OCCUPATIONAL VIOLENCE PREVENTION AND MANAGEMENT ACTION PLAN 2024-28

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Abbreviations

Abbreviations	Meaning
BAU	Business as usual
CHS	Canberra Health Services
Consumers or patients	Terms are used interchangeably to refer to people who use health services, including their family and carers.
LTFIR	Lost Time Injury Frequency Rate
OV	Occupational Violence
Staff	All employees of CHS
Treatment Facilities	Umbrella term encompassing hospitals, walk-in centres, community health centres, and other clinical facilities within CHS.
WHS	Work Health & Safety

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CEO Message

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What is occupational violence at CHS?

In Canberra Health Services (CHS), occupational violence (OV) includes physical violence, verbal aggression, or other unacceptable behaviours committed by patients towards staff members (see Table 1 for examples).

Table 1. Occupational violence incident classification used in CHS*.

Physical OV
• Any form of physical attack including hitting, punching, kicking, grabbing, spitting, shoving, pinching, throwing items, pouring things onto staff, biting, striking, pulling, slapping, tripping, scratching, pushing, kneeing, head butting, threatening with any object, attempts to undress, inappropriate touching, ripping or grabbing clothing. • Attempts to perform a physical attack, even if they miss. • Physical intimidation, such as standing over someone or striking intimidating poses. • Sexual harassment or assault • Injuries, falls or trips that occur when responding to or avoiding OV. These could include breaking up altercations or guiding clients from threatening environments. • Injuries that occur during restraint, forcible giving of medication or seclusion. • Property damage that was not directed towards staff
Verbal OV
• Verbal intimidation, including threats, name calling, yelling, verbal abuse, aggressive swearing either in person or over the phone.
Other unacceptable behaviours
• Written intimidation or defamation, including emails, social media, text messages • Racism and discrimination • Filming or photography of staff without their consent • Passive-aggressive or snide comments • Undermining behaviours
*** All definitions as above are detailed in the CHS Occupational Violence Procedure***

How we got here

OV is a global and impactful issue that requires multifaceted solutions. Health care remains a higher risk industry alongside policing and education industries.[1] Globally, about 1 in 5 health care staff experienced physical OV; and about 3 in 5 staff experienced verbal OV in the last 12 months.[2]

The impacts of OV extends to staff, patients, and health services:

Staff impacts: OV can have detrimental effects on staff's physical, emotional, and psychological well-being.[3]

Patient impacts: Patients directly involved in OV may be restrained, which is traumatizing and dehumanizing.[4, 5] As well, due to the negative impacts of OV staff well-being, OV may also adversely affect the quality of care provided to all patients.

Health services impacts: There are talent and economic losses from staff absences, turnover, and compensation claims related to OV.[3]

Recognising the prevalence of OV and its impacts, CHS commits to advancing and prioritising initiatives that contribute to a safe workplace for staff, consumers and visitors through the *CHS OV Action Plan 2024-28 (referred to as OV Action Plan* herein forward).

The *CH OV Action Plan* was developed using co-design methodology with input from various sources:

- Consultative focus groups aimed at harnessing the experiences and ideas of staff and consumers (see Figure 1).[6]
- An internal review and update of organisational or enterprise OV risk.
- Relevant evidence from the literature regarding best practices for OV prevention and management.

2023 Timeline of the OV Action Plan

May – Commenced evidence-based co-design to develop OV Action Plan

Jun – Held co-design workshops with leadership participation from Work Health and Safety, Workforce Capability, Mental Health, Patient Experience, and Security to renew and identify an enterprise OV risk → ***There is a risk of CHS staff exposure to occupational violence from patients, consumers and visitors caused by inadequate systems and processes to identify and manage potential occupational violence.***

Aug – Completed two co-design focus groups with participation from staff and consumers with lived experience of OV to gather and understand their experiences and expectations from CHS relative to OV prevention and management.

Oct – Completed co-design data synthesis.

Nov – Submitted draft to Executive Leadership for forward look and feedback.

2024 Timeline of the OV Action Plan

Jan – Revised OV Action Plan and prepared for broader consultation.

Jun – Draft sent to Network Executives for consultation sign-off

Aug – Anticipated commencement of the OV Action Plan

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Figure X. Timeline of the OV Action Plan from 2023 to 2024.

