GOOD PRACTICE GUIDELINES

Violence in the health and disability sector

GUIDANCE FOR PCBUs

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WORKSAFE
Mahi Haumaru Aotearoa

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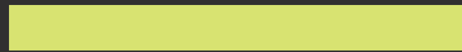

Guide for persons conducting a business or undertaking PCBUs on managing the risks of violence in the health and disability sector.

ACKNOWLEDGEMENTS

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Violence in the health and disability sector

KEY POINTS

- PCBUs must manage the risk so far as is reasonably practicable.
- Good systems provide structure for managing risk.
- Risk management includes support and care for workers and patients/clients.

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1.0 Introduction

IN THIS SECTION:

1.1 Background

1.2 Scope

1.3 Integrating violence management into your health and safety management system

Use a systemic approach to managing the risk of violent behaviour.

These guidelines are aimed at persons conducting a business or undertaking (PCBUs) in the health and disability support sector, to inform them of their duties under the Health and Safety at Work Act 2015 (HSWA). PCBUs must ensure the health and safety of their workers so far as is reasonably practicable, and eliminate or minimise risks.

Managing the risk of violent behaviour includes duties of support and care for patients/clients as well as workers. Control measures cannot be at the expense of either worker safety or patient access to healthcare.

These guidelines include:

- an explanation of how the risk of violent behaviour fits into health and safety legislation
- a PLAN-DO-CHECK-ACT approach to worker safety in the context of violent behaviour.

1.1 Background

Violent behaviour is an increasing risk to healthcare workers and community service providers. While some violent behaviour results in physical injury, threats and intimidating behaviour can cause just as damaging psychological effects.

Within the Health Care and Social Assistance industry, assault-related fatalities were at a rate of 1.73 reported incidents per 100000 workers between 2009 and 2018. This was the second highest industry rate for assault-related fatalities, recorded within combined ACC and Swift data over this time period. However it's likely that the actual number of incidents is higher, given low reporting of incidents, and a culture of acceptance or differing levels of tolerance.

Harm of any kind related to violence at work must be treated as seriously as any other work harm, as it can have serious consequences for victims. As with other work risks, it is your responsibility to take reasonable measures to manage the risk of violent behaviour to workers or others in the workplace.

There are practical steps available to PCBUs to manage the risk of violent behaviour without compromising patient/client care (see Section 4 of these guidelines). Such interventions can reduce the financial and social costs of work-related injuries, help retain skilled and motivated workers, and enhance patient/client care.

1.2 Scope

This guidance focuses specifically on healthcare and related parts of the social services and community sectors.

It provides practical advice for healthcare PCBUs whose workers or others may be exposed to violent behaviour. This could include in:

- hospitals and outpatient clinics, including emergency departments
- residential treatment facilities including rest homes, hospices/palliative care facilities, and other long-term care facilities
- disability support and mental health facilities
- non-residential service settings including general practices, specialists' rooms, rehabilitation services (physical, mental, or psychological rehabilitation), small neighbourhood clinics, and mental health centres
- community care settings including community-based residential facilities and group homes
- home environments where home and community carers are engaged
- home healthcare like district nurse or Plunket visits
- emergency response situations where first responders attend
- after-hours medical centres and pharmacies
- community care centres, and social services.

The World Health Organisation defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'.

Conscious violent behaviour can stem from acute fear, pain, grief, or communication issues. However, violent behaviour can also be unintentional, especially in a disability or healthcare environment. Unconscious violence may occur as a result of:

- head injury or neurological disorder
- post-operative effects of anaesthesia
- blood level of toxins, glucose, septicaemia, electrolytes and oxygen
- side effects of medication or treatment
- alcohol or drug intoxication
- organic psychosis
- delirium
- developmental delay
- post-traumatic stress disorder (PTSD)
- dementia.

It is important to address each incident without assumption or prejudice, and to remember that a person may not be in control of their own behaviour or even be aware of it.

For the purpose of this guidance, violent behaviour includes:

- physical assault (including biting, spitting, scratching, tripping, and grabbing)
- verbal abuse
- psychological/emotional abuse
- use of weapons
- threats of harm and intimidation
- gender-based abuse
- sexual harassment, abuse, and assault
- racial abuse.

The perpetrators and victims of violent behaviour could be workers, whānau/family, visitors, or people in the wider community.

1.3 Integrating violence management into your health and safety management system

You should have a documented health and safety management system (HSMS). This is an established set of processes to manage health and safety and maintain a high work health and safety standard in the workplace. An HSMS should include:

- policies that show an over-arching commitment by PCBUs and workers to focus and improve upon safety and health
- clear activity schedules and improvement plans
- good documentation and records-keeping
- clear allocation of responsibilities
- safe work procedures
- worker participation in every level of safety management
- risk management
- workplace inspection schedules
- emergency procedures
- equipment maintenance schedules
- incident investigation and reporting
- contractor and sub-contractor management
- recruitment and training, including staffing levels, skill mix, and workload
- security standards, including staffing levels, skill mix, and workload
- management of hazardous substances
- monitoring and auditing the health and safety management system on a regular basis to confirm that it works
- record management.

An HSMS should be integrated into every other part of the business or organisation. For example, staffing is a larger part of the business and has its own processes and principles, but should include health and safety when considering fitness for work, rostering, training in safe work procedures, and support of workers whose health or safety is impacted by work.

You need to manage health and safety risks that arise from violent behaviour within your HSMS. If you have several work sites, tailor systems to the needs of each. Cover the risk of violent behaviour and its management as part of the HSMS, in induction, training, and regular reviews, so workers know the risks and how they're managed. Test emergency response regularly with workers.

Ensure communication is consistent for every part of your HSMS. Engage workers, health and safety representatives (HSRs), union representatives, and other representatives in its development, and make sure they're involved in and up-to-date with any changes to the system.

WorkSafe encourages you to use the PLAN-DO-CHECK-ACT approach described in Figure 1.

FIGURE 1: The PLAN-DO-CHECK-ACT approach

2.0
HSWA duties

IN THIS SECTION:

2.1 Who has health and safety duties?

2.2 Managing risks under HSWA

2.3 Working with other PCBUs

2.4 Worker engagement, participation, and representation

PCBUs must ensure the health and safety of workers and other persons, and engage workers in every stage of risk management.

2.1 Who has health and safety duties?

HSWA is New Zealand's key work health and safety legislation. It sets out most of the relevant work health and safety duties that must be complied with. All work and workplaces are covered by HSWA unless specifically excluded.

WorkSafe is New Zealand's primary work health and safety regulator.

Under HSWA, everyone at a workplace has health and safety duties. There are four groups of people that have duties under HSWA – PCBUs, officers, workers and other persons at workplaces (including general public). See Appendix 1 for more information on these groups of people.

Within the healthcare sector, examples of PCBUs could be District Health Boards (DHBs), funders of care services, primary care providers, specialists operating their own practices, owners of private aged care residences, individuals engaging their own care workers, home support organisations, private medical and surgical services, rehabilitation services, emergency services, visiting services, rest homes, and disability support services.

2.2 Managing risks under HSWA

Risks to health and safety arise from people being exposed to hazards (anything that can cause harm). Under HSWA, PCBUs must eliminate risks so far as is reasonably practicable. If a risk can't be eliminated, it must be minimised so far as is reasonably practicable.

Reasonably practicable means doing what is reasonably able to be done to ensure health and safety, having taken into account and weighed up all relevant matters, including:

- how likely the hazards or risks are to occur
- how severe the harm that might result from the hazard or risk could be
- what a reasonable person knows or ought reasonably to know about the risk and the ways of eliminating or minimising it
- what measures exist to eliminate or minimise the risk (control measures)
- how available and suitable the control measures are.

Lastly, look at the cost of eliminating or minimising the risk, and whether it is grossly disproportionate to the risk. Cost can only be used as a reason not to do something when it is grossly disproportionate to the risk.

For further information, read WorkSafe's fact sheet *Reasonably Practicable*.

