Safety Chat Guidebook: A Risk Assessment Component

Developed by the Provincial Violence Prevention Steering Committee's Violence Prevention Advisory Group

OHSAH

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Introduction to BC's Provincial Violence Prevention Steering Committee

The healthcare sector is only 10% of the provincial workforce, but 40% of all province-wide WorkSafeBC claims due to "violence" arise out of the healthcare sub-sector. To address this issue, the Provincial Violence Prevention Steering Committee (PVPSC) was created with the support of BC's Healthcare stakeholders:

- Ministry of Health
- Nursing Policy Management Committee
- Health Employers Association of BC
- Healthcare Unions
- BC Health Authorities
- Affiliate Healthcare Employers

The PVPSC is coordinated by the Occupational Health and Safety Agency for Healthcare in BC (OHSAH). The PVPSC's purpose is to develop and oversee implementation of a comprehensive, cohesive, and effective provincial violence prevention strategy for healthcare worksites in BC. The PVPSC will work cooperatively with the Regional Violence Prevention Committees (RVPCs) to identify and promote examples of best practice in violence prevention.

For more information about the PVPSC, please visit http://www.ohsah.bc.ca/pvpsc.

In many healthcare workplaces, violent behaviour that is not intentional due to illness/injury is not reported because it is not recognized as "violence." The PVPSC definition of violence (in box at right) includes intentional or unintentional behaviour, regardless of illness/injury. It also includes behaviour that is often called "*aggression*".

PVPSC Definition of Violence

Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, well-being or health.

Background of the Safety Chat Guidebook

The safety chat process outlined in this guidebook was conceived by the PVPSC's Violence Prevention Advisory Group in the summer of 2008. The process was piloted and further refined in the fall of 2008 at Penticton Regional Hospital, where it was successfully undertaken as part of a comprehensive Violence Prevention Program. For more information about the safety chat pilot, please go to Appendices A, B and C. The guidebook was further evaluated during the PVPSC Violence Prevention Stakeholder Workshop which was held on February 11- 12, 2009. Workshop participants were given the opportunity to practice the safety chat process and were asked for their feedback, which was subsequently incorporated into the current document. If you have comments or suggestions for the Safety Chat Guidebook, please contact OHSAH.

Risk Assessment

> ***Risk Assessment in the Occupational Health and Safety Regulation***
>
> **4.28 Risk assessment**
>
> (1) A risk assessment must be performed in any workplace in which a risk of injury to workers from violence arising out of their employment may be present.
>
> (2) The risk assessment must include the consideration of
>
> (a) previous experience in that workplace,
>
> (b) occupational experience in similar workplaces, and
>
> (c) the location and circumstances in which work will take place.

Under the current Occupational Health and Safety (OHS) Regulation, employers are required to conduct risk assessments if there is a risk of injury to workers as a result of violence in the workplace. Please refer to the box on the right for the detailed regulation.

Based on the "Elements of a Best Practice Violence Prevention Program for BC Healthcare" document which was developed by the PVPSC, a comprehensive violence risk assessment should consist of the following components:

a) **Staff survey**: Identifies the hazards and risks of violence that staff are experiencing.
b) **Environmental survey**: Identifies hazards and the risk of violence in the work environment (e.g., access/egress, lighting, visibility, communication, weapons of opportunity, etc.).
c) **Occupational job task analysis**: Identifies occupational tasks where violence could put staff at risk.
d) **Risk factors identification**: Identifies and collects risk factors listed above.
e) **Review of worksite history**: Information collected that may be reviewed includes:

- WorkSafeBC claims related to violence (both time loss and non-time loss)
- Incident investigation reports for incidents related to violence
- Client risk assessments - a client's history of violent behaviour (or their family/acquaintance) and their triggers for violence (e.g., Alert Tool)
- First aid records
- Previous risk assessments (if any)
- Current policies and procedures and other control measures in place to eliminate or reduce risks of violence.

This guidebook focuses on the use of "safety chats" as a risk assessment tool. **Safety chats** are interviews with workers in high-priority departments to identify current practices/controls surrounding violence and opportunities to improve them. Safety chats should be used to complement the risk assessment components listed above and **do not replace** a comprehensive risk assessment which would include a review of worksite history and the work environment.

The safety chats will help with the 'solution development' function of the risk assessment. However, with additional analysis, the information on its own may be able to serve a 'problem identification' function.

The safety chat process described in this document was developed with an acute care focus; however, it contains safety chat questions that are specific to long term care and home and

community care. It is the goal of the PVPSC to revise the safety chat process for long term care and home and community care settings in 2009.

The safety chat risk assessment approach is innovative because it assesses and supports clinical practice, builds local risk assessment capacity, and keeps the process focused on implementing control measures which will reduce risk.

Safety Chat Overview: Fitting into the Violence Prevention Plan

Safety chat: one step in the violence prevention plan

When embarking on the safety chat process, an organization needs to consider how it relates other components of a violence prevention plan; a safety chat and risk assessment is the first of many steps in preventing violence. The safety chat is a valuable part of the risk assessment process that should not be completed as an independent project. It is important to determine how controls that are identified through risk assessment will be implemented and evaluated before starting the safety chat process. A communication plan to share the safety chat results and implementation plan for violence prevention controls should also be developed as part of the safety chat planning process.

Although the specific needs for controls will not be known before completing a risk assessment, it is important to have the following in place:

- A violence prevention plan;
- Organizational support for the violence prevention plan;
- A budget for the violence prevention plan; and
- Human resources allocated for the risk assessment project to act on recommendations and controls from the safety chat.

Safety chat: one part of a risk assessment

In discussions with healthcare workers and OHS professionals, three common challenges to conducting violence risk assessments were identified: 1) traditional risk assessments do not incorporate clinical practice, 2) there are not enough resources to conduct a comprehensive risk assessment, and 3) risk assessments focus on information collection instead of action planning and implementing controls.

The current risk assessment model seems to be general to all worksites, with a main focus on environmental risk factors. However, because violence represents people (particularly patients) as the hazard, OHS controls and practice need to be linked to clinical practice. This is also the best way to optimize safe care of patients and enhance health outcomes for patients and healthcare workers. The Violence Prevention Advisory Group (VPAG), a subcommittee of the PVPSC, has developed an innovative approach to risk assessment that assesses and bolsters clinical practice, builds local risk assessment capacity, and keeps the process focused on implementing control measures which will reduce risk. This risk assessment process makes use of 'safety chats', interviews with workers in high-priority departments to identify current practices/controls surrounding violence and opportunities to improve them.

According to the OHS Regulation and best practice models, an entire facility that presents a risk of injury due to violence should have a risk assessment. However, there are many benefits of selecting the higher-risk areas first for a thorough assessment. The high-risk areas have the most to gain from controls, and the risk assessment, recommendations, and implementation can be

completed more quickly when focused efforts are given to these priority areas. The short timeline also allows for faster turnaround and communication to the participating departments, which provides credibility to the risk assessment process and allows the risk assessment team and the organization to gain momentum from the feeling of success. In addition, the controls developed, tested, and successfully used in one area are more likely to be successful in other areas.

Even when dividing a risk assessment into priority areas, it is important to consider the relationships of high risk departments with other departments, and the gaps or 'broken links' in the chain of communication and violence control that may occur between departments or job specialties. Therefore, all departments (those determined by ranking departments based on internal information sources (e.g. code white incidents, WorkSafeBC claims) to be high, medium, and low risk) should incorporate in their risk assessment how they interact with other departments. Once this systematic assessment is complete, the organization should take another look at the whole system of patient flow and violence prevention controls to identify any remaining gaps and coordinate any additional controls or communication processes that may be needed.

