

Violence and Aggression at Work

Health and Safety Guidance

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1. Introduction

Violence and Aggression (V&A) at work is an emerging and significant risk for healthcare workers and community service providers. Health New Zealand (NZ) recognises this as a critical risk because of the potential for serious physical injury and psychological harm.

Under the Health and Safety at Work Act (HSWA), Health NZ has a duty to take all reasonably practicable steps to minimise risk of violent and aggressive behaviour in the workplace. The approach is guided by the values and principles of **Te Mauri o Rongo – The NZ Health Charter**, which emphasise protecting, supporting and caring for all Health NZ workers. This means creating environments where workers feel safe, respected, and equipped to manage risks, while balancing patient-centred care with proportionate and practical risk management

We are committed to the safe management and minimisation of this critical risk by:

- collaborative engagement working together to provide and maintain a healthy, and safe working environment through regular worker participation engagement and consultation
- ongoing review maintaining and updating Health NZ's violence and aggression management systems, risk control strategies, and initiatives
- continuous improvement learning from everyday work and applying innovation where appropriate to reduce the likelihood and impact of harm
- psychological safety and support promoting a culture where workers experience respect, compassion and access to wellbeing support
- responsive care after incidents providing timely support to workers affected by violence or aggression, tailored to their needs.

In healthcare settings, it is important to approach each incident without judgment, prejudice, or assumptions, recognising that individuals may not always be aware of their behaviour or able to control it.

1.1 Who is the intended user(s) of this document?

This guidance is designed for all workers and is particularly relevant to people leaders, facilities design teams, health and safety representatives (HSRs), union representatives, and others involved in developing strategies to reduce the likelihood and impact of workplace violence and aggression.

1.1.1 What is Violence and Aggression at Work?

Workplace violence and aggression refer to any situation where workers are abused, threatened, intimidated, or assaulted in circumstances arising out of, or during, their work.

In healthcare settings, these behaviours may be intentional or unintentional and can be influenced by health conditions, environmental factors, or other contributing factors. People who show or experience violent and aggressive behaviour could be colleagues, patients, whānau / family, visitors, or people in the wider community.

1.1.2 How should risk management be approached?

Risk management must prioritise worker safety while maintaining patient-centred, clinically led care that is proportionate to the level of risk. This guidance focuses on identifying and implementing control measures using the Hierarchy of Controls, starting with elimination where reasonably practicable and progressing through substitution, isolation, engineering, administrative controls, and personal protective equipment as the least effective option.

1.1.3 How is this guidance aligned with regulatory requirements

This guidance has been developed using regulatory advice from Violence in the health and disability sector – Guidance for PCBU's | WorkSafe, and other sources listed in Section 5: Further Information.

1.1.4 How should this guidance be used?

The guidance provides the principles and context for managing violence and aggression at work. To support implementation, practical tools have been developed to help apply these principles in everyday work. These tools translate the guidance into actionable steps for planning, risk assessment, and control selection.

Managers should actively seek input from workers, HSRs and enabling teams (such as Protective Services and Health and Safety) when assessing the risk of violence and aggression. Where a high level of risk is identified, controls should be reviewed regularly to confirm their effectiveness and updated as needed.

Although violence and aggression can occur in any workplace, this guidance focuses on Health New Zealand facilities and services delivered in the community. Where elimination of the risk is not reasonably practicable, other controls must be identified and implemented to minimise the risk as far as reasonably practicable.



Once you understand the guidance you can use the tools independently, without the need to refer to this document. Tools are identified by the purple cog icon and are available on the Violence and Aggression Resource Hub and in Section 6: Tools for easy reference.

This guidance is part of Health New Zealand's Violence and Aggression Work Programme, which focuses on continuous improvement across healthcare settings. Updates to this document will reflect lessons learned, emerging best practice, and feedback from workers and stakeholders as the programme progresses.

2. Understand Current Approach

Every workplace already has ways of managing violence and aggression, some formal, some informal. Understanding what is currently in place is the first step towards strengthening safety and wellbeing. This includes policies, reporting processes, support systems, and practical controls that help workers feel safe and supported.

Why does this matter? Because knowing what works well and where gaps exist helps leaders make informed decisions. It avoids duplication, highlights strengths that can be shared, and identifies areas that need attention before harm occurs. This is about learning, not blame and building on what is working and improving where needed.

The next step is to complete the **Violence and Aggression Gap Analysis and Implementation Plan**. This tool provides a simple, structured way to review key elements such as:

- policies and procedures
- Incident reporting and investigation processes
- Worker support options (e.g., debriefing, EAP)
- Control measures currently in place

Once completed, the results can guide planning and prioritise actions that make the greatest difference to worker safety and patient care.

2.1 Identify Gaps

The self-assessment is designed to help districts and services understand how well current systems manage violence and aggression. It provides a structured way to review what is in place, identify gaps, and recognise practices that work well. This is not a compliance exercise, it is about learning and improving together.

Regular review supports continuous improvement and helps meet duties under the HSWA to take all reasonably practicable steps to manage risk. It also encourages collaboration between people leaders, Health and Safety Representatives (HSRs), Protective Services and Health and Safety Delivery teams.

2.1.1 Complete implementation plan

Complete the violence and aggression checklist at a district or service level. Involve people to people leaders, HSRs, and enabling teams (such as Protective Services, Health and Safety). For each item marked “No” or “Partially”, create an action plan to address the gap. Review the plan with the district Violence and Aggression working group. Update regularly, at least annually, or when operations change or incidents occur.

[Tool 1 – Violence and aggression gap analysis and implementation plan](#) provides an opportunity to review:

- Check whether key processes and controls are in place

- Identify gaps and create actions to reduce risk
- Confirm training, reporting, and support systems
- Review working group arrangements

The completed gap analysis becomes the foundation for your district's improvement plan. It sets priorities and ensures actions are tracked and reviewed.

Tools to identify policies and procedures are in place to support a reduction in V&A:



[Tool 1 - Violence and aggression gap analysis and implementation plan](#)

2.2 Hierarchy of Controls

Managing the risk of violence and aggression means choosing the most effective ways to reduce harm as far as reasonably practicable. The **Hierarchy of Controls** provides a structured approach to do this. It starts with the most effective options and works down to those that offer less protection.

