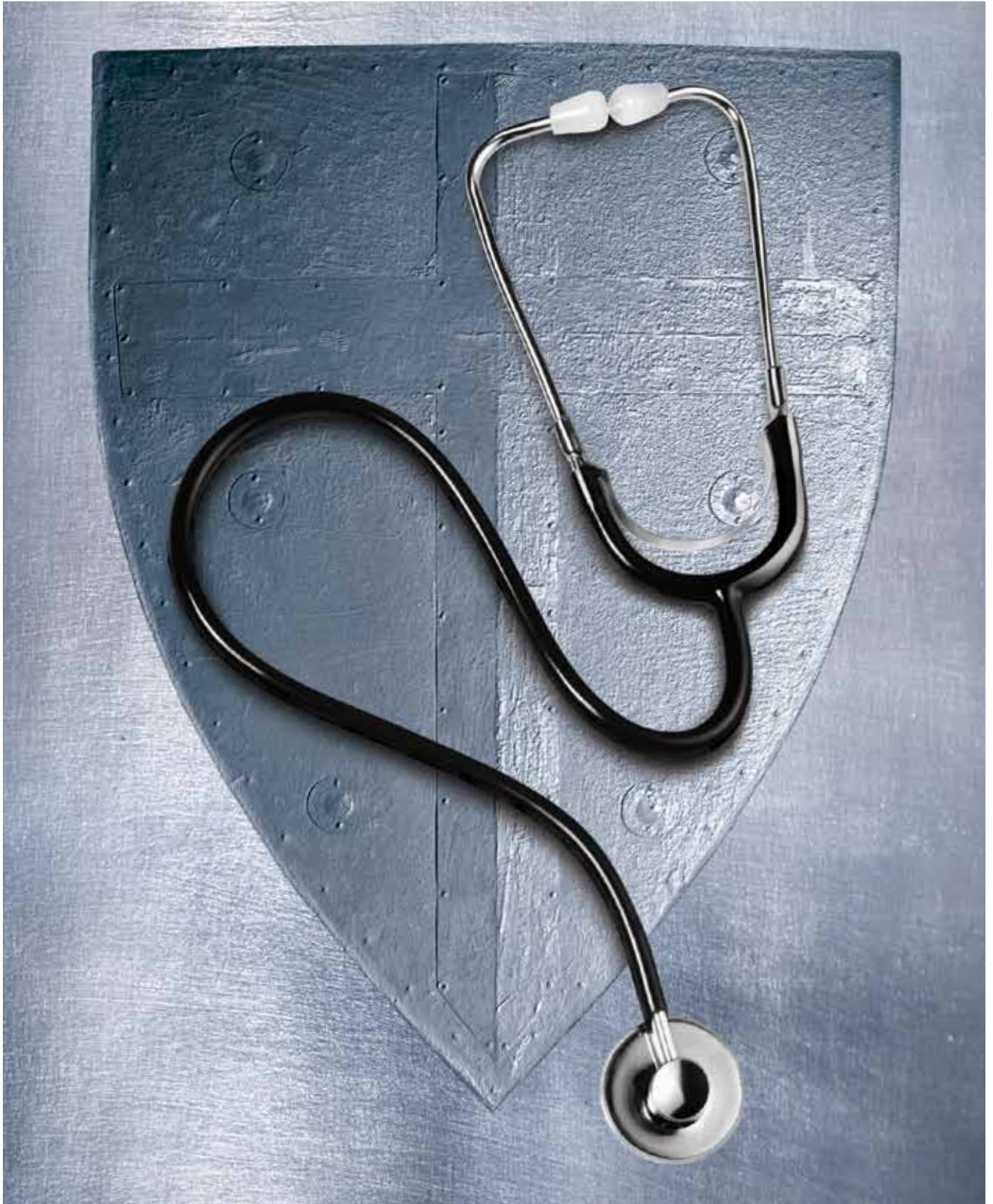




The Royal Australian  
College of General  
Practitioners

# *General practice – a safe place*

tips and tools



General practice – a safe place: tips and tools

Written by Leanne Rowe AM, Bronwyn Morris-Donovan, and Ian Watts in conjunction with  
The Royal Australian College of General Practitioners Publications Unit.

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This booklet is, in part, a collection and adaptation of the work by prominent people in the field of general practice and occupational violence.

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The Dandenong Casey General Practice Association Safety and Security Kit for General Practice is available at [www.dcgpa.com.au/\\_misc/Safety%20and%20Security%20Kit%20Sept%202008.pdf](http://www.dcgpa.com.au/_misc/Safety%20and%20Security%20Kit%20Sept%202008.pdf).

# Foreword

It is clear that general practices need to work both collectively and at the individual practice level to ensure that people in general practice remain safe and secure. *General practice – a safe place* focuses on the prevention and management of patient initiated threats to the personal safety of general practice staff. The evidence demonstrates the multidimensional nature of patient initiated violence and the need for a preventive, multifaceted response to this issue.

A number of studies have reported that about two out of three general practitioners experience some form of occupational violence in a 12 month period. At the most severe end of the spectrum of violence, four Australian GPs have been murdered in the past 12 years. Although it is important not to overreact to these rare instances of major physical assault, a preventive approach is essential as the negative consequences of any potentially violent situation can be severe. As one GP said of such an experience: 'I aged 10 years in 2 seconds'.

Because different types of violence require different responses, a balanced and comprehensive approach to violence in general practice is required. Any form of patient initiated violence should be considered as a 'sentinel event'. Some events need to trigger a 'root cause analysis' of all contributing factors, so as to try and prevent a future incident. This well accepted approach to quality improvement in health care can readily become part of a routine response to aggressive behaviour, threats, or assault in general practice.

Increasing health workplace violence is a symptom of increasing violence in Australian communities. General practitioners have an obligation to protect themselves, their team and the community as a whole if patients display criminal behaviours that pose a risk to the safety of others.

As employers, general practices also have responsibilities under occupational health and safety legislation to protect colleagues, the violent/aggressive patient, other patients, carers and staff by identifying and controlling risks associated with occupational violence. While some practitioners have been resistant to such measures, it must be accepted that security strategies are now part of modern life and routinely implemented by mental health services, drug and alcohol services, locum agencies, hospitals and other businesses.

This booklet outlines a range of practical strategies to assist general practices to appropriately minimise risks of violence, including means to:

- create a safe physical environment
- flag the files of patients with a history of violent behaviour within a practice
- assertively clinically manage patients at risk of violent behaviour
- work with other services to reduce the future risk of violence, and
- support the general practice team after experiences of violence.

In developing this resource, the authors have consulted with many experts in the field, and with practice teams working at the coalface. We recognise the topic is complex and requires different approaches in different situations.

We anticipate that this booklet will be used as a tool to encourage discussion within general practice teams about appropriate responses to manage the risk of occupational violence.

The RACGP is keen to have feedback about patient initiated violence, the ways general practice has worked to reduce the incidence of such violence, and about this booklet specifically. Feedback can be provided at [safety@racgp.org.au](mailto:safety@racgp.org.au).

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## Introduction

Internationally, there has been increasing interest in occupational violence in the health care sector. In Australia, there has been heightened interest in the safety of general practice and primary health care teams since the killing of Dr Khulod Maarouf-Hassan in 2006.

The increase in violence in the workplace is symptomatic of the overall increase of major violence in Australia.<sup>1,2</sup> Workplace violence is not an isolated incident with a simple solution. It is a dynamic and multidimensional event.

The literature suggests that occupational violence requires a multifaceted response, as it is a structural problem rooted in social, economic, organisational, and cultural factors. However, initiatives to address risks of violence in general practice in the past have tended to be largely ad hoc and are seldom the result of considered or coordinated strategies.<sup>3,4</sup>

This booklet focuses on threats to personal safety rather than the clinical management of 'difficult' patient interactions, anger management or conflict resolution. Clearly, early management of patient frustration and other feelings is vitally important to preventing violence. Other resources on these topics are included in the *Resources* section on page 41. The strategies in this booklet are related to imminent or actual patient initiated violence and effective risk control measures, which are:

- inclusive of the whole practice team, including reception staff, practice nurses, the practice manager and GPs
- pre-planned and preventive in approach, and
- multi-dimensional, encompassing physical environmental, patient directed and practice team directed strategies.

## Classification of workplace violence

A widely accepted classification divides workplace violence into three broad categories:

- 'External' violence, which is perpetrated by persons outside the organisation such as during an armed hold-up
- 'Patient initiated' violence, which is inflicted on workers by their clients, such as a patient who verbally abuses a practice nurse, and
- 'Internal' violence (or bullying) such as between supervisor and employee.<sup>5,6</sup>

This booklet only considers patient initiated violence in Australian general practice.

## Defining patient initiated violence

For the purposes of this booklet, patient initiated violence includes: 'Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, wellbeing or health'.<sup>5</sup>

There are varying degrees of patient initiated violence. Violent acts and behaviours are not purely restricted to the domain of physical or verbal aggression. What one person perceives as threatening may be perceived quite differently by another person.

In essence, patient initiated violence includes anything that makes a person feel threatened. Many patients express anger, which usually resolves with respectful communication; very few patients react violently.

What is most important is that people always acknowledge and act on their 'gut' feeling when they feel threatened.

Patient initiated violence covers a wide spectrum and can include:

- threatening or inappropriate body language
- intimidation and threats
- verbal aggression (rudeness, yelling, inappropriately swearing)
- abusive letters/phone calls/emails
- assault
- forcible confinement/false imprisonment
- acts of indecency
- sexual harassment (including innuendo, 'accidentally' touching or overt sexual advances)
- sexual assault
- destruction of property/possessions
- stalking, loitering
- armed assault
- a hostage situation.<sup>7-9</sup>

## Assault

Most people equate assault with physical violence. Physical violence is only one type of assault, and because of many people's misunderstanding of the scope of assault, it is important to explain what assault is.

Assault is a threat or a physical attack on personal safety. Assault has a different statutory definition in each Australian state and territory, but the common law definition is well understood and may result in either criminal or civil liability. A general definition of assault is: 'The intentional use of force or intimidation by one person against another, without that other person's consent or other lawful reason, which causes that other person to fear an immediate threat of physical violence or harm'.

The definition of assault has been extended to include acts that technically constitute battery such as:

- pushing
- shoving
- smacking
- holding, or
- touching of a person's body or clothes so as to cause the victim discomfort.

If a patient threatens another person using a weapon such as a dirty syringe by waving it in front of that person's face, or by some other intimidating gesture, this constitutes an assault if it is done intentionally and the act evokes fear in the person threatened. Conduct which is threatening and intimidating, but falls short of an overt act of aggression is capable of constituting an assault.<sup>10,11</sup>

## The prevalence of patient initiated violence

There are very few studies on the prevalence or circumstances of violence against GPs and their teams. One study reported that about 20% of GPs have experienced physical abuse during their careers.<sup>12</sup> A 2003 Australian study found that 63.7% of GPs had experienced at least one episode of violence over the previous 12 months, with the likelihood of having experienced violence declining with increasing years of experience as a GP.<sup>13</sup>

Younger, female GPs appear most at risk of physical violence, including sexual violence, and have been shown to experience greater fear and implement more changes to the way they practise due to their apprehension of violence.<sup>3,4</sup>

Geographical variations in experiences of violence in general practice have not been extensively studied. Both GPs working in metropolitan and rural areas appear to be at risk of medical workplace violence.<sup>3,14</sup>

## The impact of patient initiated violence

Patient initiated violence can have a serious and widespread impact on the staff member(s) involved, and the broader practice team.

