NSW Health Response to Recommendations – Peter Anderson Review into Improvements to Security In Hospitals

Interim Report Recommendation	Final Report Recommendation
CULTURE	
1. A culture of safety and security to be mandated and clearly understood across the NSW health system based on the maxim that "security is everybody's responsibility". Supported. Action is occurring within Districts/Networks to reinforce this maxim.	
2. That culture requires an understanding that staff and members of the public are entitled, both legally and morally, to the same protection as patients. Staff cannot work efficiently if they come to work fearful of being assaulted. Supported. Action is occurring within Districts/Networks to reinforce the priority of staff safety.	**49. Appropriate warnings to be posted at hospitals and other health facilities in the community indicating that aggressive and/or violent behaviour will not be tolerated, and that police will be called and charges will be pursued. In addition 'exclusion notices' may be issued.** Supported. Action is occurring within Districts/Networks.
3. An evaluation of the Nurse Safety Culture Co-ordinator positions funded in the 2017/18 Budget should be undertaken with a view to identifying opportunities to enhance the adoption of the culture referred to above. Supported. The evaluation of the Nurse Safety Culture Co-ordinator positions has been undertaken and the outcome is being considered by the NSW Ministry of Health.	
RURAL AND REGIONAL	
4. The different challenges facing regional and rural hospitals should be the focus of a similar investigation to that undertaken so far by the Review. Completed. Mr Anderson continued his review following release of his interim report in February 2019 and visited a total of 34 hospitals in rural and regional NSW.	

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LEADERSHIP	
5. The acceptance of, and adherence to, the principle that a staff safety culture is to be led by the Chief Executive of each organisation. Supported. Action is occurring within Districts/Networks to reinforce the priority of staff safety.	
6. Managers must ensure that the current culture of under-reporting of security type incidents ends. Staff are to be actively encouraged to enter all incidents into the current incident management system (IIMS). Staff are also to be advised of the efforts being made to upgrade the current system to the new ims+ to address the issues of concern. Supported. Action is occurring within Districts/Networks to reinforce the requirement to report all incidents. As part of the implementation of IMS+ all staff are completing mandatory training on how to report incidents.	**50. Districts should note that they are required to comply with clause 34 of the Security Industry Regulation 2016 which requires that an incident register is kept by master licensees.** Supported. Action is occurring within Districts/Networks to ensure incident registers are in place.
7. Managers and supervisors are to ensure compliance with the wearing of personal duress alarms where their use has been mandated. Where problems are identified regarding the use of a duress alarm then that matter is to be resolved urgently. Where a staff member requests, due to concerns for their individual safety, the issue of a duress alarm for use elsewhere in their place of work, then consideration should be given to the issue of same. Supported. Districts and Networks are undertaking random audits of emergency departments to check compliance with the requirement to wear duress alarms. Results are captured in the NSW Health Security Improvement Audit Tool (SIAT) facility report.	**51. Fixed duress alarms are to be located near the access door of a patient treatment room or staff only room, as well as at the rear of the room, so that staff can access the duress button and not get trapped.** Supported. The NSW Health Security Manual *Protecting People and Property* will be updated to reflect this requirement and Design Guides being developed (see Rec 17) will incorporate this requirement. **52. Local Health Districts/Specialty Networks share information in relation to the methods they use for staff working in the community and in particular working considerable distances away to communicate they require assistance and/or position locators.** Supported.

