 and the second half of this year, was a trial project at the Melbourne Magistrates Court involving the assessment and referral report and people suffering from a mental illness. I have to be honest and say that a number of people were not processed in relation to the legal system because it was very difficult to prove that one of those things was an essential element of an offence, having mens rea — that is, a guilty mind. That was very difficult to prove. The assessment and referral court would take those people in and consider them. That court is booked out for a considerable amount of time. It shows its popularity, for want of a better word. The court can impose treatment to ensure that these people do seek treatment. If they fail to seek that treatment, they then have to appear before a mainstream court and be dealt with there.

The other thing in relation to the smooth transition of patients is that we brought in a new form for recording waiting times. A lot of conjecture was brought about by the lack of understanding, perhaps by the police, of what was required for an assessment. There are two components to the assessment of a person with mental health issues. There must be an assessment by a mental health practitioner. If it is deemed to be necessary, they also need to be examined by a medical practitioner. That becomes a big part of the training and therefore one of the problems that we had before has now been addressed

The CHAIR — Thank you very much, Pat.

Sgt RYLE — You are welcome.

The CHAIR — That concludes the hearing today. I thank witnesses and also members of the media who were in attendance today.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into Violence and Security Arrangements in Victorian Hospitals

Sydney — 20 September 2011

Members

Mr S. Ramsay

Mr J. Scheffer

Mr B. Battin

Mr T. McCurdy

Mr Shaun Leane

Chair: Mr S. Ramsay

Deputy Chair: Mr J Scheffer

Staff

Executive Officer: Ms S. Cook

Senior Legal Research Officer: Mr P. Johnston

Witnesses

Prof Gordian Fulde, Director, Emergency Department;

Mr Ross Judd, Security Manager;

Ms Mel Kelly, A/Nurse Manager Emergency Department; and

Mr Beaver Hudson, Nurse Manager, Psychiatric Emergency Centre,
St Vincent's Hospital, Sydney.

Venue: St Vincent's Hospital, Sydney

THE CHAIR — Actually I didn't hear what the gentleman said but I suspect the question is, the Minister has given us a reference in relation to private security officers, armed in emergency wards of public hospitals in Victoria and we have a budget consideration for that resource. Our Committee is doing an inquiry looking at if in fact there is support for armed private security officers in emergency wards or a need. We are trying to get an understanding in the incidents.

We have had a number of hearings, twenty-six submissions I think, even more in relation to that aspect and other aspects of how emergency wards are laid out, supervised addict rooms. I'll just take you through what we have been doing. Also in relation to the triage area, the process that nurses goes through in relation to code grey or code black. We are covering quite a lot of area about the layout of the emergency ward. How to keep people preoccupied, the waiting times and all that. I do need to tell you and I know you want to move on. We do need to tape because it is a Parliamentary Committee.

PROF GORDIAN FULDE — You can tape whatever I say, no problem.

THE CHAIR — The conditions in relation to Parliamentary Privilege and how you provide evidence to this Committee, I do need to read out a little text in front of witnesses.

PROF GORDIAN FULDE — We agree, we agree

THE CHAIR — I'm going through this because this meeting has been quite arduous from the Premier down for you to be able to be here to talk to us. So I want to make sure we cross the i's and the t's in relation to how we collect the evidence and how it is presented. So you are covered and we are covered.

PROF GORDIAN FULDE — Can I just say one other thing? And you are going to have trouble shutting me up today aren't you? I discussed this with Mr Beaver Hudson and he is a god to us. I don't remember we worked together about ten years ago or something? There was a mega inquiry, commission, put up by the Department of Health, run under Professor Beverley Raphael? Head of the Mental Health at the time and it is one of the best, whatever that I have ever seen on these sort of things. I only recommend it to you as a frame of "they did it all". They went through minimising risk by design, went through all the architectural things from lighting in the parking stations and things, nurses that were raped in Wagga; etc. etc. It was a hospital wide thing, obviously in emergency. The other thing is that is very obvious to all of you here is that the other really bad spot in a hospital is in the mental health area. That is really a work in progress and there will always be problems of urgency. Those are the two things and we have come a long way in this. One of the reasons we have come a long way. Sorry I recommend it to you. Mr Beaver Hudson will help you and I will give you his email address. It is a formal Government document, its ten years old but it went through every aspect. I learnt a lot from it myself. It went through all the things that young Simon is talking about from the get go. From designing something to employment to what rules, all that sort of thing. It was a very comprehensive approach to it and a lot of it is still relevant. Obviously some of the stuff is dated. I suggest the 'work bees' chase that down because it is

fabulous. Anyway, can I take you on a tour now and then we come back? All this will mean so much more, and all your handouts will mean so much more once you see.

One last thing to set the stage so we don't all bunch up in front of the thing. St Vincent's has its own Act of Parliament, right? So although we get funded by like everybody else, taxpayers' dollars. We have always had our own Board, we are a Schedule 3. Whereas all other public hospitals are a Schedule 2. Which means we only have about two or three degrees of difference. In other words, if I say somebody comes down from the system and paints the whole emergency department pink to cut down aggression, we go, "just a minute, this isn't quite right". Then it turns out is what a mistake and they wanted a certain room painted pink to cut down aggression; and actually colours do matter for aggression etc.

We have been able to initiate things, especially recently in mental health. The Board was able to negotiate with the State Government, the last one, that we were able to take our mental health facility from up the hill and 'big word' we have mainstreamed it. We have made it part of the hospital and as you will see it is nearly part of the ED. So it all comes together, from resources which are obviously medically common sense. The most important thing is that it is not a silo mentality of mental health. There is not a silo mentality of security. It's not a silo mentality of all sorts of things and we all pitch in together. It comes out of the emergency department because we rely on everybody else's help to do anything really. We have been able to bring that down and mental health is through a door, one way, security through another one. And that is what I want to show you guys now. OK, you got your running shoes on?

THE CHAIR — So just to check, you are Prof Gordian Fulde?

PROF GORDIAN FULDE — That's right

THE CHAIR — And you are?

MR ROSS JUDD — I'm Mr Ross Judd, Security Manager.

Mr BEAVER HUDSON — And I'm **Mr BEAVER HUDSON** —

PROF GORDIAN FULDE — And this is Mel Kelly. OK how about we go.
(The Committee went on an escorted tour of the emergency department, securely. Mr Hudson only accompanied the Committee for part of the it)

Mr BEAVER HUDSON — What I'm going to do is give you all the safety and security management that we have here at St Vincent's, and specifically across the emergency department. But keeping in mind of course that safety and security is a hospital wide issue and what I'm going to talk about relates specifically to mental health and the emergency department; and the way in which we manage difficult or disturbed patients.

THE CHAIR — Mr Beaver Hudson, may I just ask before we begin are you happy that we tape this for a transcript?

Mr BEAVER HUDSON — Absolutely.

THE CHAIR — I should make you aware that we have a number of Acts that the evidence is protected by Parliamentary Privilege and I won't go through the whole spiel but I do need to make you aware that anyone that talks to us is protected by Parliamentary Privilege. It sits under a Committee's Act, [inaudible]. I only say that because the Premier was particularly pedantic about the information that you provide us in relation to this. Not opinion or hearsay or views. Just so you know where we are all sitting in relation to the conditions on the presentation.

Mr BEAVER HUDSON — OK, thank you. So this is a presentation that I didn't prepare specifically for you guys. I had this presentation for a Health and Security conference which I presented at last year. I believe that it covers all the elements that you may be interested in.

The management of difficult behaviour or aggression here at St Vincent's. We focus on the three C's. Sometimes I refer to them as the holy three C's of collaboration, cooperation and coordination. It requires those three key elements to make the system work. As you can see it is a multi discipline approach. We talk about how we are going to use technology. We discuss the potential for intervention in the use of that technology. We collaborate on the development of policy etc.

Before we can get going on management you have to understand that this has been a very long process and it started many years ago. But when you look at some of the underlying issues, we were able to identify the access block, which is basically getting stuck in the emergency department for inordinate lengths of time which contributed to the aggression and people's frustration. Keeping in mind that now we have mental health patients coming to the emergency department as well and here at St Vincent's they account for nearly 10% of all hospital presentations to the ED. It is a significant number. I think the average is about 3-4%. The other contributing factors of course are there is the difficulty with peoples abuse of alcohol and other substances because that complicates the picture and on top of that it delays the amount of time in getting the individual out of the department.

People with personality disorders, you may be well familiar with the term 'anti-social' disorder or 'borderline' personality. These are individuals who present with very difficult personality traits at the lower end of the spectrum. At the high end you are looking at somebody who is particularly disabled, and these are the kind of people who present with multiple presentations of overdose or self-harm or some context of psych social distress or perceived social difficulty.

The Australian [inaudible] monitoring system identified a number of factors which contributed to reducing violence. The de-escalation which is a technique to talk people down. Basically try to identify what is underlying the aggression or violence. Violence management plans I mentioned briefly, we have access to these plans which assist clinical staff to do an immediate intervention without waiting for the paper file to arrive on the ward.

Improve design – as you know the emergency department is very open plan which 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. But not only that, it makes it that much more dangerous particularly.

We have initiatives for fast tracking patients and I will talk a little about that and ways to improve our waiting times which certainly assists in managing aggression. Particularly when you are looking at not just mental health patients, but patients who perhaps present with pain. Pain we know reduces people's ability to contain their frustration. Particularly if you have been sitting there with a fracture or some pain which is associated with an injury and then you see someone walk in before you, the patients at the front don't understand the process of triage and why someone who has just walked in has gone in front of them. That can contribute to people's levels of irritability.

When you want to 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, something like that. There are high levels of mental illness associated with those sorts of refuges. High levels of criminality at Kings Cross [inaudible]. Prostitution and drug abuse which is quite significant around here and then on top of that you also have the tourist population.

Some that is not included is the tide and flow of patients that come into the city from the Western suburbs or city fringes to work and then of course that population is exchange in the [inaudible]. So it is a very dynamic population.

Approximately 41,000 patients through the ED a year, we have numbers that have been revised up. We see on average about 5,000 mental health patients and about 4,000 alcohol and drug patients.

Out of that population we emergency sedate about 1% which on average is about one person per day that is brought into the emergency department with behaviour deemed to be so dangerous and to be life threatening, we sedate them to control that.

Mr SCHEFFER — So, sorry are you saying that is an extreme measure? What about the levels?

Mr BEAVER HUDSON — Or there are lots of levels before we get there. Be mindful of the fact that when a patient arrives in that stage, so the ambulance crew will turn up with the patient shackled to a stretcher or they might arrive in the back of a paddy wagon. The person doesn't respond to calming techniques at the point of arrival, which is you say you are in a hospital, nothing awful is going to happen to you, we will give you help and support to do whatever we need to do. If that approach doesn't work and it is quite clear to the clinical staff that there is a potential for serious or significant injury, either to the individual or the clinical staff, or in fact to damage of property – will is really important as well; then we would go straight to the emergency sedation protocol. If that emergency sedation is required to manage [inaudible] then we have one particular type of pharmacological response, if it is secondary to psychosis or use of alcohol then we use another pharmacological response.

PROF GORDIAN FULDE — Mr Beaver Hudson has been instrumental with the Department of Health and others in setting up a whole lot of triage categories, protocols, NSW booklet and all that and we are very happy with it.

Mr SCHEFFER — So the scenario you have been describing is as I understand, a person presenting with these issues when they are being brought into hospital so they are under a sort of longitudinal management, they go through...in that list of potential incidents, are there also people who come in who appear to be fine and then explode? How do you deal with that?

Mr BEAVER HUDSON — It's rare indeed that someone comes in very calm and pleasant and then suddenly explodes. There are signs and symptoms which are evident if you are looking for them which demonstrates an escalation of the individuals arousal or their behaviour, which might start off with gesturing, pointing, shouting, getting flushed in the face, pacing.

PROF GORDIAN FULDE — Once again I must interject. The most common cause why people go ballistic suddenly is that they can't have a cigarette.

Mr BEAVER HUDSON — That is a contributing factor but we must not forget that patients get very frustrated and angry and they feel that their needs are not being met. That is the basic common denominator. The rule that they had might be "I want to have something to drink", and they can't, "I need pain relief", but the appropriateness of that pain relief at that time is be judiciously worked upon. Or it may very well be that the individual has taken a substance, even something like alcohol which then lowers that person's threshold and we need to control that.

Mr SCHEFFER — Last thing on that has that changed – that whole set of circumstances; has it increased or decreased over a period?

Mr BEAVER HUDSON — It's increasing in the sense that alcohol 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, having to deal with the level of perceived threats which come from [inaudible], "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.

But having said that, this catchment area has always had those issues and I guess that's why we feel like we a little bit ahead of the game because we have had that experience.

THE CHAIR — I was just wondering whether Ross would be covering the responses and reactions to violence?

Mr BEAVER HUDSON — Yes as I keep going you will

THE CHAIR — And Mel, are you going to be covering the nursing side of the process in relation to education, training and response in triage?

Mr BEAVER HUDSON — Yes we can do that.

Ms MEL KELLY — I'm happy to answer anything you want.

THE CHAIR — Are you happy to talk about some of the issues you have had or under reporting from staff in relation to incidents?

MR ROSS JUDD — I don't think it is an issue in itself from a security point of view. We have tried and attempted to make some efforts in terms of benchmarking and all those sort of things throughout our neighbouring hospitals. The difficulty purely from a security point of view is to get an agreement or consensus of what is actually, or what the thresholds are, for example, in the criminal field an assault has a definition under a Criminal Act, under the Crimes Act but it is not necessarily reflective of New South Wales Health and Zero Tolerance which is a policy we have in New South Wales. The thresholds for verbal assaults, psychological assaults and all that are not the same necessarily as the Crimes Act for example. That's just an example. So to benchmark is quite difficult because exactly what you are saying occurs. There could be some under reporting, there could be some over reporting, someone who swears in the corner of the room in one location could be perceived as verbal assault. If we were to have that same circumstance in the emergency department as a verbal assault I'm sure Mel can tell you that through every shift, multiple times there would be incident reporting of verbal assault. Exactly what you are saying is true in that sense.

It is, what are your thresholds to report, I suppose is the question.

PROF GORDIAN FULDE — The biggest thing is a mega problem and especially in mental health there is a historical attitude that goes with the job. Plus only now in the last few years has the system allowed nursing staff to actually complain and it's like getting punched in your stomach when you are pregnant, we have had a couple of cases like that. Up to that the Courts and the Magistrates have said, "Look, the person was drunk or whatever and they didn't know what they were doing. We are sorry about it but please don't bother us about it". The nursing staff feels very let down. That is changing and I think it can change a lot more yet. But it is very real.

Mr BEAVER HUDSON — Just on that point of reporting and under reporting and it is something that has to be taken into consideration. If you are in an environment where there is an increased tolerance for anti-social or [inaudible] behaviour, then the likelihood of reporting what might be regarded by you as offensive of that behaviour is going to occur because the staff is de-sensitised to that level of aggression and violence.

When I first came to St Vincent's back in 1978? It was completely common to come into the emergency department in the morning and find a [inaudible] victim, computers smashed, and nurses being punched – hardly ever reported. Why?

PROF GORDIAN FULDE — Well this is because we had no back up. We had no back up.

Mr BEAVER HUDSON — Yes we only had one security guard at that particular time.

PROF GORDIAN FULDE — No I mean back up from the system.

Mr BEAVER HUDSON — But because there was that level of acceptance it was only when it was put to the nursing team that they didn't have to tolerate that behaviour, did stuff start to change. I think cultural is a very big part of how you manage violence and aggression. Particularly in a front door facility.

Anyway, moving on. Giving you an idea of what the demand is like. This is basically a chart which demonstrates the number of admissions and discharges of patients who were detained. We know that if we retain someone against their will they will have the potential for violence, predominantly because you are denying them their freedom. As you can see there are significant numbers that come through. Section 20, these are the ambulance presentations, this is when New South Wales ambulance officers are able to compel an individual to come to hospital and get a mental health assessment. As you can see it has been climbing since July 2010 which has been a direct result of more training within the ambulance service and a shift from transportation by police to ambulance. Now of course we would like to think that would change the number of police presentations but as you can see it is much the same. Or what we have noticed is that there has been an increase overall in the number of involuntary presentations resulting from either police or ambulance intervention. This is the catchment area that we are generally responsible for. It's basically the southern shores of the Harbour, extending to the east of Bondi Beach and Bondi Junction to the CBD and going south toward Moore Park and Surry Hills.

There are two catchment areas that we are responsible for, there is the mental health catchment area which is generally the CBD area as far as Double Bay and then we have the general ambulance area which is covered by a matrix. So we can have patients being brought from the city and across the North Shore. That leads to problems of accessing notes and previous history from some of the interventions.

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 able to get into the emergency department and prevent people getting into the waiting room. It sends an automatic duress to security who will respond within 90 seconds if not sooner.

THE CHAIR — Do you have a separate isolation room?

Mr BEAVER HUDSON — No we don't.

Ms MEL KELLY — You mean a seclusion room?

THE CHAIR — Yes

Mr BEAVER HUDSON — Seclusion is a facility for mental health service proper not for an emergency department. I have strong feelings about locking people up. We don't need to lock people up, that is the bottom line. If you want to lock people up then take them to jail.

THE CHAIR — The room you pointed out to us in the emergency department....

Mr BEAVER HUDSON — That's not lockable. That's an assessment room.

THE CHAIR — How do you use that room?

Mr BEAVER HUDSON — Anybody who has a behavioural disturbance or anyone we feel is at risk of self-harm, it is a way of containment.

PROF GORDIAN FULDE — We put violent people in there initially and we go through as you mentioned the steps to try and get them to settle, that can be medication, talking to them, and all that sort of stuff. It is a work in progress and yes it does contain them but we don't lock them up. Because that door is not lockable.

Mr BEAVER HUDSON — As I mentioned, 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 MRA 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.

This as you can see demonstrates (this is an old graph) basically tells the triage nurse that security stand by is required.

MR ROSS JUDD — Can I just briefly talk to that? The standby is a proactive strategy that we have adopted. So as Mr Beaver Hudson said, 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 it has proved very success. 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. That's the terminology we use for it. We do a lot of those daily.

Mr BEAVER HUDSON — The advantage of having security standby is that as a 60kilo nurse standing against a 110kilo bloke, you can negotiate terms of entry and behaviour because you have security behind you. So intimidation plays a lot lesser role in that kind of dynamic because you have security behind you.

PROF GORDIAN FULDE — The little red asterisks come up instantly in triage, as soon as the name is put in. It's all over the place.

Mr BEAVER HUDSON — Once we have the MRA we have access to online management plans. These are available immediately. We don't need to wait for a paper record. This can be accessed as soon as the person is at the front door. We know who he is, we know how he generally presents, and we know what kind of

interventions work. What more importantly we know is what does not work. This means the clinician on duty at that time doesn't have to reinvent the wheel in terms of dealing with this particular patient.

I mentioned as well that we have what we refer to as Care Levels and the intent of the care levels is to provide the kind of risks that the individual we will present. We have Care Level 1 which are those that we are concerned might self-harm, 2 is for those who might harm others and then 3 is for someone who might be a bit ambivalent about being in the department or has a change in mental status.

PROF GORDIAN FULDE — Do you guys all have a copy of this have you? Sorry I thought you did, I apologise. Ross's presentation is also very comprehensive and I will give you my copy. Please get the workers to get it sent down.

Mr BEAVER HUDSON — This is the ambulance entry. When the new emergency department was being designed, there was a lot of collaboration around the design of this particular 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 department because they have seen something for themselves.

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.

These are the [inaudible] they are located right smack bang in the middle of the emergency department. There are plusses and minuses of their location there. On the negative side they are right next to our resussbays which are high activity/high energy environment, particularly when there are calls coming through. Equally you have got critically unwell patients in the resuss bays and then you have an anti-social, loud individual, kicking, banging, and screaming.

PROF GORDIAN FULDE — I've got older people where you saw with someone going "f this" or "f that", it's a thing we have had to accept. I don't like it and I would love to design it out but I can't.

Mr BEAVER HUDSON — The rooms themselves are somewhat clinically austere; they are of solid construction which mitigates against noise. There are two points of access and ingress which is at the front, the big wide door which facilitates entry for three people abreast to get someone in. Then the back door is narrow and is controlled by these proxy cards. The way in which they are designed to work is when a nurse is in that room, the magnetic lock on the door releases which allow free access. Once a clinician leaves the room that door silently re-engages again.

The mattresses, they look very psychiatric but the purpose behind this is when we do have a situation when we take a patient down or control their behaviour, the last thing we want is solid heavy hard sharp edges which could contribute to injury. That's just a foam mattress.

I mentioned earlier on about emergency restraint. This is the restraint trolley that we use; we only have one set of manacles.

PROF GORDIAN FULDE — And this is used very reluctantly. We don't do guns and we don't use handcuffs because on a medical point of view you open up whole risk factors of patients potentially ending up with the coroner when you restrain them.

Mr BEAVER HUDSON — What our aim is to get from a physical take down to the sedation in as fast a time as possible. That requires a degree of planning and pre-emptiveness and an example would be before we do a sedation, the drugs would be drawn up, the security staff would be in the department, the clinical staff would know what their individual roles are, there would be a clinical reader nominated to determine when this particular intervention is going to start and a pre-negotiation is given to the patient, "OK we have asked you to take your medication, you are not able to comply, we are concerned about your behaviour, we are going to give you some medication". "We are going to move you from this room to this room and I would like you to do that". The patient then escalates and says "No I'm not going to do that thank you very much" then we give instructions for security to move in, they secure the individual, they escort them into the resuscitation bay, placed onto the trauma bed, nursing staff will apply the restraints, the doctor gets out the access, the drug is administered and generally within about ten to fifteen minutes the whole procedure is complete.

PROF GORDIAN FULDE — And it's very safe because the emergency medical are working with the psych and security and we are the ones that know what to do with an unconscious patient where psych don't. So that's a really big thing. That is the same cubicle you go in if you are having a heart attack, we have the monitor, we are taking over their conscious and life functions. And that's a big deal and its full ICU rescussication mode.

Mr BEAVER HUDSON — You might be wondering "why would you want to do that" – what it provides us with is an opportunity to stop and regroup. So what sort of management do we want to put in place, what sort of contingencies do we need to activate, where is this patient going to go from here. It's very difficult to coordinate any kind of care when you have someone kicking, spitting and screaming. So first things first. Let's put them to sleep so then we can focus on what the management issues are going to be.

PROF GORDIAN FULDE — Also at the very front end of all this we still have to be 100% sure that this is purely a psychiatric thing. People with medical conditions can act mad and bad. It's our duty. They cannot go to mental health until they are medically cleared.

Mr BEAVER HUDSON — I guess the other side of the coin in terms of why we do this is that the physician will give advice on the appropriateness of the sedation and management and appropriateness of care in relation to medical patient's background, age, their previous medical history.

One of the potential disposition pathways would be psychiatric emergency care centre, which is a six bed facility which

PROF GORDIAN FULDE — That was the door I pointed at.

Mr BEAVER HUDSON — It's a brief stay, psychiatric facility, in a sense that we have a 48 hour window of operation for an individual and that is to conduct a more detailed assessment or investigation into their condition or to provide respite for family or carers or to provide some of kind of break in behaviour, if someone has had a bad relationship breakup and they take a handful of Panadol, sometimes they just need 48 hours to just to regroup their thoughts. While it is a psychiatric facility and it focuses on psychiatric assessment and management will also provide a facility for people who don't have a full-blown mental illness but they are responding to situational crisis.

Again security and safety is a big issue within the PEC and that means the entire department can be kept under observation from the nurses' station if necessary. So we have cameras and duress alarms throughout the whole place. We can talk about duress alarms. Every member of staff....

PROF GORDIAN FULDE — We've done that.

Mr BEAVER HUDSON — OK.

PROF GORDIAN FULDE — The other thing with PEC and anything else, once again the marriage between emergency nurses and emergency doctors and the mental health people has been one of pivotal parts of making it work. Because the patient is a patient and it doesn't matter if it is a heart attack or mental attack, these things happen together.

Mr BEAVER HUDSON — 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.

You know how the monitors work?

PROF GORDIAN FULDE — Yes we have done all that.

Mr BEAVER HUDSON — OK. These are the common security events.

PROF GORDIAN FULDE — We've done all that.

Mr BEAVER HUDSON — OK, triage?

PROF GORDIAN FULDE — No

Mr BEAVER HUDSON — Well I mentioned very briefly how the triage is designed to work which is a first and single contact with the emergency department. An ongoing process which means that you can ring triage to increase their clinical emergency and the response expected from that particular condition.

PROF GORDIAN FULDE — There used to be a medical triage system and a mental health sort of triage system. The two were totally different and somebody who is in great trouble, so what we have done is we have married the standard emergency medicine triage system integrated with mental health presentations. Mr Beaver Hudson was a large part of the Department of Health New South Wales policy but it is vital because mental health did not triage or people would say, my people would say “He is so and so and he is always off his head” and they would wait and no one would see them and all that sort of thing. It is absolutely pivotal I recommend to you most highly you get this document. Mr Beaver Hudson will show it to you. Its policy and it’s in train but you have to bring mental health into the standard triage, because the first person to see them is the triage nurse.

Mr BEAVER HUDSON — The process of triage focuses on [inaudible] circulation and disability. When looking a mental health type presentation you can still use those same principles but you have to go to attitude, behavioural and cognition and disability. The disability refers to existing diagnosis. I have already talked to you about what we do at the point of triage.

The rapid assessment (RAT), this is about the fast tracking I mentioned. So we have is ambulance and voluntary walk-ins, the RAT team can intervene very quickly in the waiting room with those clients. Those people who have arrived involuntarily we have the SAT team which is the Special Assessment Team. Our next focus is on those people who present primarily from a mental health assessment.

If you go across the State you will find this variable in the way 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 Royal Alfred 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. What we have here at St Vincent’s is a parallel assessment process. That is we 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. With these particular individuals, they have been brought against their will for a psychiatric assessment, not for a physical check-up. They have to understand that resident medical officers who work within psychiatry have sufficient skills to pass a stethoscope over somebody, sufficient skills to determine whether a person looks well or not. It’s really not that hard. If somebody in the context of a mental health assessment gives the impression that there is an underlying physical cause for their behaviour, they are basically holding their stomach. You don’t need to be a blind man with a black stick to work out maybe there is something wrong with this person. That kind of collaboration and cooperation is essential in being able to move rapidly from one form of investigation, physical or psychiatric to another [inaudible].

To enforce and ensure that we have established the journey that the particular individual should be taken we have these flow charts over the place which demonstrate who is responsible for what and in this instance everything that is in red, the primary lead will be with emergency personnel. Anything in green will be psychiatric emergency personnel to lead. Stuff that it is in yellow is generally [inaudible] and anything in blue is for security or police.

By having well established protocols people don't have to think. In the middle of a crisis you don't want to have to refer to a manual, you want to be able to just do it.

PROF GORDIAN FULDE — It takes individuals out of it too.

Mr BEAVER HUDSON — Individual decisions, maybe individual judgements as well. So 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.

PROF GORDIAN FULDE — Which is really awful. And just to add to it but Ross will get to it, but the thing is, at any time, and it is mandatory, any time, any staff member can request that security, and it's the same at airports, Olympics do it now, it can be requested, we don't do it on everybody but a very low threshold. Any nurse, doctor whatever can request security do that. They have to submit themselves to it.

THE CHAIR — Did you say that Ross would cover that? We have about ten minutes.

MR ROSS JUDD — I think from my point of view, I have a very sharp, short and brief in terms of security electronics infrastructure. I have a presentation but I'm conscious of the time. I can give you the presentation in soft copy. We only have such a short time it might be better if we save it for question and answer type things.

THE CHAIR — So do you want to just finish off?

Mr BEAVER HUDSON — OK, very quickly. One of our strengths is our ability to manage aggression requires the coordinated response from these specialists to be involved who work together. The way that we achieve that is by having regular meetings. Those meetings will involve specialities of social, emergency mental health. We do that every fortnight. Every quarter we meet with at police and ambulance to discuss operational issues, discuss issues which are occurring between our relative staff groups, particularly our chiefs of operation. We have a benchmark of 30 minute clearance for police because we are very much aware that they have finite resources and they need to get back out there. Also not forgetting that the idea is to get the patient off them and into hospital care as quickly as possible.

PROF GORDIAN FULDE — Well you have got the message. We really work with each other. People who never used to know the other skill group – we now work together and we are friends.

Mr BEAVER HUDSON — I think the thing to take from all of this is when you work together and you plan for what is very likely to happen given the environment that you have got, then the need for armed, we don't have armed security personnel. God knows there are times when you think we could do with it, but the reality is that as long as you know the environment that you are working in and you have cooperative and collaborative relationships with the entire staff, it's a whole of hospital response and not just left to security to manage. You don't necessarily need to have big stringent security measures like people walking around with guns.

My personal experience of this department is that yes it gets noisy, yes it gets really scaring sometimes but underneath it all I know that whatever comes through the front door we can cope with it. It's not going to result in meeting violence with violence because all that does is create yet more violence. Remember that this is a care facility and that is what it is designed to do. It is very difficult to maintain dignity and compassion with a gun.

MR TIM MCCURDY — How regular do you have evaluation or a form of evaluation of your security process? You spoke about the meetings you have. Is it an annual thing, is it a formal arrangement? Are the nurses and the police involved or is it just an in house thing with [inaudible]?

MR ROSS JUDD — We deal with a whole range of levels. In terms of the regular meetings, we do reviews of adverse incidents of course. They are through formal channels. Externally from a New South Wales Health point of view and internally, we are required to do a very comprehensive risk assessment of our systems and all the stuff we have in play. That does include the violence aspect. I regularly, monthly report an operational report to the various Executive and that includes our statistical analysis of all the incidents from a security point of view.

We are required under the Security Industry Act to log all our activities, so our patrols, any incidents that our security staff are involved in, they will type up an incident report. We have a very small but very effective information reporting system that we manage and I can quickly gather statistical data from that.

PROF GORDIAN FULDE — We also have the RCA (Root Cause Analysis). If bad shit happens, that automatically goes to Root Cause Analysis and Investigation and it's not any one individual here but it goes to the Hospital Executive, neutral people above so there are inbuilt checks and obviously all systems run on bad things ensuring that we capture the bad things to look at.

MR TIM MCCURDY — I understand that if any shit happens, but how does a nurse who is feeling threatened, hasn't been threatened, hasn't been in an incident, how do you know when she is not feeling comfortable?

PROF GORDIAN FULDE — Mel might be able to answer that.

MR ROSS JUDD — How do we...

MR TIM MCCURDY — Is there a process involved that you would know...?

PROF GORDIAN FULDE — Any nurse can use the reporting system which is on every computer in the hospital which any staff can member and now we are getting better and better and encouraged to fill out. If something happens in my department, it's a goldfish bowl and several other people know about it. So it would be very unusual...

MR JOHAN SCHEFFER — The way that you said you are getting better and better at it, does that mean that they weren't doing that but they are improving?

PROF GORDIAN FULDE — Absolutely. We touched it before the tour. 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, zero tolerance. In other words, occupational health and safety, everyone should have the right to go home in the same shape that they arrived.

THE CHAIR — And people say to us, top management says what you say but when we talk to nurses they say that's just what they tell you, on the ground it hasn't changed that much. What is your response to that?

PROF GORDIAN FULDE — I think that's very real but that's why I think you gentlemen came here, you can tell that we have an attitude here, a collaborative attitude that it is not in any way acceptable. We have waiting lists of people wanting to work in my emergency department. We have lots of the Murdoch's and the Packers but we have also have a lot of unpleasant people, and that came be elderly people who are demented and we are very supportive of our staff. That needs to get through but I think there is a lot of home work to be done through the system.

MR ROSS JUDD — I can also say that they have introduced a system just over the recent three or four years. It's an internal reporting system which is called RiskMan, is the terminology of the system but it is effectively, and I won't say it is a catch all but staff can enter any type of incident or any type of issue – not HR issues as that is outside the equation. But any OH&S issue or other incident that has caused the staff member some problem, it's an opportunity for that person to document whatever the issue was and it gets responded through a whole matrix of our infrastructure – various departments.

Mr BEAVER HUDSON — The thing you have to remember is that the staff is encouraged to pre-empt, so they don't activate a duress alarm when someone tells them to "f off" or makes a fist. They activate duress as soon as the prickles on the back of their neck go up; it's when they are in a situation where they are not

comfortable. So by activating the duress then you can avoid hopefully the crisis when violence occurs.

MR ROSS JUDD — That's in the orientation for all of our staff – it's mandatory. I do a spiel to all our new starters about all the security arrangements and the preventative side is our really number one aim/strategy that we try.

PROF GORDIAN FULDE — You are on the money. It's ongoing education and support. That will take a generational change.

Mr BEAVER HUDSON — But the conversation with the community who come into our emergency department is one that it is going to be safe and two we are not going to put up with your nonsense.

MR SHAUN LEANE — Your security staff have [inaudible] to police?