2.3 Working with other PCBUs

More than one PCBU can have a duty in relation to the same matter (overlapping duties).

PCBUs with overlapping duties must, so far as is reasonably practicable, consult, cooperate and coordinate activities with other PCBUs so that they can all meet their joint responsibilities. PCBUs do not need to duplicate each other's efforts.

An example of overlapping duties could be a memorandum of understanding between emergency services and a DHB as to how they will collaborate and meet their duties in the emergency department. This could include the information the emergency service would provide to emergency department (ED) workers at patient/client transfer, who would have primary control of the patient/client at different times and in different areas, and what records would be generated by each party after the fact.

For more information on overlapping duties, see our guidance: worksafe.govt.nz

2.4 Worker engagement, participation, and representation

You must involve their workers and HSRs in workplace health and safety matters by:

- engaging with workers on health and safety matters that may directly affect them
- having worker participation practices that give workers reasonable opportunities to participate effectively in improving health and safety on an ongoing basis.

Having worker representatives is one way for workers to participate. Well-established ways to do this include having trained HSRs, health and safety committees (HSCs) and unions. Other representatives can include community or church leaders. Worker representatives should be elected by the workers and workers should be involved in deciding how worker engagement and representation should be organised.

You must engage with workers and HSRs This could be achieved by:

- finding out how health and safety issues affect how they organise, manage, and carry out their work
- sharing information and taking worker views into account
- involving them in the decision-making process when you are identifying, assessing, and deciding how to deal with work risks
- encouraging them to share ideas about what should be included or updated in health and safety documents
- including people with a range of technical, clinical, and operational knowledge and experience.

For more information on worker engagement, participation and representation, see our guidance:

- Worker Engagement, Participation and Representation
- Worker Representation through Health and Safety Representatives and Health and Safety Committees

3.0
Risk identification and assessment

IN THIS SECTION:

3.1 Identifying the potential for violent behaviour

3.2 Assessing the risks

Assess each risk you identify, and apply the control measures that are most effective and appropriate.

The first step in risk management is to identify hazards at the site, or in the case of planning a new site, thinking about eliminating hazards through design. Look at the whole operation, including overlaps with other PCBUs, from a high level and work down.

In the case of violent behaviour at work, look at the factors which could trigger or escalate a confrontational situation. These factors could include:

- overcrowding
- patients/clients or whanau/family members under stress
- poor facilities
- lack of information about new patients/clients
- cultural insensitivity
- training gaps.

Tense situations can be worsened by overcrowding, patients or whānau/family/families under stress, poor facilities, lack of information about new patients, cultural insensitivity or training gaps.

Establish that verbal abuse and threats are considered violent behaviour – identifying that level of behaviour early and putting control measures in place to manage or limit it could mean more serious situations are avoided. Be aware that violent behaviour may not come from the patient/client, but from a friend or whānau/family member, a passer-by, or even another worker.

3.1 Identifying the potential for violent behaviour

For risks that have unacceptable outcomes (such as the potential for a person to die or be seriously harmed as a result of violent behaviour), even if they have a low likelihood of occurring, you should look at credible worst-case scenarios. To work out how violent behaviour poses a risk to your workers or others:

- look at previous incidents in your organisation. Any threatening behaviour (including written and verbal threats, such as on social media or by telephone) should be taken seriously
- ask your workers about any experiences they have had or heard about – you must engage with your workers when identifying risks
- find out what similar organisations have experienced.

Set up clear processes from the start of every new patient/client relationship. Patient/client assessment can help to identify the risk, and allow control measures to be put in place from the moment the relationship begins.

Risk identification needs to be repeated consistently and frequently to identify emerging risks, for example, arising from new drugs, equipment, facilities or environment, and for every new patient/client.

3.2 Assessing the risks

Assess the risks of violent behaviour causing harm. This means assessing likelihood and consequence.

Think about:

- who might be exposed to violent behaviour
- what the potential consequences of exposure to violent behaviour are (for example, what severity of injuries or ill-health could result? Could harm be cumulative over multiple incidents? Could injuries have long-term, life-changing effects? Could victims suffer debilitating long-term trauma? Is there a risk of death?)
- how likely the consequences are (for example, very likely, likely or unlikely under usual business conditions)
- what is the nature and context of the violent behaviour (when does it occur, what are the types of violent behaviour seen?)
- what helps to manage the violent behaviour.

You must decide which control measures are most appropriate for each identified risk. Apply the hierarchy of controls as described below to choose the most effective control measures in your circumstances.

The first step in the hierarchy of controls is to try to eliminate risks so far as is reasonably practicable. If elimination is not reasonably practicable, the risk needs to be minimised, so far as is reasonably practicable. The hierarchy is shown below.

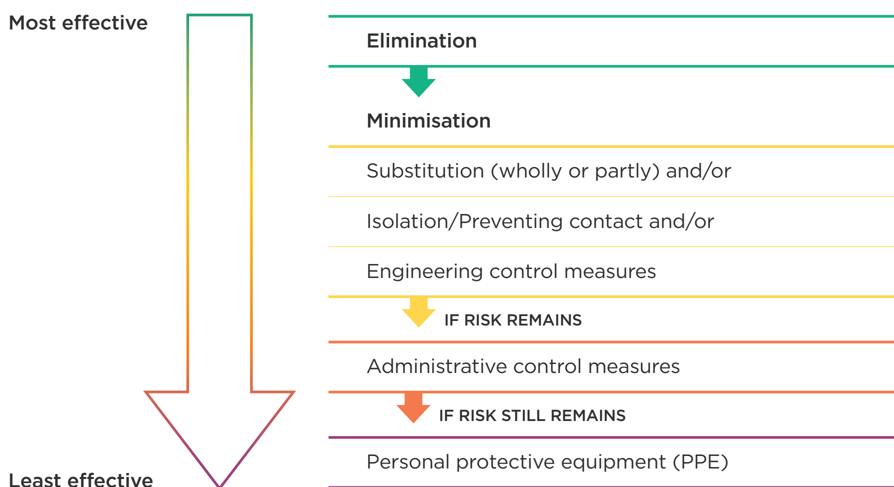

FIGURE 2: Hierarchy of controls

For further information on risk management, see our guidance:

- General risk and workplace management – part 2
- Identifying, assessing, and managing work risks

4.0 Risk management

IN THIS SECTION:

4.1 Policies

4.2 Leadership

4.3 Facility design

4.4 Staffing

4.5 Training

4.6 Patient/client assessment

4.7 Transfer of information

4.8 Safe work practices

4.9 Home and community care

4.10 Emergency services

4.11 Emergency planning

Embed risk management into every part of the work.

Once planning and assessment are complete, it's time to put in place the control measures – this is the 'Do' part of PLAN-DO-CHECK-ACT. If elimination is not practicable, you need to minimise that risk, so far as is reasonably practicable.

Systems and processes to manage the risk of violent behaviour should be integrated into your larger HSMS. They should include:

- a policy of management and organisational commitment
- smart health and safety-focused facility design (where possible)
- clear allocation of responsibilities
- worker participation
- adequate staffing, training, and assessment
- high quality of service to the patients/clients
- emergency planning
- incident reporting and investigation
- support, rehabilitation, and return to work planning
- evaluation and review of the system and processes.

It's easy to focus on administrative control measures when trying to manage the risk of violent behaviour. Consider and identify other types of control measures such as substitution, engineering or isolation, to minimise the risk of harm. This can be incorporated into facility design, even in minor renovations.

4.1 Policies

A positive and robust health and safety culture begins at senior management and spreads throughout an organisation. All influential stakeholders (including unions) must be involved in health and safety. Such a culture can add significant value. It can lead to the organisation having a good reputation for being committed to health and safety, engaged and more productive workers, decreased worker absence and turnover, and workers participating positively in risk management. A strong health and safety culture can potentially deliver safer healthcare for all as well as increased economic returns.

Develop a violence prevention policy which makes a strong commitment to violence prevention. It should include clear aims and performance targets. The policy statement should be reinforced through periodic review by senior management.

