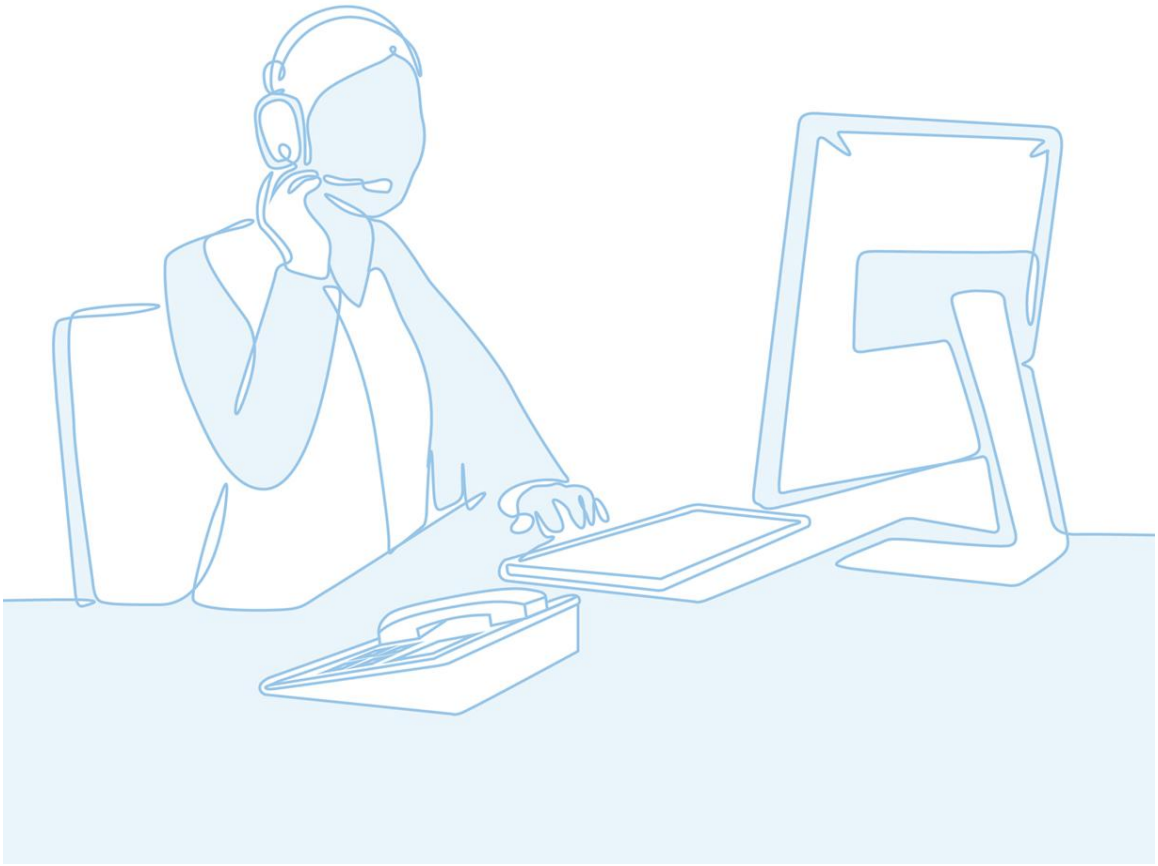
Community Physician Health and Safety Program

Medical Office Staff De-Escalation Pilot:

Outcomes and Key Learnings



SWITCH BC

Safety, Wellbeing, Innovation, Training & Collaboration in Healthcare

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BRITISH COLUMBIA

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Report Summary

New De-Escalation Tools for Medical Office Staff

From February to July 2025, SWITCH BC's Community Physician Health and Safety (CPHS) program conducted a provincewide pilot to introduce new de-escalation tools designed to support Medical Office Staff (MOS) in managing escalating or potentially violent patient interactions. This innovative and unprecedented project focused on supporting workers who are essential to the health, safety, and effectiveness of community medical clinics. Funded by Doctors of BC and the Ministry of Health, through the Physician Health and Safety Agreement, the pilot supports the broader CPHS program goal of developing forward-thinking tools that improve working conditions for community physicians and their staff.

At the heart of the pilot is the HEARD+D tool: a simple, practical framework to guide conversations during escalating situations. HEARD+D stands for Hear, Empathize, Assess, Resolve, Defuse, and Document. Designed for use in both in-person and phone-based interactions, the tools are supported by resources such as quick-reference cards, tip posters, and scenario-based examples - both written and audio - that help medical office staff build practical skills that they can apply in real time.

Methodology

Nineteen MOS across urban, rural, and remote regions of British Columbia piloted the tools in community clinics over four weeks. Weekly digital surveys were used to gather feedback on the tools and assess implementation outcomes such as satisfaction, ease of use and integration, and confidence.

Findings

Feedback was clear: the tools were easy to use. The tools helped staff stay calm and boosted confidence in both de-escalating patients and documenting incidents as part of health and safety procedures. The tools were also seen as being inclusive and adaptable across roles and clinic settings.

