CHALLENGING BEHAVIOUR TOOLKIT

TOOL 2

Organisation-wide Self-assessment Audit Tool

for challenging behaviour committees

Government of South Australia

SA Health

Contents

Introduction

Challenging behaviour is any behaviour with the potential to physically or psychologically harm another person, or self, or property. It can range from verbal abuse through to threats or acts of physical violence.

Workers in health services may be exposed to challenging behaviour during the provision of health care or other supporting business services. It can present as verbal aggression or the more serious physical violence and assault. Patients, visitors and member of the public can exhibit behavior that is challenging to workers.

When challenging behaviour incidents occur the disruption to health service provision is not compatible with the safe delivery and quality of care, nor is it compatible with the provision of a safe environment for patients, families, carers and workers.

Purpose of the tool, and how and when to use it

This Tool enables effective risk management preventative strategies to be identified at an organisational level, and reasonably practicable risk control measures introduced, monitored and reviewed for effectiveness.

It is a holistic risk management approach to:

- preventing (through primary control measures such as good governance and leadership, patient screening and assessment)
- responding (through early intervention, observation and monitoring, escalation and referral)
- managing an incident (through to tertiary control measures such as workers having skill, knowledge and expertise) and recovery post an incident (through debriefing, open disclosure, recovery and learning, and other recovery strategies).

Tool 2 will assist health services to;

- Identify hazards and risk in the work environment which may increase the potential risk of challenging behaviour in the provision of patient care
- identify and analyze gaps and developing actions to control or mitigate risk.

How and when to use Tool 2

The tool must be completed and reviewed **at least** annually in consultation with workers, health and safety representatives, safety and quality officers, local WHSIM consultant(s), volunteers, supervisors and managers, clinical educators and consumer and carer representatives. Responsibility for completion lies with the LHN Health Services Challenging Behaviour Committee and/or equivalent (Preventing and Responding to Challenging Behaviour Policy Directive). Health and safety representatives, as relevant, must be involved in this process to ensure that accurate information about risk control measures is communicated and consultation takes place within the local workplace.

Tool 2 is a fillable PDF document which must be used by the health service.

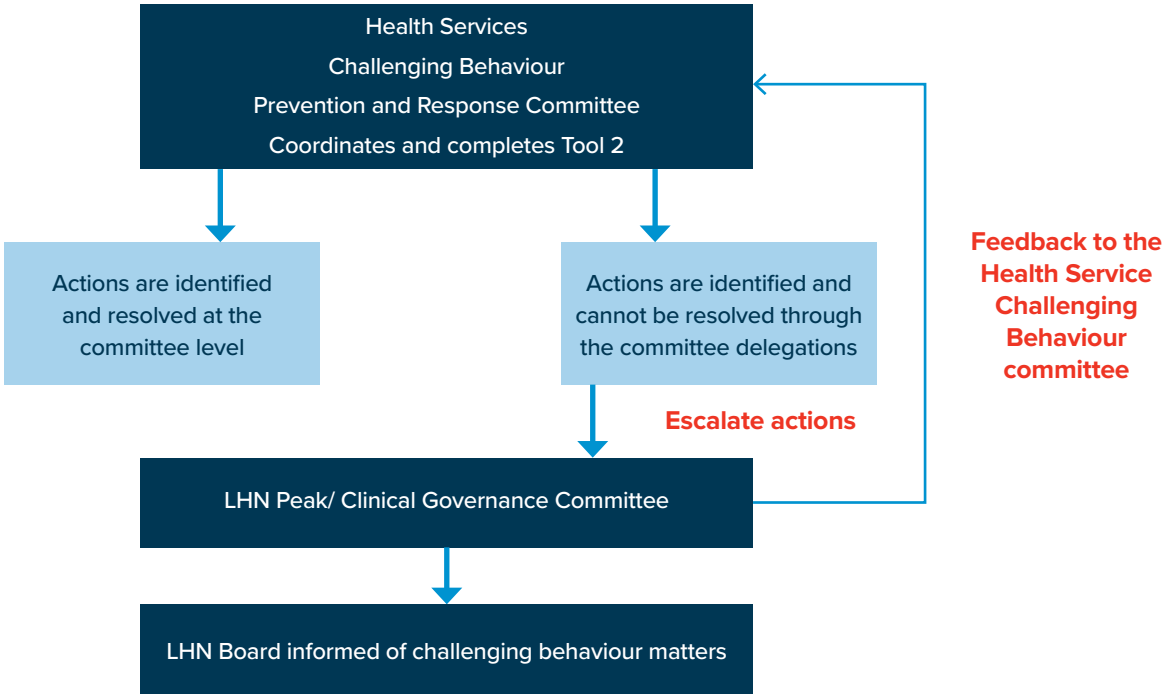
Parts 6a and 6b of Tool 2 will assist in the development of a Risk Treatment Plan (action plan) These action plans must be approved annually by the LHN/Health Service Peak decision making committee (for example, LHN Clinical Governance Committee), and endorsed by the CEO and Governing Board.

Reference should be made to *Tool 3 – Example Terms of Reference for a Health Services Challenging Behaviour Prevention and Response Committee*, to ensure that the designated responsibilities for challenging behaviour prevention, recognition and response are governed and escalated appropriately.

Governance and escalation

The following flowchart illustrates governance and escalation of risk and issues identified.

Where matters cannot be resolved by the Challenging Behaviour committee (or similar), the matters must be escalated to the LHN Peak decision making committee (for example, LHN Clinical Governance Committee, or equivalent) for inclusion into their action plan.



Further information is available

- Preventing and Responding to Challenging behaviour policy directive and toolkit
- Minimising restrictive practices in health care policy directive and toolkit
- Work Health and Safety Injury Management (WHSIM) policy directive
- Mechanisms for Hazard identification and Risk management (WHSIM) procedure
- SA Health Risk Management framework
- Mental Health Services Pathways to Care Policy Directive and Guideline.

Hazard identification and risk assessment tool for challenging behaviour in health services

Date: _____ Completed by: _____ Local Health Network / Health Services / Business Unit: _____

