RACGP

General practice management toolkit

Managing the wellbeing of staff and self

Module 11

General practice management toolkit: Managing the wellbeing of staff and self

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Introduction

The health and safety of staff is a primary concern for all businesses. Practice owners are responsible for the protection of the wellbeing of staff and contract workers involved with the business. The wellbeing of general practitioners (GPs) is an area of concern in Australia and other countries. Health concerns mainly relate to emotional wellbeing. Evidence suggests the physical health of doctors is better than the general community but, broadly, their emotional health is not as good as expected for a health professional.

Sources of stress for GPs have been categorised as organisational, patient and personal.[1] Studies tend to show that organisational sources, rather than patient issues, cause the most stress. This reinforces the importance of practice management activities and government in providing support for doctors.

Overwork stands out as the key issue in stress due to extended work hours, on-call work, and work interruptions and intensification. Financial pressures are also important, with the financial returns for GPs being much lower than for other medical disciplines.

Violence towards healthcare workers is recognised as a global problem. Violence and the threat of violence in general practice must be addressed proactively. In most practices it is not possible to provide complete security. Instead, measures need to be focussed on reducing the risk and having effective procedures to manage situations that can escalate into violence.

Learning outcomes

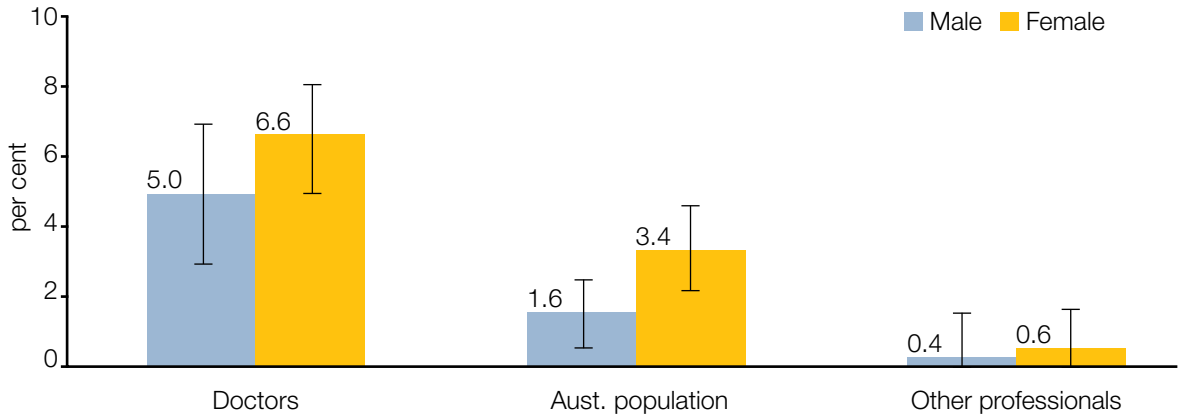
After completing this module you will be able to:

- understand sources of stress in general practice
- recognise personal health needs and potential problem areas
- recognise risks to personal safety
- understand the process of conducting a violence risk analysis for the workplace
- identify the potential signs of patient agitation and the techniques for conflict de-escalation
- identify design elements that reduce risk of violence in the practice.

1. Personal healthcare

Doctors are generally healthier than the general population in relation to lifestyle factors such as healthy eating, moderate drinking, not smoking, not using illicit drugs, exercising and maintaining a healthy weight. We do less well in terms of mental health as shown in the *2013 National Mental Health Survey of Doctors and Medical Students* (*Figure 1*).

Level of very high psychological distress by gender in doctors, the Australian population and other Australian professionals aged 30 years and below



The most common source of work stress reported by doctors related to the need to balance work and personal responsibilities (26.8%). Other sources of work-related stress include too much to do at work (25.0%), responsibility at work (20.8%), long work hours (19.5%), and fear of making mistakes (18.7%). There were some differences in work stressors within subgroups of the population. For example, overseas trained and Aboriginal and Torres Strait Islander doctors were more likely to report being very stressed by racism and bullying. Females were more likely than male doctors to report being very stressed by life and work stressors.

Source: National Mental Health Survey of Doctors and Medical Students 2013.[2]

Figure 1. Psychological distress by gender in doctors, the Australian population and other Australian profession aged 30 years and below

1.1 Managing our most valuable resource – our health

The medical culture has developed around a code of commitment that places patient's needs ahead of our own. When we take care of own needs (eg. time away from work) there is often feedback that our patients' needs are not being satisfied. Patients may complain when their doctor is unavailable for an appointment on the day they request it. In the light of these pressures, it is readily understood how doctors neglect their own health.

Overwork occurs when individuals experience a negative outcome as a result of the need to work long hours. Doctors vary widely in their perceptions of workload and a wide range of factors influences the experience of work stress.

In the aviation industry, for example, the risks associated with overwork and fatigue are well recognised. Regulations prohibit rostering of commercial pilots for more than 30 hours in any seven-day period. Reserve time for pilots (being on-call) is limited to a continuous period of no more than 16 hours.[3] In contrast, government workforce calculations are based on a full-time GP working at least 40 hours per week.

The Australian Medical Workforce Advisory Committee report, *The General Practice Workforce in Australia: Supply and Requirements to 2013*, found a third of GPs work 35–49 hours per week and

another third work 50–64 hours per week.[4] Using a comparison with commercial pilots, this would suggest two-thirds of the GP workforce is working excessive hours.

Medicare Australia calculation, using billing data to provide a full-time workload equivalent (FWE), reinforces the expectation that GPs should keep up with the average even if it means overwork. FWE does not include hours on-call, which further add to GPs' burden of work.

