



Department Health & Human Services

Public Health Services Security Model Review (C5965): Report-Executive Summary



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EXECUTIVE SUMMARY

BACKGROUND

Healthcare workers across Australia are particularly vulnerable to occupational violence & aggression (OVA) because they are at the front line when dealing with people in stressful, unpredictable and potentially volatile situations. It is important that healthcare workers are protected from the risks and incidence of OVA.

Although there has been considerable effort in the past to address the issue of OVA, the problem remains a significant issue for health services and their workers. Since 2005, a number of reports have been written that make recommendations on how to reduce the incidence of occupational violence in health services. These include the Victorian Taskforce on Violence in Nursing (2005), the Inquiry into Violence and Security Arrangements in Victorian Hospitals (2011), the Australian Nursing and Midwifery Federation 10-point plan to end violence and aggression (2014), the Victorian Auditor-Generals report - *Occupational violence against healthcare workers* (2015) and the *Violence in Healthcare Taskforce report – taking action to reduce violence in Victorian hospitals* (2016).

However, violence remains an issue for both staff and patient safety within hospitals and requires particular attention.

In 2016, the Violence in Healthcare Taskforce (Taskforce) was established to identify issues and make recommendations on opportunities to reduce violence in Victorian hospitals as well as support the implementation of the Victorian Government's election commitments to address violence in healthcare. The Taskforce's report, released in June 2016, has identified that better guidance and support is one key component needed to improve organisational management and responses, with a stronger focus on whole of health service approaches, coupled with strong leadership and accountability.

One of the recommendations made by the Taskforce was that a review of hospital security arrangements be undertaken with a focus on quality, including security responses, training and management of security staff. In December 2016, the Department of Health and Human Services (the department) conducted a survey on security arrangements in 85 Victorian health services. 84 responses were received, from 76 health services. The survey covered the following themes: security arrangements, staffing, roles, education, training and development, incident response, post-incident response, reporting, risk identification and security and environmental audit processes.

This review follows on from the department's survey.

OBJECTIVES OF THE REVIEW

1. Understand existing security arrangements in Victorian health services including staffing, risk assessment, training and post incident review practices.
2. Identify appropriate and effective security models for the prevention, management and response to occupational violence for Victorian public hospitals taking into account the unique circumstances of small rural health services.



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3. Provide recommendations to the department regarding security requirements for Victorian health services.
 4. Develop guidance material including a set of principles and standards outlining security requirements to aid health services in the prevention, management and response to OVA.

OVERVIEW OF SITE VISITS

Site visits were organised and undertaken between 20 July and 23 August 2017 with a total of 61 stakeholders attending site meetings, up to 15 at larger and 2-3 at smaller health services.

Prior to undertaking site visits, LPGA prepared and forwarded the 15 participating health services 19 questions relating to the individual arrangements at each health services including, responses to code grey/black, incident reporting platforms and reporting compliance, levels and frequency of OVA training provided to staff, security staff numbers, coverage and whether they deployed an in-house or contracted model and the level of coverage on each shift. The questions were complimentary to the department's survey questions of 2016 and were prepared with the intention to solicit current and accurate information.

The participating 15 health services represented the following peers groups, 3 x Major, 3 x Sub-Regional, 2 x Regional, 3 x small rural health services (SRHS), 2 x Tertiary and 2 x Local health services and encompassed a range of services including emergency, mental health, acute, subacute, maternity, dental and residential and aged care services.

The following themes were discussed with each health service:

- Site specific responses to OVA
- Incident reporting procedures and data collection
- OVA management training
- Security officers roles and responsibilities in OVA responses and generally
- In-house versus outsourced security models, advantages and disadvantages
- Interaction between security officers and clinicians
- Risk assessments to determine levels of security officers on each day/shift
- Post incident critical incident reviews
- Consistency of security arrangements across sites
- General site specific security arrangements and concerns
- How smaller health services cope or manage without security officers.

NOTE: stakeholder meetings were also conducted with the Australian Medical Association (AMA), Health Workers Union (HWU), Australian Nursing and Midwifery Federation (Victorian Branch) and Health and Community Services Union (HACSU).

