Information for employers

Prevention and management of violence and aggression in health services

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WorkSafe Victoria (WorkSafe) recognises and appreciates the time and expertise given by all professionals, organisations and associations who participated in the original development of the guidebook and this refreshed version.

This version of the guidebook is being released to coincide with the launch of a public awareness campaign targeting occupational violence and aggression (OVA) in healthcare, developed in collaboration with the Department of Health and Human Services (DHHS) and Ambulance Victoria. The key message of the campaign is that violence and aggression towards healthcare workers is never okay.
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Rural Ambulance Victoria
South West Healthcare
Southern Health
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Western Health.
1. Introduction

1.1 Purpose and scope

Prevention and management of occupational violence and aggression (OVA) is an occupational health and safety (OHS) issue that requires a multi-faceted organisational approach. Employers should identify, prevent and manage OVA in health service workplaces.

This guidebook aims to help health service employers understand their duties under the Occupational Health and Safety Act 2004 (Vic) (OHS Act), and provides guidance on how to:

• identify hazards and risks related to OVA
• implement appropriate control measures
• respond to incidents and learn from incidents to improve prevention.

This guidebook is designed to be a resource for managers, supervisors, health and safety representatives (HSRs) and others involved in developing strategies to prevent and manage OVA. The guidance in this guidebook may also be useful to employees.

This guidebook should be read in conjunction with the toolkit found at the end of the publication. References to these tools are made throughout this guidebook.

1.2 Definitions

Occupational violence and aggression (OVA)

OVA involves incidents in which a person is abused, threatened or assaulted in circumstances relating to their work. In this guidebook, OVA includes a broad range of actions and behaviours that can create risk to health and safety of employees. It includes behaviour often described as acting out, challenging behaviour and behaviours of concern.

OVA can result in an employee sustaining physical and/or psychological injuries, and can sometimes be fatal. Employees can be exposed to OVA from a range of sources including clients, consumers, patients, residents, visitors and members of the public. Examples of OVA include, but are not limited to:

• biting, spitting, scratching, hitting, kicking
• pushing, shoving, tripping, grabbing
• throwing objects, damaging property
• verbal abuse and threats
• using or threatening to use a weapon
• sexual harassment or assault.

Threat

In this guidebook, threat means a statement or behaviour that causes a person to believe they are in danger of being physically attacked. It may involve an actual or implied threat to safety, health or wellbeing. Neither intent nor ability to carry out the threat is relevant. The key issue is that the behaviour creates a risk to health and safety.

Health Services

For the purposes of this guidebook, health services include acute health services, mental health services, and aged care services. They include public, private and denominational health services. However many parts of this guidebook may be applicable to other workplaces.

1.3 Leadership

Prevention and management of OVA requires active engagement from all levels of the health service, starting with the board and senior leadership including the CEO.

Board and senior leadership’s active and visible commitment to systematic prevention and management of OVA is critical in driving continuous improvement. Senior leadership can have a powerful influence in developing a positive safety culture where priority is placed on the health, safety, and wellbeing of employees.

Senior leadership should demonstrate a commitment to a culture where OVA is not accepted as part of the job by:

• setting health and safety objectives and accountabilities
• ensuring effective health and safety systems of work are in place to identify and control risk
• allocating resources to prevention and management of OVA
• developing and promoting policy and key initiatives
• consulting with and supporting employees
• monitoring and reporting on performance outcomes and acting on issues and opportunities for improvement.

Board members and senior leadership should also carry key accountabilities for the delivery of OHS improvement initiatives, including the prevention and management of OVA.
2. OVA and the law

2.1 Context

Victoria’s health services operate within a complex legislative environment. This guidebook has been developed in reference to the requirements of the OHS Act and the OHS Regulations.

Occupational Health and Safety Act 2004

Health care employers have a responsibility to comply with Victoria’s OHS laws, including the duty to provide a workplace free from risks to health and safety. OHS duties are designed to ensure the highest level of protection to employees, patients and others in the workplace from risks to their health, safety or welfare.

Managing OHS risks can ensure health services are effectively delivered and employees are protected.

Under the OHS Act, employers must consult with employees and HSRs, so far as is reasonably practicable, when, for example, identifying or assessing hazards or risks to health or safety at a workplace. Both employees and HSRs are a valuable resource in planning an effective and safe workplace design because they typically know the work practices and workplace better than anyone. While not mandatory, consideration should also be given to consulting patients.

The OHS Act also imposes duties on, for example, employers, self-employed persons, a person who manages or controls a workplace (eg an owner), designers of buildings or structures, manufacturers and, employees (including independent contractors and their employees).

See the WorkSafe Position How WorkSafe applies the law in relation to Reasonably Practicable for information on complying with statutory duties under Victoria’s OHS laws at worksafe.vic.gov.au.

Workplace Injury Rehabilitation and Compensation Act 2013

The Workplace Injury Rehabilitation and Compensation Act 2013 regulates Victoria’s WorkSafe workplace injury compensation and rehabilitation system.

WorkSafe compensation is a statutory no-fault compulsory insurance scheme. Employers, where required, must take out a WorkCover policy to insure themselves against compensation claims for workplace injuries and diseases. The scheme aims to insure employers against the impact of economic loss caused through injury to workers.

Employees are entitled to WorkCover benefits if they suffer a work-related injury or disease. If an employee is unable to perform their normal duties because of a work-related injury, the employee may be entitled to weekly benefits. WorkCover will also pay the approved costs of medical and like services required due to work-related injury or disease.

Other Legislation

Other legislation relevant to OVA in Victoria includes the:

- Crimes Act 1958
- Summary Offences Act 1966
- Mental Health Act 2014
- Aged Care Act 1997
- Information Privacy Act 2000
- Health Records Act 2001
3. Review, prepare and implement

3.1 Context
Organisations should have a solid foundation on which to build relevant, sustainable and continuously improving strategies to prevent and manage OVA. These strategies should be based on organisation-wide OHS risk management. The recommended approach is cyclic and underpinned by consultation with employees and HSRs as required by the OHS Act.

3.2 Preparation
Preparation should consider the operational and organisational impact of policies and procedures and any changes that need to be made to documents, building design or work practices.

Solid preparation should answer the following key questions:
• What data and other information needs to be accessed?
• Who will lead the preparation?
• Who will be consulted?
• How will information be collected and analysed?
• How and to whom will outcomes be reported?

Answering these key questions provides a starting point for preparing **Tool 01 – Organisational self-assessment** that can help:
• identify an organisation's current situation related to compliance, governance, policies and procedures
• guide decisions about priorities for action to prevent and manage OVA
• provide a baseline from which to review progress associated with implementing policy and practice changes and other control measures.

A staff survey could also be used to identify staff knowledge of organisational requirements and their needs in relation to continuing education and training. A sample staff survey can be found at **Tool 02 – Staff survey**. Alternatively, **Tools T1-Exposure to risk calculator** and **T2 – Aggression risk calculator** could be used for self-reporting risks associated with exposure to OVA. Feedback should be provided to employees from reports and surveys, particularly if any corrective action or changes to policy and/or procedures are necessary.

Once an organisational self-assessment has been completed, preliminary hazard identification should be done to identify risks associated with:
• current compliance requirements
• organisational shortfalls (eg current governance structure, policies, procedures and training programs)
• environmental impacts.

Risk management
The aim of OHS risk management is to eliminate or reduce risks to health and safety in the workplace, so far as is reasonably practicable. It is a continuous process of hazard identification, risk assessment and control, and evaluation of control measures. Employers must consult with employees and their HSRs (if applicable) when, for example, determining risk controls in the workplace.

A comprehensive risk assessment can form part of the initial preparation stage of the OHS continual improvement cycle. A risk assessment can help identify hazards in the workplace and the frequency of potential exposure to risks. In turn this will help guide the implementation of control measures.

Remember: just because there is no history of incidents, does not mean hazards do not exist.

Hazard identification in the context of OVA prevention and management
The nature and location of work, type of clients, business hours, service and facility access, staffing levels and employee skill mix all affect the hazards present in a workplace and the risk of exposure to OVA.

The factors listed below may increase the likelihood and risks of employee exposure to OVA:

**Workplace design:**
• unrestricted movement of the general public throughout health service facilities to areas that are easy to access or unsecured
• poorly-lit areas of a facility
• limited access and exit points, privacy, ease of access to telephone and toilet facilities.
Review, prepare and implement

Policies and work practices:
- long waiting times
- low or inadequate staffing levels and skill mix
- visiting times (eg visitors may be aggressive, or may trigger aggression in clients)
- poor customer service
- isolated or remote working locations
- denying someone service
- handling cash
- investigating and/or enforcing specific legal requirements (eg mandatory reporting of child abuse)
- noise
- activity at night.

Client related:
- physiological imbalances or disturbances
- substance misuse or abuse
- intoxication
- acute and chronic mental health conditions
- distress or frustration.

These examples are not exhaustive and there may be other situations that expose staff to risks of OVA, particularly where there is direct interaction with the public.

Incident and injury record review or audit

Review of incident and injury records, first aid reports and workers’ compensation claims may help analyse trends and identify patterns of OVA.

The data should be analysed to establish a baseline for monitoring changes in reporting, measuring improvement, and to monitor and analyse trends. The data can also be used to support decision-making processes associated with setting priorities for further investigation, assessment, action or review.

Walk-through inspection and checklist

A checklist is a useful way of identifying hazards and does not require expertise in OHS. It is a systematic way of gathering and recording information quickly to ensure hazards are not overlooked. A checklist may help identify issues to be considered during risk assessment.

Things to consider in a walk-through inspection are:
- security
- entry and exit points/options
- lighting
- methods of communication
- work schedules
- physical layout and natural surveillance points, and
- service delivery processes.

Risk assessments

A risk assessment involves examining hazards that have been identified in the workplace in detail to assess whether they give rise to a risk of injury.

Risk assessments can help determine whether a hazardous situation may result in harm and can assist employers make decisions about appropriate control measures.

When assessing the risks of OVA, the following questions should be asked:
- How likely is it that an act of violence or aggression will occur?
- How severe would the impact of such an act be?
- Is there any information regarding previous incidents of violence or aggression in the workplace?
- Do control measures exist and are they adequate?

A written record of risk assessments will assist with periodic reviews, whether done annually, when operations change or when incidents of OVA occur. Risk assessments also help assess the effects of change, provide a body of organisational evidence that will identify achievements and assist in further decision-making.

Tool T1 – Exposure to Aggression Risk Calculator uses a risk matrix to self-report exposure to OVA that might otherwise go unreported and could be used as part of the hazard identification and risk assessment process.
Review, prepare and implement

Incident and ‘near miss’ investigation

Tool 01 - Organisational self-assessment allows for the review of current systems, expectations and processes associated with reporting and investigations.

Incident management and investigation is discussed in chapter 5.

3.3 Risk Control

Risk control is a process of implementing effective measures to eliminate or reduce risks to health and safety, so far as is reasonably practicable. Under the OHS Act an employer must eliminate risks to health and safety, so far as is reasonably practicable. If risks cannot be eliminated, the OHS Act requires risks to be reduced so far as is reasonably practicable.

3.4 Review

When reviewing control measures, check if the introduced controls have reduced the risk from when it was previously assessed. This may require hazard identification and risk assessments to be repeated to ensure all risks to health and safety have been controlled so far as is reasonably practicable.

Where the review of risk control measures reveals some remaining risk, a new risk assessment should be conducted and new control measures considered and implemented to ensure the risk is reduced so far as is reasonably practicable. Satisfactory control of risk is often a continual consultative process that involves trialling and refining control measures and considering employee feedback, new technology and changes in knowledge.

The review of risk controls should also analyse data such as incident data to guide ongoing decisions about further actions.

3.5 References

More information on the risk management process can be found in WorkSafe’s Controlling OHS Hazards and Risks at worksafe.vic.gov.au.
4. Workplace design

4.1 Context

This part of the guidebook provides guidance on how to establish and maintain employee safety and security by developing appropriate facilities, work spaces, building services and systems.

It will assist anyone involved in the design, development and management of health services to identify environmental risk factors for OVA.

The objective is to eliminate or reduce, so far as is reasonably practicable, the likelihood of OVA occurring by using safe design, as this may be more effective in reducing risk than relying on work procedures or training alone.

4.2 Design process

Eliminating risks by good design involves incorporating OHS into the design process from the beginning. Important decisions should be made early in the design process. This is because it may become more difficult and costly to make changes as the project progresses.

When designing a new health service workplace or altering an existing workplace, design processes should follow a risk assessment and involve consultation with employees and HSRs.

It is important to specifically consider OVA at all design stages for refurbishment or extensions to existing health services and for new purpose-built facilities.

It is also important to monitor the progress of any refurbishment/extension work as changes made to designs during implementation may create additional safety risks.

Strategies for ensuring good consultation on design can include:

- creating user groups - user groups should be made up of a mix of managers, employees, HSRs and designers. External users, such as Ambulance Victoria when designing an emergency department, should also be involved.
- training the user group in design awareness including skills and knowledge in relation to the design process.
- establishing a transparent consultation process – clearly document and conduct it in a language and style suitable for all participants.
- visualising the design – use tape or chalk on the floor to do a simple mock-up of an area, computer mock ups, layout plans etc.

**Stages of the design process**

Involve key stakeholders, including direct care staff, during the whole design process to achieve the best result. An integrated approach to considering safety (and, in particular, the threat of OVA) should occur at each design milestone. Good design can eliminate or reduce the risk of OVA, enhance quality of care, and optimise workflow and communication.

**Tool D2 – Violence and the design process** outlines issues that should be considered at each stage of the design process.

The table below outlines some of the key stages in the design process and the associated activities and considerations.

Remember: it is easier to change a line on a drawing than to alter a finished building. The WorkSafe publication *Designing Safer Buildings and Structures* provides guidance and tools for use in the design process and to help follow the recommended process to address OHS issues.
## Workplace design

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activities/considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design brief preparation</td>
<td>Establish consultation structures. Brief user groups. Develop design awareness.</td>
</tr>
<tr>
<td>Feasibility</td>
<td>Map out and cost design proposal to determine if the scope is realistic given available resources. Focus on issues that may influence the potential for OVA to occur such as the location of key entries and exits. Consider the location of key departments that may influence the potential for OVA to occur (eg locate emergency department so that access is limited and separate from core hospital areas).</td>
</tr>
<tr>
<td>Contract documentation</td>
<td>Select and cost materials. Consider OVA-related design issues such as colours and lighting.</td>
</tr>
<tr>
<td>Construction</td>
<td>While the building is being constructed, there may be some issues relating to OVA that need to be considered, such as construction noise or the closure of some areas, which should be communicated to clients and visitors.</td>
</tr>
<tr>
<td>Post-occupancy evaluation</td>
<td>Evaluate any design shortcomings that may impact on employee, client or visitor safety. Collect, review and analyse data on OVA and the impact of design.</td>
</tr>
</tbody>
</table>
4.3 Crime prevention through environmental design (CPTED)

CPTED can be used to address OVA. Principles should be applied to health service environments and incorporated into the work of architects, engineers, builders, maintenance staff and landscape gardeners.

