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ENVIRONMENTAL SCAN 317

Prevention of Occupational Violence and Aggression in Acute and Home-Based Health Services

Exploring interventions for prevention and management

An Environmental Scan to provide information on interventions that aim to reduce occupational violence and aggression in health services.

Dr Sarah Oxford / Dr Ivana Randjelovic / Ashleigh Blaire / Dr Sophie Pointer / Dr Janine McMillan

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EXECUTIVE SUMMARY

Background

Occupational Violence and Aggression (OVA) is a key hazard influencing mental and physical injury claims in Victorian health services. A range of interventions and risk controls exist to prevent or reduce harm from OVA, but limited published evidence exists on their effectiveness. There is also limited information on how these interventions are being used in health services and whether new or emerging controls are delivering improved results.

Aim, Objectives and Methods

The aim of this research was to identify interventions, risk controls and frameworks that have been implemented and evaluated in acute health services to prevent and manage OVA, including services provided in people's homes (home-based care). Objectives included:

1. To identify organisational policies, risk controls and other interventions that have been implemented to prevent or reduce OVA; and to explore how they have been evaluated and their effectiveness.
2. To understand how different health services approach and manage OVA across their health service and how they tailor OVA management to different settings (e.g., different interventions in emergency wards and home care settings).
3. To understand what barriers and enablers affect implementation of interventions and risk controls.
4. To understand how the worker safety outcomes are being used and evaluated.

An evidence review was undertaken utilising a rapid systematic review methodology on research published since 2020. Interviews and focus groups were conducted with key staff (N=16) from 11 health services in Victoria.

Key Findings

Evidence Review

The review included eleven studies, of which eight were primary studies, and three were systematic reviews. The studies were published between April 2021 and September 2022. In total, fifteen interventions were found.

Overall, the review found that the more holistic approach to OVA tends to bring better results in preventing incidents. The educational component remains one of the most important aspects of interventions. However, it is not sufficient as a stand-alone approach. Similarly, if not married with more proactive elements, various risk assessment approaches (tools and checklists) will increase recognition of OVA but will not necessarily prevent it or increase staff's sense of safety. Lastly, post-assault support from peers, a Project Coordinator, and leadership engagement increased the staff's sense of being heard and helped them mitigate the feeling of helplessness.

Types of interventions

The evidence review found six types of interventions aimed at the prevention of OVA in healthcare settings, including:

- Behavioural Emergency Support Team
- Assessing patients on admission
- Post-OVA support
- Walkthrough interventions
- Suite of interventions
- Educational interventions.

Outcomes

Overall the interventions had predominantly positive outcomes. Findings showed:

- Decreased OVA incidents, physical violence, verbal violence, Emergency Code Greys and the need for restraints
- Helped screen patients/situations and helped monitor and manage patients
- Increased Planned Code Greys, effectiveness of skills and strategies used in patients' management plans, reporting OVA incidents and perception of organisational support
- Had predominantly positive impact on staff (see Table below).

	Topic	Outcomes for staff	Number of interventions
Positive changes	Skills	Caring for aggressive patients	2 interventions
		Situational awareness	1 intervention
		Early recognition skills	3 interventions
		Coping with OVA	1 intervention
		Communication techniques	1 intervention
		De-escalation techniques	2 interventions
	Knowledge	Psychiatric resources	1 intervention
	Feelings	Being cared for	1 intervention
		Decrease in anxiety when managing OVA	1 intervention
		Decrease in burnout	1 intervention
	Attitudes	Changed attitudes about OVA	1 intervention
	Relationships	Between staff and security	1 intervention
Mixed outcomes	Confidence	Staff's confidence in managing OVA	3 positive, 1 no change
	Feeling safe	Feeling of safety at work	1 positive, 1 no change

Interviews and Focus Groups

Occupational violence and aggression is a problem that involves complex systems and intersecting barriers and enablers. Incidents of OVA can occur anywhere within a health service, but health services identified the Emergency Department (ED) as the location where most OVA incidents occur.

Most health services have OVA committees that focus specifically on the prevention and management of OVA. Health services with OVA committees that have positively impacted the health service credited executives for championing the cause, which has driven top-down cultural change.

Services where executive leaders champion OVA prevention have allocated more resources to experiment with innovative training ideas. These health services offer training with multiple modules and components tailored to specific high-risk roles (e.g., incident responders), special wards (e.g., ED, paediatrics, geriatrics) and home-based care. Irrespective of location and size, health services identified similar training challenges, including staff shortages, generic training, and the need for more de-escalation and standard physical, practical skills training.

Because OVA is complex and health services have diverse department contexts with various needs, there are many strategies for prevention and mitigation. Examples include leadership and teamwork strategies, prevention instruments and risk and behaviour management tools. Interventions and tools identified as the most beneficial included buy-in from executive leadership, changing structural issues that improve the patient experience, planned code greys and anything that provided staff with more support (e.g., clinical lead, security) before and during an incident. However, robust evaluations are needed.

Participants addressed many intersecting barriers and enablers in their health services. These were common among all health services but varied in intensity. Opportunities for improvement include:

Individual – Working to alter a staff culture that normalises OVA and underreports.

Health Services – Addressing staff shortages and burnout, under-resourced OVA prevention staff/teams, and improving structural issues that inhibit the patient's experience (e.g., loud noise)

Community and public policy – Improving the general publics' negative behaviour towards staff; resolving the tension between legal entitlements that confuse health services; enabling de-escalation training, and creating a standardised approach to physical interventions.

Health services appreciated WorkSafe's efforts to date. Suggestions for further investment from WorkSafe included providing a platform for information sharing, supporting health services with evaluation and benchmarking, and being proactive with visits, improvement notices and prosecutions.

BACKGROUND, AIM AND OBJECTIVES

Occupational Violence and Aggression (OVA) is a key hazard resulting in mental and physical injury in health services in Victoria. A range of interventions and risk controls exist to prevent or reduce harm from OVA, but limited published evidence exists on their effectiveness. There is also limited information on how these interventions are being used in health services and whether new or emerging controls are delivering improved results.

The aim of this research was to identify interventions, risk controls and frameworks that have been implemented and evaluated in acute health services to prevent and manage OVA, including services provided in people's homes (home-based care).

Objectives:

1. To identify organisational policies, risk controls and other interventions that have been implemented to prevent or reduce OVA; and to explore how they have been evaluated and their effectiveness.
2. To understand how different health services approach and manage OVA across their health service and how they tailor OVA management to different settings. (e.g., different interventions in emergency wards and home care settings)
3. To understand what barriers and enablers affect the implementation of interventions and risk controls.
4. To understand how the worker safety outcomes are being used and evaluated.

APPROACH

Evidence Review

Four academic databases (Medline, ProQuest, PsycInfo, and CINHAL) were searched using the appropriate coding strategies for each database. The following search strings were utilised:

- violence OR aggression OR hostility OR violent OR aggressive behaviour AND
- occupational OR work-related OR workplace AND
- prevention OR strategies OR methods OR techniques OR interventions OR best practice AND
- healthcare OR healthcare OR hospital OR health services OR health facilities.

In addition, a search using a simplified version of search terms was conducted in Google Scholar.

Please refer to Figure 1 below for a methodology overview.

Inclusion and Exclusion criteria

The studies were included if they were published between April 2021 to September 2022 (the last date of the search was 23.09.2022). The starting date was determined based on the dates for the previous update prepared for WorkSafe by RTK People Strategies.[1]

Inclusion criteria:

- Studies published in English
- Peer-reviewed primary studies and systematic reviews
- Interventions conducted in healthcare settings
- OVA is defined as patient and visitor violence.

Exclusion criteria:

- Study did not relate directly to healthcare services
- Study did not address prevention strategies or interventions
- Individual case reports
- There was no evidence that the intervention was evaluated
- OVA was defined as lateral violence and bullying.

Lastly, the studies were excluded if they were already presented in the report prepared by RTK People Strategies[1]. With that regard, two studies were eliminated, Arnetz et al.[2] (included in both Kumari et al. 2021 and Somani et al. 2021) and Baby et al.[3] (included in Kumari et al. 2021).

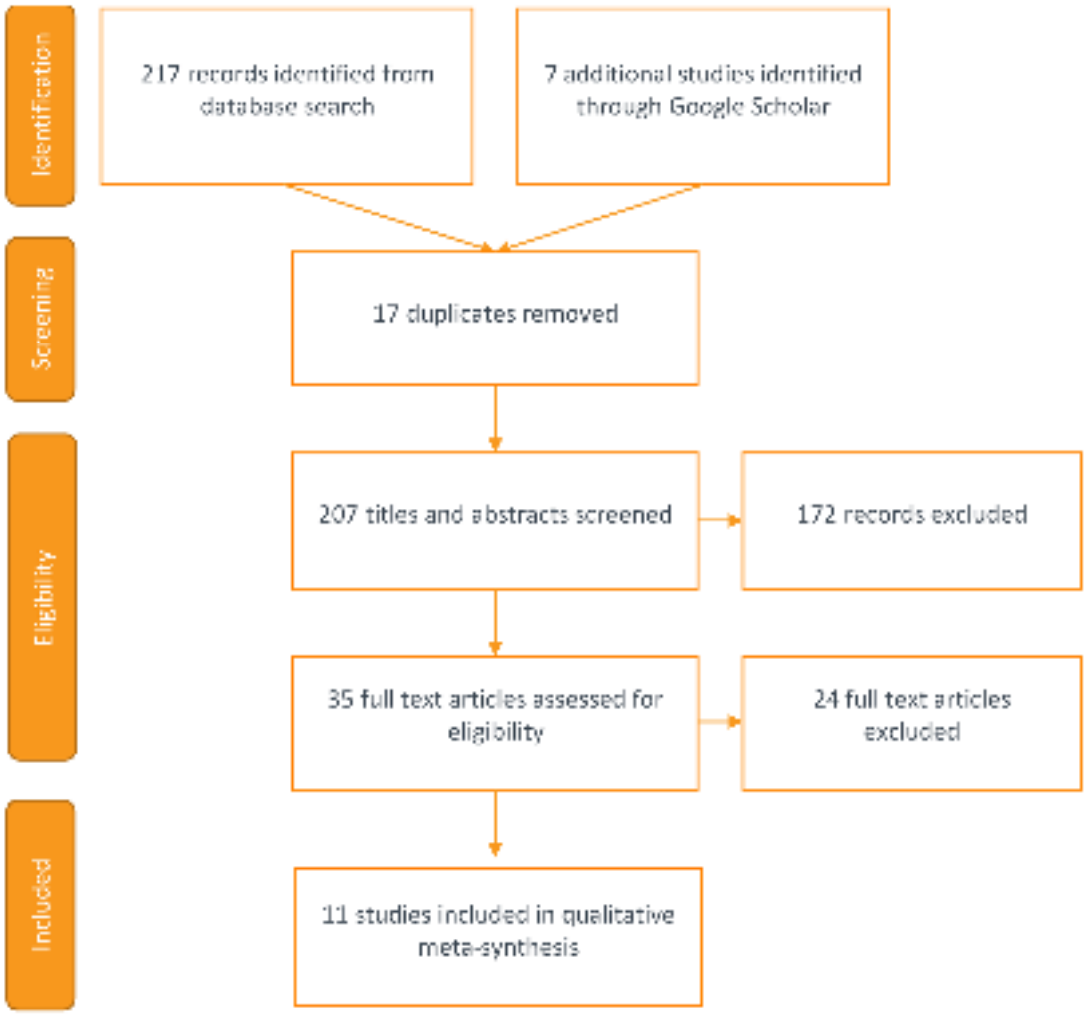

Fig 1. Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) Checklist

Interviews and Focus Groups

Semi-structured interviews and focus groups were conducted with staff from 11 health services in Victoria. The ISCRR Research Team collaborated with WorkSafe Victoria to develop the interview guide (see Appendix). A purposeful sampling strategy was utilised to identify participants. In this approach, WorkSafe provided ISCRR with a list of 24 health services operating across Victoria. ISCRR researchers divided this list into cohorts based on demographics of metropolitan, regional and private sector.