What we will do

Overview of OV Action Plan

The OV Action Plan aligns with the Socio-Ecological Model (SEM).[7] SEM is a prevention-focused framework that conceptualizes OV as a multifactorial event. SEM assumes that OV is an interplay of individual, relationship, community, and societal risk factors:

Individuals refer to the characteristics of a person that predisposes them to violence and aggression.

Relationship pertains to interpersonal interactions between consumers and staff, or situations that precipitate violence.

Community reflects physical locations or settings wherein relationships are formed, and interactions occur.

Society is a broader setting where norms, cultures, or standards are cultivated that shape individuals, relationships, and communities.

Alignment of the OV Action Plan to SEM prompts decision-makers to:

- Assess OV risk factors relative to Individuals, Relationships, Community, and Society simultaneously; and
- Develop and implement multi-component interventions specific to the identified risk factors.

Therefore, CHS' strategic goals to prevent and manage OV are (Figure X):

1. Understand the vulnerabilities and complex needs of individuals involved in OV;
2. Cultivate constructive relationships between staff and consumers;
3. Foster physically and psychosocially safe systems and processes for staff and consumers to engage and interact; and
4. Set and disseminate societal standards of acceptable behaviour for staff, consumers, carers, and visitors.

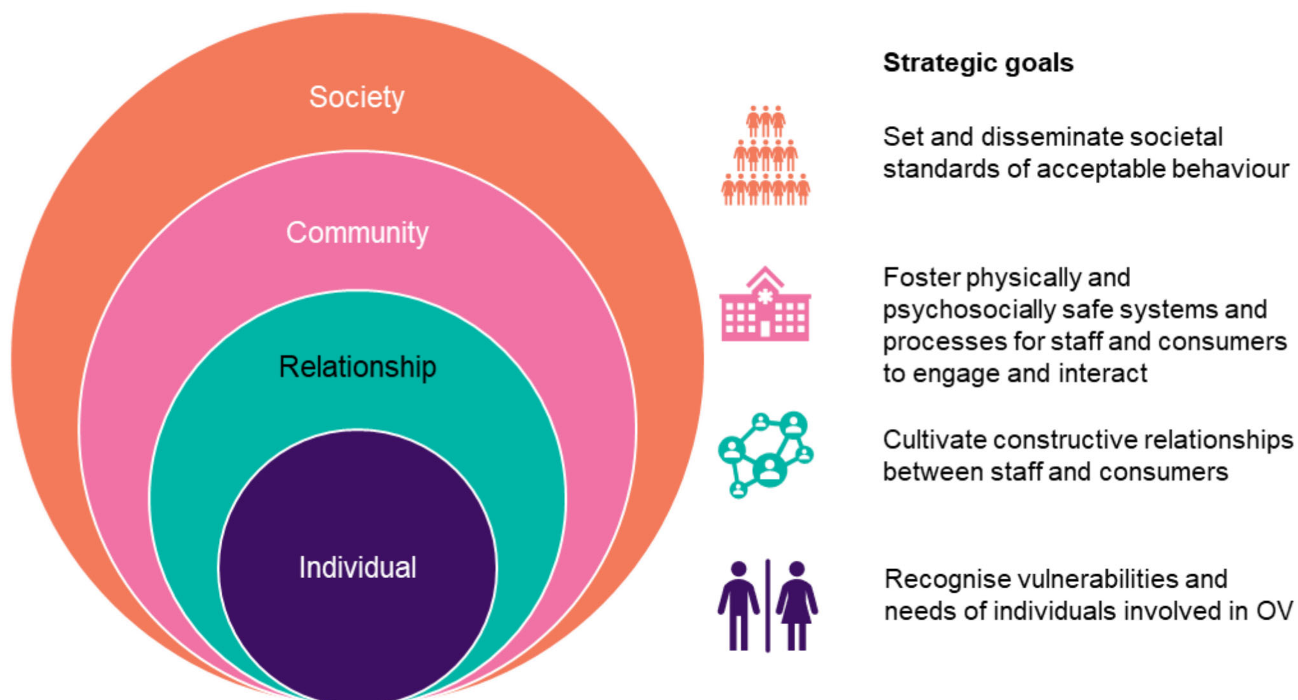

Figure X. Overview of multifaceted strategic goals in the OV Action Plan for individuals, relationships, community, and society based on the Socio-Ecological Model for Occupational Violence Prevention.

