Progress on Occupational Violence Prevention in Victorian Health Services

Including a snapshot of the work arising from the Taskforce on Violence in Nursing
Progress on Occupational Violence Prevention in Victorian Health Services

Including a snapshot of the work arising from the Taskforce on Violence in Nursing
Acknowledgements

The Department of Health would like to acknowledge the members of the Victorian Taskforce on Violence in Nursing, the Implementation Reference Group and the various working parties and health service employees who shared their extensive knowledge and expertise in the Victorian health sector to inform this work. Also, the Heads of Workplace Safety Authorities work has been very useful in informing the outcomes outlined in the report.
# Contents

Summary of progress .................................................. 1
Introduction .............................................................. 4
Strategy 1: Setting the policy framework ......................... 5
Strategy 2: Raising awareness ....................................... 15
Strategy 3: Enhancing the justice interface ....................... 23
Strategy 4: Supporting education and training .................. 31
Strategy 5: Effective reporting and monitoring .................. 36
Occupational Violence Prevention Fund 2008–11 ............... 43
Future directions ......................................................... 55
Appendix 1 Taskforce recommendations and organisations with responsibility to lead implementation .......... 56
Appendix 2 Reference group membership ......................... 63
Appendix 3 HWSA compliance campaign ......................... 64
Appendix 4 Occupational Violence Prevention Fund: identifying risks and evaluating actions ............... 67
Summary of progress

The Victorian Taskforce on Violence in Nursing was asked to identify and review existing systems, procedures and policies in place in Victorian health services and recommend strategies to reduce the incidence of violence. The extensive experience of the taskforce members provided a valuable contribution to the development of solutions which culminated in 29 recommendations.

The department was responsible for ensuring the implementation of a number of the recommendations, whilst health services were also responsible for the direct implementation of some recommendations.

The work required strong engagement with the sector and a focus that included local solutions to local problems. The department played a major role in identifying and disseminating best practice in the prevention and management of occupational violence. Clearly, health services did not start the process of implementation from a level playing field, so the department played a large role in promoting greater consistency and building capacity of health services in the prevention and management of occupational violence. Accordingly, distribution of available resources required an equitable approach, which considered the varying needs of health services.

Evaluating and reporting on the implementation required the development of a program logic. At the outset of the program implementation, the department’s evaluation team worked with Nursing and Midwifery Policy to develop a framework for assessing the impacts of the work undertaken. The first key rationale for the work was that occupational violence adversely impacts on health workforce retention and service provision. The second rationale for the work was that the taskforce had identified community attitudes and organisational culture as key factors contributing to violence against health workers. These factors are much harder to quantify and often there is a considerable lag time between implementation and culture change. Therefore, the feedback sought from health services post implementation included qualitative impacts in addition to the fiscal accountability requirements for program funding. This included both subjective and objective views, including responses from staff, clients and visitors. The feedback has helped to identify future requirements and options for the prevention and better management of occupational violence against nurses and health workers.

The program logic for the evaluation was agreed to by the implementation reference group, which was appointed by the Minister and included representatives from health services, WorkSafe and health sector unions. The improvements sought through the implementation and evaluation through the program logic included:

- improved awareness of the impact of violence in health care settings
- improved collaboration between health services and police in managing violence (refer to the Building Better Partnerships Project on page 29)
- improved health service understanding of and compliance with relevant legislation
- improved availability and analysis of occupational violence data (refer to strategy 5 page 36).

1 A program logic is a way of presenting the theory behind a program’s actions. It describes the assumptions or hypotheses about why the program will work, showing the presumed effects of activities or resources. It is a tool which identifies the links in a chain of reasoning about ‘what causes what’ and links resources, activities, outputs, impact and outcomes. A program logic can be used as a tool to reveal and examine the assumptions that underlie program strategy and to identify risks.
Further medium term impacts sought were targeted training, improved worker satisfaction with the management of workplace violence and maintaining the community perception of health service environment safety. This report will demonstrate the achievement of the short and medium term impacts set out in the program logic. It also outlines case studies of taskforce members and staff feedback about prevention initiatives.

Results of a national compliance project related to taskforce recommendations

Impacts of the implementation are demonstrated through the results of the Aggression Management in Hospitals Intervention and Compliance campaign undertaken by the Heads of Workplace Safety Authorities (HWSA) (refer to page 64 for more information). The purpose of the HWSA health service aggression management project was to:

- assess the quality and reliability of reporting systems within designated areas of workplaces in relation to aggressive behaviour
- assess the validity of risk assessments within workplaces in relation to aggressive behaviour
- assess the level of aggressive behaviour-related risk controls within workplaces and compare this level of risk control with existing standards
- evaluate, where appropriate, the effectiveness of past and current control initiatives
- improve the industry’s (for example, CEOs, managers, OHS personnel and workers) and key stakeholders’ awareness and knowledge of the risks associated with aggressive behaviour through the provision of information to assist them to recognise and evaluate the risks in their industry and inform them of ways to effectively eliminate or minimise risks to people’s health, safety and welfare
- raise the awareness of best practice and the possibility of sanctions resulting from non-compliance with safety requirements.

The outcomes of the project demonstrated a high level of compliance in the areas of policy and procedures, design, incident investigation, training and incident reporting systems for Victorian public sector health services. This report contains results from the project. Throughout the document, graphs are used to demonstrate the level of compliance in Victoria compared with the national average.

Whilst it is important to acknowledge the good work that has been done in Victoria, there is always a need for health services to be vigilant in the provision of a safe and healthy workplace. That is why the work included a focus on the continuous feedback loop for prevention and management of occupational violence.
## Program logic – underlying intention of the Occupational Violence Prevention initiative

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Key activities</th>
<th>Department of Human Services</th>
<th>Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational violence on health workforce and service provision</td>
<td>Review taskforce recommendations for workplace violence prevention</td>
<td>Occupational violence policy framework</td>
<td>Occupational violence prevention policy framework</td>
</tr>
<tr>
<td>- The 2005 Victorian Taskforce identified community attitudes and organizational culture as key factors contributing to violence against health workers</td>
<td>Identify and prioritise occupational violence prevention strategies to address identified risks</td>
<td>Identify and engage key stakeholders</td>
<td>Develop occupational violence prevention policy framework</td>
</tr>
<tr>
<td></td>
<td>Recruit staff to support rural implementation of occupational violence policy and literature</td>
<td>Establish relationship and develop reporting protocols with local police</td>
<td>Develop statewide policy on managing weapons in health services</td>
</tr>
<tr>
<td></td>
<td>Establish reporting and collaboration protocols with local police</td>
<td>Continuously monitor HS data to improve management of occupational violence</td>
<td>Develop occupational violence reporting and monitoring requirements</td>
</tr>
</tbody>
</table>

### Impacts

<table>
<thead>
<tr>
<th>Short term</th>
<th>Medium term</th>
<th>Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved awareness of the impact of violence within healthcare settings</td>
<td>Improved management of violence in healthcare settings</td>
<td>Improved retention of health workers</td>
</tr>
<tr>
<td>Improved targeting of violence prevention and management training</td>
<td>Improved health service understanding and compliance with relevant legislation</td>
<td>Improved health worker satisfaction with the management of workplace violence</td>
</tr>
<tr>
<td>Improved targeting of violence prevention and management training</td>
<td>Improved health service understanding and compliance with relevant legislation</td>
<td>Improved health worker satisfaction with the management of workplace violence</td>
</tr>
</tbody>
</table>

### Key activities

- Review taskforce recommendations for workplace violence prevention.
-Occupational violence policy framework.

### Department of Human Services

- Occupational violence policy framework.

### Health Services

- Occupational violence policy framework.
Introduction

In 2004, the Victorian Government established the Victorian Taskforce on Violence in Nursing (‘the taskforce’) to examine key issues and recommend strategies to address occupational violence against nurses and midwives.

The taskforce brought together government, industrial, regulatory, health service and clinical nursing representation to provide strategic advice to the government regarding:

- violence and bullying in the workplace directed towards nurses
- strategies to reduce the occurrence of violence and bullying.

In its final report (Department of Human Services Victoria, 2005), the taskforce made 29 recommendations aimed at addressing the problem of violence against nurses and midwives in a more consistent and coordinated manner. The report can be accessed at http://www.health.vic.gov.au/nursing/promoting/noviolence#tb12

For a full list of the recommendations and the lead organisations refer to appendix 1.

The implementation of the recommendations was overseen by a high-level reference group of stakeholders, including representatives from unions, WorkSafe and health services, and human resource directors. The reference group monitored progress of the implementation of the recommendations from the taskforce. A full list of reference group members is provided in appendix 2. The group met two to three times a year between 2007 and 2011 and received nine status reports. The status reports that were provided to the reference group were published on the Nursing in Victoria web page.

Activities from the department were led by Nursing and Midwifery Policy, with involvement from various other areas of the department, including Mental Health, Aged Care, Capital Management Branch and Quality and Safety Branch.

The Occupational Violence Prevention Fund (refer page 43) was administered by a fund manager and two working groups supported strategies three and five (see below).

This document describes the key learnings, experiences and outcomes of the implementation of the taskforce recommendations. Using the five strategies as a guide, it highlights key themes, case studies and summary data to provide a summation of the vast work undertaken.

Implementation approach

Strategic areas of focus

The 29 recommendations made by the taskforce fit logically into five strategic areas of focus, namely:

**Strategy 1** Setting the policy framework

**Strategy 2** Raising awareness of the importance of violence and bullying prevention and management

**Strategy** Enhancing the interface between health services, the police and the justice system

**Strategy** Ensuring that education and training for the prevention and management of aggression reflects the organisational context and the needs of the employee

**Strategy 5** The development of effective reporting and monitoring systems, including a standardised minimum data set that will enable health services to report, monitor and compare incidence of bullying and violence
Strategy 1: Setting the policy framework

Strategy 1 focused on the development of a framework that includes a policy statement, uniform definitions of bullying and violence, and tools and examples to assist in local implementation.

**Incorporating recommendations: 1–4, 9, 10, 13–16, 22, 23 and 26**

The recommendations in Strategy 1 included the requirement for the department and health services to take a more consistent approach to the prevention and management of occupational violence. This includes the use of uniform definitions, having a clear policy statement and statements of expected behaviour, and adoption of a standardised code grey.

**Focus**

The implementation of the recommendations associated with Strategy 1 focused on:

- achieving greater consistency for a more systematic approach
- building capacity of employers for local solutions to local problems.

**Activities**

**Greater consistency**

Health services are social institutions that reflect the communities in which they exist and can have an impact on the society for which they provide healthcare through their organisational culture.

The risk management process in the implementation framework represents the basic preventative philosophy of occupational health and safety. It involves recognising and managing risk to the psychological and physical safety of employees, contractors, volunteers and visitors in the workplace. Prior to the implementation, many health services were working in isolation to address the problems of occupational violence, with varying degrees of success.

The best way to achieve positive cultural change in prevention of, and response to, occupational violence is to have a consistent approach. Packaging and disseminating best practice, consistent definitions, reliable approaches and facilitating information sharing were key activities for this strategy.

A policy framework and resource kit was developed and distributed for local implementation through health service occupational violence prevention reference groups. It included information about the application of a risk management process consistent with the preventative philosophy of occupational health and safety legislation and regulation.

The implementation provided an opportunity for stakeholders to raise issues and concerns confronting them in their workplaces, including matters that were believed to be ‘grey areas’ and where there had been no consistent formal information provided. Concerns were raised in relation to restraint, reasonable force and self-defence, which had the potential to expose health services to unintended and hazardous consequences. Stakeholder forums provided a non-punitive environment where health service representatives were able to describe and explore real examples of where they were unsure of their legal standing and had not been confronting vital issues.

