Implementation Guide accompanying the Tripartite Framework for the Prevention of Abuse and Harassment in Healthcare

A Reference for Community Care Organisations

June 2025

The Tripartite Workgroup for the Prevention of Abuse and Harassment of Healthcare Workers (TWG) has developed an implementation guide to accompany the Tripartite Framework for the prevention of abuse and harassment in healthcare for Public Healthcare Institutions and Private Hospitals. In April 2024, a Taskforce comprising Human Resources and Clinical representatives from various Community Care settings was formed to contextualise the implementation guide for the Community Care Organisations' (CCOs) context. Together, both the Framework and Guide form a standardised zero-tolerance policy against any abuse and harassment towards healthcare workers.

Introduction

The Tripartite Workgroup for the Prevention of Abuse and Harassment of Healthcare Workers (TWG) was established in April 2022 to spearhead a coordinated national effort to prevent the abuse and harassment of healthcare workers in the public, private, and community care sectors (see page 61 for the full list of current TWG members).

On 17 March 2023, the Workgroup announced key findings and recommendations after engaging more than 3,000 healthcare workers and more than 1,500 members of the public through surveys and focus group discussions.

The key findings were:

a. More than two in three healthcare workers said they had witnessed or personally experienced abuse or harassment in the past year. Half of them, or a third of all healthcare workers, witnessed or experienced abuse or harassment at least once a week. Frontline healthcare workers are more likely to experience abuse and harassment.

b. The most common forms of abuse and harassment are shouting, threats by clients and/or caregivers to file complaints or take legal action against the healthcare workers, and demeaning comments.

c. Healthcare workers experiencing abuse and harassment sometimes rationalise these as being part of their job.

d. Healthcare workers often empathise with clients' circumstances and do not take action against them. As a result, abuse and harassment are often under-reported.

The Workgroup recommended adopting a standardised zero-tolerance policy against the abuse and harassment of healthcare workers in any form, using a three-pronged framework of Protect, Prevent and Promote:

a. Protect healthcare workers who face abuse and harassment;

b. Prevent situations that lead to abuse and harassment; and

c. Promote positive relationships between healthcare workers and clients/caregivers.

To protect and prevent healthcare workers from suffering abuse and harassment in any form, the Workgroup has developed the Tripartite Framework for the Prevention of Abuse and Harassment in Healthcare, published in December 2023. The Framework is accompanied by this internal Implementation Guide.

The Framework and Guide is to be supported by a **public education campaign**, which seeks to promote positive relationships of trust and respect between healthcare workers, clients, and their caregivers. The campaign also aims to clarify appropriate expectations of healthcare workers' roles and promote respect for healthcare workers.

Purpose of this Guide

This Guide aims to provide clear articulation and guidance on the definitions of abuse and harassment, assesses and classifies abuse and harassment cases, and recommends follow up actions to take against perpetrators.

The Framework and Guide were developed after extensive engagement with healthcare workers and members of the public through surveys and focus group discussions. It also incorporates best practices within the public healthcare clusters' existing protocols, contextualised for community care settings.

It is important to note that the Guide sets the basis for a unified set of standards for healthcare institutions to follow. Public healthcare institutions under the three Clusters – National Healthcare Group, National University Health System, and Singapore Health Services – have adjusted their existing protocols for consistency and coherence with the Guide, and we encourage Community Care Organisations to do the same. We believe that both the Framework and Guide can set the basis for a positive shift in mindsets and behaviours of individuals towards healthcare workers.

Healthcare institutions are encouraged to engage their healthcare workers on the changes to be implemented to maximise the effectiveness of the Guide. The Framework has been published on MOH's website so there is transparency for healthcare workers and members of public to be aware of the recommended standards. The public healthcare clusters have committed to adopting the Framework, with the aim of revising and updating their internal protocols across their hospitals and institutions by June 2024.

Link to the Framework:

Content

1 Definition of Abuse and Harassment

1.1. Abuse and harassment can occur in physical and/or virtual settings, when an individual, through his or her words, communication, actions, or behaviours that are inappropriate, threatening or insulting:

(1) causes a healthcare worker to feel intimidated, alarmed, or distressed; and/or
(2) hinders or impedes the healthcare worker in carrying out his/her duties.

Examples of abuse and harassment include but are not limited to the following:

a. Words, communication, actions, or behaviours that are inappropriate, threatening or insulting;

b. Unsolicited taking of photos and videos and publishing them on social media in a way that identifies a healthcare worker or their relations (i.e., doxxing), making abusive allegations or threats about them or their organisation;

c. Threats that may include reputational, financial, or physical harm;

d. Discriminatory behaviour (due to race, religion, gender, nationality, language, or any other factors);

e. Repeated incidents or behaviour that may have a cumulative negative impact on healthcare workers' emotional or psychological well-being; and

f. The above actions, regardless of the intention of the perpetrator, including by those under the influence of alcohol and/or drugs, with cognitive impairment, confused, with dementia or of young age.

1.2. Table 1 illustrates the definitions of abuse and harassment, with examples. The examples listed in this table are non-exhaustive.

Table 1: Examples of abuse and harassment

Type	Examples of abuse and harassment
Verbal	• Use of vulgarities, insults, intimidation (e.g. shouting, scolding, threat of harm), threats of using social media to 'shame' staff. • Repeated and baseless demands (e.g. requests for specific clinical interventions not ordered by the doctors, immediate explanations of investigations, and not wanting to be cared by specific staff for discriminatory reasons).

Type	Examples of abuse and harassment
Physical	• Physical assault (e.g. kicking, biting, hitting, slapping, grabbing), throwing items, actions that result in damage to the property of staff, healthcare institution, or other clients.
Sexual	• Sexual remarks • Indecent exposure (including sending obscene photos/videos) • Molest or inappropriate physical contact
Others	• Stalking and doxxing of staff (e.g. online doxxing through the Internet/social media). • Persistent demands and complaints from the same client/next-of-kin (NOK) or other family/visitors through front-facing operational channels (e.g. to healthcare institutions' customer support etc.) • Unsolicited video-recording / photo-taking / voice-recording, which may cause distress to the staff or threaten the staff's reputation. • Use of threats of self-harm to manipulate healthcare workers and/or demand attention, service, or other interventions. • Persistent negative behaviour intended to cause distress to the healthcare worker (including but not limited to sarcastic comments, silent treatment, or refusal to cooperate).

1.3. This Guide should also apply to contract staff and employees of contractors providing services in a work site. The overarching principle is that healthcare institutions should commit necessary resources to support and protect all staff who may encounter abuse or harassment due to work done within their premises, regardless of whether they are employed staff or outsourced contractors. Healthcare institutions may include this protection under their service agreements with contracted service providers or through other appropriate means.

1.4. The workgroup understands that there have been incidents of abuse and harassment witnessed and experienced among staff in healthcare institutions. While not within the scope of this Framework, the key principles in managing such incidents are similar. For example, stepping forward to report, provision of support and assistance to victims, and ensuring appropriate actions to prevent recurrence. Abuse and harassment among healthcare workers will similarly not

be tolerated, and healthcare institutions should put in place necessary safeguards to protect the victims.

2 Risk Factors and Circumstances for Abuse and Harassment

2.1 Clients, their next-of-kin (NOKs) and caregivers often face uncertainty, stress, and worry in work sites. In such situations, a small number of them may act in a manner that causes distress to staff. While healthcare workers empathise with clients and their families, healthcare institutions should take steps to prevent potential abuse and harassment, and protect staff when such situations arise.

Root causes and circumstances leading to abuse and harassment

2.2 To support healthcare institutions in strengthening their preventive measures towards abuse and harassment, we need to first understand the root causes and circumstances leading to abuse and harassment incidents.

2.3 Based on focus group discussions, abuse and harassment incidents are most likely to occur during periods of high activity and client-staff interaction, such as during mealtimes, visiting hours, and during client transportation. By extension, such incidents will most likely occur in areas where perpetrators may experience high stress, such as outpatient clinics, as well as in areas where staff may not have quick access to security assistance, such as parking areas and clients' homes.

2.4 Table 2 summarises the root causes of abuse and harassment, and circumstances under which they occur, based on views obtained from healthcare workers and members of the public in focus group discussions. While the root causes of abuse and harassment have been broadly divided into three categories below, incidents of abuse or harassment are often multi-faceted with related causes.

Table 2: Root Causes and Circumstances Leading to Abuse and Harassment

Stakeholder	Root Causes/ Circumstances	Examples
Client/ Caregiver	Discrimination	Xenophobic and racist behaviour by clients
	Mismatched Expectations	Expectations of healthcare workers to provide services outside their job scope
		Disagreements on protocol such as restrictions on eating, drinking or tobacco or alcohol use
		Involuntary admission to a work site
		Lack of trust in healthcare worker's care decisions and actions

Stakeholder	Root Causes/ Circumstances	Examples
	Insufficient self-control or diminished mental capacity	Environmental and psychological stressors
		Medical condition (e.g. mental health issues) or substance intoxication
		Individuals prone to outbursts or tantrums (e.g., agitated adolescent minors)
Staff	Perspective on abuse and under-reporting	Normalisation and tolerance of abuse, leading to under-reporting of incidents
Healthcare Institution	Limited manpower and resources	Surge in workload, which will make it challenging to accede to all service requests expediently
		Inadequate security and/or training
	Inconsistent enforcement and unclear processes	Lack of clarity over reporting; not updated on outcomes of reported cases
		Under-utilised support measures for staff
		Inconsistent response to negative behaviour

Staff groups and settings more likely to encounter abuse and harassment

2.5 With the above root causes and circumstances in mind, healthcare institutions may further organise its internal protocols and support measures depending on the staff groups working in the respective work sites.

a. In general, frontline staff are more likely to experience abuse and harassment from clients/NOKs.

b. The likelihood of abuse and harassment is also higher from clients with mental illness or clients who are under the influence of medication and are unable to control their behaviour.

c. Given this, healthcare institutions should strengthen their staffing and operations to better protect these groups of staff and take proactive measures to offer support where possible. (Refer to Sections 4 and 7 for the comprehensive list of measures).

