



**ACT Health**

# Challenging Behaviour Guideline for ACT Health Services

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# Introduction

## Guideline statement

This guideline provides the framework for ACT Public Health Service staff for the prevention, management, and response of occupational violence (OV) strategies. These strategies aim to reduce episodes of OV and/or challenging behaviours demonstrated by patients/consumers, carers, and visitors within ACT public health services. This guideline supports a shared vision approach to minimising harm and cultivating a safer culture in the ACT public healthcare systems.

## Background

Under the *Work Health Safety Act 2011 (ACT)*, all reasonably practicable steps must be taken to protect staff through the elimination or minimisation of risks related to work practices. Work Health and Safety legislation is designed to ensure the health and safety of staff and others in the work environment, where health is defined as both physical health and psychological health.

In 2016, the Australian Nursing and Midwifery Federation (ANMF), ACT Branch, advocated for a broad reaching, in-depth review of workplace safety, including a review of OV, challenging occupational behaviours and workforce practices to improve the safety of Nurses and Midwives in the ACT. The ACT Government made a commitment to develop a safety strategy for nurses and midwives which resulted in the launch of the *Nurses and Midwives: Towards a Safer Culture (NM TASC) Strategy* in December 2018.

The Nurses and Midwives: Towards a Safer Culture – The First Step – Strategy provided the foundation for positive cultural change in ACT Public Health Services. The ACT Government has committed to The Nurses and Midwives: Towards a Safer Culture ‘The Next Steps’ Strategy to support the ACT Public Health Services to embed the safety strategies.

## Key objective

This guideline provides risk management guidance and strategies for health services to promote safe, healthy, and productive environments for all persons who enter ACT public health services. This includes Nurses, Midwives, other health workers, patients/consumers, their carers and visitors.

This document outlines the expectation that ACT Public Health Services are committed to the implementation and support of actions to prevent and/or safely respond to challenging behaviour.

## Scope

All Healthcare staff (including students and volunteers) in ACT Public Health Services including the ACT Health Directorate and Canberra Health Services.

The ACT Public Health Services will be responsible for monitoring and maintaining OV policy and procedures, and media campaigns to promote a shared vision approach to minimising harm and cultivating a safer culture in the ACT Public Health Service healthcare system.

All staff must adhere to the principles described in this guideline, and its relevant referenced resources. This guideline applies to, and places an obligation on organisations, all staff, patients/consumers, carers, visitors, and members of the public to:

- support a positive and safe healthcare environment,
- support a culture of safety and respect for all staff, patients/consumers, carers, and other persons during the provision of healthcare related services, and
- contribute and/or provide quality and consistent care, with positive outcomes during the provision of healthcare related services, and/or interaction with staff who provide the service.

Patients/consumers, carers, and visitors will take reasonable care to:

- ensure they respect all staff, other people, and property during access to ACT Public Healthcare Services and abide by the rules, and laws, and
- acknowledge that health services will act against all persons who knowingly or intentionally cause psychosocial harm to workers or people in the care of ACT Public Health Services.

Interactions or conflicts that do not involve a patient/consumer or carer and occur between two or more staff are not in scope. Violence between staff members is addressed in the ACT Government Respect, Equity and Diversity Framework (2010) and the Public Sector Management Act (1994).

## Definition

Psychosocial health refers to the physical, mental and social state of a person. A psychosocial hazard is anything that can cause physical or psychological harm. When psychosocial hazards are not effectively identified there can be an increased risk of psychological and physical harm (Safe Work Australia, 2024).

OV is a psychosocial hazard. It is defined as any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, or injured in the course of, or as a direct result of, their work, by someone other than another staff.

OV may include personal intimidation, verbal abuse, physical assault, sexual harassment, threatening behaviour, abuse through technology (text, emails, and phone calls), making vexatious complaints, and making derogatory, slanderous, or threatening statements to or about another person. Consequently, OV gives a staff reasonable cause to believe their health and safety is at risk.

Challenging behaviours are actions and/or behaviours that may psychosocially harm another person, self or property. Challenging behaviours and/or actions can be deliberate/intentional or unintentional and can take different forms, any of which can:

- potentially or stop, interrupt, or limit the ability for health service or care to be provided in a way that is safe for both patients/consumer and staff; and
- result in a person or people feeling unsafe or threatened or feeling that intervention, or retreat /withdrawal, is warranted to avoid, or limit, physical or psychosocial harm to someone, or property.

There are many terms used to refer to those accessing health-related services across the continuum of care. To maintain consistent language, we refer to individuals as “person”, “patient”, “consumer”, or, in some cases “carer” or “visitor”.

Table 1. Examples of challenging behaviour, verbal occupational violence, and physical occupational violence (ACTPS Managing Occupational Violence Policy, 2023).

Challenging behaviours	Verbal OV	Physical OV
Aggressive gestures	Swearing	Spitting
Eye rolling	Derogatory statements	Hitting
Sneering	Threats	Physical assault
Discrimination	Abuse through technology- emails/texts/phone calls	Sexual harassment
Racism		Sexual assault
		Damage of property

## Principles

Effective prevention, response and follow up of challenging behaviour must be integrated, comprehensive and territory wide. Below are the principles that support this guideline:

1. Staff, patients/consumers, carers, and visitors are entitled to be treated with equality and respect.
2. Health care must be delivered in a way that minimises the risk of psychosocial harm to health care staff, patients/consumers, carers, and visitors.
3. Staff are supported by an education strategy to prepare them with the knowledge and skills to effectively implement multi-component interventions that identify, prevent, and respond to challenging behaviour in the workplace.
4. Protocols for reporting, monitoring, and addressing challenging behaviour incidents are promoted and accessible to all staff, emphasising that staff who report incidences cannot be discriminated against.
5. Staff have the responsibility to report all incidents of OV with a staff incident report and report criminal offences to ACT Policing.
6. The ACT Public Health Service demonstrates a commitment to fostering a consistent proactive approach to managing challenging behaviours, with a focus on preventing, eliminating, and mitigating risk.
7. Staff and workplaces have a responsibility to design services, foster workplace culture and train staff to consider the pressure points for staff, patients/consumers, carers, and visitors to improve the experience of people using services.

