

Violence and aggression against emergency workers Focus Group 2

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 2

I1: "Excellent, thank you very much. So we can get started. We're going to start off looking at reporting so if we could discuss the experience you guys have had with reporting violence and aggression at work. And any barriers or any motivations that impact your decision to report."

C2: "Time's a big one I think. [And this] department, there is such like a fast-paced environment that sometimes...it's hard to put those Riskmans in sometimes and [you need] that time outside of work hours to actually sit down and do it. I find time's a big factor in reporting."

C1: "I think the culture is changing. I've been here for 25 years plus. And I think in the time...like we've seen so many projects, so many different... particular with the mental health side of ED, that we used to be just quite used to a level of verbal aggression and verbal violence. And even...in the last few years we're definitely...definitely putting a stop to that, and definitely saying it's not okay. So that's good. But I don't know how much of that we still take on board and it's not reported."

C7: "I think a lot of it is not reported."

Agreeing in background

C1: "It have to be like...it would be so many times...it'd be so many times a day...." *Laughs*

C7: "You couldn't report everything."

C1: "No, [it's not possible]."

C7: "And I think a big barrier is, it's definitely time, but it's...it's your in-charge, nurse in charge, management... yeah that's a barrier as well. Because you can go to them and say 'look I've just been abused' and not a lot can happen because of the way the department is running or what's going on, on the cohort or with the patient. You can't move people around or..."

C5: "Also, what happens generally as well is you go...well not generally but a hell of a lot, is you say somebody is being verbally abusive, it happens a lot at triage, [for a starter], and a lot from relatives. You escalate it, but what happens is there is no comeback on them apart from their issue is resolved a

lot quicker. Because they want to stop the trouble. They want to stop...and stop the aggression. And instead it not just being a clear cut of 'no, this is not how you behave, you stop or you have to...'. What they want happens. And I find that...and that is actually...that's just actually encouraging behaviours, even though we say we don't have the tolerance, there is a massive tolerance already. Especially..."

Agreeing in background

C1: "I think that's true. It has to stop at the front door and it has to be out there in the community before they enter the hospital."

C5: "They have people, and I've heard it, and I've seen it and they say 'oh, make a fuss and you're seen quicker'. And I've seen it so many times on things like social media."

C7: "And they do. They scream and rant in the waiting room, and suddenly, bang (*snaps fingers*), they're in the door, they get seen, they get sorted. Because nobody wants a carry-on."

C1: "Well, we don't want the spin off of it, I suppose, escalating other people, which it does. And particularly with [mental health]. But it's not okay."

I1: "Do you have any other course of action at all for these people in the waiting room besides giving them what they want?"

C2: "Zero tolerance."

C1: "Tell them to leave." *Laughs*

C5: "No...ban them...yeah, security and gone."

C2: "I always call the security."

C1: "They can just be Joe Blow relatives."

C3: "With frequent presenters, the security are on to them. Quite often, they will present and ask the triage, and if I'm at triage, they will come and ask, you know, you're okay? Can we sort them out? But it's a matter of letting the floor coordinators know and AOUs know. Because sometimes if they watch, they will come out and speak to the patients and their family as well. But it depends on who is on."

Agreeing in background "Yeah it's very dependent"

C3: "It's very dependent on the shift and..."

C2: "And if you have a full waiting room, which is the majority of the time when you're in triage, [you've got] limited time to, like, worry about someone else

kicking off as well...like a line is out the door and the ambulance is rocking up, it's like..."

C1: "And in all fairness, like...sometimes, I work as an [...] here as well..."

Laughter

C1: "You might be having you know, traumas arriving, there might be all hell break out in Resus, with you know arrests, and chopper's landing. And who knows what's going on."

C7: "And the cubicles, there could be 7 people in there that are really crook that need to not be there, and then you've got someone in the waiting room carrying on like a pork chop, because they've had to wait for a cup of tea..."

C1: "But it's not always a patient, it's often...it can often be family that are very aggressive to us."

Agreeing in background

C1: "And really, really rude."

Agreeing in background

I1: "And does that ever get reported?"

C1: "Probably not."

Agreeing in background

C2: "It's hard with family though, because I find it difficult to report. I want to report an incident, remember, and I find it hard to do cause they are not actually registered on the system, they don't have any details about them, who they were. All I had was the patients name."

C1: "In saying that though, you might write...I would write notes in the patient's [notes] to say incident with family members regarding 'a, b, c' and what we did to try and rectify it. And there is always us trying to sort of like..."

C5: "[We still pander, we pander to it]. It should be a simple click. You can't do it anywhere else. This is the only place that I know where you can go in, swear at someone to get what you want, from the [onset], 'okay, give me two sec, I will try to sort this' if you were in any other place, you get: this is not how you behave, security, out. Its'...even if you're stressed, even if...I can be horrible when I'm stressed, I don't go aggressively to people and...we are, we're just [pandering], even though we're saying we're doing stuff, we're really, really not. Even...okay we'll get the floor coordinator to see you, did he really need to speak to a floor coordinator who's busy? When they are just being damn right rude. It's should be very, very, very...click, right this is how it is, if you're not going to...if you're going to talk to me like that, I will get

security to ask you to leave. Especially if it's relatives, because they are not here with sick...something that needs to be addressed. There is no reason for them to be here, but support. We don't do it often enough."

C7: "We don't. The other things is that what is reported don't ever get any feedback."

Agreeing in background

C7: "We don't know what the repercussions were to the person that was abusive. So...the stock standard excuse is 'oh they were admitted, they have mental health issues, that's why they were abusive. It doesn't really wash anymore. Because every second person has something, has a mental health issue of some description. I...that's just an excuse. And because we don't get feedback, we don't know...so you can have focus groups, and you know, we run lots of focus groups within the department, but there's no feedback. And I don't see any positive change. And I haven't been here as long as C1, but I'm coming close. And...I don't think the abuse is any less, if anything it's worse."

C1: "It's worse, it is worse. I think that..."

C3: "I think we're encouraged to report it more now though."

C1: "Totally."

C7: "I don't think we are. I don't think we have time to report it."

C1: "We have few really horrendous..."

C7: "No one is staying back for free and doing the Riskman."

C3: "But it wasn't even a thing to make sure you instant report that. Like back when I started 8, 9 years ago, now they're like report that and dududududu..."

C7: "No it was, we just..."

C1: "Not so much verbal though I think."

Agreeing in background

C1: "And I think it's terrible to think that physical you would and then a couple of like really horrendous incidents in the last 12 months, and so we've started a really big thing of tapping out. Which is wherever you work in the department, if it's all...which is like...I'm not going to say it's a band-aid...it's not a band-aid, it's helping those, that staff members get away from an area that is possible going to cause them stress. And you know, ultimately [vicious] down the track. But it is getting them away from difficult patients becoming violent. But it's not reporting, is it?"

C7: "And it doesn't always help, does it?"

C1: "So that's something we've done within the department to help."

Inaudible chatter in background

I1: "We want to discuss the tap-out program as well, so the way it was sort of explained to us that when, you know, you've de-escalating a patient for a long time, and you're getting fatigued and you're sick of it. Then you can swap with someone else, is that...?"

C1: "Well an example that comes to mind straightaway was last week. I was in charge of short stay and when you're in charge over there, you come over to relief the [...] in ED and she was busy in Resus. And two of the girls that we're on the gold side just...like sometimes it's happens you come to the desk and everyone just comes *zoom* (*noise indicating people immediately coming to the desk*)" *Laughs*

C1: "They were both like just giving me all...and I was like why don't we just...hang on, slow down, and we went through it all, and basically they were just at their wit's end. It was...they weren't crazily busy on that side, but there was one very manipulative, very nasty individual that was just getting under their skin, to the point were this one nurse just ended up in tears. So she clearly couldn't stay on that side. So I did a complete swap and put them complete...well they went for a break, and then I swapped them onto the blue side for the rest of their shift. And swapped the other nurses to the other side. But you know, it's happening more and more."

I1: "So it's getting utilised? The tap-out process?"

C1: "Absolutely. Well I hope that everyone feels they can do it."

C7: "I've never used it."

C1: "Cause I never have an issue with anyone wanting to do that."

C2: "For a while, when we're having the [muster] slides, there was in purple or something... so you had your allocations at the start of the shift, and if it's purple it's like..."

C5: "It's mean challenging potentially..."

C2: "...you might have a that might require you to tap out. So you kind of come into your shift like okay it's going to be a bit of a challenging one. And knowing that you have that option to be like..."

