**REMOTE AREA WORKFORCE
SAFETY & SECURITY PROJECT**

REMOTE HEALTH WORKFORCE SAFETY & SECURITY REPORT:
LITERATURE REVIEW, CONSULTATION, & SURVEY RESULTS

Citation: CRANAplus 2017. *Remote Health Workforce Safety and Security Report: Literature review, Consultation and Survey report*. CRANAplus, Cairns

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Table of Abbreviations

AHW	Aboriginal and Torres Strait Islander Health Worker, including AHPRA registered Indigenous Health Professionals. While the full term will usually be identified, AHW is used in tables and documents where format limits space
AMRRIC	Animal Management in Rural & Remote Indigenous Communities
COAG	Council of Australian Governments
CRANAplus	Peak professional body for the remote and isolated health workforce of Australia
CRANApulse	CRANAplus weekly email newsletter
CPPT	Culture, Prevention, Protection, Treatment
CPTED	Crime Prevention Through Environmental Design
FIFO	Fly-In Fly-Out
4WD	Four Wheel Drive
GPS	Global Position System
IHP	Indigenous Health Professional
IVMS	In Vehicle Monitoring System
MEC	Maternity Emergency Care
OHS	Occupational Health and Safety – used when referring to the title of past research & publications, and including current Victorian & Western Australian legislation
PLB	Personal Locator Beacon
PTSD	Post-Traumatic Stress Disorder
RAW S&S	Remote Area Workforce Safety and Security
RDAA	Rural Doctors Association of Australia
RAN	Remote Area Nurse
RRMA	Rural Remote Metropolitan Area
WA	Western Australia
WHS	Workplace Health and Safety
WSR	Workplace Safety Representative

Executive Summary

Introduction

Remote health workforce safety & security has been a long-standing concern. In early 2016, assaults on Remote Area Nurses (RAN) and the murder of RAN Gayle Woodford sparked a groundswell of anger and distress within the health industry, professional organisations, the public, and political leaders. Government and Industry looked for response strategies to promote workforce safety and security.

The Remote Area Workforce Safety & Security Project is a twelve-month CRANAplus initiative funded by the Commonwealth Department of Health. The project outputs comprise:

1. Facilitating a national conversation about concerns and ideas regarding the safety and security of the remote health workforce – stakeholder consultation.

2. Developing practical safety and security guidelines for remote health practice

3. Undertaking a literature review, to build on existing work done on safety and security in remote health

4. Developing an industry handbook on 'Being Safe in Remote Health'

5. Creating an easy to use safety and security 'self-assessment tool'

6. Developing a free online learning module on 'Working Safe in Remote Practice'

7. Providing input into the CRANAplus App to include the 'Being safe in Remote Health' information; and

8. Ensuring appropriate resources are made freely available for use by the broader remote and rural workforce.

This report documents two project outcomes:

- A literature review on safety and security in remote health will be available, building on the 2012 'Keeping People Safe' Literature Review of *the Working Safe in Rural and Remote Australia Project*

- Facilitating a national conversation about concerns and ideas regarding the safety and security of the remote health workforce.

The Rural Doctors Association of Australia (RDAA) implemented a rural and remote workforce safety project in 2011. The RDAA *Working Safe in Rural and Remote Australia* project report is recommended as valuable background reading on this issue. The two projects have different guidelines and target populations, so care needs to be taken with extrapolating the results from one project to the other.

Methodology

The Remote Area Workforce Safety and Security project has involved the completion of a literature review, the conduct of stakeholder interviews, and a survey completed by ninety currently/recently practicing remote area clinicians. The compilation of these three components form the basis of a draft report that was provided to the project's Expert Advisory Group, with feedback resulting in minor editing before publication.

The Project used a multi-faceted approach to identify and collect published and 'grey' literature for the literature review. With the assistance of the Australian National University Research Library staff of the Canberra Hospital Library, searches were undertaken of several electronic databases.

During national consultation, symposia were held involving 194 participants. Meetings were also held with 68 representatives from 23 government and community organisations; and questionnaires were completed by 90 health clinicians who were currently or recently working in remote areas.

At meetings, individual discussions and through questionnaires, it was reinforced that the project's goal is to document information and, through this process, identify positive responses and interventions available to promote improvement to remote health workforce safety and security.

All State and Territory Health Departments were written to regarding the project and were invited to contribute any policy or strategic initiatives or evidence to help inform the project.

Literature Review Results

The literature review identified that the national healthcare workforce is experiencing an increased rate of assault. Staff working alone and in isolation are at greater risk of serious assault due to their limited access to rapid security response systems. Remote and very remote populations in Australia experience higher rates of disease and health risks. The remote health workforce is also exposed to many of these risks while being under considerable burden to provide services in a difficult and resource limited environment. Considerable effort has been made to research and document the remote health workforce's perception of risk factors, impact of risk factors on clinicians and, to a lesser extent, options to promote workforce safety and security. Existing recommendations should be considered further according to Workplace Health and Safety regulations.

The remote health workforce is ageing, and workforce numbers per 100,000 population have decreased. Availability of adequate numbers of experienced and new staff is important to maintaining workforce safety, security and wellbeing, as well as providing an appropriate level of service to remote community residents.

Apart from the *Working Safe in Rural and Remote Australia* project, research has primarily focused on risks and violence to the remote area nursing workforce. Analysis of known severe episodes of injury and death of the remote health workforce over the past twelve months suggests that being female, in or around your own accommodation, and after hours' times are risk factors. While available information is likely incomplete, it appears that severe assaults are more commonly criminal events than actual worksite violence. It is not clear how frequently perpetrators are motivated by intended sexual assault, however this is a risk factor requiring recognition in staff induction and orientation.

Workplace Health and Safety regulations provide a legal structure identifying the rights and responsibilities of employers and employees. However, there are gaps in implementing regulations, and effective monitoring of regulation compliance is difficult in remote health services. The industry will benefit from all stakeholders developing a better understanding of WHS legislation and regulation, and how it can be used to promote safety and security.

Violence and general risk assessment tools have a role in supporting the safety and security of the remote health workforce. However, their actual contribution to ensuring safety is limited, and availability/use of such tools does not shift employer WHS responsibilities onto the individual.

Research to date has predominantly identified perceptions of violence and risk issues, with little research identifying the characteristics and effectiveness of different interventions. This is needed to inform the industry about how to benefit from resources available to promote workforce safety and security. Positive information and successful initiatives need to be more frequently identified in literature and the media.

Industry specific literature has focused on violence, to the detriment of other significant threats to remote health workforce safety and security. Other issues warranting research and intervention include: Vehicle and travel safety; Dog attack; bullying and harassment; and personal health and wellbeing.

Consultation and survey results

Twenty-five percent of questionnaire participants reported that the Aboriginal and Torres Strait Islander communities in which they worked had no Aboriginal or Torres Strait Islander Health Workers. The absence of Indigenous clinical staff impacts negatively on both the cultural safety of services available to communities, and the safety of RANs and other members of the remote health workforce.

Aboriginal and Torres Strait Islander Health Workers identified that some hazards and risks they experienced were the same as those experienced by RANs, but many were different. If an angry or drug affected person came to the clinic intending to harm staff, everyone would be at similar risk. Aboriginal and Torres Strait Islander health staff were more susceptible to internal family and community violence – domestic violence, community punishment, or assault by others trying to project blame onto others.

RANs and other health staff, were at increased risk because they frequently did not know the personality or background of community residents or visitors. They were also at increased risk at times, as they were usually last to be aware of tensions in the community and the likelihood of violence. External staff were at times more susceptible to property damage and violence because investigation and punishment for the offence was a slow, unwieldy process which often remained incomplete.

The characteristics of remote communities were often identified as impacting on population health and staff safety. Several respondents noted that many communities themselves are experiencing social disruption, creating difficulty in contributing to sustained safety activities. Rather than blaming small communities for their problems, respondents identified that communities needed assistance to engage more in health activities. As one clinician stated, 'Communities have to be the solution, not the problem'.

While not identified in research, dog attack was the most frequently identified work related risk raised by RANs. Dog attack also impacts on service provision, as it keeps clinicians from engaging with the community.

Remote health workforce recruitment, turnover and churn impacts on service provision and staff safety. Health services, two government supported staff mobilising agencies and approximately 130 Nurse Recruitment Agencies operate throughout Australia. All agencies and mobilising services contacted acknowledged some responsibility to ensure that health services and new recruits were made aware of safety issues such as insecure accommodation & recent assaults. They were also amenable to ensuring staff were provided with workplace safety guidelines if this was identified as industry best practice.

While some employers seem to achieve reasonable staffing continuity, there is a trend for clinicians to approach remote area work as a limited duration interest. Some clinicians limit their planned remote experience to one placement of a few months to two years. Other clinicians start with long term plans, only to cut back to short contracts as remote area work wears them down. Many clinicians identified that they could cope with frequent workplace change, but were less able to cope with working continually in one location.

Road travel in remote areas involves increased risks, and uses driving and vehicle skills not generally required by urban residents. Most health services stipulate that a manual driver's license is mandatory. However, fewer services have clear ideas about what driving skills and training their staff need. Many remote workforce members were quite scathing about the lack of preparation of staff for bush driving. It was noted that even basic 4WD courses did not prepare one for driving long distances on dirt roads in varying weather conditions.

The traumatic events of 2016 have motivated remote health stakeholders to prioritise workforce safety and security. Project consultation has identified that practical interventions are occurring at all levels, although not in all locations. It is important to acknowledge efforts made, and support wider uptake of these initiatives.

However, progress and compliance to date has not been consistent. Some services and managers do not seem to understand their legislated responsibilities, still believing that clinicians are primarily responsible for their own safety. Similarly, some clinicians are undermining safety and security systems. Many clinicians have identified that they felt bullied into not implementing safety guidelines by staff who did not believe risk exists, or who preferred to work alone, allegedly so their own poor clinical practice was not observed by others.

Many participants in the remote health industry identify bullying as being a significant stressor. While some examples seem to reflect the emotional pressures experienced by many managers and clinicians, other examples alleged unprofessional behaviour. Several clinicians reported that bullying by management had resulted in their now only working through recruitment agencies. A few RANs provided evidence of managers using AHPRA complaint notification systems. Only months later, after significant emotional, professional and financial cost, did the relevant Board determine that the clinician concerned had no case to answer.

Managers identified fewer examples of bullying. Some RANs had been known to threaten to resign if specified demands were not met. Also, some managers have been placed in the impossible position of being required to improve service safety while meeting performance indicators that involve budget efficiencies.

Horizontal violence – that perpetrated by clinicians against peers, usually working in the same clinic, was the type of bullying most frequently identified during project consultation. FIFO staff identified bullying by peers as the most common reason for them declining to return to a clinic. They also identified that having 'good staff' at a location was a significant motivator for them to apply for or accept further offered contracts.

The lesson from this feedback is that the workforce itself has a core role in promoting or weakening safety and security. Sometimes differences of opinion will best be resolved through using interpersonal communication. At other times, proactive management interventions are required to promote the safety and security of staff.

Conclusion

Part A of this document, the Literature Review, built on the 2012 *Working Safe in Rural and Remote Australia Project* report, and noted the conclusions of additional available research published from 2011 onwards. National Model Workplace Health and Safety guidelines prompted re-consideration of some pre-2010 research finding and recommendations. Analysis of violent / trauma events involving the remote health workforce over the past 12 months resulted in re-evaluation of what was previously accepted as the major hazards and risks affecting staff safety and security.

Part B of this document collated information provided during industry and community consultation. It also reports on findings from the questionnaire completed by 90 currently or recently practicing members of the remote health workforce. This information reinforced many of the priority issues identified in the literature review. Consultation also identified significant safety and security issues not prioritised in research, and provided up to date information about the opinions and motivation of Fly-In Fly-Out RANs, an increasingly significant component of the total remote health workforce.

In preparing this report, the project has gathered comprehensive information about issues influencing remote health workforce safety and security. This provides a sobering account of the challenges faced by clinicians and managers.

Many of the identified issues can be responded to positively with limited cost implications, although the contribution of industry stakeholders is required to progress change. However, other initiatives involve considerable costs. Procurement, repair and maintenance of facilities, accommodation and equipment will require the contribution of funding agencies.

Using the information compiled from the literature review and industry consultation, the project is now well placed to progress with the completion of other outputs. These will support remote health stakeholders to promote workforce safety through the effective use of workplace guidelines, risk assessment tools, training, and industry resources. Other strategies, such as education of incoming clinicians about safety and security issues, clinician communication and de-escalation training, and orientation options for Fly-In Fly-Out staff will require future inputs by employers and professional organisations.

Australia's remote health sector is committed to engage in their role and contribute further to the health of the community. However, the traumatic events occurring through 2016 have challenged their capacity to do this. A three-pronged response requires: Reducing the risk of assault; Improving workforce knowledge and skills in activities that support safe implementation of their clinical role; and Reducing bullying and promoting personal wellbeing across the industry through education & supportive supervision by management.

Activities based around this approach will improve the capacity of staff to enter, practice, and remain safely in the remote health workforce.

The following summary of issues and recommendations provides a guide forward:

Issue	Recommendations
1 Workforce injury and death Analysis of known severe episodes of injury and death of the remote health workforce over the past twelve months indicates that being female, in your accommodation, and after hours' times were risk factors. Assaults are commonly perpetrated with criminal intent.	• Security of accommodation needs to be based on crime protection through environmental design, quality construction techniques, and timely maintenance. • All facilities to be audited annually for compliance with safety & security guidelines. • Incoming staff need to be informed of risk issues and educated around effective and consistent use of safety guidelines before commencing work. • All episodes of assault or injury to be reported by the workforce and collated by employers through a formalised reporting process.
2 Staff assaulted during Business Hours & On-Call Past research and project consultation has identified unacceptable levels of violence and aggression towards staff.	• Workplace safety guidelines should identify that RANs are always accompanied on-call and at other work times when risk issues are identified • All call-outs should be externally monitored and identify time, nature of call-out, patient/caller ID and safe completion of the episode of care. • All remote health services should develop, resource, implement and review workplace safety guidelines. • Prior to commencing work, staff orientation should identify safety issues & safe work guidelines.
3 Responding to critical events Research reports that staff feel under skilled in assessment, communication, & de-escalation of critical events.	• Training should be developed and rolled out for the remote health workforce with content including Risk Assessment, Communication, and De-escalation skills.
4 Locating and assisting staff when something goes wrong The remote and isolated health workforce lacks consistent & effective early response and locator process.	• Clinic, accommodation, and if required, personal alarm systems should be assessed & as necessary upgraded to emit a loud local alarm as well as alert off-site monitoring services. • Remote health vehicles should be fitted with a GPS tracking device. Depending on work location & use, an Epirb (locator beacon) and more complex real time vehicle monitoring systems should be considered. • Personal alarms should be considered for larger and more complex health centres and services.
5 Workforce driving skills, MVAs Staff reported inadequate preparation for hazards resulting from driving 4WD vehicles in varying climate conditions on remote dirt roads.	• Staff who have formal first respondent (Ambulance) responsibilities should be educated and resourced as 'emergency service workers' in accordance with the jurisdictions first respondent processes. • Training and experience is required in safe and effective basic maintenance, trouble-shooting and changing a flat tyre. • Training and experience in basic 4WD skills. • Training and experience on long distance driving in remote areas on dirt roads in varying weather conditions.

| 6 | **Workforce emergency communication equipment** | • All remote health vehicles should be equipped with a Satellite phone. |

6 **Workforce emergency communication equipment**

Many staff are untrained and lack experience in effective use of emergency communication equipment. Staff reported that satellite phone communication was often unreliable

- All remote health vehicles should be equipped with a Satellite phone.
- Training and practice in Satellite phone set-up, use and troubleshooting of reception issues should be completed prior to staff working on-call.
- Where in use, training & practice with HF radio transceivers should be completed prior to staff working on-call.
- Annual communication equipment maintenance should be included with the health vehicle maintenance schedule.

