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INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

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INQUIRY INTO VIOLENCE AGAINST EMERGENCY SERVICES PERSONNEL

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback on the Inquiry into Violence Against Emergency Services Personnel, currently being conducted by the New South Wales (NSW) Legislative Assembly Committee on Law and Safety.

ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients across Australasia. ACEM considers the *Inquiry into Emergency Services Personnel* as timely, particularly in regards to the current situation in NSW, and offers the following feedback from an emergency medicine perspective.

ACEM notes that, in recent years, inquiries similar to the *Inquiry into Violence Against Emergency Services Personnel* have been conducted by other jurisdictions.[1] A number of recommendations have subsequently been provided by these inquiries relating to improving internal hospital policies and procedures and enhancing security, education and training.[2] For example, the 2005 *NSW Health Taskforce on the Prevention and Management of Violence in the Health Workplace* resulted in the development of the *Zero Tolerance to Violence in the NSW Health Workplace* policy.[3] The policy includes mandatory requirements that call for NSW Health organisations to develop work systems and environments that enable, facilitate and support a "zero tolerance" approach to workplace violence, including violence prevention programs.[4]

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[1] Parliament of Victoria Drugs and Crime Prevention Committee. *Inquiry into Violence and Security Arrangements in Victorian Hospitals and, in particular, Emergency Departments – Final Report* (Melbourne: Drugs and Crime Prevention Committee, 2011).
[2] Ibid.
[3] New South Wales Ministry of Health. *Preventing and Managing Violence in the NSW Health Workforce – A Zero Tolerance Approach* (Sydney: NSW Ministry of Health, 2015).
[4] Ibid, 4.

However, workplace violence continues to affect and have a significant impact across the healthcare sector. Emergency departments in particular are settings in which violence is more likely to occur.[5]

In recent months, there have been a number of violent incidents within EDs (e.g. the January 2016 shooting at the Nepean Hospital in NSW), and ongoing incidents of alcohol and other drug-related violence within the ED also continue to be reported. These reports are substantiated by studies demonstrating that 90 per cent of ED nurses have experienced physical intimidation or assault, with all experiencing verbal abuse.[6] Furthermore, in a 2014 survey more than 90 per cent of ED clinical staff reported that they had experienced physical aggression in the previous year by an alcohol-affected patient.[7]

Existing research findings and recommendations offered in similar inquiries or legislation is therefore highly valuable, and ACEM strongly recommends that the NSW Legislative Assembly Committee on Law and Safety consider and review existing recommendations and legislation when compiling its final report.

Factors contributing to violence against ED staff

ACEM considers it necessary to recognise that violence is not always physical. ACEM's *P32 Policy on Violence in Emergency Departments* defines violence as acts of physical assault, verbal abuse, threats, and aggressive behaviours.[8] These acts can be perpetrated against staff as well as patients within the healthcare setting. Many factors contribute to violence against ED staff. These can broadly be viewed as patient, environmental and institutional factors, some of which are described below.[9]

Patient factors

- Drug and/or alcohol use.
- Distressed or frustrated patients or family members of patients.

[5] Victorian Auditor-General. *Occupational Violence Against Healthcare Workers* (Melbourne: Victorian Auditor-General, 2015), 16.
[6] Marcus Kennedy, "Violence in emergency departments: under-reported, unconstrained and unconscionable," *Medical Journal of Australia* 182, no.7 (2005): 362.
[7] Diana Edgerton-Warburton, Andrew Gosbell, Angela Wadsworth, Katie Moore, Drew B Richardson and Daniel M Fatovich, "Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations," *Medical Journal of Australia* 204, no.4 (2016): 155.
[8] Australasian College for Emergency Medicine, *P32 Policy on Violence in the Emergency Department* (Melbourne: ACEM, 2011).
[9] Jessica L Taylor and Lynn Rew. "A systematic review of the literature: workplace violence in the emergency department," *Journal of Clinical Nursing* 20 (2010): 1073.

- Confused, disoriented or mentally unwell patients.

Environmental factors

- Long waiting times.
- Close proximity of aggressive patients or family members of patients to staff workstations.
- Overcrowding and access block.[10]
- Uncontrolled movement of the public.[11]

Institutional factors:

- Insufficient security (personnel and infrastructure).
- Staff working alone or in relative isolation.
- Inadequate handover of violent patients from law enforcement or other health providers.
- Lack of staff training in managing aggressive patients.
- Frustration between health care providers.