1.2 Effects of fatigue

Fatigue can be a subtle factor affecting the wellbeing and professional performance of doctors. Increased attention has been given to this in relation to hospital doctors, but community doctors face similar issues.

The National Aeronautics and Space Agency's (NASA) Fatigue Countermeasures Program has found that fatigue causes impairment to:

- muscle strength and coordination
- vision and perception
- memory
- performance monitoring
- error management
- decision making
- motivation and attitudes
- communication
- ability to cooperate.[3]

The University of South Australia published research in *Nature* that compared fatigue to blood alcohol levels. The research shows after 10 hours of work, every additional hour is equivalent to the effect of a 0.004% rise in blood alcohol concentration. Researchers found 17 hours of sustained wakefulness was equivalent to a blood alcohol concentration of 0.05%.[5]

Sleep debt is also a recognised factor in fatigue. Many people have 1–1.5 hours less sleep per night than they really need, accumulating a sleep debt of 5–7.5 hours per working week. Weekends are often used to catch up on the debt. Alcohol, while acting as a sedative, actually interferes with rapid eye movement (REM) sleep, reducing the overall effectiveness of sleeping hours.

Work intensification refers to increases in the intensity or the effort of work. It includes longer hours of work, the addition of new work activities and working at a faster rate.

Increasing levels of work intensity characterise the changes occurring in general practice: expanding medical knowledge, workforce shortages and difficulties in accessing the GP lead to patients wanting more issues covered at each visit. Structural changes around care, including Medical Benefits Schedule (MBS) items and systems of care for chronic disease management, reduced hospital stays and hospital access problems are all familiar to practising doctors.

1.3 Work stress

Protecting and enhancing your personal wellbeing

Occupational health psychology recognises that job strain results from high demands combined with a perceived low level of control.[6] There is substantial evidence that doctors experience high levels of work stress, which has been demonstrated to contribute to increased cardiovascular disease (1.2 to four-fold for men) and depression (three-fold for women).[7]

Two models have been widely used to study the effects of stress in the workplace:

- **Demand–control model** (*Figure 2*), proposed by Karasak, focuses on the interaction between job demands and the individual's level of control.[8] In a medical setting this can be readily identified where patient and management demands can be high, but the doctor has a perceived low level of control and low levels of support. This may refer to practice or government support.
- **Effort–reward imbalance model**, developed by Siegrist, focuses on the relationship between levels of effort and the return (reward).[9] GPs continue to lag behind their specialist colleagues with regard to financial reward and recognition for the type of work done.

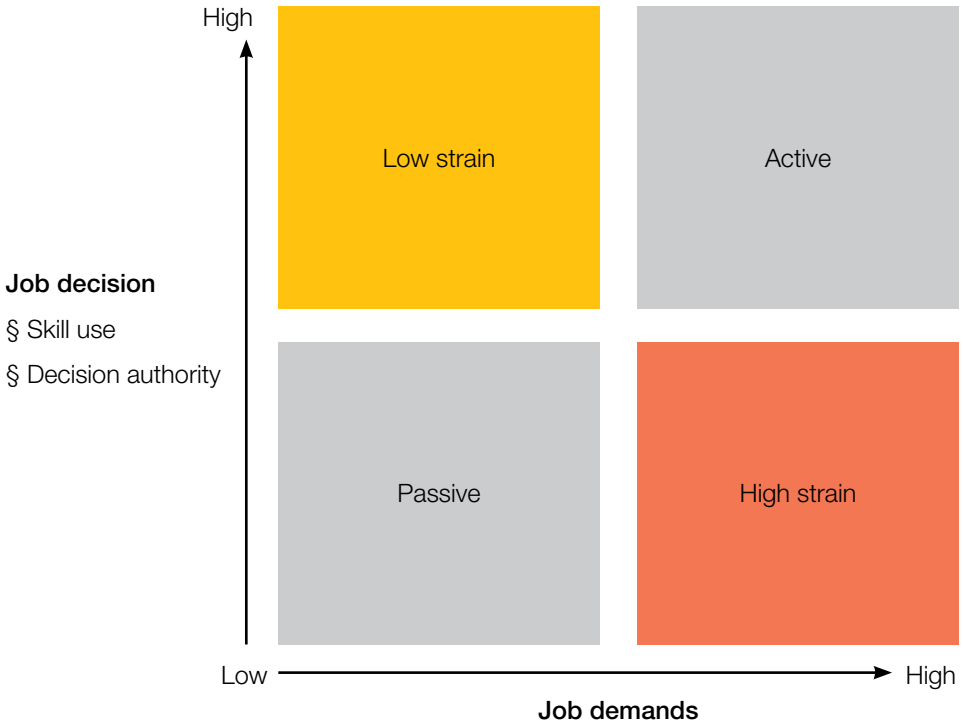


Figure 2. Karasek's demand–control model[8]

Riley has used these models to help understand the work stressors of Australian doctors (*Table 1*).[6]

Table 1. Work stressors, balance and support

Demand–control balance (after Karasek) Strain results from high demand and low control	
Demand Time pressure Competing demands High expectations (self and others) Emotional intensity of work	**Control** Decision latitude (sufficient authority to make decisions) Skill discretion (mastery)
Effort–reward balance (after Siegrist) **Strain results from lack of reciprocity between effort and reward**	
Effort Demands (extrinsic), coping (intrinsic)	**Reward** Work satisfaction Remuneration Recognition Esteem and status
Support **Strain results from inadequate physical and social support**	
Instrumental support Physical environment Effective infrastructure **Relational support** Agreeable and supportive work colleagues Appreciative superiors Significant personal relationships	

Adapted from Riley G. Understanding the stresses and strains of being a doctor. MJA 2004;181(7):4.

