

Guide for violence and aggression training in Victorian health services

Guiding principles

The purpose

The Department of Health and Human Services' (department) *Guide for violence and aggression training in Victorian health services* provides a suite of training principles based on a tiered approach for different staff groups. These best-practice training principles will support consistency in a minimum standard of violence and aggression training across Victoria.

The guide has been developed using evidence based literature on standards of occupational violence and aggression training, particularly in emergency and mental health, as well as consultation with sector representatives.

Background

In 2015 the Victorian Auditor-General released an audit report titled *Occupational Violence Against Healthcare Workers*. The report identified that training content, duration, mode of delivery, assessment and program evaluation varied greatly across Victorian health services. It was recommended that the department, in collaboration with health services, develop a set of core occupational violence training tools that can be adapted by health services to their local context as required.

To support Victorian public health services, a suite of guiding principles have been developed to build the minimum level of knowledge and competency required of the workforce to prevent and manage occupational violence. These guiding principles will ensure training is delivered consistently across key work groups and based on best practice principles.

Applying the guiding principles

Each health service is responsible for reviewing their training programs against the guiding principles to identify gaps and areas for improvement.

The department will be monitoring health services' progress in aligning their training programs with the guiding principles. To support this, resources and tools will be made available to health services in 2017, including an evaluation framework to ensure training programs meet their stated objectives and online scenarios that can be used with existing health service training programs.

It is anticipated that health services will work towards implementing these principles in 2017-18.

Principle 1: Training programs are tailored to the requirements of different staff groups

Staff who have contact with patients and visitors have a set of knowledge and skills, relevant to their role, to prevent and manage violence and aggression.

Elements of core training

1.1. Staff whose role involves contact with patients and visitors are trained in:

Knowledge

- Relevant elements of medico-legal principles: duty of care, common law, Mental Health Act 2014 (Vic), Crimes Act 1958 (Vic), Occupational Health and Safety Act 2004 (Vic) and regulations and staff rights
- Orientation to relevant safety and security policies and procedures at induction to the organisation and following transfer to a different or high risk environment
- Staffing roles and responsibilities in Code Grey and Code Black responses
- Mental health literacy
- Predisposing factors and triggers for aggression and violence
- Orientation to incident reporting on Victorian Health Incident Management System, including the purpose of reporting
- Social factors such as age, gender, religion, culture, language, sexual orientation and other special needs that influence the experience of healthcare and the healthcare environment
- Interpersonal factors between staff and consumers or visitors that may contribute to violence and aggression, such as communication style and techniques to overcome barriers
- Self-awareness of personal signs of increasing anxiety, to support: early recognition and preventive approaches; and management approaches

Skills

- Recognition of early signs of agitation
- Communication skills, including customer service considerations
- An introduction to verbal and non-verbal de-escalation techniques
- Use of equipment and controls such as duress alarms

1.2. Specialised areas such as obstetrics, adolescents and community based workers may require additional knowledge and skills in preventing and managing violence and aggression in these settings.

Elements of clinical staff training

1.3. Clinical staff are trained in the following additional areas.

Knowledge

- Challenging behaviours, including those due to medical causes such as pain, substance abuse, medications, mental health, fear and organic illness

Skills

- Environmental and consumer risk assessment. Environmental risk assessment may be supported by tools developed by WorkSafe¹
- Safe restraint procedures and clinical monitoring requirements, recognising that all restraint measures carry some risk (for example, applicable in facilities authorised to use restraint under the Mental Health 2014 Act (Vic))

Elements of supervisor training

1.4. Supervisors are trained in these additional areas:

Skills

- Early intervention, conflict resolution and supervisory coaching
- Post-incident de-briefing and support for affected staff
- Providing support for affected patients, carers and visitors
- Injury management support for injured workers
- Hazard identification and management within the local environment including identification of systematic contributing factors to violence and aggression (for example, exploring the interplay between environmental factors and individual factors, such as personality and mental health, that influence aggression)
- Incident investigation and implementation of appropriate controls
- Data collection for incident reviews

Training elements for security staff and non-clinical staff who support an incident response

1.5. It is recognised that a range of non-clinical staff may be called upon to respond to incidents of violence and aggression such as security officers or other hospital staff. Training for these staff members includes:

Knowledge

- Orientation to current policies and procedures (including Code Grey and Code Black) at induction to the organisation and following transfer to a different or high risk environment
- Staffing roles and responsibilities in Code Grey and Code Black responses, in particular, the security role being part of the clinically led response team
- Relevant elements of medico-legal principles: Mental Health Act 2014 (Vic), common law, Crimes Act 1958 (Vic), duty of care towards patients and visitors
- Health literacy (especially around common mental health disorders)
- Recognition of early signs of agitation
- Orientation to incident reporting on Victorian Health Incident Management System, including the purpose of reporting

Skills

- Introduction to verbal and non-verbal de-escalation techniques
- Communication skills, including customer service considerations
- Safe restraint techniques

Principle 2: Training is delivered as part of a model of care

Training for the prevention and management of clinical aggression should be located within a recovery-oriented, person-centred, family/carer inclusive, trauma-informed model of care.

