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CC3 Behavioural Management - Dealing with Participant Violence and Aggression

Purpose

1. To ensure that appropriate arrangements are in place to deal effectively with participant-related violence and aggression. This includes achieving the best possible outcome for the participant and ensuring the safety of all concerned (the participant, other participants, family members and staff).

Alignment with Practice Standards

1. Module 2: Provider Governance and Operational Management
2. Module 3: Provision of Supports
3. High Intensity Daily Personal Activities
4. Specialist Behaviour Support Module

Legislative Alignment

1. National Disability Insurance Scheme Act 2013
2. Work Health and Safety Act 2011 (Cth)
3. Work Health and Safety Regulations 2011 (Cth)

Key Responsible Executive

Chief Executive Officer

For More Support

Head of Multidisciplinary Care

Policy Statement

1. This policy applies to Management, all registered nurses and care staff, all SAVVY employees and volunteers, Local medical officers (LMOs) and other health professionals as required.

2. Participant/participant-related physical and verbal abuse
    a. participant/participant-related physical and verbal abuse to staff and other participants is a sensitive but prevalent problem in aged care. It is becoming more significant as people stay at home longer and often have very complex behavioural needs when they enter residential care. It can also extend to community settings (participant outings, participant homes).

3. People with challenging behaviour
    a. As outlined in SAVVY's policy CC1 Behavioural Management, aggression is one possible form of challenging behaviour. In our policies, 'people with challenging behaviour' refers to people whose behaviour causes stress or distress to the person with the behaviour or any number of other people interacting with them including other participants, care staff, family and friends. Challenging behaviours are associated with a decline in their cognitive capacity, generally due to dementia and/or various other medical conditions.
    b. There are a number of terms used to refer to the behavioural symptoms of dementia including: challenging behaviours; behavioural and psychological symptoms of dementia (BPSD); and behaviours of concern (BOC). Throughout this policy, we refer to these as challenging behaviours, but other terms are used interchangeably.

4. What is aggression and what does it look like in dementia?
    a. Aggression in dementia is characterised by physically and/or verbally threatening behaviours directed at people, objects or self. It is often quantified by specific acts that can include:
        i. verbal insults, shouting, screaming
        ii. obscene language
        iii. hitting, punching, kicking
        iv. pushing, throwing objects
        v. sexual aggression.

5. Violence
    a. Violence is physical aggression. The Macquarie Dictionary defines it as rough or injurious physical force, action, or treatment: to die by violence.

6. Causes of aggression
    a. With many participants in aged care facilities (or participants in the community) suffering from illnesses such as delirium and dementia, their mental states are likely to be changeable and unstable due to the results of drugs, therapy, pain, and indeed the illness itself. As such, aggressive behaviour is not uncommon.
    b. The term aggression is often used interchangeably with agitation yet aggression can present independently or as a consequence of agitation.
    c. Aggression can be a purposive and overt response to a violation of personal space or a perceived threat. Not unexpectedly, it often occurs during personal care tasks involving close carer-participant contact.
    d. For instance, personal hygiene activities, particularly bathing, can provoke anxiety or fear in the person with dementia and hence tend to be the most frequent circumstances around which aggressive behaviours occur. When they are anxious around provoking aggressive behaviours, carers may attempt to complete the task in the shortest possible time that can further inflame the situation.
    e. Carers need to be aware that their communication style can contribute (positively or negatively) to the person with dementia's behavioural response.

f. Aggressive behaviour may be a manifestation of unmet physiological and/or psychological needs. While there is no single cause, common precipitants of aggression in dementia include:
   i. pain or discomfort
   ii. constipation
   iii. hunger and/or thirst
   iv. medical illness including infection
   v. boredom
   vi. loneliness
   vii. dehydration
   viii. depression
   ix. environmental stressors including staff/carer communication.

7. Dealing with participant/participant aggression
   a. In the main, dealing with participant/participant aggression should be approached in the same positive way as other challenging behaviours (as outlined in SAVVY's policy CC1 – Behavioural Management).
   b. Aggressive behaviour can be seen as a form of communication as the person with dementia is less able to articulate their needs effectively. The crucial task for the clinician is to attempt to understand what is underlying the aggressive behaviour for the individual with dementia. Interventions targeting the cause will likely assist in reducing the behaviour.
   c. Handling the emotional, physical and mental demands of each participant/participant can be challenging. However, it can be made easier by taking the time to get to know the individual and by forming a bond with them. By having an understanding of what makes them "tick" and an idea of what can ultimately trigger aggressive behaviour in that individual, then it is possible to recognise the signs early enough before problems occur.
   d. Individualised, person-centred care based on psychosocial management is preferred. Interventions should be considered on a case-by-case basis. Where necessary, pharmacological interventions can also be considered. This is especially in situations that place the person with dementia and/or others around them at risk, requiring an urgent response.
   e. The issue of restraint as a form of intervention is canvassed in SAVVY policy CC36 Use of Restrictive Practices. In general, SAVVY endorses as preferred practice the minimal use of restraint as the last resort.