7 **Workforce Fatigue**

Environment, workload & wellbeing pressures result in fatigue, reducing staff capacity to work effectively and respond rapidly to critical events.

Staff are expected to self-monitor wellbeing rather than this being a shared employer & employee responsibility.

- Employers should actively manage fatigue through a fatigue management program/process. Including monitoring of rosters, on-call hours worked, timely use of leave, and supportive staff supervision to identify and respond to fatigue and challenges to wellbeing.
- Professional/Clinical supervision should be available for and required of all remote health clinicians and managers.

8 **Staff retention**

Staff attrition, turnover and churn challenges capacity to consistently implement safety and security guidelines. The transient workforce has limited opportunity to engage with communities in which they work.

- Managers have the primary responsibility of proactively monitoring the workplace environment and intervening where required to fulfill WHS obligations.
- Further rollout of the CRANAplus Bullying App and other resources is required to support individual clinicians and engage the workforce in how to manage workplace bullying.

9 **Violence and trauma data**

There is limited statistical information available on which to identify and analyse the incidence and characteristics of violent and traumatic events involving the remote health workforce.

- A register of Remote Health Workforce Assault and Trauma should be maintained to monitor incidence and nature of events to better inform preventive actions. The register should be cross-jurisdictional and use a standardised data set.
- Research should be undertaken about the incidence and characteristics of workplace violence perpetrated against remote health staff, and effective preventive and response strategies.

10 **Reduced number of Aboriginal & Torres Strait Islander Health Workers in many indigenous communities**

The lack of AHWs in many health centres increases workforce safety risks and diminishes the capacity of services to provide culturally safe health care.

- Relevant organisations should be supported to undertake further work about this workforce shortage.

11 **Dog attack**

Dog attack/dog bite is a frequently occurring form of injury experienced by the remote health workforce.

- Education resources e.g. AMRRIC videos to be a mandatory component of remote health workforce orientation.
- Health Services and professional organisations to initiate contact with animal management services to promote working safely around dogs.

12 **Workforce safety & security not adequately promoted**

Lack of national safety & security standards contributes to varying quality of, and compliance with employer safety guidelines.

- National remote health workforce safety and security standards are required to provide compliance benchmarks for health service Safety & Quality programs
- Sharing information about successful interventions through industry presentations & other communications motivates managers and clinicians to take control of implementing effective workforce safety initiatives.

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1   INTRODUCTION

Remote health workforce safety & security has been a long-standing concern. It has been a consistently identified theme in industry literature since the 1990's[1]. In early 2016, assaults on two Remote Area Nurses and the murder of RAN Gayle Woodford sparked a major groundswell of anger and distress within the industry, professional organisations, advocacy groups, the public, and political leaders. At national level, consultation looked for response strategies to support the industry and isolated communities.

The Remote Area Workforce Safety & Security Project is a Commonwealth Department of Health initiative implemented by CRANAplus. The project is to be completed over twelve months from July 2016 to June 2017. Project outputs comprise:

1. Facilitating a national conversation about concerns and ideas regarding the safety and security of the remote health workforce – stakeholder consultation.

2. Developing practical safety and security guidelines for remote health practice

3. Undertaking a literature review, to build on existing work done on safety and security in remote health

4. Developing an industry handbook on 'Being Safe in Remote Health'

5. Creating an easy to use safety and security 'self-assessment tool'

6. Developing a free online learning module on 'Working Safe in Remote Practice'

7. Providing input into the CRANAplus App to include the 'Being safe in Remote Health' information; and

8. Ensuring appropriate resources are made freely available for use by the broader remote and rural workforce.

The project target group – the remote health workforce - is identified as including Remote Area Nurses & Midwives, Aboriginal and Torres Strait Islander Health Workers, Allied Health staff, Medical Officers, on-site support staff (drivers, administrators) as well as visiting clinicians and health service managers.

It is, however, recognised that RANs are the professional group most frequently living alone in remote communities, most frequently identified as assault victims, and whose safety and security issues have been most widely documented. While the project focus is on the remote health workforce, it is recognised that project documentation & resources may also be of use to other remote area workers and residents. This report documents two project outcomes:

• A literature review on safety and security in remote health will be available, building on the 2012 Literature Review of the *Working Safe in Rural and Remote Australia Project*
• Facilitating a national conversation about concerns and ideas regarding the safety and security of the remote health workforce.

1.1   Background: The working safe in rural & remote Australia project

The Working Safe in Rural & Remote Australia project was implemented by the Rural Doctors Association of Australia (RDAA) in 2012[2]. The project was the collaborative work of the RDAA, The Australian College of Rural and Remote Medicine, the Australian Nursing & Midwives Federation, the Police Federation of Australia, the Queensland Teachers' Union, and CRANAplus. The project report & literature review provides a comprehensive background description and analysis of safety & security issues affecting Teachers, Police and Health staff in rural and remote Australia. The report reviewed international and national literature from the late 1990's to 2011.

The RDAA report is required reading for anyone seeking to understand the background to current safety & security issues affecting the remote health workforce. The report's Executive Summary is included as Attachment 1 of this literature review. The complete Working Safe in Rural & Remote Australia report is available on-line at https://crana.org.au/files/pdfs/RDAA_draft_final_report_-_October_2012_20121018030356(1).pdf

While the Working Safe report provides essential background information, there are significant differences between the RDAA Project and the Safety & Security Project.

1.2   Scope of the two projects

The RDAA literature review equated 'working safe' to 'available literature on the prevalence, risk factors and impact of workplace violence in rural and remote Australia'. Additionally, of the three identified categories of workplace violence (External, client initiated, and internal), the Literature Review focused on client initiated violence – that inflicted on workers by customers or clients.

The Remote Area Workforce Safety & Security project identifies a broader interpretation of the topic, including the three identified categories of workplace violence as well as other significant safety & security issues including: after-hours/on-call roles; vehicle/travel & communications; accommodation; animal management; and impact of the remote context on personal safety and wellbeing.

The RDAA project took a 'whole of community' approach', looking broadly at how violence impacting on the target industries could be reduced in rural & remote Australia, allocating respondents according to Rural, Remote and Metropolitan Areas (RRMA) 4-7. The mandate and outputs of the Remote Area Workforce Safety & Security project require that it focuses on remote & very remote areas (RRMA 7) and the remote health workforce.

1.3   Extrapolating conclusions from the 'Working Safe' survey

The *Working Safe in Rural and Remote Australia* survey did identify issues outside workplace violence e.g. 'driving for work on roads in rural or remote Australia' and 'staying in work accommodation when travelling'. The survey included 624 respondents, of whom 57% (354) were health professionals. Of this group, 19% (67) identified as working in a population of less than 1000, and another 29% identified as working in a population of less than 5000. While such communities (e.g. Kununurra, Birdsville, Katherine) are remotely located, they are likely to have supermarkets, hospitals, libraries and other amenities not necessarily available in the small very remote communities, usually with a population 100-2500 people, that are serviced by the remote health workforce identified as part of this project.

Similarly, Remote Area Nurses and other remote clinicians do not share the career characteristics of police and most teachers working in small, very remote communities. All Police and most Teachers are public service employees who see their remote experience as a 2-3 year component of a longer-term career.

Remote clinicians are as likely to work for the Private Sector, Non-Government Organisations or Aboriginal Medical Services as they are to be government employees, with many being recruited through private recruitment agencies. They are far more likely to be working a 1-2 month Fly-in Fly-out contract, with very few contracting to remain in one location for more than one-two years.

Identifying such issues is not a critique of the Working Safe in Rural and Remote Australia project. However, it is important to appreciate that the projects have similarities and differences. Consideration needs to be given before extrapolating information from one project to the other.

1.4   Methodology

The Remote Area Workforce Safety and Security project completed a literature review, conducted stakeholder interviews, and collected data from questionnaires completed by ninety currently/recently practicing remote health clinicians. Questionnaire respondents were comprised of a convenience sample of clinicians participating in Remote Emergency Care courses, and others met during national consultation. Participants on the Remote Area Workforce Safety & Security Facebook group were also invited to participate. Approximately 30 percent of respondents were CRANAplus members.

Consultation was not anticipated to engage all the remote health workforce and stakeholders. However, within the resources and timeline available, a representative sample was able to contribute. The draft report was then provided to the project's Expert Advisory Group, with feedback resulting in minor editing before publication.

1.4.1 Literature Review: strategy & methodology

The Remote Area Workforce Safety & Security project literature review is a focused review building on the *Working Safe in Rural & Remote Australia* literature review. While the 'Working Safe' project took a whole-of-community approach for both rural & remote areas, this project's mandate is to focus on the remote health workforce.

The Remote Area Workforce Safety & Security literature review acknowledges the conclusions of the Working Safe document relating to international/national definitions of workforce, workplace violence & remote settings, and does not attempt to repeat this work. As a result, the Remote Area Workforce Safety & Security literature review could focus on the (relatively limited) volume of remote area health specific literature published since 2010.

The Remote Area Workforce Safety & Security project used a multi-faceted approach to identify and collect published and 'grey' literature for this review. With the assistance of the Australian National University Research Library staff of the Canberra Hospital Library, searches were undertaken of the following electronic databases:

i.   Health Management **(Proquest)** a collection of resources in the field of health administration, including journals and dissertations.

ii. Australian Health Collection. **AUSThealth** 1966+ Indexes - Australian Health and Medical literature. It is comprised of a number of separate databases: AMI (Australian Medical Index) 1968-2009 APAIS - Health (Australian Public Affairs Information Service) 1978+, ATSIhealth (Aboriginal and Torres Strait Islander Health Bibliography) 1900+, AusportMED, CINCH Health 1968+, DRUG database 1974+, Health & Society 1980+ , HIVA 1980+, HEALTH Collection 1977+, RURAL 1966.

iii. Nursing & Allied Health **(Proquest)**. Includes full-text journals and dissertations, Evidence-Based Resources (Systematic Reviews, Evidence Summaries, and Best Practice Information Sheets) from the Joanna Briggs Institute, and the Medcom Video Training Program Collection.

iv. **Health and Medical Complete (Proquest)** indexes journal covering clinical and biomedical topics, consumer health, and health administration.

v.   **MEDLINE (OvidSP) 1946-present** The U.S. National Library of Medicine´s bibliographic database covering the fields of clinical medicine, nursing, dentistry, veterinary medicine, the preclinical sciences, health administration, and the health care system. Medline uses the MeSH (Medical Subject Heading) thesaurus to index each article.

vi. **PubMed.** Produced by the U.S. National Library of Medicine PubMed contains more than 21 million citations for biomedical literature from MEDLINE, life science journals, and online books.

Combinations and key words used when searching included:

Occupational health & safety remote; Remote area workforce job descriptions; Remote health workforce safety and security; Clinic/health service safety and security guidelines; 'Never alone'; Remote area nursing; Remote area nurses; working in remote areas; safety in remote areas; workplace safety rural & remote areas; Workplace violence or work place violence; Workplace bullying; Violence/prevention & control/psychology; Occupational stress; and Workplace health & safety. All searches were linked with rural and remote.

Literature was also accessed by undertaking searches using Google, Google scholar, and searching the websites of government, peak bodies, associations and health services for relevant policy, Workplace Health & Safety (WHS) documents and workplace safety & security guidelines. As the project's scope of safety and security was determined, literature to pertinent issues such as risk assessment, Four Wheel Drive (4WD) safety, and animal management in remote communities was also reviewed.

As the literature review was to inform project guidelines and resource development, the review remained limited to this goal, with only key documents included in the review. This is not a widely documented area of practice. Of approximately 200 items identified, only 60 of the most relevant literature and documents were reviewed in detail. These included government policies and guidelines, academic articles (presentations & publications), and workplace documents.

1.4.2   Symposia, Consultation and Survey: strategy and methodology

In the course of national consultation, symposia were held involving a total of approximately 190 participants. The symposia provided valuable opportunities to inform industry representatives about the project and initiate contact with clinicians & employers, however large group sessions did not provide an opportunity for more detailed discussion about issues and interventions.

Two strategies were used to better identify the positive and negative safety & security experiences of both clinicians, health service managers, and others relevant to the project.

1. Meetings were held with 68 representatives from 23 different organisations.

2. Questionnaires were completed by more than 90 remote health clinicians who were currently working remote or had been remote located within the past six months. There are current efforts being made to improve remote health workforce safety & security. The six-month cut-off was used to ensure respondents were providing currently relevant information. A copy of the questionnaire is included as Attachment 2

Recent and continuing efforts are being made to improve safety and security of the remote health workforce. As a result, questionnaire participation was restricted to currently practicing remote area clinicians, and those who had been working remote within the past six months. These selection criteria were used to ensure that information provided by informants was current. Previous research has identified past issues and this project did not seek to replicate past work.

Participation of clinicians completing the questionnaire included a mixed convenience and opportunistic sample including: Clinicians who were attending CRANAplus training courses; Clinicians who participated in interviews and symposia; and Clinicians participating in the project's Remote Area Workforce Safety and Security Facebook group.

Questionnaires were also distributed by different Health Services, including those employing Allied Health clinicians. Confidentiality of respondents was protected by their sending responses directly to the project's Professional Officer.

Approximately 30% of those who completed the questionnaire were CRANAplus members.

To encourage respondents to contribute openly about what can at times be challenging and distressing issues, strict confidentiality guidelines were identified. The commitment made to respondents and those participating in interviews was that project documentation and reports would not identify individuals, locations, or organisations.

At meetings, 1:1 discussions and through questionnaires, it was reinforced that the project's goal was to document information and, through this process, identify positive responses and interventions available to promote improvement to remote health workforce safety and security. This limits identification of those interviewed.

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Part A: LITERATURE REVIEW

2 LITERATURE REVIEW

2.1 Workplace context

The literature review identified that nationally, the healthcare workforce is experiencing an increased rate of assault. The Healthcare & Social Assistance sector (Australian Bureau of Statistics classification group) has a low industry mortality rate (0.2/100,000) compared to the Agriculture, Forestry & Fishing sector (17/100,000). However, the Healthcare & Social Assistance sector has one of the highest injury rates. While achievement in reducing injuries has been successful in many occupations, with a 26% decrease in serious injury nationally since 2011, the Healthcare & Social Assistance sector has only achieved a decrease of 13%, with improvement having plateaued over the past 5+ years.[3,4]

Research examining violence in Australian hospitals found that all emergency nurses (*n* = 266) who participated in the study reported experiencing some type of violence in the workplace. Verbal abuse occurred either face-to-face (58%) or over the phone (56%), physical intimidation or assault was reported by 14%, and threats made to 29% of participants[5]. 2014 Data from the Australasian College for Emergency Medicine identifies that 92.2% of emergency nurses and doctors experienced alcohol related physical aggression from patients in the past year[6].

