Workplace Violence Risk Assessment

for **Langley Memorial Hospital**

Conducted by
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1.0 EXECUTIVE SUMMARY

This Workplace Violence[1] Risk Assessment for Langley Memorial Hospital (LMH) was conducted primarily during March through June of 2001, at the behest of Langley Memorial Hospital, the South Fraser Health Region (SFHR) and the Workers' Compensation Board of British Columbia (WCB). This latter organization provided the funding for the project, which was handled by a Steering Committee made up of representatives of management, unions and the WCB. A team of specialists from Advance Workplace Management Inc.[2] (Advance) carried out the Risk[3] Assessment.

1.1 Project Methodology

- Reviewing internal information, data, current practices and procedures;

- Conducting employee surveys and interviews;

- Carrying out a physical worksite audit; and

- Reviewing existing workplace violence prevention and management training.

1.2 Langley Memorial Hospital's Ongoing Action Plans

- A Management of Aggressive Behaviour Training Program was being developed at the time of this Risk Assessment containing proposed components appropriate for healthcare facilities[4];

- The hospital's Security function had recently been established as an in-house rather than contract function, a step viewed positively by most people surveyed for this project;

- An updated incident[5] reporting form had been developed which, when used appropriately for all reportable incidents would result in an improved database being available to analyze trends.

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[1] See Appendix K: Definitions
[2] See Appendix A: The Advance Team
[3] See Appendix K: Definitions
[4] See Appendix J: Planned SFHR Management of Aggressive Behaviour Training Program
[5] See Appendix K: Definitions

1.3 Notable Research Findings

■ More than three-quarters of LMH staff consider workplace violence a problem;

■ More than half (55%) of staff report only some or none of their exposures to workplace violence;

■ Staff training was the most desired solution to dealing with the issue of aggressive behaviour;

■ Service expectations, patients' substance abuse, low staffing levels and patient acuity were perceived by staff as the main factors contributing to workplace violence;

■ Lack of a consistent single database recording all incidents made it difficult to accurately understand the true extent of workplace violence at Langley Memorial Hospital.

1.4 Risks - Staff and Worksite Design

Staff risks

Staff at Langley Memorial Hospital are at similar levels of risk from workplace violence as their colleagues in other hospitals, a risk considered inherent in the healthcare industry.

■ Staff at high risk of exposure to workplace violence are employees who work, or are required to attend patients, in Emergency and Psychiatry;

■ Additionally, employees who respond to potential or actual incidents of violence, such as participants in Emergency Behavioural Response Teams (Code White [6]), and Security (Protection Services) staff are also at high risk;

■ Nursing care staff not mentioned above are a moderate risk of exposure to workplace violence. However, during data analysis when incident reports were compared with injury[7] reports anomalies became apparent. On nursing units 3S (Alternate Level of Care), 4S (Medical/Paediatrics), and 2N (Medical/Surgical/ICU) there were a number of documented staff injuries but correspondingly few or no incident reports. Because it is possible that incidents and injuries are underreported, incident reports/injury trends should be carefully monitored;

■ Other staff, not involved in direct nursing care, i.e. Diagnostic Imaging and the Laboratory, are also considered to be at moderate risk. Staff required to provide diagnostic or other services to violent patients, should be provided with appropriate training programs for managing aggressive behaviour.

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[6] See Appendix K: Definitions

[7] See Appendix K: Definitions

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■ Staff involved in money transactions (Cashier, Accounting Department collections, etc.) should receive job-specific training in dealing with irate customers, robbery prevention, etc.

■ Members of staff not mentioned above are at low risk of encountering or being injured as a result of aggressive behaviour.

Worksite design risks

Few serious incidents at Langley Memorial Hospital could have been averted or minimized by adaptations to worksite design. However, a number of recommendations have been included to deal with physical adjustments that could achieve a reduction in potential risks. Departments in this category include:

■ Emergency and Emergency Seclusion room;

■ Psychiatry;

■ Cashier's office;

■ Diagnostic Imaging; and

■ General facility and grounds.

1.5 Recommendations for Action

This list summarizes the main recommendations provided by the Advance team:

■ Establish master and supporting policies that clearly indicate the hospital and Region's commitment to patient and staff safety, and communicate this commitment widely and frequently;

■ Give the responsibility for actions in this area to a credible senior executive with the appropriate authority and resources to achieve desired outcomes;

■ Develop a consistent database, including both resolved and unresolved incidents, and use the analysis of the trends indicated by the data to better understand risks and to practice appropriate quality improvement;

■ Make worksite design changes in Emergency, Psychiatry and their Seclusion Rooms to reduce staff vulnerability to injury;

■ Implement a comprehensive four-step training program, paying particular attention in the short-term to refining the Code White team membership criteria and expanding the training offered to this team to equip them with the essential skills for this behavioural response to violent incidents; and

■ Continue a process of ongoing risk assessment and periodic program evaluation.

2.0 BACKGROUND AND CONTEXT

In early 2001, the South Fraser Health Region (SFHR) initiated a workplace violence risk assessment at Langley Memorial Hospital (LMH). A joint union, management and Workers' Compensation Board of BC (WCB) committee took primary responsibility for the project. Funding for the project was provided by the WCB.

SFHR contracted with Advance Workplace Management (Advance) to conduct the LMH workplace violence risk assessment. The consulting firm's team of specialists[8] undertook to review the current workplace violence situation at LMH and to make recommendations for short and long-term actions that would improve the hospital's workplace violence prevention and management program.

In particular, SFHR wanted to understand the risks faced in the acute care areas of LMH, the level of preparation for handling these risks and how to take advantage of both short- and long-term opportunities to mitigate identifiable risk situations[9] as much as feasible.

This effort has few precedents or models upon which to draw: within BC no review of this magnitude has been carried out to date by a community facility.

Prior to confirming the scope of work for this project, the Steering committee hoped to create a report that could be a model for the Health Care Industry in BC. However, budget and timeline limitations resulted in a project specific to LMH's experience and situation. Although some of the components and methodologies used here may be applied generally within other health care environments, Advance suggests using significant caution if applying these findings and recommendations directly to any other institution; work group or work environment. The handbook prepared by the WCB of BC "Preventing Violence in

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[8] See Appendix A: The Advance Team

[9] See Appendix K: Definitions

Health Care"[10] offers a generic step-by-step approach for performing a workplace violence risk assessment.