In healthcare settings, eliminating violence and aggression completely is rarely practicable while maintaining patient care. However, we can take steps to minimise risk using a mix of controls. These should be selected based on the work environment, the tasks being carried out, and the level of risk identified.

Given the Health NZ environment, where healthcare is delivered:

- Elimination of violence and aggression in a clinical setting may not be practicable whilst maintaining patient care. Health NZ has the ability to trespass any person from the premises refer to section 4.5.
- Different risk controls may be required based on the workplace; work area and work being delivered. All risk assessments need to consider this environmental context when identifying controls.
- Certain controls such as client reviews and management plans may already be or need to be embedded into clinical activities for consistency and effectiveness.

2.2.1 Applying the hierarchy of controls

Understanding the hierarchy of controls is one thing and applying it in real situations is where it makes a difference. The next step is to look at how these levels translate into practical actions in your workplace. Here's an example of how you can work through the hierarchy when planning controls for violence and aggression.

Training supports every level of the hierarchy. While training is traditionally considered an administrative control, in healthcare settings it enables our people to identify risks earlier, make effective use of environmental, and security controls, communicate concerns, implement escalation pathways and access timely support.

Below are some examples of how multiple controls can be used simultaneously. These controls are provided as examples only, and a risk assessment should be undertaken to determine the most effective controls for each task or activity.

A combination of controls may be required particularly when only administrative controls are possible. Ensure control measures for related risks are also considered and implemented for example fatigue (psychosocial risk), moving and handling or safe movement of people and vehicles.

In many environments, control measures will already be in place. We encourage you to review these against this new guidance along with your staff, Health and Safety reps and Health and Safety teams.



Figure 1: Example of Hierarchy of Control for Violence and Aggression

2.3 Monitoring and Review

Regular monitoring and review help confirm that controls are working as intended and highlight opportunities to improve. This is not just about checking compliance it's about learning from everyday work and adapting to changes.

Reviews should look at:

- **Training:** Is it current and relevant to the risks staff face?
- **Incidents and investigations:** What patterns or lessons are emerging?
- **Trends:** Are certain areas, times, or activities showing higher risk?
- **Focus areas:** Any new hazards or changes in the work environment?

Practical tips:

- Schedule reviews at least annually, and after significant changes or incidents.
- Involve colleagues, staff, Protective Services, Health and Safety, and Health & Safety Representatives.
- Use data from incident reports, feedback from violence and aggression working groups, and staff feedback to guide improvements.
- Share findings and actions with your team to build trust and encourage participation.

Monitoring is about asking: *“Are our controls helping work go well? What can we do better?”*.

2.4 District Working Group

It is recommended that all districts establish a violence and aggression working group to monitor and review their performance regarding violence and aggression in the workplace. These groups provide a space for collaboration, learning and practical problem-solving. The purpose of the group is to review trends and patterns from incidents and investigations. Look at training coverage and whether it meets current needs. Identify areas where controls are working well and where improvements are needed. Share ideas and feedback from frontline teams. The composition of the group should include clinicians, people leaders, health and safety, human resources, protective services representatives, union delegates and health and safety representatives.

Tools to support monitoring and review Violence and Aggression:



[Tool 2 - District Violence and aggression Reference Group - Terms of Reference](#)

More information	For more information on general H&S risk management processes, reasonably practicable guidance, and hierarchy of controls, refer to the <u>Work-related H&S Risk Management Guideline</u>. Risk assessments can be captured on the editable <u>Work-Related Risk Assessment Template</u>
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3. Environment

3.1 Workplace design

Design plays a key role in reducing the likelihood and impact of violence and aggression. When planning a new health service or making changes to an existing space, consider safety early in the design process. Decisions made at the start are easier and more cost-effective than changes later. All design processes should follow the Work-related H&S Risk Management Guidelines and incorporate Safety in Design principles as well as Physical Protection System Design Philosophy.

Violence and aggression risks are best managed through an integrated approach. Effective control measures are achieved when workplace design, monitoring arrangements, operational procedures, clinical workflows, staffing models and training are considered together, rather than implemented as standalone controls. Decisions relating to one element should consider their impact on the wider operating environment.

Protective Services, Health and Safety, clinical representatives, facilities teams and other relevant subject matter experts should be involved from the earliest stages of new builds, planning, design, significant refurbishments, re-design of higher-risk areas and changes to security systems.

These tools help ask the right questions, involve staff and Health and Safety Representatives, and document decisions so improvements are practical and consistent.

- Use  [**Tool D1 – Safe Space Assessment Checklist**](#) to review existing spaces or planned layouts. This checklist helps identify risks and assess hazards linked to layout, visibility, furniture, fixtures, and security features.
- Use  [**Tool D2 – Safety in Design Planning Guide**](#) when planning new builds or significant redesigns. It outlines factors that should be considered at each stage of the design process. From master planning to post-occupancy review and prompts consultation with the right people. Best practice would be to seek advice from Protective Services and Health and Safety as part of the design process.

-  Use the Physical Protection System Design Philosophy where design affects physical security, zoning, access control, CCTV, duress alarms, intrusion detection, security lighting, lockdown, monitoring, or response arrangements.

Good design can reduce triggers for aggression and make it easier for staff to respond safely and design choices influence visibility, escape routes, and the ability to call for help quickly. Eliminating and minimising risks by good design involves incorporating health and safety into the design process. It creates environments that feel safe and welcoming for patients, visitors, and staff. Important decisions should be made early in the design process, as changes become more difficult and costly as the project progresses. Good design can reduce the risk and/or consequence of workplace violence and aggression, enhance the quality of care, and optimise workflow and communication.

When engaging contractors for building or refurbishment projects, include health and safety requirements as part of the procurement process. This helps integrate safety in design from the start and ensures risks are considered throughout the project lifecycle. For practical steps on embedding health and safety into procurement and contractor management, see the **H&S in Procurement & Contractor Management Guideline**.

When planning new facilities or major redesigns, consideration should be given to relevant Australasian Health Facility Guidelines, security design principles and local service delivery requirements.

3.2 Physical environment

The physical environment can influence behaviour. Well-designed spaces can reduce stress and lower the likelihood of aggression. Poor design can make situations harder to manage.

Design should apply safety by design and Crime Prevention Through Environmental Design (CPTED) principles where relevant. This includes natural surveillance, clear lines of sight, appropriate lighting, clear boundaries between public and non-public areas, and design that supports the intended use of the space.