Remote populations of Australia experience a higher burden of many diseases including Obesity, Coronary heart disease, Diabetes, Chronic obstructive pulmonary disease, Alcohol and other substance use, Lung cancer, Suicide, and Domestic violence – increasing the demand for available services. Some remote area health hazards impact on the remote health workforce as well as the broader community e.g. Travelling long distances on poor road conditions with unfenced stock, Reduced accessibility to health infrastructure and specialist services, Climate extremes, High fresh food costs, and Low rates of physical activity[7,8,9].

The poor health status of Australia's indigenous population contributes to the disparity between national health status and that of the rural and remote community[10]. Of significance to the safety and security of remote health staff is the reported increase – some suggest epidemic - in domestic violence in rural and remote Aboriginal and Torres Straight Island communities. 'Indigenous females and males were 35 and 22 times as likely to be hospitalised due to family violence-related assaults as other Australian females and males.' 'For indigenous females, about one in two hospitalisations for assault were related to family violence compared to one in five for males. Most hospitalisations for family violence-related assaults for females (82%) were a result of spouse or partner violence.'[11]

In its submission to the Victorian Royal Commission into Family Violence, the Aboriginal Family Violence Prevention and Legal Service identified that 'family violence reports had tripled in the few years prior to 2014', and that '90% of Victorian Aboriginal children in out of home care were removed because of family violence'.[12]

Identifying information about any specific health or social issue results in collating negative data. It's important to acknowledge that this information is part of a bigger, usually more positive picture. As identified in the Australian Indigenous Health*InfoNet* (2016) *Summary of Aboriginal and Torres Strait Islander health[13]*,

> *"Australia's Aboriginal and Torres Strait Islander people's health continues to improve slowly although they are still not as healthy as non-Indigenous people overall. The reasons why the health of Indigenous people is worse than for non-Indigenous people are complex, but represent a combination of general factors (like education, employment, income and socioeconomic status) and health sector factors (like not having access to culturally appropriate services or support)."*

2.2 Remote health workforce occupational stress and safety

Academics and clinicians have completed a valuable body of research over the last ten years, building on work conducted during the 1990's. The limitation of existing research for this project is that the focus has been on Remote Area Nurses (RANs) rather than the broader remote health workforce. While many of the findings of research can be considered relevant to all remote health staff, it must be recognised that RANs – and very occasionally medical staff - are most frequently the clinician who is a long-term resident in remote communities, with allied health staff and managers usually only visiting for shorter periods. RANs, and sometimes Aboriginal and Torres Strait Islander Health Workers, are likely to be the only staff with after-hours and on-call clinical responsibilities in remote health services.

Similarly, little information is available about perspectives on Aboriginal and Torres Strait Islander Health Workers' safety. Some relevant information has been identified as part of the Project's consultation and survey.

The remote nursing workforce is characterised by an ageing population, high staff turnover, and a reducing total workforce. Rickard (2010) has identified that many RANs work for periods of only two months, with the average career span being approximately three years.[14] Lenthall, Wakerman and Opie et al (2011)[15] identify that while nursing workforce numbers have increased overall, numbers located in very remote areas dropped by approximately 8%, from 934 to 865 per 100,000 population, during the period 2003 to 2007. It is not known whether this trend has continued through the following decade, however 69% of respondents to the 2016 CRANAplus membership survey identified that they were over 50 years of age. A summary of the CRANAplus 2016 Membership Survey is attached as Appendix 2.

Dade Smith (2016)[16] identifies that in 2011 the average age of nurses in the Australian workforce was 44.5 years, with those over 50 making up 38.6% of the workforce. The percentage of nurses aged less than 25 has dropped from 25% to 8% of the total workforce since 2005. A diminishing workforce of short term ageing staff cannot provide a sound foundation for industry safety and wellbeing. It is not surprising that the workforce needs assistance to improve safety and security.

Job demands most strongly associated with increased levels of occupational stress for remote area nurses were identified by Opie, Lenthall and Dollard (2011).[17] They included: responsibilities & expectations; emotional demands; workload; the remote context & isolation; cross cultural issues & culture shock; staffing issues; poor management practices; difficulties with equipment & infrastructure; and workplace violence.

McCullough, Williams and Lenthall (2012)[18] provide a detailed description of RAN workplace hazards which is best identified in the originally published table:

Table 1: Priority hazards as identified by expert panel. Mean values were calculated as follows: Not a hazard=0, Minor Hazard=1, Moderate Hazard=2, Major Hazard=3, Extreme Hazard=4. The items with the highest mean represented the greatest hazard.

Rank	Hazard	Mean	Agreement %	Character
1	Attending to patients in your own home	3.5	88	Environment
2	Inability to securely lock after-hours consulting area	3.4	80	Environment
3	Lack of common sense of nurse	3.4	90	Nurse
4	Intoxicated (alcohol or illegal drugs) client	3.4	80	Client
5	Alcohol outlet in a community	3.3	80	Organisation
6	Stress and burnout of nurse	3.3	90	Nurse
7	Single entry/exit to the clinic	3.2	70	Environment
8	Poorly developed communication skills	3.2	90	Nurse
9	Inadequate security of staff residences	3.1	80	Environment
10	Inexperience as a RAN (<4 years)	3.1	80	Nurse
11	Underdeveloped instinctive responses ('gut feeling')	3.1	90	Nurse
12	Work culture that tolerates verbal abuse as 'part of the job'	3.1	80	Organisation
13	Inadequate external lighting (particularly over access routes & external utilities)	3.0	70	Environment
14	Rigid personal belief systems of nurse	3.0	80	Nurse
15	Tiredness and fatigue of nurse	3.0	70	Nurse
16	History of violence by client	3.0	80	Client
17	Insufficient experience in assessment of mental health issues	2.9	70	Nurse
18	Lack of management follow up of violent incidents	2.9	70	Organisation
19	Lack of understanding of the risk and effects of violence by management	2.9	70	Organisation

Reference: McCullough, Williams and Lenthall (2012)[18]

2010 research conducted by Opie, Lenthall, Dollard et al[19] correlated varying types of violence (verbal aggression/obscene language, property damage, physical violence/assault, sexual harassment, sexual abuse/assault, and stalking) with symptoms consistent with Post Traumatic Stress Disorder (PTSD): re-experiencing symptoms – nightmares & flashbacks, hyperarousal – easily startled, and avoidance/psychic numbing – avoiding activities, places & people.

While the incidence and impact of experiences varied, respondents as a group were burdened by their experiences, with subsequent negative impact on their capacity to cope with their work/living environment, and diminished capacity to care for themselves and their patients.

The research does not suggest that the study group fulfils PTSD diagnostic criteria. However, PTSD-like symptoms can include: feeling emotionally overwhelmed; diminished capacity to manage challenging situations; poor sleep; reduced motivation and capacity to manage self-care; low energy; irritability; and a sense of dis-empowerment and inability to make change. Significantly, it is this population of RANs who are expected to provide on-site mentoring and orientation to new and incoming short term staff.

Workplace Health and Safety legislation & regulations in all States and Territories of Australia prioritise the safety of workers above their work responsibilities. However, selective negative media representation of issues – where problems are highlighted without equal representation of positive responses - can contribute to disempowering workers from promoting their own safety & security.[6]

Workplace bullying was not specifically identified by the above research. However, it is a significant issue affecting the remote health workforce. Wilson and Akers[20] provide a comprehensive description of the nature of bullying in the remote health workforce, identifying both issues and response strategies, noting that: Contact re bullying accounts for 40% of the phone calls received by the CRANAplus Bush Support Services; Some workplaces, especially those experiencing their own management disruption and turmoil, are more susceptible to bullying; and the impact of bullying experienced in a rural or remote setting may be amplified due to the relative shortage of support that exists in comparison to larger regional and metropolitan areas.

Dade Smith[16] provides some analysis of the range of issues associated with remote health workforce occupational stress, identifying that while poor management is regarded as a significant issue, the remote health management pool is very limited, the manager often being 'the last man standing'. Managers can be an easy target for clinician frustration. However, the Australian Bureau of Statistics reports management interventions to improve safety have been occurring for several years. McCullough, Lenthall, Williams and Andrew (2012)[21] also note briefly that 'the development and implementation of a safety plan might be hampered by a lack of interest from health centre staff'.

Apart from the work of Wilson and Akers, most available research identifies clinician and expert perceptions of stress and violence rather than measurement of actual incidence. As identified in the Working Safe in Rural and Remote Australia report:[2]

"Our analysis sought to correlate concerns about verbal abuse from community members, physical abuse from community members, and bullying or harassment from colleagues with actual experiences of these incidents. The results suggest that perceived risk could be greater than actual risk. Of the respondents that expressed serious or some concern, … generally less than half (and in some cases, well under half) reported actually experiencing these incidents in the past 12 months. Some key informants also suggested that perceived risk was greater than actual risk. Specifically, some key informants said people new to rural life often perceived greater levels of risk than actually existed, whereas people who had lived and worked in rural and remote Australia for many years tended to feel safer."

2.3 Responding to remote health workforce safety and security issues

Opie, Lenthall and Dollard (2011)[17] have contributed to this topic using Brooks' et al 2010 'Culture, Prevention, Protection & Treatment (CPPT) model of intervention layers for the Prevention and Management of Aggression' to document strategies applicable to the remote health context.

This work documents what appears to be a very useable model of Support Strategies, Primary Prevention, Secondary Protection, and Tertiary Treatment/Support which aligns reasonably closely with OHS/WHS response hierarchy guidelines.

Using a Primary $\Rightarrow$ Secondary $\Rightarrow$ Tertiary Prevention model, McCullough, Lenthall, Williams and Andrew (2012)[21] developed a 'Violence Management Toolbox' of strategies under the headings of: Education and training; Professional support; Organisational responsibilities; and Community collaboration. The content of this research provides a valuable checklist to inform further work.

While the approaches documented by these researchers are both similar and widely accepted, further consideration of what interventions will most effectively contribute to improving safety and security is needed.

Occupational Health & Safety protocols do not feature significantly in either of the above documents. Baker-Goldsmith (2014)[22] identifies several significant points in relation to WHS legislation and regulation, including:

"The primary duty holder in relation to workplace health and safety is the employer… because the law recognises that it should place the higher level of duty on those who have control of the issues that give rise to risk and therefore have the capacity to control them. In this way, the law seeks to motivate those who have control to exercise that control to the extent that it is reasonably practicable."

"Fundamentally, a worker is required to refrain from knowingly doing anything that places themselves or others at risk and to work within the safe systems of work put in place by their employer. They are not and cannot be required to take on the employer's responsibility for their health and safety at work."

"A duty holder, in managing risks to health and safety, must: (a) eliminate risks to health and safety so far as is reasonably practicable; and (b) if it is not reasonably practicable to eliminate risks to health and safety – minimise those risks so far as is reasonably practicable.

The absolute duty is to manage risk and ONLY if it is not reasonably practicable to eliminate risks entirely can an employer legally resort to lower order risk controls and then must do so in a hierarchical way. Where risks cannot be eliminated, the duty holder must minimise risks, so far as is reasonably practicable, by doing one or more of the following:

- *substituting (wholly or partly) the hazard giving rise to the risk with something that gives rise to a lesser risk;*
- *isolating the hazard from any person exposed to it;*
- *implementing engineering controls.*

If a risk then remains, the duty holder must minimise the remaining risk, so far as is reasonably practicable, by implementing administrative controls.

If a risk then remains, the duty holder must minimise the remaining risk, so far as is reasonably practicable, by ensuring the provision and use of suitable personal protective equipment.

It can be clearly seen from the above provisions that it is not consistent with the law for an employer to go straight to lower order risk controls such as training or procedures in circumstances where they have not properly explored whether it is reasonably practicable to implement higher order control measures. This is especially so when the potential exists for death or serious injury, the exposure is frequent and an adverse outcome can be reasonably foreseen given historical information."

Recommendations to reduce violence documented in recent research have identified issues proposed by research participants and experts, however, many of the recommendations themselves do not appear to have been validated, E.g. self-defense techniques[21]. Using another example, while the use of security alarms is generally supported, there is no clear analysis and agreement about whether alarms should best go to a remote monitoring station, emit a locally audible warning, or both.

Remote health workforce representatives – managers, WSR's and others - need to develop the skills to effectively complete hazard identification and risk assessment, considering likelihood and consequences, local context and resources, as well as legislated guidelines. Once hazards have been identified and risks assessed, responses need to be prioritised and implemented according to the OHS/WHS hierarchy of risk control interventions.

2.4   Characteristics of remote health workforce violent events

Worksafe Australia statistics do not provide accurate or comprehensive information about the nature of violence perpetrated on the remote health workforce,[2] however some information about the characteristics of recent significant events is available. The remote health workforce is widely scattered and relatively small in numbers. It would not be fair to those who have experienced violent trauma to be re-traumatised by having event details publicised. However, some analysis of past assaults is important to target responses to specific risks. Information in the following table was accessed from a range of academic, media and personal communication sources.

Table 2. Characteristics of significant/violent events with RAN as victim, 10/2015-11/2016*

Gender	Nature of event	Location	B/H or A/H	Called out on call	RAN Experience > 4 years	Single RN Post
Female	Sexual Assault	Staff Accommodation	A/H	No	Unknown	Unknown
Female	MVA death	Road - Patient transfer	A/H	Yes	Yes	Yes
Female	Sexual Assault	Staff Accommodation	A/H	No	Unknown	Unknown
Female	Sexual Assault	Staff Accommodation	A/H	No	Unknown	Unknown
Female	Murder	Staff Accommodation / surrounds	A/H	Unknown	Yes	No
Female	Assault	Home visit	B/H	B/H	Yes	No
Female	Assault	Home visit	A/H	Yes	Unknown	No
Female	Assault	Staff Accommodation / surrounds	A/H	No	Yes	No

*This information does not identify all violent events experienced by the remote health workforce during the past twelve months. Events not identified here may have been acutely distressing and traumatic to those involved.

From a WHS perspective, it is acknowledged that the less frequently an event occurs, the more difficult it is to predict future similar events and implement effective preventive measures. While the statistical significance of the above information is not clear, it does suggest that gender, after hours, being in/around the RANs accommodation, and remote vehicle travel are indicators of moderate to severe risk.

