

# Preventing work-related violence in NSW Hospitals

A multi-level risk assessment toolkit

2023

Developed by the Centre for Human Factors and Sociotechnical Systems at UniSC for SafeWork NSW, in consultation with the Action Against Violence in NSW Hospitals Working Group.

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# 1. Background

Work-related violence (WRV) is an important health and safety issue in healthcare and especially within hospital environments. Research worldwide has shown that healthcare workers in hospitals are at high risk of WRV from patients / consumers, visitors and other healthcare workers (Mento et al., 2020; Nelson, 2014; World Health Organisation, 2020). Previous research has also shown that WRV is a complex and multi-factorial issue and has identified the need for systems thinking approaches to be taken (Salmon, Coventon & Read, 2021; 2022).

Risk assessment is a critical component of safety management, providing the opportunity to proactively identify and control risks to worker safety. According to legislation (NSW Work Health and Safety Act 2011 and Work Health and Safety Regulation 2017), health organisations, as a person conducting a business or undertaking (PCBU), are required to manage risks to workers associated with WRV. Various policies and guidelines currently exist to support risk assessment and management processes for WRV, including:

- [The SafeWork NSW \(2021\) Code of Practice for Managing Psychosocial Hazards at Work](#)
- [The SafeWork NSW \(2022\) Violence in the Workplace Guide](#)
- [The NSW Health \(2022\) Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies manual](#)
- [The NSW Health \(2015\) Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach policy directive](#)
- [The Australian Commission on Safety and Quality in Healthcare \(2017\) Comprehensive Care Standard \(Action 5.34\)](#)

The aim of this document is to supplement existing policies, guidelines, and methods by introducing guidance material and a set of systems thinking tools to support WRV risk assessment in hospital settings. The toolkit should be used and applied in the context of existing legislation, health policy and guidelines, which may change from time to time.

This guidance document is part of a suite of systems thinking resources for preventing WRV in hospitals. More information about the problem of WRV in hospitals, systems thinking approaches, and the suite of tools, is available in the Systems Thinking for Preventing Violence in NSW Hospitals Overview.

## 2. A systems thinking approach to risk assessment & management

The intention of risk assessment is to proactively identify and manage risks, supporting the implementation of controls that prevent them from occurring or mitigate negative consequences if they do occur. Managing the risks of WRV against healthcare workers within hospitals is a shared responsibility, with formal risk management responsibilities attributed to: decision makers within a district / healthcare organisation, a hospital facility, department or work area unit, as well as managers and supervisors of healthcare workers (SafeWork NSW, 2022).

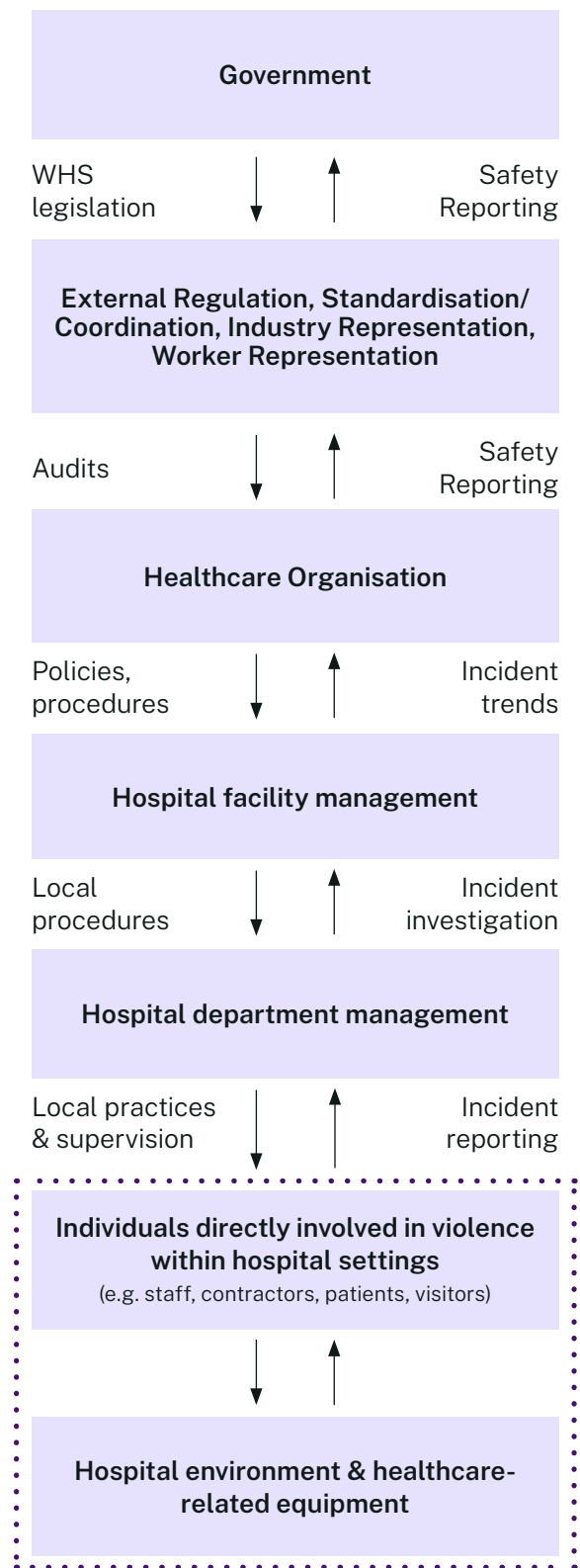
As described in the Systems Thinking for Preventing Violence in NSW Hospitals Overview, systems thinking emphasises that safety is a shared responsibility that spans all levels of work systems. A key principle of systems thinking is that it is not possible to understand or prevent incidents or adverse events without examining the broader system and the interactions taking place across it. When considering the risk of WRV from a systems thinking perspective, it is important to consider that sources of risk arise not only from patients / consumers and visitors who demonstrate violent behaviour, but from the decisions and actions of individuals and organisations across the wider hospital system.

The concept of vertical integration, proposed in Rasmussen's (1997) Risk Management Framework (Figure 1) proposes that safe system functioning is supported by a dynamic control loop operating across work systems. This is supported where decisions made at higher levels of the system flow down the hierarchy and are reflected in the decisions and actions of individuals and organisations at the lower levels, often achieved via control mechanisms. In addition, information about the current state of safety and effectiveness of existing risk controls is communicated up the hierarchy to inform the decisions and actions of those at the higher levels, achieved via feedback mechanisms passing information back up the system.

