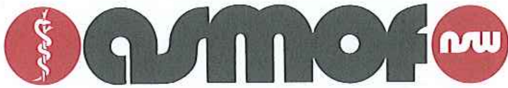
Australian Salaried Medical Officers' Federation (New South Wales)

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31 August 2017

Ms Elizabeth Koff
Secretary
NSW Ministry of Health
Locked Mail Bag 961
NORTH SYDNEY NSW 2059
By post & email

Attention: **Ms Michelle O'Heffernan**
By email: **mohef@doh.health.nsw.gov.au**

Dear Elizabeth

RE: REVISED NSW HEALTH SECURITY RELATED POLICIES

Thank you for the opportunity for the Australian Salaried Medical Officers' Federation (NSW) ('ASMOF') to provide our feedback to the Ministry on NSW Health security related policies – namely, "Protecting People and Property Manual" and "Violence Prevention & Management Training Framework for the NSW Public Health System – PD2012_008".

Annexed to the ASMOF letter is the template provided by the Ministry with our preliminary feedback.

In addition, ASMOF makes the following comments:

Comment 1 with respect to Code Black Teams
(referenced under the section headed "Code Black Arrangements" on and from page 65 of the Ministry's consolidated draft revised policies)

ASMOF is aware of the common practice for Medical Officers from prevocational to advanced trainee level to be rostered to Code Black teams, without any training on how to approach these situations. They are usually 'counted in the numbers' for purposes of team physical restraint (therefore Category 3 staff under PD2012_008). Furthermore, ASMOF is also aware that they are unable to be properly trained for the task given the requisite 3-day Violence Prevention and Management ('VPM') training course is impractical for the large groups of Medical Officers who rotate through afterhours rosters. Consequently, they receive no training at all and yet are still rostered to respond to, and potentially be involved in restraint of, aggressors where the need arises. Given the escalation in violence in NSW public hospitals this is clearly an issue.

From a work, health and safety perspective, ASMOF proposes that either a) Medical Officers are appropriately trained for involvement in Code Black teams, or b) their clinical role (i.e. attending to medical management and patient welfare) in Code Black situations is more specifically defined, with an exemption from involvement in restraint processes.

Comment 2 wrt Surveillance Camera
(referenced under the section headed "Camera Surveillance" on and from page 12 of the Ministry's consolidated draft revised policies)

ASMOF proposes that the live feed from the surveillance camera be visible not only at staff stations in emergency departments but also to the patients and their relatives as they are standing at

reception. This is to ensure they are made aware their behaviour is being monitored/recorded and may (hopefully) encourage them to behave more respectfully and appropriately.

Comment 3 wrt Mandatory Requirements
(referenced under the section headed "Mandatory Requirements" on and from page 74 of the Ministry's consolidated draft revised policies)

The section is rather vague. Specifically, what do these "mandatory requirements" entail with respect to VMP training? Will there be a combination of online modules and hands-on training, and/or simulated situations as well? And will the training include de-escalation strategies, both individual and team-based approaches to situations?

Comment 4 wrt Emergency Lockdown
(the new requirement referenced on page 57 of the Ministry's consolidated draft revised policies)

Will the emergency lockdown procedure be mandated by NSW Health, or will it be left at the discretion of each Local Health District or the individual emergency departments to decide?

Comment 5 wrt Police Officers and the Carrying of Firearms in Emergency Departments

There is no description relating to when police officers may carry firearms in emergency departments. ASMOF considers that they should only be allowed to carry weapons under strict criteria (or not at all) to minimise the risk of their weapons being commandeered by a perpetrator who may have a mental health issue, or is violent, or is under the influence of drugs / alcohol.

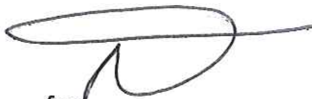
*   *   *

The above comments and annexure are provided to the Ministry on a preliminary basis.

Please keep ASMOF informed of developments, including communicating to us any further revisions envisaged by the Ministry.

Please direct correspondence on the matter to Tiffany Tran, Industrial and Policy Advisor, at tiffanyt@asmof.org.au, or by phone contact on 02 9212 6900.

Yours sincerely



for
Dr Tom Karplus
Secretary
ASMOF NSW

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LHD / Branch / Pillar	Section Title	Pg #	Paragraph #	Feedback / Suggested Change / Amendment
	using mechanical restraint on patients			It is suggested that this section should include a statement that prone restriant should NOT be used in NSW Health facilities due to the risk of physical harm to patients to whom it is applied.
	using mechanical restraint on patients			This section currently suggests that the decision to apply mechanical restraint is led by "the nurse". ASMOF proposes that the decision should be led by a medical officer, unless there is no relevant medical officer present or contactable the senior nurse is responsible.
	using mechanical restraint on patients			The section should specifically mention that the use of mechanical restraint will trigger various obligations such as use of a restraint register.
	section on emergency departments (ED)			The section should include additional obligations of the health service: to move any behaviourally distrurbed / violent or potentially violent patient out of the ED in compliance with ETP targets (ie within 4 hours of arrival). As currently written, the policy does not address the widespread practice of health services leaving these patients in ED for prolonged periods of time, and such practice only increases the need for sedation and restraint, and impacts heavily on ED staff and other patients.
	section on the ED			The section should state that room sizes / clinical treatment spaces in the ED should comply with the minimum size outlined in the ACEM guidelines.
	section on the ED			The section should state that multiple patients, e.g. on "treatment chairs", should not be placed in a treatment space or room designed for one patient.
	section on the ED		,	The section should explicitly state that ED overcrowding and access block cause increased wait times for ED patients and must be eliminated so as to reduce potential wait times and overcrowding in ED (when a violent incident occurs in ED, overcrowding puts more patients at risk).
	section on the ED			Please correct the reference to ACEM: it should read the "Australasian College for Emergency Medicine" and not as it's currently written.
	section on the ED			The section should state that potentially violent patients being brought to the hospital for known care (e.g. scheduled mental health patient from the community, patients from corrective services, or interhospital transfers) should not be transferred to the receiving hospital ED, but should go directly to the location of definitive care (e.g. the site mental health unit; the ward; the outpatient clinic etc.). This will minimise hand overs, minimise exposure of staff and other patients, and minimise total time the patient is at the health facility.
	section on staff ID badges			The processes outlined appear to be excessive to the risk, and the likely outcome is that processes and bureaucracy faced by staff will be even more onerous than existing practices, for no improvement in safety at work.
	section on staff ID badges			The requirements outlined should not obstruct the ability of staff to work at the facility, for example, there should be adequate notice of review / updating of ID, and this should facilitate ease of this process particularly for part-time, rotating and out of normal hours staff.
	section on staff ID badges			There should be an easy, immediate/on the spot way to get a short term badge if a staff member leaves it at home; for students, observers, etc.

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	section on staff ID badges			All processes should recognise the need for clinical work to continue at any time day or night in the face of a badge being lost or misplaced, as clinical environments often experience shortages of staffing level that they cannot afford losing a staff member in the event of lost or misplaced badge.
	section on staff ID badges			What about locums?