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| Evaluating occupational violence and aggression training  |
| Framework for health services |

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# Background

Occupational violence and aggression (OVA) training in health services across Victoria is guided by seven best-practice training principles, based on a tiered approach for different staff groups. The seven guiding principles are articulated in the Department of Health and Human Services’ 2017 [*Guide for violence and aggression training in Victorian health services*](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/violence-aggression-training-guide-health-services)<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/violence-aggression-training-guide-health-services>. These guiding principles support a consistent minimum standard for OVA training throughout Victoria.

The guiding principles were developed using evidence-based literature on standards for OVA training, particularly in emergency and mental health, as well as consultation with sector representatives.

This framework was then developed based on:

* a review of best-practice literature about the evaluation of training
* a rapid review of recent literature on OVA in healthcare
* consultation with the relevant staff in a small sample of Victorian health services (two metropolitan, two regional and two small rural)
* advice from sector representatives in the Violence in Healthcare Reference Group.

# OVA training evaluation framework

The evaluation framework supports health services to ensure that OVA training programs are targeted appropriately and give staff the skills and confidence to manage violent or aggressive behaviour. To this end, health services need to ensure training programs meet their stated objectives, and are consistent with the seven guiding principles.

The evaluation framework is accompanied by a tool (in Microsoft Word format) that health services can use to evaluate their training programs.

Implementing the guiding principles will involve modifying or expanding current OVA training programs in many health services, which have different contractual and training delivery arrangements, as well as variable content and approaches. The intent is to support health services to continue to provide OVA training that meets the needs of their local operating circumstances, but at the same time achieves consistency of content and meets minimum standards.

A longer-term goal is to eventually achieve recognition of prior learning between health services, so that OVA training completed by health service staff is recognised and ‘transportable’ as staff move between organisations and roles in the Victorian health system. Any recognition of prior learning will still require staff to participate in team activities, wherever they are based, in accordance with relevant statewide guidance, including practising Code Grey responses.

# Differences between health services

Health services that use the framework will have many differences, including:

* the rate of incidents of violence or aggression throughout the service’s work areas
* the types of incidents of violence or aggression experienced in the health service
* the types of services provided and their associated risk levels
* staffing numbers, profile and turnover
* the use of and arrangements regarding security staff (for example, whether they are employed by the health service, outsourced, or there are no dedicated security staff)
* management arrangements and responsibilities for OVA training provision, monitoring and reporting
* management awareness of and familiarity with the guiding principles
* the number and type of OVA training programs provided
* the stage of development of OVA training programs (for example, long-established programs versus those that have been running for less than 12 months)
* arrangements for OVA training provision (for example, delivered by in-house staff or an external provider)
* familiarity with and use of existing tools to monitor and evaluate OVA training
* perceived need for OVA training, and consequently whether it is a priority for the health service.

Although a health service may outsource the delivery of training or purchase training modules from a provider, the onus of ensuring adherence to the guiding principles remains with the health service.

This framework is intended to support health services to achieve consistency with the guiding principles, while accommodating the variations between health services.

# Aims of this framework

The framework aims to:

* be flexible enough to accommodate health service differences
* wherever possible, use existing data sources that form part of routine data collection in Victorian health services
* wherever possible, facilitate the use of freely available monitoring and measurement tools already developed for Victorian health services
* support the use or adaptation of existing in-house tools and processes for monitoring and measurement where preferred by a health service
* enable the tracking of trends in relevant data over time, as the guiding principles become embedded in OVA training programs across Victorian health services.

# Structure of the OVA training evaluation framework

Tables 1–7 (below) present the overarching evaluation questions, aligned with the relevant guiding principles*.*[[1]](#footnote-1)For each evaluation question, indicators and suggested data sources are provided. Where tools for collecting the data already exist (for example, tools developed by WorkSafe Victoria[[2]](#footnote-2)), these are listed as possible data sources.