Note: The term patient is used throughout this document to represent all people in receipt of care and includes people who could be termed consumers or clients.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Part 1 – Prevention of challenging behaviour (primary risk controls)					
1.1 Governance, Leadership Commitment, Culture and Quality Improvement					
1.1.1 Challenging behaviour integrated principles > *Refer to SA Health Preventing and Responding to Challenging Behaviour policy directive for principles, and to Tool 3 for Example Terms of Reference for health service CB Committee*					
Are there governance structures and escalation systems in place? Is there visible leadership support in the support of workers, review of data, prevention of challenging behavior, in the response to incidents and related challenging behaviour matters?				Health Service/LHN Boards receive LHN reports, action plans and data. LHN peak decision making committees (for example, LHN Clinical Governance Committee) receive reports containing challenging behaviour data, and governance systems are in place to escalate challenging behaviour related matters.	Health service/LHN Boards do not receive LHN reports and do not know the impact of challenging behaviour within their respective local health network. LHN Peak decision making committees (for example, LHN Clinical Governance Committee) do not receive reports or unresolved actions and do not know the impact of challenging behaviour within their respective local health network
Does the health service have a challenging behaviour committee or similar for the prevention and response to challenging behaviour? Does the challenging behaviour committee escalate unresolved matters to the relevant LHN Peak decision making committee (for example, LHNs Clinical Governance Committee)? > *Refer to Tool 3 – Example terms of reference for a health service challenging behaviour prevention and response committee.*				The health service has a challenging behaviour committee or similar The Health Service Challenging Behaviour committee utilizes the governance of the LHNs Peak decision making committee (for example LHN Clinical Governance Committee) to address challenging behaviour. The health service has a representative on the LHN Peak decision making committee.	The health service does not have a challenging behaviour committee or similar, or representation on the Peak decision making committee (for example, LHNs Clinical Governance Committee). The health service does not utilise the LHN Peak decision making committee for challenging behaviour issues and escalating unresolved matters.
Is leadership committed to related initiatives such as White Ribbon Australia, and have enabled accreditation within their respective workplaces?				The workplace is White Ribbon accredited and initiatives are implemented, e.g. procedures and processes are in place to respond to gendered violence, and support individuals and staff.	White Ribbon initiatives have not been considered and the workplace is not White Ribbon accredited.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Does your health service support the challenging behaviour integrated principles inclusive of: > safe workplaces > safe, high quality, patient-centred care > respectful behaviour > taking action against persons who intentionally and deliberately cause or threaten physical and/or psychological harm and/or property damage?				The Health service implements and supports the challenging behaviour integrated principles, including: > respectful behaviour > safe and high quality care > takes action against persons who intentionally and deliberately cause or threaten physical and/or psychological harm and/or property damage > integrate challenging behaviour principles into local procedures and instructions	The Health service does not support and promote > respectful behaviour > a positive safety culture > local procedures and instructions which support the challenging behaviour integrated principles.
Are health service governance and/or mechanisms in place to support consumer engagement and consumer participation in service planning, design and evaluation? > Refer to SA Health Consumer, Carer and Community Engagement Strategic Framework > SA Health Partnering with Carers Policy Directive > Partnering with Carers Strategic Action Plan				Consumer participation and engagement opportunities are evident.	Consumer service participation and engagement opportunities are not available or not evident.
Other related Hazards: > _____ > _____ > _____					
1.1.2 Work Health and Safety legislative obligations > *Refer to SA Health Work Health and Safety Injury Management (WHSIM) policy directive* > *Refer to SA Health Mechanisms for Hazard Identification and Risk Management procedure (WHSIM)*					
Are health service WHS defined Officers aware of their WHS obligations and elements of due diligence?				WHS defined Officers at the Health Service have been identified. Officers have completed training for defined officers	WHS defined Officers at the Health Service have not been identified. Officers have not completed training for defined officer training
Are workers made aware by their health service of their WHS obligations and general duty of care to not place themselves or others at risk during the provision of care or support services?				Workers are inducted and aware of their general duty of care , and have completed the challenging behaviour module.	Workers are not inducted and are not aware of WHS obligations. Workers have not completed the challenging behaviour module

