Safe Work Australia

Workplace violence is not ok

Keeping our emergency departments safe

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[*Opening visual of slide with text saying ‘Safe Work Australia (logo)’, ‘Virtual Seminar Series’, 'Workplace violence is not ok, Keeping our emergency departments safe, Tiffany Plummer, Gerard Hayes, Petrice Wallis, seminars.swa.gov.au, # virtualWHS', image of employees in seminar listening to presenter*]

[The visuals during this webinar are of each speaker presenting from lectern on stage whilst other speakers are seated, with reference to the content of a PowerPoint presentation being played on a large background screen]

**Michael Borowick:**

Welcome everybody. I'm Michael Borowick, an Assistant Secretary of the Australian Council of Trade Unions and one of two union representatives on Safe Work Australia.

Today's discussion is on *Workplace violence is not ok – Keeping our emergency departments safe*.

Firstly I wish to acknowledge the traditional custodians on the land on which we meet, the Ngunnawal. I acknowledge and pay my respects to their continuing culture and the contribution they make to this city and to this region.

Each day our front line workers, our first responders in any emergency, our police, fire and ambulance officers and our health care workers face serious risks to their health and safety from occupational violence.

This is simply unacceptable and importantly it shows we are still collectively failing to meet the most basic work, health and safety right, that workers are not harmed as a result of doing their jobs.

The acute and accumulative emotional and physical toll on workers, their workmates and their families from occupational violence is huge. In part one of this series which we released in October last year we heard from our first responders as they shared with us their very personal stories of the impact of occupational violence on them.

Unfortunately these stories do not represent isolated incidents, but rather experienced daily across Australia.

Today we are going to focus on violence against health care workers. A recent study undertaken by Monash University found that two thirds of nurses, midwives and personal care attendants had experienced occupational violence in the previous 12 months alone.

It is estimated that one in five victims of occupational violence in health care report it.

This occurs for a range of reasons including the lack of co-worker management support, lack of management action and the common perception that violence is just a part of doing the job.

The idea that health care workers should think that being subject to abuse, aggression or physical assault was just part of the job is deeply disturbing and says much about how we are addressing or not addressing this important issue.

Importantly there is currently no systematic, comprehensive and user friendly reporting system for this information which I think is one of the many reasons that this issue is not getting the attention it deserves. I am sure we'll hear more about this today.

Occupational violence against first responders in health care, enforcement and emergency services is a growing problem as these individuals deal with people in extreme circumstances, people who are distressed, angry, confused or under the influence of alcohol or other drugs.

I acknowledge as do other Safe Work Australia Members that this is difficult and a complex topic, a truly wicked policy problem with huge financial and human costs. But we need a systematic approach to start tackling this problem and tackle it now, not wait.

Occupational violence does not respect state boundaries, political ideology, limited budgets and it does not operate neatly within occupational silos. Decisions made in the legal, justice and health domains will impact upon each other whether we like it or not. Policy decisions made at the national and state levels and most directly by organisations will play out to varying degrees in workplaces right across Australia. We all have a role to play and we need to work together. Governments, both federal and state, must consider how policies they make will impact on the ground.

Our work health and safety inspectors are very aware of the problem. In my own state of Victoria, WorkSafe Victoria is undertaking campaigns to increase awareness of this important issue and actively working with organisations to help them improve the prevention of occupational violence risks and management of the aftermath when unfortunately incidents do occur.

All work health and safety regulators will investigate and where appropriate prosecute if a serious incident occurs.

While investigations via work health and safety regulators can reveal important information about why and how the incident occurred that organisations can then act on, everyone here would agree that it is far preferable if organisations implement effective risk identification before the incident occurs and of course they should actively monitor if their risk control processes are really working.

Public and private health providers need to ensure they recognise and address the issues and wherever possible design it out, use the hierarchy of control, not rely on de-escalation training alone and ensure they systematically introduce effective prevention and management controls. Think innovatively about solutions and involve those who are most affected and who usually have great ideas about how problems can be fixed, the workers and their unions.

So today's discussion I hope begins national, state and of course organisational level discussions. I'm looking forward to hearing from our panellists and taking these insights back to discuss with other Safe Work Australia Members.

Without further ado I’m pleased to introduce our panellists.

Tiffany Plummer is a Registered Nurse at St Vincent's Hospital in Melbourne with 27 years' experience. She chairs the Aggression Prevention Management Committee and coordinates the Hospital's Aggression Prevention Program and takes part in investigation of serious incidents.

As a member of the Department of Health and Human Services Violence in Health Care and other important reference groups, she knows what's going on across her state.

Gerard Hayes has been deeply involved with the Health Services Union and the New South Wales health care system for over 30 years. Initially an Intensive Care Paramedic and now more recently a HSU Delegate and Secretary of the New South Wales branch of the HSU since 2012.

Since then he has presided over high profile campaigns that focus on the safety of workers in hospitals and in other health care settings. Gerard is passionate about working with health service workers to improve their safety in New South Wales hospitals.

Petrice Wallace brings a perspective from one of our work health and safety regulators. She delivers a range of prevention programs for WorkSafe Victoria. With a background in physiotherapy with extensive experience in delivering work health and safety strategies in both the private and public organisations, she knows from personal and professional experience how important this issue really is. I am sure that the Victorian lessons are equally applicable across Australia.

Finally but not last in any terms of importance of course, the man of the moment, our Facilitator Mr Nick Housego. Nick is a specialist facilitator for the Department of Agriculture and Water Resources. Passionate about facilitation, he is a Director Memberships and Chapters on the Global Board of the International Association of Facilitators. I think you'd agree we're very lucky to have him here today.

In 2013 he was designated a Certificate Professional Facilitator by the International Association of Facilitators.

Would you please join me in welcoming our panellists today?

(Applause)

Nick Housego:

Well thank you.

Tiffany, Gerard, Petrice, thanks for joining us today for the panel.