Based on direct input from participants, SWITCH BC created more scenario-based examples, a workstation-friendly reference card, and clearer guidance on documentation. The result is a practical, easy-to-implement suite of resources that addresses the urgent need for frontline staff to safely and confidently handle escalating patient interactions. It fills a critical system gap in support tailored for medical office staff. These tools are now available to all MOS across the province through the CPHS web portal.

Recommendations and Next Steps

- **Support adoption** by launching tools on the CPHS portal, along with clear integration resources for clinics. This will be supported by targeted communications to raise awareness and encourage uptake.
- **Build partnerships** by engaging pilot sites and medical office assistant (MOA) networks to support implementation. Continued collaboration with Divisions of Family Practice and the Community Based Specialists Working Group will help bring the tools to MOS already working in clinics.
- **Engage learners** by integrating the tools into MOA post-secondary education programs through collaboration with teaching institutions.
- **Expand reach** through partnerships with health organizations ensuring the tools serve a wide range of care settings.
- **Measure success** through ongoing monitoring of downloads and usage, follow-up surveys with pilot clinics and learners, and feedback from new adopters to guide future development.

The tools provide medical office staff with practical, respectful, and effective strategies to manage escalations, including situations involving violence, along with guidance on documentation to support future health and safety planning and prevention. We look forward to seeing these resources make a meaningful impact on staff wellbeing and support positive patient interactions throughout the community clinics of British Columbia.

1. Introduction

Medical Office Staff (MOS) are increasingly facing challenging patient interactions, often without the tools or training required to respond safely and effectively. These encounters can lead to safety concerns and administrative burdens, which negatively impacts both staff wellbeing and clinic operations. Strengthening skills in patient de-escalation offers a range of benefits to MOS and community-based physicians: it helps reduce stress by boosting confidence in challenging situations, minimizes absenteeism by empowering staff to stay or return to work after difficult encounters, improves staff-patient relationships through calm, clear communication, and reduces the likelihood of patient complaints. It also supports safer, healthier, and more welcoming clinic environments and increases overall efficiency by allowing staff to focus more time on care.

From February 2025 to July 2025, SWITCH BC's Community Physician Health and Safety (CPHS) program conducted a provincewide pilot to develop, test, and evaluate new innovative de-escalation tools designed to support MOS in managing escalated or potentially violent interactions. This project was supported by Doctors of BC and the Ministry of Health and engaged nineteen MOS participants across urban, rural, and remote clinics in British Columbia. Tools tested included the two HEARD+D tools, de-escalation dos and don'ts posters, and scenario-based examples tailored to in-person and on-phone interactions. The evidence-informed and innovative de-escalation tools were developed by SWITCH BC Health and Safety Advisors, and reviewed by SWITCH BC staff, Doctors of BC staff, CPHS Physician Advisors, pilot participants, a representative from the College of Physicians and Surgeons of BC, and the CPHS Oversight Group, including Doctors of BC physician representatives and Ministry of Health representatives. This report summarizes the pilot's methodology, implementation, and outcomes.

2. Pilot Objectives

- **Primary Objective:** To develop, test, and evaluate innovative de-escalation tools designed to support MOS in preventing and managing challenging patient interactions, with the goal of improving staff health, safety, wellbeing, and working conditions in community medical offices**.**

- **Secondary Objective**: Assess implementation outcomes including acceptability, appropriateness, usability, normalization/familiarity, ease of integration, adoption, confidence in de-escalating, and confidence in documenting.

3. Pilot Methodology

Design: Mixed-methods pilot with four weeks of tool usage by two cohorts (in-person or on-phone de-escalation groups), supported by weekly electronic surveys.

Participants: A recruitment form was distributed to MOS across the province via emails to program connections (e.g., Divisions of Family Practice staff, clinic managers, Task Group Physician Advisors). There was high interest in the pilot, 52 MOS responded to the call for participating in the pilot over two weeks. From those interested, 22 MOS across a diverse range of clinic types, regions, and backgrounds were selected using equity and diversity criteria. Participants were assigned to one of two groups: one which tested the tools for in-person de-escalation (*n* = 11) and the other which tested the tools for on-phone de-escalation (*n* =11). All participants were compensated for their time at the current Doctors of BC MOS rates.

Data Collection Tools: Weekly surveys were used to measure all pilot objectives. Weekly log sheets were used by MOS to record use of tools and feedback throughout the week, to help inform survey responses.

Data Analysis: A mixed-methods approach was used: wherein qualitative data was used to inform tool revisions prior to provincial release and descriptive data analysis was performed on remaining survey data to assess implementation outcomes.

4. Pilot Timeline

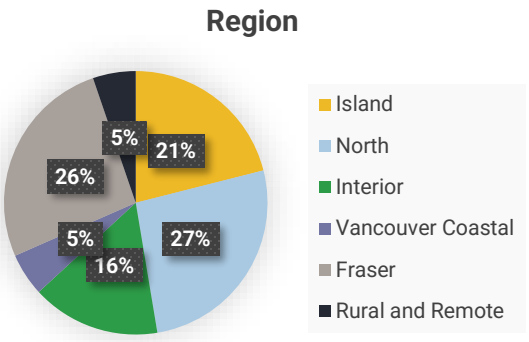
PHASE	TIMELINE	ACTIVITIES
Planning and Preparation	February 2025	• Define objectives and success metrics. • Tool development. • Review tools with Physician Advisors. • Recruit MOS pilot participants.
Pilot Preparation and Training	March 2025	• Create participant manual (provided upon request). • Training of participants via Zoom kick-off meetings. • Finalize tools and supporting materials based on feedback. • Formalize data collection tools.
Pilot Testing (4 weeks)	April 7 – May 2, 2025	• Pilot testing: participants used tools and submitted weekly surveys. • Observe and support as needed.