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8. All Local Health Districts and Specialty Networks are to have a system in place to ensure that clinical staff inform security staff when they become aware that a patient, who may present a behavioural challenge, is en route to the hospital. Supported. Action is occurring within Districts/Networks to identify a business process to support this communication. This requirement will also be embedded in the relevant chapter of the NSW Health Security Manual *Protecting People and Property.*	
<u>Recommendation as amended in Final Report</u>: **9. Staff who have been threatened or assaulted resulting from a deliberate act of violence are to be encouraged and supported to report the assault to police and to request action be taken by the police against the perpetrator. Staff are to continue to be supported through any subsequent criminal justice proceedings. To this end, the member of staff is to be supported by another member of staff from the taking of statements through to attendance at court. Clearly this recommendation will be influenced by the clinical condition of the perpetrator. Local Health Districts/Specialty Networks should be aware that there is no requirement for staff of hospitals or other health facilities who are victims of assault to use their personal address rather than their business address when pressing charges or taking an AVO against an individual.** Supported. Action is occurring within Districts/Networks to ensure staff are supported following an incident, including support if they choose to make a statement to Police. Post incident standards for supporting staff and seeking AVOs will also be embedded in the relevant chapter of the NSW Health Security Manual *Protecting People and Property.* This will be supported by an Information Sheet that can be provided to staff by their manager.	

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10. The effectiveness of local liaison committees with police and other agencies are to be reviewed to ensure appropriate representation is present and that the meetings are held regularly. Any difficulties identified at the local level which are not resolved should be escalated in line with the NSW Health/NSW Police Force Memorandum of Understanding for further consideration. Supported. Action is occurring within Districts/Networks to ensure liaison committees are working effectively.	**53. Police and paramedics should inform emergency department staff when bringing in patients with challenging behaviours who may pose a potential risk. To this end, the existing and all future MOUs with third party agencies should include provision for such information to be provided prior to arrival at the emergency department.** Supported in principle. The Ministry will consult with the NSW Police Force and NSW Ambulance to include this recommendation in the MOU. **54. Where applicable, appropriate liaison should be established with both Corrective Services NSW and Australian Border Force to ensure effective processes, including early notification, are in place where patients are brought to hospitals from correctional facilities or elsewhere, and detention centres.** Supported. The draft MOU with Corrective Services sets out agency responsibilities for all matters relating to custodial patients. The Ministry is liaising with the Department of Home Affairs (and Australian Border Force) to establish a Memorandum of Understanding for provision of health services to detainees in NSW public hospitals. **55. Local Health Districts/Specialty Networks should establish appropriate liaison with Family and Community Services (FACS) to ensure the safety of staff is maintained during any proposed interventions by FACS staff.** Supported. The Ministry will consult with Department of Communities and Justice. **56. In some parts of the state where there is no established police presence, consideration should be given to discussions with Local Government NSW, the peak organisation representing the interests of NSW general and special purpose councils, with a view to identifying potential opportunities for support in certain security-related circumstances.**

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	Supported. The Ministry will consult with Local Government NSW.

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GOVERNANCE	
11. Each Board of a Local Health District or Specialty Network is accountable for the security and safety of staff, patients and visitors. Consideration should be given to having security / staff safety as a standing agenda item for each Board meeting and, where they exist, each Board sub-committee dealing with audit, risk and compliance. Supported.	
12. The required NSW Health Security Improvement Audit Program is to be fully resourced and implemented in each Local Health District and Specialty Network, and reported to the Board through the Board sub-committee dealing with audit, risk and compliance. Supported. Districts and Networks are undertaking their security improvement audits in accordance with NSW Health policy.	
13. A central security audit function be established with appropriate resourcing to drive compliance and consistency of security policies and standards throughout NSW Health. Supported. The function has been established within the NSW Ministry of Health.	**57. The central security audit function established within the Ministry of Health, should not be confined to one of audit but one of identifying and sharing best practice across the whole system to improve security** Supported.
14. Where there are both Security Officers and Health and Security Assistants (HASAs) in the one location, action must be taken to ensure both groups operate as one integrated team with a strong professional relationship and an ultimate single line of reporting within each Local Health District/Specialty Network. Supported.	**58. That the security function within Hunter New England Local Health District transfer from HealthShare NSW to Hunter New England Local Health District.** **59. That the security function at Royal North Shore Hospital transfer from HealthShare NSW to Northern Sydney Local Health District.** Supported. Implementation will occur in consultation with staff and union(s).