Strategic Goal 1: Understand the vulnerabilities and complex needs of individuals involved in OV

Historically, the focus has been on recognising static (i.e. violence history) and dynamic risk (i.e. behaviours of concern) factors of consumers. While there is value in using risk assessment tools under the premise of 'early recognition and intervention',[8] they have their limitations because they do not necessarily explain why people present or behave as they are.

In this OV Action Plan, violence and aggression are conceptualised as behaviours stemming from anger – an individual's emotional response from environmental (i.e. noise, clutter) or situational triggers (i.e. unmet need or goal).[9] This conceptualization has implications for partnering with consumers to understand how staff can support them to control triggers and regulate their emotional response to triggers.

Statistically, people with adverse childhood experiences (ACE), cognitive impairment, schizoaffective disorder, personality disorders, and substance use disorder are more likely to be involved in OV than those who do not have these conditions.[10, 11] These people may be more vulnerable because they:

- have difficulties expressing their unmet needs (i.e. basic, clinical, or psychosocial)
- have challenges processing information or emotions
- perceive health settings as traumatizing or unsafe
- be experiencing heightened appraisal of threats to their safety
- feel disempowered
- have poor social support system
- hold ongoing distrust of health professionals due to past traumatic experiences.

Without a holistic understanding of OV risks and vulnerabilities of individuals, staff may be underprepared to engage and support consumers and render them vulnerable to OV exposure too. Education and training around trauma-informed care and strengths-based approaches are fundamental elements to equip staff with the knowledge and skill to:

- understand and limit triggers
- anticipate the likelihood of OV risks and take appropriate action
- engage and support individuals – be it in their homes or treatment facilities
- support peers to recover from OV incidents.

Further, to complement the above, CHS will aim to provide relevant education and training with tangible wrap around services and support that are far-reaching and accessible for consumers e.g. liaison services, mental health outreach, psychotherapy, rehabilitation.

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
1.1 Partner with consumers to explore triggers for challenging behaviours and understand how we	Safety Management Plans+ or Positive Behaviour Support Plans for people with OV risk	+Senior Director – Work Health and Safety | People and Culture	Commenced	Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
can support them to limit those triggers				
1.2 Educate staff on the principles of trauma-informed practice, and strengths-based approach to support consumers	OV education and training programme to incorporate trauma-informed care, strengths-based approaches	Senior Director - Workforce Capability | People and Culture	Not yet commenced	TBD
1.3 Explore and strengthen the availability and accessibility of services to support	Review and enhance availability of wrap around services and support for vulnerable consumers	Executive Director - Mental Health, Justice Health and Alcohol and Drug Services	Not yet commenced	Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
vulnerable consumers in the community and treatment facilities				

Strategic Goal 2: Cultivate constructive relationships between staff and consumers

Constructive relationships are built on presence, trust, rapport, positive regard for each other, collaboration, good communication, mutual respect, and shared goals. To form a constructive relationship, it helps to recognize first the factors that hinder it. Inadequate staffing, staff's attitude, use of stigmatising language, lack of meaningful communication, miscommunication, being ignored, feeling unheard, and bad news have been cited by consumers as contributors of conflict.[12] Further, staff cite that wait times, postponements or cancellations, access to services, and inefficient workflows as predisposing factors.[13] Therefore, to cultivate constructive relationships CHS must limit these factors.

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
2.1 Explore and implement approaches that help to build trust, rapport, positive regard for each other, collaboration, good communication,	Safewards[14] in designated wards in collaboration with Towards a Safer Culture (ACT Health Directorate)	Executive Director - Nursing & Midwifery and Patient Support Services	Commenced	Funded - sponsored and BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
mutual respect, and shared goals.				
2.2 Implement means that encourage or assist consumers so that their concerns and needs are heard and addressed	Feasible approaches include: i. Patient Dialogue ii. Family Meeting iii. Say GDAY Communication Framework (currently used in Dhulwa Mental Health Unit)	Team leaders or managers at a local level	Commenced as BAU	Funded - BAU
2.3 Understand consumers' health	Multimodal communication plan	Executive Director – Quality, Safety,	Commenced as BAU	Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
literacy, communication needs and preferences	when communicating with patients, such as verbal, written information sheets, and teach-back	Innovation and Improvement, via the Chair of the Communicating for Safety BAU Committee in alignment with Standard 6 – Communicating for Safety		
2.4 Explore models of service that are efficient and optimize staff-consumer ratio	Safe Ratio	Executive Director - Nursing & Midwifery and Patient Support Services	Not yet commenced	To be determined