## Person-Centred Care

The Australian Commission on Safety and Quality in Health Care (ACSQHC: 2023) National Safety Quality and Health Service (NSQHS) Standard 2 ‘Partnering with Consumers’, aims to ensure that all patients/consumers are at the forefront of the design, delivery, and evaluation of healthcare systems and services. The scope of this guideline will ensure all ACT Public Health Services are committed to maintaining the NSQHS standard (ACSQHC, 2023) by delivering healthcare services to all healthcare users using a person-centred approach, while also acknowledging the impact of trauma. A person-centred approach with trauma informed care principles will lead to a responsive healthcare service, improved safety, foster transparency and trust between staff, patients/consumers, carers, and visitors, and empower patients/consumers, carers, and visitors to share information and become active participants and decision makers.

All health services in scope for this guideline are committed to delivering person-centred care which can be defined as a way of thinking and doing things that sees health care users as equal partners in planning, delivering, and monitoring the improvement of safe, quality care that meets their needs. Person-centred care means putting people and with their consent, their Nominated Persons, their carer, and their families at the centre of decisions and seeing them as experts, working alongside health professionals to achieve the best outcomes (ACT Health Quality Strategy, 2018).

It is acknowledged that at times, despite the best efforts of staff to provide person centred care, other factors will contribute to the incidence of challenging behaviours when done knowingly and willingly.

Figure 1 below illustrates some examples of the negative emotions that can arise when health care is not delivered with a person-centred approach.

Calm, positive and engaged in care	↔	Anxious, negative, aggressive, disengaged
Respected	↔	Disrespected
Safe and secure	↔	Unsafe, threatened, abused
Informed, involved	↔	Ignored, excluded
Able to express opinion or complain. Listened to	↔	Unable to make choices, disempowered
Rapport with staff, feel able to ask question	↔	Isolated, lonely
Satisfied with treatment and services	↔	Dissatisfied

Figure 1 Negative emotions arising when person-centred care not delivered.

(SA Health, 2015. Policy Directive on Preventing and Responding to Challenging Behaviour, p. 16).

Patients/consumers, carers, visitors, and members of the public have expectations of how they should be treated when engaging with health care services. A perception that care is unsafe or not

meeting their specific needs can trigger an escalation that results in challenging behaviour. Triggers for anxiety, agitation or aggression include long waiting times, lack of privacy, lack of respect and information, fear, clinical conditions, intoxication, and withdrawal.

## Context in which challenging behaviour may occur.

### Staff, ethics, and respectful behaviour

All ACT Public Health Services are committed to providing work environments that are safe and supportive of all its staff and adopt positive ethics and a culture of respect. Prompt action must be taken by management to deal constructively with behaviours which are not considered respectful in health services.

### Patients/consumers and staff in the provision of care

Challenging behaviour may occur in any health service settings. Negative factors such as insufficient personnel and equipment, lack of information and communication breakdowns increase the risk of challenging behaviour in the health care setting (Mento et al, 2020). The level of risk in a particular setting, may come from the type of service provided, the manner in which it is provided (for example centre-based, in home, out of hours), the number of staff and the patients/consumers using the service. These determine the level of risk posed and the capability of the workforce and/or other persons.

### Patients/consumers and trauma

Trauma informed care recognises that most people have experienced trauma in their lives, and that trauma may be a factor for people in distress. The impact of trauma may be lifelong and can impact the person, their emotions, and their relationships. The complexity of trauma can result in increased responses that may appear 'out of proportion' (Blue Knot Foundation, 2023).

### Patients/consumers and health care design

The physical environment in health care settings can affect the incidence of challenging behaviour. Lack of natural light, comfortable furnishings and quiet spaces may lead to agitation and aggression. Overcrowding and confined spaces, and inaccessible staff can also increase the risk of challenging behaviour towards staff (MohammandGorji et al. 2021).

### Patients/consumers and characteristics

The frequency of challenging behaviour has been associated with psychiatric unwellness and altered cognitive states such as dementia and confusion. Pain and discomfort are also known contributing factors. Risk factors around patient/consumer presentation includes patients/consumers with substance abuse, patients/consumers with young children, and those presenting with suicidal or self-harming behaviours (Cabilan & Johnston, 2019).

# Guidance for the development of mechanisms for preventing and responding to challenging behaviour.

This guideline introduces a practical risk management approach to assist in the identification of hazards and risks (strategic and operational) associated with the prevention, recognition, response, and management of challenging behaviour. This approach uses an integrated staged model to assist in identifying preventative strategies and risk control measures, as defined below.

1. Prevention - Primary control measures.
2. Early Intervention - Secondary control measures.
3. During an incident - Tertiary control measures.
4. After an Incident - Post intervention and response.

Intervention or strategies to prevent and respond to challenging behaviour are guided by evidence and expert opinion across many diverse fields, such as work health and safety, organisational development professionals, psychiatry, psychology, security services and wards persons, emergency medicine, geriatrics, and customer service.

Some of these interventions involve proactively establishing:

- an optimal organisational safety culture including patient/consumer-centred care practices,
- a supportive and safe physical environment,
- development of expertise, role clarity, skill and knowledge amongst all staff, and
- a supportive and psychosocially safe work environment.

Identifying and reporting the risk of OV early, coupled with a dynamic approach to risk assessment, can significantly reduce the rate of critical incidents, reduce the use of restrictive practices, improve patient care and boost safety for staff, patient/consumers, carers, and visitors (Cabilan & Johnston, 2019).

A planned and systematic process is an effective risk management approach to identify hazards and risk factors that have the potential to lead to incidents of OV. This approach enables health services to develop risk control strategies to suit their specific health settings and circumstances. The risk management process can be found in Attachment 1 of this guideline.

## Section 1 - Prevention: Primary control measures.

ACT Public Health Services must develop and implement effective risk control measures to address challenging behaviour. A combination of multiple level risk controls such as primary preventative measures are effective and include:

- organisational governance that outlines expectations, accountabilities, and resources to allow a collaboration within the system,
- awareness of the triggers and clinical drivers of challenging behaviour,
- effective communication skills, that guides expectations and boundaries, and the provision of comfort measures. This includes the use of interpreters and translator services where required,
- education and training directly related to OV prevention and management strategies, situational awareness, and early identification of escalation (including identification of patient/consumer triggers that may lead to frustration and challenging behaviours),
- safe workplace design and service design that enable clear communication between the healthcare services, staff, and patients/consumers, and
- caring for patients/consumers and their health care rights.

### Organisational safety culture and governance

Safety culture is defined as ‘a product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation’s health and safety management’. A common interpretation of safety culture is ‘the way things are done around here’ (ACSQH, 2023).

