

Violence and aggression against emergency workers
Focus Group 1
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Legend

In this report, the candidates are numbered in the order of speaking, "C1" stands for the candidate speaking first, "C2" for second etc. "I1" stands for the first interviewer, "I2" for the second interviewer, etc.

Focus Group 1

I1: "Great. Thank you very much. And when we're talking, if you can try and project a little bit, just cause we've got the recorders in the middle of the table. Just try and be loud if you can. Right, so, we've got two questions we are going to go over, or two topics. One is reporting, and then we are going to talk about perpetrators. So firstly, if you can just talk about whether you have reported incidents and what you find [would be] barriers or motivations for you for reporting. We'll need someone brave to start."

C8: "Do you mean reporting as in to police? Or to senior staff? Or..."

I1: "So you can discuss, yeah, if [you want to] report in house, in Riskman, or if you have experience reporting to the police."

Inaudible comment in background

C3: "The Riskman is too difficult, we don't bother."

Other candidates agreeing in background

C3: "You don't bother. You write in the notes that 'patient aggressive, Code Grey called', and then you talk about the outcome with the Code Grey. But when it comes to Riskman, I don't we have any studies at all, or any evidence at all to show that we have Code Grey here in the department."

C10: "I think they are done though."

C9: "They're done, but we're..."

C3: "It's completely [under]..."

C9: "I think we don't do them enough, because we don't have time to do them. Riskman could take 10 – 15 minutes, because it is so god damn complicated. There are all these different tick boxes, and nothing works properly. We barely have two seconds a lot of the time, so, and then we want to have a break, we don't have to go throughout the whole incident again. So it just doesn't get done. And I think we are one of the lowest [...]"

C3: "It's almost designed to be a barrier."

C4: "Yeah, well I think..."

C3: "It's designed to be difficult, time consuming."

C9: "I think they were saying that because we don't do it enough, it is actually showing that we are one of the safest hospitals in Victoria."

General laughter

C9: "Because the Code Greys from the security aren't actually measured or quantified or anything...it's all about the Riskman, and because we don't do them, it's saying that we are safe, yeah, which is a lie."

I2: "I'm on the [...] committee, so when they present data of the previous month about Code Greys and Blacks, you think are underrepresented."

C4: "Absolutely."

C3: "The best stats are kept by security. Security have to...they log every job, and they got a running sheet of details. And so the best stats Code Greys is in security. We don't report them. We just write in the notes what's been going on."

C4: "We have multiple Code Greys a shift and attached to one of those is meant to be a Riskman. There is no way I could... I reckon 100% I could confidently say that when a Code Grey is called, no stat... as my colleague said, you would you know, in the notes, but if you call 15 Code Greys a day, there is no way you get 15 Riskmans associated with that. You might be lucky to get one, if that."

C8: "I think from a, like I mean, this is probably a bad attitude from needing point of view, but, we take something... you have to have a serious injury or something like that to then do a Riskman. From a Code Grey... So if someone is threatening violence or being..."

C3: "[For potential work cover stuff]"

C8: "Yeah, no, it's true though. Like if someone's, you know, threatening violence, or indicating that they might become violent, you know, I think, we will get security there, we wouldn't necessarily Riskman, just the Code Grey. But I think if someone was injured, then they would. Which isn't necessarily the right thing to do, because it is more than risk, you know, risk is now being... as an injury, but I think yeah, from a..."

C10: "We have a very high threshold, we tolerate so much, that it has to be an significant incident or a significant threat before we actually do something."

C10: "Because we are so... it's just water off a duck's back, to be abused, threatened."

C9: "It's a daily."

C10: "Yeah, which is pretty tragic really. And I'm not... I'm certainly talking about drug and alcohol affected [patients]"

In background: "Or mental health..."

C10: "Or mental health. It's different abuse from mental health I think."

Agreeing in background

C10: "They come in combination though, really, the sort of...the abuse I think we are talking about. The threats..."

C8: "And it is getting worse, I think, and it is also, I think, there is more of a push now to report things, as far as, you police goes and things like that. I've been here for...I've been in the hospital for 10 years, but it's probably only the last few years, that unless something major happened, you wouldn't really hear about it. But now to try and prosecute people that are...you know even if it is like spitting on someone or something like that, you haven't necessarily got physically hurt but it is, like, really inappropriate, disgusting behaviour. That now [that will go] and try to report those sorts of things."

C4: "And I guess I can speak from experience, like, now the reporting is 10 times better. 2014, I was assaulted by a patient and ended up 11 months, I was on work cover. This system itself let me down. I wasn't supported. And I went to the police and they basically turned a blind eye with some other associated issues that were out of their hands."

So, you know, 11 months, like, looking at the bigger picture, I guess people sometimes are a bit blasé because, you know, oh it was a near miss, but until you are actually assaulted, whether [that person is] spitting, or, you know, I received a physical injury. People are a bit blasé and they don't actually understand, I guess, the mental, the financial impact that it has globally. And obviously, there is getting back to work as well. Because then you're confronted with that same patients on a daily basis, multiple times a day.

And so yeah, 2014, like, that was hell for me, I'm not gonna lie. And yeah, there was literally no support. And then yeah just all the work since then, as I said like, it has, you know, 200% improved and...you know, all...we went through all the motions and what not. But yeah, it would be...I would've actually said support from both organisation and police 5% in my case in 2014. So to know that other people are making reports and, you know, getting followed up and getting action, and people are getting charged. From someone, who was there with nothing, that wanted something, like that's a huge, for me, that's a huge sort of positive step."

I1: "I guess the question is, isn't it, whether an increase in reporting, what difference would that make, do you think? To the bigger picture... So if you

did report every Code Grey incident that occurred, what difference would you think that make?”

C3: “Well, it would support some staff who have been on PTSD. We have some that have gone off on that. And they’re...their claim was [unhelped]. It would support, if we...the same with the [safest] department doesn’t reflect what we are actually saying.”

C9: “Maybe we would be able to get more staff, potentially, if we reflect that it is extremely dangerous that we [needing all] these one-on-ones, but we can’t actually *inaudible word* specialising, it doesn’t happen [...]”

C3: “It supports with the NRTs, like proof for the business case model for having NRTs or having extra security staff.”

C8: “Yeah it’s...like I had a incident the other night, there was a man who was essentially just probably drug seeking, but he was just being so horrible. And was more verbal threats, but it was just...shouting out things...he was getting all the attention in the department despite there being really unwell people in Resus. It was all verbal, you know, but he was threatening to wait for me outside when I went home and things like that which is like, you know, I don’t need to hear that at work.

And the steps taken... you know, I was in charge, so there was another girl who was sort of directly involved with that as well, and she Riskman-ed it and they sent this man a letter saying basically like we’re acknowledging what has happened and if... you know, we have a zero tolerance, and sort of part of me wants to, like, this guy’s got an anti-social personality disorder. I almost feel like this is going to fuel him more because he was so angry that we hadn’t helped him, despite the fact that he actually managed to jump a 7-hour wait, because he was causing a ruckus. Which was really frustrating as well.

And, you know, I guess flagging these patients is a big thing for us, so we can identify as soon as these people rock up to triage, that we can say, he’s a high risk, you know, at the triage [we link] people and we can flag them, but you know, sometimes you don’t know until it’s too late that this person has these risks previously, and you know, been in jail for 15 years for assault, or, you know, really high risk people.

Yeah, and part of me sort of goes, ‘great, he’s gonna get a letter, that’s nice’ (*sarcastic sounding*), you know, and, but obviously, what else can you do. But he didn’t actually cause any harm, but again you have to cop that everyday, and so I guess trying to document how much we actually deal with that sort of thing. And know, male or female, but I guess being a female, leaving a night duty you don’t want think that some guy who’s been in jail is going to wait for you outside, you know. And that’s what we cop, and...yeah, it’s...I don’t know what a better way to do it is, other than sort of tell the powers above.

And I don’t think this guy will care about his letter. But at least, if those steps start getting taken, that you can say to the police, ‘this is what’s happened

previously', and, you know, that there is more zero tolerance, I suppose, for the next thing."

C6: "I also had an experience in the behavioural assessment unit, where we had a young female who had had previous post-traumatic stress from... she was a rape victim. So because she was quite young, there was some barriers there where the psychology... well the EMH [Emergency Mental Health] didn't really want us to call any Code Greys on her, because it could re-introduce her post-traumatic stress.