Patient and environmental factors, such as alcohol and drug use, are often exacerbated by inadequate practices to protect ED staff or by the poorly managed institutional contributors to violence. This results in ED staff being exposed to a high risk of violence in their workplace through multiple channels.

A number of comments provided by ED nurses and physicians to the *Alcohol Harm in EDs 2014 Survey* highlight the regularity and impacts of violence on ED staff:

"Verbal abuse is an hourly occurrence. One or two people removed for physical aggression each shift, staff members injured severely enough to have days off every few months, patients restrained by security/code black every 2-4 hours. Serious property damage (window/wall broken) every 1 or 2 months." [ED doctor, female]

"Staff are regularly faced with physical/verbal aggression due to alcohol presentations - several members of staff have had chairs thrown at them, one underwent a shoulder reconstruction after sustaining a dislocation from a patient. We are constantly abused and vilified." [ED Nurse, male]

[10] Australasian College for Emergency Medicine, *S127 Statement on Access Block* (Melbourne: ACEM, 2014).
[11] Taylor and Rew, "A systematic review of the literature," 1073.

Adequacy of current practices to protect emergency services personnel

ACEM regards current practices to protect ED staff as inadequate and recommends that appropriate resources are allocated to the health care sector in order to prevent ongoing physical and psychological injury to workers.

The reduction and elimination of workplace violence in the health sector should be an essential component of local, regional and national policies. ACEM supports the suggestions made in the *Final Report*[12] of the Parliament of Victoria Drugs and Crime Prevention Committee relating to hospital policy, management and infrastructure, and suggests that these policies could assist workplaces in creating a culture of reporting violent behaviour, and a climate of rejection of violence in their organisations. Implementation of the *Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach* policy would also offer similar outcomes.[13] These policies should be actively promoted by hospital executives and management, and be supported by the adequate provision of appropriate systems. These include:

- Offering support for reporting violence.
- Implementing risk management approaches.
- Adopting a zero tolerance approach to workplace violence.

ACEM considers that there are five key areas in which current systems to protect emergency services personnel are insufficient, and strongly recommends that additional resources are allocated to improve these practices and address the institutional factors that can contribute to violence.

[12] Parliament of Victoria Drugs and Crime Prevention Committee. *Inquiry into Violence and Security Arrangements*.
[13] New South Wales Ministry of Health. *Preventing and Managing Violence*.

1. Security

In NSW, as in other jurisdictions, EDs lack sufficient access to security personnel and infrastructure. While this is an issue for EDs in metropolitan areas, for small, non-tertiary or rural hospitals it is a more significant problem.

ACEM members working in rural or non-tertiary hospitals have reported that they must rely on police assistance, when issues of workplace violence arise. This response can be variable and problematic, particularly if police are occupied with other community emergencies. The reliance on police assistance is often due to the lack of availability of security personnel in general, or after midnight particularly. Emergency department staff, particularly nurses, can often be left without security during these hours. This is also a time when police resources are at a lower level.

ACEM considers this a significant problem, as patients affected by alcohol and other drugs are more likely to attend the ED on weekends and late at night. These are peak periods for alcohol-related presentations, as seen in ACEM's 2014 seven-day survey, with such presentations representing 14.1% of total presentations on both Saturday and Sunday.[14]

Options for reform

ACEM strongly suggests that ED security is improved through sufficient staffing and training, but also at an institutional level, through the provision of and access to appropriately trained security and/or law enforcement personnel, and combined with effective ED design.[15]

ACEM notes that in 2002 the International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organisation (WHO) and Public Services International (PSI), published the *Framework Guidelines for Addressing Workplace Violence in the Health Sector*.[16] This Framework outlines an integrated approach to addressing workplace violence in the health care sector, and contains information on prevention, management and mitigation of workplace violence.

[14] Diana Edgerton-Warburton, Andrew Gosbell, Angela Wadsworth, Daniel Fatovich, Drew Richardson and Katie Moore, "24/7, Seven-Days a Week Alcohol-Related Presentations Represent a Significant Burden to Australasian Emergency Departments, *Emergency Medicine Australasia* 28 (2016), unpublished.
[15] New South Wales Ministry of Health. *Preventing and Managing Violence*, 8.
[16] International Labour Office, International Council of Nurses, World Health Organisation and Public Services International, *Framework Guidelines for Addressing Workplace Violence in the Health Sector* (Geneva, 2002).