CPTED principles fall into three broad categories:

1. **Territorial reinforcement** which aims to create a strong sense of ownership of a space. It is promoted by features that define property lines and distinguish staff areas from public spaces, such as landscaping, signs, gateways and fences. Ongoing maintenance and housekeeping are key aspects of territorial reinforcement to show the space is cared for.

2. **Access control** should be provided through physical and symbolic barriers to prevent unauthorised access to an area, such as locks and signage. It will attract, restrict or channel movement by making it clear where people can and cannot go.

3. **Surveillance** aims to ensure key areas, such as interview rooms, waiting areas and pathways to car parks, are clearly visible to staff. It can be electronic (eg CCTV) or natural (eg windows or by strategically positioning buildings, access-ways and meeting places, and lighting).

4.4 Design controls

General high-risk areas

Reception and waiting areas

As areas of first public contact, receptions and waiting rooms should provide security and protection for employees, while still allowing good communication with clients and visitors. They should be designed to prevent unauthorised entry and also provide staff with good visibility of people entering the area and using the waiting room.

The reception area should be easily identifiable, accessible and properly staffed to minimise client or visitor impatience and irritation. Clear signs should indicate where clients or visitors should report, particularly if they are to undergo triage before they register.

The reception desk serving the main entrance should allow for surveillance of everyone entering the hospital. A high and wide desk increases the distance between a receptionist and visitor, offering some level of protection. Height differentials can contribute to a person’s ability to exhibit intimidating behaviours therefore, staff should be seated at eye level with visitors (or higher). The desk should be clear of items that could be used as weapons and separation windows can also be used to enhance employee protection.

Treatment and interview rooms

High visibility and controlled access to interview rooms can assist in reducing the risk of OVA, and having two entry/exit doors can allow for appropriate means of escape by staff should it be required. The layout should not permit obstacles between staff and the door, and furniture should be arranged to prevent employees from becoming trapped or cornered.

The decor should have a calming effect on the client, with comfortable but minimal furniture in interview rooms or crisis treatment areas. Furniture and fittings (eg picture frames) that are difficult to use as weapons (eg hard to lift, without sharp corners and edges) should be used.

Rooms should be square-shaped, have two doors, secured/controlled access, and duress alarms. Glass windows should be made of safety/laminated glass. Windows that are one-way or that can be switched between opaque and transparent can be helpful for maintaining visibility without disturbing clients. Doors should be outward opening with peep holes if required. Door handles should move in a downward motion or can be non-ligature.

Staff/nurses station

The staff/nurses station is the primary space where visitors will engage with employees and the main hub where employees will congregate to undertake administrative duties. The following should be considered:

- a high and wide reception desk
- desk based duress alarms that can be used in times of distress
- a second exit/door from the office area or a “safe” secure room that employees can escape to
- reflective mirrors if corner vision is required from the nurses station

Desk space should be kept clear of any items that could be used as a weapon such as vases, staplers, pamphlet holders or scissors.
Pharmacy and drug rooms

Pharmacy and drug room design should incorporate a secure physical separation between pharmacy operations and the public. Integrated security systems should also be used for access and audit functions. Design considerations should be applied to medication distribution points and medication rooms.

The pharmacy is a vulnerable part of the building and should have a separate alarm zone within the main alarm system.

The design of pharmacy locations should start with the perimeter barrier to the space and include infiltration-resistant protective measures that start from a solid floor to a solid ceiling or roof. Design should prevent access from suspended ceilings through air ducts, cable or utility infrastructure, roof hatches, skylights, and unprotected external windows or doors etc.

To prevent customers coming into direct contact with employees, the pharmacy counter should be high and wide and the floor behind it should be raised if employees prefer a seated position.

Screens should be made out of laminated glass. Ideally, there should be a transaction drawer or alternatively, a security window which has an opening large enough to permit communication and transactions only. A fully opening window should be avoided. A duress alarm should be fitted behind the counter and there should be natural surveillance and CCTV coverage of the pharmacy area. Controlled drugs, such as narcotics should be secured in lockable storage cupboards and toilets should not be located in or near the pharmacy or drug rooms.

Employees and others authorised to access the pharmacy should do so through one primary entry point that has restricted access. An audit trail should be kept of all entries through this and any other entry points. Delivery and receipt of goods should be channelled through a designated controlled entrance that allows for screening of personnel prior to entry. A video intercom or other visual mechanism should be installed to allow employees to view and communicate with those requesting access.

Drug rooms should be secured (swipe card/code access) with only authorised access allowed. Doors should be self-closing and a viewing window should be in place to allow natural surveillance.

Car parking

Staff parking should be within safe, designated areas and include:
- limited and controlled access
- a defined perimeter
- natural surveillance over the whole area
- ample lighting
- low-level defensive planting
- traffic-slowing measures
- one-way systems
- separate footpath/vehicle routes.

Cash office

The cash office is another vulnerable part of a building and should also have a separate alarm zone within the main alarm system. It should not form any part of the external structure, but be within easy reach of the main entrance. The walls should be masonry and built to the underside of the floor above. The office should also be fitted with a laminated glass screen to provide security for employees handling cash.
High-risk areas

Emergency Department (ED) or Emergency Room

<table>
<thead>
<tr>
<th>Factors that may increase the risk of OVA:</th>
<th>Examples of design control measures</th>
<th>Supporting measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• waiting times</td>
<td>• limit public entry points</td>
<td>• give employees authority to grant or refuse entry</td>
</tr>
<tr>
<td>• other people</td>
<td>• control access to treatment areas</td>
<td>• ensure duress and emergency response procedures, including Code Grey, Code Black and other responses, are in place</td>
</tr>
<tr>
<td>• providing care to people who are in distress, afraid or under the influence of drugs and/or alcohol</td>
<td>• provide comfortable, spacious waiting areas with enough seating for peak demand times</td>
<td>• ensure lockdown procedures are in place</td>
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<tr>
<td>• substance abuse</td>
<td>• provide safe rooms/secure areas for staff to retreat to during OVA emergencies</td>
<td>• ensure security and reception employees are able to see all areas of the ED through the use of security cameras and/or mirrors</td>
</tr>
<tr>
<td>• volatile emotional situations</td>
<td>• separate paediatric and adult waiting areas</td>
<td>• ensure employees are clearly identified (eg use ID badges with triple-break lanyards or retractable key/ID fobs that clip to pockets/belt loops)</td>
</tr>
<tr>
<td>• clinical aggression</td>
<td>• ensure clear signage for way finding</td>
<td>• identify visitors upon entry</td>
</tr>
<tr>
<td>• mental health conditions</td>
<td>• provide private areas for separation of distressed or disturbed people</td>
<td>• install computer systems that support retrieval of patient information including alerts for aggressive behaviour</td>
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<tr>
<td>• cognitive impairment etc.</td>
<td>• install wide and screened reception counters</td>
<td>• implement a weapons management policy</td>
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<tr>
<td></td>
<td>• use strategic CCTV and monitoring</td>
<td>• locate security staff close to the ED.</td>
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<td></td>
<td>• consider the queuing system used (eg use a ticket/number system)</td>
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<td></td>
<td>• install bollards to restrict vehicle access near doorways</td>
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<td></td>
<td>• remove narrow underpasses or lanes leading to car parks and public transport</td>
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<tr>
<td></td>
<td>• separate staff car parks from visitor/client parking and ensure they have ample lighting</td>
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<tr>
<td></td>
<td>• install desk based duress alarms and/or provide personal alarms</td>
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<td></td>
<td>• ensure direct/separate access for high violence risk clients</td>
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<td></td>
<td>• where possible, affix items (eg chairs and tables) to walls or floor</td>
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<td></td>
<td>• provide secure storage for potentially dangerous items</td>
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<td></td>
<td>• provide a gun safe for the temporary storage of emergency services firearms (ie for when armed police officers present with a patient)</td>
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<tr>
<td></td>
<td>• flush mount fixtures and fittings (ie not just mounted on a wall, but inset) and unbreakable.</td>
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</tbody>
</table>
# Workplace design

## Maternity and Paediatric Units

<table>
<thead>
<tr>
<th>Factors that may increase the risk of OVA:</th>
<th>Examples of design control measures</th>
<th>Supporting measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• volatile emotional situations</td>
<td>• control access to treatment areas</td>
<td>• identify visitors before they enter these units</td>
</tr>
<tr>
<td>• family disputes</td>
<td>• ensure employees can actively monitor entrances using natural surveillance and CCTV</td>
<td>• actively monitor visitors’ movements using natural surveillance or CCTV</td>
</tr>
<tr>
<td>• family violence, and/or</td>
<td>• install desk based and personal duress alarms.</td>
<td>• ensure employees are clearly identified (eg use ID badges with triple-break lanyards or retractable key/ID fobs that clip to pockets/belt loops)</td>
</tr>
<tr>
<td>• child protection issues.</td>
<td></td>
<td>• implement duress and emergency response procedures</td>
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<td></td>
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<td>• locate meetings related to child protection issues away from other clients</td>
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<tr>
<td></td>
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<td>• implement clear communication processes between the unit and child protection officers.</td>
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</tbody>
</table>

## Aged Care

<table>
<thead>
<tr>
<th>Factors that may increase the risk of OVA:</th>
<th>Examples of design control measures</th>
<th>Supporting measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• change in routine</td>
<td>• control stimuli (eg noise, pedestrian traffic)</td>
<td>• provide a set routine with regular employees</td>
</tr>
<tr>
<td>• disinhibition</td>
<td>• provide safe walking circuits</td>
<td>• provide clients with activities, distractions, sensory modulation and choice</td>
</tr>
<tr>
<td>• dementia</td>
<td>• allow clients sufficient personal space in bathrooms, bedrooms and dining areas and provide unobstructed travel paths to these areas</td>
<td>• maximise resident independence.</td>
</tr>
<tr>
<td>• anxiety</td>
<td>• use access control to specialised wards and exit doors/lifts where required</td>
<td>• carry out risk assessment and screening of residents prior to admission</td>
</tr>
<tr>
<td>• fear, and inappropriate placement of clients into unsuitable facilities.</td>
<td>• ensure employees can actively monitor entrances using natural surveillance and CCTV</td>
<td>• communicate behavioural expectations to client and family prior to admission</td>
</tr>
<tr>
<td></td>
<td>• provide adequate space and ensure living and common areas are uncluttered</td>
<td>• be flexible in timing of care tasks.</td>
</tr>
<tr>
<td></td>
<td>• install ample lighting and provide access to natural light</td>
<td>• develop a communication system that alerts employees to client behaviour / mood (eg use of a traffic light system)</td>
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<tr>
<td></td>
<td>• install appropriate floor coverings with no trip or slip hazards</td>
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</tbody>
</table>

### Mental Health

#### Factors that may increase the risk of OVA:
- client mix
- overcrowding
- inadequate staffing
- substance misuse
- boredom
- delirium
- restrictions on smoking
- involuntary admission and absconding
- psychological state of patient.

#### Examples of design control measures
- ensure good visibility, especially for entrances and exits
- provide appropriate space (including outdoor areas) so patients have adequate personal space to retreat to when threatened or do not want to interact with others
- provide secure storage for potentially dangerous items, such as kitchen and occupational therapy equipment and/or visitor belongings
- provide a safe isolation room
- flush mount fixtures and fittings (i.e. not just mounted on a wall, but inset)
- fix furniture to walls, floors or ceilings where appropriate
- install outward-opening doors
- provide good ventilation and acoustics (e.g. soundproofing)
- create direct access routes to the facility from other areas such as the ED
- create female only areas.

#### Supporting measures
- provide a set routine with regular permanent employees
- provide clients with activities, distractions, sensory modulation and options
- maximise client independence.
### Workplace design

#### Other considerations for health services

<table>
<thead>
<tr>
<th>Area</th>
<th>Risk/Problem</th>
<th>Controls</th>
</tr>
</thead>
</table>
| Noise           | Noise can be irritating and/or overwhelming and can exacerbate stress and aggression, particularly in people with cognitive impairments. | • avoid loud volumes on communal area televisions and radios  
• use teletext/ captions on waiting room televisions  
• decrease the number and volume of overhead paging and bells  
• use soundproof walls or double-glazed windows to reduce noise from the external environment  
• natural sounds and background music can be relaxing and help reduce stress |
| Light           | A lack of natural light can cause distress and have negative effects on mental health, including social withdrawal and general unhappiness. Glare can have a similar effect on behaviour. | • install windows or skylights to provide natural light  
• avoid harsh overhead artificial lighting. Instead, use diffuse and glare-free lighting which can contribute to a relaxed environment |
| Colour          | The colours of walls, buildings, signs and uniforms have been found to impact on human behaviour. | • Soft shades of pink have been found to reduce anxiety, blood pressure, arousal and time taken to return to a calm state  
• To help minimise anxiety, a bright room with light colours is preferred over a room with dark colours |
| Temperature and climate | The likelihood of aggression increases as the temperature does. | • install climate control systems  
• ensure adequate ventilation, especially when rooms are at maximum capacity |
| Space           | Lack of space can increase agitation. | • provide indoor and outdoor spaces where clients can be alone or spend time with visitors  
• consider furniture on wheels that can be safely moved to clear a path for clients with limited mobility and their carers  
• design waiting areas to minimise over clustering of clients |
| Safe zones      | There are times when a situation cannot be defused and staff must retreat for personal safety. | • provide a safe area for staff to retreat to in case of OVA |
4.5 Security and access

Effective building security requires:

- secure perimeters, including doors and windows (eg through controlled access, self-closing doors, air locks)
- safe access and exit, especially after hours and during emergencies
- controlled access to vulnerable areas (eg through swipe card access and elevator control)
- clear signage
- systems that allow employees to be identified.

Furthermore, the security operating system needs to be:

- secure enough to resist attempts to breach it
- able to effectively differentiate between those who have authorised access and those who do not
- able to prevent unauthorised entry but not prevent exit
- reliable, regularly maintained and tested
- designed to include a back-up system or process for providing access in the event of failure.

4.6 Alarm systems

The choice of an alarm system depends on the nature of the workplace, the activities undertaken and the level of risk. Employees working in the relevant areas should be consulted when determining alarm system requirements, where alarms should be located and protocols for its use.

When identifying appropriate alarm systems, health services should consider if:

- the alarm system complements other security/protective measures
- the alarm system’s features and configuration suit the facility’s needs and risks (expert advice should be sought)
- employee training in the use of the alarm system and response procedures is needed
- ongoing maintenance of the system (eg schedule of replacement of batteries for mobile duress alarms) is needed
- what testing of the system is needed (eg testing by clinical staff at each shift change).

A duress alarm is only a means of indicating that someone needs assistance – the response to the signal is the important part of the duress process. It is essential to establish a reliable and timely response system to an alarm (see 5.7 Incident Management). Alarm drills are a good way to test if the duress response system is working.