MR ROSS JUDD — Yes they are. I thought that was a question someone would ask of me. In terms of whether they should be contracted or not? As I said in the earlier part of the presentation in the office, we spend a lot of time and energy developing our own training mechanisms that are supported by the industry security requirements and licensing and all that. Our own systems training is supported then by the specialist training, so Mr Beaver Hudson will give our guys effectively a one on one security psych lay persons brief cooks tour of psychology. So the guys have some information and they understand some of the terminology that the clinicians are using, they can work with the staff on a basic understanding and for those reasons we do have, when we are short staffed, we do have contractors here and we do have to train them to meet a minimum standard that we have. For those reasons our expectations, if we only have one external contractor that we work with, we really require the same people to return because we have to have a standard that they can meet to help us do the work.

When I first started there were some issues with security as you would see in the media reports, security personnel in other locations bounces and those sorts of things. As I said before we changed our focus was on who we are going to select and we concentrated on guys...

PROF GORDIAN FULDE — What is the retention rate? Is that important?

MR ROSS JUDD — It's very important.

PROF GORDIAN FULDE — The whole cooperation – if you have a litmus test of how things work is when other craft groups know us and we know them by their first names. It obviously won't be everybody but if you go into hospital and no one knows everyone's first name, when you have a team approach like taking violent patients down with security, doctors/nurses, no one knows each other – it's shameful.

Mr BEAVER HUDSON — It's a very collegial environment.

MR ROSS JUDD — So retention wise, touch wood I haven't had anything for two or three years.

MR SHAUN LEANE — It sounds like you have come a long way in a short time. It might be twelve years ago but that isn't a long time in the scheme of things but there has been a big investment hasn't there? There has been a big investment when you look at the cameras, your duress buttons, your training, there has been a huge investment in this area.

MR ROSS JUDD — Yes

PROF GORDIAN FULDE — But also going on – if I don't really like something that has happened I may talk to the individual or talk to Ross – they might talk to me about one of my doctors being whatever and as we all know, a lot of this is done on a personal basis. We get to know each other and that is how it works.

MR ROSS JUDD — So in summary my presentation is going to be exactly where we were and where we are now and a whole lot of training and education and different systems. That's true but what Gordian said is true, my guys definitely have the upmost respect of both Gordian and Mel and Mr Beaver Hudson 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 peoples 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 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.

Mr BEAVER HUDSON — And I think again we go back to what underpins this, the need for group/clinical leadership in the management of those aggressive and violent incidents – not handing it over to another group to go and deal with it. We have seen in the press the outcomes when security are just told to go and fix that problem and when you have control then we will get involved, what happens is people get injured, die then we have got the questions around was it appropriate for security to be involved at that point? Couldn't you have tried something else? The way in which we approach is through this collaborative approach means that there is mutual support so we are all working together for one end which is to make the situation and that person safe as possible so we can then deliver the care that is needed. That's the game we are playing. If we can do that together as efficiently and effectively as possible it makes the working day that much more enjoyable, it brings much better job satisfaction and ultimately what it demonstrates is that we become the agency of choice. I would challenge for you to go and speak to ambulance or police and they will report that the currently St Vincent's is by far less frustrating – they believe that their patients get much better care because of this need by our team to work to a process together.

MR SCHEFFER — Just coming back to where I started my contribution to the question earlier on about firearms in hospitals which is a policy that the Victorian Government took to the election. Your response to that has been extremely [inaudible – ambulance sirens] but when I drew it all down, [inaudible – ambulance sirens] one of the things you said we don't do it because we don't need to have a [inaudible – ambulance sirens] but in another hospital in another setting, a country town [inaudible

– ambulance sirens] that’s fine for you, you don’t need it because you have these resources and all these smart people to help you work it out but we do. So my question is there a fundamental reason beside from need, a fundamental reason why you object?

PROF GORDIAN FULDE — Yes very simple. 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. In other words I put it to you and your electorate and that’s where a lot of this comes from, that is inexcusable. It can never be excused and I would come down to Victoria as an expert and I would be very hostile because I would not see that ever being necessary.

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 is a police issue. The police come in and have to shoot somebody, so be it. It’s not a health issue. Once you start losing your clear vision of this 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. They have Tasers – beautiful thing, let’s face it. That would probably solve most problems you could even see in a hospital. Never would I accept in the first instance of a health care professional harming a patient.

THE CHAIR — I’m very conscious that we are running out of time. Perhaps we could get something from Mel.

Ms MEL KELLY —I don’t disagree with what they say.

THE CHAIR — Is there anything you would like to say from a nursing point of view?

Ms MEL KELLY — No just reiterate that we are a team, there is no one single person in the ED. We have respect for each other and that’s why it works. We could almost do this without speaking most of the time. We know this is what happens, this is how it goes. The best thing for the patient is in our minds at all times.

THE CHAIR — Do you have any other questions?

MR SCHEFFER — I only have one last thing [inaudible] research that you pointed us towards [inaudible] violence against nurses and doctors.

PROF GORDIAN FULDE — There is lots of it. If you have somebody in Victoria – it’s a matter of searching the literature base – there is lots and lots. You will come up with lots of arguments. Somebody will suggest you [inaudible] because it has to be looked at scientifically, it has to be meaningful. There is a lot of stuff and its scientific basis if just recording but there is more and more stuff coming out and what you want to look at, and what is relevant to what this Committee is looking at has to be done. So I would suggest you get an emergency physician/emergency nurse, but yes if you email me I will put you on a trail or people who have done it etc.

Mr BEAVER HUDSON — In fact, in Victoria, in Melbourne in October there is the annual conference Hospital and Healthcare Security and Safety.

THE CHAIR — Yes we are going.

MR ROSS JUDD — So are we. We are both presenting down there.

THE CHAIR — So I just want to be clear we don't have armed guards in Victorian hospitals and emergency departments. This inquiry is to see if in fact there is a need and all the evidence collected so far – there is not one person any clinical asset who has indicated they would support having firearms in hospitals. So just in case there might be a suggestion that mad Victorians we are all going to have armed people in hospitals – that is not the case. We are doing the inquiry to see if there is a need for security guards that will be armed with firearms. I have to say that the evidence at this stage is clearly indicating that most of them [inaudible].

I have to say there have been examples where, I mean you are quite lucky in that you are employees of the hospital in relation to security. A lot of hospitals we have interviewed say they are contractors, they revolve.

MR ROSS JUDD — That's the issue. A general contractor versus an employee – there are definitely marked differences and part of our overall strategy is the education of the security team but they have a bit of a career path as well. So we have a structure in place that supports them whilst they are here so there are things like remuneration and things like how we want to ensure we keep those skills for those people. There are definite skills that they need to have and the system is always evolving. So our guys are always learning. Particularly I would say within the last twelve or fourteen months with the various risk threats, mental health, Caritas [Inaudible] Moreland House facilities coming into the one building. That has become a massive learning curve for our staff, not only in the planning of the building because we had some input into that. How we would do our work in that particular building. So the staff had input into what they thought would be the best way practically on the ground to operate. There were some learning's within the building itself about how mental health would function and all the rest of it. Once you have skills there you need to retain them. Whilst it in the vernacular only security work, in hospital security if they are doing the right things it is a lot more than just security work and knowledge they need to have.

Mr BEAVER HUDSON — And 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, in other words, we have done that before and it didn't work then what are we trying to do now. That really helps. So that sense of ownership 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, let's just be careful. They are very much a part of the entire team.

THE CHAIR — On behalf of the Committee I thank you all, particularly for your time and passion about what you do. It's clearly demonstrated. Thank you very much.

PROF GORDIAN FULDE — Have you got all the contacts? I have given you my card. We will get you whatever we have about literature and other things.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Sydney—20 September 2011

Members

Mr S. Ramsay

Mr J. Scheffer

Mr S. Leane

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Senior Research Officer: Mr P. Johnstone

Witnesses

Mr B. de Caires, Chief Executive Officer; and

Mr P. Johnson, Manager, Compliance and Regulatory Affairs, Australian Security Industry Association Ltd.

The CHAIR—Welcome, Brian and Peter. Thank you very much for your time. My name is Simon Ramsay, I am the chair of the joint parliamentary committee for Drugs and Crime Prevention in Victoria. This is our second reference—we have two running concurrently at the moment—of which we have to report back to parliament, most likely, this second reference at the start of next year, and the first reference possibly a bit later. We have been to St Vincent's this morning where we have had a first-hand look at the emergency department there and spoken to the director of emergency services, nursing staff and also those running security in that hospital, as we have done in a number of hospitals in Melbourne. We are starting to get a feel in relation to security arrangements in New South Wales, Western Australia and Victoria. You understand this reference was in relation to the minister making a pre-election commitment for private security officers in emergency wards in public hospitals in Victoria. We did commit pre-election and now passed legislation to allow specifically trained private security officers armed on railway stations between the hours of 6 p.m. and dawn in those high-risk areas, and there was a budget consideration for PSOs in emergency wards of hospitals armed also. Naturally enough there was a number of issues that arose out of that commitment. The minister has asked us to set up an inquiry to look at what security arrangements might be appropriate for Victorian hospitals in the emergency departments. That is where we are at. We are collating that information and have been for the last four months.

Thank you again for participating in this inquiry. I have to put some conditions around the evidence you will provide to this hearing. As you will appreciate it is being recorded and we will use that as part of our deliberations. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. We are happy to provide you with a proof version if you wish to correct transcript at the earliest opportunity.

Mr DE CAIRES—Peter is going to start. He probably has more background directly in the hospital centres.

The CHAIR—We have allowed until 12.30.

Mr JOHNSON—I have some dot points and that will give you the opportunity to ask questions. You are the one that is being educated. It is important from that point of view. You already have an understanding of what ASIAL is and the national peak body for the security industry. We represent 85 per cent of the security industry of employers. Personal background: you may have a little bit from me, but in security since 1973, being police and also private security, and significant years experience within hospitals in Victoria; also reviewing hospitals in New South Wales, recently the redevelopment of the Royal North Shore. We lost the tender but we reviewed the hospital. I was on the successful tender program for the Royal Children's Hospital in Melbourne, and also run the Southern Health Hospital security risk management in Melbourne, and also associated with Spotless who run the hospital in Melbourne from The Alfred hospital security, and many other services there.

My role is full-time with ASIAL. I am the manager for compliance and regulatory affairs. One of the overriding things is that violence exists in all hospitals but it exists

at different levels and different degrees, depending on the hospital itself. One of the overriding factors that I see from our experience is that any ability to address the problem with violence in hospitals is that it is a team approach and it is a necessary element of security, and the security response. It is really all about risk management assessment required for each hospital, and each hospital emergency department. They are all slightly different. They have different areas, anywhere around Australia, from a construction point of view to the physical security to the actual staffing levels and the quality of staff that are there. A risk management approach is something that has to underpin all the assessments of security requirements in EDs.

Security staff training is a requirement. However, the higher level of security and response training is not needed by everyone in a hospital environment, especially if they look at a team response to security. One of the areas of importance from health care at any hospital that I have seen is that a chain of command is an important element in the security response within health care, and the chain of command is one that I will make mention of is the responsibility of hospital management, whether they have an internal security team or whether they engage an external security provider. Whether that is one of our members or as internal security, their own employees, but certainly the chain of command is important in that teaming approach. That chain of command is also important in regard to dealing with patients or dealing with visitors. They are the two things that you can have situations that occur significantly in emergency departments. We deal with patients, we deal with visitors, and depending on the type of clientele we are dealing with is depending on whether it is an assisted medical response or a total security response.

The organisation, one of the things that it should not be—in looking at the terms of reference in your inquiry—they should not abrogate their responsibilities in regard to security. Many organisations say they may engage an external security provider and say, 'It's your responsibility,' when in actual fact, hospitals should never abrogate their responsibility for security whether they engage commercially or internally engage or employ people. It is their responsibility, management's responsibility, to provide that service and provide it appropriately.

One of the things I would draw your attention to is that any provision of security services within an hospital ED is that the people are fit for purpose. In your tours around hospitals—and I have seen it in New South Wales, in regional New South Wales, and also in Victoria—that we have people that are not fit for purpose providing security services. That means you will find examples—and I can give you examples if you wish—of security people that are 72 years of age providing frontline emergency security response in EDs. I question whether that is fit for purpose. Therefore the whole management structure needs to address those areas: physical ability to respond to such a wide range of response requirements in emergency departments.

The other area is one that we sometimes do not like to refer to is really a gender balance. In health care we have a significant number of females in the health industry; not so much in the ED, we tend to have a reasonable gender balance, but when you move into mental health—and recently I presented to an inquest whereby a patient died as a result of being restrained and the thing being used, it escalated to a degree whereby security were then called and had to restrain the patient, and ultimately the patient died after being restrained for 30 seconds. Restraint asphyxia was one of those

areas of concern. We need to consider, depending on the risk assessment of each ED or each health care facility, they really need to have a look at. If there is a gender imbalance, you may need to balance that out with a security balance and how you are dealing with it because it is very important, and sometimes that physical presence in gender balance is important. I have seen some fantastic female security responses and medical responses, but I have also seen situations escalate because of a gender imbalance in regard to when it is a difficult situation and a physical response.

Security training and licensing: again we see New South Wales as a total licence situation and therefore 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 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. When we have made recommendations over many years it is now reflected in most of the hospitals that their security are appropriately licensed and trained, but that does not mean they have to do it in Victoria, and it may be a potential weakness that you see when there are areas of hospitals wanting to appoint a security person. They have staff they have nothing else to do with, they cannot do certain work and they might put them on the door as security. They do not need to be licensed in Victoria if they are an employee of that organisation. That is a comment in regard to minimum training and a licensed requirement that has an anomaly in Victoria.

Security is not only physical security, it acts as control, CCTV and other measures of after-hours lockdown in regard to emergency EDs. It is the access and egress, who can come in, how they get out and the managing of their behaviour whilst they are in an ED department. That is one that needs to be actively provided by a combination of health care professionals and also security people that are present. When you have a lockdown situation in ED you are trying to manage some types of people that sometimes attends in ED and you do not want them inside, and also the situation is managing the general behaviour of people. Many hospitals, including Royal North Shore Hospital here, The Alfred hospital, Southern Health, Monash Medical Centre in Dandenong, in particular, where their EDs are extremely busy. Behavioural issues are sometimes managed by warnings, by issuing of notices, by issuing of letters.

Therefore the people are excluded from attending, visitors and patients included. That is not only ED, it happens everywhere. An example is we have a dialysis unit whereby one dialysis patient would remain outside and physically assault another dialysis patient because they turned around and did not like the way the TV channel was changed. Hospitals are dealing with varying degrees of aggression all the time, and that particular patient was managed by direct communication warning, and ultimately he was removed from the dialysis at that unit. The health care industry had to find another location of dialysis for that particular patient.

Hospitals do not have to accept everyone. Hospital management have the right to manage appropriate behaviour and exclude people where their behaviour is not providing a safe work environment for the employees. That is one of the tools that management still should need and maybe consideration of a warning program that is recognised right across the ED departments in all areas. Again we are educating

everyone that comes through ED that there is a behavioural standard required in attending EDs. We know they are emotional times, we know there are situations that are certainly hard but one where people still have a responsibility and all employers still have a responsibility to provide a safe workplace. I made a comment in regard to the behavioural. It is not only patients, it is also visitors.

There are specific comments in regard to protective service officers. We are an association of employers. You might say protective service officers, because they come from a government agency, we are totally against it. It is not the case. The thing is they are like a contracted service coming into a hospital. The only comment we have is that we do not support protective service officers in providing security with the emergency departments of the hospital. We do not feel it is appropriate and we believe that police protective service areas would not recognise appropriately hospital management, and the status of hospital management. We do not believe that that is a sustainable structure. It abrogates the hospital's management and I do not see in my experience and from our association's point of view. We feel that the chain of command, the demarcation, the provision of service, having experienced security and how health professionals deal with security in the current situation, that will only be exacerbated by the provision of protective service officers in a hospital that will feel that they are under a totally different chain of command and not moving with the appropriate hospital's requirements.

We believe and consider that the PSO answer would be more costly and again a financial impact on the hospital. That again removes the hospital's responsibility to manage its own environment. In regard to the cost, if that cost is applied to the hospitals for the additional training of appropriate frontline people in response teams, that would be a better allocation of those funds.

The other area we are looking at is the reporting process of incidents within EDs. We would probably question the quality and the standard of the reporting process. One I would encourage is certainly it would be a good consideration if the reporting process would standardise right across all hospitals, health care. There is a program called Risk Mate that is used in some of the hospitals. It may not be perfect but the reporting process, the staff's education to use that process, the ease of access of report, and therefore the data extraction is one that is on a standard platform. You would really have a good understanding of what goes on. A lot of situations, a lot of incidents in hospitals and EDs do not get reported. We need to encourage staff to be able to identify that. We then become fearful of the unbelievable statistics that we see coming out of EDs. There are a lot of incidents but most of them, a lot of them, are managed well. We need to improve on that.

The other area is the authority and power of security officers within the hospitals, as an employee or as a subcontractor. The security officer has no more authority than that of a person representing the hospital. There are no specific powers in regard to security. In previous hearings that you have conducted over recent years, in 2010, one of the recommendations was that there would be an offence created to hinder a security officer or a health care worker. That has not been implemented in Victoria. We certainly recommend that that be implemented as a priority and therefore you would strengthen the response to a security officer's handling of a situation, or if a person was hindering them in the operation of their duty, which a lot of visitors may

do. Patients are hindering the opportunity of a health care response, a security response. There is a specific offence and that would strengthen it.

Also you could consider that the security officer in the health industry has no greater power than that of the rest of the normal citizen. That is under section 458 of the Crimes Act. The consideration should be that in those circumstances, that work environment, a security officer may be better equipped if they also have the authority under section 459 of the Crimes Act. That power of arrest is one that is extended more beyond one that I have seen and if a person is behaving in a manner—in simple terms, if you lose sight of a person that committed an offence, that person loses the authority to arrest. In a hospital environment you can have a situation that existed where the person is observed, that person is seen on CCTV but they have lost sight of, you have technically, legally lost power of arrest. Security officers are unable to respond, they can only observe and report, and the police response to hospitals—depending on the location, depending on the demands of police services—they certainly are not always quick to respond. I think in providing managed and controlled additional power and authority to security in hospitals would be of benefit to that situation.

They are a few points from our general point of view. They are only in point form and certainly I am happy to expand while I am answering questions.

The CHAIR—Thank you.

Mr LEANE—You are on the end of a long line of witnesses we have had but you made a point that has not been made as far as the situation where a protective service officer that may, hypothetically, be allocated to an emergency department hospital in Melbourne, they answer to the police commissioner, and down the line—the way it works in parliament—I think they answer to, and I am happy to be corrected, to the Melbourne regional superintendent. The point you are making is the police chief or the super might say, 'I want you to act in this particular fashion in this circumstance because you're my guy. I'm responsible for you, you're my guy.' But then the hospital may have a whole different ethos about how they would like to deal with issues. They would be saying to the protective service officer, 'We don't want you to act that way at all. Our policy is X and you're being told Y.' We have a scenario where that if that PSO does X or Y, he has opened himself up to not following one stream of instructions. It is a bit messy but how do you get over that? How do your members get over that? Your members that are contracted into a hospital, are they under the instructions of the hospital or do you have a similar problem?

Mr JOHNSON—The problem does not exist to the degree of what you are suggesting, which I have also suggested will appear, taking instructions from a doctor when the PSO is told to hold that person's leg for half an hour. 'Hold the person down while I administer'—they are part of a security response team. 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. Depending on whether they are dealing with a patient or depending on whether they are dealing with a visitor,

would that PSO under their chain of command take direct instructions and do as they are told, and if in fact an incident—

Mr LEANE—Would they be bound to?

Mr JOHNSON—The relationship may be, that is why the chain of command is one that—is it smooth enough, is it able to be overcome, and I think there is already existing processes that do overcome it. I see where that chain of command and existing structures of PSOs—we have it in New South Wales, we have it in South Australia that they have a different chain of command and they are responsible to different people. You are introducing another level of difficulty in management within the health care industry.

Mr LEANE—Around training: is there, or do you see there should be a module of training for security guards that would work in an emergency department environment?

Mr JOHNSON—Certainly. Any security person that works in an emergency department should undergo different training than that of a general security officer.

Mr LEANE—Is that available?

Mr JOHNSON—Yes, there is. Many hospitals do it. You get MOVATE which originated in Geelong which is supported by the union. It is a little bit more tailored to that environment. We introduced special training in Southern Health. Spotless introduced special training for their people in regard to dealing with aggression and also learning how to use restraint techniques that are more appropriate in hospitals. Remember, as security officers, they should not have their batons and handcuffs in an emergency department. It is not a good look. But they still need to be able to restrain a person, they need to work as a team, and specialised training is required. That needs to be in a budget.

Mr SCHEFFER—What did you mean when you said in your oral presentation—I am paraphrasing it—'High level training is not necessary, especially where they operate as part of a team and have a strong chain of command'?

Mr JOHNSON—When you are talking about what training is required and dealing with aggression, every employee of the hospital does not have to undergo training. They may need to undergo code black training. That is personal threat. They need to understand the evacuation process. They need to understand fire response. They do not need to know how to operate, as part of that critical response team, where security and medical staff join together to respond to an incident.

Mr SCHEFFER—You are saying they do not need to—

Mr JOHNSON—All staff do not need that high-level training. The identified staff need that higher-level training. Security, emergency departments and people working in mental health, they need that high-level training. The 11,000 people that work for Southern Health only, say, maybe 3,000 people might need it; or the 9,000 that work for The Alfred only 2,000 need that training. They did refresher training as well. It is a cost, and the thing being used that needs to be either within the health

organisation's budget, within the budget of the contracted service, and that is where even putting in that equation for PSO would be making that even more complex.

Going back to one of your questions, when a PSO does something wrong, who investigates them? When a security officer engaged as a contract service to a hospital does something wrong, the hospital says, 'I don't really want that person, not part of our mix,' and the contractor goes, 'How can I manage this?' I take the personal side. If they are an internal employee, they go under their own process of managing a difficult employee. The PSO says, 'Mate, you're stuck with him, he's rostered there.' There is some difficulty there.

The CHAIR—Is there a national standard for training within the organisation—security in hospitals?

Mr JOHNSON—Yes, there are some Australian standards. There are some hospital standards in Australia. They talk about what people should know. They talk about process procedure, but there is nothing in regard to restraint training that is standardised. Ultimately that is why I said it should all be underpinned by a risk management approach. If you have a department that is a country ED, you are going to manage that differently. If you have a major Royal Melbourne Hospital ED, you manage it differently. The training may need to be different. The response is different, the number of people available are different, but there is no specific training that says, 'You shall do certain training.' The hospital decides on that. In fact some hospitals would provide no further training of their contracted internally employed person; or external provider, any more than what they had had in, say, a licensing program which is not quite as suitable for hospital emergency departments. You need to have a little bit extra. You are dealing in a very special area of anguish, anger. You have to learn how to identify that incident before—instead of it being minutes at the top, bringing someone down from an emotional, aggressive situation is hard.

Even medical staff find it difficult, and security sometimes the only way is to restrain the person and escort them from the premises, and that is difficult. You have to be able to see the anguish, talk to the person, calm them down, eyeball them. That is why it is a combination of electronic security, CCTV, access control, and security officers there with a manner, tone, dealing with it, open hand techniques, body positioning. That is what you learn. You do not stand face to face, you are not at a football match, you are at a hospital where the person wants to see you as a security authority but does not want to see you in an aggressive situation. You have to calm them down. You have to teach these people open-hand techniques, the selection of language, the positioning of their body so it is not confrontational but you are ready to respond. When you are dealing in a team, you know you are talking to this person but you know your offsider is over there ready to grab an arm when an arm comes at you to hit you. They are the situations there.

When a person is in a bed and they are under the influence of drugs and all they want to do is spit and claw at you, that takes a different type of person. The security officer is there but does not have a mask on because everything is happening so quickly. The next minute you get a whole face full of spit from a person and then that security officer has to then say, 'Human being', you have to be calm and hold that person. We have seen people—and I have sacked people that have acted inappropriately in response to that. That is why training is needed.

Mr SCHEFFER—You mentioned in your opening remarks that you worked at The Alfred hospital.

Mr JOHNSON—Yes, and Southern Health. I did more work with Southern Health.

Mr SCHEFFER—We have met with The Alfred, and you also said in your presentation that hospitals do not have to accept everyone and there can be a warning program there. When The Alfred came to talk to us, they talked about a system where if they identified a person who came into the hospital who was acting in a way that the hospital staff found unacceptable—and that would be analogous to the way a person would operate in the street outside a nightclub—and they felt it was appropriate in those circumstances to ask that person to go away and maybe go to the GP, that kind of process. I personally found it very difficult to know how you would make that judgment and tested that, without knowing in The Alfred, with other witnesses that came to talk to us. I think it would be fair to say that while some were happy to entertain that, as a general notion that was not found to be acceptable. What my question is really, is that something that you worked with The Alfred to develop through, and could you tell us a bit more about it.

Mr JOHNSON—No. I understand the process you are talking about. That would be the card system. A few people are supportive of the card system because it is a little bit more black and white than the people who are applying it. But to decide how to apply it becomes a very subjective process. What we have found more in the other area is to empower the hospital staff and security with knowledge of what their rights are and what their authority is, and issue a notice to a person whereby the director of nursing at the time or whoever is in charge at the time, they may issue the notice to the person, because it may be a medical condition and you do not want to place the hospital at risk by putting a person with a medical condition out on the street inappropriately. Therefore you then get a security person making that decision, not quite appropriate. If it is a visitor and they are behaving inappropriately, yes, a security officer can make that decision. But remember they are dealing with very emotional people, and all they want to do is to see their parent treated appropriately and not waiting for another two or three hours. The thing is we have always encouraged that it is part and parcel of the medical process in dealing with anyone that has a medical condition, and if their behaviour is inappropriate, the nursing staff, medical staff—

Mr SCHEFFER—What do you mean then when you said that hospitals do not have to accept everyone?

Mr JOHNSON—The thing being is, you do not have to accept a person in your emergency department if they are a visitor.

Mr SCHEFFER—I see.

Mr JOHNSON—You can ban them from the premises. In fact, people that have behaved—and patients that have behaved inappropriately—have been banned from hospitals. They have received a notice from the hospital saying that unless it is an emergency they will not be treated at the hospital because their behaviour is so

over the top that staff are threatened by the individual, and when they do come to the hospital you will find that they take up the services of a security firm, and a permanent security officer is standing with them for the whole time they are in hospital, including the ward, the whole lot. That is when resources are consumed, because they move from the emergency department into a ward and they still have to have a security person with them, otherwise staff are feeling uncomfortable. They have not committed an offence per se but their behaviour is such that they can go off any time. Mental patients create a lot of that problem. Mental health is another area of great concern, and it is not specific to your terms of reference, of course, but mental health occurs in ED and that is one of the things that you have to be very aware of. A lot of this aggression that occurs in ED can also be linked to mental health issues on people attending and presenting at emergency departments.

The CHAIR—Brian, I am mindful of time and I am wondering whether you would like to make some comments.

Mr DE CAIRES—Pete has covered most of them. We are looking for an approach which creates a reasonably level playing field, you are comparing like with like. In a role with security personnel they have different accountabilities to what the protective security officers would have. As Peter said there is national training competencies for security officers which is a well developed package which is a baseline. There are modules that can be added for specific areas, such as hospitals, to make those roles a little bit more tailored. The infrastructure is there. As Pete said, in Victoria you have the in-house—you have different requirements, they do not have licence and probity check, all the other things you would have to do if you were privately contracted. We believe it should be consistent for all.

Mr SCHEFFER—That was the next question I wanted to ask but since you raise that, why?

Mr DE CAIRES—That is a question we ask because we believe whoever is providing the service, whether it is in-house or contracted, there should be a baseline. The public should expect that there is the basic standard.

Mr SCHEFFER—Is there evidence to suggest that in-house security teams in hospitals are behaving in ways that would be not up to a standard?

Mr JOHNSON—Most in-house now are becoming licensed, and they are licensed. In fact everyone that we have associated with, the hospitals have moved to make sure their internal people are licensed, but they do not have to be licensed.

Mr SCHEFFER—You are saying the legislation require that—

Mr JOHNSON—It takes away any inability for any hospital to have people operating security that are not appropriately licensed, probity checked or trained.

Mr SCHEFFER—Is your view on that informed by public interest or is that informed by—it places a limitation on your business?

Mr JOHNSON—Historically it is a combination of unsatisfactory performers—historically—where they moved into security.

Mr SCHEFFER—That is a public interest issue.

Mr JOHNSON—I think that has been overcome significantly today because most hospitals now realise, after being educated, that they should have someone that is licensed and trained. The main ones we have dealt with now, so therefore you are dealing with probity, licensing and what have you. But the option is there that if something needed to be, they could throw any person into a security role as an in-house, in a uniform, and they do not have to be probity checked or licensed. The option is there, say, from a public safety point of view, to remove that totally.

Mr SCHEFFER—It does not have any impact on your capacity to compete for the provision of these services in any of these hospitals?

Mr JOHNSON—No. It means that at least we know, from a public positioning, any security officer in a hospital is probity checked, is licensed and has gone through some training. It does not matter whether they are in-house, contracted or whatever. They are all the same. You asked me if a hospital is, I could not tell you until I went and checked, but if it was the standard we would say, 'It has to be.' It is a bit more comfort—

Mr SCHEFFER—There is a register, is there?

Mr JOHNSON—There is a state register. The police keep it. It is a private agents registry which is now called LRD, and under the police. That is a public register. You can go and check every person's licensing security in Victoria.

Mr DE CAIRES—Those standards are gradually moving through COAG to a level of harmonisation. The standard in New South Wales is the same as WA or Victoria. Up until recently it was different.

The CHAIR—Is there a fee attached to the licence?

Mr DE CAIRES—For an individual, yes.

Mr JOHNSON—It is about \$100 something a year for a licence. But to get the training a person would probably have to look at about \$1,000 training now to get a licence. The other thing is that every security officer in most states now—because COAG require it—they are constantly under probity checks. Therefore if a security officer commits an offence, the licensing authority will know within 24 hours they have committed an offence. If it is an offence that such they should not be holding a licence, that person will be notified and asked to explain why. That does not exist if you are internal.

The CHAIR—They can still work in Victoria at least where the legislation does not apply.

Mr JOHNSON—That is correct, yes.

Mr DE CAIRES—Fingerprinting is being rolled out now. It has started this year. They are fingerprinting all security personnel. Again that is through Live Scan. It started in the last—

Mr JOHNSON—Nationally, most states are doing it now. Tasmania has come on board with fingerprinting. Queensland has come on board, and Victoria is now doing Live Scan screening of all security officers who must be fingerprinted and obtain a national police clearance for their licence. They are under constant monitoring, which is good.

The CHAIR—Brian, I know you want to finish your presentation but I want to raise quickly something I think we should explore. Peter, you talked about in relation to the Crimes Act and you quoted section 459.

Mr JOHNSON—Yes.

The CHAIR—In fact your suggestion was that we need to look at some new legislation that will enforce a penalty against someone—and I am not quite sure, you talked about an offence to hinder. I am not sure exactly what that means.

Mr JOHNSON—Under the Drugs and Crime Prevention Committee 2010, recommendation No. 1 was that:

The committee recommends that the offence of assaulting, obstructing, hindering or delaying a hospital or health worker or a licensed security guard or an emergency worker in the execution or performance of their duties be enacted in Victoria.

That has not quite happened but that was last year's recommendation in regard to violence, and we believe that is still valid and I believe you would enhance the security significantly if we reviewed that, because their power of arrest is no more than a public citizen when in actual fact there are so many incidents in hospitals whereby they probably need a little bit more in regard to section 459 of the Crimes Act which you believe you can arrest a person on suspicion. The assault may have taken place, you have lost sight of that person, they have run through the hospital grounds, they are in the hospital, you see the person again, and the security officers under legal terms cannot arrest that person because the connection is broken. Section 459 would allow them to detain that person on suspicion if they assaulted that hospital worker or did the theft or whatever. I do not necessarily say that should happen to all the security officers outside, but in a health environment you would strengthen the position of that security officer significantly. It would certainly go a long way in implementing recommendation 1, because that then becomes a specific offence.

When that security officer gets assaulted, which is a regular occurrence, or was hindered or held back while they are detaining a person, their relative is holding the security officer back, that is a specific offence. At the moment they do not do anything about it because the police will not charge anyone, the hospital will not do it. But once you have a specific offence it is easy. They say, 'Mate, you're under arrest for hindering a health worker. You grabbed that doctor and pulled the doctor away. You're under arrest.' It is not assault, they were hindering. Therefore they can then detain the person, calm the situation down, and also sitting behind all that there is also

the rights and responsibility and protection of a security officer working within that environment. That is probably a little bit outside of your scope.

Mr DE CAIRES—As part of that the Australian Research Council published a report in May. One of them was powers of private security personnel. There were a couple of academics—one from Griffith University and one from the University of South Australia—looking at situations that it may be appropriate to review the powers that private security personnel have.

The CHAIR—I was not on the committee prior and that is why I am probably asking these questions. Part of the act you are referring to is enable private security officers to arrest, rather than the actual penalty itself? Is that the basis of what you were saying?

