**PROTECTING STAFF FROM VIOLENCE**

**GUIDELINES**

**NBAG**

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INTRODUCTION

**NBAG recognises that violence against hospital staff and visitors at the hospital is a growing concern**. This paper considers the issue of physical safety of staff in the workplace and specifically protection from violence. We are not dismissing environmental safety (e.g. infection), psychological safety (e.g. bullying) or physiological safety (e.g. fatigue) however believe the issue of physical safety is one that deserves specific attention at this time.

As a union: DHB partnership, NBAG’s focus is rightly on the employment relationship. In doing this piece of work we have not sought to “balance” other factors such as patient, family or whanau rights or needs, but focused on the party’s responsibility for employee safety.

This paper seeks to reduce the vulnerability of staff to harm from violence in any workplace setting, whilst predominantly this will be hospitals it includes community clinics and facilities and patient housing, looking at prevention, protection, incident management and post incident strategies. There are a range of issues that may be relevant to considerations including variation in the level of risk, the practicality of protective measures for prevention of threats to personal safety and the availability of emergency help when such threats are identified or acted upon. We therefore recommend a systematic process be applied.

A risk management approach is likely to be most effective, focusing on risk identification, risk assessment, risk control and evaluation of the effectiveness of risk management strategies. This document is intended to give some guidance to the violence management efforts of hospitals, practice managers and individual employees. The risk management process includes:

* Risk identification.
* Risk assessment.
* Risk control.
* Resourcing-staffing and equipment.
* Policy on violence.
* Complaint mechanisms.
* Physical environment.
* Personal protection.
* Education and training.
* Additional security measures.
* Post-incident management.
* Monitoring and evaluation.

**Prevention**

Occupational health and safety (OH&S) legislation places on employers and employees a general duty of care to provide and maintain a safe and healthy workplace. There are a wide range of workplaces and different times of day in which staff work: many staff work shifts, many provide after-hours services and some provide care in the community, and work in isolation including in patients homes, requiring travel by vehicle or plane. All these variations must be accounted for.

Violence risk management needs to take into consideration the work environment. Some workplaces, such as major hospitals, are able to provide formal protective measures in terms of both prevention of and responses to violence against staff whereas other see staff working in isolation, perhaps on their own, particularly outside static workplaces, for example on home visits.

To be successful violence risk management requires the commitment of management through leadership and sufficient investment of time, money and personnel. This includes commitment to regular audits of the organisation’s vulnerability to violence to inform risk management planning.

Consultation with staff is essential for violence risk management planning to be effective. A risk management methodology should be used in conjunction with the detailed knowledge of staff in the local work environment to develop tailored solutions to violence problems. It may be appropriate to assemble a working group of staff to specifically develop a violence risk management plan.

DHBs should develop a zero tolerance policy regarding the management of violence including verbal abuse and ensure that staff understands this. We suggest all DHBs should develop, in conjunction with consumer councils’, community and iwi, a code of acceptable behavior and responsibilities for patient, family and visitors with specific reference to the rights of staff to respect and to be free from violence. This code is a clear request for all people to be treated with respect and for this to be reciprocated. This code should be publically and clearly displayed in DHB premises, provided to all primary carers and family and visitors and enforceable.

Whilst staff have the right to be safe they must also understand that to keep themselves safe they must accept some responsibility. Failure by staff to follow policy or correct procedure in the interests of some perceived patient, family or whanau right or impact is common in our workforces. It is also common for fear of repercussion to drive inappropriate responsiveness. Management leadership in supporting the rights of staff to be safe is imperative. Staff should know protocols and procedures and be required to use them. Post incident management to assess this dynamic and how effectively it is being managed should always occur.

A system should be in place for reporting violent incidents and staff should report all violent or aggressive incidents and threats that have endangered, or have had the potential to endanger, a staff member’s safety including all threats involving the use of a firearm or weapon. All serious threats should automatically be referred to the police. A clear system for applying for trespass orders and if necessary restraining orders should be known to all staff. When these are in place, an alert system should be in place that is timely including accessing support from Police.

**Risk Management Strategy**

Risk Identification and Assessment

In order to prevent harm, a robust system for the identification of risk is required: we cannot prevent that of which we are unaware. The identification of risks in relation to violence should take into account information from workplace inspections and security assessments, incident and accident reports / investigations, complaints, and other information obtained from staff and users of healthcare facilities.

Risk assessments determine if a hazardous situation may result in harm and make decisions about appropriate control measures. When assessing the risks of occupational aggression and violence, workplaces should consider the:

* Likelihood of an act of aggression or violence; and
* Likely severity of an act of aggression or violence; and
* What control measures exist and if they are adequate.

Assessments of identified risks should be undertaken to arrive at ratings of both the likelihood of each risk occurring and its impact. These ratings should be used to ascertain the level of each risk so that the relative priority of actions to deal with these risks can be determined.

Risk Control

The resourcing and timing of steps to control (eliminate or minimise) risks should reflect the level of each risk as identified through risk assessment. (See below for some risk prevention and control strategies).

Incident and injury record review or audit

Every Incident must be reported/recorded and reviewed to help analyze trends and identify patterns of aggression and violence. The data should establish a baseline for monitoring changes in reporting, measuring improvement and reporting processes. Data can also be used to support decision-making processes associated with setting priorities for further investigations, assessment and or review.

Post-incident Management

Post-incident management activities should include post-incident support (such as first aid, medical attention, and incident debriefing), incident reporting, and incident investigation activities which include recommendations to help prevent future recurrence.