C1: "I reckon people tap out too when they've had...just, you know, families...we're talking about aggression... sometimes families might not be verbally aggressive towards you, but they can be really...what's that word..."

In background "Intimidating"

C1: "Just underlyingly...."

C6: "Or really passive aggressive."

C1: "Yeah, and that can just be just as wearing and horrible for someone to have to put up with for hours. And I've moved people for that reason."

I2: "Have you... is anyone here tapped-out?"

C5: "No."

C7: "Never."

C2: "Yeah, I have in Resus before. A few times with my Resus colleagues, because I've had really, like, just a...you know..."

C1: "Emotionally draining..."

C2: "Yeah I've definitely used it to...maybe not violence, but with other things..."

I1: "Is it a bit of a specific area, Resus? Like..."

C2: "Nah, it just depends on what cubicle the person's shackled in and what come in. Yeah, I don't know...it depends."

I1: "And did you...sorry Rosie, did you decided for people to tap out? Like they didn't make the decision, you..."

C1: "Oh, I asked them. No I said...they just...they wanted to... they wanted to...and you always say to them like, you know, would you like to go and... where would you like to go? Where would you like...are you okay? Can you continue working? All that sort of things and then, yeah..."

I2: "Can I just say...cause at least two of you have talked about reporting in your own time, not in work time, so when a shift is finished. Is that common? That you don't get time...?"

Lots of 'yes' in background

C6: "That's very common."

C3: "I think the only time I've reported, done Riskman report... I think it was just the one time, and that was at the end of the shift. Because I had a Resus shift and I had just didn't have the time to do it."

More agreeing in background

C3: “And by that stage almost over it a little bit as well, so you just want to get it over with. You want to get home. So going back through and re-living...”

I2: “So the quality of the report is not going to be high if it is completed at all.”

Agreeing in background

C5: “And it’s the same with the...like...”

C3: “And you have already de-escalated yourself a bit as well. So you’re not as **makes angry typing noises and motions**”

Laughter

C6: “And at the same time, you trying keep that report as objective as you can. So you...that incident may happen at 3 o’clock in the afternoon, and by the time you have time to actually sit down and start putting reporting in, it’s probably 9:30 – 10 o’clock. So during that time you’ve probably already de-escalated or you’re trying to remember the details as to what exactly happened. And to make it...”

I2: “So it’s not [contemporary]... basically if you...the documentation you do in the history is real time, but this...this rarely is. So it’s not accurate. It’s based on memory over...”

Agreeing in background

C3: “And I still find them so hard to do.”

All candidates agree

C1: “That’s probably one of the things that Riskman is difficult.”

C3: “I always miss a section, have to go back and there’s another highlighted bit that is missing.”

C5: “And the other thing is that as well that if it’s something...cause I’ve done it each time and I’ve gone to the police station and that’s out of time and that is really bloody lengthy. And very, very tedi...you know, you don’t get anything from it so, yeah...”

C1: “Cause staff do get threats to, like people will be verbally to the point where they just go ‘you just wait and I’ll keep...you know...wait in my car for you.’ ”

C7: “Yeah, I’m going to follow you (...)”

C5: “And it is so worrying when they know your shift times too. You’re like “aaah”.”

C2: "Security has walked us out to the car before and...because we're feeling unsafe getting out at work."

C7: "But staff have been threatened on trains and trams...I mean two workers they've got the wrong... on the hospital, a lanyard on or their scrub top. And they've been abused so..."

I1: "How do you think the reporting to the police is?"

C5: "Disgusting. I have absolutely no time for it any more."

I1: "Right..."

C5: "I've been...I've had a man throwing blood at me, shouting...and this is on security...they were recording it at the time, because they came to attend. And he was a known anti-social, and personality disorder. And I went to report it to police. He's thrown blood at me, shouting 'I've got HIV' and every obscenity that I'm very good at, at me. And I went reported him. It's not a crime. That was it. It's so closed door and I was like 'mate, whatever', tried to ring the next day, because I only work nights. And try to ring the next day to get the police liaison but no one like that... 'We don't have anyone like that'. And it's like 'yes you do'.

And then of course, I want to go to bed. I've got kids and things, so it's like...give up. And another time I went over and a women had punched me in the face. And 'oh what was she brought it for?' and 'oh, she is a psychiatric patient'. No, she is actually waiting to be assessed by them. She's coming with what you believe is a psychiatric problem. And...and...well we can't charge her. So they didn't charge her. So it's just a pointless...to me, I don't bother now."

C7: "So mental health seems to be an excuse that the police use to not charge people who are assaulting health care professionals. And that's not an excuse. Because they wouldn't tolerate it so much, but we have too."

I1: "So we were informed that there was like a new document put out, which clarified you procedures for reporting to the police. And there was the liaison between police and health care staff, and also the police had a bit of a change of out look where they would try and charge, or at least process those patients. But practically..."

C5: "Yeah they say..."

C1: "Was that recent?"

C5: "It was recent enough that it was when we had the hospital liaison and everything. And that's why [person A] wanted me on the clinical aggression time. And I was like 'nah', because it put me off..."

I1: "So they haven't translated into practise and made it easier for you to report it?"

C5: "Personally, no. However, I don't know about other people's experiences. Maybe it's been even more streamlined since then. Because I do know that our management were furious when they heard of what the police had said. But still no feedback either..."

C7: "It hasn't been promoted. Like I...is it been promoted? Do you know of it?"

C5: "It's been promoted. It's not been followed through."

C1: "I did notice there was someone from North Melbourne that came through just while we were having lunch one day. And he wanted to...he's one of the police...do you know who would be? To wanting to make sure that the staff felt that they could...you know, use..."

C7: "[Nobody mentioned though]."

C1: "In a different way we feel..."

C7: "If they're on the floor, and deal with them...sorry..."

C1: "No that's alright."

C7: "If people on the floor don't know about it, it's pointless. It's an absolutely pointless exercise. Cause they're fine up here, you know...it's no good if just management know that this process is in place, if we, on the floor, who [aren't supposed to] receive occupational violence, are not aware."

C1: "Processes to report to police?"

C7: "Yeah. So I didn't know that the process had changed."

C1: "I don't know if the process has changed."

I1: "I don't know if it's changed, but it's been clarified. So there was some document that at least explained for you what you had to do. The way that it was explained to me is that people didn't know what to do. And they didn't report, because they didn't know how to go to the police and report it. So there was just a document that told you what to do. So not changed, but clarified."

C7: "I don't know where that document is."

I1: "Okay."

C7 laughs

C1: "I suppose it's difficult if you do, do it and you don't feel like you've been heard. Like C5 said, that's pretty disappointing."

C5: "Especially when you know the outcome...the HIV one... the other question I got was 'well, has he got HIV?' I went 'no, he's got hepatitis'. But that's not the point. If you threatened someone with a syringe, and say I got HIV, that's actually classed as a crime."

I2: "To me, not knowing if it's HIV or not, is no different to knowing if the gun is loaded or not."

Agreeing in background

C5: "Exactly, exactly. And I'd even said 'look, we've got it on video footage. Security are happy to download it and everything for you.' And...yeah, total barriers. Whether it's different...I'm a night shift worker, like I say, there is less staff about and things like that. Irrespective it should be addressed. But yeah, no charges."

C2: "I only reported once and it did get taken quite seriously because a police officer was involved as well. And it ended up being on the media. The family ended up getting footage...I think we looked at this...the gentleman got pushed against the wall. And it was...and he went to hit me and hit a police officer. So it was quite a big event. They came back and interviewed me three days after the event. And if it weren't for my Riskman, and doing it at the time, I wouldn't have remembered any details. I think at the time having written it down, dot point by dot point, helped a lot. Yeah, because the family ended up taking...getting footage of everything happened and getting to current affair."

C7: "Oh that's right."

C2: "But what they said that her father was [...], but he was, like, legless-ly drunk and incoherent and very verbally and physically aggressive. But that wasn't showing on current affair of course."

C5: "No"

Laughter

I1: "What information do you report on your patient notes in terms of aggression? Like if there's an aggressive incident what...how much information do you put on there?"

C2: "I do brackets, I do speech [...]"

C5: "I keep writing and writing and writing."

C7: "So there's an alert button one so that we can make sure...they got that little symbol so we know that they're aggression risk."

C5: "And then it can be entered on IPM of what sort of aggression risk. But in symphony notes, you put it in the progress notes, which are very limited space so you end up being: continued, continued, continued."