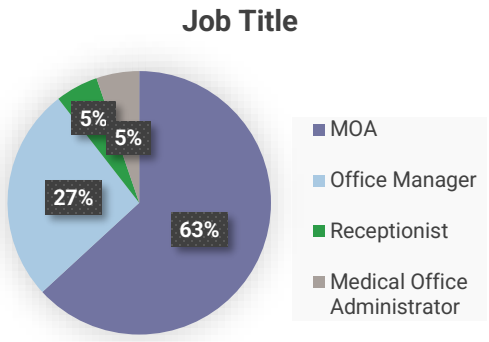
Data Analysis and Revising	May 2025	• Organize and analyze survey data. • Revise tools based on findings. • MOS testimonials. • Communications plan finalized.
Designing and Review	July 2025	• Final revisions to content. • Graphics and layout improvements. • Communications and external partner review and endorsement.
Release, Reporting, and Promotion	July 2025 – August, 2025	• Launch provincially on CPHS web portal. • Draft project report for Oversight Group and external partners. • Targeted and social media communications.

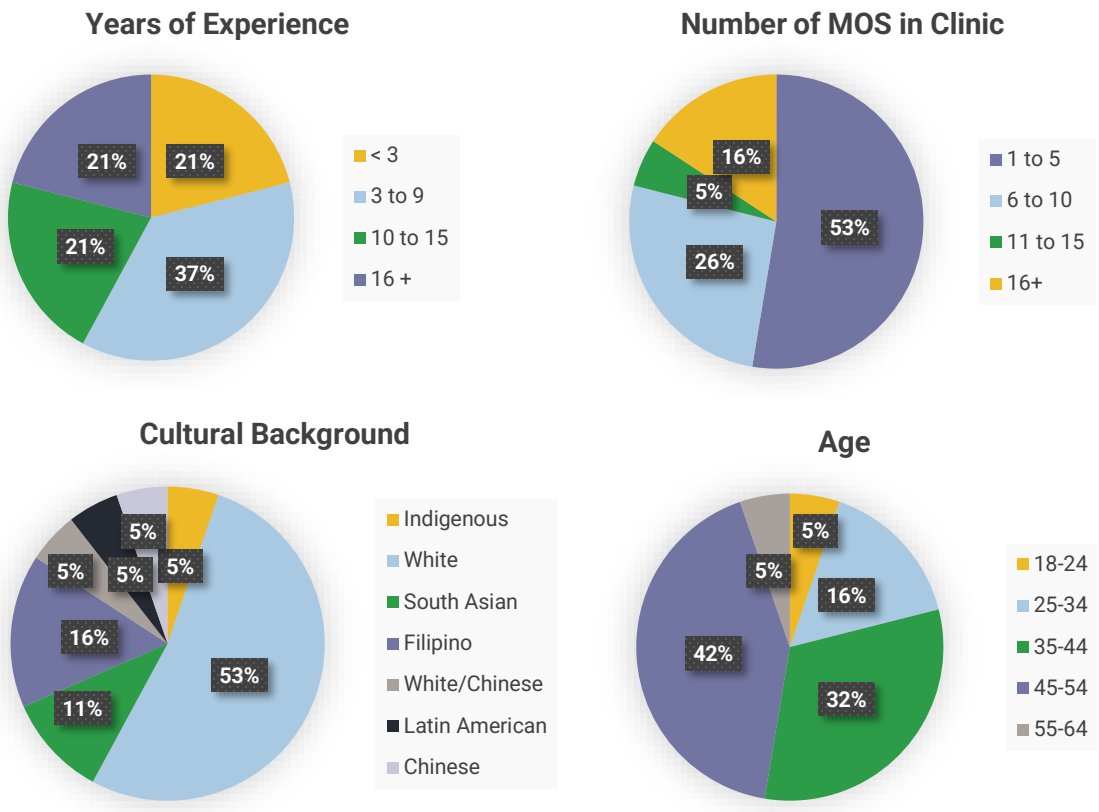
5. Pilot Results

5.1 Participant Sociodemographics

Twenty-two MOS from across the province were selected to participate in the pilot. Three MOS discontinued participation during the pilot, resulting in a final sample size of 19 MOS. Sociodemographics collected included region, practice type, job title, employment status, age, years of experience, education, staff numbers, gender identity, Indigenous identity, disability identity, and cultural background. A summary of sample sociodemographics are as follows:







For a breakdown of all sociodemographics, also separated by group (in-person vs. on-phone), see Appendix A.

