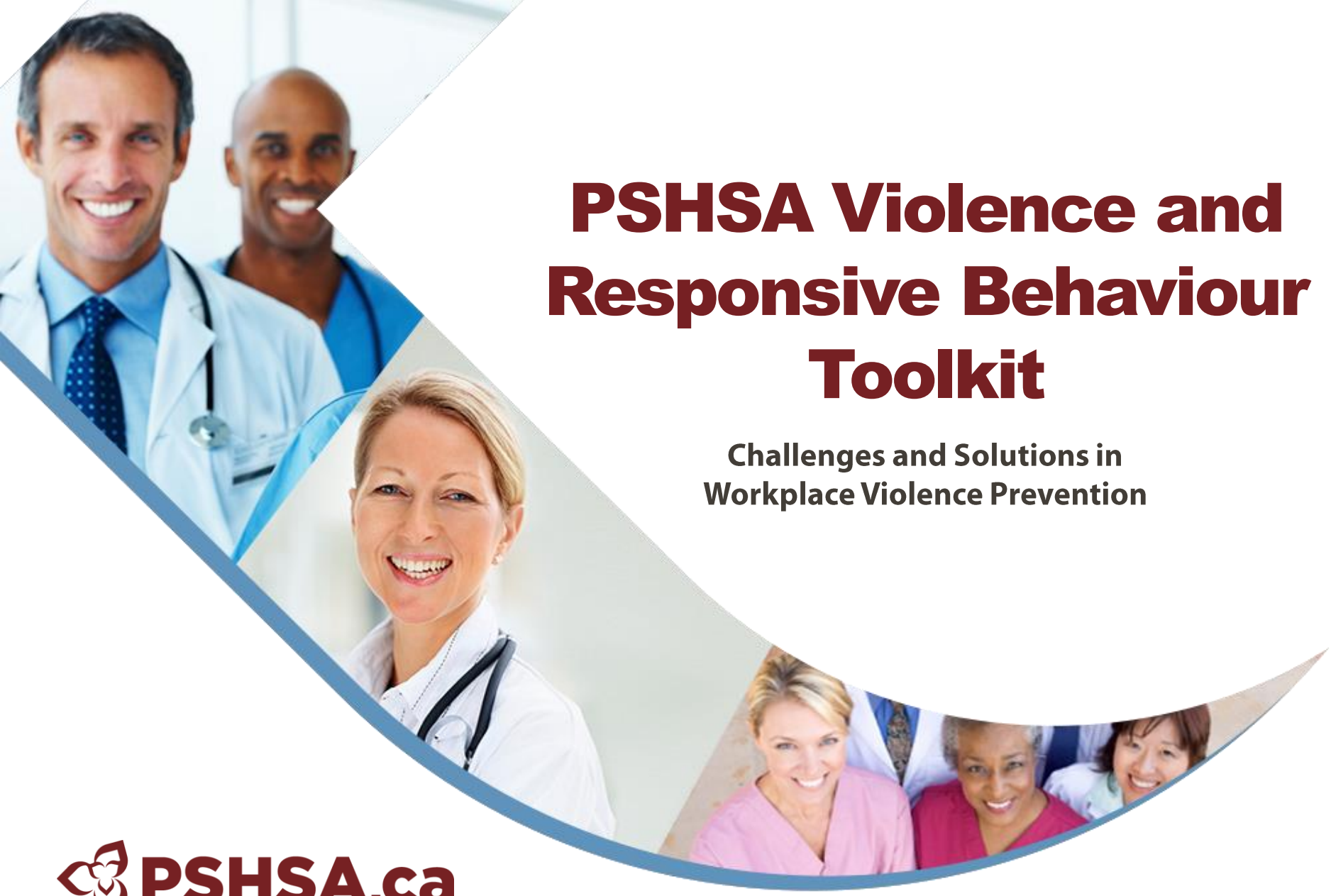


PSHSA Violence and Responsive Behaviour Toolkit

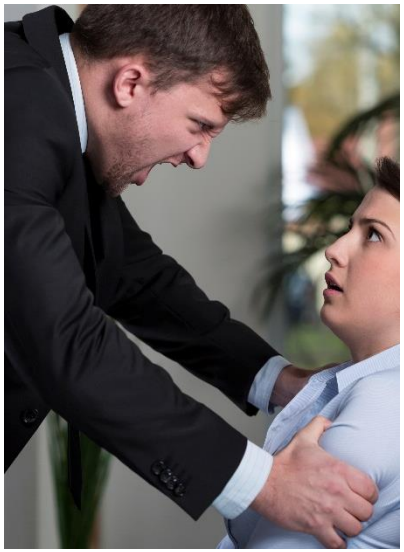
Challenges and Solutions in Workplace Violence Prevention

PSHSA.ca

The Challenge

Workplace violence is *an occupational problem AND a quality of care issue requiring a cohesive, multifaceted system and organizational approach*.

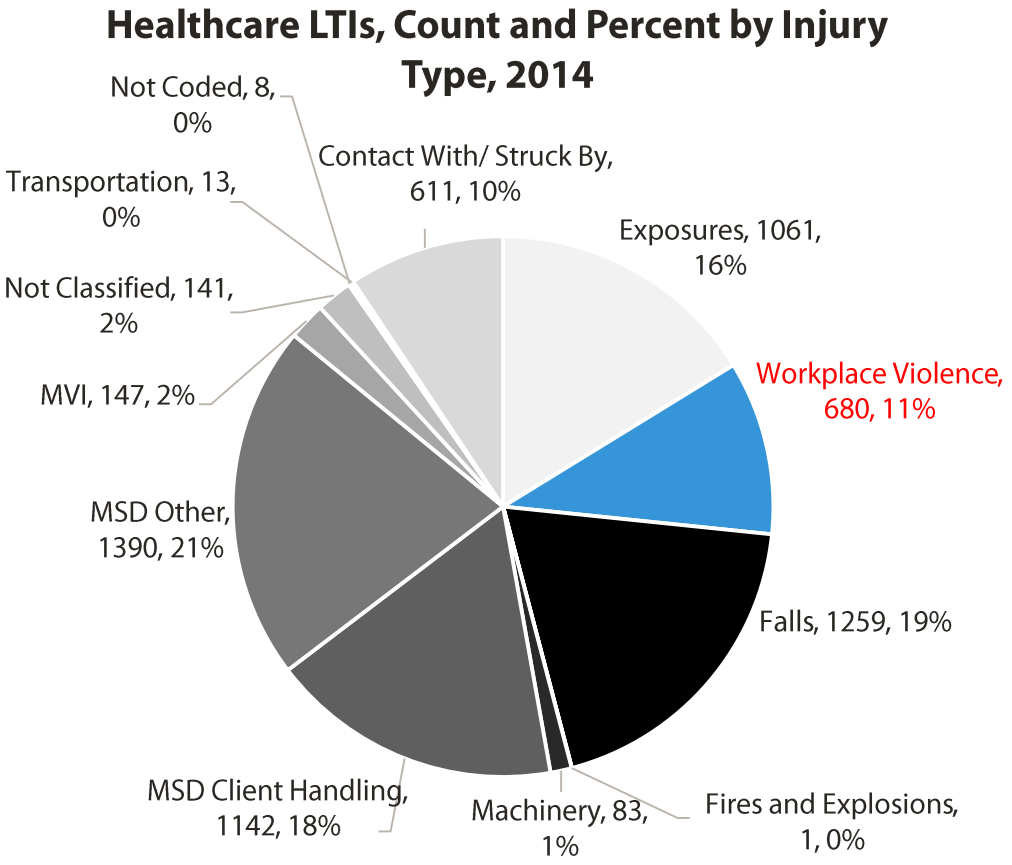
Violence in Healthcare



A Sense of Urgency

Proportion of LTIs by Injury Type, Healthcare

- Workplace Violence currently makes up 11% of Healthcare Lost Time Injuries
- Survey results significantly higher with some reports as high as 34% in the last year
- Reports highest in geriatrics, palliative care, psychiatry, critical care and emergency rooms.