Training elements

2.1 The focus is on the least restrictive strategies, yet cognisant of the need to maintain the safety of consumers and staff

2.2 The model of care should be included in the training. Such models of care may include, but are not limited to, the following:

- Person-centred care is a philosophical approach to service development and service delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for themⁱⁱ. To succeed, a person-centred approach should also address the staff experience, because the staff's ability and inclination to care effectively for patients is compromised if they do not feel cared for themselvesⁱⁱⁱ
- Safewards is a model that has been established to guide^{iv} the way people understand and respond to conflict and containment on mental health wards^v
- Recovery-orientated care is a broad empirical and philosophical paradigm that emphasises an individual's journey to a full and productive life, with or in the absence of episodes of mental illness^{vi}. The restrictive interventions in designated mental health services' guidelines also advocate for the reduction of restrictive interventions such as restraint and seclusion^{vii}
- A trauma-informed care approach acknowledges the central role that trauma has played in the consumer's life and recognises the presence of trauma symptoms in the consumer's display of aggressive behaviours
- The 'six core strategies' for reducing the use of seclusion and restraint are based on trauma-informed and strength-based care^{viii}

Principle 3: Training strategies are tiered to deliver least restrictive interventions

Staff training includes a range of strategies, including primary (minimising the risk of violence before violence develops), secondary (used when violence is perceived to be imminent) and tertiary (controlling or reducing a violent incident that is already underway) strategies appropriate to their role.

Training elements

3.1 Standards for the training of primary strategies:

- Legal and policy parameters, as outlined in principles 1.1 and 1.5
- Maintaining a safe therapeutic environment
- Recognising and responding to clinical deterioration
- Observations through engagement
- The use of sensory modulation techniques to assist people in self-regulating aggression

3.2 Standards for the training of secondary strategies including training in:

- De-escalation skills as outlined in principle 1.1
- The use of skills to establish appropriate limits

3.3 Standards for the training of tertiary strategies including:

- Creating an awareness in staff of the guidelines for the use of pharmacological approaches in managing aggression including the use of Pro Re Nata (PRN) medication^{ix}
- Reinforcing that reducing the use of seclusion and restraint is not associated with an increase in clinical aggression
- The use of restrictive intervention as a last resort measure
- Policies and procedures regarding the use of seclusion, physical restraint and mechanical restraint (as

referenced in principles 1.3 and 1.5)

- Policies and procedures for the use of physical restraint
- Policies and procedures for the use of mechanical restraint

Principle 4: Training programs are delivered to staff based on an assessment of risk in their work area

Staff training addresses the differing knowledge and skill requirements for the assessed level of risk of violence and aggression in their local work area.

Training elements

- 4.1 Organisations assess work areas according to the risk of aggression and violence to staff and provide training accordingly^x**
- 4.2 Low risk areas complete a core training program, as outlined under Principle 1**
- 4.3 Medium risk areas complete the core training program and additional modules that advance core training concepts, including advanced communication and verbal and non-verbal de-escalation**
- 4.4 High risk areas complete training for medium risk areas and additional training to develop skills in breakaway techniques and de-escalating a broad spectrum of patient presentations in a variety of settings. They should also understand the array of interventions available to them including, but not limited to, medications, restrictive interventions^{xi}, and how to readily form a functional team for Code Grey responses**
- 4.5 Supervisors in high risk areas should receive training in the management of complex situations and how to assess and modify environmental influences on clinical aggression**
- 4.6 Supervisors and staff in high risk areas should consider the specific needs of those areas with particular reference to mental health, drug and alcohol intoxication, forensics, acquired brain injury and children or the elderly**

Principle 5: Training methods are, where reasonably practicable, evidence-based, cost-effective and reflective of local need

The mode of delivery for training may vary between health services, however approaches are evidence-based and cost effective for the local environment.