5.2 Qualitative Outcomes

Within weekly surveys, participants were asked:

- *During the past week, what did you like about the de-escalation tools (HEARD+D tool, Tip Sheet, Scenario-Based Examples)?*
- *How might the tools (HEARD+D tool, Tip Sheet, Scenario-Based Examples) be improved to better support patient de-escalation?*
- *How might the HEARD+D tool be modified to make it easier to use?*
- *What about the HEARD+D tool made it easy/difficult to integrate into your daily workflow?*
    - *How might the HEARD+D tool be improved to make it easier to integrate into your daily workflow?*
- *How can the HEARD+D tool be improved to better support you in documenting escalated incidents after they occur?*

Feedback was used to strengthen the tools prior to their provincial release. Overall, participants were very satisfied with the de-escalation tools. For example, participants shared:

- *"I like how the tools (specifically the HEARD+D tool) acknowledge both the needs of the patients and our own."*
- *"The HEARD+D tool is very easy to understand. Does not matter if you are new to the job or if you have been doing the MOA job for years."*
- *"It's simple, straightforward, and easy to use."*
- *"I have become familiar with its content and can now use it automatically without having to check it beforehand."*
- *"Helping me not feel like the problem is mine, but I can be part of the solution to the situation."*

Below are examples of common requests from MOS participants that were actioned and used to improve the tools and learning resources:

- Additional scenario-based examples of the tools in use to help support skill development (requested nine times across the pilot).
- A quick reference card for the HEARD+D tool to be used as an in-the-moment tool at workstations (requested seven times across the pilot).
- Guidance for how to document an incident after it occurs, such as a charting notation example (requested four times across the pilot).

5.3 Quantitative Outcomes

Survey completion rate:

Condition	Week 1	Week 2	Week 3	Week 4
Entire Sample (N= 19)	17 (89.47%)	15 (78.95%)	19 (100%)	16 (84.21%)
On Phone (N=10)	8 (80%)	7 (70%)	10 (100%)	8 (80%)
In Person (N=9)	9 (100%)	8 (88.89%)	9 (100%)	8 (88.89%)

The results below represent mean scores reported at week 4 of the pilot, as this timeframe reflects when participants had the most time to familiarize themselves with and test the tools. Sample sizes at week 4 are presented in the survey completion rate table above.

Full results across each week are provided in *Appendix B*. Overall, a positive trend was seen over time, in that reported outcomes improved throughout the pilot.

Overall satisfaction with the HEARD+D tool:

On-phone group	In-person group	Entire sample
92.86%	91.07%	91.97%

Overall satisfaction with the De-Escalation Tips Posters:

On-phone group	In-person group	Entire sample
94.64%	85.71%	90.18%

Applicability of the HEARD+D tool to a community medical office setting:

On-phone group	In-person group	Entire sample
94.64%	89.29%	91.96%

Ease of use of HEARD+D Tool:

On-phone group	In-person group	Entire sample
89.29%	91.07%	90.18%

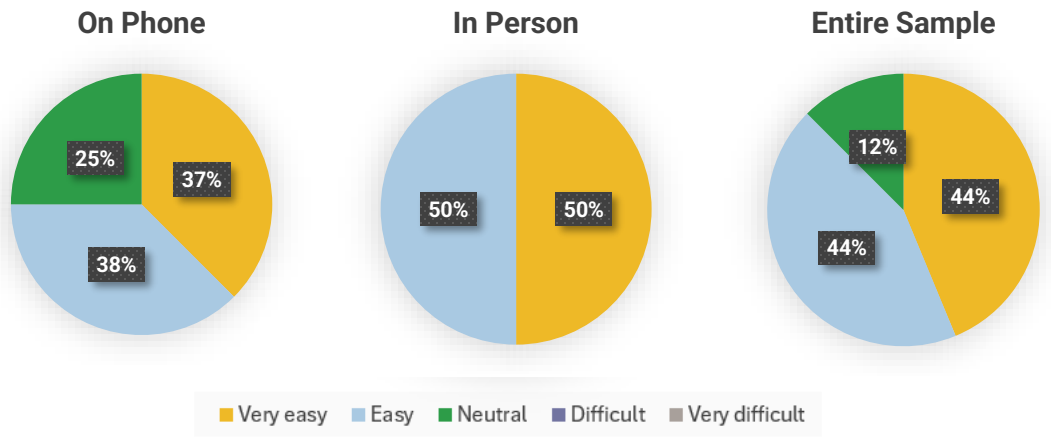
Familiarity of HEARD+D Tool:

On-phone group	In-person group	Entire sample
92.86%	92.86%	92.86%

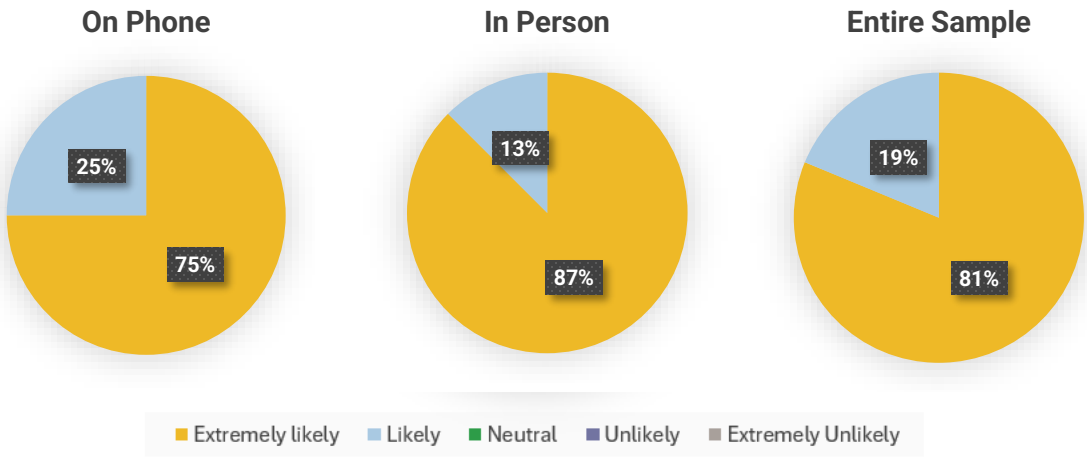
Disruption to office operations (HEARD+D and Tip Posters):

On-phone group	In-person group	Entire sample
35.71%	26.79%	31.25%

Ease of integration of HEARD+D tool into daily clinical workflow:



Likelihood of the HEARD+D tool becoming a part of normal work:



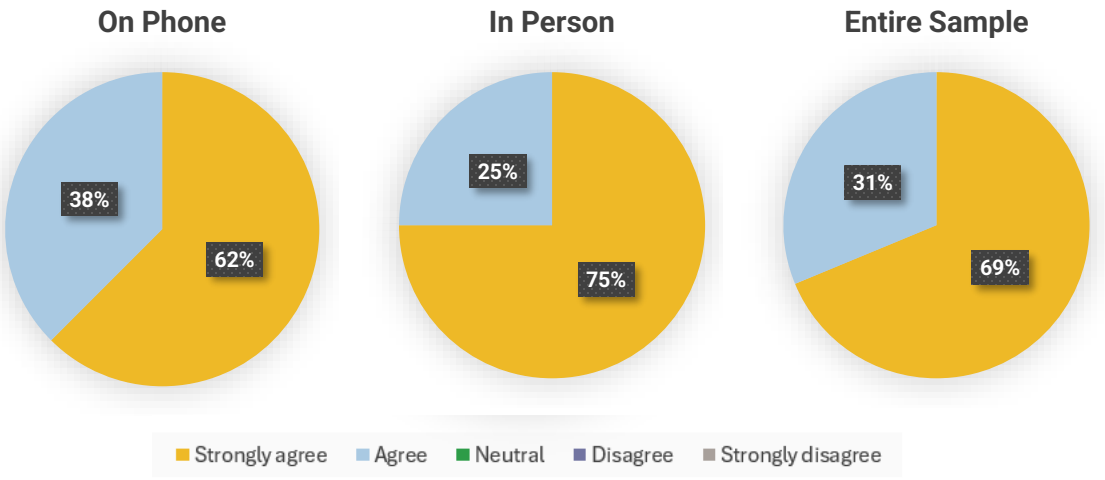
Confidence in de-escalating patients:

On-phone group	In-person group	Entire sample
91.07%	89.29%	90.18%

Confidence in documenting incidents after they occur:

On-phone group	In-person group	Entire sample
91.07%	89.29%	90.18%

The tools will benefit MOS equally, regardless of factors such as race/ethnicity, social needs, literacy, or available resources:



6. Key Insights

- As shown by recruitment rate and qualitative feedback, there is a high need and interest in de-escalation tools for community-based Medical Office Staff across British Columbia.
- Medical Office Staff appreciated that there were resources and support being developed specifically for their needs.
- MOS felt that scenario-based examples of the tools in practice, tailored to a community medical office, would be supportive in helping them to skill-up in de-escalation.
- There was high satisfaction with the tools, indicating strong MOS approval.
- After using the tools, MOS reported increased confidence in both de-escalating patients and documenting incidents.
- Results forecast strong clinic-implementation outcomes. Most participants found the HEARD+D tool easy or very easy to use and integrate into their daily routines, the tool was viewed as applicable across different community medical office settings, and a large majority indicated that they were likely or extremely likely to continue using the tools post pilot.
- Nearly all participants believed the tools would benefit all staff equally regardless of race, social needs, or literacy levels.

7. Final Tools

Pilot participant feedback was used to revise and strengthen the newly developed MOS de-escalation tools prior to their release on the Community Physician Health and Safety (CPHS) Web Portal. Medical Office Staff from across the province can now access final tools within the Violence Prevention module, including:

- HEARD+D Tool for In-Person De-Escalation.
- HEARD+D Tool for On-Phone De-Escalation.
- HEARD+D Reference Card.
- In-Person De-Escalation Dos and Don'ts Poster.
- On-Phone De-Escalation Dos and Don'ts Poster.
- Scenario-Based Examples for In-Person De-Escalation.
- Scenario-Based Audio Clips for On-Phone De-Escalation.
- Additional violence prevention and de-escalation learning resources.

8. Operationalization of Tools

The Community Physician Health and Safety program has developed an easy to navigate guide to summarize how to operationalize the tools in a community medical office, reducing administrative burden for physicians and their staff (see *Appendix C*). This guide summarizes the tools, training required, and how to best integrate the tools into clinical operations, ultimately supporting a safer and healthier work environment.