The tables follow the guiding principles numerically, and do not reflect any priority between evaluation questions. The data sources are provided as suggestions, and their use will be an internal decision by relevant managers. Not every health service will be able to, or will need to, gather evidence from every data source. Varying approaches will reflect the differences between health services described above.

In 2018, health services will be at different stages of implementing and maintaining an OVA training program. To reflect this, the evaluation questions and indicators are aligned according to the stage of development of an OVA training program. This alignment is based on the evidence in the training literature about what type of evaluation could/should occur at each stage of development (phase) of a training program (see **Appendix 1**). Health services should involve their organisation’s occupational violence committee and health and safety representatives at every stage of development.

The table below shows which phases are relevant for training programs within their first six months, those that have been in place for six to 12 months, and those that have been in operation for more than 12 months.

| Maturity of OVA training program | Relevant evaluation questions | Purpose of the evaluation questions |
| --- | --- | --- |
| First six months of implementation of OVA training program | Implementation phase | Audit, needs analysis and baseline data collection |
| First six to 12 months of delivery of OVA training program | Implementation phase | Check ongoing compliance |
| Acquisition phase | Continue data collection; monitoring and review |
| More than 12 months of OVA training delivery | Implementation phase | Check ongoing compliance |
| Acquisition phase | Continue data collection; assessment and monitoring of impact; review; feedback |
| Impact phase |

# Recommended schedule for evaluating OVA training programs

This framework is not based on a fixed schedule, although health services may choose to align with other reporting processes to maximise efficiency.

In the first year, all health services should use the tool at least to evaluate the implementation phase and collect baseline data. The subsequent frequency of evaluation will vary between services.

At a minimum, annual review and evaluation is recommended.

# Using this framework

This framework should be read in conjunction with the 2017 *Guide for violence and aggression training in Victorian health services* (the guiding principles).

When evaluating their training programs, health services should refer to the full [guiding principles document](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/violence-aggression-training-guide-health-services) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/violence-aggression-training-guide-health-services>.

# Overarching evaluation questions, aligned with the principles

**Evaluation questions and indicators** are linked to:

* **the guiding principles** in the *Guide for violence and aggression training in Victorian health services* (2017)
* **phase** of development of OVA training within a health service: as a visual aid, the columns for evaluation questions and phase in each table are shaded differently for each phase, as shown below.

|  |
| --- |
| Implementation phase |
| Acquisition phase |
| Impact phase |

**Indicator numbers** link to the indicators in the accompanying evaluation tool.

**Data sources** are linked to WorkSafe Victoria tools where appropriate and to other possible tools or routine data collections or reports. WorkSafe Victoria tools are included as a guide for a health service that may not have developed or regularly used its own tools. The intention is to list tools that are freely available and can be used or adapted to monitor OVA training in an organisation.

Table 1: Questions and indicators for guiding principle 1

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Are the training programs tailored to the requirements of different staff groups in your health service? | Implementation | **1.1** Programs have been developed based on a training needs analysis of different roles and staff groups | * Staff survey (e.g. WorkSafe Victoria tool 02: staff survey)
* Other staff consultations
* Occupational health and safety (OHS) review
* Incident analyses
* Risk calculations for staff groups (e.g. WorkSafe Victoria tool T1: exposure to risk calculator; WorkSafe Victoria tool T2: aggression risk calculator)
 |
| **1.2** Relevant representative groups and staff at all levels have participated in the consultations that inform the needs analysis |
| **1.3** Training programs’ structure and content align with the knowledge and skills requirements stipulated in the guiding principles, and are tailored for different staff groups as follows:* Core training
	+ staff whose role involves contact with patients and visitors
	+ specialised areas e.g. obstetrics, adolescents, community-based workers
* Clinical staff training
* Supervisor training (including post incident response training)
* Training for security staff and non-clinical staff who support an incident response
 | * Training program structure and content
* Course participant data for each staff group in the health service
* Frequency of training or updates/refreshers for each staff group in the health service
 |
| Have staff been trained in relevant content? | Implementation | **1.4** Staff have completed training courses relevant to their role and work area | * Percentage of staff completing a training course during the evaluation period by staff group (disciplines[[3]](#footnote-3) and roles) and by training course
 |
| **1.5** Progress toward reviewing/updating content | * Contractual arrangements with external provider (if used)
* Management plans for reviews/updates
 |
| **1.6** Processes in place to update training content as new standards/requirements/resources become available |