Data source: WSIB EIW Claim Cost Analysis Schema, June 2015 data snapshot.

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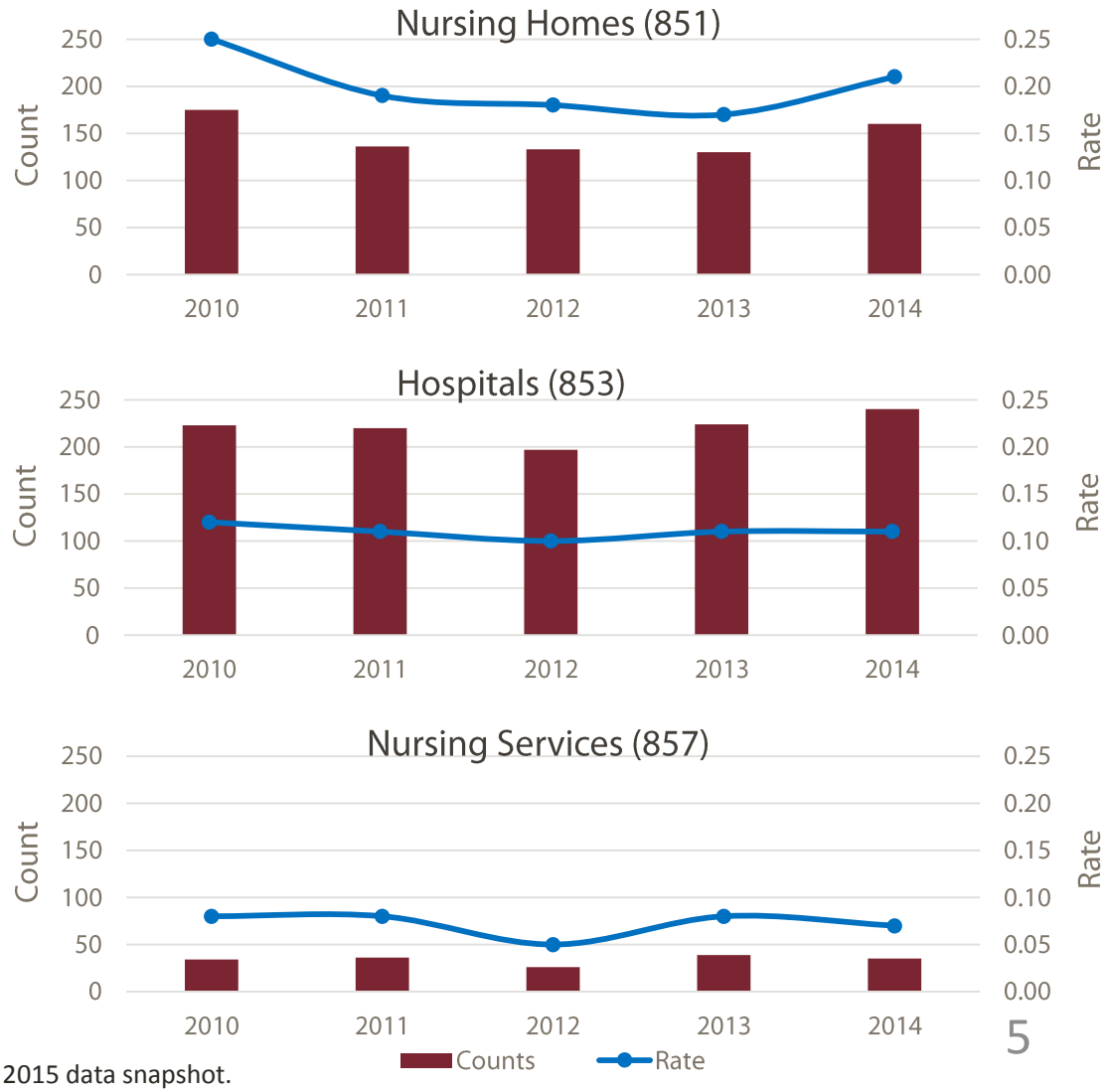
Healthcare Trends

Workplace Violence LTIs Over 5 Years, Specific Rate Groups

- Nursing Services (rate group 857), Nursing Homes (rate group 851) and Hospitals (rate group 853) make up 64% of Workplace Violence Lost Time Injury Counts in Healthcare
- Hospitals and nursing homes have seen recent increases in both LTI rates and counts due to workplace violence.



Data source: WSIB EIW Claim Cost Analysis Schema, June 2015 data snapshot.

Role Perspective

Jobs Reporting the highest # WV in 2014

- In 2014, of the 10 occupations reporting the highest incidents of workplace violence, 4 are healthcare-related.

Occupation	# LTIs	% WV LTIs
Elementary and Secondary School Teacher Assistants	271	15%
Police Officers (Except Commissioned)	259	14%
Nurse Aides and Orderlies	234	13%
Community and Social Service Workers	196	11%
Registered Nurses	148	8%
Correctional Service Officers	141	8%
Elementary School and Kindergarten Teachers	87	5%
Registered Nursing Assistants (RPNs)	82	4%
Bus Drivers and Subway and Other Transit Operators	64	3%
Secondary School Teachers	33	2%
All Others	337	18%
Total	**1,852**	

Healthcare Sector Occupations: 660, or 36% of total.

Data source: WSIB EIW Claim Cost Analysis Schema, June 2015 data snapshot.