To ensure a culture of safety ACT Public Health Services require:

- governance structures and processes must outline roles, responsibilities, expected behaviours and accountabilities,
- resources allocated to address and support safety concerns, and actions to respond to behaviours that undermine safety,
- collaboration between all services is required to seek solutions to staff and consumer safety concerns, this includes learning from incidents and continual improvement activities,
- support and assistance for all persons who have been exposed to incidents of challenging behaviour, and there are consequences for those who knowingly and willingly jeopardise safety of others, and
- understanding of the context in which challenging behaviour may present in their work area and have targeted strategies to address these.

### Effective communication

The NSQHS Second edition (ACSQHC, 2023), calls on healthcare services to have systems in place to support effective communication with patients/consumers, carers, and families, between staff and care teams, and across organisations. These systems of communication can help ensure shared decision making and safety for both staff and patients/consumers. A standardised approach to communication must be implemented to help staff provide the best possible care whilst protecting

their own wellbeing. The NSQHS Standard 'Communicating for Safety' (ACSQHC, 2023), notes the requirement to provide resources and tools for communicating patient care and treatment to all members of the workforce. This includes the use of standardised tools, such as, ISBAR (Identify, Situation, Background, Assessment and Recommendation) and ISOAP (Identification, Subjective information, Objective information, Analysis and Assessment, and Plan handover tools).

The Digital Health Record (DHR) system allows staff to maintain the delivery of safe, quality person-centred care. The information contained in the DHR system is designed to capture and maintain clear, concise, and timely records of patient/consumer care and treatment whilst ensuring patient/consumer access to their records in a timely manner. The guiding principles of DHR ensure consistent and structured approaches are maintained and that every decision will involve putting the patient/consumer first, whilst providing coordinated and safe person-centred care. DHR will allow staff to prevent, manage, and respond to OV based on historical and current data collection. The DHR system will ensure known risks that may have the potential to harm others is communicated to all staff involved in the persons care and treatment, or transfer of care and treatment, including:

- Clinical handover.
- The requirement of health staff to use interpreter or translator services.
- Relevant Ambulance, Police, or staff from detention facilities.
- Transfer of patients/consumers between wards, health services, home or residential aged/disability care, crisis assessment and treatment team.
- Support services and security staff.
- When there is a known risk of challenging behaviour, or an incident has already occurred, there is a requirement to inform the receiving service.
- Whether or not the patient/consumer has an Advance Agreement, Advance Consent Direction and/or Nominated Person form either on their person or as part of their electronic care record.

A discharge or transfer summary is to be completed on DHR prior to the patient/consumer transferring to another ward or discharging from the service. The following information must be provided by the transferring team and requested by the receiving team as part of the discharge process:

- Clinical notes.
- Behavioural history.
- Patient/consumer management plan such as inclusive of any restrictions or behavioural agreements.
- Triggers of challenging behaviour.

## Triggers

Nine triggers may make an individual more or less likely to be violent or aggressive and may cause them to react.

1. Clash of people - each person is undergoing their own stress and dealing with their own complex mix of clinical and non-clinical needs.

2. Lack of progression - there are few situations in our lives when we are forced to wait for lengths of time without any sense of progression.
3. Hospital environments - many people describe a dislike of hospitals, not least because they are full of sick people. Beyond the patients/consumers, hospitals can be uncomfortable places which are not pleasant to spend time in.
4. Dehumanising environments - sometimes the way patients/consumers are managed can lead to a loss of perspective. Examples include feeling ignored, lack of understanding as systems are regimented and difficult for an outsider to understand, restriction on what patients/consumers are allowed or not allowed to do, and anonymity.
5. Intense emotions - people may be experiencing extreme life events, suffering with pain or stress, or having to witness other people coping (or not) with their own stressful experiences.
6. Unsafe environments - very busy environments with considerable amounts of equipment and large numbers of people using the space. Sometimes these factors can trigger or worsen violence.
7. Perceived inefficiency - from a patient's or consumer's perspective it can sometimes feel as if staff are disorganised and lacking focus. Patients/consumers observe themselves and others seemingly waiting for hours, while staff 'busy themselves' with perceived nonessential tasks.
8. Inconsistent response - healthcare environments are often tightly controlled by policies, guidance, rules, and regulations – much of which is difficult to decipher, inconsistently applied, and can be contrary to what happens in practice.
9. Staff fatigue - over time, staff can become both physically and emotionally tired, struggling to find the energy to deal with the constant flow of patients/consumers.

(Adapted from NHS Design Council, 2011.p7).

High risk settings may include Emergency Departments (ED), maternity, aged care, geriatric, paediatric, medical, and surgical, mental health, residential, rehabilitation and community (home) care.

## Clinical drivers

Challenging behaviour may indicate the presence of a mental illness and/or mental disorder. Several diagnoses or conditions can predispose people to exhibit challenging behaviour. People who have experienced previous trauma in their lives are more likely to have increased emotional responses in situations where they feel unsafe, unsure, or challenged.

There is a potential for challenging behaviour to occur in any health care setting, but some environments are higher risk due to providing care to people:

- in stressful situations (e.g. onset of sudden serious illness, traumatic injury or event) ,
- in circumstances where staff are working alone, in isolation or with minimal staff,
- with clinical conditions that can influence their behaviour (e.g., dementia, brain injury, substance withdrawal or people experiencing periods of mental ill health, mental illness and/or mental disorder), and

- When there is an indication that challenging behaviour is caused by deterioration of cognitive function, emotional wellbeing, mental ill health, mental illness and/or mental disorder or drug misuse, then early recognition and appropriate care and treatment are essential. Staff must have information about the common drivers of challenging behaviour to assist them in recognising triggers (see [Attachment 2](#)).

Guidelines exist for screening, assessment, diagnosis, and treatment of many relevant conditions and these must underpin care. There are numerous factors that contribute to failures to recognise and respond appropriately to clinical deterioration. These include different levels in staff knowledge and skills, how care is delivered, organisational systems in place, and how information is communicated. Although complex and overlapping, a consistent approach that addresses all factors must be implemented to ensure the most appropriate and timely intervention occurs, reducing the likelihood a person's challenging behaviour will escalate.

The Australian Commission on Safety and Quality in Health Care noted key elements of a 'system for managing cognitive impairment' (See Attachment 3).

## Education and Training

The purpose of education, training and information is to provide staff with skills, knowledge, attitudes, competencies and understanding relevant to their roles, responsibilities, and accountabilities. Ideally a suite of resources should be made available to account for variation in requirements and learning styles. It is recommended that any education should be made available to students and volunteers within the ACT Public Health Services. Organisations could provide more tailored training to staff for specific high-risk presentations such as delirium, dementia, and acute mental health illness. Training and information provided to staff will depend on:

- the work environment and type of service provision, and
- the role, and other responsibilities assigned.