I1: "So you do documents what's happened."

C5: "Everything."

Agreeing in background

I1: "But it doesn't get reported."

Agreeing in background

C3: "I think that's happened more often though"

C1: "Usually, that would be an incident though that...like that has really bugged you though, isn't it? Like it has to be something like...not just the usual like..."

C6: "It has to be something..."

C1: "F off or..."

C7: "Being called something like [...]"

C2: "That's the thing it becomes the usual, which is like, it shouldn't be."

Inaudible chatter

C5: "Commonly known as the C-bomb."

Laughter – inaudible chatter

C1: "You just sort of get used to that level...I know you do become immune it to a degree."

C2: "I don't know, maybe I think like the junior nurses though..."

C7: "...like common, we've just met, you can't call me that."

I2: "It's normalised, isn't it?"

Agreeing in background

C1: "Mental health more, but I think I find it really confronting when you have relatives that are so rude and disrespectful and just...yeah...just expectation of you know... and sometimes I think too we're very, not complacent about it, but very mindful of 'maybe they don't understand the process' or 'the

processes are confusing' or you know, everyone that comes to ED is usually stressed, not where they want to be, long wait times."

C5: "But that's excuses. That's excuses for..."

C1: "Yeah, I know and that's what I think we do."

C5: "Yeah, we make excuses"

C1: "We sort of say okay they're being very badly behaved, but sometimes even if you go out of your way, which is what we always do to try and de-escalate, to explain this is the reason, this is happening, this is happening. It still doesn't matter to a lot of people, they still feel...you know, that they can easily target someone or abuse a staff."

I2: "If there was a system that would be efficiently used to report, real time, what would it look like."

C1: "Simple."

I2: "Simple."

C7: "Really simple."

C1: "Really simple."

C7: "But it needs to be actioned. There is no point reporting if there is no action taken, so...."

C5: "And then feedback."

C7: "And then feedback."

C2: "Probably something on Symphony, like a dropdown..."

C5: "No but Symphony is going anyway. And it's controlled by a doctor. He sets up most of Symphony."

C2: "Yeah, but if there were with like our new program that you could be like, oh this patient just done something or..."

C1: "Preferably if it was simple just to... for physical or verbal violence. Just a report for violence. And you just go access on it and it could just be like where, who involved, who was notified, what happened, blabla, done."

C4: "What...as a junior new person, what is the outcome of Riskman? Cause I... they..."

C5: "They read it..."

C4: "It's all about like trying to figure out [...] kind of procedure of how to make it not happening in the future, isn't it?"

I2: "Yeah."

C5: "Yeah, and it's..."

C7: "They are followed through."

C2: "It's based on the severity to where it goes, what department, like how high up it goes, who sees it..."

C5: "Somebody sees it in like Chanel...no, she deals with complaints. But half of them you won't even see because it's already been documented and the person who goes through is like...a lot coming from the wards against us and then sometimes 'oh can you answer this one?' And then they always have to be followed up, the Riskmans, but the follow up we get with the violence ones is an email 'Oh, I heard about this shift, is there anything we can do to help?'. But..."

C7: "But the email came three weeks after the event."

C5: "...after the event, when you're just over it."

C7: "And you've already drank 4 bottles of wine and eaten 5 boxes of chocolate."

C4: "And that's not really the outcome you're looking for either. The outcome that you're looking for is that the person that did what they did is told or is disciplined in some way, and that isn't going to happen, is it."

I2: "Ideally Riskman could be used as a tool to match intervention with outcome, so a lot of interventions have been put in place of the last few years to try and mitigate violence. None have solved it. But nobody really knows if it's been effective, because Riskman is incomplete.

We've got no idea how...what interventions have made any difference to...because it's Riskman, it's actually about managing risks. And we don't know to what extent the risk has been even changed, with the interventions, because of the lack of reporting. I go to the occupational violence and aggression meeting every month, and [we talk through them] someone stands up and talks about the number of Code Greys and blacks across the organisation. And I'm already thinking this is maybe 1% of what's actually happened."

Agreeing in background

I2: "So we need to better... if we don't know what's happening, we'll never know how to stop it, if that makes sense."

Agreeing in background

C5: "It would...it would be much better if there was just one specific program for...separate from Riskman, that's just for violence and aggression reporting. From both relatives and patients. And then it's streamlined, then it's focussed on that. As opposed to having to sift through Riskman, is it ward versus ED or wherever or [...]."

I2: "And something you can do in work time."

C5: "That's quick and easy."

C1: "Yeah, quick and easy."

I2: "Not in your own time."

C1: "Yeah something you can do then and there, present time. Maybe say, 5 minutes I've got to sit down and do this. Yeah done."

C7: "Or I just do my notes...bam bam...quickly do this."

C5: "And then it could be...that could be used because things like your frequent flyers that are a complete and utter nightmare...and then you've got hospitals, those patients aren't allowed to set foot in them. They don't...they refuse them, why don't we? Every single time they come back, they come back. But if you had something like that, you say 'nah', now this family has been systematically over the last three years a nightmare. We need to do something about this. Because it is not changing behaviours."

I2: "At what point do you know, if you're on triage, at what point do you know this is that patient that caused troubled before."

C5: "When you're looking at them when they walk in the door."

Laughter

C5: "You get to know them."

C6: "Yeah, you get to know them, like the frequent flyers."

C2: "You don't see anything until they're classed and merged."

C7: "Unless you know their face."

C5: "Unless you know their face when they come walking in."

C7: "Then you can go back in their notes and they will have a care plan or another something..."

C5: "A lot of the time the [clerks] as well, the [clerks] spend a lot of time out that front, [...] it's like 'oh who we've got.'"

Laughter

I2: "Does it change your objectivity of how you perceive that person knowing that they're a repeat perpetrator?"

C5: "Oh hell yeah. Yes, it definitely does. We're meant to not [...], but of course it does. Cause you got to be wary, this one's known, a certain one's known for being, you can't put them inside because they're going to be super aggressive, but you have to be..."

C7: "Or you can't put them through to BAU, they have to come through the main department or so."

C5: "So you do. You still talk to them, but you've got to, but it's always there in the back of your mind."

Agreeing in background.

I2: "It's interesting how human behaviour can change. And sometimes if you behave differently they could pick up on those vibes and they could then behave differently as well."

C5: "Definitely, you can escalate them very easily. And then, yeah...they're humans."

C4: "From that point to, sometimes they will come into the cubicle, you do your assessment and everything, and not have looked at the computer, to see that as well. Like, I'll sort of assess the patient, and go to the computer and do my notes, and I will see that there is an alert. And I'd be like 'really? Why? This patient is lovely or...' I don't have that problem."

So that's an interesting point too, because then someone might walk past me saying be careful of that one they can be really whatever, and I'm like oh I did not get that at all. So that's a different perspective in that as well. To put that alert on someone and then they are not that."

C5: "But there, the thing...the problem with those, the management plan ones, the [arrest] ones that we have, they can still get bloody sick. And so there is such a high risk group and you still got to look at them, properly. And yeah..."

C7: "If someone's drunk or drug-affected at triage, I quite often just put them as an aggression risk."

C5: "Oh I do, yeah."

C7: "Even if they are being okay, but they've the potential to do that."

C2: "Potential to escalate, yeah."

C7: "There is that potential there."

C5: "Or they got that look."

C7: "Yeah, yeah."

Laughter

C5: "You'll be a pain in a minute."

Laughter, some mumbling

C2: "I call security about those patients too. If I'm in triage by myself, and there is a couple in the waiting room that I think are too unsafe to come in, I call security and 'just so you know there is a couple out here that I'm keeping an eye on, I'm a bit worried about, last time they were here they did this, that', you know, if something were to go off...And they're usually very supportive and yeah..."

C1: "They're already onto it."

Agreeing in background

C5: "I was going to say, security know a lot of our frequent flyers."

C2: "Just knowing that they know, that I'm like thinking the same thing and the waiting room is full and they kind of got their eyes on them. Because they can see outside of the department too. So they see the ones that are having their [CDs]and doing all their...yeah..."

C1: "[There's eyes...]"

Laughter

I1: "So we're sort of transitioning where we want to go anyway. We're about half way through. Do you want to do a recap what we've talked about reporting?"

I3: "Maybe just briefly, sorry, I'm just trying to see if captured all the things that we talked about on the reporting. So I think one factor is time that stops from reporting. It's workload itself. It's also after work you don't want to stay on and the whole process is pretty cumbersome, or Riskman. Also, when it's not real time it might not be accurate.