Challenges from the Literature

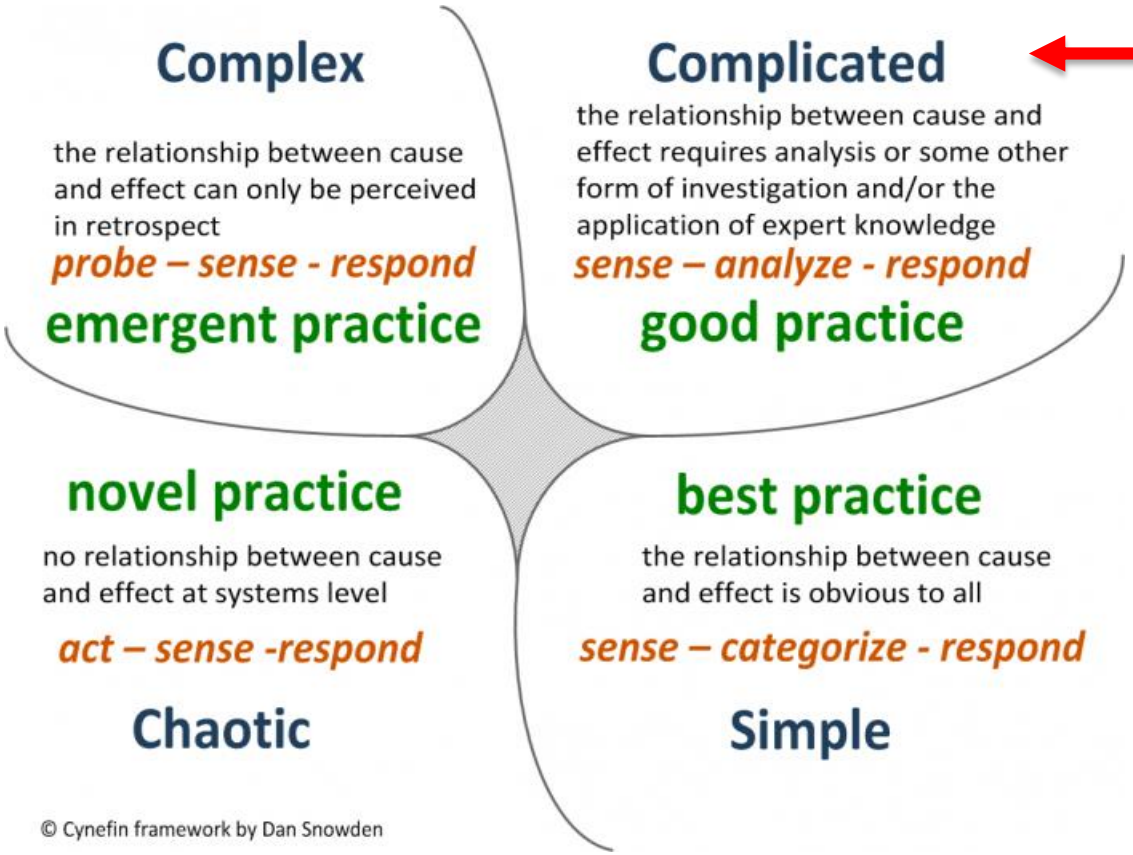
- Workplace Safety Culture (changing the mindset that "workplace violence is part of the job in healthcare")
- Workplace violence prevention and management program varies in content, delivery, and effectiveness, and little empirical knowledge on workplace violence interventions.
- Organization and leadership commitment and buy-in to implement leading practices and tools (all levels of leadership)
- Tools need to be scaled down, user-friendly, and delivered in multi-faceted approach.
- Knowledge translation (KT): must integrate tools into everyday thinking - the day to day processes and everyday work.
- Transfer of care occurs across many healthcare subsectors
- Evaluation, particularly systematic evaluation is key and should be built into every program.

Toolkit parameters

- What did we feel was necessary:
  - Validated
  - Consistent
  - Scalable
  - Consensus-based
  - Easy to use
  - Applicable across sectors

Approach to Workplace Violence Prevention & Management

The Cynefin Framework



We should approach workplace violence prevention and management from a **good practice** approach rather than from a **best practice** approach.

Research & Evaluation

Survey with Experts

Focus Groups with Staff & Managers/Supervisors

Toolkit revisions

- Easy to use?
- Is all relevant information captured?
- If the tool is used what changes do you expect?

- Easy to use?
- Is all relevant information captured?
- If the tool is used what changes do you expect?

- Significant facilitators or barriers to implementation?
- Has identification and control of hazards improved?

Focus Groups with Staff & Managers/Supervisors

Pilot toolkits

Toolkit revisions

Toolkit ready for full implementation and posting on PSHSA website

Institute for Work & Health

The Solution

Collaboration

Bringing people together to deliver proven solutions.

- A collaborative approach to increase knowledge of management of aggression and responsive behaviours, and to develop and deliver effective solutions
- Achieved through engagement of stakeholders and partners across the System and healthcare
- Ultimately, will support System efforts to prevent injuries and illness

Steering Committee

Approach

Phase 1: Discovery	• Engaging stakeholders to understand the challenges, situational context, and opportunities in identified segments • Framing the issue, examining barriers to knowledge transfer, and examining delivery mechanisms	Site Visits Focus Groups Report on Issues / Priorities Identified
Phase 2: Design / Development	• Identifying consensus-based principles and best through review of programs, policies, compliance tools, training curricula, and delivery methods across relevant sub-sectors • Understanding and respecting differences in segments	Communication Plan Consensus-Based Model & Toolkit Pilot Implementation MOL-ROP Submission
Phase 3: Delivery	• Developing an appropriate delivery model across sub-sectors • Working with stakeholders to optimize capacity, improve scalability, and use most effective delivery channels	Education Sessions Implementation at 3 Workplaces Plans: KMb, Research & Evaluation Final Report

Phase 1 Discovery:

- Leading Practices:
  - Therapeutic relationships between clients and health care providers (e.g., BSO)
  - Comprehensive program: development, implementation, and evaluation
  - Orientation, education and training of all workers on core content of workplace violence prevention and management
  - KT interventions tailored to specific barriers for change and partnership with educational institutions
  - Multi-modal approach to education and training delivery
  - Knowledge retention = embed into daily practice through daily 15-minute group huddles, shift change in person, engagement of family members, enforcement of intake admission criteria, peer safety coach, focus on supporting middle managers and promoting team work
  - Application of knowledge to daily practice (e.g., knowledge retention, ability to practice, peer support, safety champion, etc.)
  - Provincial Toolkit for flagging high risk patients to ensure consistency
  - Leveraging already developed resources:
    - DVDs developed by Vancouver Coastal Health that detail all technical aspects of workplace violence prevention and management
    - Cleveland Clinic DVD on customer service

Phase 2- Priority Areas for Workplace Violence

5 Priority Areas for the Toolkit	Additional Priority Areas
▪ Organizational Risk Assessment ▪ Individual Client Risk Assessment ▪ Flagging ▪ Security ▪ Personal Safety Response System	▪ Workplace Violence Related Safety Indicators & Reporting Transparency ▪ Board Governance Leadership ▪ Senior Management Commitment & Leadership ▪ Middle Management/Supervisor Leadership ▪ Joint Health and Safety Committee Engagement ▪ Employees Participating in Change (EPIC) – Participatory Approach ▪ Increase Public Awareness ▪ Develop & Implement Controls (Change Management) ▪ Systematic Approach to Post Incident Follow Up ▪ Knowledge Translation ▪ Comprehensive Training Program for Workplace Violence

Framework

Step 1:

Senior management commitment and employee participation

Step 2: Assessing your program needs

Step 3: Developing the program components

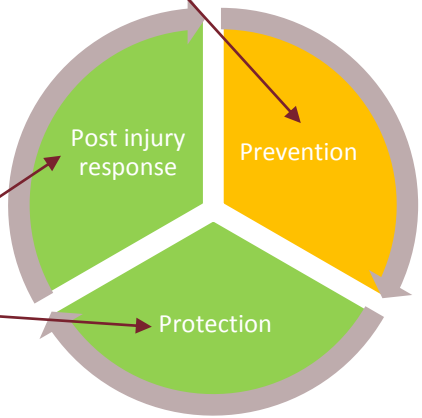
Step 4; Implement the program (marketing, communication and training)

Step 5; Evaluate the program

Risk Assessment Matrix

Probability rating	Impact rating: Catastrophic	Critical	Minor	Negligible
Very likely	High	High	High	Low
Likely	High	High	Moderate	Low
Possible	High	Moderate	Low	Very low
Unlikely	Moderate	Moderate	Low	Very low
Highly unlikely	Low	Low	Low	Very low

BEHAVIOUR	Score 1 for history or if observed	DESCRIPTION
1. History of violence/aggression		History of being physically/verbally aggressive towards a caregiver or another person
2. Confused		Disoriented — e.g. unaware of time, place, or person
3. Irritable		• Easily annoyed or angered • Unable to tolerate the presence of others • Won't follow instructions
4. Boisterous		• Overtly loud or noisy — e.g. slamming doors, shouting when talking, etc.
5. Verbal threats		• Raises voice in an intimidating or threatening way • Shouts angrily, insulting others or swearing • Makes aggressive sounds



PSHSA Priority Areas Completed

Board Governance Leadership

Increase Public Awareness

Board Governance

Public Services Health & Safety Association:
Ontario's #1 health and safety training provider

Visit **pshsa.ca/product/health-and-safety-for-board-members/**

HEALTH & SAFETY FOR BOARD MEMBERS ELEARNING

Corporations, officers and directors are ultimately responsible for compliance with the Occupational Health and Safety Act (OHSA). Beyond this legal obligation workplace health and safety makes good business sense and can affect an organization's bottom line.

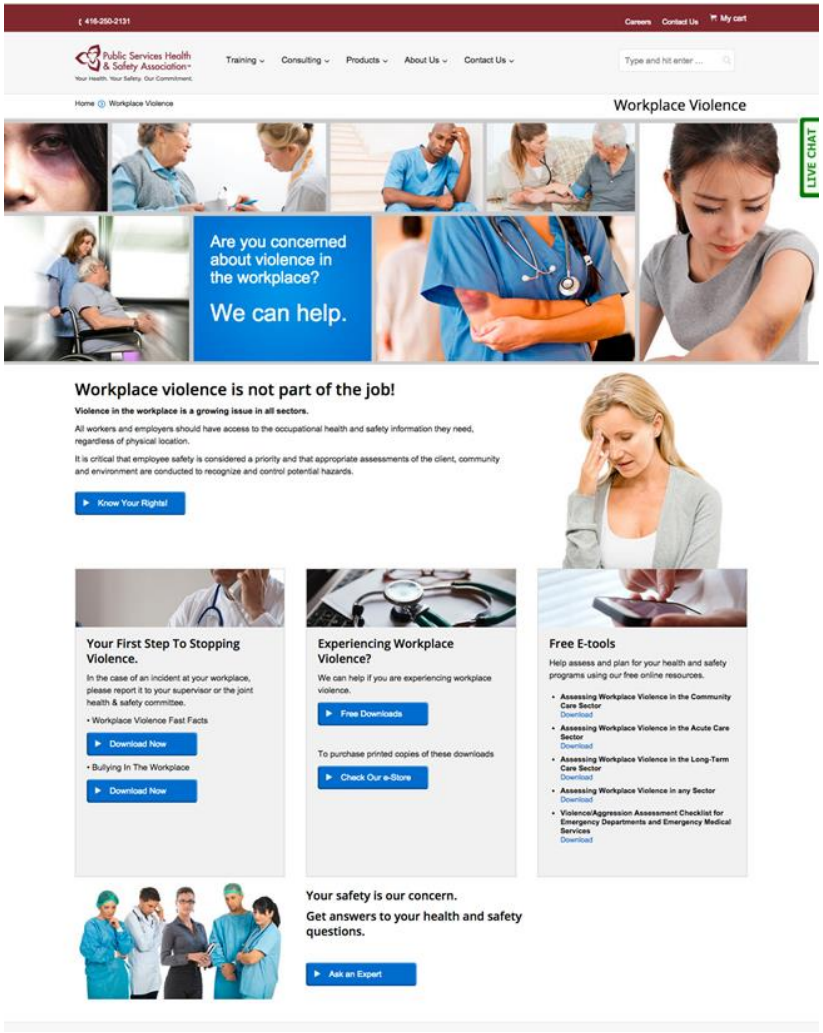
Public Awareness Campaign

- Increase awareness about health and safety issues in Ontario among healthcare workers
- Educate people about PSHSA risk preventive services and measures

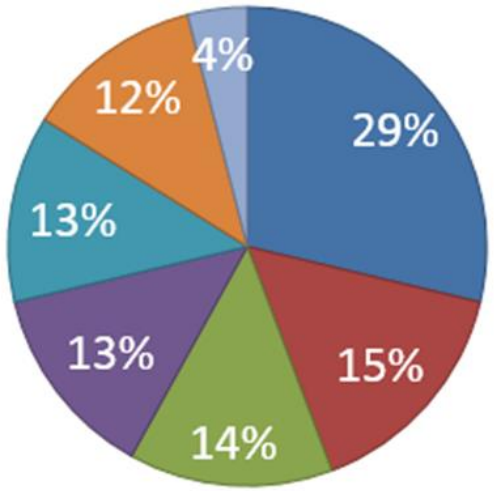
Digital Campaign Type	Targeting Demographics	Metrics
Programmatic Display & Retargeting	• Health care workers • Families of clients	• 2,120,521 Impressions • 7,172 Clicks • 0.34% CTR
Point of Interest(Location Based) / Mobile:	• Hospitals • Medical buildings • Doctors offices • Health care facilities • Treatment and Rehabilitation facilities • Related Points of Interest	• 492,400 Impressions • 2,082 Clicks • 0.42% CTR
LinkedIn	• Health Care Industry - executives • Mid-level management • Supervisors • Medical specialists	• 488,822 Impressions • 972 Clicks • 0.20% CTR

Public Awareness

Public Awareness Campaign



Workplace Violence Web page actions



- Free Downloads
- Start a Live Chat
- Request a Call Back
- Legislation
- Email us Today
- Safety Groups
- Specializing Services

Organizational Risk Assessment

Organizational Risk assessment: Pre Assessment Checklist

JHSC

- Support for effective functioning
- Ensure duties are being met
- Evaluation of effectiveness: **The Centre for Research Expertise in Occupational Disease (CREOD)** Assessment Tool

Culture

- **Institute for Work & Health Organizational Performance Metric** (IWH-OPM)
- PSHSA Climate Assessment Tool

PH&S

- **BizLife Solutions**: Psychological Health and Safety Assessment- Based on CSA Standard for Psychological Health And Safety
- **Workplace Strategies for Mental Health** Questionnaire
- PSHSA Healthy Work Environment Portal

Identify Hazards and Risk Levels

Public Services Health & Safety Association
Your Health. Your Safety. Our Commitment.