The physical severity of a violent incident does not necessarily correlate with the extent of the emotional impact on the recipient. Rather, it is the presence or absence of malice by the perpetrator that correlates with impact.<sup>5</sup> The emotional cost from both perceived and real threats can be considerable and cumulative.<sup>7</sup>

The effects of patient initiated violence are primarily psychological, social and professional, and include:

- high levels of anxiety
- poor concentration
- difficulty listening to patients
- depression
- stress related illness
- social withdrawal
- absenteeism, including avoiding patient types or sites
- high staff turnover
- difficulty recruiting
- diminished productivity
- diminished staff satisfaction, and
- reduced participation in the medical workforce.<sup>6,14</sup>

Workplace culture is an important determinant of how individuals and the practice as a whole respond to the consequences of workplace violence. On one hand, the adverse consequences may be exacerbated by a lack of support by the practice team. On the other hand, the emotional cost of violence can be alleviated by the presence of a supportive and communicative environment.

## Multidimensional framework of patient initiated violence

The framework of patient initiated violence is the foundation of the 'tips and tools' booklet. It is designed to illustrate the dynamic flow of patient initiated violence in general practice. The framework begins with pre-incident factors, which can be considered as 'risk factors' of violence and aggression. When an incident occurs, such as verbal assault, a post-incident response is necessary to determine what risk factors can be modified to minimise the risk of the incident occurring again.

Creating a safe environment requires a multidimensional approach. It is more effective to make numerous small changes, across a range of domains, rather than one significant change in isolation. The next three sections of this booklet consider patient initiated violence from three domains:

- Phase 1 - the patient/perpetrator
- Phase 2 - the general practice team
- Phase 3 - the practice environment.

### Zero tolerance

A 'zero tolerance' policy indicates that specified behaviour will not be tolerated under any circumstances, and that non-negotiable sanctions will be imposed when that behaviour occurs.<sup>15</sup>

Zero tolerance considers the perpetrator in isolation rather than the complex interaction between the perpetrator, the practice staff, and the environment. The emphasis of zero tolerance is on risk management and protecting victims rather than dealing with the problems of perpetrators.<sup>16</sup>

Many GPs feel that zero tolerance policies do not work. This is reflected in the statistics relating to violence in general practice that show under-reporting of violence.<sup>17</sup>

General practitioners usually exercise professional discretion about behaviours that fall into clinically, ethically or medicolegally grey areas and more obvious criminal behaviour requiring police intervention.<sup>14</sup> They also recognise their obligation to treat patients who may be at risk of violent behaviour but who require assistance in an emergency.

General practitioners are concerned that zero tolerance does not address the underlying causes of violence. Zero tolerance by GPs toward patient initiated violence may be detrimental if there is an underlying medical or psychiatric cause of the violent behaviour. If such a patient is denied medical or psychiatric care, the violent behaviour may inadvertently be deflected toward the community or to other medical practices.

It must be emphasised that while zero tolerance may not be effective, 'doing nothing' is not an option. A more positive outcome is likely with assertive clinical management of patients at risk, an approach that sometimes involves the mental health system and the police.

## Phase 1 – The patient/perpetrator

While there are no reliable indicators of an individual's capacity for violence, there are certain characteristics that indicate a potential for violent behaviour.<sup>7</sup>

Patient risk factors include:

- past history of violence
- alcohol or drug intoxication or withdrawal
- poorly treated or untreated mental illness such as borderline personality disorder and psychosis associated with disordered and persecutory thinking, and
- cumulative stress (eg. grief, fear, distress, anxiety, pain) combined with other unanticipated events such as long waiting times.<sup>7,18</sup>

### Origins of patient initiated violence

Violence rarely 'comes out of the blue'. It is commonly preceded by behaviour that indicates a potential for violence. In addition to the above risk factors, there are many reasons why a patient may be angry, including a patient who:

- is dealing with acute or chronic pain
- is anxious about a serious diagnosis or report
- is seeking drugs of addiction or prescription shopping, and
- has had difficult past encounters with GPs or practice staff.

When responding to the patient or perpetrator, it is important to consider that rudeness and signals of impending violence might have their genesis in treatable health problems.

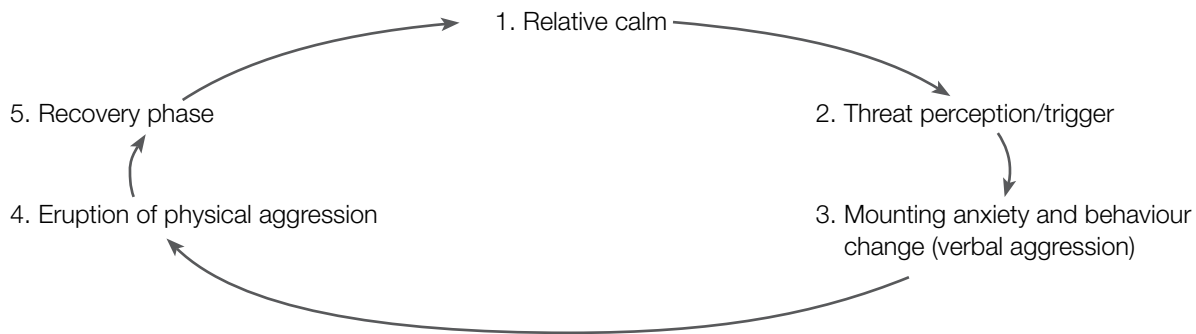
An appreciation of the underlying origins of a patient's escalating frustration and agitation can assist in:

- effectively de-escalating the situation, and
- identifying the most effective and appropriate clinical and medicolegal risk management strategies to deal with the problem and prevent its recurrence.

Sometimes patients are more likely to exhibit violent behaviour if there is a history of the practice tolerating or ignoring inappropriate behaviour from patients. Patients may come to believe this is acceptable behaviour in the practice, and learn to use their violent behaviour as a means of receiving what they want.<sup>7</sup>

## The cycle of aggression

It is important to recognise the different stages of aggressive behaviour. Retrospective reviews of incidents of aggression reveal a pattern of sequential events. It is useful to consider this pattern as it may assist in recognising and evaluating both perceived and real threats.<sup>8</sup> The pattern of events is represented schematically as a repeating cycle with distinct stages.



**Stage 1:** The individual is at rest. There may be a heightened state of alertness.

**Stage 2:** The individual perceives internal and external cues as threatening – this could be a cue from the environment, staff or other patients. The person may misperceive internal cues, such as their own anxiety surrounding a medical condition.

**Stage 3:** There is a significant increase in central nervous system activity as anxiety escalates. Attempts to relieve anxiety are displayed as restlessness, hypervigilance, and verbal abuse.

**Stage 4:** The individual feels increasingly threatened and vulnerable. High anxiety and discomfort are released through physical aggression.

**Stage 5:** Recovery phase. An individual's physical and emotional response may be below his/her normal baseline calm.

A patient in stage 1, 2, 3 or 5 may continue to be very dangerous but may be amenable to negotiation. It is imperative the threat continues to be treated seriously, even when the patient's aggression has settled.<sup>8</sup>

## Warning signs of escalating aggression

General practitioners and practice staff deal with patient anger on a daily basis. While patient anger is unpleasant, GPs and practice nurses are usually very experienced at resolving conflict. However, sometimes it can be difficult to determine when anger is escalating to the point of violence and how to respond appropriately to different levels of violence.

The warning signs of escalating aggression include:

- veiled and overt threats to GPs, staff, or other patients
- outbursts of irrational anger
- violent gestures such as pointing, swearing, verbal abuse, slamming objects (eg. doors, chairs)
- either intense staring at you or avoiding looking at you (this often depends on cultural background)
- increased psychomotor activity – restlessness, repetitive movements, pacing, arousal, and inability to sit still
- refusal to communicate, withdrawn
- harmful, violent thoughts and disordered thinking about violence
- warning signs from early episodes of violence, past history of violence.<sup>8,9,19</sup>

Always acknowledge your 'gut' feeling when you feel unsafe and act on it by leaving the room immediately and alerting other staff.

## De-escalating violence

If you believe you are not in immediate danger, you may find the following steps helpful in de-escalating violence:

- **Appear calm, respectful, self controlled and confident** – think ‘stay cool and professional’. This may be easier said than done, especially when an individual is screaming at you or using abusive language
- **Use reflective questioning where you can.** Put the person’s statements into your own words and then check to see that you have understood. By repeating or reflecting a person’s message in the form of a question, you will give him/her the opportunity to clarify the message. Engage in conversation; acknowledge concerns and feelings – let the patient know you are listening. For example ‘You need to see a GP as soon as possible, is that correct?’
- **Watch the way you speak.** If you are not in immediate danger, be clear and direct in your language – clearly explain your intentions. Avoid jargon and complicated choices. A person who is losing control cannot process complex information. Complex questions will increase anxiety and can make behaviour more difficult to manage. For example, ‘I’d like to help you’
- **Watch your body language.** As the person becomes increasingly agitated he or she will pay less attention to your words and more attention to your body language. Be aware of your space – maintain as much physical space as possible. Avoid too much eye contact as this can promote excessive outbursts in some people
- **Embrace silence.** Surprisingly, silence can be a very effective nonverbal intervention. Silence on your part allows the individual time to clarify his or her thoughts. It can provide valuable time to reassess the situation.<sup>20,21</sup>

If the patient is amenable to reason, try these communication techniques to attempt to de-escalate conflict<sup>22</sup>:

- **Portray your actions as being in the patient’s best interest.** Portraying your reason for the need for action or change as being in your or the practice’s best interest to a patient who is building their level of anger can be inflammatory. By portraying your suggestions or actions as being in their best interests, an angry patient is more likely to undertake a ‘cost-benefit’ analysis of your suggested change rather than automatically dismiss your suggestions as oppositional or unacceptable
- **Use a sequence of ‘yes’ questions.** It is very hard to remain angry with someone who you keep agreeing with. An effective technique to attempt to de-escalate aggression is to ask a sequence of questions that the patient can only answer ‘yes’ to.

The most effective way to undertake this technique is to do short summaries of the patient’s perceptions and views as expressed to you with questions at the end such as: ‘Have I got that right? Or: ‘Is that what you mean?’ A sequence of 5–6 questions where the patient is answering ‘yes’ is a powerful way to increase the likelihood that that an aggressive patient will see you as being on their side, even if they remain angry with the issue.

- **Maintain a solution focus.** This technique involves asking the aggressive patient to problem solve the issue they are concerned about by seeking as many options as they can think of for their problem. By simply listing the options they generate rather than arguing about the pros and cons of each option, there is the potential to stretch the person to develop hybrid or compromise options that are more acceptable to both parties. Anger is usually associated with ‘black and white/all or nothing’ thinking and the skill of nonresponding to the initial ‘black and white’ options and respectfully pushing the patient for more (often greyer) options can be very effective. By calmly acknowledging that everything is an option, and stretching the patient for alternatives, a different conversation can be moulded. It is very difficult to remain in an aggressive frame of mind if you are engaged in a process of basic problem solving.

Where possible, have a process that will allow appropriately graded restrictions on the patient’s action, for example:

- Formally advise a patient that their violent behaviour, and any recurrence of it, is unacceptable (see *Appendix 1* for an example of such an approach)
- Consider approaches such as an ‘acceptable behaviour agreement’ (see *Appendix 2* for an example of such an agreement)
- Consider discontinuing care (see page 15 and *Appendix 3*).

## Mental illness and violence

Research suggests that people with a mental illness are more likely than others to engage in violent behaviour.<sup>23</sup>

It is important to recognise the risk of harm to self or harm to others in severe psychiatric illness, such as in the first year of onset of psychosis, and particularly, if there is a delay in getting treatment.

Psychosis needs to be viewed as a medical emergency as it is associated with an improved prognosis with early medical treatment. Delay in treatment usually results in severe life long disability. People with psychosis are much more likely to harm themselves than others.