Then there is a huge issue around families being rude, but also being difficult to approach, because they are not the patient, so you don't have a relationship with them, or you don't know them. You don't get feedback on the

system. So when you do report, there doesn't seem to be any positive change. There's a lot of frequent flyers. The positive role of security: helping you get to your car, but also being there, monitoring and signalling things maybe before you do. And being very supportive. Did I miss anything?"

C4: "Can I add another one?"

I3: "Yeah?"

C4: "Just as a barrier, being like a young junior staff member as well, not having the experience to deal with certain types of clients, and I sometimes feel like I could've said or done things different that would've de-escalated them earlier. So often I think like, not embarrassed by, but I think I could have said or done things different. Oh I don't want to report it, because it's might fault that they might have got a big aggressive."

C3: "The training this afternoon will help you."

C4: "Which I have done, but I don't know, it's sort of like..."

C1: "They shouldn't be aggressive to you, in the first place."

C4: "Yeah that's right."

I3: "I was thinking that..."

C4: "That's just what goes through my head. Like, [idiot], you shouldn't have said that or you should've said something different. [And then I often think] I don't want to report."

I3: "And it might work the other way as well. People might, you know, have less inhibitions becoming aggressive to you because now they know..."

C7: "And you know even the most experienced people don't deal with that thing very well sometimes. [...]"

C5: "And also, that's your critical thinking and everyone does it after an event, anyway, that's part of what you do naturally. It is what it is, and you did what you did, and you just..."

C4: "Yeah."

I3: "It's good that you feel that you are using that as a young person. I was actually probably...I was expecting you to say that people find it easier to harass you, but you..."

C4: "I do find that they often think they can manipulate you a little bit easier, as you're younger and questionable, which you [clue] onto that very quickly. But sometimes you can use that to your advantage to do."

C5: "But it's very true that. You pull out your mum's voice and it works."

Laughter

C4: "Sometimes I'm like I can use it to my advantage as well. Like I know that they think that they can...like I can use that in the same way."

C1: "I also think that it's also just the non-negotiable terms, isn't it?"

Agreeing in background

C5: "It's straight talking."

C1: "And I mean, I've had times, many times, when fly into Resus or somewhere and you have patient's relatives that are just out of control, and I've just said to them, you know, you have to actually stay outside. If you can't, even if they are relatives...I'll obviously try to talk to them and everything, but if they are just out of control, they have to stay outside. They can't...we just can't put up with them."

I2: "Can I ask you, the zero tolerance policy..."

Laughter

I2: "Do you, I'll put that in inverted commas, do you find that has given you permission to not use de-escalation skills?"

C7: "We don't have a zero tolerance."

C5: "No."

C7: "We tolerate it every day."

I2: "So the policy is..."

C7: "The policy is a waste of paper."

I2: "Okay."

C2: "If the patient is not unwell, or the family was not unwell, and you've tried to, you know, reason with them, and why are they upset, and understanding where they may be coming from. And saying that I understand, but this is something that we don't tolerate here in the department. I think I do use those words, I find that I do."

C1: "Yeah, so do I. All the time."

C2: "I'll go I understand you are in a stressful environment, your family is unwell, but I do not appreciate being spoken to that way and we're going to

have zero tolerance. And I'll warn you on this. We'll help you out as much as we can, but...I do use it."

C5: "I do use that line definitely, but I follow through with it. They come back and it's like 'nah, out.' "

Laughter

I1: "So zero tolerance works, sometimes?"

C2: "Yes"

I1: "For some people."

C5: "It depends on the person, it depends on the barriers, you've got so many different barriers. You've got the doctors are bloody massive barriers. We get 'oh no, no, they might...' 'no, are you sitting out here with them swearing and trying to get at you through that, well, what used to be [wires], now it's glass. No, you've not. Do you actually...they're vitally well, this is someone that's been seen by a GP in the morning, they can go'. 'No, no, no', and I've had it several times. And they can.

And with...even...there was a situation recently where someone I know so, so well and she never arcs up for me ever. But she's always in the waiting room and somebody from triage didn't realise this and then the treating doctor didn't know her. She didn't have a management plan. And the EMH...referred to EMH and she was arcing up. She was being very obstructive to other people's care and everything. And I wasn't even looking after here. And I just noticed she was in the thing. I spoke to the doctor 'can we pop her? This is all you need to do. She's not going to do any...', but because she didn't know her, she wouldn't take that risk.

And then EMH, 'no, no, no the doctor wants me to be able this decision'. Then it was a shift change, and within 10 minutes I had her back sitting out in the waiting room, because the EMH, who knew her, was like 'no, with this sort behaviour, she can sit out there.' And that de-escalated it straightaway. The behaviour then stopped. So it's the knowledge about people, their access and appropriate mental health plan...the care plan, it's not mental health plan, just care plan, for these like frequent presenters and trust between each other would help as well. But we'll never get that, because new doctors, they don't know us."

C1: "There is a lot to read at Triage too, isn't it?"

C5: "Well it doesn't come up until they're linked, aren't they?"

C1: "Yeah, yeah, we had a perfect example of a girl the other day that was put inside, and, ah, she was just off her head. She was just so loud, and nobody could have a conversation with her and she was very threatening, in her way of behaving. And I went across because it was [all hell there]. And she

targeted me because I had black scrubs on at the time, so she thought I was security and the phone just happen to ring, cause I was in charge. And it wasn't me calling someone.

So she just immediately tagged onto me and was like 'you've called security' but then she was like coming at me. So I started walking backwards. But, as they were coming up the other way, because she was so out of control, we had to take her into the room, but nobody had managed to read her management plan. And part of the management plan is not to shackle her, not to put her in isolation, not to do all the things that they were just about to do. Luckily one of the EMH guys came running over, who's gorgeous, and just, he immediately just went, 'no, no, no, take it all off, take it all off' and then within a few minutes had her calmed down. But see, it's very hard, that's quite a...they're quite a [...] thing to read through, like they are quite a detailed..."

C7: "Which they need to be."

C1: "They do need to be. In triage you reading...you transferring people every two or three minutes."

C7: "If something happens."

C5: "You want something to come up quick. Doesn't usually go inside, especially when they are borderlines. They are the ones that generally do...the containment doesn't work for them, it escalates them or something."

C7: "Or the drunks ones that aren't generally meant to go to BAU. Or [someone] in a cubicle inside because a triage nurse is junior or hasn't come across them yet. And you go, well they don't need to be..."

C5: "And that's all preventative, as well, that stops a lot of the aggression."

C1: "I think...I think all the television ads and all the stuff in the communities are a really good thing. I think there just has to be more and more and more. You know, there's like...you know, for the paramedics, you know as well as us, there is all the stuff that has been in the media recently, [we should just] say no."

C5: "Yeah, but it's alright having all the adverts but they need to have the action. There needs to be visible seen that there really is a zero tolerance."

C2: "Why did our video get taken off Triage? I was meant to ask that."

C5: "Because, was it because of the...oh that one..."

C2: "The one that they...the zero tolerance video."

C5: "Because I know the posters all got taken down, because it could be translated as something else for people who couldn't read English. Or something. It looked like we beat people or something."

Laughter

C5: "But yeah, so they took down the ones with the spitting and punching."

In background "Really? What?!"

C5: "Yeah."

C2: "Because I found it very beneficial. Because people would be lighting up and they would be watching the video..."

C5: "[Person B] looking cute?"

C2: "Well I think another hospital has mirrors, don't they? So at triage, so when a patient walks in, they can see themselves. So when they are being aggressive, they can see their own reflection and then..."

C5: "That's a really good idea."

C2: "And they see how, like, you know..."

C5: "How they are coming across."

C2: "I mean if you're looking at yourself in the mirror having these faces, and then you go 'ooh, that's not me, settle down, take a step back' that was really interesting."

C5: "Because that would...that would..."

In background "Who's thought of that?"

C2: "I think the hospital, I think."

Inaudible chatter

C7: "It's also the consequences to their actions. So that's a big problem. So [it's the key] to misbehave, and behave inappropriate to nurses, and get away with it. And they know they'll get away with it."

C5: "Yeah, like with those ambulance..."

C7: "And like Maria's example, the cops weren't even interested at all that someone punched her at work. And obviously, neither was the organisation, which is pretty poor. So there is no consequence for the actions. The same with those two ferals got off for punching the crew in [...]. So if there is no consequences to the actions then the behaviour will continue. You have to break the behaviour cycle."