As Michael so articulately pitched it the workplace is becoming quite violent in the health area. You're in the front line Tiffany at St Vincent's. Would you mind giving us a little bit of an insight of what that front line is looking like today?

**Tiffany Plummer:**

Yeah, so we have certainly noticed over the last two or three years an increase in aggression incidences particularly occurring in our emergency department. We collate data that kind of over the last few years has certainly shown that increase and when we look at why there's an increase, it's complex and it's just not one reason, but there's things like we are seeing people with multi drug issues, whether that be methamphetamines, alcohol is still certainly a very big problem in our community.

Where St Vincent's is situated, we're sort of a city based hospital but sit just on the outer around an area called Fitzroy and we deal with a lot of homeless people. So a lot of the patients that may experience or show clinical aggression often have a whole range of homelessness, mental health, drug and alcohol issues going on. Also I think it's important to remember when these people come through emergency they get admitted and they go upstairs and so their aggression or clinical aggression continues, not just in ED but…

**Nick Housego:**

It doesn't stop at the front door.

**Tiffany Plummer:**

It doesn't stop at the front door.

**Nick Housego:**

Yeah, okay.

Gerard what are you seeing from a broader viewpoint? You've obviously got many members who are in the health workers area. You must be getting some interesting and quite surprising results coming in and feedback from your workers?

**Gerard Hayes:**

It's unfortunate that it's not quite surprising. It's quite predictable. Society has got a lot of pressures on it. So whether it's a drug and alcohol issue, there's ice issues and we can talk about that later on that has been put as a main cause. It's a growing cause, but the main cause clearly is still alcohol. We see that from the paramedic point of view when they do attend a scene, bringing patients in and we've got to remember at the end of the day these people are all patients so there's a bit of a difference to normal law enforcement, but from the security personnel, the clinical staff in the hospital this affects right through and the point was just made it's just no in the ED, it's right throughout the hospital.

**Nick Housego:**

ED?

**Gerard Hayes:**

ED, the Emergency Department.

**Nick Housego:**

I'm just going to have to pick us up on jargon because I know the industry lives in it and I want to make sure that our audience can understand what we're going, so Emergency Department.

**Gerard Hayes:**

I want to really make the point clearly that what we see exhibited in the Emergency Department through drug and alcohol presentations, through mental health presentations, we also see anxiety from family members. In New South Wales alone in the last 12 months the Prince of Wales Hospital Maternity Department had the riot squad turn up.

**Nick Housego:**

Had the riot squad?

**Gerard Hayes:**

The riot squad turn up and the same thing happened at Royal Prince Alfred Hospital in the Geriatric Department, the riot squad turns up.

Now drug and alcohol isn't the issue there. Family anxiety and other matters come into place. These are not areas that you should have to have law enforcement exercising their role when it is a health setting and people should be able to be managed in a health way.

**Nick Housego:**

Okay.

So Petrice from the Regulator's point of view and you're coming from the Victorian base, what's some of the information that you're seeing now coming across your table, giving an insight as to how you might regulate this industry? There are changes obviously?

**Petrice Wallis:**

Yeah. So the Victorian Government and WorkSafe and the Department of Health are all really focused on this issue now. We've had a couple of Auditor General reports occur over the last couple of years looking into health and safety and specifically occupational violence in health care.

So there's a real focus on it. There's a number of task forces and advisory groups and reference groups that have been set up to actually address the issue. But from WorkSafe's perspective and WorkSafe has actually set up a dedicated industry-focused team which is my team now called the Health Practice team to really focus on health care along with like our other major risks, so construction, earth resources, major hazards. So they've really decided that this is an industry that we really need to focus on from a risk perspective.

So the information that we are getting is from these reports but also we've done a number of research projects through our research partners and Michael alluded to some of that earlier. We also run – we have an inspectorate team that actually do 500 visits every year specifically focused on occupational violence. So we collate all that information and analyse that to see what's really happening in the workplaces.

So what we're seeing when we pull all that together, what we see are some common themes and that's lack of awareness and recognition and prioritisation of the issue at leadership level but also throughout.

**Nick Housego:**

So when you talk about leadership level, what level is that really? Is that board level or…

**Petrice Wallis:**

Board level, executive level and actually throughout because we know even the front line workers have that perception that it's part of the job. So that …

**Nick Housego:**

Wow.

**Petrice Wallis:**

…awareness or recognition that even clinical aggression is occupational violence and something that we need to address and is what we're seeing.

**Nick Housego:**

Okay.

**Petrice Wallis:**

So the other things we're seeing are obviously the under reporting. We're seeing a real reliance on low order controls, so just focusing maybe just specifically on training and not the design controls that we know can have a better effect. Our incident investigations when we're looking at those when we go out to our visits we're seeing a lot of pretty poor incident investigations which is obviously a real missed opportunity in terms of understanding the real causes of what's going on and preventing those causes.

The last thing I want to say is Tiffany talked about moving patients through the system and the other thing we're seeing a lot of which is the lack of transfer of information. So often we know known triggers or management strategies for dealing with – to help de-escalate or prevent issues and that information, we don't have good systems and processes in place for passing that information along the line. So if we had done that a lot of incidents could have been prevented or managed to a lesser degree.

**Nick Housego:**

So it begs questions around policy, what government should be doing, those sorts of activities. But before we go into that because it's easy to get bogged down into the policy stuff I want to get a little bit more understanding of someone comes in to the hospital and they are suffering from let's say a mental health depression issue, who brings them in?

**Tiffany Plummer:**

Yep. So we have some really good partnerships with our local police and we do even training with them. So normally if say a patient's been brought in with the police they'll normally give our triage nurse a phone call and…

**Nick Housego:**

To warn them that's coming?

**Tiffany Plummer:**

To warn them that they're bringing in. They'll give us an ETA, an estimated time of arrival and then our triage nurse will then call what's called a Code Grey which is a code that we use to deal with clinical aggression of a patient.