The research, site audits, interviews, surveys and analysis which formed the basis of this report and our recommendations occurred primarily between March and June of 2001. This coincided with a challenging time for Langley Memorial Hospital. Throughout the early months of 2001 contract negotiations with two major unions, the British Columbia Nurses' Union (BCNU) and Health Sciences Association (HSA), were ongoing, and resulted in job action. The many people at LMH who cooperated with the project team have to be commended that they participated in the questions and surveys regarding this project, above and beyond the normal workload of a busy community hospital.

The incident data was that supplied to us and was amalgamated to the maximum extent feasible, but multiple sources and incomplete data limited our analysis.

2.1 Langley Memorial Hospital and the South Fraser Health Region

The South Fraser Health Region provides health services to almost 600,000 people, living in the Municipalities of Delta, Langley and White Rock, and the City of Surrey. Langley's population represents approximately 120,000 of that total. The Regional revenue for fiscal 2000/01 was almost $485 million. Total Regional workforce is 6,500 of which 1,700 work for Langley Memorial Hospital.

The following table details the main activity statistics for the four regional hospitals for both fiscal 1999/00 and 2000/01.

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[10] See Appendix C: Report References

Acute Care Services	Delta		Langley		Surrey		White Rock		Region	
	99/00	00/01	99/00	00/01	99/00	00/01	99/00	00/01	99/00	00/01
Patients admitted	3,052	3,046	9,535	9,445	15,923	15,143	7,987	7,696	36,497	35,330
Emergency visits	21,686	21,809	39,036	39,455	73,470	71,830	31,616	27,265	165,808	160,359
Births	-	-	1,490	1,514	3,336	3,331	785	739	5,611	5,564
In-patient surgeries	771	695	2,741	2,585	5,455	5,100	1,877	2,032	10,844	10,412
Day surgeries	2,261	2,492	5,552	8,012	7,215	7,156	2,433	2,454	17,461	20,114
Total beds	160	160	430	430	572	574	521	523	1,683	1,687
Acute beds	60	60	200	200	356	358	178	180	794	798
Extended care beds	100	100	230	230	216	216	343	343	889	889
Revenues (millions)									$418.74	$484.53
Employees										6,500
Physicians										700
Population (1999/2000)		102,901		117,813		292,960		74,912		588,586

Table 1: South Fraser Health Region — Acute Care Services
1999/2000 and 2000/2001 Statistics

Langley Memorial Hospital's Acute Care section offers the normal range of medical and surgical services to the community, including an Emergency Department, supported by the appropriate diagnostic, professional and support services.

Nursing units include:

- Medical and Critical Care
- Surgical and Surgical Day Care
- Paediatrics
- Obstetrics
- Psychiatry
- Emergency

Additional direct patient care services include:

- Laboratory
- Diagnostic Imaging
- Dietary
- Physiotherapy
- Occupational Therapy
- Pharmacy
- Social Work
- Pastoral Care

The usual range of administrative functions is available to assist patient care activities, many of which have been centralized to more efficiently serve the needs of the Region as a whole:

- Health Records and Admitting
- Engineering and Maintenance
- Information Services
- Materiel Services
- Sterile Processing
- Human Resources

- Quality Assurance

- Finance and Planning

- Education

- Housekeeping and laundry

Three unions represent many of the staff at Langley Memorial Hospital, and contracts are negotiated on a province-wide basis. The nursing staff are members of the British Columbia Nurses' Union (BCNU), many paramedical staff are represented by the Health Sciences Association (HSA), while other staff belong the Hospital Employees' Union (HEU), a division of the Canadian Union of Public Employees (CUPE).

The hospital is also served by an active group of volunteers and its capital equipment purchases are assisted by the community's donations to the Langley Memorial Hospital Foundation.

3.0 PROJECT METHODOLOGY

At the outset, Advance Workplace Management Inc. (Advance) proposed a risk assessment process consisting of six main steps[11]. This section reviews both the planned and achieved steps, noting where plans were adapted to increase the value of the assessment for the hospital. Results of each step are detailed in later sections of this report.

As the project got under way, Advance undertook a number of steps to create employee awareness of the project, including information on how to contact the project team. Among other things, Advance distributed a poster throughout the acute care area of the hospital[12] and included project information in the hospital newsletter. At the conclusion of the survey portion of this project, a general thank you letter was distributed expressing appreciation to staff for their cooperation and assistance.

3.1 Review of Internal Information, Practices and Procedures

Planned steps

This review of current related internal materials covered 1999, 2000 and the first three months of 2001. Included in the review were:

- current policies;

- guidelines and violence-related codes;

- prevention program materials; and

- patient-related incident reports provided by LMH.

Data were also gathered from Security reports to expand the scope of analysis. Other internal and external documents were included in this review, such as WCB inspection reports and Joint Occupational Health and Safety Committee (JOHSC) minutes. Advance was also to conduct interviews with key department heads and selected staff.

Included in this step of the assessment were reviews of available information from other BC facilities.

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[11] See Appendix B: Project Methodology

[12] See Appendix H: Project Announcement

Actions achieved

Advance successfully completed the majority of these steps. During the interview phase of the project, the team discussed with hospital staff the organization structure in place to support the workplace violence programs.

Significant effort was expended on organizing available data into a format that allowed for somewhat more reliable and meaningful analysis. Because LMH's data records were retrieved from a number of sources, Advance made every effort to compile these into a single database for analysis. As we worked with the data, our team had significant concerns about omissions and duplications.

LMH initially provided patient-related hospital incident reports from Regional Employee Injury Exposure data. A member of staff or a member of the Code White team completed these reports. When Advance examined these documents, it quickly became evident that they did not capture the potential for violence at the hospital, because they did not record incidents that were either successfully resolved or were non-patient related. As a result, additional sources of information were examined. These included:

- Guard reports. From these daily-duty logs, incidents that were successfully resolved were identified. Because of the volume of materials involved, these reports were only examined for the year 1999;

- Security incident reports. Contract security staff completed these reports for incidents involving both patients and non-patients;

- Maintenance/Engineering logs. These reports provided information on the occasions when personnel from this department were called to assist with an incident, whether or not it was resolved successfully; and

- Injury reports due to acts of force or violence collected as part of the work for an Ergonomics project.

By carefully examining this supplementary information, and compiling it into a single database, we were able to create a better picture of the risks experienced in Langley Memorial's acute care facility. However, our concerns about the reliability of the resulting database were not entirely resolved.