1.4 Professional burnout

Burnout describes a syndrome of emotional decomposition after exposure to prolonged work strain. It is characterised by:

- emotional (and physical) exhaustion
- depersonalisation and detachment
- loss of job satisfaction.

The nature of general practice is prone to create work strain. How then should we protect and maintain our health and wellbeing? The demands on GPs are likely to continue at the present level and possibly increase. Therefore, it is necessary to assume more control of the work environment in order to maintain the balance.

Box 1. Assessing risk of professional burnout

Take time out to answer 'yes' or 'no' to the following questions:

- Are you highly achievement-oriented?
- Do you tend to withdraw from offers of support?
- Do you have difficulty delegating responsibilities to others, including patients?
- Do you prefer to work alone?
- Do you avoid discussing problems with others?
- Do you externalise blame?
- Are your work relationships asymmetrical (eg. always giving)?
- Is your personal identity bound to your work role or professional identity?
- Do you often overload yourself (ie. have difficulty saying no)?
- Is there a lack of opportunities for positive and timely feedback outside your professional or work role?
- Do you abide by 'don't talk, don't trust, don't feel'?

The more 'yes' responses, the greater your risk of professional burnout.

Table 2. Sources of stress

The sources of stress on doctors are the subject of ongoing research and include:	
work intensity	**demanding and abusive patients**
competing demands on time	threatened and actual violence
resource limitations	workplace relationships with colleagues and staff
external controls, such as government regulation	managing a business
rapid changes in knowledge, policies and procedures	loss of public respect
conflicting demands (work–life balance)	after-hours and on-call work
emotional content of consultations	interference with family and social life
medicolegal threat(s)	poor remuneration (compared to expended effort)

Primim non nocere (first do no harm) – to yourself. *Hippocrates* paraphrased in Editorial MJA 2006;184(2):49.

Box 2. The RACGP GP Support Program

A free, confidential service to assist RACGP members manage life's stressors, including personal and work related issues.

The service is provided by IPS Worldwide® (IPS), an Australian company with more than 25 years' experience in establishing member assistance programs.

Face-to-face counselling is available at more than 200 locations throughout Australia. Visit www.racgp.org.au/yourracgp/membership/extrabenefits/wellbeing/gpsupport/ for a list of locations.

To make an appointment, call 1300 366 789 and quote RACGP/QI&CPD member number.

For crisis calls, call 1800 451 138.

For queries about the service, see the link above or call the RACGP member helpline on 1800 331 626.

1.5 Achieving work–life balance

Work–life conflict arises when the pressures from the work domain and other life domains are incompatible. Medical practice has the potential to foster this conflict. More doctors are choosing to work part-time in order to perform other roles and activities. In particular, there is a generational change from older male doctors who work full-time to younger female and male doctors who work part-time. The effect on the GP workforce has been well recognised.

Doctors need to take control of their work schedule and environment to avoid burnout and maintain good health. It is necessary to follow our own advice to be effective as a doctor. We need to:

- ensure we get the vital requirements of adequate rest, healthy eating, regular exercise and good relationships
- be prepared to say no to demands that interfere with the opportunity to achieve the above vital requirements
- regularly visit a GP to prevent or effectively manage health problems
- share issues of concerns with colleagues
- refresh and renew our professional life through continued professional development, including working in areas of special interest
- maintain and develop interests outside of the profession.

Key recommendations from the RACGP publication, *Keeping the doctor alive: A self care guidebook for medical practitioners*:

- Maintain an effective support network.
- Consult your own GP.
- Strengthen management skills.*

* This requires personal management skills and professional management support.

1.6 Doctors' health advisory services

Doctors' health advisory services have been established to provide independent and confidential support and advice for doctors and medical students who are experiencing health problems, which mostly relate to mental health. The services have the strong support of medical organisations and regulatory boards that recognise the need for special services to support the medical profession. A list of contacts around Australia and in New Zealand is provided in the Appendix.

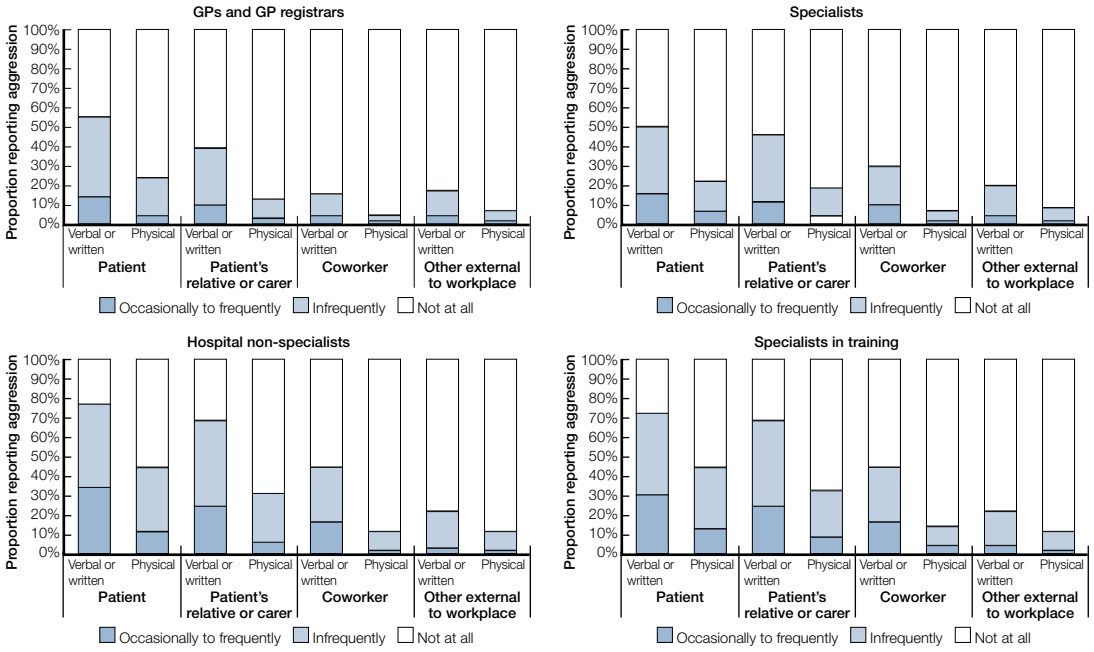
2. Staff health issues

Occupational health and safety (OH&S) regulations are covered in *Module 3 – Occupational health and safety issues*.