Principles for education and training are:

1. The organisation develops a tiered framework approach to training to ensure all staff receive appropriate levels of training according to risks within their area of work and role.
2. Education is flexible and follows principles of adult education, providing consideration for special needs of employees from diverse backgrounds including disability, culture, gender, literacy and first language.
3. A variety of educational resources are developed to support frontline health teams including utilising an inter-professional, scenario-based team training approach in conjunction with other delivery methods.
4. Education is based on evidence-based best practice guidelines and policies, including Australian Capital Territory Work Health and Safety Act 2011 and NSQHS Standards (ACSQHC, 2023) focusing on safety for all – staff, patients/consumers, carers, and visitors.
5. All new staff are provided basic education in orientation programs.
6. Staff are involved in the design, delivery and evaluation of education programs.
7. Health care patients/consumers are involved in the design, delivery and evaluation of education programs.

8. Education is evaluated to measure short-, medium- and long-term outcomes related to incidence of violence and identify improvements in future program development.

Topics for services to consider in training programs include:

- Fostering a culture of partnership between health care clinicians and patients/consumers including promotion of shared decisions and setting of mutual expectations related to behaviour.
- Developing a culture of leadership and shared vision for minimising harm within individual health environment settings to:
  - implement effective screening and assessment tools
  - assess risks within the area informed by current, relevant data
  - support staff to provide consistent responses to escalating behaviours
  - implement response systems including code grey and code black teams
  - encourage a culture of reporting and feedback within the local area
  - develop teams to undertake effective post-incident follow-up.
- Embed models of care such as Safewards to effectively reduce restrictive practices such as seclusion, bodily restraint, and forceful giving of medication.
- Promote the use of existing procedures and guidelines that recognise, assess, and adequately manage cognitive impairment.
- Identifying changes in behaviour, preventative de-escalation, evasive and self-defence training for staff working in areas of high risk and when responding to code grey and code black responses.
- Education on trauma informed practice and de-escalation techniques.

## Safe Workplace Design

Relying on assessment, work procedures or training alone is not enough to address challenging behaviours in the workplace. Consideration must be given to the health and wellbeing of staff, as well as the development and maintenance of appropriate facilities, workspaces, building services and systems.

Design principles for older people especially those with dementia including access to outdoor spaces should also be considered. Risk factors must be identified at the design, development, and management phases of health services with the aim of eliminating or reducing, as much as possible, the likelihood of occupation violence taking place by using safe workplace design. Building designers are required to translate the design briefs into physical plans and fit out standards (usually drawings, pictures, and samples). These design proposals are then consulted on, approved, and turned into plans and engineering diagrams.

Staff and consumers with experience in the work area, including Health and Safety Representatives should be included in design consultation (Adapted from SA Health, 2015. Policy Directive on Preventing and Responding to Challenging Behaviour, pp. 10-12).

Making changes to the environmental stressors that may arise from the:

- physical environment,

- patient/consumer journey (sequence, timing, steps, avoiding duplication, information handover, coordinating services), and
- working environment.

Changes can:

- create a calmer and more relaxing environment,
- improve patient/consumer and staff safety,
- improve response times for care and support service provision,
- improve work related efficiencies,
- decrease the number of incidents, and
- improve the response and actions associated with incidents should they occur.

Actions are aimed at improving the physical environment through changing its design, functionality and integration with workflow, its ability to support the patient/consumer journey, and information provision via physical communicative designs.

Health services can refer to nationally and internationally recognised programs, for example, Crime Prevention through Environmental Design (CPTED) and the Australasian Health Facility Guidelines when re-designing or re-developing existing facilities or establishing new facilities. CPTED is a set of design principles used to discourage crime and promote building security. Key CPTED principles are as follows:

#### **Territorial reinforcement**

- Making it clear that the workplace is under the control of the health care and support business services.
- Using clear branded directions such as signage and maps to define 'Staff only' access areas, reception areas, waiting rooms.

#### **Access control**

- Defining and implementing boundaries between staff only and public access areas, via the use of physical barriers and/or signage and markings. This ensures that staff are separated from incidents of OV if they present.
- Natural surveillance.
- Ensuring line of sight is present for waiting rooms and reception areas.
- Ensuring there are no hidden or screened areas, particularly in clinical settings where OV are more likely.

#### **Maintenance**

- A well-maintained area sends the message that people notice and care about what happens in an area.
- A visually appealing facility with appropriate environmental stimulus and facilities, i.e., telephones, drinking water for patients/consumers, carers and visitors will assist.

Environmental and workplace design must also consider the physical features of the surrounding areas if OV incidents occur.

The following design features must be considered:

- an accessible, safe, and secure place of retreat for staff, patients/consumers, and members of the public.
- furniture design and environmental fit out that does not provide objects that could be used as weapons and keeps potential triggers such as cash and medications secure.
- physical barriers to prevent staff from being assaulted or being subjected to physical acts of OV, e.g., screens, ward security doors and safety glass.
- clear entry and routes, accessibility and positioning of fixed duress alarms in reception, treatment, or interview areas; and
- clinical care spaces with low risk fit out to provide comprehensive physical care for patients/consumers with challenging behaviours.

## Caring for patients/consumers and their health care rights

Effective patient/consumer communication strategies consider cultural diversity and health literacy, gender, sexuality, disability, cultural and spiritual background, and English proficiency/language barrier. Creating an environment for patients/consumers, carers, and support persons where they feel safe to ask questions and express concerns should be a priority.

Raising community awareness of challenging behaviour when done knowingly and willingly is a necessary addition to promote awareness for staff. Setting clear expectations through consistent messaging across ACT Public Health Services is needed to achieve a successful broader approach to address OV against staff. Where there is an acceptance culture or inconsistent responses to challenging behaviour, when done knowingly or willingly, patients/consumers, carers and visitors may consider swearing, shouting and other 'minor' behaviours do not constitute OV. These patients/consumers, carers and visitors are likely to attend various health services and settings and adhering to consistent practice will reinforce the expectation of appropriate behaviour.

Numerous state governments have implemented community awareness campaigns in recent years to educate the public about OV and challenging behaviour when done knowingly and willingly showcasing the message that health care staff deserve respect. Campaigns have included posters, social media, advertisements, health facility signage and website content.