And it was a little bit difficult because we only have male security staff, so that was a barrier for us. But as a result of not calling these codes when we should've, at end of all of this despite escalating, we had a staff member assaulted, but prior to that this patient had also said death threats to myself and the other staff. And nothing was going to be done about it.

We did Riskman, but at the end of the shift I said, like, I've done all that I could in my power to try to reduce this. And I escalated and despite that I was still given death threats. It's not as bad as being physically assaulted, like the other staff member, but I still felt that it was necessary to go to the police. Because she literally said if I see you on the street, I'm going f-ing kill you. And she's like 'I'll remember your face, just you wait'.

And then it's the same sort of feeling, like threatening to be here when we finish work, and like, that's the sort of thing that you don't want be living with, thinking like 'oh I wonder if that girl is around'. But anyway, so I, because of that specific reason, I went to the police and reported her. And it was only because I was going, that the other staff member decided okay I suppose I should probably do something about this. She was physically hurt, but she wasn't really discussing the mental side of things as well.

And the other reason that has probably driven...that drove me to go in, was that only that week we had somebody from the police saying that you really do need to escalate when this...threats of violence, verbal aggression as well, because that's just so underreported, like we get that on a daily basis. But Riskmans, we just don't report it. But yeah, so that was something that I..."

I1: "Do you think the new procedure...they've got those clearer procedures about how you report to the police, do you think that was useful in you going to the police? Or is it more the police officer telling you to report, basically?"

C6: "Well, the police officer saying something during the week, I was like, actually we do need to report this. That, that played a role. Also the fact that she literally pointed to one of our posters that talks about aggression in the workplace and she said 'no wonder you get assaulted' and I was like 'oh okay, really?' So she used that, and I don't know whether that actually triggered her to then become more aggressive, I'm not sure. [It sort of] worked in the opposite. I suppose the poorer outcome was that I never heard anything from the police. There was no follow-up at all. So I don't really know what happened to her afterwards. And I know that the person that was assaulted

didn't hear anything back either. So we don't know what the outcome was, but I suppose the only positive is, there is a record of her doing something, if anything was to, like, happen."

I1: "So we also want to know a bit about that, the new system, with the new procedures. And apparently there is a liaison between police and the health care staff? Not sure when that happened. So..."

In background "New system?"

I1: "Oh it's not really a new system but new procedures or clearer guidelines about how you should report to police?"

C8: "I don't know person... I know that culture-wise there's been a big push to tell us to do...not to tell us but to encourage us, just basically being like, you know it's not deaf ears. I guess we're lucky there is actually a police station around the corner, which, this is a bad way of looking at it, but if you just had a 10-hour night duty, you can't be bothered going wherever, but that is, you know, probably convenient, that it's close, [to go] North Melbourne.

C10: "We did have an [insert] with a coppa..."

Agreeing in background

C8: "I think the thing with when you've got a 180 staff members, like you don't know everything that happens here if you're not on weekdays and at in-services, but you know, there was obviously a really big...you know, we made a video. And there was a big push in our department about..."

C3: "There was a video?"

C8: "There was."

Laughter

C9: "It plays in the waiting room, like 24/7."

C3: "Does it?"

Agreeing in the background

C3: "I miss the TV..."

Laughter

C9: "You read your emails?"

C3: "I do read my emails, I haven't seen this one."

C8: "Yeah, so I guess culture-wise they've really put a lot of effort in trying to say you will be supported. Our boss wants to be told, she's not someone that would sort of discourage you telling her. That's my personal opinion. And...yeah, so I guess culture-wise, but I don't know actually personally about a formal system that's changed other than..."

C9: "Other than there is more encouragement."

C8: "Yeah"

C9: "I haven't experienced anything either, I haven't reported anything but as far as police go or..."

I1: "Yeah, it sounded like there is a liaison between police and the health care staff to feed you back some information, so you guys haven't experienced that?"

C8: "It's sort of vaguely familiar, that stuff happened, but a lot happened in this sort of, I don't know, year?"

Agreeing in background

C8: "Like I said, we've had...I mean it was on the news, our boss was on the news. There was lots of communications and I guess a lot happens here in a short period of time, sometimes, and then you carry on. But..."

I1: "But in practise? You haven't really noticed you get fed back much information from the police."

Several candidates "No"

C7: "Didn't know there was a liaison at all." *Laughs*

C8: "It's not surprising to hear after that, but then I don't know that there..."

Agreeing in background

C7: "It makes sense... sounds like it would be great."

C3: "It's...there's another... there's 100 new security cameras in the hospital and I got a really great relationship with security [of this]. I'll go in there and chat with them, and they just pull up all the latest videos." *Laughs* "Some of it is a [Benny Hill] show. But, I have a really great report with them, so I can pull up the video and I can have a look at it. But that is actively discouraged by the hospital. If they get caught, they get told off. They don't get in trouble, they get told off. But there is a resource there that we're not allowed to use. That we can't...like we've got all the videos of what goes on, and who is... I've even done it to find valuables. Cause patient's said I'd come in with a bag, so I've looked at the triage when they've come in and there's no bag there. And I have that report with them but nobody else does...not many."

C9: "Sometimes in the waiting room though, and you're triage nurse, say you've been doing something else, I've...well after...they do let you go in to actually see what's happened."

C4: "Yeah, you see themselves [blowing] themselves on the ground instead of actually collapse."

Laughter

C3: "Yeah, but we're actively not...the hospital-wide...I don't know who owns those videos or how we can access those videos. I'm sure the police will probably request them, if we actually try to press charges. But it is not actively supported for us."

C8: "I think they use them, like all the... same thing when it was kind of popular in the news, I suppose, that was all footage, not Royal Melbourne specific, it was hospital specific. But a lot of that was from us. And so I reckon they do. If an incident happen, they would always, it would always be there to use."

C3: "[If it got that far.]" *Laughs*

C8: "Yeah, yeah."

I1: "So, it sounds like you do know why we report everything, you have some motivation to support, is that not enough to overcome the barriers?"

C9: "If there was like a paperwork system, where you just grab a piece of paper or something, wrote down what has actually happened instead of ticking every single box, having to go through hundreds of little boxes and finding the right one." *Agreeing in background* "You never know if you've done it right and you always have to email to fix [if you do]. So if you just have a piece of paper, wrote what happened, why you're reporting it and how it affected you or something, and that put in a box. I reckon that would get done 100 times a day."

C7: "Even if there was a separate thing within Riskman where you could say, like, an incident of occupational violence, just make it so much simpler."

C9: "Yeah."

C7: "Cause at the moment there is just so many checkboxes, and half the time you don't know which bit to select, and it just gets tedious."

Inaudible background comment

C7: "Especially, yeah, especially, if you've got one patient. You're working on the [...] side, and you've already called three or four codes on the same patient, you know you are going to have more for the rest of the day. And you

just know you are not going to...so if there could be a simpler process for incidents such like this, it might be more effective.”

C8: “I think outcome too is, as already said, like this sounds really bad, but what’s it for us, like, if you don’t hear back. You know, verbal threats are a hard thing, but if someone suffered physical and they still haven’t heard back from police if this person’s been charged. I know people have been charged, but... and also from a hospital wide point of view, whether it is literally we need more staff or more security dedicated to emergency, cause, like we have so many codes... and some many...we...we’re quite good at [calling] plan Code Grey, like if we think someone’s at risk, we’ll get those [by now].

We had some one at the behavioural unit the other day. He was just starting. He was a big boy, loud and you know, we just called plain code, so security’s there. But then if two other codes happen upstairs, they’ve got to split their time.

So I guess from a reporting point of view I guess if you thought that’s going to be turning to stats to then say actually on average this many times a day we are feeling threatened. And then that turns into something, then I think people would be more inclined to do it. But, getting told that that anti-social personality guy is getting a letter send to him, I was like, good that something has happened, but that is not going to necessarily deter him.

And I think I could name 5 names of the top of my head and everyone would be like ‘ugh, god’ and we know them so well. They’re frequent flyers. They come in and unfortunately, they do have these personality disorders or anti-social personality disorders where they...they’re not deterred and they thrive on conflict, I suppose. And the police know them, we know them. But, you know, whether it’s more...there’s one triage nurse overnight, and they have to cop these people that come through plus manage a waiting room of how many other people. And these people are really hard to de-escalate. And the whole waiting room of other patients have to deal with this person in their waiting room.”