The team arrives and we will escort that person under a Code Grey from the police.

**Nick Housego:**

So when they get the Code Grey does this mean staff respond in a special way?

**Tiffany Plummer:**

Staff respond in a special way. We have a team of six at St Vincent's but that varies depending on personnel availability and resources. You know, smaller rural hospitals don't often have security.

**Nick Housego:**

Yes. We'll go to the rurals.

**Tiffany Plummer:**

So our team will arrive. We will bring the person in to what we call a BAR room which is a Behavioural Assessment Room and basically it works like a resuscitation room of their behaviour. We decide you know, through consultation and discussion with the patient with the handover from the police what the right way to treat this patient is.

We do it really with as much respect and dignity that we can. This is a person who's normally under acute distress and it may be if we're dealing with a behaviour that is unsafe, it may mean that that means that we give a chemical restraint of some sort which decreases the risk of harm to them.

Then once that's given they're moved into the main department where they're really closely monitored, normally one to one.

**Nick Housego:**

So what happens there with the police? What's that interchange? How does that happen?

**Tiffany Plummer:**

Yep. So the police give us a handover and really once they've given a handover the patient belongs to us. They become part of St Vincent's. So we normally get the handover. If the patient is maybe handcuffed we will have the handcuffs removed. We may need to still use a physical or mechanical restraint while we're putting an IV in to give a chemical restraint or we may even just do an intramuscular restraint, the chemical restraint.

But it's really at that moment you're looking about safety. It's about risk and it's safety to them and it's safety to others. Others is other people in our department, so other patients and other families. It's also about making sure that their distress isn't prolonged.

**Nick Housego:**

Okay.

**Tiffany Plummer:**

You know, someone really aggressive is under a lot of duress.

**Nick Housego:**

Yeah. So Gerard, your workers in your area would be seeing this on a fairly regular basis. What are some of the concerns? What are some of the risks that you see particularly from a government point of view where they need to be looking at 'What are the investment processes?', 'What are the things we should be doing?', not to ignore it, not to let it stay as usual, but to actually take it and try and really control it so that we can lessen the impact, lessen the risks on workers?

**Gerard Hayes:**

I think the point's just been made if a policy is followed and there are good policies out there, treatment and the care of a patient is generally well done. Unfortunately it's not resourced, it's not seen as a priority generally. So what is in the policy isn't necessarily what's going to occur. That occurs in sort of large metropolitan hospitals and also to a larger degree in regional hospitals. So people are doing what they can with what they have and clearly what they have is not enough.

We've just been through 12 months' worth of consultation following the shooting at Nepean Hospital where a Police Officer and a Security Officer were shot.

**Nick Housego:**

Could you just elaborate a little bit on that?

**Gerard Hayes:**

Twelve months ago in January…

**Nick Housego:**

What was the trigger?

**Gerard Hayes:**

The trigger was it was an ice related patient and not without getting into the particulars of the matter, it became a very volatile situation very quickly. People reacted particularly well, both clinical support staff and others but the fact of the matter was there is very little proactive support and strategic investment in security. We look at security as part of a clinical function. It's not similar to security that you would see at an entertainment facility or something along those lines.

So the resourcing needs to be undertaken and here we are 12 months later, we haven't seen any dramatic increase in resourcing.

**Nick Housego:**

After that Nepean incident.

**Gerard Hayes:**

After that Nepean incident and Nepean's one. We've seen a nurse killed at Bloomfield Hospital in Orange in New South Wales, a patient was killed at Kempsey Hospital in regional New South Wales and recently a resident was killed in Morisset Hospital in New South Wales.

These are dramatic things, but let's say on a day to day basis what occurs, nursing staff are 12 to 15 times more likely to put in a claim through work related violence from a workers' comp point of view.

**Nick Housego:**

Wow.

**Gerard Hayes:**

Ambulance paramedics are 15 to 35 per cent more likely to put in a claim and that claim get accepted. Over the last six years approximately 3,700 workers' comp claims have been made by nurses and paramedics and been accepted which represents about…

**Nick Housego:**

That's in New South Wales?

**Gerard Hayes:**

Yes, in New South Wales and that represents about 7.2 per cent of the total claims. So it's a significant amount and it's growing.

So what we're saying to governments and regulators is that this is an important part of the clinical function in the hospital. If you get it right it's not a police function. The police should hand over and be able to move on but if it's not resourced we hope for the best.

Now recently in New South Wales we've been to the Industrial Relations Commission on a work health and safety matter because of this very issue that police come, the patient's handcuffs are taken off, one security officer is left to look after that patient, that security officer and nurse is…

**Nick Housego:**

So just take us through that security officer. We hear that term. Is that the people that are just walking around with their security badges on in general, like the people outside here out of this room today? Or are they trained security people in that space?

**Tiffany Plummer:**

I also work as an After Hours Coordinator. So I attend Code Greys as part of that role and we have in-house security personnel and a security team. They are absolutely integral to the functioning of our hospital.

**Nick Housego:**

But it begs the question, is there enough of them?

**Tiffany Plummer:**

No.

**Nick Housego:**

Right, okay.

**Tiffany Plummer:**

No, but they are an amazing resource but they are absolutely seen as a part of the clinical team in regards to particularly security in Code Grey.

**Nick Housego:**

So that's what we're referring to when we talk security?

**Tiffany Plummer**

Yeah

**Gerard Hayes:**

Yeah, very much so and one good thing that the New South Wales Government Ministry of Health have done as a result of the last 12 months is they've introduced a health security training program through TAFE so people when they come into the workforce are trained in terms of understanding health as opposed to maybe working as a bouncer and maybe working somewhere else.

It needs to be part as I said before, of that clinical function that is going to support clinicians to be able to look after a patient in the best possible way and understand what they're doing.

**Nick Housego:**

Okay.