While some data is unknown, this table does not identify a high correlation between risk and single nurse posts, or risk and duration of remote health experience. This does not suggest that single nurse posts are safe. As documented in the CRANAplus position paper on Single Clinician Post, the reasons for shutting or expanding single nurse posts are well documented and compelling.[23]

What should be considered from this table, is the type of severe violence of which RANs are victims. Violence in and around the workplace is identified under three categories[2]:

- *Criminal (external) violence – where the victim is targeted for reasons possibly not related his/her work role E.g. sexual assault, or with intent to steal resources s/he has access to (medications, vehicles)*
- *Workplace (Client initiated) violence – perpetrated by patients, or patient visitors/family members*
- *Internal violence – between co-workers and supervisors/employers*

This indicates that the more common type of severe violence to which RANs are at risk is criminal rather than workplace related.

> *This is an important issue to identify, as the risks and perpetrators of each form of violence differ markedly, as do the violence prevention strategies that are needed for each group.[2]*

Equally important but less clear from currently available information, is the role of intended sexual assault in triggering episodes of violence towards RANs. Sexual harassment remains a serious challenge for employers in Australia.[24] Sexual assault is a frequent cause of injury or death for women in the United States, with women working alone / in isolation recognised as being at particular risk.[25] Available information identifies that similar levels of risk exist in Australia.[26]

Employers have a responsibility to limit risks associated with sexual harassment and sexual assault[24]. It appears that preventing and managing the risk of sexual violence needs a higher profile in remote health workforce induction and orientation.

The other issue raised by this table is that remote health workforce safety and security involves more than managing workplace violence. Vehicle travel in remote areas has considerable risk, with Worksafe Australia statistics identifying it as by far the single greatest cause of severe injury or death of the Australian workforce.[27] Other safety and security risks identified during the project included threat of dog attack, the possible presence of Asbestos in older community buildings, and maintaining personal wellbeing. These topics are not covered in the literature review, but are identified elsewhere in this report.

2.5 Implementing Workplace Health and Safety regulations in remote areas

WHS regulations include specific mention of the remote area workforce, identifying employer responsibility to provide safe and secure accommodation in locations where private rental is not available.[28] There are guidelines for setting up Workplace Safety Committees (Employer initiated or at the written request of five full time employees), and processes for staff to complete Workplace Safety Representative (WRS) training. In the event of a significant risk being identified, a WSR can initiate a Priority Improvement Notice. This triggers a Worksafe Australia visit. If the WSR concerns are confirmed, Worksafe assumes a monitoring role, having the capacity to fine an employer if problem resolution does not occur in a timely manner.

Currently, these guidelines are very difficult to implement in remote health locations. Staff turnover is high, the small workforce is scattered over vast areas, and the potential for Worksafe staff to attend and review a hazard is very limited.

2.6 Risk assessment

There is considerable enthusiasm for the development and use of risk assessment tools by clinicians. Risk assessment is identified as part of the Violence management toolbox.[21] Development of *'an easy to use safety and security self-assessment tool'* is also an output of this project. Given this, it is useful to review the literature relevant to the development and use of risk assessment resources.

A comprehensive collation of community information relevant to the RANs role – essentially a Community Safety Audit - is an essential component of an incoming clinician's orientation. Topics required could include: Clinic & after-hours safety, Accommodation safety, Vehicle and Communications safety, and Personal Wellbeing. Additionally, a brief safety and security self-assessment tool would assist new staff to frame their response to an emerging tense or frightening situation. However, risk assessment tools are a support to, rather than an alternative to more robust safety systems.

Over 100 different violence risk assessment tools are frequently in use, with research identifying that when used to predict violent offending, they had predictive values of 27-60%.[29] Some are actuarial, involving comprehensive review of an individual's history – not a viable option in the acute setting. Some are diagnosis based, while others have a behavioral focus.

Assessment of offender threat, combined with a brief checklist broader context issues can be of assistance in contributing to safe clinician decision making, especially by providing new/incoming clinicians with a decision-making guide. Mason and Julian (2009)[30] identified that the tool used by Tasmanian Police was 'an improvement on informal, subjective assessments.

Care must be taken in the use of such tools, in case clinicians feel over-confident that a low violence prediction result means they are safe. Additionally, Baker-Goldsmith[22] notes that any risk assessment by an individual puts

> *"expectation and responsibility for determining the risk control strategy on the individual… rather than (the employer) putting in place a clear and appropriately directive system (for the individual) to rely on."*

Assessment tools have a role in promoting safety and security. However, as with any assessment process, clinicians need to understand and use the tool regularly to enable its effective use.

2.7 Zero tolerance to violence

Zero tolerance to violence policies have been identified in research, industry and workplace publications as a basis for expectations of patient/community behaviour, and a staff right to safety at work.[6,21] As discussion on this topic identifies, the situation is more complex than a brief poster statement can identify. Zero tolerance cannot be the health industry response to violence associated with head injury, dementia and other organic causes. Similarly, empathic communication and de-escalation (rather than zero tolerance) are recognised primary responses to escalating interpersonal tensions and when confronted with aggression, both in the clinical environment and the tea room.

Clinicians have also identified concern that the zero-tolerance policy implementation often begins and ends with posters, as health services often demonstrate little commitment to prosecution of perpetrators.

However, with violence to some service providers reaching epidemic proportions, some governments are streamlining the prosecution process.[6]

2.8 Education and training for remote health workforce safety and security

A net search of educational institutions was conducted to identify if and how available courses were responding to violence and other safety / security issues identified in remote health workforce research. The websites of 22 organisations comprising tertiary education institutions, professional organisations, and research centres were reviewed. A range of education and training opportunities were offered, including short, topic specific courses (e.g. Pharmacotherapeutics), Graduate Certificate, Graduate Diploma, Masters and Doctoral programmes.

This section of the web based literature review was unable to locate any course content about the range of health, safety and security issues identified in research and this report. Some relevant information may be provided within units focusing on rural and remote health context, and research has been conducted by post graduate students of these organisations. It may be that that safety and security issues are regarded as workplace orientation subjects rather than aspects of education.

2.9 Social Media

Social media is being increasingly acknowledged as a legitimate publication location and required area of research. Some groups within the remote health workforce, notably RANs, appear quite active in social media, with five+ relevant Facebook sites currently active. While safety and security issues are frequently identified on most these sites, a formal review of this content has not been conducted as part of this project.

Social media research has its own set of issues, including the fact that people who have posted comments, documents and links can usually delete or change these at any time in the future. Additionally, Social Media over-represents 'Post Truth' too easily. Opinion and appeal to emotions can frame discussion, and facts become secondary to belief.

Facebook pages with organisation representation responsibilities do not lend themselves to the freedom of ideas and comment represented in the broader social media environment. Additionally, the relative anonymity of social media has occasionally resulted in cyber bullying. The remote health workforce does appear to be subject to both the positive and negative potential of social media.

2.10 Workplace safety guidelines

While workplace (employer) safety guidelines provide essential information relevant to promoting remote health workforce safety and security, they have not been included as a body of work in the literature review. Some guidelines are web based and publically accessible. However, others are location/service specific, content is un-published, and undergoing regular review.

3 SUMMARY OF THE LITERATURE

3.1 What is known

1. Nationally, the healthcare workforce is experiencing an increased rate of assault. Staff working alone and in isolation are at greater risk of serious assault due to the limited availability of security supports and rapid response systems.

2. Remote and very remote populations in Australia experience higher rates of disease and health risks. The remote health workforce is also exposed to many of these risks while being under considerable burden to provide services in a difficult and resource limited environment.

3. Research has documented the workforce's perception of risk factors, impact of risk factors on clinicians and, to a lesser extent, options to promote workforce safety and security. Existing recommendations need to be considered further under the broad umbrella of WHS regulation.

4. The remote health workforce is ageing. Workforce numbers per 100,000 population have dropped by approximately 8%. Availability of adequate numbers of experienced and new staff is important to maintaining service quality and consistency, as well as workforce safety, security and wellbeing.

5. Apart from the *Working Safe in Rural and Remote Australia* project, research has primarily focused on risks and violence to the remote area nursing workforce. Given shared context and workforce characteristics, it is likely that RAN focused research will be relevant to the broader remote health workforce.

6. Analysis of episodes of significant injury and death of the remote health workforce over the past twelve months suggests that being female, at home, and after hours' times are risk factors.

7. Available information indicates that severe events are more commonly perpetrated with criminal intent rather than because of work hazards. It is not clear how frequently perpetrators are motivated by intended sexual assault, however this is a risk factor requiring recognition in staff induction and orientation.

8. Workplace health and safety regulations relevant to the remote health workforce provide a comprehensive legal structure identifying the rights and responsibilities of employers and employees. Compliance with legislated requirements is inconsistent, and effective monitoring and implementation of WHS regulation is difficult in remote health services.

9. The industry will benefit from all stakeholders, including employers, employees, professional organisations, researchers, and educators, developing a better understanding of existing WHS legislation and regulation, and how it can be used to promote safety and security.

10. Violence and general risk assessment tools have a role in supporting the safety and security of the remote health workforce, however their contribution to safety is limited. Availability and use of such tools does not shift employer WHS responsibilities onto the individual.

11. Research into remote health workforce safety and security has focused on aggression, abuse, violence, bullying and harassment.

3.2 Gaps in the literature

Leaving aside what would be helpful to enrich our understanding of remote health workforce safety and security, the most significant gaps in our knowledge are:

1. There is limited information identifying the incidence and characteristics of moderate and severe violent events impacting on the safety and security of the remote health workforce. WHS statistics do not provide this information, with our knowledge of this issue being further limited by poor reporting of events by workers, and poor identification of events by employers.

2. Research has predominantly identified clinician perceptions of violence and risk issues, with little literature identifying the characteristics and effectiveness of different interventions.

   This is needed to inform the industry about how to get the most benefit from resources available to promote remote health workforce safety and security. Documentation of positive information and successful initiatives is needed to balance reporting that focuses on problems and traumatic events.

3. Research and industry literature has focused on violence, to the detriment of other threats to remote health workforce safety and security. Significant other issues warranting research and publication include: Vehicle and travel safety; Dog attack; Bullying and harassment, and risks to/promotion of personal health and wellbeing.

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PART B: CONSULTATION & SURVEY

4   CONSULTATION REPORT

4.1   Introduction

Project consultation has involved conducting symposia in South Australia, the Northern Territory, Queensland, Tasmania, and Western Australia, with additional contact made with Canberra based agencies. Where possible, meetings have been arranged with Professional organisations, Advocacy groups, Health Service Managers, and Nursing Recruitment Agencies.

CRANAplus Remote Emergency Care (REC) and Maternity Emergency Care (MEC) courses have been used as a point of contact with prospective and currently employed remote area clinicians – both CRANAplus members and non-members. A Facebook group 'Remote Area Workforce Safety and Security' was set up to link in with clinicians not otherwise able to access project information, and project contact options were identified on the CRANAplus website and the weekly CRANApulse newsletter. Presentations about the project and safety & security issues were made at the 2016 Rural & Remote Health Research & Scientific Conference, Canberra, and the 2016 CRANAplus National Conference in Hobart. The project's work has also been profiled in the Australian Nurse & Midwifery Journal.[31] Phone discussion and email communication was used with several organisations not otherwise able to be contacted.

Additional input is being sourced from the Project Expert Advisory Committee, however the Committee's contribution is not identified as an individual component of the consultation report.

It was not anticipated or expected that consultation would be able to engage all remote area clinicians, however the goal was to collate information about the range of issues influencing the remote health workforce from all major stakeholders. By completion of the project's national consultation phase, no significant new information was being identified.

Confidentiality was a major issue for the project and many respondents. The goal of the project is to support all stakeholders to improve the safety and security of the remote are workforce. Allocation of responsibility for past events was not considered a part of this process.

To support confidentiality, symposia, interviews and questionnaires all identified that project documents and reports would not identify individuals, specific locations, or health services. This limits the project's capacity to list individual consultation participants, but contributed to Health Services and others being generous in sharing information about safety issues and protocols.

Table 3. Consultation and Survey participants

	Number of Organisations/Activities	Number of participants
Organisations	26	49
Symposia	8 presentations	189
Questionnaire	-	85
Total:	**35**	**323**

Stakeholder discussion brought to light some issues that are very relevant to the safety and security of the remote health workforce, but were not identified in the literature review. Where possible, literature and resources on topics that can contribute to promoting workforce safety have been referenced. The following significant issues were identified during stakeholder consultation:

4.2   Recruitment and retention of Aboriginal & Torres Strait Islander Health Workers

Respondent comment identified that approximately 25% of Indigenous communities had no Aboriginal or Torres Strait Islander Health Workers. The absence of Indigenous clinical staff impacts negatively on both the cultural safety of services available to communities, and the safety of RANs and other members of the remote health workforce.

Dade Smith identifies that "While there is an undersupply (of Aboriginal & Torres Strait Islander Health Workers), this is the only health discipline with few retention problems." However, this was not the situation identified in project consultation.

Some clinicians and researchers interviewed during project consultation felt strongly that expecting Aboriginal & Torres Strait Islander Health Workers to be the first clinician on-call was only pushing safety issues down-stream. They identified that Aboriginal & Torres Strait Islander Health Workers already have significant, sometimes overwhelming demands placed on them by members of their community, and that further pressure would result in higher rates of attrition.

A manager observed that in recent decades, many Aboriginal & Torres Strait Islander Health Workers have been trained 'and you have to wonder where they all are now'. It was also noted that some Aboriginal & Torres Strait Islander Health Workers went on to complete Enrolled Nurse training 'because the money and career opportunities are so much better', while others were recruited into other service or administration roles.

Other than basic statistics, there doesn't seem to be much easily accessible information about Aboriginal & Torres Strait Islander Health Workers recruitment and attrition. While this issue sits outside the mandate of the Safety and Security project, it remains an issue which will continue to impact on the wellbeing of remote indigenous communities, and the remote health workforce.

4.3 Safety of Aboriginal & Torres Strait Islander Health Workers

Only a limited number of Aboriginal & Torres Strait Islander Health Workers were interviewed as part of the project or completed questionnaires. Issues they identified included:

Some risks to RANs and Aboriginal & Torres Strait Islander Health Workers were the same, but many were different. If an angry or drug affected person came to the clinic intending to harm staff, everyone would be at similar risk.

Non-community staff – RNs and others, were at increased risk because they frequently did not know the personality or background of community residents or visitors. They were also at increased risk as they were usually last to be aware of tensions in the community and the likelihood of violence.

Aboriginal & Torres Strait Islander Health Workers were more susceptible to internal family and community violence – domestic violence, punishment, or assault by others trying to project blame onto the Health Worker. No distinction was made about where the crossover point between work related and non-work related violence lay.

Another clinician identified that RANs and others were at times more susceptible to property damage and violence because investigation and punishment for the offence was a slow, unwieldy process which often remained incomplete. Assault or property damage to other community residents was avoided by some perpetrators if it had previously resulted in rapid and painful retribution.

4.4 Providing services in communities experiencing social disruption

Clinicians, health service managers and others noted that many communities had limited capacity to support health service providers as the communities themselves are experiencing considerable social disruption. Whether it be from loss of elders/leaders, substance misuse, internal tensions, or loss of direction from multiple causes, many remote communities do not have a cohesive population able to provide after-hours support for health services. Blaming small communities is not an answer. As one clinician identified, 'Communities are the solution, not the problem'.