Mr JOHNSON—It is a different form of arrest in different circumstances. Under section 458 of the Crimes Act 1958, that power of arrest is for any person in the public. If you or I see anyone committing an offence in front of us we can make a citizen's arrest. Section 459 is not a citizen's arrest, it is a member of the police force. That power means you can arrest a person on suspicion and that means you lose connectivity, you do not see them. It means you believe they have done it. Some additional power may be appropriately extended to health care security but more so is that hindering one was a good recommendation from your committee last year and we would encourage it, and we have encouraged the government to consider that and apply it, but we would also like to see that extended to security officer crowd controller because if that extended to outside your scope—but that extended to where a crowd controller was hindered in their operation, because they are slightly different, although they are dual licence-holders, that would give a crowd controller a little more comfort in dealing with circumstances. It would certainly give a security officer and a health care worker a lot more comfort knowing that if they were hindered that person could be arrested then and there for hindering, obstructing. They may not have been hit or assaulted but hindered or obstructed. That would control the situation, give the authority to arrest, because an offence has been committed in front of them.

The CHAIR—If Victoria Police were faced with the same situation what charge would apply?

Mr JOHNSON—They would still be able to charge a person. If Victoria Police come along and you said, 'I saw that person hit the doctor in the emergency department'—

The CHAIR—Hindering?

Mr JOHNSON—No, hindering, if that is occurring in front of you, section 458 applies. There is no problem about that at all.

The CHAIR—Only the police but not the security person, that is the point, is it?

Mr JOHNSON—If recommendation 1 was implemented and that occurred in front of the security officer, the security officer could arrest that person there and then, no problem. But if in fact an incident occurred and the person decamped the

scene and was found 10, 15 minutes later in the hospital environment, that person could not be arrested unless they were then unlawfully on the premises, or some other charge. Police can arrest a person because you give a description of the person, that is that person, 'I arrest you on suspicion.' That is section 459 of the Crimes Act. Maybe a little bit more authority could be extended to the security officer.

The CHAIR—Thank you for that.

Mr DE CAIRES—I think I am done.

Mr SCHEFFER—I have another question. Does ASIAL have a policy, whether you recommend to your members or recommend to your actual clients, on where it is appropriate for the officers to wear firearms or not, and obviously the context of this is whether it is appropriate in hospitals?

Mr JOHNSON—No hospital I have ever worked at permitted firearms for security people. In my experience if we had prison officers attending with a firearm, we would ask the prison officers to lodge their firearms in the safe. If we had police attending with firearms in a hospital environment, we provide services for police to secure their firearms in a safe at the hospital, not to carry them.

Mr McCURDY—No-one has used that?

Mr JOHNSON—No. When you are in that tight situation and you have a firearm on your hip and you are right face to face with a person, they are aggressive, and you are trying to deal with a patient and you have a visitor standing behind you and you have a firearm on your hip, the minute it is out of the holster and then they have a firearm in their hands if someone is inappropriate. Even in the most threatening situation let's train our people to know about, 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. Your terminology is saying, 'You're a cowboy, you're a protective service officer with a firearm in a hospital. 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. That is my years of experience. 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?

Mr DE CAIRES—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; not so much in Victoria but certainly in New South Wales, in Sydney, huge targets. There is a strong move away from firearms with most operators in the industry.

Mr McCURDY—It becomes a tool of the trade, doesn't it, the gun?

Mr DE CAIRES—It ramps it up.

Mr McCURDY—It is like asking you to go for the rest of the week without your iPad and your phone.

Mr JOHNSON—I would be lost.

Mr McCURDY—Yes. If you have trained people to have firearms and then asking them to not have them—

Mr JOHNSON—That is right. That is why the comment in regard to security is not only the person, the security is access control—lockdown. Suddenly you have those doors closed, they cannot get through, and your staff and your patients are protected. You might be in a waiting area but you have members of the public you are trying to look after, you have that aggressive person, you have security. They may be able to contain that even further but you are protecting people.

Mr SCHEFFER—I wanted to ask about capsicum spray.

Mr JOHNSON—Let's put it this way: the choice between capsicum spray and firearms, you can have capsicum spray. Is it a tool? Western Australia would be looking at that sooner than any other state in Australia. A lot of people do not want to see it. We really do not have a position on it from an industry association point of view. Capsicum spray could be used in certain areas but hospitals are also against batons and handcuffs. Most of the places I have set up, we have a policy of no batons, no handcuffs. Remember the handcuffs are a position of restraint. Restraint in hospital, once you get into hospital you are under a different legislation structure in regard to restraint measures. We have enough trouble when we are required to tie a person down in a bed or use some form of restraint mechanism. You have to record that and register that. Handcuffs could be all right for those members of the public. I would extend to handcuffs if appropriately trained, appropriately licensed, but I am not a supporter of capsicum, personally.

Mr DE CAIRES—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?

The CHAIR—The Austin Hospital have—

Mr JOHNSON—Batons and handcuffs, they will have shields. Other hospitals would have a shield or would use other devices like a soft-padded barrier so you can push against the person, remove them from the area, put them down while you restrain them. I have no problems with handcuffs if they are managed appropriately. Capsicum spray—you get to the next stage—does not always work. Remember these people are angry and sometimes when you use capsicum spray and they are angry, it does not achieve the results you want and it makes them even angrier. Sometimes—we keep on saying—the best tool of a security officer in a hospital is your mouth, the 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, and then you are a cowboy.

The CHAIR—You talked about the mouth. I suppose it is a bit of a dumb question in relation to security but we were at a hospital this morning where there were a couple of man mountains as security guys. Is the physical presence generally in security as important maybe as—

Mr JOHNSON—Sometimes size is not important but I have seen terrible situations existing on a ward and a security officer in uniform walks around that corner and the patient says, 'I guess I'm really in for it here, aren't I?' Then they stop. The physical presence is a very good tool, but realising that once security is involved you have got to the stage where, 'We're not going to put up with this any more.' Sometimes they give medical staff, health workers, such a hard time—a patient that is aggressive—and security presence is good. Size is good but then again we have some small people in security roles and they use their mouth very well and some of them have excellent restraint skills. Before you realise it you go, 'How did they put me down?' They have grabbed a hand, they have put a lock on it, they are down on the ground, they are breathing properly and they are restrained. That is why handcuffs can be helpful there but then a lot of hospitals do not like it, a lot of health care workers do not like it.

It is the education and training process and the team. You get these health care workers and security people realising they are so dependent upon each other. If you bring your PSOs in, and your PSOs do not become part of that team as easily. But if you get the contracted person in or the internal security officer and they realise that they coexist, and they have to coexist. 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.

The CHAIR—All right. Thank you both very much. We appreciate your time.

Mr JOHNSON—If you wanted any of those other reports or the survey we conducted, we are happy to forward that through. Section 5 of that deals with the occupational health and safety aspect of the industry and deals with the assaults that security officers have been subjected to, and the relationship of police numbers and security and how that all happens, and some of the world statistics as well might be a reference point. We are happy to send that through.

The CHAIR—Great, thank you.

Witness withdrew.

Hearing suspended.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Sydney—20 September 2011

Members

Mr S. Ramsay Mr J. Scheffer
Mr S. Leane Mr T. McCurdy

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Senior Research Officer: Mr P. Johnston

Witness

Professor D. Chappell, Sydney Institute of Criminology.

The CHAIR—Welcome, Prof Chappell to this joint parliamentary committee of Drugs and Crime Prevention. Thank you for your time. You are aware of the inquiry that we are presently taking on at this stage.

Prof CHAPPELL—Yes, I have seen the terms of reference as they were provided to me.

The CHAIR—I appreciate not only your time but your knowledge and expertise. Looking at your biography which Sandy provided us is very extensive.

Prof CHAPPELL—Sorry to burden you with that.

The CHAIR—No, we look forward to that. This inquiry has been really interesting. I think we have taken on about 30 submissions plus and a number of hearings which I have lost count but it has certainly generated a lot of interest not only within our own circles but the media circles as well, about how the government might respond to our recommendations. Anything you can tell us or impart from your considerable knowledge we will appreciate, and also the opportunity for us obviously to ask questions. We have until 2.15 for this session. If we can keep within that time frame that would be good. Before you start, professor, there are some preliminaries we have to adhere to, to protect you and us.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I expect you have read or had a look at the guide for witnesses presenting evidence. We are recording the evidence and will provide a proof version of the transcript at the earliest opportunity. You can correct it as appropriate which is important. We will now pass over to you.

Prof CHAPPELL—Thank you very much, Chair, for the invitation to speak with you today. I must say I have long had an admiration for the work in general of Victorians in this area of violence prevention and particularly workplace violence, and followed with interest the developments over the past decade or so, including I had an involvement, as I think you are aware, with the Taskforce on Violence in Nursing and also, going much further back—I will say a bit more about this—the National Committee on Violence which arose as a result of some tragic events in Victoria.

What I had prepared was a short PowerPoint and I will speak to my pictures which you are not able to see. I thought what I would do is give you a couple of reflections on how I see the state of violence in the health sector and then have time for you to ask any questions you may have later, specifically to your terms of reference. It is important at the beginning to emphasise how influential the health sector has been generally in setting the agenda for dealing with violence in the workplace, as well as violence at large. The World Health Organisation has put this as one of its priority areas to reduce violence around the world, and it has offered considerable guidance to nations who are members of the WHO in how to best achieve goals of violence prevention, including workplace violence.

I am sure in the search you have already probably done of your literature you will find not only the major World Health report, which I think was issued in around about 2000 on violence and its prevention, but also guidelines that they produced in combination with the International Labour Office in the early 2000s, simply titled Workplace Violence in the Health Sector. I had some involvement in that development of those guidelines, since at the time I was working as a consultant with the ILO, and some of my publications stem from that involvement. It is not only, of course, at the international level that there has been very considerable interest in this issue. In the United Kingdom, for example, the National Health Service, which is one of the largest employers in the whole of Europe, has done a great deal to address issues associated with violence in the health sector, and they issued some of the first guidelines in this area which have been influential in not only the United Kingdom but also here in Australia. The so-called zero tolerance policy that came from the United Kingdom National Health Service was picked up fairly much here during the 2000s and found its way into some of our recommendations.

Quite apart from the international level—and these efforts at national level—we in Australia have done a great deal as well. We should not be hiding behind a bushel. We have done as much as any country to really tackle issues associated with violence and workplace violence, and health workplace violence. As I indicated, Victoria has been one of the leading agencies in this regard. The Taskforce on Violence in the Health Sector, which I was involved with has developed what I think are some of the best sets of guidelines that exist in this country and indeed elsewhere. I am sure you are very familiar with the handbook for *Workplace Prevention and Management of Aggression in Health Services* which is a very comprehensive document and which gives guidance to any manager or individual member of health services staff as to how they can best protect themselves against violence.

There has been considerable publicity in other campaigns to try and put at the public level, information about the fact that violence is utterly unacceptable in the delivery of health service, and those who are responsible for violence and who also have the capacity will be dealt with. The Australian Nursing Federation has also produced extensive guidelines on this subject. If you look around the country I am sure you can find many other individual states that have information available. In New South Wales I was co-chair of a committee that looked at the problems of violence in the New South Wales health workplace in the early 2000s. At the time I was also the president of the Mental Health Review Tribunal here in New South Wales and as the title perhaps suggests we had considerable issues associated with violence since we were dealing with especially forensic patients who often committed quite horrendous acts of violence and who we had to make decisions about their care and treatment. We were very much conscious of this as an issue.

One of the things that that committee did when it held its hearings was to commission research because it was felt very strongly by the members of that committee—my co-chair was Prof Beverley Raphael, chief psychiatrist at the time in New South Wales. It was emphasised that it was only evidence based and research based information which really could allow proper policies to be put in place and tested, and that too often in the past at least, policies have been advanced without any evidence base and not necessarily finding any successful outcome. The research that we undertook was the first of its type in Australia. I have brought a copy of the research findings which were published separately in the *Journal of Occupational Health and Safety of*

Australia and New Zealand in 2003. I co-authored this with Dr Clare Nahi who was the person who did most of the actual research. It is titled 'The occupational violence experiences of 400 Australian health workers,' and at the time New South Wales was very sensitive about publishing this and did not want to have their name attached to it. However, I think I am not revealing any state secrets now to indicate that that was in fact New South Wales where the research took place.

Also this study was used by the World Health Organisation in the development of its guidelines. With your permission I will give you that. I think you will find in that a description of quite a deal of the sorts of information that we were able to make available to policy-makers and would accept the basis for the guidelines that were later developed. I am sure you will have copies of that document which are widely available. There has also been—as I am sure again you found—enormous literature in the professional journals, one of which was a special issue, *The Medical Journal of Australia*, which I contributed an editorial to, dealing specifically with emergency room violence. I suspect you will already have that special issue.

I would like to come now to the National Committee on Violence which, as I say, I chaired. It was set up in 1988 by the Prime Minister in agreement with all of the state and territorial ministers and premiers to look at specifically the ways in which violence at large could be diminished in Australian society. Following those shootings that took place in Melbourne in 1988, I think it was, the Hoddle Street massacre, and the Queen Street massacre. At the time I was the director of the Australian Institute of Criminology and we put together a very significant research program to support the committee's work which was ultimately published in association with the report. I mention this because I think from that experience of the national committee, the three things I felt came out of it, firstly, was that the problems of addressing violence are extremely complex and difficult, and there are no easy explanations or understanding of violence; secondly, in order to make any sensible policy decisions you must have access to decent data and information, and we found when we looked at this in Australia that there was not that type of information widely available at the time. We, for example, noted that in Victoria there was no Office of Crime Statistics that produced this information, nor when it came to health care were there systematic data sources that we could address to look at what was happening in the context of violence in the health sector.

The third strong impression we had was that if you get involved in this area you also have to have enormous patience because when you look at the recommendations usually they are read by some but little necessarily gets taken up in the policy agenda. That was especially the case with our committee which made very significant recommendations about gun control and the diminution of the number of weapons and access to weapons in Australia. It was not, of course, until the very tragic circumstances at Port Arthur some six years after we published our report that those recommendations were taken up by Prime Minister Howard and put into effect. But at least we can say that that committee's work did, on the issue of gun control, eventually bear fruit, although I would have to say we did not recommend the gun buy-back scheme which I think was enormous courage on the part of the Prime Minister at the time and has been a very important step in helping to diminish the incidents of acts of mass murder in this country, resulting from people having access to high-powered weaponry.

Unlike our colleagues in France, across the Pacific, in those states this is a significant problem still, and I noticed in a quick flick through some of the literature recently that in hospitals, particularly in the United States, one of the biggest issues is worry about people coming in with loaded weapons and using them in that context. However, I also acknowledge that we unfortunately have a problem too with weapons in our own hospitals but hopefully not nearly at the level that we can see in the United States.

What I will try and do very briefly, with your permission, is to come back to one of the first things I said about my impressions coming from the National Committee on Violence, and that was the complexity of what we are talking about here, addressing violence. My PowerPoint was very much linked to this but I will try and explain. One of the things we have done is to develop a model of how violence does occur in workplaces. What you have in general is obviously a perpetrator of violence and a victim and each of those people—the perpetrator and the victim—have individual features associated with them which influence how they react in these situations and what type of violence may be used. This occurs in the context of the workplace and there are situations at risk and it leads them to outcomes for both the organisation where the workplace is, the individual person who is the actual victim of violence, as well as the workers around them.

In the context of the health sector, the perpetrators that are most likely to be found are those of clients and customers, and I suspect that is probably the group that you are focusing most on. Also, of course, perpetrators can be fellow workers and that is especially the case with bullying. We know from quite a lot of research now that bullying is a significant problem in health workplaces. Then there is also the risk of stranger attacks, criminals who may come into the health workplace. That is not so much a problem, I think, in most cases. There may be cases in which people come in searching for drugs or perhaps for money from health premises. It may be that there are some situations where, as an outcome of domestic violence, some stranger comes in and attacks a member of staff or someone who is in the hospital. That is one of the situations that came out, I notice, in our research in New South Wales. I think to our surprise at least, one of the areas of risk was in the maternity suite of some hospitals where women were giving birth to children who were up for adoption and where there was family friction and the father would come in and create significant problems for the staff.

As far as the victims are concerned, of course, in the health workplace, fellow workers are obviously victims, a bystander who may be present at the time that violence occurs, and clients and customers themselves who may be injured. The individual risk factors are many. I will not labour them, but in terms of those who are perpetrators, obviously we know—or from lots of evidence—that people with a history of violence are usually young, they may well have had a troubled childhood, there are strong links between alcohol and drug use. I have to mention I was very interested and very impressed by your recent report on preventing violence in public places and your emphasis on alcohol and its impact on violence. That comes into the hospital setting, and many of the people who come in are under the influence of alcohol and drugs.

Those with mental health problems also are a significant coterie of perpetrators of potential violence. Having recently worked with the New South Wales Police in their mental health intervention program which is involved in the provision of significant

training to New South Wales in the management of their interactions with people with mental illnesses, I know they frequently take people with mental health problems to emergency rooms for assessment and there is always that risk that they will be people who might display violence, and often they are very repetitive events as far as the police and emergency rooms are concerned, and the same people who are taken in are released and come back again and again. There was one case—35 times in one year—that we were looking at recently here in New South Wales.

As far as the risk factors of victims are concerned, we do know quite a deal about that as well, and obviously the age and experience of a person who is a potential victim is one of the keys that health staff who have significant experience in areas where there is a high risk of violence are more likely to be able to deal with issues associated with aggression and avoid it becoming an explosive problem. We also know that gender is important. Women seem to be better at defusing violence than males. You can influence very much those factors through training. As far as the risk factor is concerned, once you enter the workplace, we are getting to know quite a deal. In the context of hospitals, very much the physical features that you encounter are very important. I am sure you have heard a lot about crime prevention through environmental design and the importance of having a well designed and built hospital; hospitals which allow for the work to be performed in a safe and secure way, but also in a way which does not increase the risks of people becoming aggressive and so on.

We also know that some workplaces are more at hazard than others because of the external influences that may occur, particularly, for example, if you have a hospital that is located in an area where there are a lot of pubs and nightclubs and things. You are much more likely to get customers coming in who are a threat and are aggressive. There are also, we know, a lot about the task situations that influence violence: working alone, working with people in distress, working with drugs in a work situation, all increase risk. We note especially that people who are in hospital settings have quite a lot of those vulnerable qualities associated with the work they perform, all of which then leads—if violence does occur—to a number of possibilities, one of which of course is death. Fortunately we have very few deaths in our hospitals resulting from workplace violence, but it does happen. Certainly during the time that I was at the Mental Health Review Tribunal we had two or three cases where mental health patients killed fellow patients or killed staff. That is an area obviously of the ultimate, utmost concern. Quite serious injury can result, and disability, and probably much more psychological impacts that violence can have on staff and others from bullying and harassment and so on.

The effects of all this on the productivity of enterprise is significant. It can lead to obviously absenteeism, a tarnished reputation for the hospital concerned, if it is the hospital. It means often there may be difficulties in attracting and retaining good staff. These are all things that need to be avoided. For the victims of the violence there is obviously illness, disability, financial loss, impact on families, resignation, transfer and even suicide. All of these things in combination suggest that tackling workplace violence, particularly in the hospital settings that you are concerned with, are very important. There are now many things that can be done to alleviate the pressures that exist in those workplaces and make them safer for everyone.

I also should put in a commercial here that I have produced a book with a friend/colleague, *Violence at Work*. It is available from the International Labour Office who published it. Thank you.

The CHAIR—Thank you very much, professor. You have provided us with a number of questions that certainly I would like to ask but I will defer to the committee for questions.

Mr McCURDY—The resistance to guns in hospitals is quite consistent throughout everybody that we have been talking to. I note that as time has gone on for all of us we have gladly accepted going through security all the time we are going to Parliament House, whether we are going to the airport obviously, and a lot of that retrospective because of what has happened, whether it is 9-11, all those other issues over the past, all of a sudden we have said, 'We've got to check you for guns and knives.' Does there come a point where we have accepted it that greatly that we will walk into every hospital and go through the same security screening? Obviously the police do not like handing over their guns at any given time because that is part of their tools of trade, because they do not know what they are confronted with. Obviously if you get into a hospital situation, people do take weapons in. Do you see a point where we will readily accept that that is part of the process as well?

Prof CHAPPELL—No, I do not think so. I know that here in New South Wales, certainly in mental health institutions—and I cannot speak with that much authority about it beyond that—it is standard practice for the police to hand in their weapons at the time they come to the facility. Also looking back, having been in several quasi-judicial roles where police have come in, we have always insisted that they take their weapons off when they come into court, and so on. I do not think, in Australia anyway, we are likely to see that changing. I do think we will see, and in fact are seeing, the provision of security checks at all hospitals that might be at high risk, and I think that is an unfortunate but necessary reality, as far as we are concerned, with the sorts of risks that now exist with knives, I think, rather than probably with guns. I would hope, providing we maintain the gun legislation that we have had now in place since 1996 that it will be a rare occasion that we will see someone anyway come in with a gun to a hospital.

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.

Mr LEANE—You mentioned the zero tolerance policy. It seems there has been a real cultural change in the last decade around health institution management and health professionals around what is acceptable in that environment. A health professional today at St Vincent's was saying that 12 years ago you would come to a shift and there would be windows broken, someone would be punched et cetera. Do you think that culture change has gone full cycle or is there still more to go?

Prof CHAPPELL—I think we are much less tolerant with violence than we perhaps used to be. That is in part because of the developments we have been talking about, especially those in the health sector. But the zero tolerance slogan—I think was a slogan—came not from health but from drugs and drug control. I think the term really has a bit of a dirty association in that sense and although 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.

Of course, the big thing is that so many people who are violent in the context of health environments are people who have no capacity to understand what they are doing, and that is especially so with people with mental illness and people with dementia, both of whom are increasingly coming into the emergency rooms and coming into contact with health staff. I think we are much less prepared nonetheless to accept violence, that is especially the case of bullying which we tended to ignore largely and completely in workplaces and health workplaces. We are also doing a lot more in the context of building new hospitals to try and design out a lot of the risks that were associated in the past with violence that were being seen as quite acceptable.

Mr SCHEFFER—If I understood you correctly you came in on this with the Hoddle Street and the Queen Street tragedies in Melbourne.

Prof CHAPPELL—Yes.

Mr SCHEFFER—I think you made a comment in your presentation that at that time there was a dearth of evidence and data around incidents like that in other kinds of violence in workplaces. Fast-forwarding now—what is it, nearly 30 years, getting on to that—we have some body of data.

Prof CHAPPELL—Not enough.

Mr SCHEFFER—That is what I want you to talk about. But in the context of that, what do we know about the seriousness of the problem, given what Sean has asked you about getting on top of it in, in some ways, and the incidence and the prevalence, whether it is increasing, where it is increasing. What is the picture that the data is showing us?

Prof CHAPPELL—I have to say that nationally we still do not have the data to answer that question, with one exception and that is homicides which are recorded accurately, I think, and which have now been monitored since the National Committee on Violence. I was personally involved in setting up the Homicide Monitoring Program which is now being run by the Australian Institute of Criminology since 1990, and it reports all homicides that take place in the country and the circumstances surrounding them. It also records police high-speed chases, and

police deaths in custody, those areas. In those fields we do have some accurate and reliable information.

Mr SCHEFFER—That is good.

Prof CHAPPELL—That shows that homicide in workplaces are relatively rare. I think it is somewhere around five per cent or seven per cent of all homicides in Australia each year occur in workplaces and that, as I said, some of them do occur in health workplaces. Whether they are going up or down I am not absolutely sure, but I think the answer is we have had a reduction in homicides generally and that is reflected also in the context of hospitals.

Mr SCHEFFER—You did in your comments earlier on attribute that in large measure to the gun policy that the Howard government introduced the gun buy-back scheme. Do we know that?

Prof CHAPPELL—Certainly the gun lobby would not support that view. There has been quite a heated debate in the academic literature about whether or not the gun control measures that came in in 96 really had this impact. The best evidence is that it has had an effect on reducing the amount of gun-related violence at large in the country and it has been, to that extent, an effective measure.

Mr SCHEFFER—That is homicides and police chases and those other things. What about the other data that you said was not in such good shape?

Prof CHAPPELL—We do not have very good national data on it. You need to look at individual jurisdictions. I have not, I must admit, looked at Victoria for some time and I have not, either, looked at other local jurisdictions. When we started the New South Wales research there was very little recorded information and we adopted those by—we had this research done and it identified what were the hotspots so far as violence was concerned in the workplace. No surprise probably to us now. Those officers are probably most at risk; very often attend what amounts to combat scenes and take in the combatants and they may resume their combat in hospital, certainly on the way there. The emergency room staff then receive the combatants as well and they too are quite high risk. Other areas of workplace violence which are heightened are in mental health—no surprise—and aged care.

Mr SCHEFFER—Aged care?

Prof CHAPPELL—Aged care, yes, with dementia.

Mr SCHEFFER—Okay.

Prof CHAPPELL—That is where, of course, things like zero tolerance do not make much sense because you are not going to whip someone off who is an aged, demented person to court and prosecute them for being violent. I have strongly suggested in the past that we did need to have much better data and our occupational health and safety authorities should agree on some universal definitions of the sorts of violence—

Mr SCHEFFER—Sorry to cut across you but the data in homicides that you mentioned before, who keeps that?

Prof CHAPPELL—The Australian Institute of Criminology.

Mr SCHEFFER—Are they the appropriate organisation to gather data in other areas?

Prof CHAPPELL—No, I think it would probably be the national occupational health and safety body. I forget quite what it is called now, but it is the Commonwealth's agency. They are, of course, at the moment involved in trying to promulgate national occupational health and safety legislation, that we have a uniform approach to this across the country. I think it is very important that once we have that uniform legislation it might make it easier for also agreement to occur on collecting national data. In the United Kingdom they have very good data. The Healthy and Safety Executive in the United Kingdom keeps this information and records it. They have good data against which to measure the impact of their policies as to whether or not they are working. It is not only individual hospitals but they feed it all into a national database. We have nothing like that.

Mr SCHEFFER—Okay. Can I ask you one other thing about this document here.

Prof CHAPPELL—Yes.

Mr SCHEFFER—I should say what it is called for Hansard. The *Journal of Occupational Health and Safety*, 'The occupational violence experiences of 400 Australian health workers,' that document. You said when that was released, the New South Wales government felt a bit sensitive about it.

Prof CHAPPELL—New South Wales health did.

Mr SCHEFFER—Is it useful for us to know why?

Prof CHAPPELL—Well, no-one likes showing their dirty linen in public, and especially health agencies. They were very apprehensive about this. It is a very political area, very sensitive.

The CHAIR—Professor, we are coming to the end of the session. Getting back to the nuts and bolts about what we have to do to report to parliament in relation to the recommendations out of this inquiry, we have provision for expenditure for protective services in hospitals as a security measure. A number of our submissions and the hearings that we have conducted indicate there is probably little support for armed PSOs in emergency wards. Many of the larger hospitals have their own staff in relation to security and others use contractors. The dilemma is, of course, then if we do not use the budget clearly for PSOs who not armed in emergency wards, where might this money be spent best if spent at all? We have heard a lot about training, we have heard a lot about sentencing, licensing, the Crimes Act and a number of other issues in relation to flexibility for both penalty and action by security. Where would you suggest may be the best investment the government could make in relation to increasing the safety in the workplace for all emergency wards in public hospitals?

Prof CHAPPELL—Can I ask you one question. I am not quite clear what protective officers are. Are they fully-fledged police officers?

The CHAIR—They are not. A commitment was made in relation to providing security on railway stations between 6 p.m. and dawn, security on platforms. The Deputy Premier and the Minister for Police said, 'We will provide 140 PSOs'—as we call them—'that are specifically trained'—but not to the standard of Victoria Police—'through the Police Academy.' They actually go through an induction very similar to what a police person would do, except it is a shortened version.

Prof CHAPPELL—With full weapons, not just with a stun gun?

The CHAIR—No, full weapons. There is provision in the budget for armed PSOs going through the same training for security in emergency wards in hospitals. However, the Health Department says it can understand Victoria is a little sensitive about having armed PSOs in hospitals, hence this inquiry.

Prof CHAPPELL—I see. I did not realise, yes.

The CHAIR—(indistinct) in relation to providing a safer workplace. I guess he has made clear to us that, as has many other witnesses, there is little support for armed PSOs. In fact I think a lot of your work has been quite separate from the actual security—or PSOs as we know it—in Victorian environments as fully in the workplace. Given the inquiry I was wondering whether you might see it as an appropriate investment for Victoria to make.

Prof CHAPPELL—Yes. I think one aspect of this is you have very good guidelines here for prevention and management of violence, and check lists and risk assessment tools and so on. I would, if nothing else, first suggest that with the guidelines you have they ought to make sure they are being used because so often in these areas we develop lovely constitutions, we develop lovely guidelines and no-one then applies them. Application would make things safer. I have no idea how well these are being implemented. I did find from one piece of information I downloaded from the acting chief nursing adviser from November last year, suggesting that there has been a significant reduction in the number of workplace injury claims in Victoria since you have been putting in place these measures. It does seem they are having an effect. Less aggression is being used, less physical injuries anywhere, and less psychological injuries.

The CHAIR—But that is generally across workplaces, isn't it?

Prof CHAPPELL—No, specifically in health.

The CHAIR—Okay.

Prof CHAPPELL—For the record I have noted it is by Katie Fielding, acting chief nursing adviser, and I assume it is a presentation made in the PowerPoint form, 18 November 2010. It has some figures in there about the impact on WorkCover claims.

The CHAIR—Part of the reason I thought for a minister to make that commitment was, in fact there was an increase in antisocial behaviour against nursing staff, particularly in emergency wards that are high risk, high active on the weekend, particularly in relation to alcohol, drugs and mental health.

Prof CHAPPELL—Yes. I think I would put my money, frankly, into the control of alcohol, alcohol reduction. 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. The National Committee on Violence recommended—one of its recommendations—prohibiting electronic and print media advertising of alcohol. I do not think that was ever picked up by anyone.

The CHAIR—Not for want of trying.

Mr SCHEFFER—Do you mind if we explore that a bit more. It is important because we have not had that response before to that question. Let's say around \$20 million the government has tagged for some remedial action around violence in hospitals, particularly emergency wards. What we have asked different hospitals is, 'What would you do with the money?' Part of the fear is that would be all soaked up in clinical treatment and we will never see the light of the day. They said, 'Yes, provided it's tagged,' so it really does go to protecting staff and workers in hospitals. That is the general view. You are saying something quite tangential to that, that it would be perhaps better if that \$20 million was spent in looking at alcohol—

Prof CHAPPELL—I think you have to look at the context in which violence occurs and how it occurs. From the moment that an ambulance officer has to go and deal with someone who has been injured in a fight or something of that nature, until the time they come to the emergency room, they then have to deal with the same people there. You have no security. This particular feeling comes, I have to say too, from the National Committee on Violence. We looked at what was happening at St Vincent's Hospital, that is obviously smack bang in Kings Cross. They have a significant number of people who come in with serious injuries, quite apart from staff risks, as a result of violence occurring in clubs and pubs. Bouncers were a big problem; there were a lot of people being beaten up by bouncers. The clubs and things were open to long hours into the night but now there is some attempt at closing times, use of plastic glasses and a whole range of things like that. That is where I would be putting my money, to be honest.

The CHAIR—Thank you. We welcome that comment because our other inquiry is about community safety programs and how to deal with things, and domestic violence particularly, and also with young people fuelling up with alcohol, going to clubs, using amphetamines and other drugs to keep that high going, and falling out at about three or four in the morning and then creating mischief. Your comment is interesting. Nationally they are having a debate about tobacco advertising. I can see it moving into the area of alcohol. I think you are on the money—

Prof CHAPPELL—I hope I am.

The CHAIR—Certainly on some of the commentary that has been made in relation to advertising. Thank you very much, professor. We appreciate it.

Prof CHAPPELL—Thank you.

Witness withdrew.

Hearing suspended.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Sydney—20 September 2011

Members

Mr S. Ramsay

Mr J. Scheffer

Mr S. Leane

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Senior Research Officer: Mr P. Johnston

Witness

Dr L. Luck, Associate Head, School of Nursing and Midwifery, University of Western Sydney.

The CHAIR—Lauretta, thank you very much for making your time available for this joint parliamentary committee of Drugs and Crime Prevention. I might read you the conditions around which you will be providing evidence to this committee this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I hope you have received or read or sighted the guide for witnesses presenting evidence.

Dr LUCK—I have, thank you.

The CHAIR—We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity. You can correct it as appropriate.

Dr LUCK—Thank you.

The CHAIR—I will invite you to make your submission here to us today.

Dr LUCK—Pleasure. Thank you so much for inviting me. I hope I can contribute in a meaningful way to your deliberations. What I would like to do and what I have done here is really taken the results of my PhD work and I am trying to contextualise it for you because it is very focused on nurses, and in particular I looked at ED nurses. I did that in many respects deliberately for two reasons. First, we have a lot of work done with violence towards mental health nurses. It is a different issue and they have different geographical boundaries and different set-ups in the ward. I had to look somewhere else. Secondly, I thought, because we know it is an international problem that I could ask the nurses what they did. That is what I have done for my PhD work.

Slides shown.