Another difficulty involved the lack of comparative data from other BC facilities. This information, while it is collected in most facilities, was not available in a form satisfactory for comparative purposes. Where information was available, it quickly became evident that without common definitions and procedures, comparison would be almost meaningless. The necessary SFHR information was available to make a comparison of injuries resulting from violent behaviour that resulted in WCB claims from the four Regional hospitals.

3.2 Surveys and Interviews

Planned steps

The planned worker survey was to take the form of focus groups in a design tailored to LMH. Between ten and fifteen focus groups were proposed over five separate days. The goal was to survey 150 - 170 staff (10% of 1500 – 1700 staff to provide a statistically significant sample) including a representative sample of people from each job category, unit and shift.

In addition to the focus group survey, Advance planned to interview selected senior management, department heads, union representatives and staff members.

For anyone who wanted to share information and who did not have alternative means, Advance offered a confidential (toll-free) call-in line for all staff [13].

Actions achieved

Our intention was to interview 10% of employees (150 -170), but the job action in progress at the hospital and the lack of willingness on the part of many staff to participate limited the scope of the survey. This affected the planned focus groups and Advance redesigned this phase of the project. Instead of focus groups, written questionnaires were developed, and 122 responses were collected from a representative cross-section of individual staff members, who were also interviewed by the project team. The number provides a useful portrait of staff perceptions, though more responses would have improved upon our ability to generalize from the findings.

Interviews with senior management, department heads, union representatives and staff members were carried out as planned. In addition, a number of external stakeholders were interviewed, such as RCMP officers and WCB personnel.

3.3 Work Site Audit

Planned steps

The planned worksite audit consisted of a review of physical facilities: engineering controls, physical security and specific risk areas including summoning assistance, access control, perimeter controls, environmental issues and high risk units.

Actions achieved

Both general and specific observational tours were conducted during the course of the project. In addition, information offered during the survey phase was taken into account

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[13] See Appendix H: Project Announcement

when considering aspects of physical plant safety. The areas of the hospital considered most at risk were examined in considerable detail.

Work site surveys were carried out for the following hospital areas:

- Emergency Department (ER),

- Psychiatry (Psych - 1S),

- Seclusion rooms (ER and Psych),

- A representative nursing unit – Medical/Surgical/ICU (2N),

- Cashier's office,

- Switchboard,

- Diagnostic Imaging,

- Admitting reception area.

In addition, Hospital entrances/exits, stairwells, main waiting room, overall grounds and parking areas were reviewed. General tours were conducted of the following areas:

- Maternity (3N),

- Alternate Level of Care (ALC - 3S),

- Medical Laboratory,

- Operating Room/Post Anaesthesia Recovery Room,

- Physiotherapy,

- Occupational Therapy/Rehabilitation,

- Ambulatory Care,

- Maintenance,

- Housekeeping,

- Food Services,

- Accounting and Administration.

3.4 General Workplace Violence Prevention Training Review

Planned steps

For this step, Advance planned a review of current general workplace violence prevention training programs at Langley Memorial Hospital and the South Fraser Health Region, including training materials. This was in addition to the planned, detailed review of the Code White training activities.

Actions achieved

The Advance team successfully completed a detailed review of general training activities and programs.

3.5 Code White Team: Operational and Training Review

Planned steps

The main steps in this segment of the project were to include meeting with key stakeholders, attending one training session, examining criteria for selection of Code White Team members, as well as reviewing the role, mandate and training of the Code White Team. Part of the review of the Code White training was to include assessing the mix of didactic education and verbal/physical skills training.

The plan included interviews with a representative sample of participants, looking at past experiences/incidents, and identifying dynamics that hindered or enabled the training program.

Training requirements for in-house security staff in the violence prevention program were also to be reviewed.

Actions achieved

This fifth step in the risk assessment process was modified, as no Code White training occurred at the hospital during the time of this project. The Advance team offered to conduct a training session for the Code White team, to assess their skills and training, but due to essential staffing levels and costs, this offer was not implemented by LMH.

Apart from this one omitted step, the Advance team conducted a detailed review as planned.

3.6　Analysis and Recommendations

This report represents the final step in the project and, as requested by the LMH team, covers our review of existing systems for reporting and preventing incidents of force or violence. It also includes our analysis of the data provided and recommendations for future actions at LMH. In addition to the specific steps outlined here, a significant number of external sources were explored for relevant information.[14]

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[14]　See Appendix C: Report References

4.0 RESEARCH & ANALYSIS

4.1 Analysis of Employee Survey Data

At the outset of this project, the Advance team planned to conduct a series of focus groups to determine staff perceptions of the practices in place for management of aggressive behaviour. However, due to the fact that job action and essential staffing levels were occurring at the hospital during the project, this phase of the project was adapted to allow for staff to respond to written questionnaires, as well as being interviewed, primarily on an individual basis. The questionnaires and interviews were administered to a representative cross-section of personnel on all shifts, and targeted staff working in high-risk areas, such as the Emergency Department and the Acute Psychiatric unit.

Using a short written questionnaire[15] regarding individuals' experiences with workplace violence at Langley Memorial, as well as personal interviews, responses were collected from 122 staff members of a total workforce of approximately 1700. This number of responses provides a useful portrait of staff perceptions, though more responses would have improved upon our ability to generalize from the findings.

Table 2 details the breakdown of departments and employees surveyed. Within each area and each job category, individuals were selected at random.

Departments Surveyed	Number of Employees
Housekeeping, Admitting, Food Services, Switchboard, Security, Maintenance, Unit Clerks, Volunteers, Social work	33
Emergency, OR, 2N, 1S, 4S, 3N, ALC	30 RNs 17 LPNs
Laboratory, Diagnostic Imaging, Physiotherapy, Occupational Therapy/Rehab, CT Scan	38
Administration	4
Total	**122**

Table 2: Demographics of Survey Respondents

No further breakdown of the number in this table is provided. First, further breakdown compromises the promised respondent confidentiality, and second, the numbers within the breakdown would be so small as to make analysis meaningless.

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[15] See Appendix D: Employee Survey form

In general the tabulated results indicated that:

- 78% of respondents reported violence was a problem;

- 22% responded that it was not a problem.

For this survey, the WCB definition of violence or aggression was used, i.e. "the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening[16] statement or behaviour which gives a worker reasonable cause to believe that worker is at risk of injury".

