SafeWork NSW

Preventing work-related violence in NSW Hospitals

Department Level Risk Assessment Tool

2023

NSW GOVERNMENT

UniSC Australia

Centre for Human Factors and Sociotechnical Systems

This tool provides guidance to support risk assessment of hospital departments for the prevention of work-related violence (WRV). The tool provides a set of prompts for supporting risk assessment processes using systems established within your organisation.

1. Planning for risk assessment

Prior to conducting the assessment, gather and review relevant data and consult with those with knowledge and expertise.

Review relevant sources of information:

- Facility risk assessments
- Incident data and trends relating to WRV
- Internal investigation reports into incidents involving WRV
- Internal and external audit / compliance findings
- Complaints and concerns raised by staff, patients, or others
- Other relevant reports and data

Consult with:

- Workers and their representatives (clinical, ancillary, allied health, security, cleaning, retail, reception / administrative), as well as student/volunteers (as relevant)
- WHS Officers
- HSRs
- Other relevant persons within the department and facility

2. Hazard identification

Work-related violence arising from different sources and in different contexts should be identified. Consider a broad definition of violence (includes physical assault, sexual assault, intentionally coughing / spitting on someone, harassment, threats, bullying, intimidation, gendered violence, family violence occurring in the workplace, verbal abuse, written abuse, armed robbery and malicious damage).

Immediate sources of risk may include:

- Patients with clinical presentation suggesting risk of violence (e.g., current illness with physiological imbalances or disturbances, intoxication, withdrawal)
- Patients or visitors with past history of violence
- Patients or visitors demonstrating behavioural indicators (e.g., physically or verbally threatening, attacking objects)
- Visitors with signs of intoxication

Indirect sources of risk may include:

- Internal factors (e.g., policies and procedures, management attitudes, knowledge and experiences, culture and norms, budgetary constraints)
- External / societal factors (e.g., community attitudes, police availability / workload, standards, government investment)

Contexts to consider include:

- Patient / visitor / public areas
- Treatment and interview rooms
- Reception areas, offices, and staff-only areas
- Busy periods (long wait times), issues of overflow or other mismatch of resources and patient needs
- Daytime versus after hours operations
- Working alone
- Type of unit
- Staffing, skill mix and worker demographics (including age, sex, skills and experience)
- Various tasks undertaken in the department (i.e., personal care tasks)

3. Risk assessment and prioritisation

If required, assess the likelihood and consequence of WRV associated with different sources and different contexts.
In relation to consequences, WRV can result in physical injuries / fatalities, as well as psychological harm from single incidents or exposure to multiple incidents over time. In relation to likelihood, while violence may be assessed as more likely to occur in some contexts (e.g., mental health wards, emergency departments), violence can arise in any context of the hospital, meaning that risk controls are required in all environments.

4. Identification of risk controls

Risk controls should be considered from the perspective of the PREVENT framework. Multiple risk controls should be implemented within each of the PREVENT areas, avoiding over-reliance on staff-based controls. The following risk controls are based on recommended practices, but departments should consider their own circumstances in developing risk controls, including other controls that fit outside of the PREVENT categories.
Patient / consumer
• Supervision of staff to ensure application of screening tools / checklists (where mandated) • Supervision of management plan implementation • Processes for requesting medical assessments or medication reviews • Supervision to ensure regular communication with patients (e.g., patient rounds, including in emergency department waiting areas)
Resources
• Rostering ensures availability of appropriately trained staff and that teams have an appropriate skills mix[1] • Skills mix checked at shift commencement • Work design and staffing supports team to manage evolving situations • Supervision of inexperienced workers • Workers with appropriate skills / experience available for higher risk tasks and higher risk patients / consumers
Environment
• Checks that furniture, fixtures and equipment are not able to be used as a weapon. Items required for care are removed when not in use • Access controls are in place for staff areas and supervisors ensure that staff maintain secure access • Availability of exit paths, safe rooms and safe retreat areas for staff • Processes for placement of higher risk patients • Safe spaces are available for patients at risk of behavioural deterioration (e.g., Safe Assessment Rooms) • Visibility / line of sight available for monitoring of staff interacting with higher risk patients

1 Appropriate numbers of experienced staff, staff trained in de-escalation, restrictive practices, and Code Black responses

- Appropriate levels of lighting
- Visibility of security staff (where relevant)
- Worker access to personal and fixed duress alarms with supervisors encouraging their use

Visitors

- Implementation of strategies for communication of behavioural expectations (via signage, condition of entry signage and notices, management plans) in the local work area
- 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

Escalation

- 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
- Supervision and encouragement of workers to call for supervisor / senior worker / clinician or for code black response as appropriate
- Post-incident debriefing and support

Notification

- Supervision of workers and encouragement to add flags for patients with history of violence
- Supervision of workers and encouragement to check patient records for flags on admission / transfer
- Supervision and encouragement of workers to request information about violence / aggression during handover (e.g., between shifts, from ambulance officers, police, other facilities)
- Conduct of staff huddles to discuss patient flagging, effectiveness of risk controls and need for additional risk controls
- Regular and ongoing consultation with workers to regarding the effectiveness of current systems and controls

Training

- 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)
- Checks that workers have received relevant refresher training
- Supervisors model communication and de-escalation skills to workers

5. Evaluation of proposed risk controls

Once a suite of risk controls has been identified, consult with relevant individuals (see step 1) to consider the controls holistically, evaluate their overall effectiveness and decide whether they are acceptable or additional controls are required.

In risk control evaluation, consider:

- Does the set of controls address WRV from all relevant sources?
- Does the set of controls address WRV in all relevant contexts?
- Will controls always be available (i.e., day/night shifts, infrequent or emergency situations)? If not, what will be implemented at such times?
- Are the controls likely to be sustainable over time, acceptable to stakeholders, feasible, and aligned with recommended practice?
- Are there additional reasonably practicable controls that can be implemented within the department?
- Might any controls introduce new, unintended risks that need to be managed? (e.g., negative impacts on staff safety / wellbeing; patient safety / wellbeing)
- What measures can be used to review the effectiveness of the control, once implemented?

6. Post-implementation risk control review and improvement

Consider the following strategies to monitor the implementation and effectiveness of controls:

- Regular consultation with workers (with feedback to workers on outcomes of consultation)
- Regular monitoring of flags regarding patient / visitor risk of violence, with workers rewarded for adding flags
- Regular monitoring of department incident data for incidents involving WRV, with workers rewarded for reporting incidents
- Investigation of incidents involving WRV, with feedback on actions taken provided to workers
- Workers encouraged to report situations to supervisors where risk controls were not available, workers rewarded for raising concerns. Information about risk controls not being available is provided to management
- Any other risk controls identified in step 5 (see above)

Further Resources

SafeWork NSW (May 2021). Code of Practice: Managing psychosocial hazards at work. NSW Government. Retrieved from https://www.safework.nsw.gov.au/__data/assets/pdf_file/0004/983353/Code-of-Practice_Managing-psychosocial-hazards.pdf.

Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies. https://www.health.nsw.gov.au/policies/manuals/Documents/prot-people-prop.pdf

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.

Disclaimer

Catalogue No. SWNSW_35810_23
SafeWork NSW, 92–100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.safework.nsw.gov.au