ACEM suggests that employers should draw on the suggestions in the Framework Guidelines. For example, adequate staff presence is available at night and for the treatment of patients with a history of violent behaviour.[17] Furthermore, ACEM considers that organisations have a duty of care to train staff in aggression management systems and risk identification, as well as in how to effectively report on incidents of violence. ACEM strongly supports the suggestions in the Framework Guidelines and considers that organisations should seek to meet these standards to the best of their ability.

ACEM also recommends that education and training on the impacts and risks of workplace violence, through strategic approaches implemented in locations in which violence against health care workers often occurs, should be extended to the general public. This could be achieved through campaigns raising awareness of these impacts and risks, but also institutionally through strategic ED design which has the capacity to communicate the expected behavioural standards of patients and their family members when in the ED.

ACEM considers that all EDs should have sufficient security personnel available at all times, as well as rapid access to law enforcement personnel, and suggests that these measures can be enhanced through appropriate ED design. The ACEM *G15 Emergency Department Design Guidelines* offer a number of security recommendations in relation to designing EDs.[18] These recommendations include:

- CCTV cameras in visible locations and monitors facing the patient to provide a visual cue that they are being observed and are accountable for their behavior, with due reference to patient confidentiality concerns.
- Close proximity of security staff to the ED, with high visibility.
- A well-lit area with natural surveillance by staff.
- Controlled access points to clinical areas.
- Clear communication methods and duress alarms throughout the ED, including in ambulance bays.

ACEM also notes that the external design of an ED must be carefully considered, given that these locations are usually open for 24 hours.

[17] Ibid.
[18] Australasian College for Emergency Medicine, *G15 Emergency Department Design Guide*, third edition (Melbourne: ACEM, 2014).

ACEM strongly believes that all patients, visitors and staff in the ED have the right to a safe environment and an obligation to contribute to it. ACEM therefor believes that there should be a nationally consistent approach to reporting, educating, legislating and cooperating to reduce and eliminate incidents of violence against all workers within the health care sector.

2. Interaction with other emergency services

ACEM notes that patients affected by alcohol or other drugs, as well as those suffering from psychiatric disorders and who have been violent, are often brought to the ED by police for examination by an authorised medical officer, prior to being taken into custody, for admission into hospital for further treatment, or for "medical clearance" for discharge.[19]

ACEM considers that the handover of these patients to ED staff from police can often prove complex and problematic. ACEM members report that, in some instances, ED staff are not provided with adequate information regarding the violent behaviour that has led to the patient's transfer to the ED. ACEM finds this practice extremely concerning, as it poses significant risk to both ED staff and patients. Such patients may be treated in close proximity to other patients and staff, may be examined without the appropriate levels of security being available, or may be examined and treated by junior staff without adequate support.

Comments provided by ED nurses and emergency physicians have highlighted the risks of treating violent patients in close proximity to children and other patients:

"I feel especially sorry for the children who co-habit our department, and pregnant women, the intellectually impaired, the elderly...all those vulnerable patients who are made to feel vulnerable or threatened by one person's behaviour." [ED Nurse, female]

"I was obviously pregnant and working as a registered nurse in the ED and was threatened by a patient (in front of his kids and wife) that he was going to punch me in the stomach. I found this quite upsetting." [ED Nurse, female]

ACEM notes that violent patients brought to the ED by police or ambulance officers often have a previous record of violence. This record may be documented in a hospital's registry but is, more often than not, recorded in the registries of ambulance, police and/or mental health services. However, these registries operate on a jurisdictional level and are not linked or accessible at the national level, meaning that records of violent offenders are not accessible to all emergency services, or other medical facilities.

[19] Mental Health Act 2007 (NSW).

Options for reform

In order to facilitate ongoing and improved inter-agency cooperation, ACEM strongly supports the creation of a state-wide working group, in which ED physicians and staff, security personnel, police and ambulance workers could cooperate to prevent workplace violence in the health care sector, and develop effective systems for handover from police services to ED staff.

ACEM suggests that such a working group would therefore be a suitable forum in which to discuss the development of mechanisms to more effectively manage the transfer of violent individuals to the ED. For example, ACEM considers that, instead of bringing violent individuals to the ED for medical clearance by default, assessments of these individuals by the appropriate medical practitioner could be undertaken in a controlled environment external to the ED, such as a police watch house. ACEM notes that the employment of police medical officers may assist in this practice. Following an assessment, individuals would only be transferred to the ED if medical treatment were required. ACEM considers that this is only one of many ways in which different emergency agencies could cooperate.