C5 inaudible comment

I1: "So I believe you guys, here, put in...they send out letters to people that have been violent. Like an accountability letter to tell them what they've done and it's not appropriate."

C1: "Yeah, I heard that."

In background "Do they?"

I1 *Laughs* "That's one thing."

I2: "Who didn't know that?"

C3: "I didn't know that."

C2: "Is this new?"

Agreeing background on not knowing about the letter

C1: "I read about it somewhere, I can't remember where."

I2: "[...]maybe?"

C1: "Yeah, it was in one of our emails."

C5: "Why don't we get apology cards?"

C1: "So it must have been in our emails, because I read it, I read it."

General mumbling in background.

I1: "So then I probably can't really get much discussion on it whether it would be effective or not."

C7: "I know previously there has been letters written, and I've seen them in patient's history. And the patient's signed them. And the patient still blows up."

C2: "I've found conversations [in there used sometimes] very beneficial, like when the patient has come in, drug and alcohol affected, not within their normal self. Come in to BAU, sleep 24 hours, wake up mortified. It happens...it actually happens more than I thought it would. They're apologetic, they're upset and you sit down and you actually have a very frank conversation with them, I find that very beneficial. I don't know if it actually sticks with them, but for me it helps. But I don't know..."

I2: "Probably...a heartfelt apology feels really good, doesn't it?"

C3: "We often don't get 'thank you's.'"

Inaudible chatter – laughter

C1: "It's human nature...people are just...it's human nature, it's strange."

C2: "And if you feed them what exactly they were saying and how they were acting, it's pretty confronting when you don't have the recollection of what occurred, like..."

I1: "Is there a specific demographic of patients that are receptive to that feedback afterwards?"

General agreeing

C5: "The younger ones."

C2: "Young, recreational drug users and alcohol. Not the...no one that has a chronic user. It's usually all the ones that are still trying their way, their, you know..."

C6: "Yeah usually it's not chronic, more recreational."

C5: "Having fun in their twenties, basically. The young people."

C7: "And it's both male and female."

General agreeing

C2: "And like when they are waking up in nappies, because they have peed themselves. And it's like, that's pretty confronting..."

C5: "In a hospital"

C2: "You know, like, I'm a continent, ambulant 23-year-old, and I'm in bed in a nappy and a gown, because I peed myself. It's pretty...if that's never happened to you; it should give you a bit of shock, maybe to change some of your actions."

C7 inaudible comment

I1: "So very specific to that group?"

C3: "I think so, it's very rare that that would happen to someone who's a chronic user."

I1: "And this accountability letter that they're sending out to people, do you think that would work for many people or some people or...?"

C5: "Nah, they'll just go to a different hospital. If I was that person, I'd go, well I'll never go there again, that's it."

C2: "I think the people of the same demographic, the same one I just told you about, but then again..."

C1: "Wouldn't you be embarrassed if it was you?"

C5 responds but inaudible. C2 continues comment but inaudible.

C7: "They're not going to find...they're not going to read the letter. The last thing [they're going to do] is a letter from us saying if you misbehave, you're not welcome in our hospital. They're just going to be 'well shove that where the sun doesn't shine', I'm coming anyway."

C5: "Also, a lot of them are transient. They've...they harm us not so much, some...but people who are... because a lot of these people aren't going through a great point in their lives...and they can be between places. Half the time that letter is not going to get there. Also, you looking at this 'oh that's from the Royal, I'm not looking at that, it might be a bill' or it might be this...I've not looked at mail because I thought 'oh I know what that is' and just thrown it. So it's not a...they just need to be charged."

C2: "I think also all the actions, all the end results and implications that occur are different to each..."

C5: "Each individual."

C2: "Yeah and like each sector of people."

C1: "And it is mixed up, isn't it? With all the drugs and alcohol, and..."

C7: "And behaviours."

C1: "And behaviours."

I1: "Yeah, so one thing that we wanted to discuss that is each type of people...so what would be the specific categories of people that are being aggressive and violent?"

C1: "Any."

C5: "It's just across the board."

C1: "It's anybody"

Others agreeing in background

I1: "Any people?"

General agreeing

C7: "It can have a lovely little 90-year-old that doesn't say boo to a goose, and suddenly it is 5 o'clock, and bang sun down, and she just goes off her chops."

Laughter and agreeing in background.

C3: "So you acutely confused, demented elderly patient, *inaudible comment*, your alcohol and drug affected."

C2: "Alcohol and drug affected."

Some other inaudible comments in background

I1: "And you approach them differently to your alcohol, drug affected, mental health patient?"

C5: "Yes."

C3: "Yeah of course. Quite often AB has given me the heads up 'look they're being quite aggressive' in the oldies. That they're winging punches, so just be careful kind of thing."

C2: "You're not going to get security, like 6 brawly blokes like pin down this 40 kilo woman, shackle her and you know..."

I2: "And you are very unlikely to report that 90-year-old?"

General agreeing

C7: "And you wouldn't."

C1: "It's like an expectation that they....they're confused and they..."

C5: "Yeah, but you do Riskman just in case you end up on work cover. They broke your finger or something. But that's it. That's as far as you go with that."

I2: "Would you do a Riskman then?"

Someone in background "Nope"

Mixed reactions from different candidates, unclear from who.

C5: "Just in case. To cover my back so I got paid. But not to get them in...or any outcome for them but..."

I2: "So Riskman potentially is used for a different purpose than risk? To cover..."

C5: "Yes, as well it's validation. It's a documentation of an event that's happened so that you got the back up and the proof, when..."

I2: "Which isn't the original intent of Riskman, of course, but that's what it's become, isn't it? Because..."

C5 & C1: "Yeah."

C7: "It's a paper trail."

Some mumbling in background

C2: "I think you have those...a lot of mental health, psychotic..."

C5: "And you've got a lot of your entitled people."

Agreeing in background

C5: "They just walk in and think the world is theirs. I want this now."

C1: "Absolutely. I was going to say, one day I remember at triage, and...I can't remember who I was working with, but this lady arrested in my arms, and we did a full...pretty much started to resus in the waiting room, which is not ideal, but we had to. So I'm doing CPR in the waiting room, got her through, got her back down to Resus, and we're sort of like 'phew, they all took over her care'. And this person said 'I've been waiting for dudududu.' And then I said to them like 'did you not just see what happened?' like...You know sometimes you glaze over and you just think really? And that was just a...that wasn't anyone in particular."

I1: "Do you think waiting is a big cause of aggression?"

C3: "100 percent."

C7: "Absolutely."

C5: "Oh yeah yeah yeah."

C1: "Big cause of violence."

C2: "But then you have your person that waits for, like, 6 hours and..."

C5: "Quietly"

C2: "Quietly, turning pale..."

Some other inaudible comments, laughter.

I1: "Probably can't move."

Agreeing

C7: "Yeah the quiet asthma in the corner of the waiting room."

Lots of barely audible (joking) comments about quiet people waiting

C6: "The silent sufferers will be more unstable. Like that ones that are quiet and happy to wait, sometimes can be the sickest."

C5: "Yeah the sickest."

C1: "Yeah, and then that's hard because how do you educate when you've got this multi-cultural society, plus the demographics of like you know, like C5 said, entitled people down to people who got really no idea how the system works, or people that really know how the system works. It's pretty difficult. How do you get to all those? It's like people that call for ambulances that don't need an ambulance, you know. Or people that should've gone to the GP, who, you know..."

C5: "Or should've got an ambulance, but didn't? And they just bring them with their tongues chopped off."

General agreeing in background

C1: "Yeah, it's really hard – like how do you educate them all so they end up choosing the right path I suppose."

I2: "What do you think has changed the entitlement way of thinking? So I think we sort of agreed, haven't we, that people feel entitled. And someone mentioned something about the instant nature of knowledge...so do you think the Internet, social media may have changed what people expect?"

C7: "Hugely."

C5: "Yes. And what their diagnosis is. Because people genuinely...they'll go...you google, you can diagnose yourself with every single thing under the sun, but they don't have the medical knowledge so they get themselves really wound up. They're already semi-entitled and think yeah I need to be seen, this is an emergency department, therefore they see me immediately. Nah, they don't know that, so there not..."

C3: "We also hear...GP and the nurse on call got a lot to answer to sometimes as well. Because they're like if you call an ambulance, you'll get seen straightaway, you know...Well that's not the case, you still will be waiting two hours in there."