Duress alarms

A duress alarm emits a signal to call for assistance when a person is under attack or feels threatened. When installing a duress alarm, identify the features required and ensure:

- fixed alarms with duress buttons are strategically located throughout the facility
- mobile duress alarms are worn by at risk employees inside and outside the facility
- an electronic global positioning system (GPS) is used.

Fixed alarms

Fixed alarms or panic buttons should be hard-wired and operated by strategically placed and easy-to-reach buttons installed throughout the area where a potential threat exists.

Personal alarms

Personal duress alarms may be used where an employee is ‘mobile’ in the course of their work. For example, in wards or emergency departments where there is a risk of being confronted by aggressive behaviour. Personal alarms should be attached to an employee's clothing, but not worn around the neck.

Training

Employees should be trained in how to effectively use equipment and security features (eg alarm systems and access control systems) at induction and refresher training.
Workplace design

4.7 Resources

WorkSafe resources (available at worksafe.vic.gov.au):
Working Safely in Visiting Health Services
Designing Safer Buildings and Structures

Department of Health and Human Services resources (available at health.vic.gov.au)
Chief Psychiatrists guidelines
Safewards

Industry Standards and Guidelines:
Emergency Department Design Guidelines, Australasian College for Emergency Medicine, 2014

Other resources:
Royal Women's Hospital and Bendigo Health:
Strengthening hospital responses to family violence project: haveyoursay.thewomens.org.au/shrfv-project
5. Policy, procedures and practice

5.1 OVA prevention policy

Developing and implementing an OVA prevention policy clarifies behaviour expectations and demonstrates a commitment to OHS. The policy should be developed through consultation across the organisation with HSRs, employees, managers and other relevant stakeholders.

A policy should include the following elements:

**Purpose statement**

The purpose statement should reflect:
- an intention to provide a safe and healthy workplace where employees are not subjected to OVA
- a commitment to support employees who are exposed to, or have witnessed, OVA.

**Definition of scope**

- The policy should include a definition of OVA.

**Objectives**

Objectives of the policy should outline that:
- OVA is not acceptable and will not be tolerated
- appropriate action will be taken if OVA occurs
- reporting incidents is mandatory and based on a no-blame approach to investigation
- incidents will be investigated with a view to prevention and continuous improvement
- training and educating employees in the prevention and management of OVA is tiered and based on exposure to risk, following OHS principles that are updated and ongoing.

**Responsibility**

The policy should outline roles and responsibilities of relevant employees and give them appropriate authority to carry out their responsibilities under the policy.

**Risk management**

The policy should address:
- proactive hazard identification and risk assessment of situations and sources of risk
- risk control designed to eliminate or minimise the risk of violent and aggressive behaviour
- systems for communicating/sharing information internally and externally about clients or visitors who have a history of or are currently exhibiting violent or aggressive behaviour, including triggers and management strategies
- references and related documents.

The policy should include documents and sources used to formulate the policy and related organisational documents.

**Authorising committee/position in the organisation**

The policy should be endorsed by senior leadership and any authorised committees.

**Dates of approval and review date**

The policy should be regularly monitored and reviewed to ensure it reflects changes in legislation and organisational needs.

The policy should be formulated in consultation with HSRs and employees and reflect the organisation’s specific requirements. The policy should also be displayed in a prominent place for all employees to view.

An example policy is attached to this document as Tool P1 – Violence prevention policy. If this example is going to be used as a starting point, consider how it may need to be adapted to the organisation’s specific requirements following consultation with HSRs and employees.

5.2 Organisational procedures

Health services should communicate that OVA will not be tolerated and that appropriate action will be taken if such behaviour occurs. This should be supported by the organisational policies, procedures and codes of conduct.

Health services should develop a staged approach to the management of OVA and outline the approach taken in an OVA policy and accompanying procedures. A staged approach may include:
Policy, procedures and practice

- warnings, alerts and care planning
- restriction of visiting rights
- alternate treatment arrangements
- contracts of acceptable behaviour
- conditional treatment agreements
- refusal of service (except for treatment of life-threatening conditions)
- prosecution.

The options in the staged approach should be applied in descending order taking into account:

- the level of risk
  - frequency and severity of the behaviour
  - extent of exposure of staff
- ability of the client or visitor to understand the issues associated with the behaviour
- capacity to modify behaviour
- previous attempts to resolve the matter
- the ability to read and understand English.

**Warnings**

A written warning should:

- focus on the behaviour and possible effects the behaviour may have on employees, other clients and visitors and not on the person or their intent
- be drafted in consultation with key stakeholders such as relevant clinicians
- clearly identify the matter of concern and expected acceptable behaviour
- be polite, respectful, non-judgemental and informative
- use plain English
- clearly indicate the consequences of failing to behave in an acceptable manner include information about how to appeal the warning
- be signed by a senior manager with an appropriate level of authority.

**Treatment agreements**

Some circumstances may need a conditional treatment agreement to be established, such as where the client repeatedly attends treatment:

- under the influence of alcohol and/or other drugs
- with disruptive friends, relatives or others with a history of OVA
- late at night or at change of shift times
- in a manner that threatens, attempts or perpetrates OVA against employees.

Treatment might be deferred until risks can be better controlled – for example, when more employees (or more experienced employees) are on duty. It may also be necessary to arrange for treatment in a safer location.

Clear behavioural expectations and the consequences of failing to comply (e.g., treatment at a different location or the banning of visitors) should be considered.

Agreements should be:

- developed in consultation with the client and other relevant stakeholders (e.g., carer, relatives, clinicians, security staff)
- objective and focused on the behaviour not the person
- reviewed regularly
- completed in a safe and therapeutic environment
- have an appeal or complaint mechanism.

**Sanctions**

When other strategies are not appropriate, treatment may have to be refused, except in life-threatening circumstances. This option should only be considered after other control options have been explored to their full capacity.

Examples of decision-making and communication with respect to sanctions can be found in Tool P6 – Warning Notice.

Employees should be aware of procedures for requesting police or security assistance and how to make a report to police about an assault following the incident.

Regular communication should be maintained with local police after an incident has occurred.

Warnings, treatment agreements and sanctions for clients and visitors should be integrated into an organisation-wide alert system.
Policy, procedures and practice

A record should be made of any conversations held with clients or visitors explaining the nature of warnings, treatments or sanctions that may be in place.

5.3 Procedure to practice

The prevention and management of OVA should be integrated into day-to-day practice through relevant documented work procedures. Procedures should describe details of the organisational arrangements to identify hazards, and assess and control risks specific to OVA, including responsibilities of clinical and non-clinical staff. It is important regular reviews of procedures are undertaken.

Work procedures need to:
• describe circumstances in which the procedures are to be followed
• define roles and responsibilities
• describe specific risk controls
• outline steps to monitor and evaluate effectiveness of controls
• include emergency response arrangements
• provide guidance on incident reporting and near misses
• provide guidance on post-incident response including incident investigation.

Clinical protocols should also be implemented to prevent and manage clinical OVA arising from a client’s medical or psychiatric condition. Clinical OVA requires a clinical response for prevention and management.

Examples of procedures and practices relevant to the prevention and management of clinical OVA could include:
• reporting incidents and near misses
• limiting the number of client support people/visitors
• identifying OVA risk in admission criteria and admission screening processes
• communicating expected waiting times, client condition, treatments or treatment delays with clients and visitors
• cultural awareness and the appropriate use of interpreters
• exchange of relevant information within and external to the organisation
• use of lanyards with a safety breakaway
• supply of security equipment such as duress alarms
• use of up to date behavioural management plans, and communication of client and visitor responsibilities and expected behaviours eg through communication of client code of conduct.

Health services should have a weapons management policy aligned with the DHHS publication Preventing Occupational Violence: A policy framework including principles for managing weapons in Victorian health services (2011).

5.4 Behavioural risk factors

The most reliable predictor for the likely occurrence of OVA is previous violent or aggressive behaviour. To prevent the risk of injury to employees and others, clients with a history of violence or aggression should be identified and risk assessed. This information should then be effectively communicated to employees and other service providers as required.

Employees should be provided with resources to identify and assess behavioural risks and to determine if any violent or aggressive behaviour has occurred in the past.

At pre-admission or presentation, the following risk factors should be considered:
• current status (eg under influence of alcohol and/or drugs)
• current level of aggressive behaviour
• unwelcome treatment, pain and/or anxiety
• long waiting time
• information provided by family, friends or other service providers
• history of OVA including at health services.

A risk assessment should be conducted if conditions change or if there are any other indicators the behaviour might be a problem.

An example of a high-risk screening tool for presentation (triage) can be found in Tool P2 – High risk screening, and a tool for combined violence risk identification and assessment is included in Tool P3 – Violence hazard identification and risk assessment.

Risk factors and control measures for a particular client should be noted and highlighted in a care management or treatment plan, after completing a behaviour assessment worksheet (Tool P4 – Behaviour Assessment).
Transfer of information

Information about any known risks of OVA that may pose a threat to health and safety should be provided to employees who may come into contact with the client or to another organisation/ward/unit to which the client is referred.

Transfer of information should take place when a client is transferred:

- internally between wards or units at a health service
- between two campuses of a health service
- between two health services
- from a critical assessment team (CAT) to a health service
- between a residential care facility or a group home and a health service.

Where a health service is aware of a risk of violent or aggressive behaviour, they should inform the service, department or facility the client/patient is being transferred to, of this risk.

The receiving service, department or facility should also request this information as part of their admissions process.

5.5 Alert systems

Alert systems, or ‘file flagging,’ are used for a variety of clinical risk management and client safety reasons (eg to identify clients with life threatening allergies) and can also be used to identify client behaviours that could create a risk to health and safety.

Alerts can be electronic or placed on hard copy files and should be accessible to any health service employee who may come into contact with the client. Client alert systems should be integrated and aligned to allow for transfer of alerts across a health service.

Organisations should have an alert policy covering governance including how frequently alerts are reviewed. Criteria for alerts should be carefully developed and linked to safety issues that arise from a client's behaviour rather than the client's personal characteristics.

A client alert procedure should:

- clearly define the purpose for the alert and focus on behaviour and risk
- identify the person to whom the alert refers (eg client only, family, regular visitors)
- include steps for behaviour management planning
- identify who has been delegated responsibility for initiating, reviewing, removing alerts, and reviewing and updating associated management plans.

An example of a client alert can be found at Tool P5 – Client Alert. Alternatively, a visual prompt such as a sticker on the client’s record may be used. The information should be objective, reviewed regularly and kept up-to-date.

If a client file has an alert flag it should be supported by an up-to-date management plan.

Multi-disciplinary care plans can be developed to deliver a consistent care approach. In addition to HSRs or OHS staff, family members can also provide valuable input into care planning and their involvement can assist in ensuring clear standards of expected behaviour are set.

When an alert is identified, employees should be prompted to complete an assessment of the client’s current behaviour. The management plan should be reviewed and updated to ensure that care is provided in safe manner.
5.6 Incident management

If an OVA incident occurs or escalates, it is important employees have immediate response options such as a Code Grey or Code Black response.

The response approach selected needs to be appropriate to the situation and employee training/skills and may include:

- review by a clinician
- calm verbal and non-verbal communication
- verbal de-escalation and distraction techniques
- support from other resources such as more senior employees attendance by a duress response team, security or the police
- a request that the aggressor leave
- withdrawal to a safer location
- an internal emergency response
- an external emergency response
- evasive self-defence
- initiating a duress response
- the use of the least restrictive restraint practice. Note: organisations should have a clear policy on the use of restraint and seclusion, aligned to the DHHS guidelines

Post-incident response

Organisations should have a formal incident management and post-incident response policy and/or procedure.

Priorities following an incident may include:

- safety for all concerned including people such as staff, clients or visitors who may have witnessed the incident
- medical attention for anyone injured during the incident
- psychological support such as trauma-crisis counselling, critical incident stress debriefing, peer support and employee assistance programs
- assistance with police and judicial processes (eg giving evidence in court about an incident)
- assistance with WorkCover compensation claims and return to work planning
- reporting
- investigation
- implementation of outcomes
- review of risk controls.

5.7 Reporting

Incidents of OVA should be reported immediately by employees or by management on their behalf, to facilitate post-incident response and investigation. The organisation should have an incident reporting system to facilitate reporting.

Reporting allows for appropriate investigation and collection of data to assist in understanding and responding to emerging trends and issues in particular units or across the health service. Data on OVA reporting and incident trends should be presented to senior leadership and the Board of the health service.

External reporting may also be required, including to WorkSafe in the case of notifiable incidents. See WorkSafe Guide to Incident Notification on worksafe.vic.gov.au for further information about notifiable incidents.

It is an offence to assault a health care professional. Employees may choose to make a police report following an incident. Health services should have a process to support employees make a police report. Making a police report assists police build profiles for repeat offenders, identify crime trends and support prosecutions.
5.8 Incident investigation and review

Incident investigations should be undertaken by a suitably trained employee, such as a Nurse Unit Manager, Aggression Coordinator or Facility Manager.

The investigation process should be documented and conducted in a systematic way to identify risks and hazards inside and outside the facility. Investigations provide learning opportunities to improve risk controls to prevent future incidents and should be conducted without seeking to blame individuals or groups.

An investigation should document the:

- type of incident that occurred
- date and time of incident
- site of incident
- people involved – including witnesses to the incident
- outcome of the incident
- injuries sustained by employees and/or clients
- recommendations to prevent future incidents occurring.

Investigation should also include a comprehensive review of the client's journey including behaviours and triggers (i.e. what has taken place in the days and hours leading up to an OVA incident/s.)

Contributing factors to the incident should be identified including:

- clinical factors
- client care or client/visitor concerns
- workplace design
- equipment failure/maintenance
- communications
- human resources
- any other risks or hazards.

As well as speaking with employees involved in or witness to an incident, it may also be necessary to consult other agencies or service providers (e.g. police, ambulance officers or general practitioners) to obtain detailed background on an incident, further actions or other relevant information.

Reporting the findings, recommendations and outcomes of an investigation should enable control measures to be introduced and practices reviewed to minimise the risk of future incidents. Information about the outcomes and recommendations from the investigation should be communicated to relevant employees in a timely manner. This could be through a discussion at shift handover, a copy of the investigation report being provided to relevant staff, reporting through committees, or reporting to boards, senior leadership and managers.

Recommendations should be implemented using action plans. Actions plans should assign dates to review and assess whether revised control measures are effective.

Page 5 of 10 of Tool 01 – Organisational self-assessment provides an organisational self-assessment of incident documentation, reporting and investigation processes that is aimed at helping identify potential gaps in relevant organisational systems.
6. Training and education

6.1 Context
Training and education is considered an administrative control measure. It can compliment and support higher order control measures, such as design, policy and work practices. Training that is based on a comprehensive needs analysis will be more effective than training that is not.

6.2 Principles
Training programs should be relevant to the workplace, be based on organisational needs and appropriate to the needs of employees and the client group involved. Training programs should also be practical and accessible.