3. Interactions with other services within the health care sector

ACEM notes that changes to the *Mental Health Act* in NSW with the gazetting of EDs has seen increasing numbers and lengths of stay for mental health clients within EDs. This has been compounded by increased access block. The combination of these factors often leads to escalation of violent behaviours and increased risk to staff and patients. This is particularly true in hospitals without on-site mental health facilities.

Options for Reform

The development of purpose built facilities where a joint assessment and management can be carried out safely would have the capacity to significantly reduce violent episodes in this patient group. This would further be enabled by development of clear role delineation for each service to avoid episodes of conflict and confusion between departments that lead to delays in disposition.

4. Under-reporting

Retrospective surveys of staff and ED Directors have shown that up to 70 per cent of episodes of violence are not formally reported using hospital incident reporting or other similar systems.[20] ACEM understands that this under-reporting predominantly stems from the complexity of the forms that staff members must complete in order to report incidents of violence, as well as a lack of time to file these reports.

ACEM members also report that, as a result of the frequency of incidents, ED staff can become desensitised, with violence against them normalised as part of their role. This can lead to the perception that reporting instances of workplace violence is of little use, with few changes perceived at the institutional level.

Options for reform

ACEM supports the implementation of an accessible national database, with the capacity to support a reporting system, as well as data and information collection mechanisms, in which staff would be appropriately trained. This database would therefore also contain reports of violence against health care workers, and a record of the perpetrators. Such a database could be made available for access by emergency services personnel, general practitioners (GPs), mental health workers, and other appropriate staff within the healthcare sector. ACEM notes that due care and attention would need to be given to the privacy concerns.

[20] Kennedy, "Violence in emergency departments," 363.

5. Appropriateness of current sentencing options

ACEM notes that both the *Health Services Act 1997* and the *Crimes (Sentencing Procedure) Act 1999,* provide protections for public officials who are assaulted. However, the definition of the term 'public official' is broad, and does not specifically refer to nurses, doctors, or support staff within the hospital.

There are significant challenges regarding health services personnel reporting incidents of assault, or pressing charges against those who have assaulted them. A therapeutic relationship usually exists between the healthcare worker and the individual who assaulted them, as well as desensitisation, or the belief that violence against staff in the health care sector is the norm:

"This is a constant and daily scenario in my department [verbal and physical aggression]. I feel that it is now an expectation of the role of ED medical, nursing, ancillary and clerical staff to put up with abuse from the public and justify this abuse on the basis of decreased mental capacity due to drugs, alcohol and mental illness." [ED Nurse, female]

"We as a specialty have come to accept abuse that other public services would have only to a minor extent." [ED doctor, male]

ACEM considers that the lack of specific reference to nurses, doctors, or support staff could be one of the many drivers against reporting assault or charging perpetrators of assault, and recommends that the lack of specific provisions for these individuals within the *Health Services Act 1997* is addressed.

Options for reform

Due to the physical and ongoing psychological impacts of physical or verbal abuse, ACEM strongly suggests that those affected by workplace violence are provided with the appropriate short, medium and long term assistance during investigations, legal proceedings and their return to work.[21]

Consideration should also be given to revising existing legislation, and introducing new legislation, which specifically refers to violence against doctors, nurses, and support staff in hospitals where

[21] ACEM, *P32 Policy on Violence in the ED*.

necessary. Such legislation could also allow for EDs (as a whole) to issue restraining orders against "repeat offenders", patients or their relatives, who have committed repeated acts of violence against ED staff while receiving treatment. Under such legislation, these individuals would only be permitted to return to the ED in which they had previously and regularly committed these acts if medically unwell.

ACEM also strongly supports increasing the penalties for violence against emergency services personnel, in order to strengthen the deterrents for perpetrating violence against health care workers and other public officials.

Thank you for the opportunity to provide feedback to the NSW Legislative Assembly Committee on Law and Safety. ACEM considers that through addressing the institutional contributors to violence, the patient and environmental contributors could be mitigated, and therefore strongly suggests that reform is undertaken in regards to policies and procedures (and the associated training), security measures, legislation, interagency cooperation and ED design.

If you require any clarification or further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager Fatima Mehmedbegovic [redacted]

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