C9: “I had one spit on a patient the other day in the waiting room, just cause [he] was sick of waiting over an hour. It’s an 8 hour wait.” *Laughs*

Agreeing background

C8: “And that all turns into angst to triage nurse like this is what you’re letting happen, when you’re like ‘Well I’ve got ambulances coming through the back door. I’ve got a waiting room full of people that I’m trying manage and then one or two, you know, aggression risk people that...’ You may have report it ten times or call the police and then they come turf them, then they get sectioned by another set of cops and they bring them straight back. And then you’ve got to deal with them again. And so, I guess, from a reporting point of view, you’re just like what am I getting out of this? Cause this is a repetitive thing that happens, so...”

C7: "That's a really point actually. They do just get brought back in."

Agreeing in background

C8: "Yeah, and it's obviously really difficult for the police too because these people..."

C9: "Yeah, and it's not their fault."

C8: "Yeah, it's problem with..."

C6: "Or they get escorted out and then throw something at the front door, smash the window. [Then something has to be done with it.]"

C4: "They were talking about this on nights recently, as well, other hospitals, once...they can ban patients. So obviously if there was something that was really dire that happened."

C3: Inaudible comment

C4: "You know, they can't go back to that hospital. But that might be something bad happen here, that because of...the duty of care that we've got to them, that we have to keep...or they keep coming back. And then we're subjected to their ongoing aggression. So I don't know if a lot of people find that really hard knowing that there are some organisations, which are very happy to ban. I'm not saying that that would be an easy process, but, you know...on one hand you can ban people, cause of their increased or their ongoing aggression, but yeah, we get them kicked out then, as you said, [hard for the] cops to have to bring them back."

C8: "They run into traffic somewhere and they get brought back."

Agreeing in background

C4: "And then we're sort of dealing with them all over again."

C7: "Yeah, you can see them three or four times in a shift."

C8: "I think the police are good in that regard that they'll take us seriously and stuff. And it's trying to...suppose...you know, like, the more we know people, the more we can get, sort of, quicker responses from our mental health team. But from, like, a nursing point of view it is quite difficult. We're waiting on a mental health person to say yeah this person can go.

And we have a duty of care, we don't want to think that we let someone go that is gonna harm someone in the...so there is like an ownership on us to be safe for the community as well when we say 'yeah, you can leave' or you know, to get someone escorted out before they've been seen and are causing, sort of, a situation. When you're like well then they are just going to

go outside and then what are they going to do. So that's something we have to go home and think about as well, which is really difficult. So..."

C6: "Yeah they start becoming verbally aggressive to vulnerable patients that are sitting outside, getting out of their cars, and...are outside smoking or something."

C3: "[They clean out the waiting room...]"

C6: "Hey?"

C10: "I've always been taught to de-escalate. [It went] confrontation, de-escalation, find out the issues, but I don't think any of us have the time anymore to actually...and it's not part of our priority to sit there and actually try to calm someone down, find out what the issue is...and, you know, it's easy just to... 'You either like it or you don't, this is how it's going to be' and you move on, you know. And I think that..."

Inaudible comment in background.

C10: "Yeah, and I think it's going to...if someone's aggressive and they're violent they need to get out. And there is [point], you have the opportunity to de-escalate and find out the issues, but it's a luxury. It's, you know..."

I2: "[Do you think] the zero tolerance policy has discouraged de-escalation communication skills?"

C10: "Well, absolutely, I mean, and there is a point where I think it's been [beneficially]... I think if you work here enough, you get the vibe or where people are at, and you sort of get a... it's an innate feeling of what's someone's like and you can decide how quickly [they're going] towards down that track. Whether they're reasonable or whether it's just futile in even having a discussion with this person, just you know..."

C3: "I actually think the zero tolerance gives me a little bit of confidence and support. I try and de-escalate, get along really well with most psych patients, and I spend a lot of time with BAU, because you know...I don't know...I enjoy it."

Laughter in background

C3: "I don't mind 27, 28, 29. You can't do it everyday, it's really challenging, but zero tolerance gives me confidence."

C9: "To say no."

C3: "Even a false believe that I might be supported if something happens beyond that. But yeah, I like it being said because it actually gives us a back...a grounding to say you can stop talking like that or you can leave. And

then you can...we can then escalate Code Grey and say he's going. I don't...you know... but I [think] our patients all the time..."

C9: "I agree, I think we all try and de-escalate in a way. I don't think there is anyone who just yells back. We also try to talk people calm or we try and make sure to [start]... it's just how long do we do that for and what's our patient's [similar]. Have we done 10 hours a night, 10 hours of being abused, or 9 of those hours or something? What does our patient say? I agree that zero tolerance is a good [backup]."

C8: "Yeah, and I think most people here, despite what we do, cop like, you know... we want to be helpful. We want to care for people. And you know, a lot of these people have had like horrendous upbringings that you know we wouldn't wish upon each anyone. So you want to have that kind of overall opinion that you're like 'alright, let's take a step back and think about why there are at this point now, and why they are in this crisis'. But at the same time, yeah, having the zero tolerance thing gives you that sort of reassurance that you're just like you might have done this but we need to be protected as well, because otherwise..."

C10: "But your empathy, and your resilience and your strength is dwindled down to a point, I think, that you're either [give them the choice or take the choice]. That sounds very simplistic, but it's not simplistic necessary obviously. But people aren't going to cho... choices."

C4: "But one of the barriers, one of our big problems is the delays in EMH reviews. Like we can talk someone down and get them to say you're going to be seen by...you've come in under a section 351, so you then need to be seen by mental health, otherwise you'll be put on an AO. If you're being abscond, you will be brought back and going be on an AO. And we can calm them down and do all this diversion-tactics, you know, nicotine patches, diazepam, [...], you can do all that. But if we're waiting 6, 7, 8 hours for EMH, then they are just going to escalate. And in that cycle of escalation as well..."

C9: "...and they can't go out for a cigarette..." *partly inaudible comment*

C3: "And then they can't leave, so it gets to the point where we sedate and then EMH comes in and say I can't assess."

In background "Cause there sedated." *Laughter*

C3: "And it's just like you, ugh...anyway, they need to be on a [time-manage] study, you know, they need...I know that there is a new boss in EMH and that there is more staff, but in this mental enquire that the government is going to do, it's going to be fantastic. Because they need to be assessed. But one EMH [assesses] two patients overnight, and then documented on everyone is saying workload to busy for assessment in the morning, you think..."

C10: "They make some big decisions, though."

C6: "The same..."

C9: "And they [have to spend] hours on paperwork."

C3: "They make some big decisions, they can make some preliminary decisions too. They can assess the patient..."

C9: "I think we've actually improved, remember that like every time, the last view months at triage, when I've had a section 351, actually, there has been someone from the EMH office. This is daytime hours, I don't know about overnight."

C3: "Yeah they don't usually..."

Very brief discussion, 3 candidates talking over each other – inaudible.

C4: "...twice and I did it, and yeah the EMH came out or they rang me, if they were busy, so there was..."

C9: "Yeah, a couple of people that have been really good, they're some of the...yeah."

C3: "It's very sketchy, I've..."

C4: "It depends on who's on."

C9 & C3: "Yeah."

C3: "And there is a new boss in EMH so maybe she's looked at that and decided that's one of her roles to...but you're [doing] a section 351, you did page a triage and you're suppose to have a floor coordinators and security and EMH is suppose to show up. I think security and floor coordinators are often losing..."

C10: "Most people don't do them..."

C8: "We don't carry a pager, so that's the problem. We're not there, we don't see it."

C3: "Yeah."

C8: "It's not ideal. I rather a phone call but that means you've got to call 10 people so, you know...from..."

In background "...escalating..."

C3: "Yeah, so there are three cohorts of people, they're suppose to..."

C7: "And a senior medical officer as well"

C3: "And a senior medical officer..."

C8: "They don't get it."

C3: "Maybe [you don't], so you're doing this...you're... the page at triage is suppose to fast track them into BAU, or to...like a senior medical doctor can remove section 351 and the obligations under the AO. And say that if they abscond from that point, we're not seeing police after them. Or we're not... you know."

C10: "And we're meant to give notification so..."

C6: "I just, before we get to far away from what we were discussing, just want to sort of say on the flip side, with patients escalation and using the zero tolerance. I think that sometimes the staff members that are sort of using their role in a negative way, as in like, trying to overpower patients when they don't really need to, and being inappropriate. Like this patient's come in and we sometimes just assume what we're hearing is correct."