Using the Tool

- Review items in the hazard column
- Assign a degree of risk to each category element

Hazard Category 1 – Physical environment risk assessment				
Hazard	**Violence Type**	**Degree of Risk**	**Controls**	**Potential Solutions**
1.1 Arriving/ departing work examples: o Travelling alone to and from work, including using public transit o Public transportation not close to facility o Arriving/departing during off hours (e.g., on-call staff) o Walking into facility via various entrances from street o Building entrances and exits not clearly identified o Doors/windows left unsecured	I, II, III, IV	☐ High ☐ Moderate ☐ Low ☐ Very Low ☐ N/A	1. Safe travel into/ out of/ within/ between buildings	• Explore possibility of public transit made available at main entrance of building. • Maintain outdoor lighting for visibility. • Appropriately identify facility entrances (e.g., staff only, restricted, etc.). • Monitor/inspect design features of entrances and report deficiencies — e.g., lighting, lines of visibility, secured access, etc.
			2. Safe travel practices	• Implement travel-safety guidelines and ensure staff are aware (refer to PSHSA's 'Assessing Violence in the Community: a Handbook for the Workplace'). • Implement a safe-walk program — e.g., buddy system or security/safety escort. • Ensure staff use designated walkways. • Ensure staff use proper / access-controlled entrances / exits — e.g., using coded cards, keys, buzzers, etc. • Consider making other travel arrangements for staff coming in or leaving during off hours.

Determining Risk Level

Risk Assessment Matrix				
	Impact rating			
Probability rating	Catastrophic	Critical	Minor	Negligible
Very likely	High	High	High	Low
Likely	High	High	Moderate	Low
Possible	High	Moderate	Low	Very low
Unlikely	Moderate	Moderate	Low	Very low
Highly unlikely	Low	Low	Low	Very low

Organizational Risk Assessment Scale	
Probability ratings	**Impact ratings**
A – Highly likely B – Likely C – Possible D – Unlikely E – Highly unlikely	Catastrophic — fatality, coma, severe emotional trauma (mental health diagnosis), cannot return to work Critical — severe injury (loss of, or loss of use of limbs, permanent disability), hospitalization, significant emotional trauma (absenteeism or change in work attendance), extended lost time from work (e.g., more than 3 days) Marginal — minor injury (bruises, cuts), moderate emotional trauma (EAP or peer support needed), lost time of less than 3 days Negligible — no injury, minimal emotional trauma (no psychological support required), no lost time from work

Develop and Implement an Action Plan to Control Risk

- Review the controls and solutions Consider if additional controls are required
- Assign responsibility
- Notify appropriate stakeholders
- Determine timeline
- Share results with the JHSC

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Individual Client Risk Assessment

Individual Client Risk Assessment Toolkit

1. Violence Assessment Tool (VAT)
2. Community Violence Assessment Tool (C-VAT)
3. Sample Interventions
4. Sample Policy

VAT: Behaviours Observed

- Complete for all clients at first contact
- Identify observed behaviours
- Add the scores to get a total out of 12

BEHAVIOUR	Score 1 for history or if observed	DESCRIPTION
1. History of violence/aggression		History of being physically/verbally aggressive towards a caregiver or another person
2. Confused		Disoriented — e.g. unaware of time, place, or person
3. Irritable		• Easily annoyed or angered • Unable to tolerate the presence of others • Won't follow instructions
4. Boisterous		• Overtly loud or noisy — e.g. slamming doors, shouting when talking, etc.
5. Verbal threats		• Raises voice in an intimidating or threatening way • Shouts angrily, insulting others or swearing • Makes aggressive sounds

Total behaviour score		

VAT: Risk Rating Scale

- Compare the total behaviour score to the Risk Rating Scale scoring
- Determine risk level as low, moderate or high
- Each level requires specific interventions

SCORE	LEVEL OF RISK	INTERVENTION
0	Low	No intervention required
1-3	Moderate *1 = low moderate* *2 = medium moderate* *3 = high moderate*	
4-5	High	
6 – 12	High/imminent	

Sample Interventions: Acute Care

If the risk of violence is high:

- Add an 'Alert' flag to the client's chart / electronic tracker.
- Contact Security and/or request Security presence.
- Contact police if behaviour escalates — e.g. call 911.
- Notify the charge RN and/or your immediate supervisor.
- Contact support staff if required.
- Initiate a referral to your:
  - department manager
  - security
  - physician
  - geriatric emergency management nurse
  - behaviour management staff
  - psychiatric services
  - all treating staff

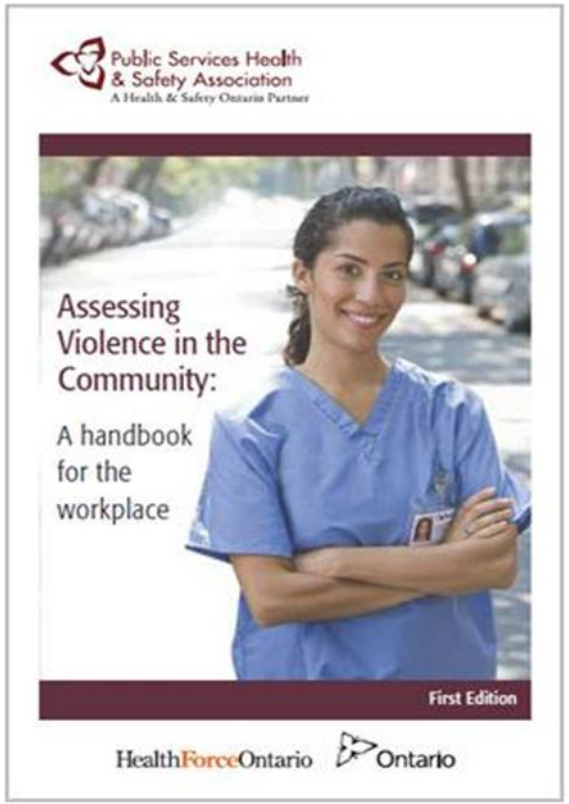
Sample Interventions: Acute Care

If the risk of violence is high(cont'd):

- Triage the client to a seclusion room, or a room with closed circuit surveillance / direct observation from nursing station. Refer to 'Seclusion Room Checklist'.
- Consider the need for restraints (physical and / or chemical) as a last resort.
- Work with your manager or supervisor to adopt a:
  - care plan or violence-behaviour plan
  - personal safety response system — e.g. mobile phone or personal alarm
- Document triggers and interventions, and include the client and / or substitute decision maker only if safe to do so.
- Reassess the client's behaviour according to organizational policies and documented triggers.
- Remain calm and provide frequent reassurance and support.
- Increase staffing under 'High Intensity Funding' or 'Form 1' (specific to long-term care sector).
- Inform the client or substitute decision maker that the client has been flagged.