When asked whether they report violent incidents:

- 41% indicated that they report all incidents,

- 42% report only some incidents, and

- 13% do not report incidents at all

- 4% have never experienced an incident of force or violence at work.

The Advance team was concerned to note that 55% of respondents either report only some or no incidents. In order to make this response, staff had to be aware that they were omitting to report what they knew to be reportable incidents. This assumes that their definition of reportable incidents is accurate.

Those who only report some incidents gave their reasons, as described in Chart A:
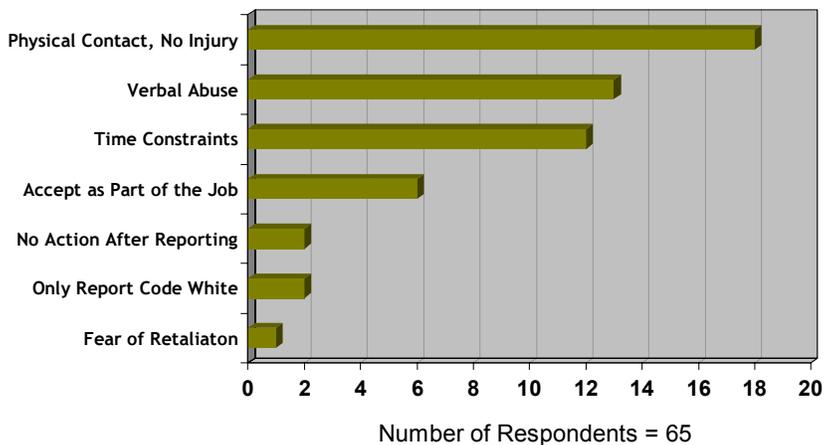
Chart A: Reasons Given for Staff Reporting Only Some Incidents

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[16]   See Appendix K: Definitions

There was a wide range of responses to the question regarding contributing factors to the problem or threat of violence as illustrated in Chart B:
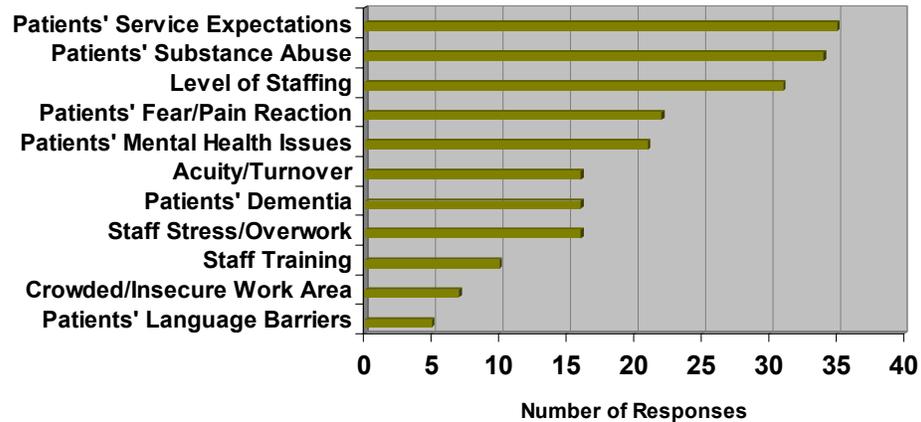
Chart B: Factors Contributing to the Threat of Violence

Respondents were asked their perception of trends in workplace violence at Langley Memorial Hospital. Results of this question indicated that:

- 47% perceived that violence was increasing,

- 7% felt it was decreasing, and

- 46% thought that there was no change.

Assisting employees to respond more effectively

When asked to suggest steps LMH might take to help employees respond more effectively to violence, more than half (56%) of respondents cited better and ongoing education and training as the preferred step: skills in defusing, recognizing potential violence, self-defence training, Crisis Prevention Institute[17] (CPI) programs, Management of Aggressive Behaviour (MOAB) training, were all mentioned. The need for training and leadership for the Code White team was noted by 16% of respondents.

Other suggestions to improve the way in which employees respond to violence included:

- increasing staff (24 responses);

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[17]   See Appendix K: Definitions

- improving response to assistance when requested, both from nursing and security staff (17);

- developing & implementing improvements to physician assessments and the notification system for violent patients, in particular for lab and diagnostic imaging (16);

- increasing awareness/information sharing on violence prevention practices, code white protocols and security procedures (13);

- making changes in staffing, physical facility and equipment to increase security for high risk work areas i.e. Emerg Triage, Fast Track, Obs 1 & 2 (13);

- improving security for staff working nights or alone, particularly parking areas and on hospital premises (9);

- improving incident response – including post incident support, debriefing, follow-up, and corrective action (9);

- improving system of standing orders for meds (5); and

- management acknowledging the problem of violence (3).

4.2   Interview Feedback

Advance team members, in addition to collecting responses to a written questionnaire, interviewed most of those who completed the survey. Predictably, comments from the interviews confirmed the data from the surveys.

Typical observations focused on:

- Increased patient acuity, heavier workloads and decreased resources result in less time to spend with patients;

- Concerns about increasing stress levels, with the result that staff feels less able to deal with difficult situations;

- Desire for more formal in-depth training, particularly for those involved in responding to Code White incidents;

- The need to flag higher-risk patients for areas such as lab and diagnostic imaging, and

- A desire to improve the overall system for managing aggressive behaviour.

Other comments recorded during these interviews included:

- There is concern about the Fast Track area of the Emergency Department, where members of staff work alone with sharps, scalpels and other such potential weapons easily accessible to aggressive patients;

- Clinical systems need to ensure appropriate assessment, management and timely treatment for patients exhibiting a tendency to aggressive behaviour;

- While purple dots on charts, when used, alert staff to individuals likely to present a threat, no specific information about risks or triggers is provided; and

- Staff in general experience verbal abuse and intimidation far more often than they experience physical assaults[18].

- Advance personnel discussed with each interviewee the WCB definition of violence[19]. In spite of this, it has been difficult to define "violence" as individual reactions vary considerably when exposed to threats, intimidation or aggression.

It was also noted from the interviews that some members of staff, particularly nurses and those in Psychiatry, experience a sense of professional failure when patients reacted negatively to the care provided. This factor is just one of many leading to significant underreporting of aggressive incidents in healthcare.

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[18] See Appendix K: Definitions

[19] See Appendix K: Definitions

5.0 INCIDENT & INJURY DATA ANALYSIS

Prior to providing our analysis of the available incident data, it is important to point out that the true incidence of violence at LMH is not known. What is known is that 42% of staff who responded to our survey indicated that they only report some incidents, while an additional 13% do not report incidents at all.