4.5 Dog bite / dog attack

While not identified as a safety issue in research, it is likely that dog attack is the most common type of violence/injury that the remote health workforce has to deal with. Dog attack stood out as the most frequently identified work related risk raised by almost all groups of RANs when discussion of safety issues was initiated. Numerous clinicians identified examples of their own experiences, scars and suture lines included.

They cited examples of community residents and community services staff being attacked and needing treatment on site, or requiring evacuation for surgical repair. Past reports of the death of young and frail aged residents were identified to substantiate their concerns.

Dog attack is a safety threat that also impacts on provision of services. Several clinicians and managers identified personal or unofficial guidelines recommending that clinicians should not leave their vehicle when in the community. Staying in the ambulance does limit the risk of dog attack, however it also limits engagement with the community.

Learning about the role of dogs in indigenous communities, and behaviours – both personal and organisational - that will reduce the risk of attack will improve workforce confidence and safety. Senior et al[32] discusses Dogs and People in Aboriginal Communities, while a 2016 video produced by AMRRIC[33] provides a resource that is very relevant to the day-to-day safety of the remote health workforce.

4.6   Remote Health Workforce recruitment, turnover and churn

Recruitment of clinicians to remote health services is difficult. Recruitment places a major drain on the resources of many health services, with some having turned totally to Recruitment Agencies to source staff. Two Government supported staff mobilising agencies also support recruitment to NT Health Services. There are approximately 130 Nurse Recruitment Agencies operating throughout Australia, although not all appear to specialise in the recruitment of staff to remote areas.

Private agencies identified that they factor in Workers Compensation cover for their staff, although this is likely also paid by Health Services – an apparently un-necessary cost duplication. All Agencies and mobilising services contacted acknowledged some responsibility to ensure that health services and new recruits were made aware of reported safety issues such as insecure accommodation, and recent assaults. They were also amenable to ensuring that staff were provided with employer workplace safety guidelines if these were available.

While some employers seem to successfully achieve reasonable staff continuity, there is a general trend for clinicians to approach remote area work as a limited duration commitment. They either limit their planned remote experience to one placement of a few months to two years, or start with long term plans, only to commence short term contracts as their tolerance to the work diminishes. Many clinicians agreed with the idea that they could continue to cope with work change, but were less able to cope with work continuity.

While the term Fly In Fly Out (FIFO) is an now accepted term for this workforce, there are implications specific to FIFO RANs. The general FIFO workforce has long term contracts identifying an annual salary, with FIFO schedules identified as part of the contract. Most FIFO RANs are only paid while they're working, with contracts dependent on availability of acceptable placements. This impacts on salary and job security.

While the churn of staff – frequent movement of staff within the industry – supports the ongoing availability of clinicians, it is detrimental to staff safety and service provision. Short term staff have little opportunity to establish good communication with community residents and other staff. Their ability to identify potentially risky situations early, and their capacity to utilise existing relationship bonds to defuse threatening situations is limited.

4.7   RAN fatigue

Challenges to staff health and wellbeing have been identified in research, and this was further identified during project consultation. The average age of RANs, who make up most the remote health workforce, is increasing, possibly now being around 50 years. This implies a high percentage of skilled and experienced workers; however, this may not be the case as many incoming RANs are already mature aged – skilled in their existing clinical roles, but new to remote area work.

Extremes of temperature, humidity or aridity take a toll on the health and energy levels of everyone who lives in remote Australia. The baseline health status of an ageing workforce will not be as good as it will for a younger cohort. Many RANs are managing their own chronic illnesses and struggling to maintain their own wellbeing. Some health managers identified RAN exhaustion as a priority concern. Many clinicians identified access to fatigue leave after being on-call as essential to their wellbeing and safety.

4.8 Road travel in remote areas

As previously identified, road travel in remote areas involves increased risks, and requires driving and vehicle skills not generally known to urban residents. Most health services stipulate that having a manual driver's license is a mandatory employment requirement. However, fewer services have clear ideas about what driving skills their staff need, and how they could go about acquiring these skills.

Several remote workforce members were quite scathing about the lack of preparation of staff for bush driving. It was noted that even basic 4WD courses did not prepare one for driving long distances on dirt roads in varying weather conditions, possibly while also being the primary clinician caring for an acutely ill patient. Roads are often quite wide, and travel at 80-100kph or more not uncommon. As one clinician noted, 'The sicker the patient, the faster they drive, one sandy or boggy section or road, or a moment's lapse in concentration can have disastrous consequences, especially in a large vehicle with a high centre of gravity, cumbersome steering and suspension not designed for high speed work'.

Some services whose staff often travel long distances identified that they have considered, or are already using, in vehicle monitoring systems (IVMS) while a few more use GPS Tracking as a safety and security precaution. As well as providing a vehicle location system, IVMS sends an alert if a vehicle has had a serious accident or roll over. Review of the monitoring system can also identify if vehicles have been traveling over the speed limit, or if they have been subject to harsh acceleration or braking.

4.9 Action and inaction to prioritise safety & security

The traumatic events of 2016 have prompted remote health stakeholders to prioritise workforce safety and security. Project consultation has identified that practical interventions are occurring at all levels, although not in all locations, and with varying commitment to compliance with existing guidelines. Equipment such as the SafeTCard – a combined ID card and monitored personal alarm - has been used by an organisation aware that their staff working alone in a building can be at similar immediate risk to those working in remote areas. Government and NGO health service managers identified that the lead taken by remote health services is also being used by rural and some urban agencies who have staff working alone in office and community settings.

During consultation, project staff have observed safety cages constructed in health facilities, man-down and other personal alarms, increased staffing to facilitate 'always accompanied' on-call strategies, recruitment of security staff, development of best practice guidelines by peak agencies, and increased focus by clinic teams and area managers on the consistent implementation of safety guidelines. It is important to acknowledge efforts made to date, and support continuation and wider uptake of these initiatives.

However, progress to date has not been consistent. Despite recent high profile events, some services and managers do not understand that they have a responsibility to do everything reasonably possible to ensure the safety and security of service staff, believing that clinicians are primarily responsible for ensuring their own safety. Some managers identified their primary safety responsibilities as ensuring clinicians had demonstrated the capacity to practice in a safe manner.

Similarly, some clinicians are undermining safety and security systems by inaction or action. Personal alarms hang on a hook in the office rather than on a belt or lanyard around the neck of those at work. Many clinicians identified that they felt bullied into not implementing safety guidelines by other staff who did not agree that risk exists, or who preferred to work alone so their allegedly poor clinical practice was not observed by others.

4.10 Bullying and harassment: down, up, and horizontal

Many participants in the remote health industry identified concern about the nature and incidence of bullying. Rather than actual bullying, some of the events described seemed more to reflect the overwhelming emotional stress experienced by both managers and clinicians working in remote health services. However, other examples described episodes of repeated unprofessional behaviour by individuals, both managers and clinicians. Several clinicians detailed the bullying by management that had resulted in their now only working through Recruitment Agencies.

A few RANs provided detailed evidence of managers using AHPRA notification systems to make complaints. Only months later, after significant emotional, professional and financial cost, did the relevant Board determine that the clinician concerned had no case to answer.

In December 2016, the Senate Standing Committees on Community Affairs has recently completed a review of the medical complaints process in Australia. The review specifically noted that Nurses and Midwives were included under the term medical. The Committee's report identified six recommendations:

Recommendation 1

The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:
• acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;
• recognise that working together and addressing these issues in a collaborative way is the only solution; and
• commit to ongoing and sustained action and resources to eliminate these behaviours.

Recommendation 2

The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.

Recommendation 3

The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.

Recommendation 4

The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.

Recommendation 5

The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.

Recommendation 6

The committee recommends that a new inquiry be established with terms of reference to address the following matters:
• the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;
• whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;
• the roles of AHPRA, the National Boards and professional organisations – such as the various Colleges – in addressing concerns within the medical profession with the complaints process;
• the adequacy of the relationships between those bodies responsible for handling complaints;
• whether amendments to the National Law in relation to the complaints handling process are required; and •
other improvements that could assist in a fairer, quicker and more effective medical complaints process.

Recommendation 6 has already been actioned, with the new Committee established. Submissions can be made till 24/2/17, and the report is due on 10/5/17. Information is available through the following link: *Complaints mechanism administered under the Health Practitioner Regulation National Law*

Managers identified fewer examples of bullying. RANs have threatened to resign if individual (and sometimes unrealistic) requests were not approved. Also, some managers have been placed in the impossible position of being required to improve services safety while meeting KPI indicators that involve budget efficiencies.

Horizontal violence – that perpetrated by clinicians against peers, usually working in the same clinic, was the type of bullying most frequently identified during project consultation. FIFO staff reported bullying by peers as the most common reason for them to avoid returning to a clinic. They also identified that 'good staff' at a location was often the major factor in their decision to apply for or accept an offered contract.

Respondents reported that some people who choose to work in remote locations appear to prefer their own company. Other clinicians were identified as warm and welcoming. FIFO clinicians provided multiple examples of arriving to dirty accommodation, with no food available and the shop shut, one noting that 'the person I was relieving had left the bed unmade and rotten food on the kitchen bench. It was disgusting'.

Dirty accommodation isn't necessarily the responsibility of other remaining staff, but not providing even basic food requirements to tide your new team member over till the next day isn't a good way to commence a new working relationship.

Individual or peer group undermining of existing safety guidelines was a concern identified by many staff. Most FIFO clinicians who had worked for a year or two on different contracts identified that they have experienced this situation, but this is not to say that FIFO staff were never criticised for similar behaviour.

The lesson from this feedback is that the workforce itself has a core role in promoting or weakening its safety and security. Sometimes differences of opinion will best be resolved through using clinician interpersonal communication skills, while at other times, despite the difficulties in staff recruitment and retention, management needs to intervene and direct its staff to cooperate with safety guidelines, or initiate other actions to protect the safety and security of all staff.

4.11   Challenges of remote management and supervision

Good clinical services, and good safety systems, require good management and supervision. Respondents experiences varied, with comments from different individuals, services, and locations identifying positive or negative experiences relating to management of issues including: Administrative demands keeping clinicians from their clinical role; No availability of relief staff for holiday breaks; Bullying (vertical & horizontal); Support after traumatic events; and pro-active intervention to resolve problems before they became critical.

Use of Information Technology systems including Telecommunications, Electronic databases; and Electronic transfer of diagnostic information & results was acknowledged by respondents as having improved information sharing opportunities for remote health services. Concerns were more frequently raised about inter-personal communication and supervision of staff.

As previously identified, difficulty recruiting and retaining staff is a significant issue for most remote health services. This appears to have resulted in some services avoiding proactive staff supervision for fear of losing staff. Clinicians whose work history was poor E.g. repeated complaints of bullying or unprofessional behaviour, retained employment. Similarly, despite the physical and psychological challenges of remote health work being acknowledged in research literature and experienced on a day to day basis in health services, many services left the responsibility for wellbeing primarily with the individual – 'You've got to tell us if you need help, or need a break', rather than supervisors intervening to promote and maintain staff (and service) wellbeing.

Project consultation identified two different types of management and supervision of remote health services, one was characterised by frequently reported tension and distrust between managers and clinicians, while in the other, managers and staff worked as a team, not always happy about each other, but feeling generally supported, acknowledging their shared goals and appreciating individual roles.

Clinicians who felt they were heard, acknowledged and supported by managers at clinic and regional level spoke far more positively about their role, and their intention to remain within the service while personal and professional considerations allowed. Those clinicians who lacked trust or respect for their managers were more likely to use frequent turnover (churn) as a coping mechanism.

Respondents identified that there were many remote health clinicians who were considered by their peers to be burned out or otherwise less able to contribute positively and safely to their profession. These staff seemed to find a location where they could remain, largely unsupervised, to the detriment of communities, other clinicians, their employing service, and probably themselves.

4.12   Asbestos

A number of health staff working in remote communities identified Asbestos as a possible health and safety hazard, citing examples of building damage and old dumps of asbestos containing building materials. The use of asbestos ceased in the late 1970's. Prior to that, Asbestos was used extensively in building materials such as: roofing; external and internal walls/cladding; paint; and tile glue. Buildings constructed during or after the 1980's will not have any asbestos products.

Federal, State and Territory governments all have major asbestos management strategies. Information and links can be found at https://www.asbestossafety.gov.au

5   CLINICIAN SURVEY

While not required as a part of the project consultation, use of a questionnaire was a valuable way for clinicians to contribute to the project. When asked about safety and security issues, clinicians current and past would immediately offer a description of their most traumatic experiences. The questionnaire provided a structured opportunity for clinicians to identify information about factors that challenged and promoted safety and security, as well as identifying positive and negative factors influencing the use of safety and security equipment and workplace practices.

Given the increased efforts to improve safety and security following the murder of Gayle Woodford, questionnaires were only collected from currently practicing clinicians, or those who had worked remote within the past six months. However, all clinicians contacted during the project were offered copies of the questionnaire, as it provided those preparing for remote area work with an opportunity to consider safety and security issues they could be likely to experience.

A copy of the questionnaire is attached as Appendix 3

The survey should be considered as data collected during the project rather than a research project. The questionnaire was developed to fit the needs of the project rather than answer a research question. Ethics approval was not sought for this part of the project.
Results reflect information provided by 90 currently or recently practicing RANs. Not every question was relevant to all respondents. Percentages are based on the total number of respondents to each question. While percentages are used to measure response rates, results should be considered as trends rather than a finite workforce indicator.

Note: Survey reliability. Results documented here refer to respondent answers, and do not necessarily reflect the lived & worked experience of each remote area clinician. In identifying 'experienced and directly observed events', more than one respondent could be referring to the same event, or events may have occurred within the past twelve months, but prior to a respondent arriving. As a result, there is the potential of both under and over reporting of responses. This information is therefore considered to represent trends rather than solid replicable data.

5.1   Questionnaire results and discussion

The first part of the questionnaire sought demographic information to enable results to be identified according to different States and Territories, if this was considered warranted, and to enable follow-up contact by the project if further information was sought about individual clinician experiences. More than 90% of respondents were happy to provide location information, a few (predominantly non-nurses) declining citing identification and confidentiality concerns.

Question 1. *How long have you been a RAN? How long have you been employed <u>at your current or most recent location</u>?*

Average length of remote area experience of respondents was five years, with the range of responses being 1 month to 20 years. Time at current job averaged 14 months, the range being 1 month to 11 years.

Results were skewed by a small number of respondents who were permanent remote town residents. A few RANs who were nearing retirement had lived and worked in the same remote town for most of their lives. Excluding the 8-10% of respondents who have worked remote for over ten years would provide a more accurate description of characteristics of most the remote health workforce.

Project consultation identified a common description of a RAN career commencing with a 2-3 year contract, then comprising shorter and shorter periods in any one location until the clinician worked only 1-2 month FIFO contracts. This workforce 'churn' is disorienting for communities, clinicians and health services. However, extreme churn does not appear to be a necessary industry characteristic. Some Services / States and Territories seemed to maintain a stable, longer-term workforce than others.