Such programs should also be based on principles of adult education to ensure relevance and support for programs. Special needs of employees, such as skills, gender, disability, literacy and first language, also need to be considered.


6.3 Needs analysis
A comprehensive training needs analysis should be completed before any training programs are introduced. A needs analysis can be conducted using questionnaires, staff surveys (Tool 02- Staff Survey) or focus groups in specific work areas. Training needs can also be identified through incident analysis, OHS systems reviews and the use of risk calculator matrices. Risk calculators at T1 – Exposure to aggression risk calculator and T2 – Aggression risk calculator of this guidebook relate to a tiered approach to staff training and education.

6.4 Tiered approach
A tiered approach to training is recommended to ensure the right employees get the right training, based upon their identified risk of exposure to incidents and their roles, responsibilities and expectations within the organisation.

Programs should help employees understand:
• risk factors for OVA
• clinical and non-clinical causes
• signs of escalation and imminent violence
• communication strategies
• prevention measures
• workplace policies and procedures
• emergency and post-incident responses
• the right to withdraw to safety at any time.

6.5 Additional considerations
The content of a basic level program might be included in the organisational orientation program as part of an OHS overview.

This level of training might be sufficient for an employee employed in an area such as human resources.

A more detailed program could be suitable for an employee working in environmental services, while an even more extensive program would be needed for clinicians. The organisational context and the expectations placed upon staff should be considered when making these decisions. For example, in a small hospital where non-clinical employees may fill multiple roles, such as payroll, accounts payable and reception, a mid-level program would be valuable.

Within the employee skill mix, key members of each shift team should have demonstrated skills, training and experience in the management of behaviours and conditions relating to the risk in that environment (eg dementia care, cognitive deficit, or challenging behaviours).

Code grey/code black response team members require theoretical and practical components with regular updates and opportunities to practice techniques and strategies as part of a team.

Evasive self-defence training
Evasive self-defence training should only be provided after all other possible risk control strategies have been implemented and the level of risk warrants such a response.

Where evasive self-defence training is to be provided, it should:
• emphasise retreat and self-protection
• cover relevant legal issues, such as the concept of
reasonable force and dangers and precautions when using evasive self-defence
- be developed and delivered by appropriately experienced and accredited experts
- provide techniques relevant to the staff group, the risks they face and environments they work in
- include the requirement for, and provision of, regular practice
- consider the physical characteristics of the staff group and of the clients or others demonstrating aggressive behaviours where possible.

Security staff
The needs of the health service should be considered before employing security staff or subcontracting a security firm. Security personnel should be appropriately qualified for the role.

Their inclusion in organisational training will assist in clarifying roles within response teams. Health Services employers should refer to the DHHS website at [health.vic.gov.au](http://health.vic.gov.au) for more information about training for security staff.

Managers
Tailored training for managers should ensure they:
- understand the adverse impacts of OVA on employees, clients and the workplace
- develop skills to prevent OVA within the health service setting
- understand the obligations of the employer to provide a safe workplace for employees and clients
- understand and manage their own behaviours, including the capacity to shape behaviour of others through role modelling, setting clear standards and effectively managing incidents
- understand their role in facilitating, supervising and supporting the implementation of organisational policies and procedures
- implement the organisation’s employee support processes during any recovery phase of an incident
- are able to undertake systemic investigations following an incident.

Managers at all levels should participate in the consultation that informs the training needs analysis and in the implementation of training modules.

6.6 Providers and programs
Trainers can be recruited from the existing workforce if there are employees appropriately skilled in meeting the needs identified by the training needs analysis. Alternatively, external providers could provide the training program.

The training needs analysis and organisational review of control measures (see chapter 3) should inform the choice of training provider and program.

6.7 Evaluation
Training and education evaluation determines if a program has achieved its stated objectives. Information should be gathered at various stages of the design and delivery processes to:
- determine the effectiveness of training
- support decision-making about current and future training
- enable documentation of information and program improvements
- help determine the overall quality of the training provided to employees.

An evaluation tool should be developed or adopted during the needs analysis phase of training design. Methods for using the evaluation tool may vary depending on organisational needs and resources. To make it meaningful, attention should be given to when it is used as well as how it is designed. Best-practice principles indicate that ideally, evaluation of a training intervention for the prevention and management of OVA should be conducted before, during and after the training.

Pre-training evaluation provides a baseline measurement that the effectiveness of the training, once completed, can be measured against. Pre-training evaluation could involve processes referred to in this chapter as well as employee surveys.

Evaluation during the training can inform the process and highlight any specific needs for a group or individual. It is a technique used by trainers and educators to ensure they are meeting the needs of participants rather than a specific tool for information gathering.

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Post-training evaluation provides valuable information about design and delivery, but does not measure learning transfer or medium-to-long-term benefits of a program in the workplace. Tool T3 – Post-training evaluation tool – short term could be used immediately after training to evaluate program relevance and key learnings for participants. In the
context of OVA prevention and management, immediate post-training evaluation is a minor part of the evaluation process.

Post-training evaluation in the medium-to-long-term should involve ongoing monitoring. A learning needs analysis could be conducted 6–12 months after the training to identify ongoing deficits in skill or knowledge. An example of a medium-to-long-term post-training evaluation can be found at Tool T4 - Post-training evaluation tool – medium to long term.

Competency-based assessments could also be conducted. A sample competency-based assessment can be found at Tool T5 – Competency-based assessment. It is recommended that individuals with solid OHS knowledge administer this kind of assessment to employees.

Findings from the application of Tool T4 – Post-training evaluation tool – medium to long term should be fed back into the overall evaluation of control measures for the prevention and management of OVA in the workplace.
7. Further Information

Further information can be found in the following documents:

**WorkSafe Victoria resources** ([available at worksafe.vic.gov.au](http://worksafe.vic.gov.au))
- A guide for employers: preventing and responding to work-related violence
- Occupational Health and Safety in Boards
- Working Safely in Visiting Health Services

**Department of Health and Human Services resources** ([available at health.vic.gov.au](http://health.vic.gov.au))
- Guide for violence and aggression training in Victorian health services – Guiding principles
- Preventing Occupational Violence: A policy framework including principles for managing weapons in Victorian health services, Department of Health and Human Services, (2011)
- Occupational Violence in Nursing: An Analysis of the Phenomenon of Code Grey/ Black Events in Four Victorian Hospitals, Department of Human Services, 2005

**Reports and inquiries:**
- Violence in Healthcare Taskforce Report, June 2016
- Inquiry into violence and security arrangements in Victorian hospitals and, in particular, emergency departments, Drugs and Crime Prevention Committee, 2011
- Victorian Taskforce on Violence in Nursing, Final Report, Department of Human Services, 2005

**Other resources:**
- A 10 point plan to end OVA, ANMF (Vic Branch): anmf.org.au
- Alzheimer’s Australia (Vic Branch): vic.fightdementia.org.au

**Standards and guidelines:**
8. Tools

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Organisational self-assessment

The aim of this self-assessment is to enable organisations to obtain an overview of current systems, policies and procedures that support aggression prevention and management strategies.

The organisational self-assessment has been designed to enable employees to complete specific sections of the document. The major components for organisational self-assessment can be divided easily for targeted assessments within organisations. They are as follows:

• Organisational structures, governance and processes
• Policy content
• Procedures that support staff in client management
• Risk management
• Measurement and evaluation
• Documentation, reporting and investigation
• Human resource management, training and education.
## Tool 01 Organisational self-assessment

### Organisational structures, governance and processes

This template looks at the generic organisational structures that are in place to support occupational health and safety activities.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Our organisation has an occupational health and safety (OHS) committee.</td>
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<tr>
<td>Our OHS committee has current terms of reference that are reviewed every three years.</td>
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<tr>
<td>The terms of reference reflect reporting/communication requirements and processes to executive and board/committee of management levels.</td>
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<tr>
<td>Our documentation reflects a consultative and cooperative approach to OHS.</td>
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<tr>
<td>Policies and procedures are consistent with current legislative and statutory requirements.</td>
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<tr>
<td>Policies and procedures are reviewed every three years.</td>
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<td>Our health and safety representatives (HSRs) have received the training required to fulfil their roles within the organisation.</td>
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<tr>
<td>Our policies and procedures support employees in implementing the aggression prevention and management policy of our organisation.</td>
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<tr>
<td>Our organisation has a documented client charter/bill of rights.</td>
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<tr>
<td>Our organisation client charter includes ‘client responsibilities’.</td>
<td></td>
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</tbody>
</table>
## Tool 01 Organisational self-assessment

### Policy content

This template provides an opportunity to review policy content related to aggression prevention and management of client-initiated occupational aggression and violence.

<table>
<thead>
<tr>
<th>Our organisation has a formal written aggression prevention and management policy for the prevention of occupational aggression and violence.</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• applies to all employees</td>
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<tr>
<td>• acknowledges the employer’s responsibility to provide a work environment free from risk of OVA</td>
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<tr>
<td>• includes a clear statement that staff should not tolerate, or put themselves at risk of exposure to, OVA</td>
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<tr>
<td>• includes a statement about identification of risk factors associated with OVA</td>
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<td></td>
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<tr>
<td>• states the provision of training for all employees who have contact with the general public, appropriate to their identified level of exposure and risk</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• requires all incidents, ‘near misses’ and threats of OVA to be reported</td>
<td></td>
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</tbody>
</table>
# Tool 01 Organisational self-assessment

## Policies and procedures that support staff in client management

This template provides an opportunity to review policies and procedures related to client-initiated occupational aggression and violence.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are easy-to-see and accessible public displays that advise clients this is a ‘violence-free’ workplace.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Our organisation has an incident/aggression/security response team.</td>
<td></td>
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<tr>
<td>Our organisation has security staff.</td>
<td></td>
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</tr>
<tr>
<td>Written policies and procedures for staged client warning notices, treatment contracts and refusal of treatment have been reviewed in the past three years.</td>
<td></td>
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</tr>
<tr>
<td>Requesting security assistance:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Our organisation has a written procedure for requesting assistance from security staff that identifies situations that could require assistance and communication channels when assistance is required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requesting police assistance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our organisation has a written procedure for requesting assistance from police that identifies situations that could require assistance and communication channels when assistance is required.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The procedure has been written in consultation with local police.</td>
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</tr>
<tr>
<td>There is an organisational procedure for reporting violent or aggressive incidents to the police.</td>
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</tr>
</tbody>
</table>
### Tool 01 Organisational self-assessment

<table>
<thead>
<tr>
<th>Physical and chemical restraint and seclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Our organisation has documented policies and procedures on restraint and seclusion of clients.</td>
</tr>
<tr>
<td>The documents include:</td>
</tr>
<tr>
<td>• the use of defusing/de-escalation techniques as preventative measures in the first instance</td>
</tr>
<tr>
<td>• how to access additional support if situations continue to escalate</td>
</tr>
<tr>
<td>• responsibility and accountability for the decision to physically restrain a client</td>
</tr>
<tr>
<td>• responsibility and accountability for the decision to chemically restrain a client</td>
</tr>
<tr>
<td>• procedures that reflect actual resource availability for client restraint</td>
</tr>
<tr>
<td>• client seclusion policies and procedures that are compliant with legislative requirements</td>
</tr>
<tr>
<td>• seclusion procedures that reflect actual resource availability for safe client care.</td>
</tr>
</tbody>
</table>
## Tool 01 Organisational self-assessment

### Documentation, reporting and investigation

This template provides an opportunity to review documentation and reporting and investigation processes following an incident or 'near miss'.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organisation has a system for reporting incidents of OVA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees are aware of their obligation to formally report incidents of OVA (e.g. at orientation or unit meetings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All incidents of OVA are reported within 12 hours of occurring.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our system for reporting incidents is accessible to all employees.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our system captures the following information:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• type of incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• date and time of incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• site of incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• people involved in the incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• outcome of incident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• injury to staff member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• injury to client</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• mitigating circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All incidents of OVA are systematically investigated to identify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• clinical contributing factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• workplace design contributing factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• patient care or patient/visitor concerns contributing factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• equipment failure, maintenance, requirements that may have contributed</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• human resource contributing factors</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• communications contributing factors eg. handover</td>
<td></td>
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</tr>
</tbody>
</table>
## Tool 01 Organisational self-assessment

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• personnel involved in the incident (to ensure they receive support and have an opportunity to be consulted)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• previously unidentified risks or hazards.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Comprehensive reports of incident data are tabled at relevant meetings.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Outcomes of investigations are made known to the staff involved and HSRs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summaries include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• follow-up risk assessments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• recommendations for control measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• action plans for implementation of recommendations including dates for review and revised control measures.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Data associated with all incidents is maintained to enable analysis, tracking and identification of trends over time.</td>
<td></td>
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</tbody>
</table>
**Tool 01 Organisational self-assessment**

**Human resource management and development**

This template provides an opportunity to review human resource management and development processes related to client-initiated aggression and violence.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organisation has a documented code of conduct for employees.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>All position descriptions make reference to an employee’s obligations in relation to OHS.</td>
<td></td>
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</tr>
<tr>
<td>There is a process for determining staffing levels in known high-risk areas of the organisation.</td>
<td></td>
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<tr>
<td>All areas have appropriately qualified and experienced staff available/rostered to cover all hours of operation.</td>
<td></td>
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<tr>
<td>The mix of casual/agency staff on duty is balanced by permanent staff known to the clients.</td>
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<tr>
<td>There is capacity to rotate staff into alternate duties to reduce exposure to aggression.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Our organisation has procedures in place to provide staff with backup and support when working alone or in isolation.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Support is offered to staff following a serious/critical incident:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• in the immediate aftermath of an incident</td>
<td></td>
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<tr>
<td>• within 24 hours of an incident</td>
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<tr>
<td>• one week after an incident</td>
<td></td>
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<tr>
<td>Support is offered and provided with respect for individual needs and personal support mechanisms.</td>
<td></td>
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<tr>
<td>Our organisation has access to skilled debriefing personnel/services.</td>
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</tbody>
</table>
## Tool 01 Organisational self-assessment

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organisation has an employee assistance program (EAP) available to all employees.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Our staff are guided through all WorkCover processes by experienced staff.</td>
<td></td>
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</tr>
<tr>
<td>In the event of a WorkCover claim being accepted and processed, staff are supported in the development of a return to work (RTW) program that aligns with input from health professionals involved in their care, treatment and management.</td>
<td></td>
<td></td>
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<tr>
<td>Psychological support eg. Informal debriefing and peer support are available on an ongoing basis.</td>
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</tr>
<tr>
<td>Employees are encouraged to and supported in reporting incidents of OVA.</td>
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<tr>
<td>Support is offered to staff through police and legal processes following incidents of OVA.</td>
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<tr>
<td>OHS education is provided to all new employees during orientation and induction to the organisation.</td>
<td></td>
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</tr>
<tr>
<td>Our organisation has/accesses a tiered education and training program related to aggression prevention and management.</td>
<td></td>
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</tr>
<tr>
<td>Employees who receive skill-based training are provided with updates for skill maintenance on an annual basis.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emergency response team (ERT) members are provided with opportunities for skill maintenance with other team members at least every six months.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ERT members are provided with updates on education and training annually.</td>
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</tbody>
</table>
### Hazard identification, risk assessment and management

This template provides an opportunity to review hazard identification, risk assessment and management processes related to client-initiated aggression and violence.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our organisation has a formal documented process for reporting risks/hazards.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Any member of staff is able to report a risk/hazard.</td>
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</tr>
<tr>
<td>Identified risks/hazards are formally assessed and documented by appropriately trained and/or experienced people.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Documented risk assessments include possible control measures to eliminate or minimise risks as far as is reasonably practicable.</td>
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<tr>
<td>Control measures are introduced that are proportionate to the identified risk.</td>
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<tr>
<td>Control measures are reviewed within three months, or sooner, to evaluate their effectiveness.</td>
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<tr>
<td>Identified risks/hazards and assessments are reported at OHS meetings.</td>
<td></td>
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<tr>
<td>Reviews are conducted following an incident of violence or aggression to identify hazards that had not previously been identified</td>
<td></td>
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<tr>
<td>Reviews of the working environment are conducted following a significant change in function.</td>
<td></td>
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<tr>
<td>Reviews lead to:</td>
<td></td>
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<tr>
<td>• further risk assessments when a hazard is identified</td>
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<tr>
<td>• implementation of risk controls to prevent injury or recurrence of an incident</td>
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<tr>
<td>• changes to the working environment</td>
<td></td>
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<tr>
<td>• new/changes to existing work practices</td>
<td></td>
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<td></td>
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<tr>
<td>• updates or development of new written procedures</td>
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</tbody>
</table>
## Tool 01 Organisational self-assessment

### Measurement and evaluation

This template provides an opportunity to review measurement and evaluation processes related to client-initiated aggression and violence.