Dr LUCK—These are the questions. I am not going to read it out because you have it in front of you, but essentially what I was really looking at is violence that came from patients, their family and friends, not interdisciplinary violence or horizontal violence or bullying or other aspects of what is seen in the workplace, but outside of what I have actually studied. Particularly, I have sequential aims in my study. The first aim was ask the enrolled nurses, who have worked in a context with a lot of violence towards nurses, 'How do you go about picking up who might be violent?' Secondly, I wanted to ask people, 'If you are confronted with someone you believe has the potential to be violent, what are you going to do about it? How might you avert that circumstance? After it has happened then what do you do with each other and for each other and for yourself to deal with the sequelae of the violence?'

They are the questions. What was important to me was to ask the people who were engaged in the issues. This is by way of explaining that this is not a quantitative piece of work. You will not find comments about whether the hypothesis was approved or not or rejected. This was mostly done with field work and, as you can see, I have spent a lot of time in the context, and this was across days, across duties, 24/7, to try and get a capture, a snapshot, of what was happening. I then interviewed in a semi-structured, informal way the registered nurses who agreed to participate. When I saw

incidents or some event in the ward I would then go back to a registered nurse and say, 'Tell me about that.' I really tried not to make assumptions about what their motivation was or what their knowledge was for their actions and behaviours.

I observed some events, and they were 16 violent events, and my motivation for that was to see who was engaged in a violent event, when was it happening, how did they come into the ED, and that kind of demographic but useful information about the patients and families, and registered nurse for that matter. It was much more a qualitative approach looking at the events as they occurred. What is typical of qualitative research with that amount of data, as you can probably imagine, is the theme in our findings. The finding themes which we can work through hopefully address the question. Most of this work you will see is published and it would be easier to get a more full understanding of what I did.

The first thing I looked at was conveying caring. What do registered nurses do to try and avert violence? A lot of what I found here, as you can see, is fairly much the type of interpersonal skills we try to engender in our student nurses. What I became very aware of through my research was that more experienced nurses would probably have a different approach than people who were, say, not as experienced, and probably more able to pick up on subtleties and more able therefore to respond at those times.

Mr SCHEFFER—That is growing out of their experience. Informal learning. It wasn't that they had been off and done formal training around that?

Dr LUCK—The ED I worked at was—and I probably should have given this background as well. It was an ED where at that point in time they were fortunate enough not to have had any really major event happening. They did not have any nurses who had been subject to physical abuse, but I know that you know that it does not matter where you are, you are going to have lots of verbal abuse. To answer your question, what I heard from the participants was that they felt their life experience, as well as their nursing experience, gave them more understanding of the subtle things that were happening before it occurred.

Mr SCHEFFER—The reason I ask you that is we have heard—and I suppose we sense this or know it—that women are probably better at it than men, if you would take that just as a proposition.

Dr LUCK—Yes.

Mr SCHEFFER—But we have also heard about training people who work in these areas and the way their body is oriented towards the person who might be presenting with some difficulties, the pitch of their voice, open-ended questions, the way they use their hands, and all that kind of stuff.

Dr LUCK—Yes.

Mr SCHEFFER—You are saying here that the older nurses were more in command of that suite of strategies. What I am asking you, that was completely haphazard. Some of the things they did might have worked, others might not have worked so well. There was no real structure around how they did that, other than a kind of informal human growth?

Dr LUCK—Yes, I think that is fair to say, absolutely. Even to take that one step further, I was fortunate enough to have as the people who consented to my study, people who probably had those skills. I also had some people who were registered nurses for only a couple of years. I saw quite a distinction between people who had been in nursing for some time, versus people who had not been there for very long. Can I say this as well, I have done some further work and as you can see most of what I found here in terms of, 'Well, how do we avert violence?' was around informing people, treating people respectfully, really interpersonal skills.

I have done some further work with this and I think this is really interesting because it was very contextual to where I was. My next piece of work on this—they knocked out things like offering tea and coffee. At the ED I was looking at they said, 'This is really important because people can be here for 16 hours and not have a cup of tea or anything.' For that ED they identified that as something that will help people to maybe feel less anxious.

Mr McCURDY—Communication as well. People approaching them, talking to them and offering them a cup of tea.

Dr LUCK—Yes, telling people what happened and what is happening.

Mr SCHEFFER—So what is the first one up there mean: not admitting violent patients into ED?

Dr LUCK—The emergency department—and this was something that was almost the very first thing that people said, that at triage you actually need to make some decisions about who came in and out, and because my work was patients, families and friends, it was also making judgments about what family and what numbers of family it might be safe to have inside.

Mr SCHEFFER—What happens to them if they are not admitted, what does admitting them mean?

Dr LUCK—I just mean letting them through the door, as opposed to—

The CHAIR—This is family members of patients—family or friends of a patient.

Mr SCHEFFER—Not the patients themselves?

Dr LUCK—No, not the patient.

Mr SCHEFFER—I misunderstood you.

Dr LUCK—There is a point of what physical barrier is to maintain safety. What was really clear here as well—and again to go back to your question about what happens, what differentiates a more experienced person from a less experienced person. A more experienced person also watches what was happening around their space. They would approach a patient so they were not somewhere where they could be hit, kicked, grabbed et cetera. They would be standing in the middle of a person's

body or right towards the end of the bed. There were those experiential decisions that people made; not consciously. I mean, as you can see you need to dig around to get people to tell you.

The other thing that was really interesting is they looked at their environment. If they had someone that looked like they had the potential to be violent they would move IV poles and move things that the person could potentially use as a weapon. Again that was what I saw in my data from more experienced registered nurses, as opposed to the less experienced registered nurses.

Mr LEANE—This work you have done, has that been translated into a training module for the student nurses or am I jumping the gun?

Dr LUCK—No, that is okay, this part hasn't. This was a version. If I can bring you to the next one which was—

The CHAIR—You go in the order you like. Do not worry about us.

Dr LUCK—I would really like to do this. I have had a small amount of funding for this to expand this a little bit more because I think it does belong at a top end of some training program. I think you are right. My focus is particularly on people with less experience as registered nurses because you could be losing them in the workforce. It is a workforce issue. If you can do something to keep people safer then we may in fact keep them for longer, as it were.

The CHAIR—Yes.

Dr LUCK—As I said, I put this out to Adelphi and had some other experts look at it. I am making it more sophisticated to see if it will work. My next piece of work, however—this is what I call STAMP. When I was looking, I came to these registered nurses and said, 'What behaviours do you see that might give you the tip-off that someone has the potential to be violent?' This work has taken off, and this work we have an ARC grant for. What we are trying to do is to get some validation, see the validity and the liability of these behavioural cues to see whether someone could pick it up, again like a less experienced registered nurse or enrolled nurse and say, 'Right. The person is exhibiting this, this and this. I need help. I need a colleague to help me with this.' It is called STAMP. Again, what is really interesting about this it came from a registered nurse but they are kind of intuitive pieces of information. The way people are looking at you, staring. Someone is in bed in the ED. As you know they are mostly open areas. The patient's relatives and friends would be watching the nurse going backwards and forwards. We say that is a cue that someone is getting fairly agitated about what kind of service they are getting.

Obviously the tone and volume of voice. You have probably experienced this already: even defining violence is a bit sticky because as soon as someone starts swearing we will say, 'That's violence, that's the end.' Other people might say, 'That's something I can deal with or tolerate and I don't categorise that in quite the same way.' Anxiety I think has to be a really big one in hospitals. You have people who are hurt, who are in a hectic place that they do not know about would be anxious. Mumbling and pacing are two I am working on.

The CHAIR—I have noticed that behaviour in our parliament. I am going to talk about this one by taking you to the next slide. This one addresses the thorny issue of zero tolerance because I know we definitely have policies that cross all states about zero tolerance. The registered nurses I spoke to were a little bit more tentative about whether zero tolerance worked or not because their underlying goal was to give patients care. What I found was something really interesting is that they make judgments about when they considered something—the policy applied for zero tolerance. If someone was violent the code would deal with the person in that situation. What they did was divide it into, if they were perceived as being legitimately at ED—and the best way to explain it is they could not have gone to a 24-hour medical centre. They needed to be using those services. If they had some mitigating factors, ie, a mental illness, dementia, a very unwell child, then that group of people tend not to have—we do not have zero tolerance.

If someone in another area, who the nurses did not think they were legitimate ED users, and they did not think there was any reason to mitigate that behaviour, then that quadrant they would say, 'We have a zero tolerance policy,' and they are likely to go and get security. As these two things approach the X it tended to be a much more subjective, personal approach to violence. Can I also say there was difference between if they thought the violence was a personal attack or if they thought the violence was something to do about the system. If the registered nurse thought, 'Well, this violence is about the system, it's about our health services, about what we can provide. It's about triage, it's a lack of understanding,' they saw that very differently if someone was abusing them as an individual. This is the violence here that I am talking about, there was no personalisation of violence. As soon as it was personalised, there was no doubt in people's minds that it was a zero tolerance episode.

Mr McCURDY—Frustration versus genuine anger.

Dr LUCK—Yes, and even to the stage I had in my transcript someone who was telling me a story about a person swearing at them but saying that it was about leg. They said they did not see that as violent, that was the language they could use because of who they are.

The CHAIR—Zero tolerance is the reporting structure in relation to a nurse being vilified by a patient or—

Dr LUCK—Sorry, I was talking about zero tolerance in terms of a policy that says that no violence is permissible.

The CHAIR—Yes, but from the nurses point of view how do they respond to that in relation to a zero tolerance policy?

Dr LUCK—Regretfully, in my data, the nurses that I spoke to were not very convinced that it was an effective mechanism to stop violence. The other thing I also saw in my data is most nurses said they would not report it because they did not feel it was going to go anywhere.

The CHAIR—Yes, that is one thing: how effective is the zero tolerance.

Dr LUCK—I can go further to say that some 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.

The CHAIR—Is that because they do not understand the policy or they are worried about the recriminations by management by recording an incident?

Dr LUCK—In my data I did not find any of those. It was more, 'I don't think anything will happen. It's kind of like I wasted my time.' That is not to say that those other attitudes do not exist but certainly not from what I found or heard.

The CHAIR—Thank you.

Dr LUCK—The next part is how registered nurses in a working situation thought they could deal with the sequelae of violence. There are two parts to this: firstly, they thought one of the most important things about dealing with it and maybe even about averting it is about working together. What I heard a lot was the fact that they liked to work in more open spaces with curtains because they could hear each other behind the curtains. They felt that gave them a capacity to hear if someone was in trouble behind the curtains and therefore intervene, or if someone was managing something very well, some of them said, 'Nurse X manages that very well and we listen and learn from her.'

Mr SCHEFFER—On the other side of that transaction, do patients present differently if they are behind a curtain? Do they feel—because there are more noises and distractions for them—if they are in pain and they want to concentrate on managing that, does it distract them, as distinct to them being in a separate room that is silent and closed off?

Dr LUCK—I do not know that I can answer that for you, I am sorry.

Mr SCHEFFER—That is okay.

Dr LUCK—I think the whole concept in nursing of that magic curtain—we do call it the magic curtain. We put the curtain across and then we ask people very intimate questions as if no-one can hear. It has a mystique about it, really. But, no, I am sorry, I cannot answer that but the registered nurses were saying they found that helpful, and the less experienced registered nurses said they found that helpful. I had one beautiful incident where things were going a little bit south and the registered nurses were listening and letting the less experienced registered nurse manage things. As things were not going as well, there was this gentle step-in. This group of registered nurses like that. They like that as a way of helping each other and dealing with potential events.

Finally, which I found quite fascinating—and it really flies in the face of a lot of articles you read about nurses saying, 'This is part of the job'—I did not hear that once in my data. No-one conceptualised violence as being part of the job.

The CHAIR—That is good.

Dr LUCK—But they did decide they needed some personal coping skills and they did not find the hospital support mechanisms useful. In fact when I asked a number of people about what happens if there is an incident, what would you do, they gave me an example of an incident where a young child came in and they knew the relatives. They found that an incident. They wanted to use the formal mechanisms them for counselling. But the day-to-day violence, what was happening, they did not see that as something they needed counselling for. They thought, 'What's a much better process, to talk in the tearoom with each other, debrief with each other, debrief with people we trust with each other and don't take it home.' Just about all the registered nurses I spoke with said, 'What do I do with it? I don't take it home. If I do talk about it, I'll talk about it with other registered nurses, like my sister or my mother, whoever is another registered nurse.' They were very clear about not letting that go home. Again I do put a caveat on the fact that during the time of my research—and I know for the couple of years prior to that—there had not been any devastating incidents for a health care person.

The CHAIR—Thank you, Laretta. Questions from the committee.

Mr McCURDY—I will make a start. You used the words 'losing people from the workplace'.

Dr LUCK—Yes.

Mr McCURDY—That is where you were headed near the end there. I am trying to work out whether the hospitals are taking that seriously. Do we have a little way to go or a long way to go in terms of those relationships and the hospital boards understanding the way the nurses feel, as opposed as security. You talk to security and they say they are doing this. How far are we along that line?

Dr LUCK—I would have to give a personal supposition to that, but what I can say when we look at the data of nurses that stay in hospitals, we have an average age of 43 or 44 and we have people there from one to three years, registered nurses, and then this huge dip and then nine years thereafter. We are losing registered nurses at about three to four years. But just as a matter of my experience, working with the people at Eastern Illawarra Area Health Service which no longer exists. I am not quite sure what they are calling themselves at the moment. I know that they are addressing workforce issues and trying to have individual transition programs for registered nurses. I do not know the success of that. There are probably a lot of reasons why people leave at that period of time. I would think if you went to someone outside of the health industry and said, 'This is a really great job for you. You're probably going to be yelled at 16 or 17 times a day and you may well get hit,' people say, 'No, thanks very much, you can keep your job.' Whereas it is endemic in health.

Mr LEANE—Going back to the training, is there that element of student nurse training where—

Dr LUCK—We want to keep them.

Mr LEANE—'There could be some aggression towards you and this is how we suggest you deal with it.' How much of an element of that is there in training?

Dr LUCK—At the moment, certainly in our curricula—and when I have worked at other universities in their curricula—the issues of violence tend to be addressed in the mental health units. It is kind of a bit skewed towards a really different context. What is happening in mental health teaching at the moment, it tends to be much more communication driven, rather than medical model driven, and I think we might see some differences there. Whether people and students extrapolate those skills—because people tend to bundle things—whether they extrapolate them into other areas, I am not sure about that. But from what I saw we see registered nurses outside of mental health in a different circumstance and a different context than people inside a mental health unit because it is set up so differently.

Mr LEANE—Do you see the need for more training in that area?

Dr LUCK—Yes, I do.

Mr SCHEFFER—We have talked to a lot of senior hospital staff who have talked to us about generally a lot of issues and they say things are in hand, and they have talked a lot about the working relationship between the hospital security teams and the medical people. 'It's travelling okay,' is my general sense of it. On the other side when we have heard from nurses there is not quite the same confidence. There is a sense of day to day they are under the hammer a bit and we have heard some quite strong statements from nurses telling us that they are subject to the kinds of things you alluded to. Do you think there are two tiered perceptions about what is going on?

Dr LUCK—I am happy to answer that one because it is in my data. During the course of my research the security for this particular ED changed. It changed from more of an on-call situation to a higher presence of security in the ED. It was very easy for the nurses to get someone to stand by with them. This is certainly not something I have published but what they did say is they felt safer because what would happen is they felt the security would have a presence and then that would sometimes de-escalate what was happening; not necessarily because we have human variance but they felt a little bit more confident. Having said that I saw circumstances where security were there and certainly had a presence but the registered nurses were managing what was happening with a patient, including getting weapons away from them and calming them down.

Mr SCHEFFER—I appreciate that but what I was driving at was that given all that—for example, under-reporting, 'It's part of the job, live with it.' Exactly what you were saying to Sean; if you went up to somebody and you said, 'You get abused so many times a day, would you like the job?' 'No thanks,' that kind of scenario that nurses feel that that is their space, and they appreciate the security systems, but at the end of the day they really feel that there is pressure about them not to report and not to kick up a fuss. Whereas senior management say, 'No, no, of course they report. We have processes in place and we encourage everyone to report,' and it is not quite sometimes coming together. That is what I am really asking, but you may not know anything about it.

Dr LUCK—Yes. Well, what I can say is there are registered nurses that did not feel there was any point in reporting because they did not think anything would change.

Mr SCHEFFER—Yes, that is what I am getting at.

Dr LUCK—That was how they approached it. As I said, they thought a big event was something terrible happened to a patient. They never said though they thought it was part of the job.

The CHAIR—You would think in a workplace it would be different, wouldn't it?

Dr LUCK—Yes. I know the literature is replete with that kind of attitude but I did not actually have that finding.

Mr SCHEFFER—I guess part of the job is complicated because I figure in your presentation you are saying that it depends what abuse is. Someone uses a range of expletives to describe their own condition. It might be interpreted by some to be their self-expression, whereas to somebody else it might be seen as being aggressive language. There is a bit of that and that might be part of the job space.

Dr LUCK—Yes, that is exactly the problem of saying, 'What is violence?' It is difficult in terms of policy, and in terms of training it is really difficult to say, 'This is black and white. This is on this side of the fence and that is on that side of the fence.'

The CHAIR—Thank you very much, Laretta, for your time. We appreciate that.

Dr LUCK—A pleasure.

Witness withdrew.

Hearing suspended.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Sydney—20 September 2011

Members

Mr S. Ramsay	Mr J. Scheffer
Mr S. Leane	Mr T. McCurdy

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Senior Research Officer: Mr P. Johnston

Witnesses

Ms J. Edwards, Director, Nursing Midwifery Services;
Dr R. Donnelly, Director, Medical Services;
Mr J. Jewitt, Director, Corporate and Finance Services; and
Ms T. Zarkos, Executive Officer to Executive Director,
Royal Prince Alfred Hospital.

The CHAIR—Thank you very much for making your time available, the four of you. This a joint parliamentary committee of Drugs and Crime Prevention. I might read you the conditions around which you will be providing evidence to this committee this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have read the guide for witnesses presenting evidence to parliamentary committees and you understand the conditions around it. Nodding of the heads. We are recording the evidence and we will provide a proof version of the Hansard transcript at the earliest opportunity and you can correct it as appropriate. Now, Jo, are you the leader presenter?

Ms EDWARDS—Not the leader presenter but I was going to introduce representatives from Royal Prince Alfred.

The CHAIR—Thank you. We have allotted three-quarters of an hour for this session and if we can perhaps keep it to that time and there will be time for questions.

Ms EDWARDS—Sure. My name is Joanne Edwards. I am the director of nursing midwifery services at Royal Prince Alfred. With me today is Joseph Jewitt who is the director of corporate and finances; Dr Roy Donnelly who is the director of medical services; and Tina Zarkos who is an executive officer to the executive unit with a background in the emergency department as a manager, as well as a long history of working as a nurse there. We thought we would start with Roy giving a bit of an overview of Royal Prince Alfred and the types of patients that we have within our facility and then we will hand over to Joseph who will talk about our security services and essentially the management of potential aggressive or violent patients or visitors.

The CHAIR—Sandy has provided you with information about the inquiry and the basis upon which we are having these hearings.

Ms EDWARDS—Yes.

The CHAIR—I do not need to go into any of the detail?

Ms EDWARDS—No. We had the opportunity to talk to Sandy today.

The CHAIR—Good, thank you.

Dr DONNELLY—I am going to talk for two minutes to give you an overview of the hospital. Royal Prince Alfred Hospital is a major tertiary facility in Sydney. We have about 900 total acute beds. In terms of our emergency department activity we have 63 and a ½ thousand emergency department attendances which I think tied for second place in terms of the busiest emergency department in New South Wales. Out of that we get about 19,000 admissions for emergency per year. In terms of ambulances we have about 19,700 ambulance attendances per year. That was last financial year. In summary we see about 54 ambulances per day in the emergency

department out of about 174 total presentations. In New South Wales terms, Australian terms, it is quite a busy department.

The hospital itself, as a major tertiary hospital, provides full spectrum of specialist clinical care across most clinical specialty areas, both to local residents and also across the state. We have statewide transplant service for liver and renal transplantation. We have a large cancer service unit. We are the biggest maternity in the state, a significant facility. In terms of our location demographics we are located in the inner west of Sydney about a kilometre and a half that way; a mixed demographic of people living in million dollar terraces, versus people living on the street. Mixed age groups: we had a bit of a boom in young people having babies in the area recently. That has increased our paediatric population. We do have in that area a not insignificant number of people with drug health issues and mental health issues which create clinical and behavioural challenges for the hospital and they often present through the emergency department. That is my summary of the hospital structure and demographics. I will hand over to Joseph to talk about security issues.

Mr JEWITT—RPA is obviously part of New South Wales Health. In terms of our security arrangements we fall under the broad governance that is set by New South Wales Health. In a general sense the legislative framework that informs our work is the Occupational Health and Safety Act 2000, Workers Compensation Legislation, the Crimes Act, the Privacy and Personal Information Protection Act, Enclosed Lands Act and the Mental Health Act. Within that legal framework there is a manual that is developed by New South Wales Health called 'Protecting people and property'. That manual provides the overall government and framework that informs the local policies and arrangements that we have in place in terms of security.

New South Wales has a zero tolerance to violence in the workplace across all health facilities in New South Wales. We have posters and brochures that are available in key areas at the hospital informing members of the public and patients coming into the hospital of that. That obviously informs of a training program et cetera that we have for our staff in the facility. We also have a *Rights and Responsibilities* brochure that is given to all patients on admission. That *Rights and Responsibilities* brochure outlines our responsibilities to patients in terms of treating them with dignity and respect and making sure that they are informed about their care at every stage of the care process. It also clearly states to these patients that they are to behave in a way that does not impinge upon the rights and wellbeing of patients or staff when they come into our facility, and doing so may lead to their removal from the facility. We make sure that is clearly understood by people coming into our institution.

We adopt a risk management approach in terms of our security arrangements. It follows broadly the OH and S Act and policy frameworks. It has four key sets: hazard identification; risk assessment; risk control, and monitoring and review. We use this process to be able to identify what are the particular risks for our institution and the strategies we need to put in place. But it also helps us identify where the high-risk areas are and obviously the emergency department is an important area of focus for our facility.

In terms of our actual security response to incidents there are three levels of security response. The first level is a request for security assistance. This is where the local attempts to de-escalate a situation which would involve the local management and

staff in verbally de-escalating and trying to resolve whatever conflict or issue has occurred, has not worked. Then they can call for a security presence to attend that department and security staff can then be deployed. That can be in the form of being a physical presence within the department which might help defuse the situation from escalating. It also might form part of the team that is assisting in verbally de-escalating that situation.

The second level is a duress response. That response is activated through duress buttons that are located in key areas throughout the department. Certainly in the emergency department there are personal pendants that the staff carry on them that they can use to activate a duress response should they feel unsafe. That can occur if staff are feeling threatened or feel that there is the potential for an escalation in aggression or escalation of an incident, or when there is violence threatened.

The third level is a code black response. The code black response, similar to the duress response, is a response whereby security are notified through a paging system that there is a code black. It is like an emergency response in the hospital. Also members of the executive are notified that there is a response and attend, or there is also the after-hours managers because they carry the same pager respond. We also have other services, such as the porter service attend, not so much to be involved in the situation but should the patient need to be restrained and then moved they assist with that process. We try and make sure that all of the people who might be needed to then manage what has become an escalated level of violence they are there to help attend and manage the situation as carefully as possible.

Throughout our facility we have CCTV surveillance. We do not have surveillance within the clinical areas where patients are assessed and treated, but we do have surveillance in areas that are deemed to be high risk and public thoroughfares and we can use that surveillance to monitor what is happening across the facility. We also use that surveillance to coordinate a response to an aggressive incident. There is 24/7 monitoring of that CCTV feed surveillance within a control room, and it usually the leading hand for security that is monitoring, and in radio contact with the security staff we can then coordinate the activities of the security staff and we deploy them as necessary.

We also have an extensive access control system throughout the hospital. That access allows for limiting public and patient access into non-public areas. It is obviously a swipe card system where the cards are issued with the authority of the executive director and have a photo ID with the person's name and position. If staff encounter someone in a department or an area where there should not be a member of the public they cannot identify, they can politely approach them and ask them who they are. If they do not have a valid ID they can then notify security of that person's presence in that area.

As I flagged before there is the Enclosed Land Act, and that act gives us the authority as the administrators of the campus the ability to remove or deny access onto the campus for anyone who we believe poses a risk or a threat to our staff or patients. That act allows us to issue a warning to let people know that they may be barred from accessing the service. Should the behaviour persist, security staff are able to issue what is known as a barring notice. That barring notice means that if that person does

not leave the campus, or re-enters the campus within the period set out in the barring notice, the police will be called and they would be subject to prosecution and a fine.

We usually make sure with issuing such notices that there are very clear exemptions in terms of accessing urgent care or gaining permission from the executive of the hospital should the person need to present for any medical appointments or to access care, but it at least allows the mechanism for us to control entry onto the campus for anyone that we deem to be a high risk of aggressive behaviour as demonstrated in the past. In terms of the emergency department, as I have already flagged, staff are provided with personal duress alarms, and there are duress points throughout the emergency department. Also the design of the emergency department, it has security glass at the front reception. 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 are distressed or concerned about waiting times.

We have access control from the waiting room into the acute area. In terms of the acute area we have the nurses station elevated so there is clear visual range throughout the department, that if there is a potentially escalating situation that becomes known to the team early. Security is also located adjacent to the emergency department and if there are any concerns there can be an immediate response from the security staff to those concerns. In terms of staff training we, as a philosophical approach, take a team based response to the response of aggressive incidents. We feel that is an important way in terms of ensuring both our staff safety and patient safety, but it is also important in terms of managing the safety of the person who is involved in the escalating aggression. That team based approach is led by a clinical leader which is usually the senior clinician within the department or ward, or the person in charge of the care of that patient. That is important in terms of the identification and the understanding of any underlying medical issues that might be contributing to the behaviour, but also making sure that in the response there is appropriate monitoring and observations of the individual to make sure they are minimising any potential risk of harm to them but also coordinating those activities, both in terms of the containment and de-escalation of that incident, and making sure that any other members of the public—patients or staff—are appropriately directed out of the area and kept safe as well.

We provide specialist training to our clinical staff that focuses on verbal de-escalation and defusing of aggressive incidents. We are currently reviewing that training to also ensure a focus on physical restraint and take-down procedures as well. Security staff are licensed security officers, and with their security licence have the authority to search people coming into the facility and also remove people from the facility if directed to do so. Also we provide additional training which includes the sensitivities and the issues that they will encounter within a health care facility, and that training particularly looks at how to verbally de-escalate situations with patients and members of the public; the physical restraint techniques and take-down procedures, and very much a team based response, that when an incident is occurring, if possible, gathering the team together, and having clear delineation involves responsibilities, who is going to do what, and what the ultimate goal is in terms of managing the situation. It might be to administer medications; it might be to remove the person from the area, and making sure it is a very clear plan that after the intervention has occurred what is going to happen with that individual, be it removing them from the department,

medication, that everyone knows exactly what is going to happen once the intervention has occurred and that there is no delay or confusion caused once people start to respond.

All incidents that involve security staff are reported through a system called Handy Data and that provides us with a detailed information and classification of incidents, but also a narrative of what has occurred. That allows us to be able to monitor trends, high-risk areas, changes in the nature of incidents that occur throughout the facility that can then inform training or other security responses. We also record incidents in our IIMS system which is a general incident information management system that is used in clinical areas. Again that allows us to classify incidents that occur and have a clear risk assessment and history of the incident. Both of those data sets are reviewed by relevant managers on a regular basis, that even minor incidents are reviewed. Serious incidents will require a formal investigation, post-incident, which is an important learning opportunity to identify any particular problems or issues in terms of the response, or opportunities to improve the response in future.

In terms of post-incident response, it is really important in terms of the debriefing of staff who are involved in the incident. That occurs with the managers that are in charge, both as a learning opportunity and also as an opportunity to identify any staff that may be particularly distressed as a result of the incident. We have an employee assistance program which is like a staff counselling program. Referrals are made to that service to all the staff involved but certainly if there is any concern about the impact the incident has had on a staff member.

In terms of broad local governance at RPA, we have a bimonthly Security Review Steering Committee which has representation of staff from a variety of classifications and groups that meet with the executive. That is an important forum where we review our local procedures and policies; review incidences and any trends; review the training arrangements that are in place for our staff, and identify any opportunities to change those local arrangements. We have an online security improvement tool that is filled in by the department manager on an annual basis and that allows for the facility to identify any security risks or problems that may exist in any of our departments or clinical areas. That information is reviewed by that Security Review Steering Committee that I mentioned earlier. We also have an annual security improvement audit that involves external auditors in that auditing process. That follows largely the same framework as the departmental one, but includes the entire facility with a focus on high-risk areas, such as ED, pharmacy, mental health, critical care areas. A report from that audit is provided to the executive and an actual plan developed to improve any opportunities in terms of the security arrangements and to address, in particular, recommendations that may come from that audit process.

Every five years we also undertake an external security audit and that is a specialist security consultant is brought in with experience within health care facilities to do a full audit of the security arrangements for hospital, and again a report is provided to the executive and an action plan is developed. That audit process would actively involve staff in high-risk areas as part of that consultation process in developing that report. We also have a very good relationship with the local area command, New South Wales Police. I personally have contact with local area command and will regularly report to them any concerns or issues, or discuss any issues that may come up, the interaction between the hospital and police. We also have a formal meeting

with them that involves mental health, drug health services, hospital executive and the local area command as a more formal mechanism of resolving any issues or problems that may come up and improving that relationship between the two organisations.

In general we have a very good relationship with the police and they respond very quickly to any concerns that we have. Any issues that we cannot manage at a local level, there is an immediate response to notifying police, and the police respond very quickly. We have found that a very good relationship. I think that is it.

The CHAIR—You have covered a fair bit of ground, thank you, Joseph.

Mr McCURDY—Can I get some clarification before we move on. I have assumed that it is in-house security employed by the hospital, not a contract?

Mr JEWITT—Yes. We have a security services department, and the staff within that department are registered security officers that are employed by us and are specially trained by us in terms of their role within the hospital. We do at times use agency security but that is the exception, and not in patient areas or high-risk areas.

Mr McCURDY—Do your guys carry handcuffs or batons or anything?

Mr JEWITT—No, they do not.

Mr LEANE—We have had described to us, across three states now from different hospitals, about the code black teams. Something unique to your hospital is that you said you had an executive member on that—

Mr JEWITT—Yes.

Mr LEANE—Which sounds like a good idea, but could you elaborate on that. What was the genesis of that or what was the motivation?

Mr JEWITT—In general it is about making sure that there is a senior person involved in leading the response and making sure that in terms of any kind of decision-making, in terms of the management of the patient, that there is somebody on hand to help guide that process. Often, particularly with patients, a code black might result because of concerns or problems in relation to the care being provided, people being frustrated by waiting times et cetera. My understanding is—and the procedure has been in place long before my time—that it is about making sure there is that senior involved who can not only help coordinate the staff but be there to make any kind of decisions that are needed to help de-escalate and manage that issue.

Mr LEANE—The other question I had was, you said there is added training to the security personnel or extra training around the sensitivities of where they are actually working. Is that an in-house program that you have developed yourself?

Mr JEWITT—RPA is part of a health service called the Sydney Local Health District, and there is a registered training organisation that is run within that health service called the Centre for Education and Workforce Development. They provide a program called CIPO, which is Critical Incident Positive Outcome. It is a training program that deals with the full spectrum of techniques and verbal de-escalation and

identifying early on that there is a situation that potentially could escalate to become an aggressive incident, right through to the actual physical techniques in terms of take-down and patient restraint. That is an in-house program that we provide to our staff. It is provided to clinical staff, as well as security staff. It really is the backbone of that team based response, that everybody understands what the particular roles and responsibilities are. It also provides staff with an overview of the legal framework that governs the management of aggressive incidents as well that they all understand what their obligations are, the limitations in terms of what they can do, but also what they can lawfully do under the Mental Health Act and other relevant legislation when intervening in an aggressive incident.

Mr LEANE—Are you finding that incidents are increasing or decreasing over recent years?

Mr JEWITT—No, we have not found there has been a significant increase in the incidents in terms of the data we have available to us, bearing in mind that the data available to us is self-reported data in the system. But, no, there has not been any significant increase.

The CHAIR—To carry on with that, what sort of incidents? Are they basically alcohol-fuelled or mental health issues, drug-related or other?

Mr JEWITT—I think, as Roy Donnelly had said earlier, there is a variety of people that access our facility. There could be a spectrum of issues that underpin aggressive incidents, in our view. With a busy emergency department there can be times when—whether there be underlying issues around mental health or drug issues, but also when people become very impatient with waiting times, become very confused and disorientated in the clinical environment in terms of what is happening. 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.

The CHAIR—Thank you. Jo, where to from here?

Ms EDWARDS—We are open to questions from you.

The CHAIR—Do you want to make any other presentations to us before we ask any more questions?