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are consultation, communication and collaboration processes in place for workers and patients at your health service to assist in identifying challenging behaviour hazards and areas of risk in the health service work and care environments?				Consultation, communication and collaboration processes are in place for workers and patients with in the health service in identifying challenging behaviour risk eg. Team huddles, committees, work groups, debriefs.	Consultation, communication and collaboration processes are not in place or considered for workers and patients with in the health service eg. WHS Consultative Committee.
Are there provisions for reviewing environmental design factors? eg. Security, sensory				Work site safety inspections (WSSI) are completed based on the health setting risk profile (min annually). Refurbishment and building plans consider security and other challenging behaviour aspects.	Work site safety inspections are not completed or are not aligned with the health setting risk profile. Challenging behaviour design factors are not considered in refurbishment and building design.
Other related Hazards: > _____ > _____ > _____					
1.1.3 SA Health policies, guidelines and procedures					
Are all workers aware of the: > SA Health Prevention and Responding to Challenging behaviour policy directive and toolkit > Challenging Behaviour Safety Management (WHS) policy guideline > Minimising Restrictive Practices in Health Care policy directive and toolkit > Restraint and Seclusion in Mental Health Services policy guideline and toolkit > National Safety and Quality Health Service Standards (Standard 5)				Workers are aware and have been involved in the implementation of these policy directives, guidelines and toolkits.	Workers are unaware of these policy directives, guidelines and toolkits.
Are there LHN, SAAS, Statewide Clinical Support Services procedures in place to guide activities to prevent challenging behaviour (primary risk controls)?				Procedures address areas of recognised challenging behaviour risk.	Procedures are not developed and/or do not consider challenging behaviour risk.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are there procedures in place to guide the appropriate response to challenging behaviour, ensuring worker, patient and other person's safety? (Tool 10 Stepped Response to Challenging Behaviour)				Procedures address areas of recognised challenging behaviour risk, for example, high risk settings and high risk clinical conditions.	Procedures are not developed or do not consider challenging behaviour risk.
> *Refer to Tool 6 – Guide to reporting and review of incidents* Do all staff know how to report challenging behavior incidents into the Incident Management System (Safety Learning System)? Are workers supported to report incidents? Are incidents reported into the appropriate incident reporting systems, monitored, reviewed and analysed to determine actions to reduce risk?				The health service has a positive culture for recording and reporting hazards, incidents, injuries and illnesses, etc. The health services complete incident investigations in a timely fashion and implement risk control measures. Data is considered by the: > Health service Challenging Behaviour committee > LHN clinical governance committee (or equivalent). WHS Due Diligence reports are a meeting agenda item of the LHN WHSIM Governance Committee.	The health service has a poor recording and reporting culture for hazards, incidents, injuries and illnesses, etc. The health services does not complete incident investigations in a timely fashion nor implement risk control measures. Challenging behaviour related data is not considered by the > Health Service Challenging Behaviour committee > LHN clinical governance committee (or equivalent) WHS Due Diligence reports are not a meeting agenda item of the LHN WHSIM Governance Committee.
Other related Hazards: > _____ > _____ > _____					
1.1.4 Identifying other hazards associated with challenging behaviours					
What is the level of risk for each clinical settings, including times of elevated risk and the elevated level of distress and emotional involvement associated with the service? ***High risk settings include, but are not limited to:*** Emergency Departments, Emergency and Ambulance services, Drug and Alcohol services, Residential Aged Care, Community – health care and primary health, General Medicine and Surgical wards, Mental Health, Paediatric, Maternity and Health Services, Rehabilitation.				The risk levels are identified and risk control measures are implemented.	Clinical setting risk levels are not identified.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Has the level of risk associated with individuals or groups with some health conditions, for example: Mental illness, Substance misuse, dementia, delirium, brain injury been assessed and clinical management strategies been implemented.				Groups and individuals are identified and preventative risk control measures are implemented, for example, preventative care plans/comfort plans are developed and identify triggers/risk of challenging behaviour.	Health condition risk levels are not analysed or identified. Preventative care plans/comfort plans do not address the risk of challenging behaviour.
Has the level of risk associated with patients who may require specific and sensitive care been assessed and clinical management strategies been implemented? For example people: > with past trauma, traumatic experience > who are a child, adolescent, older person (>65) > who have a chronic physical condition > who identify as being: – Culturally and Linguistically Diverse (CALD) – Aboriginal Torres Strait Islanders people – Lesbian, Gay, Bisexual, Trans, Intersex, Agender/Asexual (LGBTQIA+) > Have social or other risk compounders				Patients risk levels and vulnerability are identified and risk control measures are implemented, for example preventative care plans/ comfort plans are developed and identify triggers/risk of challenging behaviour.	Patients risk levels are not acknowledged or identified. Preventative care plans/comfort plans do not address the risk of challenging behaviour.
Has the level of risk presented by the types of challenging behaviours been assessed and risk management strategies been implemented. Do any of the following incidents occur at your health service? What are the most common, and how frequently do they occur? > Absconding > Verbal abuse > Property damage > Threat of physical abuse > Intrusive behaviour > Resisting lawful treatment > Physical assault				The most common types, and frequency, of challenging behaviour are considered in identifying risk control measures.	Common types of challenging behaviour are not considered, and risk control measures are not implemented.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Other related Hazards: > _____ > _____ > _____					
1.2 Workforce capacity – training and education requirements There are items relating to training needs throughout this tool > *Refer to Tool 5 Education and training Framework* > *Use Tool 5 to assist with a gap analysis of training needs*					
Are all workers provided with an induction and orientation at the health service, including site specific induction on challenging behaviour prevention measures, and emergency response? This includes completion of the mandatory SA Health online learning course Prevention and Responding to Challenging behaviour. Note: If this mandatory training is below 90% for the local workplace, Managers are required to add the low performance to their action plans				All workers have an induction within 3 months of commencing work at the health service.	Worker inductions do not take place in the first three months of work.
Are workers provided with training and education relevant to their roles? For example, training associated with safe work procedures and equipment if they will be applying restraint?				Emergency response teams and other workers in high risk settings receive training.	Training has not been considered for all workers.
Do workers have skill, knowledge, attitudes, values and abilities relevant to their role, their setting, and patients they provide a service to? > This includes ensuring skills remain up to date and are best practice				All workers are appropriately skilled and experienced for their role, setting and service provision.	Not all workers have the skill and experience for their role, setting and service provision.
Do workers have access to training and learning programs, specific to their needs? > This includes ensuring that Staff are supported to attend training				All workers including volunteers and students have received training specific to their needs. All workers are supported to attend training specific to their needs	Not all workers, including volunteers and students have received training specific to their needs. Workers are not supported in attending training specific to their needs.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Do workers have the skills and knowledge to understand and respond to the kinds of challenging behaviour most commonly experienced in their workplace? e.g. verbal abuse, threats, physical assault, intrusive behaviour, resisting lawful treatment, absconding, and property damage				All workers have received training specific to the most common types of challenging behaviour.	Not all workers have received training about the most common types of challenging behaviour.
Other related Hazards: > _____ > _____ > _____					
1.3 Providing lawful, ethical care – legal treatment orders and policy parameters > *Refer to Tool 1 – Quick guide to policy and legal information relating to challenging behaviour*					
Do workers understand the requirements and protections offered to workers and patients, particularly in situations where there are legal orders or any restrictive practices are used?				All workers understand their obligations and protections under relevant legislation.	Not all workers have sufficient understanding of relevant laws.
Are procedures in place for assessing decision-making capacity, and for seeking informed consent? Are patients aware of the services they are to receive?				Procedures and processes for informed consent are developed and implemented. Patients and consumers are kept informed about service delivery and process.	Procedures and processes for informed consent are not available or implemented. Patients and consumers are not informed about service delivery.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.4 Team work, communication and clinical handover > *Refer to SA Health **Clinical Communication and Patient Identification clinical directive**, **NSQHS Standard 6 Communicating for Safety** and **TeamSTEPPS®2.0AU** resources*					
Do teams have a mix of complementary skills and knowledge i.e. effective inter-professional and culturally competent skills to manage situations?				Experienced workers are allocated to fill front line positions. New workers are partnered with more experienced workers initially.	Inexperienced workers are allocated to fill front line positions. New workers are not mentored or supported.
Are there adequate numbers and mix of skilled workers				Staff numbers are increased at critical times. Skilled staff are available at critical times.	Staff numbers are not supplemented at critical times. Skilled staff are not available at critical times.
Does a balance exist between staff stability and rotation to avoid burnout (fatigue) in high risk settings?				High risk setting rosters take into consideration roles and risk levels experienced by workers. Workers are rotated according to roles and tasks. Roster coordinators are trained in identifying workers at risk and understand roles and tasks.	No consideration given to staff rotation. High risk settings and workers at risk not identified. Roster coordinators are not experienced to identify workers at risk, and do not have an understanding of roles and tasks.
Are all workers trained in principles and practices of effective teamwork (such as Team STEPPS®2.0AU), applicable to their roles?				The health service ensures that workers have participated in training, such as TeamSTEPPS®2.0AU.	Workers have not participated in training, such as TeamSTEPPS® 2.0AU.
Do all workers know how to share information, including communicating and documenting critical information: > among team members > at handover to other clinicians > to patients, their family, carers and substitute decision makers? Are handovers structured to meet the requirements of the Clinical Communication and patient identification Clinical Directive and NSQHS Standard 6, for example, to ensure patient safety, continuity and transfer of care?				Clinical communication meets the requirements of policy and Standard 6, for example: > Ensures patient safety > Continuity and transfer of care	Clinical communication does not meet requirements of policy or Standard 6, and for example, may result in miss communication, misunderstanding, patient incident, complications of care.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.5 Communicating with patients, consumers and the community > *Refer to SA Health* ***Consumer, Carer and Community Engagement Strategic Framework, Partnering with Carers policy directive, Consumer, Carer and Community Feedback and Complaints Management Strategic Framework*** > *Consumers: patients and potential patients, carers and organisations representing consumers' interests. When referring to consumers, SA Health is referring to patients, consumers, families, carers and other support people.*					
Are workers trained in communication and engagement skills, patient centered care i.e. trauma informed care, dignity in care which enable treating patients, carers, families and the community with dignity and respect				All health service workers have completed an e-learning communication module and cultural competency training, for example, the Aboriginal Cultural Learning module, Partnering with Consumers and Community module. All workers understand and implement patient-centred care and uphold health care rights.	Workers are unaware of clear communication techniques or the principles of patient and worker diversity. Workers have not completed any communication or cultural competency training. Workers are not aware of patient centred care and health care rights, or approaches to support these.
Are workers trained in customer service principles, and in procedures for complaints handling?				Workers participate in consumer feedback and complaints management training as part of induction.	There is no training provided.
Clinicians: > actively involve patients in their care > meet the patient's information needs > share decision-making				Clinicians use organisational processes (Partnering with Consumers Standard) when providing comprehensive care to: > actively involve patients in their care > meet the patient's information > share decision-making	Clinicians do not use organisational processes (Partnering with Consumers Standard) when providing comprehensive care to: > actively involve patients in their care > meet the patient's information needs > share decision-making
Are workers trained in communication strategies to assist in information provision to patients, taking health literacy into account? E.g. people who identify as Culturally and Linguistically Diverse (CALD)				All health service workers have completed an e-learning communication module and understand health literacy principles. e.g. Health care workers have completed the TeamSTEPPS 2.0 AU training.	Workers have not been informed about communication techniques and health literacy. Healthcare workers have not completed the TeamSTEPPS 2.0AU training