Through email, ISCRR contacted 11 health services, requesting staff from senior positions and 'frontline' positions to voluntarily participate in a 45-minute semi-structured interview about the prevention and management of OVA at their workplace. All health services contacted indicated an interest in participation; four requested focus groups so multiple staff members could participate, however, on the date three scheduled focus groups were replaced by interviews as five additional staff cancelled.

Once the participant agreed to take part, a Zoom meeting was scheduled at a mutually convenient time. At total of 16 interviews or focus groups were conducted with health service staff, including those in senior roles such as Director, Manager and Advisor (n=13) and frontline staff, such as HSR

nurse (n=3). Reasons for the limited number of frontline staff interviewed included scheduling challenges due to staff resourcing and frontline staff workload. Interviews and focus groups lasted between 45 and 90 minutes.

Interviews and focus groups explored interventions that have been implemented to prevent or manage incidences of OVA and their evaluations. Participants were probed on best practices, evidence of success and asked for suggestions on how WorkSafe could help them prevent OVA in the workplace. Participants provided details on specific examples when possible.

After hearing about OVA prevention and management at 11 health services from 16 participants, it was deemed that the project had reached data saturation, and further interviews were not required.

Participants provided consent for the recording of the information and for the use of the information provided. To ensure participants cannot be identified in this report, quotes are attributed to the health service they represented, rather than a participant number. The interviews were transcribed and themes were identified inductively through thematic analysis coding and refined through content analysis using NVivo 12 software.

Ethics

This research was approved by Monash University Human Research Ethics committee on June 29, 2022 under project code 32992. All participants identities are confidential, and their quotes de-identified in the report.

EVIDENCE REVIEW

A total of eleven studies were included in this review, of which eight were primary studies (see Table 1), and three were systematic reviews (see Table 2). The three systematic reviews included in this report contain further primary studies published between the year 2000-2021. To avoid repetition, interventions that were already included in the previous update prepared for WorkSafe by RTK People Strategies were not presented in this report. In total, fifteen interventions were identified.

Ten interventions were conducted in the USA, while one was conducted in each of the respective countries: Australia, Canada, France, Pakistan and Sweden. Nurses were the predominant population for the interventions (eight interventions), followed by emergency department staff (four), general staff (two), and intervention-related staff (one intervention). Academic and teaching hospitals were the most common setting for interventions (seven), followed by the emergency departments (four). Acute hospital settings and general healthcare were settings for one intervention.

Intervention duration times varied widely. The educational components lasted between one hour and three months (when training multiple staff), while the interventions lasted four months to ongoing. Several studies did not report on the duration of interventions. The interventions' intensity was seldomly reported; only five studies included this information. In some interventions, the intensity was more frequent, e.g., the intervention was administered on the patient's arrival and then regularly when checking for their vital signs. [4] In others, the intensity was reported as only once a year, e.g., a training implemented as a part of nurses' annual professional development.[5]

The interventions employed multiple methodologies, including evaluations (five), prospective studies (three), quality improvement projects (two), quasi-experimental studies (two), pragmatic cluster cross-over trial (one), and a retrospective case-control study (one). Data collection methods also varied between interventions, with the most common being pre- and post-implementation surveys. Other methods involved collecting data on the emergency response team or security calls, surveillance records, incident reporting and patient records, and using scales.

The interventions were grouped based on the type of support they aimed to provide, including Behavioural Emergency Support Team interventions (three), assessing patients on admission (two), post-OVA episode support (three), walkthrough interventions (three), a suite of interventions (two), and educational interventions (two). The following section of this report outlines the interventions.

Table 1. Interventions characteristics (primary studies)

Author/year	Intervention	Country	Population	Settings	Duration/Intensity	Methodology/methods
Christensen et al. 2021	Behavioural Emergency Response Team (BERT) program	USA	Nurses & nursing assistants n=302 Telecommunication dispatchers n=20 BERT Responders n=78 Bedside nursing staff n=43	Acute care hospital setting, academic medical centre	Training 3 months, intervention ongoing Intensity N/A	Plan-Do-Study-Act evaluation Baseline questionnaire, formal reports of aggressive patient encounters, documentation from patient safety rounds, and records of activated BERT responses.
Hasselblad et al. 2022	Behavioural Intervention Team (BIT)	USA	Nurses n=82	Academic medical centre hospital. The BIT rotated between an adult medicine unit and a mixed cardiac unit monthly	N/A	Pragmatic cluster cross-over trial Pre- and post-implementation surveys.
Okundolor et al. 2021	A suite of multifaceted interventions to reduce patient-to-staff violence in psychiatric ER	USA	Psychiatric emergency room staff n=82	Psychiatric emergency services in a large public, academic hospital	Approximately 2 years Intensity N/A	The performance improvement project, Plan-Do-Study-Act evaluation Hospital incident reporting tool, and surveys were conducted pre-intervention (baseline), during & post-intervention.
Senz et al., 2021	Brøset Violence Checklist integrated with a score based	Australia	ED nurses n=83	Metropolitan teaching hospital	Ten months	Evaluation

Author/year	Intervention	Country	Population	Settings	Duration/Intensity	Methodology/methods
	notification and response framework			- Emergency Department	Checklist completed on patient's arrival, and regularly together with vital signs check	Pre/post-implementation survey, point prevalence study, the rate of planned and unplanned (emergency) security responses to OVA.
Shaikh et al., 2022	Low-cost client, policy, and provider interventions for preventing OVA	Pakistan	ED staff and patients Karachi n=481 Peshawar n=135	Two tertiary-care emergency departments	Training 3 months. Intensity N/A	A quasi-experimental pre-post longitudinal study Pre and post-intervention surveillance.
Thompson et al. 2022	De-escalation training (DET)	USA	Nurses n=98	Academic medical centre - cancer centre	Duration N/A Training administered once	Quality improvement (QI) project Clinician Confidence in Coping with Patient Aggression survey (CCPA), data collection from number/type security calls pre/post-intervention.
Tommasini et al. 2022	Behavioural Emergency Support Team (BEST)	USA	Nurses n=N/A	Teaching hospital	Two years BEST code called as needed	Evaluation Behavioural diagnoses of BEST code patients.
Yost et al., 2022	Behaviour Management Consultation-Liaison (BMCL) service	USA	Nurses n=46	Academic medical centre	The one-hour training session; the intervention ran for 4 months Training delivered once	Quality improvement project Pre- and post-intervention survey.

Table 2. Intervention characteristics (systematic reviews)

SR	Author/year	Intervention	Country	Population	Settings	Duration/Intensity	Methodology/methods	QA score
Kumari et al. 2021	Wong et al. (2015)	Interprofessional collaboration training and self-defence strategies	USA	Emergency Department staff: nurses, physicians, hospital police, and ancillary staff n=106 Female=61, Male=44	Emergency department (ED). New York Simulation Centre for the Health Sciences (NYSIM)	Duration N/A For nurses, training delivered as a part of the annual PD. For residents, training delivered in 10 sessions.	Pre-post-test design. The survey, Management of Aggression and Violence Attitude Scale (MAVAS)	5 – Fair (75% -50% (6.75-4.5) Johanna Briggs Institute Critical Appraisal Tools.
Somani et al. 2021	Hamblin et al. (2017)	Worksite walkthrough	USA	Supervisors and staff of 41 hospital units across the seven hospitals n=15,000	A large metropolitan hospital system	6 weeks Intensity N/A	A structured worksite walkthrough. A questionnaire sent to intervention and control groups 12 months after the intervention was conducted	Low risk of bias N/A
Somani et al. 2021	Kling et al. (2011)	Violence risk assessment system 'The Alert System'	Canada	Nursing staff n=N/A	Acute care hospital	N/A	Retrospective case-control study	Low risk of bias N/A

SR	Author/year	Intervention	Country	Population	Settings	Duration/Intensity	Methodology/methods	QA score
							Hospital violence incident rates	
Somani et al. 2021	Gillespie et al (2014)	Intervention focusing on environmental changes, policies and procedures, and education and training	USA	Nurses n=209	Four emergency departments	18 months Intensity N/A	A quasi-experimental, repeated measures design Baseline Demographic Survey, Monthly Survey, Violent Event Survey	Low risk of bias N/A
Somani et al. 2021	Arnetz & Arnetz (2000)	The Violent Incident Form (VIF)	Sweden	Nurses n=1500	47 healthcare workplaces, including emergency departments (5), geriatric (7), psychiatric (32), and home healthcare sites (3) in Stockholm County, Sweden.	12 months Intensity N/A	Prospective study Pre and post-intervention survey	Low risk of bias N/A
Wirth et al. 2021	Gillespie et al (2013)	Intervention focusing on environmental changes, policies and procedures, and education and training	USA	Emergency department employees (nurses, physicians, and unlicensed	Three Emergency Departments	21 months Intensity N/A	Cross-sectional evaluation study using action research Formative evaluation of the program implementation and a	1 - Poor/low (<3 = low quality) Johanna Briggs Institute

SR	Author/year	Intervention	Country	Population	Settings	Duration/Intensity	Methodology/methods	QA score
				assistive personnel) n=53			summative evaluation of the program and components	Critical Appraisal Tools
Wirth et al. 2021	Touzet et al. (2019)	A five-component intervention programme designed to address long waiting times and lack of information.	France	Healthcare workers n=30	Adult ophthalmology Emergency Department - Urban university hospital	18 months Intensity N/A	Single-centre, prospective interrupted time-series study Patients' data, medical records	5 - Moderate (4-6 = moderate) Johanna Briggs Institute Critical Appraisal Tools

Behavioural Emergency Support Team Interventions

Three papers discussed the implementation of the Behavioural Emergency Support Team (BEST) interventions.

Behavioural Emergency Support Team (BEST)

Tommasini and Iennaco[6] evaluated the implementation of the **Behavioural Emergency Support Team (BEST)** in a teaching hospital in the USA. The intervention was modelled on the Rapid Response Teams already delivered in various hospitals to manage medical emergencies. The BEST provides support for non-psychiatric staff in behavioural emergencies that occur outside of a behavioural healthcare setting. The team was composed of a team leader, the medical patient's primary nurse, the medical unit's charge nurse, the patient's primary medical provider, and protective services officers. An off-shift nursing leader and an on-call psychiatrist were available during off-shifts, weekends, and holidays.

When the BEST code was called, the team leader facilitated a huddle to assess the situation and plan the intervention, de-escalation techniques and communication. The team gathers again once the intervention has finished to de-brief, discuss a patient's triggers, and model follow-up strategies and modifications to the treatment plan to prevent future risks. Lastly, the flow sheet of the BEST code is added to the electronic medical records (EMR).

Data were collected on the eight medical wards over the period of two years. During that time, the code was called 124 times for 96 patients, including 19 repeated events. The response team used verbal de-escalation techniques in all codes, psychopathic medications were used in 63% of codes, and physical restraints were used in 16% of codes. Staff injury was reported for two out of 124 BEST codes.

The intervention resulted in a decreased need for restraints, a better sense of safety for staff, a decrease in burnout, a heightened sense of being cared for and overall better knowledge of psychiatric resources. However, the intervention was resource intensive, and everyone involved was staff trained in the BEST model. The researchers found that due to staff shortages in the healthcare industry, this intervention may not be feasible or replicable in other settings.