8. Dealing with physical aggression and violence
   a. While prevention is always the desirable approach, there are times however when aggression occurs without warning so staff need to have the processes in place to deal with such situations.
   b. Under the WHS Act 2011, SAVVY has a duty to ensure the health, safety and welfare of workers and others in the workplace, as far as is reasonably practicable. The duty relates to staff and participants alike. As part of this duty, SAVVY ust exercise due diligence in ensuring that adequate resources are provided to eliminate or, if not practicable, to control the risk of participant-related violence and aggression in the workplace.
   c. The New South Wales Nurses and Midwives' Association (NSWNMA) has identified some common elements related to incidents of participant-related violence and aggression towards staff and other participants, which apply across the entire industry. Applicable aspects have informed this policy.

9. Responding to duress situations
   a. Early recognition of an incident and a resulting effective and appropriate response can minimise the risk of injury to workers, participant/participants and others, and in some circumstances actually prevent the further escalation of a situation.
   b. However, despite all efforts to minimise the likelihood of participant/participant related violent or aggressive incidents occurring in the SAVVY facility or community settings, incidents that require urgent assistance can still occur.

c. It is important that all staff are aware that there is a range of options available when faced with violent events. One action available to all staff is triggering a duress response. The exact nature of the duress response will vary depending on the circumstances, location, nature of the incident, and availability of staff to respond. However, it must be available to each shift and be planned and prompt.
d. All staff should feel confident that when seeking urgent assistance, an effective response will be initiated. Staff should also be assured that it is better to trigger an alarm/seek assistance early as this can prevent escalation.

10. Clinical and non-clinical (corporate) incidents
    a. In this policy, most duress response arrangements are directly primarily at 'clinical' incidents. Such incidents are where the safety of a staff member, participant/participant or others is threatened by the behaviour of a participant/participant. These types of incidents would largely involve a clinical response, with external assistance such as the police only where necessary.
    b. Other violent or aggressive incidents may be where the safety of a staff member, participant/participant or others is threatened by the behaviour of an individual or a group of persons who are not participants or participants, or where there are other threats such as a robbery or break in. These types of 'corporate' incidents will often involve external assistance such as the police, rather than a response by clinical staff. As such, they are not the focus of these duress response arrangements.

11. After the event
    a. Rather than brushing aside this kind of behaviour as 'just one of those things that happen' each and every incident of participant aggressive behaviour should be reported and investigated. All efforts should be made to understand the cause of the aggressive outburst and consideration given to minimising the risk of it happening again.
    b. Where there has been participant to participant aggression, it needs to be ensured that all relevant external compulsory reporting and guidelines are followed. (Refer relevant SAVVY policies in the reference section below).
    c. Also, it is important that post-incident debriefs be conducted that consider information from all staff involved in the incident. It is also important that there be appropriate support for all those who were involved in the incident (including but not limited to staff, participants/participants, family members).

Procedures

1. Management is responsible for:
    a. In terms of dealing with the possible risk/incidence of participant-related violence and aggression, developing/reviewing admissions policies and criteria to ensure that they are appropriate to SAVVY 's capabilities.
    b. Ensuring that a system of security auditing is in place. Specifically, this involves:
        i. Routinely (at least annually) conducting a WHS assessment of SAVVY's safety and security needs in relation to participant-related violence and aggression. This is to include an appropriate risk assessment of all SAVVY work locations, and community settings (participant outings, participant homes).
        ii. Addressing in the assessment the need for appropriate staffing levels (avoiding staff working alone and in isolation), especially in the DSU, or other locations where staff are caring for participants/participants with challenging behaviour.
    c. Undertaking routine and adequate consultation with staff in relation to their security needs.
    d. Ensuring appropriate duress response arrangements are in place. Specifically, this involves:
        i. Developing, in consultation with staff and other stakeholders, written duress response plans (as distinct from evacuation plans) for relevant work locations. Such

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duress response plans will take into account the risk assessment for the location, as well as other particular circumstances and available resources.