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are workers able to identify when an interpreter is required? Are interpreters available and provided when required?				Workers are skilled to recognise when an interpreter is required. Interpreters are available and accessible when required.	Workers are not skilled to recognise when an interpreter is required. Interpreters are not always available or accessible when required.
Is all relevant written information available in the patient's preferred written language?				Patient information is available in multiple languages.	Patient information is limited and only available in English
Have patients and their families been informed about patient rights, responsibilities and participation in their own care? For example, their privacy and that of other patients and behavior within a health facility.				Health services have provided information to patients on patient rights, responsibilities and participation.	Patient information limited and/or not provided.
Other related Hazards: > _____ > _____ > _____					
1.6 Providing effective treatment and care for patients > *Challenging behaviour may indicate the presence, or be the symptom of a cognitive, emotional acute illness, mental health problem, substance abuse or other underpinning medical condition.* > *Refer to Tool 4 – Clinical guidelines and additional resources.*					
Workers have knowledge and skills in best care for a patient's health condition, so as to provide best recovery and symptom management, relevant to their roles.				Individual team's skillset enhanced in their area of expertise to ensure staff are able to respond and provide patient centred care that address clinical conditions of its consumers.	Not all workers are familiar with current evidence-based best practice for the care of patients in their service. There are gaps in care provided.
Do all workers have skills and knowledge of strategies that will help to avoid the escalation of challenging behaviour, through addressing triggers and causes?				Workers can initiate communication, respond to patient concerns and immediate needs, resolve conflicts, and manage complaints.	Workers are unable to recognise early challenging behaviour and do not preventatively intervene.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are workers trained in recognising and understanding special care and needs for patients underpinning medical condition, triggers and the effect on personal preventative plans (positive behaviour management plans, comfort plans)? For example, trauma informed care, when to call for assistance (stepped response) and plans are documented, for example, in Sunrise EMR and PAS.				All workers have received training and integrate strategies to reduce challenging behaviour into care plans.	Workers have not been trained nor understand how to identify and reduce triggers for challenging behaviour.
Are patients screened or assessed for risk of challenging behaviour at pre-admission and on admission? > Are patients who are at risk monitored for deterioration in mental state throughout their hospital stay?				Patients are appropriately screened and assessed at pre-admission and on admission to health services. Existing flagging, alerts or precaution systems are used to communicate risk of challenging behaviour. Patients are observed and monitored for deterioration in mental state.	Not all workers are familiar with current evidence-based best practice for the care of patients in their service. There are gaps in care provided.
Has the health service identified previous behaviours and plan preventative care accordingly? Have previous incidents been reported?				Previous incidents are reviewed and preparation for an individual's care is made.	Previous incidents not reviewed.
Do care plans include strategies to reduce incidence of challenging behaviour, as required?				Care plans include strategies to reduce risk of challenging behaviour. The specific needs of patients are considered in developing challenging behaviour risk control measures.	Care planning is not modified in response to changes/deterioration in physical and mental (including behaviour or emotional) state.
Are patients, carers and family involved in the development of documented health care plans?				Health care plans are developed in collaboration with patients, carers and family.	Health care plans are not developed or discussed with patient's carers or family.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.7 Health system design and environment > *Refer to the SA Health Protective Security Policy and resource: Security Self Audit* *Note: Security self-audits must be completed annually by 30 June each year and provided to the Agency Security Advisor.*					
1.7.1 Designing workflow and patient journey through services					
Do health services review and improve the workflow, considering workers' and patients' needs resulting in improved patient outcomes, journey and safety? Take into account the following elements when developing procedures: > response times of service provision > response time for workers to achieve service delivery/task > safety > order or sequence of tasks > time allocation for task > physical movements of patients relative to service provision > physical movement of workers to provide patient care and services.				Health service procedures have been developed and reviewed to ensure that they address challenging behaviour risks. Procedures align with SA Health Policy and Policy Guideline requirements. All SA Health Policy and Policy Guidelines and procedures are available, implemented, monitored and evaluated.	Health service procedures have not been developed, reviewed or evaluated to determine how well they address challenging behaviour risks. There are no effective and implemented procedures for dealing with challenging behaviour. All SA Health Policy and Policy Guidelines and Health Service procedures are not readily accessible.
Are all workers rotated into alternative duties to reduce exposure, as necessary?				Work rotation is used as an administrative risk control measure by the health service to reduce risk.	Work rotation is not considered or used as a risk control measure.
Are strategies in place to minimise patient waiting times as much as possible?				Waiting times for appointments are minimised, and patients are notified of delays and options provided.	Long waiting times for patients, and no notification or provision of information.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.7.2 The health service's physical environment for patient care > *A health services facility design contributes to the early prevention of challenging behaviour.* > *A well maintained and visually appealing health service will be respected.*					
Is the health service maintained externally, for example, no graffiti or clutter, clean, refuse bins available?				The health service is clean and well maintained.	The health service is not clean, unkept, not maintained e.g. graffiti, cluttered debris.
Do waiting areas have systems to notify patients about their progress in a queue?				Waiting areas have numbered or electronic systems to indicate waiting times and progress.	There are no systems to indicate patient's progress in a queue.
Are waiting areas comfortable for patients and visitors e.g. chair comfort, enough space, access to drinks, telephones, well ventilated, clean and tidy?				The facility is comfortable for patients, carers and visitors.	Waiting areas are uncomfortable. Patient needs and personal facilities are not provided.
Are there suitable activities for waiting patients, children and visitors?				Waiting areas have facilities and entertainment, such as television, reading material, children toys and books.	Allocated waiting areas do not provide for patients, are limited in capacity and do not contain additional material for entertainment, for example a hallway outside a consultant's room door.
Is the health service environment calming and subdued?				Environment is calming and serene (noise, traffic, colour scheme, low temperature, etc.).	Environment provides high stimulus for patients and visitors (noisy, bright solid colours, high temperature).
Is the noise level in the health service area minimised? Are quiet areas with some privacy available for de-escalation and calming techniques?				The health service has allocated quiet areas and noisy areas are separated from quiet rooms etc.	The health service has not considered noise as a risk factor for challenging behavior. The health service does not have facilities to assign a quiet area.
1.7.3 Safe access, egress, signs and wayfinding for patients > *The physical accessibility contributes to a safe environment for all workers, patients, carers and visitors* > *Services are signed*					
Is clear information provided to patients about how to access the service				Patients are provided with clear information about accessing the services and the steps involved in their care.	Patients are not provided with clear information about accessing the services and the steps involved in their care.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are Information, Enquiries or Help services available in all areas?				These services are available in all areas.	These services are only available at entry.
Are both entry and exit areas of the health service clearly visible, signed and secured? Has consideration been given to the disabled?				Separate access and egress. Signage and directions are clear, fit for purpose and consistently branded showing exits and entry.	Only one point for both access and egress. Signage and directions are not fit for purpose, not maintained and obscured.
Is directional signage clear and appropriate to identify the service area?				Directions to all patient service areas are clearly signed, branded and fit for purpose.	Directions are not provided or clearly visible. Directions are not consistently branded or signed in the health service.