---

2 Bold type is used to highlight recommendations that the Department of Health was the lead for/nominated to implement.
As a response to this, the policy document *Preventing occupational violence in Victorian health services: a policy framework and resource kit* (Department of Human Services, 2007) provided clear and concise information about the legal rights and responsibilities of health services in relation to restraint, reasonable force and self-defence. This resource has been updated to reflect changes to legislation, particularly in relation to weapons (Department of Health, 2011).

**Figure 1: Heads of workplace safety authorities (HWSA) audit results – aggression management policy**

Figure 1 provides the results of a compliance audit undertaken by HWSA (see page 64 for detailed information about the project) in 2009 in relation to public sector health service policies for aggression management. It compares Victoria’s results with the national average. Criteria for assessment included: the existence of an endorsed policy, staff awareness and consultation around the implementation of the policy, inclusion of a risk management approach, and explicit management commitment to the policy.

The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 0-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.
Code grey

The theme of greater consistency extended the taskforce’s desire to introduce a statewide definition of code grey. Code grey is an alert to elicit a rapid clinical response to a situation of anticipated danger or risk by a person towards themselves, other patients, staff members or visitors. This type of response may involve verbal de-escalation or restraint of a potentially aggressive person by an emergency response team trained in aggression management. Code grey has had demonstrated positive results when used in Victorian health services. It is activated when an unarmed person becomes verbally or physically aggressive such that they present a danger to themselves or others; requires physical or chemical restraint as part of clinical management; or uses physical aggression to destroy property. The health services plan for the identification, assessment and control of the risk of occupational violence and this planning process should involve appropriate medical, nursing, administrative and clinical staff.

Case study 1: St Vincent’s Health

**Code Grey and Incident Investigation**

St Vincent’s Health established and implemented a Code Grey response that uses a set model with a fixed team and strict rules around the response. The Code Grey is explained and promoted to all staff so that everyone is aware of its operation. The Code Grey response is a clinical rather than a security response that involves a six person team led by a medical registrar and senior nurse. All Code Grey incidents are reported on Victorian Health Incident Management System (VHIMS). Since the system has been introduced, there has been an 18% reduction in verbal and physical assaults.

To progress the recommendation within a national framework, representations were made to Standards Australia to achieve national consistency. The status of the standard includes a code black which denotes a response to both an armed and unarmed threat. The code grey implementation included a 2007 survey of health services which showed that all respondents used code black to respond to an armed threat and 48 per cent of respondents used a code grey to respond to an unarmed threat. A number of health services sought funding through the Occupational Violence Prevention Fund to assist with the implementation of code grey. Assistance was provided by the department to implement the code grey in services that did not already have it in place through information provided in the policy framework document as well as funding through the Occupational Violence Prevention Fund.

3 For a detailed description of the Occupational Violence Prevention Fund refer to page 43
“We have worked on infrastructure changes and improved CCTV (closed circuit television) coverage and overhead paging. This is crucial in managing our code grey incidents. Prior to receiving funding for this improvement, it was impossible to feel confident in our response procedures. Recent incidents have shown that during a code grey the correct response personnel turn up to the event and others avoid the incident area.”

Small Rural Health Service, Quality and Risk manager

Prevention and management of bullying

The importance of greater consistency through the development and implementation of practical policies was highlighted as a major issue in relation to the problem of bullying in health services. To that end, the taskforce engaged a specific subcommittee to tackle the concerns.

The taskforce accepted the WorkSafe definition of bullying and recommended that the department and health services adopt that definition and use it consistently. Recommendations also included the adoption by health services of ‘consistent management strategies’ that include a clear organisational policy with a ‘safe’ reporting structure, timely and consistent response from management and support for ‘realistic’ outcomes.

The department provided information and links to WorkSafe bullying prevention literature in the Preventing occupational violence: a policy framework including principles for managing weapons in Victorian health services (Department of Health, 2011). An online resource directory provides direct and easy access to information and strategies to assist health services to respond immediately, appropriately and effectively to incidents of, or the risk of, bullying in the workplace; it can be accessed at http://www.health.vic.gov.au/nursing/promoting/noviolence/bullying.
Case study 2: Taskforce Bullying Prevention Subcommittee

Bullying Prevention Subcommittee

“I elected to go onto the Bullying subcommittee as I felt that there was probably a considerable amount of bullying that occurs in the workplace, it is underreported, and as a DON I have a duty of care to address this issue.

Our subcommittee on bullying was chaired by Bobbie Carroll who was the chair of the Metropolitan Directors of Nursing (DON) Group at the time. On this working party the DONs from Aged Care were also represented as well as Health Services Union of Australia, health services, human resource directors and Nurse Policy.

Our objectives were to:

• classify various types of bullying
• recommend strategies to prevent and manage bullying in the workplace
• recommend guidelines for use by organisation with respect to
  – policy development
  – implementation
  – risk management and monitoring systems.

We were also asked to recommend strategies to increase awareness to undergraduate nursing students and registered nurses, of issues associated with bullying.

I must admit I enjoyed my time on this working party. We reviewed current literature, debated issues and discussed how we could enforce no violence without being accused of violence ourselves, and issues of performance management without the risk of being accused of bullying. We discussed how withholding information constituted a form of bullying and how rostering could be used as a control over staff. We discussed how we could develop a nurturing environment with students and grads when in some work environments the practice of nurses ‘eating their young’ is accepted. We realised that we need to support our students and grads and that a culture of bullying is a sure fire way of culling the crop. In the end we decided that the culture of the organisation is pivotal in developing resilience and nurturing. We need to give nurses the courage to speak up and the systems to protect them.

By developing policies and guidelines we anticipated that this would give nurses and managers a clearer picture to follow. It would remove some of the subjectivity that often plagues nurses when acting on or reporting occupational violence. We wanted to ensure that it didn’t matter whether you worked at a major metro health service or a small bush nursing centre that clear guidelines could be followed.”

Maxine Brockfield Rural CEO, Executive Director of Nursing, Reference Group member
Building capacity of employers

The devolved governance structures that are a key feature of the Victorian public health system mean that health services are accountable for managing the services they provide. Hence, a number of the recommendations required health services to undertake certain activities for the prevention and management of occupational violence. These included the requirement to establish an aggression management reference group to be responsible for the development of local policies and procedures. These were assisted by the policy framework and resource kit provided by the department.

The implementation process was able to support and build capacity in the system in a number of ways, including through the funding of regional resource officers.

The distribution and size of many of the rural health services meant they were potentially underserviced in terms of access to expert occupational health and safety advice. To address this, a facilitating resource was provided to each of the five rural regions to work with health services for a period of 12 months. The aim was to assist health services to apply a focused approach to assess the effectiveness of meeting their obligations and to aid in planning for remedial activities.

The occupational violence objectives of the regional resources were:

- to provide a shared regional service to assist with information and resource sharing, collaboration and to facilitate the response to regional specific issues
- to establish and maintain networks
- to ensure a consistent approach to application of the Preventing occupational violence in Victorian health services: a policy framework and resource kit (2007) at the local level.

Over the 12 months they operated, the regional resource officers were instrumental in establishing a baseline of status of implementation of Victorian Taskforce on Violence in Nursing recommendations. They assisted with establishing aggression management reference groups within health services, providing specialist occupational health and safety advice in relation to the prevention and management of occupational violence, and promoting best practice in relation to occupational violence prevention. The resource officers assisted health services in the establishment of appropriate procedures for the prevention and management of workplace violence.

Figure 2 details results of the HSWA audit relating to the development and implementation of an appropriate range of workplace aggression management procedures. The graph demonstrates the performance of Victoria in comparison with the national average. Prompts for inspectors to ascertain compliance included whether or not health services had procedures for sedation and restraint, warning and sanctions, file flagging, alternate treatment arrangements, contracts of acceptable behaviour and good practice indicators including consideration of the range of procedures in place, documentation, training in procedures, monitoring of response times, review and effectiveness of procedures.
Figure 2: HWSA Audit results – workplace aggression management procedures

The HWSA compliance project investigated health services’ ability to recognise deficiencies in design and areas of required improvement in hospital layout and design. The audit also examined whether or not information about design of the health service and its impact on occupational violence was easily retrievable. Prompts used by inspectors included reviewing samples of incident reports and risk assessments. Figure 3 shows that 95 per cent of Victorian health services audited were compliant in this area, comparing favourably to the national average.
Figure 3: HWSA Audit results – design

The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 0-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.

“Not only is it a safe environment it also protects the dignity of the patients”

(quote in relation to process in a metropolitan emergency department of having a separate entrance and procedure for patients who are displaying a potential for violence)
As part of the implementation, the Occupational Violence Prevention Fund 2008–11 was established to help health services remediate their highest priority risks. Related to Strategy 1, the following are examples of the work undertaken:

<table>
<thead>
<tr>
<th>Health service/hospital</th>
<th>Fund round</th>
<th>Initiative funded</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon Health</td>
<td>2</td>
<td>Code grey</td>
<td>Barwon Health has successfully met the requirements for code grey to align with common/best practice throughout Victorian healthcare facilities. Barwon Health has:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• altered relevant policy and procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• provided education and/or training to the various levels of responding members of the emergency team/s and all staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• updated resources and materials, including the provision of the updated personal information to all staff that is carried with their Barwon Health identification.</td>
</tr>
<tr>
<td>Otway Health and Community Services</td>
<td>2</td>
<td>Alterations to emergency (urgent) care unit</td>
<td>Nurses’ station is now secure and staff report feeling safer and less exposed.</td>
</tr>
<tr>
<td>Inglewood and District Health Service</td>
<td>1</td>
<td>Installation of security doors and sign in procedures. Upgrade of after hours monitoring with access control</td>
<td>Survey of staff post-implementation indicated a high level of satisfaction with measures undertaken.</td>
</tr>
<tr>
<td>Western Health</td>
<td>1</td>
<td>Occupational violence audit</td>
<td>The audit was completed in December 2008 and the detailed final report was presented to key committees for review. A risk management plan was developed as a result of the findings in the report.</td>
</tr>
<tr>
<td>Dunmunkle Health Services</td>
<td>1 &amp; 2</td>
<td>Installation of CCTV and duress system. Upgrade of front entrance doors.</td>
<td>Enhanced security, with staff reporting they feel more secure, particularly during night shift when staff levels are reduced – now have the ability to monitor and control who has access to the facility.</td>
</tr>
</tbody>
</table>
For more information about the Occupational Violence Prevention Fund 2008–11, refer to page 43.

Resources developed during implementation


These documents are available to download from:
Strategy 2: Raising awareness

Strategy 2 focused on the development of a communication strategy including a public awareness campaign.

**Incorporating recommendations: 5, 8 and 11**

Strategy 2 recommendations included the development of education and awareness for the community, police and the judiciary to promote a better awareness of occupational violence. It also required health services to establish an aggression management reference group to develop policies and procedures around the management of incidents of occupational violence, primarily through a clinically-led aggression management team.

**Focus**

The implementation of the recommendations associated with Strategy 2 reflected a focus on:

- changing expectations within the workplace and broader community
- promoting a positive culture where there is no place for violence
- collaboration and connections for successful dissemination of best practice

**Activities**

**Changing expectations**

Anecdotal evidence from the taskforce suggested a public perception that exposure to occupational violence was ‘part of the job’ and was expected. The challenge was to promote greater awareness and understanding of the impact of occupational violence on health workers and the difficulties it creates for staff, visitors and clients. While communication activities in health services need to be tailored to reflect the local context, the taskforce identified that the overarching objectives of all occupational violence communication strategies should be to:

- raise awareness about the impact of violence on healthcare workers
- promote the message that violence against healthcare workers is unacceptable
- discourage a culture of violence being accepted as part of the job.