Petrice in your space thinking through as a regulator there's a bit of carrot, there's a bit of stick. Okay. You've got to be able to enforce but also encourage people to do things. Are you doing proactive training working with boards at a level to teach hospitals how they might do things? How are you getting your message through to those who make decisions?

**Petrice Wallis:**

Yeah. So we're actually running a really innovative program at the moment which we're calling our Hospital Intervention Program where we're actually engaging with hospital boards to help them improve their safety leadership and culture from the top down. We know that obviously if you start from the top then that can filter down. That's the same with any kind of business thing. But that program's really interactive. We start with senior managers from WorkSafe going in and presenting to the board. Then our team go in and do some work with the health and safety teams in the hospitals mapping what their current state is and helping them come up with sort of actions to really address, focusing on culture and leadership. We're sort of half way through this program.

Then what we're doing is bringing all that information back to the board. So senior management from WorkSafe come back to the boards again with the health and safety team from the hospital around what they've found and what they sort of are suggesting to do. Then the end of this program is going to end with a forum where the hospitals will bring the board and the senior executives from the hospitals together in a forum for everyone to share what they're doing. So and I think that's really important because we're saying if everyone's trying to address it by themselves that's, you know, that's just everyone either reinventing the wheel or we're not learning from each other. So that forum, we're really looking forward to that forum about sharing and trying to really facilitate that across the organisations.

**Nick Housego:**

So as we're talking at the moment, we're talking about our own localities, but this is a national issue. It's an international issue. How do you see some of the things happening from a national point of view, and Gerard I'm looking at you first? How do we take things like I think there's a Code Black that's operating nationally on how we deal with things in hospitals at the Code Black level. In the Code Grey I understand that's not being displayed and not being run as a national standard, but could be. What are some of the things that you would like to see happen there at the national level?

**Gerard Hayes:**

Look, I think Petrice has just summed it up. I'd like to see peak bodies not continuing to reinvent the wheel and do very little about it and spend a lot of dollars to be able to attempt to resource that. We need to have a consistent strategy right across the board.

In terms of and I use the term sort of security. I'd like to use another term because I think there's a better term to use, I just can't think of what that is at the moment, but in the hospital setting whether it's in the ACT or whether it's in Victoria, Western Australia or New South Wales there are similar approaches in a different way. Consistency of approach is the answer right across the board and I think this is something that from a peak level we can start to filter through. I think this forum that Petrice mentioned is going to be very important along those lines.

**Nick Housego:**

Yes.

**Gerard Hayes:**

But the repetitive spending to get to the same answer makes absolutely no sense and I think as already said, there are some good policies in place but they're not resourced. If they are resourced and then there's an extension of those policies I think things will go very well in the future; and I think the important part is what we do in the next year or two years will have great effect and great benefit over the next 15 years which is going to be moving a lot quicker than what we're seeing at the moment.

**Nick Housego:**

Okay.

Tiffany are you concerned a little bit about the fact that you get staff from all over Australia come and work in the hospitals? How do you make sure that you've got those standards operational across? Now you're just working from one hospital. But you've also got rural and regional. What happens out there?

**Tiffany Plummer:**

Yeah I think rural and regional it's still a problem around under resourcing and you've got emergency, like satellite departments where there might only be one or two staff members.

**Nick Housego:**

You were saying six was it that…

**Tiffany Plummer:**

We actually have our Code Grey team is made up of six personnel, yeah. So if you've only got two working over a night…

**Nick Housego:**

So if someone comes in to the Ganmain Hospital in New South Wales and it's got a night nurse on and one or two staff…

**Tiffany Plummer:**

So they'll obviously have to use the police but maybe the police might be at a, you know, at a car accident or some sort of other accident. So then they might need to utilise their fire officers, but again they might not be. So you know…

**Nick Housego:**

It's a bit tough.

**Tiffany Plummer:**

Yeah.

**Nick Housego:**

Well.

**Tiffany Plummer:**

Yep.

**Nick Housego:**

Gerard is that something you can reflect on? We discussed briefly before we came in here that there was an issue at Wellington in New South Wales. Did you want to elaborate a little bit on that for the audience?

**Gerard Hayes:**

Absolutely. The issue is you can be reactive or proactive. We can look at places like Bathurst Hospital which have a huge bank of monitors, they can record everything that went on. But the fact of the matter is it's not going to prevent anything. It will be used later on in a litigious way. That doesn't resolve the problem and this is where investing in monitors is good but you've got to have someone who is actually going to be able to intervene prior to issues occurring.

When we do look at places like Wellington who do have issues in relation to alcohol, ice as many country towns do, a police officer or officers may be out of town and 2- 400 kilometres away sometimes doing work. Can't get there in a reasonable time, so what are we going to do?

The answer in New South Wales at the moment is we'll have potentially cleaners who will act as security people. One, they probably don't want to. Two, they're in a situation where they will respond once the issue has occurred. We need to prevent that issue occurring and that can only be done by adequately resourcing and treating this issue as a serious issue.

The other thing too is education within the health system is really important. I think if you went through all the clinicians, all the allied health professionals and a range of other people and said 'What is the role of the security officer?' and you'd probably get 100 different answers but all thinking they have powers to restrain people, detain people, potentially search people. Those things don't exist and we need to give people the understanding of being part of a clinical team is very important. These are the powers and abilities that these people have to assist that clinical team and then we can move forward together.

**Nick Housego:**

Petrice, the rural and regional areas, how are they coming onto your focus from a point of view of just you've got to put down state wide standards and…

**Petrice Wallis:**

Yeah. So we have regional offices. So our inspectors, so all of our programs we do regionally as well as in the metropolitan areas and part of the program I was talking about before the leadership program we actually have a number of regional hospitals that are participating in that program.

So we're doing presentations. So we'll be going out and doing some presentations for example to aged care forums. We will be going to three regional areas as part of that as well and we even go and work in the regional areas as well from that.