At the time of the project, certain data were unavailable to incorporate in our analysis. This included:

- Claims cost data;

- Total days lost to incidents resulting from the use of force or violence; and

- Average days lost for these claims.

5.1 Analysis of Incidents

Our data analysis at Langley Memorial Hospital for the years 1999, 2000, and January 1 to March 31, 2001 used the information provided to us by the Hospital and the Region:

- Regional Employee Injury Exposure Incident Reports;

- Security Incident Reports;

- Guards' daily activity logs (Guard Reports); and

- Maintenance/Engineering Log, documenting the response of staff in this area to requests for hands-on assistance.

In some analysis, as mentioned below, we also studied injury data due to force or violence collected for an ergonomics project.

About the data

When Advance started to collect the data that would identify the violence-related risks faced by the hospital, we discovered that there appeared to be inconsistencies in the method of data collection for acts of force or violence at Langley Memorial Hospital. As already noted, the data that we canvassed revealed many duplications, omissions and, more often than not, failed to illuminate adequately what prompted the incident or situation in question, the nature of the threat of aggression or violence, and what was done in response to the incident or situation. As an example, precipitating factors were typically noted in less than half of all incident reports for the years 1999, 2000 and 2001. When a detailed report of the incident was provided, this was not done so consistently. For example, some security guards provided substantial detail regarding a specific incident; other guards provided virtually no information of any value. Hence, there is a need for a standardized

system of incident reporting, including a single reporting form to be used in all circumstances.

If data collection remains inconsistent and non-uniform, it will be impossible for Langley Memorial to determine whether the problem of aggression is worsening or improving, and at least equally important, whether or not responses designed to prevent future incidents are having a positive impact.

The lack of a consistent system of data collection and the lack of a system that mandates an ongoing monitoring of any changes over time represent key limitations in the formation of a risk assessment process for LMH. The development of a standardized incident reporting system at LMH, used by all employees for all incidents and injuries, will assist the hospital in determining risk to employees. We believe that substantial confusion is created by having many separate sources of data, managed by different departments, with different forms and different emphases in reporting. A single system of incident reporting, with the provision of additional detail for Code White incidents, would allow Langley Memorial to track violent incidents in a consistent manner, and to routinely inform employees with respect to the incidents that have occurred, their nature and frequency, and the responses that have been taken to reduce recurrence.

With the formation of an in-house security department (Protection Services) in April of this year, Langley Memorial is now ideally situated to construct such a system, monitored within the hospital by Protection Services staff and the Joint Occupational Health and Safety Committee. We believe that this Committee, given the diversity of its membership and consequent variations in areas of responsibility, is well situated to respond to incident reports on a regular basis, to recommend corrective actions where necessary, and to monitor the effectiveness of these corrective actions over time.

Total incidents

In 1999, there were 143 situations and incidents. In 2000, there were 153 situations and incidents, representing an increase of 7% over 1999. In the first quarter of 2001, there were 52 situations and incidents, compared with 32 situations and incidents for the first quarter of 1999 and 24 situations and incidents for the first quarter of 2000. No reason for this significant variation in the data for 2001 could be identified with any degree of confidence.

Years	Number of Incidents	% Change
1999	143	Baseline
2000	153	7%

Table 3: Percentage Change in Incidents for Years 1999 and 2000

Comparison of 1st Quarters	Number of Incidents	% Change
1st Quarter 1999	32	Baseline
1st Quarter 2000	24	(25%)
1st Quarter 2001	52	61%

*Table 4: Percentage Change in Incidents in the
1st Quarters of 1999, 2000 and 2001*

Note that we were asked to exclude from our analysis incidents occurring in the Long Term Care or Extended Care unit.

Location of Incidents

The two areas most at risk of experiencing incidents are the Emergency Department and Psychiatric units (see Chart C). More than 80% of incidents due to force or violence in the acute care area of LMH during the past few years were clustered in these two areas.

This is probably not a surprising finding to those who work at Langley Memorial or at most acute care hospitals, but it is a finding of relevance for the training of employees and the deployment of Code White teams.
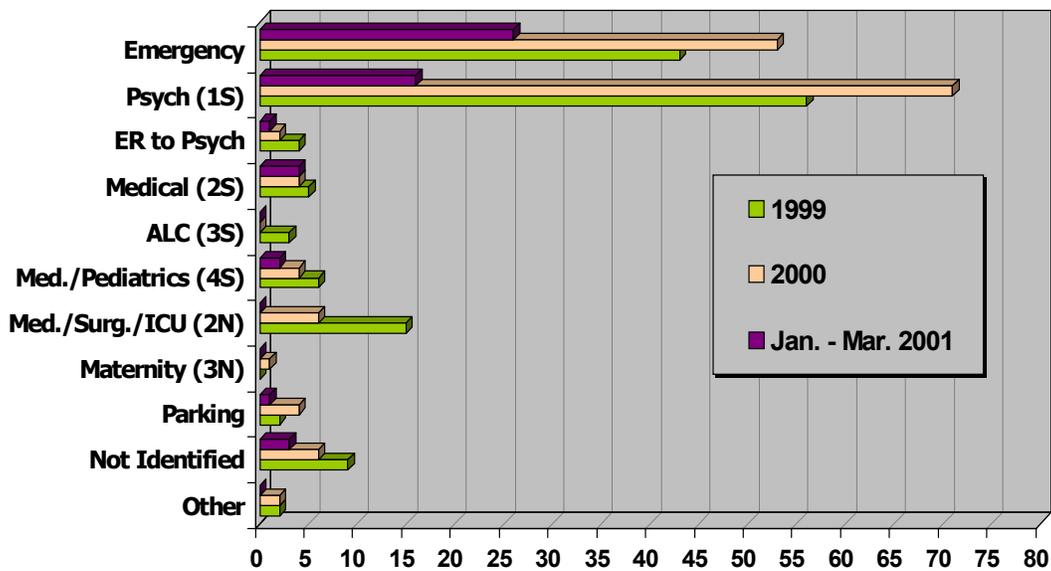
Chart C: Location of Incidents

Occurrence of incidents by time of day

The data analysed present a mixed picture of the occurrence of incidents throughout each 24-hour period. Based on the Incident Reports only, these appear to be spread relatively evenly throughout the day at Langley Memorial, with the exception of the early morning hours from 4 to 10 a.m. During this time incidents tend to be about one-third as likely as at other times of day.