Ms EDWARDS—To elaborate on code black, any code blacks that occur are put on to our executive report on a daily basis. If we are off site, the after-hours managers are the executive representative on the code black. We have a good feel for what is going on within the organisation and having that dialogue with our after-hours managers or our nursing managers that are on site all the time, we keep in touch with what is going on 24/7. That certainly assists with ensuring patients have the

appropriate management plan around their behaviours. The management plans are very much put in place from a multidisciplinary perspective. There is good medical staff engagement around the expectations of what the patient should or should not do, and how they can conform to their treatment, but in turn how we need to respond to what is going on.

Ms ZARKOS—I think we have covered a lot of the information that happens within the emergency department. Generally there is a good team approach there in the medical, nursing, security working together to de-escalate—de-escalation is the first step; talking to people, keeping them informed and advising them of what delays might be and what the treatment plan is, you are moving, for instance (indistinct) to know what was going on. There is a good response there.

Mr McCURDY—Is there a formal process that ensures that no weapons come into the hospital, no knives or—

Ms ZARKOS—There is no screening. You do not walk through a metal detector when you walk into the department.

Mr McCURDY—How does the director of nursing—how do the nurses feel? Are they comfortable in that environment or are there concerns that you feel come from them?

Ms EDWARDS—Our emergency department staff are skilled. They also have the appropriate training. They can quickly identify risks and act accordingly. If they had any concerns about somebody's behaviour, whether it is a relative or a patient, they would ask for security assistance. They would not wait for a code black to occur, they would be getting help early to intervene.

Dr DONNELLY—We do not commonly have incidents like that where there are weapons. It is very rare. We escalate to the police immediately and we get a very good response from the police who will be there very quickly. That is our escalation to those situations. It is rare, but we always get a very good response from the police.

Mr LEANE—You might have read on our terms of reference there was a thought bubble from the Victorian government that most witnesses are popping, as far as stationing armed protective service officers, which is a form of VicPol, in ED wards to help with security. Would you see that as appropriate at your hospital? Would you see that as something you would embrace or not?

Ms EDWARDS—I think at RPA the service that is currently in place works very well. We have a very good governance structure around the management of difficult patients or visitors. We have ongoing review of the data to identify trends and really the system we have in place currently works. The only thing we are working on currently is around the educational components and how we are going to deliver education in the future to the whole multidisciplinary team. That is what we are working on currently.

The CHAIR—In other hearings we have had, some issues have come out—and I want your response—in relation to the design of the emergency wards, that is people come in—and I think it has already been said that obviously if they come in

with an injury they want to be seen very quickly and if there are long waiting times it certainly exacerbates the anxiety in family, friends and patients. There is an issue about having an assessment room put aside for those of a violent nature that can be taken away from mainstream to assess their medical needs. There has been a suggestion that nurses tend to under-report any sort of antisocial behaviour to them or violent behaviour because one is a lack of interest by management and, two, a fear of repercussion if they do report incidents in work hours.

The security issues we have covered off. I want to raise the training issue. It has been said to us there is a need for specific training in security in relation to security in hospitals and emergency department as against normal security work in other workplaces. Obviously there is a social issue in relation to mediating or de-escalating violent behaviour. That is a quick comment on those issues. The point I am getting at is if we are not investing in protective service officers, where might we best invest our money to provide greater security in the workplace in emergency wards? Is it in the design area, training area, education area?

Mr JEWITT—I think it is multifactorial. 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. That has worked quite well for us. Also providing an important link—because Mental Health Services are not managed at a facility level—to the mental health service so that the patients, particularly patients who are identified as high risk, are escalated and it is identified to the Mental Health Services that in fact they are high risk and not appropriately managed within our emergency department and need admission, that 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.

I also think in terms of the training you provide a broad spectrum of training to your staff but that team based approach means you are getting the benefit of a variety of skills and expertise from the team, both medical, nursing, as well as security staff, that helps provide a much more comprehensive and effective response than if it was left to one particular category of staff to provide that response. That is why from our point of view the training program we provide is complementary across those groups and, as a further improvement to that, we are looking at running that training as multidisciplinary and bringing those staff together to look at that, specific to how you coordinate that team based response to role plays and in-service programs, probably an ongoing program.

Ms EDWARDS—Managing the waiting room, as Joseph mentioned before, the customer service model for our admin staff that are out there. We are also introducing volunteers into the waiting room to really be a liaison between what is going on out there with some feedback potentially 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 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.

The CHAIR—Thank you all very much for your time.

Witnesses withdrew.

Hearing suspended.

DRUG AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Sydney—20 September 2011

Members

Mr S. Ramsay Mr J. Scheffer
Mr S. Leane Mr T. McCurdy

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Senior Research Officer: Mr P. Johnston

Witnesses

Mr D. Grubisic, Security Manager;
Mr D. Dawson, General Manager; and
Ms S-A. Redmond, Director, Clinical Governance, Blacktown Hospital.

The CHAIR—Thank you very much for making your time available. This a joint parliamentary committee of Victoria for Drugs and Crime Prevention. We have two inquiries running at the moment. One is in relation to community safety programs, and the other is the one that you are here today speaking to which is looking at violence and security arrangements in Victorian hospitals. I assume you know the background to the inquiry. It came out of a budget allocation for protective service officers to be put in certain emergency wards of public hospitals in Victoria. They were to be trained and carrying firearms; an election commitment of 940 PSOs on train stations between dusk and dawn. Consequently, a number of stakeholders were concerned about the implementation of that policy, particularly in relation to carrying firearms, and the minister has seen fit to pass a reference to us to set up an inquiry to see what other security measures we might recommend to parliament. That is the background to the inquiry.

Thank you, you are the last for the day, but that is not to suggest any less importance. We have had a very full couple of days which has been fantastic. The hospitality from the stakeholders in New South Wales has been very good. We have allocated about three-quarters of an hour for the session. Please use that as you see fit. We do like to ask questions, obviously, because we need to tease out areas of interest for us. We are happy to wait until you have made your presentation or, if you are happy, we will interject as we go along.

Ms REDMOND—Interject as you will. I am sure it will be fine.

The CHAIR—Thank you. Before we do I might read you the conditions around which you will providing evidence to this committee this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have read the guide for witnesses presenting evidence to parliamentary committees and you understand the conditions around it. We are recording the evidence and we will provide a proof version of the Hansard transcript at the earliest opportunity and you can correct it as appropriate.

Mr DAWSON—I might start off for the team to say with our experience what we have recognised that there are a number of factors that impact on the propensity of incidents of aggressive and violence in our emergency department. Through our experience, the way we look at particular factors, which I will name now and come back to later to talk a bit about. The factors that impact, that propensity for violence and aggression are the clinical care aspects; organisational capacity, systems and processes, obviously policy guidelines and engineering and design. In saying that the underlying principle is around risk assessment and mitigation which is absolutely critical. Being a part of the New South Wales Health requires all our districts, including Western Sydney Local Health District of which includes Blacktown and Mount Druitt, there is compliance with two specific policies: one is protecting people and property, New South Wales Health policy guidelines for security and risk management in health facilities, and the zero tolerance response to violence in New South Wales Health workplace policy and guidelines. They really guide the business we do in this specific area.

In our local health district we have established a security business review group which basically assesses our services and our facilities against the compliance of legislation and against this policy. We also at Western Sydney Local Health District utilise a system called the 'incident information management system' locally called IIMS to report and investigate all clinical incidents. If they are related to security violence aspects they are still reported in that clinical incident management system and there is a significant process of that being assessed and treatment plans put in place to manage the root cause of those incidents. There is also a Riskmate system which is a corporate organisational system that all corporate risks are entered into. Again that gets processed through the organisational corporate systems to ensure we take note of what is happening there and put systems in and risk mitigation strategies in place.

Of course, all high-risk matters are escalated directly to the board via the various board subcommittees we have. There are a number of board subcommittees that include audit risk management, finance performance and health care quality committees; particularly the audit risk management and health care quality committees will receive specific impacts around the incidents that occur and information, and obviously the finance performance and management strategies and the expenditures related to those. We have staff consultation mechanisms in each of the facilities as part of the Occupational Health and Safety Committee that also deal with aspects of defining risks and hazards and managing those through a consultative process with staff. We have also been introducing a whole series of programs that are tailored to responding effectively to difficult or challenging behaviour. That has now become available online, face to face, and also we are looking at the refresher programs for our staff clearly to be able to bring themselves up to speed in terms of being able to manage the early signs of the incidents to avoid it getting into a full-blown aggressive or violent incident.

Coming back to the factors I named before, again from my experience, the first factor—if I can spend some time talking about—the clinical factor, what we recognise clearly is the importance of people's skills and knowledge in terms of being able to understand the types of patients that come into the department and what they present with. We are often faced with patients with delirium, patients with alcohol overdose and other mental health conditions that come straight to the ED, either brought by ambulance, brought by police or otherwise. It is the capacity to assess, but it is also the capacity to assess the dormant ones which come to us sometimes and there might not be any specific signs that are visibly apparent as in someone is going to escalate very quickly. It is really about staff having enough information and that vigilance to be able to pick up any early signs that might happen. Those early signs can happen for a range of other reasons, which I will go through in a minute, again from our experience.

Some of the elements around clinical practice, how do we pick up those early signs? 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 but if that is

not communicated to the next person—and 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.

Those are some of the opportunities sometimes we might let go by if we do not manage it from a clinical perspective. That comes back to roles for people. What is everyone's role? Everyone believing they have a role in doing that, whether it is the doctor, the nurse or the person delivering the meal tray or picking it up, how do these people pass on that information. I think there is a different level of thinking, it is not necessarily a presence of the security officer standing there 24 hours watching patients, watching movements. There is a significant clinical part, clinical factor, that comes into play in terms of being able to manage this.

The second one I was going to talk about is around organisational capacity. That covers physical capacity—in terms of beds and having enough beds to have patients move from the emergency department into a bed quick enough is critical. Sometimes when patients or their families are left in the ED for a long time—and the ED is a very stimulating environment, lights on 24/7, actions happening—that can also raise people's anxiety et cetera, critically, the availability and capacity of beds. The understanding again of the workforce we talked about, and part of that is building organisational capacity in some of the assessment I related to earlier but doing that in a more team environment. You are not only giving people information and knowledge building, but building their capacity as a team. In fact, the doctors, the nurses, the security staff, everyone has a sense of working together as a team, they know what they are all looking for and what they are managing. That is something that we come to learn that has been more important, and we are certainly looking at that.

The other part of the organisational capacity is clearly the partnership with the local command and how we have that connection in terms of response, visitation by the local command et cetera in terms of supporting, providing presence and providing education and also staff then have a feeling that when it gets escalated there is a very quick response.

I might move on to systems and process which is around ensuring we have regular testing in place. We have standardisation of alarms and what those alarms mean, in that we have duress alarms, and really being able to identify the exact location of those duress alarms. There is a very clear process of a duress alarm—when do you hit one, and when it goes off, who does what, and how is it actually done. Again it is about streamlining some of those processes. Importantly as well is also encouraging the system of reporting because all too often when an incident happens and we talk to people, we hear, 'Well, something bad happened but it wasn't as bad as before,' and people have not reported that. It is also that system of getting people to report.

Policy and guidelines: as I reflected there is organisation from the New South Wales Health policy perspective, there are policies. Then, of course, we have guidelines in place at the facility from an LHD perspective as well. It is important that those policies are reviewed and are actively managed to make sure they are being implemented on the floor. Again it is something we pick up through the risk management investigative process, ensuring that those policies are up to date and ensuring that the right people are taking responsibility to make sure that their staff within their unit are abiding by it.

The last area we found has had significant impact in terms of ensuring a safer emergency department are obviously engineering and design. Things, such as lighting, to ensure well lit spaces, CCTV coverage with signage to indicate that there is CCTV coverage and also general signage. That can range from information around waiting times, information on what process is going to happen, as well as information on restricting areas. Sometimes we do not do that too well in terms of what areas are restricted et cetera. The last one we talked about was the duress alarms which is really about standardisation ensuring that they are standardised across the whole facility, if not across the whole district, that staff, wherever they work know how it works and what they are meant to do. Where they are located, if they do not have a personal one, at least they know exactly where they are. The orientation process around the engineering and design, when people start, are also absolutely critical.

Those are the things we have learnt and we have implemented at Blacktown and across the LHD which we thought might be a starting point for the conversation this afternoon.

The CHAIR—Thank you. Do either of you two want to make a presentation at this stage?

Ms REDMOND—I am happy to speak later, if you wish, but in terms of being the director of clinical governance my focus really is about patient safety and clinical quality. We felt it was very important to focus on that today because I think by the time, in clinical areas, we are calling security guards et cetera we know we are in difficult situations. Sometimes that happens where the clinical care has not been quite what we would have hoped for. I have worked in both the metropolitan and rural LHDs and I am very mindful that you are not dealing with only one kind of homogenous emergency department. They range from, of course, Westmead, where I am currently based, to little, tiny hospitals who might have one or two nurses on at night. There are a lot of challenges in applying security across the system.

We do know that the level of patient satisfaction is really very much related to communication. We know that when people wait a long time they often get frustrated. In terms of our programs we think all of those other programs—communication skills, interpersonal skills, escalating clinical concerns, recognising a deteriorating patient—are really important things that underpin a good, safe system. If the patient is better managed from a clinical point of view you can often prevent those episodes of violence or aggression. That is really important.

The other thing I thought the committee might be interested in is there is a group in New South Wales called the Clinical Excellence Commission. I am not sure if you are aware of their work.

The CHAIR—No.

Ms REDMOND—They do a lot of work on patient safety and clinical quality. In fact collaboration with Southern Cross University they looked at service quality and communication in emergency departments. They looked at four hospitals across New South Wales and looked very much at how staff interact with patients, waiting times, waiting rooms, about how much comfort was there for patients et cetera. I

spoke to Cliff Hughes who is the CEO of the Clinical Excellence Commission and he would be happy for you to contact him if that would be helpful. They have done some quite interesting work in terms of how patients are managed in the emergency department from those first few words when you enter an emergency department, how you are greeted, how you are managed, how a waiting room is managed in terms of crowd control or whatever it happens to be. It might be helpful for you to speak to the Clinical Excellence Commission.

The CHAIR—Thank you for that. I see Sandy madly writing that down and I am sure that will be followed through.

Ms REDMOND—I can give you some details.

The CHAIR—Dunko, do you want to make any comments at this stage?

Mr GRUBISIC—Sure. My role, I work more on the front line and I deal more specifically with security officers. I have been an officer myself a few years ago when I worked up the chain, but 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. I have basically come down to having internal factors and external factors. 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 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.

The other factor that I have is the external factors, especially with the emergency being the front house for the hospital. The external factors influence the patients and visitors that have arrived prior to coming into the hospital system itself. Then we need to make our decisions based on the training that we have through the Security Industry Registry and legislation. At Westmead Hospital, and also at Blacktown, we do have a lot of presentations as far as drive-by shootings and gang-related issues that present themselves. A lot of the time we contact the police for their assistance and their intelligence. We also put in strategies to minimise any chance of risk. If worse comes to worst we may need to do a lock-down of some sort to eliminate the threat.

From both the internal and external factors, it all comes down to the risk management approach and how we can deal with those situations as they arise. I have been involved with Blacktown, Westmead and even Nepean Hospitals as far as putting in risk assessments and dealing with the recommendations from these risk assessment to deal with specific matters that arise as far as the internal and external factors. I have recently conducted one for Westmead Hospital. If we look around the security officer training—and that would be aggression minimisation training, but not only verbal de-escalation but also working with clinical procedures to safely deal with the patient as presented. Patients that come into the hospital do not have 'one system fix all'. We have a lot of different methods to deal with situations. We have highlighted this fact. We are in the process of trying to organise a training base, not only for security officers but corporate services staff members, plus the clinicians as well. We are all working together and rowing in the same direction.

We need to understand that security have an approach that the clinicians need to understand and vice-versa. That is where we find a lot of issues where the clinicians seem to think that security are going in heavy-handed, but we are relying on the poor information that the clinicians are providing to us. There is a bit of friction in that regard. The other points we have spoken about in the risk assessment for the emergency department at Westmead Hospital, I will quickly refer to some of the recommendations. The type of restraints that we have: we have previously used a lot of the old restraints which patients have been able to get out of. We have done a risk assessment and identified that the same type of restraints do not fit. We need to look at new measures and new ways to restrain people so they cannot get out, and from a manual handling point of view it is easy to put these people down in a safe manner that they can be either sedated or managed.

Training: what Dominic spoke about was engineering and design is a massive factor. We are very fortunate at Westmead Hospital that the ED design, the whole front end will be refurbished. A lot of the things we have learnt through past incidents we can apply to the future design of the hospital, such as having an airlock, having an overriding switch that we can automatically close the front doors if there are a large group of, say, Middle Eastern males that could pose a problem, that sort of thing, if I am getting into a specific type of scenarios. From an engineering point of view—this is where my role fits in that I look at these type of engineering roles, such as the type of duress systems we have, the type of responses from security and the processes involved in attending and responding in a quick time frame. A lot of that comes down to financial and budgetary restraints as well. We would love to put in a new beautiful system that would be very effective but we cannot do that straightaway. It is a process over time and trying to manage a slow implementation of current electronic systems et cetera.

In a nutshell there are so many facets to a response to security that it is not only security officers, it is not only clinical, it is the whole range that everything is dealt with in a succinct manner. Early identification can be sorted out from the people dealing with the patients to a quick response from security, to having systems that work that we can get the signal there straightaway, that type of thing.

The CHAIR—Thank you. Questions from the committee.

Mr LEANE—The security staff you deal with, are they in-house?

Mr GRUBISIC—Yes, I manage the in-house security but at times we do call upon contract security if required for specific tasks. We had an incident in one of the ICU areas that occurred and we needed additional security to manage the threat, to make the nurses feel safe and have some type of emergency response. We called upon contractors.

Mr LEANE—I know you said the training could be for health professionals and for the staff. Is there training tailored for the security staff?

Mr GRUBISIC—Not exactly. That is what we are currently working on at the moment. I am working with the OH and S team. We have been to a few aggression minimisation training sessions that also includes restraint and take-downs,

that type of thing. We are doing a comparison at the moment. There are still a few providers that we need to evaluate and then make a determination of where we go. Some of them—I will not mention their names—seemed a little bit too much up-front as far as the restraints go, and if done incorrectly it could be quite dangerous. The other providers that we are going to assess, I guess it needs to be done in a delicate manner and that is what we are trying to assess. From a security point of view we get all different types of security. We have some officers that are great at some things, and some that are not so great. It is a matter of trying to work with everyone that I have and do it in the safest possible manner than I can.

Mr SCHEFFER—My question is related to data. How do you collect data on the kinds of incidents you have, and could you talk to us a bit about whether there has been an increase in incidents or a decline, and also about the composition of the kinds of incidents that have been presenting to you at Blacktown?

Mr DAWSON—The incidents are recorded, as I said, in two systems: one is the IIMS system and one is the Risk Mate system. The incident management system really picks up when there is a clinical nature of the incident, but if there was an incident, for example, in the carpark, a security incident, then the Risk Mate would pick that up. That is the differentiation, when there is a patient involved in an incident, versus something that has happened elsewhere. All the incidents are recorded and go to the Occupational Health and Safety Committee for review in terms of, if things are going up or things are coming down. We do not have the data with us, but essentially we roughly see approximately three incidents at Blacktown Hospital in a week that security might be called to assist. They can vary across the whole campus, not necessarily in the ED.

In terms of incident numbers going up, I cannot categorically tell you the numbers but over the last couple of years there is an insignificant increase—

Mr SCHEFFER—Not significant?

Mr DAWSON—Not a significant increase.

Mr SCHEFFER—Okay.

Mr DAWSON—I am more than happy to take that up and get some data if that is requested.

Mr SCHEFFER—Also the data from the two systems that you put in, that goes through your Occupational Health and Safety Committee, and then what happens to it there? Is there a statewide aggregation of that data that gives us a system-wide picture?

Ms REDMOND—In terms of the incident information management system and the clinical information, there absolutely is, and the Clinical Excellence Commission, who I mentioned before, gives state-wide reports on that clinical data. That is in fact where they at times might choose to focus on a particular area, such as communication, because when they have looked at the themes emerging from the clinical data they found some problems. Certainly that is used at a state level for the clinical information.

Mr SCHEFFER—Okay. And national?

Ms REDMOND—No, I do not believe so, but the Australian Commission for Quality and Safety, I understand, is going to over time look at the data from across the state jurisdictions, but I do not believe there is a national report at this stage. I think nearly all of the clinical information systems are statewide information. However, in terms of clinical systems there are national standards coming in, in the next little while, but I do not think they would particularly look at issues of aggression or violence.

Mr SCHEFFER—Coming back to hospital level, when Dominic was talking—I hope I did not lose focus while you were giving your presentation, but you talked about the issue of getting people to report, and then I think what you said after that was that sometimes after an incident somebody might reflect and say, 'It wasn't as bad as we thought.'

Mr DAWSON—There might have been an incident A that no-one might have talked about but then incident B gets reported. We talk about incident B and then someone might say, 'Well, there was kind of an incident,' and that was incident A but no-one had reported that incident. That was what I was reflecting in terms of saying—

Ms REDMOND—I think anecdotally there is some under-reporting in the sense that people have begun over the years to tolerate some behaviours that perhaps we should not as health services.

Mr SCHEFFER—You are saying that over a period of time people are tolerating behaviours they would not have tolerated in the past, or the other way around?

Ms REDMOND—That people are tolerating or seeing behaviours perhaps more frequently than they have in the past and are therefore not reporting quite as often.

Mr SCHEFFER—Yes. I appreciate there are always judgments and uncertainties about this. It is not an exact type of thing. That segues into evidence we have been gathering where, on the one hand, we have heard from nurses who say—not your hospital but in Victoria—there are very serious situations they find themselves in where they are really not encouraged to report and where they feel really at risk a lot, and then from senior management, people such as yourself, will say, 'We've got things under control,' and talk them through all the different mechanisms and processes and procedures. For me it is a bit of a double view and I am not sure whether it is coming together. Would you say, if you could speak for your nursing people, that they would share the confidence that you have communicated to us, or would they feel they are being really discouraged from reporting sometimes?

Ms REDMOND—Certainly I would hope they are not discouraged from reporting but I think in relation to your comments about, do nurses feel fearful, I think there are many instances where nurses and clinical staff feel fearful about the work environments that they are in. I think they are well aware of some of the support mechanisms around them but nonetheless they feel fearful at times and worry about

whether help is closely enough at hand. I do not think we would dispute those feelings and we are very mindful of those feelings. As you are probably aware there have been a number of incidents that happened in New South Wales where clinicians feel rightly concerned about environments that they perceive to be high risk, and certainly the emergency department is one of those areas where staff often feel at risk.

We obviously put all the things in place in terms of having a quick response and security available and good lighting and what have you, but nonetheless they remain places where events happen, and often happen quite quickly and sometimes unexpectedly. That is one of the reasons as well that we are really trying to focus on good clinical care for patients as well, to try and prevent some of those things happening, because some patients have delirium, mental health issues or whatever it might be. We are mindful about getting definitive treatment as quickly as we can for those patients and they are not escalating into those situations.

The other work that I mentioned from the Clinical Excellence Commission is all very much about making sure we do manage waiting rooms that people understand things like the triage process and why it might be that they are waiting. There are a number of other things like that that we are trying to improve over time as well.

The CHAIR—Can I ask a question to Dunko. In July there was an incident which I think was at the Blacktown Hospital in relation to nurses clearly demonstrating publicly that they were not happy with the security arrangements. I am interested to know what initiatives have been put in place into the hospital since July, not only are those employed in the hospital feel safer but longer term where you have a process in place that deals with the security arrangements.

Mr DAWSON—I may take that question for Blacktown specifically.

The CHAIR—Okay.

Mr DAWSON—I will identify two things. Immediately after that particular security incident concern we had, we put in an interim arrangement of having a 24-hour security officer within the emergency department. Clearly that was to recognise two things: one was to identify and to acknowledge the insult the individual had had, and the unsafe feeling the other staff had. It was important that myself and the organisation ensured that staff were feeling safe. What they wanted was a security officer there for 24 hours a day. That is currently an interim arrangement and that was an agreed process until we had some further conversations—and there are some conversations in place—as to the best way of ensuring the staff feel safe within the emergency department.

At the moment it is the focus of consultations with the emergency department nursing staff, and with the relevant unions, as to where we will go, essentially to ensure that there was some level of—a feeling of safety in something that we can do with the staff. That is the first bit of the response. There have been a number of—

The CHAIR—Can I ask you, is that security person part of staff or is that an external contractor?

Mr DAWSON—At the moment it is an external contractor.

The CHAIR—You have no other security apart from that 24-hour security person?

Mr DAWSON—We have security within the campus, standard security, which is what we have always had.

The CHAIR—Are they staff, are they?

Mr DAWSON—Yes, staff.

The CHAIR—They are licensed security people?

Mr DAWSON—Licensed security, yes. This additional member of staff, the 24/7, is contracted out. We could engage someone straightaway without having further impacts. There have been a number of other things that are in place. There were a series of reviews undertaken. That is part of the learning that we have identified. We have looked at a lot of the environmental stuff and there are some things and process around—we have already made some improvements in lighting. There currently is an assessment around the CCTV adequacy. There is some work happening, in consultation with the staff, around changing some of the signage and adding some signage on as well. There was also a review of how the use of cutlery within the emergency department and how meals are delivered and how the trays are removed and where things are stored. There has been some recommendations around that. In fact two weeks ago we moved to a different dinner meal. We did not have to have knives and forks for the dinner meal. We have a dinner and we have a supper run. That has removed the need to have knives and forks at night-time.

We are in the process of constructing a cupboard within the emergency department in an area where any of the unused stuff is stored away in the cupboard. One of the things that the risk assessment identified was sometimes patients go off to x-rays or tests or whatever and their meal tray, with the required implements to eat it, are left on the table. That can be left there for a period of time until they return. In terms of the risk assessment it was, how do we remove anything that might be of risk, particularly given the incident that you referred to relating to a knife. That was something that had to be looked at very closely. There is a cupboard that is going up in the emergency department and we will be able to move all that kind of stuff into it. Those are the key things we have done immediately.

There is currently a working party which includes people from occupational health and safety, security and the clinicians working through the other recommendations within the reviews that we have conducted to ensure we can implement them adequately as we move forward.

The CHAIR—Thank you.

Mr SCHEFFER—A question we have asked people—and Simon raised this in his introduction—is about whether protective service officers should bear arms in hospitals. I think I know what your view is on that but could I ask you to indicate that to us, what your view is on that?

Mr DAWSON—As far as the use of handguns—

Mr SCHEFFER—Or capsicum spray or tasers.

Mr GRUBISIC—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.

Mr DAWSON—Certainly, to add to that, all our lessons learned, it is not about having that or using that level of force to de-escalate. One of the reasons why we talked about the importance of partnership with the local command is absolutely for that reason; the importance of them being able to—when we say something is serious, you know, we need them there in 30 seconds type thing. That would be a position from the hospital and supported by the LHD, at least at this point, to be able to say we have gone through some assessments around batons and handcuffs and we have certainly had our views around that as well. I think it would be quite safe to say I do not think we will be supportive of that.

Ms REDMOND—Certainly from a clinical governance perspective, the cases I review are about patients who are very well unwell, often elderly, have mental health issues et cetera. I could not possibly imagine any of those circumstances requiring someone to use a weapon. To be honest I could not imagine a weapon being helpful in those circumstances because you are dealing with a patient who is delirious or confused and in fact I think many would become much more frightened and distressed than they already are. I think patients families would be horrified to think that we were in fact using weapons in some manner to calm their family member. I cannot imagine how that would in fact calm a patient. I would be very concerned about that. As I said, I have been involved in a number of cases where patients have become very confused and I cannot envisage how somebody having a weapon would in fact help clinical staff in that situation.

The CHAIR—Okay. You appear not to be alone. Thank you very much. We appreciate the time you have given us this afternoon.

Witnesses withdrew.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 10 October 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Mr K. McNamara, General Manager, Victoria and Tasmania, ISS Security;

Mr S. McIntyre, General Manager, Health Sector, and

Ms J. Nicholson, Project Manager, Spotless; and

Mr J. Rogers, National Operations Manager, and

Mr B. McDonald, National Integrated Security Manager, Wilson Security.

The CHAIR — Thank you very much for appearing to give evidence to the joint parliamentary Drugs and Crime Prevention Committee. I am required to read you a notice in relation to public hearings which will protect you and us in relation to any comments you might make outside this room. I will take it that you have all heard and agreed to the conditions collectively, then I will introduce Kerry.

Welcome again to this public hearing. As it is a public hearing, the media might come in and out, as has happened on other occasions — just be aware of that. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege.

I am sure you have read or sighted the guide for witnesses presenting evidence to parliamentary committees; I am sure Sandy would have provided you with that information. Hansard will record the evidence, and at the earliest opportunity you will be provided with a proof version of the transcript which you can correct as appropriate.

Again thank you for your time; we appreciate it. A lot of people have given us an awful lot of time, and there has been a lot of interest in this inquiry, perhaps more so than for the other inquiries we have conducted. To me, being a member of this committee — which is relatively new, I might add — and to others who have sat on a number of inquiries, this appears to stimulate a fair bit of interest from the media and other stakeholders. It is an important one for us, and we have a strict time frame in which to deliver to Parliament.

Mr McNAMARA — I have some documents here which I will hand around.

The CHAIR — Is this the PowerPoint we could not deliver to you because the technology at St Andrews Place did not quite match the presentation?

Mr McNAMARA — Yes, it is the same presentation.

The CHAIR — Sorry about that.

Mr ROGERS — We generally have a preference to sit around the table and talk about it, anyway.

The CHAIR — Just bear in mind that because we have a fairly tight agenda we have allowed an hour for the presentation between you all. I guess it is up to you how you want to split up the time.

Mr McNAMARA — In starting, I will skip the first two pages and just give a basic overview of the business of ISS Security and indicate how we operate and the facilities that we operate as a facility management company, with security being one of those arms. ISS Security has approximately 1000 guards and a patrols division mainly in corporate security and critical infrastructure; it has nothing to do with pubs, clubs or shopping centres. We look after Melbourne Airport, the port of Melbourne and the Loy Yang B and TRUenergy power stations. The two hospitals we have at this point in time

are the Royal Children's Hospital — which is due for transition at the end of the year or is under transition at this point in time — and Eastern Health hospitals, which comprise the Box Hill, Maroondah and Angliss hospitals; they are the three main ones.

Box Hill Hospital is probably one of the largest acute hospitals. It has 398 inpatient beds, with roughly about 42 000 presentations. It has mental health services plus general and specialist medicine, intensive care, surgery and teaching services. It also has ties with Monash, La Trobe and Deakin universities. The Angliss Hospital has a high-level aged-care facility, known as the Edward Street Nursing Home. That covers the south-west of the Yarra Ranges as well as Croydon and parts of Ringwood. It supports health-care needs with low complexities, so it is a fairly low-risk type of hospital. The Maroondah Hospital services include emergency medicine, general and specialist medicine, general and specialist surgery, critical care services and ambulatory and allied health services. One of the issues there is that specialist adult mental health services are also provided at that particular hospital.

Eastern Health, as I said, comprises the three hospitals. The services we provide there are catering, security, health services, open space, including grounds services such as mowing and gardening, mobile patrols and alarm responses. The security staff provide contracted services and are full-time employees; we do not use subcontractors, for obvious reasons. At the Royal Children's Hospital we basically provide security. That is broken down into a control room, building operations duties, such as responding to alarms, and responding to code greys and code blacks, which are fairly minimal at that particular hospital. The security staff there provide contracted services and are full-time employees. Again, there is no subcontracting at any time.

The security staff we have at the hospitals remain with a site for the duration of their contract — that is, across the three Eastern Health sites as well as at the Royal Children's Hospital — unless there is a request from a client to have one of those individuals removed or if at some point in time they resign.

Mr LEANE — How long is the tenure usually?

Mr McNAMARA — It is normally three plus one plus one. There is normally a two-year extension capability. The security staff are vetted by us in the first instance as to their suitability to be able to conduct the work at a particular site. We look at their experience when we are placing those particular individuals at the various hospitals. We look at the levels of risk at each of those hospitals against the person or persons we are sending to a particular site. Obviously that is followed up by an interview, once we have approved them, with the contract manager for a hospital, so there are two levels of approval prior to any person being placed at a hospital. Upon acceptance by a hospital and after our vetting, they commence their training and are placed on a full-time roster.

Part of the training process is obviously the security licence training, which is done through the LSD of Victoria Police as part of the security requirements. The company induction is basically in relation to our SOPs, our training and the company SOPs. The site familiarisation training is to make the employee familiar with the particular areas of the hospital that they may have to respond to an incident in or that they need to know. There is also the ISS and hospital standing operating procedures, or SOPs.

SAFE training is conducted at Eastern Health. SAFE stands for safe aggression-free environment. That is level 3 training, and it is mandatory for all staff working in high-risk areas, emergency, code grey teams, mental health, community health, aged care and other areas identified as high risk. That is provided generally by the hospital OHS staff. Obviously they have a vested interest in providing that training and ensuring that the training being provided is sufficient to meet the requirements of that particular hospital. The emergency management training for the fire wardens and the like is also conducted by the hospital.