Table 2: Questions and indicators for guiding principle 2

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Is the training delivered as part of a model(s) of care? | Implementation | **2.1** The work area’s model(s) of care is included in the training | * Contractual arrangements with external provider (if used)
* Training programs’ content
 |
| **2.2** Each training program reflects one or more of the recommended models of care:* Person-centred care
* Family/carer inclusive
* Recovery-oriented care
* Trauma-informed care
* Another approach
 |
| **2.3** Training provider has appropriate qualifications and experience in the health sector | * Trainer qualifications and experience
 |

Table 3: Questions and indicators for guiding principles 2 and 3

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Are the training strategies tiered to deliver the least restrictive interventions? | Implementation | **3.1** The content standards are met for the training of:* Primary strategies – minimising the risk of violence before violence develops (training element 3.1)
* Secondary strategies – used when violence is perceived to be imminent (training element 3.2)
* Tertiary strategies – controlling or reducing a violent incident that is already underway (training element 3.3)
 | * Training programs’ content
 |
| **3.2** While focusing on the least restrictive strategies, training also promotes awareness of the need to maintain the safety of consumers and staff |
| Have staff been trained in relevant content?Does the content taught in the programs adhere to the standards required by the guiding principles? | Acquisition | **3.3** Staff have completed training courses relevant to their role and work area | * Percentage of staff completing a training course during the evaluation period by staff group (disciplines and roles) and by training course
 |
| **3.4** Progress toward reviewing/updating content | * Contractual arrangements with external provider (if used)
* Management plans for reviews/updates
 |
| **3.5** Processes in place to update training content as new standards/requirements/resources become available |
| **3.6** Training content creates awareness of the evidence, policies and procedures supporting the use of restraint as a last resort | * Training programs’ content
* Evaluation during or immediately after training (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
 |

Table 4: Questions and indicators for guiding principle 4

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Do the training programs address the differing knowledge and skill requirements for the assessed level of risk in the local work area? | Implementation | **4.1** Needs assessments of the organisation’s work areas according to risk have informed training program content and frequency for different work areas | * Staff survey – needs assessment questions (e.g. *WorkSafe Victoria tool 02: staff survey*)
* OHS review
* Incident analyses
* Risk calculations (e.g. WorkSafe Victoria tool T1: exposure to risk calculator; WorkSafe Victoria tool T2: aggression risk calculator)
* Course content
 |
| **4.2** Training program content covers the required elements in the guiding principles for:* Low-risk areas
* Medium-risk areas
* High-risk areas, including specific requirements for supervisors and staff
 |
| Have staff completed training programs appropriate to the assessed level of risk? | Acquisition | **4.3** The following training has been completed:* Low-risk areas have completed core training
* Medium-risk areas have completed core training and additional modules
* High-risk areas have completed medium-risk training and additional modules
* Supervisors in high-risk areas have competed prescribed training
* Supervisors and staff in high-risk areas have completed recommended additional training
 | * Training register
* Percentage of staff completing a training course during the evaluation period by staff group (disciplines and roles) and by training course
 |
| **4.4** Training frequency and refresher training is appropriate to work areas | * Frequency of training or updates/refreshers for each staff group
* Training register
* Percentage of staff completing a refresher course during the evaluation period by staff group *(disciplines and roles)* and by training course
 |
| **4.5** Participants report preparedness, confidence, knowledge and skills | * Evaluation during or immediately after training (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
* Evaluation longer term after training (e.g. WorkSafe Victoria tool T4: post-training evaluation tool – medium to long term)
 |