Behavioural Emergency Response Team (BERT)

A similar intervention was discussed by Christensen et al.[7], who evaluated **a Behavioural Emergency Response Team (BERT)** program. BERT was designed to report and de-escalate aggressive patients in an acute care hospital and was implemented as an ongoing initiative. The intervention involved a group of employees, including a baseline group, telecommunication dispatchers, BERT responders, and bedside nursing staff who all received training before implementing the intervention.

Daily safety rounds were held between the nurses and safety officers to proactively identify and pre-empt potentially violent situations. The BERT team was engaged if an incident became violent. In the aftermath of a violent episode, the staff held de-briefing sessions and a post-reporting system was implemented to keep track of the incidents.

Baseline cross-sectional data were collected from nurses and nursing assistants about the prevalence of patient aggression, confidence in working with aggressive patients, and the relationship with security officers. Violent episodes were tracked through incident reporting pre-intervention, during the intervention, and at the first-year mark. The researchers also monitored how often the BERT code was called and a potential threat identified.

The study showed that the safety rounds and partnership between nursing staff and security officers were a success, and 41 potentially aggressive patients were identified. The nursing staff were reported to be more confident and capable of managing potentially aggressive patients. The BERT

code was called only three times in the first year but more often in the following years. This was explained by the success of the safety rounds and because the nurses became more familiar with the process.

Behavioural Response Team

Okundolor et al.[8] evaluated a suite of interventions organised around the **behavioural response team (BRT)**. The authors included the following elements in their intervention: behavioural response team, pre-shift meetings, screening for patients at risk for violence, the Golden Hand protocol and signage to communicate high-risk patients, mitigating countermeasure interventions, post-assault de-briefing, and peer and leadership post-assault support. This intervention varies from the above-mentioned similar interventions in two ways: the Golden Hands protocol and post-assault support.

The Golden Hands protocol screens out patients with a propensity for violent outbursts in order to avoid triggering the patient into an aggressive episode. The patients were discussed in the pre-shift meetings before staff commenced their shift. All critical information about patients was documented on a form and updated at the end of each shift. When working with the aggressive patient, the staff used mitigation techniques, including working in pairs, maintaining a distance, and maintaining a line of sight on the patient.

The addition of the post-assault peer support helped promote staff resilience and experience sharing, which in turn, helped with psychological and emotional support. Another type of post-assault support was visitations from the leadership, indicating the assaults on staff were a priority. Both peer and leadership support aimed to mitigate feelings of helplessness and being unsupported.

The outcomes of the intervention show that the utilisation of the Golden Hands protocol helped to successfully screen the most aggressive patients allowing the staff to focus resources and efforts on the high-priority individuals. It also helped with monitoring and managing patients. Overall, the intervention helped staff improve their efficacy in dealing with aggressive situations and be more confident when dealing with aggressive patients.

Similar to the previous two interventions, the research team found BRT to be resource-intensive and for that reason may be difficult to replicate in other psychiatric emergency departments.

Assessing patients at admission

Assessing patients at admission as an OVA prevention strategy was discussed in three studies. The interventions included using a behaviour intervention team, checklist and a risk assessment form to screen patients.

Behaviour Intervention Team

Hasselblad et al.[9] utilised a Behaviour Intervention Team (BIT) intervention in which a psychiatric mental health practice nurse and a social worker proactively screened patients on admission to determine potential behavioural issues. The team was supported by a psychiatrist when needed. Based on the screening outcomes, the BIT provided nursing staff with mitigating interventions, including psychiatric consultation, behavioural plans of care for nurse/patient interaction, and other psychosocial support.

Overall, the nurses reported an increased ability to provide care to aggressive patients. They also reported lower physical abuse and decreased anxiety when managing aggressive situations. However, the intervention did not help reduce documented disruptive behaviours.

Brøset Violence Checklist

Senz et al.[4] evaluated the implementation of a multifaceted intervention in an emergency department of a metropolitan teaching hospital in Melbourne, Australia. In the first round, the educational component for the nursing and medical staff was implemented (there were no further

details about the content of this component). The Brøset Violence Checklist (BVC) with integrated score-based notifications and response framework was introduced in the next stage. The BVC is a tool that assesses confusion, irritability, boisterousness, verbal threats, physical threats and attacks on objects.[10]

The BVC was added to the already existing observation chart, and the screening was conducted for all newly arrived patients and updated on an ongoing basis at the same time as other vital signs. The patients were ranked based on the score, and the risk was classified either as low (score of 0), moderate (1–2) or high (>2). Accordingly, the response framework was used by healthcare staff to decide further steps, including de-escalation techniques, pharmacological interventions, or physical restraint.

The study results show a significant improvement in confidence in and performance of risk screening and an increase in perceived organisational support. The confidence to prevent violence and feelings of safety at work did not improve. Pre- and post-intervention prevalence data showed that the risk of violence assessment increased from 30% to 82% and for the subset of patients with a mental health or alcohol/drug presentation, from 54% to 100%. Lastly, the study found a clinically significant decrease in Emergency Code Greys and a statistically significant increase in Planned Code Greys.

The Alert System

A violence risk assessment system named **'The Alert System'** was evaluated by Kling and colleagues.[11] In this intervention, nurses used a risk assessment form to assess patients on admission to identify those at an increased risk of violence. A patient identified as a potential risk had a flag added to their chart and received a wristband. These signs were used to warn staff to exercise caution when approaching the patients. The staff were also trained in strategies for working with a potentially violent patient, including prevention and de-escalation strategies. Other protocols available to staff included wearing a personal alarm, having the security team nearby, removing sharp objects from the patient's room, and not entering the patient's room alone.

Overall, the OVA incident rate decreased during the intervention implementation period, from 1.6 events per 100,000 worked hours to 1.1 events per 100,000 worked hours.

Post-OVA episode support

Two studies evaluated interventions aimed at post-incident support, including consultations with a clinical psychologist and sessions with a project coordinator.

Behaviour Management Training and Behaviour Management Consultation Liaison

A two-element intervention consisting of **behaviour management training and behaviour management consultation liaison** services was evaluated by Yost and colleagues.[12] First, the staff were trained in proactive methods for daily interactions with patients and reactive strategies matched with the previously identified aggressive behaviours of patients with neurological conditions. Next, a clinical psychologist provided the behaviour management consultation to four high acuity units with the highest violent incidents. Consults were initiated by staff or offered in the aftermath of an OVA event. The focus of the consults was to create a patient-focused behavioural treatment plan and help staff consistently implement the plans.

Overall the behavioural emergencies decreased by 50% in the three months after the intervention. Staff reported increased confidence in caring for patients with neurological conditions and the effectiveness of skills and strategies used in patients' management plans. Staff also reported feeling supported by the leadership and having clear roles and responsibilities.

Violent Incident Form

The effectiveness of the **Violent Incident Form (VIF)** intervention was assessed by Arnetz & Arnetz.[2] The intervention aimed to implement a structured reporting of OVA incidents in the healthcare

setting in Stockholm, Sweden. The VIF is a one-page checklist that allows for the data of the violent incident, including time, place, perpetrator, activity, and consequences, to be collected. A follow-up support session with the project coordinator was available for staff who experienced an OVA incident. The session aimed to discuss the incident, check if the staff member needed further support, and for the coordinator to learn the details of the incident.

Overall, the nurses in the intervention group reported 50% more workplace violence incidents when compared to the control groups. The increased awareness of high-risk situations for workplace violence, strategies to avoid such situations, and dealing with aggressive patients was reported in the intervention units.

Walkthrough interventions

Walkthrough interventions were employed in three studies and accompanied by recommendations for environmental, administrative and behavioural changes.

3-component intervention

In the two studies by Gillespie et al.[13, 14], the researchers evaluated the implementation of a **3-component intervention** in emergency departments in the USA. The intervention aimed to deliver environmental changes, policies and procedures, and education and training. In the environmental aspect, the researchers conducted walk-throughs with hospital staff and recommended potential changes. Next, the research team designed a proposal for policies and procedures for each hospital based on stakeholder discussions. The proposals were reviewed and approved by the chief of nursing. Lastly, the researchers developed educational content based on the inputs from employees and managers.

The employees rated the intervention as moderately beneficial. The most important aspects of the intervention were environmental changes and classroom education. Lastly, there was a significant decrease in physical assault incidents and threats against ED workers.

Worksite walkthrough

A similarly structured **worksite walkthrough** intervention was evaluated in the study by Hamblin et al.[15] The walkthrough was conducted for 21 hospital units and was restricted to 45 minute sessions. Data were also collected from unit-level OVA incident reports. Based on the information from both walkthroughs and incident reports, a unit-specific Action Plan was developed to be completed by unit supervisors and their staff. Three types of prevention strategies were suggested:

- Environmental (panic buttons, locks)
- Administrative (policies for workplace violence, safety procedures)
- Behavioural (staff knowledge and training for workplace violence incidents).

The results showed that participants found the walkthrough intervention beneficial for OVA reduction.

Suite of interventions

Two studies evaluated suites of interventions aimed at OVA incidence reduction.

Multipronged intervention

Shaikh et al.[16] evaluated **a multipronged intervention** in two medical centres in India. Firstly, a surveillance system was installed, and data on violent incidents were collected over three months. The software was developed to gather and record the data, and the surveillance officers were trained to record the information. Next, low-cost interventions aimed at clients, policy and providers were implemented.

Client-oriented interventions included raising awareness about OVA through posters, pamphlets, and videos about trusting healthcare workers and following their advice. Interventions aimed at providers included training for doctors, paramedics, and security guards. Policy-oriented interventions included briefing healthcare workers on responding to OVA and seeking help, introducing visitor IDs, and training management staff to share waiting times and progress with patients.

The results show that in Karachi, physical violence incidents decreased by 42.9%, while in Peshawar, verbal violence incidents decreased by 47.7% and physical violence incidents by 57.9%.

5-component intervention programme

Touzet et al.[17] evaluated a **5-component intervention programme** designed to address long waiting times and lack of information. The following components were included in the intervention:

- computerised triage algorithm to manage patients based on the seriousness of their cases
- improved signage to assist with patients' understanding of the care pathway
- information on the waiting time was broadcast on a TV in the waiting rooms
- a mediator trained to intervene when patients showed signs of impatience or nervousness and in case of conflict involving a patient or visitor
- video surveillance cameras were installed behind the admissions desk and in corridors and connected to the hospital security control room.

The study's results showed that the number of self-reported acts of violence decreased from 24.8 per 1000 admissions pre-intervention to 9.5 per 1000 during the intervention period.

Educational interventions

De-escalation technique training was the subject of two interventions.

De-escalation Training

Thompson and Zurmehly[18] evaluated the **de-escalation training** for nurses in an academic medical centre setting. The training was based on crisis intervention training, trauma-informed care, and Richmond's ten steps of de-escalation, which are as follows:[19]

- respect personal space
- do not be provocative
- establish verbal contact
- be concise
- identify wants and feelings
- listen closely to what the patient is saying
- agree or agree to disagree
- lay down the law and set clear limits
- offer choices and optimism
- de-brief the patient and staff.

Originally developed to be delivered face-to-face, due to the COVID-19 restrictions, the training was transitioned to an online environment. The training included videos of simulated patient scenarios and post de-briefing sessions. The de-escalation training was administered once to help nurses with situational awareness, early recognition, and improved coping and confidence in dealing with aggression.

A 10-item Confidence in Coping with Patient Aggression (CCPA) scale was used to measure nurses' confidence in coping with patient aggression. The de-escalation training was evaluated based on the participant's knowledge and skills gained in training. In addition, monthly de-identified Excel spreadsheets were used to report security calls, the incidence of violent episodes, and injury events.