Below are the steps in the proposed safety chat risk assessment process:

1) Violence Prevention Project Leader/Occupational Health and Safety (OHS) Specialist develop a violence prevention plan.
2) Violence Prevention Project Leader/OHS Specialist and joint occupational health and safety committee (JOHSC) obtain organizational support for a violence prevention plan, the safety chat, risk assessment, and implementation of violence prevention controls.
3) Planning Phase
    a. Project Leader collects and summarizes internal information. The Project Leader should be an OHS or Workplace Violence Prevention staff member.
    b. Project Leader selects priority areas using internal information and presents to the joint occupational health and safety committee (JOHSC).
    c. JOHSC provides feedback on risk assessment plan and safety chat questions.
    d. JOHSC and Project Leader select worker and manager safety chat leaders, develop a safety chat toolkit and create a plan for the safety chat process.
    e. Project Leader trains safety chat leaders.
4) Safety Chat Phase
    a. Project Leader or safety chat leaders contact department managers to schedule safety chats.
    b. Safety chat leaders conduct safety chats.
5) Information Summarizing Phase
    a. Safety chat responses collected and summarized by Project Leader/safety chat leaders.
    b. Safety chat leaders, Project Leader and JOHSC summarize themes and make recommendations based on Project Leader's safety chat summary.
    c. Safety chat leaders, Project Leader and JOHSC develop on action plan for recommendations.
6) Communications phase

a. JOHSC communicates themes from safety chats and recommendations to participating departments (1-page summary).
b. JOHSC submits written, documented recommendations to employer.
c. JOHSC follows up with employer and communicates control implementation plan to each participating department.

Planning Phase

Involving the JOHSC

Involving the JOHSC in the safety chat process presents a great opportunity to build capacity in a JOHSC and provides the JOHSC with a meaningful project to work on. It is unlikely that the bulk of the work will be carried out by the JOHSC members, but they can be involved throughout a violence risk assessment. Some ideas on violence prevention activities the JOHSC can be involved in include:

1) Developing a working sub-group that focuses on violence prevention. This group may involve non-JOHSC violence prevention experts to act as resources.
2) Obtaining commitment and support from management, OSH stewards, and target departments.
3) Reviewing the target departments and providing information that might not be available in injury reports (since violence is under-reported).
4) Reviewing the safety chat questions and suggesting which additional question bank topics might be included.
5) Communicating the safety chat plan and how it fits into an overall violence prevention plan to the organization/specific departments.
6) Helping to conduct the safety chats.
7) Discuss the gaps identified by the safety chats
8) Developing and submitting recommendations based on safety chats results.
9) Communicating safety chats results back to target departments, along with an action plan for implementing violence control measures.
10) Overseeing the implementation of a violence prevention action plan (via regular updates from OSH team).

Obtaining Organizational Commitment

The risk assessment process is successful when there is organizational commitment to support the process and respond to the results. Organizational support may be obtained by getting the support of the hospital Chief Operating Officer, Community Administrator, and/or the Site Director of Care to support the safety chat process. This is vital to any future process since resources are required to support the time that the JOHSC, Project Leader, workers and safety chat leaders need to carry out safety chats. An example budget for this process can be found in Appendix D.

The Project Leader should initiate communication by informing the facility's managers, union stewards/OHS representatives and JOHSC about the safety chat risk assessment process and what it will require of them and their colleagues. In particular, high priority departments should be

contacted at an early stage to ensure that the process is supported and to allow for any modification to the plan. This can be achieved by sending a one-page description of the safety chat process, goals, and topic areas to target departments to let them know about the project. See Appendix H for a sample 1-page communication.

It is recommended that the Project Leader assist the JOHSC in practicing the safety chats amongst themselves when introducing the safety chat process. This will help build support and enthusiasm for the safety chat process.

Collect and Summarize Existing Internal Information

After obtaining organizational support, the Project Leader should arrange a series of meetings with the JOHSC to discuss the risk assessment process.

Prior to these meetings, the Project Leader should compile and summarize the following:

1) WorkSafeBC Claims related to violence (both time loss and non-time loss). Claims should be assessed based on the incident descriptions and numbers of incidents.
2) Incident Investigation Reports for incidents related to violence.
3) Patient Safety Learning System site trends regarding violent incidents.
    a. A typical client's history of violent behaviour (or their family /acquaintance) and their triggers for violence.
    b. Ways of assessing and communicating patient risk factors/history (e.g. Alert Tool).
4) Security records of code whites, security calls, stand-bys, interactions with police or corrections.
5) Previous Risk Assessments (if any).
6) Current Policies and Procedures and other control measures in place to eliminate or mitigate risks of violence.
7) Training curriculum and training records.
8) JOHSC minutes regarding violence.

Other potential sources of information include: first aid records; OSH/violence program evaluations; previous environmental surveys or site inspections; floor plans, police reports, and maintenance records for repairs or outstanding work orders.

Underreporting of violent incidents should be taken into consideration when assessing internal information sources. In addition to assessing the sources described above, it is recommended that the following individuals be consulted for their knowledge about the risk of violence to workers throughout the organization: the JOHSC, occupational health and safety manager, director of care or someone else in the organization who has knowledge of the facility's work situation.

Select Priority Areas

Prioritizing the highest risk areas can be done using the summarized information on injury and claims rates, violent incident reporting, patient characteristics and the experience of similar worksites. The Project Leader may also ask the JOHSC or OHS workplace representative at the facility to identify high risk areas for violence. Depending on the timelines and resources

available to the team, 2-3 priority departments should be selected by the Project Leader to start with. It should be made clear that the remaining departments will also be assessed on a priority basis, which will occur after the highest risk departments have been assessed and are working on their action plans in conjunction with the employer. A prioritization method and plan needs to be developed and agreed upon by management and workers. A risk assessment prioritization plan should include a timeline for completion in order to enforce accountability, and regular communication of priorities and timelines. Risk prioritization should take place on a regular basis to ensure that changes in risk level or nature of the work are captured in the risk assessment.

Once the high risk areas are identified, the list should be presented to the JOHSC by the Project Leader to discuss how best to communicate and implement the risk assessment process, as well as any modifications to the plan based on the knowledge of JOHSC members. For example, JOHSC members from high-risk departments with poor reporting cultures may have suggestions for other high risk departments.

The following questions may be used to help identify high risk areas:

1) How frequent do different types of violent events (verbal, physical, sexual assault) occur? Note that there is known to be a high degree of underreporting of violent incidents. Violent events include near misses and encounters with weapons of opportunity such as furniture and medical equipment.
    a) How severe are the incidents?
    b) What is the total time loss, or amount of healthcare treatment/first aid required?
2) What are the possible or potential outcomes of violence that may not be directly measured (psychological trauma, distress, overload resulting from time loss and presenteeism, legal or public relations consequences)?
3) Is there a time pattern with frequency differing by time of day, week, or month?
4) Is there a trend of increasing or decreasing frequency over months or years?
5) Is there a geographical pattern with certain areas or departments having more incidents?
6) Is there a pattern with certain job titles, tasks (such as feeding or bathing), or schedules?
7) Can you identify any contributing factors or situations that lead to a violent event? What is the frequency of different contributing factors, and is there a pattern?

This information would be useful in targeting control efforts and developing plans for controls that could be included in the safety chats to gather worker feedback.

Identify Safety Chat Leaders

Designating one team of people (with at least one constant person) to conduct the safety chats will help ensure consistency in questioning and allow for themes and general impressions to be formed. It will also be easier to schedule time for the safety chat leaders if there is only one team to coordinate. **It is recommended that the Project Leader select a 'safety chat team' that consists of one JOHSC worker representative and one management representative that is selected by the JOHSC.** The management representative would ideally be the organization's OHS specialist or violence prevention program manager. Having a bipartite team helps workers feel comfortable giving candid responses. Having management and worker representatives present shows the organization's commitment to the process and underscores the importance of workers' feedback. Department and OHS managers may also find it helpful to attend the safety

chats to get an idea of how controls are working in direct care practice. However, to allow the best chance to get a candid response, supervisors should not conduct safety chats in their own departments. Having managers/supervisors hear experiences and solutions from other departments through the safety chat process can have the added benefit of 'cross-pollinating' ideas within the organization.