Changing expectations relates to changing culture and it is very difficult to shift people’s entrenched views. Change needs to evolve over time and is difficult to measure. The best way to ascertain a shift in culture is to gauge whether there is improved health worker satisfaction. To gauge a change in community expectations is even more difficult.

Another area that required a shift in views was around the interface between health services and Victoria Police. While Strategy 3 contains a cluster of activity relating to this interface, specific work on raising the awareness of Victoria Police of the experience of nurses and other health workers was undertaken.

*Every day’s a challenge: responding to violence in Victorian health services* (Department of Human Services, 2009) is a multimedia resource developed in collaboration with Victoria Police and WorkSafe Victoria to promote greater awareness and understanding of the impact of occupational violence in Victorian health services and how it can make every day a challenge for staff, visitors and clients.

This resource used the experiences of real people, such as police and health care workers, talking about real experiences in their own words. It challenges viewers to think about their attitudes to, and beliefs about, violence in healthcare and how these affect others.
The following quotes are examples:

“It just makes us feel that it sometimes isn’t worth it if that’s what’s going to happen to us at work. We feel that we’re not important.”

Nurse metropolitan health service

“It’s very important for nurses to know that we have a code of practice and procedures and that we will investigate assaults and crime and criminal activity which may involve them or the hospital… also important that we have nurses not feeling vulnerable, that they will investigate, that they have rights and we will treat it seriously.”

Inspector, Victoria Police

“Even minor acts of aggression and violence can have a lasting impact on a person’s wellbeing”

‘When people are constantly getting hit or injured it really starts to wear on the team. People start to get ill… it’s called compassion fatigue.”

Paul Healy, Health and Community Services Union (HACSU) Assistant Secretary- Every Day’s a challenge)
Promoting a positive culture

The department developed and tested some messages that balance the need to convey a strong message that violence is unacceptable in our health services without having the unintended consequence of creating negative consumer expectations regarding the prevalence of violence. These messages were:

- A workplace free of violence and bullying. Everyone has the right to be safe.
- A workplace free of violence and bullying is a better place to care for you and your family.
- A workplace free of violence and bullying: A better place for work, a better place for care.

Health services were provided with information to support them to identify key stakeholders and develop local communications strategies and tools and a plan for managing issues. Advice was also provided around setting tasks and timelines, establishing a budget for communications, and methods of evaluating communication strategies.

Conveying the message about having a workplace free of violence is one way to influence workplace culture, which is one aspect of the aim of a more comprehensive ‘safety culture’. A number of the taskforce recommendations were aimed at approaching the task of cultural change from different perspectives. Safety culture literature outlines five interlocking components required for promoting positive cultural change: an informed culture, a reporting culture, a learning culture, a flexible culture and a just culture.4 Safety cultures evolve gradually in response to local conditions, past events, the character of the leadership and the mood of the workforce. Therefore, if there is a less than desirable culture in a workplace, positive change takes time and requires a multifaceted approach. The following case study provides an example of a health service that was able to identify a ‘change in culture’ through surveying staff to ascertain their workplace satisfaction.

---

Case study 3: Alpine Health

Safe Practice and Environment Committee

Alpine Health received grant funding through the Occupational Violence Prevention Fund 2008–11. This funding has been an important catalyst in Alpine Health’s analysis, actions and review of policy and operational position in relation to workplace-related violence and aggression.

Alpine Health’s Safe Practice and Environment Committee formed a working party which developed a plan of priority-based actions. This was augmented through regional links with occupational violence and aggression project approaches (Phase 1 and Phase 2).

Alpine Health was able to achieve a number of important and lasting contributions to the mitigation of occupation-related violence and aggression in the workplace, both for nurses and other staff who support the work of nurses.

Alpine Health measured the response of nurses to the initiatives and found:

- nurses responded positively to these initiatives both in terms of directly informing the extent and configuration of ‘solutions’, as well as playing a role in continuing to monitor their ‘fit for purpose’ as it relates to mitigating the risks associated with workplace occupational violence and aggression
- nurses have reported feeling supported by the inclusion of these initiatives
- recent results from the People Matter Survey (August 2011) indicate that staff feel more satisfied with their workplace.
Collaboration and connections

Prior to the implementation of the taskforce recommendations, health services were addressing occupational violence with varying degrees of success. Some health services had sophisticated local processes and procedures in place. The challenge was to harness the good work already being done and provide opportunities for the sharing of information and ideas.

The implementation encouraged connections and collaboration through bringing together interest groups to work on specific elements of the implementation. For example, during the development of the occupational violence prevention policy document, the security officers information sharing group (which was meeting regularly on a number of security issues) was given the opportunity to provide input into the document and outline some practical issues facing health services in relation to occupational violence. Similarly, the occupational health and safety managers group was consulted through the development of the policy framework.

The process for application for funds through the Occupational Violence Prevention Fund required health services to use an occupational health and safety risk management framework. This meant that directors of nursing needed to collaborate with occupational health and safety managers to be successful in their application.

Case study 4: Grampians Region

An example of a regional approach to tackling occupational violence

The Grampians Region consists of 12 hospital-based health services, four bush nursing centres and stand-alone community health centres, all spread over 40 sites.

The Grampians Region implementation was coordinated by a project officer who established the Grampians regional occupational health and safety networking forum (GROHSNF). The group was made up of key occupational health and safety personnel from each health service in the region. A review of health service occupational violence prevention and an audit of local implementation of taskforce recommendations were conducted. Implementation of recommendations included the development of e-learning packages, including an aged care specific e-learning tool. A working party developed a local policy suitable for regional and rural areas. The regular forum meetings provided health services the opportunity to share information and resources.

Health services were given assistance where required to navigate the process of applying for assistance for remediation through the Occupational Violence Prevention Fund. Over the three rounds of funding, the Grampians Region received more than $400,000.

For example, West Wimmera Health Service received funds for its Nhill and Jeparit campuses. Nhill External linked doorbells to nurse pagers so that after hours when a patient/client presents at one of the external doors staff are aware that they are there. Previously staff were only aware a patient was waiting outside if staff were at the nurses station and able to see them on the monitor or were able to hear the doorbell. This improved occupational health and safety through increased security for staff after hours and eliminating the risk of patients remaining unnoticed outside for a length of time. Jeparit received funding for the installation of gates at the nurses station, which will limit patients and residents walking into this area, thus improving security and safety for staff and information contained in this area.
Collaborating and connecting with WorkSafe

WorkSafe monitors compliance with the Occupational Health and Safety Act 2004 and its regulations; provides advice in relation to occupational health, safety and welfare; and engages in, promotes and coordinates the sharing of information to achieve the objects of the Act.

WorkSafe provided high level representation and advice to the taskforce and was represented on the implementation reference group and the justice interface working group. Its work with HWSA (see Appendix 3) also had a major focus on the area of occupational violence prevention.

In 2006, WorkSafe funded a project through the safety development fund to develop a handbook for prevention and management of aggression in health services. This project ran in tandem with the taskforce implementation and used an inclusive process which encouraged collaboration on occupational violence prevention. The resulting guidance document was complementary to the taskforce work and the occupational violence prevention policy framework. The document was adopted by other jurisdictions through WorkSafe Victoria’s representation on HWSA.

The collaboration between WorkSafe, the department, health services and the unions representing health workers enabled the development of a compliance tool (see page 67) which has been used for the Occupational Violence Prevention Fund (see page 22) and was also adopted by HWSA for their compliance project.

As well as working in partnership with WorkSafe, the following are other examples of connections and collaborations that assisted in ensuring that the useful findings of the taskforce have a sustained and integrated impact:

- Building better partnerships
- OH&S committees
- Regional consortia
- Victorian Health Emergency Managers Group
- Emergency Care Improvement and Innovation Clinical Network
- WorkSafe safety development fund project
- Justice interface working group
- Aggression management reference groups
- Implementation reference group
- OH&S managers group
- Security officers group
- Metropolitan and rural directors of nursing groups.

---

5 WorkSafe 2008, A handbook for workplaces: prevention and management of aggression in health services, 1st Edn, WorkSafe Victoria, Melbourne
Case Study 5: Best Practice Forum

Victoria Police and health services celebrate partnerships and share ideas and lessons learnt from occupational violence prevention initiatives

Assistant Commissioner Andrew Crisp and other representatives from Victoria Police, WorkSafe and public health services came together for a best practice forum on occupational violence prevention in Victorian health services. The forum was held at St Vincent’s Health Service on 2 December 2011 and hosted by Nursing and Midwifery Policy.

This special event celebrated the work across the state in implementing the 29 recommendations of the Victorian Taskforce on Violence in Nursing.

Highlighting the benefits of partnerships, it provided an opportunity for representatives from nurses, occupational health and safety managers, educators and security staff from health services across Victoria, as well as ‘experts in the field’, to share their initiatives and local approaches to creating a safer workplace. Topics included:

- taskforce and implementation from a rural perspective
- a design perspective on preventing occupational violence
- building and promoting partnerships to manage and prevent occupational violence
- the importance of training and education in managing and preventing occupational violence
- deterring, detecting and managing weapons in health services.
Occupational Violence Prevention Fund 2008–11

As part of the implementation, this fund was established to help health services remediate their highest priority risks. Related to Strategy 2, the following are examples of the work undertaken:

<table>
<thead>
<tr>
<th>Health service/ hospital</th>
<th>Fund round</th>
<th>Initiative funded</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yarrawonga District Health Service</td>
<td>1</td>
<td>Upgrade to security systems (CCTV &amp; duress alarms), signage and seating</td>
<td>The work was coordinated through the Safe Practice and Environment committee and required various staff to work collaboratively. The health service reported that the funding had a positive impact on focusing more on occupational violence and raising staff awareness.</td>
</tr>
<tr>
<td>Kyneton District Health Service</td>
<td>1</td>
<td>Signage and personal duress alarms.</td>
<td>Staff reported that the duress alarm system was having an impact across all of KDHS. They intended to purchase extra duress buttons that will work on the same system and provide back up for the nursing staff.</td>
</tr>
<tr>
<td>Dunmunkle Health Service</td>
<td>2</td>
<td>Replace electronic doors at front entrance</td>
<td>Staff reported that the new doors provided a more secure environment for residents, staff and visitors.</td>
</tr>
</tbody>
</table>

Resources developed during implementation


Multi-lingual cards which were developed using the key messages for the prevention and management of occupational violence.

Available at: http://www.health.vic.gov.au/nursing/promoting/noviolence
Strategy 3: Enhancing the justice interface

Strategy 3 focused on enhancing the interface between health services, Victoria Police and the justice system.

**Incorporating recommendations: 5, 6, 7 and 12**

The recommendations for Strategy 3 included developing education and awareness for the community, police and the judiciary to promote a greater understanding of occupational violence and its impact. The strategy also included recommendations to consider issues of occupational violence and current legislation; the development of guidelines for managing weapons in health services; and the development of procedures for the reporting occupational violence incidents in health services to police.

**Focus**

The implementation of the recommendations associated with Strategy 3 reflected a focus on:

- partnering and collaboration where openness and participation are encouraged
- proactive approaches where people learn from failures
- strengthening processes to encourage ongoing commitment.