Overall, the results showed improved situational awareness, early recognition skills, and confidence in coping with aggression.

The study was conducted at the beginning of COVID-19 pandemic when the healthcare settings were dealing with enormous pressure and staff shortages. To minimise time away from work and to make it more cost-efficient the training was delivered online.

Simulation-Based Educational Intervention

Wong et al.[5] evaluated **a simulation-based educational intervention** aimed at emergency department staff of the New York Simulation Centre for the Health Sciences. They utilised a team-based approach to design a novel patient safety curriculum targeting staff attitudes toward patient aggression, de-escalation techniques, and team collaboration during patient-related behavioural emergencies. The intervention also included personal self-defence techniques and team-based interprofessional approaches to managing the OVA.

The study found the intervention supported staff to utilise communication techniques better to identify early signs of OVA, and de-escalation techniques improved attitudes towards violent episodes.

OVA FRAMEWORKS AND TRAINING IN VICTORIA

OVA location and frequency

Interview and focus group participants were asked about the frequency and location of OVA incidents at their health service. Most health services identified the Emergency Department (ED) as the location where most OVA incidents occur, particularly acute aggression. Second to the ED were acute geriatric wards that address aged care and delirium, and mental health wards. Other high-risk areas included acute general medicine and neurology wards.

Health services are designed and resourced to provide models of care that aim to deliver care in the most appropriate setting for a person's clinical condition.

Some health services have completed risk assessments and provide advanced training. Staff working within wards that experience high incidences of OVA are more likely to receive advanced training in OVA prevention and management. Staff working in areas not identified as higher risk are less likely to identify or anticipate aggression and are likely to be less resourced and trained to respond.

While OVA incidents are more likely to occur in specific wards, OVA can occur anywhere due to multiple factors, such as changes in a patient's condition that may impact their cognition or behaviours or other factors that are known triggers for aggression, such as mismatch of expectations, service delivery frustrations, and distressing or traumatic news.

The COVID-19 pandemic resulted in regulations not allowing or limiting when and how a visitor could see a patient. These restrictions resulted in an increase in OVA incidents from visitors themselves, but a reduction in OVA incidents in some health services.

> *We need to stamp [OVA] out. The incidents are rising. OVA incidents were reduced when the visitors weren't allowed to be in the hospital, which was quite interesting. But now it's slightly increasing. And the extent of the incidence as well are definitely like the - the circumstances, they are definitely taking a huge toll on the hospitals and the staff as well. – Health Service 4*

In addition, home-based or community care also increased during the pandemic. However, participants did not report increased OVA incidents in those locations.

Tracking OVA incidents requires a nuanced view, as many variables affect the data. For example, all participants discussed the common culture of underreporting. OVA incidents occurred at much higher rates at public health services (e.g., "every five minutes") than at private. However, the private health services noted that the low incident rate results in staff with a lack of experience managing OVA. When an incident occurs, "it can really go quite pear-shaped" (Health service 11). This will be further discussed in the section addressing barriers, but of importance is that it is challenging to capture meaningful data and to have confidence in the data that is available.

OVA policy and frameworks

Five health services briefly discussed their OVA prevention frameworks, which they explained govern what they do in the OVA space. For example, one health service's framework has five pillars: management, education, response, reporting, and review. In addition, they have an OVA policy, which demonstrates the organisational commitment to create and maintain an environment free from OVA and sits within the OVA committee.

Another health service's strategic framework is based on the Australian Nursing and Midwifery Federation (ANMF) 10-point plan, with a strategic policy based on feedback from an audit.

One CEO recently stepped into the chair position of the health service's OVA committee, and they are now championing the development of an organisation-wide strategy to prevent and manage OVA.

> *It's going to be a three-year strategy which will provide direction as to where we plan to be and with clear outcomes, clear plan of actions to go with those plans… for being held accountable to make sure that we're making change in the OVA space. – Health Service 6*

Another health service spoke at length about applying a systems thinking approach, using the System-Theoretic Accident Model and Processes (STAMP) framework. They have drawn on STAMP to review and revise the risk of OVA throughout their health service. Historically, a clinical perspective had been used. In this framework, staff across all levels of the business are asked about OVA contributing factors. Unique to this approach is the inclusion of complex processes and unsafe interactions. This information and current controls are then analysed across all levels of the business. Finally, interdependencies between the levels and relationships are examined.

> *We think the STAMP model's a lot more comprehensive, and it takes away from that sort of - that lower-level thinking that we find is quite common. – Health Service 2*

New ways of thinking that have evolved from this model include:

- exploring the tracking of visitors and contraband entering the health service
- analysing the 10 high-risk patients for frequency and severity of OVA
- revising care plans to pre-plan admissions
- improving security, such as CCTV.

> *We were looking at further efficiencies around job demands and the assessments that they make, and also the development of more robust risk management systems or tools specifically for those consumers, and even at a ward level to then help inform admissions and discharges. – Health Service 2*

This health service has found STAMP helpful. Feedback from staff included feeling heard and that their input is reaching executive decision-makers.

> *The feedback from staff is that they've got greater visibility and understanding that we hear their concerns and we're actually trying to address some of their concerns. However, I think that can be strengthened. I think that's a key thing in terms of any of the work that we're doing, updating them and communicating with them and ensuring that they're seeing things move forward. – Health Service 2*

OVA committees

Most health services have OVA committees that focus specifically on the prevention and management of OVA. These committees meet either monthly or bi-monthly to review significant incidents, consider root causes, discuss statistics and work to improve these trends.

Committee members frequently comprise a substantial representation of the health service staff from across the organisation. Examples include the CEO, executive directors, union representatives, security team representatives, health and safety team representatives, and nurse unit managers. Larger health services have subcommittees that liaise with local sites and clinical functions. Staff are given various options to report their experiences. Many health services identified staff inclusion as critical.

The fact that our org wide committee is truly org wide, so it's not just a few people from acute making decisions for everybody. It's got representatives from across the spectrum including our HSRs and they've been almost more valuable than anybody else because they're on the ground. – Health Service 8

Health services without a specific committee stated they address OVA as a standing agenda item in their broader OHS or WHS committee meetings. These committees meet bi-monthly or quarterly.

Successful committees have CEO champions and wide representation

Participants whose health services have OVA committees that positively impact the health service credited their CEO for championing the cause, which has resulted in driving top-down culture change. The trend of CEOs taking ownership of OVA prevention and management began within the last five years. A few health services identified that a culture shift occurred with the appointment of a new CEO who prioritised OVA.

[Executive leadership] has been a big impact. We haven't rolled it out yet, but we are 95% there, whereas before we were probably 10%. – Health Service 10

You kind of have to have those two executives working together, and one of them take this on and drive it. I think some of the issues that come around with other organisations if you don't have high enough people driving it is you're talking about systemic and organisational-wide changes, so you need that level of support. – Health Service 6

There's been a slow shift at the start because there was a lot of things getting put into place and trying to build that foundation, and now that things are coming through then you can see that we are better educated and better equipped to deal with occupational violence and aggression. – Health Service 9

Health services without OVA committees had less CEO buy-in. Further, as the quote above suggested, clinical patient safety was positioned dichotomously to staff health and safety, which prevented OVA from being prioritised.

...it's not seen as a safety risk. It's actually seen as a clinical risk. – Health Service 11

What I get told is that again, this clinical versus health and safety argument – and clinical always seems to take priority. – Health Service 3

Training

OVA training is mandatory for any public health service in Victoria; but it is not standardised. The Department of Health (DH) *Guide for Violence and Aggression Training in Victorian Health Services* provides health services with a suite of best-practice training principles for the level of OVA risk exposure. This is the minimum standard of violence and aggression training required in Victoria.

Participants identified numerous OVA training programs, which have been created, purchased, shared and built upon across numerous health services in Victoria. The success of each has varied by health service. Each health service provides a slightly modified version of OVA training to its staff, but there are commonalities among what is offered, particularly in the first training phase.

At the minimum, the first training phase includes the required DH criteria. This training is primarily online and over a number of modules introduces workplace aggression and violence. The timing ranges from 40 minutes to three hours, health service depending, and is mandatory for all staff to

complete annually. Phase one was delivered face-to-face by many health services before the COVID-19 pandemic but, due to social distancing rules, is currently offered online at most health services.

The second training and potentially third training phases are not mandated by the DH and vary by health service. These trainings commonly target workers who are the most at risk of experiencing OVA. Advanced trainings are held face-to-face for specific unit employees and tend to be required every two years, but the respective health service decides upon this. Topics addressed include practical, physical strategies such as de-escalation and breakaways.

In-depth training and evaluations

Services with executive leadership championing OVA prevention have more resources to experiment with innovative training ideas. These health services offer training with multiple layers and components tailored to specific high-risk roles (e.g., incident responders), special wards (e.g., ED, paediatrics, geriatrics) and home-based care. These customised trainings are designed either in-house or through a consultant. The aim is for staff to gain practical, unit-specific skills focusing on de-escalation.

Similarities among advanced training processes include:

- Conducting risk assessments of the entire health service to identify which roles are most at risk of OVA
- Having trainings audited for compliance and standards
- Surveying staff before designing the trainings to learn what staff need and how they want to learn
- Evaluating the trainings and continually using staff feedback and OVA data to improve them

Examples of these trainings and evaluations include:

- One health service uses QR codes to make the evaluation accessible and received feedback that training boosted staff confidence but also that the mandatory trainings are difficult for nurses to balance on top of their workload.
- One health service applies The Patrick Model of evaluation, assessing formal and informal training methods by rating them against four levels of criteria: reaction, learning, behaviour, and results. In other words, in addition to providing feedback about the training, participants must answer questions before and after the training that evaluate their learning.
- One health service focusing on culture change includes real-life staff examples of OVA incidents and makes it interactive by questioning the learner about how they would respond. In their evaluation, more than 70% responded that the training examples would change their practice; most of the remaining respondents noted they already prioritise their safety.
- A few health services have found that role play scenarios and mock drills have boosted staff confidence as staff practice their responses.
- One regional health service received staff feedback that the sessions were too long, so they are dividing them into specific unit topics.
- Three health services are trailing Virtual Reality (VR) goggles. Some already use VR for clinical exercises like resuscitation, which has been successful. They hope VR will allow staff to be dynamically immersed in the work environment better when practising assessing risk and making de-escalation decisions. A VR module costs about AUD $50,000.

> *We just did a new video where - because we had people who work on inpatients' homes, so we did one where they were walking into a house, and them not picking up all the cues, so they conceal the cues and they've got these interactive goggles. And then you can sort of see the environment of the home. – Health Service 11*

This module actually is around personal safety and it's about doing a risk assessment of your environment first and foremost…You're placed in a room where there's no patient, and it will say to you that there's ten weapons that can be used in this room. Pick out the potential weapons. – Health Service 10

What health services need to improve training

Irrespective of location and size, heath services identified similar training challenges.

More staff and compliance - The repercussions of the COVID-19 pandemic created challenges for all health services. The restrictions on density limits resulted in OVA training competing with other training priorities for staff time and space. All health services dropped face-to-face learning for online modules. Staff shortages resulted in at least one health service failing to meet key performance indicators. One health service noted that staff have been attending training on their days off.

What we want to see is our number of compliant staff coming up. So, at the moment we're down to around between 60 and 70% even though it's mandatory, because people just can't get to either computers or can't get face to face. – Health Service 8

In the current climate it's really hard to get them off the floor. And also, we don't have enough staffing in line. And we can't have them in a row. – Health Service 11

Before 2019, you could run 20 people in a room, you don't have to worry about the density sort of side of things. With COVID now, we measure by the one per square metre rule. So that means that obviously more training sessions need to be held, more time and capacity as well for the trainer. – Health Service 4

Bespoke training – Health services with generic training stated they would like bespoke training or are planning to launch it next year; health services with customised trainings identified trainings specialised training for specific wards (e.g., geriatric) or specific staff cohorts (e.g., security) as critical to the success of their training.

