SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Violence Prevention and Management
TYPE OF DOCUMENT	Procedure
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LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1 – Clinical Governance NSW Health PD2015_001 Preventing and Managing Violence in the NSW Health Workplace – a Zero Tolerance Approach
REVIEW DATE	August 2028
FORMER REFERENCE(S)	SESLHDPR/341 - WHS Violence Prevention and Management
EXECUTIVE SPONSOR	SESLHD General Manager, Corporate Services
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FUNCTIONAL GROUP(S)	Workplace Health and Safety
KEY TERMS	Aggression management; Management of violence in the workplace; Management and care of patients who display violent behaviour.
SUMMARY	This procedure describes the early detection, documentation and management of violence and aggression throughout the organisation.

1. POLICY STATEMENT

SESLHD recognises its duty of care to all workers, patients, visitors, volunteers, contractors and students, through the minimisation of harm and protection from acts of aggression and violence.

The *Violence Prevention and Management Procedure* has been developed to ensure SESLHD has a systematic framework that complies with requirements outlined in NSW Health Policy Directive PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace – a Zero Tolerance Approach.

Note – management of incidents of violence or aggression perpetrated by SESLHD staff toward patients/clients or other staff is outside the scope of this procedure.

2. BACKGROUND

Violence is defined as any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault.

While SESLHD may not be able to prevent all initial unanticipated acts of violence or aggression, the organisation provides this procedure to:

- Manage the initial incident to minimise the risk of adverse outcomes to patients and workers.
- When possible, prevent a reoccurrence from the same person.
- When a reoccurrence of violence or aggression cannot be prevented due to the person's clinical condition, that the care management systems are implemented to minimise the risk of further aggression and the associated adverse outcomes.
- Communicate the level of aggression risk represented by a patient to all other SESLHD workers and others present.
- Where the aggressor is not a SESLHD patient, provide a written initial warning and management strategy for subsequent breaches of the behaviour code, which is transparent, documented and auditable.

3. DEFINITIONS

Refer to Appendix 1.

4. RESPONSIBILITIES

4.1. Workers:

- Attend all required training and education in violence prevention and management.
- Implement respectful interactions in all patients, co-workers and public contact situations.
- Identify and respond to escalating aggressive behaviour or acts of violence, if safe to do so.
- In the event of a personal threat, follow the CODE Black emergency procedure.

- Report all incidents to the appropriate line manager through iMS+.

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4.2. Line Managers:

- Ensure all workers are trained in and are using the Violence Prevention Management Training Framework approaches to managing patient and visitor interactions.
- For Departments where high-risk patients are routinely admitted, ensure all workers are trained and competent in Violence Prevention Management Module 2– Personal Safety, and rosters are managed accordingly.
- Provide appropriate safe staffing levels to work with patients identified as per patient care planning, specialling (one to one nursing/security) business rules and safe work practices.
- Ensure violence/aggression risk is documented and regularly updated in patient care plans.
- Establish local processes for communicating the potential violence risk to all workers entering or working in their work area.
- Ensure violence/aggression and Code Black incidents are reported in IMS+.
- Assist workers in the de-escalation of a patient or visitor and/or implement other control measures as appropriate.
- Coordinate the Code Black response to violence or aggression.

4.3. Security Officers:

- Respond to a Code Black: When a Code Black is called, Security Officers must attend the scene immediately (if safe to do so), providing support to the clinical team.
- Support de-escalation efforts: In collaboration with the clinical staff, Security Officers should support the application of de-escalation techniques and follow the agreed patient care plan, ensuring their actions align with the overall response led by the clinical team.
- Incident reporting and escalation: After the situation is resolved, Security Officers are responsible for documenting the incident using appropriate reporting systems, such as iMS+ and Handidata, and providing a detailed report to the Security Manager.