Table 3: Examples of staff groups and settings who are more likely to encounter abuse and harassment

S/N	Settings / Staff Groups	Examples
1	At point of admission and/or discharge	• Counter staff • Staff administering Admissions or Financial Counselling processes (e.g. patient service associates) • Staff administering appeals for Financial Assistance (e.g. Medical Social Workers)
2	Areas where unexpected queues may accumulate, or where rejections and bad news may be communicated	• Pharmacy staff (e.g. dispensing medication before discharging to go home) • Staff in charge of communicating deterioration in clients' condition to NOK
3	Home-based care	• Staff working in home-based care may be vulnerable to abuse and harassment, as they operate outside of the healthcare premises and are isolated. Health and community care providers providing home-based services may consider a risk-based tiering framework for staff protocols when managing clients (e.g. working in pairs).
4	Foreign staff	• Foreign staff may be more likely to experience discriminatory remarks (e.g. racial slurs and insults)
5	Nurses and support care staff	• Nursing and support care staff (e.g. patient care assistants and healthcare assistants) as they have more direct and prolonged contact with the clients in close quarters
6	Others	• Customer service staff who are manning phone hotlines

3 Assessing the Severity of Abuse and Harassment Incidents

Who should assess the severity of an incident?

3.1 Based on the definition of abuse and harassment in Section 1, most incidents should be identified and assessed for severity by staff and his/her immediate supervisor. Cases should be escalated based on their assessed severity levels (See Sections 5 and 6).

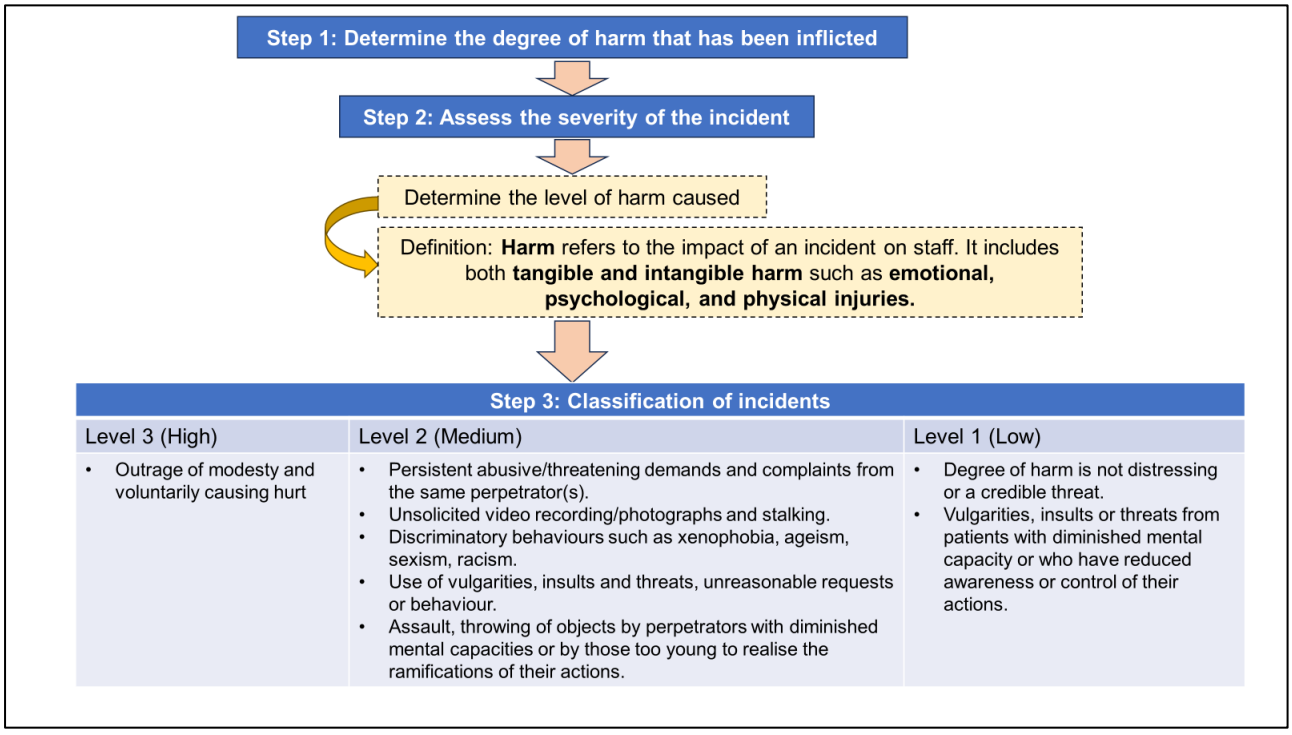
Assessment criteria

3.2 Severity assessments will determine the eventual follow up actions per Para 7.3. We recommend assessing the severity of an incident based on the degree of harm caused.

3.3 The degree of harm refers to the impact of an incident on staff. It includes both tangible and intangible harm such as emotional, psychological, and physical injuries. This can be broadly classified as low, medium, or high.

3.4 Chart 1 illustrates the process for assessing the severity of an incident of abuse or harassment.

Chart 1: Process for Assessing Severity of Abuse and Harassment



3.5 The level of severity may be classified broadly into three levels (i.e. Level 1, 2 and 3), depending on the degree of harm. The severity classification will depend on the specific details of each incident.

a. **Level 3 (High)**

Level 3 incidents refer to abuse and harassment that causes a high level of harm or distress – for example, outrage of modesty and voluntarily causing hurt. Examples of past cases are illustrated below.

In Jul 2022, a middle-aged male subject was sentenced to seven weeks' jail for the offence of Voluntarily Causing Hurt towards a nurse at Tan Tock Seng Hospital (TTSH). The offence was committed in Jun 2021. He had been conveyed to TTSH and assessed to be intoxicated and combative. The nurse, who was on duty at the hospital's emergency department, held onto the male subject's leg so that the doctor could administer an intravenous drip. However, the male subject started reacting aggressively, struggling violently and kicking his legs in the direction of the nurse. During the struggle, he kicked the nurse in her upper chest and collarbone. The male subject pleaded guilty to the charge of Voluntarily Causing Hurt for the incident in Jun 2021.

* * *

Acknowledgement:
Case example above was provided by the Ministry of Home Affairs

b. **Level 2 (Medium)**

Level 2 incidents refer to abuse and harassment that causes a moderate level of harm and distress to a healthcare worker.

The examples include:

i. Abusive/threatening demands and complaints from the same perpetrator(s) received through multiple channels;

ii. Unsolicited video recording/photographs used to threaten victims' reputations, stalking;

iii. Discriminatory behaviours such as xenophobia, ageism, sexism, racism;

iv. Use of vulgarities, insults and threats, unreasonable requests or behaviour; and

v. Assault, throwing of objects by perpetrators with diminished mental capacities, or by those too young to understand the consequences of their actions.

The case examples below are an illustration of the cases that can be classified under Level 2.

"Unfortunately, the nurses, most of us are foreigners. So, then they will say, 'if you are not happy then go back to your own country', or 'without us, you have no pay'."

"He [patient] was threatening me, 'I can complain, I know some senior minister and everything. I can send you back home.'... you feel threatened. You feel scared also. Even though this is my home already, I still feel threatened that this person can actually complain about what I'm doing, and I can lose my job."

"She started to throw things at us, so I got thrown at… got throw umbrella, throw tea, whatever she can see … and it was very loud, she would scream and shout and verbally abuse you and throw things at you."

"I think it's fair that we update them, but there are certain routine kind of tests that we might do, which they also expect immediate updates. Some of these are patients who are very well, or very stable, I don't think that there's a need for us to update them immediately…"

- *Extracted from focus group discussions.*

c. **Level 1 (Low)**

Level 1 incidents refer to abuse and harassment that would appear to an average person, as acts that do not cause any real harm but may serve to annoy, frustrate, or slow down work tasks due to the perpetrator's lack of cooperation.

The examples include:

i. Vulgarities, insults or threats from clients with diminished mental capacity or who have reduced awareness or control of their actions, and where the healthcare worker assesses that the degree of harm is not distressing or a credible threat.

4 Incident Response and Post-Incident Management

4.1 Despite best efforts by staff to prevent or de-escalate situations, incidents of abuse and harassment may still happen. When this happens, staff must undertake remedial measures quickly to stem the abuse, and approach their supervisor and peers for support as appropriate.

Responding to Client Perpetrators On-Site

4.2 The following measures are recommended to avert further damage arising from the incidents:

a. Verbal management

b. Physical restraint

c. Pharmacological restraint

Further action may still be taken afterwards. For fuller resolution, see Sections 6 and 7.

For physical or pharmacological restraints in the work site, an important emphasis is the overriding need to safeguard the client's safety.[1]

A. Verbal Management

4.3 When abuse and harassment occur, victims are encouraged to communicate firmly and clearly to the perpetrator that his/her behaviour is inappropriate and should be ceased immediately. This should be communicated in a timely manner, with the intent to check inappropriate behaviour and prevent further escalation of tension.

For Information: Clusters' Best Practices in Managing Clients with Diminished Mental Capacity:

When managing perpetrators with diminished mental capacity who may not be responsive to verbal management, staff may consider performing re-direction or distraction techniques to calm the perpetrator first.

For instance, when there is an incident of unsolicited photo taking or video recording of healthcare workers by clients or their NOKs:

a. Staff and healthcare institutions have the right to request the perpetrator(s) to stop their actions. Staff may also wish to clarify with the perpetrator(s) their intention for taking the photo or video, and seek their cooperation to delete them.

[1] Joint Commission Standard PC.03.05.01.

b. We emphasise calling out the behaviour and giving a verbal warning. Staff can consider expressing to the perpetrators in a firm and professional manner, that their actions are causing distress to them and affecting their work. It may be necessary to do this consistently until perpetrators stop their behaviours.

c. Escalation to the Police (see Para 6.1) may be considered if the perpetrators become aggressive, refuse to cooperate and, if:
   i. The photos or recordings are of the Healthcare workers' intimate body parts (whether clothed or unclothed).
   ii. The perpetrators have demonstrated an intent to harass or intimidate the staff with the photos or recording.
   iii. The photos or recordings have been put up online, accompanied with falsehoods or distressing statements meant to abuse or harass the staff (also see Para 4.21).

4.4 Staff should seek step-in assistance from colleagues where necessary. If the victim is a less experienced or junior staff, his/her immediate on-duty supervisor is to be informed as soon as possible for appropriate intervention.