Are car parks suitably situated, clearly signed for direction and designed to increase visibility for example, appropriate lighting?				Carparks are visible and clean with good lighting. Good clear directional signage. Access and egress via lifts or stairs clearly signed and accessible. Lighting and visibility is appropriate. Bins provided and emptied regularly. Presence of security is evident for property and self – CCTV, attendees, security visible.	Carparks are not clean or maintained. Signage is poor. Signage clutter detracts from communication intent. Lighting is poor. Rubbish and debris evident. Feel of insecurity for property and self upon entry.
Do all workers wear identification badges and/or identification badges which may also serve as electronic pass-card security for staff only or restricted areas?				All workers, including students and volunteers are easily identifiable. All workers have electronic – pass cards for security staff only or restricted areas	All workers, including students and volunteers are not easily identifiable. Workers do not have electronic – pass cards for security *staff only or restricted areas*
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.7.4 Workplace physical security - environmental design for worker safety > *Security Managers/Officers assist with security threat analysis.* > *Refer to the SA Health Protective Security Policy Directive, and Security Self Audit, Crime prevention through environmental design (CPTED)* > *All SA Health employees and non-employees providing "a service" or "for service" on SA Health premises must meet the requirements of the SA Health Criminal and Relevant History Screening Policy Directive prior to commencement of their service.*					
Is the health service secure, maintained and fit for purpose. For example, but not limited to : > is safety glass used > are there limited moveable objects > is lighting appropriate e.g. Carparks, walkways, stairwells > is signage appropriate > are staff identifiable > are visitors identified by badges/ stickers > is CCTV used in high risk areas > can the design of the health service cater for Challenging Behaviour situations? Note: Consider SA Health linked closed circuit television (CCTV) for high risk areas, including pharmacy, cashiers, community care settings, areas identified through workplace safety inspection, security self-audits, security assessments.				The health service is secure, maintained and fit for service delivery. Facility risk assessments conducted. High risk areas for have CCTV installed, monitored and maintained The health service design can cater for challenging behavior situations.	Security and maintenance of the health service is not considered or limited. High risk areas have not been identified or do not have CCTV installed. The health service design cannot cater for challenging behavior situations.
Does the environment have limited movable features, e.g. furniture, pot plants; that may be used as a physical object? Note: this may be an identified risk for home or community care settings.				Patients and visitors are screened for weapons by authorised officers, for example, security officers who enforce hospital by-laws. Fit out provides fixed storage and flush mounting of fixtures.	Objects that may be used as weapons, are concealed, using fixtures or in private home. Fit out provides potential weapons for patients, visitors or other persons.
Is the health service located away from licensed premises, high crime areas or buildings?				The health service is aware of geographic, location and demographics of the area and associated risks.	Considerations have not been given to area surrounding the health service.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
1.7.4.1 Natural surveillance					
Are there areas where it would be difficult for another person to see that assistance was needed if a situation escalated or where it would be difficult to see a perpetrator approaching and restrict access if concerned? E.g. Waiting areas, reception, outpatients, emergency				It would be easy for another person to see that assistance was needed if an attack occurred. An assessment has been undertaken and risk mitigation has occurred in identified hot spots Waiting rooms have been allocated inline of sight. Reception and service areas are visible to other workers. Workers can see who is approaching and can restrict access.	No opportunity for incidental surveillance. No consideration has been given to CPTED principles and line of sight. Reception and service areas are obscured to other workers.
1.7.4.2 Territorial reinforcement					
Is access to the premises and vulnerable areas appropriately controlled?				Access is restricted to the health service. Access to vulnerable areas is limited.	No consideration has been given to the risks associated with vulnerable areas. Access is not restricted and has multiple areas of entry.
Are barriers in place to reduce physical access to workers in high risk areas i.e. reception areas allow separation of patients, and visitors from workers?				CPTED principles have been considered and are applied at the health service.	Unaware of CPTED principles.
Are there physical and/or symbolic barriers that separate workers only areas? e.g. 'Authorised personnel only' sign				Health service has given consideration to physical and symbolic barriers i.e. reception desk, transparent shielding, authorised personnel signage. CPTED principles have been used to guide workplace design.	The health service does not implement physical or symbolic barriers to segregate workers and patients or visitors etc. Patients and other people are able to enter authorised personnel areas due to lack of signage, barriers etc. CPTED principles have not been used and design does not control risks.
Is visiting access restricted or controlled?				Visiting hours and accessibility information is provided to consumers, carers and/or family.	No defined visiting or access hours. Visiting or access hours ignored.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are visitors allocated visitors identification badges/ stickers?				Risk assessment undertaken The health service provides badges/ stickers to all visitors, enabling identification of all persons while on the premises.	Badges/stickers are not available at the health service. Unknown persons are walking around on the premises.
Other related Hazards: > _____ > _____ > _____					
1.7.4.3 Design features for emergencies					
Are communication, duress and other alarm systems present, maintained and tested? Note: Provision of duress alarm systems to site specific locations, workstations and on persons where required				These are installed, maintained, tested and accessible.	These are not installed, resourced, maintained or tested.
Are duress alarms easily accessible and not observable?				Alarms can be accessed without observation.	Alarms can only be accessed under observation.
Is it possible to separate workers from patients and members of the public? (protective barriers/screens)				'Staff only' areas are segregated, signed etc.	Worker and patient areas are not defined.
Are there readily accessible secure safe areas for retreat should a situation escalate? Are workers informed?				Secure areas are readily accessible.	There are no secure areas for retreat.
Do safe secure areas have a communication system in place to notify of the situation and seek assistance?				Communication systems are present in safe retreat areas.	No communications systems have been installed in these areas.
Are there a number of ways to exit the health service? Are exit points unlocked and readily accessible to all workers?				There are defined exit routes. All exit doors remain unlocked for easy worker exit.	Exit routes are not defined and are locked after hours. Exit doors are routinely locked prohibiting exit in emergency.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are there routes of escape from all treatment and/or interview rooms? Do service areas have easy access and egress for workers? I.e. no partitions for entrapment.				All workers have been informed of exit/escape routes. Treatment rooms have been allocated accordingly in design.	Escape routes have not been defined.
Other related Hazards: > _____ > _____ > _____					
1.8 Planning responses to emergencies > *See also 1.7.4.3 and During an incident (Part 3)*					
Are security services or equivalent readily available, should they be required? Do workers have access to internal response teams/emergency services?				Immediate assistance is readily available.	Assistance cannot be easily accessed when required.
Is there information available for workers and patients about the activities and roles of security officers authorised under the Hospital By-Laws?				Information is available for all workers and patients about roles of Hospital By-Laws authorised officers and security officers.	Information is not available.
Are procedures in place which define activities of emergency response teams (ERT), including composition of the team and member's roles and responsibilities?				Emergency response teams are skilled, clinically led and members have completed specialised training, as relevant. Emergency response teams activities, roles and responsibilities are documented and defined clearly.	Emergency response teams are not skilled in response. Emergency response teams are not clinically led. Emergency response teams are adhoc in membership and activity.
Do all workers know how to call/ access internal emergency response teams, or equivalent for Regional locations? If applicable to the service, do all workers know where duress alarms are and how and when to use them?				Workers have been informed how and when to call/ access Security Services. All duress alarms and systems are functional.	Workers have not been provided with information to call/ access Security Services. All duress alarms and systems are not functional or are ineffective.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Does each area have a procedure or plan for their response to a high risk incident, that includes each team members roles, movement of workers and evacuation of other people (patients, visitors, other workers)?				Each area has a plan for emergency situations, including roles of team members, and these are practiced.	No plans exist and workers do not have practice of strategies required, e.g. evacuation and securing areas.
Other related Hazards: > _____ > _____ > _____					