FINDINGS

1. Highly trained security personnel are an essential component in the prevention, management and response to OVA.
2. Security personnel received varied OVA training across the health services visited. Inconsistent training modules were evident, however all training offered is designed to equip security personnel to detect and diffuse aggressive behaviours and if required to effect physical restraint. Importantly, there is a particular focus on de-escalation techniques. Our review found that there is a higher level of training for security personnel in major metropolitan and large regional health services that deploy security services 24/7. The training elements outlined in the department's *"Guide for violence and aggression training in the Victorian health services"* for security staff and non-clinical staff who support an incident response, do not appear to have been implemented by all participating health services.
3. Some health services deploy an in-house security model while others prefer an outsourced model or in some cases a hybrid model, i.e. in-house supported as required by outsourced contract security. There is no "right or wrong" model and both have their administrative, financial and operational advantages, or disadvantages, and it is what is working most effectively for the respective health services. There was no measurable difference observed in the quality and/or effectiveness of in-house or outsourced security officers in the prevention, management and response to OVA. Effectiveness was commensurate with the supervision, professionalism, quality and training provided by health services and/or external contractors.
4. The levels of on-site security varies significantly in regional/rural health services with some smaller health services deploying security personnel 24/7 while other larger health services do not have any security officers on duty during the day and evening shifts and only provided security overnight. For example, there are two regional health services of similar size and numbers of emergency department (ED) presentations that deploy vastly different levels of security personnel. One health service deploys five security officers across three shifts 24/7, while the other only deploys one security officer overnight and have no security officers on duty during day and evening shifts. It would appear both health services adopt different methods to assess their security risks.

Other regional/rural health services rely on private security companies to provide external patrols and responses, if or when available, with potential delays of 30 to 60 minutes in some cases. Likewise, many regional towns do not have a 24/7 police station and support from police may not be immediately available and in some cases may take up to an hour or more to attend.

5. Where security personnel are deployed, the numbers who attend code grey/black responses vary significantly. For example, at one major metropolitan health service, four security officers attend all code grey responses, while at another only two security officers attend and request assistance when necessary with others deploying two or three security officers. Typically,

major health services risk assess the code responses and adjust their security resources accordingly. At smaller regional and metropolitan health services only one security officer will attend as often there is only one on duty. As mentioned previously, several health services do not deploy security officers and the first and only responders are clinicians at times supported by personal service assistants (PSAs). No consistency of service delivery exists of the numbers of security officers required to respond to code grey/blacks and/or OVA incidents, although the department introduced Code Grey Standards in September 2017 stating “the team must include clinically and security trained staff members”.

6. Several regional/rural health services with multiple sites have little or in some cases no access to external security patrols to respond to duress alarms or to support emergency response teams. Often there is no police presence in several regional/rural towns.
7. Deficiencies were evident for the delivery of “hospital specific” security officer training particularly for security officers unfamiliar with the health care sector. The department’s *“Guide for violence and aggression training in Victorian health services (May 2017)”* adequately provides for “hospital specific” training however did not appear to be universally implemented by participating health services.
8. All participating health services recognise the value of CCTV cameras. The CCTV coverage varies significantly with major metropolitan health services having extensive coverage with large CCTV control rooms, while smaller regional/rural and local health services deploy CCTV technology in recognised high risk areas. The vast majority of health services do not deploy specialised 24/7 “real time” monitoring by security officers, rather depend on recorded images for post incident analysis. Control room operators exist at a few major metropolitan health services, however their role is not specific to monitoring CCTV cameras but is multi-faceted.
9. There was some evidence health services undertake formal risk assessments to determine the requirement for or the numbers of security officers they deploy on each shift. Largely, the need for any increase of numbers deployed are incident driven together with using data from incident reporting systems. The risk assessment approach was more evident in large metropolitan health services where formal business cases must support any requests to increase onsite security coverage.
10. Major metropolitan and some large regional health services, with mental health units and EDs are well prepared and experienced in the prevention, management and response to OVA. Conversely, other large regional and some smaller sub-regional and local health services appeared complacent and under prepared in their response to OVA incidents. Moreover, several do not deploy any on site security officers to support OVA response teams and rely solely on a response from clinical staff, although Code Grey Standards introduced by the department in September 2017 state “the team must include clinically and security trained staff members”.