For Information: Clusters' Best Practices in Managing Clients with Diminished Mental Capacity:

For perpetrators with diminished mental capacity, healthcare institutions may consider re-engaging the perpetrator with a different senior staff if the situation cannot be contained at first attempt or by the immediate on-duty supervisor. The perpetrator should be informed that his/her behaviour will not be tolerated if he/she persists.

4.5 If the perpetrator persists, further actions should be taken as outlined in Para 7.3. The HOD should assess the incident severity (see Section 3) to determine the appropriate measures to be taken (see Section 7).

4.6 Staff are advised to activate their security teams or HODs if they feel physically threatened, at risk of harm, or if the perpetrator turns violent. They may also choose to call the police (see Para 6.1).

4.7 If the perpetrator's persistence is driven by an underlying condition, verbal management may not be effective. He/she may be restrained physically or pharmacologically if assessed to be clinically appropriate and necessary to ensure the perpetrator's own safety.

For Information: Clusters' Best Practices in Managing Clients with Diminished Mental Capacity:

When managing perpetrators with diminished mental capacity, healthcare institutions can consider to first employ active and definitive medical interventions and treatment where applicable, as these would be the best method to curb abuse or harassment behaviours.

B. Physical Restraint

4.8 Physical restraint refers to any physical method of restricting a person's freedom of movement, physical activity, or normal access to his or her body. These include:

a. Articles that keep the body immobile in a chair, such as body vests;

b. Items that confine individuals to their beds, such as body vests or tightly tucked sheets; and

c. Hand mittens, with and without restraints.

4.9 Physical restraint must only be used in clinically appropriate situations, after all reasonable alternatives have been considered.

a. The perpetrator's well-being and safety should be the primary motivation for administering such restraint, instead of resorting to it as a behavioural management measure.

b. Physical restraint may only be relevant for Level 2 or Level 3 incidents **where there is physical harm or the risk of it**.

c. The duration, intensity and manner of restraint chosen should be the least restrictive necessary to control the situation. At the same time, healthcare workers should prioritise the safety and dignity of the perpetrator/client.

4.10 Only clinical leaders may order the use of physical restraints after a clinical assessment, with the following to be observed:

a. Informing the personnel-in-charge if the order is initiated by the advanced practice nurse or registered nurse;

b. Activating security personnel to overpower violent clients where necessary, before restraints are applied;

c. Documenting all instances of such restraint in the perpetrator's medical records which will contain the reason, manner, and duration of restraint. Doing so would help protect healthcare workers against allegations such as false imprisonment and battery;

d. Informing the perpetrator's NOK of the restraint applied as soon as possible;

e. Monitoring perpetrators on physical restraints at regular intervals for complications arising from the restraints, to determine if the restraint may be discontinued once the threat of danger is no longer present; and

f. Placing extra care and attention on restrained perpetrators' need for nutrition, hydration, elimination, physical comfort, range of motion and psychological condition.

C. Pharmacological Restraint

4.11 Pharmacological restraint refers to medication used in addition to or in replacement of the client's regular drug regimen, to control extremely agitated and disruptive behaviour during an emergency. Like physical restraint, ensuring the client's well-being and safety must be the primary motivation for administering pharmacological restraint.

4.12 Pharmacological restraint is to be administered only as a last resort measure in limited circumstances. This can be when perpetrators experience agitation from drug/alcohol withdrawal or become combative due to trauma from multiple injuries. The underlying medical condition giving rise to the agitation must be considered and treated.

4.13 Common methods of pharmacological restraint include oral or intravenous Benzodiazepine or parenteral neuroleptic. Only physicians may administer such drugs, in consultation with the perpetrator's personnel-in-charge. If a decision is made to administer such restraints, proper documentation must be done (see Para 4.9).

4.14 Healthcare institutions should devise internal operating protocols on the drugs and dosage to administer based on the perpetrator's medical condition:

4.15 Similar to physical restraints at Para 4.9, perpetrators on pharmacological restraints must be monitored at regular intervals for complications that may arise, and also to be re-assessed if the restraint is still necessary.

Management of Non-Client Perpetrators

4.16 For non-client perpetrators, such as NOKs or visitors who engage in abuse and harassment, Para 4.3 - 4.4 on verbal management of the situation similarly applies at first instance.

4.17 In addition, healthcare institutions should also activate their security teams or HODs to escort any non-client perpetrators out of the institution's premises if the abusive or harassing behaviour persists.

Activation of Auxiliary Police Officers (APOs) and/or Security Teams

4.18 In general, healthcare institutions should review the level and type of security required, with due consideration given to the type of work sites and the likelihood of abuse and harassment. For example, Psychiatric Wards/Nursing Homes typically require a greater security presence. Institutions which require higher levels of protection may consider deploying Auxiliary Police Officers (APOs) to be on-site, in addition to security teams. In situations where staff are working off-site (e.g. at the homes of clients) and are unable to immediately activate the relevant security personnel, they are permitted to disengage with the client and leave the work site. They should then notify their HODs by phone.

4.19 In the event of an incident:

a. Staff should activate their APOs, security teams or HODs when they feel physically threatened, when the perpetrator resorts to violence, or when assistance is required to physically restrain a client.

b. Supervisors and staff who are in close proximity to the incident (e.g. staff of the same ward or from adjacent wards) should step forward to render help to their peers by outnumbering the perpetrator(s), their NOKs and visitors, prior to the arrival of APOs, security teams or HODs.

4.20 Healthcare institutions should set up internal protocols for the activation of APOs, security teams or HODs, their response times, devise rules of engagement with perpetrators, and determine the degree of involvement expected from medical staff (see Para 7.3 for further details). We further recommend for:

a. APOs, security personnel or HODs to report to the requesting work site within a target time frame (e.g. five to fifteen minutes) as specified by the institution, commensurate with the level of incident severity; and

b. Staff and APOs, security personnel or HODs to remain in contact and provide live updates, where possible.

Escalation to the Police

4.21 Notwithstanding Para 6.1, which sets out the situations where a healthcare worker should call the police, we recommend for staff to consult their supervisor if they are unsure whether to do so. For institutions with no APOs or security personnel on-site, escalation to the police should be considered if there is a threat of physical harm. More information on the process for cases escalated to police can be found in Section 6.

Responding to Perpetrators Off-Site

4.22 Abuse and harassment incidents that take place outside of the healthcare institution's premises should be addressed. We recognise that incidents that arise outside of an individual's course of work but on account of the individual

being a healthcare worker can be as distressing and require assistance. This segment recommends appropriate remedial measures based on common off-site incidents.

a. **Threats of physical harm made on social media or online platforms**: Victims should call the police if they perceive the threat(s) to be real and suffer distress as a result, see Para 6.1. They are also encouraged to document or keep records of the threats made as part of the evidence to be provided to the police. This can be through taking photographs or screenshots of each instance of harassment which may include threats, photos, videos, messages, and comments.

b. **Doxxing targeted at healthcare workers:** Doxxing is the act of publishing the private personal information of another person without the consent of that individual, with the intent to cause harassment, alarm or distress. In the healthcare context, doxxing could involve making public the identity of a healthcare worker, coupled with unsubstantiated complaints about his / her professionalism or work ethic.

    i. Victims of doxxing should similarly adopt the recommended measures in Para 4.22a.

    ii. For both doxxing and online threats, victims should consider making a report to the platform where the incident happened. Most established platforms would have moderators to evaluate reports received, to see if takedown requests were substantiated, in line with their user policies. Healthcare institutions should assist the victims with such reporting processes if required.

Responding to Unmeritorious Complaints by Perpetrators

4.23 There may be an increase in the number of retaliatory and unmeritorious complaints by perpetrators in response to the follow up action(s) they receive arising from their abusive or harassing behaviour. Healthcare institutions should develop the process to manage such complaints comprehensively.

4.24 As a general approach to all complaints received, healthcare institutions should thoroughly investigate the facts without bias. If the necessary checks show that staff had not made any lapses, supervisors should proactively assure the staff that the complaint will not be held against his/her performance record.

Complaints found to be unmeritorious and arising from an abuse or harassment incident are to be disregarded, e.g. if a perpetrator complains about discharge from care, healthcare institutions may respond to clarify the reasons for discharge and the clinical assessment if care was no longer needed urgently. If the perpetrator is unable to raise new points in his/her complaint, institutions may disengage from further replies.

4.25 For complaints sent to external parties (e.g. MOH, Members of Parliament etc), healthcare institutions should clarify the facts briefly with the external parties, including the outcome of internal investigations carried out previously, if any.

a. Care should be taken to minimise the frequency with which the affected staff has to recount details of the incident.

b. If the complaint is without merit, healthcare institutions should state so upfront, with the assurance that due process was followed. This will allow external parties (e.g., MOH, Members of Parliament etc) who receive the complaint to better understand the situation, and provide better support to healthcare institutions by taking the same stand towards the complainant.

   MOH will obtain the facts from the healthcare institution(s) and assess appeals on a case-by-case basis to ensure fair representation. If a complainant misrepresents his/her case, and the actions taken have been firm and fair, MOH will support and reinforce the decisions of the healthcare institutions.

Post-Incident Management and Relief for Victims

4.26 Healthcare institutions should offer their support to victims post-incident and encourage them to use the support resources where required. This is to be done in conjunction with reporting the incident (see Section 5). Support measures may include but not be limited to:

a. Medical treatment;

b. Time-off or re-assigning of duties;

c. Claims for injury or damage; and

d. Resources for mental health support and follow-up

4.27 Medical treatment. Healthcare institutions should provide victims with immediate medical attention and extend medical resources to those that need medical care. Victims may also be allowed to take time-off from work to seek medical treatment.

4.28 Time-off or re-assigning of duties. To avoid repetition of abuse and harassment from the same perpetrators, healthcare institutions should consider re-assigning duties temporarily or granting the victim time-off from work to recover from any trauma sustained. Time-off may also be provided to victims for them to prepare for and attend police interviews, where necessary. Perpetrators should be made aware that the change in their care staff had resulted from their unacceptable conduct, and not due to their dissatisfaction with the victim(s). The victim(s) should also be assured the same, and that accepting time-off or re-assignment of duties is to remove them from further risk of abuse, and should not be taken as suggesting any inability to carry out their duties competently.