De-escalation training – All health services identified de-escalation as a critical component of OVA prevention and management. Staff surveys at many health services have identified that more de-escalation training is wanted.

We would really benefit from de-escalation training in relation to somebody's condition rather than how do I get people's hands off me sort of restraint type of education. – Health Service 5

Resourcing for OVA teams – Many health services identified that their OVA team within the health service is understaffed and under-resourced, which hinders the facilitation of training and evaluations.

It's not enough at all. And also, in terms of pushing out training, there's me, and then there's a 0.3, so three days a fortnight to do training. But that only accounts for high-risk training and doesn't account for any of those medium areas, any of the home care, aged care people. – Health Service 4

Resourcing for training –Training requires staff time. One health service identified that training time has been continually reduced every few years. Additionally, training is expensive, especially when hiring external contractors.

They should in my opinion provide more money and more time. I want more time for my course. A lot of areas are only training staff two hours or four hours or max one day. Mental health might get half a day of online theory here and one day of practical. That's not enough. You're not addressing physical skills in that time. – Health Service 1

These programs are really expensive to attend. These external companies, they're really expensive. And so, it's hard to send multiple people off to training when it costs. So for example, the [company] training was $10,000 in total for one trainer to be trained, to train people…there's so many times we'll be putting the focus and the energy and the expense for getting somebody trained, and then they might move to a different ward... – Health Service 4

Standardised physical practical skills – Many health services noted that their trainings are strong in theory because they follow the DH guidelines but weak in practical application. Health services want standards for physical interventions.

One of the biggest things in the education space for me would be some kind of standardised physical practical skills…where it's covering breakaway techniques, it's covering holding patients, it's covering seclusion, mechanical restraint, all those things that staff need to know. It's so important, and they need to know. If it was provided to health care organisations, they wouldn't have these huge costs in training people. – Health Service 4

Prescriptive training – A few health services discussed how the DH and Victorian Government have recommendations on training, but no overarching best practice is required, as evidenced through evaluation. They argued this leads to various interpretations and a need for more alignment among health services.

So there was talk a couple of years ago around the department putting out actual guidelines for, say, if you work in a Victorian hospital, these are the approved techniques, standards, things like that that should be taught. But we do have instead is all of us as hospitals getting together in different kind of working groups and going, "Hey, what are you doing? What are you doing?" that sort of type of thing. – Health Service 3

Include security and non-clinical staff – A few health services discussed that they were developing a training module for security and non-clinical staff or that they need one.

Gap analysis – One health service identified that they need to conduct a training gap analysis.

Figuring out what provider is best – A few health services have tried various trainings and consultants but find it challenging to find the best one.

INTERVENTIONS AND RISK CONTROLS IN VICTORIA

Participants were asked to discuss either early anecdotal feedback or evaluation results. Because OVA is complex and health services have diverse department contexts with various needs, the strategies for prevention and mitigation are many and greatly vary.

Thirty-nine interventions and risk controls are explored below. The tables are grouped in themes: leadership strategies, teamwork strategies, prediction instruments, risk and behaviour management tools, adverse incident reporting tools, incident intervention, security personnel, physical deterrents and supports, and guidelines. Many interventions and risk controls have not been evaluated. Information on evaluations is included in the right-side column.

Table 3. Leadership strategies

Title	Description	Evaluation, challenges and next steps
Staff advisor or champion	This role slightly varies by health service, but essentially it is a delegated nurse practitioner, clinical educator or HSR who works alongside staff, to educate, review high risk code greys and assist clinical staff with behaviour management plans to prevent future escalations.	One health service identified that they are planning to expand the advisory role as they have identified the prevention of Code Greys and escalations.
Clinical lead	A highly experienced staff member is identified on the ward as the key person to give instructions during an OVA incident, de-brief staff, and ensure follow-up protocol is completed afterwards. The lead wears a designated coloured vest identifiable to staff but not obvious to patients.	The Clinical Lead role can be challenging to implement and works better in some wards. For example, it is difficult to implement within the ED due to the size and complexity of the department. In addition, some wards require multiple leads. Staff feedback from the first couple of wards where it was rolled out less than a year ago was limited, but responses were overwhelmingly positive, stating that it works, and staff see the benefit because it builds staff confidence; they know their role and what to do. It is anticipated that it will be rolled out organisation wide.

Table 4. Teamwork strategies

Title	Description	Evaluation, challenges and next steps
Tap in and Tap out	This is an organised expectation that staff working in the ED with complex patients can 'tap out', and senior management will support them to take a break after four hours.	This has been successful in this particular ED.
Debriefing sessions and response checklists	A space to verbally review the incident, offer support services and ensure staff are okay; a guide for managers to support staff and for staff to follow after an OVA incident.	
Behaviours of concern response team	Staff can refer patients or call a code grey, resulting in a medical team responding.	The nurse or team have a clinical focus.
Behaviour management progression and flow chart	This is a one-page document to assist staff with what is required during an OVA incident.	
Divert (De-escalation Intervention Early Response Team)	The nursing staff in trauma and neurosurgical wards can call divert to get a team of support for a patient urgently.	This is a strategy when escalation is present in a patient, before a code-grey is called.

Table 5. Prediction instruments

Title	Description	Evaluation, challenges and next steps
Prediction instruments	Brøset Violence Checklist	The BVC assists staff predict violent behaviour. The form has six questions. The form is inexpensive, but implementation requires staff be trained on how to use it.

Title	Description	Evaluation, challenges and next steps
	4AT Rapid Clinical Test for Delirium	The 4AT is a simple bedside tool that helps practitioners detect delirium in day-to-day practice that does not require training.

Table 6. Risk and behaviour management tools

Title	Description	Evaluation, challenges and next steps
Comprehensive Care Plan	A template in the electronic system that identifies people with high risk or needs that require more comprehensive care.	This helps with designing behaviour management strategies.
About Me form	A form given to the patient to help individualise their care and develop their behaviour management plan.	The form provides a score for all patients. Form uptake is unknown.
Home-based risk assessment tool	This is a part of a more extensive risk management procedure to be completed prior to a first home visit by a clinician through a phone interview with the patient.	
RAGE	The Rating Scale for Aggressive Behaviour in the Elderly (RAGE) measures aggressive behaviour ranging from not cooperating to physical violence.	It has been used in the psychogeriatric ward in assessing individuals and the collective ward; now being used to assist and guide future admissions.
Behaviour Contract or Statements of Care	The clinical unit will meet with a patient and the ward staff to talk about the rights and responsibilities of the patient.	This is new at many health services and is identified as helpful with calling out problematic behaviour and explaining the health services expectations to the patient. In one private health service, if the patient will not agree to the plan, they are discharged and blocked from future admittance. However, this is extremely rare. This cannot be a contract in a public health service.
Letter of accountability	This is a letter sent to a patient explaining that their behaviour was inappropriate and that if they return to the hospital in the future, they may require security.	This has not been evaluated.

Title	Description	Evaluation, challenges and next steps
Behaviour of Concern discharge	Patients not under the Mental Health Act that exhibit significant behaviours of concern are discharged to the public sector.	This is an option only for the private sector.
Pre-screening	Patients are asked about previous history when under anaesthetics.	
Patient screening with ward considerations	Patients are screened for level of risk, and the risk is compared to other patients on the ward and staff capacity; if it puts the ward at risk of incident, then the patient is placed in a different unit.	
Visitor screening	Visitors are required to sign in, show their identification card and explain their relationship with the patient.	If an incident occurs, the health service staff have the appropriate information to follow up with Victoria Police.

Table 7. Adverse incident reporting tool

Title	Description	Evaluation, challenges and next steps
Victorian Health Information Management System (VIMS) – Risk Manager (RiskMan)	DH states that all health services are required to implement locally based clinical risk management systems, or to enhance their existing clinical risk management systems, in line with the *Victorian Clinical Governance Framework*. The RiskMan safety information system tracks and reports all adverse incidents that occurred in the workplace.	Once information is recorded in RiskMan, health services are legally required to respond. RiskMan is complicated, and retrieving meaningful data from it is challenging. In addition, there is a culture of underreporting across health services. One health service is about simplifying RiskMan by adding questions that align with behaviour support plans.
EPIC Electronic Medical Records	Electronic medical record system helps to flag aggression and share information among staff.	One health service uses this for alerts concerning ED or dementia patients.
ACCIMAP	This is a systems thinking tool for incident investigation.	This requires staff training.

Title	Description	Evaluation, challenges and next steps
		One health service explained that this has been helpful in incident investigation but also with trend analysis. It allows thinking to be shifted away from person-centred thinking for incidents and provides a systems perspective.

Table 8. Incident intervention

Title	Description	Evaluation, challenges and next steps
Code Grey	DH defines a Code Grey as an organisation-level response to actual or potentially violent, aggressive, abusive or threatening behaviour exhibited by patients or visitors towards others or themselves, which creates a risk to health and safety. While local arrangements will vary, Code Grey policies and procedures must align with the principles and minimum standards outlined in the department's *Code Grey Standards*.	All health services use the Code Grey intervention and monitor incident severity and the number of Code Grey calls. Code Greys are used frequently. Data from two health services demonstrated that staff are now more confident to call Code Greys. They interpreted the uptake of this intervention is positive because the use of Code Greys prevents more drastic OVA incidents. A challenge with Code Greys has been what happens after the situation with the patient because staff will have various training and ideas. That conundrum led to the development of the clinical lead role; a person designated to make the next plan. Staff have noted that de-escalation efforts attempted prior to calling a Code Grey are not captured in the data.
Planned Code Grey	A protocol where staff call to get support for an OVA incident to prevent it from happening.	Statistics on Planned Code Grey as a low-level response to prevent potentially escalating OVA demonstrate strong uptake by staff. The number of Planned Code Greys called by staff continues to increase yearly among numerous health services. This proactive approach is what several health services believe should be mandatory.

Table 9. Security personnel

Title	Description	Evaluation, challenges and next steps
Security rounds	Security team leaders meet with the nurse in charge of every unit twice a day to be updated on patients of concern.	
Body cameras	Security staff wear body cameras, and when an incident occurs, they state aloud that the camera is being turned on, and they record.	One health service noted data from the ED reception and triage areas revealed that people are more reluctant to verbally abuse staff when recorded. However, at the same time, staff are more reflective and accountable for their behaviour too. A second health service had anecdotal feedback from security staff that incidents were de-escalated once the security stated the camera would be turned on. Further footage was used in court to demonstrate racist behaviour towards an ED security staff member, resulting in a conviction and a perception of safety for staff in the ED.
Security observers	Security contract workers become observers in one-to-one care situations when the patient is unwell, and there is a high risk of violence. The contractor sits in or outside the room of the patient.	This is expensive, but staff feedback is overwhelmingly positive. Staff have said they feel safer on the ward because of the security observer.
Security officer uniform	Security uniforms are traditionally black and reflect military uniforms. One health service is trailing changing the uniform to a calming colour. Security also wears a relaxed polo top and jacket. The goal is for them to look more casual and less threatening.	This will be implemented in the near future.