We must note, however, that the portrait provided by adding the Security Guard Reports into the incident data brings a different conclusion. When we add the Guard Reports (only analysed for 1999), we see a much greater frequency of incidents during the evening and early morning hours. The Guard Reports suggest that virtually no incidents occur between 8 a.m. and 4 p.m., and that 137 of 159 incidents in 1999 occurred between 6 p.m. and 2 a.m. We have determined from interviews and from the data that when contract security was in place the Maintenance and Engineering staff generally responded to incidents during the day. In the evening and early morning hours, Maintenance and Engineering operated at low staffing levels and contract security staff responded to virtually all incidents. In other words, if we discount Guard Reports, as distinct from Security Incident Reports, we have the impression that problems associated with violence and aggression are spread quite evenly throughout the day. With the addition of the Guard Reports, however, we can see that there are more incidents during the evening and early morning hours. Two different sources of data produced quite different portraits of the occurrence of incidents by time of day (Chart D).

We should also note that the overall distribution of incidents by time of day is likely to be different in the Emergency Department than in the Psychiatric unit, the two units with the overwhelming majority of violent incidents. The Emergency Department of the hospital tends to experience most of its incidents during the late evening and early morning hours of the day, while incidents in psychiatry are spread somewhat more evenly around the 24-hour clock.
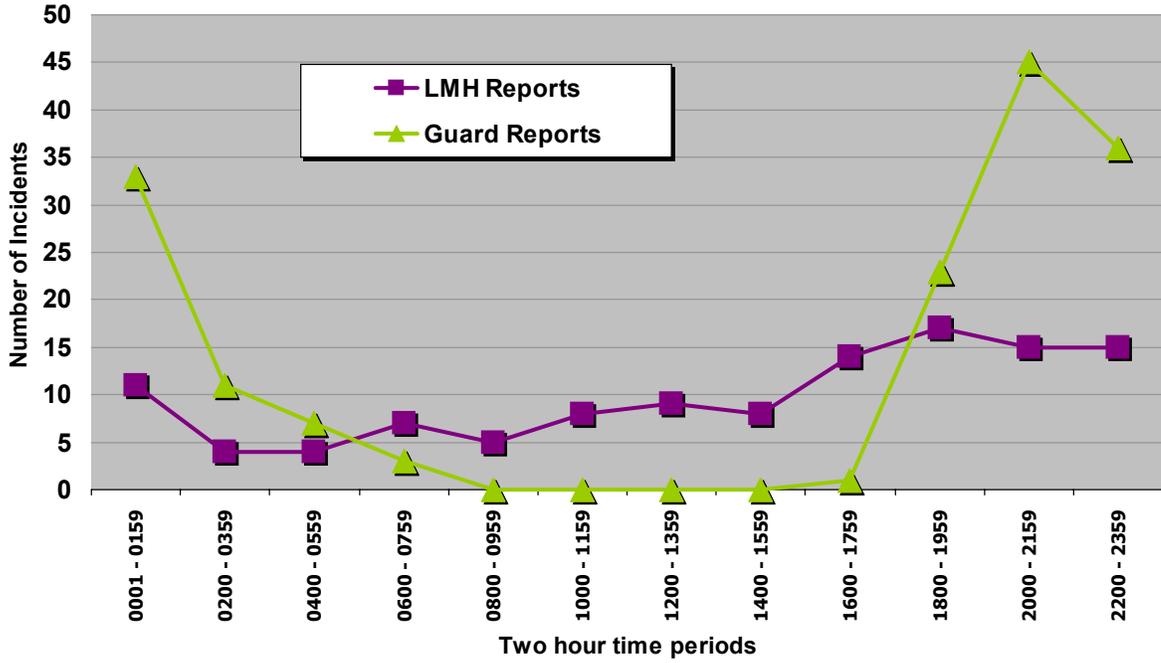
Chart D: Occurrence of Incidents by Time of Day for 1999

Occurrence of incidents by day of the week

Incidents are spread relatively evenly across the seven days of the week (see Chart E). As this chart also indicates, the differences among days of the week are not consistent from year to year; the figures for 1999 are not consistent with the figures for 2000 or 2001. In other words, there is no reason to believe that there are a disproportionate number of incidents at Langley Memorial on any given day of the week, regardless of the source of the data. None of the data analysed showed any discernable trend in incidents occurring on a particular day of the week.
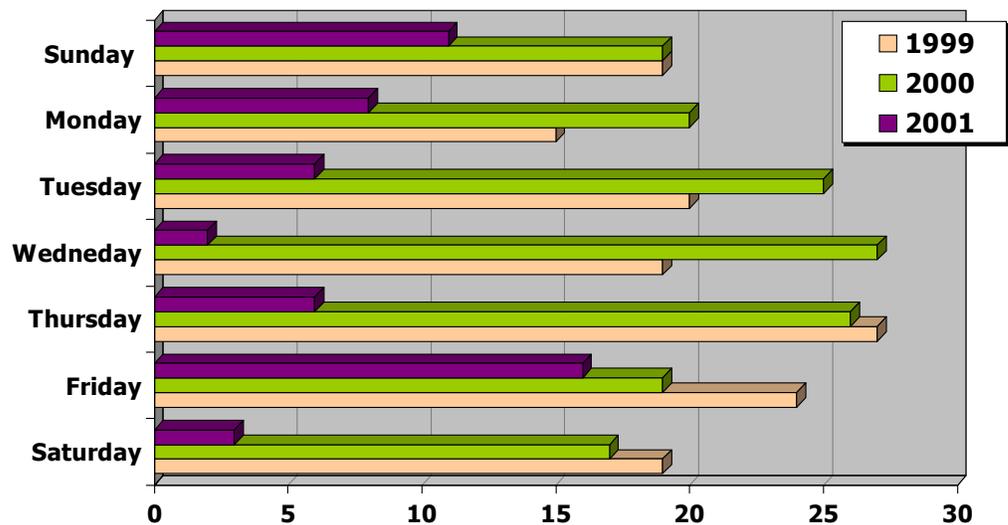
Chart E: Occurrence of Incidents by Day of the Week

Occurrence of incidents by month of the year

Incidents at Langley Memorial occur relatively consistently within the months of the year (see Chart F). As was the case with Chart C, Chart D indicates that differences among months are not consistent from year to year; the figures for 1999 are not consistent with the figures for 2000.

