Interim Report

Improvements to
security in hospitals

Peter Anderson
February 2019

Improvements to security in hospitals

Introduction

My appointment to lead a review into the safety of staff, patients and visitors in NSW public hospitals was announced by the Hon Brad Hazzard, Minister for Health, on 16th November 2018. The Terms of Reference, attached at Annexure A, required a report by February 2019.

The process adopted in order to meet the timeline for reporting in February was to convene the Working Party, meet with the identified stakeholders and visit several hospitals to meet staff and inspect the facilities. Initially, the hospital visits were to be undertaken prior to Christmas with the exception of the Forensic Hospital which was to be done in January. It was intended that the stakeholders interviewed would submit a formal response to the Review by 10th January 2019 to enable the report to be completed.

The Security in Hospitals Working Party comprised the following:

Peter Anderson	Chair
Phil Minns	Deputy Secretary, People, Culture and Governance
Dr Teresa Anderson	Chief Executive, Sydney Local Health District
Scott McLachlan	Chief Executive, Western NSW Local Health District
Gary Forrest	Chief Executive, Justice Health and Forensic Mental Health Network
Ross Judd	Security Manager, St Vincent's Hospital
Rodney Scott	Security Manager, Wagga Wagga Health Service
Sarah Marmara	Principal Project Officer, System Purchasing Branch NSW Ministry of Health
Attendees – NSW Ministry of Health	
Annie Owens	Executive Director, Workplace Relations
Sharon Litchfield/ Melissa Collins	Director, Industrial Relations and HR Policy
Michelle O'Heffernan	Principal Policy Officer, Workplace Relations
Fiona McNulty	Project Officer, Office of Deputy Secretary PCG

The issues being raised during both the stakeholder consultations and the hospital visits caused a reconsideration of the process being undertaken.

As a consequence further visits and consultations were undertaken during January. This meant that a major hospital in each of the eight local health districts (LHDs) comprising the Sydney metropolitan, Central Coast and Illawarra regions plus the two specialist networks have been visited. Specifically they were: Gosford; Nepean; Westmead; Children's Hospital, Westmead; St Vincent's; Royal Prince Alfred; Prince of Wales, Wollongong; Royal North Shore; and Forensic Hospital. A major (Dubbo) and smaller (Wellington) hospital in the Western NSW LHD were also visited.

Time constraints have prevented the Review from comprehensively considering both the general and specific security issues relevant to regional and country LHDs. It is true that some security issues cross both metropolitan and regional boundaries however the unique challenges confronting regional and country hospitals deserve special consideration in their own right.

The Working Party has met on four occasions and has provided invaluable input into the review.

STAKEHOLDER CONSULTATIONS

The following organisations or office holders have been formally consulted:

- NSW Nurses and Midwives' Association
- Health Services Union
- Australian Medical Association – NSW Branch
- Australian Salaried Medical Officers' Federation (ASMOF) NSW
- Australian Paramedic Association (NSW)
- NSW Health Security Managers Liaison Committee
- Dominic Morgan, Chief Executive, NSW Ambulance
- Commissioner Peter Severin, Corrective Services NSW
- Acting Commissioner Gary Worboys and Deputy Commissioner Jeff Loy – NSW Police Force
- Assistant Commissioner Anthony Crandell, Commander, NSW Police Educational Services
- Police Association of NSW
- Weapons, Tactics, Policy and Review Unit of NSW Police Operational Safety & Skills Command
- Australian Security Industry Association Limited (ASIAL)
- NSW TAFE
- SafeWork NSW

STAKEHOLDER SUBMISSIONS

The following organisations or office holders provided a written submission:

- NSW Nurses and Midwives' Association
- Health Services Union
- Australian Salaried Medical Officers' Federation (NSW)
- Australian Paramedic Association
- SafeWork NSW
- Justice Health & Forensic Mental Health Network
- Barrier Industrial Council (BIC)

A number of private submissions have also been received and considered from a range of individuals both within and from outside the NSW Health system.

From the outset I advised everyone with whom I met that I wished them to be frank in their discussions otherwise everyone would be wasting their time. Where assertions were made that required "testing" that was done and on many occasions documentary supporting evidence for certain matters was requested and received.

PREVIOUS INQUIRIES AND REPORTS

I wish to make it clear that with regard to many of my findings and recommendations they are in part based on what is already happening in one or more places depending upon the particular issue.

A substantial amount of policy documents, reports and briefing papers were made available to me by the NSW Ministry of Health. Every request for additional information was promptly acceded to by the Ministry.