It is important not to further stigmatise people with mental illness. It is important to re-emphasise that most people who are violent are not mentally ill and most people who are mentally ill do not display violent behaviour.<sup>24</sup> In fact, people with mental illness are more likely to be victims rather than perpetrators of violence.<sup>24</sup>

Many people with mental illness also suffer from the complications of violence such as:

- post-traumatic stress disorder
- anxiety
- depression
- drug and alcohol misuse
- suicide.<sup>25</sup>

There is a subgroup of people with serious mental illness and multiple risk factors at increased risk of violent behaviour who should be immediately recognised and assertively managed by a multidisciplinary health team, either voluntarily or involuntarily as appropriate.<sup>26</sup>

The common profile of a person in this subgroup is a young person with active delusional psychosis (usually schizophrenia), persecutory symptoms and disorganised thinking, who is abusing alcohol or other drugs. In these cases, the patient is usually lacking insight, resistant to engagement, noncompliant with treatment and socially isolated. Persecutory thoughts should be explored fully for violent intent toward themselves or others.<sup>26</sup>

### Involuntary treatment of a patient

The objective of mental health legislation is to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection. Legislation (including the criteria for involuntary treatment of patients and the procedures for involuntary admission) differs from state to state and territory.

Police and/or ambulance officers in attendance at a scene requiring the care or treatment of a mentally ill person will generally be able to reassure a practitioner of the appropriate action as the situation requires.

The following website provides access to relevant parliamentary sites, and through them, to the current version of the mental health legislation for each jurisdiction: [www.scaleplus.law.gov.au/othersites.htm](http://www.scaleplus.law.gov.au/othersites.htm).

## Drug seeking behaviour and violence

Alcohol or drug intoxication or withdrawal is a risk factor for patient initiated violence.

Drug seeking behaviour is also a risk factor of patient initiated violence. General practitioners and practice staff should exercise extreme care with 'prescription shoppers'. Patients who are intoxicated or have a known drug dependency and try to obtain licit drugs should be reported to the relevant state/territory drugs and poisons unit.

If GPs and staff feel threatened by a patient, especially someone who is affected by drugs and seeking a prescription, they should consider giving the patient what they want and asking them to leave immediately, to avoid a possible violent incident. Always call the police and your state/territory drugs and poisons unit in this situation. Do not confront the patient.

However, if you perceive there is no danger, GPs should not provide small amounts of medication to 'prescription shoppers' just to 'get rid of patients'. If you suspect a patient of requesting medicine in excess of medical need, you can call Medicare Australia's Prescription Shopping Information Service (1800 631 181).

Adverse drug reactions have resulted from the provision of drugs of addiction to patients with a known addiction problem. Prescribing to prescription shoppers has been the subject of numerous Coroners' inquests, and resulted in several investigations by state and territory medical boards.

There is a useful website for GPs and other health professionals on issues associated with alcohol and other drugs, which has information on:

- screening and early recognition
- assessment
- brief interventions
- motivational interviewing
- treatment options and efficacy
- challenging behaviours (including drug seeking behaviour)
- comorbidity
- pain management
- polydrug use
- pregnancy
- referral and shared care, and
- surgery.

For more current information on drug and alcohol use and mental health, visit the Australian General Practitioners Network's 'Can Do' website at [www.agpncando.com/](http://www.agpncando.com/).

A copy of *Alcohol and other drugs – A handbook for health professionals*, which expands on the information displayed on the website is available at [www.health.gov.au/internet/main/publishing.nsf/Content/Phd-aodgp](http://www.health.gov.au/internet/main/publishing.nsf/Content/Phd-aodgp).

## Prescription Shopping Program

Legislative provisions are in place in relation to the Prescription Shopping Program to protect doctors who report 'prescription shoppers'. It is preferable, but not essential, to obtain patient consent before you contact the service. Once a doctor is registered with the Prescription Shopping Program, they can call the service 24 hours a day, 7 days a week on 1800 631 181 to find out if the patient has been identified under the program.

If the patient has been identified under the program, the doctor can then request details on the type and amount of medicines that the patient has received over a recent 3 month period.

Certain criteria must be met before a patient is registered on the Prescription Shopping Program. Either the patient has, over a recent 3 month period:

- been prescribed Pharmaceutical Benefits Scheme (PBS) medicine by six or more different prescribers, or
- been prescribed/dispensed 25 or more 'target' items, or
- been prescribed/dispensed 50 or more PBS medicines.

The patient information provided to registered doctors does not include:

- PBS medicine where the full cost is less than the patient contribution
- emergency drug (doctor's bag) supplies
- PBS medicine supplied by a pharmacist in an emergency
- medicine subsidised under the Repatriation Pharmaceutical Benefit Scheme (RPBS), and
- non-PBS medicine, such as private prescriptions and medications dispensed by public hospitals.

In order for this program to be effective, all GPs must be active in using it.

More information on the Prescription Shopping Program can be accessed at [www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.shtml](http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.shtml) or by calling Medicare Australia on 1800 631 181.

## Flagging patient health records

A history of violent behaviour remains the single best predictor of future violence. However, in the health care setting information about history of violence is not always readily available, limiting the capacity to which staff can be forewarned about a potentially violent encounter.<sup>27</sup>

As a general rule, practices should flag the health records of patients who demonstrate aggressive or violent behaviour or who are at risk of violent behaviour. Practices need to have a policy in place outlining the criteria for file flagging. The policy should include:

- a clearly defined purpose for the flag, eg. to protect the health and safety of treating staff
- a standard mechanism for flagging patient health records which makes the information readily available to those who need it
- clearly defined scope of who has access to the information, eg. treating practitioner only, restricting access to the staff on a 'need to know' principle
- readily accessible information on managing patient initiated violence, eg. how to manage the patient so that violence is minimised
- a mechanism to review flagged files to ensure ongoing relevance.<sup>28</sup>

There are both formal and informal means of flagging patient files.

Some practices flag the computer based appointment program with notes such as 'patient at risk of aggressive or violent behaviour' or 'care for this patient discontinued on [insert date] due to violent behaviour'. In paper based systems, some practices use 'Post-it' notes at front reception to flag patient names. However, this system is open to error for patients with the same name, or where the note becomes inadvertently attached to another file.

It is important to establish an agreed and standardised mechanism for flagging patient files within the practice team. This mechanism needs to be included in the orientation process, as well as in practice policies.

### Flagging patient health records and anti-discrimination laws

While anti-discrimination laws may sometimes influence the steps that can and should be taken to deal with patient initiated violence, they do not specifically prohibit the flagging of health records. These anti-discrimination laws also do not require GPs and their practices to tolerate or accept criminal acts.

To comply with anti-discrimination laws, GPs and their teams, need to take a commonsense and proportionate response to perceived or actual threats, taking into account the relevant factors for the patient, the practice and other people involved.

Legal advice provided to the RACGP on the impact of anti-discrimination laws on management of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

### Medicolegal tip

Some patient initiated violence occurs because the patient has a disability. When it does, discrimination laws come into play. Those laws make it unlawful to discriminate on the grounds of disability, and this can extend to behaviours resulting from, or caused by, that disability.

### Flagging patient health records and defamation laws

Whatever form of flagging patient records is used, the information contained in the records needs to be clinically and factually accurate. This is particularly important given that patients have statutory rights of access to ‘their’ health records, and some patients may seek to argue that the flagging in some way has unlawfully defamed them.

Legal advice provided to the RACGP on the impact of defamation laws on the management of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

### Flagging patient health records and privacy/confidentiality issues

The flagging system, and any communications about the patient either within the practice or beyond it, also needs to comply with confidentiality and privacy laws.

Legal advice provided to the RACGP on the impact of confidentiality and privacy laws on the management of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

## Acceptable behaviour agreements

An acceptable behaviour agreement (see *Appendix 2*) indicates that although a patient has acted unacceptably, the practice team is willing to continue a therapeutic relationship with the patient, provided the patient complies with the conditions outlined in the agreement.

In the medical profession there is a body of support for the use of acceptable behaviour agreements as a useful tool to modify behaviour.<sup>29</sup> However, practitioners should note that acceptable behaviour agreements are not suitable for universal application. The context in which they have been found to be effective is in clinics that have the following characteristics:

- a proportion of patients suffer from drug/alcohol abuse related conditions, drug seeking behaviours, or mental instability
- the practitioners who use such agreements are highly experienced in dealing with patients having drug/alcohol addiction and related conditions or mental instability, and
- the circumstances are such that the patient can be persuaded that there is a trade off, beneficial to the patient, in agreeing to modify behaviour as a condition of continuing treatment.

While the utility of acceptable behaviour agreements has strong support, agreements are not appropriate and are more likely to trigger aggression where:

- the practitioner is inexperienced in dealing with patients having drug/alcohol addiction and related conditions or mental instability
- where recourse to an acceptable behaviour agreement is an over reaction to a trivial incident, and
- in an emergency situation.

It is recommended that where acceptable behaviour agreements are used, they are introduced as follow up to a letter indicating that the provision of care by the practice will be ceased if the unacceptable behaviour continues. Even then, caution needs to be exercised and medical staff need to give careful consideration to the likely risks.

- Where possible the agreement should be tailored to the actual behaviour observed in the individual
- Where possible use written agreements
- Establish clear boundaries
- Patients need to be informed of the consequences of stepping outside the boundaries set out in the acceptable behaviour agreement, eg. termination of the doctor-patient relationship except in an emergency
- Establish a review process.<sup>29</sup>

The consequences need to be one which the practice can and will carry out. In this context, it is important for the practice team to be in agreement with the policy.

The behavioural demands imposed by the arrangement need to be reasonable, rather than unfair, excessively burdensome or disproportionate to the risk (see *Appendix 2* for a sample document).

Legal advice provided to the RACGP about legal issues associated with 'acceptable behaviour agreements' can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

### Medicolegal tip

Acceptable behaviour agreements do not necessarily form legally binding contracts, and may therefore be unenforceable if tested in court.

## Discontinuing care where safety concerns exist

A practice may consider discontinuing care to a patient where genuine safety concerns exist as these concerns may prevent GPs and practice nurses from providing ongoing high quality care. If a practice is considering discontinuing care to a patient it needs to reflect on the situation of the GPs, their practice team, and on the patient.

A practitioner is not compelled to continue a treating relationship with a patient where the practitioner is unwilling to do so. In terminating the relationship, caution should be exercised in emphasising to the patient the need for continuing care, if there is such a need.

To consider what is reasonable under these circumstances, it may be useful to:

- ask yourself the question: 'What would my peers say and do in this situation?' Would your peers understand and support your choice to discontinue care if they were in the same situation? If you believe they would, then this supports your decision
- reflect on the patient's situation, especially any short term risks to their health by discontinuing care. It can be useful to consider what action your peers would consider appropriate to meet the patient's health needs.

If a delay in treatment would harm the patient, then, if practicable, it is important to explain this to the patient.

You may need to:

- Advise the patient of an appropriate place to get care other than your practice
- Advise the patient of the importance of getting care
- Act to reduce imminent harm to the patient (eg. treating them in an emergency and/or call an ambulance).

The doctor has an ethical responsibility to ensure that administrative staff do not turn away patients with urgent medical problems without reference to the doctor. Furthermore, the doctor has an ethical duty to assure him/herself that the patient does not have a life threatening emergency before the patient is declined immediate attention or referred to another practice or hospital.<sup>30</sup>

You may need to consider the risks to other people (eg. other patients who come to the practice) and factor this into your decision.

In a nonemergency situation where the relationship with the patient is terminated, the doctor must:

- ensure the patient understands that the relationship has been terminated. This decision can be conveyed face-to-face or via a letter
- propose a realistic way for the patient to seek continuing general practice care, where possible.<sup>31</sup>

If it is appropriate to talk with the patient face-to-face, carefully consider the way you tackle the discussion and ensure the practice is prepared for the discussion.

It may be more appropriate to send the patient a letter advising them that you are discontinuing their care. In the letter:

- outline the boundaries you are setting (eg. the patient is not to call the practice or attend the practice)
- with the patient's permission make an offer to transfer a copy of the patient's health information to a new practice.<sup>32</sup>

General practitioners and practice staff need to be mindful of anti-discrimination laws when discontinuing care. Patients cannot be excluded on the grounds of illness (including mental illness) or disability. Anti-discrimination laws do not require GPs and their practices to tolerate or accept criminal acts.