Again, there is no reason to believe that there are a disproportionate number of incidents at Langley Memorial during any specific month of the year, again regardless of the data analysed. The number of incidents in January and February of 2001 was considerably higher than in previous years, though the reasons for this are not clear; the figures for March of 2001 are, however, consistent with figures for the two previous years.
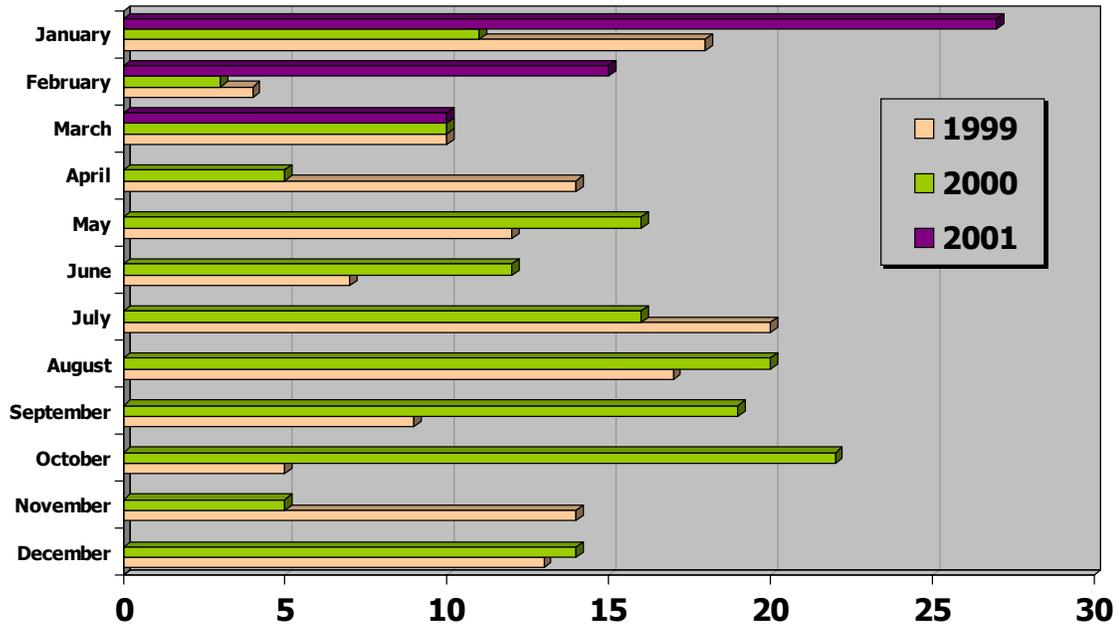
Chart F: Occurrence of Incidents by Month of the Year

Incidents with precipitating factors identified

The most commonly reported precipitating factors for incidents involving aggression or violence at Langley Memorial Hospital are "psychological problems" (Chart G), although it is important to note that precipitating factors are only reported in about half of all incident reports. It is also necessary to bear in mind the source of these psychological problems are not identified, so it is not possible to determine whether these are caused by dementia or drugs.

Also noted as variables of significance are intoxication, suicidal behaviour, and drug overdose or addiction. Again, the underlying cause of suicidal behaviour is not identified in any of the sources of information.

There are three significant points to make with respect to this data:

1. It is possible that these categories overlap. In other words, a drug addicted and intoxicated person with psychological problems may be present in a single incident.
2. These data again reveal the inadequacy of current incident reporting at Langley Memorial. In about half of all incident reports there is no mention of any precipitating factor, and in the overwhelming majority of all reports, there is very little narrative that would allow the reader to determine how and why the incident occurred.
3. We must set out an important caveat for the data presented: if we are to add the Guard Reports to the mix (only available for 1999), we find that intoxication plays a much greater role in the precipitation of incidents than the frequencies in Chart G suggest.
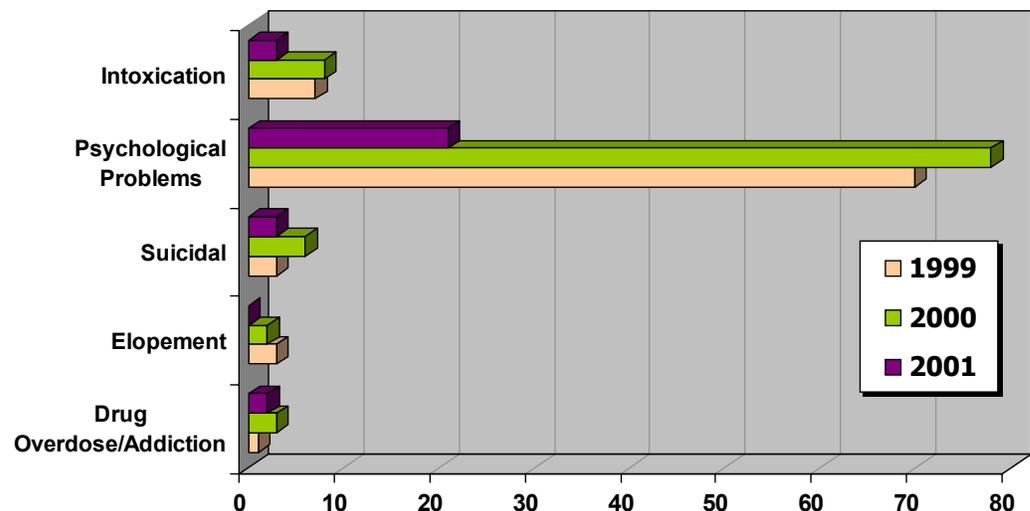
Chart G: Incidents with Precipitating Factors Identified