C-VAT: Step 1 – Pre-Visit Assessment

Section A: Behaviours Observed



BEHAVIOUR	Score 1 for history or if observed	Intervention REFER TO SECTIONS A1–A4 of the COMMUNITY CARE HANDBOOK: *Assessing Violence in the Community*
1. There is a history of violent or aggressive behaviour in the client or in other people in the home.		
2. Firearms or other dangerous weapons are kept in the home.		
3. The client has been threatened recently.		
4. The client is confused and/or disoriented regarding time, place and/or person.		
5. The client is irritable and/or unable to tolerate the presence of others.		Determine if this person(s) will be present during the service visit.

C-VAT: Step 1 – Pre-Visit Assessment

Section B: Contributing Factors

Question	Yes / No	Intervention REFER TO SECTIONS A1–A4 AND E1–E2 OF COMMUNITY CARE HANDBOOK: *Assessing Violence in the Community*
1. Are there triggers associated with the client's violent/aggressive episodes — e.g. when limits are set, or during specific activities/events?		
2. Is there resistance to the visit from either the client or other people in the home?		
3. Does the client have any medical conditions that may predispose them to violent or aggressive behaviour — e.g. head injury, substance abuse, or cognitive impairment?		

C-VAT: Step 2 – Pre-Travel Assessment

Getting there	Yes / No	Intervention REFER TO SECTIONS B1–B3 OF COMMUNITY CARE HANDBOOK: *Assessing Violence in the Community*
1. Have you identified the safest route to get to the client?		
2. Do you know the crime rate for this location?		
3. Does the client know approximately when you are arriving?		
When you arrive	**Yes / No**	**Intervention** **REFER TO SECTIONS C1–C4 OF COMMUNITY CARE HANDBOOK:** *Assessing Violence in the Community*
4. Has the closest and/or safest parking spot been located?		

C-VAT: Step 3 – Client/Home Community Hazard Assessment

Section A: Environmental conditions

Section B: Communication/access

Section C: Behaviours observed

Section D: Contributing factors

Section E: Self-awareness

Sample Interventions: Community Care

If the risk of violence is moderate:

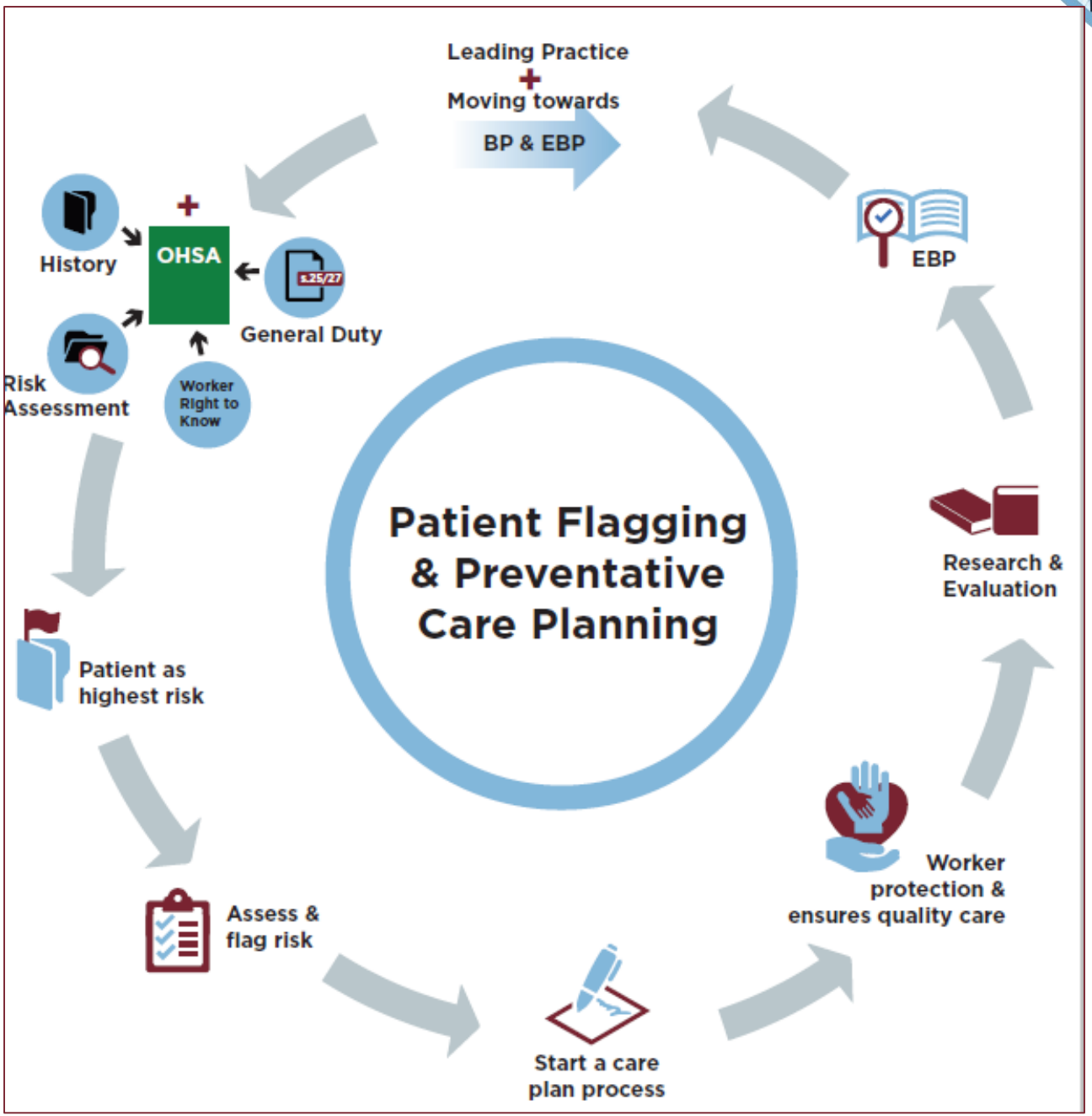
- 'Alert' flag to chart/electronic tracker
- Contact supervisor
- Continue to observe client's behaviour through routine activities and interactions
- Work with manager/supervisor to adopt a:
  - Care plan or violence-behaviour plan
  - Personal safety response system – e.g. mobile phone or personal alarm

Sample Interventions: Community Care

If the risk of violence is high:

- 'Alert' flag to chart/electronic tracker
- Politely end visit if you feel threatened; be prepared to call police
- Inform supervisor/senior management/administrator-on-call of potential risk of violence
- Work with manager/supervisor to adopt a:
  - Care plan or violence-behaviour plan
  - Personal safety response system – e.g. mobile phone or personal alarm
- Re-assess client's behaviour according to organization's policy and documented triggers

FLAGGING


Leading Practice
+
Moving towards
BP & EBP
History
+
OHSA
s.25/27
General Duty
Risk Assessment
Worker Right to Know
EBP
Patient Flagging & Preventative Care Planning
Research & Evaluation
Patient as highest risk
Assess & flag risk
Start a care plan process
Worker protection & ensures quality care

Objectives

- The primary objective of this toolkit is to develop a Flagging Program Handbook for organizations in acute care.
- The secondary objectives are to develop:
  - A sample flagging policy that can be adapted for the acute care setting
  - A question and answer (Q&A) document to help answer privacy concerns related to patient flagging, and to clarify legal requirements under Ontario's Occupational Health and Safety Act
  - A sample information brochure for patients and families

Handbook contents

- Types of flagging
- Flagging legislation: balancing worker safety with patient privacy
- Ten privacy principles
- Five Steps for Developing a Flagging Program
  - Appendix A: Workplace Violence and Health Information Privacy Fact Sheet
  - Appendix B: Sample Flagging Policy
  - Example A: Patient and family / visitor brochure
  - Example B: Flag symbols
  - Example C: Door / unit signage
  - Example D: Flagging algorithm

Flagging Algorithm

Previous violence flag?