I deliberately refrained from reading the following documents until January to see whether I was forming some of the same conclusions to be found in those reports:

- BRI Report – NSW Health Emergency Department Security Review 2016
- Violence in Healthcare Taskforce Report Victoria 2016
- Occupational Violence against Healthcare Workers Victoria 2015
- Occupational Violence Prevention Hospital and Health Services Taskforce Report Queensland 2016

Significantly the broad thread of these reports remain the focal point for the matters being raised with me by the stakeholders consulted and during the visits to the hospitals.

Over the last three years an enormous amount of effort has been expended in promulgating a myriad of policies and initiatives dealing with the issue of safety and security, resulting from the 12 point plan on hospital security developed in February 2016, and those recommendations relating to hospitals from the Inquiry into violence against emergency services personnel. In light of this significant and ongoing effort it is a matter of considerable concern that the objectives underlying this work have not been consistently achieved across the NSW Health system.

Improvements to security in hospitals

Review Findings

The NSW health system has always been extremely complex and has undergone a variety of changes with regard to both administration and the provision of clinical services over the past three decades.

From an administrative perspective the most significant of these changes was the devolution of responsibility to local health districts and speciality networks. This means that when looking at security across the state, what becomes apparent is the variation in the way security is managed in local health districts and specialty networks and the way security practices and policies are interpreted and put in place. This is further compounded by the separation and variation that exists within the districts themselves. The fundamental difficulty in this regard is that there is no standardisation of the approach to security.

Providing security in hospitals requires a wider approach than just that of an individual hospital. There needs to be relationships within a hospital, with other hospitals and health facilities in a district, and those relationships should also stretch across districts to neighbouring hospitals and facilities. Relationships with such agencies as NSW Ambulance, the NSW Police Force, Corrective Services NSW and Australian Border Force, are equally as important.

With the increase in global security threats in recent years, we have witnessed unprecedented levels of cooperation between organisations involved in security both at the domestic and international level. Here in Australia substantial improvements have been achieved within and between organisations having a security focus.

Similar consultation and co-operation is required across the board in the NSW health system with regard to security services.

All this is occurring at a time of ever-increasing hospital presentations creating challenges in emergency departments (EDs) and wards. These challenges range from: addressing the demand for acute and sub-acute mental health services; drug (particularly ice) and/or alcohol affected people; hospital services for the escalating numbers of aged and ageing persons; and, meeting the result of ever increasing anger-related presentations as well as treating weapon-inflicted injuries.

Any delays in the timely movement of patients through EDs can increase the pressures on EDs. However where it impacts on patients with behavioural disturbances who of necessity are awaiting assessment and having to undergo stays in busy EDs, then this leads to an increasing security risk.

This is best illustrated by the increasing use of the incorrectly titled security "specials" whereby a 1:1 security presence with a patient is required due to a patient's behaviour. In Victoria and in South Australia they are referred to a 'sitters'. In the health system the use of the term "special" always refers to a clinician providing specific care to a patient. The use of security officers to be positioned on a 1:1 basis near a patient should not be referred to as "specials".

A major problem that has been identified relates to the process when a person arrives at an ED and whose behaviour is a matter for concern. The person may have been a "walk-in" or been brought to the hospital by police, ambulance or corrective services. If the person is suffering injury then obviously the injury needs attention. The person may also or alternatively be exhibiting significant behavioural issues which create a potentially dangerous security/safety situation.

The necessity for a coordinated and health-focussed security focus and service across the state has never been more self-evident.

CULTURE OF SAFETY AND SECURITY

It is evident from all the consultation and observation that there needs to be a clearly understood and mandated culture of safety and security across the health system.

Security is everybody's business and everybody's responsibility. It must permeate the organisation from the top down i.e. it must be led by the Chief Executive and acceptance of and adherence to the culture cannot be left to the individual. Above all there cannot be different views across local health districts and speciality networks. There is a compelling case for the Master Licence to be held by the Chief Executive (as it is in some LHDs) with the opportunity to appoint a "close associate" under the provisions of Section 5 of the Security Industry Act 1997.

All staff must be involved in the promotion of and adherence to the new culture. It is all about eliminating risk where that is possible. In this regard it was of some concern to hear on more than one occasion that the security suggestions by clinical (and other) staff were disregarded in planning new facilities.

Basic security is as simple as ensuring that "swipe" doors are not propped open or used to allow members of the public to access parts of facilities they are not entitled to use. Attempting to undertake a lockdown of part or all of a hospital becomes that much more difficult if staff continue to do things such as those referred to above and observed during many visits.

Equally it is also about extremely busy people ensuring that things are not left lying around even for a few minutes which could be accessed by people who might misuse them or use them as a weapon.

