ACT Government | ACT Health

GUIDELINE DOCUMENT

Challenging Behaviour Guidelines for ACT Health Services

Document number	**AHDPD-20:2020**
Effective date	22 July 2020
Review date	22 July 2022
Author branch	Office of Professional Leadership and Education
Endorsed by	Nursing and Midwifery: Towards a Safer Culture Steering Committee
Audience	Calvary Public Hospital Bruce Canberra Health Services ACT Health Directorate
Version number	1

Contents

Introduction

Guideline Statement

This guideline provides the framework for ACT public health care workers (workers) to manage and respond to occupational violence (OV), experienced as challenging behaviour, demonstrated by patients, consumers and visitors accessing or being treated by ACT public health services.

Background

Under the Work Health Safety Act 2011 (ACT), all reasonably practicable steps must be taken to protect workers 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 workers and others in the work environment, where health is defined as both physical 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 provides the foundation for positive cultural change in ACT public health settings, and a strategic approach to reduce harm to staff, patients, visitors, contractors and others. This guideline forms one outcome against priority actions identified in the Strategy.

Key Objective

This guideline provides risk management guidance and strategies for health services to ensure safe, healthy and productive services are maintained, and a safe environment is provided for all workers and consumers.

This document outlines the expectation that health services will be committed to the implementation and support of actions to prevent and/or safely respond to challenging behaviour to avoid, where possible, the development of aggression or violence.

Scope

All Health care workers (including students and volunteers) in ACT public health services including:

- ACT Health Directorate;
- Canberra Health Services (inclusive of the University of Canberra Hospital and Community Health Centres); and
- Calvary Public Hospital Bruce.

All workers 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 workers, consumers, carers, visitors and members of the public to:

- support a positive and safe working and care environment;
- support a culture of safety and respect for all workers, consumers, carers and other persons during health service provision;
- contribute and/or provide quality and consistent care, with positive outcomes during the provision of service, and/or interaction with workers who provide the service.

Consumers and visitors will take reasonable care to:

- ensure they respect all workers, other people and property during access to health services and abide by the rules, laws;
- acknowledge that health services will act against all persons who knowingly or intentionally caused physical or psychological harm to workers or people in the care of ACT public health services.

Interactions or conflicts that do not involve a consumer or carer and occur between two or more workers 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

Occupational violence 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 worker.

Occupational violence 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, occupational violence gives a worker reasonable cause to believe their health and safety is at risk (International Labour Organization).

Challenging behaviours are actions and/or behaviours that may or have potential to physically or psychologically 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 actually stop, interrupt or limit the ability for health service or care to be provided in a way that is safe for both consumer and workers; 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 psychological 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”, “consumer”, “patient” or, in some cases visitor.

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. Workers are entitled to be treated with equality, respect and recognition of their right to a safe and healthy workplace.
2. Health care must be delivered in a way that minimises the risk of physical or psychological harm to health care workers.
3. Occupational Violence against workers is unacceptable.
4. Workers are supported by an education strategy to prepare them with the knowledge and tools to effectively identify, prevent and respond to challenging behaviour in the workplace.
5. Protocols for reporting, monitoring and addressing challenging behaviour incidents are promoted and accessible to all workers.
6. The ACT public health system demonstrates a commitment to fostering a consistent proactive approach to managing challenging behaviours, with a focus on preventing, eliminating and mitigating risk.

The following behaviours are always unacceptable:

- swearing /verbal abuse/shouting;
- recording without permission (still images, video or sound);
- threats, including threatening gestures;
- any form of intimidation;
- any form of violence against another people;
- any damage to property.

Person-centred care

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 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).

Person-centred care is important in all populations, but even more so in populations who are vulnerable or disadvantaged. These may include people who have limited literacy, communication difficulty, have a disability, have a mental illness, are from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander peoples. For some people communication with health providers can be difficult and the unfamiliar environment may cause anxiety, their experience may benefit the involvement of family, carers, patient advocates spiritual advisors and other support roles.

It is acknowledged that at times, despite the best efforts of workers to provide person centred care, other factors will contribute to the incidence of challenging behaviours.

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

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, 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

Workers, ethics and respectful behaviour

All ACT public health services are committed to providing work environments that are safe and supportive of all its workers 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.

Consumers and workers in the provision of care

Challenging behaviour may occur in any health service settings. This guideline outlines the context in which challenging behaviour and violence may occur. 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 workers and the consumers using the service. These determine the level of risk posed and the capability of the workforce and/or other persons.

Section 1 – 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 to, 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 consumer-centred care practices.
- a supportive and safe physical environment.
- development of expertise, role clarity, skill and knowledge amongst all workers.
- A supportive and psychologically safe work environment.

Identifying and reporting the risk of occupational violence (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, patients and visitors (Emergency Medicine Australasia, 2019).

A planned and systematic process is an effective risk management approach to identify hazards and risk factors 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 2- Prevention: primary risk control measures

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 strategies are effective and proactive measures include:

- effective communication skills;
- education and training;
- safe workplace design; and
- caring for 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).

To ensure a culture of safety in health services:

- governance structures and processes must outline roles, responsibilities, expected behaviours and accountabilities.
- resources must be 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 workers and consumer safety concerns, this includes learning from incidents and continual improvement activities
- there is support and assistance for all persons who have been exposed to incidents of challenging behaviour, and there are consequences for those who jeopardise safety of others.
- all workers must understand the context in which challenging behaviour may present in their work area and have targeted strategies to address these.

Effective Communication

Effective inter-professional teamwork is strongly correlated with the delivery of safe, quality person centred care. Safe care requires that clear, concise and timely communication occurs in a manner that ensures the consumer and those involved in the planning and delivery of care have an opportunity for input, know the plan and assess the plan for risk. Poor communication can cause harm to consumers', visitors and workers. Sharing information amongst clinical teams and across services or organisations is needed to help protect staff from avoidable exposure to challenging behaviour.

Known risks that pose a threat to staff must be communicated to anyone involved in the care, treatment or transfer of patients (and with their visitors) including:

- Clinical handover;
- Relevant Ambulance, Police or staff from detention facilities;
- Transfer of patients between wards, health services, home or residential care, crisis assessment and treatment team;
- Support services and security staff; and
- When there is a known risk of challenging behaviour, or an incident has already occurred, there is a requirement to inform the receiving service.

The following must be provided by the transferring team and requested by the receiving team as part of the discharge process:

- Clinical notes;
- Behavioural history;
- Triggers of challenging behaviour; and
- Patient management plan (inclusive of any restrictions, behavioural agreements, etc).

A standardised approach to communication must be implemented to help workers provide the best possible care whilst protecting their own wellbeing. National Safety and Quality Health Service (NSQHS) Standards (second edition.)- Communicating for Safety, notes the requirement to provide resources and tools for communicating at key high-risk situations to all members of the workforce. The ISBAR tool (Identify, Situation, Background, Assessment and Recommendation) supports a standardised approach to communication.

Education and training

The purpose of education, training and information is to provide workers 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 health services. Training and information that must be provided to staff will depend on:

- the work environment and type of service provision
- 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 National Safety and Quality Health Service Standards (second edition.); focusing on safety for all – staff and consumers;
5. All new staff are provided basic education in orientation programs;
6. Workers are involved in the design, delivery and evaluation of education programs;
7. Health care 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 health care consumers including promotion of shared decisions and setting of mutual expectations related to behaviour;
- Developing a culture of leadership 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.

- Reducing restrictive practices such as seclusion, bodily restraint and forceful giving of medication which may occur in different health units; and
- 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.

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 developing and maintaining appropriate facilities, workspaces, building services and systems. 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 consultation on design.

(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 journey (sequence, timing, steps, avoiding duplication, information handover, coordinating services); or
- working environment.

Changes can:

- create a calmer and more relaxing environment;
- improve consumer and worker 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 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 workers 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 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 workers 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 workers 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 with challenging behaviours.

CPTED key work system design principles

- Procedures for people to access services. For example, appointment procedures provide information about (or even limit) waiting times can reduce frustration at times of heightened emotions.
- Teamwork, communication and resourcing. For example, review and reinforce staffing in services at specific times when risks are heightened, such as during festive seasons and events or during public health outbreaks such as the flu season.
- Working in unpredictable environments may increase risk, e.g. working in a remote or isolated work setting where normal support systems are not readily available. In these situations, robust reliable communication systems including a communication plan and strategy followed by emergency, medical and rescue assistance procedures must be defined.
- Minimisation of handling cash/drugs and/or valuables.

(Adapted from SA Health, 2015. *Policy Directive on Preventing and Responding to Challenging Behaviour*, pp. 10-12).

Caring for consumers and their health care rights

Effective consumer communication strategies consider cultural diversity and health literacy. Creating an environment for consumers and their families to feel confident and safe to ask questions, express concerns and ensuring their full understanding are the top most desired outcomes of good communication. Communications should include information provision and shared decision-making with consumers and carers.

Community awareness

Raising community awareness of challenging behaviour is a necessary addition to awareness raising aimed at staff. Setting clear expectations through consistent messaging across ACT Government health services is needed to achieve a successful broader approach to address OV against workers. Where there is an acceptance culture or inconsistent responses to challenging behaviour, patients, consumers and visitors may consider swearing, shouting and other 'minor' behaviours do not constitute OV. These patients, 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 behaviours, 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 support. Key messaging may include:

- identifying what does and does not constitute OV, especially that challenging behaviour IS a form of OV;
- that OV will never help and always hinders patient care;
- the equal rights of patients, consumers, visitors and staff to be safe in health care settings;
- the equal responsibilities of patients, consumers, 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 3-Early intervention: secondary risk control measures

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

Identifying and managing challenging behaviour

Multiple studies support structured assessment tools that can more accurately predict imminent aggression than unaided clinical judgement (Ogloff & Daffern, 2006; Barry-Walsh et al, 2009; Griffith et al, 2013; Lantta et al, 2016).

In order to be effective, screening and assessment tools must be:

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

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.

Clinical drivers of challenging behaviour

Challenging behaviour may indicate the presence of a cognitive, emotional or mental health problem, including substance abuse. 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 workers are working alone, in isolation or with minimal staff;
- with clinical conditions that can influence their behaviour (e.g. dementia, head injury, substance withdrawal or people experiencing periods of mental ill health); and
- When there is an indication that challenging behaviour is caused by deterioration of cognitive function, emotional wellbeing, mental ill health or drug misuse then early recognition and appropriate care and treatment are essential. Workers 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, staff attitudes 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' which is listed in Attachment 3.

Section 4- During an incident: tertiary risk control measures

Challenging behaviour typically occurs when patients or visitors 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:

- 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; and
- the person's ability to read and understand English.

Triggers

Nine triggers may make an individual more or less likely to be violent or aggressive and may cause them to react (NHS Design Council).

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 such lengths of time without any sense of progression.
3. Inhospitable environments - many people describe a dislike of hospitals, not least because they are full of sick people. Beyond the patients, hospitals can be uncomfortable places which are not pleasant to spend time in.
4. Dehumanising environments - sometimes the way patients are managed can further 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 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 be party to how other people are 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 help to trigger or worsen violence.
7. Perceived inefficiency - from a patient's perspective it can sometimes feel as if staff are disorganised and lacking focus. Patients 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.

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

Minimising Restrictive Practices

Reducing restrictive practices such as seclusion, restraint and forceful giving of medications is essential to the provision of safe health services for consumers, visitors and workers. Consistent with the objectives of the *ACT Mental Health Act 2015 and 5th National Mental Health and Suicide Prevention Plan*, there is a commitment to reducing and where possible, eliminating restrictive practices in mental health services.

All ACT public mental health services and in areas in a hospital that have been proclaimed and approved as an approved mental health service when working with people who are experiencing mental illness are required to have in place local procedures and clinical practices. These are to reduce, and where possible, eliminate the use of restrictive practices. Workers in all disciplines who work with mental health consumers in any setting are required to engage in this work (Framework for reducing restrictive interventions).

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

- Consumers, their support networks and workers are treated with respect and dignity and their rights and responsibilities are essential to promoting safety.
- People with lived experience, carers, workers, management and government have a role in the design and implementation of 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 consumers and their carers to ensure these programs are grounded in real-life experiences
- Adapt process and policies to embed reflective practice and critical reviews of incidents as they arise

Trauma Informed Care

Many people with mental illness and within 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.

Skills can be developed through training relevant to the workers and their roles. There are different types of training in de-escalation techniques, for example, conflict resolution, training in open disclosure and some workers have additional skills in limit setting, diversionary techniques and sensory modulation.

Workers must 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.

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 a Code Grey can be called in an actual or potential behaviour exhibited by a patient or visitor that creates a risk to health and safety of workers.

Code Grey must be clinically led, with the response team comprising 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 multi-disciplinary 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.

Code Grey	When a patient or visitor becomes verbally or physically aggressive to the extent that they present a threat to themselves or others.
Planned Code Grey	An anticipated response initiated by staff for scheduled events (e.g. patient 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 5- After an incident: post intervention

Providing staff with a clear procedure for what will occur once a report has been made, including defined responsibilities for staff, management and the broader organisation is likely to improve staff's confidence to manage challenging behaviour.

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 worker after the incident.
   - will encourage staff, patients, consumers, carers and visitors who experience serious OV.

2. **Keep in contact with the worker affected and offer support**
   - Contact the worker as soon as possible after an incident and determine how and when contact will be maintained.
   - Maintain regular contact with the worker.
   - Determine what support is required for the worker to return to work as early and safely as possible.

3. **Provide information on early intervention programs**
   - Employee Assistance Program (EAP).
   - Service specific service providers in the ACT (please contact your directorate/agency HR if you are unsure of these).

4. **Assist with reporting incident and workers compensation (if required)**
   - Complete staff incident form on RiskMan. One report should be added to RiskMan per incident, either:
     - by the worker if they have returned to work within 48 hours of the incident; or
     - by the manager (on behalf of the worker) 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 RiskMan 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.

Consequences of Challenging Behaviour

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 behaviours

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

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

Section 6- Reporting

Despite known high levels of OV towards workers, 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 workers (Pich, et al., 2010).

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

Strategies to increase reporting include:

- ensuring reporting platforms are simple and easy for workers to complete; (J Morphett Collegian 2018;)
- considering methods to capture high-volume, low impact incidents such as verbal abuse;

- Empower workers to expect a safe workplace an approach where empowering and involving staff, empower staff to report; (ANMF Victoria Branch 10 Point Plan);
- Management must demonstrate commitment to changing the culture of health care workplaces to reflect no acceptance of violence in health services;
- Health Services ensure workers are involved in action plans/strategies in the management of OV; and
- Use 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.

Governance Each ACT Public Health Facility 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 consumer engagement • Review of relevant data and information	
Key Actions	**Data Source, evaluation and metrics**
• Ensure governance structure to allow for quality improvement and to evaluate outcomes of strategies	• Committee meeting papers
• Ensure local policies and procedures in place to decrease incidence of challenging Behaviours	• Policies, procedures and guidelines
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 are developed are systems place	
Key Actions	**Data Source, evaluation and metrics**
• Review of screening, assessment and care to ensure it is provided in accordance with legislation and current clinical practice	• Medical Records
• Ensure procedures in place including: • Preventative strategies including screening in place • Restraint minimization • Clinical management including de-escalation	• Rates of screening

Prevention -changes to systems of care There are systems in place to enable prevention through design of service delivery (primary risk control)	
Key Actions	**Data Source, evaluation and metrics**
• Develop and implement strategies to review and improve safety of service design and environment, work practices and patient journey	• Committee meeting papers • Safety culture surveys
During an incident There are systems to ensure timely, safe and effective response for the protection of workers and 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	• Education and training records • Policies and procedures • Consumer feedback • Consumer experience surveys • Post incident review
Training and education Workers participate in relevant training and education	
• Ensure workers have the skills and knowledge relevant to their roles around getting help, equipment and policies and procedures	• Education and training records • Training Schedules and participation
Reporting and reviewing incidents An organisation wide system is in use and is reviewed Workers have skills and knowledge on reporting and review relevant 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	• Audit of medical records • Analysis is system wide data • Patient 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	• Medical records-documentation of application of force

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

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 workers to be safe at work.

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

References and Related Documents

References

- Anderson, K. (2011). *WORKPLACE AGGRESSION AND VIOLENCE: Nurses and midwives say NO.* Australian Nursing Journal, 19(1), 26-9.
- Cumming, A. (2016). Australian Commission on Safety and Quality in Health. *Webinar No 2 Getting started: Lessons from the field*. https://cognitivecare.gov.au/wp/wp-content/uploads/2017/08/Webinar-No-2-Getting-started-and-lessons-from-the-field.pdf
- Biancosino, B., et al. (2009). *Factors related to admission of psychiatric patients to medical wards from the general hospital emergency department: a 3-year study of urgent psychiatric consultations*. Int J Psychiatry Med 39(2): 133-146.
- Calow, N., et al. (2016). *Literature Synthesis: Patient Aggression Risk Assessment Tools in the Emergency Department.* Journal of Emergency Nursing, Volume 42, Issue 1, pp. 19-24.
- Daniel, C., et al. (2015). *Feasibility and need for violence risk screening at triage: an exploration of clinical processes and public perceptions in one Australian emergency department*, Journal of emergency medicine, Vol 32, pp. 457-462.
- Canberra Health Services Operational Procedure -Occupational Violence (OV)
- Emergency Medicine Australasia (2019). Letter to the Editor *Introducing routine risk assessment for occupational violence and aggression in the emergency department*.
- Canberra Health Services—Fact Sheet-managers responses for Occupational Violence (OV) related to injury
- Goldberg, S. E., K. H. Whittamore, et al. (2012). *The prevalence of mental health problems among older adults admitted as an emergency to a general hospital*. Age & Ageing, 41(1): 80-86.

- Griffith, J.J., Daffern, M. & Godber, T. (2013). *Examination of the predictive validity of the Dynamic Appraisal of Situational Aggression in two mental health unit,* International Journal of Mental Health Nursing, Vol 22, 485-492.
- Griffiths, A., A. Knight, et al. (2014). *Preparation to care for confused older patients in general hospitals: a study of UK health professionals*. Age & Ageing, 43(4): 521-527.
- Lantta, T., Kontio, R., Daffern, M., Adams, C.E. and Valimaki, M. (2016). *Using the Dynamic Appraisal of Situational Aggression with mental health inpatients: a feasibility study,* Patient Preferred Adherence, Vol 10, 691-701.
- Luck, L., et al. (2007). *STAMP: Components of observable behaviour that indicate potential for patient violence in emergency departments.* Journal of Advanced Nursing, Vol 59(1), pp. 11-19.
- McKenna, B., et al. (2016). *A literature review and policy analysis on the management of clinical aggression in Victoria*, Auckland University of Technology and Swinburne University of Technology, Melbourne Victoria.
- McKinnon, B., Cross, W. (2008) *Occupational violence and assault in mental health nursing: A scoping project for a Victorian Mental Health Service*. International Journal of Mental Health Nursing, Vol 17, pp. 9-17.
- Monks, R., A. Topping, et al. (2013). *The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: a grounded theory study*. Journal of Advanced Nursing, 69(4): 935-946.
- Muir-Cochrane, E., & Duxbury, J. A. (2017). *Violence and aggression in mental health-care settings. International journal of mental health nursing*, 26(5), 421-422.
- National Patient Safety Agency. (2007). *Recognising and responding appropriately to early signs of deterioration in hospitalised patient.*
- NSW Health (2018). South Eastern Sydney Local Health District Work Health and Safety – Violence Prevention and Management in the Workplace Procedure. https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDPR341%20-%20Violence%20Prevention%20and%20Management.pdf
- Ogloff, J.R.P and Daffern, M. (2006). *The Dynamic Appraisal of Situational Awareness: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients*. Behavioural Science and Law, 24, 799-813.
- Partridge, B., & Affleck, J. (2017). *Verbal abuse and physical assault in the emergency department: Rates of violence, perceptions of safety, and attitudes towards security*. Australasian Emergency Nursing Journal, 20(3), 139.
- Pich. (2019). *Violence in Nursing and Midwifery in NSW: Study Report*. New South Wales Nurses and Midwives Association Reports, Issue 2019.
- Pich, J., et al. (2010). *Patient-related violence against emergency department nurses*, Nurse Health Sciences, Vol 12, pp. 268-274.
- Pich, J., Kable, A., & Hazelton, M. (2017). *Antecedents and precipitants of patient-related violence in the emergency department: Results from the Australian VENT Study (Violence in Emergency Nursing and Triage)*. Australasian Emergency Nursing Journal, 20(3), 107.
- SA Health. (2015). *Policy Directive on Preventing and Responding to Challenging Behaviour*.

- SA Health website (2019). *Challenging Behaviour for health professionals*. https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Clinical+resources/Clinical+topics/Challenging+behaviour/
- Sands, N. (2007), *An ABC Approach to Assessing the Risk of Violence at Triage,* Australian Emergency Nursing Journal, No.10, pp.107-109.Department of Health and Human Services (2014). *Violence prevention and management: Standards for development of training and organisational responses in Victorian health services*. file:///C:/Users/fiona%20day/Downloads/Melbourne%20Health%20Report-v02%20-%20PDF%20(3).pdf
- WorkSafe ACT website (2018). Work safe in the workplace – Health and community services.https://www.accesscanberra.act.gov.au/app/answers/detail/a_id/3532/kw/work%20related%20violence#!tabs-11

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:

- Clinical Governance
- Partnering with Consumers
- Health care Associated Infection
- Medication Safety
- Comprehensive Care
- Communicating for Safety
- Blood Management
- 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, worker safety, Work Health and Safety, WH&S, safe workplace, worker health, risk control measures, risk assessment, control measures, risk management, code grey, challenging behaviour policy, OH&S, worker

Version Control

Version	Date	Comments
1	June 2020	NM TASC Steering Committee endorsed (Date)

Attachments

Attachment 1-Risk management process

Figure 2 The risk management process

Step 1: Identify the hazard	Identify the hazard - what or who could cause harm to workers, and/or other persons
Step 2: Assess the risk	Assess the risk - understand the nature of harm that could be caused by • how likely it is that harm may occur e.g. rare, unlikely, possible, likely, almost certain • how serious the harm could be e.g. insignificant, minor, medium, major, critical
Step 3: 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
Step 4: 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 workers 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 carers, visitors and patients, 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 past 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)

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 patients 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, carers and family;
- provide a supportive environment; and
- manage transitions effectively.

Attachment 4-Tiered behaviour management strategy

tr