The safety chat leaders should have the following qualities:

1) Clinical knowledge and experience – at least one leader should have the clinical experience to be able to interpret the responses form workers on clinical practice and controls.
2) Knowledge of OHS principles – the worker and manager representative should have knowledge of OHS principles. Ideally the manager representative would be the violence prevention program manager.
3) Aptitude for interpersonal communication – safety chat leaders should have good active listening skills and the respect of their peers/workers in the department. They should also be advocates for violence prevention interventions.
4) Neutral - safety chat leaders should be objective and should not be from the target departments, as this might limit candid responses from workers.
5) Well-developed note-taking skills.
6) Genuine interest in the topic and a desire to make workplaces safer.

Prepare the Safety Chat Leaders

Training for safety chat leaders is minimal; safety chat leaders can meet with the Project Leader for approximately an hour to go over the safety chat process and the interview questions, with an emphasis on getting information without leading or prompting. If comfortable with the process, safety chat leaders may be able to conduct interviews after having the safety chat questions emailed to them with a brief introduction and opportunity to ask questions over the phone with the Project Leader.

Safety chat leaders should be provided with a 'toolbox' of organization resources for immediate intervention when conducting safety chats. Examples of what could be included in a safety chat resource toolbox include:

- An action plan for situations where a worker is triggered by the discussion and needs support or debriefing;
- A behavioural specialist referral for a problem patient; and
- Copies or explanation of the organization's policies, for example, the protocol for managing family/visitor expectations

The safety chat resource tool box should be assembled by the JOSHC and Project Leader during the planning stage before undertaking the safety chats. The Project Leader should also go through the materials in the toolbox with the safety chat leaders as part of their training.

Develop a Plan for Summarizing Safety Chat Responses

The plan for reviewing and analyzing the information collected from the safety chats should be developed by the Project Leader, JOHSC and safety chat leaders before safety chat interviews are conducted. Deciding on the process for summarizing safety chat responses is particularly

important because the role of the Project Leader, JOHSC, safety chat leaders and/or other human resources in the information summarizing process will vary depending on the selected method.

For more information on the different options for summarizing safety chat results, please refer to the section on Summarizing Safety Chat Responses.

Information Collection Phase

Scheduling with Priority Departments

The safety chat leaders, Project Leader, or the JOHSC will need to contact the managers of high-priority departments to coordinate an interview time. The 'best time' may vary between departments; safety chats in the morning may be better for the Emergency Department whereas safety chats in the afternoon may be better for most other departments. The safety chat leaders or Project Leader should confirm with the priority department managers that the scheduled interview times will not exclude workers from some shifts.

The safety chats require approximately 20 to 30 minutes for each of worker and manager safety chat leaders to conduct a safety chat with one individual. However, there is variation in how much detail workers give in response to each question. If there is not sufficient time, a chat leader could provide a contact card or number to the interviewee in case they want to add more information.

Conducting safety chats may be conducted using different methods e.g. with focus groups, pairs of workers etc.; however, it is recommended that safety chats be conducted with one worker at a time because it may be the most efficient and will provide each worker with the opportunity to express their opinion. This may involve the need to schedule one replacement 'float' worker to rotate through and replace a department's workers. In departments where a float cannot be obtained, it may be difficult to free workers for an interview therefore safety chat leaders need to be flexible when scheduling safety chat interview times with workers.

Selecting Interviewees

In the best practice risk assessment model, it is ideal to get input from ALL staff members, especially in a smaller organization. A paper survey can still be used to collect information from each person, but better quality information and more suggestions are likely to be collected from the safety chats. The tradeoff is that the safety chats take more time, both for the leader and the participants, and so are more expensive. For this reason, the safety chats will capture fewer people than a paper survey.

In general, one would aim to conduct safety chats with about 25 workers to capture the range of experience in a facility. It may be possible to collect enough information from less than 25 workers at smaller facilities or in situations where response to violent incidents is systematic within or between units. In situations where the response to violent incidents in a facility is very inconsistent, it is recommended that more safety chats are conducted with more workers.

Since staff experiences are dependent on a variety of factors, it is best to conduct safety chats with as many workers as possible. The manager of a department should also be interviewed; this interview may occur first as part of the 'gaining support' phase. Information gathered from the safety chat with the department manager may also be used to inform the selection of safety chat questions for the department.

It is recommended that clinical and support staff be included in the safety chat (support staff may need an abbreviated list of questions), as well as visiting staff from other departments, such as phlebotomists or porters, and staff that work on different shifts. To make the safety chat process as efficient as possible, workers can be selected based on whoever is working in a department during the scheduled time, and whomever is at a natural break in their work when the chat leaders are ready for the next interview. It is best to have selection be as objective as possible (the next person into the nursing station) rather than have the department supervisor select the interviewees.

Safety Chat Content

The safety chat questions have been designed with worker and manager input to avoid 'leading' workers to a socially desirable answer. The questions are also framed to ask about a worker's unit rather than the worker themselves, and it should be clear in the introduction to the safety chat that the interview is about typical practice of a unit to help develop interventions - it is not evaluating the practice or behaviour of individual workers

The safety chat questions in this document are focused on identifying risks to healthcare staff that result from violent patients and potential solutions to reduce the risks. Safety chat questions beyond the core list of questions may be added to focus on risks that are specific to a unit and/or care setting, or to investigate risks identified during the facility risk prioritization process. These questions can be taken from the additional question bank in Appendix E or developed in conjunction with the local JOHSC. It is recommended that all risks identified during the risk prioritization process be incorporated into the safety chat questions.

The safety chat preamble, core safety chat questions, additional questions, and guide with tips for interviewers are found in Appendix E.

Information Summarizing Phase

Summarizing Safety Chat Responses

The method for reviewing and analyzing the information collected from the safety chats should be determined in advance to help develop timelines and insure it is adequately resourced. There are multiple options for summarizing safety chat responses, depending on the time and resources available. Methods of summarizing responses could range from detailed to more general processes, including:

- Combing through all feedback for quotes and safety chat themes;
- Discussing general impressions of safety chat themes;
- Summarizing all worker input into the top two or three areas of need to act upon.

The main goal is to identify the gaps between what is being done and what controls are needed for violence prevention. The information gathered from the safety chats will form the basis of an action plan for selecting and implementing violence prevention controls, therefore any method that achieves that goal is a good one.

The process of identifying gaps and forming recommendations may be started by answering the following questions:

1) Are there currently clinical practices or other controls which help control the risk for violence?
2) Are these clinical practices and other controls adequate?
3) Where are the gaps between current violence prevention practices and controls that are needed?
4) Which gaps pose the highest risk to staff?
   Risk prioritization should involve consideration of the frequency of the risk, the likelihood of the risk leading to negative outcome, and the severity of the outcome. However, the main purpose of prioritization is to determine the order in which risks are addressed, not to discount risks or to exclude risks that will be targeted by control efforts.

A selection of the options for summarizing safety chat responses are outlined below.

Transcribing themes

Summarizing all the safety chat responses onto a single document can be completed based on paper copies by the Project Leader, clerical or support staff. The compiled information should consist of assembling the typed responses from all the participants under their respective question headings (Please refer to the example in Appendix F). Additional summarizing, such as the number of positive, negative, or neutral responses to a certain question or the main themes related to 'challenges' or 'what works' is best done by the safety chat leaders. Themes could be summarized and presented to the JOHSC along with a list of gaps between violence prevention practices and controls that are needed in each department.

Discussion with safety chat leaders/JOHSC

The safety chat leaders can discuss the themes and topics brought up by the safety chat participants and present them to the JOHSC for discussion. In a larger group, it may be useful for themes, quotes, or topics to be written on post-it notes and reordered, categorized, or prioritized by the group until the key violence prevention issues and potential control measures are selected.

Summary sheet

The safety chat leaders can spend some time after completing safety chats in a department to discuss the main violence prevention concerns and possible control measures. These can be condensed onto a summary sheet (Please refer to the example in Appendix I). The summary sheet can then be forwarded to the JOHSC for comment and development of an action plan and/or recommendations.

Recommending Control Measures

All immediate hazards and any corrective measures that can be addressed immediately should be dealt with immediately, not at the end of the risk assessment. For example, if there is an inventory problem with mechanical restraints, that should be dealt with right away. Copies of requests for violence prevention controls should be sent to the JOHSC for follow up. Changes in work process or clinical practice will be longer-term solutions and will require a more strategic implementation, especially when training is required.