GOVERNANCE

Above all it needs to be understood that security is not a "facilities" matter it is a "governance" matter. To this end the issue of security should be a standing agenda item for all boards and, where they exist, sub-committees dealing with risk, audit and/or compliance. It matters not if there is a nil report to boards or sub-committees, assuming there is nothing to report, it does however establish a commitment to the process and sets an example for all others in the system.

The greatest threats to an effective security system is complacency.

It must be clearly understood by all that adopting policies and then failing to implement those policies is indefensible. It is best exemplified by the situation where security manuals are interpreted and applied differently. Evidence to the Review suggested that there was a lack of uniformity with regard to a Code Black.

Arguments opposing standardisation of matters such as these beggar belief.

One of the most worrying matters relates to the wearing or rather non-wearing of duress alarms. Several reasons were given as to why this occurs. Problems identified by staff need to be addressed in a timely manner so that the duress alarms can serve the purpose for which they were recommended and purchased.

Similarly, if an item, such as a security door, requires repair or replacement that action should be undertaken as soon as possible. If that action is to be delayed for budgetary or some other reason, such as contractor delays, then that delay and the reason for such delay needs to be signed off by the Chief Executive and noted by the Board.

CCTV exists in a number of locations. The issue remains how many are constantly monitored? Are all systems effective from an evidentiary perspective? It also raises the question of district-wide coverage from both a total security perspective generally and a CCTV viewpoint in particular.

As it was my intention that any recommendations to be made by the Review would be evidence-based, I sought information as to the capacity of the Incident Information Management System (IIMS) system to provide specific information as to: time; day of the week; type of event; and other relevant information upon which to base specific recommendations particularly as to staffing levels. I was advised that the current system was unable to provide that information however I was briefed on the considerable work that had been undertaken to upgrade the IIMS system. This included a proposed pilot scheme for the new upgraded incident management system, known as ims+, to be conducted in this year (2019) with the intention of a full rollout of the upgraded system by late 2020.

In almost every consultation I have undertaken, I have been advised that there is a "culture" of under-reporting in IIMS of incidents relating to violence and aggression against staff, particularly in EDs. Data suggests the number of recorded incidents of

this type in EDs averaged barely one per day. It was consistently contended that ED staff did not input into IIMS (for a variety of reasons) whereas staff in mental health and wards generally did. This response was so widespread that it made reliance on the current IIMS statistics problematic.

This is in no way to downplay the substantial number of incidents in non-ED locations but rather to point out it would be prudent not to rely on those figures as the basis for immediate specific decisions.

It was disturbing to say the least to hear during my hospital visits from experienced doctors and nurses about the increase in aggressive and violent behaviour that they are experiencing, and the apprehension this brings.

There was also some reluctance on the part of clinical staff to become involved in any physical "takedowns" of patients.

Adoption of and adherence to a culture of safety and security would of necessity require all staff to input all appropriate matters into IIMS. Conversely it is necessary that at the very least the new ims+ enables a speedy inputting of an incident, identification of the person making the entry and follow up of the incident being reported.

UNDERSTANDING THE ROLE OF SECURITY OFFICERS

There is a clear lack of understanding of the powers and responsibilities of security officers. As a consequence security officers are regularly being asked (or directed) to do things that are outside their role, responsibility and powers. To a very great extent this problem could be best handled by adopting the "clinically-led" team approach (which includes security) that has been proven to work so well in some places.

For such an approach to work effectively it falls to medical staff in particular to fully appreciate their own role in the security effort and to ensure that all those who are likely to be confronted with a security incident (including security officers) are aware of each other's responsibilities and above all to work as a team. In the same way any debriefing held subsequent to an "event" should involve all relevant personnel involved in the event including security.

It is also both counter-productive and in my view unsustainable for clinical staff to become aware that a potentially "difficult" situation may be about to arise and not to immediately inform security who may be required to attend.

It is in everyone's interest to have early warning and identification of a potential problem. The existence of a sound and proven "team" approach will almost certainly contribute to the way in which volatile situations can be effectively handled in a less volatile manner.

POLICE LIAISON

A Zero Tolerance approach must be adopted regarding criminal offences committed against patients, staff and members of the public in or on health facilities.

There is an understandable reluctance for staff to become involved in the criminal justice process as a witness. The reality is that unless action is taken against offenders they will continue to offend. Courts should be given the opportunity to impose an effective deterrent against such behaviour. This alerts the general public that offences against hospital staff will not be tolerated.

Any staff member who is such a witness should be encouraged and supported in assisting the police. This should include the staff member being accompanied during the taking of a statement by the police, whether at the hospital or at the police station, and also being accompanied if attending court. Any reluctance on the part of police to charge such offenders should be the subject of discussion at the local police liaison committee or formalised to the Commissioner of Police.