Design factors that can affect violence and aggression risk include:

- space and crowding
- lighting
- noise
- visibility and sightlines
- safe access and exit routes
- staff retreat options
- separation of public, semi-public, staff-only, and restricted areas
- furniture, fixtures, and fittings that could be used as weapons or barriers.

Treatment rooms, consultation rooms, interview rooms, and similar spaces should be designed so workers can leave the space safely if behaviour escalates. Where practicable, workers should not be positioned so that the person presenting the risk is between them and the exit, a duress alarm, or a safer staff-only area.

Some areas need specific controls because of the type of work, users, or risk profile. These include mental health areas, emergency departments, aged care, paediatric care, reception areas, and nurses' stations. Relevant controls are covered in the supporting tools and the current Physical Protection System Design Philosophy. Consult with health and safety and protective services early.

3.3 Physical Protection System

In addition to health and safety systems, security protection systems play an important role in reducing the likelihood and impact of violent or aggressive behaviour. They work best when integrated with health and safety processes and supported by trained staff who can respond effectively.

Physical Protection Systems are socio-technical systems that combine people, environment, technology, procedures, monitoring and response to manage physical security risks. These systems should be proactive and preventative, support early risk recognition, and timely intervention.

In summary, the security operating system needs to be:

- secure enough to resist attempts to breach it
- clearly distinguish between those with authorised and unauthorised access
- able to prevent unauthorised entry but not prevent exit
- reliable, regularly maintained and tested
- designed to include a backup system or process for providing access in the event of failure.

Where a security officer presence forms part of the PPS, officers should be selected, trained, located, and deployed for the healthcare environment. They should support prevention, early risk recognition, de-escalation, safe response, and clinically aligned ways of working. Not all facilities require an on-site security presence; where security officers are not present, monitoring, escalation, and response arrangements should be clear.

3.3.1 Technical Integration, monitoring and alarm assessment

Technical integration means electronic security systems are connected through a common operator interface. This can include access control, CCTV, duress alarms, intrusion detection, door alarms, intercoms, and lockdown controls.

When a critical alarm activates, the system should alert a trained operator and show the alarm type and location. Where CCTV is available, relevant camera views should be presented to support immediate assessment. This gives the operator fast situational awareness and helps inform the response.

For each facility, area, or space, the monitoring model should be clear. This includes who monitors, where monitoring occurs, who assesses alarms, who responds, and how escalation occurs.

Monitoring may occur through a Security Control Room, an approved local monitoring point, or an approved external provider. The arrangement should reflect the risk, operating hours, available staff, and response capability.

Areas using CCTV must manage privacy obligations, including how footage is stored, accessed, used, and shared.

3.3.2 Security zoning and access control

Design and access arrangements should make clear who can access each area and why. People should only access the areas they need to access. Security zoning helps separate public, semi-public, staff-only, and restricted areas. At a minimum, there should be clear separation between public or semi-public areas and staff-only areas.

Staff-only areas should provide a safer area for staff to withdraw to if needed. In higher-risk areas, access control should support staff safety by reducing uncontrolled public access, limiting unauthorised movement, and helping staff maintain separation from aggressive or escalating behaviour.

Security zoning should be supported by physical design, signage, access control, door security, staff procedures, monitoring, and emergency egress arrangements.

3.3.3 Duress Alarms

Duress alarms provide a way for workers to call for help quickly when they feel threatened or an incident occurs. The type and location of duress alarms should be based on the work area, tasks being performed, staff movement, privacy requirements, and available response arrangements.

Duress alarms may include:

- fixed duress alarms, such as buttons at reception desks, counters, interview rooms, treatment areas, and other higher-risk locations
- personal or mobile duress alarms for workers who move between areas
- GPS-enabled duress alarms for community-based or off-site work.

Fixed duress alarms should be easy to reach, discreet where appropriate, and positioned so they are unlikely to be blocked by an aggressor. They should be placed so workers can activate them without moving towards the person presenting the risk. Placement should also reduce accidental activation where practicable.

Where there is no local security team, duress alarms may alert other staff in the facility or work area so they can provide assistance. This may include audible alarms, visual alarms such as strobe lights in staff-only areas, or alerts to mobile devices. These arrangements need clear local procedures and staff training so the response is safe and effective.

Where practicable, duress alarms should be supported by CCTV to assist alarm assessment. This does not mean CCTV should be installed in areas where patients, visitors, or staff would reasonably expect privacy. Where CCTV is not appropriate inside a room, cameras may still support assessment from nearby public or circulation areas, where lawful and appropriate.

When a duress alarm activates, the system should alert a trained operator, show the alarm location, and present relevant CCTV where available. This supports immediate situational awareness and informs a timely response.

3.3.4 Training

Workers should receive practical training on how to use safety equipment and security features, such as personal duress alarms, GPS-enabled devices, and access control systems, as part of their induction. This training should focus on real-world scenarios, so workers understand when and how to activate these systems confidently.

To maintain competence and confidence, periodic refresher training should be provided. This can include:

- hands-on practice with equipment
- scenario-based exercises for responding to escalating behaviours
- updates on new technology or system changes.

Training should emphasise:

- why these tools matter for personal safety and rapid support
- clear, simple steps for activation and escalation
- integration with reporting hazards, near misses and incidents.

3.3.5 Lockdown capabilities

Facilities should have the capability to initiate lockdowns during high-risk situations to reduce exposure to harm as far as reasonably practicable.

Lockdown may apply to a whole site, the building shell, a department, a zone, or a specific area. The required capability should be determined through risk assessment and local operating requirements.

Lockdown capability should be understood realistically. It will not stop every determined person from entering or moving through a facility. Its value is in quickly controlling movement, initially denying entry, delaying further entry or movement, giving staff time to move to safer areas, and supporting a coordinated response.

The building shell is usually the first practical point to deny or delay entry. Internal lockdown points may also be needed where specific departments, zones, or areas require additional protection.

Lockdown may be activated electronically, where supported by access control systems, or manually where electronic lockdown is not available.

Lockdown should be able to be initiated quickly and with the least practical effort. Electronic lockdown can support this where it is correctly configured and available to trained personnel. Manual lockdown will usually take longer.

The time needed to initiate lockdown should be understood, practised, and considered against the site's risk, layout, staffing, and response arrangements.