Example, say a patient comes in, they've had an argument with their partner and they've said to their partner something and then the police has been called because they said they're going to kill themselves or something like that. And it's their word against the other. So this patient could come in and then they'll be like 'I didn't say that. That is completely not true. I don't need to be here.' But like until they're assessed which may take some time, they...we're just assuming they did say that. And there's been not many in that situation, but there's been situations, where staff have said 'look if you don't calm down, I'm going to sedate and shackle you'. When it's completely inappropriate to say that, because that's only going to cause an escalation to kick off and then, you know, they're not saying the right thing that time. So I think they're needs to be some education in to some, I don't know, maybe junior staff, or what have you...that's exactly why we're here today with [mock-up] training, ways to speak to people that are stressed, vulnerable, they're obviously here for a good reason."

C10: "I don't think it's junior staff by the way, I think..."

Inaudible comments

C6: "Oh yeah, it could be anyone. It's maybe people that are, you know, themselves they're really stressed and they're under the pump. And they maybe don't have that time as you were saying to reduce, you know..."

C10: "...anyone else..." *partly inaudible*

C6: "These patients are here because... this is... could be one of the worst moments in their life. So we need to take that on board and..."

C10: "Still got empathy"

C6: "Well, yeah, remember the empathy part. And not just sort of say throw it back in their face when they're obviously in a really hard time in their life. If you don't calm down, I'm going to sedate and shackle you. So like if someone said that to me, when there was a false claim against me, I know that I'll kick off. So..."

C9: "I don't know about the false claim part, I would inform them of what...so you have to inform them of the potential would be that...but it's not out of anger that 'I'm going to shackle you'."

C3: "You have to tell them what's going to happen next."

C6: "No exactly that's right."

C9: "If you try to de-escalate, it's 'look if you keep going security will be called and there might be chemical sedation, there might be...you've got some choices to make, up to you'. And you wait another 10 minutes and see what they do and everything but I think there is..."

C10: "You're empowering them."

C9: "Giving them options..."

C6: "That would be right way to do, but there is people that not do the right way. And as a result, it has a very negative..."

C9: "But there is also that tap-out process, that we've got as well. So if you've noticed someone's [shackling] out of anger, it's hard to notice someone because everyone is so busy, though. We could tap out if we're... [we've been working 10 hours and feeling too stressed,] we can go to the floor coordinator and say look I'm just making the situation worse, swap me out."

I1: "I was about to ask you about that. So you with your extended times for de-escalation, and you sort of can't be bothered de-escalating any more, and have that sort of compassion fatigue, or whatever. Have you found that the tap-out process works? Is it helpful?"

C9: "I've never done it."

C8: "I think people are going to be willing to do it...it's hard because I think people...so as a floor coordinator I'm the one try to replace staff. I haven't had it happen to me all that much that people requested to. I think people mid shift maybe not as much, but they would come in on a day and say, I think you've heard us talk about 28, 29 [goldside], that's where our, sort of, psych patients generally get allocated. They might asked to get moved, which does happen sometimes but I think you sometimes feel guilty because then you put someone else into that position."

But we, I guess, from a management point of view, they try to put across that we'll take that on with open ears and we'll swap you out. And you know, that it

can be anything, whatever is happening at home that today you are not going really deal with this situation very well. So I think...hopefully people take that on, but probably doesn't happen as much as we could. But again, you can curse yourself and put yourself somewhere else and still get an angry family member. I think that's the reality of the place, that despite...it's not just the psych patients, it's your drug-affected, you know, trauma patients, it's your family members that are frustrated that their dad's been waiting on a trolley for twenty hours, which you understand but can't do anything about. So, I guess that's the thing..."

C3: "They're the more difficult one, the family members."

C8: "Yeah. And that's everywhere in the department, I think that's the thing, you can't..."

C3: "Mental health are easy, you either stay or you go" *Laughs*

C8: "We've probably just side tracked a bit, we start talking about psych patients a lot, because that's what we default to. But it's certainly not just that. I think, and from a floor coordinator point of view, I think we sort of stopped talking about the tap-out process, which doesn't mean it's not going. But for new staff, have you heard of the tap out? You have? Yeah I was going to say we have some new staff members here, so I think it's about keeping up conversation. And we do [musters] before every shift so just making sure they get put back on the slides. So people do know that they got that possibility."

I1: "Has anyone used it? At all?"

Some 'no's in background

C6: "Purely because I think it's that that you know that if you tapping out you are now passing that issue on to somebody else and..."

C3: "Informally..."

C6: "And most people just don't want to have to...as in like..."

C3: "Informally I have. I've swapped with girls in Resus."

C8: "I think in Resus it's easy too, cause [there's a] team nurse and there's five people that you can be like 'I can't go back in there' and so it's not a formal swapping allocations. It's more just your team nurse..."

Laughter

C8: "You sort of swap around. I think most people working in Resus are like, yeah that's fine, I'll go the next stint in here and see what happens. But, yeah..."

I1: "Do you find it reassuring knowing that you could do it? Or would you...is it basically you wouldn't do it?"

C7: "It's nice to know that it's there."

Agreeing in background

C7: "Yeah, I'd like to think I'd take advantage of it but like everyone else said, you don't want to be putting someone else in that position. But it is nice to know in the back of your mind that if you're really just can't handle it anymore, there is the option to swap."

C8: "I think that being said, I think everyone else would be, like if I said to [colleague A] 'Would you mind going to gold? [Colleague B] has had a really crappy few days' and I think most people probably say 'Yeah that's fine' like 'I'm alright, I will be fine'."

C7: "Yeah that's the other side of it, we all would be more than happy to move in to that role if one of our colleagues needed to tap out."

Agreeing in background

C8: "And I think a couple..."

I3: "Shall I try to summarise, as we may want to move on at some point, try to summarise what I feel you've said so far? And if people want to add some things? There is a couple of people we haven't heard a lot from, which is fine, but if you wanted to add... So heard is, you don't... When we talk about reporting, you don't do Riskman, because it's too time consuming. You prefer paper Riskman in a way.

The follow-up is unclear, which doesn't encourage you to do anything about it as well. There's a high workload, so don't have the time to do things. There is a high threshold that you have to report anyway. So I'm imagining with all the Code Greys being called, how many are not called, sounds really massive to me. Feedback would encourage reporting, if you knew some follow-up, through the police or your own system.

You talk about repeat offenders, people that you know. So in the reporting system, what's the point because people are going to come back? That led on to, I can ban people but then they are going to rock up somewhere else and you still have to deal with them. Or you can't really ban them. Or they go outside, throw a rock and then they come back in.

There are delays in patient reviews. In zero tolerance, I've heard you say it supports the workers very much, but it might also hinder communication and it might encourage people to be less tolerant of incidents in general. And then we briefly talked about the tap-out process, where you say it's there, it's good to know it's there, but no one has used it so far. Did I miss anything? Is there anything in summing it up that you..."

I2: "What C6 said, what I've never considered before, was the gender of security guards, which I thought was a pretty interesting point."

I3: "Yeah, yeah, I did write it down but not in my summary." *Laughs* "Is there anything that we've missed? Anyone else? You might have just been listening, which is fine."

C5: "I think just the add-on...because I didn't know like... every Code Grey needs to be in Riskman. But maybe it's possible in the computer software now, that when you write the notes, there is a box to tick, that just duplicates it as a Riskman. Because you are typing there was a Code Grey because of this and that, tick the box and it duplicates it, sends it to Riskman and they sort it out."

I3: "So it should be there instead of the other way around."

C5: "[Saves you from double doing things.]"

I2: "After this, that's the next project."

Laughter

I3: "Is it?"

I2: "It is now."

Laughter

I3: "It's recorded so... Sorry, I thought it might be good to do a little bit of a summary to see whether that captured what we've been talking about."

I1: "Yeah, we're a bit over half way. We've been tearing throw it. Yeah, we might use that to segue to our next section. We want to start looking at the perpetrator. Cause a lot a of research doesn't actually include the perpetrator in trying to figure out what we should do about it or even understanding the problem a lot of the time. So we're hoping you guys could discuss common types of perpetrators you would come into contact with. And the difference between the two and how you might approach them differently."

C10: "It's an interesting word, perpetrator. It has so much heavy connotations."

I1: "There's a bit of debate to it. But there is also debate about consistency in terminology in this topic."

Short chatter about patients, perpetrator, mostly inaudible

I1: "So we're just being consistent with the terminology."

C3: "You also got your ice-addict."

I1: "Just discussing...yeah like basic demographics, and what challenges you might face in managing those or assessing those or..."