4.4. Head of Security Services/Security Managers:

- Monitor and review incident reports: Security Managers must regularly review incident reports to assess trends in violence, including the frequency and severity of incidents, and determine the need for further risk management actions.
- Collaborate with clinical and executive teams: Security Managers should liaise with department managers and, when necessary, meet with senior executives to discuss individuals involved in repeated violent incidents. This ensures the development of appropriate risk mitigation strategies.
- Engage in post-incident debriefs and continuous improvement: Following each Code Black, the Security Managers are responsible to ensure de-briefs amongst the security team are co-ordinated. This will ensure any required adjustments are made to procedures or training implemented.

4.5. Senior/Service/Stream Managers:

- Promptly respond to requests by Managers to assist with management of aggression from visitors or relatives or patients without clinical cause.
- Assist Managers in ensuring adequate staffing levels to manage the identified violence risks in their workplace.
- Consult with Managers, Security and Executive team on appropriate actions taken to date and other possible options for managing potential subsequent acts of violence or aggression.
- Enforce service restrictions or site attendance limitations as prescribed in the procedure.

4.6. General Managers/Service Directors:

- Support the implementation of this procedure.
- For persons who will not modify their behaviour following repeated requests, authorise the appropriate issuing of the Inability to Treat Notice or Termination Notice.

5. PROCEDURE

While the majority of patients who present to health care facilities constitute no risk or minimal risk, incidents of violence will occur. There may be many reasons for this, including the inherently stressful process of illness and hospitalisation and the manifestation of a clinical condition.

This procedure considers in a more conscious way the potential for aggression by utilising a risk management approach to all situations in the workplace.

5.1. Step 1 – Be respectful

All SESLHD workers are to complete My Health Learning mandatory training module – Be Aware for Personal Safety and Promoting Acceptable Behaviour in the Workplace.

While engaged with the public and in patient care all SESLHD workers are to:

- Where possible, manage environmental factors that may contribute to patient distress, for example, congested waiting areas.
- Remain respectful during all interactions and episodes of care.
- Respect another person's personal space.
- Where possible ask for permission prior to delivery of personal care and treatment.
- Continually assess for signs of rising distress, agitation or aggression.
- Be prepared to move away if required.

5.2. Step 2 – Identify and communicate the potential for distress, agitation or aggression

While working all SESLHD workers are to maintain a situational awareness of patients and other people in the area they are working in, and:

- Observe and monitor the patient or visitor for changes in behaviour or mood.

- Determine if the changes in patient or visitor mood or behaviour are escalating toward distress, agitation or aggression.
- Define the level of a person's distress, agitation or aggressive behaviour and determine whether other patients, visitors and/or workers are at risk of potential violence.
- Communicate to the team – through handover, eMR alerts, ISBAR, care plans and speaking with referrers.

Workers need to be aware of their behaviour and its possible effect on others in relation to escalating or de-escalating conflict or confrontation. It is important that an appropriate work environment be maintained in which all workers, patients and visitors are treated with courtesy.

SESLHD workers are to maintain awareness of the systems in place in their workplace to manage violence:

- Assessment and treatment protocols.
- The internal emergency procedures, including how to call for response.
- The violence and prevention management skills of the team, including de-escalation and restraint.
- Safe areas, including vehicles for community workers.

5.3. Step 3 – Assessment

5.3.1. Patient/Client Assessment

All workers are responsible to report any patient behaviour which is aggressive or a risk to safety to the person In-Charge of the area and/or their respective manager.

While the risk assessment methodology encourages a determination of the likelihood and consequence of the identified potential risk of violence, it is well-established that violent incidents can occur with little warning.

Therefore, any change in the patient/client's status must be communicated to all workers involved with the patient/client at clinical handover, on transfer of care (e.g. to Radiology, porters, another agency), and on the change in assessment.

The care plan is to be updated promptly according to the change in status of the patient/client as per established treatment and management protocols.

5.3.2. Providing care and support to Aboriginal Patients

When working with Aboriginal and Torress Strait Islander patients and families, it is important to recognise the historical trauma that healthcare systems have placed on Aboriginal people. This can cause fear and mistrust in the healthcare system which may lead to elevated feelings of distress, vulnerability and disempowerment.
A referral to the Aboriginal Hospital Liaison Officer can be made to provide cultural support to the Aboriginal patient and act as a third party to express the needs and concerns of the patient. The Aboriginal Hospital Liaison Officer should be involved in the

development of the care plan and provide culturally appropriate strategies to assist in de-escalation.
Ward Staff should ensure the safety of the Aboriginal Hospital Liaison Officer when visiting the patient.