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15. Local Health Districts and Specialty Networks must determine security staffing levels based on an assessment of risk and implement demand driven rostering of security staff to address the identified risk, similar to how clinical staff are rostered. Supported.	
16. Security staff should be positioned so that they are regularly visible in emergency departments, both in the treatment and waiting areas. Supported.	**60. Consideration should be given to embedding Health and Security Assistants (HASAs) in appropriate emergency departments and mental health facilities/units.** Supported.
17. When planning new and redeveloped hospital and health facilities, due regard needs to be given to designing out risk and taking account of the views of clinical and security staff. This should include developing design guides that assist staff and architects to incorporate security into early planning stages. Supported.	**61. Prior to finalising plans for new or redeveloped hospital and health facilities, confirmation should be sought from the Chief Executive of the Local Health District/Specialty Network that the design and layout of the facility has undergone a security review and meets all relevant NSW Health policies and the Australasian Health Facility Guidelines (AHFG). Where relevant NSW Health policies and AHFG requirements have not been applied, the Local Health District/Specialty Network Chief Executive should also be required to confirm that a documented risk assessment, meeting the requirements of work health and safety legislation, has been undertaken.** Supported. A review of current processes will be undertaken. The security planning status will be tracked at each level of project governance. **62. A review of the efficacy and governance of the current process of planning, designing and building health facilities (with particular regard to security) should be considered to ensure that the expertise and views of the facility users are taken into account.** Supported.

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	63. Barriers used at emergency department reception and triage desks and other waiting room/reception areas that have been determined to be at risk, should be of a safety glass design that does not allow a person to climb or reach through and grab at or potentially harm staff. Supported. The relevant chapter in the NSW Health Security Manual *Protecting People and Property* will be updated to reflect this requirement. **64. The width of entry/exit doors to Safe Assessment Rooms (or similar) should be a minimum of the width of one and a half doors. This design principle should be built into Health Infrastructure's Design Guidance Note for Safe Assessment Rooms.** Supported. The Safe Assessment Room design guide incorporates this requirement. **65. Local Health Districts/Specialty Networks should conduct programs for all staff reinforcing the importance of the appropriate use of swipe cards.** Supported.
STANDARDISATION	
18. The security standards set out in the NSW Health security manual Protecting People and Property, and the related policies, should be adopted in every facility as written, and compliance is to be subject to audit. Supported. SIAT assesses compliance with NSW Health Security Standards and identifies those areas of non-compliance to be remediated.	
19. A standardised "Code Black" procedure must be in place in all facilities, in line with that specified in Protecting People and Property, unless a particular localised variation can be justified. Regular practice drills	**66. Consideration be given to introducing a 'potential' Code Black similar to the "Controlled/Planned Code Grey" used in Victoria.**

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should be undertaken so that everyone understands their roles and responsibilities and skills remain current. Supported. Work is being undertaken in Districts to ensure the Code Black procedures are standardised across the District, where this was operationally viable.	Supported. The relevant chapter of the NSW Health Security Manual *Protecting People and Property* will be revised to provide standards for planned Code Blacks and compliance checked as part of SIAT.
	67. During a number of visits, it became obvious that there was an inconsistent approach to a Code Black response. At the commencement of each shift, personnel should be identified who will be required to attend a Code Black if called, and their roles should also be clearly defined and understood. Supported. The relevant chapter of the NSW Health Security Manual *Protecting People and Property* will be revised to include a template to record the Code Black team at the commencement of a shift and compliance checked as part of SIAT.
20. The use and effectiveness of current CCTV operations with particular reference to the prevention, response and evidentiary uses are to be subject to audit to ensure compliance with the NSW Health security standards for CCTV as set out in Protecting People and Property. Supported. SIAT requires evidence of risk assessments used to determine the purpose of CCTV within facilities.	**68. Local Health Districts/Specialty Networks consider establishing, where practical, an integrated district-wide CCTV operation with 24/7 observation monitoring. The Ministry of Health should consider trialling such an operation at two or more Districts.** Supported with qualification. Following a trial, implementation must be based on a local decision by individual Districts and Networks following an assessment of current CCTV coverage and infrastructure; security staffing deployment and local deployment priorities; and the capacity to centrally monitor from a remote location. There is an opportunity to further explore initiatives involving ICT with industry partners as part of this trial.
21. Security audits are to include disaster planning, lockdown procedures and incident management protocols. Supported.	**69. Local Health Districts/Specialty Networks should review their disaster management staffing and protocols.** Supported.