C3: "Well the ice-addict is easy. Because half the time they just need to have sleep. They've been pinging for three, four days. They're psychotic because they're hallucinating and they haven't slept. And if they're being aggressive and psychotic, then we just put them to sleep. And they end up in the BAU sleeping and you know... My official motto there is don't poke the bear, just let them sleep. And they wake up most of the time really quite pleasant. They get their sandwich and leave."

C8: "From a demographic point of view, in that side yeah, drugs is a big one. So probably ice is our main issue that we have here. And probably young men is...I guess there is always a physical component to a guy being more threatening than a girl because they probably can cause physical harm in that regards, as appose to, you know, a 50kg young female."

C9: "Girls seem to get their way."

C7: "I don't know."

C8: "Yeah, girls are mouthy, like as a physical threat you don't feel as... doesn't mean they're not going to hit you, but you wouldn't feel as threatening as trying to protect yourself as to a 90kg, you know, young man, from a female point of view anyway. Yeah, so I guess that's a big... in a demographic, sort of, sense.

I guess the main people we have issues with are your personality disorder slash anti-social personality disorders and ice-affected people. They're probably the two that I would come across that I have issues with. But you do get the frustrated family member, that is pretty entitled and thinks the public health care system should stop cause they've walked through the door. And they don't have much of an understanding of what else is going on and you know in trying to be respectful for that patient, they are having a stressful time and they're concerned about their family. But I think, the footage that we've seen on the (...) ads and the current affairs news, a lot of those pictures weren't actually drug-affected or anti-social people, they were frustrated patients in the waiting room that have been waiting too long and eventually cracked it."

C9: "There is a lack of education in the community about how EDs actually work. You know, it's not a first in, first dressed. There's different streams, there's waiting times for those streams, they don't...they need to know what emergency is and what's prioritised. It's just a lack of education in the community."

C8: "And I think from a triage nurse point of view, like, I think a lot of people out the front do put up brick walls pretty quickly, because you are so used to

it. That you unfortunately probably don't come across as compassionate as you might like, when someone is like I've been waiting here for this long. And we don't have control over that. As in, we can't control the waits. We can escalate to doctors as much as we can, but if they've got other, you know, patients to be seen."

C10: "If we're busy, they're busy."

C8: "Yeah, so unfortunately, you can be as diplomatic as you like, and still cop it pretty much so..."

C7: "And unfortunately all they can see is the triage nurse sitting at the desk and all the other people sitting in the waiting room. And some people going in, cause you know they might see some people going in that arrived after them, but they don't realise they're going to a different stream. They can't see the arrest and the tube and stuff that is coming through the back door, or landing on the helipad."

Agreeing in background

C7: "It's a lot of...just yeah...not understanding the context of the way that the system works."

C9: "And you can't say that, because they'll say I understand the system, but anyway..."

Agreeing, laughter.

C6: "It would be good if there was some sort way for the waiting room to know there is somebody now that is a category 1 and most of the resources have moved towards them."

C9: "I don't think it matters though."

C3: "I don't think it matters. [They've tried different things over the years.]"

C6: "I think it would. Cause as soon as you say to somebody, they've come in, they thought that, you know, say they're a category 3 with abdo pain. So they technically should be seen quite quickly. But then all of a sudden, if they were told, 'ah, there is somebody that's intubated, and now all the resources have moved to them', because, you know, they're very serious and could die. 'Oh that's okay.'

C2: "I think like a simple explanation to patients is really important, like just a brochure or even like an algorithm or something, like just to explain really simply how the emergency department works. And even if you explain to them, like, when they come in the door or you explain to them...have the brochure when they are sitting down, exactly how it works. So that kind of de-escalates the frustration that they feel, within that kind of 8 hours in the waiting room. The ones that are able to read the brochure, obviously."

C8: "It's unfortunately the rational people aren't ones that smash doors and break windows so..."

C2: "Of course."

C9: "I always say there's a nasty trauma. It's a nasty trauma. And I say that because I get...you can't say someone might be close to dying, or ETTs or anything... and because there's family members that may be in the room eve's dropping, so...I never try to use the death word or anything like that. Because if someone's related, then that... scare them a little bit."

Agreeing in background

C10: "Talk a little bit about recurrent presenters, but all these issues aren't recurrent presenters. Yeah, sort of one off things. A recurrent presenter that is problematic, [that would make a] perpetrator, they usually have a management plan. So they've been here a while, they're quite an easy pathway to deal with. They're either sick or they're not. If they're not sick, this is what you need to do. Boom, boom, boom. If they misbehave, they're out. Where..."

C8: "And they're probably, like you said, the people these personalities that are baseline, that you unfortunately can't treat. So you can't... they're not high on ice and you can sedate them and go 'great'. You need to somehow get rid of them, but then again you release them. And they get annoyed at you, because you've not listened to their concern, I suppose, whatever they walked through the door for. And then they go on to the street, and the cycle continues, I suppose."

C10: "But these are the people that are more unpredictable."

C8: "Yeah, yeah." *Others agreeing in background too.*

C8: "And yeah, I guess, recognition is the key for us. So, you know, you might get a patient that is high on ice, crashed his car and come in. And probably a bit like, you know, overwhelmed with what's just happened and he is being compliant, waiting for scans. And then 2 hours later, he's now sick of waiting for his scans, that's when he's going to arc up and cause a problem for us.

And I guess there's that duty of care being like well you're not of sound mind and you potentially have all these, you know, spinal injuries or whatever. And then you're telling this person to lie down and you're like I don't really know why I'm fighting you on your safety. But then, you know, I guess recognition then of getting security involved and that's our game pretty much of being like, how much can you manage on your own and how much do we need to chemical restraints in and yeah."

I2: "If you know someone is a recurrent perpetrator, does that affect your objective assessment?"

C8: "Yes. Of that person?"

I2: "Yes."

C8: "Yes, because you read management plans and you're like well this isn't exactly what they are saying is happening today. Like, this is their usual presentation, but today they are saying that abdo pain, but they normally come in saying that they are suicidal, and then you're like what do we do. But then, a lot of the time, people just look at the management plan like 'nah they can't come inside', you know, which maybe..."

C3: "I don't think with the management plan, it's a long, long process, and multiple people have been involved in that decision making and that social work. They've got the doctors, they've got the outreach people, and everyone...so someone's already gone through their entire history and that's their management plan. For me, it's like, it's easy...I don't have to escalate. I don't have to...I'm not doing bloods, cause... I'm not doing all these unnecessary other things. Because it's already...we've done...like, we had one yesterday, 100 CTPAs, but she keeps saying she's got PEs. And..."

C9: "A hundred?"

C3: "Yeah. The one that went into Resus 5. Never had a PE." *Laughs*

C3: "But, saying, in that sense, and it was like...we spent ages trying to get an IV on her and then the management plan comes up. Cause she had a cracking story and she was [tavi-cardiac]... That she had actual tavi-cardiac. And then in the management plan, it says don't bother with IV, it's pointless, difficult. And I'm like 'oh, done'."

I1: "So it sounds like it is kind of a simple process if they have a management plan in place."

Agreeing in background

I1: "That period up to them getting that management plan is that a lot, like you said it's a long process..."

C3: "It's a very long process. You have to be [...] does it. So you send off all these... there is a lot of flags that get [trapped] for them to become aware. So we got our care coordinators, our social workers, their local doctors, their case managers, and all that, all have to attend to multiple different meetings. And then they...and then they come up with this management plan."

C8: "These people would present like 100 times before their management plans so..."

C3: "So it's a very long process to get the management plan. So once that management plan is done, it's...to me it's like a relief. It's like, 'oh great'."

C4: "It takes the hard work out of knowing what to do. Really, because it is just there, it's kind of like you fail so you know what to do."

C9: "But at triage it's never linked."

C4: "Exactly!"

C3: "It takes a while for the management plan to link."

C9: "[Like why no management plan, well]"

C8: "Cause we type a name in and that's it. And the [clients] will link with their history. So you had an [account] person before, you might have allocated them inside. And they get linked up and they you go 'ah, oops, we know this person'.

C10: "Security is very good."

C8: "Yeah, security is very good."

C10: "Security for triage."

C3: "Security already know all..."

C10: "They will ring and say this is Joe Blow. And he's been here three times this week and we've had to kick him out three times."

Agreeing in background

C8: "From a floor coordinator point of view, the security each shift check in with us. Saying anyone [...], which is really good, so they come and say anyone, like even if we're just like he, like this sounds really awful but, he looks at me weird and I got bad a feeling about him. They're like 'great', you know, they're not going to go do anything about it, but they are aware that that person is showing signs of, I guess, certain behaviours."