For further information please refer to the SESLHDGL/088 Comprehensive Care – Section 5 – Comprehensive care for Aboriginal and Torres Strait Islander People.

5.3.3. Visitor Assessment

There are no known formal methods for assessing the risk of violence from visitors, however information gathered from the patient or patient's family may be able identify potential risks (e.g. domestic violence, estranged family or other domestic issues). Awareness of the difficulty or frustration visitors and relatives may be experiencing will assist SESLHD workers to show compassion and assist visitors and relatives to negotiate the processes and environment within Health. Refer to My Health Learning mandatory training modules 'Be Aware for Personal Safety and Promoting Acceptable Behaviour in the Workplace'.

SESLHD workers are encouraged to report to their manager any increases in levels of distress, agitation or aggression shown by visitors or relatives.

5.4. Step 4 – Control the Risk

5.4.1. Escalating Behaviour

When a worker identifies or is confronted by a person whose behaviour is a threat to safety:

- Where safe to do so, verbally engage with the person to calm them, determine the cause of the behaviour and address the cause wherever possible (de-escalation techniques). Other options to be considered may include a clinical review or requesting assistance from colleagues.
- Where all reasonable options have been attempted and/or the behaviour continues to escalate, and there is a risk to safety, the worker is to alert the In Charge and/or initiate the emergency response/Code Black procedure.

5.4.2. Emergency Response (Code Black)

After the emergency response (or Code Black) is initiated in the department or unit, all workers are to follow the local emergency response arrangements and endeavour to ensure the safety of themselves, other patients/clients and visitors.

- Police may be called where it is deemed appropriate to do so.
- Where it is safe to do so, the worker who ideally has a rapport with the person should continue to attempt to de-escalate the situation. If it becomes evident that the person may become physically violent, where possible all persons are to be removed from the immediate area for their safety until Security or Police arrive to support the situation.
- As far as possible, maintain the safety of the aggressor.
- In departments where staff are trained in restraint procedures and where appropriate, a clinician-led restraint may proceed as per NSW Health Policy Directive

PD2020_004 - Seclusion and Restraints in NSW Health Settings and NSW Health Policy Directive PD2017_043 - Violence Prevention and Management Training Framework for NSW Health Organisations.

- When security or police or the code black team arrive, the most senior person not engaged with the incident is to liaise with the code black team leader and the security or police personnel relevant information regarding the incident, including a brief background, including what has already been done to attempt to resolve the situation and what the current situation is now.
- The code black team leader or the police then assume control of the situation and determine whether to allow the person/s engaged with the individual concerned to continue managing the incident or to intervene and take command.
- For community workers, also see SESLHDPR/323 - Working in Isolation - Risk Management.

5.5. Step 5 - Monitor and Review Risks and Controls

5.5.1. Patient/Client Violent Behaviour Management

The clinical team must assess if the most likely cause of the aggressive behaviour was as a result of a change/deterioration to a clinical condition. If this is the case, prompt clinical review, treatment and necessary control is required.