Table 10. Physical deterrents and supports

Title	Description	Evaluation, challenges and next steps
Live wait time board	This board indicates the expected wait time when someone arrives at the ED.	This has been effective as a control to reduce the frustration experienced by patients and their family members.
Mobile duress pendants	At various health services, clinical staff, security staff and home-visit staff wear either a pendant or a watch with a button to activate a security and police response. This is standard across community-based care and is being rolled out among other areas of health services.	Staff feedback from one health service is that they feel safer having the duress pendant. One health service requires training on how and when to use the duress alarm; they have seen reduced incidents in the community. Another health service is currently evaluating its duress system; anecdotes reveal that staff feel there is a decrease in incidents and feel safer.
Visual symbols	Magnetic symbols are used on the wall behind the patients' bed to identify risks, including violence and aggression.	For this health service, this approach has been very effective.
Removing symbols	Health service logos were removed from cars due to people's aggressive and violent responses.	
Door	A door was added between the patient waiting area and the ward.	This added an extra layer of security because visitors stopped wandering through the ward.
Metal detector wands	Using metal detectors to prevent contraband from entering the ward.	
CCTV	Using cameras to monitor the wards.	

Table 11. Guidelines

Title	Description	Evaluation, challenges and next steps
ANMF 10-Point Plan	In 2017, the Australian Nursing and Midwifery Foundation created a guide for health services to end violence and aggression.	Health services identified they have leaned heavily on this plan when developing their policy.
10-domains of de-escalation	A 2012 study that provides guidance for de-escalation.	Found to be effective and applied as a core competent in training.
SafeWards	A model with up to ten interventions can be applied to make wards safer. Originally applied to mental health, it is now being rolled out to acute settings.	Two health services still need to complete their evaluations but anecdotally feel SafeWards is positive. One health service is about to launch SafeWards, while another does not see value.

BARRIERS AND ENABLERS

Participants addressed many intersecting barriers and enablers to preventing and managing OVA in their health services. These were common among all health services but varied in intensity. There were differences between public and private health services, which will be explored below. The themes described below have a complex interplay between each other.

	Barriers	Enablers
Individual 	• Staff knowledge, skills and attitudes • Staff underreporting • Staff lack skills and confidence	• Younger staff creating a culture shift • Feeling supported and seeing benefits increases staff confidence
Health service 	• Lack of executive buy-in and resourcing • Staff shortages • Complicated data • Structural issues	• Executive investment • OVA committee • Inclusion between clinical and non-clinical
Community and Public Policy 	• Visitor aggression • Tension between entitlements • Lack of standardised approach to physical interventions • Confusion over public vs private	• National standards help with accountability • OVA data helps combat OVA

Individual challenges

Staff knowledge, skills and attitudes

All health services identified staff culture as a critical challenge explaining that staff characteristically believe and reproduce the idea that a patient's health and needs comes before their own, and OVA is a normal part of their job.

> *I still think there is an element of acceptance that nurses get hit, punched, and abused. I still think there's an element of that from them, that that's just part of the job. – Health Service 11*

From a clinical perspective, staff very much still feel culturally – they tend to lean towards, "Oh, there is dementia. There's a delirium. They didn't know what they were doing. There was mental health." They almost make that assessment themselves rather than report the actual outcome of the incident and then leave the rest up to police. – Health service 10

There's this whole entirety of clinical teams who will do anything for the person and for the visitor and for the patient's family that puts them at risk of OVA because the person's dying. So, we absorb risk. We explain away behaviour. And we don't report until the very end, until we're extremely affected by the OVA. – Health Service 5

Further, participants explained that many staff define OVA in its extreme form, such as physical assault. A repercussion of this understanding is staff not reporting what can be perceived as less intense incidents of OVA, such as verbal abuse.

Yeah, it's part of our job. I think we need a different way of looking at OVA, as in it's not potentially somebody who's getting in your face and saying, "I'm going to punch you out," but that's the trigger. It's that change in the language of how people talk to you. – Health Service 6

The staff who tend to accept OVA as a normal aspect of health service work are the more experienced senior nurses.

What we have is a historical disengagement. We have some staff, especially in our residential facilities who feel like they've had no support for – some of them are 30 – 40 – 50 years and so, there's a real what's the point attitude. They're still fantastic staff and it's about really breaking down some of those barriers. – Health Service 8

The older the nurse is, the less the reporting. The younger the nurse is, it seems like they really have a lower tolerance for OVA, which is great, it's what we want. Whereas an older nurse will say, "Oh, I've been doing this job for 35 years. This is part and parcel of being a nurse. We get screamed at, we get spat at. It's just how it is." Whereas someone who's just graduated or in their 20s and 30s, they'll be like, "No, absolutely not." – Health Service 4

Enabler: Younger staff are creating a culture shift

Despite what all health services discussed as an entrenched cultural problem among health service staff, a shift is happening, especially with younger nurses. Staff identified as Generation Z or Millennials are reporting incidents more often and asking for help. The attitude that risk assessments are not associated with staff safety, but rather as more work, is changing.

> *So when I was training it was like, 'That's just what patients are like, don't listen to it, whatever', and then now it's very much like, 'No, that's not okay' and we've actually got the organisation behind us… I feel like there's been a shift towards protecting staff. – Health Service 9*

> *I had people say, "I've been here for 20 years, an nobody's ever told me that I can say no, not to put myself at risk because they're telling me to do it." So that's been really good. We're kind of challenging the status quo or the sort of cultural - what has become normal over time. – Health Service 7*

> *But one of the factors that we find is actually the support mechanisms have really improved over the last few years throughout the hospital. So it's not just about staff attending training and then that's it, you're out on your own. The level of escalation and the level of executive buy-in is quite phenomenal. – Health Service 3*

Staff underreporting

All health services identified staff underreporting as a critical problem that needs to be addressed in order to reduce incidences of OVA.

> *So they log the information about all of the incidences or any of the jobs that they do, and we know that there's a huge, huge discrepancy between the amount of code greys, code blacks, or duress alarms that security attend…versus how many RiskMan incidences are reported by clinicians. – Health Service 4*

> *You might see 300 codes a month, but you might get 10 reports, you know? …We still haven't been able to get those reports up. – Health Service 8*

Explanations for underreporting included staff's time, workload and feeling that it is pointless.

> *The number one barrier that they'll give us is time. We haven't got the time. …they would literally say, 'Imagine if we spent all day reporting, you'd never actually get any work done.' – Health Service 3*

> *You know, people say, 'Oh, the system's clunky.' Or like I said, a lot of it is not really appropriate because they said that it's clunky but then they'll - they use the same system to report clinical incidents. So I think it's probably time-poor, they're probably like - same as you already mentioned, they'd say, 'Oh, what's going to come out of it anyway?' – Health Service 4*

> *I think getting that buy-in can be really challenging. And then introducing systemic changes…Nobody wanted to do it. Then you have the staff resistance. You have people going, 'I'm too busy. I can't do this. What am I doing it for?' – Health Service 7*

Further, when reports are submitted staff omit important details that allow for the OVA prevention teams to learn and follow up.

> *And then when people are reporting incidents relating to OH&S, so one of these examples is OVA, they would just put in 'hit by patient,' and that's it. What did you do to mitigate the risk? 'Report it to my manager.' Well, that's not really - do you know what I mean? Like whereas if you get a clinical incident, it is so well-collated. – Health Service 4*

Underreporting makes it difficult for the health service to respond to incidents but also to improve systems. And, when staff do not feel supported, their trust in the service's systems wane.

> *I think ensuring that when you do report it, that there is something going to be done about it. It is going to get taken to the relevant people and something will come off that. It's not just simply throwing out a piece of paper that gets filed. – Health Service 6*

> *And what the research also shows is that staff become quite disillusioned by the organisation, because if they promote a zero tolerance and staff are dealing with it every single day, they will – or you're telling them one thing but you're practicing something different. – Health Service 10*

Enabler: Inclusion between clinical and non-clinical

One health service identified that the barrier between clinical and non-clinical staff is becoming smaller through various communication channels and this is an enabler.

> *So we've got Executive sponsorship which is fantastic, that helps actually make change and drive, but also that inclusion between clinical and non-clinical parties in different areas, whether it's within working groups, whether it's in committees or working groups from those committees to actually get a full holistic picture rather than just one person's point of view. – Health Service 9*

Staff lack skills and confidence

Participants discussed a skills gap affecting confidence among staff in responding to patients demonstrating anti-social behaviour.

> *They definitely feel that they're not confident – if they came to a physical restraint or some kind of restrictive intervention, they're not as confident - they're certainly not as confident in the medium-risk areas. But then again, I don't know that their confidence was huge even to begin with. But even in areas who unfortunately are doing restrictive interventions far more frequently, you're even starting to see those sort of slip in technique and you see - so the potential for injury is much higher. And they don't feel as confident in it. – Health Service 4*

As a result, senior or more experienced staff work with more patients demonstrating poor behaviour.

The barrier is that not everybody has the skills and knowledge and confidence to deal with people who are inappropriate in their behaviour. So then the majority of those incidences are left to deal with for senior staff. And that starts to impact upon them. – Health Service 5

Staff need more education on working with patients with cognitive impairment. And what's more of our issue is that we need to - and then when we're - what we call special inpatients because they're agitated - is giving them more tools on that behavioural modification - you know, don't just have someone sitting there staring at them. Talk to them and divert them. Talk about their garden, their dog, whatever it is that - their grandchildren. – Health Service 11

Enabler: Staff feeling supported and seeing benefits increases staff confidence

While a barrier was lack of resources, the recent improvements in resources connected to CEO engagement has resulted in staff feeling more supported. Many health services stated that staff confidence was an enabler. This was connected to feeling heard, experiencing responses to code grey alerts and RiskMan reports, seeing learnings from the ward used in trainings, and improved post-incident response, including relations with the police.

I think if you look at the feedback I've got, that increased confidence is a massive thing. If you increase people's confidence, they'll be more likely to manage situations before it escalates. We're not going to stop aggression…But we can mitigate it and we can manage it better. I think, if you train people. – Health Service 1

I think people seeing it as an area of priority like they do other things. I think sometimes people get very stuck into seeing the day-to-day stuff, but they don't see the bigger picture. – Health Service 7

Health Service challenges

Lack of executive buy-in and resourcing

As addressed in the previous chapter, the role of executive leadership in OVA prevention and management is a critical enabler or barrier. This buy-in determines the resources provided and the culture driven from the top of the health service. Most health services have gained executive buy-in within the past five years and are beginning to see positive changes. Even for those with executive support, there continue to be hurdles with getting OVA interventions approved and implemented. What participants reiterated is that the culture change in regards to OVA has to be driven by executives through mandates, or nothing changes.

What we often find is that we have to really struggle internally to get that stuff approved. And sometimes people - executives can just turn around and go, "No, I don't want this to be a mandatory training for everybody," for example. – Health Service 7

I've had constant headaches and challenges where I'll try and implement something through the consultation process, I'll go through and Quality will say, "No, we're not implementing that. We're doing something like that already." – Health Service 10

So no, it's not - it's more getting them to see that it is a risk. So when it doesn't happen frequently, it's very hard to get them to see that it is a risk.
– Health Service 11

Participants spoke openly about OVA being under resourced in terms of having trained staff to conduct robust training, evaluations and operate the OVA portfolios.

But in terms of OVA, there was nobody who had that OVA portfolio. Till the last year that I was there, they had somebody on a six-month role, so… so I have the role, but this area is massive and there's a lot of project work, improvement work, and lots of things that need to happen. And for us, quite a decent-sized organisation, one person. – Health Services 4

I said, "I want three days." I got one day. It's always money. I've noticed money's a big driving factor, to train… I guess the one thing I could say on that is that even if you've got a one-day course that's well attended, well received and good feedback, it's not enough. – Health Service 1

I think the first barrier is always the financial cost for the organisations. So, they need to allocate more resources, for example monies, and hire people, and recruiting. – Health Service 10

The result is that staff training is minimal, not bespoke and as the participants explained, this is evidenced in staff not having embedded theory, nor practical skills to identify and manage aggression and to problem solve.