2.1 Personal safety

Violence against health workers is a significant work hazard. The impact in general practice can be severe as there may be limited assistance available. This is particularly true for doctors working alone, after-hours or on home visits. There is concern around the world about the safety of health workers and how to best protect them. Violence is not only physical harm but also threatening behaviour, sexual harassment, verbal abuse and property damage. Verbal abuse is the most common form of violent behaviour and is frequently directed towards practice staff.

A 2012 study of Australian workplace aggression found 70% of medical practitioners had experienced verbal or written aggression and 32% had experienced physical aggression in the previous 12 months. Those at most risk were female, international medical graduates (IMGs) and hospital-based. Age and postgraduate experience were negatively associated with the risk of aggression (*Figure 3*).[11]



Source: Hills DJ, Joyce CM, Humphreys JS. A national study of workplace aggression in Australian clinical practice. MJA 2012:197(6)336–340.

Figure 3. Proportion of doctors reporting workplace aggression

In Australia, tolerance for workplace violence against healthcare workers is diminishing and many practices are adopting a zero-tolerance approach. Verbal abuse is common, particularly towards receptionists, who may be unable to satisfy patient expectations for appointments or access to the doctor by phone.

The violent death of a health worker in Australia has occasionally triggered alarm.

2.2 Risk management approach

A risk management approach should be used to develop strategies that reduce the risk of violence to doctors and their practice staff. The approach incorporates the following steps:

- **Risk identification** – identify potential risks and report all incidents where violence or threats occur.
- **Analyse risks** – all identified risks should be rated using a likelihood/impact matrix. Prioritise risks that require actions.
- **Treat risks** – develop a policy on violence with respect to zero-tolerance and communicate this widely. Use an effective complaints management system that reduces the likelihood of escalation. The physical environment should provide security and reduce hazards (eg. adequate lighting, staff-only areas and, possibly, video surveillance). Alarm systems (building, intruder, and personal duress) act as a deterrent and means of summonsing help. Education and training for doctors and staff on how to reduce threatening behaviour and how to respond in an emergency should be provided.
- **Monitor and communicate** – Where a threatening or violent incident occurs it is important to implement actions that reduce the impact of the event (first aid, medical attention, incident debriefing) and an incident investigation aimed at reducing the likelihood of recurrence.[12]

2.3 Practice environment and culture

A practice culture that expresses concern for the protection and safety of doctors and support staff is essential in effectively reducing the risks and impacts of workplace violence. When practices fail to make a genuine commitment to protect the health workers, they will be vulnerable.

Procedures need to be in place that can, where possible, avoid, diffuse or minimise violent situations. Staff and doctors need to feel able to act on intuition in regard to threatening behaviour.

2.4 GP and staff training

The health industry is a high-risk workplace for violence as a result of providing care to people who may be experiencing distress, mood and thought disorders, and/or under the influence of drugs or alcohol. There are often limited resources to deal with violent incidents in general practice and effective procedures to minimise or avoid risks are necessary.

GPs and their staff need to be well trained in people-management to enable them to identify patients who present a risk of violent behaviour. When a person is recognised as being ‘at risk’ either by their behaviour, past history, medical condition or via intuition, it is important to act on that assessment and advise others in the practice of the situation.

It may be necessary to see the patient earlier than their appointment time to avoid them waiting longer and becoming more agitated. An effective complaints procedure may provide patients an avenue to resolve issues without escalation to abusive or violent behaviour.

When a GP or staff member is threatened by a patient, it may be wise to reduce the risk of violence by providing whatever they request in order to get them out of the practice as quickly as possible. Once the threat has been removed action can then be taken to reduce the risk recurring, which may include contacting the police.

Doctors and staff need to be given adequate support following a violent incident. The degree of support will vary according to the severity of the incident and the effect on the victim(s).

2.5 Managing aggressive behaviour

It is uncommon for aggression to present without some warning. Recognising signs of agitation may enable staff and doctors to defuse a situation before it escalates. Aggressive behaviour is often a reaction to a perceived threat or frustration – a trigger event. The person may be experiencing an observable level of distress.

Persons at risk of becoming aggressive will become agitated in relation to a trigger, which may not always be discernible to others. However, their behaviour will reflect their emotional state. The agitation causes pacing, restlessness, staring or loss of eye contact and their physical stance becomes stiffened. At this time the person is experiencing a surge in adrenaline, which will lead to an increased heart rate.

As the level of agitation increases, verbal responses may become impaired (eg. slower responses, stammering, more verbal generalisations). As the agitation increases further, the person becomes verbally threatening and may make a physical demonstration to show their threats should be taken seriously. Verbalisation may then cease as the person prepares to attack. Breathing rate increases, the head moves back and the face may start to blanch due to vasoconstriction. A physical attack is imminent at this time.