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	70. A review of facility lockdown capability should be undertaken along with an assessment of plans to establish local control centres if required in the event of a disaster or incident. Supported. **71. Security managers should be an integral part of incident and emergency/disaster planning and response.** Supported.
22. Security Officers and HASAs should be part of a state-wide hospital security function enabling mobility through transfers and ongoing professional development. Supported. Mobility provisions are already available and will be described and consolidated into a document for the security workforce. Professional development will be progressed as part of Recommendation 41.	
PATIENT CARE / MODELS OF CARE	
23. The provision of a safe space in emergency departments (in the best interests of both patients and staff) is supported. Examples of such a space are "Safe Assessment Rooms" or "PANDA Units" (Psychiatric, Alcohol and Non-prescription Drug Assessment). Further analysis of the successful Behavioural Assessment Unit (BAU) pilot program at the Royal Melbourne Hospital is required with a view of possible adoption in some major emergency units. Supported.	**72. Consideration be given to developing and testing a locally adapted model similar to the BAU/BOC used in Victoria. In doing so, consideration may need to be given to opportunities within new or redeveloped hospital builds.** Supported in principle. Consultation will occur with key stakeholders, including clinical experts, to review models of care already in place, and determine an appropriate response for NSW. **73. A clinical tool/form should be developed that allows for the assessment and observation of deteriorating patient behaviour as part of routine observation rounds, in order to identify where intervention and management may be required.** Supported.

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	NSW Health Policy Directive *Recognition and Management of Patients who are Deteriorating* describes the standards and principles for the recognition, response to and the appropriate management of the physiological and mental state deterioration of patients.
24. Urgent action is required to overcome delays in mental health assessments which see patients waiting hours for such an assessment, creating a situation not in the best interests of the patient and potential to cause significant security issues for those with challenging behaviours. The use of Nurse Practitioners and Clinical Nurse Consultants (Mental Health) should be considered in this regard. Supported.	**74. The timely availability of MHEC-RAP (and similar programs) in rural areas be reviewed and consideration be given to ensuring that current delays in such assessments and decisions to admit or discharge the patient are reduced.** Supported. The Ministry will work with Districts/Networks to enhance telehealth responsiveness. The NSW Government has committed $20 million as part of its $73 million mental health support package, to expand virtual mental health. **75. There should be greater utilisation of existing accredited persons under the Mental Health Act 2007 who have the authority to either enact or lift a Schedule on a patient and enable timely access to appropriate care including admission decisions. In doing so, a review should be conducted of accredited persons across the NSW health system to identify and address any barriers to their use.** Supported. Districts and Networks will review barriers to use of Accredited Persons. The Health Education and Training Institute (HETI) provides training for accreditation twice a year and Districts and Networks will be encouraged to request additional sessions of this training if required. **76. Immediate action should be taken to overcome the situation whereby Nurse Practitioners, Clinical Nurse Consultants and accredited persons are not able to make timely decisions regarding a patient in order to ensure patients are not experiencing unnecessary delays before receiving the appropriate treatment in the most appropriate location.** Supported.