C3: "The security actually actively watches the department. So if there's someone been highlighted, they're in their office and if they're not doing anything, they've got their camera there. And say, the ones they know, they're watching them on the cameras, if they've got the time."

C8: "And they will come and tell us sometimes. Because again we don't... like I don't know everyone."

C3: "And they've identified...I've been there when they've identified someone escalating, and they've actually happen to be walking past, at the time, because they are pre-empting it."

C9: "They're good at making their presence known. At the Goldside sometimes, when they know there is a patient, that's been acting up."

I1: "With your repeat offenders, what is often their root cause of aggression? Like they're usually mental health patients or intoxicated or...?"

General chatter confirming both

C8: "Both I guess, sometimes not...sometimes I guess... when we find that they don't actually need to be here, telling them to go is a big issue, because a lot of people have social circumstances. They don't have anywhere to go. They don't have food. You know, things like that. So they just want a roof. Or they want an admission to a [load pensy]. And we tell them...one of the last code blacks we had...or maybe not the last...but in BAU, was because someone was like, you have to go. And he didn't want to, so he ripped a curtain down, and you know, code black called. And..."

C3: "They've been banned from everywhere else."

C8: "Yeah."

C3: "So they come here. Cause they want their bed, they want that accommodation. I've been told that BAUs are becoming quite well known amongst mental health patients and [AusNet] house that..."

C10: "Oh yeah it is."

Candidate in background 'Oh god'

C3: "It has, it is, because they come in here and they're a little bit psychotic or aggressive. Then we put them into the BAU and we don't kick them out at, say, 7 in the morning for the next day. Like they do with [AusNet] houses."

C8: "Yeah, cause... yeah cause we have time frame in ED. We've got big issues with moving...like there is not many ICA psych beds in the state, pretty much. So from floor coordinator point of view, my KPI...we can't have any breach 24 hour. So if, from a doctor point of view, or mental health point of view, if they can get them to the BAU, then that time pressure is off. And they have more time to figure out a plan."

C9: "They can just stay there."

C8: "Yeah."

C3: "They sit there in this black hole and if they're calm and quiet and pleasant, there is no pressure there to actually kick them out. But once, they've been seen and assessed, they medically cleared, psych cleared, is there any social issues? Sometimes we...there is a new social worker too, who has been very proactive and very good. But if there is no social issues, then that's when we start 'okay, it's time for you to leave'. But then again if it's 11 o'clock at night, we're not kicking them out."

I2: "You even give them a sandwich, is what it sounds like..."

C3: "Yeah, you give 'm food."

C8: "It's generally like...yeah assaults don't... you know, assaults and violence...you know, the patient is not getting what they want basically. They either want to be...they want pain relief, they want...you know, yeah."

C9: "Or they're okay when they sober, as soon as they have alcohol on board, that's when they [do their] suicidal plans. And then at the BAU, wake up, 'nah, feel good', get cleared, come back next day after having a bottle of wine, or two bottles, or three bottles. Or something like that."

C10: "The harder ones I think now can be either the ones that have acquired brain injury, an intellectual disability, combined with the mental health and, you know, some sort of drug use. They're...because they're not as simple, need to be [heard], can't necessarily explain a lot of their behavioural issues. They're...they're really challenging. I think as opposed to the mad drug [fucked], you know. You know what I mean? The person that shouldn't be here, is capable going elsewhere and looking after themselves. These people with intellectual disability, you just can't get it. But they want something. They get the attention and they're very difficult, I think."

C3: "I think this Code Black that happened the other day, he... the barriers were the other people...he's just been released from prison. He's 16 years in prison. He gets released. He get's on the ice, becomes paranoid, and aggressive. And so someone has decided at some stage that they are trying to keep him out of prison, they...and this is where the problem is, is that they don't want...they want to keep him away from the police, so they gave him a BAU admission to try and get a social accommodation somewhere, as he used his 3 days in St Kilda."

When you get released, you get three days, so he'd used that up, but in those 3 days he'd used ice twice. Been admitted twice, and they're like we're going try to keep him out of the police prison system again. But then his behaviour and his attitude was so poor, that in the end...so we tried...we stopped our normal management plan for these patients, to try and manage him. And in the end, he's going to take ice, and he's gonna get paranoid, and he's going to come to the police attention. I don't even know who made that decision to try 'oh, no, we're just going to admit him, short admission, until he get accommodation'. Well, it's his own fault. He had accommodation."

I2: "Can I ask one quick question about the word perpetrator? If we didn't use that word, what other word would be more appropriate?"

C10: "I think offender is less loaded."

C9: "Yeah that's what I was thinking."

C3: "I've got in trouble for calling them frequent flyers."

Laughter

C3: "Multiple presenters"

C8: "Like, I mean, we always just say patients, because that's who they are, prior to whatever they've done I suppose, I don't know what would say..."

I1: "They're not always patients, as you said..."

C8: "Yeah, yeah"

C10: "They're all frequent flyers."

C9: "I think we only call them a perpetrator if they've..."

C3: "Convicted of crime."

C8: "Convicted yeah."

C9: "...been convicted of a bad crime or something, but even then, I call them the patient."

C3: "I just call them a known risk, they've got a history of violence."

C8: "Perpetrator is probably true...like a correct word. But it is not something we would say, I suppose."

C9: "The only time I've heard it was that recent one on Bourke Street, few weeks ago, that's they only time [...]"

C8: "If they've done something previously coming to hospital, that's not directed at us, as health care workers I suppose."

I1: "It's just a very literal term the way we use it."

C8: "Yes."

I1: "It's not meant to me emotionally charged, but..."

C8: "Yeah, I mean they're not...they're patients...if someone present to me with a, you know, ingrown toenail, they're still a patient. You know what I mean. So if they come in with an issue and I've triaged them, they're a patient to me, then I don't know in post... yeah."

C3: "It's a label, innit? What type of label is politically correct? It highlights the [de-enablers]."

C7: "A family member would usefully referred to as being obstructive, or something, if they've had...if they were beginning to escalate, not so much perpetrator."

C3: "Manipulative?"

C8: "It's probably part of the culture that we just...just another person that has come in and done this, we don't sort of think about it as a..."

C9: "[Behind their backs, we'll call them] dickhead"

Laughter

I1: "We are sort of becoming short on time, but there are few other things we want to discuss. Are there other demographics of patients that could be difficult? Such as, you know, dementia patients can become aggressive. How do you guys find managing those?"

C3 inaudible comment

Laughter

C8: "Yeah I think dementia patients are a big problem for us too. And there is part of me that will always feel horrible about calling a code on frail 80-year-old man. But they...they will not hold back sometimes. You can't reason with them."

C9: "That's where security get [injured]x, with the elder patients."

C8: "And I think with things like sedation and stuff, thankfully some people with some drug addictions have tolerances to what we give them, so they can manage it. Whereas you can bomb an 80-year-old very easily, and then all of a sudden you've got an obstructed airway in someone not want to intubate, like that poses big risks."

C10: "It's really hard."

C8: "The way we manage people like that, and I don't know...that's a very difficult one for us, because there is no right or wrong way to treat these patients and we...we order specials for them. So we're just 'alright, you're going to sit with this demented patient all day' you know, which doesn't necessarily help anything, and then that person's at risk, so..."

C3: "I think it's the young, usually young, fit, healthy person who have a flu like illness and they reckon they're going to die. They're the ones that I really struggle with."

Laughter

C9: "They're not assaulting you though."

C3: "Here's some Panadol."

C4: "Different topic"

C3: "Nah, they turn to triage, and they're the ones that always approaching the desk. 'Oh, I'm dying' 'Oh, she getting short on breath'. And then the family, they...'

C8: "I think intend is a thing...probably...I would take home more from a guy that's been in jail, that's...assaulted people in the past. That's telling me he's going to wait outside for me, as oppose to 80-year-old man that has no idea where he is. That intend, that's something that would stick with me for longer."

C3: "I don't consider that a threat, you know."

C8: "Yeah, I guess..."

C4: "I guess from a management point..."

C8: "From a management point of view, no one wants to get hurt. And like, you don't want to shackle an 80-year-old or anything like that. But at the same time, from a reporting and barrier, all that sort of stuff, I think if someone is singling you out as who you are and threatening you as oppose to a demented man that doesn't know where he is, from a take home point of view. But then again, they are hard to manage; they will hit you though, like most people here have probably been swatted by a demented patient in their time. But yeah, there is no right or wrong way to manage them."