**Activities**

**Partnering and collaboration**

The implementation of the recommendations to enhance the justice interface required the active involvement of the Department of Justice, Victoria Police, Department of Health, WorkSafe and health services. A justice interface working group was established to examine the taskforce recommendations and conduct an environmental scan. The group considered issues such as weapons, procedures for reporting assaults to police, laying charges and prosecutions and related matters.

The success of this strategy (as evidenced by the resources and partnerships developed) was due to the goodwill of participants in their endeavours to better understand each others’ roles and view issues from each others’ perspectives. Prior to implementation, some health services had longstanding and ongoing local relationships, but they were informal, working in isolation and often driven by individuals. The Building Better Partnerships project (see case study 9) provided the opportunity to form collaborative committees.

Productive relationships between health service representatives and Victoria Police meant there was a ‘go to’ person for problem solving when issues arose. The non-punitive environment of problem solving provided the opportunity to refine and document procedures and processes, ensuring a more systematic approach to preventing occupational violence when the police transport a person to a health service as well as when police are called to an incident at the health service.
“Confidence has increased in the management of patients with mental health, drug and alcohol and other challenging behaviours as well as prisoners and community correction clients. The collaborative agency committee known as CAPPP has been a very positive initiative supported by the Building Better Partnerships Project. It goes from strength to strength. Each agency gets a new appreciation of the work others do and more importantly, the limitations involved in providing service. This knowledge allows for the development of collaborative strategic solutions to local problems. These solutions are designed to get the best outcome for the patients and the community.”

Small Rural Health Service Quality and Risk Manager

**Case Study 6: East Grampians Health Service**

**A collaborative approach to establishing a behavioural assessment room**

Health services in the region had generally relied on police to attend when incidents became, or threatened to become, violent. There was little, if any, security at services and no facilities to deal with aggressive people. In recognition of the risks and in response to recent violent incidents, a liaison committee was established in 2009 including key personnel from police, prisons, psychiatry, GPs, disability construction contractors, Ararat GP service and Ambulance Victoria.

The committee worked strategically, focusing on matters of mutual interest in the provision of health services, including occupational violence and aggression. With OVPF funding over three rounds, the committee was able to establish infrastructure and processes, in particular:

1. duress alarm rollout and paging service integration with the nurse call centre
2. occupational violence training for all staff
3. CCTV and public address system
4. construction of a behaviour assessment room

“The development of the Behavioural Assessment Room has been a great leap forward in providing a safe environment for staff, patients and external agencies”

Quote: Small rural health service
Proactive approaches

Prior to implementation of the recommendations, situations and questions that arose in health services involving such issues as the presence of weapons, searching of clients and use of ‘reasonable force’ were often highly charged, high risk and reactive. The taskforce listened to feedback from health services about what had been occurring ‘on the ground’ and it was evident that a more considered approach was required.

The preventing occupational violence policy document (Department of Health 2011) provides clear information regarding ‘reasonable force’ and ‘search’ when it comes to dealing with weapons in health services. This clarity, together with health services working with their collaborative committees (and if necessary obtaining their own legal advice on these matters), ensures that health services can pre-empt any situations and have a better system of preventing occupational violence.

Case study 7: Southern Health

Joint weapons management procedure

Southern Health, as part of the Building Better Partnerships project, undertook as a priority issue the task of creating a documented joint local agreement between agencies regarding processes for best practice weapons management (with a metro focus) addressing key elements including:

- detection
- deterrence
- removal
- storage
- collection by police

They developed a ‘weapons and dangerous articles management procedure’ that uses a flowchart to illustrate the required actions of those authorised to carry firearms and those not authorised to carry firearms. It refers to a memorandum of understanding between Southern Health and Victoria Police.

“Across the organisation we didn’t have a document about weapons management... we had to start from scratch”

Jenny Owen, Southern Health
Strengthening processes

It became evident through the implementation of the taskforce recommendations that in the situation where a staff member had been assaulted in an occupational violence incident, they were often reluctant to pursue the matter with police. It was clear that the process for taking these matters to police and (if necessary or desirable) through the court system, needed to be refined. This post incident response included a clear explanation of what was required of a health worker, the health service management and police at every step of the process.

An incident resolution action pack was produced and trialled at a major metropolitan health service. This was further refined and provided to the Building Better Partnerships participants to customise and trial at their local health services. The strengthening of these processes will ensure that incidents of occupational violence are addressed more appropriately though the justice system. For example, the incident resolution action pack provides information to the healthcare worker regarding their rights if they are assaulted and advice to the health service as to how they can best support their employees through the process of seeking an outcome in the justice system. The better the processes, the more likely healthcare workers will be to persevere with charges where appropriate. This will help realise the desired effect of deterring would-be perpetrators.

Figure 4 outlines the results from the HWSA audit which investigated whether workplace aggression incidents (including employee incidents and code grey and black incidents) that were reported were adequately investigated. Prompts for WorkSafe investigators in determining compliance in reviewing incident reports included the following:

- percentage of reports investigated
- who was involved in the investigation?
- were relevant risk factors considered?
- was all information relevant to the specific incident?
- are short term controls recommended?
- is control implementation tracked?
- when making recommendations for corrective actions, are past incidents/trends considered?

Investigators also asked employees who had reported incidents what feedback they received concerning the outcomes.
Figure 4: HWSA Audit results – incident investigation

The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 1-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.
Case study 8: Western Health

Learning to report again!

In establishing data on incidents of occupational violence at Western Health and to support the progression of this project, it became evident that there was a culture of under-reporting. Significant gaps were identified with the reporting of incidents of aggression which did not escalate to a Code Grey. In a three-month review period prior to the project commencement only 10 near misses were reported related to occupational violence or aggression. To target the concerns identified the current Western Health Management of Aggressive and Violent Behaviour procedures were updated to define near misses and clearly articulate reporting requirements. The local Management of Aggression Committee continues to work on these procedures with a particular focus on Emergency Response Team responses to a Code Grey. In tandem, a review of aggression training has also incorporated an enhanced profile for reporting incidents.

Activities included:

- introduction and pilot of the Occupational Violence Prevention Action Pilot Pack
- ensuring staff continue to be supported when reporting occupational violence
- establishing an active Police/Health Service Liaison Committee
- security staff workshop allowing security officers to interact with VicPol members
- security Awareness Education for all hospital staff

John Miles, Western Health
Case Study 9: Western Health

Building Better Partnerships Program

This project had as its genesis a local initiative from Western Health that received funding through the Occupational Violence Prevention Fund that demonstrated potential for wider sector implementation. The project proposal appeared to address the need highlighted by the taskforce for improvements to processes where police and other emergency services are required to interface with health services.

Health services have a distinct organisational culture, as does Victoria Police. The Building Better Partnerships Program aims to facilitate better inter-agency management of issues that occur at the interface of healthcare and key agencies, such as police, ambulance and correctional services, which in turn impact on the management and prevention of occupational violence.

Establishment funding was provided to the demonstration sites to support activities over a 12-month period. During the life of the program, processes and systems were developed and embedded into normal business practices to ensure sustainability of the partnerships. Some of the key activities for the demonstration sites were:

- local needs analysis/risk assessment of interface issues
- establishment of a collaborative committee with membership from relevant local agencies
- appointment of a police and other agencies liaison officer within demonstration site/health service
- identification of, and engagement with, key contacts within the local police service area and other local key agencies
- introduction of the Occupational Violence Prevention Pilot Pack
- ensuring staff continue to be supported when reporting occupational violence
- establishing an active Police/Health Service Liaison Committee
- security staff workshop allowing security officers to interact with Victoria Police members
- security awareness education for all hospital staff
- implementation of the activities outlined in the Occupational Violence Incident Resolution Action Pack, aimed at improving the way health services and police respond to reports of assault against healthcare workers.

The result of the Building Better Partnerships Program included five high impact interventions that build better partnerships between police and health services:

- commit to continuously building shared understandings of each other’s (agency’s) roles, strengths and limitations
- formalise joint agreements, policies and procedures
- actively manage occupational violence incidents from occurrence through to review
- focus on enhancing processes for managing absconding/missing patients/clients
- optimise the patient/client handover process.
Occupational Violence Prevention Fund 2008–11

As part of the implementation, the Occupational Violence Prevention Fund 2008–11 was established to help health services remediate their highest priority risks. Related to Strategy 3, the following are examples of the work undertaken:

<table>
<thead>
<tr>
<th>Health service/ hospital</th>
<th>Fund round</th>
<th>Initiative funded</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Gippsland Health Group (Warragul Hospital)</td>
<td>1</td>
<td>Environmental redesign of existing room in the emergency department where potential or violent clients can be safely assessed and managed</td>
<td>Positive feedback from staff, ambulance service and police regarding design and ability to quickly transform the room from a normal patient cubicle to a safe room for both staff and client.</td>
</tr>
<tr>
<td>Western Health</td>
<td>1</td>
<td>Establish a Police, Justice &amp; Western Health consultative committee aimed at identifying issues associated with reporting assaults to police and supporting employees through the judicial system.</td>
<td>The outcome of this project was such a success at a local level that it was replicated in the formation of the Building Better Partnerships Project (See case study 9)</td>
</tr>
<tr>
<td>Nathalia District Health Service</td>
<td>2</td>
<td>Purchase of a digital recorder for CCTV</td>
<td>With the ability to record footage for up to 30 days, Nathalia District Hospital was able to provide footage to local police following an incident outside the hospital.</td>
</tr>
</tbody>
</table>

Resources developed during implementation


Strategy 4: Supporting education and training

Strategy 4 focused on ensuring that education and training for the prevention and management of bullying and violence reflects the organisational context and the needs of the employee.

Incorporating recommendations: 16, 17, 18, 19, 20, 24 and 28

The recommendations for Strategy 4 included the development of guidelines to ensure minimum standards of education for the prevention and management of occupational violence and for health services to better prevent and manage occupational violence.

(Refer to page 56 for a full set of recommendations)

Focus

The implementation of the recommendations associated with Strategy 4 reflected a focus on:

- evidence-based, targeted education that responds to local needs
- sustainability of training to harness learning and build on organisational capacity

Activities

Evidence-based, targeted education

For training in the prevention of occupational violence to be effective, it needs to clearly demonstrate a proactive organisational response and be closely allied to the perceived needs and local requirements of the organisation.

The Occupational Violence Prevention Fund and policy framework apply a risk management approach that uses the ‘hierarchy of control’, which requires engineering controls to be applied, where practicable, in the first instance and other controls to be applied if a risk cannot be ‘engineered out’. Training is an ‘administrative control’ and so is a lower order control that may have a place when a risk cannot be fully eliminated.

There are many training programs available for occupational violence prevention, varying in content, quality and cost. Recent research suggests that training that is not relevant or contextualised to the organisation is not only unhelpful, but may be detrimental to the provision of a safe working environment.

“We needed a systematic process to make sure we were doing the right training for the right people in the right place.”

Louise McKinley, Western Health

Round 2 of the fund offered occupational violence training and education support packages of up to $25,000 per health service to assist services to take an evidence-based approach to the provision of training for occupational violence prevention.
Case Study 10: Melbourne Health

Management of Clinical Aggression: A Rapid Emergency Department intervention (MOCA-REDI)

Melbourne Health (in conjunction with the University of Melbourne) developed a 45 minute training program to reinforce key violence prevention principles. Research into interventions to manage aggression revealed that education can be effective in improving staff knowledge and confidence in dealing with violence. The MOCA-REDI training program is based on an understanding that various factors – environment, situation, person – come together to influence levels of violence. The program includes identification of the interplay of the environment, the patient’s perspective/clinical issues and the interaction and engagement by staff towards patients. It specifically educates and reinforces how staff can influence the outcome by awareness of their actions/responses.