(On record)

History of violent behaviour?

(As reported / on record)

Current or potentially violent behaviour from individual client risk assessment?

(As observed)

YES to any...

NO to all...

ACTIVATE FLAG SYSTEM

Enter flags into appropriate systems — e.g., electronic patient record, registration system, patient chart, unit / door signage, and wristband. Establish care-plan and controls for workers.

NO FURTHER ACTION

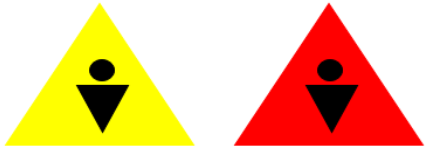
Unless the patient becomes or could become violent during the hospital visit, and as long as a flag is not already initiated, complete the Violence Assessment Tool (VAT) in the Individual Client Risk Assessment.

COMMUNICATE WITH CARE TEAM

Inform team members, Security and support staff of flagged patient, behaviours and triggers.

INFORM PATIENT OR SDM

Provide brochure to patient / SDM and explain why he / she has been flagged as violent. Have Security present if needed.



SECURITY

What is the Purpose of the Security Toolkit?

- Assist organizations establish effective security program
- Increase awareness and understanding of:
  - Security functions
  - Security program elements
  - Training requirements
- Tools to identify security program gaps; develop customized action plan

Nine Security Tools

1. Self-assessment Security Checklist
2. Security Program Gap Analysis & Action Plan
3. Sample Corporate Security Policy Template
4. Security-Related Policies & Procedures List
5. Sample Security Fast Fact Awareness Tool
6. Training Topics for Workers Managers
7. Security Guard Training Program Components and Provider Considerations
8. Sample Security Guard Training Checklist
9. Sample Security Guard Training Program

Who Should Use Checklists?

Multidisciplinary committee or task force:

- Management
- Employees
- JHSC and/or representatives
- Union members
- Existing committee e.g. workplace violence prevention steering committee
- Chair to coordinate and liaise

Establish terms of reference.

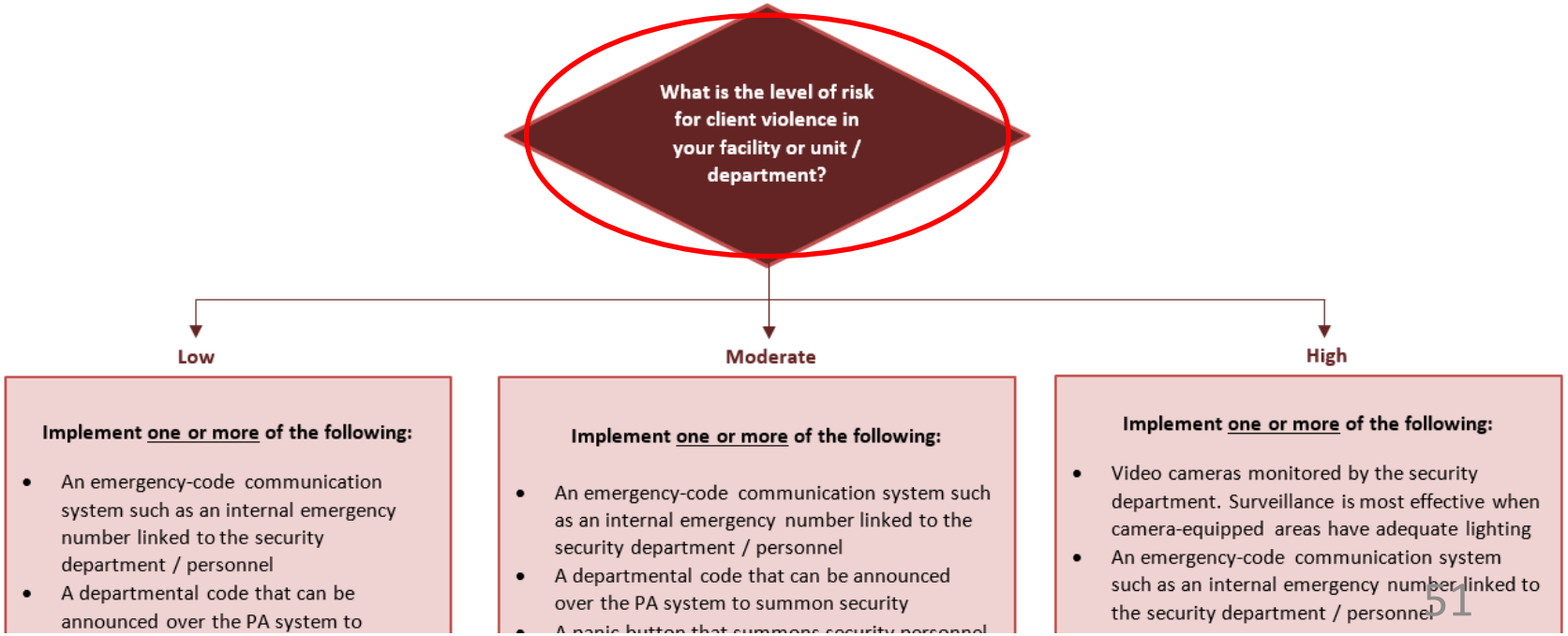
Personal Safety Response System

PSRS Toolkit Components

1. PSRS Decision Guide
2. PSRS Device List
   - Level of risk and client population
   - Sector
   - Purpose of PSRS device
   - Resources
3. PSRS Policy Template
4. PSRS Action Plan Template
5. PSRS Training Guidelines

PSRS Decision Guide

- Sector specific
- Possible risk factors and device/procedure options
- Decision Tree



PSRS Device List

Category	Device	Description	Purpose	Healthcare sector where device is most appropriate	Cost	Technical / infrastructure requirements	Limitations
D, E	**Mobile personal safety device**	This device tracks the location of the phone or tablet (which should be with the user at all times) in real time through use of GPS technology. The GPS is linked to the organization's security department / personnel and / or emergency services such as 911 and police. Once the alarm is activated, the user's location is relayed and emergency protocols are activated. The employee initiates the covert panic alarm by keying a pre-determined numeric code on the phone or tablet touch-screen.	1, 3	• Long-term care / retirement facilities where staff accompany residents beyond the residential facility • Community care	$$$$	• Computer servers integrate with the organization's email and scheduling software • Telecommunications management / services • Warranties • Batteries • Able to track when supplies run low / place orders before running out • Network access (e.g., WiFi, cable, fibre) • Administration management (e.g., device inventory and maintenance, hardware replacement) Providers: Rogers, Bell, Wind, AT&T, Telus, Fido	• Can be difficult to synchronize software and hardware installation with computer servers • Requires adequate staffing and collaboration among several programs / departments such as Maintenance, Distribution Logistics, IT, and Security • Requires additional planning in order to link with municipal emergency services • High cost