All campaign strategies led by relevant Communications and Media teams key messaging should include:

- identifying what does and does not constitute OV, especially that challenging behaviour, when done knowingly and willingly, is a form of OV,
- that OV will never help and always hinders patient/consumer care,
- equal rights of patients/consumers, carers, visitors and staff to be safe in health care settings,
- equal responsibilities of patients/consumers, carers visitors and staff to be respectful,
- the differing causes of OV (intoxication, pain, neurological condition, fear, impatience), and

- consequences of committing OV, including police presence and prosecution if appropriate.

## Section 2 - Early intervention: secondary control measures

Primary control measures may not be effective on their own if incidents of challenging behaviour are already occurring. The use of secondary control measures is required in conjunction with preventative strategies as their effect is cumulative.

### Identifying and managing challenging behaviour when done knowingly and willingly

Risk assessment tools are designed to identify the risk of challenging behaviours and assist in the process of planning and implementing strategies to help prevent challenging behaviours occurring (Viljoen et al., 2018). Multiple studies support structured assessment tools that can more accurately predict imminent aggression than unaided clinical judgement (Ogloff & Daffern, 2006; Biancosino, et al, 2009; Griffith et al, 2013; Lantta et al, 2016). When risks are identified and flagged, appropriate preventative measures can be put in place to decrease actual incidences occurring (Morphet et al., 2018).

To be effective, screening and assessment tools must be:

- simple to remember, use and implement,
- adaptable to suit the diverse environments in which staff do their work, and
- supported by tiered training and education that empower staff to recognise, monitor, respond and/or escalate incidents of challenging behaviour as required.

There are many validated screening and assessment tools that can be adapted to suit different health care settings. These will vary according to service and speciality.

## Section 3 - During an incident: tertiary risk control measures

Challenging behaviours, done knowingly and willingly, typically occur when patients/consumers, visitors or carers feel that they are not being attended to, communicated with, or receiving the care they need in a timely fashion. Lengthy waiting times, lack of privacy, perception that less sick people are being treated first, cultural and language barriers and fear can lead to escalating feelings of stress which are in turn expressed as challenging behaviour.

There are situations where a person may exhibit behaviour that is challenging for others to experience. Behaviour is a form of communication, and the person may or may not intend to

threaten or to interrupt the care being provided. For example, if the situation is very stressful and they are in pain or fearful or they have the perception that their care is unsafe and/or disrespectful. The person displaying the behaviour may be attempting to have their needs met, concerns heard, or fears for their family member recognised.

In determining the appropriate action, consideration must be given to the following:

- The staff members level of skill and knowledge to manage the challenging behaviour.
- The environment and/or organisational systems in place.
- How information is communicated.
- The risk level, i.e., how often and severe the behaviour has been.
- The person's capacity to understand the inappropriateness and impact of the behaviour.
- The person's ability to control or modify their behaviour in future.
- The person's literacy level.
- The person's ability to read and understand English.

## Minimising Restrictive Practices

Restrictive practices limit a person's rights under the *Human Rights Act 2004*. The NSQHS Standard 'Comprehensive Care' (ACSQHC, 2023) recommends the use of strategic tools, resources, and training to minimise restraint. Additionally, the ACSQHC (2023) recommends minimising, and where possible, eliminating the use of restraint and seclusion as identified in the national safety priority for mental health services in Australia in 2005. Reducing restrictive practices such as seclusion, restraint and forceful giving of medications is essential to the provision of safe health services for patients/consumers, carers, visitors, and staff. Consistent with the objectives of the *ACT Mental Health Act 2015*, the *5th National Mental Health and Suicide Prevention Plan*, and the *Human Rights Act 2004*, ACT Public Health Services are commitment to reducing and where possible, eliminating restrictive practices in mental health services.

Outside of the Mental Health Act 2015, that outlines the provisions for subjecting a person to the minimum confinement or restraint that is necessary or reasonable, there is no legislation that allows for a patient/consumer to be secluded or restrained. Seclusion or restraint may be permitted in certain situations under common law. The use of restrictive practice should be authorised by a Medical Officer in consultation with the patient/consumer, a patient's guardian, enduring power of attorney, nominated person or other substitute decision maker. The use of restrictive practices must only be considered when all alternative options to restrictive practice have been considered, with the least restrictive means to achieve safety or the care objective is employed. The use of restrictive practice must be reasonable, justifiable, and proportionate.

All ACT Public Mental Health Services and in areas in a hospital that have been approved as a mental health service are required to have in place local procedures and clinical practices aimed to reduce, and where possible, eliminate the use of restrictive practices.

Evidence shows that restrictive interventions can re-traumatise people and impede the development of trusting relationships between patients/consumers receiving care and staff. The below core principles should be considered to reduce the use of restrictive practices:

- Patients/consumers, their support networks, and staff are treated with respect and dignity and their rights and responsibilities are essential to promoting safety.
- People with lived experience, carers, staff, management, and government have a role in the design and implementation of a safe environment.
- Challenging behaviour is managed in ways that show decency, humanity and respect for individual rights while effectively managing risk.
- Restrictive interventions are used as a last resort after all less restrictive options have been tried or considered and found to be unsuitable.
- Workplace practices are informed by recovery-oriented practice, trauma-informed care and supported decision making and are necessary to prevent cultures that are experienced as either coercive or conflictual.
- Programs to reduce restrictive interventions receive effective governance and ongoing monitoring of local action plans and processes to ensure their effective implementation.

Recommendations to assist organisations to reduce their use of restrictive practices include:

- Internal assessment of the use of the three care practices- recovery-orientated practices, trauma-informed care and supported decision making.
- Workforce planning outlining alternative strategies for staff to manage aggressive behaviours and actions for leaders to engage and support others in this initiative.
- Review the utilisation of data to inform practice and monitor progress.
- Review governance structures to provide clear roles and responsibilities and promote a culture of learning and enquiry.
- Develop activity programs to reduce restrictive practices and engage patients/consumers and their carers to ensure these programs are grounded in real-life experiences; and
- Adapt process and policies to embed reflective practice and critical reviews of incidents as they arise.

## Trauma Informed Care

Many people with the mental illness and within the mental health service workforce have experiences of trauma. The effects of these experiences can be multiple, varied, complex and enduring. The use of restrictive practices such as seclusion, restraint or forceful giving of medications or experiences of a precursory nature, can trigger new experiences of trauma. Trauma-informed care is an approach where all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, with awareness and sensitivity.

## Communication/De-escalation

Communication, provision of information, de-escalation and calming strategies are effective secondary risk control measures, which can resolve, or assist to prevent the further escalation of challenging behaviours. These strategies can be used in both clinical and non-clinical settings.