The training incorporates DVDs with four scenarios based on real incidents. Participants discuss what they consider to be the main issues and factors that lead to the violence and consider what could have been done differently. The training is designed for train the trainer delivery and is facilitated by two clinicians representing different occupations, for example, a nurse and a mental health clinician.

Sustainability of training

Activities supported through occupational violence training and education support packages included a training needs analysis based on incident data, assistance with local implementation plans, development of an online tool for occupational violence prevention training, audits of training undertaken by staff across the organisation, and costs associated with train the trainer models of occupational violence prevention training.

“Prior to receiving funding from the Occupational Violence Prevention Fund, EGHS had no process for routine training of staff in occupational violence and aggression management.

The funding provided an opportunity to tailor training to individual areas of work. Our in-house trainer provided a suitable package that was well received by staff.”

East Grampians Health Services, Quality and risk manager

The recommendations for implementation included a requirement for health services to develop a training program for managers covering the impact of violence and bullying, the organisation’s expectations of the managers, and policy and procedures for the prevention and management of violence, including post incident response.

St Vincent’s Health, as part of this requirement, has implemented a program known as the Support Team Action Response (STAR). Members of the STAR team receive training by accredited, voluntary and multidisciplinary Critical Incident Stress Management Foundation Australia (CISMFA) trainers. STAR is coordinated, structured and resourced to ensure timely and effective critical incident management support to the organisation.
Case Study 11: Western Health

Risk calculator to determine training needs

Western Health received a grant in 2009 to support a project to develop a training framework using a risk calculator and to identify training needs of staff who encounter occupational violence in the workplace.

In the initial phase of the project, a survey was formulated to identify what type of occupational violence occurs in their area of practice, the type of training staff have currently attended, recommendations for future training and the needs for such training within the organisation.

Riskman data was analysed to identify high risk areas based on code greys and reports of occupational violence. A risk calculator was developed based on this data and anecdotal reports. A number of partner health organisations were consulted about staff training on occupational violence.

Consultation exercises within and outside of the network identified four levels of training based on the level and severity of exposure to occupational violence.

The risk calculator was used across the network within a number of identified, specific departments or units. The aim of the calculator is to identify the level and severity of exposure to occupational violence and align to a training framework, that is, it was used to determine the tiered level of training required.

Staff awareness about the type and level of training that is available and appropriate has improved and access to area-specific training has been enhanced.

Western Health is reviewing its overall framework again and the type of training currently in place. It is also reviewing opportunities for improvement and collaboration and has opened up dialogue across organisations to enable the sharing of resources and program material.

The recommendations from the project have provided a firm foundation to build on and will inform the organisation’s longer term strategy in relation to the prevention and remediation of occupational violence.
Figure 5 outlines the results from the HWSA audit in relation to training for the prevention of occupational violence. The three main areas for consideration by WorkSafe inspectors when determining compliance included: adequacy of training content, whether or not all ‘at risk’ employees had received training, and existence and adequacy of training records. Training content was required to include information about challenging behaviours, situation/social context, service context (waiting times etc.) de-escalation strategies, evasive self-defence and relevant policies and procedures.

**Figure 5: HWSA audit results – training**

The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 0-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.
Occupational Violence Prevention Fund 2008–11

As part of the implementation, the Occupational Violence Prevention Fund 2008–11 was established to help health services remediate their highest priority risks. Related to Strategy 4, the following are examples of the work undertaken:

<table>
<thead>
<tr>
<th>Health service/ hospital</th>
<th>Fund round</th>
<th>Initiative funded</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Health</td>
<td>1</td>
<td>Development of a risk calculator</td>
<td>See Case Study 11</td>
</tr>
<tr>
<td>Mercy Hospital for Women</td>
<td>2</td>
<td>Develop and evaluate training program</td>
<td>Staff feedback indicated that the training allowed them to feel more comfortable when faced with an aggressive situation. The training provided some simple tools that could be used to avoid and de-escalate incidents. In total 235 staff attended training.</td>
</tr>
<tr>
<td>East Grampians Health Service</td>
<td>2</td>
<td>Safety first - Sustainable tailored departmental occupational violence and aggression training</td>
<td>More than 85% of staff attended the 4-hour training session and other health services expressed interest in the program.</td>
</tr>
<tr>
<td>Maryborough Health Service</td>
<td>2</td>
<td>Train the trainer for occupational violence prevention training</td>
<td>Staff undertook aggression response training and some staff obtained a certificate 4 in training and assessment so that a ‘train the trainer’ approach was used.</td>
</tr>
</tbody>
</table>

Resources developed during implementation

Melbourne Health, University of Melbourne 2009, *Management of Clinical Aggression – Rapid Emergency Department intervention training*, publisher, place of publication (following up with Marie Gertz)

Strategy 5: Effective reporting and monitoring

Strategy 5 focused on developing effective reporting and monitoring systems, including a standardised minimum data set that will enable health services to report, monitor and compare bullying and violence.

**Incorporating recommendations: 21, 27, 28 and 29**

The recommendations for Strategy 5 included a requirement for the department to develop a minimum data set and to provide guidelines to health services to understand the significance of data collection (refer to page x for a full set of recommendations).

**Focus**

The implementation of the recommendations associated with Strategy 5 reflects a focus on:

- System-wide action using comprehensive, reliable and detailed data
- Victorian Health Incident Management System (VHIMS)
- Closing the QI – using data to inform policy/intervention

**Activities**

**System-wide action**

A definitive evaluation of occupational violence prevention strategies in health services is difficult because there is no way to count incidents that were prevented. Rather than measuring positive outcomes, occupational health and safety evaluation requires measurement of the absence of negative outcomes. For example, injury and incident rates are often used as a measure of occupational health and safety performance. Still, with more comprehensive, reliable and detailed data, there is the potential to develop more sophisticated tools for analysing what works and what doesn’t in preventing violence. A system-wide focus and action on occupational violence prevention requires uniform data. To that end, the work that has been undertaken in setting the policy framework, for example, promoting an agreed definition of violence, will assist.

System-wide data offers many possibilities, including measuring economic and non-economic costs of workplace violence; analysing patterns, including the occurrence of different forms of violence and rates of violence in different occupational categories; contributing to the development of curricula for violence prevention training; and supporting additional research in areas such as detecting warning signs and the relationship between various risk factors and actual violence.

The taskforce compiled a minimum data set that included event, type, location, severity, day and time, and perpetrator characteristics. The taskforce recommended preliminary analysis of the data set 12 months after implementation and a comprehensive evaluation three years after implementation. It should be noted that experience in other jurisdictions suggests that reporting of occupational violence incidents increases following awareness-raising initiatives. This should be seen as a positive outcome. Monitoring of statewide data related to incidents of occupational violence will be available post- Victorian Health Incident Management System (VHIMS) implementation.
Case Study 12: St Vincent’s Health

Investigations Officer

A gap analysis undertaken by St Vincent’s Health was the precursor to the appointment of an investigation coordinator responsible for investigating all reports of occupational violence to identify root cause, corrective actions and how to better involve external services agencies. The coordinator is a member of the collaborative committee established through the Building Better Partnerships project, which includes police, ambulance and relevant occupational health and safety and clinical staff. The person in this role has a clinical background as well as expert knowledge in relevant legislation, regulations, codes and standards.

Victorian Health Incident Management System

VHIMS is a system for collection and review of statewide incident information. It will allow for mechanisms to enable statewide aggregation, analysis and trending of incident data that applies to all public health services. Usable data will come online progressively. Planning for processes for statewide aggregation (that will mirror the established processes for clinical incident monitoring) has commenced.

Incorporated in the VHIMS statewide roll out was a ‘train the trainer’ education package for health services to either adopt or inform their own education framework for incident reporting across their health service. The department also developed a series of e-learning packages (available through http://www.health.vic.gov.au/clinrisk/training/elearning.htm) that underpin the best management principles of incident reporting, open disclosure, incident review and investigation. The department has promoted these resources to health services and requested that the resources be considered in orientation and induction training for staff.

“If you can analyse the data that you collect, you can use it to inform action”

Tiffany Plummer, workplace aggression investigator, St Vincent’s Health
Closing the Quality Improvement feedback loop – using data to inform policy/intervention

Prior to the implementation, there was a lack of consistency in definitions of violence as well as significant under-reporting of incidents. The view that incidents would not be taken seriously and that nothing would be achieved, changed or improved as a result of reporting the incident, was deterring staff from reporting. Advice was provided to health services about the importance of reporting and monitoring incidents at a local level.

From an occupational health and safety perspective, it is crucial that the loop be closed with the reporting of incidents. This will enable the occupational health and safety committee to identify trends, conduct a root cause analysis, and address any predisposing factors to occupational violence.

Figure 6 demonstrates how reviewing occupational health and safety performance needs to feed back into policy development around prevention measures. The Health and Safety Executive describes the importance of measuring occupational health and safety performance and its benefits, including how the measurement information helps in deciding:

- where you are relative to where you want to be
- what progress is necessary and reasonable in the circumstances
- how that progress might be achieved against particular restraints (for example, resources or time)
- the way progress might be achieved
- priorities and effective use of resources.

These factors apply in measuring effectiveness of occupational violence prevention measures adopted by health services.

---

Figure 6: Performance measurement within the health and safety management system

“You can’t manage what you can’t measure’
Drucker

‘If you don’t know where you are going, chances are you will end up somewhere else’
Yogi Berra
The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 0-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.

Adequacy of incident reporting systems was assessed by WorkSafe in the HWSA project (see figure 7). Compliance measures included consideration of whether information was readily accessible for trend analysis; whether service-related information was collected; quality of information recorded; and compatibility with other information sources. Figure 8 shows results of a comparison between the amount of incidents reported compared to the actual numbers of incidents occurring. This was determined through inspectors surveying employees and comparing survey outcomes with actual incident reports. Organisations that rated well indicated a good level of reporting when compared to the employee surveys; that is, where employee surveys were an adjunct to hazard reporting systems. This demonstrates whether the health service encourages reporting of occupational violence.
Figure 8: HWSA audit results – Employee incident reporting

The vertical axis represents a percentage of all hospitals audited. The horizontal axis represents a 0-5 rating scale determined by WorkSafe inspectors in each jurisdiction. Descriptors for 2 and 4 were not provided by HWSA.
Occupational Violence Prevention Fund 2008–11

As part of the implementation, the Occupational Violence Prevention Fund 2008–11 was established to help health services remediate their highest priority risks. Related to Strategy 5, the following are examples of the work undertaken:

<table>
<thead>
<tr>
<th>Health service/hospital</th>
<th>Fund round</th>
<th>Initiative funded</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Gippsland Health Service</td>
<td>2</td>
<td>Installation of Riskman</td>
<td>Improved analysis of incident reports and improved implementation of prevention controls. More accurate means of generating and analysing results. Ease of generating report results in different formats.</td>
</tr>
<tr>
<td>Eastern</td>
<td>3</td>
<td>Reporting and monitoring improvements to inform prevention strategies</td>
<td>Continuous improvement feedback loop assists with prevention planning.</td>
</tr>
</tbody>
</table>

Resources developed during implementation

Occupational Violence Prevention Fund 2008–11

About the fund

The Occupational Violence Prevention Fund 2008–11 was established to provide funding of $4 million over four years to support the implementation of strategies to prevent and manage occupational violence against nurses and other health workers in public health services.

Over three rounds, 66 public health services were funded to remediate 144 of the highest priority risks identified in the system.