4.29 Claims for injury, damage or legal fees. Healthcare institutions should facilitate and support victims with the claims process as much as possible to alleviate additional stress on the victims, post-incident.

a. These include assisting victims with filing for work injury compensation insurance or reimbursement claims with supporting evidence, if available (e.g. CCTV footage). Victims may then be compensated for work injuries or damage sustained to personal items, up to a reasonable limit. Information on the claim procedures should be made simple, available, and accessible for all staff, with exclusions and limits clearly listed.

b. Victims' legal fees should also be indemnified by the healthcare institution, where appropriate. This may be by way of engaging legal counsel for the victim, or to reimburse the victim for fees incurred in the process of engaging his/her own counsel.

4.30 Resources for mental health support and follow-up. Healthcare institutions should support staff in seeking mental health support through in-house or external counselling services, if required. Healthcare institutions should also work towards establishing a strong peer support network at the workplace to help victims recover from the trauma.

4.31 Supervisors of victims should follow up and monitor the victim's general well-being by having a check-in within an appropriate time frame (e.g. three days of the incident). This will enable the healthcare institutions to assess preliminarily if the victim requires more support, and to make further offers to assist if necessary.

a. Victims of incidents that fall within Levels 2 and 3 will generally require greater support. Two to four weeks post-incident, supervisors may refer to the trauma screening questionnaire (see Annex A) to assess staff's well-being and determine the appropriate support to be given to the staff.

b. If there are more than six positive responses provided in the questionnaire, further peer or mental health support should be provided to the victim. The victim's HOD should be informed of the result from the questionnaire.

c. Healthcare workers who persistently face Level 1 incidents over a protracted period should also be considered for a wellness check-in.

4.32 Table 4 summarises the range of recommended incident responses to be taken, based on severity of the incident. Actual responses on the ground may deviate or vary, depending on the professional opinion of the relevant care team.

Table 4: Recommended Incident Responses Based on Incident Severity

Recipient	Incident Response	Incident Severity
Perpetrator	Verbal Management – Staff or on-duty supervisor to communicate firmly and clearly that perpetrator's behaviour is inappropriate and must cease.	For all cases.
	Issuance of verbal warning – see 7.3(a).	For Level 1 to 3 cases.
	Issuance of written warning – see 7.3(a).	For Level 2 and 3 cases.
	Disengaging by refusing unreasonable requests – see 7.3(b).	
	Removal of abusive NOKs and visitors from premises – see 7.3(c). May involve APO/security team/HOD.	
	Discharge of abusive clients assessed to not require urgent care – see 7.3(d) May involve APO/security team/HOD.	
	Physical and pharmacological restraint. May involve APO/security team/HOD.	N/A. Meant for the safety of clients.
	Documentation of doxxing or online threats / Reporting or requesting for take-downs with the online platform / Calling the Police	For Level 2 and 3 cases involving online harms
	To investigate complaints about healthcare treatment delivered / complaints sent to external channels, to see if they emanated from any abuse or harassment incident	N/A. Depends if a link can be established
Staff Victim	Counselling services, peer support, self-care, and mental well-being resources.	For Level 1 to 3 cases.
	Medical Treatment.	For Level 2 and 3 cases.
	Claims for injury, damage or legal fees.	
	Time off and/or re-assignment of duties.	
	Support for police reports and/or legal proceedings.	
	Trauma screening questionnaire.	

5 Reporting Procedures and Internal Investigations

5.1 All incidents of abuse and harassment must be reported as soon as possible, even if the incident had already been resolved on the spot, or if the perpetrator had ceased the abuse or harassment. To do so, healthcare institutions must create the conditions for their staff to make reports easily, and ensure staff are aware of what to expect after the reports are made.

5.2 This will send a signal to our healthcare workers that each incident is taken seriously, and that they should not have to put up with abuse and harassment. Wider and more comprehensive reporting of abuse and harassment will enable healthcare institutions to:

a. Have a clearer understanding of the extent of abuse and harassment that staff experience;

b. Decide on the appropriate actions to take for each incident, including supporting their staff; and

c. Track and analyse incidents to implement precautionary and support measures.

A Supportive Culture of Reporting

5.3 Healthcare workers are encouraged to look out for colleagues who may have been abused or harassed, and encourage them to report it. They should also refer to Para 1.2 for non-exhaustive examples of behaviour or words that are deemed as abuse and harassment.

5.4 Victims should feel assured, supported and protected by the institution throughout the process of reporting and escalation. Institutions should promote and embody a culture of confidentiality, neutrality, and non-retaliation when managing incident reports. Institutions should take an impartial approach when managing incidents.

5.5 Healthcare institutions may waive the mandatory reporting requirements for staff working in work sites that primarily care for clients with diminished mental capacity or young clients who lack the maturity to understand the consequences of their offending actions, except for Level 3 cases. As these staff are likely to face a greater frequency of Level 2 cases due to the profile of their clients, they should have autonomy to decide when to make reports. However, institutions should remind these staff that reducing the reporting burden does not mean that they are expected to tolerate abuse and harassment. To mitigate the higher risk of incidents, institutions should continue to take measures to protect these staff, such as providing them with adequate staffing, training and security personnel.

5.6 As a general guiding principle, incidents of abuse and harassment that cause distress to the staff should be reported.

Mode of Reporting

5.7 A suggested reporting template may be found at Annex B below. It is the responsibility of the victim or reportee to accurately report details relating to the incident and perpetrator(s). The recommended contents of this reporting template include:

a. Date, estimated time and location of incident;

b. Name and profile of parties, including the perpetrator(s);

c. Brief description of incident including the words said and behaviour exhibited;

d. Assessment of incident severity level;

e. Identity and contact details of witness(es), where applicable and available; and

f. Potential for recurrence, to ascertain if action needs to be taken to protect staff e.g. informing other staff.

5.8 Healthcare institutions should ensure that the reporting template and format is straightforward and easy to fill, to facilitate the reporting process. This may be done by:

a. Providing multiple-choice options within the template where possible;

b. Including the option of a free text entry field, allowing the affected staff the opportunity to elaborate on the incident;

c. Allowing the report to be routed to any combination of specific individuals or departments (e.g. staff protection function); and

d. Allowing for someone else (a colleague or a supervisor) to help fill up the form on behalf of the victim if necessary, e.g. due to distress, or to overcome reluctance. The victim may acknowledge incident reports lodged on their behalf by reportees, by countersigning against the reports.

5.9 Healthcare institutions should also ensure that staff are made aware of the reporting channels. Staff should be informed through orientation/onboarding, the institution's intranet, or periodic emailers (e.g. HR announcements on staff well-being). Easy access should be granted to staff for the purposes of reporting, such as via their mobile devices or assigned work computers.

Establishing a Reviewing Authority

5.10 It is recommended that a permanent staff protection function be set-up in each institution, to oversee the well-being of staff primarily through ensuring thorough, objective and fair reviews of abuse and harassment reports. This function should work closely with existing clinical, human resource and operations departments, to be led by a senior member of the institution's management (e.g. Division Head, or a C-suite level executive).

a. Their mandate should include investigations, final assessment of severity, and determining the appropriate follow up actions to take, including whether to escalate the matter to the police or discharge a perpetrator. They should also serve as the final arbiters of abuse and harassment reports made.

b. We also recommend that the function takes on the responsibility of curating a library of training resources, based on insights derived from the process described in Para 5.14. This will allow the function to take a central view of all abuse/harassment and service quality issues, and use those insights to recommend or design appropriate training programmes for staff.

c. For the avoidance of doubt, client feedback that are distinct from complaints can be managed by a separate relevant department within the healthcare institution.

d. It is important that the staff protection function coordinates closely with the healthcare institution's department(s) that deal with feedback and complaints. This would ensure completeness in the management of abuse and harassment cases involving clients and/or their NOKs.

e. Institutions with existing departments performing part of or all of the responsibilities recommended to be performed by the staff protection function should assess if they need to re-organise those departments to facilitate the set-up of the staff protection function without duplication of responsibilities within the organisation.

f. There should be staff protection functions within each healthcare institution, with central oversight to be provided at the group level or organisation's highest authority. This would facilitate expediency for decisions to be made at institutional level, while ensuring that the functions operate in a coordinated fashion.

Reviewing Process and Internal Investigations for Incident Reports

5.11 Abuse and harassment cases that fall within Levels 2 and 3 on the severity scale should always be escalated to the victim's HOD. The perpetrator's personnel-in-charge should also be informed. However, if the victim is not confident reporting to his/her HOD, he/she may route the case directly to the staff protection function. All Level 3 cases should eventually be escalated to the staff protection function for their review. Level 3 cases should also be reported

to MOH via Agency for Integrated Care (AIC) by submitting the incident reporting template (Annex B) on FormSG within two working days from the time of the incident, or from when the case is reported to the case officer/HR/staff protection officer, whichever is sooner using information available at the time of submission.

5.12 The victim's HOD, in consultation with the perpetrator's personnel-in-charge or primary doctor, would have the autonomy to take the appropriate follow up actions laid out in Section 7, for straightforward cases that do not involve discharging the perpetrator. Examples of straightforward cases would be incidents where the perpetrator's conduct would be difficult to refute, such as when multiple witnesses to the perpetrator's abusive conduct were present or where the conduct was captured on CCTV. Less straightforward cases are to be resolved by persons performing the staff protection function.

5.13 Persons carrying out the staff protection function should review each incident report they receive in an objective manner, with internal investigations to be conducted where necessary. The internal investigations may involve review of CCTV footage and documents, as well as interviews with relevant persons. This will help healthcare institutions decide on whether to take further action against perpetrators, or to further escalate to the police. Level 3 cases should be reported and escalated to the Police for their timely assessment on whether and when investigations or arrests should be initiated (see Para 6.2, and Section 7).

Tracking and Analysis of Incidents at Institutional Level

5.14 Each healthcare institution's repository of incident reports serves as an information source for data analytics. From the data, it would be possible to understand where, when, how and to whom abuse and harassment incidents tend to take place. Such insights can help healthcare institutions decide how best to right-site and right-size resources. These could lead to optimised outcomes, such as having more security personnel or better-trained staff in work sites with a greater incidence of abuse and harassment. The data will also help healthcare institutions meet the requirements under Section 11 on tracking of abuse and harassment related data at the national level.