The violence prevention policy should be part of an organisation's broader set of health and safety policies, and should be integrated with existing business strategies and policies and the larger HSMS. The policy should cover general health and safety for workers, patients/clients, whānau/family, visitors and the general public.

It's important to emphasise that violent behaviour is unacceptable and should not be seen as 'just part of the job'.

A 'zero tolerance' policy can reflect an effective recognition and response approach, where the intention is to acknowledge what is happening in each separate incident and respond appropriately to it. Zero tolerance policies should be tailored for the circumstances.

For example, while zero tolerance will mean that a visitor, worker, or member of the public is entirely banned from the workplace after one incident, for some patients or clients (dependant on care, suffering from advanced dementia, PTSD, or high needs autism) a more individual and considered approach is warranted. This is particularly true when the environment is a trigger and the patient/client has limited control over their environment. Each incident should be treated individually, and policies should reflect that.

The choice of language used in policies needs to be appropriate to ensure it meets the context of the environment in which violent behaviour is being exhibited. For example, in the disability support context, for a 'person behaving in a violent or aggressive way' (due to a cognitive or neurological impairment) they prefer the term 'Challenging Behaviour' (recognising that the behaviour is a mechanism for communicating, rather than it being an intentional act of violence).

You must consider the rights of the people that access health and disability services when you develop your policies and practices. These rights include, but are not limited to, the rights outlined: Code of Health and Disability Service Consumers' Rights

Patients/clients users have a right to participate in decisions about and monitoring of their care services. This is particularly the case for home-based care. In addition, as at-home patients/clients are part of a healthy and safe work environment, successful policies and practices will need their agreement and buy in.

Work with other PCBUs such as the police, ambulance services and aged residential care in developing and finalising policies. Integrate your Memorandums of Understanding with those organisations and businesses into your policies, defining how you'll work together.

Policies must be developed with worker involvement, and any policy changes communicated to workers.

4.2 Leadership

Senior management need to be visible in providing strong leadership for work health and safety.

Leadership includes support for the promotion of a safety culture generally, and specifically where workers are encouraged to raise issues and participate in solutions. This includes:

- taking recommendations by HSRs and putting them into action
- providing effective training for new workers
- including health and safety issues in organisational communications
- making counselling and support available to workers who experience or witness violent behaviour
- involving workers in safety reviews and decisions
- ensuring rostering does not compromise safety
- investigating and responding to incidents and concerns constructively
- communicating information on safety performance indicators
- having strong recruitment and procurement systems.

Leadership is not just management. Workers can have leadership roles in safety management, and should be empowered to do so, as part of their participation in risk management.

4.3 Facility design

This section applies primarily to in-patient care services and community buildings. For more information on health and safety by design, see our guidance: worksafe.govt.nz

Whether planning a new facility, undertaking minor renovations or carrying out a major upgrade of an existing facility, there are opportunities to make work healthier and safer. For facilities with limited resources, and for home-based care, upgrading existing facilities is often the most feasible option. If there's budget for renovations, prioritise health and safety improvements.

There are also likely to be other benefits, such as improvements in the quality of care, increased worker morale and decreased associated costs. There are also potential benefits for patients/clients.

Facility design elements that can help to manage the risk of violent behaviour include:

Access	– safe access and quick egress from the workplace for everyone including workers and visitors – multiple areas of public access to healthcare facilities – security services at the main entrance, near the visitors' transit route in emergency departments – locate workers' parking areas close to the workplace if possible, particularly for those whose shifts change after dark – a reception area that is easily identifiable by patients and visitors, and easily accessible to other workers – restricted access to worker areas (changing rooms, rest areas and toilet facilities) – security escorts for groups of workers going to their cars after dark.
Space	– enough space per person for their comfort – waiting areas designed to accommodate all visitors and patients/clients comfortably – provide adequate seating, especially if long waiting periods are a possibility – rest areas and/or meal rooms for workers away from patients/clients, particularly when doing night work or work in areas of identified higher risk (for example, with clients/patients with a history of challenging behaviour) – protective barriers for workers at higher risk and challenging patients/clients separated from other patients and the public.
Fixtures	– good lighting that can be dimmed if stimulation reduction is needed – an environment with appropriate temperature, humidity and ventilation – sufficiently robust wall coverings to withstand physical force – fixtures and fittings that cannot be used as weapons.
Premises	When the opportunity presents itself for new premises or redesign: – design facilities with the potential for emergencies in mind – address the issue of 'black spots' (for example, with camera coverage, regular checks). These are the areas where incidents can be hidden from others or where there are lapses in phone, radio or pager communications. – address 'entrapment spots' – areas that either promote violent behaviour by confining people into tight spaces, or by restricting escape from a hostile situation – ensure interview rooms have two exits (to avoid anyone becoming trapped) and viewing windows so that other workers can intervene if necessary – ensure treatment rooms in emergency service areas are apart from public areas – use noise-dampening materials to keep noise levels to a minimum, to reduce stress, irritation, and tension – use calming colour schemes and noise-dampening materials – in problematic areas, and where proven need exists, introduce processes to ensure that contraband or banned items are not smuggled to patients/clients – ensure that windows and doors are secure – isolate potentially dangerous equipment, chemicals or medication supplies (i.e. locked cupboards where appropriate) – install closed-circuit TV where oversight may be required in geographically difficult or distant parts of the building – test these security devices and personal/other alarm procedures regularly – provide adequate security lighting and security escorts for evening or night workers.

TABLE 1: Facility design elements

4.4 Staffing

Many tasks require more than one worker, and working in pairs or more can decrease the chance of a confrontation. Employ and roster adequate workers for a calmer work environment, and for support in the case of an incident. Fatigued workers may find it harder to effectively manage the risks from violence. For more information on managing fatigue, see our guidance: worksafe.govt.nz

It's also important to have enough workers to accommodate leave being taken. Rostering should take into account enough time for workers to get to their jobs and complete tasks, and ensure that staff are able to take adequate breaks. Rotate workers who do dangerous and/or unpleasant tasks or who are new to the job, and introduce team care or buddying in situations where risk is unknown or high.

Fit the right worker to the job. Make sure workers are physically able to undertake the tasks they are employed to do. When recruiting, ensure the job description clearly states when a role requires a certain level of fitness or strength. Re-assess workers if their health or physical condition changes, especially following injury or incident. Identify new workers' capability and training needs before they begin work, and ensure they're not given tasks outside of their ability or training.

Be aware of patient/client preferences around language and culture, and avoid situations with specific risk sensitivities.

4.5 Training

You must ensure all persons are provided the information, training, instruction or supervision they need to protect them from health and safety risks arising from your work. For more information on training duties, see our guidance: worksafe.govt.nz

Effective systems for training workers are crucial for developing a culture of safety. Training should cover the range of technical skills needed to identify hazards and risks arising from work and procedures that reduce those risks.

All workers, including contractors, should receive relevant and adequate training both at entry (induction) and at regular intervals as relevant. Training should also reflect the nature of incidents reported in that unit and should cover aspects of self-protection and self-preservation, including reminding the worker of their right to refuse dangerous work (section 83 of HSWA). Some training should be mandatory for all workers. Identifying what training is needed could be agreed between management and HSRs/union representatives.

Training in the management of violence should be undertaken before exposure to potential hazards and followed by refresher training within the first year. Where possible, training should be done locally, or on-site, so teams can test their response plans in the work environment. Training should be face-to-face with a trainer where possible – online training may not be as effective.

When is training needed?

Training should be provided in the following instances:

- when a new worker starts
- when a worker is transferring from one area of care to another
- whenever an assessment or performance review identifies a need for refresher training
- as remedial action following an incident or near miss
- when workers request it
- for workers in areas that require techniques or equipment that are more specialised, for example, care of clients with spinal injuries.

What training is needed?