Question 2. *Are you employed directly by a Health Service, or through a Nursing Agency?*

62% of staff were directly employed by a Health Service in their current job, with 38% being employed by Recruitment Agencies.

This response was skewed by Northern W.A. results, as far more WA respondents were directly employed by Government or Aboriginal Medical Services. For the rest of the cohort, employment was close to 50:50 Health Service and Agency employed.

Question 3. *If you have worked through a Nursing Agency for more than six months, why do you prefer this to direct employment?*

The reasons why clinicians preferred agency employment were (by frequency of response): Flexibility; Variability; As a buffer to avoid bullying by managers and other clinicians 'you can test a place out then decide whether to go back'; To avoid Health Service politics; Better pay and better support – 'better support if things are unsafe'; and to fit in with family priorities and other career opportunities.

Government employers were generally regarded as inflexible about employment 'work with us permanent full-time or not at all'. However, this may have been the approach of management rather than government requirements, as there were a few RANs who had negotiated part-time E.g. 0.7 contracts then worked full-time for 0.7 of the year, buying additional annual leave if family commitments required more time at home. For managers looking to reduce turnover, this provides a much more stable staff presence that relying on FIFO staff.

Question 4. *How many RANs and Aboriginal & Torres Strait Islander Health Workers are employed at your current (recent) workplace?*

The number of RANs in the workplace ranged from 1-7. The number of Aboriginal & Torres Strait Islander Health Workers ranged from 0-6. The significant information from this question is that 25% of respondents working in Indigenous communities identified that no Aboriginal & Torres Strait Islander Health Workers were employed in the Health Centre.

Respondents frequently identified that working in the absence of Aboriginal & Torres Strait Islander Health Workers impacted negatively on providing culturally safe services as well as creating safety and security challenges for RANs and non-resident clinicians.

Question 5. *Do you consider your accommodation safe & secure? (E.g. Gates/fences, insect screens, fire alarms, locks etc.)*

25% of respondents identified that their accommodation was not safe and secure. Lack of fire alarms was a concern for some, however many responses identified problems with lack of security screens, broken locks, unsafe design / construction, and inadequate perimeter (fence/gate) security.

Most significant episodes of violence to remote health staff documented over the past twelve months have occurred in and around staff accommodation. High rates of insecure accommodation represent a continuing threat to staff wellbeing – A WHS hazard that can usually be responded to effectively with engineering controls.

Question 6. *Has your accommodation been broken into over the past 12 months? If yes, have 'weak points' been adequately repaired?*

Approximately 10% of respondents identified that their accommodation had been broken into during the past 12 months. Several recently employed clinicians were unsure of this information.

This information is significant, as ensuring accommodation security would appear to be the primary response required to reduce episodes of severe assault and staff trauma.

***Question 7.** Does your workplace job description identify prioritising staff safety as part of your role?*

45% of respondents said yes, 35% said no, and 20% were unsure.

While not a requirement that health services identify WHS staff safety priorities in job descriptions, many employers have used this to demonstrate their commitment to staff safety and to raise awareness among staff that they have a responsibility to contribute to maintaining their own safety as well as that of community residents and other patients.

***Question 8.** Does your workplace have 'Never Alone' or similar safety guidelines for business hours and on-call work?*

55% of respondents said yes, 30% said no, and 15% were unsure if their workplace had safety and security guidelines.

It is a concern that 15% of respondents were unsure of their current workplace safety guidelines. Agency recruited FIFO staff who do not access pre-employment orientation comprised most of this group.

***Question 9.** Are safety 'Never Alone' guidelines supported and implemented consistently?*

51% of respondents said yes, and 49% said no.

***Question 10.** If Yes for Q9, What's contributing to ensure the guidelines work? If No for Q9, What's causing problems? E.g. Nurses, Community, Management, Other issues?*

Factors that contribute to safety guidelines being consistently implemented (not in ranked order): Local Clinic manager and/or Health Service management promote safety; Adequate staffing; Availability of locally employed staff; Clear safety guidelines; Supportive / cohesive clinic team; Regular Community – Health service consultation; A consistent schedule of after-hours/on-call workers; and clear guidelines that staff are not allowed to go out on-call if there is evidence of risk.

Factors that cause problems with consistent implementation of safety and security guidelines: Management not supporting or resourcing their own policies; Inadequate staffing; No locally employed driver or Aboriginal & Torres Strait Islander Health Workers; RANs not supporting guidelines or each other; It's not always possible or practical; 'Two RANs on call mean reduced clinic hours the next day; and not having fatigue leave puts pressure on the first on-call to not wake up the second on call'.

***Question 11.** What personal efforts did you make to find out about your employer and your job location / environment prior to starting work?*

Most respondents used one or more strategies to find out about their job before commencing. These included: Direct contact with the employer/recruitment agency; An internet search; Social media enquiry; and direct contact with other RANs. 21% of respondents identified that they made no effort to find out about the health service or community before commencing work – though some, especially clinicians with limited or no previous remote area experience, noted that in retrospect, they should have.

More than 20% of respondents identified that they made no effort to learn about their prospective work environment before signing a contract and commencing work. Some experienced RANs working short FIFO contracts felt that seeking information about their next job wouldn't change their work plans. Respondents identified that some health services 'desperate to get staff' gloss over problems, and the opinion of RANs who have worked in a location previously varies. As a result, they prefer to go to a place for a few weeks and see for themselves – if they enjoy the service and placement, they'll go back. If not, they just cross the location off their list of future acceptable contracts. Significantly, who you worked with (local manager, other clinicians), seemed to be a more significant factor in considering a second contract than community characteristics.

Question 12. *Did you have any orientation before commencing employment with your current employer? If yes, how many days' duration?*

50% of respondents identified that they attended orientation before commencing at their current job. Again, this response was boosted by a more positive result from WA respondents. Orientation lasted between 2 hours and 3 weeks and occurred off site (prior to deployment) and once they had arrived at their new workplace. FIFO staff most frequently missed out on any orientation, or accessed only a brief local orientation – more of a handover than a comprehensive induction and orientation process.

Several clinicians who identified that they accessed no orientation noted that 'the (health service / clinic) was in crisis, and I was just expected to hit the ground running'. Both new and experienced RANs were exposed to this situation. Some also identified that employers felt that 'if you're been employed in a few other communities, you can easily fit in with how things work here'.

Another respondent concern was that health services scheduled orientation every 3-6 months, with participation being dependent on staff being able to be freed up from their clinical role. This meant that clinicians may have been working for six months or more before they could attend orientation. This was seen as health services 'ticking boxes' rather than actually preparing clinicians for their work placement.

Orientation is costly and requires staff to present content as well as participants. Health services noted that while this situation (3-6/12 scheduled orientation programmes) was not preferred, the option was to delay appointment of staff until orientation was scheduled – which creates another set of difficulties.

Question 13. *If you did have orientation, did it focus on health service requirements (IT, ordering Rx & supplies etc.), or did it also involve safety, security & staff wellbeing information?*

Of those who accessed orientation, 50% identified that it focused on service requirements, while 50% identified that orientation also identified personal wellbeing and safety. One respondent identified that their three-day orientation commenced with a half-day focus on safety and security issues.

Pockets of best practice identify that the remote health industry can improve overall rates of comprehensive workplace orientation. Innovative strategies will be needed to improve orientation & induction of FIFO staff.

Question 14. *Have you been provided formal (1-2 day) 4WD training, including practical driving experience, daily maintenance, & hands-on flat tyre change experience?*

33% of respondents reported being offered good 4WD training, with most identifying that they had not been offered or required to demonstrate competency in bush driving skills before commencing work in a remote health centre. One RAN said 'I flew into meet with my manager and complete payroll requirements, then they just gave me the keys and told me to drive out to the clinic.'

Some respondents said that they had attended a 4WD training session 'years ago with another employer'. Subsequent employers, if they asked about clinician bush driving skills, regarded any past training or experience as acceptable. One respondent reported being offered 4WD training 'after the roll-over accident'. A few respondents who owned their own 4WDs had done courses independently. A few respondents questioned the content of available courses, noting that driving on dirt roads in varying seasonal conditions, and when responding to emergencies, was the significant hazard for which the remote health workforce needed training – and 4WD courses did not focus on dirt road driving skills.

Question 15. *Is the main health service vehicle reliable & adequately serviced? Is it fitted with GPS tracking, Satellite Phone or High Frequency radio?*

85% of respondents identified that the health service vehicle was reliable and adequately serviced. Only 7% of respondents identified that the vehicle had GPS tracking equipment fitted. All vehicles had a fitted or accessible (mobile) Satellite phone or a HF transceiver, and a few had both. A few respondents reported that the clinic only had one shared Satellite phone, which was not always available for On-Call staff (left in the clinic, or being used in another vehicle) Many respondents identified that Satellite phone reception was very unreliable.

As with driving skills, a few clinicians did realise the importance of good knowledge and training on how to use emergency communications equipment. They had found manuals, read them and practised with equipment prior to needing it in an emergency. This shows initiative, but in the event of anything going wrong, it would not diminish employer responsibility to provide adequate training for equipment being used.

Question 16. *Have you had training & practical experience with all available communication equipment?*

55% of respondents identified that they had not had training and experience with emergency communication equipment. Of those that had, most identified that they had no training in equipment use, but had learned on the job.

Proper training in equipment use, including reception troubleshooting, may improve the capacity of staff to use emergency communication equipment effectively, and improve communication reliability.

Question 17. *Is the clinic building safe, lockable & secure? Is there appropriate lighting?*

75% of respondents identified that the clinic was secure. 91% of respondents identified that clinic internal and security lighting was adequate.

Clinic security is a significant issue. As risk factors change, Health Services are having to improve the security of workplace facilities. Serious consideration must be made of balancing security and other requirements such as Fire Escapes. Input by local staff, re use requirements needs to be balanced with the contribution of architects familiar with construction regulations and Crime Prevention Through Environmental Design (CPTED).

Question 18. *Is there reliable 24hr phone and/or radio contact with other health & community staff, your manager, and Emergency Services?*

90% of respondents identified that 24hrs contact was reliable. Others identified that it was 'mostly' reliable.

Question 19. *Are clinic alarms, personal alarms or personal locator beacons (PLBs) available for staff use? Do staff use them effectively?*

No respondents identified access to Personal Locator Beacons (PLBs). 17% of respondents identified availability of personal alarms. 75% of respondents identified that clinics had alarm systems.

There was considerable comment about clinic alarm reliability and effectiveness. Several respondents noted that the system had been tested, found unserviceable, but not repaired in a timely manner – still unserviceable after a year. Others identified that the alarm was monitored by a commercial security firm based hundreds of kilometres from the clinic, sometimes in another state. When triggered, there was nothing to indicate that it was working. The delays associated in mobilising a response using this system would not provide any emergency assistance in the event of an assault.

There was consensus that an effective alarm system needed to sound loudly on site as well as alert others that assistance was needed. False alarms were identified as a concern, with clinicians unable to constantly supervise the presence of patients and relatives (especially children) in all areas of a clinic.

Question 20 was divided into six sections. It commenced with a general framework for responding: *Since August 2015, have you experienced or directly observed (E.g. involving yourself or other staff) abuse, violence, bullying or harassment that resulted in:*

> **20.1** *Staff immediately resigning and leaving the community / health service?*
>
> 30% of respondents identified that they had experienced or observed this.

20.2 Staff leaving the community for medical treatment?

33% of respondents identified that they had experienced or observed this.

Some respondents added notes indicating that that they had included staff leaving for all/any medical treatment, not just treatment required due to violence or trauma.

20.3 Staff requiring review or treatment on site following violence?

24% of respondents identified that they had experienced or observed this.

20.4 The psychological impact of threats, bullying or assault impacting on the wellbeing of staff, and their ability to continue working?

48% of respondents identified that they had experienced or observed this.

This is a significant rate of response that is consistent with results identified in recent research referred to in the literature review. It appears linked to staff turnover/churn, with respondent comments attributing this evenly among peers, Health Service management, and patients/relatives.

20.5 Staff temporarily restricting service access or being evacuated for safety reasons?

38% of respondents identified that they had experienced or observed this.

Respondents identified some ambivalence with this action. There was concern that clinic closure could be an expression of anger that unfairly targets those who need health services, rather than those who threaten the wellbeing of health staff. Respondents supported closure/restricting service access when health services had previously negotiated this with the community, or where staff were evacuated from a clinic/community in response to threatened/perpetrated violence.

20.6 Cumulative episodes of threats, bullying or harassment being the primary cause for staff choosing to resign & leave the community?

This question focused on bullying and harassment only, distinguishing responses from question 20.4 which also included violence. 77% of respondents identified that they had experienced or witnessed this.

Respondent comments added to this response identified that the perpetrators of were most commonly health service managers or peers, with both groups being identified equally.

Question 21. *Would you be willing to be contacted personally to provide further information about any of your answers?*

67% of respondents agreed to further contact if this was needed by the project. Many who declined stated that they did so because they didn't feel they had any further information to contribute. A few declined to protect their confidentiality.

Question 22. *How would you rate your skills & confidence about de-escalating inter-personal confrontation? Response options were: 1. Very Competent; 2. Confident; 3. Requires development*

This question was added mid survey in response to de-escalation being identified in research as required training, and as bullying & harassment was frequently being raise as an issue be clinicians and managers.

Feedback to date has been provided by 35 respondents. 22% rated themselves very confident, 60% rated themselves confident, and 18% rated themselves as requiring development.

A number from the confident response group noted that although confident, de-escalation skills benefited from ongoing training, as did all clinical skills.

This question was included to identify clinician confidence with responding to all inter-personal confrontation, including threats of violence in the workplace. However, from comment provided, it appears that some respondents interpreted the question as relating only to inter-personal confrontation with other staff and management. As a result, the results should not be interpreted as accurately reflecting workforce self-measured capacity to respond effectively to threats of violence in the workplace.

6   SUMMARY OF CONSULTATION AND SURVEY RESULTS

Twenty-five percent of Indigenous communities serviced by questionnaire participants were reported to have no Aboriginal & Torres Strait Islander Health Workers. The absence of Indigenous clinical staff impacts negatively on both the cultural safety of services available to communities, and the safety of RANs and other members of the remote health workforce.

Aboriginal & Torres Strait Islander Health Workers identified that some risks to RANs and Aboriginal & Torres Strait Islander Health Workers were the same, but many were different. If an angry or drug affected person came to the clinic intending to harm staff, everyone would be at similar risk. Indigenous health staff were more susceptible to internal family and community violence – domestic violence, punishment, or assault by others trying to project blame onto health staff. RANs and others, were at increased risk because they frequently did not know the personality or background of community residents or visitors. They were also at increased risk at times, as they were usually last to be aware of tensions in the community and the likelihood of violence. External staff were at times more susceptible to property damage and violence because investigation and punishment for the offence was a slow, unwieldy process which often remained incomplete.

Several respondents noted that many communities themselves are experiencing considerable social disruption. Blaming small communities is not an answer. As one clinician stated, 'Communities have to be the solution, not the problem'.

Almost all groups of RANs identified dog attack as the hazard they experienced most frequently. Dog attack is a safety threat that also impacts on provision of services, as it keeps clinicians from engaging easily with community members.