The purpose of this training is so that we can effectively manage incidents of aggression and ensure that any physical violence is controlled in a manner that minimises the risk of injury to all persons involved — that is, hospital staff, security staff and obviously the patients themselves. All training is documented and delivered by an accredited trainer. Refresher training is conducted annually, and that is recorded on the employee's particular file.

The CHAIR — Is that training peculiar to your organisation, or is there some sort of national benchmark or state benchmark for training?

Mr McNAMARA — I cannot speak for the other states, but within the state of Victoria the level 3 training is specific to Eastern Health. I cannot speak on behalf of any of the other hospitals other than the Royal Children's Hospital. Certainly accreditation for any of the trainers is something that must be put through VicPol, or LSD.

Mr SCHEFFER — How is the training program developed? Did you buy it in?

Mr McNAMARA — The training program in place at Eastern Health is a package that has been put together by Eastern Health. They deliver the training to the individual employee.

Mr SCHEFFER — So in that sense when you say 'an accredited trainer', is Eastern Health an accredited trainer?

Mr McNAMARA — For the delivery of that particular level 3 SAFE training, yes.

Mr SCHEFFER — But also for its development?

Mr McNAMARA — I believe so, yes.

Mr SCHEFFER — Yes, there is the development of the package, and then there is the delivery of it.

Mr McNAMARA — And ongoing assessment of that particular package as well. Most of the hospitals that we look after, being the Royal Children's and Eastern Health, have a zero tolerance approach to aggression, which is normally supported by the policies surrounding the culture of non-violence. There is a real need for a coordinated and consistent aggression management program. As I said, it minimises the risk of injury to a number of persons within the confines of the hospital. As you would understand, managing aggression is quite challenging to deal with both personally and professionally because it impacts on individuals right across the particular culture.

There are changes that the ISS group has discussed in relation to the training. Whilst the majority of training is accredited for all security guards and crowd controllers within the state of Victoria, attention should be dedicated to specialist areas such as hospitals. The reason I say that is that the legislated processes for other specialist areas such as airports and the port of Melbourne, being critical infrastructure, require strict compliance with policies, procedures, training and regulations. This is followed by a strict testing of compliance, with an audit capability, on areas within those particular sectors. A specialist training requirement or certification should be enforced for security staff prior to being eligible to work within hospitals. This would ensure a minimum standard and compliance practice. Maybe discussing that particular protocol is something that should be placed with licensing services, obviously in conjunction with the hospitals. By having that, we can cater for a lot of the issues that arise and basically mitigate a lot of the issues that arise out of the consequences of that.

Mr SCHEFFER — So they are in effect recommendations?

Mr McNAMARA — They are recommendations, yes. The course or the package, as we have discussed, should include such things as basic medical terminology, psychology of violence and de-escalation techniques, dealing with distressed, injured or ill persons, powers of search in health-care settings, and specific restraint methods approved for health care. Obviously some chokes and strangles that are taught to crowd controllers are not applicable to be utilised within the health-care environment for obvious reasons, depending on the person's health and age and those types of issues. Specialist training would also assist in mitigating the associated risks to the employee, employer, hospital, medical staff and general public.

Again just looking across Eastern Health and at the Royal Children's Hospital, the interaction between security, medical staff and police involves security staff working as part of the code grey or code black team, together with the clinical staff — the medical, nursing and support staff. A code grey is a personal threat, which is a lower level. Security staff then work in conjunction with the hospital code grey teams. They are briefed prior to engaging with that particular individual by the nursing coordinator or the senior nurse at that particular hospital, but, as you know, situations can escalate from code grey to code black in the wink of an eye. You have to be able to respond to those. A code black is a serious personal threat where police assistance is required with the removal or restraint of that particular individual — any person acting outside of zero tolerance to aggression in the workplace.

We have found that trends show an increase in incidents of violence and weapons around Eastern Health; this is not so much applicable to the Royal Children's Hospital. The specific statistics on aggression and weapons are obtainable via the Department of Health or the individual hospitals. There are minimal counts of assaults on security staff within the hospitals that we look after or that are contracted to us. On these pages I have broken down the code greys and code blacks in 2010 and 2011 for the three particular hospitals, being Angliss, Box Hill and Maroondah. This will give you a little bit of a comparison between what went on in 2010 and where we currently sit for 2011. Some of the things we have looked at as a result of the — —

Mr SCHEFFER — Sorry, could I just ask: looking at, say, Box Hill Hospital's figures of 66 in January, 66 in December and then upswings at certain times, are those

fluctuations just normal variation, or do they tell us something about what is happening over the year?

Mr McNAMARA — Looking at the trends, you can certainly divide summer and winter. In summer you tend to have a trend to higher numbers of code blacks compared to the winter months. These are the trends we have reported. They may differ slightly to the statistics that the hospitals hold. They are taken from our monthly reports. We have discussed these statistics with the particular hospitals, and they have no issues with us putting them on the table.

One of the questions in the document that was sent out to us was on the discussion in relation to whether security officers should be armed. The company would say no, for obvious reasons — the training and the surrounding issues with innocent persons and the like. Police have enough trouble with consistent training all the way through for being able to deal with those particular issues. A security officer being armed in that type of situation and the removal of that particular firearm could create all sorts of issues.

In relation to capsicum spray, again we said no, because that is problematic with air-conditioning systems as it can flow right throughout the hospital. I have been the subject of capsicum, and it does tend to back away on you on occasions, certainly the same as tasers. As I have indicated, this is only from my assessor's viewpoint, and it is only our opinion on the issues that have been raised.

Some of the other considerations that we have put on the table include scanning equipment if we have high-risk areas at particular hospitals or with the statistics in relation to weapons and the like. Body scanners can assist with that particular issue, and, as I said, they can be considered in particular areas of a hospital where there are high statistics in relation to weapons and those sort of particular problems.

Mr McCURDY — What type of weapons are they?

Mr McNAMARA — Generally the weapons — and I say weapons — that we would come across would be just a general knife such as a pocketknife. We do not come across anything else really.

Mr ROGERS — Syringes.

Mr McNAMARA — Syringes, yes — obviously with AIDS and the like around. Obviously a weapon can be anything that you can pick up within close proximity to a hospital or inside a hospital. As you know, they have scissors, chairs and all types of stuff in there that can be utilised as a weapon. As a prescribed weapon we are talking about pocketknives and the like. There are certainly no firearms that we have come across in these last eight years.

Mr McCURDY — So that is where scanning equipment will pick up things that come in, but it does not stop anything once it is actually inside the hospital.

Mr McNAMARA — No, it does not.

Mr McCURDY — That would make up the majority — the chairs and syringes, as you say — more so than what comes in.

Mr McNAMARA — When you look at some of the patients that you are dealing with, they are quite clever in regards to what they are looking for in order to get out of a particular place, especially if they have been brought there by the police and dropped off at Box Hill or at Maroondah, as they often are. We have all sorts of issues that are raised as a consequence of that.

The CHAIR — Are there any other questions from the committee?

Mr SCHEFFER — I have a general question, but I will wait until everyone has presented here.

The CHAIR — I was actually working on the assumption that everyone knows everyone on this side of the table, but I might be wrong. Have you all met each other?

Mr ROGERS — Briefly in the foyer.

The CHAIR — Kerry is general manager of ISS Security. We then have Steve and Jennifer from Spotless. Steve is general manager of the health sector, and Jennifer is a project manager based at the Alfred. I have actually very quickly read your paper, even though it was delivered to us only this morning. I suspect some other committee members might not have had that opportunity.

John, you are national operations manager for Wilson Security, and, Brett, you are the national integrated security manager for Wilson Security.

Mr McDONALD — Yes.

The CHAIR — That covers off the titles. We did have Paul here, but he must be unavailable. Jessica Craven is from the *Herald Sun*, and as it is a public hearing she has the right and entitlement to be here.

Mr SCHEFFER — I just wanted to flag something with you, and if other people are going to address it, then maybe we can deal with it later, but I did want to ask you about the data that you mentioned in passing. You might not want to deal with it now, but you said in passing that these figures might not necessarily accord with what I understood you to say that the hospitals had gathered.

Mr McNAMARA — That is correct, yes.

Mr SCHEFFER — Then you also mentioned in passing that the security people — the ISS people — fill out their own reports. I wanted to ask you to talk a bit about data collection, how you use it if you already know there is a disparity, how it is all going to fit together and what in the end is it useful for.

Mr McNAMARA — The collection of information is basically based on the incident report of a particular incident, whereby the incident is recorded from start to go with the times, who is in attendance, whether it is a code grey or a code black and the particular circumstances surrounding that incident. Those incidents are then forwarded

onto the client or to the particular hospital, and that information is recorded. With a lot of the information, some of the incidents that we would class as a particular scenario or a particular level may be different to how that hospital will record that. We place our statistics into a monthly report which we present to each of the hospitals at our monthly meeting at the end of the month. When I say disparity, it is only in relation to the interpretation of what a particular incident is that there may be a disparity.

The CHAIR — Just to give you a little bit of a brief from our perspective, we have actually travelled to New South Wales — Sydney in particular — and to Perth to look at what is happening in those hospitals as well as receiving 30 submissions in relation to this inquiry. I have forgotten how many public hearings we have had. So there has been a lot of information coming forward in relation to both inquiries but to this one in particular. We have a reasonably good grounding, and I think we are starting to get a reasonably good picture of how the industry stakeholders are responding to this particular inquiry. Everything we get is just adding to that list. On that basis I have Stephen and Jennifer next on my list.

Mr McINTYRE — First of all, thanks for the opportunity to present, and I apologise that the document only came through this morning.

The CHAIR — We got it today.

Ms NICHOLSON — Have you all got a copy?

The CHAIR — Yes.

Mr McINTYRE — I will initially give a brief overview regarding Spotless and my and Jenny's roles. Spotless is an integrated facility services provider across many sectors, with a particular focus on outsourced services provision in Australia and New Zealand. Our business particularly focuses on the health piece, of which I run the Australia-New Zealand business.

In terms of a few quick statistics, we have about 2700 people providing services across cleaning and infection control, catering, facilities management, facilities maintenance and security piece. We have some contracts whereby we provide, at the most significant, 21 different services to one business — an awful lot of the outsourced services pieces within health care — through to others where there are single services provided.

In terms of what we do here in Victoria in the security piece specifically, we have obviously provided the security services at the Alfred for some time, which Jenny is going to speak to in more detail, and, having been part of the successful children's health partnership consortium with the Royal Children's Hospital, we are transitioning into those security services, have employed some people for that already and are arranging our workforce around that.

That is really all I planned to say in terms of an introduction to Spotless. I will pass it over to Jenny, who runs our Alfred contract and has a much more significant day-to-day hands-on role with all the services, which obviously include the security piece.

Ms NICHOLSON — I speak to you today as the project manager at the Alfred for Spotless. Our security coordinator, who is across the day-to-day operations there, is sunning himself in America at the moment, so he escaped this. I will speak on his behalf.

The CHAIR — Don't you mean he is at a conference?

Ms NICHOLSON — Yes, a conference — that's right! As Steve said, we provide services to the Alfred. We have been there since May 2005, and we just look after the Alfred hospital. We do provide some advice and consultation to the other two major hospitals of Alfred Health, which are Caulfield and Sandringham hospitals, but we provide the 24/7 security services at the Alfred hospital. As Steve also said, we are transitioning into the Royal Children's Hospital later in the year.

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.

Our staff work full time and part time, and there are a small number of casual staff at the Alfred hospital. Once we do transitioning to the royal children's we will be cross-training so that we have our staff available across both campuses. We understand that those environments are different, but there are plenty of similarities, and I think that will strengthen our experience base for both sites. That is that one. I will move on to the next question.

With regard to specialist training, as Kerry advised, our security officers all have the mandatory training of certificate III security, but we also have some other Spotless competencies that we provide. Our workplace safety induction occupational health and safety training is all provided by Spotless but is supplemented by some health-care training, which is on-the-job buddy training and which all our staff get when they start with us. Twice a year our security officers attend Alfred training — which is what they call DAMA, or de-escalation and management of aggression training — which is run by the Alfred psychiatry department. That is a two-day course, and all security officers do that on commencement of their employment. They also do that twice a year.

Mr SCHEFFER — Just in relation to the question I asked previously, is that accredited?

Ms NICHOLSON — No.

Mr SCHEFFER — How is it developed?

Ms NICHOLSON — It has been developed by the nursing education team at the Alfred, so it is specific to the Alfred. They also have what they call a behaviour-of-concerns training, which is a half-day of training. All the Alfred's emergency staff, including our security staff, do that training as well. Again, I do not believe that is accredited.

With regard to training, it also goes back to the staff we say we buddy trained. 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 — on improving 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. Spotless at the moment only has 2 female security officers out of 23 officers, and that is in line with the security industry, where it is about 10 per cent. We would like to see a few more if possible, and we do actively try to source it, but it is not always easy.

What changes would we like to see? We strongly believe that the industry would benefit from a nationally accredited course that is in line with what Kerry said and really specialises in the health-care setting. As you pointed out, there are a number of specialist courses in other areas and requirements in other areas of the security industry, but in the health-care setting there is nothing specific, and we would endorse that. Spotless has begun investigating the development of such a course in partnership with industry peers, and we are also investigating it with RTOs to develop that course as a registered course.

Security staff, working in tandem with the medical staff and the police, promote a safe working and caring environment. The security officers work very closely with the police — mainly at Prahran and St Kilda Road, which are very close to us at the Alfred — and with the medical staff for all aggressive incidents of patients, which are clinically led. All aggressive incidents — all code greys — are led clinically, and we provide support to those codes. A briefing session is always held between security and medical staff — and police, if they are in attendance — before any action is taken by our security officers. Time is very brief, because the action needed to be taken has to be very quick just to alert security staff to what they may be facing and what action needs to be taken by our security staff and by medical staff.

We have coined the phrase 'Hugs, not thugs', which might sound a little corny, but it does really articulate the approach we hope to take with regard to our security. We believe that all patients, regardless of their behaviour, should be treated with dignity and respect, and we understand that many patients are acutely ill, with some aggression stemming from alcohol and substance abuse, and quite a lot from mental health trauma and ageing issues. We recognise that the aggression may come from families of patients, and while this is not clinically led, it needs to be managed by security officers in a sensitive manner. In a stressful situation in an emergency department or an ICU or a psychiatric unit, it is often the families involved when we get the code greys called, because they are under such stress.

Our security officers perform an average of 120 patient restraints a month, with about a third of those requiring mechanical restraints or shackles.

The CHAIR — How does that compare with other non-patient antisocial behaviour that visitors or immediate family — —

Ms NICHOLSON — We would never shackle a visitor or a non-patient, and we only shackle patients or restrain patients — —

The CHAIR — I am sorry, we are talking about the shackling, are we? I am talking about — —

Ms NICHOLSON — All restraining?

The CHAIR — Yes.

Ms NICHOLSON — Restraining is always clinically led. We may hold visitors and call the police. So we always call the police, but we do not handcuff visitors or — —

The CHAIR — I know, but you use means other than handcuffing to restrain antisocial behaviour in hospitals, don't you?

Ms NICHOLSON — Just visitors?

The CHAIR — Yes.

Ms NICHOLSON — Or non-patients?

The CHAIR — Yes.

Ms NICHOLSON — Yes. We would detain non-patients but call the police. We would always call immediately if it were getting to a point where we felt that we would work towards eviction, and if that did not work, we would always call the police, who are very close. Does that answer your question?

The CHAIR — Thank you.

Ms NICHOLSON — With regard to injury, we have been very lucky. We have only sustained about a dozen first aid injuries and a total of five lost days through injury in the time we have been there, but none of those have been from assault; they are mainly from strain injuries from the security officers restraining patients. None are from actual assaults.

Trends in relation to incidents of violence: there has been an increase, but it has been in line with the increase in the numbers of presentations to the hospital, so the overall percentage of those being aggressive does not appear to have changed significantly. We have seen an increase in the carrying of weapons — again, knives and sharps are the predominant weapons that are held — with approximately 25 to 30 weapons per year confiscated from patients. More prevalent again, as we alluded to also, is that it is the medical treatment items that are used as weapons and missiles in the hospital.

I have mentioned there that we only have two seclusion rooms in our ED department at the Alfred hospital, so violent, aggressive patients — if we have more than two at any one time, which is often the case, unfortunately — may be put into rooms where there is clinical equipment, and that is sometimes the issue: they get hold of that equipment. It is about trying to seclude patients in an area where there are no weapons, missiles or equipment that they can use.

We are in the process of working with the hospital on implementing a hand-held metal detector to use as a condition of entry in identifying high-risk patients who may be carrying weapons into the facility, again in line with what was said previously. It is common for security officers to be scratched or kicked or spat at, but they do wear the appropriate PPE. Gloves and goggles are worn by security officers at every incident that they attend, but there has not been any serious injury or assault to our security officers, as I mentioned before.

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. There are concerns over capsicum spray, again through the air conditioning but also in confined spaces, where especially if you are in a seclusion room and there may be other clinical staff in attendance, or in psychiatry where often you are in a confined area, if you are using capsicum spray, you can affect other people.

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.

As I said, our recommendations would be maybe to improve the infrastructure, have more seclusion rooms available and have accredited training for our security officers would go a long way towards helping reduce aggressive incidents within the hospital. You had a question which was a — —

Mr SCHEFFER — Maybe we will come back to it later, if there is time. It was about data.

The CHAIR — Just on that, I am perhaps generalising, a bit like in Johan's question, but regarding the reporting mechanisms hospitals use, particularly in relation to nurses, are you comfortable that there is an appropriate reporting mechanism for collecting the incidents from nurses, and are they willing participants? Is the changing trend in antisocial behaviour because nurses are now more willing to report incidents or is the data collection perhaps better now than it was?

Ms NICHOLSON — We collect the data of all incidents and provide that to the hospital security incidents record collected by Spotless and provided to the hospital, but it does align with their data on the calling of codes and the like. The hospital system RiskMan is a fairly common system. I have seen probably in the last year that there has been an increase in RiskMan reporting, and the hospital has gone a long way to promote that RiskMan reporting is not a blame game; it is about reporting and recording incidents. I have seen a vast increase in the number — because I will be copied into anything that

has the word 'security' in it or anything in relation to security, and in just recording the actual incidents through RiskMan there has been a definite increase in that.

From a Spotless perspective, we record data, and every activity we undertake on a daily basis is recorded minute by minute or by hour by hour depending on the nature of what we do. That is provided to the hospital every day and is collated down to number of incidents and the time every incident takes over a month. That is provided to them every month.

Mr McCURDY — With the isolation rooms, you said you had two.

Ms NICHOLSON — Two seclusion rooms; that is right.

Mr McCURDY — And they are quite often needed at the same time? Is that not just the nature of the beast?

Ms NICHOLSON — Yes. This weekend I do not think five would have been enough, unfortunately, in our ED department. We also have seclusion rooms in psychiatry, but they have to get through the process before they actually get to psychiatry.

Mr McINTYRE — Notwithstanding the roughly 140 per month, obviously there are peak-hour-type activities, so you narrow that down to when the higher risk times are. They can add up.

Ms NICHOLSON — A lot of our time is taken standing by those patients in seclusion rooms waiting for review.

The CHAIR — John and Brett, thank you.

Mr ROGERS — I refer you to some notes there which you might choose to move us on through at any point if it has already been covered. We are very happy to be guided by you as we work through it. I guess of key relevance to you is the fact that we deliver services at Frankston and Rosebud hospitals, although until recently we were incumbent at Eastern Health and the Eastern Health hospitals as well, so we are very familiar with and probably able to make comparisons between those different areas.

Then we also have a number of other hospitals around the country, including being a preferred supplier for Healthscope and a number of their private facilities, so as far as a range of different services — it is not just security guarding a hospital; we also do mobile patrols and alarm responses to smaller hospitals after hours, and that sort of thing, when they are not necessarily fully staffed. We have given a quick indicative summary of what we see as the key threats in the health facilities in which we are operating, and I think it is pretty consistent with what we have heard from the first two presenters.

Clearly, the key immediate threats to our staff are drug or alcohol-influenced patients and also psychiatric patients or acute disorders of some description which elevate the risk, and then we work through what we are doing to manage some of those risks. I think there are other risks that a security supplier helps a hospital manage, and that is the risk to its own staff working in remote locations. Also the storage of pharmaceuticals and that sort of thing is another risk that I think needs to be considered as part of an overall solution.

I guess risks that we have encountered over the last number of years — and many of these have materialised at some point, I guess — are position or asphyxiation rate, abduction of patients, verbal abuse, assault, robbery, property damage and theft. Clearly some of those are far more extreme in their ratings of risk, and it is, in our view, very important to treat both the likelihood and the consequence of those risks. In every one of those cases you have got to attack both the consequence and the likelihood, and I think that is something that absolutely needs to be examined in detail as we go through a risk assessment process in any of these facilities.

The trends that we have observed — and I think the first comment I would make is that in our view there is a lack of recent, well-structured academic research into this issue. I think probably the most recent research would date back to the mid-2000s in Victoria, and it certainly would assist us in our planning and design of training and so on to perhaps seek some more recent, proper academic research, which I think is probably beyond the analysis of our own data that we are recording and managing internally. I think it needs to be a properly structured body of research that then leads into some recommendations and conclusions about the right way to manage some of these risks.

We have not seen — and I think this aligns very closely with what Spotless was saying — that any change in the volume of incidents that we have seen has been consistent with the changing volume and the management of the volume of patients that have been coming through any of the facilities that we have managed. We have seen a significant reduction in the severity of incidents over a period, and I think that is because we have been able to work in partnership with a number of — and Frankston Hospital is a very good example, where our LTI frequency rate has come down from what I would regard as being too high to a level which is nearer to being acceptable, if that gives you the right picture. That is through managing it with the hospital, having very strong reinforcement of a clinically led process and building the right culture around restraint and the de-escalation of aggressive incidents. We focus on that rather than on a more confrontational approach. I will hand over to Brett to work through some of the treatments.

Mr McDONALD — When we look at some of the risks that we see in a hospital, there are some key control measures which we always recommend. Some of those are our responsibility, and I guess also because it is a partnership, some of them are the responsibility of the facility.

With positional asphyxiation, we look at defensive tactics training. That will lead on — in a few more slides — to the fact that the defensive tactics training that is currently provided for the security industry is probably inadequate for that restraint. The frequency of it is not sufficient to develop the reflexes and the muscle memory that is needed to be able to restrain somebody effectively. We also very much promote to the cross-functional team that a restraint in a hospital is about a clinically led restraint and therefore needs to be done in conjunction with the facility and with the other key stakeholders in those code grey response teams.

In relation to rape, it is very much a risk where there are lone workers. We certainly help, where we have patrols and responses clients, to do those welfare checks or lone worker monitoring. Abduction of patients is about increasing access control and

security monitoring. There is a current Australian standard in relation to the physical security of hospitals. Even though that was developed some 14 or 15 years ago, it is still quite relevant today. Verbal abuse and assault are really about a workplace violence program. I guess when we look at workplace violence — and to your question about whether they are accredited, they are really not accredited courses, and there are awareness courses that most people go through. That is probably sufficient for verbal abuse and assault. It is about de-escalation techniques, and it is really about knowledge of the procedures. It does not address skills, so it does not address the restraint side of skills. Robbery is about target-hardening strategies, consistent with the standard. It is the same with property damage and theft.

We look at how we would work with a hospital to recommend best practice. I guess we would like to think that we can help to provide some advice and influence there. If we look at the key things that we would try to recommend, the first thing would be about how to provide and maintain a safe work environment. We would always promote regular risk assessments in line with those standards and the use of crime prevention through environmental design within those risk assessments. But probably the biggest variation we see amongst hospitals is the use of duress buttons. There are some facilities where we go in and we see a lot of duress buttons and their very effective use. Then you go to the other extreme where there are very few duress buttons. The cabled hard duress buttons as opposed to the wireless ones are really effective, as is knowing their location.

The other thing we try to recommend is emergency procedures. Most places have emergency procedures, but they tend not to provide a response plan for increased threat levels. They tend to be quite generic in nature in that they say, ‘When you have an assault or a violent incident, here is the response’. What they do not address is that increase in threat — so as the threat continues to go up, how we continue to respond. That seems to be a thing missing from our procedures.

Most places have post-incident management procedures and also incident reporting and investigation procedures. Why we do not have a lot of data is because it tends to dovetail in with a client’s expectations. For example, code grey does not always involve security, so the statistics that we collect really do not reflect what is necessarily in the facility.

Probably the biggest thing we see is a bit of a lack of clearly defined responsibilities. Quite often a code grey response or something like that involves people flocking to an area and doing something. It really is about a clinically led response, so it is about key people with key responsibilities. They all have a part to play in that, and sometimes those lines are a bit grey.

When we look at recommendations, it is about how to monitor the safety of our employees. That is really about making sure the site has a process to alert people for those code greys or code blacks and increasing the monitoring of health-care workers in remote locations.

How do we provide information and training today? Once again the training that a security officer goes through provides a bit about conflict management and a bit about how to use calming techniques and de-escalation. It is probably not sufficient for what is specific to the health-care industry, which is about the skill for dynamic risk assessment. It is a constantly evolving process. It can start with a patient and can then

involve family members and friends. It can lead also to weapons if there is something in reach. That dynamic nature needs special attention that is not catered for today in the basic security training. The awareness programs that we talked about before cover enough to talk about those calming techniques, but I guess the key point we want to make there is that it does not provide the defensive tactics training that you need to get the muscle memory and reflex, which is very much needed if you have to continually restrain people.

Mr ROGERS — We might just jump through to the second-last slide in your pack, which really summarises our recommendations. I think we would absolutely endorse the comments of the previous presenters that we need to develop a specific training package for this environment. We think we could achieve that by including additional competencies in the asset security training package that is currently structured under the training framework. I also note that the standard — AS 4485 — has a very good summary of the training that I think would dovetail well into the asset security training package as well.

We would also recommend that tenders released to the market specify a minimum training requirement. We also think there is scope for the licensing services division to review the possibility of health care being a different category under the security licence. That would then have different background checking requirements and perhaps different training requirements to allow people to be licensed to work in this field. I think it ties in directly with the approach that we all have — which is that you cannot take a bouncer out of a nightclub and expect them to cope. This recommendation would more formally recognise that, I think, at a licensing level. Thank you very much.

Mr SCHEFFER — Any last comments about data? Anything anyone has not mentioned? We are really interested in that, because we get different — —

Mr ROGERS — The data is one thing, but turning the data into knowledge is more important.

Mr SCHEFFER — Yes, precisely.

Mr ROGERS — It needs some disciplined and structured research to be completed that is current. I think that would be my observation on that.

Mr LEANE — Just a general question: security staff working at different hospitals are obviously your employees. How do you get around any conflicts that you all have your own policies and procedures that you want your employees to follow for their own wellbeing when there may be different policies and procedures where they are employed?

Mr ROGERS — From Wilson's perspective we will do our own analysis of the procedures at whatever facility we are working at, and at our own, and we will apply the highest level in each area of those policies and procedures, so the most demanding we will apply at that workplace, if that makes sense.

Mr LEANE — Yes.

Ms NICHOLSON — We have joint documentation, so our standard operating procedures at the Alfred hospital for Spotless and the Alfred are in one document.

Mr LEANE — So if you move a security guard from one hospital to another —

Ms NICHOLSON — Yes. We have not done that as yet, so we are talking about doing that. If they worked at the Alfred, they would work under Spotless at the Alfred; if they worked at Royal Children's they would develop documentation with them.

Mr ROGERS — Perhaps the shortest answer is we would work in partnership to develop a suitable amalgamation of the two policies that met everybody's requirements.

The CHAIR — Our time is probably up just about now. Thank you all very much for providing your time and presenting to this committee today.

Mr ROGERS — Thank you very much.

The CHAIR — The recommendations to the Parliament will be made at the end of the year, if you want to keep track of where we are heading after this inquiry. We will report to Parliament, and we will see what happens from there. Thank you.

Witnesses withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 10 October 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witness

Mr D. Van Lambaart, Senior Consultant, Jakeman Business Solutions Pty Ltd.

The CHAIR — Welcome, David, and thank you very much for giving us your time this afternoon. I am not sure if you heard all the introductions beforehand, but this is a joint parliamentary committee, the Drugs and Crime Prevention Committee, and we are dealing with a second reference in relation to an inquiry into security arrangements in emergency departments of Victorian hospitals. I have to read you the rules of engagement in relation to you providing evidence to this committee. If you could bear with me for a couple of minutes, we will be right to go.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and where applicable the provisions of the reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Mr VAN LAMBAART — Yes, I have.

The CHAIR — We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We do have media in the room, which is their right in relation to a public hearing. I make you aware of that. Over to you, David. We have allotted 45 minutes for this session, and we have soaked up 10 minutes of that, I am sorry.

Mr VAN LAMBAART — That is fine. I am not sure what opportunity you have had to read this.

The CHAIR — We have also provided the committee with a fairly extensive document which some may have had the opportunity to read and others may not.

Mr VAN LAMBAART — That probably came in relatively late. I was not advised until late last week that I was appearing. I did not get anything together until later in the week because I was not aware I was attending.

The CHAIR — I am sorry about that. We did have to do a bit of shuffling when one of our witnesses could not make it.

Mr VAN LAMBAART — That is okay. I am happy to go off the cuff anyway. I am not sure if you would like me to address the questions you forwarded through to me. I might start from there, because the other documents are reasonably substantive, but I may well refer to some of the attachments at the back at various stages if that is okay. We will get to them in due course.

I am sure you have an overview of my experience in hospitals or in health care. It is reasonably extensive. I have worked in the private area with Spotless for about five years at Southern Health as a security risk manager. That was the first time, to my knowledge, that a security risk manager had been engaged at a hospital in Victoria. It is true to say that when I arrived there was an absence of policy, and I see that as fairly prevalent everywhere we go, right around Australia. My colleague experienced the same thing overseas.

If we are to start at the top end of the organisational structure, there is certainly an absence of clear policy. When we enter a hospital to do a security risk review one of the first things we look for is the policy to understand where the focus, intention and direction is. More often than not we receive operational procedures rather than policy per se. Contrary to this, if you go to New South Wales, they have quite clear policies in terms of protecting property and people in the health area. Whilst that is very well documented in New South Wales, conversely we find that it is not well implemented, so we have a lot of ticks in boxes through various audits and the like, but when we come in to do an audit of our own we find that in fact it is not quite possible for all those boxes to be ticked, because we find gaps in the processes in policy development. So as a starting point, policy is certainly an area that needs to be addressed.

Whether policy is driven from the Department of Health is, I guess, another discussion point altogether, but there would be some benefit from it emanating from an area in that it would provide a degree of consistency in terms of approach, how clinicians view aggression and in particular violence within a health-care setting. I am talking about 'health-care setting' in much broader terms. It would include aged-care facilities, mental health facilities, community mental health facilities in particular that are not as well equipped to manage aggression and do not necessarily have the funding or the infrastructure in terms of security equipment in line to support their service delivery.

In terms of the prevalence of assaults, certainly as the previous presenters mentioned, verbal and physical aggression are quite prevalent in a hospital setting, although they are variable in terms of their impacts upon individual security personnel. Some are clearly more adept than others at handling physical situations. In terms of trending in relation to the incidence of violence or the use of weapons, certainly my experience at Southern Health was that weapons were quite prevalent. Particularly in the Dandenong area — again reflective of the geographic and demographic profile — at Sydney Southwest Private Hospital near Parramatta and those sorts of areas it is not unusual for security personnel to recover shanks, which are commonly used in the correctional or prisons area, machetes, kitchen carving knives, chains with bolts tied to the end, toolshed hammers, screwdrivers and the like. It is not unusual to recover those items.

I think that what needs to be understood, however, is that these items are not necessarily brought into the hospital system to be consciously used against hospital staff in the first instance, nor are they meant to be used against other people visiting the area. We primarily find that they are carrying them for perceived self-protection. They move in a different community than what many of us do. The intent in the first instance is not necessarily to cause harm to anyone within the hospital system, but certainly it has a propensity to shift in that direction should things go pear-shaped. 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 codes of own practice, where police are not encouraged to carry weapons into a hospital environment. You would have a bit of a conflict there for a start, in terms of consistency. Police officers do not normally carry weapons, that

I am aware of, when they are managing disturbed persons or persons who are under review from a mental health aspect, regardless of whether they are on a section 9 or section 10.

There is the potential to increase the likelihood of previously mentioned 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.

With regard to hospital security in Victoria and what percentage of personnel are security staff, I do not have accurate numbers that I can draw upon with any reliability. It is my broader view that the majority of security personnel are contracted rather than directly employed. This has primarily been due to the drive for associated cost reductions within the health sector and a perceived enhanced service delivery. In terms of staff being employed by specific hospitals, should that be provided by private security companies? I have had the opportunity to view a number of models. Few hospitals have qualified or expanded security risk managers, nor do they actively seek external independent security risk-management advice.

Those hospitals that have had directly engaged or employed security personnel are presently not mandated to have them trained or licensed as security officers because they are directly employed, as opposed to subcontracted or contracted security providers who are obliged to have the appropriate licensing and qualifications. Casual contracted security staff are typically allocated a roster at the sites with which they are familiar. Roles for contracted security personnel are typically static or well defined — for example, on specified patrol routes. This is in the context of having hospital-employed staff. It is very difficult to bring an external provider or contracted person into that environment. They just will not have the familiarity or the relationship with the staff that is necessary to get a positive outcome in often difficult circumstances. I do not see that happening very often.