**Nick Housego:**

So are we seeing workplace violence happening in the aged care system as well?

**Petrice Wallis:**

Yep, absolutely and a lot to do with dementia patients. So we're actually also working really closely with Alzheimer's Australia as well to try and…

**Nick Housego:**

Okay.

**Petrice Wallis:**

…because they have some great resources particularly around design things. Felicity in my team the other day was telling me about one of the design things that one place had put in place, when you've got a patient with dementia who just wants to go and catch the bus and leave. So they get really – you can imagine, if you need to catch the bus to get home to look after your child and you're being stopped the whole time, so they built a bus stop in their court yard so that person can sit at the bus stop for three hours a day. Or other good examples are you have walk ways that they can just keep walking in but they stay within the building so it keeps – so there's a lot of design stuff that Alzheimer's Australia give guidance on which is really great at actually helping prevent aggression in that space.

**Nick Housego:**

Now Tiffany you were keen to contribute to that?

**Tiffany Plummer:**

Just when we look at our data on you know, reported physical assaults on staff, there's a large percentage of them happens in our subacute or our aged care facilities. There tend to be the lower level injuries like musculoskeletal or scratches, but they often happen around you know hygiene, movement when a new person comes into a facility but aged care and occupational violence is very closely linked.

**Nick Housego:**

Okay. So is reporting the issue? The fact that I think there's only one in five incidents that are reported?

**Tiffany Plummer:**

Yes.

**Nick Housego:**

So getting that sense. I'll go to Gerard. On your people giving you that information surely we seem to be well and truly under reporting? Is one in five even too small?

**Gerard Hayes:**

Under reporting is one thing. Reporting that just doesn't have an end to it is the most important issue. In New South Wales one of the good things that's come out of this security round table is the fact that senior management and government officials all agree that the current reporting system just does not work.

It's convoluted, it's not getting back to people and addressing the concern, let alone getting to a point of working a way to prevent it happening again. So a lot of people get to the point of 'Why would I waste my time going through this exercise that may take me half an hour, and A) it will go nowhere, I won't get a response and certainly there'll be no change of practice?' So this is something that is vitally important. To get change you must be able to deal with the relevant information and again it goes to a resourcing issue.

**Nick Housego:**

Yeah, okay.

So looking at that, stepping ourselves a little bit into the future, what do you think is going to be happening that are going to be some of those key changes that you'd like to see happen?

Now Tiffany you're at the coal face, I'm going to go to you first.

**Tiffany Plummer:**

So I would like to see a better way of integrating some of our systems so that our alert systems are across organisations and even health organisations.

**Nick Housego:**

Give us an example.

**Tiffany Plummer:**

So an example might be a patient that comes to say, St Vincent's and we know this patient. We've got an alert system on their file around their violent history and it doesn't mean that every time they come in they're going to be violent. But it means that there is a history that gives the clinical staff some awareness, that they might need to look after their environment or what are the triggers for that, and hopefully they'll go and read some more information about it. But what about if that person presents you know to another hospital or to a rural area? How do they find out about that information? So there's no linkage of sharing…

**Nick Housego:**

Sharing of that…

**Tiffany Plummer:**

Yep and I think my other thing would be to have Code Grey made a national standard. I don't think Code Black is enough.

**Nick Housego:**

Could you explain Code Grey a little bit more in detail?

**Tiffany Plummer:**

So Code Grey is kind of that step beforehand. Code Black is a national standard around unarmed and armed patient aggression or aggression in a hospital and it entails police presence. Code Grey is a step before that. It's the resource that a hospital provides to deal with patient aggression and that's where we have a Code Grey team.

**Nick Housego:**

So that's a relatively new code is it?

**Tiffany Plummer:**

Well St Vincent's has actually had it for about 26, 27 years.

**Nick Housego:**

Wow.

**Tiffany Plummer:**

So we've had it established in our hospital for a long time. But it actually became a standard in Victoria around about two years ago and we've seen you know, most hospitals now have Code Grey in some form or another.

**Nick Housego:**

Does New South Wales have this?

**Gerard Hayes:**

We have a similar system, yep.

**Nick Housego:**

Right, okay, but it's not known as a Code Grey. So we've got different versions.

**Gerard Hayes:**

Yep.

**Nick Housego:**

Okay.

**Tiffany Plummer:**

And I think just the fact that it's been standardised and there has been some issues implementing it and you would expect that. We've had it for a long time and we've certainly played around with it and changed the mix of the team over times. It's a kind of fluid process but I think just having a standard that all hospitals have to look at makes a big difference.

So if you've got nurses moving around from different organisations at least they know what the basis of a Code Grey is.

**Nick Housego:**

Yep, okay.

Gerard?

**Gerard Hayes:**

If you look at what the Bureau of Crime Statistics say over the past six years we've seen assaults on hospital premises increase by 5.8 per cent. Now what that in numbers terms means, on any given month it will be people assaulted between 25 and 61 per month. These are assaults that the police are involved with.

Now if that's 5.8 per cent over the last six years and you're asking about 2025, well we've got to kick that up to probably about 15-18 per cent of people who will go to a hospital seeking help, seeking assistance, workers try to give care and assistance to people and nearly 20 per cent of them will be assaulted. The injuries that will come from that will be significant.

So I think here's the warning bell now to say if we can do something nationally, collectively and strategically we can address this. It will not happen if health and safety of workers, clinicians, everybody else in the hospital setting is put at the end of the food chain though.

**Nick Housego:**

Yes.

**Gerard Hayes:**

We understand that the health system is under stress but it can only get worse and you will not attract and retain people to stay where they find it acceptable to come to work and go home injured or go to hospital as a patient.

**Nick Housego:**

You're not expecting that when you turn up to work.

**Gerard Hayes:**

No.

