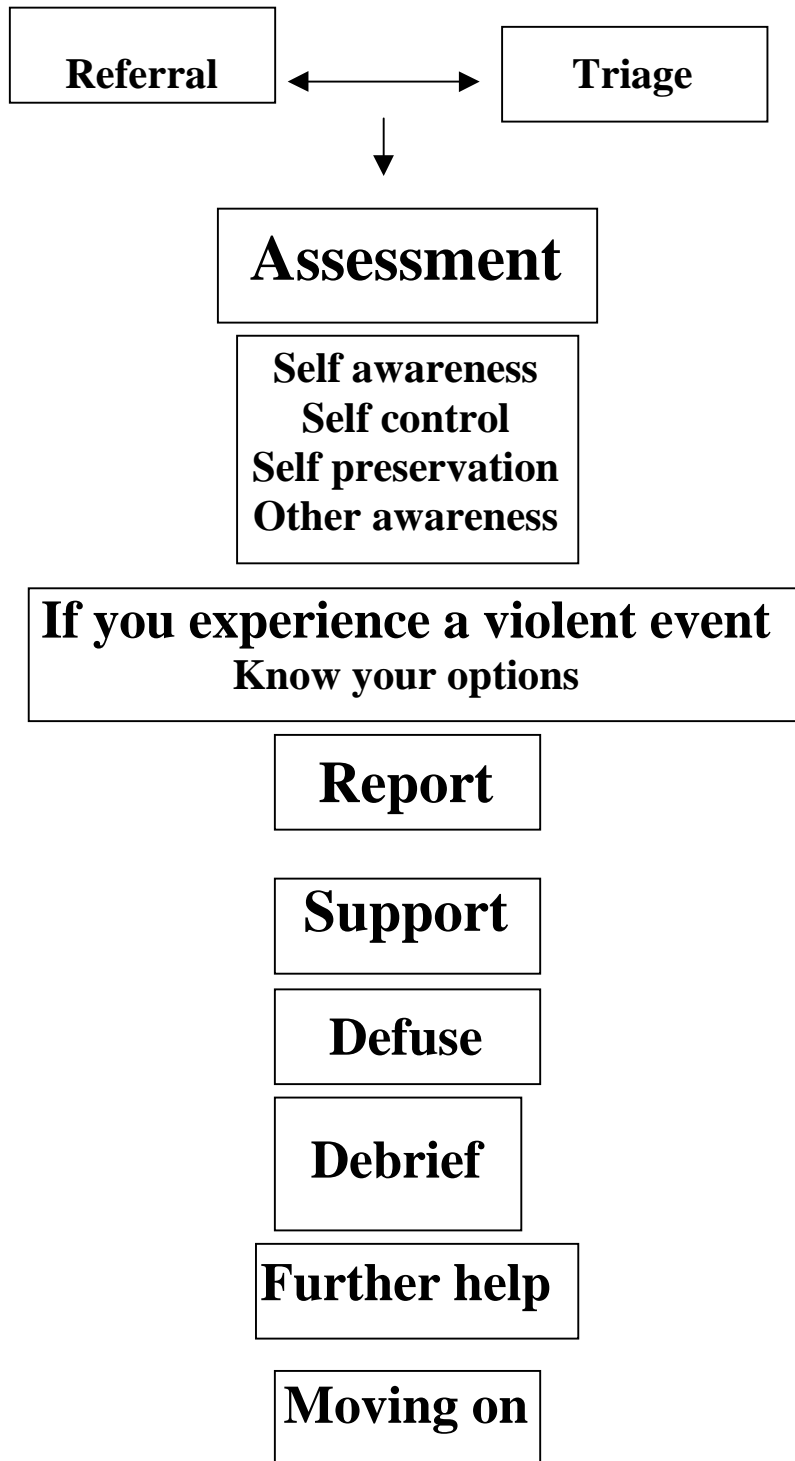


**PREVENTING WORKPLACE VIOLENCE:  
TOWARD A BEST PRACTICE MODEL  
FOR WORK IN THE COMMUNITY**

**The model**

**A BEST PRACTICE MODEL FOR VIOLENCE PREVENTION  
IN COMMUNITY WORK**



## APPENDIX 4 WORKPLACE VIOLENCE PROJECT

### **The model: An abridged version**

As can be seen, the model has several features. Some of these features are based on the document by Cherry and Upston (1997) who gave permission to use and modify their work for this project, and Bowie (1996) who developed a range of strategies to deal with violent situations. The element of 'other awareness' developed from recognition that there is minimal attention paid to the need to assess clients for cues suggesting that they may be in a volatile state, often a precursor to violence.