Risk assessment and management can support vertical integration through:

- Identifying risk sources and influences from different levels of the system hierarchy.
- Identifying risk controls which operate across the levels of the system hierarchy.
- Identifying how safety and the effectiveness of controls will be monitored (i.e., what feedback mechanisms need to be in place).
- Having a consistent and coordinated approach to risk assessment and management across the organisation.

This toolkit supports this by providing guidance for the healthcare organisation, hospital facility management, hospital department management and healthcare workers.



**Figure 1.** Rasmussen's (1997) Risk Management Framework adapted for WRV in hospitals. Example control mechanisms are shown on the left-hand side of the model (controls flowing down through the system hierarchy); example feedback mechanisms are shown on the right-hand side (information flowing up through the system hierarchy)

# 3. Risk assessment process

The risk assessment process used within the toolkit is based upon the process outlined in the Code of Practice for Managing Psychosocial Hazards at Work (SafeWork NSW, 2021), with some minor adaptations. As shown in Figure 2, the risk assessment process consists of six steps which are underpinned by leadership and management commitment, consultative processes and systems thinking principles.

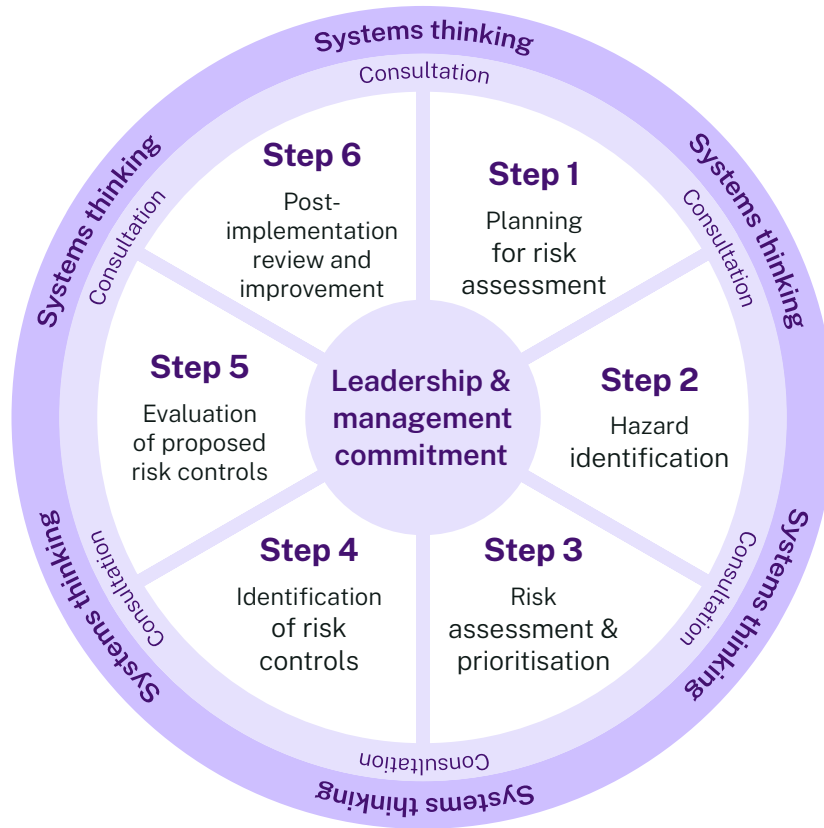


Figure 2. Risk assessment process (adapted from SafeWork NSW, 2021).

# 4. The PREVENT framework

Previous research has identified and explored a large range of potential risk controls that could be applied to address WRV in hospitals. A review of literature was undertaken to identify key themes for risk controls which have an evidence base for their effectiveness. The key themes identified were: the Patient / consumer, Resources, Environment, Visitors, Escalation, Notification and Training, which forms the bases of the PREVENT Framework. Note, the order of these themes is not intended to suggest an order or priority of controls and should not prevent the identification of controls addressing other relevant aspects of the workplace.

The PREVENT categories are used as prompts within each risk assessment tool.

# 5. Toolkit overview

The toolkit was developed to support risk assessment processes that align with Rasmussen’s (1997) Risk Management Framework and the concept of vertical integration. In addition, the toolkit was designed so far as possible to be practical, adaptable to different organisations and contexts, to be able to integrate with existing policies and processes and to be usable and time efficient.

# Implementing the Toolkit

## Planning for toolkit implementation

It is important to note that for organisations that have not already conducted significant work in the area of WRV prevention, the initial process of full toolkit implementation is likely to represent a significant project and will require appropriate time and resource investment. A project management approach is recommended, with appropriate resourcing allocated. While dependent on the size and complexity of a healthcare organisation's operations, the initiative will likely take several months to establish. Following initial establishment, risk monitoring and review and revision of risk controls may be integrated into existing risk assessment and management processes. However, additional resources will likely be required to ensure the long-term maintenance of the initiative and to maintain a focus on WRV prevention.

If full toolkit implementation is not possible or not required where the healthcare organisation already has comprehensive systems in place for WRV risk assessment, specific tools or guidance may be adopted without using the whole toolkit. For example, a monthly departmental hazard inspection may be focused on WRV and prompts from the tools could be used to facilitate the inspection. Additionally, the facility level tool may support existing processes for pre-occupancy assessments of new facilities.

A final consideration in planning for implementation is the need to provide those responsible for risk assessment and management at the different system levels with the time within their existing workloads to conduct the initial assessments, implement controls and monitor and refine control implementation. Risk management should be implemented into existing workflows where possible. Integration into existing digital system workflows may also be considered to support the process. Toolkit users may require training or mentoring in risk assessment and management to support them to use the toolkit.

## Leadership and coordination

Organisational change requires commitment from leaders across the organisation. In the healthcare setting, these individuals are balancing many competing priorities in the context of limited resources. Previous work has suggested that there is a current culture across the healthcare system of prioritising the safety and dignity of patients / consumers over workers (Salmon, Coventon & Read, 2021; 2022). There can be an acceptance by some within the system that WRV is inevitable and 'part of the job'. It is important that this attitude be challenged. Culture change is required to better balance consideration of the safety and dignity of patients / consumers with the safety of workers, ultimately finding mechanisms whereby both can be optimised.