<table>
<thead>
<tr>
<th>Reports received at OHS committee meetings relate to:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• security breaches</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• violent/aggressive incidents</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>• injuries to staff and clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• hazard reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• risk assessments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• control measure implementation/action</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• control measure reviews/outcomes</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• recommendations for further actions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• review of policies, procedures and work practices</td>
<td></td>
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</tbody>
</table>

Minutes of meetings reflect responsibility and accountability for further actions.

Executive/board of management meeting minutes reflect:

- WorkCover insurance premiums are monitored six monthly.
- WorkCover claims are reported quarterly.
- Impacts of the implementation of control measures.
Tool 02 Staff survey

Staff survey – aggression and violence

We are committed to maintaining the health and safety of all of our staff. This confidential survey will be used to help us identify occupational aggression and violence risks within our work environment and develop prevention strategies.

Please take a few minutes to complete the survey and return it to __________________________ by _____/_____/_____

The results of the survey will be provided to __________________________ on _____/_____/_____

General information

<table>
<thead>
<tr>
<th>Ward/work unit/division</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age range (years)</th>
<th>&lt; 30</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>&gt; 60</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Allied Health Professional</th>
<th>Clerical/administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurse</td>
<td>Environmental/food services</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Other (please specify)</td>
</tr>
<tr>
<td></td>
<td>Clinical assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordination</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>&lt; 5</th>
<th>5-10</th>
<th>11-20</th>
<th>20-30</th>
<th>&gt; 30</th>
</tr>
</thead>
</table>

Policies and procedures

Yes No Don’t know

Does our organisation have a non-tolerance of violence policy?

If ‘yes’ have you ever seen a copy?

Are there written procedures that deal with violence and aggression in your work area?

If ‘yes’ have you ever seen a copy of them?

If ‘yes’ are they easy to follow?

Is there a violence contact person within your work area?
Tool 02 Staff survey

Working environment and systems

Do you feel safe at work?  
Have you been provided with all necessary controls and measures to protect your safety? (eg. personal duress alarms or dual exits in interview rooms)?
Do you believe you are prepared to manage an aggressive or violent situation?

If you answered 'no' to any of the above please mark the areas you consider require improvement.

- Lighting
- Work/treatment spaces
- Restricted access
- Education and training
- Security staff
- Police liaison
- Patient/client transfers
- Communication about client history/behaviours
- Security devices
- Information about devices
- Incident reporting
- Incident follow-up

Other (please specify): .........................................................................................................................

Incidents, reporting and follow-up

1. Is there a system for accessing additional support if a client becomes violent or aggressive?
2. Are you required to report threats of violence or aggression in your work area?
3. Are you required to report actual incidents of aggression or violence in your work area?
4. Do you feel you can make reports without fear of reprisal?
5. Is there a system for reporting threats and incidents of violence or aggression in your work area?
6. If 'yes' is it easy to follow?
7. Does the supervisor/manager investigate reports without undue delay?
8. Does the supervisor/manager take corrective action without undue delay?
9. Are all co-workers formally briefed about a violent or aggressive situation before commencing duty or attending to a client?
10. Is there a program to provide support for staff directly and indirectly affected by incidents of workplace violence or aggression?
11. Are police and other emergency services called immediately and incident involving a criminal act occurs?
Barriers to reporting

12. Are there particular obstacles to you formally reporting incidents of aggression or violence?

Yes  No  Don’t know

If ‘yes’ please tick the barriers for you:

- [ ] Lack of access to reporting forms/mechanisms
- [ ] Don’t know the process for reporting
- [ ] Don’t know what constitutes an incident
- [ ] The reporting form is too complicated
- [ ] The reporting tool is geared to clinical incidents
- [ ] Lack of feedback/visible change
- [ ] Concern about retribution/blame
- [ ] Concern about how colleagues will perceive me
- [ ] Time constraints

Other (please specify): ........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Who do you tell and how?

13. Who do you report incidents of violence or aggression to and how do you report it?

(Please mark as many boxes as are applicable to you)

<table>
<thead>
<tr>
<th></th>
<th>Verbal</th>
<th>Written</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line manager</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Health and safety representative (HSR)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Colleague</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>OHS staff</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Friend/family member</td>
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</tbody>
</table>

Other (please specify): ........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
### Education and training

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

Have you ever attended any of the following, either at work or privately:

- Customer service training
- Communication skills training
- Assertiveness training
- OHS training

<table>
<thead>
<tr>
<th>Length of program:</th>
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Self-defence Training

<table>
<thead>
<tr>
<th>To what level:</th>
<th></th>
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</table>

- Aggression prevention and management training

<table>
<thead>
<tr>
<th>Name and length of program:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>When did you attend:</th>
<th></th>
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</thead>
</table>

Have you ever attended an education or training program that has covered the following topics:

- Recognising, preventing and dealing with workplace violence and aggression
- Communication and care strategies to prevent violence or aggression
- Psychiatric, behavioural and psychological conditions associated with violent or aggressive behaviours
- Respectful self-defence measures related to clients

<p>| | | |</p>
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</table>

- Do you believe you have adequate education and training related to violence and aggression prevention and management for your current position?

<p>| | | |</p>
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</table>

Are there particular barriers to you attending ‘in-house’ education and training programs that would need to be considered in planning education and training programs related to aggression prevention and management?

Please tick as many boxes as are applicable to you.

- Too difficult to take time away from daily duties
- Inconvenient location
- Inconvenient time in relation to other work activities
- Fatigue/’burn out’
- Lack of support/encouragement to attend

<p>| | | |</p>
<table>
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</table>

Other (please specify): .................................................................

<p>| |</p>
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</table>

Any other comments: ........................................................................

---

WorkSafe Victoria  Information for employers  Prevention and management of violence and aggression in health services  45
## Design and aggression – generic audit

### Health facility:  Department/work area:

### Persons involved in the audit (manager, health and safety representative (HSR), staff members, designer):

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Title:</td>
</tr>
<tr>
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</tbody>
</table>

### Date of audit:

### Audit objective

To identify aggression risks that may relate to the design of an existing or planned workplace, with reference to *Prevention and management of aggression in health services*.

### How to use the audit checklist

This checklist is designed to be used within a patient care department/work area so you may need to complete several checklists to cover your whole health facility.

- Existing workplaces - talk to staff and observe work being done to complete the checklist.
- Planned workplaces – use the scaled drawings of your proposed facility, a scaled ruler and a tape measure and work through the checklist.

### Pre-questions

Prior to completing the audit, you need to have an understanding of what patient-care activities are likely to occur in the work area. The following questions will help to explore these issues:

- What types of patients/residents/clients will occupy the department/work area (both now and in the future)?
- What special patient-care activities will be undertaken?
- What types of equipment and furniture will be used in the work area?
- How will this department/work area interact with other departments/work areas in the health facility?
## Tool D1 Design and aggression

### Design and aggression – generic audit

<table>
<thead>
<tr>
<th>Design and aggression – generic audit</th>
<th>Yes/No or N/A</th>
<th>Comments</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Strategic location</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1. Location – internal interactions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the location of the department facilitate easy interaction between related departments within the organisation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the location of the work area facilitate natural surveillance, allowing employees to view and monitor the area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.2. Location – external interactions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the location of the department facilitate any external interactions (eg suppliers, paramedics)?</td>
<td></td>
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</tr>
<tr>
<td><strong>1.3. Way-finding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the department easy to find for clients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the way-finding signage suitable for all clients (eg language, size of text) for all clients?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>2. Design of the space</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.1. Entry/exit</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Is the location of the entry/exit doors suitable for employees to retreat to safety?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Does the design of the entry/exit door facilitate clients’ independent use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the design and location of the entry/exit door facilitate surveillance of people entering/exiting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.2. Workspace (size and layout of area)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the workspace adequate for employees needs – consider equipment used and tasks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the workspace adequate for clients needs (eg personal space, movement)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the workspace adequate for storage needs so that clutter is minimised?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Tool D1 Design and aggression

#### 3. Furniture, fixtures and facilities

##### 3.1. Seating
- Is the seating for clients comfortable?
- Does the seating promote independence for clients?
- Is the layout of the seating suitable for clients (consider fixed versus moveable)?
- Is the seating easy to maintain/keep clean?

##### 3.2. Counter design
- Does the design of the counter mean that clients cannot easily jump over the counter?
- Does the design of the counter mean that clients cannot easily strike a staff member across the counter?
- Does the design of the counter mean that clients cannot easily get behind the counter?
- Is there an emergency response system (eg duress button, personal alarm) appropriately positioned and monitored?
- Is CCTV in place and functional?

##### 3.3. Client facilities
- Are appropriate toilet facilities available and easy to access?
- Are appropriate refreshment facilities (eg water, food) available and easy to access?
- Are appropriate entertainment facilities (eg magazines, TV) available and easy to access?
- Is there a specially designed waiting area to entertain children?

##### 3.4. Cash and pharmaceuticals
- Does the design limit client viewing of cash and pharmaceuticals?
- Does the design limit client access to cash and pharmaceuticals?

#### 4. Environment

##### 4.1. Noise
- Are the noise levels in the area suitable for clients?
- Are the noise levels in the area suitable for staff? *(Loud or persistent noise should be avoided).*
### Tool D1 Design and aggression

#### 4.2. Lighting
- Does the area have some natural lighting from external windows?
- Is the space free from glare? Consider reflective surfaces, need for adjustable window coverings etc.
- Does the level of illumination suit the client activities (e.g., reading, sleeping) to be undertaken?
- Does the level of illumination suit the staff activities (e.g., reading, use of a computer) to be undertaken?
- Where necessary, is the lighting adjustable or is task lighting provided?

#### 4.3. Colour
- Is the colour of the room relaxing for clients and staff? (*large expanses of strong and dark colours should be avoided*?)

#### 4.4. Temperature and odours
- Is the area well ventilated so that the temperature remains fairly constant?
- Can the temperature be maintained at an appropriate level for the type of activities being performed by clients?
- Can the temperature be maintained at an appropriate level for the type of activities being performed by staff?
- Is the area free from cold draughts where people are sitting?
- Does the area have a pleasant/neutral odour without any persistent unpleasant smells (e.g., urine/faeces, vomit, disinfectant)?

#### 5. Security
- Are employee-only areas (e.g., door locks, swipe card/key pad access) secure?
- Is there an emergency call system (e.g., duress alarms, personal pagers, emergency buzzer) available for employees?
- Is client activity monitored (e.g., natural surveillance, CCTV, presence of security staff) in high-risk areas?
- Is the CCTV appropriately designed (e.g., overt or covert system) and located (e.g., view of the area)?
## Tool D2 Violence and the design process

### Consultation structure

<table>
<thead>
<tr>
<th>Question</th>
<th>Consider</th>
</tr>
</thead>
</table>
| Who to involve | • Designers  
• Managers  
• Health and safety representatives (HSRs)  
• Employees  
• External users (eg. Ambulance Victoria)  
• OHS experts  
• Consumers (eg clients/residents) |
| When to consult | • At each key milestone/stage  
• Time allowance for consultation |
| How to consult | • Face-to-face meetings  
• Documentation of decisions  
• Feedback to participants |

### Master planning

<table>
<thead>
<tr>
<th>Question</th>
<th>Consider</th>
</tr>
</thead>
</table>
| What aspects about the general location of the facility might impact on aggression? | • General demographics and socio-economic structure of the area  
• Access to public transport |
| What aspects about the neighbouring buildings or sites are likely to impact on aggression? | • Access to other agencies such as police/ambulance  
• Neighbouring residential/industrial/business areas  
• Lighting and noise  
• Surrounding landscape |
## Tool D2 Violence and the design process

| What aspects about the facility boundaries may have an impact on aggression? | • Entry and exit  
• Busy roads  
• Public transport |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Where are the entry and exit points to the site and relevant departments, and how does this relate to security and surveillance?</td>
<td>• Entry and exit points in relation to security and surveillance</td>
</tr>
</tbody>
</table>
| Where are the major departments located and do these facilitate work flow and client/visitor flow? | • Location of departments serving clients and visitors  
• Pathways of travel |
| Is the space and location of parking appropriate to facilitate safe access for staff and visitors? | • Car park surveillance  
• Access control  
• Defined perimeter |
| What are the major paths of travel for vehicles, pedestrians and goods, and are these easy to navigate? | • Separate footpath/vehicle route  
• Clear signage, directions and signs  
• Traffic feasibility study |
| What is the likely future site development? Have adequate areas been set aside for future growth and change? | • General demographics  
• Economic structure of area |
| Is it likely that the demographics of the client or visitor population will change? | • General demographics  
• Economic structure of area |

### Feasibility study

| What types of clients are likely to occupy the facility? | • Demographics of the local area such as potential for drug/alcohol-influenced clients, specific cultural groups, etc |
### Tool D2 Violence and the design process