Table 5: Questions and indicators for guiding principle 5

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Are the training methods and modes of delivery:* evidence-based?
* cost-effective?
* reflective of local need?
 | Implementation | **5.1** Training methods consist of evidence-based approaches to adult learning | * Training approaches used within a course
* Course delivery modes
* Course content
* Agendas and minutes of relevant committees
 |
| **5.2** Joint training sessions (managers, clinicians, security) are considered for high-risk areas |
| **5.3** Relevant representative groups and staff have been consulted regarding methods and modes of delivery | * Staff survey (e.g. WorkSafe Victoria tool 02: staff survey)
* Other staff consultations
 |
| **5.4** Training provider has appropriate qualifications and experience in the health sector | * Trainer qualifications and experience
 |
| **5.5** Discrete training modules support the efficient delivery of relevant information to staff | * Course content
* Risk calculations for staff groups (e.g. WorkSafe Victoria tool T1: exposure to risk calculator; WorkSafe Victoria tool T2: aggression risk calculator)
 |
| Are the training methods and modes of delivery:* evidence-based?
* cost-effective?
* reflective of local need?
 | Acquisition | **5.6** Training is accessible to all staff (i.e. time, resources and convenient modes of delivery are available for staff to complete training) | * Course participant data
* Course delivery methods
* Course evaluations (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
* Course completion rates
 |
| **5.7** Prior learning and pre-existing skills are taken into account | * Training register
 |
| **5.8** Training is delivered in a cost-effective way | * Percentage of staff trained annually
* Course participant data
* Training budget
 |
| **5.9** Refresher training is delivered annually to work areas of higher risk | * Training needs assessment (e.g. WorkSafe Victoria tool 02: staff survey)
* Risk calculations (e.g. WorkSafe Victoria tool T1: exposure to risk calculator; WorkSafe Victoria tool T2: aggression risk calculator)
* Course frequency data
* Course participant data
 |
| Are the training methods and modes of delivery:* evidence-based?
* cost-effective?
* reflective of local need?
 | Impact | **5.10** Evidence of return on investment such as:* Longer-term sustained use of acquired skills and knowledge
* Increased proportion of staff with base level of core competency
* Increased competence of staff in high-risk areas in preventing and managing OVA
* Increased staff confidence
* Improved staff perceptions of safety
* Reduced rates of injury to staff
* Increased incident reporting rates
* Evidence of recognition of prior learning
 | * Evaluation longer term after training (e.g. WorkSafe Victoria tool T4: post-training evaluation tool – medium to long term)
* Assessment of staff competence (e.g. WorkSafe Victoria tool T5: competency-based assessment)
* Staff survey (e.g. WorkSafe Victoria tool 02: staff survey)
* Incident reporting rates
* Rates of injury to staff
* Severity rating of incidents
* Proportion of incidents that do not result in staff injury
* Training register
 |

