Prevention of Workplace Aggression Procedure

Effective: 30 August 2018

1. Background

Goldfields Mental Health Service (GMHS) is committed to the prevention and management of violence and aggression in the workplace and the provision of a safe and therapeutic environment for patients, carers, personal support person/s, advocates, staff and visitors. It promotes a consistent and positive approach to the management and reduction of violent and aggressive incidents in the workplace.

In the course of everyday interactions with patients and visitors, staff may have to deal with incidents of aggression, intimidation and or threatening or violent behaviour.

The Prevention of Workplace Aggression Policy (2004) provides information about legal frameworks, management, pre- and post-intervention strategies and reporting of workplace aggression.

Staff must report serious assaults on patients to the Office of Chief Psychiatrist in accordance with Mental Health Act 2014 Section 526 and the Department of Health Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

Clinical incidents of aggressive behaviour by any person resulting in patient and or staff harm, or identified as potentially high risk must be reported to the Regional Manager Mental Health (RMMH).

Staff, as Public Officers have the right to report aggressive incidents or assault towards themselves to the police. Staff are to advise the RMMH of their intention to report an aggressive incident or assault to the police. Team Leaders / Clinical Nurse Manager (CNM) are to provide support to staff members who decide to do so.

Note: There are provisions under the *Criminal Code Act Compilation Act 1913* related to assault on public officers.

Bullying in the workplace is outside the scope of this policy. For further information refer to the Department of Health Workplace Aggression and Violence Policy, MP 0043/16 Reporting of Criminal Conduct and Professional Misconduct Policy and OD 0437/13 Preventing and Responding to Workplace Bullying Policy.

2. Procedure

2.1 Assessment of risk

Aggressive or violent incidents may occur due to the interplay of a number of factors such as the environment, staff attitudes, perceived consumer expectations, service design, wait times etc. Staff are to be sensitive to the causes in order to minimise the risk of situations escalating to aggression and violence.

Where possible, staff are to assess the risk of potential incidents by patients prior to providing an assessment or intervention. Refer to the Department of Health Clinical Risk Assessment and Management In Western Australian Mental Health Services - Policy and Standards, 2008.

The assessment of risk may include:

- review of PSOLIS or patient records for alerts regarding a history of aggression
- gathering information from other sources e.g. family, referrer, hospital, police, where appropriate
- utilisation of the clinical interview and of standardised assessment tools Brief Risk Assessment available in PSOLIS, SMHMR905 Mental Health Risk Assessment and Management Plan and or MR46 WACHS Suicide Risk Assessment Form
- review of the context of service delivery e.g. off-site visit; secure area. Refer to the Working Alone - Community Visiting - Goldfields Mental Health Service.

2.2 Prevention of aggression/violence whilst conducting an assessment/ intervention

Clinical Risk Assessments, which include an aggression risk assessment, must be implemented, recorded in the medical record and, where a need is indicated, evaluated on a regular and ongoing basis to ensure effective control measures are in place.
Patients are required to have a clinical risk assessment as part of their initial assessment, where deemed relevant. This is to be recorded SMHMR905 Mental Health Risk Assessment and Management Plan or PSOLIS Brief Risk Assessment and reviewed on a regular basis.

Staff are to consider a range of actions to minimise risk of harm from aggression while conducting an assessment. These may include:

- conducting the assessment or intervention in a dual egress room
- conducting the assessment at the emergency department
- positioning of staff, furniture and the patient in the room that offers protection and affords safe and quick egress
- timing the appointment to coincide with the availability of other staff
- conducting assessment with a co-worker present
- involvement of Aboriginal Mental Health Workers to support cultural security for Aboriginal patients.
- leaving the interview room door ajar to allow quick exit if required
- ensuring duress systems and responses are available prior to seeing patient
- requesting police attendance during an interview
- requesting security presence in close proximity
- Determining whether it is safe to provide any clinical assessment or therapeutic intervention at that time.

2.3 Response to incidents of aggression / violence

2.3.1 De-escalation Strategies

Staff trained in de-escalation strategies are to respond appropriately to any person behaving in a manner that indicates the initial stages of aggression by implementing de-escalation strategies.
Staff are to use their skills in an attempt to prevent escalation of a situation. Where possible also alerting senior staff member.
Care and treatment plans are to include and identify known triggers for aggression and de-escalation strategies to reduce and control each patient's distress. Known triggers are to be recorded in PSOLIS or webPAS and recorded on the GFMR00A Medical / Micro / Risk Alert Notification Alert Form with the form placed in the front of the medical record.(Both hospital and community)
Staff are to are to seek assistance immediately it is deemed that the de-escalation strategies have been either partially or totally unsuccessful.

2.3.2 Responding to Aggression / Violence

If de-escalation strategies have failed to contain the situation, the person is behaving in an aggressive or violent manner, and there is a high risk to safety of staff, carer, personal support person/s and/or advocate, staff are to call for assistance / press the duress alarm and personal alarm. The site's Code Black procedure is to be activated.

Staff may take immediate action to control the aggressive person provided that it is safe to do so without injury to anyone. In the event that it is imperative that the person be controlled in spite of the risk of injury to other individuals, staff are to seek advice from the most senior clinician attending and security staff (if available)

Staff are to avoid putting themselves in danger.

Inform senior staff (Team Leader / Clinical Nurse Manager (CNM) about the situation and give details about how the incident is being managed.

3. Documentation

Where an incident of verbal abuse, threats towards another person and a "near miss" event takes place, it must be documented in the medical record.