For toolkit implementation to be successful, senior management at the healthcare organisation level must be willing to prioritise the issue of WRV. This may be demonstrated through committing time and resources to both the initial set up of WRV risk management as well as ongoing implementation and maintenance of the process and risk controls.

To achieve effective change, careful consideration should be given to who will act as the lead for the overall implementation of this toolkit. WHS initiatives can sometimes be seen as residing within the human resources division of an organisation, yet WRV is a multifaceted issue with significant clinical implications which may influence decisions regarding the appropriate area selected to lead. Therefore, it may fit best within a clinical area, supported by a multidisciplinary team (e.g., WHS officers, facility managers, mental health clinical nurse consultants, delirium clinical nurse consultants and security experts). It is expected that clinical leads (e.g., Directors of Nursing, Nurse Unit Managers) would lead risk assessments at the facility and departmental levels, also supported by or involving consultation with multidisciplinary teams.

Commitment and ownership by leaders across the organisation are important to not only support prioritisation of their own risk assessment and management responsibilities but also their willingness to release workers from rostered duties to participate in risk assessment activities. Further, a sense of commitment and ownership can support the appropriate allocation of resources (e.g., time, budget) for the implementation of proposed risk controls and new initiatives. The words and actions of leaders also have a strong influence on workers through communicating what is valued and rewarded within the organisation. Thus, engagement of leaders is critical to culture change and achieving vertical integration.

To achieve positive culture change in this area, leaders across the organisation may need information and training regarding: (1) the prevalence and consequences of WRV; (2) the WHS responsibilities of the organisation concerning WRV; (3) their roles and responsibilities in preventing WRV; and (4) how to provide feedback to their management if they experience barriers to achieving their responsibilities.

## Consultation

Consultation is a vital process supporting vertical integration as it provides a mechanism for gaining feedback about (1) the current state of affairs, including new and emerging sources of risk; (2) the implementation and effectiveness of current risk controls; and (3) ideas for proposed controls and feedback on whether proposed changes are likely to be implemented and effective in practice.

The NSW Work Health and Safety Act 2011 requires consultation with workers during risk assessment. As such, workers and their representatives should be engaged to provide input into risk assessment and management processes relating to WRV. In addition, taking a systems approach, it is recommended that other stakeholders (e.g., managers, WHS specialists, security specialists) are engaged to provide input and feedback throughout the process. The tools within the toolkit suggest specific roles for consultation; however, these are not intended to limit the range of stakeholders that may be engaged.

While consultation can take a number of forms, it is recommended that participatory activities are undertaken whereby those being consulted are actively involved and open dialogue is encouraged. Activities to consider include:

- Meetings, one-on-one discussions and / or surveys to gain feedback about current concerns relating to WRV and the perceived effectiveness of current risk controls.
- Facilitated workshops to brainstorm ideas for risk controls or provide feedback on proposed risk controls.
- Scenario-based activities to test and refine proposed risk controls.

## Supporting mechanisms

It is recommended that a WRV risk management committee be established, meeting regularly to monitor and evaluate the implementation of the toolkit as part of its role. The committee should comprise those with WRV risk management responsibilities, as well as WHS specialists, security specialists and worker representatives from across facilities. The committee could review controls in place, share learnings and good practices, and support the consistent implementation of controls.

Identifying workplace WRV prevention 'champions' at different levels of the organisation can also provide a useful way to gain support for new initiatives. Champions could attend information sessions / training on the toolkit and be available as a point of contact to assist others to fulfil their risk assessment responsibilities. They could assist in sharing success stories about improvements made in the workplace via meetings, newsletters and other organisational communication channels (e.g., intranet pages, Yammer).

## Review and evaluation of toolkit implementation

As for any new initiative, it is important to take opportunities to review progress and effectiveness and make refinements. A review, at least on an annual basis, is recommended and may integrate with existing processes, such as security improvement or WRV audits.

Evaluations of toolkit implementation might consider:

- Is the toolkit being used as planned?
- What feedback do toolkit users have regarding its implementation?
- What barriers exist to the implementation of the toolkit, or to the implementation of risk controls?
- Are post-implementation reviews of risk controls being conducted?
- Is toolkit implementation having any impact on WRV risk and incident rates?
- Has anything in the organisational or broader policy, regulatory, or societal context changed, requiring changes to the processes implemented?



# Using the Toolkit

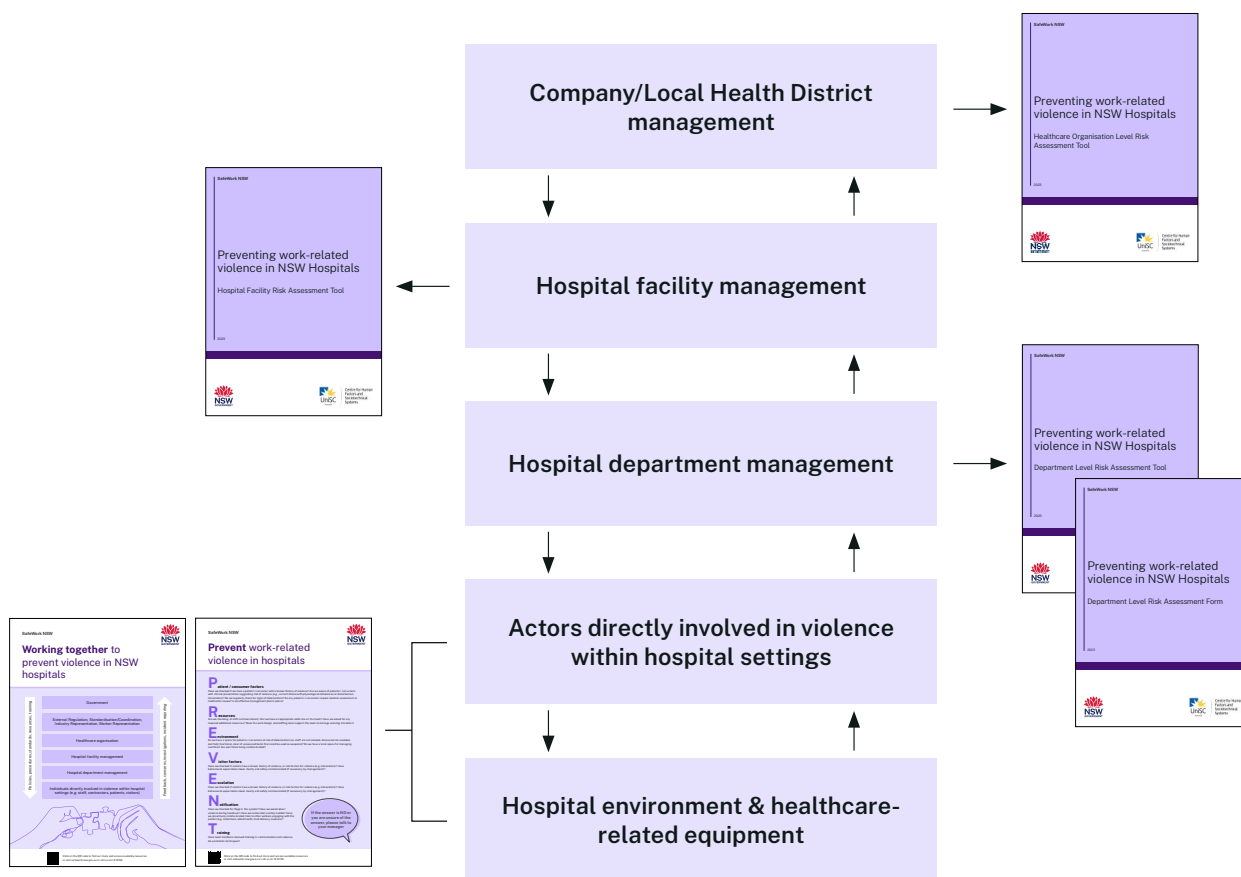
This toolkit is intended for use within healthcare organisations. It provides a set of tools that can be used at different levels of the organisation. Where possible, healthcare organisations are encouraged to adopt the tools at all levels of the organisation to support a consistent approach.