Table 6: Questions and indicators for guiding principle 6

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Do the training programs have clearly defined goals and measurable outcomes, which have been developed in consultation with relevant representative groups and staff? | Implementation | **6.1** Training goals and measurable outcomes with set timeframes are clearly articulated, and align with the guiding principles | * Course content and promotional materials
 |
| **6.2** Goals are discipline specific and appropriate for the level of pre-existing skills | * Staff survey – needs assessment questions (e.g. *WorkSafe Victoria tool 02: staff survey*)
* Training register
 |
| Do the goals and outcomes enable ongoing development of training programs, and support responsive programs that meet local knowledge and skill requirements? | Acquisition | **6.3** Training goals are monitored and reviewed | * Course data
* Course evaluations (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
* Training program review processes
 |
| **6.4** Processes are in place to feed back the training review results to inform training program development and quality improvement | * Contractual arrangements with external provider (if used)
* Post-incident procedures and policies include a feedback loop to the training program
* Evaluation during or immediately after training (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
 |
| Are the training goals met? | Impact | **6.5** Organisation has key performance indicators (KPIs) for training, which include the following as required by the guiding principles:* The proportion of staff trained
* The proportion of staff who met the goals stated in the training program
* Incident reviews and subsequent organisational or training developments
* Rates of restrictive interventions including restraint and seclusion
 | * Organisation’s KPIs
 |
| **6.6** Training is comprehensively reviewed, with evaluations conducted before, during and after training | * Pre-training baseline evaluation (e.g. WorkSafe Victoria tool T1: exposure to risk calculator; WorkSafe Victoria tool T2: aggression risk calculator)
* Evaluations during and after training (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term; WorkSafe Victoria tool T4: post-training evaluation tool – medium to long term; WorkSafe Victoria tool T5: competency-based assessment)
* Agenda items and reports for relevant committees at organisational level
 |
| **6.7** Work area needs and individual training needs are monitored and met | * Supervisor performance monitoring
* Evaluation during and immediately after training (e.g. WorkSafe Victoria tool T3: post-training evaluation tool – short term)
 |
| **6.8** Self-reported outcomes for staff such as:* Preparedness
* Confidence
* Knowledge
* Perceptions of safety
* Longer term sustained use of acquired knowledge and skills
 | * Staff survey (e.g. WorkSafe Victoria tool 02: staff survey)
* Evaluation longer term after training (e.g. WorkSafe Victoria tool T4: post-training evaluation tool – medium to long term)
* Supervisor performance monitoring
 |
| **6.9** Outcomes for staff and organisation:* Base levels of core competency for all staff who come in contact with patients or visitors
* Staff know how to respond to Code Grey and Code Black
* Increased competence of staff to prevent and manage OVA
* Increased incident reporting rates
* Reduced rates of injury to staff
 | * Assessment of staff competence (e.g. WorkSafe Victoria tool T5: competency-based assessment)
* Incident analyses
* Incident reporting rates
* Rates of injury to staff
* Severity rating of incidents
* Proportion of incidents that do not result in staff injury
* Workers compensation data such as claims, lost time, injuries etc. due to OVA
 |

Table 7: Questions and indicators for guiding principle 7

| Evaluation questions | Phase | Indicators | Possible data sources (including any available WorkSafe Victoria tools) |
| --- | --- | --- | --- |
| Is a system of review in place to ensure the best care for patients in the safest possible environment for staff? | Impact | **7.1** OVA training issues are reviewed by relevant health service committee  | * Terms of reference, agenda items and minutes for relevant committee
 |
| **7.2** Health service quality and safety committee or equivalent has a broad membership, as described in training element 7.2 | * Committee membership
 |
| **7.3** Incidents are reported to the quality and safety committee or equivalent | * Agenda items for relevant committee
 |
| **7.4** OVA data is recorded and serious incidents are reviewed in depth at multidisciplinary meetings | * Agenda items
* Minutes
 |
| **7.5** Processes are in place to feed back the results of incident reviews into training program content and quality improvement | * Contractual arrangements with external provider (if used)
* Post-incident procedures and policies
 |
| **7.6** Supervisors are trained in data collection and incident review | * Training program content
* Evaluation during and immediately after training (e.g. *WorkSafe Victoria tool T3: post-training evaluation tool – short term* [would need to be modified for management training program])
* Evaluation longer term after training (e.g. WorkSafe Victoria tool T4: post-training evaluation tool – medium to long term – level 2 aggression prevention and management training program)
 |

# Optional self-rating

In using any self-rating system, it is important to acknowledge that the OVA training program is intended to be one key contributing factor to improved outcomes in a health service. The strategy for reducing occupational violence in Victorian health services is multi-faceted and does not consist of OVA training alone. Multiple critical success factors are identified in other parts of the strategy.

This framework includes an option for a health service to rate its OVA training and assess its status on a four-point scale. After answering the evaluation questions relative to the phase of OVA training development, a self-rating can be a final check or reflection on how a service is progressing and what it may need to achieve in the next 12 months.

**This self-rating tool has been provided at the end of the accompanying evaluation tool.**

|  |  |
| --- | --- |
| Level 1 | OVA training under reviewThe health service has reviewed its OVA training needs and its current programs.Existing OVA training does not meet *all* seven principles.Further adaptation is required to comply with the guiding principles. |
| Level 2 | OVA training is compliantOVA training program* meets the requirements of the seven guiding principles
* meets all the minimum standards of the Department of Health and Human Services.