Box 3. De-escalation strategy

Recognition of the early signs of agitation may enable doctors or staff to defuse the situation using a verbal de-escalation strategy**:**

- Let the person know you are listening to them.
- Use their name to personalise the interaction.
- Open-ended questioning may determine the cause of their distress.
- Avoid matching their agitation by keeping a calm, even tone of voice and controlling your breathing (think ‘stay cool and professional’ as your natural adrenaline surge will be starting to kick in).
- Avoid direct confrontation, which will escalate the situation.
- Allow the person as much physical space as possible.
- Avoid too much eye contact as this can promote an aggressive outburst in some individuals.

3. Occupational health and safety issues

3.1 Regulatory framework

In Australia, OH&S and workers' compensation is state-based. Each state and territory is responsible for regulations and legislation. Safe Work Australia (www.safeworkaustralia.gov.au) is an agency that coordinates and develops national policies and strategies. There are common law duties to implement and maintain a safe workplace for employees and others in all jurisdictions. 'Others' include independent contractors and their employees.

The duty is expressed in terms of taking reasonable care to avoid exposing employees and others to reasonably foreseeable risks. The 'reasonableness' is based on community and OH&S authority standards, which are high.

Office safety publications are available on a number of OH&S websites, including Workcover NSW (www.workcover.nsw.gov.au) and Worksafe Victoria (www.worksafe.vic.com.au), and cover issues such as lifting, workstation ergonomics, lighting, rest breaks and exercise.

Workplace bullying and harassment is a recognised workplace health issue and needs to be addressed formally, firstly as a duty of care for staff, and secondly due to the impact on the functioning of the practice. From January 2014, the Fair Work Commission (www.fwc.gov.au) has jurisdiction to deal with complaints of workplace bullying.

3.2 Identify hazards in the practice

Using a checklist and a walkthrough can help identify many office hazards. Local work safety authorities have checklists available.

Consider the following areas of risk:

- mechanical hazards (eg. filing cabinets that tend to tip when heavily-laden top drawers are open, tripping hazards)
- physical hazards (eg. glare or reflections from computer screens, hot photocopier components, poorly designed workstations and seating)
- chemical hazards (eg. gases from oxygen cylinders and liquid nitrogen, airborne particles like photocopier toner)
- psychological hazards (eg. excessive workloads performed under pressure, lack of satisfaction from a specific job, inadequate recognition of work performed, stress from bullying)
- electrical hazards (eg. damaged electrical cords or overloaded power points that increase the risk of electric shock)
- infectious hazards (eg. needle-stick injury)
- Manual handling hazards (eg. lifting patients or large boxes from the floor or overhead).

3.3 Staff health

Infectious risks for doctors and staff in a medical practice need to be considered as part of OH&S. Education and training in standard precautions is an important aspect of risk minimisation . Body-fluid spills need to be managed according to established protocols. Infections that may create risks for pregnant women warrant careful explanation to female staff.

Practice staff are at risk of infection from patients and should be offered annual influenza vaccines. This may also reduce the risk of staff infecting patients. Hepatitis B immunisation is recommended for clinical staff. All personnel should be encouraged to be up to date with immunisations recommended as part of the national immunisation schedule for adults. See the *Australian Immunisation Handbook* for more details, available at www.immunise.health.gov.au

The RACGP *Infection and prevention control standards* (5th edition) contains comprehensive information about minimising the risk of infection in general practice, available at www.racgp.org.au/your-practice/standards/infectioncontrol

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Resources

Further reading

- Clode D, Boldro J, Keeping the doctor alive: A self care guidebook for medical practitioners. Melbourne: RACGP, 2006.
- Mason T, Chandley M. Managing Violence and Aggression – A manual for nurses and health workers. Sydney: Churchill Livingston, 2002.
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- Sutherland V, Cooper C. De-stressing Doctors – A self-management guide. Sydney: Butterworth Heinemann, 2003.
- The Royal New Zealand College of General Practitioners. Self Care for General Practitioners – Information and Review Activities. Wellington: The RNZCGP 2000.

Websites

- Australian Medical Association (AMA). Doctors' Health: Resources on doctors' health for Australian Doctors. This includes the AMA online fatigue risk assessment tool and a comprehensive list of resources. Available at www.ama.com.au/doctorshealth
- beyondblue: the national depression initiative. Available www.beyondblue.org.au
- British Medical Association doctors' health and wellbeing. Visit http://bma.org.uk and follow the link from Practice support at work.
- EPhysicianHealth.com is the world's first comprehensive online physician health and wellness resource. Available at www.ephysicianhealth.com
- Medicine in Australia: Balancing Employment and Life. Available at https://mabel.org.au
- The UK National Work Stress Network. Available at www.workstress.net
- The Centre for Professional Wellbeing. Available at www.cpwb.org/default.html

Templates

Adapted from: Mayhew C. Preventing client-initiated violence: a practical handbook. Canberra: Australian Institute of Criminology, 2000.

The activities contain additional templates.