In the face of imminent aggression, de-escalation is used to prevent the use of restrictive practices and reduce patient/consumer violence, fears and anxieties. De-escalation is recommended as the first response to violence and aggression in health care settings and are skills that can be developed

through training relevant to the staff and their roles. De-escalation involves knowledge, communication, self-regulation, assessment, activity and safety maintenance (Hallett and Dickens, 2017). This can be demonstrated through different types of training techniques that include conflict resolution, training in open disclosure and limit setting, diversionary techniques and sensory modulation. The Safewards model of care embodies interventions, including de-escalation, to effectively reduce conflict and containment. Staff must consider strategies that create a safe space. Distance can create a safe zone of protection for patients/consumers and staff, allowing the time to stop and reconsider next steps (Berring et al., 2016). Staff must also consider their own frame of mind and body language, ensuring that they speak calmly and clearly and establish empathy. Simple communication techniques like asking 'How can I help you right now', acting on concerns and being practical in assistance contributes to achieving communication for safety. Using creativity to resolve situations facilitates human integrity through a shared responsibility in decision making between staff and patients/consumers. Medication can be used during de-escalation to establish a safe and calm environment, while still allowing the patient/consumer to remain involved in their care. This means avoiding sedation where possible and offering choices to patients/consumers.

## Code Black and Code Grey

Australian Standard (AS) 4083-2010 is a uniform code for managing internal and external emergency procedures in the workplace. Code Black is an Australian emergency standard for immediate personal threat (armed or unarmed, persons threatening injury to others or themselves, or illegal occupancy). Code Grey responses are based on a risk-assessment approach and can be called when an actual or potential behaviour exhibited by a patient/consumer or visitor creates a risk to health and safety of staff.

Code Grey must be clinically led, with the response team comprising of trained clinicians, security staff, staff from the local area and staff responding hospital wide. In high-risk areas such as Mental Health and Emergency Department, response teams are typically location based and supplemented by security. Lower risk areas may benefit by having a service-wide response. Procedures should be established for all clinical areas within a health service and modified for levels of staff training and risk profile.

Data on Code Greys should be recorded and reviewed at established interprofessional meetings where the membership reflects the far-reaching impact of clinical aggression across an organisation. Aggregated data and serious incidents must be reviewed and fed back into policy development and staff training.

<b>Code Grey</b>	When a patient/consumer or visitor becomes verbally or physically aggressive to the extent that they present a threat to themselves or others.
<b>Planned Code Grey</b>	An anticipated response initiated by staff for scheduled events (e.g. patient/consumer appointment), where a prior risk assessment indicates a risk of OV.

Health services should undertake a site-specific risk assessment to inform the development of a local code grey response.

## Section 4 - After an incident: post intervention

The personal consequences of OV include physical, psychological, emotional, financial, and social problems (Shea et al., 2018). At the organisational level, the impact of OV can lead to decreased employee recruitment and retention, reduced employee productivity and reputation. Therefore, organisational support following an incident is crucial to mitigate these negative effects on staff wellbeing, job satisfaction, and organisational commitment.

### Suggested response to OV incident

#### 1. Manage the incident and injury

- Ensure all involved are safe and if required, seek first aid or medical treatment,
- Take action to prevent a further incident,
- Talk to the team and/or individual staff after the incident, and
- encourage staff, patients/consumers, carers, and visitors to report incidents of OV to police.

#### 2. Keep in contact with the staff affected and offer support

- Contact the staff as soon as possible after an incident and determine how and when contact will be maintained,
- Maintain regular contact with the staff.
- Determine what support is required for the staff to return to work as early and safely as possible.

#### 3. Provide information on early intervention programs

- Employee Assistance Program (EAP).
- Service specific providers in the ACT (please contact your directorate/agency HR if you are unsure of these).

#### 4. Assist with reporting incident and staff compensation (if required)

- Complete staff incident form on appropriate incident reporting system. One report per incident should be added to the incident reporting system, either:
  - by the staff if they have returned to work within 48 hours of the incident; or
  - by the manager (on behalf of staff) if they don't return to work within 48 hours.
- Workers' Compensation documentation, if required.

#### 5. Review/Investigate incident

- Talk to the staff member about what happened. Complete the managers section of the incident reporting system notification. This information is important to help with the investigation and develop control measures to reduce the likelihood of it happening again.

#### 6. Communication with the team/individual staff member

- Consult with staff during investigation of the incident.
- Provide staff with information about contributing factors and control measures, these updates should be provided on an ongoing basis.

## 7. Communication with the patient / consumer

- Debrief with the patient/consumer to restore the therapeutic relationship and decrease the risk of additional violence.
- Explain rationale for treatments and interventions.
- Explore alternatives for the future.
- Debrief the patient's/consumer's family.

## Consequences of challenging behaviour when done knowingly and willingly

### Behaviour management process

All reasonable efforts to retain a person in treatment must be taken prior to placing conditions that restrict their access to health services. The focus always must be one of effective risk management and prevention.

The following is a suggested order for addressing escalation or ongoing challenging behaviour done knowingly or willingly:

- Verbal warnings
- Written warnings
- Alternative Treatment Arrangements
- Conditional Agreement
- Withholding of treatment
- Workplace Protection Order

Attachment 4 shows examples to support a tiered behaviour management strategy (CHS Occupational Violence Procedure).

## Section 5 - Reporting

Despite known high levels of OV towards staff, it is widely acknowledged that OV and challenging behaviour is significantly underreported. Low levels of reporting, coupled with a high acceptance of verbal and physical abuse, are known contributors to the normalisation of OV amongst staff. Under-reporting results in an incomplete understanding of OV events and leads to further underestimation of the extent and impact of OV occurrences (Christensen and Wilson, 2022).

Reporting all incidents of violence, even those that do not require medical attention, helps to create a culture in ACT Public Health Services that does not tolerate violence. Staff that work in a culture where reporting is seen as positive is important.

Under the *Crimes Act 1900*, it is an offence to assault a frontline health worker. Such offences that cause actual bodily harm can result in imprisonment penalties of up to 14 years (Cabilan et al., 2021). These penalties are intended to highlight the significant risk of OV in healthcare, as well as deter patients/consumers from OV.

Strategies to increase reporting include:

- ensuring reporting platforms are simple and easy for staff to complete (Morphett et al., 2018),
- considering methods to capture high-volume, low impact incidents such as verbal abuse,
- empowering staff to expect a safe workplace and an approach where empowering and involving staff, empower staff to report, (ANMF Victoria Branch 10 Point Plan),
- ensuring management demonstrate commitment to changing the culture of health care workplaces to reflect no acceptance of violence in health services,
- health services ensure staff are involved in action plans/strategies in the management of OV, and
- The use of data collected to showcase innovation and improvements in different services.