Action planning for controls should be done jointly by the Project Leader, safety chat leaders, and JOHSC to ensure buy-in and to develop the most relevant controls with the best chance of successful implementation. Safety chat leaders should present their results and recommendations to the JOHSC, and the JOHSC can help brainstorm solutions in consultation with the OHS Department if required, either by adding on/modifying the violence prevention program already being planned or by recommending additional interventions.

The JOHSC will need to be involved in the development of an action plan. Although the JOHSC may not be directly carrying out the work, they should oversee the process, provide feedback, and help communicate progress/results. The action plan should include a timeline with short and long term implementation deadlines. The action plan should also identify individuals that are accountable for each task and follow-up dates or evaluation dates. The JOHSC is likely best equipped to help with communicating the plan, promoting and reinforcing new interventions, and reporting how the interventions are being received and what adjustments may need to be made.

The action plan resulting from the safety chat should include sharing violence prevention success stories and solutions discovered during the safety chats throughout the organization. Examples of solutions could be violence prevention procedures which work in one department or informal behaviour management strategies used for specific patients or diagnoses.

Potential controls and interventions should be evaluated based on timelines, feasibility, and suitability of the controls. This information may come from suppliers, trade journals, same-industry worksites, and scientific literature. Controls selection should be based on the hierarchy of controls, where elimination (such as withdrawing service from a violent client or ‘no-go’ alerts) and substitution (such as referring a patient with dementia to a specialist or unit that is equipped to deal with dementia patients) are the preferred control methods. Engineering controls (such as seclusion rooms) and administrative controls (such as working in pairs) are the third and fourth choices respectively. Please note that training, communication of protocol changes, supervision and reinforcement are necessary for the implementation of every control.

Communications Phase

Communications will overlap with all the other phases, but become the most important after department workers, managers, and supervisors have participated in the risk assessment process and there are results to report back to them. Communicating the results and outcomes of the risk assessment is very important in generating buy-in, ensuring adequate resourcing, identifying potential challenges and developing the credibility of the risk assessment process.

Reporting Back to the Participating Departments

It is important to have a communication component when implementing new controls or bringing in new policies for buy-in. It also helps to build trust and credibility in the OHS program and the JOHSC when participating workers get feedback about where their input/suggestions went, what is being done, and on what timeline. Everyone who was involved with the risk assessment should get feedback from the JOHSC and Project Leader for the following questions on the process:

What were the findings?
Which areas have the highest risks, what are the identified risk factors?
What were the identified gaps or opportunities for improvement?
What are the recommended controls?
If the controls require long-term implementation plans, what will be done in the meantime?

This is also a great opportunity to acknowledge the Project Leader and safety chat leaders, thank everyone for their participation, and re-emphasize the organization's commitment and the JOHSC's role in building a safe working environment. Since some worker suggestions from employees could be impracticable; there should be a strategy to acknowledge and thank participants for feedback without committing to implementing everything and still maintain support and enthusiasm for the action plan.

Subsequent communications from the JOHSC should update staff on the progress of implementing controls. Communications can be via newsletter, pay stubs, posters in employee areas, shift-change chats (sometimes called safety huddles), presentations to workers at staff meetings, networking through union stewards or OHS reps, or some combination of these.

Recommendations to Employer

Any controls which cannot be implemented immediately or with existing resources will need to be forwarded by the JOHSC to the employer as a recommendation. Ideally this will include any supplementary materials gathered while researching controls, as well as the action plan outlining timelines and key actors in the process. These recommendations should be documented, signed by both JOHSC co-chairs, and submitted to the employer as an official JOHSC document for response within 21 days.

Safety Chat Final Report

The final report from the Safety Chat Risk Assessment Process should include the following components:

1) A summary of the Safety Chat Risk Assessment Process;
2) A summary of the internal information used to identify the high violence risk areas;
3) A description of the high risk prioritization method and plan;
4) A summary of the results from the safety chats conducted in the priority departments;
5) Recommendations based on the safety chat results;
6) A Violence Prevention Action Plan that outlines:
    - The risks for violence that were identified and where they were identified;

- The underlying causes for violence risks;
- Proposed solutions;
- A timeline for implementing the solutions; and
- Action person(s) that are responsible for carrying out the solutions.

Please refer to Appendix G for the Violence Prevention Action Planning Tool Template that includes an example of how the template could be used.

Adapting the Safety Chat Process

The main goal of the safety chat is to identify gaps in the clinical practice and patient care aspects of violence prevention and collect information on ways the organization can span these gaps. The methods presented in this document have been successful in healthcare-specific settings, but every workplace is different and the methods may need to be adapted to the local situation. Examples of ways to modify the safety chat process include:

- Selecting specific questions to suit the needs of a department;
- Conducting safety chats with the entire staff of a small healthcare facility because of the limited number of staff members;
- Using focus groups or staff meetings instead of one-on-one interviews; and
- Adapting the vocabulary to be more accessible to the worker population.

In summary, this guidebook is intended to be flexible. With professional judgment, input from the JOHSC, and knowledge of your workplace context, the methods in this guidebook can be adapted to best achieve the primary goal: identifying gaps in violence prevention programs.

Appendix A – Penticton Risk Assessment Pilot

The Violence Prevention Advisory Group (VPAG) started working on a novel risk assessment process in the summer of 2008. After several internal drafts, the safety chat process was developed and subsequently piloted at Penticton Regional Hospital (PRH) from September to October 2008 in three high risk departments. The process described in the *Safety Chat Guidebook: A Risk Assessment Component* reflects participant feedback on the challenges, facilitators, and logistics such as time and skill sets required to conduct the risk assessment successfully. An example timeline showing the tasks, participants, and dates for the implementation of a violence intervention program, which includes a risk assessment, is included in Appendix B. It should be noted that the pilot site's recommendations and reporting back phase were not complete at the time this guidebook was written. Pilot site recommendations will be incorporated into the *Safety Chat Guidebook: A Risk Assessment Component* in 2009.

Risk assessment participant response

Feedback on the pilot safety chat process was obtained by interviewing the site managers, safety chat leaders and Project Leader after the safety chat process was complete. The reception to the pilot by the Joint Occupational Health and Safety Committee (JOHSC), site managers and worker participants was neutral-to-positive; this might reflect the overall high-functioning JOHSC, good organizational safety culture, and general cooperation between workers and management.

In the pilot, safety chat questions were reviewed by JOHSC members and managers of participating departments prior to the safety chats, which likely improved JOHSC and manager commitment to completing the risk assessment process. It was suggested that the risk assessment process could be an effective capacity-building exercise for the JOHSC.

Violence prevention training program launch

One of the interesting and unexpected findings from this pilot was the benefit of conducting safety chats during the launch of a violence prevention program. An outline of this program can be found in Appendix C.

One of the previously-identified barriers to effective risk assessments is the 'survey fatigue' experienced by healthcare workers who are continually asked to complete surveys, combined with the perception of a 'black hole' i.e. the perception that no action or feedback will result from participating in the survey. Incorporating the launch of the violence prevention program in the introduction to the safety chat shifted the focus of the risk assessment from 'problem identification' (the most common focus of risk assessment) to 'solution development'. Obtaining worker feedback on what could be done to reduce the risks helps accomplish the intention of a risk assessment: finding ways to control identified hazards.

It was reported by safety chat leaders that workers who participated in the safety chats expressed feeling empowered by being asked about how improvements might be made to reduce the risk of violence. Workers were also excited around how the safety chats could be used to evaluate the programs being implemented. Overall, it was considered a benefit to have the planning and

communication for preventative interventions take place at the same time as the risk assessment safety chats, and this process is recommended for the future.

Safety chat process

Overall, the safety chat component of the risk assessment was considered to be important, especially for the solution development aspect of the risk assessment process. This is due in part to the amount of in-depth, specific information gathered during the safety chats; it is not feasible to get this type of information with written surveys or hazard checklists. The safety chats also represented a good use of resources; the process was fairly quick and straight-forward, and once scheduled, safety chats were conducted with a minimum amount of training or intervention from the Project Leader. The simplicity of the questions, informal nature of the safety chats and emphasis on identifying solutions made it easy for the JOHSC member and manager to conduct the safety chats quickly and efficiently.