6 Process for Cases Escalated to Police

Determinants for Escalation

6.1 Determining the severity of an incident within a healthcare institution is crucial for appropriate action. Senior management/clinical leadership play a pivotal role in this process, ensuring that incidents are assessed thoroughly and escalated to the police when necessary. Should there be a reasonable concern that the perpetrator might have a mental health condition and there is threat of physical harm, it is imperative that healthcare institutions make a police report immediately, so that a psychiatric evaluation can be conducted at a Designated Psychiatric Institution, under the Mental Health (Care and Treatment) Act 2008.

a. There is physical or psychological injury from the perpetrator(s)'s actions.

b. The perpetrator has made a threat to cause hurt to the victim, particularly if the threat has been repeated and the victim has reason to believe that the perpetrator is able to carry out the threat; or

c. The institution's security personnel require Police assistance to defuse the situation, such as removing an abusive visitor from the premises.

Making Police Reports for Abuse and Harassment Incidents

6.2 When a Police report is lodged, the Police will assess the case to determine the appropriate follow-up actions. For cases where Police do not initiate investigations, Police may refer complainants to lodge a Magistrate's Complaint. After considering the case, the Magistrate may make a range of orders, including potentially directing the Police to investigate, or allowing for private prosecution to proceed. Apart from a Magistrate's Complaint, complainants may explore other channels such as initiating their own civil action via other dispute resolution mechanisms.

6.3 Common Police cases involving abuse/harassment of healthcare workers (including the examples cited in Chart 1) may include the following. All three offences below have a maximum imprisonment term of three years or less, so they are eligible to be reported via Magistrate's Complaints.

a. Intentional Harassment under Section 3 of the POHA, where the offender uses any threatening, abusive or insulting words or behaviour, thereby causing the victim harassment, alarm or distress; and

b. Harassment of a public service worker under Section 6 of the POHA[2], where the offender uses any indecent, threatening, abuse or insulting words or behaviour towards a public service worker in relation to the execution of their duty; and

[2] Please refer to the Protection from Harassment (Public Service Worker) Order 2014 for the workers and services covered by the legislation.

c. Voluntarily Causing Hurt under Section 323 of the Penal Code, where physical hurt is involved.

Outcome of Reports

6.4 The institution should update the victim/reportee through email or letter, as well as in person or over the phone if needed. This would provide accountability and transparency to the victim and reportee. Institutions should ensure confidentiality throughout the process, such as by keeping the details of the case private and on a need-to-know basis.

6.5 For cases investigated by the Police, the Police will provide the complainant with case updates at appropriate junctures. The role of the complainant is vital in ensuring follow-up on the case.

6.6 If the victim chooses to lodge a Magistrate's Complaint, institutions are encouraged to provide the necessary support. By taking a firm stand against the perpetrator, institutions will be protecting other staff from further abuse. Nevertheless, institutions may wish to note that not all cases will be prosecuted depending on circumstances of the case, and that the Courts may issue a stern warning instead. Institutions may wish to assure staff that a stern warning would still be considered a form of action taken by the Police.

Why are offenders in some cases not prosecuted?

To determine the appropriate course of action against any accused person, cases are holistically assessed based on the unique circumstances to the case. Relevant considerations would include:

a. The circumstances leading to the offending act(s);
b. The extent of the offender's premeditation;
c. The extent of harm and/or damage caused by the offender's act(s);
d. The duration of the act(s) and whether it is still continuing;
e. The availability of objective and reliable evidence, including witnesses, to prove the offending act(s); and
f. The offender's antecedents and proclivity towards such act(s).

7 Follow-Up Actions Against Perpetrators

7.1 Perpetrators may face consequences under the Penal Code, or under POHA. (See Para 3.5 for examples)

7.2 Public sector workers including healthcare workers that deliver essential services, are accorded enhanced protection under Section 6 of POHA[3]. All incidents of harassment and abuse, including those against public service workers, are viewed seriously. Appropriate action will be taken in accordance with the law, with consideration to the facts and circumstances of each case.

7.3 Healthcare institutions should also develop a suite of internal actions that can be taken against perpetrators and their caregiver (if applicable). These actions are separate from police investigations and proceedings. These may include:

a. Issuing a warning to the perpetrator(s) and their caregiver (if applicable):

i. Verbal warnings may be issued by any staff at the first instance of abuse and harassment, for incidents of any severity. Where possible, institutions may also arrange for staff of a higher rank to issue the verbal warning.

ii. A written warning may be issued subsequently by HODs or higher. The written warning serves to inform the perpetrator and their caregiver (if applicable) that stern consequences could follow if his/her behaviour persists.

b. Disengaging by refusing requests that are unreasonable or made in an abusive or harassing manner:

i. Healthcare institutions should empower staff to refuse any requests that are unreasonable or made in a threatening, abusive or harassing manner. Unreasonable requests may include frequent updates[4] on client status, services outside of staff's job scope, unsolicited contact outside of working hours, and preferential treatment without valid reason.

ii. Where possible, staff are encouraged to inform clients, NOKs, and visitors that they are unable to accede to unreasonable requests. This would allow clients, NOKs, and visitors to make alternative arrangements if needed.

iii. Healthcare institutions should support their staff's decision to refuse such requests.

[3] Please refer to the Protection from Harassment (Public Service Worker) Order 2014 for the workers and services covered by the legislation.

[4] Caregivers who wish to request for more frequent updates on resident's condition will be advised to contact the institution during allocated timings (e.g. during periods where staff are not physically attending to residents).

c. Removal of abusive visitors from premises:

i. If abusive visitors continue with their behaviour, they may be escorted out of the institution by its security team. If there is no trained security team available at the work site, there should ideally be a trained staff-on-standby from a relevant department (e.g. Operations) whom frontline staff can approach for immediate assistance if necessary. They may also be barred from visits for a period of time.

ii. The duration of each ban should be considered on a case-by-case basis. Institutions should consider the client's health condition, as well as whether the ban would cause distress to the client and visitors.

iii. Institutions are encouraged to take this course of action only after consulting the victim's HOD.

d. Discharging abusive clients:

i. Institutions should consider discharging an abusive client who no longer requires urgent clinical care. Residential settings might also consider a change in the client's environment, such as a change in the bed or floor assigned. Repeat offenders, for whom the institutions have exhausted all possible intervention methods, may approach the AIC to discuss referral options.

For Information: Clusters' Best Practices in Managing Clients with Diminished Mental Capacity:

For cases involving clients with diminished mental capacity, healthcare institutions may work with the client's family to provide insights into his/her behaviour and needs, which might have resulted in the deviation from normal behaviour. Where possible, healthcare institutions may also consider developing alternative care plans for such clients, in consultation with an interdisciplinary team consisting of relevant experts.

ii. First, there must be a clinical assessment provided by the perpetrator's personnel-in-charge showing that the client does not require urgent clinical care.

iii. Next, the staff protection function should decide whether to discharge the perpetrator. The institution's security team may be activated in case the perpetrator refuses to cooperate with the discharge.

iv. Abusive clients who have been discharged may return to the same institution for follow-ups but should be respectful towards healthcare workers during those appointments. If they continue to abuse or harass staff, institutions can take the appropriate follow up action as listed in this

section or seek guidance from relevant management overseeing the staff protection function. Healthcare institutions can offer to facilitate the transfer of care of the abusive client to other care providers as needed. This would not be seen as a failure to fulfil the duty of care.

v. For non-inpatient work sites where discharge is not applicable: e.g. chronic, ambulatory or primary care, clients who are known to be abusive may be escorted by security when seeking treatment.

7.4 Some perpetrators may have medical conditions that result in diminished mental capacity. There may also be minors who display abusive behaviours towards healthcare workers. If follow up actions cannot be taken due to reduced mental capacity or young age, institutions should emphasise preventive measures to protect staff (see section 4, 8 and 9).

Documentation of Information on Perpetrators

7.5 Healthcare workers may also document the incidents involving recalcitrant perpetrators for colleagues to take appropriate precautions against the perpetrators in the future. This would help minimise repeated abuse and harassment.

a. The perpetrator's repeated behaviour can be documented in institutions' electronic medical records (EMR) or National Electronic Health Records (NEHR) system. The intention is to facilitate the handover of information, so that other staff can take precautions. The perpetrator's behaviour should be documented in a neutral and factual manner so as not to unfairly prejudice staff against the perpetrator. Staff should continue to provide the same standard of care as with any other client.

b. Details to be documented may include date, time and place of incident(s), individuals involved, potential cause(s) of the incident, possible influence of alcohol or drugs, use of weapons, measures taken, restraints used, damaged caused, and final outcome of the incident.

For Information: Clusters' Best Practices in Managing Clients with Diminished Mental Capacity:

For recalcitrant perpetrators with diminished mental capacity, healthcare institutions can also put in place visual signages (e.g. cue cards) to inform staff to approach and treat clients with care. Staff can be advised to:

- Enlist assistance of another staff;
- Explain the procedures or tests carefully, and be always aware of the risk; or
- Review if there is a better time to perform procedures or tests and to highlight to medical team for further assessment if the client is uncooperative.

7.6 If the perpetrator did not demonstrate any unruly behaviour in his/her subsequent visits to the healthcare institution, healthcare workers may consider removing the documentation/visual signages, with explanations provided.

8 Prevention and De-escalation of Abuse and Harassment

8.1 Staff are encouraged to always be alert to potential abuse or harassment situations, and to look out for signals associated with abuse or violence. These may include frustration, anger, threats of aggression, signs of drug or alcohol use, or the presence of a weapon.

8.2 Staff should be sensitive to clients' health conditions and/or caregivers' stress to avoid situations that may escalate into abuse or harassment, particularly for persons with diminished mental capacity or minors. Staff should be trained to manage such situations. Examples of relevant training include:

a. **Effective communication skills and techniques to de-escalate tense situations**, which will build staff's confidence in handling conflicts.

b. **General stakeholder and customer relations management skills** to improve staff-to-client relationships and prevent misunderstandings and potential conflicts.

8.3 Institutions should ensure that staff undergo the basic training above, as well as those in Table 5 of Section 9. In addition, the Workgroup also recommends the following types of training as a best practice.

a. **Self-defense techniques against physical aggression** to help healthcare workers protect themselves. Such techniques may help healthcare workers break away to call for help, or to even neutralise the aggression. More details are also covered in Section 4.

b. **Portable panic buttons or body worn cameras**, if the institution chooses to deploy them. These devices could help to alert nearby members of public when staff are at risk or in danger.

c. **Techniques for managing and caring for clients whose behaviour arise from medical conditions** (e.g. those with cognitive impairment or dementia) to empower staff with confidence to manage tense situations.