Along with direct recruitment by health services, two government supported staff mobilising agencies and approximately 130 Nurse Recruitment Agencies operate throughout Australia. All Agencies and mobilising services contacted acknowledged some responsibility to ensure that health services and new recruits were made aware of reported safety issues such as insecure accommodation & recent assaults. They were also amenable to ensuring that staff were provided with workplace safety guidelines if this was identified as industry best practice.

There is a clear trend for clinicians to approach remote health work as a limited duration interest. They either limit their planned remote experience to one placement of a few months to two years, or start with long term plans, only to commence contract work as their tolerance to the workplace diminishes. Many clinicians agreed with the idea that they could continue to cope with frequent workplace change, but were less able to cope with work continuity.

Most health services stipulate that having a manual driver's license is a mandatory employment requirement. However, fewer services have clear ideas about what driving skills their staff needed, and how they could go about acquiring these skills. It was noted that even basic 4WD courses did not prepare one for driving long distances on dirt roads in varying weather conditions.

The traumatic events of 2016 have motivated remote health stakeholders to prioritise workforce safety and security. Project consultation has identified that practical interventions are occurring at all levels, although not in all locations. It is important to acknowledge efforts made to date, and support continuation and wider uptake of these initiatives.

Some services and managers do not seem to understand their legislated responsibility to do everything reasonably possible to ensure the safety and security of service staff, still believing that clinicians are primarily responsible for ensuring their own safety. Similarly, some clinicians are undermining safety and security systems by inaction or action. Many clinicians identified that they felt bullied into not implementing safety guidelines by staff who did not agree that risk exists, or who allegedly preferred to work alone so their poor clinical practice was not observed by others.

It is alarming to hear so many participants in the remote health industry identify concern about the nature and incidence of bullying. While some examples seem to reflect the fraught emotional state of many managers and clinicians, other examples highlighted examples of highly unprofessional behaviour.

Horizontal violence – that perpetrated by clinicians against peers, was the type of bullying most frequently identified during project consultation. FIFO staff reported bullying by peers as the most common reason for them to avoid returning to a clinic or health service. They also identified that having 'good staff' at a location was a significant motivator for them to apply for or accept an offered contract.

The lesson from this feedback is that the workforce itself has a core role in contributing to or weakening its safety and security. Sometimes differences of opinion will best be resolved through using clinician interpersonal communication skills, while at other times, proactive management interventions are required to protect the safety and security of all staff.

Inadequate staff support & supervision allows problem issues to become accepted and entrenched in some locations.

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PART C: CONCLUSION

7 CONCLUSION

Part A of this document, the Literature Review, built on the 2012 *Working Safe in Rural and Remote Australia Project* report, and noted the conclusions of additional available research published from 2011 onwards. National Model Workplace Health and Safety guidelines prompted re-consideration of some pre-2010 research finding and recommendations. Analysis of violent / trauma events involving the remote health workforce over the past 12 months resulted in re-evaluation of what was previously accepted as the major hazards and risks affecting staff.

Part B of this document collated information provided during industry and community consultation. It also reports on findings from the questionnaire completed by 90 currently or recently practicing members of the remote health workforce. This information reinforced many of the priority issues identified in the literature review. Consultation also identified significant safety and security issues not prioritised in research, and provided up to date information about the opinions and motivation of Fly-In Fly-Out RANs, an increasingly significant component of the total remote health workforce.

In preparing this report, the project has gathered comprehensive information about issues influencing remote health workforce safety and security. This provides a sobering account of the challenges faced by clinicians and managers.

Many of the identified issues can be responded to positively with limited cost implications, although the contribution of industry stakeholders is required to progress change. However, other initiatives involve considerable costs. Procurement, repair and maintenance of facilities, accommodation and equipment will require the contribution of funding agencies.

Using the information compiled from the literature review and industry consultation, the project is now well placed to progress with the completion of other outputs. These will support remote health stakeholders to promote workforce safety through the effective use of workplace guidelines, risk assessment tools, training, and industry resources. Other strategies, such as education of incoming clinicians about safety and security issues, clinician communication and de-escalation training, and orientation options for Fly-In Fly-Out staff will require future inputs by employers and professional organisations.

7.1 Priority Issues and Recommendations

In the course of industry consultation, it was apparent that Australia's remote health sector is committed to engage in their role and contribute further to the health of the community. However, the traumatic events occurring through 2016 have challenged their capacity to do this. A three-pronged response requires:

1. Reducing the risk of serious assault
2. Improving workforce knowledge and skills in activities that support safe implementation of their clinical role
3. Reducing bullying and promoting personal wellbeing across the industry through peer education and supportive supervision by management

Activities based around this approach will improve the capacity of staff to enter, practice, and remain safely in the remote health workforce.

The following summary of issues and recommendations provides a guide forward:

	Issue	**Recommendations**
1	**Workforce injury and death** Analysis of known severe episodes of injury and death of the remote health workforce over the past twelve months indicates that being female, in your accommodation, and after hours' times were risk factors. Assaults are commonly perpetrated with criminal intent.	• Security of accommodation needs to be based on crime protection through environmental design, quality construction techniques, and timely maintenance. • All facilities to be audited annually for compliance with safety & security guidelines. • Incoming staff need to be informed of risk issues and educated around effective and consistent use of safety guidelines before commencing work. • All episodes of assault or injury to be reported by the workforce and collated by employers through a formalised reporting process.
2	**Staff assaulted during Business Hours & On-Call** Past research and project consultation has identified unacceptable levels of violence and aggression towards staff.	• Workplace safety guidelines should identify that RANs are always accompanied on-call and at other work times when risk issues are identified • All call-outs should be externally monitored and identify time, nature of call-out, patient/caller ID and safe completion of the episode of care. • All remote health services should develop, resource, implement and review workplace safety guidelines. • Prior to commencing work, staff orientation should identify safety issues & safe work guidelines.
3	**Responding to critical events** Research reports that staff feel under skilled in assessment, communication, & de-escalation of critical events.	• Training should be developed and rolled out for the remote health workforce with content including Risk Assessment, Communication, and De-escalation skills.
4	**Locating and assisting staff when something goes wrong** The remote and isolated health workforce lacks consistent & effective early response and locator process.	• Clinic, accommodation, and if required, personal alarm systems should be assessed & as necessary upgraded to emit a loud local alarm as well as alert off-site monitoring services. • Remote health vehicles should be fitted with a GPS tracking device. Depending on work location & use, an Epirb (locator beacon) and more complex real time vehicle monitoring systems should be considered. • Personal alarms should be considered for larger and more complex health centres and services.
5	**Workforce driving skills, MVAs** Staff reported inadequate preparation for hazards resulting from driving 4WD vehicles in varying climate conditions on remote dirt roads.	• Staff who have formal first respondent (Ambulance) responsibilities should be educated and resourced as 'emergency service workers' in accordance with the jurisdictions first respondent processes. • Training and experience is required in safe and effective basic maintenance, trouble-shooting and changing a flat tyre. • Training and experience in basic 4WD skills. • Training and experience on long distance driving in remote areas on dirt roads in varying weather conditions.
6	**Workforce emergency communication equipment** Many staff are untrained and lack experience in effective use of emergency communication equipment. Staff reported that satellite phone communication was often unreliable	• All remote health vehicles should be equipped with a Satellite phone. • Training and practice in Satellite phone set-up, use and troubleshooting of reception issues should be completed prior to staff working on-call. • Where in use, training & practice with HF radio transceivers should be completed prior to staff working on-call. • Annual communication equipment maintenance should be included with the health vehicle maintenance schedule.

7 Workforce Fatigue

Environment, workload & wellbeing pressures result in fatigue, reducing staff capacity to work effectively and respond rapidly to critical events.

Staff are expected to self-monitor wellbeing rather than this being a shared employer & employee responsibility.

- Employers should actively manage fatigue through a fatigue management program/process. Including monitoring of rosters, on-call hours worked, timely use of leave, and supportive staff supervision to identify and respond to fatigue and challenges to wellbeing.
- Professional/Clinical supervision should be available for and required of all remote health clinicians and managers.

8 Staff retention

Staff attrition, turnover and churn challenges capacity to consistently implement safety and security guidelines. The transient workforce has limited opportunity to engage with communities in which they work.

- Managers have the primary responsibility of proactively monitoring the workplace environment and intervening where required to fulfill WHS obligations.
- Further rollout of the CRANAplus Bullying App and other resources is required to support individual clinicians and engage the workforce in how to manage workplace bullying.

9 Violence and trauma data

There is limited statistical information available on which to identify and analyse the incidence and characteristics of violent and traumatic events involving the remote health workforce.

- A register of Remote Health Workforce Assault and Trauma should be maintained to monitor incidence and nature of events to better inform preventive actions. The register should be cross-jurisdictional and use a standardised data set.
- Research should be undertaken about the incidence and characteristics of workplace violence perpetrated against remote area clinicians, and effective preventive and response strategies.

10 Reduced number of Aboriginal & Torres Strait Islander Health Workers in many indigenous communities

The lack of AHWs in many health centres increases workforce safety risks and diminishes the capacity of services to provide culturally safe health care.

- Relevant organisations should be supported to undertake further work about this workforce shortage.

11 Dog attack

Dog attack/dog bite is a frequently occurring form of injury experienced by the remote health workforce.

- Education resources e.g. AMRRIC videos to be a mandatory component of remote health workforce orientation.
- Health Services and professional organisations to initiate contact with animal management services to promote working safely around dogs.

12 Workforce safety & security not adequately promoted

Lack of national safety & security standards contributes to varying quality of, and compliance with employer safety guidelines.

- National remote health workforce safety and security standards are required to provide compliance benchmarks for health service Safety & Quality programs
- Sharing information about successful interventions through industry presentations & other communications motivates managers and clinicians to take control of implementing effective workforce safety initiatives.

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Appendix 1. Executive Summary, RDAA *Working Safe in Rural and Remote Australia* project report

INTRODUCTION

The *Working safe in rural and remote Australia* project aims to seek solutions to the problem of workplace violence for health workers, police and teachers in rural and remote Australia by promoting and facilitating a whole of community approach. The project is a collaborative effort of the Rural Doctors Association of Australia (RDAA), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Nursing Federation (ANF) *plus*. A Project Steering Committee comprised of representatives from each of the above mentioned organisations is overseeing the project, which is funded by the Department of Health and Ageing (DoHA).

Urbis has been commissioned by the RDAA, on behalf of the Project Steering Committee, to undertake Stage 1 of the *Working safe in rural and remote Australia* project. Stage 1 seeks to lay the foundation for preventing violence and building safer workplaces in rural and remote Australia by:

1. increasing our understanding of current initiatives/strategies and their effectiveness; and

2. developing a national framework for action for a whole-of community response to working safely.

This report addresses the first point above. It identifies current strategies and initiatives to prevent workplace violence and, to the extent possible, comments on their effectiveness. It summarises what has been learned in the course of undertaking a literature review as well as primary research comprising key informant interviews and a survey of health professionals, teachers, and police with experience of living and working in rural and remote Australia.

METHODOLOGY

Urbis used a multi-pronged approach to identify and collect publications and documents for the literature review. We focused on Australian, and to a lesser extent, international literature produced in the last 10 years. In total, approximately 80 pieces of the most relevant literature and documents were reviewed, including: academic articles; government policies and guidelines; and industry guidelines, education kits and position statements.

In addition, we interviewed 13 key informants who represented a number of peak bodies or support agencies. These interviews were conducted early in the project and helped inform the development of an online survey which was distributed through a convenience sample to police, teachers and health workers in rural and remote Australia. Over 600 responses were received, with over half of these from health workers. The survey responses were analysed using analytic software, with the open-ended question responses coded and analysed separately.

PART A: LITERATURE AND DOCUMENTATION REVIEW

The first part of the report summarises the available literature on the prevalence, risk factors and impact of workplace violence in rural and remote Australia. It also identifies the strategies that exist to improve workplace safety and reduce workplace violence. The key findings from Part A are outlined below.

PREVALENCE OF WORKPLACE VIOLENCE

While workplace violence is recognised as a serious problem, it is difficult to ascertain its prevalence. This can be attributed to:

- the absence of a mechanism to collect solid, uniform data on workplace violence in Australia
- under-reporting of workplace violence
- ambiguity surrounding the definition of 'workplace violence'.

There is no universally accepted definition of 'workplace violence'. The terms 'violence' and 'workplace' are both marked by disagreement concerning what does and does not constitute violence, and where the boundaries of the workplace begin and cease.

A definition of 'workplace violence' frequently cited, and adopted by the European Commission, is:

Incidents where persons are abused, threatened or assaulted in circumstances related to their

work, involving an explicit or implicit challenge to their safety, well-being or health.

(Hoel et al n.d:4 citing Wynne et al 1997)

There appears to be some consensus in the literature that workplace violence can be both *physical* and *psychological*, and can come from a number of perpetrators, such as customers, clients, students, co- workers and supervisors. Workplace violence can range from verbal abuse, threats and behaviour that creates an environment of fear, to physical violence, sexual harassment and homicide (Mayhew and Chappell 2005; Mayhew 2000; Leino et al 2011).

A number of researchers have developed typologies to classify workplace violence to assist in developing violence prevention programs. Mayhew and Chappell (2003), who have undertaken significant research into workplace violence, separate workplace violence into the following three categories:

- Category 1: External violence: perpetrated by people outside the organisation

- Category 2: Client-initiated violence: inflicted on workers by customers or clients

- Category 3: Internal violence: between co-workers and supervisor/employers.

This report focuses on Category 2; that is, strategies to prevent violence perpetrated against health workers, teachers and police by customers, clients, students, or other members of the public. However, a categories of workplace violence, and the different strategies that are required to respond to each one (Chappell n.d:25).

Despite the difficulties in accurately measuring the prevalence of workplace violence in Australia, a number of studies have been undertaken which provide some insight into the prevalence of workplace violence, particularly in the health sector. The health studies vary in sample size and methodology but indicate that violence against health professionals is a serious problem with key studies finding around 65 per cent of health professionals reported a violent incident in the previous 12 months; some studies reported significantly higher incidences of violence.

The literature search undertaken for this project identified significantly less literature on the prevalence of violence against teachers and police in Australia. The literature identified suggests assaults against police are relatively common, perhaps 10 per cent of officers each year (Mayhew 2001), and violence directed at teachers by students is increasing in at least some parts of Australia (Williams 2009).

A few studies have attempted to gauge whether workplace violence is more prevalent in rural and remote locations, as opposed to urban locations. Some studies have concluded that health professionals in some parts of rural and remote Australia report higher levels of violence than their urban counterparts (Magin et al 2010a; Fisher et al 1996). However, no firm conclusions can be drawn from these studies, nor can the results be generalised given the composition and challenges facing rural and remote communities vary significantly.

WORKPLACE SAFETY RISKS

In the rural and remote setting, risk factors associated with workplace violence include:

- *lack of anonymity*: in rural and remote communities, health workers, teachers and police have a prominent role, and expectations associated with the role (eg being on call 24 hours a day seven days a week) can be difficult to meet. In a rural and remote community, it can be harder for health professionals, teachers and police to remove themselves from a person with a grievance and other threatening situations.