C5: "You see that on pages, on social pages. 'Oh call an ambulance and then you get a bed and you don't get stuck in the waiting room'. I've seen it countless of times and go 'Aaah that's nonsense'. But, yeah, so then they get angry straightaway. You've offloaded someone from an ambulance, into the waiting room, 'I came by ambulance', they're straight on the back foot. And they're just going get worse and worse and escalate."

I2: "And there's a generation out there that if they can't get the information they want through one click, they get frustrated."

Agreeing in background

I2: "I find myself doing it sometimes, if I'm on my computer and the wifi is down, I'm thinking 'that's really bad'. So if I have to wait 8 hours in ED, that's going to be really, really bad essentially, for people that have that sense of urgency."

C5: "You need your answers and..."

I1: "Do you find issues with patient's advocates, family members as oppose to just patients?"

Laughter

C2: "They come up, the patient doesn't talk, two family members talking at you, it's like 'excuse me, can I please speak to the patient?' like, yeah, it's annoying."

I1: "Is it a similar thing? An entitlement, attitude that they have that might that lead to aggression or...?"

C3: "I think they're probably worried about their family member as well. They're...they're..."

C7: "And they can't see [...]"

C3: "They think...some people think they are actually dying. No they're okay, they've got a [flute], they're going to be okay."

C1: "Yeah, I think you can really make a...you can make a real difference at Triage. Definitely."

C5: "Oh a huge difference"

C1: "And huge difference. I mean I don't do it as much in the last sort of like year ago, I used to do it like nearly every second day. And often when I'm there, I'm sure that C5 and all of them have seen it and do it all the time, is you know, you can just de-escalate them while you are taking their story and you can watch their heart rate go from like 120 down to like, into a normal range. And you know, by the time you finished, and it's only like a couple of minutes, you've sort of convinced them that they are okay, they are not dying, they can wait."

C5: "And at the same time, within that space of time that you've done that, because it's true, cause most people you can A get them to...by the time you've done your effectively three minute triage, you've already reassured them, calmed them down and everything, told them it's going to be a long

wait. So you've already set them up for that, but they're happy, you've told them what you're going to do. And you can then spot who are potentially going to have issue with, because by the end of that, they're already [mug]. And then they're back within two minutes, you thinking yeah you are going to [star]."

C3: "Yeah they don't...I don't know where the expectation comes from with some people though because they come rushing in 'I need to be seen now!' 'Where's the...' 'I need a wheelchair!' 'I need you to help' 'I need you too...'"

C5: "It's really bizar."

C7: "It's just the gratification that..."

C3: "And it's like 'just calm down', 'what's the problem?' and they're just like *snaps fingers multiple times*. You know, it's an emergency department, so everything is an emergency."

Agreeing in background

I1: "Do you think bad attitude is just as much of a problem as your alcohol and drug affected patients when it comes to aggression?"

C2: "I think it's a different sort of aggression. It's a different..."

C5: "Yeah. It's a more trying aggression. It's not explosive, it's just continuous."

Agreeing in background

C2: "Yeah, it's slowly gnawing at you for 8 hours."

C5: "And you're like 'Ohh I can't escape'."

C2: "But then I think the drug and alcohol is more physical aggression sometimes."

C5: "Yeah."

C3: "Yeah, you can kind of de-escalate the waiting room patient..."

I2: "Do you get...I call it...it's almost like the more educated, sarcastic throwaway comment type of aggression, that's insidious?"

People agreeing, some candidates mentioning: "That's the word, that's the word."

I2: "And is that just as difficult to deal with...?"

C5: "It's more so in a way."

C7: "Oh yeah."

C2: "And also I think it plays in my head a bit more, like you start to like, I don't know..."

C1: "Yeah."

C5: "You react, I react do that a lot more."

C2: "Yeah, you start like...if it happens...you're like oi, you start to doubt yourself a little bit. You're like it's that...am I doing something...and you're like 'no, I'm not, I'm definitely not'. But those ones definitely hit for me more than you're this, this and this."

C1: "Even one of the doctors on short stay the other day felt quite intimidated, because a patient who'd come in [vertigo], was going and he wanted her to write a script for [anti-hypotensives], for the next 6 months. And she said 'oh look I'm sorry, I'll give you a script for the next week and then you need to go and see your GP'. And he was really demeaning in his way that he spoke to her and she was really like...and she said I'm sorry. And like number 1, that is completely unprofessional thing to do and you know, she did all the right things and you know, you need to go back to your GP, the reason you need to go back is x, y, and z. But he really pushed and was really like you little...cause she was a young resident, and then one of our consultants, Richard, just said certainly not, we're not doing that."

C5: "See, I think that's the other thing here. We've got really young staff. They look really young, and so..."

C1: "We were young once."

C5: "We were once, many moons ago" *Laughs*

C1: "When was that?" *Laughs*

C5: " But that in itself can lead to it, because they think right I'm older than this...they're still in nappies. And all that sort of thing. As well, and it is by nature I think you do."

C1: "And culturally, as well, definitely."

C5: "Oh hugely."

C7: "Expectations."

C6: "Yeah, expectations."

C1: "I mean we're still a fairly predominant female workforce. That can be a problem as well."

I2: "And the security guards are all male."

C7 & C1: "Yes."

C5: "We used to have one female though, didn't we?"

C7: "She was good because she could de-escalate when the boys just want to jump. She could..."

C2: "I've often thought about that...I've thought about that, quite some times, a female influence in that like in that quite masculine..."

C7: "She was big and muscly, but she was gentle in her approach. But if they played up, she..."

C4: "I come from Gibbsland [...] ED and we used to have one security guard, it was a 75 year old woman. Literally she would have weighed 40 kilos. And she was one of the best, because all the scary men were protective of her. And she said 'right, I need you to calm down now'. They'd go 'okay, I'm sorry', because it's like their mum. I don't want you...oh okay."

C1: "Why was she working at 75?"

Laughter

C4: "It was ridiculous. But it wasn't good for us though, because I kind of went what are you going to do if this guy comes at you. It was worrying for me. Cause they never did, they ever like...a lot of the time..."

C5: "Which goes to show as well...it's actual just down right violence and acceptable violence. Because if they can control it, they're choosing who they're conveying to."

C4: "That's exactly right, yeah."

C7: "[Vic pol] now try and run, apparently, a male and female group, so I guess, the boys are good and strong, but the girls can talk people down. So the girls...I was talking to two the other day and they said often she can talk the really aggressive people down before they're require to jump. So you know, we possibly do need female security guards."

C5: "But then the other day, I was standing in the shops and it was male, female police, and it was really interesting, cause this guy, he was...the male was obviously going be the jump... he was trying to keep this guy back, who was really going at the female police, cause he's going to go for the weaker, what he conceives as the weaker. I would've personally taken on the man before her, but..." *Laughs* "But yeah, so..."

C7: "[It can work both ways.]"

C5: "It would be good to have females on security. Cause they've got that different approach."

C3: "Perhaps not 75-year-olds."

Laughter

C5: "No, no 75-year-old. That would scare me."

C2: "[...] a lot of females as well, so if we had 3 females as well that would be like your average...and they were really good, because like you said, they talk them down...really good."

I1: "When we talk about perpetrators a lot, we often combine mental health and drug affected people in the same group. But do you find that you approach them very differently? And manage them very differently?"

C1: "Mental health and drug affected? A lot of the drug affected come in psychotic. Especially with all these...and ice."

C5: "But that's...it's not..."

C1: "So we don't always know whether it's an underlying mental health issue with drugs on board or whether it's just the drugs that caused the temporary drug-induced psychosis. So I think it's been slurred in the last..."

C5: "And that as well is where we're getting lost because it's not drug psychosis, it's the drug effect. It's that simple, it's drug effect. It's...until they sobered up and they are very different. I feel less concerned when I'm around a true mental health patient, a true schizophrenic...I've never had an issue...there's only been one that gave me slight willies. Whereas, these drug-affected, very different approach. Very, very different."

I1: "So you find both groups can be blurred, because you don't symptoms are which or...?"

C5: "Nah, I look at both very differently. Very, very differently."

C2: "I look at them differently."

C5: "But they do get blurred in their treatment, sure. Yeah, because most of them as well, the drug affected, brought in sectioned. So they immediately go under mental health. So then they..."

C2: "A majority of the time they might have an underlying mental health illness."

C1: "It is mixed. There is a large crossover."

C5: "There is a mix in it."