One of the things I've got a big issue with is that a lot of training is off the shelf. A lot of hospitals will do their course and that's it…it's not tailored.
– Health Service 1

A consequence of under-resourcing is health services becoming stuck in a cycle of reactive follow-up care rather than investing in prevention.

Obviously, we'd like to get into the pre-space and the prevention, but there's a large number of our time is spent up in the post-incident response - "Are you okay?" - supporting staff to report to police, supporting staff to incident report it. How then do we escalate the concerns? Is the patient still needing to stay here? That's often a big challenge here at [health service]. Patients often who might be the behaviours of concern instigator are actually needing to still stay here.
– Health Service 3

Enablers: Executive investment and OVA committees

The majority of health services stated within the last five years, but especially since the COVID-19 pandemic began that CEOs have begun championing for OVA by creating or joining OVA-focussed committees, reviewing OVA related data and being vocal about prioritising staff safety.

> *When something needs to be done and we've got the CEO sitting on the committee meetings, it certainly helps to get these things across the line. – Health Service 6*

> *I'd just say executive sponsorship. So just the Exec saying, 'This is a problem, and we're not going to give up until we have a better outcome.' – Health Service 9*

> *From an executive level, two of our executives are actually receiving every individual RiskMan that comes through outside of the teams. – Health Service 3*

This has made an exceptional difference within these health services and was identified as the most significant enabler.

> *There's never been any doubt around executive buy-in in relation to safety in general. – Health Service 5*

A benefit of CEO and executive buy-in was strong and well-functioning OVA committees that meet regularly and include a broad range of staff voices. Committees were the second most common enabler discussed after CEO investment.

> *We've set up our safety leadership committee, which is above the health and safety. So having that committee– with OVA as part of it has helped improve things... – Health Service 10*

Staff shortages

The COVID-19 pandemic added pressures onto what were already high-pressure environments. As a result, health services are experiencing staff shortages and staff are struggling to cope.

> *At the moment, one of the biggest barriers to potentially I guess being able to manage clinical aggression and keep themselves safe is staffing. If you walk to any ward now, they are working understaffed, tired, burnt out, different acuity, skill mix, things like that. Throw in that COVID, you've been working in PPE for two years and things like that. So we've found that it's not that occupational violence and aggression has increased over the last couple of years, but we've found that the factors - obviously, the coping factors of the individual staff is obviously different now. – Health Service 3*

> *Yeah, staffing levels. Because some aggression, some anger and aggression is caused by the system itself. Waiting for people, waiting for nurses to get to their bedside because nurses are dealing with people and stuff. – Health Service 1*

Staff shortages mean that there is less time for staff to participate in OVA training and to learn about and implement OVA interventions.

Staff shortages has been probably our biggest challenge this year, more so than COVID… We're not meeting our current [training] KPIs, just really based on getting people into a room. – Health Service 3

So a barrier really is low staff numbers and getting them into the training. – Health Service 11

Getting bums on seats has been difficult and that's caused us to change our training modules and our engagement. – Health Service 8

Staff shortages are one factor that has led to higher turnover and staff retention.

And retention is a big issue because you lose experienced staff, you replace them with inexperienced staff. You're replacing experience with inexperience, you're more likely to get other issues. Including increased occupational violence and aggression. – Health Service 1

Staff shortages coupled with complex systems result in poor communication, which can result in OVA incidents occurring that were preventable. For example, one health service discussed how a patient's medication was changed, and this sent the patient into withdrawal, resulting in a nurse being physically assaulted.

So it's like that lack of communication upon admission around interventions that nurses have no control over that resulted in one of our most significant incidences that happened in the ward in relation to OVA….and it's the lack of understanding from the medical teams around what the potential implications of that could be. Because they've done it, but then they've gone home. – Health Service 5

Another discussed how major incidences have been a result of miscommunications between nurses and the externally owned security team.

Complicated data

All health services track incidents of OVA, but the combination of underreporting, poor reporting and complicated data sets makes unpacking trends and analysis difficult for some health services.

The data's not presented in a way that would highlight those intricacies of risk that we should be trying to highlight or the trends and analysis. We have the incidences, this is what we did, but that's really basic in what the actual incident, what we potentially could've done if we knew those little nuances within those incidences. – Health Service 5

OVA data helps combat OVA

Four health services specifically identified data collected on OVA through staff surveys and incident reports helps them demonstrate weakness and where progress is being made. This too assists with garnering support and ensuring informed decisions are made.

> *I guess what carries weight with it is the data. When we show the data and it shows very clearly why your department has had x number of incidents in the past three months, it's very clear that there needs to be something done there… I'm always pretty strong on making sure that we've got data to help support in anything we're trying to get across the line. – Health Service 6*

And this data also enables bespoke training sessions.

> *We do a focus of the week, our team, so for both teams…And share a case where it happened – what we done well – what we can do better next time – a kind of case stuff type of real case analytics…So, again we're learning that experiences from the past, I think it is important too.*
> *– Health Service 10*

Structural issues

Participants spoke of structural issues that worsen the patient's experience, such as loud and repetitive noises.

> *We're trying to reduce the amount of disruption. But you know, we work in healthcare, general medicine, I was up on a ward recently and I was there for ten minutes and it was a cardiac ward. And I went, "Can someone turn those effing alarms off. They're doing my head in." – Health Service 1*

Physical spaces also create unnecessary problems, such as no doors and open spaces, resulting in people wandering the ward halls. Many buildings were created before recent recommendations that demonstrate minimising risk through ward design.

> *We got a lot of random people just walking in the department to look around – they're actually looking for a seat. – Health Service 10*

> *We have so many nurses' stations directly outside rooms where people were potentially a risk, and you have nurses, doctors, everybody talking at the top of their lungs at 2:00 a.m. We have pan rooms where the door shuts so loud that you can hear it three states away. We have rooms that are tucked down and around a corner away from everybody else and if you end up with somebody who's a risk in that room, the staff that are going down there are inherently at risk.*
> *– Health Service 8*

> *And you know, hospitals aren't made for people with dementia. Everything's white.*
> *– Health Service 11*

Community and public policy

Visitor aggression

Participants frequently discussed their frustration with the general public's behaviour, mainly how people negatively speak to staff. There was consensus that the community lacks education on OVA and what is acceptable behaviour. This was emphasised in the last few years with the COVID-19 pandemic because new rules limited visitors' access in health services, which frustrated visitors.

> *We actually had multiple incidents of staff assault, verbal assault relating to that in terms of visitors. Now, visitors sound easy because they're invited guests to the hospital, so at the end of the day they can be asked to leave. But also then they're trying to then come in and see a loved one or a visitor and things like that. So we actually have a stationary security officer at our front door now for that exact reason. We had so much occupational violence from visitors. – Health Service 3*

When the number of visitor incidents of OVA increased, health services realised they did not have information about them to report to the police and began changing their protocols.

> *I'm on the ward and I receive a visitor at the moment, we don't really know who that person is, what their relationship is to me. So are they a friend? Are they a family member? Are they my drug dealer? Are they my pimp or whatever? And then also, what are they - what is the intent for the visit? – Health Service 2*

Tension between staff and patient entitlements

Participants discussed how various entitlements, such as the Mental Health Act and OHS act, make addressing OVA challenging. For example, they noted that mental health staff have a clinical perspective of OVA, believing that people who aggravate staff are only people with clinical mental health or dementia needs. While mental illness is a significant component of OVA, participants argued that there are people who enter hospitals while intoxicated and choose to abuse staff. This results in tension between entitlements.

> *There's a difference in terms of what clients are entitled to and what staff are entitled to and they clash quite often. – Health Service 10*

> *One of the key barriers I think is the tension between the Mental Health Act and the OHS Act. The other one we see is the NDIS and government. And difficulty discharging consumers because they don't have an appropriate facility to go to. – Health Service 2*

One health service provided an example of a patient with a mental health disorder who remained in the hospital for over one year because they did not have housing. Staff were heavily affected by the ongoing abuse they received from this patient.

Participants envision more tension to come with the Mental Health Act. They predict it will lessen their ability to use restraint and seclusion. This in combination with the increase in mental illness and acuity, is resulting in staff feeling vulnerable.

> *Our in-patient units are seen almost as a dumping ground…So that's just a very small snippet. – Health Service 2*

> *But where is the line in the sand drawn where somebody might need medical care and yet they're assaulting and abusing our staff? – Health Service 3*

Various Acts and perspectives on OVA result in confusion about legalities and decision making. One frequent topic was how it is challenging for a health service, particularly a public health service, not to admit someone or to discharge a patient because of anti-social behaviour. Participants explained that there are legal concerns around these decisions, which are underpinned by maintaining the health service's reputation. Further, doctors are reluctant to listen to nurses and prescribe medication to calm the patient because of legalities.

> *Are other hospitals actually literally kicking people out? And if they are, does that mean if the [HealFth Service A] do it, they just bounce back to the [Health Service B] anyway? And then if we kick them out, do they go out to [Health Service C]? That's not a solution. – Health Service 3*

> *Some people say, "Oh, this person's got mental health problems so they couldn't help their behaviour." And I think we need some clarity around what is acceptable. – Health Service 1*

No standardised approach to physical interventions

Participants frequently discussed tension between clinical safety concerning the patient and staff safety concerning OHS, which do not always align.

> *Mental health run huge projects around reducing restrictive interventions. So that's around reducing the use of seclusion, reducing the use of restraint … And that's great and I wholeheartedly agree with that, but what then tends to happen is you'll get a lot of organisations saying, "Well we're not training our staff in restraint". And to me, that's where the difficulty lies, because I think we should have particular high-risk staff trained to restrain safely. And we always encourage people it's a last resort thing, it should never be used unless you have no other alternative. – Health Service 10*

The result is that staff are ill-equipped to respond if situations escalate to the point where restraint is required. Another participant explained that there is no standardised approach to physical interventions, which is problematic in an industry with high levels of OVA and staff who frequently move between health services.

> *There's all these different courses that you can go and go to and utilise in your hospital. There's no set one for the state. So there's no sort of standardised approach to physical interventions. – Health Service 4*

> *And we've already got KPIs around the physical and chemical restraint, but then there's that tension. And staff feel vulnerable as a result. – Health Service 2*

Confusion over public versus private

Health services spoke about the confusion over what is allowed at public compared to private health services, with one participant explaining that there is no difference in what health services are allowed to do but there is distinction in government messaging. Participants who had worked in the private sector or were currently working in the private sector noted that without government mandates resources are not always allocated to best practices.

> *Victorian government came out and said that code greys are required – they must be implemented in every public hospital. Now what about private? What about the private hospitals in Victoria? They weren't included in that. – Health Service 10*

While public hospitals experience OVA incidents more frequently, private health services note staff do not have appropriate support when an incident does occur. Further, they explained their funds are limited.

> *And I think the difference is in the privates is we don't have this endless fund of money which the publics have, particularly for training. So we've really got to be - what's the word? Really strategic on what we are going to train them on.*
> *– Health Service 11*

Enabler: National standards help with accountability

A few health services identified that national standards are an enabler because the accreditation requirement has helped staff garner internal attention and support for combating OVA.

> *I think the national standards and the fact that it's very specific in both standard five and standard eight, that violence and aggression is something that we have to be able to tick off. So, for us to be accredited, this has to be taken seriously. – Health Service 8*

SUGGESTIONS AND LIMITATIONS

Participant suggestions for reducing OVA incidents in Victoria

When discussing suggestions for reducing OVA incidents and ideas for how WorkSafe could support health services, participants needed clarification of obligations and boundaries between the role of WorkSafe and the DH. Participants had many ideas about how WorkSafe could get involved in their journey to reduce OVA. These suggestions are explored below.