References

1. Crime Prevention through Environmental Design (CPTED) http://cptedsecurity.com/cpted_design_guidelines.htm
2. A Better A&E A project led by PearsonLloyd for the NHS, UK http://www.abetteraande.com/
3. Security Design Guidelines for Healthcare Facilities 2012 International Association for Healthcare Security and Safety, Illinois http://www.iahss.org http://dp.ccalac.org/PREPAREDNESS/hazard/Active%20Shooter/Documents/Security%20Design%20Guidelines%20for%20Healthcare%20Facilities.pdf
4. Improving the patient experience program – Wayfinding and signage guidelines (2009) https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Improving-the-patient-experience-program---Wayfinding-and-signage-guidelines-2009
5. Victorian Department of Health, https://www2.health.vic.gov.au/

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Part 2 – Early intervention (secondary risk controls)					
Do all workers have skills and knowledge about screening and assessment, observation, reassessment and monitoring of the patient and the situation?				Workers can recognise early signs of challenging behaviour.	Workers are unsure about what they can do, and steps to take in response to situations.
Is training in basic deescalation techniques available for all workers? Do workers have access to training and education around early intervention and prevent escalation to crisis? For example, training that teaches: > skills for assessing, managing, and responding to risk behaviour > focuses on verbal deescalation, prevention, and early intervention > teaches physical intervention which is to be used only as a last resort. Note: this is a mandatory training requirement for all emergency response team members and security workers				All workers are trained in deescalation techniques such as calming, verbal and non-verbal communication skills, diversion and limit setting. Workers have been trained torecognise challenging behaviour and can apply early intervention techniques.	Workers do not have access to training or education. Deescalation techniques are not known.
Are workers trained in alternative strategies to minimise restrictive practices use?				Workers are trained to implement alternative preventative strategies.	Workers are not trained in preventative/distraction/ diversionary strategies.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Part 3 – During (tertiary risk controls) > *Worker and patient safety during an incident*					
Are clinical and non-clinical workers trained in deescalating aggressive behaviour (signs of aggression, verbal and non–verbal communication strategies) e.g. MAPA® (work group specific training etc.)				All clinical and non-clinical workers are trained in deescalation communication strategies. All high risk setting workers are trained in advanced deescalation techniques.	Workers are neither trained or aware of deescalation communication strategies. High risk setting workers are not identified and are not trained in advanced deescalation techniques.
Have workers who provide care to a restrained or secluded person been trained in the observation, monitoring and care required?				Workers are aware of care and observations required for physical restraint and seclusion.	Workers are not trained, and are not aware of the observations required for physical restraint and seclusion.
Have all workers who will be required to apply physical or mechanical restraint received hands-on training in the application of the restrictive practice?				Workers are trained in the safe application of physical and mechanical restraint, including > worker safety > patient safety, such as avoidance of prone position.	Workers are not trained in the application of physical and mechanical restraints, and do not know patient care required.
Are procedures in place that include a Stepped Response to seek assistance when safety is threatened?				Health services have procedures in place that define a Stepped Response to seeking assistance. Workers know when, what and who to call for assistance. For example: > In a non–emergency when security assist is called to assist with administration of treatment > In an emergency when a Code Black is called for an emergency response team. Does the Code Black emergency response meet standards? (AS 4083-2010 Planning for emergencies – Health care facilities; AS 3745-2010 Planning for emergencies in facilities)	Procedures do not define who, when and how to seek assistance. A Stepped Response to challenging behaviour is not implemented. Calling Code Black is the only strategy used.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are all workers who may be required to approve (authorise) the use of restrictive practices aware of lawful, ethical and reporting requirements?				Workers are aware of the legal, ethical and reporting requirements. Workers are aware of who can authorise the use of the restrictive practice.	Workers are not aware of the legal, ethical or reporting requirements. Workers do not know who can authorise the use of the restrictive practice.
Are all workers able to recognise their skill and knowledge limitations, and when to call for assistance?				Workers are confident in their skills and knowledge, and recognise when to seek assistance.	Workers are inexperienced and do not recognise their limitations.
Other related Hazards: > _____ > _____ > _____					
Part 4 – After an incident (post incident controls) – promoting review, recovery and learning > *Recovery strategies implemented after an incident assist in short and long term recovery, future planning and prevention of recurrence.* > *Recording and reporting informs learning and planning.* > *Refer to Tool 8 CBVA Post Incident Support Toolkit, Tool 1 – Quick guide to policy and legal information relating to challenging behaviour, Tool 6 Reporting and review of incidents of challenging behaviour.*					
Are there procedures for immediate action after an incident, including but not limited to, first aid and care for injured people, preservation of evidence, notifications and reporting, relieving staff of duty?				Procedures are in place to provide immediate care.	There are no procedures and practice is ad hoc.
Can all workers accurately report incidents of challenging behaviour into SLS? Can all workers accurately report incidents of restrictive practices in the SLS?				All workers have training in incident reporting of challenging behaviour and restrictive practices	Incident reporting is not accurate or consistent. Workers do not know how to report challenging behavior incidents. Workers do not know how to report incidents of restrictive practices.
Can workers, as applicable, document the events leading to an incident, strategies attempted to deescalate, clinical care provided before, during and after?				Documentation is completed appropriately.	Documentation of clinical aspects of an incident are incomplete.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Do all workers participate in post incident team review/organisational post incident debriefs and contribute to team learning and quality improvement activities?				Managers lead team reviews after serious incidents. All team members participate. Action is taken and outcomes are recorded in SLS.	Post incident team reviews are not conducted.
Are clinical care plans made and/or reviewed to prevent recurrence and better manage incidents should they present in the future?				Care plans are reviewed and tailored to prevent recurrence.	The health service does not recognise the use of clinical management plans as a risk control measure for challenging behaviour.
Do managers have skills and knowledge about their role after an incident, including debriefing, worker support (Employee Assistance Programs), patient debriefing and open disclosure, and incident reporting requirements?				The health service has procedures for reporting and review of incidents that includes managers' role. Managers have training in worker and patient debriefing, and Open Disclosure.	Managers are not aware of their role and responsibilities.
Do managers review incidents and provide data to the Clinical governance committee responsible for challenging behaviour prevention and response?				Managers review incidents in a timely fashion. Data and quality improvement plans are reported to committee.	Managers review incidents but take no further action.
Are workers, carers and family given the opportunity to be involved in post incident debriefing and open disclosure?				Workers, carers and family are provided with an opportunity to be involved in post incident debriefing and open disclosure.	Workers, carers and family are not provided with an opportunity to be involved in post patient incident debriefing and open disclosure.
Do workers have access to support from Managers, Work Health and Safety professionals, Employee Assistance Programs, peer support persons, Injury Management professionals, Mental Health First Aid Officers, and SAPOL (if pursuing legal action)? > Patient Incident Management and Open Disclosure Policy Directive > Management of worker related injury – illness Policy Directive				Health services have established support mechanisms and provide post – incident support to their workers. Workers are informed about and have access to : > EAP > Management Support > Peer Group Support > Mental Health First Aid Officers > Workforce Professionals > Injury Management > Claims Management > Health and Safety Representatives > Union Representatives > SAPOL assistance/Legal action.	Workers have difficulty in seeking and accessing. Workers are unaware of support, or not offered support.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Do patients, carers and witnesses have access to debriefs and support strategies, and discussion of incidents using open disclosure principles?				Clinical care includes patient debriefs and open disclosure. Health services offer debriefing to visitor, carers and families post incidents.	Health services do not provide patient assistance programs or information. Health services do not include patients, visitors or family members in patient related debriefs.
Are all patients provided with information, and opportunity to make complaints?				Patients are provided with information about making complaints.	Patients are not supported to make complaints. Patient complaints are not followed-up.
Are procedures in place to resolve worker complaints, conflict and grievances?				Health services have clear, documented processes in place for worker grievances and complaints.	Health services do not implement procedures for worker grievances. Health services do not provide the opportunity to Workers or patients for feedback.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Part 5 – Requirements for specific working environments *There are additional requirements for worker safety in the following clinical and health service contexts* 1.1 Working in unpredictable environments 1.2 Working at night or outside business hours 1.3 Remote and/or isolated work e.g. community services 1.4 Handling cash/drugs and/or valuables					
5.1 Working in unpredictable environments > *Is defined as a dynamic changing environment – requires contingency plans to address risk encountered*					
Do any workers work remotely and/or in isolation e.g. Community services, high crime areas?				Remote or isolated roles and tasks are identified. Workers that undertake remote or isolated work are identified.	Remote or isolated roles and tasks are not identified. Workers that undertake remote or isolated work are not identified.
Do workers conduct pre-visit risk assessments prior to service provision in the community?				Workers conduct risk assessments prior to community health service provision and implement risk control measures	A pre- visit risk assessment is not conducted and risks are not known.
Are monitoring systems, for example CCTVs, duress alarms and/or similar, available in community care settings				Monitoring systems are available in community care settings.	Monitoring systems have not been considered and are not available in community care settings.
Are communication devices provided for all workers?				Appropriate communication equipment is supplied, workers are trained in its use and testing and maintenance is completed.	No communication devices are supplied. No maintenance or testing of equipment takes place.
Are workers trained in emergency response, should it be required?				All workers are trained in emergency response during their induction. Workers are involved in health service mock emergency drills/ response, emergency role play, etc.	Workers are not trained in emergency response. Health services do not have mock emergency drills/response, emergency role play scenarios, etc.
Is information exchanged between workers/agencies, carers, service providers e.g. handover?				Health services ensure that relevant information is exchanged between health services and relevant workers.	No exchange of information takes place nor is considered.
Are workers monitored when working in unpredictable environments e.g. supervisor check during shift, monitoring systems?				Working alone or in isolated locations is minimised and regular call-ins are scheduled and monitored.	Workers often work alone, for example, at night and in isolated locations without extra monitoring.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are workers trained in situational (dynamic) risk assessment – for visiting homes or working off-site?				All workers understand risk management processes and are able to complete situational (dynamic) risk assessments, as required.	Workers do not understand the principles of risk assessments.
Are monitoring systems, for example CCTVs, duress alarms and/or similar, available in community care settings				Monitoring systems are available in community care settings.	Monitoring systems have not been considered and are not available in community care settings.
Are workers regularly supervised and receive support they may require?				Workers know who their supervisors are and where they are able to seek support as required.	Workers do not know how to seek support, or the role of their supervisor.
Other related Hazards: > _____ > _____ > _____					
5.2 Working at night or outside business hours > *(This may include in a health service, in the community, off-site at night or on weekends, when staffing numbers are reduced)*					
Is building access restricted when staff numbers are reduced or after hours? e.g. 'Staff only' access points.				Building access is restricted after hours.	Building access is no restricted and has multiple access points after hours.
Are risk assessments conducted for working at night or outside business hours?				Risk assessments are conducted for working at night or outside of business hours and risk control measures are implemented.	Risk assessments are not conducted for working at night or outside of business hours and risks are not known.
Is public access restricted when people work at night?				Public access and services are limited after hours.	No consideration is given to after-hours public access or services.
Is lighting externally and internally appropriate for visibility?				The health service has appropriate lighting for after-hours work.	Lighting is poor externally and no consideration is given to internal lighting for tasks to be completed.
Do all workers have readily accessible support? i.e. communication systems in place, emergency response				All workers have ready access to internal response teams/ emergency response.	Accessing internal response teams/emergency response is difficult.
Are procedures implemented for the opening and closure of the service area?				Health services have documented safe work procedures for the opening and closing of service areas.	No consideration or procedures are in place for opening or closing service areas.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are workers monitored when working after hours?				All workers providing a service after hours are monitored as per their predetermined scheduled communication plan.	Workers are not monitored by the health service and rely on others e.g. partners.
Do all workers work with others at night?				Workers have an assigned buddy if working alone at night.	No consideration given to a buddy system.
Is the service provision in a high crime area?				The health service is aware of its geographic and location.	No consideration has been given to a health service location.
Other related Hazards: > _____ > _____ > _____					
5.3 Remote and/or isolated work > *(Means work that is isolated from assistance of other persons because of the location, time or nature of the work)* > *Refer SA Health Remote or Isolated Work Safety (WHS) Policy Directive and Guideline?*					
Are all workers aware of the SA Health Remote or Isolated Work Safety (WHS) Policy Directive and Guideline?				Workers are aware of the SA Health WHS Remote and/or Isolated Policy and Guideline, and ensure its implementation by their health service. Policy is readily accessible. Procedures in place where required. Evidence of distribution.	Workers are not aware of the SA Health WHS Remote and/or Isolated Policy and Guideline and its requirements.
Do any workers work remotely and/ or in isolation i.e. off-site/on site/in the community?				Remote or isolated workers are identified.	Remote or isolated workers are not identified by the health service..
Are health practitioners aware of the requirements of “Gayle’s Law“				Manager and workers are aware of the requirements of Gayle’s Law. Workers are aware of SLS incident reporting for inability to respond due to “Gayle’s Law” requirements.	Managers and workers are not aware of “Gayle’s Law“. Workers are not aware of SLS incident reporting for inability to respond due to “Gayle’s Law“ requirements.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Are health service safe work procedures implemented to ensure all workers are accounted for while they are at work? (Relevant for community service delivery and community-based health services)				Health services have detailed safe work procedures in place and ensure implementation.	Health services do not have established safe work procedures in place. Health services do not implement safe work procedures. Workers do not abide by safe work procedures, i.e. communications schedules and accountability during remote or isolated work.
Is the health service provision in a high crime area?				The health service is aware of its geographic and location.	No consideration has been given to a health service location.
Are workers trained in situational (Dynamic) risk assessment for visiting homes or working off-site? Are workers regularly supervised and receive support?				All workers understand risk management processes and are able to complete situational risk assessments, as required.	Workers do not understand the principles of risk assessments.
Are all workers provided with appropriate risk control measures? i.e. the provisions of communication and monitoring systems, provision of second responders and the provision of ancillary equipment for emergency response.				Communication and monitoring systems are effective, present, maintained and workers have been trained in use. Emergency response, medical and first aid, and rescue safe work procedures are developed and implemented.	No communications or monitoring systems are available. Communication systems are not reliable or effective. Emergency response, medical and first aid, and rescue safe work procedures are not developed, documented or known by workers.
Other related Hazards: > _____ > _____ > _____					