Safety chats were conducted by a JOHSC member and a manager; this process was seen as good practice because workers viewed the participation of the manager in the risk assessment process as the organization's commitment to preventing violence. Managers also learned more about how workers practiced violence prevention measures in their unit during the safety chat process. The comfort of workers and candidness of their responses did not appear to be negatively impacted by the presence of the manager, possibly because a JOHSC members also there. The participation of a worker representative is strongly supported by the pilot results; joint interviewing underscored the organization's joint, cooperative approach to violence prevention. A worker representative from the JOHSC seems ideal for this role, although a worker with clinical experience, active listening skills, and training in OHS processes such as investigations could also fill this role.

Safety Chat Budget

The budget in Appendix D is proposed for risk assessment safety chats conducted at a regional hospital with ~130 inpatient beds. Safety chats would be conducted with approximately six workers in each priority department. The included costs are for wage replacement for workers being interviewed and for the safety chat leaders. It should be noted that the cost for summarizing safety chat results and developing recommendations are estimates.

In the PRH pilot risk assessment, the cost of safety chat leaders conducting safety chats, discussing results and forming recommendations was absorbed by leaders' home departments.

Recommendations

Based on the results of the PRH pilot risk assessment, the following recommendations for future risk assessments are proposed:

- JOHSC members should be informed/involved as early as possible about the risk assessment process so that they can support it via feedback and communication;
- Feedback from JOHSC members should be incorporated in the risk assessment/safety chat plans;
- Safety chats should be conducted by a JOHSC worker representative and appropriate manager representative

- Safety chats should be conducted with workers on a one-to-one basis to keep the process informal and flexible;
- Safety chats should focus on obtaining worker feedback on the potential solutions for specific OHS hazards;
- Risk assessments should be conducted while planning for or at the start of an intervention program e.g. training program or patient alerting process.

Appendix B – Example Timeline of a Violence Intervention Program

Interior Health

Hospital A
Violence Intervention Program (VIP)
ACTION PLAN

	Action	Person(s) Responsible	Date
1.	Create an operational framework to support the Violence Intervention Program (VIP).	1.	
	a. Develop VIP Committee Terms of Reference outlining the Committee membership.	a. Workplace Health and Safety (WH&S) Consultant Director of Patient Services Director of Mental Health Services	a. September 30, 2008
	b. Determine the Committee membership.	b. Director of Patient Services Director of Mental Health Services VIP Committee Chair	b. September 30, 2008
	c. Schedule first VIP Committee meeting.	c. VIP Committee Chair	October 6, 2008
	d. Present plan to JOHSC for feedback and develop communication plan	d. Risk Assessment Leader	

	Action	Person(s) Responsible	Date
2.	Communicate VIP Program implementation to site Managers and Staff. a. Provide overview of VIP operational framework to Department Head group.	2. a. WH&S Consultant Director of Patient Services VIP Committee Chair	g. October 6, 2008 (PRH Dept. Head Mtg.)
	b. Send introduction email/volunteer recruitment memo re: VIP program to all hospital staff.	b. VIP Committee Chair Project Assistant	h. October 6, 2008
	c. All Department Heads to communicate VIP implementation to respective staff members and encourage volunteer participation from each area.	c. Hospital Department Heads	i. October 7 – 10, 2008
	d. Final day of applications for Code White Training	d. Project Assistant VIP Committee Chair	a. October 17, 2008
	e. Security Provider and Staff to be apprised of VIP implementation.	e. Manager, Plant and Maintenance	b. October 7 – 10, 2008
	f. Site JOSH Committee to be apprised of VIP implementation.	f. JOSH Committee Liaison	c. October 12, 2008

	Action	Person(s) Responsible	Date
3.	Establish the Hospital Code White Team a. Secure __ Hospital staff members through staff volunteerism and Department Head encouragement and staff discussions. b. Secure __ security personnel to be part of Code White Team. c. Schedule staff and security personnel for Code White three day training sessions.[1]	3. a. Department Heads Staff Volunteers b. Manager, Plant and Maintenance c. VIP Committee Chair Assigned Clerical Support Personnel	a. October 14 – 31, 2008 b. October 14 – 15, 2008 c. November 3 – 6, 2008 November 17 – 20, 2008 December 1 – 4, 2008 December 8 – 11, 2008
4.	Focus one day training for three (3) Hospital units that most frequently have Code Whites (Psychiatry, Emergency and Unit S).	4. Unit Nurse Managers: Manager Psychiatry Manager ER Manager Unit S	November 3 or 6, 2008 November 17 or 20, 2008 December 1 or 4, 2008 December 8 or 11, 2008
5.	Schedule instructors into one day VIP Instructor Training.	5. VIP Instructors	Dates to be determined in January.
6.	Undertake a site risk assessment. a. Conduct site risk assessment using VIP Toolbox Questionnaire on Psychiatry, Emergency and Unit S. b. Compile results of assessment and develop recommendations to be followed up by VIP Committee. c. Meet with OHSAH (Occupational Health and Safety Association of Health Care)	6. a. WH&S Consultant VIP Committee Chair JOSH Rep b. WH&S Consultant VIP Committee Chair c. WH&S Consultant VIP Committee Chair	a. October 20 - 24, 2008 b. October 24, 2008 c. October 28 – 29, 2008
7.	Establish Code White Kits and determine facility placement.	7. a. WH&S Consultant VIP Committee Chair JOSH Representative	a. October 20 - 24, 2008

[1] The first and last day of each session are “day 1” therefore staff can take day 1 one week, and day 2/3 a later week to accommodate their schedules if need be.

	Action	Person(s) Responsible	Date
8.	Unit-based introduction of VIP program. a. Provide each unit with "cheat sheet" for management of the aggressive patient.	8. a. VIP Committee Members Managers	a. October 20 - 31, 2008
9.	Launch new VIP Program	9. VIP Committee	December 15, 2008
10.	Schedule Code White Team technique refresher sessions, quarterly.	10. VIP Committee Instructors	January – April 2009 June – October 2009
11.	VIP physician education sessions.	11. WH&S Consultant VIP Committee Chair Chief of Staff	February - March 2009
12.	Program Evaluation a. VIP trained staff to receive questionnaire three (3) months post-training. b. Interview site managers and administration regarding VIP Program. c. Risk Assessment recommendations reviewed regarding progress and completion. d. Repeat risk assessment on Psychiatry, Emergency and Unit S. e. Code White Report Analysis. f. Evaluation Report Completed. g. Report Summary presented to: - VIP Committee; Site JOSH Committee - Hospital Quality Management Committee h. Report summary presented to Workplace BC and SET	12. a. WH&S Consultant VIP Committee b. WH&S Consultant c. WH&S Consultant VIP Committee Chair d. WH&S Consultant VIP Committee Chair JOSH Representative e. VIP Committee Chair f. WH&S Consultant VIP Committee Chair g. WH&S Consultant VIP Committee Chair JOSH Committee Liaison h. WH&S Consultant	a. March 2009 b. February – March, 2009 c. February 2009 d. February – March, 2009 e. February – March, 2009 f. March 2009 g. April 2009 h. April 2009

Appendix C– Example of a Violence Prevention Program Outline

Objective:
Implement and sustain the Acute Care Regional Hospital Violence Intervention Plan (VIP) Process.