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11. Our review found in health services operating sub-acute services there was less need for security officer support particularly those without emergency departments, urgent care and/or mental health units. Several health services commented on the increasing risks to staff associated with managing patients with delirium and dementia.
 12. Health services that adopt a “team training” (security officers and clinicians) approach to the prevention, management and response to OVA appeared to have the most effective model.
 13. Unlike outsourced security officers, it is not mandatory in the state of Victoria for in-house security officers to hold Victorian Security Licenses. All health services in the scope of this review deploying either in-house or outsourced security officers confirmed all possess security licences. Typically, this is the trend state wide.
 14. Orderlies, Porters or PSAs that are required by their health service to support OVA (Code) response teams were generally unlicensed, although were recipients of OVA training. There is no legal compulsion for such craft groups (PSAs, orderlies) to obtain Victorian Security Licences, although this would be ideal, health services must consider the benefits.
 15. Several larger health services have a “planned code grey response” and it is considered an effective and a proactive risk mitigation measure. Notably, the department released updated Code Grey standards in September 2017 incorporating planned code grey.
 16. In addition to the Victorian Health Incident Management System (VHIMS) “Riskman” some larger health services maintain separate incident reporting platforms for security incidents including but not restricted to OVA related incidents. Again, there is little consistency as the majority of health services solely depend on VHIMS, although readily admit many incidents remain under reported. Typically, the secondary or separate reporting platforms are far more reliable as they are typically complied and maintained by security officers who record all incidents in which they are involved. Notably, the Victorian Health Information Agency (VHIA) is working to improve VHIMS. This initiative has been received favourably by health services.
 17. Hospitals have no visibility or sharing capabilities for the detection or management of repeat high risk patients or visitors.
 18. One major metropolitan health service has experienced “000” call operators responsible for dispatching police to code black events, have a limited understanding of terminology used by clinicians requesting urgent police attendance.
 19. Although it is a mandatory requirement at the majority of health services to report OVA related incidents, compliance varies between health services. Conversely, at some larger major metropolitan health services reports of OVA have doubled in the past 12 months, an indicator the culture and compliance to report is improving. Generally, there appears to be a lack of reporting of dementia related OVA incidents.

20. Typically, staff at all participating health services receive adequate training in the use of VHIMS (Riskman), however this in no way guarantees OVA and other occupational health and safety/security incidents are reported. A senior Emergency Department clinician at one major health service stated “no verbal aggression threats are recorded”, citing a lack of time and an acceptance by ED staff that “it is just part of their job”.
21. The level of OVA training offered and delivered to staff varies significantly between health services and is best described as inconsistent and disjointed.
Typically, all major metropolitan health services with emergency departments and mental health facilities offer and provide a high level of training to first responders including front line clinicians, mental health professionals, code response and/or aggression management teams (AMT) including security officers. Typically smaller regional and local health services were not as focused or committed to training first responders. Notably, in 2017 the department released the “*Guide for violence and aggression training in Victorian health Services*”. This document is a useful guide to be utilised by all health services.
22. The majority of participating health services undertake post incident reviews (de-briefs) for problematic or high level and/or multiple code grey responses. This varies significantly across health services and largely depends upon the nature of the code, operational difficulties encountered and if injuries were sustained by health workers and/or the perpetrator. Typically, where deployed, the senior security officer and or security manager together with the code response team will attend post incident reviews or de-briefs.
23. In health services where security officers are deployed, the officers are typically located in or adjacent to the Emergency Department or close to the main entrance. Some large metropolitan health services deploy a security officer in the Emergency Department 24/7 to support and respond to the needs of clinical staff. This is a growing trend and one fully supported by clinical staff.
24. One major regional hospital reported they have implemented “behavioural contracts of care” or visitation contracts to deal with known or regular aggressive patients and visitors.
25. All participating health services either have a specific OVA committee or incorporate OVA into their Occupational Health & Safety or Work, Health & Safety Committee. Health services where security officers are deployed ensure that the security manager or senior security officer attends these meetings.
26. Some major metropolitan health services have procured and deployed “body cameras” for their security officers. Feedback on their effectiveness is generally positive with evidence emerging that the body cameras are having a deterrent and de-escalation effect. Notably, in June 2017, the department released a “*body worn camera template*”. Furthermore, Ambulance Victoria has received funding from the Health Service Violence Prevention Fund to trial body-worn cameras to inform future policy development.