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	Consideration will be given to extending a pilot/research program to introduce a Nurse Practitioner model of care within selected emergency departments. See also Recommendation 75. The Ministry will also re-emphasise the requirements for assessments under the Mental Health Act 2007 and the need to assess patients in a timely manner. **77. In those locations where assessed mental health patients (or other patients for that matter) are delayed in emergency departments for lengthy periods, they be offered (where medically appropriate) access to nicotine replacement options when they raise the issue of a desire to smoke.** Supported. Currently Nicotine Replacement Therapy (NRT) is a focus for addressing tobacco smoking for mental health consumers. The NSW Tobacco Strategy 2012-2021 provides an overarching framework for the actions that the NSW Government will lead to reduce smoking and tobacco related harm in NSW. **78. Each Local Health District/Specialty Network regularly convene meetings with both emergency department and mental health clinicians to ensure a positive and ongoing interaction.** Supported.
25. There is sufficient positive feedback to justify further consideration of possible expansion of mental health initiatives such as: Operation Pacer in the St George Local Government area; PEAMHATH (Police Early Access to Mental Health Assessment via Telehealth) in Hunter LHD; Resolve Program in Nepean Blue Mountains and Western NSW LHDs; and MHAAT (Mental Health Acute Assessment Team) in Western Sydney LHD. Supported. Refer to Recommendation 79	**79. Consideration be given to expanding the PACER program in metropolitan locations.** Supported. The PACER program has been expanded to 12 Police Area Commands, and funded as part of the COVID-19 stimulus package until June 2021. Evaluation of the program will occur during 2020-21. Implementation would require additional recurrent funding. **80. Consideration also be given to piloting and evaluating Police Ambulance Early Access to Mental Health Assessment via Telehealth (PEAMHATH) in two rural locations**

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	Supported. Consultation will occur with the NSW Police Force.
26. There is a need to reduce stress and improve the waiting experience for people in an emergency department waiting room. Strategies to improve the experience of patients while waiting at an emergency department should be evaluated and where they are found to have had a positive impact on the patient/carer experience and staff safety, consideration should be given to resourcing their expansion across NSW Health. The broader implementation of these successful initiatives, when coupled with mobile security staff frequently moving through the waiting room, will have significant benefits for the operation of an emergency department. Supported The Patient Experience Program has been expanded and is funded, as part of the COVID-19 stimulus package until June 2021. Evaluation of the program will occur during 2020-21.	
27. At times, a patient's condition may require a 1:1 security presence to assist in protecting staff, the patient and property. This is a security function and should never be confused with the individual patient specials (or 'specialling') required to be undertaken by clinical staff. Supported. See recommendation 81.	**81. The nomenclature of "clinical specialling" and "security specialling" is to be adopted to distinguish between a patient requiring clinical supervision and a patient requiring security supervision.** Supported. The NSW Health Security *Manual Protecting People and Property* will be revised to set standards for the appropriate role of security in 1:1 observations. **82. The use of security specials by each LHD be urgently reviewed to ensure the most cost effective provision of same.** Supported.

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Recommendation as amended in Final Report: **28. In future, where a 1:1 security presence is required, that role must be referred to as 'security specialling' and not as a 'special'. Protecting People and Property should be updated to ensure the role and responsibilities of security staff during episodes of 'security specialling' are set out.** Supported.	
CAPABILITY	
29. All staff who work in an area where there is risk of assault/violence are required to undertake security/safety training in a timely manner, and the skills learned should be practised regularly. The training of staff should be subject to audit and the results reported to the Chief Executive and to the Board (or equivalent) through the Board sub-committee dealing with audit, risk and compliance. Supported. The SIAT requires an assessment of compliance with the requirement for all 'high risk' staff to attend violence prevention and management training.	**83. An audit and assessment of violence prevention training, participation, availability of refresher training and location of training should be undertaken. This should include the maintaining of a register of staff who have completed the training.** Supported. The SIAT requires an assessment of compliance with the requirement for all 'high risk' staff to attend violence prevention and management training. **84. A comprehensive review of occupational violence training provided to staff is required. This should include a review of the volume, content and composition of all training provided.** Supported. This will be undertaken by HETI in collaboration with the Ministry, Districts/Networks and relevant Pillars/Agencies. **85. The use of simulated training regarding staff safety and security, particularly for clinical staff, is strongly supported and should be considered.** Supported. Alternatives in delivery and education techniques such as simulations will be included in the training review in response to Recommendation 84.