These committees work extremely well in some places and less so in others. The relationship between the Chief Executive and the Local Area Commander is the key. All LHDs should review the operation of such committees in their district and maximise their effectiveness. Districts where a particular hospital services a number of Police Local Area Commands (LACs) can be challenging but nevertheless important in achieving a coordinated process.

PATIENT CARE/MODELS OF CARE

One the most challenging matters considered by the Review relates to the regularly occurring scenario where a person is brought to an Emergency Department (ED) and causes major problems and concern due to their behaviour. It may be due to illness, drugs, alcohol, mental health some other cause. The behaviour can cause considerable distress to other patients, relatives, staff and members of the public.

In situations where a mental health assessment is required, and the patient presents with challenging behaviours, there can be lengthy delays on occasions of up to several hours awaiting that assessment. During this period the person cannot be sedated as an assessment cannot then be undertaken while that person is under sedation. During this lengthy wait, the challenging behaviour can escalate and security risks are heightened.

All this is, in theory, taking place adjacent to other patients in the ED some of whom may be paediatric patients.

Psychiatric Emergency Care Centres (PECCs) have been established at a number of hospitals. Other locations have adopted a slightly different approach.

I was advised on several occasions (from different sources) of the establishment of a Behavioural Assessment Unit at the Royal Melbourne Hospital. The objective of the unit was, as reported in Emergency Medicine Australia, to "assess the impact of a new model of care for patients presenting to the ED with acute behavioural disturbance."

The Research concludes "A unit specifically designed to improve the care of patients requiring prolonged ED care due to mental illness and/or intoxication reduces the time spent in the ED and the use of some restrictive interventions. We recommend this model of care to EDs that care for this complex and challenging group of patients." A further observation was that "we observed fewer Code Grey events and episodes of mechanical restraint and therapeutic sedation."

Further consideration is required of the potential for the current trial in some selected EDs to improve the patient experience whereby there are dedicated staff whose role is to keep patients and their families up to date on their treatment plan while they are waiting. It is also necessary to consider an extension of the Nurse Practitioner and Clinical Nurse Consultant roles in addressing delays in EDs for particular circumstances whereby escalation of difficult situations can be averted or minimised.

SECURITY STAFF

In addressing the Terms of Reference a major focus must of necessity be on security staff in the hospital system.

There has been a multitude of suggestions regarding the issue and viewpoints range from one extreme to another.

Security staff include Security Officers, Health and Security Assistants (HASAs) and private/contracted security personnel.

What the hospital system **does not** require are security staff that:

- Do not understand that their role is not that of a nightclub bouncer and building guard
- Have a "punitive" attitude to their role
- Do not understand that their role is one of being part of a clinically-led team
- Do not have a commitment to the policy of de-escalation as the first response
- Think it is acceptable to sit down and spend time on their mobile phones
- Want to be quasi police in either appearance, attitude or performance
- Need to be special constables.

What the hospital system **does** require are security staff that:

- Understand that hospital security is significantly different from any other security role
- Are covered by their own "Part" of the relevant legislation i.e. Health Services Act
- Have a Health related "subclass introduced to Class 1 licences under the Security Industry Act. A modification to the Section 36 requirement re wearing of licence to be advocated or an exemption sought under Section 36(2) from the Commissioner of Police.
- Perform their role as part of a clinically-led team approach including the active participation of security in the clinical consultation team and being involved in debriefings
- Receive support from clinicians and others in the system in the discharge of their duties
- Form part of a state wide career structure that enables security staff to have effective mobility between locations
- Security officers and HASAs become part of the same structure with a single line of reporting
- That HASAs wear the same security uniform as security officers
- The title of HASAs be changed to Security and Health Assistants (SHAs) to more accurately reflect their role as detailed under the Award
- Have standardised core competencies that are reviewed annually together with an appropriate program of professional development
- In the discharge of their duties, exemplify a commitment to a "customer focus" while at the same time establishing their presence as a proactive deterrent. This will involve a subtle, but more obvious, presence encouraging interaction with patients, staff and the public as they move around a hospital.

Recruitment and retention

Consistent concerns were expressed regarding the difficulties being experienced in recruiting and retaining security staff. What is required is the right skill set, life experience, confidence and interpersonal skills. It has also been suggested that a "tool box" be developed to assist by having useful interview and scenario questions.

It would be remiss of me not to mention my perception of the great difficulty in recruiting people for a position that by definition is both security and cleaning etc. The situation in the non-metropolitan areas where the dual role is helpful is understood, however the situation in the metropolitan areas is not quite so clear cut.

It is recommended that an approach be made to universities that have substantial student bodies in undergraduate and postgraduate programs, particularly in criminology, policing and security studies. Such universities include Western Sydney University, Charles Sturt University and Macquarie University. Several thousand

students are so engaged and are looking for career opportunities both during their studies and on graduation.