I1: "Can you think any other demographics or conditions of patients that often result in violence or aggression?"

C3: "The ones that should've gone to the doctor first."

Laughter

C4: "I guess what C3 was saying earlier maybe. The ones with ABIs and people with Asperger's, that sort of thing, autism. You know they...having that primary contact that's not they're used to, they struggle with that sort of emotion and contact. And here we are trying to help them. They're already, you know, on the back foot, because of their pre-existing condition is. We're...we're not all trained in how to look after them on a daily basis. So when they have their carers in, it's really good. They can say this is how to de-escalate them, this is how to calm them. And then as well, I don't like, what's it called, the [trolley] in BAU..."

C9: "Sensory"

C4: "The sensory trolley sort of help give them things to pre-occupy them. That sort of helps. But yeah the autism and the Asperger's can be quite challenging. Just cause you're not really going to know how to look after them,

whereas with the other ones we can just go straight to giving them some chemical sedations or you know [do our things].”

C9: “Smokers in general.”

C3: “Smokers?”

C9: “Smokers! Cause they can’t stop. Even if they haven’t come in with any mental health issue, or anxiety issue or anything. They might just be in a wheel chair. They say ‘oh I need to go out for a smoke’ ‘well, how are you going to get there? I’ve got 20 things to do at once. I’m not taking you out in your wheelchair.’ And they just crack the shits.”

C4: “It’s the expectation, they think you should. And you’re like ‘no’.”

C9: “No, no, if you can get there, go!”

C4: “Oh no but what I’m saying they look at you like it’s our job to take them there, where as actually it’s not.”

C9: “Yeah, last priority.”

C4: “Yeah.”

I1: “So do you have a big problem with attitudes?”

C4: “Huge”

C10: “Our own”

Laughter

I1: “I would’ve never assumed that.”

Inaudible chatter & laughter.

C6: “I had a lady in BAU the other day, who, she didn’t get to the point of becoming really aggressive, but she had signs of it. Where she was still waiting for a mental health assessment, cause she had suicidal ideation. She started to become elevated, she needed to get home to look after her daughter’s child, so grandchild. So she had commitment that she needed to get to and started to get concerned, because her daughter needed to go to work in order to pay rent and look after them. So she then started to arc up. So there’s someone that may not necessarily cause, you know, aggression, but when put into a situation where other people are involved, may also be.”

C3: “And I completely agree with that patient, it’s the frustration. You’re simply going ‘I know’ and it’s EMH that’s delayed or...and you’re just like, you can’t leave because you’ve been under a section 351. You can say these...until EMH you can only tell her so many times. You can’t hurry them up.”

C6: "She'd been waiting like 16 hours as well, so she'd been here for sometime before she started to escalate."

C3: "Can't wait till that royal commissioning..."

Laughter

I1: "The royal commission into mental health?"

C3: "Yeah, the delays."

C9: "I agree with C6, it's family as well. They might be a single mum, no support and they've got kids to be picked up from kinder or primary school or something like that. Can't leave. They just get extremely worked up. And it's fair enough."

C8: "I think people have no idea. People never come through expecting they're going to wait 8 hours to get what they presented for attended to. Which, it sounds ridiculous, but unfortunately, it's reality. And you're the middle man, and like 'yeah, sorry I can't do anything about that' and then you cop the [blunt], cause you...I think EMH, they're job is...I wouldn't do it, put it that way. It's difficult, you know..."

C9: "They need more staff. They're understaffed."

C8: "Yeah, but yeah."

I1: "The last topic we just wanted to look at is how we can include perpetrators in interventions? And you guys have that letter that you send out to people. How you feel that works? Is that...?"

C8: "I reckon it depends on who it is. If I received that letter, I would be pretty shattered. If I'd, say, gone on an ice binge, I'd like to think baseline I am a normal productive human, but I'd accidentally gone on an ice binge and did things, and caused a bit of ruckus. And then sobered up. And found out that that had happened and found out that I got a letter, I would be pretty shattered."

But the guy that I was talking about earlier, with the anti-social personality disorder, who said he'd fallen off a wall, hurt his back, was [essentially] seeking, was horrible to everyone who came in with. Was very threatening, had...you know, he'd come before and done similar things. I don't think receiving a letter...I think it would piss him off more to be honest. So I...the way he was, because he just didn't want...he was most angry at me, because I was, I guess, the authority that came in there and said 'we have zero tolerance, you can't speak to the nurses like this bla bla bla bla bla' and then he was [harping] on about 'where's that girl? I'm gonna...' you know. I don't think him getting a letter would really deter him, like it would fuel his fire a bit

more. But, I don't know what else you do to be honest either. Cause he...I guess it's good he's got that in the back of his mind that maybe he'll be like..."

C10: "What's the letter?"

C9: "Accountability letter"

C4: "Accountability yeah"

C8: "So they're basically saying 'you've come to the hospital, you've done these things...'"

C10: "After the event?"

C4: "Yeah"

C8: "After, yeah, so..."

C4: "So it puts a flag on the history. So if they come back again, there will be an alert on there, saying this..."

C8: "It will say you've been told that we don't tolerate this so..."

C9: "So who does that?"

Inaudible chatter

C8: "So [person A] escalates. So we...I emailed [person A] and a Riskman was done about this guy and she basically [send of the letter saying]..."

C10: "There is nothing more satisfying then having someone wake up the next day or at the end of the shift and say your behaviour was [appalling]. You spat on nurses, you peed the bed, your language was foul, and people chose not to look after you. And if it's just...particularly alcohol, not so much [drug-affected], some people are totally embarrassed."

C4: "They're mortified."

Agreeing in background

C8: "When there is substance involved, normally, you get that outcome."

C10: "I hate to say there some talking to *rest of sentence inaudible*."

C8: "It's funny when they're being apologetic and you say you've done this four times before, great!"

C10: "It's not great, you might need to what you are doing and a lot of people...I think that's a pretty powerful statement."

C8: "Yeah, so it depends on who it's too. So again, like say, I would be pretty devastated if I was like, god I got a black star against my name, you know. But unfortunately it's probably only beneficial to some people. But I think everybody needs to be accountable and at least this is something that you can say 'you've been told' so you can't pretend..."

C9: "So how does that letter get send out? So if I want someone to get the letter, because they've just been atrocious."

C8: "So basically you escalate as you would, tell Susan this incident happened, people were affected, and I think you would always Riskman this and... you know, because it needs to be formally, sort of, recognised that this guy caused aggression. And again he didn't physically touch anyone, but he was horrible. Saying horrible things. You know as I said, he's a threatening man with a forensic history that is threatening to wait for people outside. And then, yeah [...]."

I1: "If you had a patient that got the letter, and they wanted to apologise or so? Would you be interested in seeing them and having them show remorse or...?"

C7: "I'd just be happy if they didn't do it again."

C8: "Yeah, I don't know...in all honesty, I wouldn't really want to see this guy again. Like that, I'm just...yeah..."

C9: "They could write a letter themselves, you know. Like document it."

C10: "That would be a big move."

Inaudible chatter, agreeing.

C10: "I think it's part of..."

C8: "It depends who they was. Knowing this man's history, I don't think he...he's not someone I would want to be...I don't really want you to see me again. Whereas, I think if it was like a drug inspired sort of rage, that I then thought they were maybe sober from, then possibly? But..."

C7: "I don't think they need to present, maybe a letter, or something, or an email, I'm sorry for the way..."

C4: "Well, that's why they did the letter as well. Cause they were wanting to put that accountability on them. They said if they sober up or whatever, they're like 'oh my god, I'm so sorry' that they are in that sense being accountable, even if they can't remember, they're acknowledging the fact that they weren't perhaps the nicest human while they were here."

C7: "What percentage of the perpetrators would that really be that accidental ice binge [end up in hospital]?"

C8: "I think a lot."

C4: "Yeah. I think you'd be surprised, I think it would be more than we actually think."

C8: "Yeah."

I1: "It might also apply to those with poor attitudes, like in the waiting room, waiting for a long time."

C9: "Social media is actually a problem now as well. We've had an incident where someone posted everything on social media about, full on (...) page."

C3: "That was the twitter girl, wasn't it?"

C9: "Mmm"

C7: "There's been a few incidents."

Background "What's that?"

Inaudible chatter

C4: "Just people updating social media as they..."