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	86. Training should be a blended approach between online and face to face with any physical training being delivered as near as practicable to the work location of the person undergoing the training. Supported. Consultation will occur with key stakeholders including HETI and Districts/Networks to identify implementation and funding implications. **87. All staff who have undergone training must be provided with regular local drills and opportunity to practice the physical skills required to maintain their safety during a restraint.** Supported. NSW Health Policy will be updated to provide a drill template to assist with determining the frequency and structure of the required drills. **88. Medical, nursing and allied health colleges be requested to include a module for their students making them aware of their responsibilities for their own safety and for those with whom they work.** Supported in principle. Implementation will be subject to consultation with the university colleges, and at the discretion of the universities. **89. Local Health Districts/Specialty Networks should ensure that during orientation for trainees/students participating in clinical placements, they are acquainted with the practical application of the concept of security and safety being part of the role of the clinical management team.** Supported.
ROLE AND POWERS OF SECURITY STAFF	
30. Security staff should not be referred to as "guards". They should be referred to as security officers or security staff. Supported.	

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31. The following statement from Information Sheet 1 – Role of security staff working in NSW Health, should be promulgated to all health staff: "In all cases security staff should work as part of a team, in collaboration with other staff, to assist with managing patients, to provide assistance to visitors, and to assist with protecting staff and securing the assets of the Agency." Supported.	
32. Clinicians must be informed of, and understand, the role and responsibilities of security staff. They must take action to integrate them into the multi-disciplinary team and include them in team discussions that discuss security/staff safety such as safety huddles and incident debriefs. Supported.	**90. That action be taken to ensure that all staff are aware that security staff are part of the clinical management team and are to be treated as such.** Supported.
<u>Recommendation as amended in Final Report</u> **33. There should be legislative change to:** • **insert a new 'Part' into the Health Services Act dealing with hospital security and safety, recognising the duties, powers, rights and responsibilities of security staff and any related matters that arise from this review that support safety in hospitals** • **ensure there are no legal barriers hampering transport of patients from one part of a hospital to another, where the hospital campus is on two sites.** Supported in principle. The Ministry will consult with the Department of Communities and Justice and the NSW Police Force in relation to this recommendation and recommendation 103.	
34. The re-introduction of "special constables" is not supported. Noted.	
35. In relation to the issue of defensive type equipment for security staff, further investigation of options and practices in other jurisdictions is	**91. Subject to appropriate trials and development of policies regarding their use, standard equipment, in addition to the current equipment**

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required to assess the suitability of any such equipment in the healthcare environment that does not compromise staff or patient safety. Noted. Following release of his interim report, Mr Anderson further investigated defensive type equipment for security staff as discussed in his final report.	**(safety glasses, gloves), should include slash and hypodermic resistant gloves, and flexi cuffs.** Supported with qualification. The process to support the introduction of defensive protective equipment includes consultation with the NSW Police Force and the completion of a risk assessment, considering all risks including potential risk to patients. Any trial would be subject to evaluation in consultation with the NSW Police Force. **92. Given the very strong advice received that two pieces of equipment are necessary in case the first item deployed does not succeed, the use of capsicum foam and control stick are recommended to be trialled as equipment of last resort where there are no other means at hand for staff to defend themselves and/or other staff/ members of the public.** Supported with qualification. As above. **93. Capsicum foam and the control stick are only to be used in circumstances where:** • **Their use is consistent with policy where neither is for the purpose of moving forward but rather as a deterrent in dissuading an advancing threat placing the safety of staff at an unreasonable risk of harm** • **Where isolate and withdraw practices have failed or are not available** • **Where a warning of use has been issued before use as a final de-escalation strategy** • **Consistent with all the above, the last resort is to deploy one or both of the defensive measures** • **Any use is the subject of reporting and review** • **Any misuse is to be considered as serious misconduct.**