The tools can be adapted as required to support local contexts and may be considered for integration into existing safety management tools or systems (e.g., IT systems) or used alongside existing systems.

The tools comprise:

1. Healthcare organisation level risk assessment guidance
2. Facility level risk assessment guidance
3. Departmental level risk assessment guidance
4. Departmental level risk assessment form
5. Worker level risk assessment poster / workplace quick reference prompts

Risk assessment forms are not provided at the organisation and facility level given the expectation that organisations have existing risk assessment systems in place. A form is however provided at the departmental level, to support the process if required. See Figure 3 for an overview of the tools and the system levels at which they can be used to support risk assessment.



**Figure 3.** Overview of risk assessment tools

The tools for each system level incorporate six steps in assessing risk (Figure 2): planning for risk assessment; hazard identification; risk assessment and prioritisation; identification and implementation of risk controls; evaluation of proposed risk controls; and post-implementation review and improvement.

## Step 1. Planning for risk assessment

In this step, prior to conducting the assessment, relevant data is gathered and reviewed, and consultation is undertaken with workers, their representatives and others with relevant knowledge and expertise.

Relevant data and information may include incident data, investigation reports, audit findings, complaints, and worker feedback. For the healthcare organisation and facility level assessments, it may be worthwhile to conduct worker surveys to gain additional input into the process.

## Step 2. Hazard identification

In this step, hazards are identified in relation to relevant immediate and indirect sources of risk, as well as consideration of relevant contexts at each system level. Contexts relate to areas of the hospital (emergency department, ward types, other locations) or situational factors (time of day, tasks, busy periods) that may increase risk.

In identifying hazards, it is important to note that WRV is a broad term and includes physical assault, sexual assault, intentionally coughing / spitting on someone, harassment, threats, bullying, intimidation, gendered violence, family violence that occurs in the workplace, verbal abuse, written abuse, armed robbery, and malicious damage to property (NSW Health, 2022; SafeWork NSW, 2022).

## Step 3. Risk assessment and prioritisation

In this step, if prioritisation is required, the likelihood and consequence of WRV is assessed. If prioritisation is undertaken, this can help to identify which hazards should be addressed first, but a plan should still be in place to implement controls for lower ranked hazards.

In relation to assessing consequences, it is important to note that WRV can result in physical injuries and potentially to fatal outcomes, as well as result in psychological harm arising from single incidents or long-term exposure to environments where WRV is common (including harassment, intimidation, verbal abuse). Further, apart from the consequences for workers, research has shown that health problems experienced by healthcare workers (e.g., depression, burnout, pain) consequently result in poor quality care, patient harm, and increased costs (Halbesleben & Rathert, 2008; Halbesleben et al., 2008; Letvak, Ruhm & Gupta, 2012). In addition, WRV is associated with staff turnover (Adams, Ryan & Wood, 2021; Li et al., 2019), which can place additional workload pressure on the remaining staff (Hayes et al., 2006).

In relation to likelihood, while WRV may be assessed as more likely to occur in some contexts (e.g., mental health wards, emergency departments, wards with patients with dementia or delirium), it can arise in any context of the hospital and fewer risk controls are likely to be in place in contexts where WRV is rare, potentially increasing risk.

As noted in the Code of Practice – Managing Psychosocial Hazards at Work (SafeWork NSW, 2021), if prioritisation is conducted based on consequence and likelihood, it is suggested to separately consider risks that are:

- Less likely, but where the consequences may be very serious to catastrophic, and
- More likely, but where the consequences may be less serious.

## Step 4. Identification of risk controls

In this step, risk controls should be considered from the perspective of the PREVENT framework (see Table 1). Risk controls provided in the guidance are based on recommended practices but are not intended to limit the types of risk controls considered and implemented. Facilities should consider their own circumstances and consult with workers to develop appropriate risk controls for their context.

Two related considerations apply to risk control development. Firstly, some risk controls are likely to be more effective than others. For example, changing the hospital environment to provide safe retreat areas, rostering for appropriate staff mixes, and good work design will be fundamentally more effective than controls that aim to change worker or patient / visitor behaviour (e.g., de-escalation training or signage regarding behavioural expectations). Secondly, multiple risk controls are more effective than single controls. Consideration should be given to the most effective mix of controls and ensuring that risk controls that create a coherent and consistent approach across all levels of the organisation (supporting the concept of 'vertical integration'). For example, signage regarding behavioural expectations in emergency departments will be more effective when coupled with organisational policies and processes regarding consequences for breaches of these expectations, along with resources and training for supervisors and workers who are expected to enforce them. In addition, consideration should be given to how supervisors and senior managers can encourage a culture whereby workers feel supported and encouraged to implement the organisational policies and processes.