Occupational Violence Prevention Fund – summary of expenditure 2008–11

<table>
<thead>
<tr>
<th>Category</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan public health services</td>
<td>0.72</td>
<td>0.53</td>
<td>0.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Rural/regional public health services</td>
<td>0.92</td>
<td>0.7</td>
<td>0.37</td>
<td>1.99</td>
</tr>
<tr>
<td>Building Better Partnerships</td>
<td>0.4</td>
<td></td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>1.7</td>
<td>1.23</td>
<td>0.96</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Fund objectives

The specific objectives of the fund were:

- to support public health services to implement the recommendations from the Victorian Taskforce on Violence in Nursing (final report)
- to assist public health services to identify and remediate highest priority occupational violence risks in the workplace
- to build capacity and capability in health services to identify, assess and control occupational violence hazards in the workplace
- to promote use of best practice approaches to preventing and managing occupational violence and bullying and support innovation.

How were applications assessed?

Applications from public health services were assessed against a range of published criteria. Health services needed to demonstrate that they had suitable governance arrangements and a plan that included appropriate milestones, budget and clear deliverables. They needed to show that they had used a risk management strategy and had considered how success would be evaluated.

A range of program areas from across the department, including capital management, mental health, rural and emergency services program areas, assessed applications.

Funds were allocated according to highest priority risks.
What was funded?

The fund considered initiatives that were consistent with the directions and recommendations of the Victorian Taskforce on Violence in Nursing, the Preventing occupational violence in Victorian health services: a policy framework and resource kit (DHS, 2007), and other relevant department policies. Initiatives were required to be based on a risk assessment with preference given to the high priority risks. Initiatives that provided an opportunity to create a sustained and permanent change to the workplace, continuously build on the evidence base, and be informed by best practice were encouraged. The fund also considered demonstrated integration with current initiatives within the organisation and/or linkages with other organisations, use of a whole-of-workforce approach (inclusive of nurses), and building on existing occupational health and safety infrastructure rather than duplication to ensure sustainable progress.

Ongoing monitoring of the fund was established to ensure projects were completed by health services as anticipated and within agreed parameters of cost and scope.

The hierarchy of control (also known as the preferred order of control) reflects the philosophy of prevention, in that the best approach is to eliminate risks. If that is not practicable, design or engineering controls are the next option, followed by administrative controls, which include training and policies and procedures. The least preferred control is personal protective equipment, which in the context of occupational violence prevention refers to personal duress alarms.

Overall, the fund achieved the following:

- Sixty-nine per cent of remediation activities focused on improving environmental design and security systems to minimise occupational violence, including minor works to improve visibility or access/egress and alarm systems (static and mobile) (see figure 9).
- Thirty-four projects over the three rounds were for remediation activities in the emergency department, six projects were in aged care, 12 in mental health and 76 were organisation-wide activities.
Figure 9: Occupational Violence Prevention Fund: Summary of activity/projects, all rounds

- Occupational violence prevention policy review/development activities
- Occupational violence prevention training and education
- Improve environmental design and security systems to minimise occupational violence

Figure 10: Funding by project as a percentage of total funding by region

- Occupational violence prevention policy review/development activities
- Occupational violence prevention training and education
- Improve environmental design and security systems to minimise occupational violence
Figure 11: Funding by project type and region

Breakdown of projects by location within health services

<table>
<thead>
<tr>
<th>Main Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged care</td>
<td>6</td>
</tr>
<tr>
<td>Community</td>
<td>1</td>
</tr>
<tr>
<td>Emergency department</td>
<td>34</td>
</tr>
<tr>
<td>Entrances</td>
<td>20</td>
</tr>
<tr>
<td>Maternity</td>
<td>3</td>
</tr>
<tr>
<td>Mental health</td>
<td>12</td>
</tr>
<tr>
<td>Organisation-wide</td>
<td>76</td>
</tr>
<tr>
<td>Radiology</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>153</strong></td>
</tr>
</tbody>
</table>

Note: Some projects are across more than one area.
Includes Building Better Partnerships (11 organisation-wide)
What was the impact of funding?

Assessing the impact of the fund is challenging because much of the activity is preventative in nature. There is no statewide incident data available for both pre- and post-intervention analysis. As higher awareness (and reporting of incidents) is a desirable outcome, there was a lot of activity around encouraging reporting.

Taskforce members provided anecdotal evidence around the personal impact of the incidence of occupational violence; this was acknowledged and addressed.

The qualitative feedback with subjective views of whether people ‘felt’ safer after prevention initiatives were implemented was as important as the objective outputs and deliverables of project funds.

Culture change takes time and staff cannot be directed to ‘change a culture’. They need environments that enable, facilitate and support change processes because this allows them to ‘own’ the changes over time. In the short term, there is an expectation that reports and claims will increase due to the increased awareness of the issue and as staff begin to see reporting as a worthwhile endeavour as reports are taken seriously.

Who accessed the fund?

The following health services accessed the Occupational Violence Prevention Fund:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>OVPF initiative or works</th>
<th>Main area</th>
<th>Round</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alfred Health</td>
<td>Upgrade ED facilities to improve prevention of occupational violence</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Improving staff safety using a multifaceted approach to reduce the risk of aggression in the Emergency Department and in general medical wards across the organisation</td>
<td>Emergency Department/elderly dementia/organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Austin Health</td>
<td>Positions/Crime Prevention Through Environmental Design (CPTED)/duress etc.</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Staff education program for occupational violence prevention and a weapon safety program (gun safes for ED and adult mental health unit)</td>
<td>Emergency Department/adult mental health unit/organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Train the trainer model for advanced physical occupational violence prevention skills, review and update e-learning packages on intranet</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Eastern Health</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reporting and monitoring improvements to inform prevention strategies</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Melbourne Health</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Mercy Health</td>
<td>Duress/CCTV/swipe access</td>
<td>Community</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Duress/CCTV/swipe access/training</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhance interface between Werribee Mercy Health Emergency Department, Western Metropolitan Mental Health Program, local police and ambulance services, plus targeted training</td>
<td>Emergency Department &amp; WMMHP setting</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Northern Health</td>
<td>Duress/CCTV/swipe access/training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Improve environmental design for the prevention of occupational violence</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Peninsula Health</td>
<td>Increased duress alarms and safe weapons storage facilities</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Expansion of clinical care support team, educational development package, de-escalation</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Peter MacCallum Cancer Centre</td>
<td>Duress/CCTV/swipe access/training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td>Royal Victorian Eye &amp; Ear Hospital</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improvements to environmental design for the safe care of high risk patients in ED</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>Royal Women's Hospital</td>
<td>Occupational violence prevention</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Southern Health</td>
<td>Improved safety for clients and staff</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Duress/CCTV/swipe access</td>
<td>Maternity</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improved safety for clients and staff</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CPTED</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Mental Health</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Better management of aggression in clinical settings</td>
<td>Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Western Health</td>
<td>Duress/CCTV/swipe access/training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Duress/CCTV/swipe access/training</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Police liaison/supporting/reporting</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Radiology</td>
<td>3</td>
</tr>
<tr>
<td>Barwon South Western</td>
<td>Training/education for occupational violence prevention</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Implementation of code grey response processes</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Review of current training and development of training program</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Security and training review, development of training program</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Barwon Health</td>
<td>Training/education for occupational violence prevention</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Implementation of code grey response processes</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Review of current training and development of training program</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Security and training review, development of training program</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Otway Health and Community Services</td>
<td>Improve environmental design of ED for safer assessment of clients</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>Timboon &amp; District Healthcare Service</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Western District Health Service</td>
<td>Improve environmental design and security systems to minimise occupational violence</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occupational violence training and education</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Gippsland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bairnsdale Regional Health Service</td>
<td>Duress/CCTV/swipe access/training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Bass Coast Regional Health (Wonthaggi)</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Central Gippsland Health Service</td>
<td>Organisation-wide</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Gippsland Health Services consortium</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Latrobe Regional Hospital</td>
<td>Mobile personal duress systems for staff</td>
<td>Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Omeo District Health</td>
<td>Duress/CCTV/swipe access</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>South Gippsland Hospital</td>
<td>Enhanced security for high risk areas</td>
<td>After Hours Clinic, main entrances, reception, CHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhancement of internal monitoring and reporting systems</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Warragul Hospital, WGHG</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Grampians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ballarat Health Services</td>
<td>Mobile personal duress alarms for staff at risk</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Woman &amp; Children's Department</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Additional training for dealing with challenging behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beaufort and Skipton Health Services</td>
<td>Enhanced security, mobile personal duress alarms for staff</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td>Djerriwarrh Health Services</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Dunmunkle Health Service</td>
<td>Duress/CCTV/swipe access/training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improve environmental design to minimise occupational violence</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>East Grampians Health Service</td>
<td>Occupational violence policy review and development activities</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Greater safety for staff through enhancements to security system</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas (ED with mental health patients)</td>
<td>Emergency Department</td>
<td>3</td>
</tr>
<tr>
<td>East Wimmera Health Service</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Stawell Regional Health</td>
<td>Duress/CCTV/swipe access</td>
<td>Aged Care/GEM</td>
<td>1</td>
</tr>
<tr>
<td>West Wimmera Health Service</td>
<td>Alert system for entrances at 5 campuses</td>
<td>Entrance all campuses</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Duress alarms for hostel (dementia patients) staff</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>West Wimmera Health Service (Jeparit)</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>West Wimmera Health Service (Nhill)</td>
<td>Duress/CCTV/swipe access</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Wimmera Health Care Group</td>
<td>Enhanced security for high risk areas</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Emergency Department</td>
<td>3</td>
</tr>
<tr>
<td>Hume</td>
<td>Review and enhancement of occupational violence policy and procedure, integrating better weapons management</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Development of an e-learning package that will support new proposed occupational violence train the trainer model</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Occupational violence management strategy, initial focus on ED, then obstetrics, mental health, home-based</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Albury Wodonga Health - Wodonga Campus</td>
<td>Training/CPTED/CCTV</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Alpine Health</td>
<td>Training/CPTED/CCTV</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Cobram District Hospital</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Goulburn Valley Health</td>
<td>Duress/CCTV/swipe access/ training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td>Mansfield District Hospital</td>
<td>Duress/CCTV/swipe access</td>
<td>Aged Care/GEM</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improved security for high risk areas including ED and aged care</td>
<td>Emergency Department, Aged Care, dementia specific</td>
<td>2</td>
</tr>
<tr>
<td>Nathalia District Hospital</td>
<td>Enhanced security for high risk areas</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>North East Health Wangaratta</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Numurkah District Health Service</td>
<td>Duress/CCTV/swipe access</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td>Orbost Regional Health</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td>The Kilmore and District Hospital</td>
<td>Enhanced security for high risk areas</td>
<td>Emergency Department, general areas including entry</td>
<td>2</td>
</tr>
<tr>
<td>Upper Murray Health &amp; Community Services</td>
<td>Upgrade of ED facilities to improve prevention of occupational violence</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Wodonga Regional Health Service</td>
<td>Occupational violence policy review/development activities</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Yarrawonga District Health Service</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas, including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CPTED</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Yarrawonga District Health Service in collaboration with Nathalia District Hospital, Cobram District Hospital and Numurkah &amp; District Hospital</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Yarrawonga/Nathalia/ Cobram/Numurkah collaboration</td>
<td>Training/education for occupational violence prevention (ED [40%] dementia [60%] related occupational violence)</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Yea &amp; District Memorial Hospital</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Loddon Mallee</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bendigo Health Care Group</td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Boort District Hospital</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas, including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Greater security for staff through security and reception area enhancements</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Hostel &amp; Nursing Home</td>
<td>3</td>
</tr>
<tr>
<td>Cohuna District Hospital</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhancement of ED security</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Echuca Regional Health</td>
<td>CPTED</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Inglewood &amp; Districts health service</td>
<td>Duress/CCTV/swipe access/ training</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Organisation-wide</td>
<td>3</td>
</tr>
<tr>
<td>Kerang District Health</td>
<td>Enhanced security for high risk areas</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td>Kyabram and District health</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Kyneton District Health Service</td>
<td>Occupational violence audit/planning</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security for high risk areas</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>Maldon Hospital</td>
<td>Enhanced security systems for the safe care of patients in ED</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>Organisation</td>
<td>OVPF initiative or works</td>
<td>Main area</td>
<td>Round</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Maryborough District Health Service</td>
<td>Duress/CCTV/swipe access</td>
<td>Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improved safety for clients and staff</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Training/education for occupational violence prevention</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mobile personal duress alarms for staff at risk, greater safety for staff through environmental design improvements</td>
<td>General areas including entry</td>
<td>2</td>
</tr>
<tr>
<td>Mclvor Health and Community Services</td>
<td>Duress/CCTV/swipe access</td>
<td>General areas including entry</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Greater staff safety through enhancements of security systems including training</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Mildura Base Hospital</td>
<td>Enhanced security, staff training, community awareness and improved CPTED</td>
<td>Emergency Department, general areas including entry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Improved security systems for mental health and maternity</td>
<td>Mental Health, Maternity</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Duress/CCTV/swipe access/ occupational violence coordinator</td>
<td>Organisation-wide</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CPTED</td>
<td>General areas, including entry</td>
<td>1</td>
</tr>
<tr>
<td>Mt Alexander Hospital</td>
<td>Improvements to environmental design for the safe care of high risk patients in ED</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
<tr>
<td>Rochester &amp; Elmore District Health Service</td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Emergency Department</td>
<td>2</td>
</tr>
<tr>
<td>Swan Hill District Hospital</td>
<td>Audit to inform local implementation of occupational violence prevention strategies</td>
<td>Aged care</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Enhanced security systems for the safe care of patients</td>
<td>Organisation-wide</td>
<td>2</td>
</tr>
</tbody>
</table>
The commitment of health services and taskforce members enabled the department to use the implementation process to set the framework and put mechanisms in place to support the continued effort required by health services to provide and maintain a safe and healthy workplace free of occupational violence. The devolved governance structure in Victoria has ensured a partnership approach to tackling the complex problem of occupational violence. Implementation activities were engineered with the intention of assisting health services to direct local attention and resources to this area.