The recruitment of 15 security staff in 2016, whereby candidates without a security licence were selected on their capabilities and their potential to work as hospital security staff, is a recruitment model worthy of further consideration. NSW Health sponsored these 15 staff to complete the four week vocational training, *Certificate II in Security Operations*, to obtain their security licence, following which they were placed in employment.

Security Uniform

The issue of a standard uniform for all security staff has been the subject of considerable divergence of opinion with the majority clearly coming down on the side of the current dark trousers/pants, practical shoes and white shirt with the word "security" embroidered thereon.

The majority view of white shirt with dark trousers/pants is therefore supported with one minor but nevertheless significant change. In order to ensure a clear differentiation between security personnel working in the hospital system and others such as those in shopping centres, nightclubs and the like, the following change is strongly suggested i.e. the word "hospital" in the same size lettering to be added to the word "security" on all uniforms. This small measure clearly reinforces the concept that security is part of the hospital itself and adds to the customer focus approach to be projected.

Consideration was given to using the word "health" in preference to "hospital", however I am convinced that the word "hospital" has, compared to "health," a more positive connotation that adds to the concept of customer focussed and professional security staff.

In considering the issue of uniform two very different approaches to uniform were encountered. The unique approach adopted regarding security uniforms in Sydney LHD has some merit and the arguments in support and the response to that "uniform" are understood. Although an attractive uniform, I did find it a little difficult to identify the "security" aspect of the uniform when viewed from a distance. I note that there is nothing but praise for the work done by security staff at Sydney LHD. Nevertheless it is felt that a standard approach is warranted.

The second example was Northern Sydney LHD. At the outset I wish to stress that I received nothing but praise for the work being done by the security staff. Indeed it was gratifying to hear of the extremely successful de-escalation approach they employed. The visual aspect however is one of concern. The vest, "appointments" type belt, "combat" boots and trousers/pants project a clear policing appearance and I found it somewhat confronting in the hospital setting. It must be re-stated that it is readily apparent that the excellent outcomes they achieve are due to the way they discharge their duties not because of the way they are currently dressed.

Equipment for security staff

By far the most vexed issue considered is that of what equipment should be issued to security staff. The current situation is that security staff are issued with protective eyeglasses and gloves. This reality is not understood by some non-security staff in the system.

There is almost universal opposition to the issue of batons and handcuffs to security staff. This opposition includes many security staff themselves. Opposition ranges from the possibility that a baton could be taken off a security officer and used as a weapon against staff. Another objection relates to the creation of an offensive rather than a defensive perception i.e. non-threatening.

Throughout the consultations and visits undertaken, I regularly raised the following worst case scenario and requested a response.

> *A person enters the waiting room of an ED and commences to cause a disturbance for whatever reason. Staff, patients and members of the public of all ages in the ED waiting room are concerned or more likely fearful.*

> *Quite properly all staff involved, including security, will then implement the policy and training they have received in order to de-escalate the situation. For whatever reason the situation worsens dramatically and police are called. It may be a hospital that does not have a 24 hours police presence nearby. Conversely it could be an extremely busy Local Area Command (LAC) who are unable to respond immediately.*

There are recent examples of persons being armed with a knife or machete in an ED that fortunately, have not manifested into a worst case scenario and the situation has been managed by security and other staff, and police.

To return to the question I posed, no one has been able to provide an acceptable answer. Obviously if the situation can be de-escalated, that is the preferred outcome. However it does not always happen nor are the police always able to arrive swiftly.

Obviously it is preferable to have patients, staff and the public remove themselves from the scene of the threat – this may not always be possible or realistic.

Advocates of capsicum spray fail to accept that the nature of the spray is such that it can spread far and wide causing difficulties for others through secondary exposure, including potentially harming not only the person it is being used on but others in the vicinity.

It should be noted that Victoria Police announced in 2013 (as reported in the Age of 22nd September, 2013) that they were moving away from capsicum spray to a *"capsicum streamer"* which has a much narrower target range than the spray. It is of even more interest that Victoria Police had already introduced a *"capsicum foam"* in 2004 for use in areas such as hospitals and trains.

Earlier this year (according to the ABC) the Victorian Government provided stab-proof vests for security staff in hospitals starting with high risk areas.

In December 2018 the ABC reported that the West Australian Health Department had called tenders for the provision of *"body armour vests"* to protect hospital and security staff from "bullets, blades and spikes".

The tender document referred to above states that the vests must: "*offer protection from multiple threats, including ballistic projectiles and will incorporate a high level of stab and slash protection from common sharp objects, including steak knives, screw drivers and other pointed and serrated objects."* The vests would also need provision for the attachment of capsicum spray and body-worn cameras.