I have experienced a quite entrenched — that is probably the best way to describe it — subculture within security personnel in health. It is not a healthy one. They do not actively invite contracted personnel into their area. In fact even when you engage new personnel they get a pretty clear message about the parameters within which they wish to work at a very early stage. I find staff who in the first three months have been cooperative and proactive from a management point of view will all of a sudden have a personality change once they become a full-time employee. The union is very strong within the health sector, and they protect their territory, for want of a better word, very carefully. You do not always get the cooperation that one would ideally like to see between contracted and internally engaged staff. This is probably a little bit of an aside from where we are at, but it may give you a bit of insight into security personnel in terms of a subculture.

I found particularly at Southern it was not a healthy environment. There were 50-plus security personnel, and internally I had to deal with issues of payroll fraud, theft of patient property, theft of cash and an inability to remain accountable to management for the way they conducted themselves on a day-to-day basis. I think that is an indicator of a broader issue that needs to be visited within this context of security: who should provide security and whether there is an advantage of contracted versus non-contracted personnel. That is not to say that you would not experience similar issues with contracted personnel if they were afforded the opportunity. I can merely convey the experiences that I had within five years at Southern, which led unfortunately to the removal of up to 16 staff over the period of five years. That tells you that the subculture is not healthy and needs to be looked at.

Mr McCURDY — As in an external audit?

Mr VAN LAMBAART — Yes, I would think so. It is very difficult as a single manager, or a one-person manager, unless you have got the support of your management team. In that situation it was a contracted management arrangement, so the management team that Spotless provided at that particular time were viewed as external to the organisation. That did not mean that there was not cooperation; there was. The CEO and legal counsel in particular were very, very supportive, but it is very difficult to make definitive change in that environment when it is so entrenched. It takes time and it takes policy development. When I arrived there were no policies. I had to write policies from scratch, and when you are trying to move that, then clearly others who do not want to have that sort of rigour and framework brought into play will actively move to disenfranchise you or disposition you. It is a very challenging environment to work within.

The CHAIR — It was said to us that one of the strengths of having in-house security is that bond with staff, and that they actually integrate into the system, particularly in the triage area.

Mr VAN LAMBAART — It is problematic, too.

The CHAIR — And what I am hearing from you is that you do not necessarily agree with that; that there are more problems or more problematic areas in relation to having new staff than external contractors.

Mr VAN LAMBAART — It is one of a number of problems. I don't necessarily have a view that one is any better than the other. They each have issues that need to be considered if you want to look at an ideal model. Certainly the familiarity has its benefits, but it brings its issues as well. When we talk about theft and the like, typically people view it as being an external or a third party, when in fact it quite often happens internally with staff, whether that be drugs or whether that be PSAs, Patient Services Assistants or orderlies removing patient valuables and the like. I had a number of investigations with the Caulfield crime investigation unit that resulted in staff being charged. There was clearly a resistance within staff for me to take decisive action and even for police to take decisive action, and that is problematic in itself.

It is not for nurses, clinicians and the like to judge whether somebody is guilty or not guilty. It is a police matter, and police should manage that from the start to the finish.

But because many of the staff may have moved from another hospital — I think it was Queen Vic. hospital across into the Monash setting, for example — when you have such close bonds and relationships, as I said, those subcultures, customs and practices tend to transfer with them and it is very hard to break down those barriers.

In terms of contracted personnel, without a doubt there are issues on that side as well. I think it is fair to say that over the last 10-odd years there has been a shift towards the PPP model, and that is driven by cost incentives and cost savings for the state to be able to deliver leading-edge clinical outcomes in hospitals and spread the costs over a 30-year period. If you move to that subcontracted model, you still have to have the subcontractors or security personnel working closely and in concert with clinical staff. That is not always easily achieved because there is that clear point of difference.

When you arrive at an organisation like I did back in 2000, and the first question people ask is, ‘Who do you work for?’, and then they might look at your business card, that straightaway gives you a bit of a mindset about where people are at. We still find that now. As consultants when you come in to undertake reviews there is a certain amount of scepticism and cynicism associated with people because they are in fear of their jobs, sometimes unrealistically. Primarily we are there to establish a gap of where the hospital is at and where ideally it would like to be and to provide a set of recommendations that will enable it to move to a better place.

Regarding contract security personnel, again over the last 10 years it is fair to say that it is very difficult for them to attract what you might term quality people and retain them over a longer period of time. The hourly rate for a security officer is particularly poor. There is quite a difference between internally engaged security personnel — what they get for an hourly rate and associated penalties and the like — versus a contracted person. Whilst there is a temptation for an organisation like a hospital to move towards a contractor for perceived savings and the like, as with most decisions there are consequences associated with those choices.

Security companies have not helped themselves. I worked for Chubb Protective Services for in excess of five years, so I have some understanding of and insight into what they are trying to do. The dilemma for them is that they are competing for minimal contracts. Some of those contracts, while minimal in terms of the quantity available, are quite significant in terms of their revenue streams, so there is a drive to push the price down. Hospitals are looking for savings and security companies are looking to secure the engagement, so the prices are pushed down.

Clearly, if you keep pushing down the prices, at some point you will hit the bottom of the barrel, and there is a dilemma with that. How do you then raise an artificially low price point and bring it back up to a level that will allow you to provide the appropriate training, to attract the appropriate people and, more importantly, to retain them over the longer term and give them some sort of meaningful career path? There is often a gap between the top end of a security company’s management and the coalface of the operational level. There is quite a significant gap in there. Security companies refuse to invest in that middle management area, because they are looking to make savings. If you ever deal with a security account manager, he or she will typically manage up to 80 or 100 accounts. Clearly you cannot regularly get to your account client base if you have that many.

When we move into the hospital system there is a propensity for them to be managed almost at arm's length. Once they secure a contract everybody gets in there and people are looking to get aligned with key stakeholders within the hospital environment. If we do not hear any noises and we do not get any complaints, clearly we will just let bygones be bygones. The dilemma with this is that in broader terms you often have a non-clinical or support services manager who is managing the security contract, and that person is wearing multiple hats. They could be managing waste disposal, cleaning and security. For me that begs the question: where is the security and risk management expertise? It is clearly absent. Virtually all the security companies now, to be fair, promote the notion of security risk managers. It is popular and gives them a sense of being up with a risk-based approach. What they do not necessarily see is a transfer of that into the operational setting.

Mr SCHEFFER — What is the skill training base for risk management?

Mr VAN LAMBAART — In terms of risk management most of them will probably do a certificate IV, which is pretty much an introduction. That is not to say they would not readily embrace the notion, because they risk manage anyway, although they probably have not defined it or understood it in sufficient detail.

Mr SCHEFFER — That does not help the problem about middle management. It still stays at the operational level.

Mr VAN LAMBAART — The risk managers are generally the line managers you would have met today or on other days, I am sure. How does that effectively transfer or translate into the operational setting? It does not necessarily transfer. Whilst you will hear discussion about policy, they are actually talking about procedures and not necessarily about policy.

Mr SCHEFFER — You started off on that basis of most of the organisations not having a policy. What would you expect to find in a good policy?

Mr VAN LAMBAART — I expect the policy to articulate a framework for performance and expectation. You have a message similar to a mission statement where you have a clear understanding. You often go to hospitals and they talk about an open and accessible environment, healthy living for the patients and all those things. Whilst they are valid in a clinical sense, the question for the security consultant is to look at it and ask, 'How can I strike a balance between providing the safe and secure environment they are looking for while at the same time respecting that a public hospital is to be open and accessible and allow people to move readily in and around that environment?'. The challenge is to find the balance. You cannot find the balance if you do not understand what the problem is.

In terms of policy development, you then break down the policy into the key areas of access and egress management, rather than the term 'access control'. You want to manage and facilitate movement through an area rather than restrict it per se. If you move people where you want them to be, you are effectively managing them. You have people pretty much where you want them to be. We do not think in terms of access control; rather, it is more about access management. Then you drive the policy down in terms of CCTV monitoring and the like, where you do not have your security

staff monitoring areas where they should not be or individuals who they should not be monitoring. They focus and have a clear framework and procedure.

Mr SCHEFFER — I mentioned to groups previously about data gathering in a way such that the data informs evaluation, which informs policy, which informs something else et cetera. What is your take on how data is managed?

Mr VAN LAMBAART — It is mixed, I would have to say. There is encouragement for staff to report all incidents regardless of what their involvement is. You may have four or five staff in the immediate area of an incident, and they are all encouraged to provide an incident report. Obviously you need to balance that by saying, ‘There is one incident and four or five versions or pieces of evidence’, and they can be collated to help you to better understand what took place. We need to be careful that we do not embellish the numbers. Likewise there are some staff who probably do not report. Because they have been in the environment for so long, they are almost what I term environmentally hardened. They have been there so long that it is like water off a duck’s back — ‘If you swear at me, who cares? I have heard it so many times before that it doesn’t bother me’. Whereas others may particularly take offence to it.

If you move to the notion of zero tolerance of aggression and violence, which I mentioned in my opening document, it is notional and means different things to different people. I question sometimes whether zero tolerance is even achievable, let alone sustainable over the longer term. For me it is more about whether you understand the nature of aggression and the propensity for it to translate or move readily into violence. If you do, how do you manage that? That comes from awareness, training and experience; it does not come in 5 minutes. It is variable and not predictable. You might think you have somebody sussed. If someone walks into a room, you might think you are going to size them up as soon as they walk into the room. The reality is, though, that you do not know what has impacted on them before they arrived at the establishment and what the trigger points are. Sometimes it takes time and interaction for that to occur.

Mr LEANE — I think you were here before when I asked Spotless and the other companies about any conflicts there may be between the procedures and policies of their organisations compared to the hospital or wherever the security guards may be placed. In your submission you talk about the conflict and disconnect there may be between a PSO, who answers to VicPol command, and hospital management or a clinician.

Mr VAN LAMBAART — Typically you are going to come against the emergency department manager, a doctor or a nurse.

Mr LEANE — Would you be able to expand on that, because in your submission you say that it should not be underestimated?

Mr VAN LAMBAART — It should not be. As with any command and control, understanding the roles and responsibilities is absolutely fundamental and key to ensuring that we do not have people overstepping the mark and that we have people understanding that there are certain times when they need to step up to the mark because their role requires them to do that. If you have a violent incident in an emergency department, it is interesting that as a security officer you will get told by the clinicians where they perceive

your role to be. That changes fundamentally when things become violent. They are not necessarily as keen to step up and undertake the physical engagement that is necessary. The notion of equal force is flawed. You cannot manage somebody with equal force because if you have equal force, you have equilibrium and nothing is happening. Clearly you need to assert yourself on the individual. The clinical approach is understood in that you may have impaired individuals. We may be trying to ascertain whether a knock on the head is the cause of the issue at hand or whether, in fact, it is part of that person's make-up. They may well be a previous patient known to clinicians in the area. When you have that situation a clinical approach and the clinical management of it is absolutely appropriate.

What I do not quite understand is why clinicians have assumed they have an in-depth knowledge of security and what is involved in security when they have no qualification or formal schooling in that particular discipline. Just because it happens within a hospital environment does not necessarily mean the hospital operator or the clinician, even though they are ultimately responsible for what takes place, is necessarily best placed to manage or lead a physical restraint or manage a violent situation. Further you have got the situation where a number of these events involve third parties who do not have anything to do with the clinical situation. It is the hangers-on, the extended gang that happens to turn up or whatever the case may be who are your root causes of the issues. So halfway through this situation are you going to change hats and say, 'I'll handball it to you. It's no longer a clinical situation to manage'?

This comes back to the fact that, regarding policies, procedures, processes and training, it is absolutely important that they train together, because we all need to understand what we are trying to achieve and what the objective is.

I hope I have answered your question. I am not sure if I have. I will wrap up, because I appreciate the time constraints. I refer you to the larger attachments and ask you to look at the mental health one first. I think it is about the second one down. With that and the one that follows — the emergency department mapping — the only thing I would suggest, if I could be so bold as to caution, is that we do not jump to a solution before we understand what the problem is. Part of this process is to try to better understand what is actually happening in emergency departments in hospitals. If you break down a mental health area, or if you turn to the following page and look at an emergency department, you will see that these are all the moving parts. It is a complex environment. It is not the case that simply putting in a protective services officer is going to solve all moving parts in a model like this. What we try to do is break down and better understand what is actually happening here and whether we have an overarching objective. Do we all understand what the objective is? Do we all understand what tools we have available to us in order to achieve an outcome? Security officers, whether they be protective services officers, private security officers or internal ones, are but one very small part of the equation of what we are trying to look at here.

I do not know what else I can say other than to suggest that when you have the time you read the document. I would be happy to come back and answer any questions, or if you want to place questions in writing I would be happy to respond.

Mr SCHEFFER — Just one more follow-up question. I do not want you to think I am a pointy head asking you about policy all the time. The question I had after that is: given the importance that you have placed on that as a kind of a head of organisation, and you say it is spotty and uneven, how do you think we could move to a situation where organisations have good standard policies around the security issue? Should it be legislative? Should it be encouraged through professional groups? What is the mechanism?

Mr VAN LAMBAART — A combination would be the easy answer, I guess, but it is probably not the one you are looking for. I would have thought it should start at the Department of Health. They should have a clear vision of where they are going and give guidance and direction to the hospitals even though ostensibly they operate separately.

Mr SCHEFFER — There is a segue, isn't there?

Mr VAN LAMBAART — If you have that clear direction, then we all know where we are heading. That does not mean you do not have the flexibility to be able to manage your own particular space, and so you should, because the service profiles are variable. Some are emergency critical care, some are children's, some are aged care, there is the Peter Mac environment and whatever the case may be. All we are saying is that if you start with a baseline or a framework, clearly you can work from there consistently because it is reasonably predictable for those using it or working within the environment, but it still allows a degree of flexibility for site-specific requirements or nuances to be reflected in the detail of those policies.

Mr SCHEFFER — Yes; okay. There was a question I meant to ask from the previous witnesses. In relation to the data collection and your second paragraph on page 1 about perception in relation to violence and aggression in hospitals, is the research that was spoken about — actually you do not have to answer the question because it was not from you. I am trying to define exactly what, particularly in relation to this inquiry, we as a committee can recommend. Is it that we invest in more research to provide the data —

Mr VAN LAMBAART — Reliable data, yes.

Mr SCHEFFER — When you say that, is that about the statistics or the way that they are formed in relation to antisocial behaviour?

Mr VAN LAMBAART — A little bit of both, but certainly more in the evaluation and trending of the data to understand what is really going on. A really simple example is that we can have a particular patient attending a hospital and, for a period, there will be heightened activity that emanates from the individual. The perception is, 'Oh, we've had a lot of call-outs', but when you drill down and actually understand it, there is a reason it has emanated from a particular individual. You learn from that and clinicians note information about that particular patient in their files so when the patient re-presents you have already got a feel for exactly what that person is about and what their behaviour is likely to be. Security staff are usually briefed about that and understand how they should move with a level of awareness about what that individual might be about. In the mental health area a person's predisposition is very much reflective of whether they are compliant with medication at a particular point in time.

The CHAIR — Thank you very much, David. We appreciate the work you have done, particularly with your paper as well as your time here.

Mr VAN LAMBAART — Thank you.

Witness withdrew.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security arrangements in Victorian hospitals

Melbourne — 10 October 2011

Members

Mr B. Battin

Mr S. Ramsay

Mr S. Leane

Mr J. Scheffer

Mr T. McCurdy

Chair: Mr S. Ramsay

Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook

Research Officer: Mr P. Johnston

Witnesses

Ms F. Diver, Executive Director, Department of Health, and

Mr T. Symonds, Acting Director, Performance, Acute Programs and Rural Health, Department of Health.

The CHAIR — Thank you for making your time available, and thank you to the minister for allowing you to make your time available. Could you please introduce yourselves?

Ms DIVER — My name is Frances Diver, and I am executive director of the hospital and health service performance division within the Department of Health. I have broad responsibility for health service performance monitoring, service planning and capital funding policy, amongst other things.

Mr SYMONDS — I am Terry Symonds. I am the acting director of performance, acute programs and rural health in the department. I work in Frances' division, and my responsibilities and that of my branch include managing policy and funding for hospitals in relation to their performance agreements with the Department of Health and the Minister for Health, and budget negotiations and policy related to acute program service delivery.

The CHAIR — My name is Simon Ramsay, and I chair the joint Parliamentary Drugs and Crime Prevention Committee. We have a full committee here and this is, I think, our last public hearing in Melbourne in relation to this particular inquiry. We have media representatives in the room, and I need to read you the rules of engagement in relation to you providing evidence to this committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975. It is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand that you will have read the guide for witnesses presenting evidence to parliamentary committees or at least have been briefed on that. We are recording the evidence, as I said earlier in relation to Hansard. We will provide a proof version of the transcript for you to have a look at and you can correct it as you see appropriate. As I said, this is a public hearing and the media are in attendance today.

Thank you very much, Frances and Terry, for your time. I will leave it to you to take us through the documentation.

Ms DIVER — Thank you. I have taken the opportunity to document some PowerPoint slides that I can take you through to give you an overview of where we are up to, what the department's role is, what the health services' role is and some of the initiatives that have been going. If you are happy, I will walk you through this presentation, and I will be happy to take any questions either during the presentation or at the end.

In terms of health service security arrangements, it is probably important to note that the Department of Health has a role in terms of policy setting, planning, funding and monitoring service delivery but, as many of you would be aware, 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, obviously.

I guess the next point to make is that the Department of Health views the issue of violence and aggression in emergency departments as being part of an occupational violence issue. We would recognise that it is an important issue and we would frame that through occupational violence, but we would also note that this is not an issue limited to emergency departments; clearly aged-care, psychiatry and maternity services and front reception as well as emergency departments are all places in which health services would experience and notice incidents of violence or aggression.

It would be important for us to make the significant point that with universal access to health-care services it is open to any member of the public to attend a health service and there is of course a risk of violence or aggression in the workplace. But because of the unique circumstances of the health-care environment, there needs to be careful consideration of what the most effective response is, particularly relating to the health-care environment where we encourage people to attend health services to seek treatment, so we would be very keen to ensure there was no barrier, perceived or real, to members of the community attending a health service for treatment.

I will move onto the next page, which is headed 'Responding to occupational violence'. The way that occupational violence has been dealt with across the health sector in Victoria is under an OH and S framework focusing on identifying the hazards, assessing all of the risks and then managing the risks through controlled mechanisms. It is very much a minimising of the risks and managing the incidents.

There is a range of systems in place to respond to violence in health services, starting with the obvious first one which is the design of physical facilities — ensuring that they have appropriate design in terms of open areas for supervision of patients and potentially also secluded areas where individual patients can be managed in appropriate circumstances. There are a range of practice guidelines, training programs, codes for emergency response and de-escalations — I am not sure if people have talked to you about code black and code grey — and also support from dedicated security arrangements within each facility, which obviously vary across facilities.

In terms of the next step in responding to occupational violence, it is important to understand that health service staff are balancing the needs of patients while responding to the underlying clinical issues. There are obviously multifactorial reasons why incidents of violence and aggression occur in a hospital setting, and they need to be addressed in the context of also ensuring there is a safe environment for other patients, for staff and for visitors.

The other issue that has been worked on across the sector recently has been the development of incident reporting systems. VHIMS, the Victorian Health Incident Management System, is a broader system of identifying and responding to clinical and non-clinical incidents in health services. That has been a significant undertaking over the last few years to establish a systematised, statewide consistent format. Health services in the past have collected their own data, and a report undertaken some years ago examined the data reported under code grey and code black. One of the outcomes of that was that this data might be useful at a local health service level but it is very difficult at a statewide level because we have inconsistent definitions and reporting. As a consequence of that and a number of other factors in relation to broader clinical incident management reporting, the Victorian Health Incident Health Management System has been established, and that has now been rolled out to pretty much all

health services across the system and will start reporting formal data so that we can actually get data out of the system at the beginning of 2012.

I thought it was probably useful to allude to the recent work that was undertaken in relation to the task force on violence in nursing. I am sure others have spoken to you about the task force which was established in the early 2000s and reported in 2005 with a whole range of recommendations. Most of those, 25 out of 29 of those recommendations, have been implemented. There was a whole bunch of recommendations related to raising awareness and improving the interface with justice, particularly with Victoria Police, education and training. As part of that a number of health services have undertaken a specific partnership with Victoria Police in terms of improving the relationship, knowing what the capability and role of police is and knowing what the capability and the role of clinical staff is in a health service, as well as security staff.

Legislation was amended to provide clarity for health service staff when they were taking weapons and firearms from patients and keeping them in a secure place. There has been a whole bunch of awareness raising. There is a DVD, a poster — I have got them here if you have not had them previously — and also some training programs around the management of clinical aggression.

Another chunk of work that came out of the task force was the development of a framework in the reporting and monitoring. I have talked about the VHIMS system for reporting and monitoring, but there is a policy framework on the prevention of violence in health services, which I also have here if you have not seen that before.

There was an occupational violence prevention fund of \$4 million over four years. That funding ceased at the end of last year but covered high-priority projects across 66 health services. They were the highest risk projects that were funded, according to a WorkSafe risk assessment system. The kinds of things that were funded through that were duress alarms and environmental design training. They were initiatives at an individual health service level. That was \$1 million every year for four years.

Mr LEANE — Was that something administered by DHS?

Ms DIVER — Correct, the Department of Health. Health services would have provided submissions. They undertook an assessment themselves based on a WorkSafe risk assessment framework, and out of those projects that were submitted to the department, individual items were funded.

Mr LEANE — Has that \$4 million has been expended now?

Ms DIVER — That is correct. It was \$1 million a year for four years. That ended and there is now a summary report being developed that identifies what was funded, what was successful and what was not, with the intention that that provides an opportunity to expand or roll out those initiatives across other health services where they were successful.

Current initiatives — where are we now given that the task force on violence in nursing has been pretty much completed and there is a summary report to come that will help inform future strategies? There are a number of initiatives, and I have

mentioned the VHIMS data. We see that as particularly important in having consistent definitions and consistent reporting and to allow health services to compare their data with other health services by also helping in targeting strategies.

The CHAIR — Can I ask about that, mainly because without getting an update on this reporting and data collection, one of our recommendations might well have been that, so from a local hospital and Timbuktu that has had a number of incidents in relation to that that were reported to management, how was all that transferred into this database? Take us through the grassroots detail of how that would happen.

Ms DIVER — Sure. I am probably not on a very grassroots level, but on a conceptual level it is a bit like a minimum dataset. We have a system where, when there is an incident in a health service, be it a clinical incident or a non-clinical incident, health services staff — nurse, doctor, ward clerk, whoever is involved in the incident — will report that to the incident management system, which is a database.

The CHAIR — Which is statewide?

Ms DIVER — Which is a statewide footprint.

The CHAIR — And every hospital uses it?

Ms DIVER — Pretty much every hospital uses it. There might be one or two that are not quite there, but pretty much every hospital and community health service uses it.

The CHAIR — Is that just software?

Ms DIVER — It is a software product that is something that has been rolled out across health services in the last couple of years. The doctor or nurse will report the details of an incident in a particular place according to a predetermined code set. That predetermined code set allows us to aggregate that information and compare it across services.

We have got the software package, we have got the training program, people are reporting incidents, but the issue that will become important is underreporting and overreporting. One of the significant issues in this area is potentially getting consistent reporting. What do people perceive as an incident? There are different thresholds for what people perceive as an incident on an individual basis. A previous person spoke about there being somebody yelling or shouting at someone and whether that was considered an issue of violence or is it just when they have had a physical incident.

There is an issue of consistency of reporting, but we expect now to have a consistent minimum dataset so that we will get consistency and we can report the data back to health services and they can compare their data with peer health services to monitor whether there are lots of incidents being reported in one hospital that look pretty similar to another hospital. They will be able to drill down and identify whether this is a reporting issue or whether it is a real issue of increased activity.

Review of hospital design guidelines is obviously important in the development of any new hospital. As new hospitals are designed, those features are taken into

consideration, but also when we do capital works in health services these become important issues. In recent times when there has been funding available for minor capital works, particularly related to emergency departments, there has been some work in the context of models of care and improving the way people can be managed in emergency departments to have a kind of behavioural assessment room — a quiet place where patients can be managed — rather than necessarily being in the open cubicle area of an emergency department.

The CHAIR — Because a lot of our work has been about the environmental issues. Obviously there are a lot of new hospitals coming on stream where you would expect to see a number of these things. Certainly from the work we have done, our recommendations will most likely include some of the environmental issues and we expect that the state will take on some of these recommendations in relation to changing the environment in the new hospitals that we are building. There is already a lot of work being done in relation to the way an emergency department is laid out in relation to how people react.

The most dangerous period seems to be the idle time when people are waiting to be assessed, and obviously we have done quite a lot of work in relation to how different hospitals are responding to that, but also the environmental way out, and also about the isolation rooms and where the mental care in relation to security is aligned to the emergency department, and a number of those sort of factors. But it would appear that quite a lot of the work has been done already in relation to that, as it is with VHIMS. The two-part question is: we have heard a lot about RiskMan, the manual that is already being used. Is that to be superseded by the new VHIMS, or is there some sympathy in relation to that manual as well.

Ms DIVER — RiskMan is a software package that was operating in a number of places and VHIMS is the next version but statewide and more developed.

The CHAIR — So it will supersede RiskMan and they will not use RiskMan anymore, they will move to this VHIMS.

Ms DIVER — My understanding is that health services collect a range of incident data so they may have a broader collection of data than the minimum dataset that we require. We require a specific dataset within the system, but health services may have also been reporting other things that they may still continue to be interested in, and it may be associated with RiskMan, but our requirement at a statewide consistent level is this set of data. That is, I guess, in the context of data burden. Health services report an enormous range of data to the department, and in ensuring that we have compliance there is a balance between a minimum dataset that provides adequate information for us to use on a statewide basis and the local things that health services may choose to collect, and they can continue to collect them as they see fit.

Mr BATTIN — What is the minimum? Do you have a minimum of what you are looking at?

Ms DIVER — I cannot provide that information to you now, but I can certainly provide you with information on what is included in the — —

Mr BATTIN — Can you also say what is the difference between yours and RiskMan, if there are certain ones that collect things that possibly should be included?

Ms DIVER — I am happy to provide you with the data specifications for VHIMS; I am very happy to provide that to you. In terms of the review of hospital design guidelines, the design guidelines are just that, guidelines, and then as health services go to capital developments in general, the approach is there are a lot of user groups and a lot of consultation around what does the design look like, but you are correct to say that supervision of waiting room areas is important in terms of making sure that you can assess patients clinically, but also if there is any potential inappropriate behaviour occurring, that allows health services to respond early. Then of course there is how we manage patients both within the emergency department and in other clinical areas in the hospital where there is potential for aggressive behaviour to develop. I guess the first approach is dealing with the clinical issues first and trying to get an understanding of what the underlying clinical issues are, and I am sure other people have spoken to you about code grey as being a de-escalation or early intervention, so a high level of code grey incidents is not necessarily a bad thing because that is, in fact, ultimately reducing the number of more serious incidents, so really code grey is being developed in Victoria in a way that allows us to have an early identification and to intervene early before something gets to a point of violence or aggression or a particular incident.

As to ongoing training and support within health services, management of clinical aggression in particular, the emergency clinical network, which is the network of emergency clinicians, and both doctors and nurses and others have worked in particular with Melbourne University and Melbourne Health to develop what is called MOCA — management of clinical aggression. That is what it stands for, but that is really about working with particular staff on how they de-escalate, and that is now a training package, which is here if you are interested. That has a kind of a talk where health services can pick it up and roll that out, and that has been implemented in, I think from memory, about 18 health services or 18 emergency departments.

The other initiatives relate to the relationships with Victoria Police, so there are relationships with Victoria Police in relation to mental health patients and section 10, and then there are overall general improvements in the way that police and health services interact with each other, so that there is an improvement in the understanding of whose role it is to do which things, and of course there is the review of the Mental Health Act that you would be aware of that will potentially make changes in relation to seclusion and restraint.

It is probably important to understand that mental health patients do arrive at emergency departments, and emergency departments are seen as an appropriate place for care of mental health patients and that an emergency model of care does operate for those mental health patients while they are in emergency departments and, yes, there is potential aggression and violence related to mental health patients, but that is not necessarily the only or the most significant issue in terms of violence and aggression in health services or in emergency departments. There can be patients with other conditions who will have an underlying clinical reason why they are ending up in a situation where there is violence or aggression. It is just an overview of the way that the Department of Health approaches and sees the issue of violence in emergency departments.

The CHAIR — I have one last question and then I will pass over to the committee. It was brought up a number of times, particularly in relation to those nurses who have appeared before this committee regarding those task force recommendations. I was of an understanding that there was a view, particularly from the nursing industry, that there were a number of recommendations not yet implemented, or implemented in a way that they actually are not in practice. Can you provide us with a bit more detail?

Ms DIVER — With the specific detail of which ones have not been implemented? I would probably have to take that on notice.

The CHAIR — Not even so much — —

Ms DIVER — Twenty five out of the 29 recommendations — I think some of the ones that are not yet resolved are the data, because we have not completed the dataset. We have implemented VHIMS but we have not got the data reported, so I think that would be considered one of the recommendations that had not been implemented, and I cannot tell you off the top of my head the other three.

The CHAIR — Is that in all hospitals in relation to the task force? Is there an expectation that those recommendations will be implemented in all hospitals or just public hospitals or — —

Ms DIVER — When I talk about implementing in health services, I am talking about public health services, so they are the health services that the government funds and manages, so that is the 86 entities that we run. It does not necessarily relate to private hospitals. I am not talking about private hospitals today. If you want information about private hospitals, I will have to take that on notice.

The CHAIR — That is fine.

Mr SYMONDS — We depend on the specific recommendations to some extent. Some of the recommendations would be recommendations for the department to implement and some would relate to hospital practice.

Mr SCHEFFER — If I could just follow up on that, they provided us with a very long list. I have not written down all recommendations but there seem to be between 25 and 30, and they have given us a percentage level of the extent to which that particular recommendation has been implemented. I am not exactly sure of the details, but across the sector, across the hospitals, they find that it has been less than adequate, basically. I guess that is the bottom line of the position that they are putting, and that a consequence of that is that there has really been no change on the ground in terms of the violence that they are often subjected to. I guess my question, given that the Chair has already opened that up, is how do we resolve that? We do not know whether it is true and we could go on for a while about which bits and how it all works out. It is probably very technical and complex, so my question is: how do you work with the ANF or how do you work with the stakeholders to get all these ticked off in a way that is agreed?

Ms DIVER — The way I think about that is that we have had the task force, it has given us its report and it has made a bunch of recommendations, some of which relate to policy development, so we have a policy — tick, that is done. There were a range of recommendations in relation to the management of firearms and weapons. The legislation

has changed — tick, that has been done. There was a requirement for improved data collection and monitoring, so the system has been put in place to do that but we have not quite got the data out for the other end. There were recommendations in relation to training and development, so we have got training tools and we have got awareness raising and we have got posters, we have got DVDs, so those have been done. I suspect, and I could go on down that list, what the nurse on the ground, who is at the front line, is saying is, ‘Well, what I am seeing?’, and I guess that is about you can implement but to what degree have all of these things been taken up?

Mr SCHEFFER — You may well be right, but just as an example, since you gave some, they say on-site security guards in the workplace 24 hours. They say 54 per cent present. Could I loosely interpret that as saying 54 per cent practical take-up or implementation? And then the next one that they have got is on-site security and workplace only after hours, 28 per cent present. I do not know precisely what that means. I would have to drill down to ask our research team, but do you understand what that might mean? Again I go back to my question: how do you end up resolving it?

Ms DIVER — Maybe if I go to what does that mean and then how I think we might resolve it.

Mr SCHEFFER — Yes.

Ms DIVER — I think our expectation is that health services have their own arrangements in place for security, and that can be a range of things. That can be an on-site security person located maybe in the emergency department, and many of them have co-located their centralised security arrangements in emergency departments. But at a major health facility in general there would be a security person on site who would provide that service who would have a broad responsibility for security of the whole site, or it may be a contracted service, or there may be other staff, such as orderlies, who have some responsibility around security in particular incidents.

If that is the survey of nurses who say, ‘Have I got my own security guard in my emergency department?’, they may not necessarily be aware of what the security arrangements are. We would say that boards and health service management need to make sure they have appropriate mechanisms in place to manage security, recognising occupational health and safety regulations and WorkSafe and all of those issues to make sure they are providing a safe environment. I guess we can sort of argue what does that really mean. In terms of how we resolve this and is it getting better or is it getting worse, we can look at WorkSafe and WorkCover claims; are they increasing or decreasing?

The information that I have been provided is that WorkSafe claims are reducing for nurses overall but that we do not necessarily have the specific data to say whether that is just all WorkSafe claims or whether it is in relation to violence and aggression. That is one source of data that we should watch. But I guess the ultimate conclusion comes when we have the VHIMS data reported to us, where we can all see if this is getting better or getting worse. I think we can be confident that most of the recommendations from the task force — the kind of implement the policy, implement the guidelines, make new arrangements, those things — have certainly been implemented at the high level, but of course there is the constant follow-up with

health services to make sure that these things are embedded in ongoing arrangements at health services. Is there anything you wanted to add?