Provide training for all workers that covers:

- the violence prevention policy
- risk assessment
- resilience
- de-escalation and disengagement
- non-injurious break-away techniques
- conflict management and negotiation skills
- recognition of early warning signs and appropriate ways to respond to them
- responses to violent situations that are tailored to individuals and specific circumstances
- restraint methods in accordance with NZS 8134: 2008 *Restraint Minimisation and Safe Practice* and any related sector standards (restraint can only be done where there is a clear restraint policy)
- emergency plans
- incident reporting
- support mechanisms in place for workers affected by violent behaviour
- responsibilities and rights under the Health Information Privacy Code (HIPC).

For supervisors, managers, and HSRs, provide information, education and training that covers:

- identifying when a worker's performance or behaviour indicates the presence of stress or likelihood of violent behaviour
- supporting workers after an incident, which may include counselling, alternative duties, Worker Assistance Programme, etc.
- creating a supportive environment
- giving workers knowledge of specialist support resources for difficult situations and provide peer support
- providing of debriefing systems
- rostering issues and emergency response planning.

Training session outcomes

At the conclusion of a training session, keep a record of each trainee's attendance and outcome, and provide verification of their participation in training.

Trainees should be assessed on the knowledge and skills taught in the session by the trainers. Trainees can also do self-assessments or peer assessments of their skills.

Evaluation of training sessions and workshops

Trainers should routinely gather feedback from trainees so that the person coordinating training and the trainers can assess the effectiveness of the training sessions. This can be done using a brief evaluation form handed out to participants at the end of the training session.

4.6 Patient/client assessment

Minimise the risk of violent behaviour by ensuring that patients/clients are placed in organisations with the ability to cope with them, and that they are cared for by workers with appropriate and adequate training and experience. It may be necessary for smaller services to develop service-level agreements with larger services to help them manage certain types of patient/client.

When a new patient/client is to arrive, find out as much information as possible, to identify patients/clients with a history and likelihood of violent behaviour. Rule 11 of the HIPC provides clear guidance on the rules around disclosure of health information including when transferring a patient/client.

Obtain a current medical report from the referral agency, general practitioner, psychologist or psychiatrist. Talk to those with recent responsibility for the patient/client (for example, caregivers, family), to get as much information as possible.

Identify any behaviour change in regular checks and assessment, and communicate these to relevant workers. Patient/client notes should include a section which assesses the risk to caregivers. In particular, the nature of the risk should be specified by asking the following types of questions:

- Is there information in the patient/client record that suggests the potential for violent behaviour?
- How frequent are incidents?
- Do whānau/family or support people report a history of violent behaviour or abuse in the recent past?

Risk information and management plans should be kept in an easily accessible place for all workers, including those that may be covering for others. Part of record management is ensuring that this information is not only current but also regularly updated.

Consider the cultural factors (for example, culturally inappropriate behaviour of worker) that may escalate or de-escalate patient/client aggression.

Tailor care approaches to each new patient/client individually, taking into account potential triggers and early warning signs, and what might calm them. The emphasis of patient/client assessment needs to be on what can support the person to behave appropriately.

The new patient/client and whānau/family should also be advised of the current policies and procedures for managing violent behaviour.

4.7 Transfer of information

A number of incidents of violent behaviour occurred because information was not transferred between agencies or to individual workers within an agency.

The reasons given why information was not transferred included:

- inadequate or not regularly updated clinical assessment or patient/client history
- inadequate documentation at the start of care
- referral agencies reported they were too busy
- workers in some healthcare organisations did not believe that it would be responsible to pass on certain information on the grounds that the ‘downstream’ caregivers were unable to handle it or didn’t need to know
- workers feared repercussions from the misapplication of the Privacy Act and the HIPC
- the organisation may have wished to place a patient/client with another organisation and therefore did not pass on information seen as likely to compromise the placement
- the ‘upstream’ care-giving organisation may not have taken steps to obtain patient/client consent when the information was initially being gathered for subsequent passing on to ‘downstream’ caregivers
- emergency admissions without the right skill mix, appropriate care provider or understanding of patient/client needs.

The normal care and precautions concerning the supply of patient/client information apply. However, information relevant to the safe and proper care of patients/clients, including information concerning risks to workers, is a necessary part of quality care and adequate health and safety management.

Consistent with provisions of the HIPC:

- Referring agencies need to provide adequate information to permit comprehensive risk identification and ongoing support plan development.
- Where a group of providers are involved in providing support to a patient/client, mechanisms should be in place to enable exchange of relevant information.
- Pass information on any incidents of patient/client to downstream caregivers.

Where there's a breakdown in communication between agencies, it can be an opportunity to revise those processes and provide feedback to the source agency, at both individual and management levels. They may not have been aware of a risk or omission, and providing feedback to help them put in place safety measures for themselves and any future service providers.

Consider communication within an organisation. Homecare or shift workers may not attend regular meetings where health and safety is a standing topic, so you need to find other communication channels so those workers get new information and regular reminders about things like reporting near misses.

Processes governing the transfer of patient/client information from the Police should be written into established and agreed policies with them. The Ministry of Health has published Information *Sharing Guidance for Health Professionals* to clarify when information should be shared with other agencies, including the Police and Oranga Tamariki: www.health.govt.nz

4.8 Safe work practices

Set up a system of safe work for your workers, and processes and rules that keep them healthy and safe at work. This includes training, communication, and codes of conduct to clearly signal what is expected of them. These should cover:

- clothing appropriate to the work. For more information on protective clothing, see our guidance: worksafe.govt.nz
- emergency response devices and personal communication devices
- information gathering and recording, especially regarding patient/client behaviour changes
- communication styles
- clear lines of retreat and emergency response
- the right to refuse dangerous work.

Where appropriate:

- signpost areas for workers, patients/clients, and visitors
- use signage to identify areas of special risk or restricted areas
- ensure that higher risk areas are visible at all times
- provide easy egress from areas where violent behaviour may occur
- install other security devices such as cameras and good lighting in hallways
- provide emergency exits.

Provide clear messages to patients/clients and their visitors that violent behaviour is unacceptable and has consequences, including potentially banning from the premises, arrest, and charges being laid.

4.9 Home and community care

Community service providers are a particularly vulnerable group. They often work in isolation and within premises that are not designed with the safety of the service provider in mind. The service provider may not know who else is present when they arrive, or what health and safety risks there are on the property.

What can PCBUs do?

The best protection you can offer is to establish a strong policy towards work violence. Ensure all workers understand the policy, and that all claims of violence at work will be investigated and remedied promptly. A PCBU has the right to decline referrals or withdraw services when the risk to worker safety is regarded as unacceptable and resolution cannot be achieved. New clients should only be accepted after pre-assessment of the property and people involved.

Develop policies and procedures for home healthcare visits, and ensure the client and any whānau/family members at the address are made familiar with them. Make it clear the client needs to manage risks to worker safety when identified (for example, locking away guns, kennelling dogs). Make sure they understand that care can be withdrawn if the client refuses to manage those risks.

In some cases the worker is the source of violent behaviour. The client is just as vulnerable in an isolated environment, and even more so if they have difficulties communicating or cannot remove themselves from a violent situation. Providers should ensure there are systems in place where clients can notify the provider about violence committed by a worker.

Establish expectations for home visits, including the presence of others in the home and communicate the worker's right to refuse to provide services in a clearly hazardous situation.

Provide training for workers so they know what conduct is not acceptable, what to do if they witness or are subjected to violent behaviour, and de-escalation and conflict resolution.

Instruct workers not to enter any location where they feel unsafe. Introduce a 'buddy system' or provide a security escort or police assistance in potentially dangerous situations or at night. Develop strategies for workers to escape unsafe situations. For more information on lone working, see our guidance: worksafe.govt.nz

Establish a daily work plan for home-based and community workers that requires them to keep a designated contact person informed of their location throughout the day. Have the contact person follow up if a worker does not report in as necessary.

Workers need to be able to access rapid support. This means both communication devices and plans that enable the rapid deployment of assistance should be considered. Equip field workers with cell phones, GPS tracking, and hand-held alarms or noise devices. A systemic approach to checking in can help where the work is rural or remote, and connectivity is an issue. An ongoing two-way communication system may be needed in some cases.