Violence Intervention Program Standard Process

1. Management requirements:
    a. Chief Operating Officer support as developed in a minimum of one face to face meeting with the VIP Coordinator and as documented in either an email or official letter.
    b. Ensure the site Senior Leadership team is provided with an overview of VIP. This can be provided by the VIP Coordinator in a 30-60 minute presentation with the focus being on:
        i. Overview of the program
        ii. Provision of relevant statistics
        iii. Program implementation budget information
        iv. Program annual operational budget
    c. Appoint a site manager responsible for the Code White process specifically to:
        i. Chair the site Code White Committee (a sub-committee of the JOHSC)
        ii. Market Program
        iii. Analyze Code White reports quarterly and provide recommendations to Senior Leadership team and JOHSC
        iv. Update Code White Team Response distribution list annually
        v. Update Code White team retention numbers and subsequent recruitment requirements annually
        vi. Ensure maintenance of Code White kits
    d. Agree to fund the ongoing training requirements as outlined in team training requirements.
    e. Provide training space and equipment (e.g. use of a laptop and projector)
    f. Provide meals/beverages for trainees/instructors attending full training day sessions
    g. Biannual update of the following policy and procedures: (if policy is an established health authority wide policy it will not be a site responsibility)
        i. Site Code White Procedure
        ii. RCMP Liaison Procedure
        iii. Options and protocols for transfer of aggressive patient requirements and procedures (e.g. to Tertiary Psych Units)
        iv. Clinical Practice Guidelines related to patient containment
        v. Post incident debriefing protocols

2. Code White Team Training requirements:
    a. Maintenance of a minimum of 1 Code White Responder / 3 beds + training of all external security personnel

b. Appointment of 2-3 onsite instructors (as identified through initial training implementation process)
c. One day annual Code White refresher training
d. Three day annual Code White member attrition training estimated at 10% of initial #'s trained
e. Annual health authority wide Code White instructor day training (1 instructor / 16 Code White team response members)
f. Code White member technique refresher sessions (1 hour/month) or 4 hours quarterly
g. Code White site instructor time for preparation, formation of Code White report analysis recommendations and provision of technique refresher training (4 hours per month)

3. Care Planning Resources
    a. Availability and communication of Universal Precaution Guidelines for Management of Agitated/Aggressive Behaviour
    b. Availability of health authority resources and contact list for management of Agitated/Aggressive Behavior for these specialized patient populations:
        i. Mental Health Adult Patients
        ii. Geriatric Patients
        iii. Adolescents and Children
        iv. Acquired Brain Injured Patient
    c. Staff education resources on medical legal charting requirements specific to documenting aggressive incidents
    d. Implementation of standard process and documents for charting/care planning

4. Patient containment equipment/process requirements:
    a. Pharmaceutical management
        i. Availability and communication of summary sheet to guide physicians on recommended products and dosages
        ii. Established clinical practice guidelines (CPGs) for safe use
    b. Seclusion room
        i. Availability of rooms meeting seclusion/isolation/quiet room facility design requirements
        ii. Established CPG for safe use
    c. Physical Code White team containment
        i. Code White kits
        ii. Skills maintenance practice sessions
        iii. Safe work procedures (as outlined in Code White Team Response training manual)
    d. Mechanical restraints
        i. Availability of mechanical restraints on each unit location and in Code White kit
        ii. Process to ensure easy access to restraints (e.g. location clearly communicated and inventory reviewed monthly)
        iii. Established CPG for safe use

e. Police liaison
    i. Defined process for calling
    ii. Defined roles and responsibilities of security and police
    iii. Defined legal process for gaining / giving patient information

5. Assessment and Communication of Risk
    a. Addition of the Aggression screening tool to all nursing admission assessment forms
    b. Implementation of the Aggression (AGG) Caution Alert Assessment
    c. Implementation and training of super users (unit managers, weekend/evening supervisors) on application procedures for an electronic Aggression Alert
    d. Availability and implementation of physical AGG alert tools and staff education resources for use of these tools
    e. Availability of the standardized Code White Report form on all units and in the Code White kits

6. Physician/medical management requirements: this will be made available through site Grand rounds and/or via video
    a. Understanding of VIP terms, such as emotional crisis and behavioural emergency
    b. Understanding of Code White Team Response process and containment options
    c. Pharmaceutical management options to control/reduce aggressive behaviour
    d. Understanding of the electronic and physical caution alert process for aggressive patients
    e. Care planning options
    f. Placement options (e.g. referral process to Cognitive Behavioral Unit, external resources etc)
    g. Best practice in management of adult, children/adolescent, and geriatric patients displaying agitated/aggressive behaviour

Appendix D – Example Budget for Safety Chats

This budget is proposed for risk assessment safety chats conducted at a regional hospital with ~130 inpatient beds. Safety chats would be conducted with approximately six workers in each priority department. The included costs are for wage replacement for workers being interviewed and for the safety chat leaders. It should be noted that the cost for summarizing safety chat results and developing recommendations are estimated.

Task	Description	Cost
Float for priority departments	1 float x 4 hours x 3 departments x $40/hour	$480
Safety chat leaders		
Conducting safety chats	2 leaders x 4 hours x 3 departments x $40/hour	$960
Discussing results and form recommendations	2 leaders x 3 hours x $40/hour	$120
Project Leader		
Introduction of safety chat tool to site administrators, communications regarding float time	1 leader x 1.5 hours x $40/hour	$60
Introduction of safety chat tool to JOHSC	1 leader x 1 hour meeting x $40/hour	$40
Training safety chat leader	2 leaders x 1 hour x $40/hour	$80
Summarizing safety chat interviews and developing recommendations	1 leader x 3 hours x $40/hour	$120
Review of results with unit managers	1 leader x 1.5 hours x $40/hour	$60
	TOTAL ESTIMATED COST	$1920

Appendix E - Safety Chat Preamble and Questions

Preamble

Hi, my name is _____(name)

- I am a member of the JOHSC and a _____(job title).
- I work on the _____ Unit/Department.

(Repeat introduction for other Safety Chat Leader)

We are doing a risk assessment to find out about how we can help prevent violence in your department. (OR We will be implementing a new violence prevention program and we would like to get your feedback to develop solutions to decrease the risk of violence on your unit.) The risk assessment involves workers and employers and is being coordinated with your local joint occupational health and safety committee.

Your department was selected to be among the first to have a risk assessment because it has high rates of violent incidents. The organization (JOHSC, violence prevention team, facility name, etc.) wants to identify areas for improvement and needs your feedback on how we're doing, and what we can do to help. We will be asking you some questions about what what's currently being done to prevent violence in your department. We will be grouping your departments' responses together so your individual responses will be anonymous.

The Provincial Violence Prevention Steering Committee defines violence as:

'***Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, well-being or health'***.

During our interview, we want to make it clear that when we ask about violence or violent behaviour, it includes verbal violence (e.g. swearing, making threats), physical incidents (e.g. throwing objects), as well as aggressive behaviour that occurs as a result of a person's illness or injury (e.g. if a person hits someone because they are in pain).

Note: The following section needs to reflect the process and plan that your organization has laid out and committed to. It is important not to elevate expectations if there is not substantial confidence that the goals and timelines will be met.

We will be conducting safety chats until _____(date) and expect to submit the report by _____(date). Depending on what is proposed, we expect that the employer will be involved in implementing controls from _____(date) through to _____(date). Your department will receive a an update on the process by _____(date).

Do you have any questions before we get started?

Safety Chat Questions (Acute Care Focus)

Session information

Date of safety chat: ____/___/___/ Site:_____ Unit: _____
MM/DD/YY

Name of Safety Chat Leader	Position

Participant information

1) What is your Job Title?
2) How long have you been working in your current area?
3) How long have you been working in healthcare?

Survey

Assessing and Communicating Risk

1) How is risk for violence typically assessed in this department? (Prompt if stuck or unclear: What does patient assessment usually look like? Who does it, how, what tool or process is used?)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

Care Planning and Documentation

2) If staff feel a patient has the potential to be violent, what do staff in your department do next to plan how to care for the patient or document information about the patient?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

3) What do staff in your department do to keep safe while caring for violent patients?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

Incident Response

4) If a patient, visitor or family member starts to become violent (e.g. verbally but not physically acting out), what tools/resources/strategies do staff in this department have to deal with this situation? (No prompting)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

5) Let's say a patient, visitor, or family member starts to be physically violent and you feel you, patients and/or other staff are in danger. What tools/resources/strategies do staff in this department have to deal with this situation? What would staff do? (No prompting)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

6) Do staff in your department have the opportunity to transfer an violent patient to a seclusion room if needed? Yes ____ No _____

7) If security is called for assistance, what is the security response like?
    i) How long does it generally take for security to arrive?
    ii) How do they react?
    a) What do staff in this department expect from security when they are called to respond to a violent incident?
    b) How effective or successful do you feel this process is?
    c) Do you have any feedback or suggestions to improve the process?