Strategic Goal 3: Foster physically and psychosocially safe systems and processes for staff and consumers to engage and interact

In OV Action Plan, a safe system and process is one that recognises OV risk, reduces the likelihood of OV, and mitigates harms associated with OV. In this vein, there are three key targets:

1) Quality of physical environment
2) Health of workforce culture
3) Robust policies and procedures

Physical environment promotes a sense of security and safety, and positive experiences for staff and consumers. Design principles that feature natural surveillance (level of openness and visibility of interactions), access control, territoriality (protection of staff only spaces), ambient conditions (welcoming, comfort, tidy, low stimulus, well lit, and positive distraction), and security equipment (i.e. video surveillance, duress alarms, metal detector, screening) will be adopted.[15]

Workforce culture influences attitudes, and attitude is an important precursor to action. For example, when staff think that OV is part of their job, they might be less likely to identify problems and solutions, report OV, or seek help. Dominant cultures that hinder safe systems and processes are part-of-the-job, poor reporting, blame, and high tolerance. CHS will strive to shift these cultures by:

- Empowering staff to set standards of acceptable behaviours and culture of respect;
- Supporting staff with time and information to report;
- Providing a just and thorough investigation of reported incidents;
- Having clear feedback loop for consumers who put staff at risk of physical and/or psychosocial harm from OV;
- Having consistent approach to OV risk that promotes low tolerance; and

- Having leadership-driven initiatives that enforce staff safety and set a culture of respect.

Policies and procedures that mandate or guide prevention and management of OV in health facilities need to be evidence-based and practical. Typically they include components, such as risk assessment, education and training, de-escalation, response framework, restraints, and post-incident de-brief.[16] However, research and innovation will be used to expand these components. Consideration for staff safety alongside consumer safety will also be prominent in further updates or developments of policies and procedures.

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
3.1 Apply standard design principles for CHS featuring natural surveillance, access control, territoriality, ambient conditions, and security equipment in new	Update to OV Procedure incorporating standard design principles	Senior Director - Work Health and Safety | People and Culture	Not yet commenced	Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
builds or refurbishments.				
3.2 Shift negative workforce cultures, such as ‘part-of-the-job’, underreporting, blame, and high tolerance	a. WHS OV Roadshow with involvement of middle managers b. OV Manager’s Response Toolkit and Training	a. Senior Director - Work Health and Safety | People and Culture b. Senior Director - Workforce Capability | People and Culture	a. Commenced b. Commenced	a. Funded – BAU b. Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
3.3 Develop policies and procedures that are evidence-based, practical, and balanced between staff and consumer safety	Review and update as appropriate OV policies and including but not limited to: • OV Procedure • Code Black • Restrictive Practices • Searching of consumers	Owners of respective policies and procedures	Commenced consultation of: i. Restrictive Practices patients who are NOT under Mental Health Act ii. Searching of consumers	Funded - BAU
3.4 Expand interventions to prevent and manage OV using data and theory	Enhance research and translation of evidence-based practices in OV prevention and	Senior Director - Work Health and Safety in partnership with Office of Research and	Commenced	Funded – BAU; External competitive funding will be sought where there is an opportunity

<table>
<tr><th>Objectives</th><th>Key deliverables</th><th>Accountability and responsibility</th><th>Status</th><th>Funding or Resourcing</th></tr>
<tr><td></td><td>management, which may include patient-level risk assessment, Grey Response, Safewards, nurse-led safety management plans and non-pharmacological interventions.</td><td>Education | People and Culture</td><td></td><td></td></tr>
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Strategic Goal 4: Set and disseminate societal standards of acceptable behaviour for staff, consumers, carers, and visitors.

Earlier we highlight that there are predisposing and precipitating factors to violence and aggression. However, there is also a public view that violence and aggression are corollary to poor enforcement of societal standards and lack of consequences for people who perpetrate violence against health care staff. CHS' tiered response includes conditional treatment agreement and legal action against consumers who intently and repeatedly display violence and aggression towards staff.