**Nick Housego:**

Petrice you've got that regulator stick, you've got the regulator carrot and you're looking to see how you can actually move the industry forward into better practice, safer spaces for the workforce, less incidents, how does that start looking in terms of programs of activities that you might want to be adopting going forward?

**Petrice Wallis:**

Well I think what we really want to see in the bigger picture is just a change in attitude and behaviours to the actual issue, so recognising that it's not part of the job, it’s not acceptable, even…

**Nick Housego:**

Who's attitude's got to change?

**Petrice Wallis:**

Everybody's. So employers, so the workplaces, the employees about you know, it's not part of your job to actually have to be exposed to this on a regular basis and the community that, you know some of the aggression that's actually happening is from patient family members and we understand that that's because there's frustration with the system and all of that sort of stuff, but somehow we've got to protect our front line health care workers by making it clear that it's not acceptable.

And I think … we're about to launch a really exciting community awareness campaign which is trying to look at all of those things and we're hoping I think that that campaign…

**Nick Housego:**

You're developing a campaign now?

**Petrice Wallis:**

Yes, in partnership – this is really exciting because this is the first time we've done this and we know WorkSafe branding. WorkSafe Victoria does really great awareness campaigns and it will include TV, radio, outdoor and all the things that go along with an awareness campaign, but we're doing it in partnership with Ambulance Victoria and the Department of Health. And so this is the first time we've done that and we're really hoping to get a really big impact on changing sort of attitudes and behaviour around occupational violence.

But also we then want to piggyback off that and say 'Right, now we've got awareness. Now all these programs we're putting in place, let's get action from…' You know, we're updating our guidance at the same time, we're doing some more research to understand things like linking patient safety with worker safety so then we can kind of raise the profile there. So that's kind of where we want to go and we'll still have the stick, we'll still have the enforcement bit but we still want to get really strategic and keep developing those partnerships and working together on it across the whole of government.

**Nick Housego:**

Okay.

Gerard if I could asking you about the international perspective. I know the unions just don't look locally, that you've got a good international network. What's happening in other countries?

**Gerard Hayes:**

It's a broad range of what's occurring. The same problems are occurring and what we're seeing locally, nationally is occurring internationally. I'm going back to Toronto very shortly in Canada to talk with people there in relation to their approach. At this point in time they've got the same systems that we have. You go to the American systems you have armed guards, you know, in the hospitals. That's not the answer.

Again it's a clinical setting and we need to be able to deal with this in a clinical way. The Canadians seem to be moving the same model as we are but I think we are living in a very fast world now. Information is very, very quick.

**Nick Housego:**

Very true.

**Gerard Hayes:**

Change happens incredibly fast. So we've now got to be not only able to adapt our legislation appropriately and nationally, not just sort of state wide. We've got to do it quickly.

We cannot keep sitting back saying 'It's acceptable for people to get injured and we will get around to it.' It's just the greatest sign of disrespect to people who are out there giving their all, caring for the community and I think that from a global perspective, I think everyone's talking the same terms, but certainly there's a whole different range. Australia's got the greatest opportunity in the world. We've got one of the best health systems in the world. We just need to focus on this aspect a lot more than we are at the moment.

**Nick Housego:**

And we're having lots of trouble attracting medical staff. We're always hearing stories about not enough nurses, not enough doctors, all this sort of stuff. I guess workplace violence would have some impact on people wanting to sign up and come in. So proactive programs that actually protect us against the workplace violence are key. Would you not?

**Tiffany Plummer:**

Absolutely. You know, it starts I think even in their education of our workforce. So you know, looking at what universities, how they're training and educating our sort of junior and student nurses. I think that needs to be looked at as well and then…

**Nick Housego:**

Is it in their training program?

**Tiffany Plummer:**

Not really.

**Nick Housego:**

Not really. It's sort of a de facto…

**Tiffany Plummer:**

Yeah so what we've noticed is that it's not and so we do work with our student nurses at each year level and then we do a lot of work and training with our graduate nurses. Yeah, and the push is really first and foremost about personal safety and I'm really fortunate to work with an organisation that is and it starts off with 'Safety is my responsibility.' You are actually your own first responder to every incident and even if you call a Code Grey, security might be two minutes away and a lot of harm can happen in two seconds, let alone two minutes.

So we really do a lot of work with staff realising and when you're working with staff who are absolutely you know there for the wellbeing of their patients and they have a lovely sort of duty of care, there's this balance that they have to find 'What's my duty of care and what's my risk to self?' and that's an issue and how do people work through that? That's not an easy - there's no black or white around it but it's making people aware about some of the decisions that they make when they actually you know, have that first confrontation or interaction with the person.

**Nick Housego:**

Yeah, that must be, the first one…

**Tiffany Plummer:**

I mean that's the basis. That's where it happens, the nitty gritty of it.

**Nick Housego:**

When you first experience it, that must leave lifelong impressions.

**Tiffany Plummer:**

Yeah and if you've got an elderly man who's aggressive but he's going to fall…

**Nick Housego:**

There you go.

**Tiffany Plummer:**

That's a dilemma.

**Nick Housego:**

Yeah.

**Tiffany Plummer:**

So do you let them fall and break their hip or do you protect yourself?

**Nick Housego:**

Could I go out to the audience now and find out if there are questions there because we've been talking fairly solidly for 40 minutes I believe. Questions? We've got a few.

So I'm going to pin the questions down, the first one here and the one at the back will be in the blue shirt. The microphone will come to you.

**Q&A Session**

Q: Thank you. That's been a really interesting discussion. Petrice you talked about some of the physical design of buildings in aged care facilities and I was wondering whether there's anything, any work's been done on the physical design of emergency departments and whatever in hospitals? Obviously that's not the only sort of solution, but can that be part of the solution?

**Tiffany Plummer:**

It was in our reception areas in our specialist clinics where we had some incidences of aggression and when we spoke to the staff they actually said they sit quite low and people come and often use their height and the fact that they're standing to intimidate.