8) If a Code White is called, what is the response like?
    i) How long does it generally take for a team to assemble?
    ii) How many people generally come?
    iii) Does the response vary during the evening/night/weekend shifts?
    iv) What is the role of the patient's primary care provider during a Code White?
    a) How effective or successful do you feel the Code White process is?
    b) Do you have any feedback or suggestions to improve the Code White process?

9) When (under what circumstances) would staff in this department call the police in addition to or instead of Code White or security?
    a) How effective or successful do you feel this process is?
    b) Do you have any feedback or suggestions to improve this process?

Overall Suggestions

10) What is the one thing which would make the biggest difference to prevent or manage violence in your department?

11) Do you have any other comments or questions about violence prevention?

If you have of any other information you would like to provide later on, please feel free to call/email ____. Here is our contact information [PROVIDE CONTACT INFORMATION FOR ONE OR BOTH SAFETY CHAT LEADERS].

Thank you very much for talking to us today! Your feedback will help us to develop better prevention programs for your facility.

Safety Chat Questions (Residential Care Focus)

Session information

Date of safety chat: ____/___/___/ Site:_____
MM/DD/YY

Name of Safety Chat Leader	Position

Participant information

1) What is your Job Title?
2) How long have you been working in your current area?
3) How long have you been working in healthcare?

Survey

Assessing and Communicating Risk

1) How is risk for violence typically assessed on this unit? (Prompt if stuck or unclear: What does the resident assessment usually look like? Who does it, what tool or process are used?)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

2) On this unit, how is a resident's potential risk of violence usually communicated to:
      i) Other caregivers?
      ii) Support staff (housekeeping, food service, maintenance)?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

Care planning and documentation

3) If staff feel a resident has the potential to be violent, what do staff on this unit do next to plan how to care for the resident or document information about the resident?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

4) What do staff on this unit do to keep safe while caring for residents who are agitated or violent?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

5) On this unit, how do physicians assist in helping staff manage an agitated or violent resident?
   a) Is this helpful?
   b) Do you have any feedback or suggestions to improve the process?

Incident Response

6) If a resident starts to get agitated and is becoming violent (e.g. verbally but not physically acting out), what tools/resources/strategies do staff on this unit have to deal with this situation? (No prompting)
   a) How effective are these tools/resources/strategies?
   b) Do you have any feedback or suggestions to improve the access to or use of these tools/resources/strategies?

7) If a resident starts to physically act out and you feel other residents and staff are in danger, what tools/resources/strategies do staff on this unit have to deal with this situation? What would staff do? (No prompting)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

8) What methods do staff on this unit use to contain a violent resident?
   a) How effective or successful do you feel this process is?
   b) If any tools (e.g. Broda chairs with tray attached) are used,
      i) Are they readily available?
      ii) Who maintains them?
   c) Do you have any feedback or suggestions to improve the process?

9) Do staff on this unit have the opportunity to contain an violent resident in a private or secure room if needed? Yes ____ No _____
   If yes:
      i) Is there a standard process used to monitor the resident?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

10) Is there an incident response process in the facility? Can you call other staff for assistance if a person (e.g. visitor, resident, family member) becomes very violent? If so:
      i) How long does it generally take for a co-worker to arrive?
      ii) How many people generally come?
      iii) Does the response vary during the evening/night/weekend?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve this process?

11) When (under what circumstances) would staff on this unit call the RCMP?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve this process?

Overall Suggestions

12) What is the one thing which would make the biggest difference to prevent or manage resident agitation/violence on this unit?

13) Do you have any other comments or questions about managing / preventing violence on your unit?

If you have of any other information you would like to provide later on, please feel free to call/email ____. Here is our contact information [PROVIDE CONTACT INFORMATION FOR ONE OR BOTH SAFETY CHAT LEADERS].

Thank you very much for talking to us today! Your feedback will help us to develop better prevention programs for your facility.

Safety Chat Questions (Home and Community Care Focus)

Session information

Date of safety chat: ____/___/___/ Site:_____
MM/DD/YY

Name of Safety Chat Leader	Position

Participant information

1) What is your Job Title?
2) How long have you been working in your current area?
3) How long have you been working in healthcare?

Survey

Assessing and Communicating Risk

1) How is the risk for violence typically assessed where you work? (Prompt if stuck or unclear: What does the client assessment usually look like? Who does it, what tool or process do you use?)
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve the process?

2) How is risk of violence communicated (prompt: dogs family area etc) to other caregivers/staff? How do you find out about client's risk for violence?
   a) How effective or successful do you feel this process is?
   b) Do you have any suggestions to improve the process?

Incident Response

3) If staff feel a client situation has the potential to be violent, or discovers that there is a risk of violence at the client's home (guns in the house, client's declining mental state, potentially violent family members), what typically happens?
   a) Are caregivers typically involved in that process?
   b) How effective or successful do you feel this process is?
   c) Do you have any suggestions to improve the process?

4) What would be a typical response from your supervisor if a risk of violence or violent incident is reported?
   a) How effective or successful do you feel this process is?
   b) Do you have any suggestions to improve the process?

5) If a client is known to have a risk of violence, how does that change the client's care plan?
   a) How effective or successful do you feel this process is?
   b) Do you have any suggestions to improve this process?

Incident Response

6) If a client or any other individual in the home starts to become violent (e.g. physically act out), what is your understanding of the organizations policies or procedure to follow?
   a) How effective or successful do you feel this process is?
   b) Do you have any suggestions to improve the process?

7) What type of situation would prompt staff to call the police/RCMP? (or: In what situations would you be instructed to call the police/RCMP)
   a) Do you feel this is appropriate or adequate?

8) Could you think of one thing that would help to keep staff safer from violence?

Bank of Additional Questions

There are several topics that may be relevant to violence prevention in some areas but are not included as core questions in the safety chat. These can be selected by the JOHS committee and the violence prevention project team as appropriate for the care settings receiving the safety chats.

1) Do staff in this department use restraints as a method to keep a patient or others safe? Yes___ No ___
    i) If yes:
    ii) What type of restraints do staff in your department use?
    iii) Can they be found quickly on the unit? Yes__ No__
    iv) Where are they generally stored?
    v) Have staff in this department been trained on the safe application of these restraints?
        1. No _____Yes___ When _____
    vi) When mechanical restraints are used in this department, what does the process look like? (Prompt if unclear on question: who determines they are needed, who gets them and applies them, what kind of follow up is there?)
        (1) Is there a clear process used for monitoring the patient?
        (2) How effective or successful do you feel this process is?
        (3) Do you have any feedback or suggestions to improve this process?

2) What are physical design features that you feel make you safe? i.e. Physical design such as exits and environmental factors such as noise, crowding. The notion here is that the workers in a department know their work area better than an external auditor, so could point out problems that might otherwise get missed.
    a) Do you have any feedback or suggestions on how to make the physical environment in this department safer?

3) What would be the protocol in this department if a patient was discovered to be carrying a weapon (i.e. brought into your department with a concealed weapon?)
    a) How effective or successful do you feel this process is?
    b) Do you have any feedback or suggestions to improve this process?

4) What would be the protocol in this department if a patient, family member, or visitor was holding or threatening others with a weapon?
    a) How effective or successful do you feel this process is?
    b) Do you have any feedback or suggestions to improve this process?

5) If staff (in this department/unit/organization) are working alone or in isolation (i.e. out of view or voice range of co-workers):
    a) What procedures are in place to keep staff safe (e.g. check-in procedure to let others know that you are safe)?
    b) How would staff get help if a patient/client/visitor/family member became violent?

6) Are violent incidents are reported in this department/unit/organization as often as they should be? Why?
   a) What would help? What could we do to increase the reporting rate in this department/unit/organization?

7) Is there departmental or organizational support for violence prevention programs/projects?
   a) Do you have any feedback or suggestions on how to improve support for violence prevention programs/projects?

8) An additional follow-up to any of the questions:
   a) Do staff know where to get the information about [question topic]?
   b) Is there is an interest in your organization to address [question topic]?