9. Next Steps

- **Support implementation of tools in clinics**: Release the tools and supporting resources provincially via the CPHS web portal. Increase program awareness more broadly across additional community medical offices following the CPHS communications plan. Provide supportive resources to assist clinics in integrating the tools into their clinical operations (e.g., operational guide, presentations to MOA networks).
- **Expand across the healthcare system**: Partner with health authorities, long-term care facilities, community-health centres, and emergency services to assess need and share resources.
- **Communicate success**: Promote tools using peer feedback and MOS pilot testimonials.
- **Strengthen partnerships:** Leverage relationships built through the pilot (e.g., with rural and remote practices) to encourage provincewide awareness and adoption.

Collaborate with Divisions of Family Practice MOA networks to reach large groups of MOS.

- **Engage MOS proactively:** Collaborate with college MOS programs (e.g., BCIT Medical Office Assistant Associate Certificate program, Langara Medical Office Administrator – Short Certificate program) to increase learners' awareness of de-escalation and resources available.
- **Monitor impact:** Establish mechanisms to track continued use, confidence, and outcomes over time.

Appendix A

Sociodemographics of the sample, by group.

Region	On Phone (10)	In Person (9)	Whole Sample (19)
Island	3 (30%)	1 (11.11%)	4 (21.05%)
North	2 (20%)	3 (33.33%)	5 (26.32%)
Interior	1 (10%)	2 (22.22%)	3 (15.79%)
Vancouver Coastal	0 (0%)	1 (11.11%)	1 (5.26%)
Fraser	3 (30%)	2 (22.22%)	5 (26.32%)
Rural and Remote	1 (10%)	0 (0%)	1 (5.26%)
Practice Type	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Family Practice	9 (90%)	7 (77.78%)	16 (84.21%)
Specialist	1 (10%)	1 (11.11%)	2 (10.53%)
Both	0 (0%)	1 (11.11%)	1 (5.26%)
Job Title	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
MOA	6 (60%)	6 (66.67%)	12 (63.16%)
Office Manager	3 (30%)	2 (22.22%)	5 (26.32%)
Receptionist	1 (10%)	0 (0%)	1 (5.26%)
Medical Office Administrator	0 (0%)	1 (11.11%)	1 (5.26%)
Employment Status	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Full-time	8 (80%)	9 (100%)	17 (89.47%)
Part-time	2 (20%)	0 (0%)	2 (10.53%)
Age	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
18-24	0 (0%)	1 (11.11%)	1 (5.26%)
25-34	1 (10%)	2 (22.22%)	3 (15.79%)
35-44	3 (30%)	3 (33.33%)	6 (31.58%)
45-54	5 (50%)	3 (44.44%)	8 (42.11%)
55-64	1 (10%)	0 (0%)	1 (5.26%)
65+	0 (0%)	0 (0%)	0 (0%)
Years of Experience	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
< 3	2 (20%)	2 (22.22%)	4 (21.05%)
3 -9	3 (30%)	4 (44.44%)	7 (36.84%)
10 – 15	2 (20%)	2 (22.22%)	4 (21.05%)
16 +	3 (30%)	1 (11.11%)	4 (21.05%)
Education	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Less than high school diploma or its equivalent	0 (0%)	1 (11.11%)	1 (5.26%)
High school diploma or a high school equivalency certificate	2 (20%)	2 (22.22%)	4 (21.05%)
Trade certificate or diploma	0 (0%)	0 (0%)	0 (0%)

Certificate or diploma specific to medical office training	2 (20%)	2 (22.22%)	4 (21.05%)
College, CEGEP, or other non-university certificate or diploma	3 (30%)	3 (33.33%)	6 (31.58%)
University certificate or diploma below the bachelor's level	0 (0%)	0 (0%)	0 (0%)
Bachelor's degree	2 (20%)	1 (11.11%)	3 (15.79%)
University certificate, diploma, degree above bachelor's level	1 (10%)	0 (0%)	1 (5.26%)
Prefer not to answer	0 (0%)	0 (0%)	0 (0%)
Staff Numbers	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
1-5	5 (50%)	5 (55.56%)	10 (52.63%)
6-10	2 (20%)	3 (33.33%)	5 (26.32%)
11-15	1 (10%)	0 (0%)	1 (5.26%)
16+	2 (20%)	1 (11.11%)	3 (15.79%)
Gender Identity	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Woman	9 (90%)	9 (100%)	18 (94.74%)
Man	1 (10%)	0 (0%)	1 (5.26%)
Non-Binary	0 (0%)	0 (0%)	0 (0%)
Prefer not to say	0 (0%)	0 (0%)	0 (0%)
Indigenous Identity	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Yes	1 (10%)	1 (11.11%)	2 (10.53%)
No	9 (90%)	8 (88.89%)	17 (89.47%)
Prefer not to answer	0 (0%)	0 (0%)	0 (0%)
Disability Identity	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Yes	0 (0%)	0 (0%)	0 (0%)
No	10 (100%)	9 (100%)	19 (100%)
Prefer not to answer	0 (0%)	0 (0%)	0 (0%)
Cultural Background	**On Phone (10)**	**In Person (9)**	**Whole Sample (19)**
Indigenous decent (e.g., First Nations, Métis, Inuit)	1 (10%)	0 (0%)	1 (5.26%)
White	5 (50%)	5 (55.56%)	10 (52.63%)
South Asian	2 (20%)	0 (0%)	2 (10.53%)
Filipino	2 (20%)	1 (11.11%)	3 (15.79%)

White/Chinese	0 (0%)	1 (11.11%)	1 (5.26%)
Latin American	0 (0%)	1 (11.11%)	1 (5.26%)
Chinese	0 (0%)	1 (11.11%)	1 (5.26%)

Appendix B

Full results presented by week of pilot and pilot group. Ordinal outcomes were measured on a 1 (low) to 7 (high) scale. Sample sizes are presented in the survey completion rate table found in the Results section of this report.