8.4 For the above, healthcare institutions should deliver training to staff in a way that is timely and relevant. Section 9 summarises all training-related recommendations in this Guide.

9 Training

9.1 Healthcare institutions should review their training curriculum regularly for relevance. Where possible, training materials should be made available on the institutions' employee portal so that all staff can readily access this information.

9.2 Table 5 summarises the basic and recommended training that healthcare workers should undergo. The recommended frequency and target staff groups are indicated in the table. More courses can be found on AIC's Learning Network.

Table 5: Basic and Recommended Types of Training[5]

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
Basic pre-employment training (Through institutes of higher learning (IHLs) and Institute of Technical Education (ITE))						
1.	Introduction to the Framework for the Prevention of abuse and harassment	To improve awareness of abuse and harassment, principles for managing such incidents, and available resources.	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4) • Reporting procedures (Section 5)	Before graduation	Students enrolled in healthcare-related courses at IHLs and ITEs	Classroom

[5] Please refer to the circular for relevant training courses with grant support available for eligible CCOs.

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
Basic Training (For delivery[6] at staff orientation for new hires)						
2.	Introduction to the Framework for the Prevention of abuse and harassment	To improve awareness of abuse and harassment, principles for managing such incidents, and available resources.	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4) • Reporting procedures and internal investigations (Section 5)	Upon joining the institution	All staff	Formal training/in-house training
3.	Institutions' internal framework/protocols on prevention and management of abuse and harassment	To provide clarity on the roles played by healthcare workers, supervisors and HODs. To help healthcare workers identify abuse and harassment and its severity, how to assess and de-escalate potential conflicts, as well as	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4) • Reporting procedures and internal	Upon joining the institution, and once every 2 to 3 years	All staff	Formal training/in-house training

[6] The delivery of the basic and recommended types of training, and its intended target audience can be subject to institutions' flexibility based on their onboarding process and/or training requirements.

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
		appropriate responses and process for reporting.	investigations (Section 5)			
4.	Effective communication skills and techniques to de-escalate tense situations	To improve staff-to-client relationships and build staff's confidence in handling conflicts.	• Prevention and de-escalation (Section 8) • Incident response (under verbal management) and post-incident management and relief for victims (i.e. resources for mental health support and follow-up) (Section 4)	Upon joining the institution, and once every 2 to 3 years	Frontline staff	Formal training/in-house training
5.	General stakeholders' and customers' relations management skills	To improve staff-to-clients relationships and prevent potential conflicts. To also cover complaints management, such as to attempt resolution at first instance if convenient or easy; otherwise to re-direct appropriately.	• Prevention and de-escalation of Abuse and Harassment (Section 8) • Incident response (under verbal management) and post-incident management and relief for victims (i.e. resources for mental health	Upon joining the institution, and once every 2 to 3 years	All staff	Formal training/in-house training

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
			support and follow-up) (Section 4)			
6.	Sharing of incidents with staff	To raise awareness and reinforce best practices for improvements. To prevent such incidents from recurring.	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4) • Reporting procedures and internal investigations (Section 5) • Process for Cases Escalated to Police (Section 6) • Follow up actions for Perpetrators (Section 7)	Upon joining the institution, and once every 4-6 months	All staff	Townhalls, informal team sharing
7.	[For Supervisors] Mental Health Support for staff (including establishing peer support network)	To help staff cope with and recover from post-incident trauma.	• Post-incident management and relief for victims (i.e. resources for mental health	Once for every newly appointed supervisor, with refreshers every 2 to 3 years	All supervisors	In-house or external service

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
			support and follow-up) (Section 4)			
Recommended Training as a Best Practice						
8.	a. Self-defense techniques against physical aggression b. Self-protection signals (e.g. The Signal for Help)	Ensure staff's safety, build confidence in managing tense situations; and improve their ability to identify high-risk situations.	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4)	Upon joining the institution	All frontline staff, especially security personnel	a. Formal training/in-house training b. E-learning/e-tutorials/educational posters
9.	Portable panic buttons or body worn cameras *(If the institution chooses to deploy these devices)*	Depending on the areas where these are deployed, to ensure staff knows how to use the portable panic buttons or operate the body worn camera; to help alert nearby members of public or colleagues when staff are at risk or in danger.	• Prevention and de-escalation (Section 8) • Incident response and post-incident management (Section 4)	Upon joining the institution and as and when required	Relevant staff as identified by the healthcare institution	In-house training
10.	Techniques for managing and caring for clients whose behaviour arise from medical conditions (e.g. those with	Equip staff with skills to care for clients with complex care needs.	• Prevention and de-escalation (Section 8) • Physical and Pharmacological	On-going	All frontline staff	Formal training/in-house training

S/N	Types of Training	Objectives	Application	Suggested Frequency	Target Audience	Setting
	cognitive impairment or dementia)		Restraints (Section 4)			
11.	Emotional Intelligence Training	Enhance self-awareness, empathy and communication skills.	• Physical and Pharmacological Restraints (Section 4) • Prevention and de-escalation (Section 8)	On-going	All frontline staff and all supervisors	Formal training/in-house training

10 Promoting Positive Relationships

10.1 The Framework and Guide will be supported by a **Public Education Campaign** set to launch in June 2025.

10.2 Where possible, the public education campaign should be complemented by further efforts at the institution level to promote trust and respect between healthcare workers, clients, and their caregivers. Institutions may communicate these messages through posters and community outreach efforts.

10.3 Institutions should correct any mismatched expectations that clients might have, through providing more information on the processes to expect in a work site, role of healthcare workers, client conduct, and the appropriate channels to raise concerns about care delivery.

a. These may be presented to and acknowledged by clients at suitable junctures, such as at the point of registration or admission.

b. Institutions should actively tap on their respective client advocacy groups as a platform to promote positive relations between healthcare workers, clients and caregivers.

c. Such ground-up perspectives would strengthen efforts to promote positive communication and appreciation between clients, caregivers and healthcare workers.

11 Outcomes and Tracking of Data at the National Level

11.1 The implementation of these efforts against abuse and harassment will result in higher awareness and reporting of such incidents. Healthcare institutions can expect an overall increase in the number of reported incidents in the short-to-medium term.

11.2 A key measure of success would be the satisfaction level of victims/reportees based on the outcome of reported incidents. Based on TWG's empirical research, 42% of those who had officially reported abuse and harassment to their healthcare institutions or the police were dissatisfied with the eventual outcomes.

11.3 Over time, as relationships between the public and healthcare workers improve, and there are strong deterrents against abuse and harassment, we hope to see a decline in the frequency and severity of such incidents.

11.4 We seek healthcare institutions' support to track relevant data on abuse and harassment. MOH requests that healthcare institutions submit an incident reporting template (Annex C) on FormSG to AIC on a yearly basis.

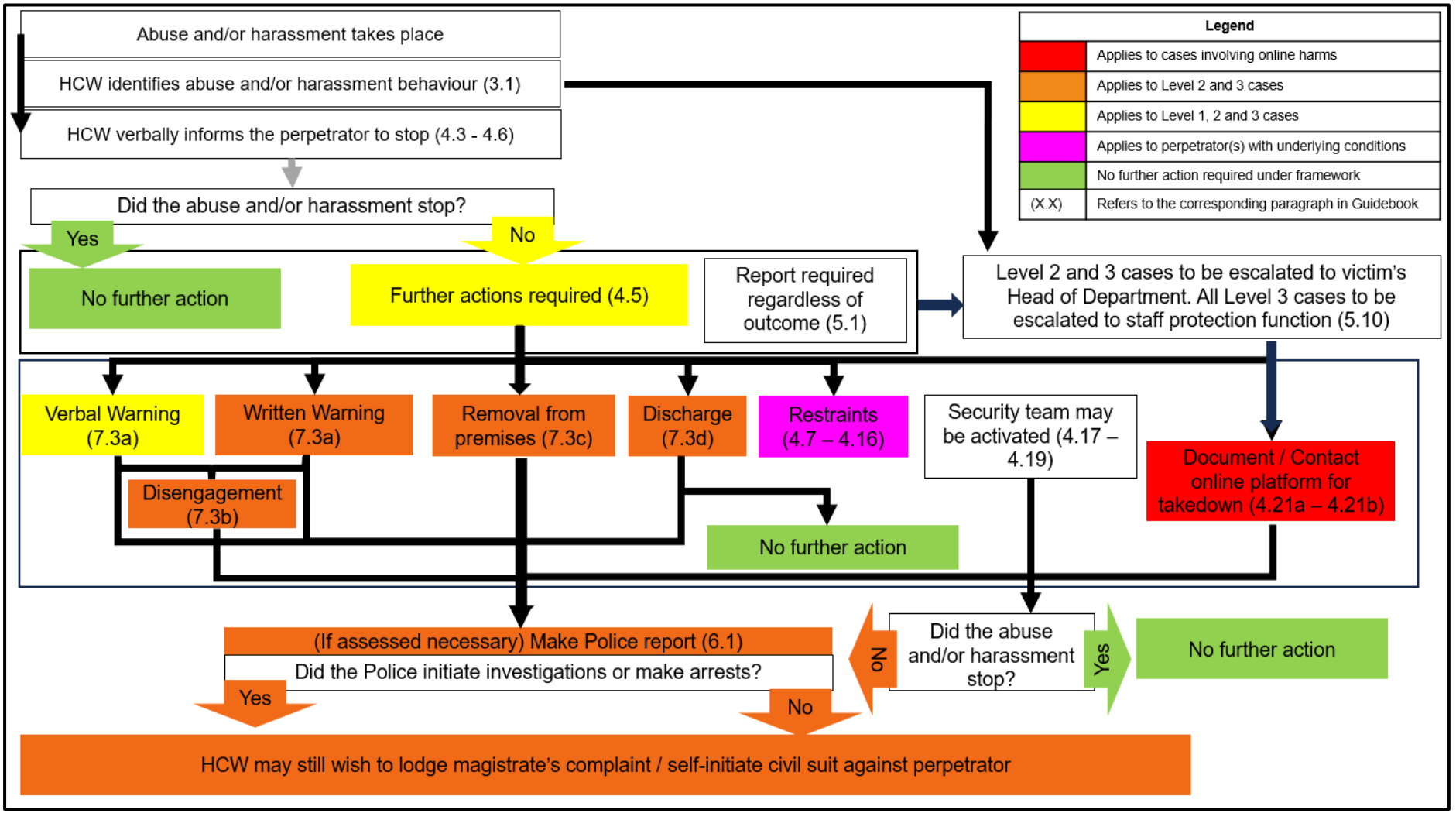
11.5 Aside from the yearly data, MOH may also request for more detailed data, such as victim's level of satisfaction with the outcome of reported incidents from time to time.