- Guidelines for interviewing/treating a high risk patient (on-site)
- Guidelines to prevent patient-initiated violence when doing home visits
- Checklist: Warning signs of impending patient-initiated violence

Guidelines for interviewing/treating a high risk patient (on-site)

- Make sure the interview or treatment is not conducted in isolation and others know where you are and who you are seeing
- Do not arrange to meet anyone when you know you will be alone in the building
- Make sure the patient knows their presence has been recorded
- Use a room in which you are visible to others, for example, with glass (security) windows, but where confidential discussions cannot be overheard
- If a room where you can be seen is not available or practical, ensure someone else is nearby
- Ensure there is a duress alarm system of some sort (phones can be disruptive)
- Stay near the door and preferably have a room with two doors
- Keep equipment in the room to a minimum as many things can be used as a weapon
- Ensure furniture is comfortable but robust enough to not be thrown
- Make sure room is well lit
- At the first sign you are in distress, staff should know who will respond and what immediate action to take
- Keep waiting time to a minimum. If the appointment is delayed, ensure patient is informed
- Shake hands when appropriate and introduce yourself by name
- Use language the patient will understand
- If escorting a patient to a room, walk beside them when on the same level, in front when going upstairs, and behind when going downstairs
- If the patient is reacting badly to you, try to arrange for the patient to be seen by an alternate doctor
- Dress appropriately, including low-heeled shoes with good grip (in case you need to move quickly) and no jewellery (necklaces can be used to strangle)
- Attempt to have equal-height seating with the patient, at an angle, and leave greater inter-personal space with aggressive people
- Maintain eye contact and adopt a relaxed posture rather than a closed-arms posture
- Maintain empathy/sympathy and paraphrase patient comments
- Try to solve some problems immediately to demonstrate you are trying to find solutions
- If you are governed by rules or regulations of some kind try to explain them
- Avoid provocative expressions such as ‘calm down’
- Never get drawn into aggression
- Listen, and show you are listening by nodding and using and phrases like ‘I see’
- Avoid tapping pens, fiddling or doodling
- If the situation is escalating, take a break to diffuse aggression

Guidelines to prevent patient-initiated violence when doing home visits

- Where possible, arrangements are made to bring patients to the practice
- The health professional (HP) is aware of the limits of their physical mobility and strength
- Detailed timetables are kept for the HP on home visits: whom they are with, how long they should be, and when they are expected back (eg. in the appointment book)
- If an unknown patient requests a home visit, it is routine to call back to check details
- Patients are assessed for violent potential before the HP visits them off-site
- Appointment records of patient name and the reason for the home visit are kept at the practice
- Procedures are in place for the HP who feels at risk, changes plans or is delayed
- Procedures are in place and followed if the HP cannot be contacted or does not return/check-in when expected
- Additional precautions are made, and records kept, if the HP is likely to be unwelcome at the home to be visited, or if the patient has some history of aggression (eg. go accompanied and alert police prior to the visit taking place)
- Before any home visit, a code word, phrase or sentence is agreed upon that can be incorporated in a telephone conversation to indicate danger
- Home-visit patients are visited in daylight whenever possible
- When the HP arrives at the destination, the parking location is assessed for nearest exit route
- Always park cars in well-lit areas
- Lock-up procedures are followed for cars, car keys, alarms, and safety equipment
- HPs take only what is essential with them to visit a patient and do not carry information that patients should not read
- HPs carry a mobile phone with a charged battery and/or personal alarm with them into the house
- The HP ensures the patient and other residents/family members know who they are and why they are there
- HPs wait to be asked inside, and let the patient lead the way
- The HP will try to ensure they have a clear exit line inside the house
- If the HP receives an aggressive reception, leave immediately if possible
- The HP avoids reacting negatively to the state of the home (eg. smell, surroundings, untidiness)
- The HP remains alert to sudden changes in patient mood at all times
- The HP is respectful to the patient inside their home as they may be perceived to be invading their personal space
- HPs do not spread their belongings around so they have time to collect everything if they need to leave quickly
- If HPs feel at risk, they leave immediately, or make a very big fuss if they cannot
- On leaving the home, HPs approach their car with keys in hand
- The back seat of the car is checked before climbing into the driving seat
- HPs are instructed to do whatever is necessary to protect themselves, and not to worry about failure of task
- Procedures for HPs conducting home visits are fully understood and well practised

Checklist: Warning signs of impending patient-initiated violence

- ☐ Complains regularly about provision of services
- ☐ Refuses to cooperate
- ☐ Demonstrates 'cries for help' in some way
- ☐ Indicates a heightened level of anxiety or depression
- ☐ Has rapid breathing, clenched fists/teeth, flared nostrils, flushing, loud talking or chanting, restless repetitive movements/pacing, makes semi-violent gestures (eg. pointing)
- ☐ Swears excessively and/or uses inappropriate language
- ☐ Threaten or verbally abuse staff
- ☐ Noticeable mood swings and/or unprovoked outbursts
- ☐ Has a condition that has been associated with an increased potential for violence (eg. paranoid schizophrenia)
- ☐ Tends to be solitary with few social contacts; unstable family life
- ☐ Sexually harasses staff
- ☐ Blames others for all difficulties
- ☐ Cause anxiety or unrest through aggressive behaviour
- ☐ Argues frequently and intensely
- ☐ Blatantly disregards organisational policies and procedures
- ☐ Throws, sabotages or steals equipment or property
- ☐ Has a substance abuse problem
- ☐ Sends violent or sexual comments via phone, email, or letter
- ☐ Makes strange or unrealistic claims (ie. losing touch with reality)
- ☐ Has a fascination with weapons and/or military hardware
- ☐ Has a history of violence
- ☐ Makes verbal threats to staff or other patients
- ☐ Tells other patients about plans to initiate violence
- ☐ Destroys property
- ☐ Has physical confrontations
- ☐ Displays and/or uses weapons
- ☐ Commits sexual assaults or arson
- ☐ Talks about self-harm or suicide

Activities

Activity 1. Assessing your work stress and personal risk

The aim of this activity is to rate your risk against 5–6 known factors of work stress that pose a threat to the health and wellbeing of yourself and staff.

1. The presence of each key factor increases risk to you and practice staff. Read each one and reflect on how it relates to your practice.