A particular set of controls to note are patient screening and risk assessment tools. Screening tools can enable healthcare workers to assess individual patients as to their propensity for WRV in a systematic way. Such tools are becoming more commonly implemented within hospital settings. A literature search was conducted to understand the current level of evidence for the applicability of screening tools in hospital settings, with key findings outlined in Appendix A. It was concluded that screening tools may provide a useful risk control within an overall suite of controls, with some showing evidence of predictive validity within emergency departments and assisting to create a culture of non-acceptance of WRV. However, limitations of screening tools include that they have not been evaluated for other pathways of admission into hospitals and that they may lead to important predictive factors, such as patient's clinical presentation and history, not included in tools, being overlooked by workers. Further, it should be noted that patient screening tools aim to identify the potential for WRV from an individual patient but do not necessarily inform the risk controls that should be put in place to prevent and manage WRV. Consideration as to whether to adopt patient screening / risk assessment tools is recommended, but should take into account the context, be done in consultation with workers who would be required to conduct the screening and should involve identifying what WRV management strategies would be adopted for patients identified as high risk.

**Table 1. Risk controls according to the prevent framework, by system level**

| PREVENT themes            | Healthcare organisation level  | Hospital facility level  | Department level  | Worker level<br>(risk assessment prompts)   |
|---------------------------|--|--|---|---|
| <b>Patient / consumer</b> | <ul style="list-style-type: none"> <li>Consider adoption of screening tools / checklists across the healthcare organisation</li> <li>Policies, procedures, and resources for the development of management plans, including engagement with patients, and their family / carers in developing plans<sup>1</sup></li> <li>Policies, procedures, and resources for regular patient communication (e.g., patient rounds, including in emergency departments)<sup>2</sup></li> </ul> | <ul style="list-style-type: none"> <li>Consider adoption of screening tools / checklists within the facility</li> <li>Resources allocated for developing management plans, including time to engage with family / carers in developing plans</li> <li>Resources allocated to ensure regular patient communication (e.g., patient rounds, including in emergency department waiting areas)</li> <li>Resources available for medical assessments / medication reviews</li> </ul> | <ul style="list-style-type: none"> <li>Supervision of staff to ensure application of screening tools / checklists (where mandated)</li> <li>Supervision of management plan implementation</li> <li>Processes for requesting medical assessments or medication reviews</li> <li>Supervision to ensure regular communication with patients (e.g., patient rounds, including in emergency department waiting areas)</li> </ul> | <ul style="list-style-type: none"> <li>Have we checked if we have a patient / consumer with a known history of violence?</li> <li>Are we aware of patients / consumers with clinical presentation suggesting risk of violence (e.g., current illness with physiological imbalances or disturbances, intoxication)?</li> <li>Do we regularly check for signs of deterioration?</li> <li>Do any patients require medical assessment or medication review?</li> <li>Is an effective management plan in place?</li> </ul> |

<sup>1</sup> See Australian Commission on Safety and Quality in Healthcare (2017) Comprehensive Care Standard (Action 5.34)

<sup>2</sup> See Australian Commission on Safety and Quality in Healthcare NHQHS Communicating for Safety Standard

| PREVENT themes   | Healthcare organisation level   | Hospital facility level  | Department level   | Worker level<br>(risk assessment prompts)  |
|------------------|---|--|--|--|
| <b>Resources</b> | <ul style="list-style-type: none"> <li>• Staffing and recruitment policies, procedures and practices that support availability of appropriately trained staff and teams with an appropriate skill mix<sup>3</sup></li> <li>• Work design and staffing supports team to manage evolving situations and allow staff involved in incidents to access appropriate support</li> <li>• Policies, procedures, contracts are in place to ensure effective de-escalation and code black responses, including clearly defined roles across the multidisciplinary team (including clinical and security staff)</li> <li>• Policies, procedures, and resources allocated to ensure availability of sufficient suitable beds and clinical resources</li> <li>• Sufficient resourcing to conduct risk management activities (consultation with staff, local risk assessment, implementation of controls, monitoring of controls)</li> </ul> | <ul style="list-style-type: none"> <li>• Staffing policies, procedures and practices that support availability of appropriately trained staff and teams with an appropriate skill mix</li> <li>• Work design and staffing supports teams to manage evolving situations and Code Black responses</li> <li>• Procedures and resources for managing unexpected events (e.g., overflow)</li> <li>• Access to security / emergency response, with appropriate response times</li> <li>• Procedures and resources for suitable allocation of beds</li> <li>• Appropriate communication and planning with security staff regarding presence / visibility and processes for them to attend and support clinical staff</li> </ul> | <ul style="list-style-type: none"> <li>• Rostering ensures availability of appropriately trained staff and that teams have an appropriate skills mix</li> <li>• Skills mix checked at shift commencement</li> <li>• Work design and staffing supports team to manage evolving situations</li> <li>• Supervision of inexperienced workers</li> <li>• Workers with appropriate skills / experience available for higher risk tasks and higher risk patients / consumers</li> </ul> | <ul style="list-style-type: none"> <li>• Are we checking, at shift commencement, that we have an appropriate skills mix on the team?</li> <li>• Have we asked for any required additional resources?</li> <li>• Does the work design, staffing level and skills mix support the team to manage evolving situations?</li> </ul> |