Doors that form part of a lockdown boundary need to provide reasonable delay. This depends on the full door set, including the door leaf, frame, locks, hinges, glazing, hardware, and how the door is installed and maintained.

Lockdown capability also depends on:

- access control and alarm configuration
- CCTV or other means of assessing the situation
- communication and escalation processes
- emergency egress and life-safety requirements
- available response capability.

Workers should know local lockdown procedures, where secure retreat areas are located, how to communicate during lockdown, the local emergency number or site emergency procedure, when to call 111, who to notify, and what information to provide.

3.4 Poster campaigns

Poster campaigns are considered an administrative control and can help raise awareness of violence and aggression risks in both community and workplace settings. While posters are unlikely to reduce physical aggression, they can support workers in responding to verbal aggression by providing visible reminders of respectful behaviour and escalation pathways. In some cases, referring to a poster during a tense interaction may help de-escalate the situation.

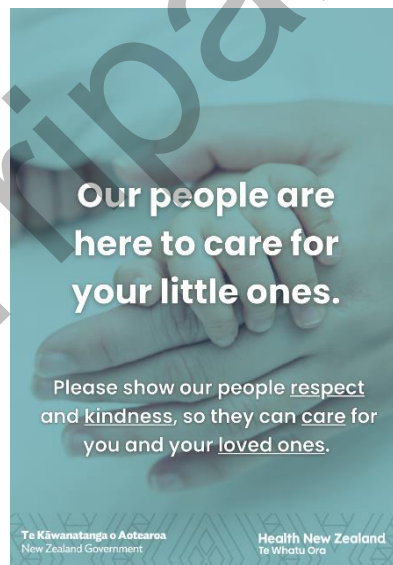
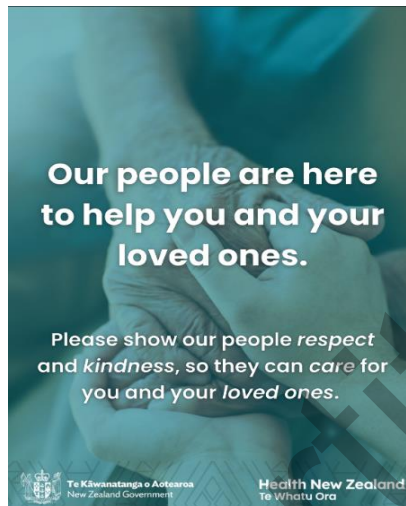
When planning poster campaigns or placing posters in key areas, consider:

- **Strategic locations:** Place posters where incidents of violence or aggression are more likely to occur (e.g., waiting areas, reception points, community hubs).
- **Visibility:** Ensure posters are easy to see and read at a glance.
- **Quantity:** Avoid over-saturation, too many posters can become “visual wallpaper” and lose impact.
- **Rotation:** Change posters regularly to keep messaging fresh and noticeable.

3.4.1 Nationally approved posters

Health NZ has a suite of national posters available for use on the [intranet \(Te Haerenga\)](#) and local posters can be requested by contacting your Health and Safety Team.

Approved national posters are as follows:



3.4.2 Locally produced posters

If you plan to include photos of local people ("Local Faces for Local places"), in your campaign, follow these steps to keep images welcoming, professional, and culturally appropriate:

- collaborate with local communications teams to manage approvals and consistency

- obtain consent from individuals before taking and using their photos
- aim for positive, approachable body language, such as:
 - smiling with a friendly facial expression
 - open posture: arms and hands visible in front of the body (avoid crossed arms)
 - preferably standing slightly side-on for a natural look
- include individuals or small groups of workers (two or more) to reflect teamwork and diversity
- backgrounds can feature work equipment (e.g., observation machines, beds), provided they are:
 - tidy and safe
 - not cluttered or visually overwhelming.

Wording and imagery used in posters should reflect approved safety intervention principles and promote a positive, respectful environment. The following nationally approved wording is recommended:

- ***You deserve to feel safe here and so do our kaimahi.***
 - *Please show our kaimahi respect and kindness, so they can care for you and your whānau.*
- ***Our kaimahi are here to care for your tamariki.***
 - *Please show our kaimahi respect and kindness, so they can care for you and your whānau.*
- ***Our kaimahi are here for you, and your whānau when you need them the most.***
 - *Please show our kaimahi respect and kindness, so they can care for you and your whānau.*
- ***Our kaimahi are here to help you and your whānau.***
 - *Please show our kaimahi respect and kindness, so they can care for you and your whānau.*
- ***Our people are here to care for your little ones.***
 - *Please show our people respect and kindness, so they can care for you and your loved ones.*
- ***Our people are here to help you and your loved ones.***
 - *Please show our people respect and kindness, so they can care for you and your loved ones.*
- ***We are here to help you and your loved ones.***
 - *Please show our people respect and kindness, so they can care for you and your loved ones.*
- ***We are here to help***
 - *Please show our people respect and kindness, so they can care for you and your loved ones.*

Example of a locally created poster:



Please show our people respect and kindness so they can care for you and your loved ones

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More information	For more information on posters, you can visit the violence and aggression at work hub. <u>Violence and aggression at work</u>
Related guidance	For advice on integrating health and safety risk management into procurement and contractor processes during building or refurbishing projects, see the H&S in Procurement & Contractor Management Guideline .

Tools for recommended use for workplace design and workplace assessments include:

- **[Tool D1 - Safe Space Assessment Checklist](#)**
- **[Tool D2 – Safety in Design Planning Guide](#)**
- **[Tool D3 – Design control card – Emergency Department](#)**
- **[Tool D4 – Design control card – Aged Care](#)**
- **[Tool D5 – Design control card – Maternity and Paediatric Units](#)**
- **[Tool D6 – Design control card – Mental Health](#)**
- **[Tool R3 – Hazard review – reception areas](#)**
- **[Physical Protection Systems Philosophy](#)**
- **[Briefing Note 1, Security Design Guidelines \(Facilities Development Briefing – Security\)](#)**,
- **[Briefing Note 2, Security Design Guidelines \(Duress Alarms Systems, Facilities\)](#)**

4. In the Community

Workers working in the community face a different risk profile for violence and aggression compared to those in Health NZ facilities. These risks need to be managed with specific, practical measures to support the safety and wellbeing of our people when working outside controlled environments.