# Evaluation of the Guideline

The table below provides an overview of the minimum standards, key actions and data requirements for the monitoring and evaluation of the Challenging Behaviour Guideline – Seclusion, restraint or use of force.

## Governance

Each ACT Public Health Services must show governance and structure in place to ensure:

- Responsibility for developing, implementing and evaluating quality improvement systems
- Inclusion of skills from Work Health and Safety, Quality and Safety, risk management, security and clinical and non- clinical staff
- Policies, procedures and guideline are accessible to all staff
- There is patient/consumer engagement
- Review of relevant data and information

Key Actions	Data source, evaluation and metrics
<ul style="list-style-type: none"> <li>• Ensure governance structure to allow for quality improvement and to evaluate outcomes of strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Committee meeting papers</li> <li>• Evaluate safe applications of restraint through review committees, such as, MHJHADS Restraint, Seclusion, Restrictive Practices Review Committee.</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure local policies and procedures in place to decrease incidence of challenging Behaviours</li> </ul>	<ul style="list-style-type: none"> <li>• Policies, procedures and guidelines</li> </ul>

## Prevention -clinical management of challenging behaviour

There are systems in place to enable prevention which includes screening and assessment of risk or predisposition to challenging behaviour and preventative care plans

Key Actions	Data source, evaluation and metrics
<ul style="list-style-type: none"> <li>• Review of screening, assessment and care to ensure it is provided in accordance with legislation and current clinical practice</li> </ul>	<ul style="list-style-type: none"> <li>• Data source: Risk reporting system, medical records and safety management plans</li> <li>• Evaluation: Does care provided align with clinical practice, policies and legislation.</li> <li>• Metrics: type of care provided or withheld</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure procedures in place including:</li> <li>• Preventative strategies including screening in place</li> <li>• Restraint minimization</li> <li>• Clinical management including de-escalation.</li> </ul>	<ul style="list-style-type: none"> <li>• Data source: Risk reporting system, medical records, safety management plans</li> <li>• Evaluation: Has the patient/consumer had appropriate screening of history, previous challenging behaviours and triggers?</li> <li>• Metrics: Did the treatment provided include preventative strategies? Did management include de-escalation strategies?</li> </ul>

	<p>Data source: Medical records</p> <p>Evaluation: Was a screening tool used prior to the incident? Which tool?</p> <p>Metrics: tool used, completion rate</p>
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**Prevention -changes to systems of care**

There are systems in place to enable prevention through design of service delivery (primary risk control)

<b>Key Actions</b>	<b>Data source, evaluation and metrics</b>
<ul style="list-style-type: none"> <li>Develop and implement strategies to review and improve safety of service design and environment, work practices and patient/consumer journey</li> </ul>	<p>Data Source:</p> <ul style="list-style-type: none"> <li>Committee meeting papers</li> <li>Safety culture surveys</li> <li>SAIR reports</li> <li>Attendance records for building design consultation</li> <li>Model of Care</li> </ul> <p>Evaluation:</p> <ul style="list-style-type: none"> <li>Are there committees supporting implementation and review of safe design</li> <li>Do staff feel their safety is a priority in their workplace?</li> <li>What is the culture of reporting incidences of OV?</li> <li>Is the model of care evidence based and promote safety for the workplace environment, practices and patient/consumer journey</li> </ul> <p>Metrics:</p> <ul style="list-style-type: none"> <li>Number of meetings held, number of attendees</li> <li>fidelity of safety plans</li> <li>survey results</li> <li>number of risk reports completed</li> <li>Does model of care principles align with best practice</li> </ul>

## During an incident

There are systems to ensure timely, safe and effective response for the protection of staff and patients/consumers

Ensure procedures in place including:

- Calling of code black/grey
- Activities and roles of security officers/wards support staff
- Drills for evacuation, securing an area

Data Source:

- Risk management system & medical records
- WHS reports
- education and training records
- post incident review

Evaluation:

- How many codes are logged in risk reporting system or document in medical records
- perceptions and understanding of staff roles in de-escalation did the staff feel supported in their post incident review? was it completed? what was the outcome of the incident?

Metrics:

- number of code greys and code blacks
- number of drill evacuations and staff attendance
- Education and training records
- Policies and procedures
- Patient/consumer feedback
- Patient/consumer experience surveys
- Post incident review

## Training and education

Staff participate in relevant training and education

- Ensure staff have the skills and knowledge relevant to their roles around getting help, equipment and policies and procedures

Data Source:

- Training attendance record
- Training Schedules and participation

Evaluation:

- Orientation training
- de-escalation training
- WHS training

Metrics:

- Evaluation of the training provided
- outcome of incident
- risk reporting frequency

## Reporting and reviewing incidents

An organization wide system is in use and is reviewed

Staff have skills and knowledge on reporting processes and review relevance to roles

Requirement for reporting national indicators for restraint and seclusion in mental health are met

- Use data to inform Quality Improvement
- Collate data from all sites
- Discuss aggregated data at executive level clinical governance
- Ensure reporting and review of all incidences meet the requirements of incident management policies and procedures.

### Data source:

- Medical records
- WHS reports
- QA reports
- Risk reporting system

### Evaluation:

- does the report meet the requirements listed in the policy
- was policy and procedure adhered to

### Metrics:

- Patient/consumer incidences -categories
- Staff incidences-physical harm, manager review and action

## Seclusion, restraint or use of force

Any seclusion, restraint, use of force, force is done as a last resort, is lawful and for minimal duration and is least restrictive for maintenance of safety

- Incidences are reported, reviewed and action taken

### Data source:

Risk reporting system  
 medical records  
 manager reports / response

### Evaluation:

- was the incident reported using appropriate platform? was it reviewed and/or actioned as per policy/procedure

### Metrics:

- Medical records-documentation of seclusion/restraint/application of force and timing of method used
- 

- Ensure local procedures are available for
- Approval and authorisation for restraint
- Safe application of restraint
- Withdrawal/breakaway/evacuation of an area

### Data source:

- Policy and procedure
- legislation
- Medical records
- Risk reporting system

### Evaluation:

- Was policy, procedure and legislation adhered to?

	<ul style="list-style-type: none"> <li>• was the restraint applied safely as per policy/procedure</li> <li>• was the staff member able to withdraw/evacuate?</li> <li>• did the environment / building design contribute to safety issues</li> </ul> <p>Metrics:</p> <ul style="list-style-type: none"> <li>• Number of injuries sustained during incident (staff/witnesses)</li> <li>• restraint documentation</li> <li>• access/egress mentioned in risk report</li> </ul>
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## Implementation

It is expected that by providing a clear guideline that identifies best practice protocols to manage and respond to challenging behaviours, individual health services will develop policies, procedures and training programs to meet their specific needs to protect the fundamental right of staff to be safe at work.

The contents of this guideline will be communicated across ACT Health Directorate, Canberra Health Services and North Canberra Hospital and other relevant teams where applicable through the provision of presentations at leadership and governance meetings.

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## Legislation

- *Crimes Act 1900 (ACT)*
- *Crimes (Health Directorate) Authorisation 2018 (No.1)*
- *Discrimination Act 1991 (ACT)*
- *Health Records (Privacy and Access) Act 1997 (ACT)*
- *Human Rights Act 2004 (ACT)*
- *Mental Health (Secure Facilities) Act 2016 (ACT)*
- *Mental Health Act 2015 (ACT)*
- *Personal Violence Act 2016 (ACT)*
- *Public Sector Management Act 1994*
- *Victims of Crime Act 1994 (ACT)*
- *Work Health Safety Act 2011 (ACT)*
- *Work Health and Safety Regulations 2011 (ACT)*

## Supporting Documents

This guideline has been developed with consideration of the NSQHS Standards:

1. Clinical Governance
2. Partnering with Consumers
3. Health care Associated Infection
4. Medication Safety
5. Comprehensive Care
6. Communicating for Safety
7. Blood Management
8. Recognising and Responding to Acute Deterioration

## Search Terms

Challenging behaviour guideline, challenging behaviour policy, violence and aggression, violence and aggression policy guideline, violence and aggression policy, work health safety, WHS, staff safety, Work Health and Safety, WH&S, safe workplace, staff health, risk control measures, risk assessment, control measures, risk management, code grey, challenging behaviour policy, OH&S, staff.

## Version Control

Version	Date	Comments
1	June 2020	NM TASC Steering Committee endorsed
1.1	July 2023	NM TASC Senior Project officers – Seeking endorsement
1.2	May 2024	Annual review, endorsed by Steering Committee (03/05/2024)

**Disclaimer:** *This document has been developed by the ACT Health Directorate specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and the ACT Health Directorate assumes no responsibility whatsoever.*

# Attachments

## Attachment 1-Risk management process



Figure 2 The risk management process

<b>Step 1:</b> Identify the hazard	Identify the hazard - what or who could cause harm to staff, and/or other persons
<b>Step 2:</b> Assess the risk	Assess the risk - understand the nature of harm that could be caused by <ul style="list-style-type: none"> <li>• how likely it is that harm may occur e.g. rare, unlikely, possible, likely, almost certain</li> <li>• how serious the harm could be e.g. insignificant, minor, medium, major, critical</li> </ul>
<b>Step 3:</b> Control the risk	Control the risk - determine the action required and the most effective risk control measure and/or treatment that is reasonably practicable in the circumstances
<b>Step 4:</b> Review control measures	Review control measures - implement, review and improve the effectiveness of the risk control measures, to ensure the preventative measures are effective as per the treatment plan and, when necessary, improved.

## Attachment 2-Common drivers of challenging behaviour

In creating these profiles, the aim was not to stereotype or pigeonhole, or to presume the guilt of innocent people. Rather, it was intended to highlight distinct challenges and ‘aggression pathways’ that can be used to focus or test design ideas.

The five profiles outlined are:

### **Clinically Confused**

Staff make a distinction between incidents with clear intent and those which, lacking intent, may have occurred as a direct result of the person’s illness or medical condition, particularly where that condition results in impaired cognition. Hypoxic pain can lead to all manner of severe confusion, for example, while a head injury can result in an individual behaving ‘out of sorts’, or dementia can lead to disorientation.

*Behaviours to note-* These individuals may not be in control of their behaviour or their reaction to stimulus. Behaviour is most likely to be directed towards nurses or other clinicians who are trying to assess or treat the person.

### **Frustrated**

Frustration is a well-documented cause of aggression. An individual’s conduct may come down to their level of self-control and their beliefs regarding acceptable behaviour.

*Behaviours to note-* Some may make their frustration clear long before they would resort to violence or aggression; others may simply ‘erupt’ with seemingly no advance warning at all. The behaviour may also take the individual by surprise – a momentary loss of control or impaired judgement.

### **Intoxicated**

Intoxication, in particular alcohol consumption, is believed by staff to be a significant contributor to violence and aggression. *Behaviours to note-* Drinking alcohol and taking some drugs can reduce people’s social anxieties (overcoming problems like shyness, for example) but also has the effect, in some situations, of making the person less likely to worry about the consequences of his or her action. The effects of alcohol on cognitive functioning may reduce the individual’s ability to process or remember even basic instructions or solve simple problems.

### **Distressed / frightened**

For many patient/consumers, carers, and visitors, being in hospital can be a highly emotional experience. These emotions can range from stress and anxiety, to shock, surprise or immense grief.

*Behaviours to note-* As emotions run high, individuals may be preoccupied, struggle to listen and be difficult to reason with. Individuals may be unusually volatile and unpredictable.

### **Angry**

A person may have history of being violent or aggressive. In normal everyday interactions they may struggle to control their behaviour, lack a clear sense of what is right or wrong, or actively seek antisocial opportunities. *Behaviours to note-* Individuals may act in a negative or abusive way in the absence of triggers. It is more likely that these individuals have little respect for any kind of authority or rules and may be unafraid of the consequences of behaving badly.

Traits of violent and aggressive behaviour (NHS Document [designcouncil.org.uk](https://designcouncil.org.uk))

## Attachment 3-System for managing cognitive impairment

The Australian Commission on Safety and Quality in Health Care noted the following key elements of a 'system for managing cognitive impairment' (Cumming, A., 2016):

- Identify patient/consumers at risk of delirium.
- Implement multicomponent delirium prevention strategies.
- Screen for cognitive impairment.
- Assess for delirium and re-assess with any changes.
- Investigate and treat the causes of delirium.
- Establish goals of care based a person's preferences.
- Address medication issues.
- Communicate effectively and seek information to provide individualised care.
- Respond to additional care needs.
- Respond appropriately to behavioural issues.
- Partner with patient/consumer, carers, and family.
- Provide a supportive environment; and
- Manage transitions effectively.

## Attachment 4 -Tiered behaviour management strategy