<sup>3</sup> Appropriate numbers of experienced staff, staff trained in de-escalation, restrictive practices, and Code Black responses

| PREVENT themes     | Healthcare organisation level  | Hospital facility level  | Department level   | Worker level<br>(risk assessment prompts)   |
|--------------------|--|--|--|---|
| <b>Environment</b> | <ul style="list-style-type: none"> <li>• Policies / strategies describe senior leadership prioritisation of WRV prevention and management and commitment to allocate appropriate resources</li> <li>• Policies and procedures for design/re-design of hospital facilities, considering environmental risk factors for violence<sup>4</sup> and effective consultation with workers and their representatives</li> <li>• Application of design standards that set specifications for health infrastructure<sup>5</sup></li> <li>• Application of design standards to reduce patient / visitor frustration and confusion (e.g., wait time information, clear wayfinding, reduced noise, and crowding)</li> <li>• Policies and procedures for patient placement</li> <li>• Policies and procedures for removal of items that may be used as weapons</li> <li>• Policies, procedures, and resources allocated for procurement of furniture and fixtures that cannot be used as a weapon</li> </ul> | <ul style="list-style-type: none"> <li>• Furniture and equipment do not pose risk of use as a weapon (including consideration during procurement)</li> <li>• Access controls for staff areas</li> <li>• Exit paths and staff safe rooms / safe retreat areas are available</li> <li>• Safe assessment rooms are available in emergency departments</li> <li>• Appropriate levels of lighting</li> <li>• Visibility / line of sight available for monitoring of workers interacting with higher risk patients</li> <li>• Security staff visible in higher risk areas</li> <li>• Personal and fixed duress alarms in place and effective</li> <li>• Mechanisms for reducing frustration and confusion (e.g., wait time information, clear wayfinding)</li> <li>• Waiting areas with reduced stimulation (not noisy / crowded)</li> </ul> | <ul style="list-style-type: none"> <li>• Checks that furniture, fixtures and equipment not able to be used as a weapon. Items required for care are removed when not in use.</li> <li>• Access controls are in place for staff areas and supervisors ensure that staff maintain secure access</li> <li>• Availability of exit paths, safe rooms and safe retreat areas for staff</li> <li>• Processes for placement of higher risk patients</li> <li>• Safe spaces are available for patients at risk of behavioural deterioration (e.g., Safe Assessment Rooms)</li> <li>• Visibility / line of sight available for monitoring of staff interacting with higher risk patients</li> <li>• Appropriate levels of lighting</li> <li>• Visibility of security staff (where relevant)</li> <li>• Worker access to personal and fixed duress alarms with supervisors encouraging their use</li> </ul> | <ul style="list-style-type: none"> <li>• Do we have a space for high-risk patients / consumers (i.e., workers are not isolated, duress alarms available, clear of unsecured items that could be used as weapons)?</li> <li>• Do we have a local space for managing overflow?</li> <li>• Are wait times being communicated?</li> </ul> |

4 See NSW Health Facility Planning Process GL2021\_018

5 See Australasian Health Facility Guidelines – Part C – Design for Access, Mobility, Safety and Security; and NSW Health Infrastructure Design

| PREVENT themes    | Healthcare organisation level   | Hospital facility level  | Department level  | Worker level (risk assessment prompts)   |
|-------------------|---|--|---|--|
| <b>Visitors</b>   | <ul style="list-style-type: none"> <li>• Policies and procedures for controlled visiting times</li> <li>• Processes for clear communication of behavioural expectations to visitors (e.g., signage, condition of entry document, management plans)</li> </ul>   | <ul style="list-style-type: none"> <li>• Controlled visiting times</li> <li>• Clear communication of behavioural expectations (via signage, condition of entry document, management plans)</li> <li>• System to formally caution visitors for behavioural issues (e.g., restrictions or bans), in line with organisational policies</li> </ul> | <ul style="list-style-type: none"> <li>• Implementation of strategies for communication of behavioural expectations (via signage, condition of entry signage and notices, management plans)</li> <li>• Enforcement of controlled visiting times and behavioural expectations of visitors. Where necessary, escalation of concerns about a visitor's behaviour to a request for limiting their access or banning them from the facility</li> </ul>               | <ul style="list-style-type: none"> <li>• Have we checked if visitors have a known history of violence, or risk factors for violence (e.g., intoxication)?</li> <li>• Have behavioural expectations been clearly and safely communicated (if necessary by management)?</li> </ul>   |
| <b>Escalation</b> | <ul style="list-style-type: none"> <li>• Policies, procedures, and resources allocated for risk escalation, with suitable arrangements for after hours operations</li> <li>• Policies, procedures, and resources allocated for timely and effective duress response (e.g., code black, police response), with clear guidance on action where an effective response is not available</li> <li>• Policies, procedures, and resources allocated for seclusion / restrictive practices<sup>6</sup></li> <li>• Policies, procedures, and resources allocated for post-incident debriefing and support</li> </ul> | <ul style="list-style-type: none"> <li>• Escalation procedures, with suitable arrangements for after hours operations (e.g., contacting police)</li> <li>• Code black response procedures</li> <li>• Clear protocols for seclusion / restrictive practices</li> <li>• Procedures for post-incident debriefing and support</li> </ul>           | <ul style="list-style-type: none"> <li>• Staff inductions include information regarding escalation processes including use of duress alarms and emergency numbers, as well as how to raise concerns about violence risk and seek additional support</li> <li>• Supervision and encouragement of workers to call for supervisor / senior worker / clinician or for code black response as appropriate</li> <li>• Post-incident debriefing and support</li> </ul> | <ul style="list-style-type: none"> <li>• Do we know the procedures for escalation, including for after hours?</li> <li>• Have we reported and escalated concerns about patient and / or visitor behaviour?</li> <li>• Do we wear our duress alarms (where provided)?</li> <li>• Can we access support to manage an escalating situation or if an incident occurs?</li> </ul> |