Key factor	High risk	Normal risk	Low risk
Staff response to confronting behaviour			
Low staff levels			
A higher level of staff turnover			
The practice being located in an area of low socioeconomic status or in a rural location			
The practice having inadequate security			

2. High levels will indicate an increased risk for yourself and staff of experiencing high levels of work stress and increased demands. It is important to recognise these to develop proactive solutions and measures to reduce the risk.
3. Once you have examined each factor, discuss the results with staff. In your discussions, consider:
   - how can high levels of risk be reduced (eg. through training)
   - what alternatives are there if these cannot be reduced(eg. procedures)

Notes

Activity 2. Assessing potential violence in your workplace

Adapted from: Mayhew C. Preventing client-initiated violence: a practical handbook. Canberra: Australian Institute of Criminology, 2000.

Use the template below to assess where areas of potential violence could occur in your practice.

Security measures checklist

Security provisions

- ☐ Restrictive access devices for all staff. For example, card keys with photo identification
- ☐ Maintenance workers and visitors who go into restricted areas must wear short-term access badges (issued at reception)
- ☐ Physical barriers to prevent patient/visitor access to most working areas
- ☐ Security locks on all public-access doorways and windows
- ☐ Comfortable, spacious waiting areas, decorated in muted colours
- ☐ Bright and effective lighting in all areas of the site
- ☐ Quality lighting in stairwells and car parks
- ☐ Closed circuit television (CCTV) where appropriate
- ☐ Curved mirrors at hall intersections or areas where a person could conceal his or her presence
- ☐ Security cameras in high-risk areas (eg. emergency treatment rooms)
- ☐ Additional security measures where drugs are stored or distributed
- ☐ Staff well trained in appropriate responses to patient-initiated violence
- ☐ Prominently-displayed signs indicating the premises are monitored
- ☐ Shatter-proof glass in windows and doors near public access
- ☐ Signs posted to notify the public that limited cash or drugs are kept the premises
- ☐ Restricted access for patients with a history of violence and additional security measures adopted when they need to be seen. For example, police will be present
- ☐ The emergency/crisis response plan requires control of patient/perpetrators (with restraining provisions where appropriate)
- ☐ Additional security procedures for staff working late or unusual hours, travelling for work, and for those working with high-risk patients
- ☐ Detailed security provisions for staff who work off-site or visit patients in their homes or at another site, including the provision of mobile phones, standardised phone check-in times and recording of patient details prior to the off-site meeting
- ☐ All staff required to report suspicious, violent or unusual behaviour to practice manager
- ☐ No obstacles to good visibility in the grounds (eg. bushes near entrance)
- ☐ Staff are escorted to parking areas after hours or in high-risk situations
- ☐ Maintenance, repair, testing and monitoring procedures are checked weekly

Emergency/crisis response plan

- Every phone has a sticker that states, 'in the event of an emergency, contact reception/security on (insert number)'
- Emergency alarm buttons are installed at reception and in all consulting or treatment rooms
- Electronic and manual alarm systems are in place
- Emergency/crisis response plan is in place
- Emergency warden system in place that is checked regularly
- Escape routes have been planned and are practiced regularly

The emergency/crisis response plan includes: post-incident control of the immediate working environment, control of violent patients, provision of information to police and guidelines for provision of media statements, post-incident investigation and analysis, and confidential debriefing of staff.

Activity 3. Building the practice environment

Adapted from: Mayhew C. Preventing client-initiated violence: a practical handbook. Canberra: Australian Institute of Criminology, 2000.

Use the below example and other material developed through the module to develop a policy statement to address personal, staff and patient safety.

Policy statement on patient initiated violence

Example

This practice aims to provide a working environment that promotes courtesy, trust, equity, and mutual respect. All acts of threatening behaviour, harassment, intimidation, threats, and physical violence are expressly prohibited.

Your statement

Template: Patient-initiated violence prevention policy

It is the policy of (name practice) to provide a safe work environment.

We:

- recognise the potential for violence arising during work and undertake to do all that is reasonably practicable to eliminate or reduce the risks to everyone in the practice
- will develop a violence prevention policy, strategies, and guidelines tailored to this practice in consultation with the doctors, staff and other health workers
- undertake to assess the potential for violence associated with the practice and our work activities, identify persons particularly at risk, take all practical steps to eliminate/reduce the risks, and provide adequate budgetary resources
- undertake to conduct regular occupational violence audits/risk assessments
- require patients to abide by the violence prevention policy
- will address the special risks for those working alone, off-site and after hours
- require full reporting of all violent incidents, including threatening behaviours, abuse, harassment and intimidation
- will take seriously, and investigate, all reports from employees about the potential for occupational violence
- agree the management response to all forms of violence will be consistent with the zero-tolerance policy and without favour. The policy requires investigation of each alleged incident and mediation procedures with a patient after significant aggressive behaviour, and may result in barring or restriction of access to future services
- affirm employees are instructed to not take risks on behalf of the employer in order to protect the employer's property
- will provide support and care, including counselling and professional care where appropriate, to those who have experienced a violent incident.

Template: Communication strategy for patient-initiated violence prevention

This practice will:

- communicate the violence prevention policy to all patients as far as is possible. For example, in waiting area noticeboards
- restrict access for patients with a history of violence towards members of the practice
- include the zero-tolerance violence policy and strategies in staff orientations
- regularly train staff in violence prevention
- periodically review the violence prevention policy and strategies
- maintain a reporting system by which victims of violence can remain anonymous so as to protect them from fear of retribution (while retaining natural justice provisions for alleged perpetrators)
- conduct post-incident support and counselling procedures without prejudice and in a manner that maintains personal confidentiality.