C1: "But if someone comes in like...acutely psychotic and off it, we will sedate them and shackle them, to contain them and to ensure staff safety and for patients safety."

C5: "Sometimes not quick enough."

C2: "And we'll reassess them properly when they're a bit more coherent, to actually be assessed by mental health or..."

I1: "So we've got mental health patients, drug-affected and alcohol-affected patients, dementia patients, patients that feel entitled or have an attitude problem, can you think of any other groups that you might regularly come across?"

I2: "What about anxiety?"

General agreeing.

C7: "Yeah, the distressed patient or family member."

C5: "The more sick they are, the less you see that. You've got the poor diseased sort of twenty-year old, the relatives are never aggressive, they're never nasty. The sick old lady, with sceptics, the family they're stressed, they're never nasty. They might be a bit [flown]...oh what's this and that. They're never aggressive, never nasty. It's the middle range."

C1: "It depends also on what's happening in their lives."

C5: "In their lives."

C1: "And you know, what problems are happening, what family issues are happening. What was it the other day we had? The day that we had Bourke Street, I was in triage, and it was, like, crazy. Actually, it was really quite interesting, there was a lady that we had in Resus that we had to move out, who was a trauma patient. And then there was another person that was involved in an accident that came in, separately later. And I had issues, we did have issues with family, because they were just everywhere. And we were trying to contain Resus, because we had the [class of thousands]. Including half the police force.

But this man went upstairs, and then in the middle of my chaos, he came down, and came to the desk and said 'oh hello, can I speak to you? I noticed you've got a lot of police here.', and I was like 'yeah, we do.'. He said 'I want to report an incident'. And I said 'what do you want to do?' And he had an incident up on the ward with then a Code Grey being called on the ward between him and his nephew. So there was some previous family dynamics that were going on. And I just took him down to security and said well obviously they've already got some information that you've [called] a Code

Grey and go speak to security and feel free to go down to North Melbourne police station. But these polices, you know we had (...), we had detectives, we had homicide squad forensic. They weren't going to deal with...so you know what I mean, like..."

I1: "You just got caught in the middle of some..."

C1: "But it was his...it was the way he was thinking. It just fascinated me, I just...so he just thought oh well, I'll just go back down to ED and they'll fix it all up for me. Because he had an [argy-bargy] with his nephew, who hadn't been speaking to that side of the family for 2 years. So we have that sort of issue too, even if you have like the nice little grandma that's dying or someone else, there can always be dynamics in the family that set them off. Definitely. That's just the nature of life, isn't it? Or like the trauma patient, who's got a wife but he's also got a partner and he's...you know what I mean, and suddenly they realise they're both here and you know...[we've seen everything]."

Laughter

C6: "Well, you know, they are obviously some of the rarer ones. That acute deliria or sceptics, they are usually well, but because whatever disease process or illness, that makes them really, really aggressive. Like the one that smashed 28 windows and stuff, that was a really, you know, it was a really sad case of someone. He's got, I'm pretty sure, some brain tumor of some sort. That was a really drastic change of character. It's almost like a psychotic episode. But it was actually all because of the cancer. And was very aggressive to the [...], because it was the same patient from across the road, he damages a few things, from across the road, came here, and damage... equipment and things like that as well. So that's like a very different approach to that violence, because that's...and the tolerance, I don't know, I find that tolerance...you almost feel sympathetic for that person, because it's not normal for this person as well and for the family to be very distressed that this person has done that."

C5: "It's awful."

C1: "And that tolerance is very different from someone that, for example, comes to you with a drug induced psychosis."

C5: "Basically someone that should know better. The other man couldn't know better."

I1: "Do you encounter that often?"

C6: "Not, not often with those case. But once in a while, you come across cases like this, they stay in your mind for a long time, because..."

C5: "Well, we do really because sceptic patients can get quite antsy."

C6: "Can get quite confused, or like the sceptic elderly..."

C5: "...when you try and put the non-invasive on them, they can just catch you, but that is...yeah, it's very different. There is a reason other than personality."

Inaudible chatter

C2: "Intellectual disability, like our colleague got bitten the other day..."

C5: "Me?"

C2: "No, in EDA."

C5: "I missed that." *Laughs*

C2: "We were trying to hold the patient down to give her a [draperedol] because she was...has severe...COPD...and she was needed to have [medical] and bit her. But it wasn't because..."

C1: "She was being mean."

C2: "It was because she had intellectual disability and she was anxious and upset...and..."

C5: "But then at the same time, that was obviously going to happen all along. That should've...even though you don't want to... at that point, for the safety, it should have been security."

C2: "But it's still in a factor of violence."

C5: "Yeah it's a factor of violence, that could have been prevented by plan to Code Grey. Even though you feel so bloody awful with these...like her. "

C1: "Cause our security guards are pretty big."

C5: "Yes, they're quite intimidating."

C1: "They're intimidating, like..."

C7: "But if you pre warn them to go in and just gentle. I only want two of you in here and this is how I want...this is how we're going to run it."

I2: "You needed to just send your 75-year-old from Gibbsland."

Laughter.

C1: "In saying that, they're amazing. They're really good. We wouldn't...I don't know how we managed without them back in the day. I don't know how we did."

C7 inaudible comment

I2: "Not on tape anyway."

C1: "No" *Laughs*

I1: "Right. In the whole scheme of things, how prevalent would you think those patients with septic or hyperglycaemia patients or post-(...) patients would be a problem with their aggression?"

C2: "Once a week, or once a day?"

C5: "Daily."

C2: "Well I think for me, my experience is once a week."

C7: "Daily."

I1: "Daily's a problem. Like that's a big deal."

C5: "Yeah, it is."

C6: "I think everyday there is definitely something like that that's happening. It may not happen to one particular staff member as much, but if you're looking at the department in a 24 hour period, I would say probably daily."

C5: "At least."

I1: "That's significant."

C6: "But, like, you know, in a 24 hour period for these people, that come in..."

C1: "Are we talking about plucking and carrying on, or because they're [toxic] or..."

C5: "Yeah."

C7: "The whole lot."

C5: "It's a lot."

C7: "So Resus and cubicle short stay, your [polar...] young girls, they can still go off."

C6: "Yes."

C7: "Not deliberate."

C2: "Not deliberately? I don't know."

Laughter – inaudible comment

C5: “Yes, I have.”

C2: “Yes, but you are conscious, you’re still quite aware of your actions, like...”

C5: “Even sceptic.”

C1: “I think that’s the difference, isn’t it?”

I1: “Sorry?”

C1: “You know someone who is ethically, the way we categorise it as different. They’re medically unwell, and they are expected...you know the delirious patients is just not aware of what they’re on about. Compared to, like C5 was saying, the drug induced psychosis, well, they’re here out of their own action, taken a drug that’s made them go...”

C2: “But yeah, they still might not be aware of their actions.”

C1: “Still not aware of their actions, I know. But we sort of don’t...”

C6: “But versus the ones that [...]”

C1: “[We excuse them]...we excuse the patients that are sceptic or...”

I1: “So a lot of people talk about intent of their aggression. But your drug induced psychosis, they’re prob...would they be...do you think they are intending to cause you harm?”

C2: “Some of them.”

C5: “They don’t go out taking...”

C1: “At that time they are.” *Laughs*

C5: “At that time they are. This is like, they don’t go out intending to be like that. However, we’ve had people and you look back on their symphony notes, they’ve been in for it previously. They know what they get like on that thing. Stop it. Go to rehab. Get off it or...”

C2: “A lot of the time they harmed themselves as well, as much as they are harm to us, a lot of those drugs...”

C3: “...drug-induced psychosis. A lot of them drug and alcohol...”

C5: “They’re just affected. And they’re just being douchy. Quite simple.”

Laughter

I1: "The medical term." *Sarcastic*

Laughter

C1: "Yeah, we've got lots of those."

C5: "At triage: acting douchy. But yeah..."

I1: "Do you many...like you talked about your repeat offenders and everything and you have management plans. Is that a long process to get a management plan in place?"

General agreeing "Yes"

I1: "How do you deal with that in the mean time?"

C5: "You just get aware. You do get aware of who's who, don't you, quite quickly. And..."

C3: "Often sending a page to the mental health team and they'll a background check and will ring 'do not put them in' or 'they need to go in' or, but you know, or they've been here last week for the same thing."