Legal advice provided to the RACGP about the risk of discrimination in circumstances of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

## What else do you need to do?

- Keep a detailed factual report in the patient's health record at the time of the incident, including a copy of any letter sent to the patient. This should be completed contemporaneously
- Agree on the practice's response to a violation of the boundaries you have set (eg. what the practice will do if the patient calls or attends)
- Be aware that you are legally and ethically bound only to treat a person in an emergency situation
- If you hold any concerns regarding the process of discontinuing care, notify your medical indemnity insurer.<sup>32</sup>

Terminating a relationship can sometimes generate difficult ethical and legal questions. The Medical Practitioners Board of Victoria provides advice at <http://medicalboardvic.org.au/content.php?sec=149>.

Occasionally, a medicolegal challenge can arise when seeking to terminate a relationship in a way that still discharges the duty of care owed to the patient. When in doubt as to your rights and duties, you should contact your medical defence insurer.

Legal advice provided to the RACGP on duty of care issues relevant to patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

## Warning others about the risk of patient initiated violence

The welfare of other health professionals and patients, especially those in nearby practices, has been consistently discussed within general practice following the killing of GP, Dr Khulod Maarouf-Hassan in 2006.

Decision making surrounding notification to a range of third persons can sometimes pose difficult legal (and occasionally ethical) questions. To help work through these medicolegal issues, a decision making checklist is included at the end of this section.

The patient's right to privacy and confidentiality (often a bar to disclosing information about patients) is not absolute and must be balanced against other important social interests that compete with privacy. It is important to first satisfy yourself that the disclosure is not only lawful, but also a proper and responsible option taking into account the interests of your patient, your staff, your colleagues and yourself.

A useful principle is that any disclosure of information, even if legally permitted, needs to involve the minimum necessary amount of information being disclosed to the smallest group of people in order to effectively manage the risk.

The RACGP *Handbook for the management of health information in private medical practice* provides guidance for general practices about privacy issues. Available at [www.racgp.org.au/privacy/handbook](http://www.racgp.org.au/privacy/handbook).

While recognising that there are many different scenarios that can arise (these are discussed in the checklist), this booklet focuses on two discrete situations:

- notifying other professionals when you fear the patient may harm them, and
- notifying/reporting to the police.

### The right to disclose information outside the practice

Because it is confidential and covered by privacy law, information about patients is treated differently to information about other people. A common theme in privacy law is that information should not be shared about a patient except with the patient's consent. However, these laws also recognise that the public interest in maintaining confidentiality must sometimes be outweighed by other competing public interests aimed at protecting individuals or the broader community. Because of these exceptions, in some circumstances the law makes it possible to share information about the patient with others, even when the patient does not consent, or where it is impracticable to seek that consent.

The rights of doctors to notify other persons about patient initiated violence are constrained by these laws. An outline of ways to make a decision about when to disclose information follows.

Legal advice provided to the RACGP on the impact of confidentiality and privacy laws on management of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

### Duty to disclose information about patient initiated violence outside the practice

It is possible, that under the law of negligence, a doctor may actually owe a duty – as opposed to simply have a right – to notify third persons that those third parties (eg. other doctors) are at risk of patient initiated violence.

Legal advice provided to the RACGP on the impact of negligence law and duty of care issues surrounding notifications about violent/abusive patients can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal). General practitioners and their team members may also wish to seek the advice of their medical indemnity insurer, where the need for disclosure is not urgent.

## Where risk to other people is serious and imminent, call the police

If you form the view, reasonably based, that the perpetrator of violence (patient or not) presents a serious and imminent threat to the life, health or safety of other medical practitioners or other health professionals in the area (eg. you think that they have ‘targeted’ a doctor, person or practice), the police should be called without delay.

You should tell the police that their assistance in warning neighbouring practices is necessary. The privacy principles are relevant to what you tell the police.

It is paramount that you form a view, reasonably, of imminent and serious danger or threat of harm to a person or the public. In these circumstances, the privacy principles do permit disclosure of personal information. In considering what is ‘reasonable’ in forming a view, the following are relevant factors, however the list is not exhaustive:

- the patient has a documented history of anger management or uncontrolled aggression
- the patient’s capacity for violence or aggression is associated with drug/alcohol dependency or mental illness such that speculation as to escalation of violence poses an unacceptable risk
- the patient’s behaviour prompting the report to police is sufficiently serious to cause alarm or fear to the safety of those witnessing the incident.

The disclosure to police of personal information about the patient is also justifiable under privacy legislation as being necessary for law enforcement in the circumstances outlined in this section.

## Where there is no time to use the police and the risk to others is serious and imminent

Police assistance in contacting neighbouring practices may not be practicable in all instances, such as where a neighbouring practice needs to be urgently alerted to an imminent threat. If you have just encountered a patient/individual who presents a serious and imminent threat, and you are genuinely afraid for the safety of another practitioner or neighbouring practice (eg. you believe that the patient has ‘targeted’ a specific doctor, person or practice), the following factors are relevant to consider:

- Is the danger imminent? Is it serious? By this, we do not mean credible, but rather that there is a risk of serious harm. If so, identify which practitioners are particularly vulnerable and prioritise contact accordingly
- Telephone or email the other practitioner/s and:
  - advise that you have just experienced a violent episode in your practice involving the named person who is the perpetrator
  - if applicable, advise that the person was demanding drugs with violence or is under the influence of drugs or alcohol. This conveys a lot of information and, unless you indicate a relationship with your practice, does not breach any doctor-patient confidence
  - advise that you have called the police to remove the person from the premises or to report a violent incident
  - advise the practitioner you have contacted that they may need to consider taking preventive measures such as locking the front door.

It is desirable for neighbouring practices to co-operate in formulating the most effective means of communication and to discuss concerns.

Consider taking the proactive step of telephoning local practice principals or medical directors and discussing the way practices in your area would respond.

Consider safeguards such as ensuring you have the mobile phone number and email address of local practitioners who may need to act with you in a coordinated manner.

## Giving nonidentifying information in other circumstances

Sometimes you may want to notify police or others about a pattern or a risk of violence/abuse, but that pattern/risk does not trigger any of the disclosures permitted under privacy law. In these situations, there are still some options available to you. For example, if you do no more than state the facts as observed and as they have occurred (ie. the threat of imminent danger and the report to the police), you have not breached any patient-doctor confidentiality. This is because the account of the situation described above does not identify the perpetrator as a patient of your clinic. It does not disclose any diagnosis or treatment. Nor does the above account breach any privacy principle.

This form of communication should involve no more than the absolute minimum amount of information necessary.

## Checklist for disclosure

This checklist is not intended for use at the time an episode of violence occurs. It is intended to be used for educative purposes for less experienced doctors and practice staff who may find it useful to have an overview of the factors to be considered when choosing to make a disclosure.

### Step 1: Identify the risk

#### Is this a case of patient initiated violence/abuse?

- If it IS NOT, proceed as you would for any other violent incident
- If it IS, continue down the checklist.

### Step 2: Assess the risk

#### A. Consider the most likely cause(s) of the violence/abuse

- In pain
- In need of care/attention
- Desperate for help
- Afraid, anxious
- Expecting early attention
- Confused
- Inarticulate
- On medication
- Psychotic
- Drunk
- Drugged
- Volatile
- Try to address the underlying causes of the violence in your response.

#### B. Consider the severity of the episode

- The nature of the violence/abuse which the patient might commit/has committed, and how serious or potentially harmful it is
- Severity is not only 'objective' (eg. the patient threw something) but also 'subjective' (eg. the way staff feel about the incident)
- Call the police where you need to
- Address any clinical issues that are safe to manage at the clinic
- Agree on a way of managing the patient should the situation re-occur
- Discuss this with the patient as soon as appropriate.

#### C. Consider the likelihood the episode will recur

Where the episode is likely to be a one-off event

- Notify the police where you believe it is sufficiently serious (but do not notify others).

Where there is the likelihood (as opposed to a theoretical possibility) that the patient will in fact commit these acts in the future

- Take steps to proactively prevent or minimise the risk of recurrence or the problems that led to it
- Ask yourself whether there is still a risk that the violence/abuse will re-occur and that others outside of the practice will be exposed to it
- If it is likely to re-occur, is the person to whom you want to communicate information a potential victim? (Ignore this question when considering notifications to police). If so, would the giving of information to them help them prepare for and possibly avoid or minimise the violence/abuse or its effects?

If it would help the other person, proceed to Step 3.

If it wouldn't help them to avoid or minimise the violence, do not notify them (Ignore this question when considering notifications to police).

### Step 3: Notify others of the risk

If you are still at the point where the notification is, on balance, appropriate, you need to think through some specific issues relevant to the various communications:

- Is it practicable to obtain the consent of the patient? If so, get it.
- Am I disclosing patient identifiable information only because it is absolutely necessary?
- Am I using the minimum necessary patient identifiable information?

### Notifying the police

You could involve the police at different times and for different reasons:

- Where you want to report a crime committed by the patient against you or your practice team. Discussions concerning these types of notifications can be found on page 28
- Where you want to invoke mental health laws permitting involuntary detention, and want the help of the police to transfer the patient to psychiatric care (see page 9 for discussion)
- Where you want to notify them about the risk of future violent/abuse against you, your team or others.

#### A. Identifying the offence

- Is the potential violence/abuse the type that would justify notification to the police?

Remember, not all forms of violence/abuse are crimes. Even when they are, there is a spectrum of criminal activity; and at one end of that spectrum the offence is relatively minor. For example, 'kicking furniture' (technically, criminal damage) and 'spitting at staff' (technically, an assault).

#### B. Weighing up the situation

- Are there any mitigating factors that would argue against notification? For example, can the issue be dealt with through risk management initiatives?
- Assuming you want the relationship to continue (and sometimes you might not), would notification either harm or end the clinical relationship, reduce the level of trust in the medical profession generally, or potentially impair the capacity or willingness of the patient to seek treatment (possibly treatment that may help to control the violence/abuse)?
- Even if these mitigating factors exist, remember that you also have separate and independent duties to your staff under occupational health and safety laws.

### Notifying health care professionals outside of the practice

#### A. Identifying the need

- Why does this health care professional need this information?
- How might they benefit from receiving the information? Would it help them to avoid or minimise the risk of violence/abuse, and if so how?
- How might the failure to share this information harm their ability to avoid or minimise the risk of violence/abuse?

#### B. Identifying whether there is a lawful way of disclosing the information to another health professional outside of the practice

Privacy laws recognise that it is in the public interest to permit certain forms of notification, even where the patient does not consent to them.

The following laws are potentially relevant to notifications to other health professionals outside of the practice.

1. The 'serious and imminent harm' exception

For this exception to operate, you need to have reasonable grounds to believe that:

- the risk of harm to life, health or safety of the recipient of information is serious
- the risk of harm to their life, health or safety is imminent
- the nature of the harm may be either to the person themselves or to the health or safety of the public
- the information must be given to someone who can act to prevent or lessen the harm
- only the information necessary to prevent the harm should be given, which may not involve disclosing all information.

## 2. The 'threat to public health or public safety' exception

Similarly, the second exception here also permits disclosure by members when they have a reasonable view about certain threats. The threat in the second situation is where there is a serious (but not necessarily 'imminent') threat to public health or public safety.

The two key elements are that:

- the threat is serious, and that
- it is a threat not necessarily to an identified individual or group of individuals, but to 'public health or public safety'.

Where this exception applies, the first question should be: Is there any reason the police (rather than the health professionals) should not be the first point of contact? If there is no justification for bypassing the police, contact the police.

And in situations where you are uncertain of your position, your rights or your obligations, contact your medical defence adviser.

## Obtaining an intervention order

If there is a continuing threat of violence or intimidation against persons or property damage, you may need to consider seeking an intervention or restraining order. The purpose of an intervention order is to protect the safety of the victim. Its effect is to restrict the perpetrator's behaviour in relation to the victim. In some circumstances the order may also restrict the perpetrator's ability to go near the vicinity of the victim's place of work or residence. Orders can be obtained without disclosing the victim's address.