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	Supported with qualification. As above. **94. It is strongly recommended the foam and control stick be only available to the most senior and appropriately trained security officer at that time on each shift. I do not recommend nor do I support the general issue of either pieces of equipment to all security staff.** Supported with qualification. As above. **95. The trial of equipment should also evaluate the clinical suitability of use of these equipment in a clinical environment.** Supported with qualification. Clinical risks and suitability will be included in the risk assessment as described in the response to Recommendation 92. **96. An assessment about the use of body worn cameras by security staff should be made following the evaluation of the current trial of body worn cameras for paramedics.** Supported. Consultation will also need to occur with the Department of Communities and Justice and the NSW Police Force regarding the Surveillance Devices Regulation 2014. **97. Consideration should be given to a provision within the Summary Offences Act 1988 whereby only "reasonable excuses" i, vi, vii, as provided in Section 11C(2) shall be applicable to a matter involving possession in a hospital as defined in Section 3.** Supported with qualification. The Ministry will consult with the Department of Communities and Justice and the NSW Police Force to identify any impacts of this recommendation.

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	98. A review of the location and content of all "conditions of entry" signs be undertaken by Local Health Districts and Specialty Networks. Supported. The Ministry will determine a template for signage to ensure statewide consistency. **99. The current authorisation under the Inclosed Lands Protection Act be reviewed to ensure appropriate coverage for each facility.** Supported. Chief Executives will review their current authorised persons with a view to ensuring all shifts are appropriately covered. **100. The policies, documentation and training relating to powers of search and removal of persons from NSW Health premises be reviewed and reinforced with all relevant staff.** Supported. The Ministry will review the NSW Health Security Manual *Protecting People and Property* to ensure the powers to request consent to search are set out. This will be supported with a Practice Guide for security staff on searching. **101. Where a patient arrives under the provisions of the Mental Health Act 2007 or the Mental Health (Forensic Provisions) Act 1990 it should be mandatory for staff to record if a search has been conducted by the transporting agency.** Supported. Consultation will occur with NSW Ambulance and the NSW Police Force with a view to adding a question/answer that captures this in the FAQ supporting the MOU. **102. For any patient, Health staff must understand they are within their rights to ask a transporting agency (that has existing powers to conduct**

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	searches) to search a patient on arrival at the hospital /health facility and a record of such a search should be kept. Supported in principle. Any search can only be conducted in accordance with applicable legislation. Where a search is warranted, reasonable and lawful it should be conducted. Consultation will occur with both NSW Ambulance and the NSW Police Force to ensure there is agreement and communication to the agency front line staff regarding this requirement. **103. In order to overcome the current uncertainty in the minds of many hospital security staff it would be appropriate for a provision to be inserted in the relevant legislation clearly enunciating the fact that staff who have effected a citizen's arrest which is reasonable in all the circumstances shall be afforded the necessary legislative protection.** Supported in principle. The Ministry will consult with the Department of Communities and Justice and the NSW Police Force.
PROFESSIONALISATION OF SECURITY WORKFORCE	
36. It must be recognised that the role hospital security staff undertake is unique to the health environment and is significantly different from any other security role. Noted.	
<u>Replacement recommendation as amended in Final Report</u> **37. Application be made to the Security Licensing and Enforcement Directorate (SLED) to exempt certain HASAs and certain casual staff from the requirement to have a Class 1A Security Licence. The interaction with SLED with respect to the recommendation, should be undertaken by the Ministry of Health.** Supported in principle. Consultation will occur with SLED with respect to this recommendation.	