This subject warrants further investigation to ensure that staff are properly protected from harm while also ensuring that the safety of staff, patients and visitors is not compromised.

Rights and responsibilities of security staff

A consistent theme from stakeholders and the hospitals related to confusion in both theory and practice as to the rights, powers and responsibilities of hospital security officers. The point should also be made that they should not be referred to as *"guards"* but either security officers or security staff. The word *"guard"* has a connotation that does not fit with the role in hospitals.

It is also clear there is considerable uncertainty in the minds of security staff. It is true that there are legislative provisions that empower hospital security staff. The common law also provides for certain situations. The reality is that security staff are uncertain of their legal position and this can be easily remedied so that they are able to discharge their duties confident in what the law is.

The most effective way to achieve this is to set out the duties, powers and responsibilities for security officers in one place i.e. a specific Part in the Health Services Act.

Another issue is exemplified by the situation at Royal Prince Alfred Hospital where some buildings are separated from others by Missenden Road. In practical terms this creates very real difficulties in terms of patient management and the powers of security staff. A simple solution would be to provide the opportunity for the curtilage of a site to be declared by way of a gazetted regulation as a "hospital" for the purposes prescribed**.**

Professionalisation of security staff

A constant theme to emerge was that hospital security staff are different from other security staff. Any proper examination of their role clearly endorses that proposition. This reality leads to the conclusion that the current licensing regime under the Security Industry Act 1997 does not reflect the true nature of the work of hospital security staff.

All hospital security staff including HASAs must hold a Class 1 licence under the Act. Class 1 licences are divided into 6 subclasses:

- Class 1A   - Unarmed Guard
- Class 1B   - Bodyguard
- Class 1C   - Crowd Controller
- Class 1D   - Guard Dog Handler
- Class 1E   - Monitoring Centre Operator
- Class 1F   - Armed Guard

All holders of operator licences must be employed by the holder of a Master licence.

There are those who may argue that a Class 1A covers the role of hospital security. This is not reflected in the various duties undertaken by hospital security staff and has a completely different focus to that envisaged by Class 1A.

Action should be taken to have a Class 1G subclass created specifically for hospital security. It should specify the competencies and training applicable to the hospital security role.

An issue of concern to many security staff relates to the provision of Section 36 of the Security Industry Act requiring the holder of a class 1 licence to wear the original licence so that it is clearly visible. It is proposed that such requirement be removed for hospital security or failing that an exemption be sought for hospital security staff from the Commissioner of Police under the provisions of section 36(2) due to the special nature of the licensee's duties.

What has become clear is that hospital security staff need some career structure. This would reduce problems associated with "mobility" within the hospital system. There needs to be some consideration of a program of professional development and potential performance recognition.

Above all the current system whereby a hospital security staff applicant has to have gained their class 1 licence from the Security Licensing and Enforcement Directorate (SLED) at their own expense and in their own time. They then, after appointment, have to attend and undergo the three day TAFE course together with NSW Health's Violence Prevention and Management training.

A small group should be authorised to undertake a review of all the training currently undertaken by hospital security staff. The objective would be to achieve an outcome whereby all the training undertaken might result in a recognised "Certificate" and establish a pathway whereby that qualification could be upgraded or enhanced.

Improvements to security in hospitals

Recommendations

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*".

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.

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.

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.

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.

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.

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.

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.

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. Representations should be made to permit staff of hospitals or other health facilities who are victims of assault to use the business address rather than their personal address when pressing charges or taking an AVO against an individual.

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.

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.

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.

13. A central security audit function be established with appropriate resourcing to drive compliance and consistency of security policies and standards throughout NSW Health.

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 a single line of reporting within each Local Health District/Specialty Network.

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.

16. Security staff should be positioned so that they are regularly visible in emergency departments, both in the treatment and waiting areas.

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.

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.

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 should be undertaken so that everyone understands their roles and responsibilities and skills remain current.

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*.

21. Security audits are to include disaster planning, lockdown procedures and incident management protocols.

22. Security Officers and HASAs should be part of a state-wide hospital security function enabling mobility through transfers and ongoing professional development.

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.

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.

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.

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.

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.

28. In future, where a 1:1 security presence is required, that role must be referred to as '1:1 security support' and not as a 'special'. *Protecting People and Property* should be updated to ensure the role and responsibilities of security staff during episodes of 1:1 security support are set out.

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.

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.

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.*"

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.

33. There should be a 'Part' of the Health Services Act dealing with hospital security and safety setting out the duties, powers, rights and responsibilities of security staff and any related matters that arises from this review that support safety in hospitals. This should also enable resolution of situations regarding the transport of patients from one part of a hospital campus to another where there is a public road between the two facilities.