- *cultural issues*: cultural issues in rural and remote communities are complex and multi-faceted; ignorance of cultural norms can result in unintended breaches of community protocols.

- *distance management and support:* in some cases, management and co-workers can be located some distance from their colleagues in rural and remote Australia; this can impact on the capacity of the workplace to be a safe environment and on the support that can be provided following a violent incident.

- *mandatory reporting requirements:* there can be practical difficulties surrounding mandatory reporting of suspected child abuse in rural and remote communities, where there may be a lack of anonymity for the professional and a community preference to resolve issues internally.

STRATEGIES TO IMPROVE WORKPLACE SAFETY AND REDUCE WORKPLACE VIOLENCE

Strategies to identify, prevent and respond to workplace violence exist at the government, industry, community and workplace levels. Some of the strategies are relevant specifically to rural and remote Australia, but most are general and can be adapted to workplaces in all locations.

It is within the Work, Health and Safety (WHS) legislative framework that most violence prevention policies and initiatives are developed and implemented. Under this legislation, employers are required to provide a safe place for their employees to work, including those who work off-site. WHS legislation is implemented at a state/territory level in Australia, however jurisdictions are currently in the process of harmonising their WHS legislation.

A large number of policy documents and guidelines exist on preventing and minimising workplace violence. These documents exist at the state/territory, national and international levels. They have been generated by governments, industry bodies, trade unions and employer groups. While the content of the documents vary, they tend to offer generalist advice that enables managers to develop workplace violence policies that address prevention, response and recovery, as opposed to providing prescriptive violence prevention programs *per se* (Perrone 1999:74).

The types of strategies mentioned in these policy documents and guidelines, and implemented at the workplace level, include:

- *Crime Prevention Through Environmental Design (CPTED):* enhancing the design of buildings with the help of architects, engineers, builders and landscape gardeners to discourage criminal activity

- *Education and training:* on issues such as recognising and diffusing violent and aggressive behaviour, self-defence techniques, communication skills, and cultural sensitivity

- *Communication procedures when working off-site:* such as a system to record the address of the place visited and time of departure and return, and scheduled telephone calls

- *Support post-incident:* such as giving the victim access to medical care, collecting evidence about the incident and completing an incident report, holding a post-incident de-brief, and ensuring the victim is fully informed of all actions taken in response to a violent incident (Mayhew 2000; Perrone 1999)

- *Employee Assistance Programs*: an early intervention strategy, which involves assisting employees with personal and work problems, through confidential counselling, educational material, referrals to self-help groups and specialist services (2003)

- *Mentoring programs*: which allow for peer networking and informal sources of advice and support.

Specific violence prevention strategies relevant to the health sector include:

- recognising and de-escalating violent behaviour

- zero tolerance policies

- flagging the files of clients with a history of violent or aggressive behaviour

- acceptable behaviour contracts

- refuse to treat directives

- intervention orders.

In the education sector, specific strategies for combatting violence against teachers include programs to create strong relationships between teachers and students, and controlling student behaviour through policies on bullying, school dress and language, and prohibition of weapons, drugs, and alcohol on school premises. In the police sector, specific strategies include wearing of body armour, and the abolition of single person patrols and single person posts.

Some researchers have sought to identify what individual strategies should be included in a *comprehensive Working safe in rural and remote Australia* project seeks to develop a whole of community approach to preventing workplace violence against health professionals, teachers and police in rural and remote locations. A whole of community approach needs to recognise and respond to the diversity of rural and remote locations in social, cultural and economic terms. It must also seek to engage the community and involve key players in the development of strategies and initiatives.

PART B: CONSULTATIONS

Part B of this document reports the findings of an online survey completed by 624 health professionals, education professionals and police in rural and remote Australia. The survey asked respondents about issues surrounding workplace safety, including any exposure to workplace violence, and effective strategies to respond to and manage workplace violence. Due to the lack of a sample frame (ie a list of police, health and education workers in rural and remote communities) a sample of convenience was undertaken. While this is a legitimate approach to quantitative sampling for hard-to-reach audiences, the sample is not random in nature and as a result, it is not possible to extrapolate the findings from this report to the population as a whole.

The key findings of this survey are outlined below.

CONCERNS AND EXPERIENCES OF WORKPLACE VIOLENCE

Generally, respondents concerns for workplace violence were not excessively high, with the majority of respondents across the three sectors reporting they felt safe most of the time while at work. There appears to be some acceptance that there is a level of risk which comes from working in these jobs or in these locations. That said, the main safety concerns for respondents focused on physical violence or verbal abuse from community members, while respondents were least concerned about experiencing sexual abuse or assault, and bullying and harassment by colleagues.

Environmental factors, such as working long and unsociable hours and working alone were also identified as contributing to feelings of being unsafe in their workplace. Isolation and working alone appear to contribute to concerns about the risk of violence.

Of the respondents that expressed *serious* or *some* concern about workplace violence, generally less than half reported actually experiencing an incident in the past 12 months. Some key informants also suggested that perceived risk was greater than actual risk. The different skill sets required to work in the three sectors was also to some extent reflected in the different concerns for safety and experiences of workplace violence. For example, police were much less concerned about driving on rural roads, but expressed concern for conducting home visits, working on their own, and working long and/or unsociable hours. Notably, health professionals were much more concerned about bullying and harassment from colleagues, than either police or health professionals. This could suggest that the issue of colleague- initiated workplace violence requires further consideration within the health sector.

Despite the differences amongst the sectors in their concerns for workplace safety, negative impacts resulting from these concerns were still felt by all respondents, and increased stress and anxiety were reported as the biggest impacts. Addressing issues which cause stress and anxiety, as well as other workplace safety concerns, may be one way in which workplaces can help their staff remain longer in their roles, and feel safer working in a rural or remote location.

SUPPORT TO PREVENT WORKPLACE VIOLENCE

Overall, respondents generally indicated they had received some level of workplace training and education. The most commonly reported education and training received by respondents included professional development, first aid training, and cultural competency and awareness training. Respondents from the health sector reported receiving the most training and education. Not surprising, the types of training commonly received reflects the different job requirements for each sector. For example, health professionals were more likely to have received training in violence prevention and aggressive behaviour management, but least likely to have received first aid training. Police and education professionals on the other hand reported receiving more training in driving in rural and remote Australia and in first aid training.

Overall, respondents generally felt the policies their workplace had in place to prevent workplace violence were adequate. Notwithstanding this, the number of respondents who reported using strategies and supports identified in the literature such as CPTED, scheduled telephone calls or acceptable behaviour agreements was low.

Suggestions on how workplaces could be improved to prevent workplace violence generally related to improved training (particularly in managing violent and aggressive behaviour), enforcing existing policies (eg zero tolerance policies) and improving work practices (eg joint patrols). Implementing such suggestions is likely to require funding and staff time. However, both lack of funding and lack of staff were identified by respondents as the two biggest factors affecting the ability of employers to respond to workplace violence.

COOPERATION TO REDUCE WORKPLACE VIOLENCE

Overall, the findings from the survey did not present a consistent picture of whether and how the three sectors were cooperating to reduce workplace violence. While some respondents did report there were formal mechanisms in place, others reported low levels of cooperation across sectors.

The role of police in providing support in emergency situations was most commonly reported as a specific example of sector cooperation, although this is in fact part of the job rather than an example of sector cooperation. Information sharing, communication and networking opportunities were also examples of how cooperation was occurring between sector professionals.

The most commonly reported suggestions for improving sector cooperation related to better information-sharing and communication through multi-agency meetings, better networking and support across the three sectors, and better education and training.
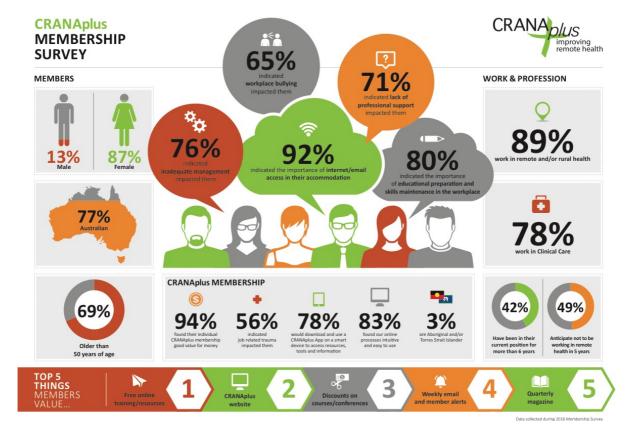
In developing options for improved cooperation, however, consideration must be given to the barriers to inter-agency cooperation identified by respondents. These include lack of staff, lack of time, lack of funding, and the different interests and priorities across the three sectors.

PART C: CONCLUSIONS

Part C of this report concludes by drawing together the findings of Parts A and B, and makes the following points.

- There is a need to develop reliable mechanisms for recording workplace violence, in each sector as well as across different locations in Australia.

- Generally, survey respondents reported feeling safe most of the time.

- Levels of concern regarding workplace violence appear to be higher than actual violent incidents.

- Any strategy to improve inter-agency cooperation needs to be flexible to build on existing levels of cooperation.

- There is a need for evaluation of violence prevention strategies and initiatives, to discover what works best in particular environments and situations.

Appendix 2. CRANAplus 2016 Member survey results

CRANAplus MEMBERSHIP SURVEY

CRANAplus improving remote health

MEMBERS

13% Male   87% Female

77% Australian

69% Older than 50 years of age

65% indicated workplace bullying impacted them

71% indicated lack of professional support impacted them

76% indicated inadequate management impacted them

92% indicated the importance of internet/email access in their accommodation

80% indicated the importance of educational preparation and skills maintenance in the workplace

WORK & PROFESSION

89% work in remote and/or rural health

78% work in Clinical Care

CRANAplus MEMBERSHIP

94% found their individual CRANAplus membership good value for money

56% indicated job related trauma impacted them

78% would download and use a CRANAplus App on a smart device to access resources, tools and information

83% found our online processes intuitive and easy to use

3% are Aboriginal and/or Torres Strait Islander

42% Have been in their current position for more than 6 years

49% Anticipate not to be working in remote health in 5 years

TOP 5 THINGS MEMBERS VALUE...

1. Free online training/resources
2. CRANAplus website
3. Discounts on courses/conferences
4. Weekly email and member alerts
5. Quarterly magazine

Data collected during 2016 Membership Survey

Lots of really useful data has been collected, and as you can see from the summary some really clear results came in! For example, if you're an employer, then you need to ensure that your staff have good internet access in their accommodation otherwise you're potentially going to miss out on attracting about 90% of the workforce who think this is important to their sustainability.

With 70% of our workforce pushing 50 years or older, and 20% of the workforce not expecting to be working remote within the next 2 years, we have some serious workforce shortage issues that we must urgently address as an industry. Some other unexpected results included:

- 5% of respondents stated that poor personal safety and security impacted on them, with 34% saying it didn't impact on them at all

- 95% of respondents felt that drug and alcohol usage was not a significant impactor

- The burden of on-call was an important workplace condition for 85% of respondents, with the day to day workload and fatigue management systems being an even higher priority at 98%

- We are pretty IT savvy with a vast majority keen for a 'remote health app', although about 50% of respondents were not fussed about Facebook or social media

Note: Membership survey results may differ to those from the Safety & Security consultation process, as the two activities had different goals, and used different questions, and survey methodologies. Comparison between the two activities is not included as part of this report.

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Appendix 3. CRANAplus National Safety & Security Project Questionnaire

The goal of the Safety & Security Project is to develop and share resources which use a positive, supportive approach to promote remote health workforce safety, and in doing so, to facilitate availability of quality health services to remote populations. Your assistance in contributing to project information collection is appreciated. Participation is voluntary. Please note that respondent name & contact information is requested to assist follow up and further communication, it is not mandatory. Confidentiality of Clinician and Health Service information is a CRANAplus priority. **Project reports and resources will not identify any specific individuals, services or locations.**

	Name	
	Email	
	What is your current work location?	
1	How long have you been a RAN? How long have you been employed <u>at your current or most recent</u> location?	Total RAN experience: Time at <u>current</u> job:
2	Are you employed directly by a Health Service, or through a Nursing Agency?	
3	If you have worked through a Nursing Agency for more than six months, why do you prefer this to direct employment?	
4	How many RANs and AHWs / AHPs are employed at your current (recent) workplace?	RANs: AHWs / AHPs:
5	Do you consider your accommodation safe & secure? (E.g. Gates/fences, insect screens, fire alarms, locks etc.)	
6	Has your accommodation been broken into over the past 12 months? If yes, have 'weak points' been adequately repaired?	
7	Does your workplace job description identify prioritising staff safety as part of your role?	
8	Does your workplace have 'Never Alone' or similar safety guidelines for business hours and on-call work?	
9	Are safety 'Never Alone' guidelines supported and implemented consistently?	
10	If Yes for Q9, What's contributing to ensure the guidelines work? If No for Q9, What's causing problems? E.g. Nurses, Community, Management, Other issues?	
11	What personal efforts did you make to find out about your employer and your job location / environment prior to starting work?	

12	Did you have any orientation before commencing employment with your current employer? If yes, how many days' duration?	
13	If you did have orientation, did it focus on health service requirements (IT, ordering Rx & supplies etc.), or did it also involve safety, security & staff wellbeing information?	
14	Have you been provided formal (1-2 day) 4WD training, including practical driving experience, daily maintenance, & hands-on flat tyre change experience?	
15	Is the main health service vehicle reliable & adequately serviced? Is it fitted with GPS tracking, Sat Phone or HF radio?	Reliable: GPS tracking: Sat Phone: HF Radio:
16	Have you had training & practical experience with all available communication equipment?	
17	Is the clinic building safe, lockable & secure? Is there appropriate lighting?	Building: Lights:
18	Is there reliable 24hr phone and/or radio contact with other health & community staff, your manager, and Emergency Services?	
19	Are clinic alarms, personal alarms or personal locator beacons (PLBs) available for staff use? Do staff use them effectively?	Clinic alarms: Personal alarm: Personal Locator Beacons:
20	**Since August 2015, have you experienced or observed (E.g. involving yourself or other staff) abuse, violence, bullying or harassment that resulted in:**	
20.1	Staff immediately resigning and leaving the community / health service?	
20.2	Staff leaving the community for medical treatment?	
20.3	Staff requiring review or treatment on site following violence?	
20.4	The psychological impact of threats, bullying or assault impacting on the wellbeing of staff, and their ability to continue working?	
20.5	Staff temporarily restricting service access or being evacuated for safety reasons?	
20.6	Cumulative episodes of threats, bullying or harassment being the primary cause for staff choosing to resign & leave the community?	
21	Would you be willing to be contacted personally to provide further information about any of your answers?	
22	How would you rate your skills & confidence about de-escalating inter-personal confrontation?	1. Very Competent 2. Confident 3. Requires development

If you have not been able to complete the questionnaire, or if you are sharing it with other remote area staff, please scan your response or answer the questions by number in an email and send to: rod@crana.org.au
Thanks, and Work Safe!