Satisfaction with the HEARD+D Tool:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	6.18	6.07	6.21	6.44	6.22
On Phone	6.25	6.14	6.40	6.50	
In Person	6.11	6.00	6.00	6.38	

Satisfaction with the Tips Poster:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	6.18	6.20	6.32	6.31	6.25
On Phone	6.50	6.43	6.50	6.63	
In Person	5.89	6.00	6.11	6.00	

Applicability of the HEARD+D tool to a community medical office setting:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	6.12	6.00	6.26	6.44	6.21
On Phone	6.38	6.29	6.30	6.63	
In Person	5.89	5.75	6.22	6.25	

Ease of use of the HEARD+D tool:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	5.53	5.73	5.79	6.31	5.84
On Phone	6.00	5.71	6.10	6.25	
In Person	5.11	5.75	5.44	6.38	

Familiarity with the HEARD+D tool:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	6.00	6.40	6.16	6.50	6.25
On Phone	5.88	6.43	5.90	6.50	
In Person	6.11	6.38	6.44	6.50	

Disruption to office operations (HEARD+D and Tip Posters):

Condition	Week 1	Week 2	Week 3	Week 4	Overall

Whole Sample	2.29	2.07	2.05	2.19	2.15
On Phone	1.62	2.43	2.60	2.50	
In Person	2.89	1.75	1.44	1.88	

Ease of integration of HEARD+D tool into daily clinical workflow:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample					
Very easy	6/17	6/15	11/19	7/16	30/67
Easy	9/17	6/15	6/19	7/16	28/67
Neutral	1/17	2/15	2/19	2/16	7/67
Difficult	0/17	0/15	0/19	0/16	0/67
Very difficult	1/17	1/15	0/19	0/16	2/67
On Phone					
Very easy	3/8	2/7	5/10	3/8	13/33
Easy	4/8	3/7	4/10	3/8	14/33
Neutral	1/8	1/7	1/10	2/8	5/33
Difficult	0/8	0/7	0/10	0/8	0/33
Very difficult	0/8	1/7	0/10	0/8	1/33
In Person					
Very easy	3/9	4/8	6/9	4/8	17/34
Easy	5/9	3/8	2/9	4/8	14/34
Neutral	0/9	1/8	1/9	0/8	2/34
Difficult	0/9	0/8	0/9	0/8	0/34
Very difficult	1/9	0/8	0/9	0/8	1/34

Likelihood of the HEARD+D tool becoming a part of normal work:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample					
Extremely likely	11/17	8/15	10/19	13/16	42/67
Likely	5/17	6/15	9/19	3/16	23/67
Neutral	1/17	1/15	0/19	0/16	2/67
Unlikely	0/17	0/15	0/19	0/16	0/67
Extremely Unlikely	0/17	0/15	0/19	0/16	0/67
On Phone					
Extremely likely	6/8	4/7	5/10	6/8	21/33
Likely	2/8	3/7	5/10	2/8	12/33
Neutral	0/8	0/7	0/10	0/8	0/33
Unlikely	0/8	0/7	0/10	0/8	0/33
Extremely Unlikely	0/8	0/7	0/10	0/8	0/33
In Person					
Extremely likely	5/9	4/8	5/9	7/8	21/34

Likely	3/9	3/8	4/9	1/8	11/34
Neutral	1/9	1/8	0/9	0/8	3/34
Unlikely	0/9	0/8	0/9	0/8	0/34
Extremely Unlikely	0/9	0/8	0/9	0/8	0/34

Confidence in de-escalating patients:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	5.71	5.80	6.11	6.31	5.99
On Phone	5.50	5.86	6.10	6.38	
In Person	5.89	5.75	6.11	6.25	

Confidence in documenting incidents after they occur:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample	6.00	5.93	6.26	6.31	6.13
On Phone	6.25	6.00	6.20	6.38	
In Person	5.78	5.88	6.33	6.25	

The de-escalation tools will benefit Medical Office Staff equally, regardless of factors such as race/ethnicity, social needs, literacy, or available resources:

Condition	Week 1	Week 2	Week 3	Week 4	Overall
Whole Sample					
Strongly agree	10/17	9/15	10/19	11/16	40/67
Agree	6/17	5/15	8/19	5/16	24/67
Neutral	1/17	1/15	1/19	0/16	3/67
Disagree	0/17	0/15	0/19	0/16	0/67
Strongly disagree	0/17	0/15	0/19	0/16	0/67
On Phone					
Strongly agree	4/8	4/7	5/10	5/8	18/33
Agree	3/8	3/7	4/10	3/8	13/33
Neutral	1/8	0/7	1/10	0/8	2/33
Disagree	0/8	0/7	0/10	0/8	0/33
Strongly disagree	0/8	0/7	0/10	0/8	0/33
In Person					
Strongly agree	6/9	5/8	5/9	6/8	22/34
Agree	3/9	2/8	4/9	2/8	11/34
Neutral	0/9	1/8	0/9	0/8	1/34
Disagree	0/9	0/8	0/9	0/8	0/34
Strongly disagree	0/9	0/8	0/9	0/8	0/34

Appendix C
Operational Guide

Community Physician Health and Safety Program

Operational Guide: De-Escalation Tools for Medical Office Staff

SWITCH BC's New De-Escalation Tools for Medical Office Staff

The new tools developed by the Community Physician Health and Safety (CPHS) program, follow a simple, evidence-informed de-escalation framework. The tools are developed specifically for Medical Office Staff (MOS) working in community-based practices to help them manage escalated or potentially violent interactions, both in person and over the phone.

Designed to integrate seamlessly into daily clinical workflows, the tools can be implemented without disrupting operations. The tools emphasize practical, rapid techniques to defuse escalating situations, protect staff wellbeing, support patient-centred care, and decrease the administrative burdens associated with patient complaints.

Tools and Resources:

- **HEARD+D Tool** (In-Person and Phone versions)- An easy-to-read flow chart designed for skill-building rather than in-the-moment use. Review regularly to build familiarity with the de-escalation techniques.
- **Quick Reference Card** (for workstation use)- Flash-card-style prompts to reinforce key de-escalation techniques and support confidence in the moment.
- **De-Escalation Tip Posters** (In-Person and Phone versions)- Dos and don'ts for phone and in-person communication to help prevent and reduce patient escalation. Review regularly and post at your workstation for easy reference.
- **Scenario-Based Examples** (written and audio)- Guided examples for employing the HEARD+D method and the dos and don'ts of communication in real-world situations.
- **Incident Documentation Guidance**- Resources to help staff accurately document incidents that caused or could have caused injury, supporting effective follow-up, health and safety improvements, and prevention efforts.

Who is it for?

All medical office staff who interact with patients or the public in community clinics.

Benefits of Adopting the Tools:

- Enhances staff health, safety, wellbeing, and confidence.
- Improves patient communication and experience, reducing patient complaints.
- Reduces burnout and emotional toll of difficult, compounding interactions.
- Provides a shared language and approach for handling escalation.
- Requires minimal training investment while increasing staff retention and job satisfaction.

Did you know?

- Over 90% of users found the tools easy to use, non-disruptive, and relevant to their roles and duties.
- After 4 weeks of using the tools, users reported over 90% confidence in de-escalating patients as well as in documenting incidents.

- Users reported feeling more supported, empowered, and prepared.

Training Requirements and Recommendations

For best use, the tools should be used as a learning resource by MOS to build skills in de-escalation.

Estimated Self-Directed Training Time: 90 minutes

1. Review the Violence Prevention module on the CPHS web portal including de-escalation tools for Medical Office Staff.
2. Review the two Tip Posters to build familiarity and reduce reliance during an incident. Print and place at your workstation where visible to you and not the patient.
3. Learn and practice the HEARD+D method. Practice responses to prepare for interactions with frustrated, angry, aggressive, or threatening patients.
4. Use the scenario-based examples (written and audio) to learn how to use the HEARD+D method.
5. Review incident reporting and documentation processes and discuss with your physician-employer how this applies to your clinic.

Implementation Steps (Clinic Level)

Successful rollout of the de-escalation tools follows a three-phase process, which can be completed in approximately 2–4 weeks, depending on clinic size and staff availability.

Phase	Action	Estimated Time
Preparation (Week 1)	• Identify a point person (clinic lead, manager, or senior MOS). • Introduce the tool at a team huddle or staff meeting. Set team expectations for practicing use. • Schedule training time for all MOS and direct MOS to online modules. (TIP: Each MOS can create an account to save their progress). • Print/distribute materials: HEARD+D tool for staff handouts, quick reference cards for workstations, tip posters for staff areas.	90 – 180 minutes
Training and Practice (Week 2)	• Allow time for self-directed training. • Encourage team to begin practicing HEARD+D with scenario-based examples. • Assign low-pressure practice tasks (e.g., use tool with roleplay or less complex patient interactions).	90 minutes per MOS

Operationalizing (Weeks 3-4)	• Encourage continual review of HEARD+D tool and use of the tool in live situations. • Schedule check-ins, team discussion, or peer feedback sessions to reinforce use. • Encourage shared learning: “What went well? What could be improved?”	20 – 30 minutes per week

Summary

SWITCH BC’s new de-escalation tools are quick to learn, easy to use, and highly adaptable for all community medical clinic environments. With just a few hours of training, clinic staff can build a healthier, safer, more prepared team culture that is better equipped to handle difficult patient situations with professionalism and compassion.

For support or to get started, visit the CPHS web portal or contact the CPHS team directly at cphs@switchbc.ca.