The model (see figure 1) consists of nine awareness and action options. These are; (1) at referral and triage, (2) assessment including four components: self awareness, self control, self preservation, other awareness, (3) awareness of options if a violent event is experienced, (4) reporting the incident (5) support, (6) defuse, (7) debrief, (8), follow up and (9) moving on. Recognising that prevention is not always possible, development of strategies to minimise the effects of violence is an integral part of the model.

### **Referral**

Clients are referred via the organisation's Call Centre (a 24 hour service) from a variety of sources, including General Practitioners (GPs) and other community agencies. As one question of many questions asked at referral we suggest the following:

*Is there any reason to think that this person or others in the house may pose a threat to the safety of our staff?*

Clients who are referred by self, friend or by a neighbour could be dealt with as part of triage.

### **Triage**

This is a vetting and allocation process of newly referred clients. At this stage, further enquiries before the initial visit are made. This involves contacting the client's GP (or other agencies that may have knowledge of the person), and asking the same questions:

*Dr. Mack, a Mr Fred Brown has referred himself/been referred by a friend/neighbour to us. Is there any reason to think that this person or others in the house may pose a threat to the safety of our staff?*

Contact and response should be noted. Following triage, the referral is sent to the appropriate admitting team.

### **Assessment**

Client assessment follows triage and acceptance. Assessment is data gathering enabling formation of a clinical judgement and preparation for care planing but we suggest it includes an assessment of potential for violence as an extension of the process.

### **Self awareness**

Self-awareness is a vital aspect of preventing a violent incident. Concepts within this element include:

- self knowledge.
- recognition of personal values, prejudices, fears and emotional and anger triggers.

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### **Self control**

Maintaining conscious self control in a threatening situation is vital for safety.

### **Self preservation**

Self preservation includes identifying risk factors and minimising risk. Most importantly, if concerned about personal safety while visiting a client at home, leave as quickly as possible.

### **'Other' awareness**

The element of other awareness evolved out of the work of the PAR group. It refers to the need to be 'other/s' focussed during the assessment and care process, identifying subtle cues that may indicate a potential for violence. Unless the assessment is 'other'/client focussed instead of task focussed, these cues may be missed.

### **Knowing the options in a violent situation**

This section acknowledges that despite best efforts, violent episodes may still occur. It is not an endorsement of the popular view that acts of violence are spontaneous, random and unpredictable. Bowie's options for dealing with violence have been described previously.

### **If a violent event is experienced -**

A simple flowchart shows steps to be followed.

### **Report**

It is crucial that all incidents are reported, no matter how trivial they may seem. Reporting forms the basis of assessing the prevalence of violent episodes. Further, when an incident is reported, strategies to modify the client's behaviour can be developed.

### **Support from management and peers**

Peer support groups are a means of helping staff members through a difficult period. Such a group can be influential in reducing a 'blame the victim' response. Research (Lanza and Carifio 1991) indicates that a common response to violence is 'the nurse must have done something wrong'.

Following a report of violence, the support and defusing team is activated. The function of the team is to provide support and an opportunity for the injured party to defuse.

### **Defuse**

*Defusing* is a team process, which includes workmates/friends as part of the defusing team. Defusing is an opportunity to 'take the heat' out of the situation. Defusing is undertaken as soon as possible after the event and should involve everyone affected by the incident.

### **Debrief**

If further help is required a more formal *debriefing* process is established through an Employee Assistance Programme or equivalent. It is *not* a role for staff colleagues. The function of debriefing is to speed recovery for those involved in a violent event who experience normal stress following an abnormal event.

### **Moving on or further help**

Defusing and debriefing are not always successful. Under certain circumstances eg if reactions increase rather than decrease referral for in depth counselling may be indicated.

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The model relies on the organisation's formal Occupational Health and Safety Committee (now called ESR Committee) to implement the model. The model is used to underpin orientation programs and provides content of the ongoing staff development programs.

### **References**

Bowie V. 1996 *Coping with Violence - A Guide for the Human Services* Melbourne: Karibuni Press

Cherry, D., and B. Upston. 1997. *Managing Violent and Potentially Violent Situations: A Guide for Workers and Organisations*. Melbourne: Centre for Social Health