Staff in the community may experience varying levels of exposure to violence and aggression. Key tools to support them include:

- pre-visit planning tools that help identify potential risks and provide options to reduce those risks
- targeted training focused on recognising early warning signs, de-escalation techniques, and safe decision-making.

Workers must be empowered and supported to:

- decide whether it is safe enough to deliver the service or visit the patient
- access a clear escalation pathway when they believe a situation is unsafe.

To strengthen safety in community settings, systematic assessment tools have been developed. These tools guide workers through:

- identifying whether there is a risk of violence or aggression
- determining appropriate controls that can be implemented before and during the visit.

4.1 Planning the visit

Each district should have a systematic process for identifying and managing risks for workers visiting patients in their homes. This process should include:

- planning the visit:  [Tool R1 – STEP Assessment – Staff safety in the Community](#), reviewing patient notes and any available information identify potential risks
- risk assessment and mitigation: consider options such as:
 - rescheduling the visit
 - arranging an alternative venue
 - having an additional colleague (buddy system) accompany the visit (note: the second person must not be a student).

If appropriate mitigations cannot be put in place, the visit should not proceed. It is important to note that where a visit is unsafe for one person, it is not automatically safe with two. Staff must be empowered to decide not to proceed if they believe the situation is unsafe. How this decision is managed should align with each Service's escalation process.

All visits should be recorded in the system to make information available for other workers and support ongoing risk management.

4.1.1 Monitoring and Communication

Workers in the community should be able to access electronic applications that can be used to 'sign in' and 'sign out' of a visit while in the community, or a manual system where workers are required to contact the office after each visit and managers should have procedures to follow up if workers fail to do so within an agreed timeframe.

4.1.2 Emergency Readiness and Response

A system must be in place to support a worker should they feel threatened or unsafe during a visit (such as an SOS system, or a phone number to call and the use of a 'code word' to alert the call taker that the worker needs help). The system must enable a quick response, which may be an emergency response depending on the situation.

The information included should include:

- name and address of client being visited
- scheduled time and duration of visit
- contact phone number
- worker's vehicle description and license plate number
- details of any travel plan with client
- any changes.

4.2 During the visit

Safety positioning should be actively considered throughout the visit to minimise risk and support a quick, safe exit if needed. Before entering the premises, workers should park close to the visit location, but not in a driveway, and consider which way the vehicle should face to enable a quick exit if required.

The worker should be alert for any risks in the environment, such as nearby activities and unsafe settings. Workers should not begin or continue a community visit if they feel threatened or unsafe. Removing themselves from potentially unsafe situations is not only supported but expected.

Workers should continually be assessing the risk when they arrive and during all aspects of the visit. If at any stage the worker identifies high risk, they should adjust their actions accordingly to ensure their ongoing safety. This may include finishing a visit early or not proceeding further. Managers must support their workers in these safety decisions and ensure appropriate follow-up on the visit and the hazard such as updating client/patient records, adding safety alerts and planning how the service will be delivered safely in future.

4.3 After the visit

If an incident occurs during a visit, it is to be reported in the applicable digital incident management system, and the incident management process is followed, this includes support for the worker and debriefs. Patient records and/or the patient file should be updated.

4.4 Community Work During a CIMS Response

When responding in the community during a CIMS event, workers face unique challenges, and safety relies on thoughtful preparation, situational awareness, and culturally safe engagement.

Workers should use:

- planning tools such as the  [Tool R1 – STEP Assessment – Staff safety in the Community](#) (Self, Task, Environment, People) before visits to identify risks and options to reduce them
- building trust from the first interaction is critical, approach all engagements with respect, courtesy, and manaakitanga, and consider cultural, social, and structural contexts when deciding who is best placed to connect with whānau
- during visits, maintain calm, observe body language, and have clear exit strategies
- empowerment to decide if it is safe enough to proceed and know escalation pathways if risk increases
- if aggression occurs, prioritise safety, de-escalate respectfully, and withdraw without confrontation
- after visits, debrief with your team and update safety information to support ongoing learning and wellbeing.

Tools recommended for community visits include:



[Tool R1 – STEP Assessment – Staff safety in the Community](#)

More information

The preferred electronic application system for lone worker is GetHomeSafe with monitoring by Hato Hone St John.

5. Patient/client information

Worker safety must be appropriately balanced with patient safety. A person-centred, culturally informed, and clinically led approach with least restrictive practices is preferred, but not at the expense of worker safety.

5.1 Patient/client assessment for reducing violent behaviour

The most reliable predictor for the likely occurrence of workplace violence and aggression is previous violent or aggressive behaviour. To prevent the risk of injury to workers and others, patients/clients with a history of violence

or aggression should be identified and risk assessed. A system must then be in place to effectively communicate this risk to workers and other service providers, in a suitably sensitive/confidential manner.

At pre-admission or presentation, the following contributing factors should be considered:

- status (e.g. under the influence of alcohol and/or drugs)
- known mental health conditions
- current level of aggressive behaviour
- unwelcome treatment, pain, and/or anxiety
- long waiting time
- information provided by family, friends, or other service providers
- history of violence and aggression, including at health services.

A risk assessment should be conducted if conditions change or if there are any other indicators that violence or aggression might occur. Below are other steps to consider

5.1.1 Gather information on new patients/clients

When a new patient or client is expected, gather as much information as possible to identify those with a history or likelihood of violent or aggressive behaviour. This includes obtaining a current medical report from the referring agency, general practitioner, psychologist, or psychiatrist. It's also important to speak with those who have recently been responsible for the patient/client, such as caregivers or family members, to get a full picture of their needs and risks.

5.1.2 Recognise behavioural change

Ensure you identify any changes in behaviour and communicate any significant observations to relevant workers. Patient / client notes should include a section that assesses the risk to caregivers by asking key questions such as:

- Is there information in the patient / client record that suggests the potential for violent behaviour?
- How frequent are incidents?
- Have whānau / family or support people reported a history of violent behaviour or abuse recently?

Tools used for this purpose are the Broset violence checklist or the Dynamic appraisal of situational aggression (DASA) form, each service should decide which form they use and how frequently this can be updated depending on internal processes.