Training elements

- 5.1 Health services can explore the following evidence-based approaches to deliver training:**
 - Face-to-face programs that include combinations of instructional learning, role play, reflection and simulation
 - E-learning modules may support and reinforce face-to-face training programs
 - A blended training model for the efficient delivery of training, including a mixture of face-to-face and e-learning. Health services needs to consider the most appropriate content for each mode of delivery
 - Joint training sessions, between managers, clinical and security staff, which supports an understanding of individual roles and responsibilities and promotes collaboration. This arrangement should be considered, especially for high risk areas
- 5.2 Training may be delivered by internal or external providers. Health services must consider:**
 - Trainer experience, which may include related qualifications
 - Training program design alignment with this training guide
- 5.3 Annual refresher courses are recommended for high risk areas**
- 5.4 Training programs composed of discrete modules support the efficient delivery of relevant information to staff**

Principle 6: Training programs have clearly defined goals and measurable outcomes

Defined goals and measurable outcomes enable on-going development of training programs and support responsive programs that meet local knowledge and skill requirements^{xii}.

Training elements

Organisational outcomes

6.1 Organisations have key performance indicators for training, this must include:

- The proportion of staff trained
- The proportion of staff who met the goals stated in the training program
- Incident reviews and subsequent organisational or training developments
- Rates of restrictive interventions including restraint and seclusion

Learning outcomes

6.2 Goals are discipline specific and appropriate for the level of pre-existing skills

6.3 A comprehensive review of training effectiveness includes evaluations conducted before, during and after-training:

- Pre-training evaluation sets a baseline for comparison
- During training evaluation highlights the specific needs for members of the group
- Post-training evaluation informs the design and delivery of the training and identifies the achievement of key learning objectives
- Longer term carry-over of the training may be best monitored through supervisor performance monitoring^{xiii}

Principle 7: A culture of continuous quality improvement underlies prevention of aggression training and responses

A system of review is in place to ensure the best care for patients in the safest possible environment for staff.

Training elements

7.1 Issues related to training should be reviewed by the relevant health service committee

7.2 Incidents are reported to health service quality and safety committees that have a broad membership including clinical disciplines, security, Occupational Health and Safety, and where appropriate may include representatives of the health service executive, police, ambulance, carers and consumers

7.3 Data on clinical aggression should be recorded and reviewed at established multi-disciplinary meetings. Serious incidents require an in-depth review

Endnote

- ⁱ Health services can find guidance on the exposure to aggression risk calculation in the WorkSafe Victoria (2008) [Prevention and management of aggression in health services – a handbook for workplaces](http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces). <http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces>.
- ⁱⁱ Australian Commission on Safety and Quality in Health Care (2011), [Patient centred care: Improving quality and safety through partnerships with patients and consumers](https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/). <https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>
- ⁱⁱⁱ Valuing People [‘What is person centred care?’](http://valuingpeople.org.au/the-resource/what-is-person-centred-care/). <http://valuingpeople.org.au/the-resource/what-is-person-centred-care>
- ^{iv} Department of Health and Human Services, [Safewards Victoria](https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards). <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>
- ^v Bowers, L. (2014b). ‘Safewards: a new model of conflict and containment on psychiatric wards’, *Journal of Psychiatric and Mental Health Nursing*, 21, 499508.
- ^{vi} Department of Health and Human Services, [Framework for recovery-oriented practice](https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b47D26EAC-5A2C-44FA-A52A-2F387F3C4612%7d&title=Framework%20for%20Recovery-oriented%20Practice). <https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b47D26EAC-5A2C-44FA-A52A-2F387F3C4612%7d&title=Framework%20for%20Recovery-oriented%20Practice>
- ^{vii} Department of Health and Human Services, [Restrictive interventions in designated mental health services \(2014\)](https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-restrictive-interventions). <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-restrictive-interventions>
- ^{viii} Huckshorn, K. and LeBel, J. (2009). ‘Improving safety in mental health treatment settings: Preventing conflict, violence and the use of seclusion and restraint’, in S. S. Sharfstein and F. B. Dickerson (Eds.), *Textbook of hospital psychiatry* (pp. 253–265). Washington, DC: American Psychiatric Publishing.
- ^{ix} Pro Re Nata - to mean as needed or as the situation arises.
- X Health services may find guidance to determine the tiered level of training based on risk in WorkSafe Victoria (2008) [Prevention and management of aggression in health services – a handbook for workplaces](http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces). <http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces>
- ^{xi} Department of Health and Human Services, Restrictive interventions involve the use of bodily restraint (physical and mechanical restraint) and seclusion. Further information can be found at, [Restrictive interventions – bodily restraint and seclusion](https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/safeguards/restrictive-interventions-bodily-restraint-and-seclusion). <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/safeguards/restrictive-interventions-bodily-restraint-and-seclusion>
- ^{xii} There is limited information in the published literature regarding effective goals and measures. Health services are encouraged to consider measures that best meet local need.
- ^{xiii} Health services may find guidance for training evaluation in WorkSafe Victoria (2008) [Prevention and management of aggression in health services – a handbook for workplaces](http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces). <http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/prevention-and-management-of-aggression-in-health-services-a-handbook-for-workplaces>

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