RECOMMENDATIONS

To strengthen security arrangements in Victorian public health services and to improve prevention, management and response to OVA it is recommended that:

1. Individual health services, as employers, remain responsible for determining the numbers of security personnel to deploy, by conducting comprehensive site-specific risk assessments using internal and/or external expertise. If health services do not have sufficient internal expertise within their health service, they should seek independent expertise for support and advice. The security risk assessments should include but not be restricted to the following elements
 - The category of the health service i.e. specialist, tertiary, major, regional, sub-regional and local.
 - Services provided, i.e. Emergency Department (number of patient presentations), Mental Health, Maternity, Aged and/or residential and aged care etc.
 - Location and population demographic
 - Local crime statistics
 - High risk patient groups
 - Environmental factors, size of facility, layout of buildings, number of access points.
 - Historical and current incident report data (VHIMS or internal reporting platforms)
 - Current levels of reported OVA incidents.
 - Number of code grey and black events
 - The number of available staff across all shifts 24/7 to support OVA response teams, (smaller and more remote health services).
 - Proximity to and availability of 24/7 police resources and private security operators.
 - Current physical and electronic security capabilities, including CCTV and access control coverage.
 - Compliance to Australian Standard 4485 parts 1&2, "Security for healthcare facilities".

SPECIAL NOTES:

- Security arrangements, including security staffing levels, should be determined by formal site specific risk assessment, rather than by arbitrary means. This ensures that the specific risks faced by each site can be identified and controls implemented to manage local circumstances.
- It is acknowledged several small regional/rural health services have remote aged care, residential and acute facilities, therefore based on their assessment do not deploy on-site security officers. However, "in-charge" clinical staff across all shifts, together with designated code grey responses teams, must receive and maintain high level OVA training consistent with the departments "*Guide for violence and aggression training in Victorian health services*"

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- Effective Security Models for prevention, management and response to OVA models will vary between health services, however should be developed based on site-specific risk assessments specific to their health service.
 - Where deployed, highly trained security officers are an essential component in the prevention, management and response to OVA.
 - Where security officers are not deployed, typically in rural or more remote and several metropolitan health services, it remains critical to deploy 24/7 OVA code response teams with training consistent with the department's *"Guide for violence and aggression training in Victorian health services"* and the *September 2017 Code Grey Standards*.
2. To support the occupational safety and wellbeing of staff in remote regional/rural facilities, health services must deploy current, effective electronic access control, lock down, duress alarms and CCTV capabilities.

At a minimum and based on site-specific risk assessments rural and regional health services must have

- Effective electronic access controls and lockdown capabilities.
 - Install fixed and mobile duress alarms.
 - Install CCTV with recording capability in high risk areas including but not restricted to all main entrance and exit points.
 - Where available, arrange formal contracts with local security patrol companies to provide security support to the health service. This support may include regular site patrols to check the integrity of perimeter security and responding to threats to staff threats.
3. Health services must ensure that security trained staff have the requisite skills, capabilities and competencies, equivalent to security personnel licenced under the Private Security Act (2004) Victoria. In addition, health service security personnel must receive healthcare specific training in accordance with the department's *"Guide for violence and aggression training in Victorian health services (May 2017)"*.

NOTE:

To complete and hold a security licence in Victoria there are several categories, however the categories relevant to health services typically include security guard and a control room operator, (to view and monitor CCTV). The competencies that must be achieved to obtain a security licence in Victoria are listed below. (Source: Victorian Police website).

The competencies are similar in both categories, however there are four additional competencies to possess a control room operator's licence.

CERTIFICATE II - UNARMED GUARD

CPPSEC2001A- Communicate effectively in the security industry

CPPSEC2002A- Follow workplace safety procedures in the security industry

CPPSEC2003B- Work effectively in the security industry
CPPSEC2004B- Respond to security risk situation
CPPSEC2005A- Work as part of a security team
CPPSEC2006B- Provide security services to clients
CPPSEC2011B- Control access to and exit from premises
CPPSEC2014A- Operate basic security equipment
CPPSEC2015A- Patrol premises
CPPSEC2017A- Protect self and others using basic defensive techniques
CPPSEC3002A- Manage conflict through negotiation
HLTFA311A- Apply first aid
TLIE2007A- Use communication systems* / TLIE2007 Use communication systems (new competency as of 18 January 2017)