➤ [Tool P8 – Dynamic appraisal of situational aggression \(DASA\)](#)

➤ **Tool P9 – Broset violence checklist**

These tools should only be used by staff who have received appropriate training and understand their purpose, limitations, scoring methodology, and escalation requirements. Structured assessment tools DASA and Broset support clinical judgement. Services should have local guidance, training, and governance arrangements in place to promote consistent application, interpretation and follow up actions.

5.1.3 Manage risk information

Risk information and management plans should be easily accessible to all workers, whilst meeting privacy obligations. There are methods of communicating violence and aggression risk while observing these obligations.

It's important to keep this information up-to-date and to ensure it is regularly reviewed given risks can increase or decrease due to several contributing factors.

5.1.4 Consider cultural factors

When assessing a patient/client, consider cultural factors that might escalate or de-escalate aggressive behaviour. Tailor your approach to care based on each patient/client's needs, considering potential triggers, early warning signs, and strategies to help calm them.

5.2 Transfer of information

Crucial information needs to be shared between agencies or with individual workers within an organisation, this allows for risk assessments to be completed and appropriate controls to be implemented to reduce the likelihood of violent behaviour. To provide the best care and ensure safety, it's essential to understand how information is transferred and if any issues need to be addressed.

5.2.1 Formal patient handover procedures

The use of a structured framework for handover improves outcomes.

An example a system is the ISBAR (introduction, situation, background, assessment, recommendation) framework is endorsed by the World Health Organisation. In the complex clinical environment of healthcare, ISBAR is suited to a wide range of clinical contexts and works best when all parties are trained in using the same framework. The ISBAR framework consists of five elements that standardise effective and safe communication.

- **Introduction:** Who are you, your role, where are you, and why are you communicating?
- **Situation:** What is happening now?

- **Background:** What are the issues that led up to this situation?
- **Assessment:** What do you believe the problem is?
- **Recommendation:** What should be done to correct this situation?

5.2.2 Importance of sharing information

While maintaining confidentiality is important, sharing information relevant to the safe care of patients/clients, including any risks to workers, is essential for providing quality care and managing health and safety.

This includes:

- ensuring that referral agencies provide enough information for comprehensive risk assessment and ongoing support plan development
- establishing mechanisms to enable information exchange when multiple providers participate in a patient's / client's care
- communicating any incidents involving patients/clients to downstream caregivers.

5.2.3 Addressing communication breakdowns

If communication between agencies breaks down, it's an opportunity to revise processes and provide feedback to the source agency. They may not have been aware of a risk or omission, so your feedback can help them improve safety measures for themselves and future service providers.

5.2.4 Internal communication

Ensure that all workers, including homecare or shift workers who may not attend regular meetings, receive new information and regular reminders about safety, such as the importance of reporting near misses. Find effective communication channels to keep everyone informed.

5.2.5 Co-ordination with external agencies

For cases involving other agencies such as police, ensure that the processes governing patient/client information transfer are written into established and agreed policies.

5.3 Alert systems

Alert systems, or ‘file flagging’, are used for various clinical risk management and client safety reasons (e.g., to identify clients with life-threatening allergies) and can also be used to identify client behaviours that could create a risk to health and safety.

Alerts can be electronic or placed on hard copy files and should be accessible to any health service worker who may meet the client. Client alert systems should be integrated and aligned to transfer alerts across a health service.

A client alert procedure should:

- clearly define the purpose for the alert and focus on behaviour and risk
- identify the person to whom the alert refers (e.g. client only, family, regular visitors)
- include steps for behaviour management planning
- identify who has been delegated responsibility for initiating, reviewing, removing alerts, and reviewing and updating associated management plans.

An example of a client alert can be found in [🔗 Tool P4 – Client Alert Form](#), or a visual prompt such as a sticker on the client’s record may be used. The information should be objective, reviewed regularly, and kept up to date. If a client file has an alert flag, where appropriate, it should be supported by an up-to-date management plan.

Multi-disciplinary care plans can be developed to deliver a consistent care approach. In addition to HSRs or dedicated Health and Safety workers, family members can provide valuable input into care planning. Their involvement can assist in ensuring clear standards of expected behaviour are set. When an alert is identified, workers should be prompted to complete an assessment of the client’s current behaviour. The management plan should be reviewed and updated to ensure safe care.

5.4 Escalation and notification process

Escalation and notification processes need to be in place to provide workers with identifiable situations that require further action, information, or support.

These processes should include who to escalate to, when and how.

Example of Escalation and notification process:



[Tool 4 – Example escalation and notification process](#)

5.5 Sanctions

Treatment may have to be refused when other strategies are inappropriate, except in life-threatening circumstances. This option should only be considered after other control options have been explored to their full capacity.

Employees should be aware of procedures for requesting police or security assistance and how to report an assault to police following the incident.

After an incident, regular communication with local police should be maintained. Warnings, treatment agreements, and sanctions for clients and visitors should be integrated into an organisation-wide alert system.

A trespass notice can be issued, this form should be completed by the person/s nominated by the district, the authorised person, will complete the form in triplicate, one will be handed to the person, one to the police and another kept on file. A trespass notice can be issued verbally; the person must be told in clear terms they must leave the property and not return.

If you deliver a trespass notice verbally, you should write down:

- the date and time you verbally gave the trespass notice to someone
- why you are verbally giving a trespass notice to that person
- the name or description of that person

Tools for recommended use for patient / client assessments include:

- [Tool P4 – Client Alert Form](#)
- [Tool 4 – Example escalation and notification process](#)
- [Trespass Notice Form Police New Zealand.pdf](#)
- [Tool P8 – Dynamic appraisal of situational aggression \(DASA\)](#)
- [Tool P9 – Broset violence checklist](#)

6. Resource/staffing

Safe staffing levels can make work safer and more manageable.

- Ensure everyone can take breaks and manage their workload to stay alert and effective, this helps reduce the risk of incidents.
- Make sure the staff are comfortable and capable of performing their assigned tasks. If they've had an injury or their health has changed, it's important to reassess their ability to do certain tasks.
- Ensure the person who is completing the rosters is aware of staff limitations.

- Awareness of your patients' or clients' language and cultural preferences can help avoid misunderstandings and reduce the risk of conflict.