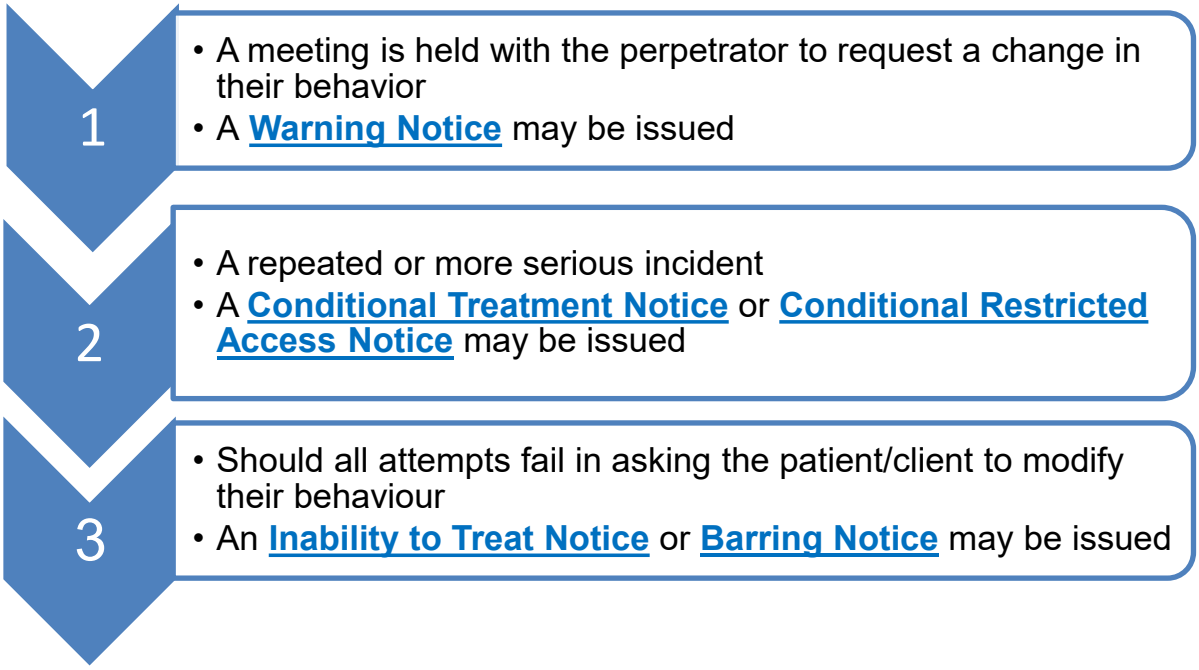
The incident is to be reported in iMS+ reporting system. The manager, in consultation with clinicians and other workers who are engaged in caring for the patient, will:

- Review the incident with the workers involved and assess the level of risk
- Coordinate the development of risk mitigation strategies, including an aggression management plan for the patient. The aim of the plan is to prevent reoccurrence of the incident where possible and to strive to reduce the potential for further violent incidences. Include site security in planning where they are on site.
- Identify the communication strategy to inform all patient contact workers including those from other departments of the change to the care plan and confirm this is communicated at clinical handover.
- Confirm with security the changes to the patient's care plan and make or update the joint intervention plan should another violent incident occur.

The Department Manager will consult with the treatment team, the Service Senior Manager, Director or Site Manager and Security for the need to arrange a meeting with the patient to discuss their behaviour.

All reasonable efforts to retain a patient/client in treatment must be taken prior to placing conditions that restrict the patient/client's access to services. The focus at all times should be one of effective risk management and prevention.

Each facility site/services must determine their local process and delegations of authority in relation to following up on a violent incident. The following cascade of events should occur:



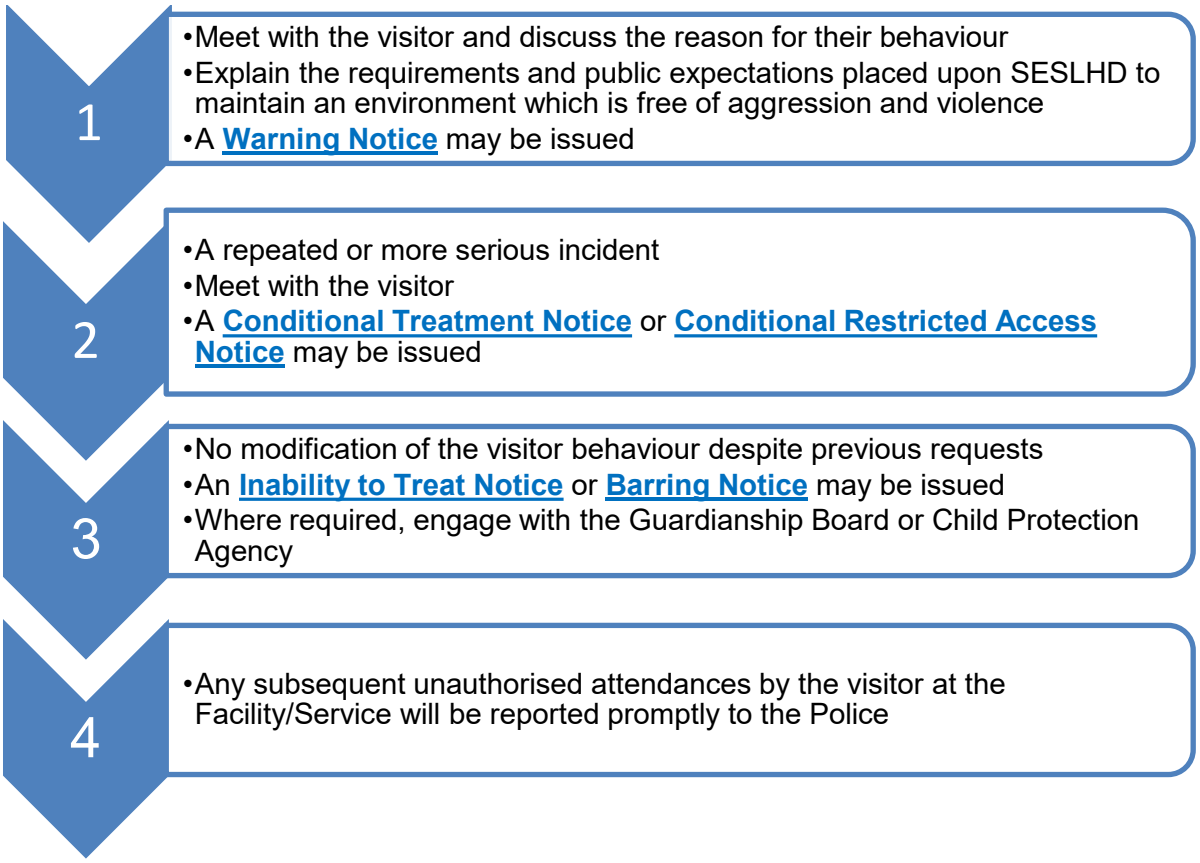
(Refer to: NSW Health Policy Directive PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace – a Zero Tolerance Approach Section 4.2.1 Written Warnings, Section 4.2.2 Conditional Treatment Agreements for Patients and Section 4.2.3 Inability to Treat)

5.5.2. Visitor or Relative Violent Behaviour Management

(Refer to: NSW Health Policy Directive PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace – a Zero Tolerance Approach Section 4.2 Longer Term Response Options and Section 4.2.1 Written Warnings)

Any non-patient violence or aggression incident is to be reported in iMS+ reporting system. The Department Manager should meet with the Service Manager, General Manager/Service Director (and the Security Manager where appropriate) for their advice and action.

Similar to a patient/client-initiated event, each site/service must determine their local process and delegations of authority in relation to following up a violent incident. The following cascade of events should occur:



5.6. Step 6 - Post-incident management

Workers involved in potential or actual incidents of violence may experience a stress response. The Manager's role is important in terms of both attitude and actions. An individual's response to a critical incident is usually related to both the incident itself and the perception of how they have been 'looked after' by their organisation, as represented by their manager.

There are a number of practical steps for the line manager to respond with practical support and activate the organisation's internal support and external professional resources, including:

1. Immediately after the incident apply Psychological First Aid (PFA)

For either one individual or a group of people have been impacted by a critical incident.

Suggestions:

a) Provide practical, personal and emotional support through:
- Reassurance about safety and work situation.
- Meeting immediate needs (drink, food, warmth, transport home).
- Listening to those who wish to share without forcing them to talk.

b) Provide practical information
- Facts and directions.
- About normal reactions to traumatic events.

- Access to professional psychological services, if and when needed coordinating Psychological First Aid, a reminder of EAP and crisis counselling available 24/7. (e.g. “we can arrange a phone chat…, we’ve contacted the counselling service, and they will arrive…”)

c) Encourage the person to use their support networks and coping skills.

d) Consider whether further professional support is required through EAP.