In the Territory, the Crimes Act 1900 and Personal Violence Act 2016 can be relied upon to hold people accountable and assist them to learn that violence and aggression are unacceptable. This measure intersects with policing and judiciary responsibilities, thus the need for interagency cooperation and involvement.

In this OV Action Plan, CHS will amplify public awareness on the detrimental impacts of violence and aggression on staff safety, their roles and responsibilities in creating safe working environments; and the potential consequences when they put staff at risk.

The influence of leadership in operationalising this strategic goal (ang the whole strategy) cannot be understated. In fact, it has been explicitly emphasized that a strong leadership that cultivates and enforces a culture of respect is pivotal to a successful OV Action Plan.[16] It can be expected that leadership teams will own and champion the implementation of this OV Action Plan.

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
4.1 Commit to consistent and fair policies that promote accountability among consumers who intentionally harm staff – physically and/or psychosocially	Tiered behavioural management strategy - warning letter, conditional treatment, and Workplace Protection Order	Senior Director - Work Health and Safety | People and Culture	Commenced	Funded - BAU
4.2 Foster interagency collaboration involving policing and judiciary to set and enforce appropriate standards of behaviour	Memorandum of understanding outlining support and response for CHS staff to maintain safety and pursue legal action	Deputy Chief Executive Officer or Chief Operating Officer	Not yet commenced	Funded - BAU

Objectives	Key deliverables	Accountability and responsibility	Status	Funding or Resourcing
	against assaultive patients			
4.3 Involve leadership teams in initiatives that emphasise mutual roles and responsibilities of staff and consumers in creating a safe environment	a. Adapt the Whole of Government Occupational Violence Campaign b. Update and disseminate of staff rights to safety and mutual expectations	Senior Director - Work Health and Safety | People and Culture	Commenced	Funded - BAU

How we will assess our progress

Quality indicators are used to ascribe effectiveness, value, and benefits; and allocate health care resources. There is no agreed quality indicators for OV currently, but core quality indicators of OV prevention and management should include effectiveness, safety, and patient-centred outcomes:

- **Safety** is the extent in which the OV Action Plan can prevent harm or bad outcomes.[17]
- **Effectiveness** is defined as the extent in which it can yield to benefits or good outcomes.[17]
- **Patient-centredness** is the extent in which the OV Action Plan meets the expectations of patients and consumers.[17]

The outcomes that are measured against each quality domain is described in Table 2.

Table 2. Target outcomes of the OV Action Plan

Quality domains	Baseline (FY2022-23)	Target Outcomes#

Safety	• N=1270 incidents reported
	  o n=612 physical OV
	  o n=624 verbal OV
	  o n=31 other unacceptable behaviours
	• 30% Repeat OV incidents
	• 4% of OV with moderate or severe injury
	• LTIFR=4.45
		1. Increase in reporting of verbal OV incidents and unacceptable behaviours in FY23-24:
		  a. Verbal OV ≥10%
		  b. Other≥20%
		2. Minimum 10% reduction^ of:
		  a. physical OV incidents
		  b. repeat incidents
		  c. OV with moderate or severe injury from FY2024-25 onwards
		3. Maintain lost time injury frequency rate (LTIFR) below 5.80 (CHS target)

Quality domains	Baseline (FY2022-23)	Target Outcomes#
Effectiveness	• 21% of CHS staff believe that OV is ‘part-of-the-job’⁺ • 48% of CHS staff report that they have been subjected to OV from patients or visitors⁺	4. Minimum 10% decrease in the percentage of CHS staff who think that OV is ‘part of the job’ 5. Minimum 10% decrease in the percentage of CHS staff subjected to OV
Patient-centredness	• Areas of improvement relating to patient experience were: ○ 17% of patients reported that staff provided explanations when their needs could not be met. ○ 8% of patients reported to experience emotional distress ○ 42% of patients reported that their distress was discussed with them. • 7 physical restraints per 1000 bed days* in mental health • 1 seclusion per 1000 bed days in mental health*	6. Enhanced patient experience 7. Benchmark restrictive practices nationally

ACT Government is implementing a new incident reporting system in 2024 which may impact the level of reporting of incidents and impact the above targets.

^ Minimum statistically or clinically significant reduction observed in Australian settings.[18, 19]
⁺Data are from FY2021-22 Workforce Culture Survey.
*Data are from Seclusion and restraint - Mental health - AIHW in FY 2021-22. It will be updated to FY 2023-24 when data become available.

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Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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