6 See NSW Ministry of Health Policy Directive PD2020\_004 - Seclusion and Restraint in NSW Health Settings

| PREVENT themes      | Healthcare organisation level  | Hospital facility level  | Department level  | Worker level<br>(risk assessment prompts)   |
|---------------------|--|--|---|---|
| <b>Notification</b> | <ul style="list-style-type: none"> <li>• Systems that enable staff to flag patients / consumers with a history of violence across the healthcare organisation</li> <li>• Processes to share information regarding aggression risk across healthcare organisations</li> <li>• Culture change processes to encourage staff to flag patients / consumers</li> <li>• Memorandums of understanding with other agencies to support information sharing regarding violence risk (e.g., NSW Ambulance, NSW Police)</li> <li>• Policies and procedures for handovers and huddles / briefings, etc to include WRV incidents and risks</li> </ul> | <ul style="list-style-type: none"> <li>• Systems that enable workers to flag violent or aggressive patients</li> <li>• Workers advised and supported to check patient records for flags on admission</li> <li>• Workers advised and supported to flag patients of concern, including any information regarding ineffective risk controls / strategies</li> <li>• Mechanisms for sharing patient flags across the facility (e.g., for collections, allied health staff, and non-clinical staff such as cleaners / food delivery staff)</li> <li>• Protocols for sharing information about violence risk during handover (e.g., between shifts, from ambulance officers, police, other facilities)</li> <li>• Pre-shift huddles to discuss patient flags / need for additional risk controls</li> <li>• Pre- and post-shift staff huddles to discuss patient flagging, the need for additional risk controls, and review effectiveness of current risk controls</li> </ul> | <ul style="list-style-type: none"> <li>• Supervision of workers and encouragement to add flags for patients with history of violence</li> <li>• Supervision of workers and encouragement to check patient records for flags on admission / transfer</li> <li>• Supervision and encouragement of workers to request information about violence / aggression during handover (e.g., from ambulance officers, police, other facilities)</li> <li>• Conduct of staff huddles to discuss patient flagging, effectiveness of risk controls and need for additional risk controls</li> <li>• Regular and ongoing consultation with workers to regarding the effectiveness of current systems and controls</li> </ul> | <ul style="list-style-type: none"> <li>• Have we checked for patient flags in the system?</li> <li>• Have we asked about violence during handover?</li> <li>• Have we conducted a safety huddle?</li> <li>• Have we proactively communicated risks to other workers engaging with the patient (e.g., collections, allied health, food delivery, cleaners)?</li> </ul> |



| PREVENT themes  | Healthcare organisation level   | Hospital facility level   | Department level   | Worker level<br>(risk assessment prompts)   |
|-----------------|---|---|--|---|
| <b>Training</b> | <ul style="list-style-type: none"> <li>• Policies, procedures, and resources allocated for all staff to be trained in communication and de-escalation techniques<sup>7</sup></li> <li>• Policies, procedures, and resources allocated to training, exercises and drills for code black teams</li> <li>• Resources for staff training in restraint and seclusion practices</li> <li>• Policies, procedures, and resources allocated for all staff training in incident reporting, patient flagging and how to escalate concerns about violence risk</li> <li>• Resources allocated for staff refresher training</li> <li>• Policies, procedures, and resources allocated to training managers / leaders in safety management including WHS obligations, risk management (including consultation with workers), responding to incident reports, incident investigation, and supporting workers post-incident</li> </ul> | <ul style="list-style-type: none"> <li>• All relevant facility staff trained in violence prevention and management (including communication and de-escalation techniques)</li> <li>• Joint training and live exercises for Code Black teams</li> <li>• Staff training in restrictive practices</li> <li>• Staff training in incident reporting, patient flagging and how to escalate concerns about violence risk</li> <li>• Refresher training</li> <li>• Consultation with workers regarding the effectiveness of training and possible areas for improvement</li> <li>• Training for managers in safety management including WHS obligations, risk management (including consultation with workers), responding to incident reports, incident investigation, and supporting workers post-incident</li> </ul> | <ul style="list-style-type: none"> <li>• Checks that workers have received relevant training, identified in consultation with workers, including local information (e.g., how to use duress alarms provided in the work area, location of code black muster points, use of safe havens)</li> <li>• Checks that workers have received relevant refresher training</li> <li>• Supervisors model communication and de-escalation skills to workers</li> </ul> | <ul style="list-style-type: none"> <li>• Have team members received training in communication and violence de-escalation techniques?</li> </ul> |

7 See NSW Ministry of Health Policy Directive PD2017\_043 - Violence Prevention and Management

## Step 5. Evaluation of proposed risk controls

In this step, once a suite of risk controls has been identified, it is a requirement to consult with affected workers and their representatives, and it is recommended to also consult with others who may have relevant feedback. The suite of controls should be considered holistically, evaluating their overall effectiveness to inform decisions regarding whether they are acceptable or whether additional controls, or improvements to controls, would be required.

## Step 6. Post-implementation review and improvement

Finally, in this step, to achieve vertical integration, it is important that strategies are in place to monitor the on-going implementation and effectiveness of risk controls. Strategies include encouraging WRV incident reporting (see also Reporting Culture Improvement Roadmap for Preventing WRV in NSW Hospitals), incident reporting, review of investigation outcomes, and reporting of situations where risk controls were not available. Workers and managers / supervisors should be encouraged and rewarded for raising concerns regarding WRV in the workplace, and mechanisms for providing feedback should be accessible and easy to use.

# Risk Assessment Reviews

Following initial implementation of the toolkit, risk assessments and risk controls should be reviewed based on the following triggers:

- Planned review dates (recommended annually); this may align with existing processes such as security improvement audits or WRV audits.
- A serious incident of WRV (including those not resulting in physical harm) or an increase in less serious incidents.
- A capital re-development or move to new facilities.
- An organisational change (e.g., change to organisational structure, equipment, or work processes, staffing levels, employment conditions or systems of work).
- Staff feedback that suggests a control measure or suite of control measures are not adequately addressing the risk.
- Consultation indicates a review is necessary.
- A review is requested by a Health and Safety Representative (HSR).
- Audit results identify concerns regarding the management of risks of WRV.

# Contributing to whole system vertical intergration

This toolkit is intended to support healthcare organisations in managing the risks of WRV. However, the concept of vertical integration also encompasses controls and feedback mechanisms implemented by organisations at higher levels of the system (e.g., WHS regulators, professional bodies, unions, government departments). To support vertical integration, it is beneficial for all parties to establish and maintain positive relationships, work collaboratively, and provide feedback regarding incident trends, the effectiveness of controls, and requirements for changes to higher level system factors to better support WRV prevention.