6.1 Appropriate staffing

6.1.1 Care capacity demand management (CCDM)

The care capacity demand management (CCDM) programme provides a suite of tools and processes designed to help Health NZ align care capacity with patient demand, supporting safe staffing levels and effective resource use. Its primary aim is to deliver:

- quality patient care
- safe, sustainable work environments
- optimal use of health resources

While CCDM applies primarily to inpatient and hospital settings, community-based workers are not currently covered by CCDM. This means managers in community services have an important role in:

- monitoring workload distribution across teams
- using local planning tools and data to identify pressure points
- taking reasonably practicable steps to maintain a balanced workload and reduce fatigue-related risk.

A proactive approach includes:

- regular team check-ins to identify workload challenges early
- flexible scheduling where possible to manage peaks in demand
- escalation pathways for staff to raise concerns about workload or safety.

7. Training

Training on de-escalation principles, alternative interventions, and effective communication should be completed before workers are exposed to potential hazards. This training is critical for reducing the likelihood of harm and supporting workers to respond confidently in challenging situations.

7.1 Tiered approach to training

A tiered training model is recommended to match the level of training to:

- Identified risk of exposure to violence and aggression.
- Roles, responsibilities, and expectations within the workplace.

This approach ensures that workers who face higher risks receive more advanced and scenario-based training, while all staff gain a solid foundation in core principles.

7.2 Frequency and content

All workers, including contractors, should receive training at the start of their employment (during induction) and at regular intervals afterwards. The training should be tailored to reflect the incidents reported in their unit and include self-protection and self-preservation techniques.

Some training should be mandatory for all workers, with the specifics determined through collaboration between management HSRs and/or union representatives.

Training based on the role provided may include:

Name of Training	Who It is for	Type of training and overview
CPI Prevention first training	Mandatory for front facing staff and their managers every two years	E – learning In your work you may encounter situations that escalate quickly into crises—times of intense difficulty, trouble, or risk that demand immediate action. This training is designed to help you recognize and effectively respond to these critical moments. By learning how to see beyond the surface behaviour and address the underlying needs of the individual, you will be better equipped to de-escalate crises with compassion and skill. In this training there are interactive video scenarios that will show you how to apply a framework to confidently approach and manage crises, ensuring the safety and well-being of your patients, kaimahi, and you.
Safety Intervention 1-day foundation training	All front facing staff	Face to face This one-day training is designed for frontline healthcare staff who engage directly with patients and whānau. It focuses on early identification and prevention of escalating behaviour through person-centred, trauma-informed approaches. The programme covers verbal de-escalation techniques, risk assessment, and non-restrictive disengagement skills for managing lower-level behaviours.

Name of Training	Who It is for	Type of training and overview
Safety Intervention 2-day foundation training	Security, Clinical leads for high-risk areas, CNM or duty nurse manager. Other high-risk areas identified through risk assessment.	Face to face 1 day as above An internationally evidence-based programme, CPI's two-day Foundation Safety Intervention Training equips healthcare staff with the skills to identify, prevent, and safely manage incidents of aggression and violence. Grounded in person-centred and trauma-informed principles, it includes de-escalation strategies, risk assessment, and safe physical interventions. The training supports organisational safety goals, reduces risk, and aligns with global best practice standards in healthcare settings.
Safety Intervention 2-day advanced and emergency workshop Prerequisite is 2-day foundation	Security, Clinical leads for high-risk areas, CNM or duty nurse manager. Other high-risk areas identified through risk assessment.	Face to face The two-day programme builds on CPI's foundational principles with advanced strategies for recognising, de-escalating, and responding to rapidly escalating or emergency-level situations. It includes high-level risk assessment, advanced disengagement techniques, and emergency physical interventions used only as a last resort to prevent serious harm. This training includes intensely demanding simulation components to ensure competencies are demonstrated.
Safe Practice Effective Communication (SPEC) training	Clinical staff in Mental Health units	Face to face This is a four-day course that combines both theoretical and simulated training. Learn the fundamental skills for communication, de-escalation and trauma informed care. On completion of this course allows participants to feel confident in their ability to communicate and de-escalate effectively with clients in a state of acute distress. They will be aware of the risks that exist for staff and discuss how to keep themselves and their colleagues safe. The day will finish with education and reflection on legal and ethical considerations for restraint, followed by skills and techniques to break-away and defend themselves if placed in a compromised or dangerous position.

Name of Training	Who It is for	Type of training and overview
SPEC refresher	Annual refresher	One day refresher course
SPEC community	Community and non-clinical staff in Mental Health every two years	Learn the fundamental skills for communication, de-escalation and trauma informed care. On completion of this course allows participants to feel confident in their ability to communicate and de-escalate effectively with clients in a state of acute distress. They will be aware of the unique risks that exist for staff working in community settings and discuss how to keep themselves and their colleagues safe. Included is skills and techniques to break-away and defend themselves if placed in a compromised or dangerous position.
In-Service Education	Clinical staff in Mental Health units	This is additional training that is given internally to refresh skills and understanding for the teams and can include topics such as • Clinical presentations and challenging behaviours • Schizophrenia • Personality disorders • Service users' perspective
Dog Do and Dont's	Community workers	Online video from external source that can provide information on what to do when visiting properties with dogs.

8. Incident Management

All incidents of violence and aggression should be reported to allow for investigations, to determine if patients may require additional plans to reduce risk to staff, and to identify trends so that control plans can be reviewed if necessary.

Supporting staff after an incident is a crucial step, which can be tailored to their needs, but an immediate or hot debrief is beneficial.

If workplace violence and aggression occur or escalates, workers must have immediate response options, such as a code response. Local procedures need to be developed, and workers trained in the process.

The response options should be appropriate to the situation and skills of the worker and may include:

- calm verbal and non-verbal communication
- verbal de-escalation and distraction techniques
- review by a clinician
- evasive self-defence
- a request that the aggressor leave the workplace
- withdrawal to a safer location
- initiating a duress response
- support from other resources such as support from more senior colleagues, attendance by a duress response team, security or police
- the use of the least restrictive restraint practice.

Note: Locations/teams/services should have a clear (and clearly displayed) policy on the use of restraint and seclusion.

8.1 Post-incident response

After all V&A incidents the focus should be on supporting and debriefing staff. There are two main debriefing types:

- Hot or immediate debriefs – completed immediately after the incident
- Cold debriefs or diffusing – completed after the incident and prior to end of shift.