The health service can demonstrate that processes are in place to measure and track:* staff training needs
* staff behaviour change
* rates of injury to staff.

The health service can demonstrate that processes are in place to review, update and assure the quality of the OVA training program. |
| Level 3 | OVA training is compliant and effectiveOVA training program meets all the requirements of level 2 and:* follow-up evaluation (six to 12 months post-training) indicates that staff are applying the skills acquired during OVA training
* rates of reporting OVA incidents have increased.
 |
| Level 4 | Best-practice OVA trainingOVA training program meets all the requirements of level 3, and the health service can demonstrate:* sustained staff behaviour change
* reduction in rates of injury to staff.

Independent assessments of staff competence indicate that staff have acquired the appropriate skills during OVA training and can apply them.Training programs of the health service may be used as a model and adapted for use by other health services. |

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# Appendix 1: Phases of evaluation in the OVA training evaluation framework – subject of evaluation and evidence base

| Phase of evaluation | Subject of evaluation | Evidence base: what should be evaluated? |
| --- | --- | --- |
| Implementation | Process evaluation:* Development/transition of training programs to align with guiding principles and meet minimum standards
 | * Line of sight phase: is the learning and development appropriate? (Australian Public Service Commission)
* Program design: needs assessment, evaluation of alternatives, quality assurance, how training is delivered (Armstrong)
 |
| Acquisition | Process evaluation: * Reaction to training
* Learning from training
 | * Learning and performance phase: is the learning and development well conducted and managed, and does it help learners gain and transfer the necessary capabilities? (Australian Public Service Commission)
* Reaction to the training: how much is learned, for improvement of future programs (Kirkpatrick)
* Reaction to training, knowledge acquisition, behavioural intention (Armstrong)
 |
| Impact | Evaluation of outcomes:* Reaction to training
* Learning from training
 | * Outcome phase: does the learning and development produce tangible and intangible results, and what impact do these have on individuals and the organisation? (Australian Public Service Commission)
* How trainees apply what they have learned, and whether training has benefited the organisation (Kirkpatrick)
* Work behaviours, change in others, organisational changes and impacts (Armstrong)
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See the References section on the previous page for full details of the sources cited in this table.

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| To receive this publication in an accessible format email Worker Health and Wellbeing <whwb@dhhs.vic.gov.au>Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Department of Health and Human Services, March 2018.ISBN 978-1-76069-290-2 (pdf/online)Available at the [Occupational violence and aggression – training page on the health.vic website](https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/training) <https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/training>(1802028) |

1. The department’s [*Framework for preventing and managing occupational violence and aggression*](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/occupational-violence-aggression-healthcare-framework-2017) *<*https://www2.health.vic.gov.au/about/publications/policiesandguidelines/occupational-violence-aggression-healthcare-framework-2017> provides guidance to health services on preventing and responding to OVA from an organisation-wide perspective*.* In that document, principles and key components in the training domain also align with this evaluation framework*.* [↑](#footnote-ref-1)
2. Please note: the use of WorkSafe Victoria tools is not mandated. However, consultations with health service representatives found that various WorkSafe Victoria tools are used by some health services. These tools are available in WorkSafe Victoria’s [*Information for employers: prevention and management of violence and aggression in health services*](https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0006/210993/ISBN-Prevention-and-management-of-violence-and-aggression-health-services-2017-06.pdf) (edition number 2, June 2017) <https://www.worksafe.vic.gov.au/
\_\_data/assets/pdf\_file/0006/210993/ISBN-Prevention-and-management-of-violence-and-aggression-health-services-2017-06.pdf>. [↑](#footnote-ref-2)
3. Multidisciplinary training is a key tenet of the guiding principles. While it is recommended that work teams are trained together, it is suggested that monitoring the completion of training by all disciplines is an important measure when evaluating training. [↑](#footnote-ref-3)