Monitoring and Evaluation

Continuous monitoring and evaluation of outcomes needs to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.

**Considerations**

Risk factors for potential aggression that must be considered in the workplace setting include:

* Physiological imbalances or disturbances;
* Substance misuse or abuse;
* Intoxication;
* Acute and chronic mental health conditions;
* Distress or frustration; and
* Uncontrolled pets (in a community or home setting)

Mechanisms for minimizing risk arising from these predictable scenarios and for dealing with the potential for aggressive and violent behavior may include:

* Education and De-escalation training of staff;
* Working in pairs when risk present;
* Presence and availability of security staff;
* Physical environment for family (e.g. quiet breakout rooms);
* Building Design;
* Entry and exit points/options and security;
* Surveillance;
* Lighting; and
* Physical layout and natural surveillance points.
* Opportunities for staff to be accompanied by colleagues when home visiting patients where risk factors may be present e.g. antenatal or postnatal visits in a situation that might be considered to be pose a safety risk.

Things to consider *(this is not an exhaustive list but provided as a starting point for consideration)*

Education and Training

* Healthcare staff, patients and their visitors should be provided with information regarding behaviour expected of them in a health care setting.
* Staff should be have access to and provided with a copy of the DHB’s policy on violence and understand what action they should take to address concerns that may arise.
* Staff should be given appropriate training to assist with the management of violence. Preventative approaches should be covered as part of such training.
* Staff should be provided with information regarding the identification and assessment of risks in relation to violence in their work environment, as well as control measures to address the risks.

Role of security services to mitigate risk

* Security staff play an important role in the hospital setting. Adequate number s of security staff should be rostered on at all times and reflect the relative risk present in the various workplaces at different times of the day.
* Security staff should be appropriately trained and screened for their suitability to the workplace.
* Security staff should be clearly visible, patrolling the hospital and readily accessible in case of an emergency or critical situation. Where the risk of aggressive or violent behaviour is heightened, security staff should be visible at all times in the work place.
* Opportunities for indirect security monitoring should be actively considered. For instance orderlies working around the hospital are an excellent set of eyes and ears on what is happening. Training them to be a part of the overall organisation’s security surveillance system could add value.

Physical Environment

* Surroundings should be made as comfortable as possible for users of health care facilities to help lower distress amongst those with health concerns.
* There should be sufficient lighting inside and in the immediate vicinity of the hospital to provide a safe and secure working environment.
* External doors should be locked at night with only the main entrances, which should be under security surveillance, left open for public access.
* Staff should have access to secure lockers in which valuables can be stored while working.
* Sufficient car parking spaces should be available to provide for all staff rostered on at any particular time or likely to be called in, including specific parking for on call/after hours work. Where parking is not within close proximity then consideration will be given to staff being accompanied by security personnel to their car or provided with a duress or security alarm.
* Staff only areas (including staff office areas, staff common rooms, and other restricted areas) should be accessible only via restrictive access devices such as card keys with photo identification.
* Parts of the workplace that potentially pose risk such as where patient notes or drugs are kept should be physically reserved for staff only.
* Reposition drugs cabinets so that they are within view of as many staff as possible (and as few non staff as possible) during the course of their work.
* Video surveillance in appropriate areas (corridors, lifts, above entrances to isolated facilities e.g. laboratories, areas with infrequent traffic outside office hours e.g. admin corridors) should be considered and, where implemented, signs should be prominently posted advising of its presence to maximise its deterrence value.
* Duress alarms should be provided in all areas where members of the public are present (e.g. wards, outpatients).
* Personal duress alarms should be carried (and monitored by security) bystaff exposed to higher-risk situations, including those working in mental health treatment areas, emergency departments and in settings where there is little organisational backup or delays in getting emergency help, such as after-hours where the staff member is commuting around the hospital through isolated corridors.

Protecting Personal Privacy

* It is a fundamental right for the occupational health and safety of staff providing services to patients, in any setting, for their personal private details including residential address, phone numbers and email details, to remain strictly confidential. This is particularly important in situations where the nature of work places them at risk of harassment and violence from unstable or maladjusted patients.
* This information should also be protected from access by other staff members who have no “need to know”. Security settings on hospital personal information files should regularly be reviewed to ensure only those that genuinely need to know have access.
* Work schedules for staff where their names are displayed, should not be visible to anyone but staff.

Complaints Mechanism

In order to encourage problems to be addressed in a non-violent manner, effective and responsive complaints mechanism should be available for staff and users of healthcare facilities. Complaint handling systems should include a risk of violence towards staff review to feed into the overall safety from violence risk assessment process.

Additional Security Measures

Additional security measures should be taken to protect staff e.g. late hours or home visits in settings where they are on their own or where emergency help is not quickly available and in places where drugs are stored or being distributed.

Home Visits

Guidelines should be in place to protect staff undertaking home visits. These may include, for example:

* providing security escorts,
* working in teams,
* Posting timetables ahead of the work day and keeping timetables recording details of visits,
* Staff should let DHBs know at the end of each visit that they have completed the visit safely and confirm where they are,
* Consideration how staff identify themselves (e.g. first name only or first name and role/function?)
* following predetermined procedures if staff become uncontactable or do not check in when expected, and
* Ensuring staff carry a duress alarm and/or work-supplied mobile phone (GPS-linked if necessary) during visits.
* Escalation training and training of safety strategies.
* Infirm alerts on client notes re hazards which may included dogs or potentially aggressive people at site.
* Requiring known aggressive people to attend an on-site clinic rather that be visited at home.

All hospital cars should be fitted with GPS locator.