12 Conclusion

12.1 Healthcare manpower is critical for the delivery of healthcare services. By addressing abuse and harassment, we can build a more positive working environment for healthcare workers. Healthcare institutions play a critical role in ensuring the safety of their staff, by preventing abuse, taking a firm stand against perpetrators, and supporting staff in the aftermath. Together, we can send a strong signal that our healthcare workers deserve to be respected and valued for their contributions to society.

12.2 The recommended flowchart for the management of abuse and harassment incidents in Healthcare Institutions can be found in the following page.

Recommended flowchart for the resolution of abuse and harassment incidents in Healthcare Institutions (mapped to corresponding paragraphs within the Guide)



ANNEX A

Trauma Screening Questionnaire

If you have recently been exposed to a potentially traumatic event (a PTE), here is a tool that may help you to identify whether you should seek additional help in recovering from its effects. Have you recently experienced any of the following:	**Yes** at least twice a week	**No**
Upsetting thoughts or memories about the event that have come into your mind against your will		
Upsetting dreams about the event		
Acting or feeling as though the event were happening again		
Feeling upset by reminders of the event		
Bodily reactions (such as fast heartbeat, stomach churning)		
Difficulty falling or staying asleep		
Irritability or outbursts of anger		
Difficulty concentrating		
Heightened awareness of potential dangers to yourself and others		
Feeling jumpy or being startled by something unexpected		

Source: C.R. Brewin, et al, 2022, as adapted by NHG-IMH

ANNEX B

Ad-hoc Incident Reporting Template on FormSG[7]

- *I/We confirm that all information provided within this Incident Report is an accurate representation of events to the best of my/our knowledge.*

- *I/We also hereby provide consent to the Agency for Integrated Care Pte Ltd to share the details of Level 3 incidents with the Ministry of Health when necessary.*

Section A: Report of Abuse or Harassment
(To be completed by the affected staff, colleague or reporting officer)

Date of incident (dd-mm-yyyy):

_____

Estimated time of incident (a.m. / p.m.):

_____

Location of incident:

_____

1. The alleged perpetrator(s) is/are a:

☐ Client(s) ☐ Family/friend(s) of client

☐ Other: _____

Name of alleged perpetrator(s), if known (if not known, pls indicate NIL):

_____

2. Please tick all the suggested examples below that best fit with the abuse or harassment that has been experienced:

Level 3 incidents	☐ Molestation ☐ Assault ☐ Battery ☐ Throwing of Objects

[7] CCOs are highly encouraged to report all Level 3 incidents to AIC/MOH: https://for.sg/cco-ad-hoc-reporting

Level 2 incidents	☐ Vulgarities ☐ Unreasonableness ☐ Racism ☐ Sexism ☐ Xenophobia ☐ Ageism ☐ Persistent Demands and Complaints	☐ Assault or throwing of objects by persons of diminished mental capacity or young children ☐ Stalking ☐ Insults ☐ Threats ☐ Unsolicited video recording and photographs
Level 1 incidents	☐ Vulgarities / insults / threats from clients with diminished mental capacity or who have reduced awareness or control of their actions	

Legend	
	Level 3 incidents
	Level 2 incidents
	Level 1 incidents

3. Brief description of incident, including assessing the extent of loss/damage (*tick all that apply)*:

☐ Physical abuse or harassment

(Optional) Incident description:

_____

_____

☐ Verbal abuse or harassment

(Optional) Incident description:

_____

_____

☐ Sexual harassment:

(Optional) Incident description:

_____

_____

☐ Others, including damages suffered (e.g. to self, to personal property):

Incident description:

_____

_____

4. Is this a repeated incident?

☐ Yes ☐ No

☐ Not sure

5. Based on your assessment, is this incident likely to occur again?
Your response will help us to warn other staff who may encounter the alleged perpetrator*(s).*

☐ Yes ☐ No

☐ Not sure

Affected staff's details

Full Name:

_____

Designation:

_____

Contact Number and Email:

_____

Submitted by (only fill in if person submitting the report is not the same as the affected staff):

Full Name:

_____

Designation:

_____

Contact Number and Email:

_____

Date of Submission (dd-mmm-yyyy):

_____

Section B: For Official Use Only (To be completed by the organisation's Case Officer (i.e. from HR or senior management, or staff protection office, if any)		
Particulars of Reporting Organisation		
1	Name of Reporting Organisation	
2	Case Officer's Details (if not the same as the person who filled in the form above)	Full Name:
		Designation:
		Contact No.:
		Email:
Follow-up action		
3	Actions taken by the Reporting Organisation	
4	Was a police report made?	☐ Yes (Case Reference No. _____ / Date (dd-mmm-yyyy) _____) ☐ No
5	Has the case been closed?	☐ Yes, please share the conclusion of the case: _____ ☐ No, please share the current progress: _____ _____
Particulars of Client/Complainant *S/N 6 to 9 are required only if the reporting organisation receives an escalation from the aggrieved* alleged perpetrator(s) *(e.g. a complaint was made by client/complainant regarding the reporting organisation's management of the incident).*		

6	Full Name of alleged perpetrator / Complainant (delete as appropriate)	
7	If alleged perpetrator is not a client, please indicate the name of the Client that the alleged perpetrator was visiting, if applicable	
8	Relationship to Client (if different from Client)	
9	CCO's Assessment / Action Plan / Comms Lines (e.g. what was the request from client/complainant? - i.e. waiver of medical bills, compensation, etc.) (the actions taken to resolve the case, upcoming action plans - blacklist them from premises etc)	

ANNEX C

Annual Batch Reporting Template

CCOs are highly encouraged to submit an annual report (as at 31 December) of abuse and harassment incidents reported by staff to AIC for consolidation. CCOs hereby consent to AIC sharing the details of the annual report to the Ministry of Health as necessary.

CCOs will be required to download a copy of the blank annual reporting template from the AIC Partners' portal[8] and uploading the completed template[9] in FormSG[10] by 7 January of the succeeding year. Cases that have previously been reported to AIC (i.e. ad-hoc reporting) should be shaded to facilitate tracking of the case update.

The data fields in the batch reporting template can be found in the table below.

1. Incident Date

2. Incident Location (e.g. institution, site)

3. Details of HCW who faced abuse and harassment
   a. Staff Profession (e.g. doctor, nurse, allied health)
   b. Staff Designation
   c. Gender (where available)
   d. Age (where available)

4. Details of other HCW who faced abuse and harassment (if any)
   a. Staff Profession (e.g. doctor, nurse, allied health)
   b. Staff Designation
   c. Gender (where available)
   d. Age (where available)

5. Type of Abuse and Harassment
   a. Physical
   b. Verbal
   c. Sexual
   d. Online harm
   e. Others (please indicate)

6. Police case (yes/no)
   a. If yes, police report number

7. Details of Perpetrator
   a. Name (if known)
   b. Relationship to HCW

[8] aic.sg/partners
[9] The uploaded excel document must be password-protected, and the password must be emailed to AHincidents@aic.sg
[10] https://for.sg/cco-annual-batch-reporting

8. TWG severity level

ANNEX D

Frequently Asked Questions concerning police reporting and investigations[11]

S/N	Topic / Question	Response
Resources on escalation of cases		
1	Resources on escalating incidents beyond the healthcare institution	a) Staff and healthcare institutions may escalate their cases to the police by I. Dialing 999 or SMS 71999 for emergency services; II. Lodging a report either in-person at the nearby police station or online. To lodge an e-report, please access the SPF website for more information. b) Alternatively, staff and healthcare institutions could consider filing a complaint at the Magistrate's Court[12]. The magistrate would examine the alleged offence and give directions for further action. For information on the process, there is a step-by-step guide available at: https://www.judiciary.gov.sg/criminal/magistrates-complaints. c) Lastly, for staff who have experienced abuse and harassment, they could also pursue civil remedy by filing a claim under the Protection from Harassment Court. The perpetrator may be ordered by the court to stop the harassing behaviour amongst other possible outcomes. The court may also order an internet intermediary or other platform owners to stop the spread of a false statement of fact. For a guide on seeking remedy under Protection from Harassment Court through the Community Justice and Tribunals System (CJTS) e-portal, please refer to: https://www.judiciary.gov.sg/civil/protection-from-harassment.

[11] For more information on Police Procedures, please refer to SPF's publicly available information booklet which contains FAQs in relation to police procedures such as arrest, custody, bail, and investigations. The PDF can be found on www.police.gov.sg/Media-Room/Publications > 'Information Booklet on Police Procedures'

[12] A Magistrate's Complaint is an application to a magistrate to examine an alleged offence and give directions for further action. Anyone who believes that a criminal offence has been committed against them can file a Magistrate's Complaint. Such complaints, however, may only be filed for offences which are punishable by up to 3 years' imprisonment, or fine, or both.

Reporting and investigation process		
2	When a Healthcare Worker (HCW) wishes to make a police report, what type of evidence is required? What is the level of involvement that is expected of the HCW when providing evidence (e.g. providing police with a list of witnesses, facilitating SPF to extract CCTV footage on-site)?	a) The type of evidence required depends on the facts and circumstances of each case. If Police are investigating the case, Police will procure the evidence and seek the complainant's assistance as necessary. b) Generally, for cases of harassment/abuse, Police actions that may require assistance from the complainant / institutions include: I. Statement recording from victim II. Statement recording from witnesses, if any *[Note: Generally, the Investigating Officer (IO) may request the victim to provide a list of witnesses as well as their contact details, for IOs to follow up on]* III. Footages (e.g., phone/video recordings, CCTV, etc), if any IV. Medical report, if physical hurt is involved c) For cases which Police do not investigate, the complainant may still wish to obtain and keep appropriate records of the acts (e.g. CCTV, text messages, photos, emails, online posts), in the event that the situation subsequently escalates. Such evidence may also be furnished when seeking remedies with the State Courts, including the Protection from Harassment Court. d) More information about remedies for harassment-related offences can be found at the following url: https://www.judiciary.gov.sg/civil/protection-from-harassment.