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any high-risk departments, such as emergency, mental health and aged care, that need special consideration?</td>
<td>• Cultural groups and demographics</td>
</tr>
<tr>
<td>What types of visitors may attend the facility?</td>
<td>• Access control</td>
</tr>
<tr>
<td>What special features does the facility need to meet organisational policies and procedures related to aggression?</td>
<td>• Isolation rooms&lt;br&gt;• Observation of clients&lt;br&gt;• Garden areas</td>
</tr>
<tr>
<td>What security measures need to be installed?</td>
<td>• Duress alarms&lt;br&gt;• CCTV</td>
</tr>
<tr>
<td>Who must be consulted in relation to identifying client aggression issues during the planning process?</td>
<td>• Department managers&lt;br&gt;• Health and safety representatives&lt;br&gt;• Employees&lt;br&gt;• OHS professionals&lt;br&gt;• Designers</td>
</tr>
<tr>
<td>What user consultation process should be included and costed into the planning process?</td>
<td>• Training user groups&lt;br&gt;• Briefing strategies&lt;br&gt;• Design visualisation</td>
</tr>
</tbody>
</table>

### Schematic design

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there is an interaction between staff and clients or visitors, there is a risk of aggression. Have all functions been documented for all client/visitor areas?</td>
<td>• Quality documentation systems</td>
</tr>
<tr>
<td>Has adequate workspace been allocated to all areas to ensure tasks can be undertaken safely and is there enough room for all those likely to occupy the area?</td>
<td>• Feedback from consultation phase</td>
</tr>
</tbody>
</table>
### Tool D2 Violence and the design process

<table>
<thead>
<tr>
<th>Question</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there is the potential for the first interface between staff and</td>
<td>• Second exit in interview rooms</td>
</tr>
<tr>
<td>clients (e.g., reception, interview rooms) has the potential for</td>
<td>• Physical barrier in reception</td>
</tr>
<tr>
<td>aggression been taken into account?</td>
<td>• Signage</td>
</tr>
<tr>
<td>Have the relationships between work areas been documented?</td>
<td>• Quality documentation systems</td>
</tr>
<tr>
<td>Does the location of different departments facilitate work and client/</td>
<td>• Access control</td>
</tr>
<tr>
<td>visitor flow?</td>
<td></td>
</tr>
<tr>
<td>Does the layout facilitate compliance with aggression-related policies</td>
<td>• High visibility</td>
</tr>
<tr>
<td>(e.g., observation of clients)?</td>
<td>• Controlled areas</td>
</tr>
<tr>
<td>Have the entry and exit points of the facility and individual departments</td>
<td>• CPTED principles</td>
</tr>
<tr>
<td>been planned to facilitate security systems?</td>
<td></td>
</tr>
<tr>
<td>What security measures and communication devices need to be installed</td>
<td>• Duress alarms</td>
</tr>
<tr>
<td>throughout the facility?</td>
<td>• CCTV</td>
</tr>
<tr>
<td>• Telephones</td>
<td></td>
</tr>
<tr>
<td>Does the interaction between the building and the external environment</td>
<td>• CPTED principles</td>
</tr>
<tr>
<td>maximise the therapeutic environment?</td>
<td></td>
</tr>
<tr>
<td><strong>Design development</strong></td>
<td></td>
</tr>
<tr>
<td>Is there adequate workspace for all equipment and fixtures?</td>
<td>• Feedback from consultation committee</td>
</tr>
<tr>
<td>Has adequate storage been planned to ensure clutter is avoided?</td>
<td>• Feedback from consultation committee</td>
</tr>
<tr>
<td>Do the furniture and fixtures minimise the potential for aggression?</td>
<td>• Consultation with department workgroup</td>
</tr>
<tr>
<td></td>
<td>• Fittings and furniture that are difficult to use as weapons, hard to lift and</td>
</tr>
<tr>
<td></td>
<td>without sharp corners and edges</td>
</tr>
</tbody>
</table>
## Tool D2 Violence and the design process

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| Is the lighting appropriately designed to minimise stress and fatigue and maximise feelings of relaxation? | • Natural light  
  • Artificial light |
| Have unwanted noises been designed out? | • Soundproof walls or double glazed windows  
  • Avoid loud volumes on TV and radio |
| Has an effective and consistent way-finding system been designed? | • Signage (directional and symbols) |
| Have positive distractions been provided to reduce stress and divert focus from pain? | • Gardens  
  • Art  
  • Views |
| Have systems for effective client communication been designed? | • Refer to consultation committee  
  • Signage in reception areas |
| Has the ventilation system been designed to minimise unwanted smells and to facilitate comfortable temperatures? | • Provide good ventilation  
  • Air-conditioning systems |

### Contract documentation

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have appropriate colours been chosen to minimise stress and create a feeling of wellbeing?</td>
<td>• Lighter colours</td>
</tr>
</tbody>
</table>
| Does the interior design facilitate feelings of relaxation and wellbeing? | • Natural light  
  • Soft colours |
| Do the floor coverings minimise glare and noise? | • Type and impact of floor covering  
  • Equipment interaction with floor surface  
  • Person interaction with floor surface |
## Tool D2 Violence and the design process

### Construction

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will any services or spaces that staff or clients previously used be changed during the period of construction and if so what impact may this have?</td>
<td>Consult with staff</td>
</tr>
<tr>
<td>Will there be an increase in noise that may impact on aggression?</td>
<td>Noise sources, Floor surfaces, TV and radio</td>
</tr>
<tr>
<td>Will temporary way-finding systems be required to facilitate navigation?</td>
<td>Directional signage</td>
</tr>
</tbody>
</table>

### Post-occupancy evaluation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of incident and injury records related to OVA</td>
<td>Review data regularly, Provide reports, Support a reporting culture</td>
</tr>
<tr>
<td>Consultation with the user group and staff regarding design issues impacting on aggression</td>
<td>Impact of aggression during design phase</td>
</tr>
<tr>
<td>Walk-through inspection of the area</td>
<td>Regular inspections</td>
</tr>
<tr>
<td>Documentation of design shortcomings and positive design features for future projects</td>
<td>Quality documentation systems, Quality filing systems</td>
</tr>
</tbody>
</table>
Tool P1 Example: Violence prevention policy

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing a violence prevention policy.

Name of organisation

Purpose

<<<Name of organisation>>> is committed to providing a safe and healthy working environment free of violence or aggression for all staff, clients and visitors.

This policy is intended to define behaviour that constitutes workplace occupational violence and aggression and to guide staff in the management of aggression and violence in the workplace.

Definitions

For the purpose of this policy, occupational violence and aggression involves incidents in which a person is abused, threatened or assaulted in circumstances relating to their work. This definition covers a broad range of actions and behaviours that can create risk to health and safety of employees. It includes behaviour often described as acting out, challenging behaviour and behaviours of concern.

Within this definition:

**Threat** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked. It may involve an actual or implied threat to safety, health or wellbeing. Neither intent nor ability to carry out the threat is relevant. The key issue is that the behaviour creates a risk to health and safety.

Examples of occupational violence and aggression include, but are not limited to:

- biting, spitting, scratching, hitting, kicking
- pushing, shoving, tripping, grabbing
- throwing objects
- verbal threats
- threatening someone with a weapon or armed robbery
- sexual assault.

Objectives

- Managers, in consultation with health and safety representatives (HSRs) will manage violence or aggression issues.
- All incidents and near misses of violence or aggression are reported via <<<reporting system>>> and followed up by the area manager or supervisor.
- In the event of exposure to violent or aggressive incidents employees are provided with support, such as psychological support including debriefing opportunities and follow up.
- All reports of violence or aggression are reviewed by <<<committee>>> and systems are investigated to identify control measures that will minimise future risk.
- An assessment is conducted and documented on all clients to identify any risk factors that may trigger an episode of violence or aggression.
- Information about clients who have a history of, or are currently exhibiting, violent or aggressive behaviour, including triggers and management strategies, is shared whenever the client is transferred internally or externally.
- Care plans will include behaviour management strategies to reduce risks of occupational violence and aggression. These plans will be reviewed as required.
Tool P1 Example: Violence prevention policy

- All reasonably practicable control measures will be implemented to eliminate or reduce risks to health and safety for staff and clients. However, <<name of organisation>> reserves the right to refuse treatment or entry to clients and visitors known to initiate violence and/or aggression towards its staff, clients and visitors.

- All employees will receive education and training in the prevention and management of occupational violence and aggression according to their levels of exposure to risk.

Roles and responsibilities

<<Name of organisation>> will:

- Promptly, objectively and sensitively review all reports or threats of occupational violence and aggression, including a review of all investigations associated with occupational violence and aggression incidents.

- Ensure critical incidents have been reported, as required, to WorkSafe, the police, the OHS Committee and the elected health and safety representative (HSR) and investigated.

Senior leadership should demonstrate a commitment to a culture where aggression and violence is not accepted as part of the job by:

- Setting health & safety objectives and accountabilities
- Ensuring effective health and safety systems are in place to identify and control risk
- Allocating resources to prevention and management
- Developing and promoting policy and key initiatives
- Consulting with and supporting employees
- Monitoring and reporting on performance outcomes and acting on issues and opportunities

Managers and supervisors will:

- Enforce policy and procedures and monitor staff compliance.
- Identify and alert staff to violent clients and hazardous situations.
- Follow up and investigate all incidents of workplace occupational violence and aggression.
- Ensure debriefing is completed for those either directly or indirectly involved in the incident.
- Track and analyse incidents for trends and prevention initiatives.

Employees will:

- Formally report all incidents of occupational violence and aggression including threats and including near misses.
- Participate in education and training programs to be able to respond appropriately to any incident of workplace aggression or violence.
- Understand and comply with this policy and all related procedures.
- Contribute to risk assessments and incident investigations.

Health and safety committee will:

- Be consulted about the development, establishment and implementation of occupational violence and aggression prevention measures and procedures.

Risk management

- Workplace hazards will be assessed appropriately and include consideration of occupational violence and aggression hazards.

- All reports of violence or aggression are investigated and risk assessments are conducted to identify control measures that will avoid similar situations arising in the future.
Tool P1 Example: Violence prevention policy

- Clients will be assessed for aggression risk factors and a documented plan of care will take those factors into account to reflect care aimed at minimising the risk of exposure to violence or aggression.
- Visitors to the service who are repeatedly violent or aggressive, or who provoke violent or aggressive behaviour, will be identified and removed from the facility.
- A staged education and training program is provided for staff based upon their risk of exposure to occupational violence and aggression.
- All new employees will receive both general and risk-specific orientation to preventing and managing occupational violence and aggression in their work area.

Endorsed by: ................................................................. Committee on  .........../........./....... (Date)
Responsible officer: Chairperson, .......................................................... (Committee/position within the organisation)
Review date: ............ / ............ / ............ (Policy and procedures will be reviewed annually)
Name: ..................................................................................................................
Signed: .................................................................................................................. Date: .........../........./.......  

Related documents
Occupational Health and Safety policy
Staff Orientation policy
Privacy policy
Risk Management policy
Incident/Near Miss Report form
Critical Incident Debriefing policy
Critical Incident Debrief procedure
Risk Management policy
Employee Support and Assistance program

Consultation
The OHS Committee has considered the following Victorian legislation when establishing this policy:
- Workplace Injury Rehabilitation and Compensation Act 2013
- Crimes Act (1958)
- Human Rights Charter
- Mental Health Act (2014)
- Aged Care Act 1997
- Victorian Health Records Act (2001)
- Information Privacy Act 2000
Tool P2 Example: High-risk screening

<table>
<thead>
<tr>
<th>Purpose/aim</th>
<th>Screening of all clients upon point of entry (triage) to identify high-level risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Brief screening tool to identify clients presenting to triage (emergency) that may be at high risk of violence or self-harm. Tick boxes when potential risk identified</td>
</tr>
<tr>
<td>User(s) – area/department</td>
<td>Emergency</td>
</tr>
<tr>
<td>User(s) – position</td>
<td>Triage nurse</td>
</tr>
<tr>
<td>Time required to complete</td>
<td>More than one minute</td>
</tr>
<tr>
<td>Source(s) of information</td>
<td>Observation, client response(s)</td>
</tr>
<tr>
<td>Review</td>
<td>N/A</td>
</tr>
</tbody>
</table>

High-risk screening (triage)

Name: ____________________________________________

☐ Tick if any of the following are observed/identified:

1 ☐ History of violence
2 ☐ Presenting with injuries inflicted by self or others
3 ☐ Substance or alcohol affected
4 ☐ Behavioural disturbance
5 ☐ Stating intention to harm self or others
6 ☐ Hyper-vigilance
7 ☐ Suspected of having weapons
8 ☐ Confusion

No ☐ 1 to 8? No risk identified Finish here

Signed: __________________________ Date: __________
Name: ____________________________________________ Position: __________________________

Any ☐ 1 to 8? Risk identified Apply safety precautions

☐ Refer to senior clinician
☐ Initiate security back-up if needed
☐ Consider treatment environment
☐ Minimum of two employees during client contact
☐ Communicate identified risk (eg. file flagging, wrist band identifier)
☐ Monitor of behaviour/situation
☐ A full assessment of aggression risk required

Signed: __________________________ Date: __________
Name: ____________________________________________ Position: __________________________

☐ Full assessment of aggression risk completed

Signed: __________________________ Date: __________
Name: ____________________________________________ Position: __________________________
**Tool P3 Example: Violence hazard identification and risk assessment**

| **Purpose/aim** | Identify hazards to clinicians’ workplace safety
| | Assess the degree of risk and
| | Determine appropriate controls
| **Description** | Hazard identification and risk assessment tool to be used for clients at high risk of violence or self-harm
| | Tick boxes when potential hazard identified and conduct basic risk assessment
| | Consider risks to both staff and other clients
| | The risk factors are not intended to be added up or used to produce a numerical score
| **User(s) – area/department** | Admissions/inpatient areas
| **User(s) – position** | Only to be completed by senior staff member upon admission
| **Time required to complete** | Less than 30 minutes
| **Source(s) of information** | Client, family, other agencies, medical records, clinical observation
| **Review** | To be advised (TBA)
## Tool P3 Example: Violence hazard identification and risk assessment

### Combined violence hazard identification and risk assessment (clinical)

Name of person ............................................................................................................................

<table>
<thead>
<tr>
<th>Hazard identification</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
<th>When and how identified, eg client, family, other agencies, clinical observation?</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(1) Client history</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of violence in a health care setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any history of escalating behaviours, aggression or violence to self or others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of substance or alcohol misuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(2) Behaviour</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug and/or alcohol affected</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agitated, frustrated or distressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbally abusive or raised voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostile, threatening or intimidating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressing violent thoughts or plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern from others regarding aggressive behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hitting furniture, banging fist, throwing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacing, staring, hyper-vigilance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn or fearful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of control or independence related to disease or disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusing treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug-seeking behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In possession of dangerous items or weapons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(3) **Social context**
- Language barriers
- Communication difficulties
- Cultural misunderstanding
- Complex/distressed family relationships
- Friends or family who may place staff or other clients at risk

(4) **Health service issues**
- Restraint or seclusion
- Refusal of requested drugs/treatment
- Removal of privileges/belongings
- Separation from family/friends
- No access to smoking areas
- Treatment delays
- Rigidly scheduled care routines (e.g., meal times, personal care)
- Sleep disruption, noise

(5) **Other relevant information**
### Tool P3 Example: Violence hazard identification and risk assessment

#### Is there a risk?

Did you answer 'yes' to any of the above questions?