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38. All security staff uniforms should consist of dark trousers/pants, white shirt with the inclusion of words/logo that identify them as "hospital security". The wearing of combat boots, appointments belts, or any other equipment or apparel that give the appearance of police or military uniforms are not supported. Completed. All Districts and Networks advised that the security/HASA uniform being worn did not include combat boots, appointments belts, or any other equipment or apparel that give the appearance of police or military uniforms.	**104. Security staff (particularly HASAs) should be offered the opportunity to wear white polo shirts rather than white business shirts, provided that the words "hospital security" appear thereon.** Supported with qualification. The decision to change the existing local uniforms would need to be taken by districts/networks in consultation with staff and unions.
39. HASAs should wear the same uniform as security officers so that they are clearly identifiable to staff, patients and visitors. The exception is where they are embedded in a location requiring them to wear similar uniform to other staff e.g. acute mental health unit. Supported See Recommendation 38 and 104.	
40. The title of HASAs should be changed to Security and Health Assistants (SHAs) to more accurately reflect the primacy of their security role, as set out in the award. Mr Anderson stated in his Final Report that this recommendation be deferred pending the outcome of Recommendation 37.	
41. Security staff and HASAs currently undertake the SLED qualification prior to being licensed, the TAFE Security in the Health Environment course, and the violence prevention and management program. This training should be formally assessed against nationally recognised competency standards so that the training undertaken is formally recognised. This would provide the basis for regular assessment of the competencies required and also facilitate a professional development pathway for those seeking advancement. It will also provide an opportunity to introduce topics such as mental health, paediatrics and customer focus.	**105. A series of educational material/ online modules should be developed on clinical conditions as a resource for security staff, to provide guidance and understanding when responding to particular situations in the clinical environment, for example drug and alcohol, mental health, community health, aged care and paediatrics.** Supported. A series of Security Practice Guides will be developed by the Ministry.

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Supported. Work has commenced on the development of a training matrix.	
42. That NSW Health seek to recruit security staff beyond the traditional methods and that an approach be made to universities such as Western Sydney, Charles Sturt and Macquarie as sources for potential security staff. Supported.	
43. Districts/Networks should establish a pool of casual security staff, similar to that for teachers, to enable suitable staff to be identified at short notice. Supported.	**106. In establishing casual pools, Local Health Districts/Specialty Networks must have processes in place to identify those individuals in the casual pool who are available to escort patients on intra-hospital transports or to undertake security observations (security specialling).** Supported.
44. A "Tool box" be developed to assist in having useful interview and scenario questions available to facilitate the identification of suitable security staff. Supported. Consultation on competencies and development of resources has commenced.	
JUSTICE HEALTH & FORENSIC MENTAL HEALTH UNIT	
45. The collaborative model currently operating at the Long Bay Hospital is to be commended. It is evident that the clinical and correctional staff work very well together in a very challenging environment. Noted.	
46. A significant divergence of opinion apparently exists between staff at the Forensic Hospital as to the most appropriate "security" measures that should be introduced. Indeed the vehemently expressed views by staff, with whom the matter of security was discussed at the time of the visit, are diametrically opposed to the position that had been put to me by the	

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union. Expressions such as "I will resign if security are brought in" seem to indicate a significant divergence of opinion amongst staff. Noted.	

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47. Having become aware of certain measures proposed by management of the Forensic Hospital it is believed that those measures should be given the opportunity to be tested. Support for that course of action is predicated on the basis of constant monitoring during the next six months, with a view to further consideration of the matter at that time. Noted.	
RESOURCING	
48. All Local Health Districts and Specialty Networks consider the recommendations from this report and any resourcing implications and make a submission to the Ministry of Health regarding resource requirements. Noted.	
IMPLEMENTATION	
	107. A governance structure should be established to provide monitoring and oversight to ensure the recommendations in this report are addressed and where practicable, implemented, reporting quarterly to the Secretary and Minister for Health. Supported.