Create a network for information sharing to reduce OVA team's isolation

Participants explained that a network or forum to share information about what is working to reduce OVA incidences would help them learn from each other and feel less isolated. Some participants noted they previously participated in forums organised by WorkSafe and acquired excellent information.

Learnings from previous OVA-related sharing platforms were to maintain the focus on evidenced-based solutions and new ideas rather than create a space to vent about frustrations. In addition, participants want this to be inclusive, with broad representation across OVA committees in Victoria to ensure they share and hear new ideas.

Finally, participants would like a WorkSafe contact to reach out to when they have information to share with other health services.

> *And WorkSafe should be at the front of that. So whether that means more webinar events, whether that means more presentations on doing work health and safety OVA … whether they workshop that towards health care, certainly, they need to start driving that. Because this industry, it hasn't started - it's deteriorating by the minute. So we really need to work together and make it a comfortable place where people can come in to work, enjoy what they do, and then leave the exact same way. – Health Service 4*

> *… if there's a committee where – because it's come up before that people would like to hear how other hospitals are doing things and to learn, because they feel pretty siloed. So if there is a way to do that that you recommend, that would be helpful. – Health Service 10*

Provide support for evaluation and benchmarking to improve interventions

Participants felt that siloes could be reduced and learning increased through increased evaluation and benchmarking. Suggestions to help facilitate this included mandating benchmarking for Code Grey, Code Black, mechanical restraint, physical restraint, chemical restraint and incidents of violence and aggression.

> *I know that's a hard thing to mandate and didn't know if WorkSafe or if it's the department. But right now, we're in isolation, we've been able to share our numbers with the [region] because we have that forum set up. We would love to know like for like. We'd love to know if our numbers are ridiculous, if we're over reporting, if we're under reporting. I don't think we can ever over report, so I'm just going to put that on record. I'd love to know what other people are doing. – Health Service 8*

Focus on prevention and take a proactive approach with improvement notices to reduce internal friction

Participants welcome WorkSafe to become more involved in their health services. Suggestions for doing so included inspectors proactively visiting and building rapport with the OVA team staff members. Further, most health services strongly requested that WorkSafe issue improvement notices to hold the health services accountable; OVA teams explained that this would help them do their job better. In addition, they encouraged WorkSafe inspectors who visit the health services to have a background in health services.

> *I only see WorkSafe when there's a notifiable incident. I think they need to be more in the prevention. Why do they not, you know, issue improvement notices when people don't have preventive systems in place? – Health Service 7*

Participants also encouraged WorkSafe to ensure that health service senior leadership is aware of their legal obligations. They explained that this would help leaders to prioritise OVA and thus make work safer for staff. Further, they want senior leadership accountable for OVA incidents.

> *There needs to be consequence in line with the consequence of the incident. For example, if you've got a staff member who has been abused and assaulted to the point where they've actually left their career, then there needs to be significant consequences for that I believe. A slap on the wrist and a $25,000 fine and getting put in the WorkSafe newsletter doesn't cut it for me. It doesn't. It needs to be where senior managers are held to account because until they are, I don't think anything will change. I really don't. So yeah, that would be the key, the main things that I would say that WorkSafe could improve upon. – Health Service 10*

In addition, they strongly suggest that people who commit incidents of OVA be held accountable and prosecuted to the full extent of the law. All health services noted that the lack of ramifications for anti-social behaviour resulted in repeat offenders.

> *I'd love to see more cases where occupational violence and aggression is seen as something that's reportable under the act. But that comes down to compliance and legislation and just I actively support the investigators when they come in because it'll only make our lives better. I think it'll be great when get to a point where that legislation's being used seriously for change. Not punitively necessarily, but when it is being used punitively, we see everybody take note and change practice because it's the only way we're going to support everybody. But I don't know if WorkSafe can necessarily do any more than they're currently doing. Let's just aim for benchmarking. – Health Service 8*

Assisting with education and training to improve staff confidence and safety

Participants had many ideas for how training and education could be improved. For example, multiple health services suggested that WorkSafe endorse a standardised training model approach, with more robust guidelines around theoretical components and comprehensive lessons that could be tailored to the health service and benchmarking. They suggested including strategies for private and public settings and information on how to best protect staff working in homes and the community. In addition, participants want more training on de-escalation and a consistent program for physical restraint that is in line with WorkSafe's requirements.

> *But we can work in alignment with the Department of Health who can make very strong recommendations around "This is what needs to be done." And I know that the Victorian Department of Health have recommendations around training, but they're only that. They're just recommendations and they're very – they're not very*

prescriptive. They're very wide in terms of anybody can do anything in between. And people do. And therefore, we've got no alignment. – Health Service 10

To assist health services with maintaining standards when staff change their employment across health services or wards, participants suggested creating OVA training that aligns across health services as a requirement for undergraduate courses. Finally, many participants suggested creating a standard qualification for people working in OVA management and prevention positions in health services. Standard qualification for people working in OVA positions in health services

Be good to have a standardised sort of program across the whole sector in Victoria because all of our training approaches do vary quite a bit. Some are great and some are substandard. – Health Service 9

Consider an OVA awareness campaign to improve the general public's behaviour

Participants provided feedback on previous WorkSafe Work-Related Violence campaigns noting the campaigns did not target healthcare settings in the best way.

I want WorkSafe to know that sometimes their statements are not geared towards healthcare. – Health Service 1

Many participants suggested that WorkSafe lead a campaign on healthcare workers focusing on inexcusable behaviour and repercussions. They requested for posters to include co-branding and messages to be ward specific as wards face unique challenges. They suggested this be promoted widely, similarly to what WorkSafe did with Work-Related Violence in the retail industry.

Require the same standards in private and public health settings to ensure equity

In particular, OVA teams in private health services were frustrated that they were not required to uphold the same procedures and protocols as public health services. They explained that having standards across the industry would help them hold their health service accountable.

Private hospitals should be getting held to the same standard as what public hospitals are from a WorkSafe perspective. And because it will allow us to do a job better. It will allow us to make sure that we can then go to the business and say, "Well this is a requirement from WorkSafe. We don't have a choice. We have to implement this." Whereas at the moment, we've got get out of jail free cards. And they get used. And I don't believe we should be able to, because our staff are still being exposed to the same violence and aggression that they're exposed to in the public sector. – Health Service 10

WorkSafe to continue providing OVA support

Participants believe the staff incident investigation tool that WorkSafe is working on to group together incidences and trends will be helpful. Further, participants found the WorkSafe website helpful but suggested it include more information for specific wards (e.g., paediatric settings).

WorkSafe are doing a really good job. They've provided this range of resources. The only thing I would say is yeah, just a little more specific to our hospital would be ideal. – Health Service 6

In terms of proactive, in terms of response, in terms of the occupational violence frameworks and all that kind of stuff. I think they're really, really good in terms of that. But again, it needs to be aligned across the whole of Australia. – Health Service 10

Limitations to addressing OVA in Victoria

Participants identified two challenges concerning evaluating their strategies: first, as addressed above, staff are underreporting incidents of OVA, so the data is not accurate; second, there is a large amount of data, but the OVA prevention teams are usually one or a few people; thus, these teams lack the capacity to analyse the data. Further, many of these strategies have yet to be evaluated.

When strategies were evaluated, the information sat within specific health service sectors. As a result, participants could not describe the results of every strategy implemented at their health service.

> *I can't really comment too much around the Brøset tool. So that's owned by our behaviours of concern and occupational violence and aggression clinical risk manager. So she sits in the QPI team. So she would be better placed. But in terms of the evaluation, the way that our team looks at it is more from an incident investigation perspective. – Health Service 2*

CONCLUSION

Occupational violence and aggression is a problem that involves complex systems and intersecting barriers and enablers. Incidents of OVA can occur anywhere within a health service, but health services identified the Emergency Department (ED) as the location where most OVA incidents occur.

Evidence review findings

The evidence review found fifteen interventions for OVA in healthcare settings. The interventions predominantly positively affected staff and patients and decreased incidents of verbal and physical violence. The interventions have also helped staff increase their skills (caring for aggressive patients, early recognition signs, and de-escalation techniques), improved their relationships with other staff members, and changed their understanding of OVA incidents.

The review also found that the more complex interventions may not be feasible or replicable in other healthcare settings due to staff shortages in the healthcare industry. It was also found that staff have struggled to find time for OVA-related professional development and training due to the high demands in their respective workplaces.

Victorian health service findings

Most health services have OVA committees that focus specifically on the prevention and management of OVA. Health services with OVA committees that have positively impacted the health service credited executives for championing the cause, which has driven top-down culture change.

Services with executive leadership championing OVA prevention have allocated more resources to experiment with innovative training ideas. These health services offer training with multiple modules and components tailored to specific high-risk roles (e.g., incident responders), special wards (e.g., ED, paediatrics, geriatrics) and home-based care. Irrespective of location and size, health services identified similar training challenges, including staff shortages, generic training, and the need for more de-escalation and standardised physical, practical skills training.

Because OVA is complex and health services have diverse department contexts with various needs, the strategies for prevention and mitigation are many and greatly vary. Examples include leadership and teamwork strategies, prevention instruments and risk and behaviour management tools. Interventions and tools identified as the most beneficial included buy-in from executive leadership, changing structural issues that improve the patient experience, planned code greys and anything that provided staff with more support (e.g., clinical lead, security) before and during an incident. Robust evaluations are needed.

Participants addressed many intersecting barriers and enablers in their health services. These were common among all health services but varied in intensity. Opportunities for improvement include:

- **Individual** – Working to alter a staff culture that normalises OVA and underreports.
- **Health Services** – Addressing staff shortages and burnout, under-resourced OVA prevention staff/teams, and structural issues that inhibit the patient's experience (e.g., loud noise)
- **Community and public policy** – Improving the general publics' negative behaviour towards staff; resolving the tension between legal entitlements that confuse health services; supporting de-escalation training, and creating a standardised approach to physical interventions.

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APPENDIX 1 – INTERVIEW AND FOCUS GROUP QUESTIONS

Background on health service

1. What is your role in the health service or what is your role in managing OVA in health service?
2. How does your workplace define OVA?
3. How often does an OVA incident occur at your service (e.g., yearly, monthly, weekly)?
    a. OHS director level or OVA coordinator level
    b. Ward level (e.g., nurses)
4. In terms of OVA occurrence, which areas are most prevalent or which areas are you are focussing on and why?

Interventions, risk controls and frameworks to prevent OVA

1. How does your workplace discuss ways to prevent OVA?
2. Is there an OVA-focused committee? Who sits on the committee?
3. What interventions, risk controls and/or frameworks are currently being implemented to prevent and manage OVA? (Repeat for each topic)
    a. Name of approach
    b. Setting where it is implemented
    c. When it was implemented
    d. What was required for implementation
    e. Key aspects of approach
    f. What you feel works and why
    g. What you feel doesn't work and why
    h. What you wished was being done and why
    i. Has this been evaluated
    j. How was it evaluated and what were the findings
    k. Do you have data to support that the intervention has reduced OVA
    l. What metrics are being used (e.g., claims numbers, incident reports, staff turnover, surveys or other qualitative measures)
    m. Can they be shared
4. Do you implement different interventions, risk controls and/or frameworks depending on the setting? Why?
    a. How is this determined?
5. Has anything been tried that did not work or created more harm?
    a. Was this evaluated?

Barriers and facilitators

1. What barriers affect implementation of OVA-focused interventions, risk controls or frameworks at your workplace?
2. What things helped the implementation of OVA-focused interventions, risk controls or frameworks at your workplace?

Conclusion

1. Is there anything else you would like WorkSafe Victoria to know on the topic of OVA in health services?