9) Have staff in this department/unit had violence prevention education or training?
   a) How long ago/how often?
   b) In training, were staff made aware of your organizations violence prevention process/policy?
   c) Was the violence prevention education/training useful?
   d) Did the training prepare staff for any violence that may occur in this department/unit?
   e) Do you have any feedback or suggestions on how violence prevention education or training can be improved?

10) When someone in this department/unit has experienced a violent incident
   a) Does the amount of support provided meet staff needs?
   b) Were staff offered Critical Incident Stress Debriefing (CISD)?

11) How is the threat of violence from a patient's/co-worker's family members/visitors assessed?
   a) If a risk of a violent visitor is identified, how is this risk communicated to staff?
   b) How does this risk change the care plan or how work is carried out in this unit/department?

12) What would you do if you suspected a co-worker was at risk for targeted violence from a spouse or family member?
   a) Tell me about what is typically done in this situation. What supports are available?
   b) How would staff in this department/unit respond if a worker's spouse or family member came to your department and exhibited violent behaviour?

13) How is risk communicated between departments? For example, when dropping off a patient to radiology or when a physiotherapist visits the department?
   a) How effective or successful do you feel this process is?
   b) Do you have any feedback or suggestions to improve this process?

Minnesota

Guide for Interviewers

In keeping with the need for adaptability and flexibility to meet the safety chat goals, an interviewer may need to expand on the questions to get the information or try different strategies to obtain good responses. Below are a few tips for interviewers.

1) It may take some time to get used to the questions. Practice on your fellow safety chat leaders and the JOSHC before going out the target departments.

2) Sometimes participants answer several questions when they answer the first one. If people answer several questions at once, keep track of what they have answered so participants do not have them repeat themselves.

3) Feel free to re-order the questions if a participant is 'on a roll' with a particular topic – just keep track of which questions have been answered.

4) Sometimes participants don't understand the question the first time. Without leading them to the answer or giving examples, feel free to re-phrase the question to help them understand it.

5) For open-ended questions on potential violence prevention controls (e.g. How is the risk for violence assessed where you work?), it is not appropriate for an interviewer to give examples of potential controls since this would bias the worker's response. The goal is to get the immediate 'top of one's head' instinct response to a situational question rather than find out what particular controls are used.

6) Sometimes participants give short or one word answers. Feel free to ask follow-up questions to get the information that will help identify the gaps. 'Why do you say that?' or 'How so?' or 'Tell me more about ____'. If they say 'It depends', then follow up with 'What does it depend on?' or 'In what situation does that happen?

7) Develop and use active listening skills:
   - Paraphrase without parroting
   - Keep open, interested body language
   - Nod and encourage their responses verbally by saying supporting things such as 'interesting', 'ok', or 'I see' to show that you are engaged.

8) When recording information during the interview:
   - Check with participants to ensure accuracy of recorded information if you are unclear about their response (e.g. Ask participants to paraphrase themselves).
   - If using abbreviations or acronyms, go through the notes after the interview to write the full words to help individuals that will be transcribing/summarizing the results later.

Appendix-F – Example of compiled safety chat responses

Overall Suggestions

13) **What is the one thing which would make the biggest difference to prevent or manage violence on your unit?**

Worker responses:

- *zero tolerance for violence*
- *access control into Emergency Room – 3*
  - *however unsure who would monitor door or video*
  - *access only with swipe card- equipment in place but not used*
  - *doors should be locked 24/7*
- *keep mental health on board as they have made a big difference*
- *more access to psychiatrists*
- *big tough security man dedicated to Emergency Room at night as there is only 3 staff on*

Appendix-G – Violence Prevention Action Planning Tool Template

Identified Issues	Location(s)	Potential Underlying Cause(s)	Recommended Solution(s)	Solution Implementation Timeline	Action Person(s)	Follow-Up Date(s)
Inconsistent violence risk assessment of patients	*Units A, C and D*	*Lack of patient assessment protocol for facility* *Lack of staff training*	*Develop protocol for conducting violence risk assessments on patients with workers, JOHSC and Unit Managers*	*January 5 to January 30, 2009*	*Violence Prevention Program Manager, Unit Managers, JOHSC Violence Prevention Program Manager, JOHSC*	*February 2, 2009*
			Develop training sessions for violence risk assessment protocol	*February 2 to 27, 2009*	*Violence Prevention Program Manager, Unit Managers*	*March 2, 2009*
			Schedule staff for training sessions and hire replacement staff	*March 2 to 6, 2009*	*Unit Managers*	*March 9, 2009*
			Re-evaluate staff on feedback	*April 20, 2009*	*Violence Prevention Program Manager*	*May 1, 2009*

Appendix-H – Pre-chat communication to targeted departments

Safety Chat: coming to a department near you!

(Health authority/organization name) and your facility's management, together with the Joint Health and Safety Committee, are doing a risk assessment to find out about how we can help prevent violence in your department. (**OR** We will be implementing a new violence prevention program and we would like to get your feedback to develop solutions to decrease the risk of violence on your unit.)

Why my department?
Your department was selected to be among the first to be assessed because it has high rates of violent incidents. We want to identify areas of need and we need your feedback on how we're doing, and what we can do to help. To do this, we will be conducting 'safety chats' with workers in these departments.

Definition of violence
'*Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, well-being or health*'

What is a safety chat?
Safety chats are interviews with workers to find out about current practices/controls to prevent violence and ways to improve them. The safety chat is a risk assessment tool that we are using as part of the risk assessment process for (health authority/organization name.

When?
Safety chats have been planned for your department on:

Day, time.

How will this help?
We will be conducting safety chats until _____(date) and expect to submit the report by _____(date). Depending on what is proposed, we expect that the employer will be involved in implementing controls from _____(date) through to _____(date). Your department will receive a an update on the process by _____(date).

Violence Intervention Program Risk Assessment Process for Acute Care

Here are the steps in the proposed risk assessment process:

1) Planning Phase

a) WH&S Consultant and Site VIP Lead collects and summarizes internal information (incident stats, JOHSC reports)
b) Site VIP Lead selects priority areas using internal information and presents to JOHSC
c) JOHSC provides feedback on risk assessment plan
d) JOHSC and Site Lead select worker and manager safety chat interviewers.

2) Safety Chat Phase

a) Site Lead contacts department managers to schedule safety chats. It is ideal to plan for a 4hour block per unit and work around unit needs (e.g. slower periods). It is also recommended to have a float nurse scheduled to backfill interviewees.
b) Safety chat leaders conduct safety chats by selecting random staff on the unit.

3) Information Summarizing Phase

a) Safety chat responses collected and summarized by site lead
b) Site lead and safety chat leaders, in consultation with WH&S – VIP, summarize themes and make recommendations.
c) Safety chat leaders present findings to JOHSC for feedback.
d) JOHSC provides feedback on action plan for recommendations.

4) Communications Phase

a) JOHSC communicates themes from safety chats and recommendations to participating departments (1-page summary).
b) JOHSC submits documented recommendations to employer.
c) JOHSC follows up with employer and communicates control implementation plan to each participating department.

Appendix-I – Gaps and Opportunities: a summary sheet for safety chats

SAFETY CHAT SUMMARY SHEET

Unit/Department/Organization:			
Safety Chat Leaders:		**Date:**	
		Time:	

Safety Chat Key Summary Points	
What violence prevention methods are currently working well?	
Outline the top 5 identified issues raised about violence prevention:	Recommended solutions?

ABOUT THIS DOCUMENT

The Occupational Health and Safety Agency for Healthcare (OHSAH), which operated from 1998-2010, was a precursor to SWITCH BC. Conceived through the Public Sector Accord on Occupational Health and Safety as a response to high rates of workplace injury, illness, and time loss in the health sector, OHSAH was built on the values of bipartite collaboration, evidence-based decision making, and integrated approaches.

This archival research material was created by OHSAH, shared here as archival reference materials, to support ongoing research and development of best practices, and as a thanks to the organization's members who completed the work.

If you have any questions about the materials, please email hello@switchbc.ca or visit www.switchbc.ca