So we did a redesign of the specialist clinics' reception areas and raised all the reception staff so that they actually look eye to eye when people come. That's a very simple environmental design but it makes everyone equal really quickly. You know, so just simple things like that can often have a big impact. Yeah.

**Petrice Wallis:**

Yeah. I think that there's a number of things we see when we're out and if you're just talking specifically about the emergency department and I think the St Vincent's Emergency Department has got a lot of design controls in place, but even things like separate accesses for when people do come in drug and alcohol affected and the BAR rooms that Tiffany was talking about.

But even things like limiting access to areas, having safety glass and we do have a really good example of one of the hospitals and I think a number of hospitals are doing this but a full redesign of their emergency department which included physical design but also systems and processes and patient flow.

And they took a really structured approach to redesigning the flow and moving people physically through the department, providing information about waiting times, providing information about what happens at each point in time, having footsteps on the floor and coloured curtains to say where they went, internal waiting rooms so people aren't sitting not knowing what's going on. So a full redesign including processes and information that had a significant impact on not only reduction in violence but also in their throughputs, in their patient satisfaction and their staff morale. I don't think they're the only ones doing that but there's definitely many design things that can happen and good examples of things that are actually happening already.

**Nick Housego:**

Okay. I'll go the gentleman at the back there and then you want a question sir? Righto, we'll get a microphone to this.

Q: Yes. My name's Peter Butler. I'm the Senior Manager of Protective Security for ACT Health and I'm also the Chairperson for the International Association of Health Care Safety and Security.

So I've done a lot of research through my organisation and based on overseas data and some of the Australian data around violence and aggression. One of the biggest issues I'm finding and that we're trying to combat as a senior manager is educating our clinical staff on that violence is not acceptable. We've had external consultants come in to do enterprise risk assessments and we've identified that violence and aggression is our number one risk for our organisation and yet our number two risk is the lack of under reporting by our clinical staff.

And when I get involved with the police and our clinical staff and to look at the levels of violence and aggression and the assaults against our clinical staff, the biggest thing we need to combat is they didn't really want to do it. They couldn't help it. They weren't feeling well.

How do we educate our clinical staff that violence and aggression is not acceptable in the workplace because until we can educate our staff firstly on actually reporting the violence and aggression and then actually trying to do something about it, we're trying to fight a losing battle.

**Gerard Hayes:**

Can I say that I think that's a really important point. It's violence and aggression in the health setting and I think clinicians need to understand it's still something that needs to be dealt with. And as we all know very little money will flow unless there's some significant data and statistics to support that. So reporting these sorts of incidents isn't trying to give the patient a hard time. It's about actually trying to build the system and identify where the shortcomings are. So, if these reports aren't occurring and they may be happening 20 per cent of the time but they're only sort of reported two per cent of the time, well clearly it's not a problem.

But this is where people get injured. The amount of nurses who get injured, the amount of allied health professionals and support workers in hospitals who get injured and the patient clearly doesn't know what they're doing, but it doesn't take away from that it was a violent situation, not necessarily a malicious situation but violent. And then if that is reported then that will help a lot to be able to be resourced appropriately as opposed to people continually getting injured.

**Tiffany Plummer:**

I was just going to say recently I present data to our different departments and recently we did some training with our ICU staff. I said 'Congratulations. Last year you didn't have one incident of verbal aggression in your ICU department' because there wasn't one report.

So when they look at the data and they go 'Oh' and I said 'So as far as I'm concerned you don't have a problem because there's no reporting of it.' So you know, it sort of just brought home to them, 'We have a big problem but no one knows about it.'

**Nick Housego:**

Okay.

Petrice, did you want to answer anything on that?

**Petrice Wallis:**

Only just that I think taking action when incidents are reported helps with that. Creating a culture within the organisation that encourages reporting and shows action is another way. And of course just increasing awareness across the board that it's not acceptable is really the way we can go.

**Nick Housego :**

The evidence that comes with reporting is good food for the mill for your folk to be able to build up a better understanding of the regulatory environment.

**Petrice Wallis:**

Absolutely. We use all the data that comes to us around understanding the issue and you know, and also then if you get the information around what's happening, the causes and then we can actually focus our attention and resources. If we've got limited resources let's focus it in the right way and we can only do that if we know where to focus it.

**Nick Housego:**

So there's a gentleman here.

*Q: Just simply how do these issues translate into the primary health care sector, AKA GP clinics, specialist clinics which physically are built in a different way and for which the staff and the clinicians may not have the same protections?*

**Tiffany Plummer:**

Yeah.

Look I think that's a big issue. I mean we have staff like our pathology staff who might be working within a GP clinic. So because they fit under our umbrella we provide them with some training and our OH&S Department will go out and look at their environment. But whether that happens with you know, individual or independent you know GP clinics I think at the moment it sort of sits with you know, those independent and what they're prepared to put in. Yep. Yeah. So yep, they're left I think.

**Gerard Hayes:**

I think this is a classic point that Petrice has made. In terms of under reporting I'm sitting here thinking that those clinics are probably pretty good. They've probably got a piano in the corner there or something along those lines and it's all very nice.

**Tiffany Plummer:**

Yeah.

**Gerard Hayes:**

But clearly when you think about it, yes these things would be occurring there. The frustrations and concerns particularly when you know, some people are struggling to be able to afford to see a doctor and those sorts of things as well. So those pressures and stressors would be there, but if I'm sitting here thinking that it's not a real issue, this is where I think pressure's got to be put on that people do report these things and we can start to address those as well.

**Nick Housego:**

Okay, and I …

**Petrice Wallis:**

Can I just say from a regulator perspective we expect that any workplace has actually looked and identified their risks and implemented appropriate controls and ongoing monitoring of that. So just because you're a small general practice doesn't mean that you're not obligated to do that and their risk might be totally different and they don't need a Code Grey response team but they do need to know that this might happen and 'What do we do in that situation if it does?' Or 'How can we prevent it?' Yep.