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
5.4 Handling cash/drugs and/or valuables					
Are cash, drugs or other valuables handled at the health service minimised and stored securely?				Cash and pharmaceuticals handling occurs away from consumers, visitors, public in a secure place with no or limited during after-hours services. Cash handling locations are minimised.	Cash and pharmaceuticals handling is visible to the consumer, visitors or the public.
Are cash, drugs or other valuables stored away from the health service, or in specific areas designed for that purpose? For example, drugs are managed by pharmacy dispensary only; patients are advised not to bring valuables to health services.				Allocated areas are assigned.	No consideration given to risks associated with cash, drugs or valuables.
Are cash or drugs handled by staff and other workers in areas that cannot be observed by patients, carers, visitors or passer-by (i.e. visible from outside)?				Health service areas handling cash or drugs are monitored and secure.	No consideration has been given to the risks associated with handling cash or drugs.
Are all workers who handle cash/drugs and valuables separated from patients and members of the public? (protective barriers/screens)				Health service workers handling cash or drugs are separated from patients, monitored and secure.	No consideration has been given to the risks associated with handling cash or drugs.
Are security measures used, e.g. CCTV, anti-jump screens, drop/timer safes, electronic fund transactions?				The health service has implemented security measures relevant to the area of work.	No security measures are in place or have been identified as risk control measures.

RISK CONTEXT AND FACTOR	YES/ NO	EVIDENCE (list evidence)	ACTIONS	RISK INDICATOR	
				LOWER RISK	HIGHER RISK
Is the health service located in a high crime area?				The health service is aware of geographic, location and demographics of the area.	Considerations have not been given of surrounds.
Other related Hazards: > _____ > _____ > _____					

References

1. Crime Prevention through Environmental Design (CPTED) http://cptedsecurity.com/cpted_design_guidelines.htm
2. A Better A&E A project led by PearsonLloyd for the NHS, UK http://www.abetteraande.com/
3. Security Design Guidelines for Healthcare Facilities 2012 International Association for Healthcare Security and Safety, Illinois http://www.iahss.org http://dp.ccalac.org/PREPAREDNESS/hazard/Active%20Shooter/Documents/Security%20Design%20Guidelines%20for%20Healthcare%20Facilities.pdf
4. Improving the patient experience program – Wayfinding and signage guidelines (2009) https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Improving-the-patient-experience-program---Wayfinding-and-signage-guidelines-2009
5. Safety Risk Assessment (SRA) for healthcare facility environments Toolkit 2019 The Centre for Health Design, California. http://www.healthdesign.org

Part 6A
Strategic and Operational Risk Assessment Matrix

Upon identification of a potential gap through hazard identification, this document will guide you in determining the severity of the risk, and what risk control measures are required to eliminate or minimise the risk presented by challenging behaviour, violence and aggression of harm/injury/illness, (both physical and psychological).

Follow the tables following for guidance in assessing the Risk Rating Priority and Evaluation.

Enter the corresponding Likelihood, Consequence and Risk Rating onto the Risk Rating column (or for incidents WHS SLS Management tab in SLS). Use the WHS Risk Treatment Plan to record actions taken and to be undertaken to control/resolve the risk for risks rated high to extreme. When determining the rating, consider the effectiveness of any current risk control measures, which may already contribute to reducing the risk.

If the actions arise from Tool 2 having been completed and coordinated through the Health Services Challenging Behaviour Prevention and Response Committee, and cannot be resolved for the health service through the committees delegations, escalate the actions arising to the LHN Clinical Governance Committee.