CERTIFICATE II - CONTROL ROOM OPERATOR

CPPSEC2001A- Communicate effectively in the security industry
CPPSEC2002A- Follow workplace safety procedures in the security industry
CPPSEC2003B- Work effectively in the security industry
CPPSEC2004B- Respond to security risk situation
CPPSEC2005A- Work as part of a security team
CPPSEC2006B- Provide security services to clients
CPPSEC2014A- Operate basic security equipment
CPPSEC2018A- Monitor electronic reporting facility
CPPSEC3012A- Store and protect information
CPPSEC3020A- Monitor security from control room
CPPSEC3021A- Maintain and use security database
HLTFA311A- Apply first aid
TLIE2007A- Use communication systems* / TLIE2007 Use communication systems (new competency as of 18 January 2017)

4. Health services must ensure the role, expectation and responsibilities of security officers together with other staff supporting security officers i.e. (PSAs/orderlies), have their responsibilities clearly defined and regularly updated to accurately reflect their position descriptions.
5. Health services must review their security arrangements at least annually, including skills, capabilities and the competencies of their security personnel, and physical and electronic controls.
6. The department develops a health care specific core training module for security personnel.
NOTE: Several health services utilise PSAs/orderlies to undertake or support security functions. This is appropriate if the required training is provided to PSAs/orderlies to assist security personnel and or undertake security duties as required.

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7. Progressively, and depending on the outcome of the Ambulance Victoria trial, major, regional/sub-regional and local health services should consider the deployment of body cameras for security officers.
 8. To avoid duplication of training for security officers (and others), the department should consider the recognition of prior learning by endorsing training programs that are consistent with the *“Guide for violence and aggression training in Victorian health services”*. This would minimise the requirement for health services to duplicate training already completed.
NOTE: it is important and a requirement under Code Grey Standards for staff to train with their local teams (security and clinical) in their local environment.
 9. Health services must continually improve the capability and coverage of CCTV and electronic access controls particularly in high risk clinical and public access areas. The capability and quality of current systems vary significantly between health services. (It is acknowledged the department has provided resources to several health services via the Health Service Violence Prevention Fund).
NOTE: a small number of health services deploy 24/7 control room security personnel undertaking “real time” CCTV monitoring and other security related duties. This is a site specific initiative and one that health services must consider when undertaking site-specific security risk assessments.
 10. Health services should locate security personnel as close as possible to the highest risk areas of their health services as determined via their risk assessment. This could include areas such as EDs and mental health units.
 11. Health services must ensure formal “post critical incident reviews” of high level OVA and other related security incidents are formally undertaken, together with adequate support models for security and clinical staff who are repeatedly victims of violence. Post incident review teams should consist of clinicians, risk and OHS managers, security manager or designate and other relevant stakeholders.
NOTE: it is important for security personnel to participate in post critical incident reviews as often they are involved in de-escalation and/or restraint techniques and are typically present during all high level incidents.
 12. Health services continue to ensure that staff understand Code Grey and Code Black procedures, including how to describe Code Grey and Code Black to emergency service personnel, including the Emergency Services Telecommunication Authority (ESTA).
 13. Large metropolitan health services should explore the benefits of utilising facility automation indoors and outdoors for security controls, including advanced video analytics for behaviour identification. This may be complimentary to, or interfaced with, current CCTV and electronic access control infrastructures to enable security personnel and/or risk managers to detect unpredictable, unsociable and potentially criminal behaviour by visitors and other accessing the health service.



CONCLUSION

After the analysis conducted together with the valuable feedback received from stakeholders and participants; coupled with industry research, the DHHS survey of 85 health services and best practice, this report provides an accurate account of the current and varying security arrangements/programs supporting the prevention of occupation violence and aggression in Victorian health services.

Core to the conclusions is that the current methods in situ at Victoria health services may be suboptimal and inconsistent in the context of demands placed on health services in the prevailing environment. This conclusion applies no matter how well-intentioned parties have been in their pursuit and delivery of consistency and excellence. It remains evident however, there is a level of complacency at some health services who have not been subjected (yet) to high-level incidents of occupational violence and aggression culminating in staff injury.

Against the background of the security and safety objectives and the pressures to improve, under the current increasing hostile environment, a reasonable conclusion is that direction, continuing public OVA awareness programs, consistency and continuity of OVA training, increased levels of static security officers, enhanced electronic infrastructure and targeted additional funding is necessary to reduce the level of OVA in Victoria health services.

Yours sincerely

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