A clinical incident involving a patient and/ or visitor must be documented in the patient's medical record and on PSOLIS. Clinical incidents must be reported using the DATIX system. Refer to the Department of Health OD 0611/15 Clinical Incident Management Policy.

All incidents involving aggressive behaviour that is being exhibited by a patient, client or visitor is to be documented in accordance with Prevention of Workplace Aggression Policy (2004). A WACHS Safety Risk Report Form (SRRF) is to be completed.

If a patient, client, visitor and or staff member sustains an injury, experiences verbal abuse, threats, near misses, it is to be reported to the CNM or Team Leader and they in turn are to report to the RMMH. This is to be documented and appropriate medical advice obtained.

4. Use of Restraints

Patients may be restrained by staff under Duty of Care, or under the provision of the MH Act in appropriate circumstances. Staff undertaking restraint must be suitably trained.

Refer to the WACHS Restraint and Seclusion Minimisation Clinical Practice Standard.

5. Defusing and Debriefing

A defusing/ informal debriefing session is to be offered where clinically appropriate, to staff immediately after the incident. Attendance at the session is to be on a voluntary basis.

All persons involved including the patient, other patients, staff and visitors who witnessed the incident are to be offered an informal debriefing / counselling session where appropriate.

The CNM/ Team Leader in consultation with the Regional Manager Mental Health is to organise a debriefing session following serious incidents or near misses which have caused distress.

Staff may also access the Employee Assistance Program.

Sentinel and Serious Event reported as per the Department of Health OD 0611/15 Clinical Incident Management Policy.

6. Incident Reporting

All clinical incidents within public hospitals/ health services are to be notified via the Clinical Incident Management System (via Clinical Incident Monitoring System (CIMS)). This includes all workplace aggression incidents (whether physical altercation is involved or not) resulting in any harm or 'near miss' to a patient.

Workplace aggression towards staff by patients or visitors are to be reported on a SRRF. An OSH Fact Sheet that identifies the key elements of the WACHS Hazard/ Incident Management Procedure is available on the WACHS OSH Communication intranet page.

CNM / Team Leader of clinical / non-clinical area is to ensure that incidents involving patients, clients or visitors are reported and investigated appropriately.

7. Definitions

Violence	Any incident or behaviour in which staff feel abused, are threatened or assaulted in circumstances arising out of, or in the course of their employment including but not limited to verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault.

8. Roles and Responsibilities

The Clinical Director and Regional Manager, Mental Health are to:

- oversee and ensure clinical governance within the Goldfields Mental Health Service (GMHS)
- assist staff in the resolution of any issues or problems that arise in the use of this procedure
- ensure that the principles and requirements of this procedure are applied, achieved and sustained
- develop systems to ensure all GMHS staff are provided with training and are made aware of their obligations and accompanying documentation relative to this procedure.

The Team Leader/ Clinical Nurse Manager (CNM) are to:

- ensure that all GMHS staff receive sufficient training, instruction, and supervision in the use of this procedure.
- monitor this document and ensure staff comply with its requirements.

All Staff are to:

- follow safe work procedures, attend mandatory training sessions when required, report to their supervisor any identified hazards associated with aggression/violence and take reasonable care to ensure their own safety and that of others in the workplace
- ensure they comply with all requirements of this procedure.
- promote a safe recovery oriented, a patient-centred culture within the GMHS.
- work within clinical practices, policies, operational directives, guidelines and the Australian Law to ensure a safe, equitable and positive environment for all.

Employers and employees have responsibilities under the Occupational Safety and Health Regulations1996 to maintain a safe work environment.

9. Compliance

This procedure is a mandatory requirement under the *Mental Health Act 2014*. Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

10. Evaluation

All processes and practices of this procedure are to be monitored, evaluated, and developed as part of an overall quality improvement process at least every three years or as necessary should any changes to legislation or an incident occur where the procedure has not been satisfactory.

11. Standards

National Safety and Quality Healthcare Standards (First edition 2012) - 1.14.1, 1.14.2, 1.14.3, 1.14.4

National Safety and Quality Healthcare Standards (Second edition 2017) - 5.33, 5.34,a, 5.34b, 5.34c, 6.4c, 6.11

EQuIPNational Standards (11-15) – 15.12.1, 15.13.1, 15.23.1

National Standards for Mental Health Services - 2.1, 2.6, 2.10, 2.13, 6.5, 8.7

12. Legislation

Mental Health Act 2014
Occupational Health and Safety Act 1984

13. References

Criminal Code Act Compilation Act 1913
Occupational Safety and Health Regulations1996

14. Related Forms

SMHMR905 Mental Health Risk Assessment and Management Plan

MR46 WACHS Suicide Risk Assessment Form

GFMR00A Medical / Micro / Risk Alert Notification Alert Form

WACHS Safety Risk Report Form

15. Related Policy Documents

Working Alone - Community Visiting - Goldfields Mental Health Service

WACHS Hazard / Incident Management Procedure

WACHS Restraint and Seclusion Minimisation Clinical Practice Standard

16. Related WA Health System Policies

Department of Health Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist
Department of Health Prevention of Workplace Aggression Policy (2004)
Department of Health MP 0043/16 Reporting of Criminal Conduct and Professional Misconduct Policy
Department of Health OD 0437/13 Preventing and Responding to Workplace Bullying Policy
Department of Health Clinical Risk Assessment and Management In Western Australian Mental Health Services - Policy and Standards, 2008
Department of Health OD 0611/15 Clinical Incident Management Policy

17. Policy Framework

Mental Health Policy Framework

This document can be made available in alternative formats on request for a person with a disability

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