Template: Anonymous patient-initiated violence staff survey

This anonymous staff survey is being conducted to identify occupational violence risks and potentially useful prevention methods. (A person independent of the practice should undertake the survey and return grouped data.)

1. Violence policies and strategies:

   Does the practice have a patient-initiated violence prevention policy?

   ☐ yes ☐ no ☐ don't know

   The violence policy here is:

   ☐ excellent ☐ fairly good ☐ okay ☐ not very good ☐ terrible

   Does the practice have a patient-initiated violence strategy?

   ☐ yes ☐ no ☐ don't know

   Does the practice hold regular meetings so everyone can openly discuss violence?

   ☐ yes ☐ no ☐ don't know

   Is there a person to contact in regard to a violent incident?

   ☐ yes ☐ no ☐ don't know

   Are there formal violence reporting procedures?

   ☐ yes ☐ no ☐ don't know

2. Occupational violence experiences:

   Do you know what to do if you are having trouble with a patient?

   ☐ yes ☐ no ☐ not sure

   Have you experienced from patients:

   ☐ harassment ☐ abuse ☐ threats ☐ assault ☐ theft

   Number of incidents in past 24 months (specify type):

   _____

   _____

   _____

   If yes, where did this violent incident come from?

   ☐ patient/ex-patient ☐ stranger ☐ staff member(s)

   Please describe:

   _____

   _____

   _____

If yes, did you report this to anyone here?

☐ yes, on the report form ☐ yes, but informally ☐ no (please explain why not)

_____

_____

_____

Have you missed work in the last 12 months because of something a patient did?

☐ yes ☐ no

If yes, please describe:

_____

_____

_____

To your knowledge, has there been any other violence from patients here?

☐ yes ☐ no ☐ don't know

3. Violence prevention training:

   The violence prevention training here is:

   ☐ excellent ☐ fairly good ☐ okay ☐ not very good ☐ terrible/useless

   Violence prevention training was provided to me:

   during induction only _____ during re-training (date): _____

   at other organisation (name): _____

   (date): _____ other (date): _____

4. Action taken by practice post-incident:
   - investigated and made changes to fix situation
   - investigated and made no changes
   - made life difficult for me
   - did not report incident
   - other

5. Recommended changes*:*

   _____

   _____

   _____

Appendix: Doctors' health advisory services

Source: AMA (https://ama.com.au/node/3592)

Name	To Contact Service	Address	Summary
Doctors' Health Advisory Service	02 9437 6552 – helpline	PO Box 422, St Leonards, NSW 2065	The Doctors' Health Advisory Service (NSW) is an independent, confidential, collegiate service that offers professional medical help to doctors, dentists, veterinary surgeons and students.
Medical Benevolent Association of NSW	02 9987 0504	Level 6, 69 Christie Street, St Leonards, NSW 2065	The Medical Benevolent Association was founded in 1896 to assist medical practitioners, their spouses and children during times of need. It is a completely independent organisation, funded solely through donations from the medical profession. Assistance is available to every registered medical practitioner in NSW and the ACT who is in need.

ACT

Name	To Contact Service	Address	Summary
Doctors' Health Advisory Service	0407 265 414	PO Box 560, Curtin, ACT 2605	For more information call 02 6270 5410 (admin)

NT

Name	To Contact Service	Address	Summary
NT uses the NSW Doctors' Health Advisory Service	02 9437 6552	PO Box 422, St Leonards, NSW 2065	The Doctors' Health Advisory Service (NSW) is an independent, confidential, collegiate service that offers professional medical help to doctors, dentists, veterinary surgeons and students.

QLD

Name	To Contact Service	Address	Summary
Doctors' Health Advisory Service	07 3833 4352 – helpline	PO Box 123, Red Hill, QLD 4059	For more information call 07 3872 2222 (office) 24-hour phone assistance

SA

Name	To Contact Service	Address	Summary
Doctors' Health SA	08 8366 0250 – 24-hour helpline	37 South Terrace, Adelaide, SA 5000 PO Box 7427, Hutt Street Adelaide, SA 5000	The service aims to provide confidential support, information and appropriate advice for distressed medical practitioners.
Medical Benevolent Association of South Australia	08 8267 4355	PO Box 134, North Adelaide, SA 5006	The Association provides assistance to South Australian medical practitioners and their families in need of assistance due to financial hardship.

VIC

Name	To Contact Service	Address	Summary
Peer Support Service	1300 853 338 – 365 days, 8am – 10pm	PO Box 21, Parkville, VIC 3052	The Peer Support Service is fully funded and supported by AMA Victoria. The service provides peer support for doctors, by doctors. All volunteer telephone counsellors are experienced doctors trained in the skills of peer support telephone counselling. All counsellors are Lifeline accredited. The service offers a point of first-contact and a listening ear. If you require ongoing assistance they will refer you to appropriate expert services. For more information call 03 9280 8722
Victorian Doctors Health Program	03 9495 6011; vdhp@vdhp.com.au	8/27 Victoria Parade, Fitzroy, VIC 3065	The Victorian Doctors Health Program is an independent legal entity established to provide a full-time professional service to meet the needs of sick and impaired doctors and medical students. Its principal aim is to assist doctors whose condition will, or is likely to, impact adversely on their ability to continue to practice medicine.
Victorian Medical Benevolent Association	0459 947 287	PO Box 141, Lower Plenty, VIC 3093	The Association provides assistance to medical practitioners and their families in need of assistance due to circumstances of hardship. In the first instance and for referral, contact the Victorian Doctors Health Program (above).

WA

Name	To Contact Service	Address	Summary
Colleague of First Contact	08 9321 3098	PO Box 604, Leederville, WA 6007	Colleague of First Contact is a 24-hour service.

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