If a worker is in trouble:

- make immediate and reliable contact with responders
- communicate the exact whereabouts of the worker
- pursue a least-delay intervention or rescue (without endangering responders).

4.10 Emergency services

Emergency workers often don't have information about the potential for violent behaviour when attending an emergency call-out or seeing an emergency patient.

In ambulances or aeromedical environments, the risk of violent behaviour is worsened by the confined space. Existing conditions may be triggered by being in a confined space.

Consider extra security in emergency departments. Set clear expectations with patients and whānau/family as to what kind of behaviour will not be tolerated.

Emergency service providers need to be aware of the increased risk to their workers and ensure they have frequent debriefs, strong reporting processes, training in de-escalation, negotiation and conflict resolution, and counselling available whenever it might be needed.

In very high-risk situations it is also possible that emergency workers are held back from a scene or from treating a patient. PCBUs should be clear that protecting their workers is important.

4.11 Emergency planning

Include an emergency plan in your HSMS. Emergency plans must be maintained, and should be tested at least yearly, and whenever there are changes to the work, workplace or health and safety systems.

Have a 'check-in system' where workers are all accounted for at the end of each shift and procedures to follow if someone does not check in.

Develop emergency signalling, alarm and monitoring systems as appropriate, and test periodically. Make sure that other workers are available to respond to alarms. Have a mixture of personal and wall-mounted alarms so that workers have a variety of options to summon assistance. Hospitals and larger commercial businesses could develop lockdown plans.

Test these systems regularly and measure the response time to ensure that intervention occurs before serious harm can be inflicted.

Ensure there are first aid supplies available to workers, and that these are maintained and refilled as necessary. For more information on first aid training and supplies, see our guidance: worksafe.govt.nz

Have a policy on when complaints should be laid with the police, which is agreed to by the local police. The police can file criminal charges for all violent behaviour, verbal and physical. However, each incident should be assessed individually and an appropriate course of action decided upon.

5.0 Incident response

IN THIS SECTION:

5.1 Immediately after an incident

5.2 Longer term

5.3 Ongoing support

5.4 Rehabilitation

5.5 Incident reporting

5.6 Worker reporting

5.7 Investigation

Managing the impact of a violent incident on workers can take time and needs consistent and genuine commitment.

Your emergency plan may give a series of steps to go through when an incident occurs, including calling the Police, de-escalating and containing the situation, and providing medical attention to anyone hurt.

There's a larger context to consider, as violent behaviour can cause significant psychological harm, and requires a staged response from the PCBU.

5.1 Immediately after an incident

Medical treatment should be arranged if necessary. The shock of a violent incident can endure for some time afterwards. It may help those involved, including bystanders, to follow these steps:

- sit or lie down
- take deep breaths
- eat or drink something
- stay warm.

Provide communication with families and arrange transport home. It may be necessary to call in additional staff to provide cover for affected workers who need to leave, so staffing contingency plans should include how this happens.

Management should engage with the victim/s within 24 hours, as well as with HSR and/or union representatives, so they can offer support. Reporting and investigation activity should start as soon as possible.

Restrict media access where possible.

5.2 Longer term

A debrief of the workers involved is required under the *Health and Disability Standards (NZS 8134.2:2008)*.

Ideally, debrief within 72 hours, or a week where there are rostering complications. Offer workers the opportunity to sit down, with a mediator or support person if needed, and process their feelings and concerns.

Provide access to support services like Employee Assistance Programme (EAP) or an equivalent. Workers should not have to use their sick leave while they are recovering from injuries sustained through work violence.

Work with the insurer or Accident Compensation Corporation (ACC) regarding medical treatment and any other entitlements, for example, earnings-related compensation or rehabilitation support.

5.3 Ongoing support

There should be a strong management commitment to supporting workers who have experienced violent behaviour. This includes:

- safe modified duties or reduced hours during the recovery phase
- appropriate (insurance and work fitness) certification by the treating doctors
- rehabilitation planning in face-to-face interviews with the injured worker
- return to work in a safe environment
- support during police investigations or prosecution
- training or re-training where necessary or requested.

5.4 Rehabilitation

PCBUs have a duty of care towards workers to ensure that their health and safety is not put at risk in any way by work activity so far as reasonably possible. PCBUs have a duty to support workers so they return to work in a safe and sustainable manner. Workers have the right to representation when return-to-work plans are developed.

Be aware of different people's reactions to a stressful situation. These may include: anger, frustration, anxiety, guilt, embarrassment, feeling like they're losing control, burnout, and emotional exhaustion. They may suffer from physical symptoms such as vomiting or migraines. Longer term, they may suffer with sleeplessness, 'reliving the event', and a fear of returning to work. These reactions should be recognised and managed quickly after the episode to reduce the risk of psychological harm.

Long-term effects may include reduced morale, impaired performance, and psychological trauma. Any or all effects may mean the victim needs extended leave. You should have:

- documented procedures for prevention and early intervention strategies, as soon as violent behaviour or the potential for it is identified
- procedures in place to be followed for an effective immediate response that controls and diffuses the situation
- a rehabilitation assessment that considers:
  - time frames for interventions
  - the responsibilities of those involved
  - the methods for assessing needs
  - consideration of cultural needs and community support
- a process to ensure that referrals are made to the relevant service providers for the appropriate treatment.

5.5 Incident reporting

Having a robust incident reporting process is a key part of any HSMS. It helps identify where control measures aren't adequate, and promote a culture of improvement. Incidents involving violent behaviour should be treated like any other incident involving harm, or near misses.

Reporting roles should be clearly allocated. If reporting is the role of the victim or affected worker, be aware this could re-traumatise that person, or even prevent them from reporting the event in the first place. Provide support to that person, and to their supervisor or manager, who may need to report on their behalf.

Management should use the reporting of incidents and near misses as learning opportunities for both workers and management, and to indicate steps that can be taken to improve on safety performance. Communicate to workers the findings and actions taken following an investigation, to maintain worker confidence in the PCBU's commitment to a healthy and safe work environment.

Incident reporting systems should involve:

- routine reporting and recording of specific events, including minor incidents and near misses
- incident and injury records containing key information about injury events, including the nature of the injuries and the circumstances leading to the incident
- analysis of reported incidents to pinpoint potential or actual failures in health and safety systems
- documenting trends in incident data over time.

Incident forms can be used to record specific events, including accidents and other incidents. For example, when recording the work activity at the time of the incident, add specific categories (for example, boxes that can be ticked) for incidents that involved violent behaviour and for which police statements were made.

Under HSWA, WorkSafe must be notified when certain work-related events occur. These events include death, and all injuries or illnesses that require (or would usually require) a person to be admitted to hospital for immediate treatment. For more information on notifiable events, see our website: worksafe.govt.nz

You may also need to report incidents to the Health Quality and Safety Commission (HQSC), or Oranga Tamariki (if a child is involved).

5.6 Worker reporting

Under-reporting of incidents can be a particular problem with incidents of violent behaviour. It can be time-consuming, complex, and painful for the victim. Workers can also feel that it will be used against them, to allocate blame or imply a lack of fitness for their role.

It is important to create a culture where reporting is encouraged, and seen as a way to participate in making the work safer. Train managers on how to respond to incidents or near misses, and commit at a management-level to receive reports without blame or negative outcome for the reporter.

Make the reporting process simple, unbiased, and something the worker can do with a colleague or manager together. Ask questions like:

- 'what were the events, in order?'
- 'what do we believe were the triggers for the behaviour?'
- 'what went well?'
- 'what could we do differently next time?'

A worker's report on the incident should not be able to be amended or edited by anyone apart from that worker. Workers with different perspectives to the incident can contribute by making their own report, or by supplying their views when approached for information during the investigation. Make sure the victim signs off on the final version of the report, and provide a copy to them for their records.