The legislation governing intervention orders varies from state to state and territory.

Generally, if you have a concern about continuing threatened violence this should be raised with the police and their assistance sought in obtaining an intervention order at the time of the complaint and followed up if necessary.

Intervention orders are generally granted only if a Court is satisfied that it is necessary to restrict the defendant's future behaviour in relation to the aggrieved person.

An intervention order limits certain types of behaviour, eg. what a person can do or where they can go. An intervention order may prohibit or restrict a person from:

- behaving offensively toward the aggrieved person
- approaching (or going near) an aggrieved person
- attending a premises where an aggrieved person lives, works or frequents
- being at a particular location
- contacting, harassing, assaulting, stalking, threatening or intimidating an aggrieved person
- damaging property owned by an aggrieved person, and
- causing another person to engage in conduct that is prohibited by the intervention order.

It is beyond the scope of this booklet to provide advice in relation to the law in each state and territory. Information and forms of protection vary from state to state and territory, and are detailed below.

### Australian Capital Territory

In the ACT, it is necessary to apply for a Personal Protection Order under the *Protection Orders Act, 2001* as amended by the *Domestic Violence and Protection Orders Amendment Act, 2005*. This is done through a local Magistrate's Court.

Applicants will need to complete an application form and affidavit, and a further confidential form. The Magistrate can grant interim orders until a hearing is held and a final order granted. These forms are available at [www.racgp.org.au/gpissues/restrainingorders#bottom](http://www.racgp.org.au/gpissues/restrainingorders#bottom).

The assistance of the police should be enlisted for the purpose of seeking an order. Further information is available at [www.victimsupport.act.gov.au/content.php?id=14](http://www.victimsupport.act.gov.au/content.php?id=14) and [www.legalaid.canberra.net.au](http://www.legalaid.canberra.net.au).

### New South Wales

A GP or member of their practice staff needs to obtain an Apprehended Personal Violence Order (APVO), as opposed to a Domestic Violence Order.

There are two pathways to obtaining the order:

- go to the local court, report the incident and then ask to have the case heard to obtain the order
- go to a police station, ask to speak to the domestic violence officer and they will get the process under way.

If a threat is imminent (eg. a patient is in the practice or consulting room) contact the police in the first instance. The police can remove the offending party and then, if there are grounds, the GP can apply for an APVO.

Further information is available at [www.legalaid.nsw.gov.au/asp/index.asp?pgid=484](http://www.legalaid.nsw.gov.au/asp/index.asp?pgid=484).

### Northern Territory

In 2008, new legislation came into force in the Northern Territory providing for the creation of a Personal Violence Restraining Order.

Further information (including the relevant forms) is available at [www.nt.gov.au/justice/ntmc/index.shtml](http://www.nt.gov.au/justice/ntmc/index.shtml) (search 'personal violence').

### Queensland

General practitioners can access a Restraining Order under the *Peace and Good Behaviour Act*. General practitioners (and/or their staff) need to file a complaint with their local court under this Act – cost: approximately \$60 which generally covers the summons fee.

If the complaint is substantiated the court issues a summons (the GP can serve the summons but it is more likely a Bailiff or the GP's solicitor will do this). Once the summons is served a court date is set and both parties should attend (although the GP could opt to be represented, eg. by their solicitor). At the court hearing the Magistrate can issue a Peace and Good Behaviour Order (or request a mediation process) – any number of recommendations can be made on this order; generally for 12 months.

The police can't actually do anything unless an offence is committed – but they can act if the Peace and Good Behaviour Order is violated.

Further information is available at [www.courts.qld.gov.au/Factsheets/M-FactSheet-PeaceAndGoodBehaviour.pdf](http://www.courts.qld.gov.au/Factsheets/M-FactSheet-PeaceAndGoodBehaviour.pdf).

### South Australia

The complainant (either GP or staff member) needs to provide details of two occasions in the past 6 months where the individual acted in a threatening manner, harassed, assaulted, was verbally abusive, intimidating, left offensive material, entered private property, or kept the property under surveillance.

It is not necessary to prove past behaviour, as an application for a restraining order is based on the person having a reasonable apprehension of fear. It is also possible for the police to obtain a restraining order by telephone in urgent situations.

A complaint should be made to the police, who will apply to the court on behalf of the complainant. In urgent situations applications can be made by telephone.

Restraining orders made interstate may be registered in South Australia giving the order the same effect as an order made in South Australia.

Further information is available at [www.lawhandbook.sa.gov.au/ch19s06s02.php](http://www.lawhandbook.sa.gov.au/ch19s06s02.php) (search 'restraining').

### Tasmania

People who want a restraining order in Tasmania need to apply to the Clerk of Petty Sessions at the Magistrates Court. If an urgent restraining order is needed, you will need to explain why.

A restraining order can issue made against a person who has:

- caused personal injury or damage to property; and unless restrained, is likely to do this again
- threatened to cause personal injury or damage to property; and unless restrained, likely to carry out that threat
- behaved in a provocative or offensive manner; likely to lead to a breach of the peace; and, unless restrained, is likely to do this again
- stalked the applicant; or has stalked someone else, causing the applicant apprehension or fear.

The Justices must consider the protection and welfare of the applicant to be of paramount importance.

The types of orders that can be made include:

- an order directing the person to vacate premises, restraining that person from entering premises, or limiting that person's access to premises; whether or not that person has a legal or equitable interest in the premises
- an order prohibiting or restricting the possession by the person against whom the order is made of all or any firearms or directing the forfeiture or disposal of any firearms in their possession
- an order prohibiting the person against whom the order is made from stalking the applicant.

Further information is available at [www.magistratescourt.tas.gov.au/\\_\\_data/assets/word\\_doc/0017/46250/form\\_48a\\_restraint\\_order\\_app.doc](http://www.magistratescourt.tas.gov.au/__data/assets/word_doc/0017/46250/form_48a_restraint_order_app.doc).

### **Victoria**

To obtain an Intervention Order in Victoria takes three steps:

- The person seeking the Intervention Order contacts the closest magistrates office, speaks with a court registrar and fills in an application form
- The police notify the defendant about the complaint
- The magistrate has a court hearing and decides whether to make the order.

Further information is available at [www.magistratescourt.vic.gov.au](http://www.magistratescourt.vic.gov.au) (search 'intervention order').

Victoria Legal Aid and the Victoria Law Foundation have produced a detailed booklet on intervention orders. This gives a practical overview of the issues and contact details. Available at [www.victorialaw.org.au/\\_download\\_Pdf.asp?pdf=Applying\\_for\\_intervention.pdf](http://www.victorialaw.org.au/_download_Pdf.asp?pdf=Applying_for_intervention.pdf).

### **Western Australia**

An intervention/restraining order can be obtained through the police, who may apply to a Magistrate for an order by telephone in exceptional circumstances.

Local police can also issue a 24 hour 'temporary' restraining order in extraordinary cases while the main application is being processed. The application is then lodged through the courts and is usually approved within 48 hours; the police serve the restraining order. There is no need to get a lawyer if the application is straightforward, unless there are doctor-patient confidentiality issues involved.

Further information is available at [www.police.wa.gov.au/YOURSAFETY/FamilyViolence/tabid/895/Default.aspx#rorder](http://www.police.wa.gov.au/YOURSAFETY/FamilyViolence/tabid/895/Default.aspx#rorder) and [www.justice.wa.gov.au/](http://www.justice.wa.gov.au/).

## Phase 2 – The general practice team

The safety and security of the practice team is the responsibility of all staff and the employer. It is important to create a practice culture where staff feel comfortable to speak up when they identify a potential problem or feel unsafe. Practice staff are well placed to identify risk factors and work with the practice team to generate practical solutions.

Risk factors for the GP and practice team include:

- face-to-face contact with patients (receiving direct attention)
- cash or high value goods (eg. controlled drugs) on site
- lack of policies to prevent violent incidents (eg. ineffective system of flagging the files of violent patients or patients at risk of violent behaviour)
- lack of familiarity with the patient, or a new patient to the practice
- young GPs, particularly women
- inexperience in recognising the signs of escalating aggression (eg. aggressive body language which could escalate if not carefully managed)
- cumulative stress, such as inadequate breaks, being tired and overworked, hampering the capacity of staff to notice signs of agitation
- ineffective communication between members of the practice team about risk identification and resolution
- ineffective communication between practice staff and the patient (and their family/carers).<sup>3,4,33</sup>

### Practice culture

General practitioners have expressed the view that violence by their patients may represent a failing on their part, akin to a lack of professional expertise or competence.<sup>3</sup> This may, in part, explain why GPs and their teams frequently display a higher tolerance for aggressive behaviour in the practice environment than they would in their personal life.

It is important to create a culture where staff:

- feel confident expressing their anxieties regarding patients and are assured that these anxieties will be acted on. This allows for the early recognition of patients who may be potentially violent and validates the concerns of staff
- do not accept threatening behaviour as a 'normal' way of working or 'just part of the job'<sup>34</sup>
- have adequate breaks to attend to physical needs (eg. lunch) so their ability to notice and respond to threatening behaviour is not compromised.

Practices need to have an agreed and planned process by which they can escalate the way in which they address patients who are, or have a propensity to be, violent.

It is useful, where possible, to deal assertively with incidents of violence. As a result, following an incident it may be useful to:

- formally advise a patient that their violent behaviour, and any recurrence of it, is unacceptable (see *Appendix 1* for an example of an approach to this)
- consider approaches such as an 'acceptable behaviour agreement' (see page 14 and *Appendix 2* for an example of such an agreement)
- consider discontinuing care (see page 15 and *Appendix 3*).

## Occupational health and safety

The potential exposure to patient initiated violence in a general practice poses an occupational health and safety (OH&S) risk.

Employers are required by law to adhere to OH&S legislation. Although legislation varies from state to state and territory, it is uniform in its purpose and employer obligations.

This OH&S legislation imposes statutory obligations on employers to take steps to minimise and to protect the health, safety and welfare of their:

- employees, and
- other people at or near the workplace (eg. other patients at the practice).

The OH&S legislation also imposes obligations on the employer to inform, instruct, train and supervise employees to ensure their safety and to eliminate, as far as is reasonably practicable, risk to health or from work related injury.

To determine what is 'reasonably practical' it is necessary to balance the likelihood of the risk occurring against the cost, time and trouble necessary to avert that risk.

Employers are obliged to consult with employees in formulating strategies to minimise the risk. Occupational health and safety issues can be managed by identifying:

- the extent and nature of the risk
- the factors that contribute to the risk
- the changes necessary to eliminate or control the risks, and
- monitoring and evaluation of the risk control process.

This could include, in some practices, formal training for practice doctors and staff by persons qualified in handling high risk aggression or other threatening behaviours which pose a risk to employee health and safety.

All employees have a duty to comply with organisational policy and procedures and to report violent incidents. Such incidents appear to be reported less frequently in the medical setting than in other workplace settings. Empirical evidence suggests that health care workers are tolerant of such behaviour because they have a natural empathy with people suffering from illness or conditions that affect their behaviour.

Where an employer is aware of the potential for occupational violence, and the risk of harm to an employee or another patient or patients is foreseeable, it would be expected that a risk mitigation program is implemented. If there is a physical assault, the incident becomes a police matter and the relevant criminal codes apply.

Each state and territory has its own government organisation responsible for these issues. Information about the OH&S requirements in each jurisdiction can be found at the following websites:

WorkSafe Victoria

[www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe](http://www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe)

WorkCover Authority of New South Wales

[www.workcover.nsw.gov.au](http://www.workcover.nsw.gov.au)

WorkCover Western Australia

[www.workcover.wa.gov.au/Default.htm](http://www.workcover.wa.gov.au/Default.htm)

WorkCover Queensland

[www.workcover.qld.gov.au/](http://www.workcover.qld.gov.au/)

WorkCover South Australia

[www.workcover.com/](http://www.workcover.com/)

Workplace Standards Tasmania

[www.wst.tas.gov.au/](http://www.wst.tas.gov.au/)

ACT WorkCover

[www.workcover.act.gov.au/docs/legohs.htm](http://www.workcover.act.gov.au/docs/legohs.htm)

Northern Territory WorkSafe

[www.worksafe.nt.gov.au/](http://www.worksafe.nt.gov.au/)

Legal advice provided to the RACGP concerning the OH&S implications of patient initiated violence can be found at [www.racgp.org.au/gpandpracticeteamsafety/medicolegal](http://www.racgp.org.au/gpandpracticeteamsafety/medicolegal).