- [ ] Risk identified
- [ ] Risk assessment and control required

#### Risk assessment

<table>
<thead>
<tr>
<th>What could happen?</th>
<th>How could it happen?</th>
<th>Who is at risk?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Consequence (tick one) – How serious is the risk?

<table>
<thead>
<tr>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### Likelihood (tick one) – How likely is it to occur?

<table>
<thead>
<tr>
<th>Rare</th>
<th>Unlikely</th>
<th>Moderate</th>
<th>Likely</th>
<th>Almost certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### Do you consider the risk to staff is low, moderate, high or extreme?

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>A Almost certain</td>
</tr>
<tr>
<td>Moderate</td>
<td>B Likely</td>
</tr>
<tr>
<td>High</td>
<td>C Moderate</td>
</tr>
<tr>
<td>Extreme</td>
<td>D Likely</td>
</tr>
<tr>
<td>E Rare</td>
<td></td>
</tr>
</tbody>
</table>

#### Consequence

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insignificant</td>
<td>Minor</td>
</tr>
<tr>
<td>A Almost certain</td>
<td>High</td>
</tr>
<tr>
<td>B Almost certain</td>
<td>Moderate</td>
</tr>
<tr>
<td>C Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>D Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>E Rare</td>
<td>Low</td>
</tr>
</tbody>
</table>
## Tool P3 Example: Violence hazard identification and risk assessment

<table>
<thead>
<tr>
<th>Safety precaution</th>
<th>Responsible</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency response plan in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security back-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duty administrator, senior clinician, psychiatric consultant, nurse, patient advocate consulted/advised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staff are aware of the risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety first (never engage if you have concerns for safety)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety tips reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal protection, communication devices and duress alarms reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment checked for safety hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate staffing (assessment of client by at least two staff)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Tool P3 Example: Violence hazard identification and risk assessment

<table>
<thead>
<tr>
<th>Risk controls</th>
<th>Date prepared:</th>
<th>Action required</th>
<th>Person responsible</th>
<th>Completion date</th>
<th>Reviewed date</th>
<th>Action completed</th>
</tr>
</thead>
</table>
### Tool P4 Example: Behaviour assessment

<table>
<thead>
<tr>
<th>Purpose/aim</th>
<th>Identify and assess degrees of aggressive behaviour which impacts on clinicians’ safety, inform care planning, and monitor behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Behaviour assessment worksheet to be used for clients who identified at high risk of OVA. Scoring for seven items.</td>
</tr>
<tr>
<td></td>
<td>The factors are intended to be added up and used to produce a numerical score, with one score for each item. Each item carries the same weight. Add scores in each column, and then add the four scores together</td>
</tr>
<tr>
<td>User(s) – area/department</td>
<td>Inpatient areas</td>
</tr>
<tr>
<td>User(s) – position</td>
<td>To be completed by a clinician upon admission</td>
</tr>
<tr>
<td>Time required to complete</td>
<td>Less then three minutes</td>
</tr>
<tr>
<td>Source(s) of information</td>
<td>Clinical observation</td>
</tr>
<tr>
<td>Review</td>
<td>Ongoing, TBA</td>
</tr>
</tbody>
</table>
## Tool P4 Example: Behaviour assessment

### Behaviour assessment worksheet

<table>
<thead>
<tr>
<th>Client name _______________________________</th>
<th>ID No __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scorer _____________________________________</td>
<td>am/pm on <em><strong><strong><strong>/_____/</strong></strong></strong></em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1 = absent</th>
<th>2 = present to a slight degree</th>
<th>3 = present to a moderate degree</th>
<th>4 = present to an extreme degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The behaviour is not present</td>
<td>The behaviour is present, but does not disrupt others (e.g., staff and/or clients). The individual may redirect spontaneously</td>
<td>The individual needs to be redirected, but benefits from such cueing</td>
<td>The individual is not able to engage in appropriate behaviour even when external redirection is provided</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Absent</th>
<th>Slight</th>
<th>Moderate</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impulsive, impatient, low tolerance for pain or frustration</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Uncooperative, resistant to care, demanding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Violent and/or threatening violence towards people or property</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Explosive and/or unpredictable anger</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Rapid, loud or excessive talking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Self-abusiveness, physical and/or verbal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Current symptoms of alcohol or substance misuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Add checks in each column: _____ + _____ + _____ + _____ =

Then add the four scores Total score:

<table>
<thead>
<tr>
<th>Total score:</th>
<th>10 or below</th>
<th>11 to 14</th>
<th>15 to 17</th>
<th>more than 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final assessment</td>
<td>Within normal limits</td>
<td>Mild occurrence</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Enter final comments here: ____________________________

---

WorkSafe Victoria

Information for employers

Prevention and management of violence and aggression in health services 67
Tool P5 Example: Client alert

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing a client alert.

<table>
<thead>
<tr>
<th>Purpose/aim</th>
<th>Identify individuals with a propensity for violence in the context of protecting staff and other clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>File flagging as used for a variety of other clinical risk management and safety reasons</td>
</tr>
<tr>
<td>User(s) – area/department</td>
<td>Inpatient areas</td>
</tr>
<tr>
<td>User(s) – position</td>
<td>To be completed by a senior clinician after risk assessment has been completed</td>
</tr>
<tr>
<td>Time required to complete</td>
<td>Less than two minutes</td>
</tr>
<tr>
<td>Source(s) of information</td>
<td>Risk identification and assessment</td>
</tr>
<tr>
<td>Review</td>
<td>Ongoing, TBA</td>
</tr>
</tbody>
</table>

Client alert

This page should be placed prominently in the front of the client's file to inform staff of potential risks to their health and safety.

Based either on assessment or past behaviour, the following potential areas or risks to staff have been identified:

- [ ] Client (patient/resident)
- [ ] Carer
- [ ] Environment
- [ ] Other, as indicated

Staff are advised to check current notes to familiarise themselves with these risks before contact, and to always use safe work practices themselves and with respect to others.

Client's file entries must inform others of any risks or potential risks.

Signed .......................................................... Designation ..........................................................

Last updated ............, /............ /............

Source: Zero Tolerance (Occupational Violence and Aggression) Policy and Toolkit, Australian Nursing Federation (Victorian Branch), 2002
Tool P6 Example: Warning notice

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing a warning notice.

<<NAME>>
<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<ORGANISATION>> on the <<DATE>> between yourself and a member of <<THE PUBLIC / STAFF>>.

You have been made aware of our organisation’s policy with regard to maintaining an occupational violence and aggression free workplace on <<DATES>> and have been provided with a copy of our policy.

This letter is to advise you that future incidents of violent or aggressive behaviour which you are involved in at this organisation will result in the development of a behavioural contract and could subsequently require police involvement, refusal to treat you through our services and legal action.

If you wish to discuss the contents of this letter with a representative from <<ORGANISATION>> please phone <<PHONE NUMBER>>. A copy of our consumer complaints procedure is enclosed for your information.

Yours faithfully

<<NAME>>
<<POSITION>>

COPIES:  Addressee  
Client file  
Hospital alert system  
Security
Tool P7 Example: Conditions and behavioural agreement

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing a conditions and behavioural agreement

<<NAME>>
<<ADDRESS>>

Dear <<NAME>>

Further to the incident that occurred at <<ORGANISATION>> on the <<DATE>> between yourself and a member of <<THE PUBLIC / STAFF>>.

You have been made aware of our organisation's policy with regard to maintaining an occupational violence and aggression free workplace on <<DATES>>; been provided with a copy of our policy; and received written warning of further actions in the event that you were involved in further incidents of violent or aggressive behaviour at this organisation.

Enclosed with this letter are two copies of the behavioural agreement for you to sign and return in the enclosed reply paid envelope by <<DATE>>.

If you wish to discuss the contents of this letter or the behavioural agreement with a representative from <<ORGANISATION>> please phone <<PHONE NUMBER>>. A copy of our consumer complaints procedure is enclosed for your information.

Yours faithfully

<<NAME>>
<<POSITION>>

COPIES: Addressee
Client file
Hospital alert system
Security
Tool P7 Example: Conditions and behavioural agreement

**ONGOING ACCESS TO AND USE OF **<<ORGANISATION>>** FACILITIES AND SERVICES**

Staff, clients and visitors of <<ORGANISATION>> are entitled to a safe environment free of violence, threats and intimidation.

**THE CONDITIONS**

I, ........................................... <<NAME>>,........................................... agree to treat all staff, clients and visitors courteously and with respect at all times.

I understand that threats, intimidating behaviour, verbal abuse, physical violence and other anti-social behaviour are unacceptable.

I accept that I will be restricted to the treatment area or ward where I am a client or visiting.

I agree to visit the hospital on <<DAYS>> only and between the hours of <<TIME>> and <<TIME>> and on every occasion that I will report to the head of security at the reception desk on arrival before proceeding to the treatment area or ward.

I understand that in certain circumstances, a security guard will be based on the ward during my treatment or visit.

I am aware that a request for information about a relative (if I am the next of kin) from a member of staff may be made through the patient liaison officer or after-hours administrator.

I understand that if I breach any of these conditions, security staff may evict me from the hospital and/or contact the police to enforce the eviction.

<<ADD ADDITIONAL CONDITIONS IF WARRANTED>>.

I AGREE TO THE CONDITIONS ABOVE AND AM AWARE THAT FAILURE TO COMPLY WITH THESE CONDITIONS WILL RESULT IN MY EVICTION FROM THIS HOSPITAL. I HAVE BEEN GIVEN A COPY OF THIS AGREEMENT.

Signed: ........................................................................................................
Tool T1 Exposure to aggression risk calculator

This risk calculator can be used across an organisation, in a specific department or unit, or with staff from a particular work or professional group to determine the level of training required. The aim of this calculator is to identify the type of aggression staff are exposed to and the frequency of the exposure.

It has been developed to enable staff to document experiences and/or perceptions of their exposure to client-initiated aggression and violence in their work environment as a means of determining the level of training required by work groups or units in your organisation. It could be used in conjunction with a staff survey, or in isolation to provide a snapshot of a current situation.

The results of the compiled data from this calculator should be reviewed in conjunction with incident and near-miss data reported formally within the organisation, position descriptions and role expectations of staff and other organisational documentation, eg training and education records and health and safety control measures that have been implemented.

For example:

- A survey of security staff might reveal exposure to 'physical aggression' on a weekly basis. This result would indicate this staff group require level 2 training. However, a review of their position descriptions might reveal they are required to participate in physical restraint of clients, removal of clients from the premises and isolated patrols of the facility that place them at risk of assault. This suggests that a level 3 training program would be more appropriate for security staff.

- A survey of clerical staff might reveal that ward clerks, switchboard and reception staff identify exposure to 'threat intimidation' on a weekly basis, while clerical staff with no day-to-day contact with the general public identify exposure to 'minor verbal aggression' bi-annually.

- A survey of an aged care work unit might reveal that nurses identify exposure to 'high aggression extreme threat' on a weekly basis while food services staff identify exposure to 'verbal aggression' on a monthly basis. However, far fewer incidents might be revealed if incident reporting data was reviewed in isolation.

In addition to identifying the level of training required by staff this simple survey can reveal some systemic issues within an organisation.

For example, it might identify:

- A workforce skilled in defusing/de-escalating situations before they become violent.
- A limited of understanding of what constitutes an aggressive incident based upon the criteria used within the survey.
- Issues associated with incident reporting processes.
- Under-reporting of incidents.
- Work practice issues within a work area that require further investigation (eg staff skill mix).
Tool T1 Exposure to aggression risk calculator

To complete this tool:
1. Note your work area, position and length of employment.
2. Identify the type/s of aggression you experience in your work from clients/visitors/relatives across the top of the table.
3. Identify how frequently it occurs to you personally from the column on the left.
4. Mark the appropriate box in the matrix.

<table>
<thead>
<tr>
<th>Work area: (eg aged care)</th>
<th>Position: (eg PSA)</th>
<th>Time Employed: (eg six years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Exposure</td>
<td>Extreme aggression</td>
<td>Severe aggression</td>
</tr>
<tr>
<td></td>
<td>attack resulting in death</td>
<td>attack resulting in serious injury</td>
</tr>
<tr>
<td>Weekly</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Monthly</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Bi-annually</td>
<td>E</td>
<td>H</td>
</tr>
<tr>
<td>Annually</td>
<td>E</td>
<td>H</td>
</tr>
<tr>
<td>5 yearly</td>
<td>E</td>
<td>H</td>
</tr>
<tr>
<td>20 yearly</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>40+ yearly</td>
<td>H</td>
<td>M</td>
</tr>
</tbody>
</table>

L = Low risk – ‘Dealing with difficult customers’ session is recommended
M = Medium risk – Level 1 training is recommended
H = High risk – Level 2 training is recommended
E = Extreme risk – Level 3 training is recommended
Tool T2 Aggression risk calculator

This risk calculator can be used across an organisation, within a specific department or unit, or with staff from a particular work or professional group to determine the tiered level of training required based upon occupational groups. The focus of this tool is staff who deal with clients by telephone or directly.

It has been developed to enable staff to document the role they carry out in client care and the type of client contact they have within that role as a means of determining the level of training required by particular occupational groups. It could be used in conjunction with a staff survey, or in isolation to provide a snapshot of a current situation. It enhances the snapshot provided by the exposure to aggression risk calculator (Tool T1).

The results of the compiled data from this calculator should be reviewed in conjunction with incident and near-miss data formally reported within the organisation, position descriptions and role expectations of staff and other organisational documentation such as training and education records and health and safety control measures that have been implemented.

To complete this tool:

1. Note your work area, position and length of employment.
2. Identify the type/s of aggression you experience in your work from clients/visitors/relatives across the top of the table.
3. Identify how frequently it occurs to you personally from the column on the left.
4. Mark the appropriate box in the matrix.

<table>
<thead>
<tr>
<th>Work area: (eg Acute)</th>
<th>Position: (eg Physio)</th>
<th>Time Employed: (eg three years)</th>
</tr>
</thead>
</table>
# Tool T2 Aggression risk calculator

<table>
<thead>
<tr>
<th>Type/level of client contact</th>
<th>Occupational group</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Isolated – secure</td>
<td>Reception enclosed</td>
<td>Admissions</td>
<td>Triage and reception open</td>
<td>Hands-on</td>
<td>Hands-on care mental health</td>
<td>Part-time security</td>
<td>Full-time Security</td>
</tr>
<tr>
<td>Telephone, physical contact, visitors/relatives, client handling, restraint and violence issues</td>
<td>L</td>
<td>L</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Telephone, physical contact, visitors/relatives, client handling and restraint</td>
<td>L</td>
<td>L</td>
<td>M</td>
<td>H</td>
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<td>E</td>
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<td>E</td>
</tr>
<tr>
<td>Telephone, physical contact, visitors/relatives and client handling</td>
<td>L</td>
<td>L</td>
<td>M</td>
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<tr>
<td>Telephone, physical contact, visitors/relatives</td>
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<tr>
<td>Telephone and physical contact</td>
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<td>M</td>
<td>M</td>
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<td></td>
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<tr>
<td>Telephone and enclosed contact</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td></td>
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<td></td>
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<tr>
<td>Basic telephone response only</td>
<td>L</td>
<td>L</td>
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</tbody>
</table>

*L = Low risk – ‘Dealing with difficult customers’ session is recommended  
*M = Medium risk – Level 1 training is recommended  
*H = High risk – Level 2 training is recommended  
*E = Extreme risk – Level 3 training is recommended*
Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing post training evaluation tools.