3	As HCWs are unable to step away during their work shifts, they said that they sometimes need to use their personal time to attend police interviews. To make it more convenient, can a police interview be conducted over the phone/Skype or at least on hospital premises, or must it be at the police station?	a) Statements recorded by the Police may be tendered in Court as evidence, if the case goes to court. Statements are therefore recorded in person, typically in a Police station. This is the case regardless of the occupation of the person giving the statement, and is not unique to HCWs, nor to harassment cases. b) For cases where the complainant calls '999' for Police assistance and Police attend to the scene, the complainant's statement **<u>may</u>** (but not always) be recorded at scene. Where the complainant lodges a report to an officer at a Police station, the statement would generally be recorded along with the lodging of the report. That said, there may be situations where the IO assesses that it would not be conducive for the victim's statement to be recorded on the spot (e.g., lack of privacy, victim is not in appropriate state of mind, etc). *[Note: for the Guide, we are recommending the healthcare institutions provide time-off to staff as part of measures for post-incident management. Staff could use this time-off to lodge a police report if necessary.]* c) The IO may also contact the complainant to arrange for further statements to be recorded, if necessary. d) For cases where the complainant has lodged an electronic Police report, the IO will contact him/her to arrange for his/her statement to be recorded.
4	Besides a police report, HCWs are also encouraged to submit an internal report. This means that the HCW might need to recount the incident repeatedly, which can be traumatic. Does SPF have SOP to minimise the number of times victims have to recount the incident?	a) Statements recorded by the Police as part of a Police investigation are treated as confidential and are independent of an internal report that HCWs may have to submit to their healthcare institutions. b) HCWs may choose to bring along the internal report to the Police station when he/she wishes to lodge a police report to show the Police officer, but it cannot substitute a Police report or a statement. Minimally, HCWs can expect to recount the incident to the Police at least once.

Legal thresholds and criminality		
5	What is the threshold for a case of abuse/harassment to be classified under (a) Penal Code, (b) POHA, or (c) eligible only for a Magistrate's Complaint? HCWs have said that they don't understand why SPF proceeds on some cases but not others. With a limited understanding of the processes involved, this, in turn, can cause HCWs to be discouraged from reporting. Could SPF share on the thresholds involved in the assessment, such as extent of injury, egregiousness of incident, intention of suspect.	a) Classification of offences depend on the facts and circumstances of the case. Common cases involving abuse/harassment of healthcare workers include: I. Intentional Harassment under Section 3 of the Protection from Harassment Act, where the offender uses any threatening, abusive or insulting words or behaviour, thereby causing the victim harassment, alarm or distress. II. Voluntarily Causing Hurt under Section 323 of the Penal Code, where physical hurt is involved. b) Depending on the facts and circumstances of each case, the Police will assess the appropriate follow-up actions. c) For cases where Police do not initiate investigations, Police may refer complainants to lodge a Magistrate's complaint should they wish to pursue private prosecution or ask for the Magistrate to direct Police to investigate. Upon receipt of the complaint, the Magistrate will review the case, and may direct the Police to inquire into the allegation's truth or falsehood if assessed to be necessary. d) Apart from a Magistrate's Complaint, complainants may explore other remedies such as initiating their own civil action via other dispute resolution mechanisms. For example, the victim may apply for a Protection Order against the other party, or file claims against the other party, under the Protection from Harassment Court. The victim may also apply for mediation at the Community Medication Centres.
6	In the event that a HCW declines to press charges for personal reasons (e.g. feeling embarrassed, or no time to go through the process), can a healthcare institution do so instead?	a) Once a Police report is lodged, assessment of whether to initiate investigations, and whether to prosecute the offender in Court ("press charges"), lies with the Police and AGC respectively. The complainant's wishes are a relevant, but not determining factor, in whether the offender is prosecuted. b) Separately, the Criminal Procedure Code allows for private prosecutions, including in instances where Police do not investigate an alleged offence.

	Similarly, if the HCW is willing to press charges, can the healthcare institution see through the investigation and court processes on their behalf? It might be more practical for the HR and legal teams to oversee these processes where possible, since they are likely to be more experienced.	
7	Clients may threaten to harm others if they are discharged. If they carry out their threats after being reviewed and discharged, what safeguards are there for the treating team/institution? The challenges to such discharges are also that they may return soon after with presenting complaints of thoughts of harming themselves or others again.	Healthcare workers should call for Police assistance if necessary, such as where there are criminal offences disclosed or law and order issues involved (e.g., the client threatens to harm others or is causing nuisance or harassment). Police will assess accordingly to determine next steps (e.g., assess if criminal offences are disclosed).
8	HCWs in hospitals often receive people who are intoxicated and belligerent from Police officers. While waiting for the individuals to sober up, HCWs may be subjected to harassment and abuse. Would	HCIs may encounter situations where Police escort individuals to HCIs for treatment, and resume thereafter. Should there be law and order concerns, HCIs may call for Police assistance. In general, police resources would only be dispatched where there are criminal offences disclosed, or where there are issues of law and order involved. We recommend that healthcare institutions provide sufficient resources (e.g., security resources) to support healthcare workers in managing difficult clients. Nonetheless, healthcare workers may call for Police assistance if necessary. For example, if there are

	it be possible to 'return' such cases to police custody after the clients are attended to?	new developments in managing the client, e.g. if the intoxicated client becomes aggressive and abusive.
9	Would SPF be able to share details on the process for a Magistrate's Complaint, such as cost and timeline?	a) The process for filing a Magistrate's Complaint can be found at the following website: https://www.judiciary.gov.sg/criminal/magistrates-complaints
Case outcome and closure		
10	We recognise that the time required to investigate and process cases can vary. Is it possible for SPF to provide data on the median time frame for reference? This would help manage expectations by the healthcare institutions, so they can stop asking the IO for updates.	a) The Police investigate a wide range of offences of varying complexities, which will affect the length of the investigation. Generally, cases with higher complexity (e.g., multiple persons involved, linked to a series of cases) will take longer to be investigated (e.g., more case persons to be interviewed, more evidence to be secured and reviewed). b) Moreover, Police are one of many parts of the criminal justice process. For example, we consult with AGC for an independent review of the evidence and for a prosecutorial decision. c) As such, we would not be able to comment on the average length of time taken for investigations.

11	In general, at what points in the case process can victims expect updates? For example: a) When SPF completes its investigation b) When charges are filed against the accused c) When the case is awaiting trial d) If SPF decides not to file charges	a) Generally, victims can expect case updates at the following junctures: i. Update on whether investigations have been initiated. ii. If an arrest is made iii. If the offender is charged in court iv. Upon conclusion of the case, including if there are outcomes other than prosecution (e.g. warning), or if investigations are closed pending fresh leads. b) Every case is unique, and the time taken to conclude investigations will be different for every case.

Glossary

Term	Definition
Clinical Leader	Refers to senior clinical staff who provide team leadership and supervision in the Medical, Nursing, Rehabilitation, Social Work, and other Allied Health domains.
Heads of Department (HODs)	Refers to the heads of department (e.g. Nurse Managers and Nurse Clinicians at the work sites, or Assistant Director of Nursing). It may also include other clinical professional heads such as Head of Allied Health Professionals and Head of the doctor's team. In some cases, HODs may also be referred to as the Chiefs of the multi-disciplinary clinical team.
Healthcare Workers	Refers to doctors, nurses, pharmacists, allied health professionals, support care staff and can also include administrative and ancillary staff when there are client-facing tasks. Also used interchangeably with "staff". It may also refer to staff who are outsourced or contracted, as long as they are working within the healthcare institutions premises.
Healthcare Institutions (HCIs)	Refers to any healthcare organisation, including public or private acute hospitals, community hospitals, nursing homes, centre-based care providers, home care providers, etc.
Next-of-Kin (NOKs)	Refers to a client's living relatives who are either related by blood (i.e. biological children) or legal standing (i.e. spouses or adopted children).
Client(s)	Refers to individuals receiving treatment performed by healthcare workers either at public or private acute hospitals, community hospitals, nursing homes, centre-based care providers, home care providers, etc.
Penal Code	Refers to the Penal Code 1871.
Perpetrator(s)	Refer to person(s) who have directly or indirectly contributed to the incident(s) of abuse and harassment. These may include clients, their NOK, and visitors.
Personnel-In-Charge	Refers to senior leadership members who oversee clinical operations (e.g. Clinical Directors), staff management, and regulatory compliance in healthcare institutions.
POHA	Refers to the Protection from Harassment Act 2014.

Term	Definition
Reportee(s)	Refers to person(s) who report cases of abuse and harassment to the victim's management, or to the police. This may be the victim, or a third party (including the victim's colleagues or supervisors) familiar with the abuse and harassment incident.
Tripartite Workgroup for the Prevention of Abuse and Harassment of Healthcare Workers (TWG)	Refers to the workgroup set up in April 2022 to develop, coordinate and drive the implementation of strategies and practices to prevent staff abuse and harassment in the healthcare sector.
Staff Protection Function	Refers to the proposed function or functional equivalents overseeing the well-being of healthcare workers at institutional and cluster/group level, by ensuring proper and fair reviews of incident reports and being the final arbiters of abuse and harassment incidents. Also responsible for collecting client feedback and curating a library of training resources.
Victim(s)	Refers to the healthcare worker(s) who have been on the receiving end of abuse and harassment.
Work site	Refers to community care settings which include but are not limited to – community hospitals, nursing homes, hospices, rehabilitation homes, sheltered homes, active ageing centres, dialysis centres, senior care centres, and homes of clients (for home care services).
Zero-Tolerance Policy	Refers to the commitment and adherence towards the principles and processes for reducing and managing instances of abuse and harassment towards healthcare workers, as set out within this guidebook for healthcare institutions. The policy intent is to contribute towards a safe and healthy working environment for all healthcare workers.

TWG Members

S/N	Name	Designation	Organisation
1.	Mdm Rahayu Mahzam	Minister of State, Advisor of TWG	MOH
2.	Mr Vincent Wu	Deputy Secretary, Policy, Co-chair of TWG	MOH
3.	Prof Chua Hong Choon	Chief Executive Officer (KTPH, YCH), Co-chair of TWG	NHG
4.	Mr Derek Tan	Chief, Manpower and Talent Division	AIC
5.	Ms K Thanaletchimi	President	NTUC, HSEU
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