5.7 Investigation

Investigate all incidents of violent behaviour and, where appropriate, make changes to practice. Changes may include:

- regular training and retraining programmes
- reassessment of the risk status of that patient/client
- changes to the relevant care plans, including clinical reassessment
- changes to the management measures for that unit
- rotation of workers in certain areas
- complaints being laid with the police and the police laying charges
- procedural steps regarding the right to refuse to carry out work likely to cause serious harm
- a long-term plan to address facility needs (for example, funding).

Communicate investigation findings and the changes that you make as a result to your workers.

Investigations should be conducted by workers and managers trained to do so. They must engage with workers, HSRs, and union representatives throughout investigations and any resulting change.

6.0 Monitoring and improvement

IN THIS SECTION:

6.1 Monitoring

6.2 Continuous improvement

6.3 Learning from incidents

6.4 Learning from audits

Applying lessons learned from the results of audits and investigations can contribute to a safer and more productive work environment.

Monitoring helps you check that your organisational systems and control measures are working and that they are being used consistently by all workers. Consult a range of workers, particularly those who have worked with the control measures.

A specific part of monitoring is to conduct audits of risk assessment procedures. An audit is a performance review to ensure that systems and processes are being used consistently by everyone. Where there are gaps, an audit provides information that enables improvements to be made.

These checks can be part of the larger auditing systems in place, or self-contained.

6.1 Monitoring

The first step in setting up a monitoring system is to identify information that is already collected. This information may be held in several locations or databases within an organisation. Develop a list of these information sources and a plan for how the sections relevant to violent behaviour could be integrated into a single data set.

The next step in setting up a monitoring system is to plan what additional information needs to be collected to maintain an overview of how well risk management is working. Where possible, arrange to combine any new data collection with existing data collection systems to minimise the costs of collecting additional data.

Workers and their representatives are an excellent source of information on whether systems and control mechanisms are working – engage them in the process.

You should typically use monitoring information as a starting point and extend the information to build a comprehensive view about how well the HSMS is being implemented. If there is little or no monitoring or audit information available, a process evaluation will need additional time and resources to gather the information required.

6.2 Continuous improvement

You should act immediately to improve control measures and processes whenever problems are identified, or when the opportunity to upgrade is presented.

Carry out ongoing monitoring and scheduled HSMS audits. Schedule additional checks after changes have been made to the workplace, or systems. Revise your control measures whenever monitoring indicates an opportunity to do so.

A commitment to continuous improvement will have knock-on positive effects on your work culture. Where workers can participate and can see that management is invested in their health and safety, communication and practice will often improve.

6.3 Learning from incidents

Following an incident and resulting investigation, you can use the information you gather to plan changes to minimise the risk of future incidents. Communicate this information to your workers so they become aware of the risks in their work and how those risks are being managed.

Engage with workers about your risk management system. Seek feedback from them regularly in whatever way works best for your workers – this could either be in person, through representatives, or through surveys.

Report back to workers about what action will be taken after investigations are complete or audit results are received. Open communication, demonstrating a commitment to improvement, and recognising the value of their contribution will support them to continue participating and reporting.

6.4 Learning from audits

Once the results of an audit are available, and areas for improvement have been identified, start those improvements as soon as possible. This should be done formally in an action plan, with timeframes specified for the actions to be taken. Ensure health and safety representatives are involved, as well as workers in the areas needing improvement. The best people to action positive change are those who will be affected by it.

Appendices

IN THIS SECTION:

Appendix 1: HSWA key concepts

Appendix 2: Example work risk assessment – home and community care

Appendix 3: Example work risk assessment – long term or aged care

Appendix 4: Example work risk assessment – non-clinical areas

Appendix 5: Example client assessment

Appendix 1: HSWA key concepts

TERM	DEFINITION
Administrative control	A control measure that is a method of work, process, or procedure designed to minimise risk.
Control measure	In relation to a risk to health and safety, means a measure to eliminate or minimise the risk.
Due diligence	The due diligence duty requires directors and other officers under HSWA to take reasonable steps to: – know about work health and safety matters and keep that knowledge up-to-date – gain an understanding of the operations of the organisation and the hazards and risks generally associated with those operations – ensure the PCBU has appropriate resources and processes to eliminate or minimise those risks and uses them – ensure the PCBU has appropriate processes for receiving information about incidents, hazards and risks, and for responding to that information – ensure there are processes for complying with any duty, and that these are implemented – verify that these resources and processes are in place and being used. Officers must exercise the care, diligence and skill a reasonable officer would exercise in the same circumstances, taking into account matters including the nature of the business or undertaking, and officer's position and nature of their responsibilities.
Engagement	A PCBU (person conducting a business or undertaking – see below) has to engage with its workers on health and safety matters. A PCBU engages by: – sharing information about health and safety matters so that workers are well-informed, know what is going on and can a say in decision-making – encouraging workers to have a say – listening to and considering what workers have to say – giving workers opportunities to contribute to the decision-making process relating to a health and safety matter.
Engineering control	Means a control measure that is physical in nature; and includes a mechanical device or process.
Harm	Illness, injury or both. This includes physical or mental harm caused by work-related stress.
Health and Safety Committee	Supports the ongoing improvement of health and safety at work. An HSC enables PCBU representatives, workers and other HSC members to meet regularly and work cooperatively to ensure workers' health and safety
Health and Safety Representative	Is a worker elected by the members of their work group to represent them in health and safety matters, in accordance with subpart 2 of Part 3 of HSWA. Throughout these guidelines, the term HSR means an elected representative who meets the requirements of HSWA and Worker Engagement, Praticipation, and Representation (WEPR) Regulations. It does not apply to people who are referred to as HSRs under other arrangements, but who are not elected under HSWA.
Officer	An officer is a person who has the ability to significantly influence the management of a PCBU. This includes, for example, company directors and chief executives. Officers must exercise due diligence to ensure the PCBU meets its health and safety obligations.
Other person at workplace	Examples of other persons at workplaces include workplace visitors and casual volunteers at workplaces.
Participation	Worker participation practices are what the PCBU puts in place so that workers can help to improve workplace health and safety on an ongoing basis. These practices make it possible for workers to share ideas and information, raise issues, and contribute to decision-making on an ongoing basis.
PCBU	A PCBU is a 'person conducting a business or undertaking'. A PCBU may be an individual person or an organisation. It does not include workers or officers of PCBUs, volunteer associations with no workers, or home occupiers that employ or engage a tradesperson to carryout residential work. A PCBU must ensure, so far as is reasonably practicable, the health and safety of workers, and that other persons are not put at risk by its work. This is called the 'primary duty of care'.

TERM	DEFINITION
So far as is reasonably practicable	Core health and safety duties require PCBUs to ensure health and safety 'so far as is reasonably practicable'. When used in relation to these core duties, something is reasonably practicable if it is reasonably able to be done to ensure health and safety, having weighed up and considered all relevant matters, including: – How likely are the hazards and risks to occur? – How severe could the harm that might result from the hazard or risk be? – What a person knows or ought to reasonably know about the hazard or risk and the ways of eliminating or minimising it. – What measures exist to eliminate or minimise the risk (control measures)? – How available and suitable is the control measure(s)? Then weigh up the cost: – What is the cost of eliminating or minimising the risk? – Is the cost grossly disproportionate to the risk?
Worker	A worker is an individual who carries out work in any capacity for a PCBU. This includes a worker, a contractor or sub-contractor, an apprentice or trainee, a person on work experience or a work trial, or a volunteer worker.
Workplace	A workplace is a place where a worker goes or is likely to be while at work, or where work is being carried out or is customarily carried out. It includes a vehicle, vessel, aircraft, ship or other mobile structure and any waters and any installation on land, on the bed of any waters, or floating on any waters. So certain locations will only be classed as workplaces while work is being carried out at those locations. Most duties under HSWA relate to the conduct of work. However, some duties are linked to workplaces.
WorkSafe New Zealand	WorkSafe is the government agency that is the New Zealand's primary work health and safety regulator. WorkSafe collaborates with PCBUs, workers and other duty holders to embed and promote good work health and safety practices, and enforce work health and safety law.