Post-training evaluation provides valuable information about design and delivery, but does not measure learning transfer or medium-to-long-term benefits of a program in the workplace.

**Tool T3** could be used immediately after training to evaluate program relevance and key learnings for participants.

To assist us in providing relevant training, please complete this evaluation and leave in the box provided.

<table>
<thead>
<tr>
<th>Topics covered in this course</th>
<th>Very relevant</th>
<th>Relevant</th>
<th>Little relevance</th>
<th>Not relevant</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understanding the legal context, including the employer’s duty of care, the right to protect yourself and the use of reasonable force</td>
<td></td>
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<tr>
<td>2. Definitions of violence, and how it occurs</td>
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<tr>
<td>3. Non-physical management of violence including:</td>
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<td></td>
</tr>
<tr>
<td>• customer service</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• verbal and non-verbal communication skills</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• cultural diversity</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• diffusion</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• de-escalation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. Organisational policy, procedures and practices in relation to work-related violence (including roles and responsibilities of management and staff, reporting and accountability)</td>
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<tr>
<td>5. Post-incident reactions and support, including psychosocial follow-up, and internal and external support mechanisms</td>
<td></td>
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</tr>
<tr>
<td>6. Physical intervention and management skills, including withdrawal, breakaway, control and restraint techniques</td>
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</tr>
</tbody>
</table>

Are there any additional topics you would like to have covered during this training program?  ........................................................................................................................................................................

What would you have excluded from the program?  ..........................................................................................................................................................................................................................................................
Tool T3 Example: Post training evaluation tool – short term

Key learnings

1. List two new things you have learnt today about the legal duty of care pertaining to:

Employers: ____________________________________________________________

Employees: ____________________________________________________________

2. List three ways which you can change your current practices in your workplace to prevent and/or manage client-initiated aggression or violence:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

3. What are the three risk factors for aggression and violence?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

4. What are three signs of a person becoming aggressive or impending violence?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

5. A patient in your work area becomes agitated and you fear he/she may become aggressive or violent. What would you do?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

6. Who should you notify if there is an episode of aggression or violence in your work area and how should they be notified?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Tool T4 Example: Post training evaluation tool – medium to long term

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing post training evaluation tools.

This evaluation tool has been developed for use at least six months after training to assess knowledge and skill retention and the effectiveness of the training program.

The tool has three components:

• general information
• introduction (usually following orientation), and
• level 2 and 3 training.

The introduction questions are numbered 1-8. The evaluation could cease at that point or continue to question 21 for people who have completed aggression prevention and management training programs at levels 2 and 3.

We are committed to maintaining the health and safety of all staff. This evaluation will assist us in determining the effectiveness of the aggression prevention and management training and education program.

Please take a few minutes to complete the survey and return it to ....................... by ........../........./..........

The results of the survey will be provided to ........................................ on ........../........./..........

Thank you for taking the time to complete this survey.

General information

<table>
<thead>
<tr>
<th>Ward/work unit/division .................................................................</th>
<th>□ Male</th>
<th>□ Female</th>
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<tbody>
<tr>
<td>Age range (years):</td>
<td>□ &lt; 30</td>
<td>□ 30-39</td>
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</table>

Occupational group, please tick one of the following:

□ Allied health professional                                     □ Clerical/administration
□ Nurse                                                          □ Environmental/food services
□ Medical                                                        □ Other (please specify)
□ Clinical assistant                                              ...........................................................
□ Coordination                                                    ...........................................................

Years of experience:    | □ < 5 | □ 5-10 | □ 11-20 | □ 20-30 | □ > 30
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<tbody>
<tr>
<td>I have completed:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation</td>
<td>□</td>
<td>□</td>
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<td></td>
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<tr>
<td>Level 2 Aggression Prevention and Management training</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3 Aggression Prevention and Management training</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DATE</th>
</tr>
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<tbody>
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</tbody>
</table>

Thank you for taking the time to complete this survey.
1. The *Occupational Health and Safety Act 2004* (OHS Act) applies to:
   - A. Employers, contractors and visitors
   - B. Patients and employees
   - C. Visitors and patients
   - D. Employers and employees, including contractors

2. Our organisation has the following combination of policies and procedures related to occupational violence:
   - A. Restraint, seclusion, zero/non tolerance, code of conduct, incident reporting
   - B. Occupational violence, OHS
   - C. Hazard identification, risk assessment, Code Black
   - D. All of the above

3. Occupational violence occurs:
   - A. When an employee is threatened or physically attacked in the workplace
   - B. When an employee is threatened or physically attacked in the street
   - C. When an employee is threatened or physically attacked in their home
   - D. All of the above

4. Following an aggressive or violent incident I should:
   - A. Discuss it with my colleagues and family
   - B. Complete a hazard report and advise my supervisor
   - C. Report the incident to my supervisor and complete an incident report
   - D. Advise the health and safety representative (HSR) and do a risk assessment

5. If I am involved in an aggressive or violent incident related to my work and need some additional support afterwards, I should:
   - A. Discuss the issue with my colleagues
   - B. See my general practitioner/local doctor
   - C. Contact the human resources department
   - D. Contact my supervisor for support and guidance

6. The main reason clients become aggressive is because:
   - A. They are in pain
   - B. They feel they have no choices
   - C. They are thirsty and hungry
   - D. They are substance affected

7. In relation to aggression and violence at work:
   - A. I have a right to withdraw to safety at anytime
   - B. I am always involved in de-escalating/defusing incidents within my work area
   - C. I should always call for assistance/a code response regardless of the situation
   - D. All of the above

8. Please rate your current level of anxiety at the possibility of dealing with an aggressive client on the scale below.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Low)</td>
<td>(High)</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

WorkSafe Victoria  
Information for employers Prevention and management of violence and aggression in health services 79
Tool T4 Example: Post training evaluation tool – medium to long term

Evaluation tool for participants post training for staff that have completed a level 2 Aggression Prevention and Management training program

This brief evaluation will assist to determine the effectiveness of the aggression prevention and management training program. If you have not completed a level 2 or 3 training program do not proceed. If you have completed a level 2 or 3 Aggression Prevention and Management training program please take a few minutes to complete the survey and return it to [specified address] by ___ / ___ / ___.

The results of the survey will be provided to [specified recipient] on ___ / ___ / ___.

9. The Patient Rights and Responsibilities Bill/Charter:
A. Protects staff from aggressive and violent behaviours in the workplace
B. Outlines the rights and responsibilities of patients and aims to support a partnership between patients and their health care providers
C. Requires that all patients receive immediate attention
D. Makes patients responsible for their actions

10. ‘Client-initiated aggression’ means:
A. The client is looking for a fight
B. Known or unknown circumstances have provoked an aggressive response from a client
C. That staff should see aggression as ‘part of the job’ in the health industry
D. None of the above
E. All of the Above

11. If a client is becoming aggressive I should:
A. Use distraction techniques to avert an incident
B. Pacify the client by giving in to their demands
C. Stand my ground
D. Try to resolve the issue using good communication focusing on the actual cause for the aggression

12. Risk assessments related to OHS:
A. Should always be done by the OHS committee chairperson or manager
B. Must be completed following an incident that places an employee’s health or safety at risk
C. Occur following identification of a hazard
D. All of the above

13. Conflict can be verbal, physical and/or psychological. Which strategy is the most useful in conflict management?
A. Focus, listen and argue the point
B. Focus, listen, be assertive and give ultimatums
C. Focus, listen, be assertive and offer choices
D. Give the client what they want
Tool T4 Example: Post training evaluation tool - medium to long term

15. I would know a situation was escalating because:

A. All staff would be fearful and clients would be anxious
B. Voices would be raised and threats would be made
C. The client would be becoming increasingly agitated, sarcastic and angry towards staff
D. Staff would be arguing with the client and giving ultimatums

16. Under the OHS Act I have a duty to:

A. Take reasonable care for my own health and safety
B. Report unsafe practices and incidents
C. Take reasonable care for the health and safety of others who may be affected by my acts or omissions at work
D. All of the above
E. None of the above

17. Under the OHS Act my employer has a duty to consult:

A. When determining membership of the OHS committee
B. By sharing information with employees and giving reasonable opportunities to express views about the matter
C. When making decisions about measures to be taken to control risks to health and safety
D. All of the above
E. None of the above

18. Aggression and violence usually arise as a result of:

A. Pathophysiological changes for the client, anxiety, miscommunication and long waiting times
B. Noisy environments that are brightly lit and intruders and drug seekers
C. Mental health problems that require immediate psychiatric attention
D. All of the above

19. The term 'reasonable force' means:

A. An immediate code response is required
B. A person must be secluded to prevent damage to people and property
C. Action that is commensurate with the situation
D. Physical action that will prevent injury or damage to people or property

20. Please rate your current level of confidence in managing an aggressive client on the scale below.

1 2 3 4 5 6
(Low) (High)

21. How many times in the past six months have you used the knowledge and skills learnt at the training program you attended?

Any comments:
Tool T5 Example: Competency-based assessment

Note: this is an example only and not intended as a template. Consider the needs of your organisation when developing this tool.

This competency-based assessment tool has been developed for use by those with solid OHS knowledge.

This competency assessment instrument has been developed to help identify individual needs in relation to client-initiated aggression prevention and management. It is recommended that for use by people with expertise and sound knowledge in OHS, beyond a common sense approach, and with a capacity to assess individual competence. It could be used to obtain information from a sample of staff across an organisation, or in a targeted way with a particular work unit/group within an organisation.
### Tool T5 Example: Competency-based assessment

<table>
<thead>
<tr>
<th>Rating</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **Competent** – no prompting required | • Demonstrates an understanding of ‘non-tolerance of violence’ principles.  
• Meets the stated criteria with no assistance.  
• Performs all essential steps correctly.  
• Demonstrates accuracy and safety in completing the required assessment.  
• Demonstrates sequential process in assessing the patient.  
• Performs the assessment within an acceptable time frame  
• Demonstrates an understanding of ‘non-tolerance of violence’ principles.  
• Meets the stated criteria with minimal assistance (may require one or two prompts).  
• Performs all essential steps correctly.  
• Demonstrates accuracy and safety in completing the required assessment.  
• Demonstrates sequential process in assessing the patient.  
• Demonstrates sequential process in performing the task.  
• Performs the assessment within an acceptable time frame.  
• Unable to demonstrate an understanding of ‘non-tolerance of violence’ principles.  
• Requires three or more prompts to complete the assessment task.  
• Assessment task completed in an unacceptable time frame.  
• The patient assessment process lacks sequence or is disorganised.  
• The performance of the task lacks sequence or is disorganised.  
• A breach of safety occurs. |

---

Employee's name: __________________________  Signature: __________________________  Date: __________

Assessor: __________________________  Signature: __________________________  Date: __________
### Tool T5 Example: Competency-based assessment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1:</strong> The employee understands the importance of OHS and acts in accordance with aggression prevention and management policies and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 The employee demonstrates an understanding of the employer's statutory duty of care.</td>
<td></td>
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<tr>
<td>1.2 The employee demonstrates an understanding of his/her own duty of care in relation to the Occupational Health &amp; Safety Act 2004</td>
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</tr>
<tr>
<td>1.3 The employee demonstrates an understanding of the principles of Zero Tolerance to Violence in the workplace</td>
<td></td>
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<tr>
<td>1.4 The employee can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control</td>
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<tr>
<td><strong>Objective 2:</strong> The employee demonstrates an understanding of risk management in the context of the client-initiated aggression prevention and management within our organisation</td>
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<tr>
<td>2.1 The employee can explain the process for reporting incidents in the workplace</td>
<td></td>
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<tr>
<td>2.2 The employee is able to identify incidents or near misses that require reporting</td>
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<tr>
<td>2.3 The employee understands the organisation’s aggression prevention and management policy and its implications</td>
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<tr>
<td>2.4 The employee can explain the risk management process in the workplace with respect to hazard identification, risk assessment and risk control</td>
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<tr>
<td>2.5 The employee demonstrates an understanding of risk assessment principles associated with the physical environment, work practices and a client’s ability to comprehend and communicate</td>
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</tr>
<tr>
<td>2.6 The employee understands the procedures involved for proper storage and maintenance of duress alarms and personal safety devices</td>
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</tbody>
</table>
### Tool T5 Example: Competency-based assessment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 3:</strong> The employee is able to identify and assess the aggression and violence risks associated with a client according to their needs and abilities.</td>
<td>C</td>
<td>P</td>
</tr>
<tr>
<td>Objective 3.1 The employee is able to identify common causes of client-initiated aggression in the workplace</td>
<td></td>
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<tr>
<td>Objective 3.2 The employee is able to describe patterns of behaviour in clients that might indicate escalation to an aggressive or violent situation</td>
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<tr>
<td>Objective 3.3 The employee is able to identify environmental hazards in relation to client-initiated aggression or violence</td>
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<tr>
<td>Objective 3.4 The employee is able to discuss diffusing techniques appropriate to the client's needs and abilities and to the workplace</td>
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<tr>
<td>Objective 3.5 The employee is able to explain how to access further assistance if a situation becomes violent</td>
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</tbody>
</table>

**Key:**
- **C** = Competent: no prompting required
- **P** = Competent: some prompting required
- **N** = Not competent
WorkSafe Victoria

Agent contact details are all available at worksafe.vic.gov.au/agents

Advisory Service
Phone: (03) 9641 1444
Toll-free: 1800 136 089
Email: info@worksafe.vic.gov.au

Head Office
222 Exhibition Street, Melbourne 3000
Phone: (03) 9641 1555
Toll-free: 1800 136 089
Website: worksafe.vic.gov.au

For information about WorkSafe in your own language, call our Talking your Language service

<table>
<thead>
<tr>
<th>Language</th>
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</tr>
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<tbody>
<tr>
<td>廣東話</td>
<td>1300 559 141</td>
</tr>
<tr>
<td>Ελληνικά</td>
<td>1300 650 535</td>
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<tr>
<td>Македонски</td>
<td>1300 661 494</td>
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<tr>
<td>Italiano</td>
<td>1300 660 210</td>
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<td>普通话</td>
<td>1300 662 373</td>
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<tr>
<td>Српски</td>
<td>1300 722 595</td>
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<td>Español</td>
<td>1300 724 101</td>
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<td>Türkçe</td>
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