ii. Developing an appropriate duress response capability, including the availability of duress response alarms in the DSU (and other locations if appropriate).

iii. Ensuring relevant staff are trained in the duress response procedure and protocols for summoning assistance (including the use of duress alarms or other equipment where appropriate)

iv. Ensuring adequate numbers of trained staff are available to respond to duress calls.

e. Ensuring regular training of staff in behaviour management/mental health. Specifically, this involves:
    i. Ensuring there is adequate and sufficient training of staff in mental health issues related to the ageing process
    ii. Ensuring relevant staff have demonstrated skills, training and experience in the management of behaviours and conditions relating to that environment e.g., dementia care, cognitive deficit, or challenging behaviours

f. Ensuring there is adequate staff training in
    i. violence prevention and management including identifying early intervention opportunities to prevent the escalation of an incident
    ii. dealing with direct physical aggression
    iii. understanding the duress response procedure including when they need to activate a duress alarm to ensure prompt response to the incident (refer point 3 above)
    iv. de-escalation and restraint techniques, in line with relevant external requirements and professional guidelines

2. Management and supervisors (registered nurses) are responsible for:
    a. Managing post-incident issues. Specifically, this involves:
        i. Undertaking necessary care of the participant/participant including identifying and treating any underlying medical conditions and reviewing/developing an appropriate behaviour management plan.
        ii. Informing the participant/participant's doctor and family as soon as possible after the incident.
        iii. Recording the details of the duress call and the response provided.
        iv. Ensuring that the required incident investigation, reporting and recording occurs as soon as possible after the event (utilising iCare).
        v. Ensuring that any compulsory reporting is made to the police and the Department of Social Services, within set guidelines and required timeframes, where there is participant-to-participant reportable assault.
        vi. Conducting post incident debriefs that consider information from all staff involved in the incident and supporting those who were involved in the incident.
        vii. Conduct a systematic investigation including a review of the system in place, policies and procedures, and other relevant issues.
        viii. Consideration of relevant guidelines and procedures for the management of workplace injuries and return to work arrangements.

3. All staff are responsible for:
    a. Ensuring their own safety and the safety of all other participants.
    b. Attending training in violence prevention and management and duress response management (refer point 2.a.iv above)
    c. Fulfilling any delegated role and responsibilities in the implementation of a duress response
    d. Documenting involvement in the duress incident in accordance with procedures
    e. Participating in any operational review and debriefing of a duress incident
    f. Cooperating with changes to procedures and any other preventive measures identified through any risk management or post-incident investigation processes.

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References to other SAVVY policies

1. CS3.5 Participant Record Management
2. HR4.17 Information Technology
3. CC1 Behavioural Management
4. CC36 Use of Restrictive Devices

References to other external materials

1. Behaviour Management – A Guide to Good Practice. Managing Behavioural and Psychological Symptoms of Dementia (BPSD). Dementia Collaborative Research Centre – Assessment and Better Care (DCRC-ABC) at the University of New South Wales 2012.
2. Guidelines for working with people with challenging behaviours in residential aged care facilities – using appropriate interventions and minimising restraint. NSW Department of Health, 2006
3. Letter to SAVVY from Brett Holmes, General Secretary, NSW Nurses and Midwives' Association (NSWNMA), dated 21 June 2013, re workplace safety and security in residential aged care
4. Managing aggressive behaviour in aged care facilities, Nursing Careers Allied Health www.ncah.com.au, Posted 27-09-2012
5. Managing challenging behaviour in older adults with dementia. Ashok A and Anderson D, progress in Neurology and Psychiatry, Vol 15, Issue 3, May/June 2011: 20-27.
6. Poole's Algorithm: Nursing management of disturbed behaviour in aged care facilities by Julia Poole, Clinical Nurse Consultant, Department of Aged Care and Rehabilitation Medicine, Royal North Shore Hospital & Community Health Services, St. Leonards, NSW 2065. First printed 2000
7. Prevention and management of aggression in health services - a handbook for workplaces; December 2009, WorkSafe WA in conjunction with WorkSafe Victoria
8. Protecting people and property: NSW health policy and standards for security risk management in NSW health agencies, June 2013
9. Work Health and Safety (WHS) Act 2011

Supporting documentation

1. Participant files and admission notes
2. Assessments, care and service plans, incident reports, progress notes, charts
3. LMO continuous medical history notes
4. Behaviour monitoring chart
5. Restraint monitoring chart
6. Individual participants' medication charts
7. Audits

Version Control

1. 1 April 2023 - New Policy Creation