WORKSAFE
Mahi Haumaru Aotearoa

Appendix 2:

Example work risk assessment – home and community care

Date: DD / MM / YEAR	Time: AM PM	Department:
Site:		Name: (recorder)

Survey participants

Name:	Name:
Position:	Position:
Name:	Name:
Position:	Position:

		MOST LIKELY CONSEQUENCES					
	WORKERS	**Risk or concern identified through staff survey only**	**Injuries or incidents not requiring first aid or medical treatment**	**Minor injury requiring medical treatment (injury report completed)**	**Significant injury causing time loss, multiple medical visits, hospitalisation**	**Significant injury resulting in prolonged time loss or loss of work in own occupation**	**Serious injury resulting in loss of work in any occupation or death**
Probability	Is expected to occur in most circumstances	2	2	2	1	1	1
	Will probably occur based on current practice	2	2	2	2	1	1
	Might occur at some time in the future based on current practice	3	3	3	2	2	1
	Could occur but doubtful	3	3	3	2	2	1
	May occur but only in exceptional cases	3	3	3	3	2	2

Above matrix adapted from the Australian/New Zealand Standard AS/NZS 4360:2004 – Risk Management Standard

Home and community work risk assessment

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Entranceway					
Is lighting sufficient to light entrance and walkway?	Y N NA				
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be obstacles?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Patient/client rooms					
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Are exits blocked by furniture or other items?	Y N NA				
Do patient/client rooms lock?	Y N NA				
If so, can the locks be easily unlocked by workers?	Y N NA				
Is lighting adequate?	Y N NA				
Do doors allow for safe entry and exit?	Y N NA				
Hallways, stairways, and bathrooms					
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Is the area free of clutter that could restrict the ability to leave?	Y N NA				
Emergency communication					
Can workers notify others in the event of an emergency?	Y N NA				
Working alone of in isolation					
Has a lone worker risk assessment been completed and control measures established?	Y N NA				
Are workers familiar with the assessment and risk management plans?	Y N NA				
Do workers follow the lone worker plan?	Y N NA				

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Pets and unrestrained animals					
Are there pets in the home?	Y N NA				
Could the pets present a threat?	Y N NA				
Can the pets be contained or restrained prior to the worker visit?	Y N NA				
Threats of violent behaviour incidents					
Are there procedures in the case of weapons being discovered?	Y N NA				
Assessing and communicating the risk					
Is the patient/client assessment completed before working with them?	Y N NA				
Is the patient/client assessment revised regularly and in cases of behaviour change?	Y N NA				
Is the patient/client potential for violent behaviour communicated to all workers?	Y N NA				
Is the patient/client assessment communicated to any other agencies in the case of transfer of care?	Y N NA				
Care planning and documentation					
Are all relevant agencies involved in planning?	Y N NA				
Are frontline workers included in care planning?	Y N NA				
Do workers have access to the care plan before care starts?	Y N NA				
Are workers updated regularly and as needed?	Y N NA				
Have workers been trained on risk assessments?	Y N NA				
Incidents and emergency response					
Are there procedures for emergency response?	Y N NA				
Do workers know how to respond to an emergency?	Y N NA				
Parking area and outside the home					
Are there clear sight lines into and out of the building?	Y N NA				

Appendix 3: Example work risk assessment – long term or aged care

Long-term or aged care work risk assessment

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Nursing station					
Are there physical barriers to prevent public access?	Y N NA				
Does the layout prevent entrapment?	Y N NA				
Can staff call for help from this location?	Y N NA				
Do sightlines allow good visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Medication storage					
Are there access control measures in place for medication storage?	Y N NA				
Reception or administrative areas					
Are there physical barriers to prevent public access?	Y N NA				
Can staff call for help from this location?	Y N NA				
Resident rooms					
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Are exits blocked by furniture or other items?	Y N NA				
Do patient/client rooms lock?	Y N NA				
If so, can the locks be easily unlocked by workers?	Y N NA				
Is lighting adequate?	Y N NA				
Does the area outside the room allow for safe entry and exit?	Y N NA				
Is there a communication device in the room?	Y N NA				
Does the layout prevent entrapment?	Y N NA				
Hallways, stairways, and bathrooms					
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Is the area free of clutter that could restrict the ability to leave?	Y N NA				

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Signage inside the building					
Is there appropriate signage for the public to know their location and where to go?	Y N NA				
Is there clear signage in common areas about expectations of behaviour from both residents and visitors?	Y N NA				
Emergency communication					
Can workers notify others in the event of an emergency?	Y N NA				
Is PPE regularly maintained?	Y N NA				
Is the alarm system tested regularly?	Y N NA				
Do staff know how to use the alarm system?	Y N NA				
Is there an emergency plan in case of the alarm being activated?	Y N NA				
Are staff trained on the emergency plan?	Y N NA				
Is CCTV available?	Y N NA				
Is CCTV maintained, working, and monitored?	Y N NA				
Lighting					
Is there sufficient lighting to illuminate each work area?	Y N NA				
Working alone or in isolation					
Has a lone worker risk assessment been completed and control measures established?	Y N NA				
Are workers familiar with the assessment and risk management plans?	Y N NA				
Do workers follow the lone worker plan?	Y N NA				
Threats of violent behaviour incidents					
Are there procedures in the case of weapons being discovered?	Y N NA				
Access					
Are there secure staff-only areas?	Y N NA				
Can emergency workers access all areas?	Y N NA				

Assessing and communicating the risk					
Is the patient/client assessment completed before working with them?	Y N NA				
Are patient/client assessments conducted consistently?	Y N NA				

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Is the patient/client assessment revised regularly and in cases of behaviour change?	Y N NA				
Is the patient/client potential for violent behaviour communicated to all workers?	Y N NA				
Is the patient/client assessment communicated to any other departments and agencies in the case of transfer of care?	Y N NA				
Care planning and documentation					
Are all relevant agencies involved in planning?	Y N NA				
Are frontline workers included in care planning?	Y N NA				
Do workers have access to the care plan before care starts?	Y N NA				
Are workers updated regularly and as needed?	Y N NA				
Have workers been trained on risk assessments?	Y N NA				
Do workers know what information they need to work safely?	Y N NA				
Incidents and emergency response					
Are there procedures for emergency response?	Y N NA				
Do workers know how to respond to an emergency?	Y N NA				
Are there emergency numbers on or near telephones?	Y N NA				
Parking area and outside the building					
Are there clear sight lines into and out of the building?	Y N NA				

Appendix 4: Example work risk assessment – non-clinical areas

Non-clinical and administrative work risk assessment

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Reception and administrative area security					
Are there physical barriers to prevent public access?	Y N NA				
Can staff call for help from this location?	Y N NA				
Do sightlines allow good visual scan of the area?	Y N NA				
Can workers easily access a more secure area when necessary?	Y N NA				
Hallways, stairways, and bathrooms					
Do sightlines allow a visual scan of the area?	Y N NA				
Is the area free of objects that could be used as weapons?	Y N NA				
Is the area free of clutter that could restrict the ability to leave?	Y N NA				
Signage inside the building					
Is there appropriate signage for the public to know their location and where to go?	Y N NA				
Is there clear signage in common areas about expectations of behaviour from both residents and visitors?	Y N NA				
Are "staff only" areas clearly marked?	Y N NA				
Emergency communication					
Can workers notify others in the event of an emergency?	Y N NA				
Is PPE regularly maintained?	Y N NA				
Is the alarm system tested regularly?	Y N NA				
Do staff know how to use the alarm system?	Y N NA				
Is there an emergency plan in case of the alarm being activated?	Y N NA				
Is the emergency plan regularly reviewed to ensure effectiveness?	Y N NA				
Are staff trained on the emergency plan?	Y N NA				
Is CCTV available?	Y N NA				
Is CCTV maintained, working, and monitored?	Y N NA				

	YES/NO/ NOT APPLICABLE	OBSERVATIONS AND CONTROL MEASURES	PRIORITY	ACTION ITEMS	INTENDED OUTCOMES
Lighting					
Is there sufficient lighting to illuminate each work area?	Y N NA				
Working alone or in isolation					
Has a lone worker risk assessment been completed and control measures established?	Y N NA				
Are workers familiar with the assessment and risk management plans?	Y N NA				
Do workers follow the lone worker plan?	Y N NA				
Threats of violent behaviour incidents					
Are there procedures in the case of weapons being discovered?	Y N NA				
Access					
Are there secure staff-only areas?	Y N NA				
Can emergency workers access all areas?	Y N NA				
Incidents and emergency response					
Are there procedures for emergency response?	Y N NA				
Do workers know how to respond to an emergency?	Y N NA				
Are there emergency numbers on or near telephones?	Y N NA				
Parking area and outside the building					
Are there clear sight lines into and out of the building?	Y N NA				

Appendix 5:

Example client assessment

This form is to be completed by clinical healthcare worker or manager/supervisor and reviewed regularly and in the case of changed behaviour.