Mr SYMONDS — The only other comment I would make is that because the data through statewide reporting will come after we have put initiatives in place to improve awareness of occupational violence as well, it is not necessarily straightforward that we will be able to look at that and see that an increase in reports shows that things have got better or worse, because underreporting, even if it is just related to the technical rollout of the system, is allied to a culture in health services, an awareness and recognition. We are trying to improve that as well and at the same time.

The CHAIR — Other committee members? Tim?

Mr McCURDY — I think I have nearly got an answer. I first of all thought the VHIMS data was sort of fed in from the health service and then went back to the health service, but will it be benchmarked and used for all health services? That is what I am trying to ascertain. I think I am getting close to the answer. That is what it is more designed for.

Ms DIVER — Yes. Health services will input data. They will produce their own reports for their boards or management or occupational health and safety committees or whoever is interested at a local level. That data also comes to the department. We get that data from, let us say, at least 80 health services. We can then manipulate that data — —

Mr SYMONDS — Analyse that data.

Ms DIVER — Analyse that data to provide reports that we will look at a statewide level, but we can also provide that data back out to health services. Perhaps if three emergency departments in an area want to see their data, we can give them their data.

Mr McCURDY — It is raw data, like on how an incident was treated or how it was handled? Is it analysed so that you can say, 'This was the incident and this is how it was handled. It gets 5 out of 10.'? Or is it not like that?

Ms DIVER — We do not score the response, but through that dataset we can identify the location of the incident. I will have to check, and I will when I provide the data specifications for the VHIMS data, to say what items are collected. But we can undoubtedly identify the location, the time, the date and the worker involved. I am sure there are a number of other fields; I cannot reel them off right now. But that allows us to provide some comparative data to health services in due course, once we have our robust dataset. We have to validate the data obviously, and there is a whole bunch of issues in relation to having a robust dataset.

The intention is that that will be a valuable tool for health services to examine their own experience, but it will be an important tool for us to look at trends recognising the context in which we are looking at that. If we see a sudden increase in incidents of violence at a health service, first of all we would talk to the health service to find out what was happening at their health service. If you find that they have just done an awareness raising program, then that might be related, or it may be that there was a

specific incident or a series of incidents in relation to a particular patient, or not. It is not just the data; it is the context in which people are analysing the data.

Mr SYMONDS — If your question was about the appropriateness of the health service response, I think it is fair to say that information would be available to health services and requires quite in-depth local analysis of incidents. Root cause analysis is now routine, for instance, following not just occupational violence but also other clinical adverse events and so on. The results of those root cause analyses will not come to the department through VHIMS, so you will not find any of the really important, long-term findings about causes in this dataset. It is going to describe aggregate trends statewide in how those events occur, but the appropriateness of the response based on a good understanding of the causes is something that health services will be getting their heads around.

Mr McCURDY — Okay.

Mr LEANE — Was the Department of Health involved in formulating the potential initiative of introducing protective services officers to be stationed in emergency departments?

Ms DIVER — I have not been involved in that initiative, and I am not aware of the Department of Health being involved in that initiative.

Mr LEANE — Are you aware of something that was called for by your local boards or local management, or calls in the Department of Health that have happened?

Ms DIVER — No, I am not aware of the department or health services being involved in initiating or promoting that particular policy.

Mr LEANE — That initiative. Thank you.

Mr BATTIN — Underreporting has obviously been one of the big issues with violence against nurses. There are two reasons generally for underreporting: one, it is too hard — there is too much paperwork to do or it is too difficult to do; or two, there is no action so people feel that they have reported previously and there has been no action. With the setting up of the VHIMS system, what is going to be the process? The information comes back to you guys. How quickly will you guys go back to a specific hospital to say, 'You have an ongoing concern here or something we can identify from the data that has come through'? How quickly will they get response?

The reason I ask that question is that if a nurse has something happen to them and seven months later a phone call comes through from the Department of Health, by then they have already spread the bad word that it is a waste of time. How quickly will they get a response, and what sort of response will they expect?

Ms DIVER — It is probably an important time to emphasise that health services themselves are responsible for the day-to-day management. Where there is an incident and a nurse reports an incident, for example, it is up to local management to deal with the incident. Local management has a number of mechanisms to find out about local incidents: there is inputting data into VHIMS, and the health service will have local arrangements where management will see those reports — yesterday, the previous shift, the previous week, the previous month. Health services will manage that; I am not in a

position to comment on exactly how that will operate. I imagine it will operate quite differently in different health services.

My understanding of the role of the department in terms of getting the data — I am pretty confident but not entirely sure — is that it is a monthly submission to the department, but we would probably be looking at that data on a monthly or quarterly basis. It is really about informing policy and evaluation and providing data back to health services for comparative purposes. The data that is provided to the Department of Health is not about managing the response to an individual incident. It is up to local management to respond to a violent incident on a Wednesday afternoon in a maternity unit and deal with that particular incident.

If over time the department identified an increasing number of incidents in a particular area, then the department would be very interested in looking at that from a policy point of view to say, ‘What is happening here?’ and to talk to health services and talk to stakeholders, find out what the issue is and then respond in a policy sense. It will identify if it is a reporting issue or if it is a real issue, and it may be, and therefore what should the appropriate response be from the policy perspective of the department to assist health services in managing that individual incident.

Mr SYMONDS — The only thing I would add is that we have material and initiatives in place to educate health-care workers and their managers about their responsibilities in line with what Frances was saying. An example would be the occupational violence incidence resolution action pack, which has templates in it for expected responses, not just from staff in terms of reporting but also for managers in terms of responding and whole organisations. It includes working with the police et cetera. Frances is right: it is the responsibility of health services to manage incidents and ensure that health-care workers feel that reported incidents are dealt with and addressed. But we also have initiatives in place to ensure that health services and health service managers are aware of their responsibilities in the process.

The CHAIR — Can the system differentiate between the number of patients going through as to the reported incidents? We can only assume that there will be more and more patient traffic through the system and we expect the data should be able to reveal the increase in patient numbers as against the increase in incidents. We do not want to see a trend going up yearly because there are more patients — —

Ms DIVER — Because we are treating more patients.

The CHAIR — going through the system. Yes.

Ms DIVER — Sure. Those are dealt with through a number of means, such as the number of incidents per bed day or the number of incidents per separation or the number of incidents per presentation. There are ways of equalising the data so that you can present rates of incidents rather than the absolute volume of incidents.

The CHAIR — The history would be important as against the present to actually understand the protocols in place that are working.

Mr SCHEFFER — I have one final question, and it relates to policy. It is not a policy question of you, it is an operational one but it relates to policy generally. It has

been put to us that it would be a good thing if health services had proper security policies for their services; they seem to be non-existent at the moment. Is there any work going on inside the health department to include that as part of service agreements?

Ms DIVER — In terms of service agreements, we have a system of a statement of priorities with our major health services. Our largest 40-ish health centres have a statement of priorities, which is a relatively brief document by design that focuses health services on the key priorities that the government has and that the health service has. Sitting behind that are the policy and funding guidelines. The policy and funding guidelines outline the responsibility of health services in terms of their legislative requirements — meeting WorkSafe or WorkCover or occupational health and safety requirements. I would need to take on notice whether there is anything contained in that about health services having a requirement to have a security plan.

Mr SCHEFFER — A security policy.

Ms DIVER — Sorry, security policy.

Mr SCHEFFER — Our understanding is that they have a lot of plans, but that they do not — —

Mr LEANE — They have procedures.

Mr SCHEFFER — Yes, procedures, but they do not have a policy.

Ms DIVER — Yes. The policy framework from the department is headed *Preventing Occupational Violence in Victorian Health Services*, which maybe you have seen. Contained within this is the policy principle:

Health services must have an integrated health workforce policy that acknowledges the imperative to provide safe and healthy workplaces and that specifically recognises the prevalence of occupational violence in health care.

It is a broadly stated requirement, but I would not be able to tell you if it is contained within the policy and funding guidelines right now.

Mr SCHEFFER — That is probably enough. You have pointed us to that. Thanks.

The CHAIR — Are there any other questions from the committee? Are we able to access those policy procedures and documents over and above that particular one that is freely available, which many of the committee members have seen?

Ms DIVER — I have a bunch of things that are available, and I am very happy to leave them for the committee.

The CHAIR — Just the laws and protocols in relation to occupational health and safety in the workplace in public hospitals.

Ms DIVER — Sorry, what was that?

The CHAIR — The laws and protocols in relation to security arrangements in public hospitals.

Ms DIVER — Are you talking about the Occupational Health and Safety Act and the legislation?

The CHAIR — No. I do not want a copy of the act. I am just wondering about the one in relation to policy in the Department of Health in relation to security in hospitals. Is that the only document?

Ms DIVER — This is the key document. There are a number of other documents such as the management of weapons in health services, and there are also some documents in relation to the Department of Health and Victoria Police protocol for managing mental health patients, ambulance transport of people with mental illness, the occupational violence incident resolution action pack. I am sure you have the task force recommendations. I am not sure if you have this, which is an analysis of code grey and code black events in four Victorian hospitals. Those are the main documents that I have brought with me, plus a few other posters and bits and pieces.

Mr SCHEFFER — You are sort of — —

Ms DIVER — I am very happy to leave them with you. If there is anything in there that — —

The CHAIR — If it is all right with you, I might ask our research officer to chat with you after this session and see what documents she might need help with.

Mr SCHEFFER — Also on the task force stuff too, just to get that tightened up.

Ms DIVER — Sure — the four things that had not been considered to have been implemented by us?

Mr SCHEFFER — Yes.

The CHAIR — Thank you very much. We really appreciate your time and again your availability to present to this hearing.

Committee adjourned.

DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into violence and security in Victorian hospitals

Ballarat—18 October 2011

Members

Mr S. Ramsay

Mr B. Battin

Chair: Mr S. Ramsay

Staff

Executive Officer: Ms S. Cook

Senior Research Officer: Mr P. Johnston

Witnesses

Mr A. Rowe, Chief Executive Officer;

Dr J. Cruickshank, Director, Emergency Medicine;

Mr T. Reinders, Occupational Health and Safety Manager; and

Mr R. Dekleva, Security Manager, Ballarat Health Service.

The CHAIR—Welcome, members of Ballarat Health. I chair the joint parliamentary committee of Drugs and Crime Prevention. Whatever you say will be recorded and used as part of our evidence collection for our recommendations to parliament. Given this is a parliamentary inquiry, there are some conditions in which you provide evidence, and some of you would have done that before, I am sure, and others may not have. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. I understand you have received and read the guide for witnesses presenting evidence to a parliamentary committee. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity. You can correct it as appropriate. We also do have media coming in and out during the afternoon in relation to the evidence provided.

This part of this hearing is in relation to a second reference that was provided by the Minister for Police to us to look at security in emergency departments of public hospitals, and in particular to that reference was the item of armed protective service officers—PSOs—in emergency departments. As part of that reference obviously we are looking to get a view from the hospitals. Andrew, I understand you will be the lead speaker, thank you.

Mr ROWE—First of all if I could thank you for this opportunity. Security of our staff has always been of paramount importance to us, and certainly as an organisation there is a lot we have done. In terms of the BHS presentation, Tim is going to go through a series of points. Certainly, Jaycen, as the director of the emergency department has very much first-hand experience, as does Robert, as our head of security who will also add to that as well. I will hand over to Tim.

Mr REINDERS—Thank you for the opportunity to talk here today. I guess our emergency department is no different to a lot of others you have heard about or know about across the state. We are obviously exposed to violence and aggression and we have this reported to us. What I have done is I have put dot points down to each of the four questions you have raised. I will go through some of that. Violence and aggression is heavily reported in the organisation. We do not get a significant number of injuries that come out of that but those injuries are identifiable type injuries but we know that there are stress levels and those things that people do not report or acknowledge but we know it happens out there amongst nurses and doctors.

We use VHIMS—Victorian Health Information Management System. It is provided to us by Public Health Services. We use that as a database for reporting and that is where we keep all our data. I believe the data goes straight to DHS anyway on violence and aggression. Based on that particular data we worked out over the last six years or so that 2.6 incidents per month were being reported through the emergency department, but we know that there are obviously far more than that, that does occur. 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.

We know that staff are under constant pressure with time, and the nature of the environment in emergency departments is obviously quite stressful. I am sure Jaycen will add to that because he works in there all the time. We know they are stressful and time-critical environments when dealing with emergency situations. The organisation has implemented over the last five or so years, an enormous amount of interventions, and across the whole of the organisation, to try and manage the issues of violence and aggression, the design of the emergency department—crime prevention through environment design—and processes we have for training of staff over a period of time. We also have an online violence and aggression training program which we assisted the Department of Health to develop. We have a whole range of policies and procedures. We have a zero tolerance to violence and aggression policy within the organisation. We have signage at all our main entrances, warning people and letting them know we have a zero tolerance to violence and aggression. We obviously have cameras and we have security staff. We have done just about everything that is required of us.

A few years ago Worksafe Victoria put out a framework for managing violence and aggression in the workplace and it had something like 20 or 30 recommendations and we have pretty much implemented the majority of those to some degree, and I think pretty much all of them—and some of them more so than others—we have been able to. We have done an enormous amount to combat violence and aggression within the organisation. We also have a violence and aggression committee which I chair. We meet monthly and we review violence and aggression statistics. We look at the documentation and we look at other issues that we think can be implemented to try and reduce the exposure to violence and aggression or at least manage it when it does occur. Certainly in areas like our emergency departments it is an unpredictable event. When people come in you cannot always predict that they are going to behave in a certain way or what is going to happen. But we have also developed pre-codes where we ask the ambulance officers, the police—and I think Rob can talk a little bit more about this if you like. But it is another method we have used to try and identify where somebody who is known to the organisation, or we know is going to come to the organisation and we can prepare for that as well. It gives us another way of being proactive around trying to identify when somebody may behave in a difficult manner.

We have also developed what we call violence and aggression response teams. These are people who are not security officers but they work within other departments, but they have been trained to assist security to respond to incidents of violence and aggression. They might work in the environmental health services department, they have a pager and when a code grey is called they will respond and, if needed, they will assist, but if they feel they are not required then they will go back to their job. There is a code black system as well within the organisation. We have done an enormous amount to try and manage and deal with violence and aggression within the organisation. As I said before, we have implemented virtually all of the recommendations made by Worksafe.

The CHAIR—Are you happy to take questions as we go along?

Mr REINDERS—Sure.

The CHAIR—You talk about different codes with repeat aggressive patients. Do you have any philosophy about non-treatment of repeat aggressive patients coming in?

Dr CRUICKSHANK—It actually depends on someone's competence. The principle of informed consent guides all treatment in the emergency department. Someone has to be informed about their care, and that consent is that they agree to have treatment or not have treatment and so on. The problem with someone who is violent or aggressive is that there are a number of medical and traumatic conditions that can cause that behaviour. If that person has low blood sugar or oxygen, or fell over and hit their head when they were intoxicated, it may be a medical cause of their bad behaviour. It is generally accepted that you would treat each patient on their merits, and after assessment of ruling out the medical cause as best you can, then you might determine at this stage that it is bad behaviour rather than the person being unwell, and at that point you might then have someone leave the premises. To turn someone away without a proper assessment may risk someone dying in the street. It is a necessary part of the emergency department that we have to sort through those patients.

The CHAIR—Do you have specialised rooms for assessments in those aggressive patients?

Dr CRUICKSHANK—We have two different places where we will look at those. 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.

Mr ROWE—We have certainly had patients that have a history of poor behaviour and aggression towards staff and we have entered into contractual arrangements with a number of these patients indicating that we expect a certain standard of behaviour from them. In addition, we have managed their attendance at the hospital and we may well have the security personnel present. There have been a number of patients we have indicated that unless their behaviour reaches a certain acceptable standard we will be unable to treat them. Generally speaking, those measures have been able to ensure that their behaviour has been reasonable and appropriate.

The CHAIR—Thank you.

Mr REINDERS—The pre-code also works for psych services. Rob deals a lot more with this than I do, but the concept is pretty much the same. If they have somebody who is already in the psychiatric unit but they have to have a meeting or a dialogue or someone with them, but they know they have the potential to act up, then

they will call security into their presence or to assist them with that. That is more or less what our pre-codes mean. I think it is a fairly new idea, is it?

Mr DEKLEVA—It was introduced about 18 months ago and it seems to be working. It has been taken on by the staff quite positively. We are a very strong advocates of a proactive approach to reducing or mitigating the risk that staff can be exposed to with the potential of violent patients. It normally gives us sufficient time to be able to develop a strategic approach to how to deal with that, whether a patient is being presented either through ambulance or by police members or the patient has already been admitted and their behaviour is escalating as a result of the treatment not achieving the desired outcomes. What it does with limited security resources, we can support the security resources with trained violence and aggression team members. We can approach and develop a strategy with the nurse unit manager or nurse in charge as to what the care plan would be for that particular patient during that foreseeable period where that patient may escalate. Normally the escalation is a result of them being advised of something that they do not want to hear, particularly in our psychiatric facilities where a patient is going to be presented to a medical board, and the outcomes of that medical board may be of a negative outcome for the patient, or there has been a history of those types of patients escalating, not wanting to accept the findings of the board.

In the past those situations would be dealt with as a post-incident; wait for the patient to escalate; wait for the patient or the client to demonstrate violence and aggression or potentially injure a staff member and then there would be a security response. We have turned that around and have taken a different approach; be on the front foot, have the right support services there for the patient to reduce the likelihood of them escalating as a negative result of their treatment.

Mr BATTIN—Do you record those incidents then?

Mr DEKLEVA—Yes.

Mr BATTIN—A pre-code and then the results of what happened.

Mr DEKLEVA—I record those. We do not record them on the VHIMS system unless the incident escalates, but I record it for my own statistical analysis but also to be able to gauge the success of that particular strategy and I am finding that that has reduced 50 per cent of those potential incidents from ever escalating because we have a sufficient number of resources there to manage that patient and their care plan, or to be able to implement their care plan as a result of those findings.

Mr REINDERS—Another thing we have done recently is we have moved our security officers offices next door to the emergency department waiting room with one-way glass. They are right there if anything should happen. While we welcome the government's initiatives with armed guards and things like that, I do not think the armed guards are a solution for the emergency department, but assistance with increased security per se would assist the organisation to increase its security cover, especially across the organisation as well. While we do have training programs for aspects of the organisation—obviously we are a big organisation with aged care, psych, acute nursing, allied health and all that and we do have training for a variety of these areas—it is an ongoing issue. It is a constant issue for us trying to maintain the

training as we get new staff or we want to run refreshers and things like that. Support in that for us would assist our organisation in continuing the improvement strategies that we have already implemented to try and maintain them, and to continue to have additional training all the time for staff would be useful for us.

Mr ROWE—Logistically speaking 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 it. We need to backfill to ensure that they have the time to do it. That is a significant issue for us. As an organisation we do not support the arming of security personnel. We believe that would probably inflame a number of situations. We do enjoy a good relationship with the local police, and if there are situations that are out of our control then we certainly have mechanisms and processes in place to notify the police and we generally get a very quick and good response from the police force.

The CHAIR—Andrew, to put us in the picture, and in light of Robert's presentation, do you currently engage security officers in-house that are employed by the hospital?

Mr ROWE—Yes, we do.

The CHAIR—Are they trained under any specific accreditation in relation to particularly hospitals or emergency departments?

Mr DEKLEVA—There is not a security accredited or a training qualification for security officers for health services. All the officers that I have are security accredited. They have undertaken training which has been accredited for hospital staff or clinical staff, but there is not anything in the industry that is nationally recognised or within the state to be specifically designed for security personnel in the health sector to deal with violence and aggression.

Mr BATTIN—Do you see a need for national accreditation?

Mr DEKLEVA—Absolutely. Having this dialogue with other security specialists within other health services we all feel very passionate that there needs to be a form of national accreditation in training. There is one for the hospitality industry where security officers work in that environment, there are for security officers working in aviation and so forth. I do not see this being a sector that does not require a specific form or model of training to deal with the specific needs of the health services sector.

Mr ROWE—I think Rob is right insofar as when you consider the complexity for some of the situations that our staff find themselves in, for example, there 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. There are also patients affected by drug and alcohol. We also come across distressed relatives and people that are in an extreme form of grief. We also have acutely unwell psychiatric clients. We also come across intellectually disabled patients. In recent times we have seen more patients from Corella which is a facility

for sex offenders in Ararat and they are routinely admitted to Ballarat Health Services for treatment. The situations that our staff come across can be incredibly complex, incredibly difficult and I would certainly support an accreditation process and additional training for our security personnel.

The CHAIR—Thank you.

Mr BATTIN—Has your hospital undertaken any specific studies into the ongoing violence, or the violence that has happened in the hospital? Take away the recommendations from the outside; your own recommendations that you have implemented at a local level that you think could be used at the hospital?

Mr ROWE—We were involved in a research project a number of years ago which essentially identified the magnitude of the issues that we confront. We certainly have response processes in place. We have signs at all our entrances indicating we do not tolerate certain behaviours, we have zero tolerance. In relation to new staff in orientation, we give them a firm grounding on the processes we have in place to protect them in the workforce. We also have debriefing and counselling to assist staff who are going through a difficult situation. I cannot answer whether all other hospitals have the arrangements in place that we do, but we are constantly reviewing what we need to do to improve, and if there are things identified that we can do further we certainly will undertake them. Jaycen, have you any thoughts as to what further actions we might be able to undertake?

Dr CRUICKSHANK—I have a clinical research program in the emergency department and that does not feature. However, some of the things we do overlap with other programs. We implemented a system of stickers for our notes as a prompt to standardise the care of the patient. Education is great but it was probably delivered some time in the past. Whenever we have anyone restrained—and that includes physical restraint, chemical restraint, includes having someone preventing you from leaving by being nearby and stopping you from going—we are obliged to put a fairly large sticker on the notes, and it has prompts and tick boxes which helps us. We document the reason we restrained the patient; by what means, and there are some prompts about medication and escalation in there. We have used research in other areas to show that using stickers and prompts in documentation standardises the care and also helps you prove later on that the care was adequate, by having adequate documentation. We have implemented that program, we have audited it and we have good compliance with it.

In terms of taking the next step to clinical research it is quite hard to measure the outcomes. Often that is one of the challenges for performing researches, 'Well, what outcome am I talking about?' Our project is probably focused on risk management to standardise care and also to standardise our documentation and prove it was adequate where one particular case that was referred to the Health Services Commissioner, Beth Wilson, who said that on reviewing those notes that was the best set of notes she had seen and was the easiest to investigate because the notes were so clear and standardised. We have stuck with that program and we presented it at a health department forum which the Victorian Health Department organised here perhaps 18 months ago. That was presented to all emergency departments.

Mr BATTIN—Just one other thing, Jaycen, in the department, one of the things we continuously come across is under-reporting.

Dr CRUICKSHANK—Under-reporting is rife.

Mr BATTIN—Can you give any reasons why you feel that would be happening, the under-reporting?

Dr CRUICKSHANK—The next patient in the line, that is why. You make a decision—you would think if the head of department has not reported every incident he has been involved with, then you would say that is a bit of a worry because quite often, at 4.00 in the morning, in treating other patients, I have been involved with helping security guards restraining someone, and then there are other people waiting to be seen and you think, 'I can document this incident or I can go and see the next patient who might have—you know, that rash might be serious.'

Mr BATTIN—Yes.

Dr CRUICKSHANK—I think it is the pressure to deliver patient care and the doctors will prioritise the patient before the paperwork. We try and fight that battle as best we can but it is a fact of human nature, I think.

Mr ROWE—One of the contributing factors too is that we have seen a substantial increase in patients seen in our ED. 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.

The CHAIR—Can we get a picture of—given the VHIMS data collection in relation to reporting, and presuming there is a greater willingness by staff to report and, as Brad says, we have been hearing a lot about the under-reporting by staff for a range of reasons, and the increase in patients, how does that jell with the incidence of whatever it might be, the antisocial behaviour, aggression or requirement to provide security officers to quell the incidents? Is it up, is it down, flatlining?

Mr DEKLEVA—I utilise the VHIMS database for recording all the code responses and pre-code responses, but aside from that we have a patient observation provision that we provide to our key areas, where there may be a patient who has been assessed and is a high-risk patient, and subsequently requires security personnel to monitor that patient, rather than a nursing staff member. Taking that into the framework, I have done a statistical analysis of what the organisation has experiencing over a six-month period in 2009; the growth that the organisation has had in the number of patients that we have seen since then; the actual redevelopment of the hospital. We have a redeveloped emergency department. We have recently had a redevelopment of our maternity outpatients. Our psychiatric services has had a redevelopment. The organisation is growing. We have had a quite substantial number of patient numbers growth we have demonstrated through those reporting systems.

Mr ROWE—What Jaycen can do is contrast the results from VHIMS and other research.

The CHAIR—Andrew, just bearing in mind the time, you have obviously come with prepared presentations. We are happy to hear them but we would also like to ask questions. Do you want to do the presentations? We have not heard from Jaycen and I think we have partly heard from Robert. It is up to you, Andrew, how you deliver it.

Mr ROWE—I think we have pretty much covered the points that we would like to make and we would be more than happy to take questions.

Dr CRUICKSHANK—One point about education. If I can give you some information about data. We have data here from 2004 through 2010. We had 2.6 incidents per month of violence and aggression in the ED, but when we used a much simpler tool in the emergency department, 9.6 incidents per month over six months. The key difference was the staff had a much simpler tool to complete which in terms of time it was worthwhile, and the staff were engaged to complete that.

The CHAIR—Is that under the new data collection?

Dr CRUICKSHANK—We set up a very simple database.

The CHAIR—Your own, yes.

Dr CRUICKSHANK—Our own database which had much less information to be collected, and we had a much higher incidence of reporting there.

Mr REINDERS—We tried to find a more accurate idea of the number of incidents that were occurring and again we felt that the VHIMS, for the reasons that Jaycen mentioned before—it is a time critical environment and you do not have time to sit there. In other parts of the organisation and for other issues the VHIMS works well and people do report and have the time to sit down and report, but it is different in the ED because of the nature of the environment. We did find that using, as Jaycen said, the simplified data, we received far greater reporting and a more accurate idea of the total number of incidents that were occurring per month in that environment.

Mr BATTIN—It would be fair to say, Jaycen, one is a simple one and obviously the VHIMS one has more detail.

Dr CRUICKSHANK—Yes.

Mr BATTIN—I do not want to say any incident is better or worse, but for an incident that does not appear as bad, on the minor level, that you have less information, so something on the simpler form would be fantastic. Then obviously there are certain incidents that you have to have full reports because of the fact you have injuries and what have you.

Dr CRUICKSHANK—The simple tool was completed when we needed security present. Whether it was simple or had escalated, every time we had security present as a 'just in case' or because we needed them, that was the reporting. That was

what the staff were engaged in, was to say, 'Well, if you think you need security presence to be safe then we should document that, and if you do not document it then you're not going to be able to make your own workplace safe.' That is how we motivated the staff. I agree with you there might be some slightly less severe incidents but one of the policemen who participated in our training has never been involved in a physical confrontation because he is such a good de-escalator. Part of the violence and aggression training, the response is to get there and de-escalate the situation quickly before it gets out of control.

Mr BATTIN—I have not seen VHIMS, how it works, but would it assist in the hospital if VHIMS was addressed, when you are entering the details you say, 'It's only a verbal, someone swore at me. Here's the incident.' You do not need to put in any more details, but as soon as it says, 'Was someone belted?' it will click back and that is when it starts to go into more information. Would staff then—for the minor ones they could, as I said, do in a minute, but the major ones they have to understand obviously it is going to take a lot longer, from the hospital's point of view, so they can put in what is going to happen later on.

Dr CRUICKSHANK—My philosophy is only collect data that you intend to use.

Mr BATTIN—Yes.

Dr CRUICKSHANK—That suggestion you make seems very reasonable which is do not collect an enormous amount of data about minor incidents.

The CHAIR—Except the only issue I see there is when the data is provided to the Department of Health in relation to a holistic approach to incidents it could skew—you might have an intimidation that might be recorded as an incident in Ballarat but in Dandenong it is not intimidation, it is a screwdriver at your throat which is totally different.

Mr ROWE—If you are not seeing a total number you are probably not then able to pick up some of the trends.

Dr CRUICKSHANK—I would like to comment specifically on training if that is okay.

The CHAIR—Yes.

Dr CRUICKSHANK—Will we get staff in emergency departments who are qualified to deal with violence and aggression. I do not support weapons in the department under any circumstances, and whether that is capsicum spray or guns and stuff, we do not like it. We think that situation will potentially get out of control. In terms of qualified staff we support security staff rather than the police. I think medical staff and nurses need to have the skills. I am a qualified emergency specialist. It is in our curriculum for emergency specialists to deal with aggressive patients, and it is dealt with in the same level of importance as a trauma patient. It takes the same level of resources—six nurses and a couple of doctors—to get this patient under control, as it does for a seriously injured patient. I think these people need to be dealt with in that way.

The national curriculum framework for junior medical staff includes being competent and dealing with aggressive patients in their education as well. Medical staff should be qualified to deal with it. The majority of it is the medical factors, good communication skills and de-escalation. 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. They are more likely to go and do other things. I do not think there is the quality of courses for medical staff to attend at the same level as resuscitation, when they really are quite similar in terms of patient risk.

Getting staff to utilise their education entitlements to go and undertake training is important, and there is the balance between on-site education, which has been covered already, it is very labour-intensive but there certainly has to be elements of our current training, and certainly online training where you can do a lot of the pre-reading at home. It minimises in our face-to-face training the amount of time you take your staff away from the clinical environment to get education. Any online modules like that would be greatly appreciated.

The CHAIR—Thank you, Jaycen. Robert, do you have anything further to add?

Mr DEKLEVA—It has been mostly covered by the other members here and I am more than happy to answer any questions on specific items you want further information on.

The CHAIR—No, we are fine.

Mr ROWE—Probably the key things, as we see it at the moment, in terms of trying to move forward and address this problem, we believe that appropriate training of staff is a key point. We also need assistance in relation to undertake that training by removing a staff member from the workforce and being able to backfill them. That is a key point. We also believe additional security personnel would greatly assist us. In addition, like many emergency departments, we have seen very substantial increases in the numbers coming through. I think commensurate funding increases to recognise the greater numbers coming through is also a key point.

The CHAIR—On that, Andrew, if there is a requirement for more security in your hospital, why isn't the board of management appropriating resources to that?

Mr ROWE—It is like a lot of things insofar as there are competing priorities. There are a number of significant critical needs that we have as well. We simply cannot afford to put the level of resourcing into security. We believe it is satisfactory but in an ideal world we would certainly increase the levels of security personnel. We also believe in terms of reporting that the existing system is a disincentive to report and the VHIMS system, which is a recently introduced system, is onerous and continues to lead to under-reporting. We think something needs to be done there to make the system easier to utilise. Also in relation to security personnel in terms of accreditation and training, we would also support that as well.

The CHAIR—Thank you. Would you be happy if we took your presentations and used them as part of the inquiry?

Mr ROWE—What we would like to do, having had this discussion, is to make a number of changes, refine it and submit it to you, if that is okay.

The CHAIR—Yes. This inquiry is due to be completed—in fact it is being written now—before the end of December. So there are time issues in relation to providing further evidence, particularly for the staff—

Mr ROWE—We could have this to you in the next two days.

The CHAIR—Right. What I would personally like to see is if you could identify areas improving the VHIMS system. You have spoken about it, but maybe provide some detail about where you see the inefficiencies or the onerous nature of having to participate in such a data collection.

Mr ROWE—My understanding is—and I can be corrected on this—that the VHIMS system is basically an agreement by the states to comply with Commonwealth requirements to ensure a standard form of reporting across Australia. I am not aware of how it could be amended to overcome that problem but again we certainly would like to see some changes.

The CHAIR—Okay. So are we talking about—there is the old system of reporting and there is a new one that is to be rolled out, as I understand it.

Mr ROWE—It is VHIMS.

The CHAIR—Are we talking about the new one?

Mr REINDERS—The Riskman was the old system, and the new one is the Riskman system, it is just an updated version called VHIMS—Victorian Health Information Management System. It is an enhanced version of the old system. We have it and we have been using it for a while now. I think it is fully rolled out in Victoria from what I understand. In general it is designed as a clinical incident management system, not safety or anything else. The other requirement from it is the Department of Health only want violent incidents towards nurses reported on it. It needs to be enhanced in other ways as well. That is the data they want, whereas other people throughout the organisation are exposed to it as well.

In the main, the system works well, but in the ED, for the issues we mentioned before where it is time critical, it is time-consuming and onerous, as Andrew said, to add data in. If we can enhance some of the elements in it to make it quick and easy to use and, as Brad mentioned before, having some key information entered, then I do not have to—

The CHAIR—If you would like to identify that maybe in the refined presentation, we would appreciate it. Thank you very much for your time.

Mr ROWE—Thank you.

Witnesses withdrew.

Hearing suspended.