2. Debrief (Hot/cold)
   Debriefing provides an opportunity for persons involved in an incident to reflect on what has happened, what went well and where there are opportunities for improvement. They are to be approached with a learning mindset and to aid in developing a shared understanding of the incident.
   Hot debrief occur immediately following or soon after the incident.
   Cold debrief occur days or later following allowing time for more information to be collected.

3. Refer the incident for investigation and assistance with reviewing the controls through the Health, Safety and Wellbeing team or Clinical Safety and Quality processes and systems.

4. With Senior Management, review the options for re-establishing a therapeutic relationship with the patient/client as needed.

5. The Facility should have processes in place to ensure they meet their duty to report all physical assaults and serious threats of assault to the Police.
   Where affected workers wish to take further action, they should be supported to report physical assaults and serious threats of assault to the Police.

6. AUDIT

This procedure will be audited through the Ministry of Health SIAT Audit every two years.

7. REFERENCES

External

- *Security Industry Act 1997 No 157 (NSW)*
- *Work Health and Safety Act 2011 (NSW)*
- *Work Health and Safety Regulation 2011 (NSW)*
- SafeWork NSW Managing Violence Resources
- SafeWork Australia How to manage work health and safety risks

Internal

- NSW Health Policy Directive PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace – a Zero Tolerance Approach
- NSW Health Policy Directive PD2017_043 - Violence Prevention and Management Training Framework for NSW Health Organisations
- NSW Health Protecting People and Property Manual
- NSW Health Policy Directive PD2020_004 - Seclusion and Restraints in NSW Health Settings
- My Health Learning mandatory training module – Violence Prevention and Management Awareness
- My Health Learning mandatory training module – Violence Prevention and Management – Promoting Acceptable Behaviour in the Workplace

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
June 2013	Draft 0	Document revision commenced
December 2013	Draft 0	Document reviewed, incorporating feedback from stakeholders
July 2014	Draft 1	Approved by District Executive Team 24 July 2014
March 2018	Draft 2	Violence Prevention and Management working party
May 2018	Draft	Major review indicated. Draft for Comment
June 2018	Draft	Final draft approved by Executive Sponsor
July 2018	Draft	Processed by Executive Services prior to progression to Executive Council
July 2018	1	Approved by Executive Council for publishing
August 2021	2	Minor review commenced.
February 2022	3	Minor review: repair of weblinks, formatting and minor edits by Natasha Tonkin - Health Safety and Wellbeing, and Diane O'Donaghoe – Head of Security Services. Approved by Executive Sponsor.
4 August 2025	4.0	Addition of reference to current MoH condition of entry and notices. Changes to sections 4.3 and 4.4. Removal of previous appendices referring to outdated notices. Approved at SESLHD Executive Meeting.

Appendix 1 – Definitions

Key Term	Definition
Code Black	means the arrangements for providing a timely and effective response to violent incidents. The summoning as a priority sufficient numbers of skilled multi-disciplinary personnel to a developing incident or an incident in progress in order to prevent or minimise injury or other harm, contain the incident until external assistance arrives or resolve the incident. See NSW Health Protecting People and Property Manual – chapter 29 Code Black Arrangements for further information These responses will depend on a number of factors including the nature and severity of the event, whether it is a patient, visitor, intruder or other person, equipment available to staff and the number, skills and experience of the staff involved. Staff working in community/outreach (including domestic) settings must also have access to a way of summoning assistance in the event that they are facing a personal threat or attack.
Personal Space	means the distance from another person at which one feels comfortable when talking to or being next to that other person, and where any threat to that personal space would make them feel uncomfortable. Personal space is subjective and varies between individuals.
Safe Areas	means secure rooms or offices within the health facility where staff can retreat to in the event of a violent incident. A safe area may be a lockable staff room, or a secure lockable office. A safe area should have a telephone so an emergency call can be made, or good mobile phone reception.
Violence	means any incident or behaviour in which staff feel abused, are threatened or assaulted in circumstances arising out of, or in the course of, their employment including verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault.