Inquiry into Violence and Security Arrangements in Victorian Hospitals
AMA Victoria Submission

Doctors and other health care professionals must be able to work in an environment in which adequate procedures and policies operate to ensure their safety – only then can health care professionals be expected to deliver high-quality health care in an environment which promotes healing.

AMA Victoria welcomes this inquiry which should lead to the introduction of considered methods which minimise and prevent violence in Victoria's hospitals.

Incidence

There is limited accurate information available on the incidence of violence within emergency departments (EDs) however hospital staff exposure to aggression in the workplace has been well documented and is internationally recognised as a significant problem.[1] Commentators argue that doctors and nurses, particularly within EDs, regularly experience aggression;[2] on this, there is almost universal acceptance.[3] Doctors argue that violence in EDs and health facilities is at an unacceptable level and evidence suggests that such violence is increasing.[4]

Doctors within Victoria have reported that there is an epidemic of violence and aggression in EDs in our state's hospitals. Health care professionals are arguably forced to accept workplace violence as inherent to their profession, and intrinsically linked to their work.[5] This should never be accepted. Surveys of Australian nurses have indicated that many regard violence as "part of the job".[6]

It has been reported that violent incidents in EDs in Australasia occur at a rate of approximately 3 per 1000 emergency presentations.[7] In Australia, violent and unarmed threats involving patients in the ED have been recorded at an incidence of between 0.3% and 2%.[8] A study conducted at the Royal Melbourne Hospital ('the RMH study') found that from the 47,109 ED presentations analysed, 151 Code Greys were called. This is a rate of 3.2 per 1000 presentations.[9]

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[1] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 686
[2] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 3
[3] Delaney J (2001), Prevention and Management of Workplace Aggression: Guidelines and Case Studies from the NSW Health Industry, Central Sydney Area Health Service, Sydney (available through www.workcover.vic.gov.au).
[4] Delaney J (2001)
[5] Delaney J (2001)
[6] Bowie, V. and Malcolm, J. 1989, "Violence Against Human Service Workers", in J. Sheppard (ed.), *Advances in Behavioural Medicine*, Cumberland College of Health Sciences, Sydney, vol. 6, chapter 11, pp. 157–86.
[7] Australiasian College for Emergency Medicine, 'Violence in Emergency Departments' *Policy Document*. Ratified March 2004, http://www.acem.org.au/media/policies_and_guidelines/violence.pdf (accessed June 2011).
[8] Brookes J, Dunn R. The incidence, severity and nature of violent incidents in the emergency department. Emergency Medicine (Fremantle) 1997; 9: 5–9. 18. Phillips G. Senate 2005 Select Committee on Mental Health (written and oral submissions). Melbourne: Hansard; 2005.
[9] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 12

It should be noted that the RMH study, which focuses on the frequency of Code Grey calls, does not include in its figures the number of violent events for which a Code Grey call was not made. According to anecdotal evidence, a significant number of cases involving aggressive behaviour within EDs do not trigger a Code Grey. These types of violent events should be considered in any evaluation of the incidence of violence in hospitals and EDs. Another study has found that Australian registered nurses rate second highest amongst employee groups for workers' compensation claims as a result of violence.[10] A NSW survey indicated that 90% of ED nurses experience physical intimidation or assault at some point in their career, and 100% experience verbal abuse.[11] International data supports these findings. [12]

According to evidence, health workers are at significantly higher risk of experiencing violence in the workplace. An evaluation of workers' compensation data in Western Australia has revealed that during July 1995 to June 1998 almost half of all workplace assaults resulting in injuries or time lost from work are in health-related industries and community services.[13] A UK study of human service workers has shown that nurses and ambulance personnel were the two occupational groups most at risk from assault in the workplace.[14]

There are a multitude of reasons to explain the higher risk at which health professionals find themselves. Patients in a health care setting are often in a vulnerable situation – very often they will be anxious, possibly in acute pain, and in a position where they are expected to reveal very personal information about themselves.[15]

It is also important to note that high levels of violence within health settings are not only confined to EDs and hospital services.[16] A UK study has found that 10 per cent of general practitioners included in the study had been assaulted and 5 per cent threatened with a weapon. Another survey of general practitioners found 11 per cent had been assaulted and 91 per cent had experienced verbal abuse.[17]

The probability and severity of violence experienced by individual health workers varies between job tasks and the times at which workers are at work.[18] In Australia, fatalities on-the-job are low.[19]

There is strong anecdotal and empirical evidence that shows that health care workers in Victorian hospitals experience high rates of violence. This situation needs to change.

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[10] Perone S. Violence in the workplace. Canberra: Australian Institute of Criminology, 1999. (Research and Public Policy Series, No. 22.)
[11] Lyneham J. Violence in NSW emergency departments. *Aust J Adv Nursing* 2000 Dec-2001 Feb; 18(2): 8- 17.
[12] Kennedy M P, 'Violence in emergency departments: under-reported, unconstrained, and unconscionable' (2005) 183 *Medical Journal of Australia* 7, 363.
[13] Delaney J (2001).
[14] Mezey, G & Shepherd, J (Ed) (1994) Violence in health care: A practical guide to coping with violence and caring for victims, Oxford University Press, Oxford. pp 83–93, 195.
[15] Mayhew C (2000) *Preventing Client-Initiated Violence – a Practical Handbook*, Research and Public Policy Series, no 30, Australian Institute of Criminology, Canberra (available through www.aic.gov.au).
[16] Delaney J (2001).
[17] Cembrowicz, S. and Ritter, S. 1994, "Attacks on Doctors and Nurses", in J. Shepherd (ed.) 1994, *Violence in Health Care: A Practical Guide to Coping with Violence and Caring for Victims*, pp. 13–41, Oxford University Press, Oxford.
[18] Mayhew C (2000) *Preventing Client-Initiated Violence – a Practical Handbook*, Research and Public Policy Series, no 30, Australian Institute of Criminology, Canberra (available through www.aic.gov.au). P 9-10.
[19] Driscoll, T. Mitchell, R. Mandryk, J. Healey, S. and Hendrie, L. 1999, *Work-Related Traumatic Fatalities in Australia, 1989 to 1992*, National Occupational Health and Safety Commission, Ausinfo, Canberra.

Causes

A survey of 104 hospitals in California found that 53% of all hospital assaults occurred in EDs.[20] Reasons cited for the violence included 24-hour accessibility, easy access, minimal security, overcrowding, long waiting times, and inadvertent provocation by overworked or insensitive staff. Negative waiting room environmental factors have been suggested as contributors to violence in the ED.[21]

ED patients commonly present with psychiatric illness, substance abuse, or both. Staff often find it necessary to chemically restrain (by administration of sedation or antipsychotic medication) or physically restrain the patient so that they can perform an assessment.[22] The patient may need to remain restrained until their mental state improves. As a result, these patients commonly spend many hours in the ED whilst being treated, or may experience delays in transfer from the ED to a place of definitive inpatient treatment.[23] Prolonged exposure to the noise and activity in an ED can contribute to the patient's pain or fear, and heighten relatives' anxiety.[24]

Violence in EDs often involve patients with acute behavioural disturbance and, according to some reports, patients presenting with this condition are on the rise. [25] This trend has been attributed to the increase in use of recreational drugs such as 'ice' and underage alcohol abuse.

Violent incidents can also occur as a result of individual patient hostility which may be unprovoked or caused by a minor event.[26] Violence can arise from visitors and carers as a result of their being upset, anxious, or uninformed about medical procedures.[27] While studies in the US have found that levels of violence in EDs are commonly exacerbated by the fact that patients carry weapons, this is not a common occurrence in Australia.[28]

Mental health patients in emergency departments

Increasingly, EDs in major hospitals are performing a significant role in providing care to patients with mental health issues. The ED is often the initial point of contact, entry and treatment for patients with acute mental illness.[29] In 2002 the Victorian Department of Human Services Emergency Demand Coordination Group found that there had been a 13.2% increase in mental health presentations to Victorian EDs from 26, 902 to 30, 985 over 2000 and 2002 respectively.[30]

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[20] 'The California Emergency Nurses Association surveyed 104 hospitals in the state. *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 683.
[21] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 683.
[22] Knott JC, et al p 4
[23] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 685
[24] Hill S, Petit J. The violent patient. *Emergency Med Clinics North America* 2000; 18(2): 301-315.
[25] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* p 683
[26] Knott JC et al p 3.
[27] Mayhew C (2000) *Preventing Client-Initiated Violence – a Practical Handbook*, Research and Public Policy Series, no 30, Australian Institute of Criminology, Canberra (available through www.aic.gov.au).
[28] Mayhew C (2000)
[29] Management of mental health patients attending Victorian emergency departments, Knott J C, Pleban A, Taylor D, Castle D, 2007 *Australian and New Zealand Journal of Psychiatry* 41:9, 759.
[30] Gardner D. *Analysis of VEMD mental health emergency department presentations in 2000/01.* Melbourne: Emergency Demand Coordination Group, Department of Human Services (Victoria), 2002.

In this context, the ED commonly provides a management setting for patients with mental issues concomitantly affected by drugs.[31] However, most EDs are not secure environments for such patients who are at risk of self-harm or harm to others.[32]

Compounding these problems is the fact that there are often lengthy delays in processing patients with a mental illness. ED staff must wait for members of the psychiatric review team to assess patients, and Victorian doctors' experience suggests that systems and paperwork burdens prevent psychiatric workers from seeing these patients promptly, particularly within two hours of handover.

In addition, EDs are often required to deal with patients who have what is commonly referred to borderline personality disorder. In the past, such people were institutionalised but are now not actively managed by anyone. Typically these patients do not meet the criteria for involuntary detention under the mental health legislation. Additional resources should be directed to the provision of mental health services, thus lessening the burden on EDs and hospital staff.

Severity – a study of the Royal Melbourne Hospital

The RMH study is valuable, particularly given the limited general data available. Of the 151 Code Greys called, most occurred on Saturdays and the majority were called in the evening and overnight, with the peak rate occurring between midnight and 4am. In more than half of the Code Greys, a psychiatric illness was felt to be a contributing factor to the call.

A weapon was involved in only eight of the codes, and notably these instances did not involve knives or guns; the items consisted of personal items (such as shoes) or broken equipment. In 106 cases, the perpetrator needed restraining, 29 of the perpetrators were "talked down" and 16 were escorted from the hospital premises. Of those restrained, 69 were manually restrained by staff, 81 were shackled and 87 required some form of chemical restraint.[33]

Impact

Several commentators have argued that violence and the threat of violence has had a significant effect on employees who work in Australasian EDs.[34] Employers and employees can be affected in a number of ways, including by high levels of anxiety, depression, stress-related illness, as well as absenteeism and turnover amongst victims. There may be resultant diminished productivity, job satisfaction, decreased morale, decreased employee engagement, and difficulties with staff recruitment and retention.[35] The cumulative effect of violence may also result in clinician 'burnout.'[36]

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[31] Knott J C et al, 765.
[32] Knott JC et al, 766.
[33] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 9-10.
[34] Sheline Y, Nelson T. Patient choice: deciding between psychotropic medication and physical restraints in an emergency. Bulletin of the American Academy of Psychiatry and the Law 1993; 21: 321–329.
[35] Mayhew C (2000) page 6.
[36] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 686.

Violence in hospitals and EDs also regularly affects other patients and their visitors, commonly children. Patients should not have to endure abusive behaviour from other patients – whether directed at them or at other parties. This not only flies in the face of hospitals as a therapeutic environment, but also has the potential to antagonise other patients in a waiting room.

Underreporting

All figures associated with violence in hospitals and EDs must be viewed in light of the fact that underreporting of such incidents by health care workers is common. [37]

The authors of the RMH study argue that the findings suggest that under-reporting may have occurred.[38] A widely accepted estimate is that 1 in 5 incidents are reported.[39] Other studies report that up to 70% of violent episodes are not formally reported.[40] The reasons for non-reporting are many and varied. Doctors' experience in Victoria suggests that the paperwork and time-consuming nature of formal reports is a significant reason for failing to report an incident.

Lack of data

As mentioned above, there is a lack of adequate data on the incidence of violence within health care settings. There are a multitude of reasons for this; one being that many workplace violence episodes are not included in national workers' compensation databases.[41]

Other reasons include the lack of consistent definitions in the literature of violence in EDs and the fact that differing thresholds for initiating Code Greys exist between institutions. These factors limit comparisons between studies.

Recommendations

The evidence summarised above points to the clear conclusion that security arrangements in Victoria's hospitals and EDs must be improved. Safeguards must ensure the safety of our health care workers, and reduce their vulnerability to verbal abuse, intimidation, or physical harm in the workplace. Measures must also be implemented to counteract the prevailing assumption that violence in a health care setting is permissible and intractable.

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[37] Australiasian College for Emergency Medicine, 'Violence in Emergency Departments' *Policy Document*. Ratified March 2004, http://www.acem.org.au/media/policies_and_guidelines/violence.pdf (accessed June 2011).
[38] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 13
[39] Mayhew C (2000) p 7.
[40] Lyneham J. Violence in New South Wales emergency departments. *Aust J Adv Nurs* 2000 Dec-2001 Feb; 18(2): 8-17 & Merfield E. How secure are Australian emergency departments? *Emerg Med (Fremantle)* 2003; 15(5-6): 468-474.
[41] Delaney J (2001), Prevention and Management of Workplace Aggression: Guidelines and Case Studies from the NSW Health Industry, Central Sydney Area Health Service, Sydney (available through www.workcover.vic.gov.au).

Records

Every Victorian hospital should have a system for reporting violent incidents and staff should be encouraged to report all violent or aggressive incidents that have endangered, or have had the potential to endanger, staff safety. Clear and accurate recording of management, events and the reasons behind the action taken can aid care in similar events in the future, as well as protect staff from clinical and legal criticism.[42] Comparing records immediately after an event (for instance between doctors, nurses and security staff) may help overcome the problem of underreporting.[43]

Subsequent to incident reporting, investigation activities should follow which include recommendations to help prevent these incidents from recurring. Investigation activities are an integral part of workplace occupational health and safety procedures.

Simplifying the complaint process

As has been outlined, the experience of ED doctors in Victoria suggests that hospital staff often do not make formal notification of violence and assaults in EDs because it is complicated and time consuming.

Mechanisms for reporting and the forms to be filled out should be designed in a way that makes them easy to complete. Forms should not be burdensome and unnecessarily complex. Ideally, user friendly electronic databases should be used to capture the necessary data.

Education and training

Information should be provided to all health care staff, patients and visitors outlining the standard of behaviour expected of them within hospitals and other health care settings. Hospital waiting rooms should have posters and patient information sheets conveying the expected standard of behaviour and potentially the ramifications for failing to adhere to them.

Appropriate levels of education and training must be made available to staff in order that they understand what action they should take in the event of a violent incident, and how best to manage such an incident. Managing and potentially restraining an aggressive patient can involve a high number of staff and security. It is important that some staff members are allocated a leadership role (typically an experienced doctor) and that each member of staff knows what role they are to play in the event of violence.

Training should incorporate preventative strategies including effective communication skills; for instance lowered voice tone, eye contact and non-threatening body language which may assist in diffusing a situation. Clear explanation of treatment decisions and the reasons for them may also assist.[44]

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[42] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 686.
[43] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 14
[44] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 683.

Guidance should also be given on the identification and assessment of risks in relation to violence in their work environment, as well as control measures to address these risks. All hospital staff, but particularly ED staff, should be trained to recognise early signs of violent behaviour and the management of such signs.[45] This involves 'recognition of verbal and non-verbal cues' and 'an ability to utilise environmental and clinical resources to ensure a calm, controlled situation.'[46]
The above measures can help to cultivate a nonviolent culture and promote a safer workplace.[47] However it is also important that staff training involves reinforcing the importance of patient autonomy.[48]

Customising safeguards and strategies

It should be recognised that while some workplaces, such as major hospitals, are able to provide formal protective measures, others, such as small hospitals, cannot provide the same sorts of formal protective measures. In lower volume lower acuity workplaces the risk of violence may be lower, but the impact of it is likely to be higher when it does occur because of the lack of immediate response and assistance from security staff or police. Both settings should incorporate underlying policies which promote the personal safety and security of all staff.

Prevention strategies must be customised within each health care setting. Strategies should consider that increased incidence occurs after hours when fewer trained staff are available to assist.[49] This is also necessary because, as the RMH study identified, the likelihood of violence increased at night times, and on weekends.

Formal risk assessments should be conducted at each workplace, taking into account the times most likely to result in violent events. Continuous monitoring and evaluation of outcomes needs to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.

Visible, unarmed security staff

Hospitals should provide trained security officers on duty 24 hours a day. EDs should have easy and responsive access to security officers at all times. Security staff should be positioned in very close proximity to EDs, and available immediately when requested, either by a formal Code Grey call, or by informal means. This can act as an effective deterrent to violent behaviour and importantly can reassure staff in the event that their safety is threatened.