Health services are now better equipped to prevent and manage occupational violence at the local level with the use of a policy framework, examples of best practice that they can adapt to their local circumstances and a suite of communication tools to raise awareness of the issue.

In 2011, the Victorian Government gave terms of reference to the Drugs and Crime Prevention Committee for an inquiry into violence and security arrangements in Victorian health services. The committee’s final report noted that, “the policy frameworks, review, documents and legislation that have resulted from the Taskforce recommendations, serve as an excellent basis for addressing occupational violence”. Indeed, Victoria compares favourably to the national average in all areas of occupational violence prevention, but in particular, policy and procedures. The Victorian Government has provided a whole-of-government response to the committee’s recommendations and planning for their implementation is underway.

The committee did note, however, that there needed to be “concerted action to expedite the implementation of these policies on the ground”. The case studies in this report provide a number of examples of activity occurring at the local level which may be replicated by those health services seeking to further maximise the outcome of good work undertaken. The MOCA REDI is an example of the local application of an evidence-based program that can be used with success. As comparative data from the VHIMS becomes available, health services will be able to consider their reported incidents against others to improve their local prevention activities. The Building Better Partnerships program has demonstrated a move by health services beyond introspective initiatives and towards a committed interagency response using proven interventions.

There is no one magic bullet that will eliminate the complex causal factors of occupational violence. There is a need for comprehensive proactive organisational strategies to be complemented by wider social initiatives to address the roots of violence in our communities. Integrating risk assessments into care processes and using a comprehensive occupational health and safety framework is a good approach to tackling this challenging problem.

Future directions
Appendix 1

Taskforce recommendations and organisations with responsibility to lead implementation

Recommendations

Occupational violence and aggression

Recommendation 1
The Department of Human Services and healthcare facilities adopt a uniform definition of occupational violence consistent with the definition and classifications developed by the askforce on Violence and Aggression Subcommittee in this report.

Recommendation 2
That the Department of Human Services and healthcare facilities adopt a policy statement that has key messages including:

• violence against nurses is unacceptable and must be proactively addressed
• there is not a culture of tolerance of violence in the workplace
• encouraging a culture of reporting amongst nurses.

Recommendation 3
That the Department of Human Services develops a framework for the prevention and management of occupational violence and aggression for adoption in Victorian healthcare settings and that this work be primarily informed by:

• NSW Health Zero tolerance to violence in the NSW health workplace - policy framework guidelines (2003)
• Department of Human Services Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services (2004).

Recommendation 4
That the Department of Human Services will:

• establish a hierarchy of response guidelines for a uniform system of sanctions in response to violence and aggression against nurses. The response should include warning systems, contracts of acceptable behaviour, and the enforcement of sanctions/consequences.
• develop guidelines that include the duty of care and legal responsibilities of all parties. Case study examples should be provided to highlight the issues to be considered in determining strategies and responses to occupational violence and aggression against nurses in the workplace.

Recommendation 5
That the Department of Human Services develop education and awareness programs for the community, police and the judiciary, to promote a greater understanding of occupational violence in nursing.

Recommendation 6
That the Department of Human Services requests the Department of Justice to consider the issues of occupational violence in nursing and consider legislative mechanisms and strategies that will improve the safety of nurses and other healthcare workers.
Recommendation 7
That the Department of Human Services considers the development of statewide guidelines with respect to weapons and dangerous articles within the healthcare setting. This may include introducing legislation or guidelines in health services that relate to the search and removal of weapons and/or dangerous articles, the storage, disposal or return of such articles, and to allow police to receive and hold such property, regardless of whether it is to be used as evidence in relation to a crime or that charges are to be laid. This matter should be considered together with other legislative issues referred to the Department of Justice.

Recommendation 8
That the Victorian Government and health services develop, pilot and implement a public awareness campaign that:

- promotes an expectation of behaviour and consequences for unacceptable violence and aggression
- clearly states the message that violence towards nurses is unacceptable.

Recommendation 9
That the Department of Human Services, in consultation with health services, adapts for broad use: The industry occupational health and safety interim standards for preventing and managing of occupational violence and aggression in Victorian mental health services (Department of Human Services 2004) for post-incident management.

Recommendation 10
That the Department of Human Services introduces, at the state level, a standardised Code Grey (violence and aggression emergency) and Code Black response (armed threat).

Recommendation 11
All health organisations will:

- establish an aggression management reference group which will be responsible for developing policies and procedures around the management of aggressive incidents, primarily through a clinically-led aggression management team
- ensure that all clinical areas undertake a risk assessment and give consideration to a number of strategies, including the development of guidelines to address the needs of each different setting and reviewing the need for appropriately trained security personnel
- establish, in all high-risk departments, security measures that include a response by staff who are trained in the prevention and management of violence and aggression during hours of operation
- consider how to address the broader issues of physical restraint and seclusion within non-designated mental health areas
- develop guidelines for emergency responses during operating hours in smaller health facilities or for those nurses working in community, rural and remote settings.

Recommendation 12
That the Victorian Government considers procedures for reporting to police, laying charges and prosecutions, including the potential for legislation for nurses similar to that developed for ambulance officers. (A memorandum of understanding, similar to that adopted between NSW Health and NSW Police, is a useful reference.)
Recommendation 13
The Department of Human Services and health services commit resources to support:

- the implementation of strategies to prevent and manage violence and aggression against nurses and other health workers
- strategies developed in areas that include design, personnel, equipment, publications and training
- the evaluation of the strategies following their implementation
- preliminary analysis of the data set and strategies 12 months after implementation and a comprehensive evaluation of the same after three years.

Recommendation 14
The principles of affecting behaviour through environmental design and management should be applied to all future building development and refurbishment.

Education

Recommendation 15
Health services develop a clear statement of expected behaviour, outlining acceptable and unacceptable behaviour, for both staff and consumers.

Recommendation 16
The Department of Human Services develops guidelines to ensure a minimum standard of education is provided to all nurses.

Recommendation 17
Health services:

- provide education and training for nurses to prevent and manage occupational violence and bullying. The education and training addresses the key elements identified by the Education Subcommittee, including prevention and management of occupational violence and bullying
- provide nurses, including part-time and casual bank nurses and other healthcare employees, with education and training as part of the orientation process to a new organisation
- ensure all nurses in the workplace undertake continuing education and training programs that address occupational violence and bullying at least on an annual basis
- provide additional specific training to staff working in identified high risk areas
- maintain a database of all nurses who have completed education, and develop systems to ensure the adequate education of casually employed nurses in relation to occupational violence and bullying and that these systems meet the requirements of the Occupational Health and Safety Act 2004.

Recommendation 18
Providers of agency nurses ensure nurses receive education and training in the prevention and management of occupational violence and bullying prior to undertaking casual employment with any healthcare facility. This education is to include all key elements identified as a minimum educational and training requirement.
Recommendation 19
Health services develop specific education programs for all managers, covering:

• the impact of occupational violence and bullying on the workforce
• the organisation’s expectations of the managers, inclusive of policy and procedures for prevention and management of incidents
• the importance of supporting staff to report incidents
• the obligations of the manager
• techniques and available support mechanisms for staff and managers.

Recommendation 20
That the Minister for Health requests:

• the Nurses Board of Victoria to require, through accreditation processes, nursing courses leading to registration to include OH&S principles, particularly those that address occupational violence and bullying
• the Australian Nursing and Midwifery Council to consider the development of competency standards pertaining to OH&S principles and require the inclusion of OH&S components of occupational violence and bullying.

Recommendation 21
Higher education providers and health services create a mechanism for monitoring and evaluating the prevalence of bullying and violence experienced by students in the workplace during clinical placements.

Bullying

Recommendation 22
That the Department of Human Services and health services accept an agreed definition of bullying that is aligned with the WorkSafe definition and use it consistently.

Recommendation 23
That health services establish consistent management strategies that include:

• clear organisational policy with ‘safe’ reporting to an objective, senior, listener
• timely and consistent response from management
• support for realistic outcomes.

Recommendation 24
That health services establish management education strategies that:

• explore and articulate mechanisms to assist organisations to manage situations where, despite investigation, no clear resolution is obvious and/or possible
• emphasise positive behaviours in the workplace
• raise nurses’ awareness of the differences between bullying behaviours and legitimate business practices, for example, legitimate and reasonable performance management and organisational change
• minimise ambiguity so that bullies and victims are aware of the subtleties and trivialities that comprise bullying in nursing.
Recommendation 25
That the Department of Human Services develops and disseminates a statewide ‘tool kit’ containing bullying prevention strategies (adapted from WorkSafe Victoria Guidance Note 2003) that:

• includes examples of policies, procedures and suggestions for culture change
• ensures consistency in the approach to managing bullying
• provides a useful resource that contributes to quality improvement processes
• includes readily accessible policies, procedures, case studies and customised pamphlets for nurses
• uses innovative ways to convey messages about bullying behaviours that are relevant to nursing.