34. The re-introduction of "special constables" is not supported.

35. In relation to the issue of defensive type equipment for security staff, further investigation of options and practices in other jurisdictions is required to assess the suitability of any such equipment in the healthcare environment that does not compromise staff or patient safety.

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.

37. A new subclass covering "Hospital Security" should be introduced to Class 1 licences under the Security Industry Act. A modification to the Section 36 requirement in the current security industry legislation, mandating wearing of the licence be sought failing which an exemption should be sought under Section 36(2) from the Commissioner of Police.

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.

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.

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.

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.

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.

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.

44. A "Tool box" be developed to assist in having useful interview and scenario questions available to facilitate the identification of suitable security staff.

JUSTICE HEALTH AND FORENSIC MENTAL HEALTH NETWORK

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.

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

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.

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.

Terms of reference

Improvements to Security in Hospitals

1.   Introduction

1.1   The Ministry of Health (the Ministry) is engaging a consultant (the Consultant) to identify and consider whole of NSW Health strategies for security in hospitals (including those in the Justice Health and Forensic Mental Health Network) to ensure staff, patients and visitors are kept safe from violence and aggression (the Project).

2.   Background

2.1   In January 2016, a violent incident occurred in the emergency department of Nepean Hospital when a police officer and a member of the security staff were shot by a patient who seized the police officer's gun.

2.2   In February 2016 a Roundtable was convened and involved unions, frontline staff and managers. *A 12 Point Security Action Plan on Hospital Security* was developed and endorsed by the then Health Minister (**Attachment 1**).

2.3   Action has been taken to implement all actions within the *12 Point Security Action Plan on Hospital Security*, noting that some actions, such as embedding a stronger work, health and safety culture and rolling out the new incident management reporting system (ims+) are of a long term nature.

2.4   Action 3 from the *12 Point Security Action Plan on Hospital Security* required an audit of 20 emergency departments (the remainder of the emergency departments completed a security self-assessment). Every emergency department then developed a plan (the Remedial Action Plan) to address areas of non-compliance identified through the external or the self-assessment.

2.5   Every emergency department also implemented actions arising from the recommendations from the external ED audit report (the Implementation Plan).

2.6   In February 2018 the Government submitted its response to the *Legislative Assembly Committee of Law and Safety – Report of the Inquiry into Violence Against Emergency Services Personnel*. A number of the recommendations reflected and reinforced the value of the work that was already underway as part of the *12 Point Security Action Plan on Hospital Security*.

2.7   Recent incidents at Blacktown Hospital, where a nurse was stabbed after a patient gained access to an unsecured staff meal room, and Nepean Hospital, where a person adjacent to the entrance of the emergency department wielded a knife, have further highlighted the risks present for staff, patients and visitors when exposed to individuals exhibiting threatening or disturbed behaviours

3.   Scope and purpose of the Project

The Consultant will, in undertaking the Project, have regard to but will not be limited by the matters listed below:

3.1   Consider the impact of the *12 Point Security Action Plan on Hospital Security* in setting a framework for improving hospital security.

3.2   Invite submissions from relevant stakeholders, including but not limited to the Health Services Union, the NSW Nurses and Midwives' Association, Australian Salaried Medical Officers' Federation and the Australian Medical Association.

3.3   Consider any additional state-wide strategies that are required to achieve further improvements to security in NSW hospitals (including those in the Justice Health and Forensic Mental Health Network), with a particular emphasis on any changes required to NSW Health policies, practices and legislation.

3.4   NSW Health and its staff acknowledge that the responsibility for public safety always remains the role of NSW Police. Nevertheless the future role of NSW Health security staff and contractors will be examined.

3.5   Have regard to previous inquiries and reports and the decisions taken by Government and NSW Health in response.

3.6   Have regard to the relevant best practices in other Australian and NZ health jurisdictions and the appropriateness or otherwise for their adoption in NSW.

3.7   Specifically consider the effectiveness of the TAFE/NSW Health training program on security and safety that has been implemented under the 12 point action plan.

3.8   Recommendations are to take account of the fact that NSW Health retains as its core function the provision of health services to promote, protect, develop, maintain and improve the health and wellbeing of individuals. Care still needs to be provided to people who are coping with serious illness and injury which may impact on behaviour, while ensuring that the workplace is safe for staff, patients and members of the public.

4.   Key deliverable and work product, completion timeframe and key contacts

4.1   The Project requires that the Consultant provides a report addressing the specified scope and purpose.

4.2   The Project Report will contain recommendations, with commentary on the rationale for each recommendation.

4.3   The Consultant will be supported throughout the Project by an internal Departmental Working Party and appropriate administrative support provided by the Ministry of Health.