PSRS Action Plan Template

- Keep track of PSRS implementation progress
- Complete after an organizational risk assessment
- Can implement different PSRS devices in different units/departments, or same device throughout the facility

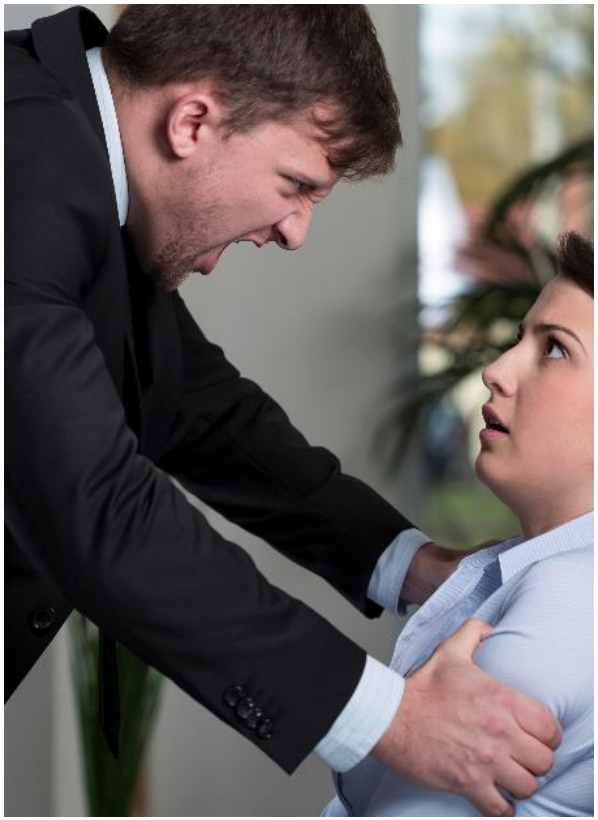
PSRS procedure or device option	Resources	Limitations	Rationale	Person(s) / group(s) responsible for overseeing set-up and maintenance	Anticipated start and end dates of set-up	Staff requiring training	Staff trainer	Anticipated training start and end dates	Anticipated PSRS start date
#1:									
#2:									
#3:									
Etc.									

Unit / Department / Entire site (Identify the unit / dept, or whether the PSRS will be implemented throughout the facility):	_____
Level of risk as determined by an organizational risk assessment (circle one):	low / moderate / high

PSRS Training Guidelines

- Evidence-based and practice-informed tips
- Read through tool in full to understand gaps and considerations in place in your organization
- Sections:
  - Objectives
  - Important considerations
  - Training content & methods
  - Evaluation
  - Timing

Preventing Violence in Healthcare

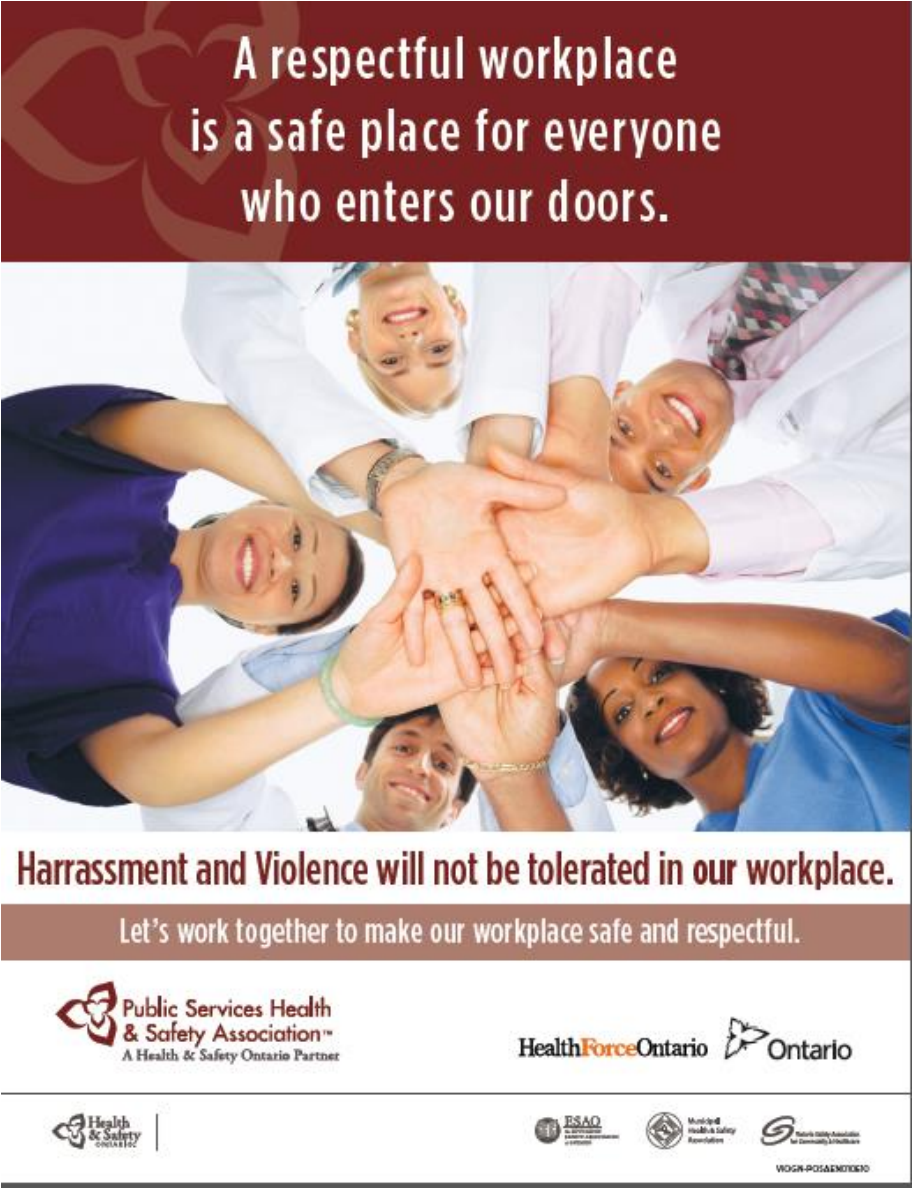


Tips/ Lessons Learned

- Collaborate
- Engage Stakeholders
- Pilot and Elicit Feedback
- Revise
- Maintain Adaptability

Next Steps for Ontario

- Improve usability of the tools
- Enhance Knowledge Translation
- Joint Ministry Workplace Violence Leadership Table and Working Groups
  - Leadership and Accountability
  - Hazard Awareness and Control
  - Communication and Knowledge Translation
  - Indicators and Reporting



QUESTIONS?

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Public Services Health & Safety Association™

Your Health. Your Safety. Our Commitment.

Thank you!

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