Recommendation 26
That the Department of Human Services:

• promotes management of bullying in accordance with the WorkSafe Victoria Bullying and Violence at Work Guidance Note (February 2003)
• further researches nursing culture to identify key factors that may trigger bullying behaviour by nurses, thereby enabling a more targeted approach to prevention
• considers sponsorship of innovative strategies to prevent bullying and disseminate ideas and outcomes to health services.

Reporting tools

Recommendation 27
That the Department of Human Services:

• develops a statewide minimum data set that includes key critical fields, with reference to the critical fields identified by the Reporting Tools Subcommittee
• develops guidelines to assist health services to understand the significance of data collection related to violence and bullying and to collect critical field information
• pilots the data set across a sample of Victorian health services prior to implementation.

Recommendation 28
All health services submit a minimum data set to the Department of Human Services on a biannual basis.

Recommendation 29
That the Department of Human Services makes aggregated local data results available to health services and WorkSafe Victoria to compare local prevalence and nature of events and create statewide benchmarking.
## Responsibility for recommendations

Responsible parties for implementation of taskforce recommendations

<table>
<thead>
<tr>
<th>Rec No.</th>
<th>Victorian Taskforce on Violence in Nursing Recommendation</th>
<th>Victorian Government/ DHS</th>
<th>Health services</th>
<th>Department of Justice</th>
<th>Nurses Board Vic/ ANMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop uniform definitions of violence</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Develop policy statement</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Develop a framework for prevention and management of occupational violence</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Develop response guidelines including duty of care and legal responsibilities</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Develop education/awareness program for police, judiciary and community</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Request DOJ consider legislative issues re occupational violence</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Consideration of guidelines re weapons</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Develop, pilot and implement a public awareness campaign</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Adapt post incident management information</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Introduce a standardised code grey/ black response</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Develop specific policies and procedures</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Consider procedures for reporting to police</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Commit resources to support strategies as detailed</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Environmental design principles applied</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Develop statement of expected behaviour for staff and consumers</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Develop guidelines for minimum standard of education for nurses</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rec No.</td>
<td>Victorian Taskforce on Violence in Nursing Recommendation</td>
<td>Victorian Government/ DHS</td>
<td>Health services</td>
<td>Department of Justice</td>
<td>Nurses Board Vic/ ANMC</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>17</td>
<td>Use DHS guidelines for staff education</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Agency nurses receive education/training re violence</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Health Services develop education programs for managers</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Ministerial requests to NBV and ANMC</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Higher education and health services monitor and evaluate student workplace incidents</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Develop uniform definitions of bullying</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Establish consistent management strategies</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Establish education management strategies</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Develop toolkit containing bullying prevention strategies</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Promote management and research of bullying as detailed</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Develop statewide minimum data set as detailed</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Submit data to Department of Health for minimum data set</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Make aggregated data from minimum data set available to Health Services and WorkSafe</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2
Reference group membership

Adjunct Professor Belinda Moyes, Director, Nurse Policy Branch, Department of Human Services (Chair)
Ms Lisa Fitzpatrick, Secretary, Australian Nursing Federation, Victoria Branch
Ms Denise Guppy, Assistant Secretary, Health and Community Services Union
Mr Jeff Jackson, Secretary, Health Services Union
Ms Kath Canham, Executive Client Manager, WorkSafe Victoria
Mrs Bobbie Carrol, Nursing and Midwifery Advisor, Royal Women’s Hospital
Ms Maxine Brockfield, Chief Executive/ Director of Nursing, Kyabram District Hospital
Ms Louise O’Connor, Director of Clinical Services, Epworth Eastern Private Hospital
Ms Christina Wilson, Human Resources Director, Peter MacCallum Cancer Centre
Ms Katherine King, Human Resources Director, St Vincents Health (Replaced Christina Wilson)

Roles and titles are as at time of establishment of the reference group.
Appendix 3

HWSA compliance campaign

The Heads of Workplace Safety Authorities (HWSA) is a group comprising the general managers (or their representatives) of the peak bodies responsible for the regulation and administration of occupational health and safety in Australia and New Zealand. The HWSA mounts national compliance campaigns targeted at specific industries across all jurisdictions. These campaign initiatives support the National OHS Strategy 2002–12, and facilitate the development of consistent approaches to nationally recognised priorities.

The HWSA reports that in 2001–02, 16,990 workers’ compensation claims were made by the health and community sector nationwide: 11.6 per cent of claims made by all industries for that year. The number and proportion was higher in 2005–06, with 17,590 claims (12.6 per cent of claims made by all industries for that year). Of all the health and community sector claims for all types of mechanisms of injury in 2001–02, 6,465 claims were made relating to hospitals (not including psychiatric) (38 per cent of health and community claims). This number and proportion was higher in 2005–06, with 7,014 claims for that year (40 per cent of health and community claims). The number and proportion of claims owed to the mechanisms of injury related to aggressive behaviour were higher in 2005–06 compared to 2001–02.

The purpose of the HWSA health service aggression management project was to:

- assess the quality and reliability of reporting systems within designated areas of workplaces in relation to aggressive behaviour
- assess the validity of risk assessments within workplaces in relation to aggressive behaviour
- assess the level of aggressive behaviour related risk controls within workplaces and compare this level of risk control with existing standards
- evaluate, where appropriate, the effectiveness of past and current control initiatives
- improve the industry’s (for example, CEOs, managers, OHS personnel and workers) and key stakeholders’ awareness and knowledge of the risks associated with aggressive behaviour through the provision of information to assist them to recognise and evaluate the risks in their industry and inform them of ways to effectively eliminate or minimise risks to people’s health, safety and welfare
- raise the awareness of best practice and the possibility of sanctions resulting from non-intervention with safety requirements.

The intention of the approach was to educate the healthcare sector through a balance of information, assistance and enforcement activity.
Methodology

- Formation of a national working group.
- Identification and sharing of available aggression-related products that could be used or modified for the campaign’s implementation.
- Development of terms of reference for the national working group.
- Identification and agreement of the campaign scope.
- Finalisation and endorsement of:
  - detailed campaign concept paper
  - the campaign framework plan
  - the evaluation strategy.
- Development of a generic audit tool and supporting materials.
- Development of an anonymous employee survey tool.
- Consultation with relevant key stakeholders.
- Delivery information/education sessions to stakeholders and industry.
- Training of inspectors.
- Media release and letters to CEOs (where jurisdictions considered this appropriate).
- Field audits and surveys conducted.
- Analysis of results.
- Preparation of report for Working Group and HWSA.

Results of Aggression Management in Hospitals Intervention and Compliance campaign

Over the period April to December 2009, 163 audits were undertaken and 1,320 employee surveys were returned and the results collated. The breakdown by jurisdiction is shown in Table 1.

Audits and surveys by jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th># of audits</th>
<th># of employee surveys returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>31</td>
<td>174</td>
</tr>
<tr>
<td>Queensland</td>
<td>36</td>
<td>704</td>
</tr>
<tr>
<td>South Australia</td>
<td>22</td>
<td>200</td>
</tr>
<tr>
<td>Tasmania</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Victoria*</td>
<td>34</td>
<td>-</td>
</tr>
<tr>
<td>Western Australia</td>
<td>34</td>
<td>230</td>
</tr>
<tr>
<td>Total</td>
<td>163</td>
<td>1320</td>
</tr>
</tbody>
</table>

* Victoria did not participate in the employee surveys
The Audit Tool

The Audit Tool collected information on the hospital’s profile (for example, size, type, location and services provided) and assessed each hospital’s management of aggression, including the risk controls that were in place. A total of 13 elements were assessed using 5–6 point rating scales. As well as rating the hospitals on each element, the inspectors also identified any barriers during the audit to the control of aggression risks. The elements audited were as follows:

1. Policy
2. Procedures
3. Hazard Identification
4. Incident Reporting Systems
5. Employee Incident Reporting
6. Incident Investigation
7. Risk Assessment
8. Risk Controls – Training
9. Risk Controls – Emergency Response Procedures
10. Risk Control – Other
11. Design
12. Re-Design
13. Management Commitment

The Audit Tool used a format similar to that used in the previous health industry HWSA Campaign Safe Steps – Manual Tasks, Slips and Trips in Hospitals. For each element a series of prompts were included for the inspectors, as well as a series of performance requirements to guide scoring. The tool was based in part upon the requirements of WorkSafe Victoria’s A handbook for workplaces: aggression management in hospitals but with a stronger emphasis upon incident reporting and investigation.

As with any audit process where subjective assessments are involved, “inter-rater reliability” is an issue (i.e. the degree to which Inspectors would give the same ratings to the same hospital). To improve inter-rater reliability the Audit Tool was supplemented by Inspector training as well an Inspector Checklist and a Suggested Procedure for conducting the Audits (see Part 2 of the Report). For some audit elements mandatory scores were also included (e.g. a Policy that lacked a risk management framework could be scored no higher than 3).
Appendix 4

Occupational Violence Prevention Fund: identifying risks and evaluating actions

The Occupational Violence Prevention Fund (OVPF) was a non-recurrent fund intended to assist with the implementation of the recommendations from the taskforce. As such, it was vital that funds be expended in an equitable and prudent manner for outcomes that were sustainable. Because the provision of a safe and healthy workplace is a legislative requirement of health services as employers, the challenge in expending the funds was that they be used as leverage to assist health services to embark on a process of identifying their occupational violence risks. Once health services identified their risks, it was incumbent on them to then assess and control them. The process around applying for funds encouraged health services to examine and conduct an audit of their workplace and transition from subjective and vague concerns and processes around occupational violence prevention to having an objective and rigorous process for managing risk.

The following tool was provided to health services to guide the identification, assessment and control of occupational violence hazards. It uses a matrix approach in determining priorities for the control of hazards. It was developed by WorkSafe in collaboration with the Department of Human Services and relevant unions. It was originally developed for use by WorkSafe inspectors to inform their enforcement activities; however, it was of assistance for health services to determine priorities in occupational violence prevention.

<table>
<thead>
<tr>
<th>High risk (Red)</th>
<th>Medium risk (Amber)</th>
<th>Low risk (Green)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practices in the red column should not be used in workplaces. An employer who allows those practices to be used is likely to be in breach of OHS legislation.</td>
<td>The practices in the amber column are less effective in reducing risk as compared with the green column and should be treated as interim solutions only. In some instances, practices in this column may be in breach of OHS legislation.</td>
<td>The practices in the green column should be regarded as the minimum target for all worksites. This category meets compliance requirements given the state of knowledge today.</td>
</tr>
<tr>
<td>Where non-compliance with legislation is detected, or where there is an immediate risk, a notice or direction will be issued to control the problem, unless the matter is addressed by the duty holder at the time or its detection and in the presence of the inspector.</td>
<td>Where non-compliance with legislation is detected, or where there is an immediate risk, a notice or direction will be issued to control the problem, unless the matter is addressed by the duty holder at the time or its detection and in the presence of the inspector.</td>
<td>No notice. Best practice is identified in some questions that go beyond compliance with OHS laws, given the current state of knowledge. Over time, best practice may become state of knowledge.</td>
</tr>
</tbody>
</table>
As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly and with each incident to evaluate program success. Responsible parties (managers, supervisors and employees) should collectively re-evaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve the following:

- Establishing a uniform violence reporting system and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.
- Analysing trends and rates in illness/injury or fatalities caused by violence relative to initial or ‘baseline’ rates.
- Measuring improvement based on lowering the frequency and severity of workplace violence.
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness.
- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness.
- Keeping abreast of new strategies available to deal with violence in the healthcare and social service fields.
- Surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later.
- Complying with legal requirements for recording and reporting deaths, injuries and illnesses.
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.
- Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives or other employee groups.