C3: "Have a look at the google reviews on Triage, it's awesome."

Laughter

C3: "And all are true."

C8: "I think reflection is a big thing. Because a lot of people, when they...you know I think they act out when they can't control their emotions. And then a reflection on that...then maybe that wasn't the right avenue to get down, I think, probably...and if they got turfed, then they'll probably go, well I didn't actually get what I wanted anyway. So maybe getting a letter saying you've done this...I think possibly...you know that might be helpful for some people."

I1: "So appropriate for some cohorts of patients, but irrelevant to others?"

C8: "Yeah, maybe not irrelevant. This is...I...yeah I don't know, I probably spend about two hours with this man, and I wouldn't want to see him again. This is purely based on the fact that he was horrible then, but he's done it a few times before, and he had a forensic history. So for me, and I guess, anti-social personality disorder, when you've got a diagnosis of that, there's sort of some assumption that you're rational thinking probably isn't quite...you know...doesn't probably coincide with what I think is rational thinking. But, I wouldn't tell them not to do it though. So I wouldn't say, nah don't bother, you know what I mean."

I3: "I have one question that has been on my mind but I didn't want it surface – is it getting worse? "

Multiple candidates saying 'Yes, absolutely'

I3: "Why?"

C3: "Heroin was a lovely drug."

Laughter, agreeing

I3: "The other thing you mention is alcohol."

C9: "Yeah that's up there."

C3: "Yeah there's always been alcohol. But since they swapped from ice became cheaper than heroin, they're all on the ice and the ice...like heroin overdose, they became sleepy, and (...) after."

C8: "I think a big problem we have is time. So I think the thing is that people aren't getting what they want within what they think is reasonable time frame. And that's, you know, that's the...you know, the trauma patient lying on his back for scans, waiting to get cleared, that is uncomfortable, wanting to get up, doesn't want to use a bottle to wee in. Your psych patients, saying 'you can't leave, but I've got no answers for you'. Or they've come in saying, I want help and three days later there in the BAU and they still haven't got a communication about what's happening, because there's been no LDU beds for the patients to go to. And triage, there's one nurse overnight for 100 patients in the waiting room. So I think that's one reason why it's worse. Because people frustrated with the way the system works, and we're frustrated. And so we're probably not as compassionate as once were either, because we can't be."

C3: "I think we're extremely..."

C8: "And yeah, obviously ice and things like that too."

C6: "And yeah, the triage nurse from 7 till 9, is by herself, or himself, and there have been 20 people coming in, they've all got pain but there is only one triage person there. And they can't leave the desk to then, go get some pain relief and then, you know, everywhere is just so busy, and you can't get help."

C8: "So I think it's worse in that regard, I think people are probably still acting out as they were, but there is more accountability now to say actually you don't need to deal with this at work. We're not actually here to be...the last sort of two years I suppose I think there has been more emphasis like, yeah you're an emergency nurse, but you don't need to cop this. So that's probably better. But I think the sheer volume of getting 250 people through our door per

day, and trying to manage everyone of those people's needs is a difficult thing."

C9: "...write a letter to the government" *sentence partly inaudible*.

C8: "Yeah, yeah."

C10: "I've been doing this job for, god, 30 years. And I think people have the best health care that they've ever seen."

Agreeing in background – some inaudible chatter.

C10: "They wait less, they get fair treatment, they're paying low fees. Man, 20 years ago, you wouldn't have gotten this service. I think, I hate to say, to the young kids in this room, not just young kids. But I think people no longer know how to wait anymore. They have their things instantly. "

Agreeing in background

C8: "Yeah well maybe it's an expectations thing. I think that's what's gotten worse as oppose to..."

C4: "There is a sense of entitlement."

C10: "And I think the younger, now it's going to make me sound like an old women, but it's not about this entitlement, but years ago, the police would come in. You wouldn't question, you would do as you're told. If a doctor came in, you would listen. But now, you know, they don't give a fuck. You know they [...] all they wanted."

C9: "[With technology the way it is, it provides instant gratification.]"

C10: "And it's not just the young people, but I think people have lost the ability to wait and be...what's the word? Considerate to other people needs, and just take their turn, and just... I think that's long gone. I think emergency departments are the best they've ever been. I think it's good that we don't tolerate the violence. I think it's really important that we acknowledge and deal with it. But I just can't... it's not the wait times I don't think."

C3: "I hated the four hour rule when it started. Because the four hour rule is given us that incentive to actually have a plan within four hours."

C10: "You should have been here 20 years ago."

C8: "It's painful but have to have it to function."

C7: "Yeah."

C3: "And it's, but that's streaming the four hours that...and I completely agree, we're so much better than when I first started."

C8: "The only detriment to that is probably BAU, because people get put there really early when they're probably not safe. That's the only thing that I would say...and I find that difficult, cause I move, I agree to put people over there, that then might come back to bite you. That then flair up, but..."

C4: "You're going to be looking after them somewhere so BAU might as well be the place. I'm trying to think..."

C10: "It's interesting. It's an interesting time."

Agreeing

I2: "It's a good comment that. It's, you know, what has changed..."

Inaudible comment

C10: "Our caring is far superior than it ever was."

C8: "I think we're doing an excellent job considering how many people we get through the door. But I think whether it's patients perception, or just volume, or expectations or I don't know. So that's what's I think has gotten worse."

I3: "Is it also that people go to ED easier? With complains that they normally wouldn't?"

C3: "They don't go to the GP."

C4: "You don't need to pay to come to ED, is a common... when you ask in Triage."

I3: "I'm not saying that's automatically linked to...but then it adds to the workload. It adds to the wait time."

C9: "And they often feel if they have private health insurance they should be seen first. There is a bit of a lack of understanding about the difference between the public and the private systems."

C6: "There is a lot of GP referrals though."

C3: "Yeah that's fine."

C6: "Hell of a lot."

Inaudible chatter in background

C4: "You know, Friday night for an example, overseas student. Came in said that they cut. I undid the bandage, could not see a mark on their finger. I was like show me where, and they were pointing. I even pulled the finger. There was no...the skin was intact. Oh no, no, no, they had to see a doctor. I'm like

you're kidding me. This is going to cost you 500 whatever dollars, you're going to be waiting for 4.5 hours minimum, for nothing. Oh no, I need to see a doctor. Spoke perfect English. So it wasn't a matter of... 'I don't want to pay to see my doctor', but I'm like you're paying 550 odd dollars to wait and see. They just don't want to use the GP services. That sometimes is, you know...you can offer that suggestion, but I was just like don't understand. They don't understand."

I1: "Alright, thank you very much. I think we've run out of time now. But that was really great. You guys filled in a complete hour and a half."

Laughter

I1: "Nice work. And we really appreciate your time. And input."

C10: "Well it's good that we're being listened too. And if it was just allowed to happen and cruise along, then you know...I think it is nice that people are wanting to work and do something."

C8: "What are you hoping to get out of it?"

I1: "So the aim of the overall project is to try come up with an evidence-based interventions. Because at the moment, basically, people come up with an idea and that might work and do it, but nothing proven to work. So that's our aim. It's to try and see if we can come up with a solution. Hopefully interventions that work."

C8: "Is this in sort of paramedicine as well? Or more hospital?"

I1: "So my topic is emergency health care, so paramedic and ED, cause we have similar patients. Our social environment is really similar."

C8: "Like we're lucky sometimes, because you guys have probably de-escalated or given us notice."

C10: "...aggression on nurses. [...]"

Laughter & inaudible chatter

I1: "We're looking at it from the other perspective. But yeah, I understand."

C8: "We just have to cop them when they wake up, I suppose."

Laughter.

I1: "Yeah, we have the same patients in very similar conditions. And that's why we've chosen this..."

C10: "You drop them off to us."

I1: "We palm them off to you. We ignore them till we get here." *Sarcastic*

Laughter

I2: "And about this research too, we don't know what you've done that has worked. So everyone has jumped from one intervention to the other. And they've all build on each other. But there's been no reflection about what's worked, what hasn't."

C8: "Yeah, they've done the studies what sedation works best and things like that but not...avoiding..."

I2: "Yeah. And also looking at the perpetrator's perspective as well, that's the real cause of the problem. But no one has really tapped into that. It's all been what can we do to after the event, not how can we prevent it happening."

C10: "We can give you some names."

Laughter

I3: "You do know your patients really well, very interesting."

C10: "Yeah, we'll get them to come around."

Laughter

I3: "Thank you."

End of Focus Group 1