## Reporting a violent incident to the police

Violence in general practice and other health care settings has a history of being seriously under reported to police and other authorities.<sup>15</sup> A widely accepted estimate is that one in 5 incidents of violence in the health sector is reported.<sup>17</sup> This estimate has not been tested in Australian general practice.

Reporting of a violent episode is influenced by three factors:

- severity of the injury – the more severe the injury, the more likely the GP or practice staff will report it to police
- legal responsibilities including those of employers – ‘external’ violence, such as an armed hold-up, is a criminal matter and almost always is reported to police
- the propensity of an individual to report – the GP or practice nurse may feel a sense of obligation to continue treatment for the patient. Staff that see low level violence or aggression as part of the job are less likely to report it;<sup>18</sup> GPs have also raised concerns about the impact of privacy law.

Many GPs and practice staff believe that reporting a violent episode to the police will not result in any action. Similarly, many cases of aggressive or abusive behaviour by hospital patients and visitors are unreported, largely because hospital staff do not believe any action will be taken as a result of any investigations.<sup>35</sup>

Nevertheless, assaults should be reported to the police. All forms of occupational violence require action under OH&S legislation.

## Effective relationships with local police and others

An important aspect of a prevention strategy is developing relationships with local police. They can identify potential risk factors and provide advice around securing the practice environment.

It can be useful to have effective referral arrangements with local mental health services, domestic violence, child protection and alcohol and drug services. This can reduce uncertainty and related anxiety for patients who need referral to these services. It is also helpful to share the care of patients at risk of violent behaviours and to manage them as part of a multidisciplinary team.

It is important to have readily available the contact details of key local services such as:

- Police: dial ‘000’
- Local police station
- Drug and alcohol services
- Crisis assessment and treatment (CAT) services
- Local hospital
- Phone and fax number of neighbouring medical practices, and allied health practices.

## Responding to stalking

Stalking is a common form of violence against GPs and requires early intervention and special attention.

Legal definitions of stalking vary in Australian states and territories. Some jurisdictions require the accused to have engaged in a course of conduct before an offence is considered to have occurred. Some jurisdictions have expansive, but nonexhaustive, lists of the type of conduct that will amount to stalking or harassment, including:

- following, loitering near, or approaching a person
- loitering near, watching, approaching or entering a place where the victim lives, works or visits
- keeping the victim under surveillance
- telephoning, sending electronic messages to, or otherwise contacting, the victim or any other person
- interfering with, threatening or hiding property in the possession of the victim
- giving offensive material to the victim or any other person, or leaving it where it will be found by, given to, or brought to the attention of, the victim or another person
- stopping, confronting or accosting a person in a public place, or
- forcibly hindering or preventing any person from working at or exercising any lawful trade, business or occupation.

Consider these suggestions:

- document every contact with the stalker, including telephone calls, emails, letters and deliverables
- record all cases of being followed by car, on foot, or being watched. The documentation provides evidence that you have been stalked
- have a practice telephone with a caller identification screen. Log all calls from the stalker, recording the time, date and nature of the call (eg. 'heavy breathing')
- contact the police every time the stalker makes contact. The police should also keep documentation. Ask for a copy of the police log
- request that the local police assess the security of your practice
- change your home phone number to an unlisted number and only provide it to people who need to know
- advise your co-workers, friends, family and neighbours of the situation and ask them to watch for any unusual activity near your home, workplace or vehicle
- keep the outside of your practice and home well lit and free of too many bushes that might provide a stalker with a place to hide
- install extra locks, deadlocks, window security, floodlights, security screens and door alarms in your practice and at home
- file a restraining/intervention order against the stalker through your solicitor (see page 23)
- never enter into a conversation with the stalker. Most stalkers are very personable and persuasive and are able to solicit a reply
- consider enrolling in a self defence class
- vary your routine. For example, go home by different routes at different times and arrive at work at different times
- if you travel by public transport, plan your trip to avoid excessive waiting times at bus/train stops. When leaving your vehicle ensure you are not being followed
- support from the practice is crucial if the stalking occurs at or near work.<sup>7,36</sup>

## Reviewing an incident of patient initiated violence

The most effective way to prevent a recurrence of a violent incident is to review incidents as they arise and implement safeguards as appropriate. Physical violence does not need to be the trigger for an incident review. Any behaviour that makes a staff member feel threatened warrants a review.

There are three steps in any quality improvement process:

1. Investigate the incident and identify potential safeguards
2. Implement change – prioritise safeguards and solutions
3. Establish a mechanism to evaluate progress.

### Investigate the incident and identify potential safeguards

Following an incident of violence or aggression in the practice there is value in bringing together a diverse practice team to review what occurred. Each staff member should reflect on what happened from their own point of view, as influenced by their position in the workplace. This facilitates the development of diverse safeguards and barriers to minimise future incidents.

To assist in developing clearly articulated safeguards, focus on system breakdown, rather than an individual.<sup>29</sup> Safeguards do not need to be complex or expensive to be effective.

Questions to consider in the review include:

- What happened?
- What factors may have triggered the violence?
- Could the incident have been prevented?
- What safeguards or barriers can be put in place to minimise a recurrence? (Within the practice team brainstorm possible safeguards.)

### Implement change, prioritise safeguards and solutions

Once the review is finalised, it is likely that the practice will be left with a range of possible safeguards or solutions. It is important to prioritise these. Be mindful that it is not always feasible or desirable to implement them all.

One way to establish priorities is to use an 'ease-impact analysis'. For this analysis a four quadrant diagram is drawn, with each square representing 'ease' and 'impact' (as shown below).

<b>EASY to do</b> Has LITTLE IMPACT	<b>EASY to do</b> Has HIGH IMPACT
<b>HARD to do</b> Has LITTLE IMPACT	<b>HARD to do</b> Has HIGH IMPACT

Using the diagram, solutions can be evaluated in terms of their ease of implementation, as well as their potential for impact. Solutions that are easier to implement and have high impact are stronger priorities than those with less ease or impact.<sup>37</sup> An example appears on the following page.

<p><b>EASY to do</b> Has LITTLE IMPACT</p> <p>The practice manager writes a crisis response for the practice. However, staff are not yet oriented to the crisis plan</p>	<p><b>EASY to do</b> Has HIGH IMPACT</p> <p>Flag the medical record of patients who have a past history of violence</p>
<p><b>HARD to do</b> Has LITTLE IMPACT</p> <p>Duress alarms installed in all consulting rooms. However, staff are not yet trained in responding to duress signal</p>	<p><b>HARD to do</b> Has HIGH IMPACT</p> <p>Ensure all consulting rooms have two exit points</p>

In setting priorities, ask: ‘What does it ‘really take’ to implement the safeguards needed to improve our systems?’ Also think about the way people in the practice may react to the proposed changes:

- Does someone have a lot invested in the way things work at the moment?
- Does someone have a strong opinion about the potential changes?
- Think about the benefits and for each person answer the question: ‘What’s in it for me?’
- Who needs to take action to make the change a reality?
- Who needs to be aware of the change? How can you make them aware of it? (Do you have regular staff meetings where this information is conveyed?)
- Does the change need to be reflected in the practice policy and procedures manual? Who is responsible for making sure this happens?
- How and when will you ‘iron out’ any wrinkles if the change does not work the way you intended, or does not achieve what you want?

### Establish a mechanism to evaluate progress

When a change has been implemented it is important to review:

- what worked, and why
- what did not work, and why
- whether the change is sustainable, and
- generate alternatives that can be trialled.

## Debriefing for the practice team

The effects of violence in the workplace are serious. When there is an incident involving patient initiated violence, it is valuable to provide staff with the opportunity to debrief. Debriefing serves two primary functions:

- it provides staff with an opportunity to take care of the ‘person’ aspect of patient initiated violence. It allows for an opportunity to seek emotional support and resolve personal issues that may have arisen from the incident
- it provides an opportunity for the whole practice to ‘intellectualise’ the situation and review what happened from a quality improvement perspective.

Depending on the severity of the violence and cohesion of the practice team, debriefing may be provided by an external psychologist or a member of the practice team. The opportunity to consult an appropriate health professional, external to the practice, needs to be offered to all staff members.

Questions to consider in the debriefing session may include:

- What happened?
- What factors may have triggered the violence?
- Could the incident have been prevented?
- What safeguards or barriers can be put in place to minimise a recurrence?

In particular, the practice team could discuss:

- management of agitated patients in the waiting room
- staff training in de-escalating aggression
- systems for flagging patient files
- relationship with the CAT of your local mental health service
- chaperoning during consultations, and
- protocols around the use of duress alarms.<sup>38</sup>

## GP and practice team checklist

- The practice has a crisis response plan in place to manage and respond to patient initiated violence and a duress alarm signal
- All staff are well trained in responding to the crisis response plan
- The practice uses clinical meetings and case conferences to discuss a practice wide approach to patients who present a safety risk (eg. where there is a history of inappropriate behaviour the patient's file is flagged if ongoing care is being provided)
- Practice staff notify a GP or practice nurse promptly if a patient arrives under the influence of alcohol or other drugs, just as they would notify the GP of other risk factors such as chest pain or difficulty breathing
- At least one staff member, in addition to the GP, is present when the practice is open for routine consulting – this includes on-site after hours consulting. (See the RACGP *Standards for general practices* for further information. Criterion 4.1.2. Available at [www.racgp.org.au/standards/412](http://www.racgp.org.au/standards/412))
- Consulting rooms close to reception are used after hours and on weekends
- Practice security arrangements are covered in the induction of all new GPs, practice staff and medical students
- The practice has a policy that encourages practice staff not to go into a consulting room with someone about whom they have concerns
- The practice team acknowledge and act on the safety concerns raised by reception staff (and other staff as relevant) before taking a patient into the consulting room
- The practice team is trained in 'people management', enabling staff to:
  - spell out their expectations of behaviour within the practice (establish ground rules) early and clearly
  - recognise and attempt to assist 'difficult' patients, and
  - prevent, control and 'de-escalate' violent situations within their role in the practice
- All practice staff are confident to disclose uncomfortable feelings or episodes that concern them. Unless this occurs, a perception can arise that inappropriate behaviour is a 'one off', when in fact it has happened to other people in the practice
- Reception staff are encouraged to call the police when necessary
- Staff are escorted to car parks after hours – this could be two staff leaving together.

## After hours work

The provision of after hours care can be provided by GPs within the practice, a local cooperative of GPs, a medical deputising service, or through an arrangement with the local hospital.

Practices need to have effective mechanisms in place to ensure GPs or locums providing after hours services are promptly informed of any patient who is at risk of demonstrating violent behaviour. General practitioners providing care outside normal working hours need to make sure systems are in place to ensure their safety and security.

If your practice engages a deputising service it is essential you alert the service about a patient at risk of demonstrating violent behaviour to ensure the safety and security of staff providing after hours care.

The RACGP *Standards for general practices* requires that practices make arrangements for access to primary medical care for their regular patients outside normal opening hours (see [www.racgp.org.au/standards/114](http://www.racgp.org.au/standards/114)).