4.4   The Project Report will be submitted to the Secretary of the NSW Health by no later than **Wednesday 14 February 2019**. Any potential slippage in the timeframe for submission of the Report should be advised at the earliest possible opportunity.

5.   Policy Context

5.1   The Consultant will have due regard to the following relevant NSW Health Policy Directives:
- Protecting People and Property NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies (the Security Manual)
- PD2018_013 Work Health and Safety Better Practice Procedures
- PD2015_001 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach
- PD2017_043 Violence Prevention & Management Training Framework for NSW Health Organisations
- PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW
- PD2015_004 Principles for the Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint
- Memorandum of Understanding – NSW Health and NSW Police Force (2018)
- PD2010_024 Fire Safety in HealthCare Facilities
- PD2014_004 Incident Management Policy
- PD2015_043 Risk Management - Enterprise-Wide Risk Management Policy and Framework - NSW Health
- GL2015_007 Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments
- GL2013_002 Management of NSW Police Force Officers' Firearms in Public Health Facilities and Vehicles
- GL2006_014 Aged Care – Working with People with Challenging Behaviours in Residential Aged Care Facilities

Action Plan arising from Security Roundtable   Attachment 1

1. Deliver an intensive program of multi-disciplinary training of ED staff including nursing, security and medical staff in managing disturbed and aggressive behaviour and ensure each member of the multi-disciplinary team is clear about their respective roles.

2.
   - Deliver a program to engender a stronger workplace health and safety culture and ensure all staff, including junior doctors, nurse graduates and other rotating staff are adequately inculcated into the safety culture
   - Ensure clinical unit and hospital managers are specifically trained to understand and give effect to their Workplace Health and Safety obligations and ensure their local workplaces have a zero tolerance to violence

3. Undertake a detailed security audit of the following EDs:
   - Bankstown Lidcombe Hospital
   - Blacktown Hospital
   - Blue Mountains Hospital
   - Byron District Hospital
   - Calvary Mater
   - Cooma Hospital
   - Hornsby Ku-ring-gai Hospital
   - John Hunter Hospital
   - Nepean Hospital
   - Orange (noting co-location with Bloomfield)
   - Prince of Wales
   - Royal Prince Alfred
   - Royal North Shore
   - Shoalhaven
   - St Vincent's Hospital Sydney
   - Tweed Heads Hospital
   - Wagga Wagga Rural Referral Hospital
   - Wellington Hospital
   - Wollongong Hospital
   - Wyong Hospital

   The audit will cover compliance with policy and mandatory training requirements, adequacy of ED design in managing aggressive patients, adequacy of security staff numbers, hospital liaison with local police on incident response to acts of physical aggression in EDs, and handover by police of physically aggressive individuals requiring treatment.

   The audit will recommend any strengthening of policies and procedures needed for EDs, in particular to adequately respond to behaviours of individuals, affected by alcohol or drugs, including psycho stimulants such as "ice", presenting at EDs.

4. Establish a working group to recommend strategies to increase the professionalisation of NSW Health security staff and how best to integrate their roles in a multidisciplinary response to patient aggression.

5. Partner with TAFE to train existing security staff in a security course purpose designed for the health environment.

6. Sponsor the recruitment of a new intake of trainees to qualify as security staff through the health specific course and recruit and train further staff following consideration of the results of the security audit.

7. Establish a Reference Group of expert clinicians to develop specific patient management and treatment pathways, including disposition and transport options, for patients presenting to EDs under the influence of psycho-stimulants such as "ice", both for immediate management and longer term referral and treatment.

8. Immediately examine availability of Mental Health and Drug & Alcohol resources including the use of telehealth options for rural and regional areas for patients presenting to EDs under the influence of psycho-stimulants such as "ice", both for immediate management and longer term referral and treatment.

9. Work with NSW Police to ensure arrangements adequately and consistently cover liaison, firearms safety, handover and incident response involving aggressive individuals presenting at public hospitals including pursuing prosecution of offenders.

10. Examine whether legislative changes are required:

    - to make clear that a victim's status as a health worker, which is already an aggravating factor when sentencing an offender convicted of assault, covers hospital security staff.

    - to provide adequate legal protection to security staff who act in good faith and under the direction of health professionals, who require assistance in order to render lawful medical treatment or care of patient.

11. Identify the circumstances in which security staff are able to exercise power to remove from public hospital premises individuals who are not patients and who are acting aggressively or who are otherwise causing disruption.

12. Improve incident management reporting systems to ensure they are user friendly, well utilised and provide transparent management and feedback loops to staff making the reports.