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[45] Australasian College for Emergency Medicine, 'Violence in Emergency Departments' *Policy Document*. Ratified March 2004, http://www.acem.org.au/media/policies_and_guidelines/violence.pdf (accessed June 2011).
[46] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 683.
[47] Kennedy M P, 'Violence in emergency departments: under-reported, unconstrained, and unconscionable' (2005) 183 *Medical Journal of Australia* 7, 364.
[48] *Textbook of Adult Emergency Medicine, 3rd Ed, Cameron et al (editors)* 684
[49] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 *Emergency Medicine Australas* 351-358 p 12

AMA Victoria opposes the use of armed guards in hospitals — in particular the placement of armed security staff into EDs. This measure has the potential for unintended serious consequences for the safety of staff and patients should firearms be discharged in close confines. More so, the sight of guns has the potential to unnecessarily intimidate patients or the public.

Also, the presence of weapons in EDs may lead to conflicts escalating into more serious incidents. The presence of guns may induce patients or their visitors to bring weapons of their own into EDs. Additionally in the close confines of the ED a gun could be appropriated by a patient (we are aware of at least two examples). Most concerning though are the consequences of guns being used inappropriately by the guards themselves. A patient who could be subdued through alternative means may end up being shot. We are of a Victorian case which supports this contention.
AMA Victoria recommends that all armed personnel who attend EDs (such as police officers and security guards) be required to place their weapons in an appropriate weapons locker prior to entering an ED.

There are other effective means of controlling aggressive patients in a health care setting which do not require the presence of guns and will not have such potentially dire consequences.

Use of light, colour, and art

In relation to health facility design, there is growing evidence to suggest that the carefully considered use of natural light, colour and art in the workplace has a calming effect on both staff and patients alike and decreases the incidence of anxiety-related incidents and associated medication requirement.[50]

Visible security monitoring devices

Doctors working in Victorian EDs have indicated that visible TV monitoring should be in operation within all Victorian hospitals, in appropriate locations. A suggested system includes that which is currently being utilised in banks whereby a presenting patient can see themselves on a TV monitor.

These devices should be placed with the triage nurse at reception, so as to immediately convey to patients and visitors that they are being watched, and that their behaviour is being recorded. These systems include an alert mechanism which is effective and relatively inexpensive. All EDs should have a combination of fixed alert trigger points, and mobile individual duress alarms. This response requires the presence of 24-hour trained security staff.[51]

Other aspects of hospital and ED design can also prevent outbreaks of violence. These include high visibility within the workplace, particularly in areas where drugs are stored, and restricted access areas.

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[50] Eisen & Nanda: Effects of Art On Patient Stress In A Psychiatric Unit: Can Art Affect Cost Savings? *June 2011 Journal Of Psychiatric and Mental Health Nursing.*
[51] Kennedy M P, 'Violence in emergency departments: under-reported, unconstrained, and unconscionable' (2005) 183 *Medical Journal of Australia* 7, 364.

Behavioural Assessment Rooms

Better facilities are needed in Victoria's EDs to deal with mental-illness-related and drug-related behavioural disturbance. Behavioural assessment rooms are an effective intervention for calming aggressive patients. Separating potential aggressors and removing sources of provocation has the potential to calm and relieve aggression. These specialised treatment rooms have been successfully trialled at St Vincent's Hospital and should be implemented in all public hospital EDs across the state.

For mentally ill patients

Given that current data indicates higher levels of patients presenting at EDs with a mental illness, it is recommended that greater efforts and resources are invested to ensure more prompt disposition from the ED to an appropriate mental health bed for suitable mental health patients. In particular, additional resources should be allocated to employing more psychiatric workers in hospitals especially within regional and rural areas. This would facilitate prompt performance of mental health assessments of patients and ease the currently high congestion levels within EDs.

Increasing penalties

Treating doctors should not be subjected to violence, abuse or threats to their safety.

AMA Victoria supports enhanced penalties for those who are violent towards hospital staff. This could cost-effectively reverse the trend of violence towards doctors and nurses in EDs and the wider health care setting. Assaults on health workers should become an aggravated offence and carry more significant fines, and longer jail sentences. This would bring penalties into line with those for assaults on police officers.

Increasing penalties for assault would be an effective way to send the message to the public that doctors and nurses occupy positions of respect.

Metal detectors unnecessary

AMA Victoria does not support the introduction of weapon searches or metal detectors. Given the lack of incidents involving traditional weapons such as knives and guns, this is unnecessary and could undermine the therapeutic nature of a hospital.