### Questions to ask before attending a home visit

- Is this a regular patient of the practice?
- Will it be dark when I arrive?
- Do I have a working torch?
- Are the streets well lit?
- Will I be walking along any deserted streets to get to the house?
- Am I visiting a block of flats?
- Do the lifts work?
- Will other people be around?
- Where are the nearest shops/places to escape in an emergency during the night?
- Do I feel safe and if not, why not?
- Am I visiting alone?
- Am I carrying a personal alarm/mobile phone? Is it charged?
- Do I have the patient's phone number in my phone?
- Who knows where I am going?
- Do I have a system in place for reporting back to the practice or home?<sup>19</sup>

### The tipping point

The 'tipping point' in the escalation of violence, refers to the point at which things have gone too far. In the situation of a home visit, it may be helpful to have pre-prepared 'get out' phrases such as:

- 'So sorry, I left something in the car', or
- 'My phone is vibrating – it'll be the service switchboard operators' (or whatever phrase is appropriate to your after hours arrangements).

Once you have left the house it is inadvisable to go back in. What made you take this action in the first place is unlikely to have changed appreciably.

Do not go and retrieve your doctor's bag. These are replaceable items which can be retrieved at a later date with a police escort. Move away from the house. Drive around the corner and call your 'alert' person.

If you share on-call work with other GPs in your practice, or there is no switchboard/operator keeping track of your movements, think about how and who you would alert if you reached the tipping point.

Did an offence (physical violence) occur? Offences should be reported to the police.<sup>19</sup>

If you feel you are in immediate danger for any reason, move toward a safe place and leave the room/house without delay.

## Checklist for home visits

Always think in advance about the situation you may be walking into – you can effectively manage a good percentage of potential personal safety problems just by anticipating and being mindful.<sup>19</sup>

Consider these suggestions:

- Make sure more than one person knows where you are going, including the patient's name and address and what time you expect to return
- Ensure documented procedures are in place and followed if staff feel at risk, unexpectedly change plans or are delayed
- A triage process must be in place when assessing the need for a home visit. Do not accept calls from patients threatening suicide or domestic violence, or from patients using threatening language or who are not known to the practice
- Do not visit patients requesting specific pain relief medication or repeat prescriptions. Advise them to come to the clinic (and, if relevant, do not forget to let the after hours service know)
- If possible keep a database of all patients who have special management instructions and divert all patients who are flagged to alternative care after hours
- When speaking to the patient, ask them about parking – can you use the driveway, could someone move their car to make room for yours?
- Always park your car so it is facing in the direction of your exit
- Park your car under a street light, lock the doors, and check the back seat before unlocking your car on return
- Walk on the light side of the street, and stay away from bushes
- Do not put signs on your car indicating you are a doctor
- Keep a record of the registration number, make, model and colour of each staff member's car
- Keep your bag close to you at all times; do not leave it unattended
- If you need to use a lift, make sure to stand by the control panel so you can control the lift and get out if needed
- Education is very important – make sure all of the practice team understand the guidelines and include safety as part of the induction process
- Never become complacent – be alert.<sup>7</sup>

Adapted from: Melbourne Medical Locum Service. QA&CPD activity, 'Don't be a Hero', 2007

## Narcotics policy for home visits

- Leave narcotics locked in the boot of your car, preferably in a locked box
- Only in the most extenuating circumstances (eg. palliative care) should you write prescriptions for narcotics and only after all reasonable steps have been taken to verify the identity of the patient
- Do not routinely prescribe Schedule 8 substances or other addictive medications, including benzodiazepines, when providing home visits\*
- Some patients have their own supply of narcotic drugs from their usual doctor and request administration by a GP after hours. These patients will fall into two categories: the management of acute pain or the management of chronic pain
- In the case of acute pain management, a letter from the patient's usual doctor authorising narcotic administration is not sufficient unless very recent (within a few days) and refers to short term use only
- Letters should be closely checked to establish that they are genuine
- In the case of chronic pain management, patients may have a doctor's letter which is not likely to be recent. The patient's usual GP needs to provide a management plan for chronic pain patients and a copy of the drugs and poisons permit.

If you feel compromised in any way leave the patient's house without treatment. If personal safety is at risk give the patient whatever they want and leave immediately.

Adapted from: Melbourne Medical Locum Service. QA&CPD activity, 'Don't be a Hero', 2007

\* Schedule 8 refers to Schedule 8 of the Australia wide Standard for the Uniform Scheduling of Drugs and Poisons. Schedule 8 drugs (or controlled drugs) are substances which should be available for use, but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence'. (Department of Health and Ageing, Therapeutic Goods Administration, Poisons Standard 2007, page 10). Examples of S8 drugs include methadone and morphine. See RACGP *Standards for general practices* for further information on storage of S8 drugs. Criterion 5.3.1. Available at [www.racgp.org.au/standards/531](http://www.racgp.org.au/standards/531)

## Phase 3 – The practice environment

Every aspect of the practice environment has a significant influence on the behaviour of patients, staff and others. In order to prevent and manage aggression, practice staff need to work in a well designed, carefully considered environment.

However, environmental design as an isolated approach is not sufficient to address all security issues, and due consideration should be given to the vital role of practice staff in preventing and responding to aggression.

A balance needs to be created between maintaining a relaxed and inviting environment and facilitating smooth delivery of services, while ensuring safety of staff and other patients. This balance will be different for every practice depending on the nature and degree of risk.<sup>29,39,40</sup>

### Risk factors

- Insecure storage of Schedule 8 drugs (eg. storage of Schedule 8 drugs that are accessible to patients such as samples visible in consulting rooms)
- Absence of functioning duress alarms
- Poor waiting area facilities (eg. insufficient space, waiting area not visible from reception area)
- Poorly designed consulting rooms (eg. patient chair blocks the exit door)
- After hours consultations (eg. using upstairs consulting rooms or rooms away from reception area after hours)
- Poor lighting (eg. poorly lit corridors, poor external lighting in the car park and surrounding property)
- Insecure car parking.

## Crime prevention through environmental design principles

This section is focused on crime prevention through environmental design (CPTED). CPTED is a formally recognised, criminological construct aimed at enhancing those aspects of building design that discourage violence and aggression in the workplace.

CPTED involves identifying conditions in the physical and social environment that allow an opportunity for violence to occur in the workplace.<sup>41</sup> Identified risks are minimised through design (or re-design) of the practice and its immediate surrounds in ways that reduce opportunities to commit violence.<sup>42</sup>

CPTED strategies are usually comparatively cost effective compared to the economic loss from acts of violence in the practice, which may include damage to property, days lost to staff on leave, and high staff turnover.<sup>43</sup>

One of the main criticisms about CPTED is the need to strike a balance between securing the workplace, practicality and aesthetics. Excessively overt security can create a fortress-like mentality and is not particularly welcoming to either patients or staff.<sup>41</sup>

### Site specific environmental strategies

All environmental strategies are most effective when they are tailored to site specific risks in an individual practice or health centre. Site specific strategies include:

- effective barriers
- waiting areas, for example:
  - all patients are visible by practice staff
  - areas contain no objects that could be easily thrown (eg. to assault staff with)
  - minimise perceived waiting times by providing distractions (eg. views to garden or water feature)
- consulting room set up
- increased visibility
- duress alarms, and
- closed circuit television.<sup>44</sup>

## Effective barriers

Architectural or engineering design can control access to specific areas to deter a violent episode, for example:

- counters should be sufficiently wide so that it is difficult for a person to lean over and strike or physically contact a worker
- a physical barrier between the reception area and consulting rooms to prevent unrestricted patient access to consulting areas
- locks on cupboards where 'hot products' are stored, such as Schedule 8 drugs, and
- fencing to prevent practice grounds and car park being used as a public thoroughfare.

Good design can ensure that staff are safer, while still ensuring access for people with disabilities.

## Things to consider when designing a new front counter

The design of counters and desks should be determined by their purpose and the degree of risk associated with the tasks and work area.<sup>29</sup>

- Counters should be sufficiently high to make it difficult for an adult to climb or jump over
- The floor height can be raised on the staff side so that employees are higher up than patients (this also minimises ergonomic risks to staff).

## Waiting areas

Waiting areas need to be as comfortable and spacious as the existing space allows. When waiting times are identified as a contributor to the degree of risk, consider ways in which patients can be distracted while waiting.

Important considerations are:

- ventilation and temperature control
- adequate seating and a clear path to reception
- water dispensers, toilets
- ways to alter the perception of time spent waiting (eg. an appropriate selection of reading material to keep patients occupied, or distractions such as being able to see an outside garden), as reducing perceived time waiting can reduce anxiety and frustration
- the strength of external doors and windows
- a poster for the waiting room informing patients about expected behaviour at the practice (a poster for the waiting room accompanies this booklet\*)
- furniture should be robust enough that it cannot be thrown or used as a weapon, and
- providing clear signs and explanation for delays in appointments may reduce risk.<sup>7</sup>

\* The poster accompanying this booklet is designed for display in the practice waiting room. It is deliberately uncomplicated, sending a straightforward message.

This poster demonstrates the practice's attitude toward violence and aggression.

Be mindful if you display this poster in your waiting room and choose not to act on behaviours that breach this position – you are sending a message to your patients that your practice does tolerate a certain level of threatening behaviour.

Before you display the poster, think about how your practice will respond if a patient demonstrates aggression or violence. Your response needs to be consistent.

## Consulting rooms

There are a number of simple ways to improve the safety of the consulting room:

- arrange furniture to ensure the doctor's chair is closest to a door, with no obstruction blocking the exit. When designing new consulting rooms, consider including two doors, allowing for two exit points
- furniture should be kept to a minimum and robust enough that it cannot be thrown or used as a weapon. Consider arranging the consulting room desk to separate the GP and patient. (See *Appendix 4* for a diagram of effective design and layout of a consulting room)
- establish a system to alert other practice staff in an emergency. Some practices use:
  - a speaker phone and single dial to reception which allows the GP or practice nurse to press one button and have the activity in the consulting room heard in reception
  - a pop-up computer message, activated by pressing one computer key that alerts reception staff to the situation. (This is dependent on reception staff observing the pop-up and responding)
  - a key word, that when used out of context alerts other staff to a dangerous situation.

## Increased visibility

The careful design of a building, including internal and external surroundings, can increase visibility and act as a deterrent.

'Natural surveillance' can assist practice staff and patients to monitor the safety of people at the practice. Perpetrators know they are more likely to be caught if visibility is increased. Simple measures may help modify their behaviour and act as a deterrent.<sup>5</sup> Examples include:

- good lighting and visibility in high risk areas such as car parks, storage areas and corridors, especially during the evening and night hours
- positioning the reception desk so that staff working at it routinely look toward the doors of consulting rooms
- visible duress alarms, and
- closed circuit television.

## Duress alarms

Duress alarms can be considered as part of the risk control response. They should not be considered on their own as the primary risk control mechanism, rather they form part of an overall risk management approach.

If you have a security system installed:

- ensure you have a routine for checking the battery back up
- staff are aware of procedures for getting assistance and using the alarm, and
- staff response to the alarm needs to be practised and standardised as far as possible to reduce confusion.

## Closed circuit television

Some GPs working in high risk areas have installed closed circuit television (CCTV) in the waiting room (only) and a monitor in every consulting room. However, patient privacy must be considered if CCTV is in use and a notice must be displayed in the waiting room and on the front door informing people that CCTV monitoring is in progress.

The presence of CCTV is of itself an effective deterrent, while additional continuous monitoring (which in most cases places unrealistic time demands on staff) acts as a further safeguard.

## Checklist for the practice environment

Some of the suggestions in the checklist below can be readily implemented into existing practices, while others are more achievable during the design/building phase of a practice (eg. ensuring consulting rooms have two exit points).

- Physical barriers are in place to prevent access by patients to working areas – patients cannot readily gain access to consulting rooms without passing reception
- Patient waiting area is comfortable, spacious and well lit
- Security locks on all windows and access doorways
- No obstacles to good visibility on the ground, such as bushes near the entrance, tall hedges around the perimeter of the building
- Effective lighting in corridors, car parks, walkways and external surrounds of the building
- Additional security measures are in place where medications are stored or being distributed (eg. locks on storage cupboards)
- If appropriate, curved mirrors placed at hall intersections where a patient can conceal his or her presence
- Glass in windows and doors are shatter proof
- Waiting room and consulting room signs are prominently displayed that notify the public that limited cash and drugs are kept on site
- Duress alarms are installed (where practicable)
- CCTV is in use where appropriate (with prominently displayed signs where in use)
- Chairs in consulting rooms are arranged so the GP or practice nurse is sitting closest to the door. (See *Appendix 4* for ideas regarding layout of a consulting room)
- Where possible, consulting rooms have two exit doors.