It is important to carefully consider the *intention of the* debrief you are running. Debriefs should only focus on listening, acknowledging, and normalising reactions without pressing for details = learnings can come later.

Support for staff does not end with a debrief, a plan should be put in place to support staff whether they are showing signs of distress or not. Our EAP is always available to support with post-critical incident wellbeing and 1-1 wellbeing support.

All incidents need to be reported, investigated, and reviewed. An investigation should include a comprehensive review of the client's journey, including behaviours and triggers (i.e., what took place in the days and hours leading up to a workplace violence and aggression incident/s). Significant incidents need to be reported and potentially notified to WorkSafe New Zealand (a process that is only undertaken by the Health and Safety Delivery teams). In case of a significant incident contact your Health and Safety Delivery team, they will assess whether it is notifiable and ensure the appropriate escalation and approvals steps are carried out prior to notification.

Assaulting a healthcare professional is an offence and Workers may choose to make a police report following an incident. Health NZ will support the wellbeing of workers making a police report, including the provision of paid

time to do so (includes any time required relating to the police complaint, such as police interviews and court appearances). Making a report helps police build profiles for repeat offenders, identify crime trends, and support prosecutions.

8.2 Additional support

Health and Safety and Protective Services can support in prevention, early intervention, response, investigation, post-incident review and implementation of risk controls. Their involvement should form part of a multidisciplinary approach alongside clinical, operational and leadership teams.

More information	For more information on debriefs, their purpose, how and when to conduct them refer to Supporting staff through workplace challenges For more information about our Employee Assistance Programme (EAP) see Mental health support
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9. Common Terms and Definitions

Term	Definition
Client	A person who receives health or wellbeing services that are not primarily medical treatment. This term is often used in community, mental health, or social care settings.
Consultation	Providing workers and others (e.g., HSRs) with information and taking their views into account before making decisions about safety and wellbeing.
Critical Risk	A risk that has the potential to cause serious harm or fatality if not effectively managed. These are the risks that matter most because the consequences are severe.
Critical Risk Control	A control that is essential to prevent or significantly reduce the likelihood of a critical event. These controls must be verified and monitored regularly because failure could lead to catastrophic outcomes.

Term	Definition
Risk Control	A measure or action taken to eliminate a hazard or minimise the risk so far as is reasonably practicable. Controls can be physical (e.g., equipment), procedural (e.g., safe work practices), or behavioural (e.g., training).
HSR	Health and safety representative
HSWA	Health and Safety at Work Act (2015)
Guidance	A guidance document outlines OHSW advice and guidance on a particular topic or matter. Guidance will not usually be measured via formal OHSW verification and assurance activities.
OHSW	Occupational health, safety and wellbeing
Patient	
Policy	A high-level document which sets out Health NZ's approach to an element or part of managing OHSW. The operational policy generally outlines the Health NZ's principles and specific roles and responsibilities associated with the topic.
PCBU	Person conducting a business or undertaking
Procedure / Process	Terms which may be used to describe a document which outlines how a thing is done, or specific steps that must be taken. The effectiveness of, and compliance with a procedure / process / specification may be measured – generally more for nationally applicable documents.
SME	Subject matter expert

10. Further information

Further information can be found in the following:

- [Health and Safety at Work Act 2015](#)
- [Health and Safety at Work \(General Risk and Workplace Management\) Regulations 2016](#)

- [New Zealand Public Health and Disability Act 2000](#)
- [Health Information Privacy Code 1994](#)
- [Privacy Act 2020](#)
- [Human Rights Act 1993](#)
- [Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#)
- [Crimes Act 1961](#)
- [Summary Offences Act 1981](#)
- [Trespass Act 1980](#)
- [WorkSafe Identifying, assessing and managing work risks Quick Guide](#)
- [WorkSafe Violence in the health and disability sector Good Practice Guidelines](#)
- [WorkSafe Queensland Prevention and management of work-related violence and aggression in health services](#)
- [WorkSafe Victoria Prevention and management of violence and aggression in health services](#)
- [ILO and WHO Framework guidelines for addressing Workplace Violence in the Health Sector](#)
- **[Ngā Paerewa Health and Disability Services Standard](#)**
- **[Health NZ, Our Role and Priorities](#)**
- **[Health New Zealand | Te Whatu Ora Health and Safety Policy](#)**
- **[Health New Zealand | Te Whatu Ora Protective Services Policy](#)**
- **[Health New Zealand | Te Whatu Ora Harassment and Bullying](#)**
- [Health New Zealand | Te Whatu Ora Restraint minimisation and safe practice policy](#)

11. Documents and Tools

Tools for use during the planning step include:

Tool 1 – Violence and aggression gap analysis and implementation plan – Can be used to identify opportunities to improve V&A controls based on all levels of the hierarchy.

Tool 2 – District Violence and Aggression Reference Group Terms of Reference - Can be used to support the implementation of a district level working group to monitor and review V&A.

Tools for use during hazard or risk assessments include:

Tool R1 – STEP Assessment – Staff safety in the Community – Tool used in some districts that supports safe working in the community, it is well established and can be used across districts

Tools for workplace design and workplace assessments include:

Tool D1 – Safe Space Assessment Checklist - Designed to be used within a patient care department/work area so you may need to complete several checklists to cover your whole health facility.

Tool D2 – Safety in Design Planning Guide – Tool used when renovating, changing or constructing a new public facing area within a healthcare environment.

Tool D3 – Design control card – Emergency Department (ED)

Tool D4 – Design control card – Aged Care

Tool D5 – Design control card – Maternity and Paediatric Units

Tool D6 – Design control card – Mental Health

Tool R3 – Hazard review – reception areas – Used to consider opportunities for improvement in reception areas, presented as a checklist.

Tools for patient/client assessments include:

Tool P4 – Client Alert Form – Example of file flag that could be used in a patient file

Tool 4 – Example escalation and notification process

Trespass Notice Form Police New Zealand.pdf

Tool P8 – Dynamic appraisal of situational aggression (DASA)

Tool P9 – Broset violence checklist

Tools for Security:

Physical Protection Systems Philosophy

Briefing Note 1, Security Design Guidelines (Facilities Development Briefing – Security),

Briefing Note 2, Security Design Guidelines (Duress Alarms Systems, Facilities)

12. Document Control

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1.0 (Published)	15 September 2026	S.Ehlers	Initial publication

Tripartite