References

1. Challenging Behaviour Toolkit Tool 3 – Terms of reference for a Health Services Challenging Behaviour Prevention and Response Committee
2. SA Health Procedure Mechanisms for Hazard Identification & Risk Management
3. SA Health Risk Management Framework

Table 1: Strategic and Operational Risk Assessment Matrix

STRATEGIC AND OPERATIONAL RISK ASSESSMENT MATRIX							
CONSEQUENCE (Impact) RATING GUIDE							
LEVEL	**CATEGORY**	**CLINICAL**	**FINANCIAL**	**OUR PEOPLE**	**LEGAL, POLICY AND REGULATORY**	**ORGANISATION/ CONSUMER**	**CORPORATE REPUTATION AND IMAGE**
1	**Insignificant**	Negligible clinical event resolved without impact on consumer or organisation.	Financial loss of either less than $250,000 or 0.05% of budget.	Negligible staff injury or near miss accident. Insignificant industrial grievance.	Immaterial legal, regulatory or internal policy failure without penalty implication.	Event with negligible impact on delivery of services to consumers. Internal inconvenience only.	One off negative media coverage only an no repuation impact.
2	**Minor**	Clinical event resolved with minimal short term impact on consumer or organisation.	Financial loss of either between $250,000 to $1 million or between 0.05% to 0.2% of budget.	Staff lost time injury. Local temporary poor engagement. Industrial grievance resolved internally.	One-off minor legal, regulatory or internal policy failure resolved without penalty.	Event with short term impact on delivery of services. Some impact on consumers or partners.	Isolated adverse media exposure. Temporary minor negative impact on reputation.
3	**Mediium**	Clinical event resulting in temporary injury or impact with considerable effect on consumer or organisation. Internal investigation required. May require external mediation.	Financial loss of either between $1 to $5 million or between 0.2% to 1% of budget.	Temporary injury to staff. Ongoing widespread engagement issues. Industrial disputation mediated with no major penalty.	Repeated legal, regulatory or internal policy failure with penalty implications requiring internal investigation.	Event requiring considerable remedial action with moderate impact on consumers or partners. Temporary loss of important information.	Repeated isolated negative reporting in media. Temporary breakdown in key relationship. Short term reputation damage.
4	**Major**	Clinical event resulting in serious permanent injury, requiring internal ad medico legal investigation, external mediation, major penalties or compensation payments.	Financial loss of either between $5 to $10 million or between 1% to 2% of budget.	Serious permanent injury to staff. Entrenched engagement problems. Inability to recruit staff with necessary skills in key areas. Staff walkout and industrial stoppages.	Systemic legal, regulatory or internal policy failure with major penalty requiring extensive internal inquiry and external review.	Event with major impact on delivery of services. Major impact on consumers or partners. Temporary loss of critical information.	Widespread negative reporting in media leading to high-level independent investigation with adverse findings and longer term reputation damage. Premier of Ministerial involvement/intervention by Cabinet. Breakdown in key relationship(s).
5	**Critical**	Failure in clinical governance processes/ systems resulting in fatality requiring extensive internal and medico legal investigation, coroner's notification, significant penalties or compensation payments.	Financial loss of either greater than $10 million or 2% of budget.	Staff fatality. Simultaneous loss of a number of critical staff (e.g. Executive)	Substantial failure in internal governance and control structures resulting in Royal Commission and significant penalty.	Event with significant impact on delivery of services across SA Health for an extended period. Significant impact on consumers or partners. Permanent loss of critical information.	Sustained adverse media exposure. Total loss of confidence within community and with the Government. Parliamentary enquiry. Serious long term impact on reputation.

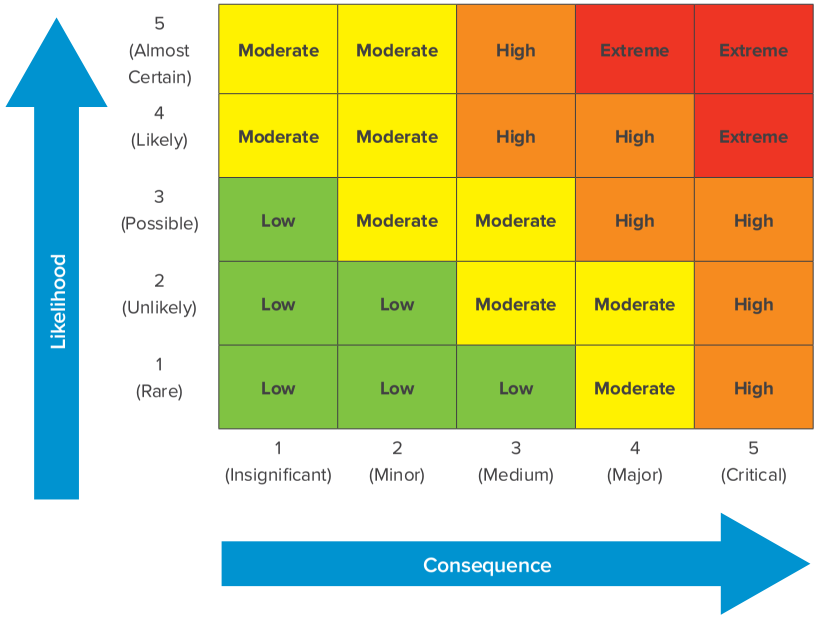
NB: Financial impact is assessed in context of your Unit/Division/Department/Health Network/Service budget (funding allocation); the highest financial impact must be applied.

STRATEGIC AND OPERATIONAL RISK ASSESSMENT MATRIX

LIKELIHOOD RATING GUIDE *(Consider historical factors, such as whether the risk has happened before in the past and how frequently it has occurred)*

LEVEL	CATEGORY	PROBABILITY DESCRIPTION
1	**Rare**	Once in 10 YEARS < 1% probability of occurrence Event may only occur in exceptional circumstances in the long-term future
2	**Unlikely**	Once in 5 YEARS 1% – 20% probability of occurrence Event could occur but not anticipated in the foreseeable future
3	**Possible**	Once a YEARS 20% – 50% probability of occurrence Event could occur within short-term timeframe
4	**Likely**	Once a MONTH 50% – 99% probability of occurrence Event could occur in most circumstances
5	**Almost Certain**	Once a WEEK or DAILY > 99% probability of occurrence Event is expected to occur in most circumstances, risk is occurring now

RISK ASSESSMENT MATRIX (indicating priority & action)



ACTION REQUIRED* *(Refer SA Health Risk Management Framework for details)*

CONTROLLED LEVEL OF RISK (Current Risk)	ACTION DESCRIPTION
Extreme	Immediate action required and commitment of executive. Treatment Plan prepared and documented in < 2 weeks (if applicable), escalate to SA Health Chief Executive via Health Network or Service Chief Executive Officer/Department Executive if unable to be mitigated to a lower level and not already reported, active monitoring of controls
High	Executive attention required Treatment Plan documented in < 1 month, monitoring of controls at least quarterly
Moderate	Management responsibility must be specified and accountability defined, Treatment Plan optional cased on benefit to business, periodic ongoing monitoring of controls
Low	Responsibility must be specified. Treatment Plan options based on benefit to business (NB: requires control evaluation to be completed), monitoring by Management consider excess or redundant controls

RISK CONTROL		
Strategies to support development of risk treatment plans. Elimination is the most effective risk control measure.		
BEST ↕ LEAST	**Elimination**	Complete removal of hazard or risk of exposure to the hazard e.g. remove the problem/process.
	Substitution	Replace hazardous plant, equipment, substance or work process with a less hazardous one
	Enginerring Controls	May include: redesigning/re-engineering the workplace or maintenance, using a patient lifter, fixing guards.
	Administration Controls	May include: introducing new work practices, placing signs, training in safe work procedures/safe work method statements.
	Personal Protective Equipment	Use safety shoes, goggles, splash glasses, gloves, etc. The least effective method of control but may be required to protect workers from hazards in the workplace, in conjunction with other controls.

Part 6B
[Name] Risk Treatment Plan

Complete the Risk Treatment Plan (FOR219) (or simpler version action plan) to facilitate the implementation of future risk control measures, and to provide evidence of hazard management activity.

Record hazards identified and their description followed by the current risk control measures (if any), risk rating priority, including the controlled risk rating; planned actions to be taken; responsible person who will undertake the action; the timeframe that the activity is to be completed, risk review and outcome.

LHN/SAAS/DHW: _____ Date plan established: _____

Completed by: _____ Signature: _____ Date: _____

HAZARD IDENTIFIED DESCRIPTION	CURRENT RISK CONTROL MEASURES	LIKELIHOOD	CONSEQUENCE	CONTROLLED RISK RATING	PLANNED TREATMENT	TREATMENT OWNER	TREATMENT DATE	RISK REVIEW/ OUTCOME

Refer to CPR015 Procedure Mechanisms for Hazard Identification & Risk Management.

Reference may also be made to the SA Health WHSIM Worksite Safety Inspections Checklist *series for local workplace inspections.*

For more information

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Safety and Quality Unit
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