**Nick Housego:**

A question down here?

*Q: Yes, thanks. Petrice you mentioned the role of the community. I wonder if you could say more about how the community can be part of the solution? Whether - we have talked a lot about what workplaces can do and the interaction there, but obviously the impact of workplace violence goes beyond just the workers and goes into the community. So yeah, is it just being aware or is there more that the community can do?*

**Petrice Wallis:**

I think it's not just being aware. It's about having the attitude that it's not okay and that you know everyone I think has been in a situation where you're frustrated with something and you might feel like verbally attacking someone for something because of a system issue. But I think it's really important to understand that the people that you might be abusing are not the people that actually have created the issue. There's systemic issues that actually need to be dealt with that can change that. It really isn't okay to be attacking our people who are actually trying to care for people who are ill.

**Gerard Hayes:**

Can I just jump in there because I think that's a really important issue. I'll just raise this at the moment. Our union with others has supported the lock out laws in New South Wales. There's a whole heap of backlash on that. There's a whole heap of community debate on that.

For us we see a decrease in assaults of over 37-40 per cent of people, a decreased presentation in emergency departments by about 35 per cent. These are good outcomes but the community wants to push back.

So I think it's a debate we have to bring the community with us. It's a societal change that we're seeing and people have different points of view. We need to engage that but we can't have paramedics, nurses, doctors, clinicians being punching bags because people just don't get it. But we are absolutely obligated to educate people as to why and I say this from the time kids are in school, that social behaviour doesn't need to get out of control. Social behaviour in the next 25 years needs to be respectful and work with people at every level.

**Tiffany Plummer:**

Yeah. Well I was going to say St Vincent's Sydney was certainly very instrumental in helping bring about some of the discussions around the lock out laws. In Victoria we don't have lock out laws. I think even just from a clinician's point of view there is this, you know, idea occasionally that it is okay to have a go - and I think sometimes that's about choices, about what people make and who they think that they can speak to. You know, health care is predominantly female and I think that needs to be, you know, that’s…

**Nick Housego:**

Recognised?

**Tiffany Plummer:**

…something to be recognised, yep. So there's a whole you know, society sort of norm at play in a way. I think yeah, community has a big part to have a look at. It's kind of reflected at itself to sort of say 'Well, you know if I see a family member…', you know, '…maybe I do need to step in and say that it's not appropriate' and you know have a discussion or think a little bit about what you're going to be like under distress and how you're going to manage that and not everyone has the resources…

**Nick Housego:**

To do it.

**Tiffany Plummer:**

…or the education or the foresight but at least if we get the discussion happening you can start making people have some reflection.

**Nick Housego:**

So going back to Michael's opening comments, they were quite stridently around hoping to move us to more of a national focus around this.

Let's advance our thinking to 2025. Now I'll ask as closing comments to go, and give some thoughts as to what a successful system would look like by 2025? Now we're not talking a decade here. We're talking upwards of seven years, okay? What are some of the key things, key messages that we would like to sort of inform people in government, inform people who are doing the design of workspaces, informing the community about better respect and I'll start with you Tiffany?

**Tiffany Plummer:**

Well I would say that it's everybody's responsibility…

**Nick Housego:**

Okay.

**Tiffany Plummer:**

…you know that we need to make sure that everyone has a part to play in it. It doesn't just happen when you suddenly are involved in the health care system and then you see it and then you go 'Oh this is awful that this is happening.' You know, there needs to be broader recognition earlier on. As a community, as Australians, this is our responsibility.

**Nick Housego:**

What happens in your workspace right at the front door where the police are bringing them in?

**Tiffany Plummer:**

Yep, so I think really…

**Nick Housego:**

Is there a change in design? Do vehicles need to be redesigned?

**Tiffany Plummer:**

Yep, I just think good communication between the stakeholders. I think that's really important. So continuing to broaden those really good communications between all the relevant parties and get them on board about how things are done. I think that's something in Victoria we've seen that's been really, really helpful and that can only improve. There's a way to go.

**Nick Housego:**

Gerard?

**Gerard Hayes:**

I think it's all about from the top down, transparency. Decisions that are being made need to be made openly, clearly and are able to be explained and they're made on the back of information that has been supplied from thorough consultation with not only the community, but health workers right from whether it's the clinicians, the paramedics, the nurses, the food services people, the security officers, right the way through.

The most important thing and I continue to harp on this, you get nowhere unless you're prepared to invest. And we know and we hear all the time how much the health system costs but the health system will cost more if people cannot be cared for when they get within the system.

**Nick Housego:**

And less functional.

**Gerard Hayes:**

Absolutely less functional. We've mentioned things about attraction and retention. Injuries alone will put people out of the workforce. So there's a whole range of issues but they need to be and I think dealt with on a national basis consistent across the nation and so no matter which state you're working in we all understand how the rules apply.

**Nick Housego:**

Apply nationally.

Petrice?

**Petrice Wallis:**

And I agree with what both Gerard and Tiffany have said. I think we need to just keep working together across the government, across you know, borders. But I also think we need to integrate it more into just the normal. Like hospitals have a lot of performance management systems and commitments that they have to make. If we can integrate – and accreditation and things like that. If we can integrate this as part of the measurement and bring it up to that level that it becomes one of the other things like you know, meeting their budget targets…

**Nick Housego:**

Yes.

**Petrice Wallis:**

…then that's going to make a big difference because that then means that the top level of the organisations have to focus on it and then that creates systems approaches down below to make those happen.

**Nick Housego:**

So it's working in both directions from the top down and bottom up?

**Petrice Wallis:**

Yeah.

**Nick Housego:**

Ladies and gentlemen I think that brings us close to our time for today and I want to thank you for your participation, but could I ask you to thank the panel for their involvement.

(Applause)

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