Patient's name:	Date: DD / MM / YEAR
Identification number:	Initial assessment Reassessment

1. Risk indicators

Read the list of behaviours below and identify behaviours that will require specific care interventions. A score of 1 is applied for past occurrence of any of the History of Violence behaviours; and additional scores of 1 are applied for each observed behaviour. Add the scores – **the maximum is 12**.

History of violence

SCORE 1 FOR ANY KNOWN OCCURRENCE	SCORE
Exercising physical force, in any setting, towards any person including a caregiver that caused or could have caused injury	
Attempting to exercise physical force, in any setting, towards any person including a caregiver that could cause injury	
Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury	

Observed behaviours

SCORE 1 FOR EACH OBSERVED BEHAVIOUR CATEGORIES	SCORE
Confused (disoriented, for example, unaware of time, place, or person)	
Irritable (easily annoyed or angered; unable to tolerate the presence of others; unwilling to follow instructions)	
Boisterous (overtly loud or noisy, for example, slamming doors, shouting etc)	
Verbal threats (raises voice in an intimidating or threatening way; shouts angrily, insulting others or swearing; makes aggressive sounds)	
Physical threats (raises arms/legs in an aggressive or agitated way; makes a fist; takes an aggressive stance; moves/lunges forcefully towards others)	
Attacking objects (throws objects; bangs or breaks windows; kicks object; smashes furniture)	
Agitated/impulsive (unable to remain composed; quick to overreact to real and imagined disappointments; troubled, nervous, restless or upset; spontaneous, hasty, or emotional)	
Paranoid/suspicious (unreasonably or obsessively anxious; overly suspicious or mistrustful, for example, belief of being spied on or someone conspiring to hurt them)	
Substance intoxication/withdrawal (Intoxicated or in withdrawal from alcohol or drugs)	
Socially inappropriate/disruptive behaviour (makes disruptive noises; screams; engages in self-abusive acts, sexual behaviour or inappropriate behaviour, for example, hoarding, smearing faeces/food, etc)	
Body language (torso shield – arms/objects acting as a barrier; puffed up chest – territorial dominance; deep breathing/panting; arm dominance – arms spread, behind head, on hips; eyes – pupil dilation/constriction, rapid blinking, gazing; lips – compression, sneering, blushing/blanching)	
TOTAL SCORE	

Patient's risk rating: Low (0) Moderate (1–3) High (4–5) Very high (6+)

Completed by:	Date: DD / MM / YEAR

2. Overall risk rating

Apply the total behaviour score to the Risk Rating Scale to determine whether the patient's risk level is low, moderate, high or very high. Each level provides cues for further action to consider. If moderate or high/very high risk is determined, complete Section 3 to identify factors that may trigger or escalate violent, aggressive, or responsive behaviour and ensure the care plan includes measures to avoid or reduce risk behaviours identified.

OVERALL SCORE	ACTIONS TO TAKE
Low Score of 0	◯ Continue to monitor and remain alert for any potential increase in risk ◯ Communicate any change in behaviours, that may put others at risk to the unit manager/supervisor ◯ Ensure communication devices/processes are in place (for example, phone, personal safety alarm, check-in protocol and/or global positioning tracking system)
Moderate Score of 1–3	◯ Apply flag alert ◯ Promptly notify manager/supervisor so they can inform relevant staff and coordinate appropriate patient placement, unit staffing, and workflow ◯ Alert security and request assistance as needed. Ensure to inform security of risk management plan ◯ Scan environment for potential risks and remove if possible ◯ Ensure Section 3 is completed and initiate the violence prevention care planning process– care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers ◯ Use effective therapeutic communication (for example, maintain a calm, reassuring demeanour, remain non-judgmental and empathetic, and provide person-centred care) ◯ Be prepared to apply behaviour management and self-protection teachings according to organizational policy/procedures that are appropriate for the situation – training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe MORB training, self-defence ◯ Ensure communication devices/processes are in place (for example, phone, personal safety alarm, check-in protocol and/or global positioning tracking system) ◯ Communicate any change in behaviours, that may put others at risk to the unit manager/supervisor ◯ Inform client of vat results, when safe to do so other ◯ Other:
High Score of 4–5 or **Very high** Score of 6+	◯ Apply flag alert ◯ Promptly notify manager/supervisor so they can ensure relevant staff are on high alert and prepared to respond ◯ Alert security and request security assistance as needed. Ensure to inform security of risk management plan ◯ Scan environment for potential risks and remove if possible ◯ Ensure section c is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers ◯ Use effective therapeutic communication (for example, maintain a calm, reassuring demeanour, remain non-judgmental and empathetic, and provide person-centred care ◯ Be prepared to apply behaviour management and self-protection teaching appropriate for the situation in accordance to organizational policy/procedures – training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe, MORB training, self-defence ◯ Initiate applicable referrals ◯ Ensure communication devices/processes are in place (for example, phone, personal safety alarm, check-in protocol and/or global positioning tracking system) ◯ Communicate any change in behaviours, that may put others at risk, to the unit manager/supervisor so they can coordinate appropriate patient placement, unit staffing, and workflow ◯ Call 111/initiate code white response as necessary ◯ Inform client of vat results, when safe to do so ◯ Other:

3. Contributing factors

Physical, psychological, environmental, and activity triggers can lead to or escalate violent, aggressive or responsive behaviours. Documenting known triggers and behaviours and asking your patient/client to help identify them can help you manage them more effectively and safely. Use the information collected to develop an individualized violence prevention care plan and a safety plan to protect workers at risk.

<table>
<tr><th>QUESTION FOR CLIENT</th><th colspan="4">CONSIDERATIONS (select any that apply)</th></tr>
<tr><td>To help us provide the best care possible, please describe if there is anything during your stay that could cause you to become agitated, upset or angry (for example, I am agitated when...)</td><td>Physical
Hunger
Pain
Infection
New medication
Other:</td><td>Psychological
Fear
Uncertainty
Feeling neglected
Loss of control
Being told to calm down
Being lectured
Other:</td><td>Environment
Noise
Lighting
Temperature
Scents
Privacy
Time of day
Days of the week
Visitors
Small spaces/ overcrowding
Other:</td><td>Activity
Bathing
Medication
Past experiences
Toileting
Changes in routine
Resistance to care
Other:</td></tr>
<tr><td>What works to prevent or reduce the behaviour(s) (for example, when I am agitated, it helps if I...)</td><td>Go for a walk
Listen to music
Watch TV
Draw
Read
Have space and time alone
Talk 1:1 with:
Participate in activities
Consult a family member or friend</td><td colspan="3">Potential de-escalation techniques
Identify potential de-escalation strategies using above information such as respect personal space, actively listen, offer choices, give eye contact, use humour.</td></tr>
</table>

Notes

Disclaimer

This publication provides general guidance. It is not possible for WorkSafe to address every situation that could occur in every workplace. This means that you will need to think about this guidance and how to apply it to your particular circumstances.

WorkSafe regularly reviews and revises guidance to ensure that it is up-to-date. If you are reading a printed copy of this guidance, please check worksafe.govt.nz to confirm that your copy is the current version.

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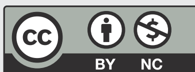

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