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# Appendix A. Summary of patient screening / risk assessment tools

A targeted literature search was conducted to identify patient screening / risk assessment tools with evaluation evidence available. A wide range of tools were identified, including: The Brøset Violence Checklist (BVC; Almvik et al., 2000); Dynamic Appraisal of Situational Aggression (DASA; Ogloff & Daffern, 2006); Historical Clinical Risk Management-20 (HCR-20; Webster et al., 1997); Management of Clinical Aggression – Rapid Emergency Department Interventions (MOCA-REDI; Gerdtz et al., 2011); Classification of Violence Risk (COVR; Monahan et al., 2005); Staring, Tone/volume of voice, Anxiety, Mumbling, and Pacing (STAMP; Luck et al., 2007); Staring, Tone/volume, Assertiveness/non-assertiveness, Mumbling, Pacing, Emotions, Disease progress, Anxiety & Resources (STAMPEDAR; Chapman et al., 2009); The Emergency Department Workplace Violence-Questionnaire (ED WPV-Q; D’Ettorre et al., 2020); 17-Cue Violent Assessment Tool (Wilkes et al., 2010); Violence Risk Screen Decision Support in Triage (VRSDSiT; Daniel, 2015); Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995); Psychopathy Checklist Revised (PCL-R; Hare, 1980 & 1991); Psychopathy Checklist Screening Version (PCL-SV; Hart et al., 1995); Revised Violence Risk Appraisal Guide (VRAG-R; Quinsey et al., 1998); Violence Rating Scale-2 (VRS-2; Wong & Gordon, 1999); Short-Term Assessment of Risk and Treatability (START; Webster et al., 2009); Violence Risk Screening-10 (V-RISK-10; Bjørkly et al., 2009); Clinical Assessment of Need, Violence Appraisal System (CANVAS; Guite et al., 1998); Violence Risk Assessment Tool (M55; Kling et al., 2006); Aggressive Behaviour Risk Assessment Tool (ABRAT; Kim et al., 2012); and the Queensland Occupational Violence Risk Assessment Tool (QOVPRAO; Cabilan & Johnston, 2020).

Three screening tools that have been more widely adopted and have been evaluated in the hospital context are summarised in Table B1. These are: the Brøset Violence Checklist (BVC), the Dynamic Appraisal of Situational Awareness instrument (DASA) and the Staring, tone, volume, assertiveness, mumbling, pacing, emotions, disease progress, anxiety & resources (STAMP/EDAR).

The BVC and DASA tools were both initially developed for the prediction of imminent violence (over a 24-hour period) and a systematic review and meta-analysis of risk assessment tools for forensic psychiatric hospitals found that they both performed with higher accuracy than other tools (Ramesh et al., 2018). The tools performed particularly well for screening out low risk individuals (Ramesh et al., 2018). The STAMP / EDAR tool was developed specifically for the hospital emergency department context (Chapman et al., 2009). It is a behaviourally-focussed framework that does not allow for prediction of violence in patients, but can alert healthcare workers of behavioural precursors to violence without prior knowledge of patient history. It is yet to be evaluated in terms of validity and reliability, although it is implemented widely in hospitals internationally.

**Table A1. Overview of the BVC, DASA and STAMP/EDAR**

| Patient screening / risk assessment tool                        | Description   | Evaluation  |
|---|---|---|
| <p><b>Brøset Violence Risk Assessment Checklist (BVC)</b></p>   | <ul style="list-style-type: none"> <li>• Most studied violence risk assessments for assessing risk of violence among patients in a 24-hr period</li> <li>• Developed for short-term psychiatric wards</li> <li>• A six-item checklist - quick &amp; easy to use</li> </ul> <p><b>Risk factors incorporated within tool:</b></p> <ul style="list-style-type: none"> <li>• Confusion, irritability, boisterousness, verbal threats, physical threats, attacks on objects</li> </ul>   | <ul style="list-style-type: none"> <li>• Best validity and reliability among psychiatric in-patient violence risk assessments (Anderson &amp; Jenson, 2019)</li> <li>• Potential for use in general acute care settings (Ghosh et al., 2019)</li> <li>• Performed particularly well for screening out low risk individuals (Ramesh, Igoumenou, Montes, &amp; Fazel, 2018)</li> <li>• Demonstrated good sensitivity, specificity &amp; predictive value in hospital emergency departments (Partridge &amp; Affleck, 2019; Senz, Ilarda, Klim, &amp; Kelly, 2021)</li> <li>• Risk information can be used for communication between healthcare staff for treatment planning and risk management (Ghosh et al., 2019)</li> <li>• There is a risk that other important predictive factors such as patient's clinical presentation and history, not included in this tool, could be overlooked (Cabilan &amp; Johnston, 2019)</li> </ul> |
| <p><b>Dynamic Appraisal of Situational Awareness (DASA)</b></p> | <ul style="list-style-type: none"> <li>• Developed to assess the risk for imminent aggression among patients in a 24-hr period</li> <li>• Developed for short-term psychiatric wards</li> <li>• A 7-item observer-rated risk assessment instrument - quick &amp; easy to use</li> </ul> <p><b>Risk factors incorporated within tool:</b></p> <ul style="list-style-type: none"> <li>• Irritability, impulsivity, unwillingness to follow directions, sensitivity to perceived provocation, easily angered when requests are denied, negative attitudes, verbal threats</li> </ul> | <ul style="list-style-type: none"> <li>• Strong predictive validity of imminent violence or aggressive behaviour within 24-hour psychiatric care (Conor et al., 2020)</li> <li>• Potential for use in general acute care settings (Ghosh et al., 2019)</li> <li>• Performed particularly well for screening out low risk individuals (Ramesh, Igoumenou, Montes, &amp; Fazel, 2018)</li> <li>• Has been found to have predictive validity for use in evaluating behavioural health patients in an ED setting (Conor et al., 2020)</li> <li>• Risk information can be used for communication between healthcare staff for treatment planning and risk management (Ghosh et al., 2019)</li> </ul>   |

| Patient screening / risk assessment tool  | Description   | Evaluation   |
|---|---|--|
| <b>Staring, tone, volume, assertiveness, mumbling, pacing, emotions, disease progress, anxiety &amp; resources (STAMP/EDAR)</b> | <ul style="list-style-type: none"> <li>Developed for emergency department settings</li> <li>Behaviourally focussed framework for assessing observable violence risk in patients</li> </ul> <p><b>Risk factors incorporated within tool:</b></p> <ul style="list-style-type: none"> <li>Staring and eye contact, tone and volume of voice, anxiety, mumbling, pacing, emotions, disease process, assertive/non-assertive, resources</li> </ul> | <ul style="list-style-type: none"> <li>Easy to administer by nurses working in general acute care with no prior knowledge of the patient's history (Cabilan &amp; Johnston, 2019)</li> <li>Does not allow to predict whether the patient will become violent or not, although effective to alert ED workers on behavioural precursors to violence (d'Ettorre, Mazzotta, Pellicani &amp; Vullo, 2018)</li> <li>Predictive validity of the tool is not known, and a scoring procedure is yet to be developed (Ghosh et al., 2019)</li> </ul> |

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