The RACGP publication *Rebirth of a clinic: a design workbook for architecture in general practice and primary care* addresses many design considerations. This resource is available to purchase in hard copy from the RACGP at [www.racgp.org.au/publications/orders](http://www.racgp.org.au/publications/orders).

## Additional resources

Cognitive Institute. Mastering Difficult Patient Interactions. Course available from [www.cognitiveinstitute.org](http://www.cognitiveinstitute.org)

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## Appendix 1. Proforma warning letter

[Insert practice address]

Date

Dear Mr/Ms

Staff at [insert practice name] have recently reported an incident [insert date or approximate date when the incident occurred] where you [insert a phrase that objectively describes the patient's violent behaviour] and that they were threatened by your behaviour.

The Practice has a duty of care to ensure that the safety of patients and staff in the practice is maintained. Therefore we cannot tolerate your threatening behaviour.

We are prepared to continue with your treatment at this practice provided that you are willing to significantly modify your behaviour. We propose to develop a mutually acceptable Behaviour Agreement with you. This agreement will outline the conditions and behaviours we expect at the practice, and the consequences of breach these conditions.

If you wish to enter into a Behaviour Agreement, please ring the practice to discuss this letter.

An alternative to an agreement about your behaviour would be for you to seek care with another general practitioner.

We will transfer a copy of your health record to your new general practitioner on receipt of their contact details in writing.

Yours sincerely

Practice Manager

## Appendix 2. Proforma acceptable behaviour agreement

### Acceptable Behaviour Agreement

I, \_\_\_\_\_ (individual) agree to enter into an agreement with

\_\_\_\_\_ (practice) ('the Practice') based on the following conditions.

As a condition of the Practice agreeing to continue my treatment, I promise that I WILL NOT whilst I am in the clinic:

- Swear at staff or in the presence of other patients
- Shout or make offensive remarks
- Make verbal or physical threats
- Attend when intoxicated with alcohol and/or drugs
- Damage or steal property
- Act in a manner which is likely to cause harassment, alarm, or distress to others in the general practice

\_\_\_\_\_ (other)

If I breach this agreement I understand that:

- I may be asked to leave the practice
- Police attendance may be requested by practice staff, and
- My future attendance at this practice may be discontinued and I may have to seek health care elsewhere.

### DECLARATION

I confirm that I understand and agree to the conditions of this undertaking.

I also acknowledge that the consequences of breaching the conditions of the acceptable behaviour agreement have been explained to me.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_  
(GP, nurse or senior staff member)

## Appendix 3. Proforma letter to discontinue care

[Insert practice address]

Date

Dear Mr/Ms

Staff at [insert practice name] have recently reported an incident where you [insert a phrase that objectively describes the patient's violent behaviour] and that they were threatened by your behaviour.

The safety of patients and staff in this practice is very important to us. Therefore we cannot tolerate your threatening behaviour of [insert date].

As a result we are discontinuing your care at [insert practice name].

This means that you are unable to attend this practice for ongoing medical care.

Please do not contact the practice or come to the practice for an appointment.

Please find another clinic at which to receive your health care.

We will transfer a copy of your health record to your new clinic when we receive a written request with the new clinic's contact details.

Yours sincerely

Practice Manager

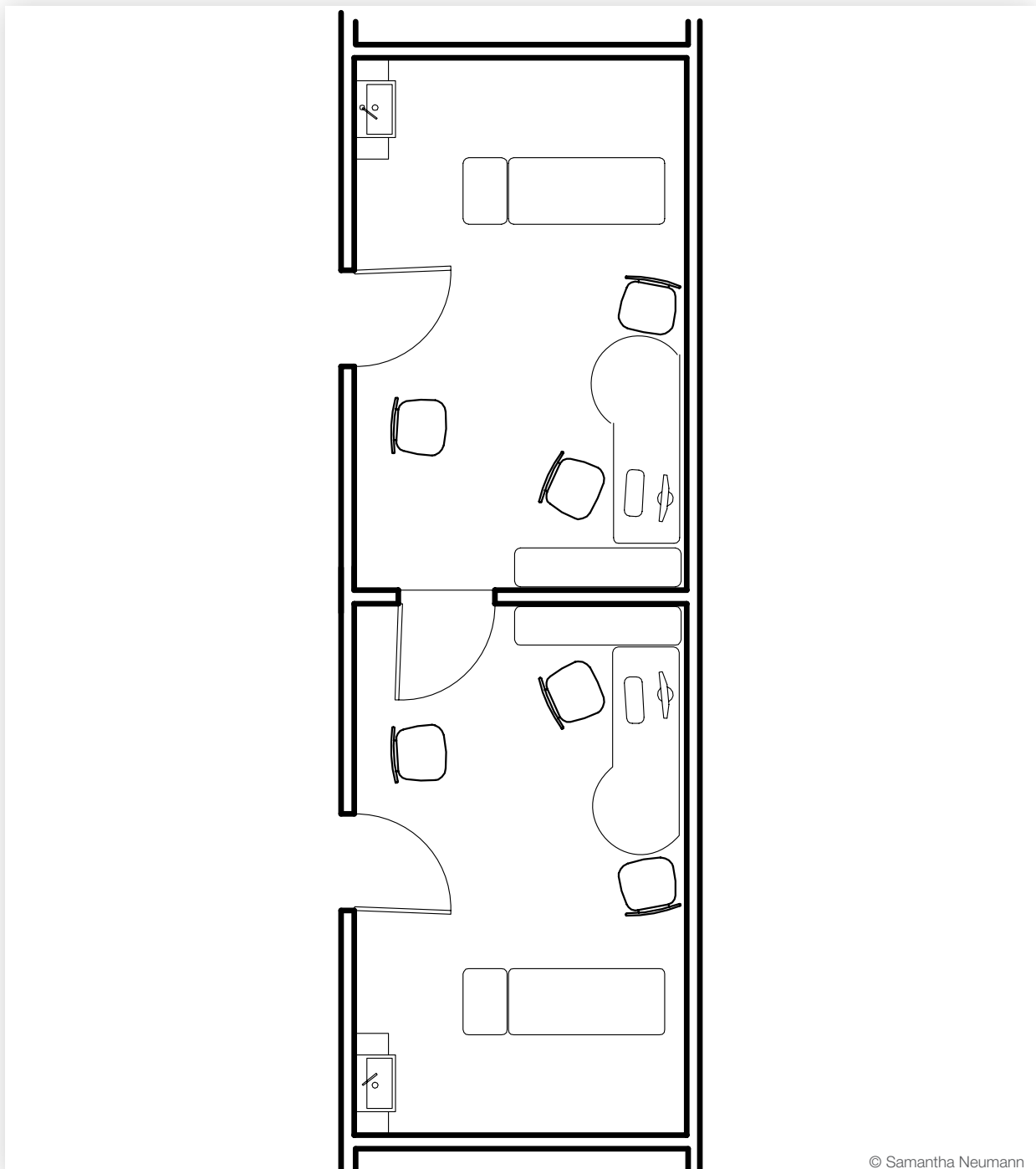
## Appendix 4. Layout of the consulting room

The illustrations below demonstrate two examples of design and layout of a consulting room. The consulting room design demonstrates the feasibility of designing two exit points in consulting rooms, with the clinician seated closest to an exit point.

Extra seating space allows patients to bring family and friends into the consulting room.

*Figure 1* demonstrates how to design consulting rooms with examination beds positioned away from the wall, allowing 360 degree access when examining patients.

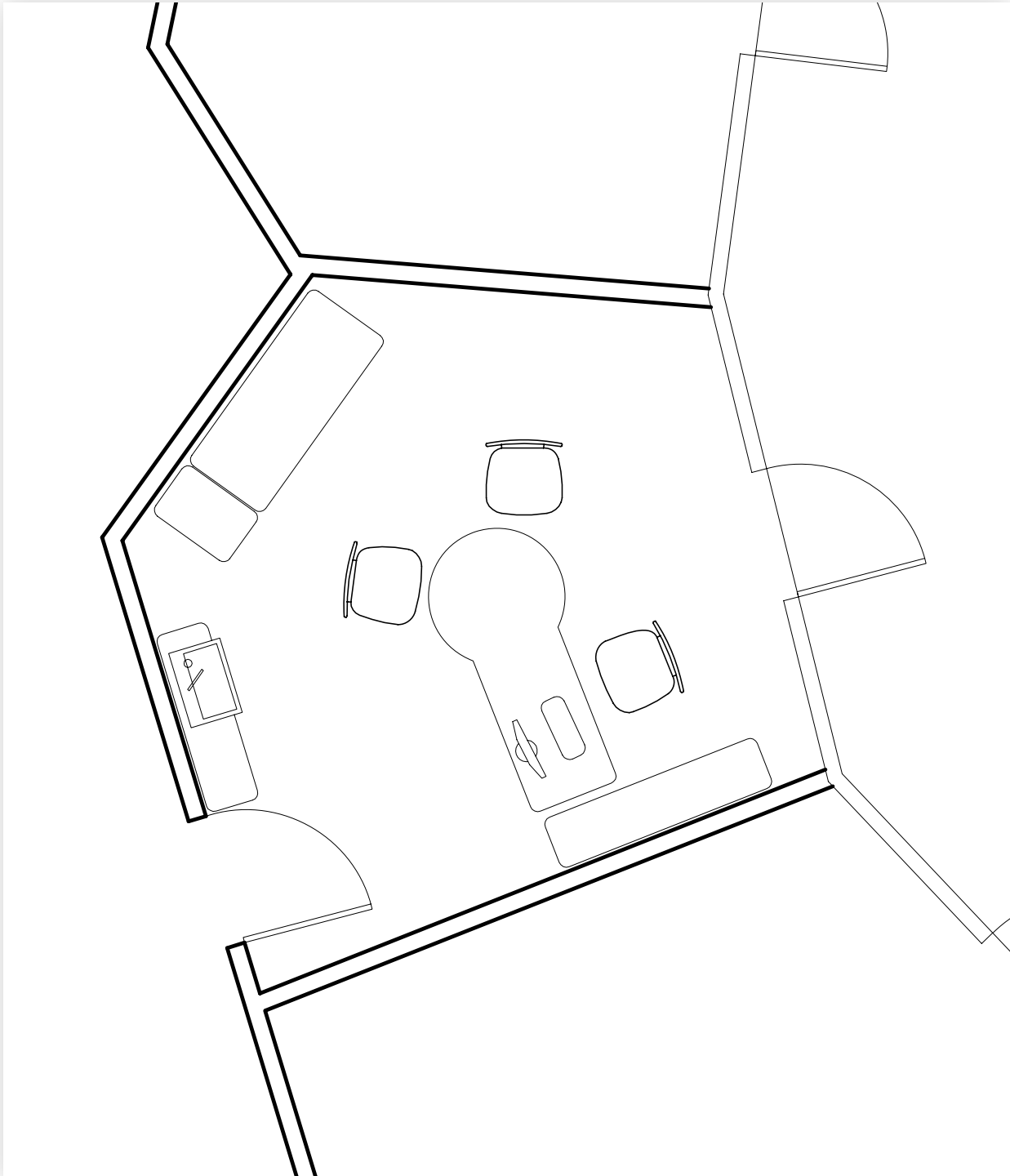
Figure 1. The consulting room



## Appendix 4. Layout of the consulting room

Figure 2 and 3 illustrate that however desirable, it is sometimes not practical to incorporate a stand alone examination couch in the consulting room. Both designs demonstrate an uncluttered consulting environment.

Figure 2. The consulting room



## Appendix 4. Layout of the consulting room

Figure 3. The consulting room