C5: "But to get management plan... so they got the EMH management plans, that don't come up on our system, and...because they have a different system. But to get another management plan, and...they have to have presented a certain amount of times, they have to...you have to then email one of our consultants who then liaises with one of the [care...] and they liaise with other hospitals, because a lot of them have plans in other hospital systems as well, so it's massive long process. And sometimes just even sitting down, you notice this person and you think they seriously need a management plan. You look at the presentations and everything. You don't have time in the shift. And at the end of the shift, you just want to go home and get to bed, or go home and have a drink or something. So it does make it difficult. Yeah the linking with the mental health care plans that... yeah we don't have access to that."

I1: "Yeah okay. And cause we're looking how we can try and include the perpetrator in our interventions, you said how the hospitals can ban patients, so if they have that letter that has some substance behind, do you think that's more effective? Or is that just passing the problem on?"

C5: "What do you mean?"

I1: "So hospitals can ban patients, but can you guys do that?"

C5: "We don't do that."

C7: "No, we don't."

C5: "We don't. We have certain things, like certain patients can't go to the BAU or...but that's it."

C7: "They're not banned."

C5: "They can still come here."

I1: "Yeah, so if you're giving them a letter saying you can't be violent, we have to accept you anyway, does that seem like it would still work?"

C5: "No it wouldn't work. Because you're just saying can't be violent, and they're gonna."

C7: "Their interpretation of violence might be different to ours. They might think it's being physically. Verbally violence is okay, because it's...they're not being physically violent. So they might say what's your problem? I just called you the C-bomb six times, but I didn't belt you today, you should be grateful."

I1: "Fair enough. How appropriate do you think banning patients is from the emergency departments?"

C5: "Certain, certain situations, there's only a couple that I would say yeah, because like I said earlier, they still get sick. They're still high risk [...]."

C1: "We still have a duty of care. So, you know..."

C5: "Yeah."

C7: "They need to be responsible for their own care as well, they need to take responsibility for their action. If they can't learn, then they should be banned. Because at the end of the day, we all want to go [to home to our families]."

C5: "Mm. I don't come to work and get paid enough to not [...] on that behaviour, but like, at the end of the day, they can still be a trauma. We used to get a young guy, and I knew him. And he was actually lovely; he's never been aggressive. But he had [...] seizures so he could be [post-dictol]. He ended up in here, and I ID hem because I walk on shift and went 'oh, it's blah-blah.' And the police were like 'you know him?' and he'd been assaulted and he got a [severac]. And so they can still potentially...so banning them categorically...but in his situation, that was an unknown male. So because they didn't have ID. And yeah, because I don't know how the ambulance works. But they know that they are certain people they can't take to St Vincent's. St Vincent's would take. So..."

C7: "It comes up on their MDT."

C5: "Does it? So okay yeah. So they don't. So potentially these people...and the violent ones are actually at risk for trauma because they go around behaving like pork chops in the community and they might get bashed. And so

we are the trauma hospital, so it's a hard one. I don't think it'd work, but for non-urgent medical, yes it should be banned. You can't differentiate [...]"

Inaudible comment

C7: "Irresponsibility versus your own behaviour. And nurses always, there is an ache in us that we have a duty of care, if even they are being turds."

Laughter

I1: "We're nearly out of time, but I was just wondering, is there anything you have come across in practise that...or you thought of that would be practical to apply to perpetrators of violence?"

C7: "I think you learn to speak their language."

I1: "Yeah?"

Laughter and inaudible comment

C7: "If they speak to you...you can...it goes different two ways, but generally if they speak to you in particular way, and you speak back to them in that way, I find that it can be reasonably effective."

C3: "I disagree with that."

C1: "Yeah."

C7: "It's also...it varies...it's varied personal. I don't know if C5 said but..."

C1: "I think it's case by case, it's case by case. Definitely."

C7: "But if you learn their language..."

C1: "But we're very intuitive I think, most of us, particularly the ones that have been exposed to lots and lots and lots of it, you become very, you just a...I don't know what it is. It's obviously just that exposure, exposure."

C2: "You know what approach you can have with this person, compared to someone else. What tone to use."

C7: "And you can see them when they're beginning to escalate so if you can see it early you can jump in to de-escalate it."

C1: "In psychotic patients, there is no point in trying."

C7: "[Because they obviously just not there.]"

C1: "You just need security, you need someone...they just need to be sedated."

C5: "Just need to sedate, they'll sleep. Which we don't do quick enough and I think that's...because you'll find that everyone will agree. You've got a few and you've got your psychiatric patients, you've got your drug-induced people, one starts arcing up, that should have been sedated when they arrived, because you're not going to get anywhere. They are obviously severely drug affected or psychotic. They should be...chemically sedated, not mechanically.

Because the minute they start, ever other one starts coming out. It's just escalating them, and it leads to more potential violence. And if it was just...so immediately addressed and sorted, they would be getting what they need to, sleep. It wouldn't be...so there is less Code Greys, less aggravation...but barriers again, a lot of doctors don't want to immediately...or new staff or young staff. And like you were saying before with the...we know, you learn quite quickly, but not quickly enough, certain types how to de-escalate. We have a very quick turnover, a very high turnover, staff are very young. So there's still that period where they don't know these skills or these people. So it's just too much."

C7: "And there is [patient] occupational violence to, which we didn't actually talk about. But I've seen, as one mental health patient or drug abused patient is going of their chops and then the next one goes of their chops and then the next one goes off their chops. And then the next ones annoyed by..."

C1: "Yeah I was just thinking about that. That can actually be quite frightening, actually."

C7: "I've seen patients punch patients."

I1: "Wow"

C1: "Yeah, yeah, yeah."

C7: "[One minute they're swearing and then BANG, and you're like whoops.]"

C1: "Also, someone can be sedated and then we'll take the shackles off them. Because obviously we've got a duty of care not to leave them sort of tied to a bed if we don't need to and like, sometimes the guys that are in drug psychosis doesn't necessarily mean that they wake up and they're rational and easy people."

C5: "No" *Laughs*

C1: "There not always easy people, even if they don't have continued psychotic symptoms. And we had these two guys in BAU and that was like...that was so fast. The one started to rant up and down. The other one started to wake up. And I'll tell you what, he was only a small, but he was off that bed and the next minute he is like 'yeah mate yeah yeah' and they were like agreeing with each other, and I was just like 'no, stop talking to each other'.

Laughter

I3: "Can I ask a quick question, cause you've raised doctors as barriers."

C5: "Yes quite a few. I find them, they can be...you've got very junior doctors, and they don't...they're learning and they've been in...and they just pick up patients. They think they need to be...they shouldn't pick up very sick patients. They shouldn't pick up necessarily the [...]."

C3: "They're probably scary drugs for them to prescribe too."

C5: "Yeah well they're not allowed to as well. And, yeah yeah..."

C2: "...got in her book with all there's like [...]"

I3: "So they're trying to manage to much? They're out of their depth?"

C5: "Yeah they think they can talk...it's like, you won't be able to talk them down. They're not speaking logically, they just need..."

I3: "Need experience."

C5: "Yeah, yeah."

C7: "And none of them listen to an experienced nurse."

C5: "They..."

C7: "They're doctors so they..."

I3: "Do you think doctors are less exposed to violence?"

C5: "Yes, because they get to walk away. They're not standing there with that patient. They have hundreds of other...lots of other patients, they see a two minute window of that person."

C7: "They run. Leave it to the nurses, they'll manage"

Laughter

C5: "And they very much underscore on violence."

I2: "Because you said underscore, can I ask one question? Music therapy? Does that help?"

Laughter

C6: "Not necessarily, because sometimes... we do have a piano down in our department and sometimes..."

C5: "It is straight outside gold cubicles."

C1: "Shut that noise up."

C6: "Which is right outside where we are generally put our psych patients or psychotic patients, and many times they're making things worse, not better."

C5: "Can you imagine it, you're on drugs and you thinking 'What? I'm hearing music, I'm hearing music. What the hell is going on with me.'"

Laughter

I3: "Maybe we should try your idea that you were going to project on the ambulance."

C1: "What's that?"

I1: "Was that pictures of puppies?"

I3: "The Youtube films..."

C2: "The ones with cute puppies?"

I3: "Yeah, I don't know if you have to watch it for 16 hours though..."

I1: "You'll probably get sick of puppies."

Laughter

I1: "Alright. I'm pretty sure that's our time. Thank you so much! Did anyone want to add anything just before we leave?"

C2: "I think we do, do some good things, I don't think it's all bad. We are being better at it I think."

C5: "We are but we're not supported."

C1: "We'd love to have some feedback, of where all of this is going. We'd love to know."

End Focus Group 2