Incidents classified by code type: White, 33, and combination

Incidents by classification - Code White (Team response to a behavioural emergency, see Psych Manual 12.060), Code 33[20], (Team stand-by for administering medication or provision of escort to and from Seclusion rooms or nursing units, see Psych Manual 12.064) or not specified – are illustrated in Chart H. As the chart demonstrates, in almost 20 per cent of incidents the nature of the classification is not specified. More significantly, however, there is virtually nothing within incident reports that allows the reader to determine why a Code 33, rather than a Code White was called (or why a Code White rather than Code 33 was called). Chart H suggests, at least by implication, that there is a need to construct clear and consistent guidelines for the calling of a Code 33 and a Code White; there is a corresponding need to review these calls to ensure that the guidelines that are developed are consistently applied over time.
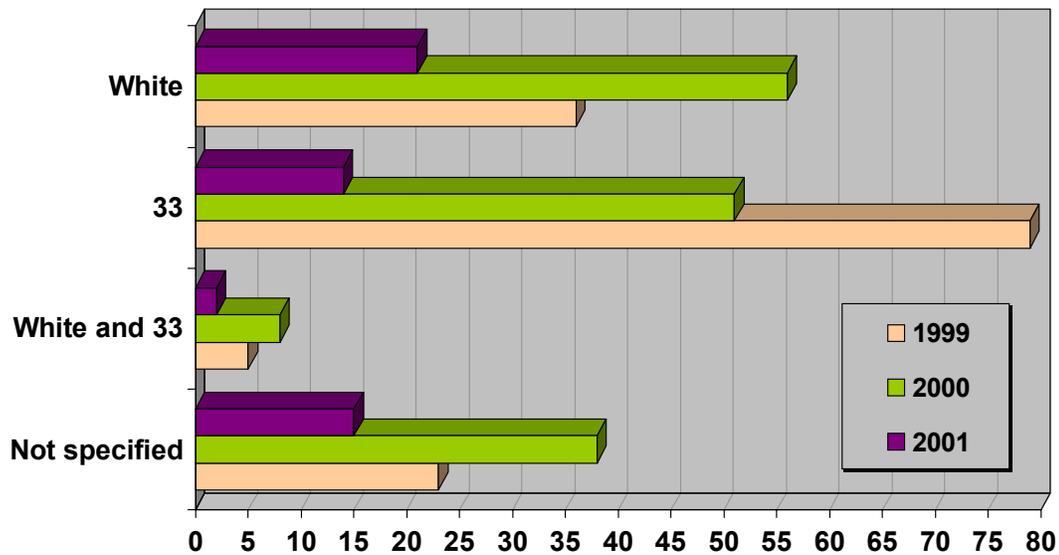
Chart H: Incidents Classified by Code Type

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[20]   See Appendix K: Definitions

Types of incidents due to force or violence

Hospital staff appears to be most at risk of experiencing verbal hostility (22.3%) or intimidating gestures (21.9%). This conclusion is drawn from responses received from 65 LMH employees who provided information on the types of aggression they experience working in the acute care sections of the hospital. However, of more concern is the almost 20% likelihood of being subjected to striking, kicking or grabbing. Chart I below shows the categories of aggression reported by staff, using the WCB definitions[21] of each category.
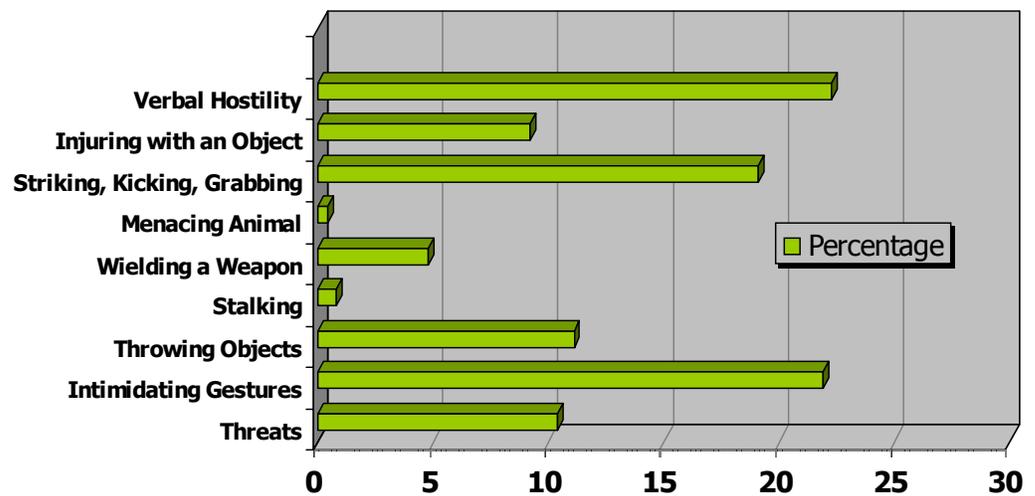
Chart I: Types of Violent Incidents

RCMP presence during violent incidents

A number of LMH management and staff interviewed by the Advance team expressed concern about the number of times RCMP was called to the hospital. This question appears to have come to the fore because of the number cited in the recent Coroner's report, which indicated that RCMP attended at LMH on 113 occasions in 1999 and 112 calls from January to September of 2000.

Our research was unable to correlate the number in the Coroner's report with any of the data available. When asked, the RCMP was unable to provide a breakdown of the number cited in the report. However, it appeared from the data we analyzed that the vast majority

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[21]   See Appendix K: Definitions

of reported incidents (approximately 80%) at LMH are resolved without RCMP involvement. There was not any evidence of the RCMP attendance being primarily linked to incidents of violence at the hospital.

Of particular note is the fact that it is not possible to identify who initiated the RCMP presence in the hospital. There are no data indicating how many times the RCMP involvement was at the request of hospital personnel.

Chart J graphically represents the results of our analysis of the LMH incident/security reports regarding RCMP involvement in violent situations.

In 1999, the RCMP was identified as being present during 22 of 143 situations at Langley Memorial Hospital, representing 15.4% of situations. Of these 22 situations, the RCMP was present in 4 situations because they had brought the patient to the hospital. In one situation, the RCMP officers were present because the event involved theft from the hospital. Another event involved the RCMP because they were questioning two patients who had been fighting with each other. One other event involved the RCMP because they were returning a patient to the hospital.

In 2000, the RCMP was identified as being present during 28 of 153 situations, representing 18.3% of situations. In 3 of these 28 situations, the RCMP brought the patient to the hospital. In 2 of the situations, the RCMP was already on site. In another situation, a patient called the RCMP.

In 2001, the RCMP was present during 16 of the 52 situations that occurred, representing 30.8% of situations. In 7 of the 16 situations, the RCMP brought the patient to the hospital. In one situation, the patient called the RCMP. In another situation, the RCMP was already on site and assisted during the event. During one situation, the RCMP used a taser gun to subdue a patient, but the records do not indicate whether this patient was arrested.

The data from the RCMP and from LMH information could not be correlated in any way to provide useful conclusions. What must be determined is the reason why RCMP officers were at the hospital, which should be captured within a master incident reporting system. If future statistics show that hospital personnel are increasingly calling the RCMP to assist with violent patients, this trend would require careful analysis.
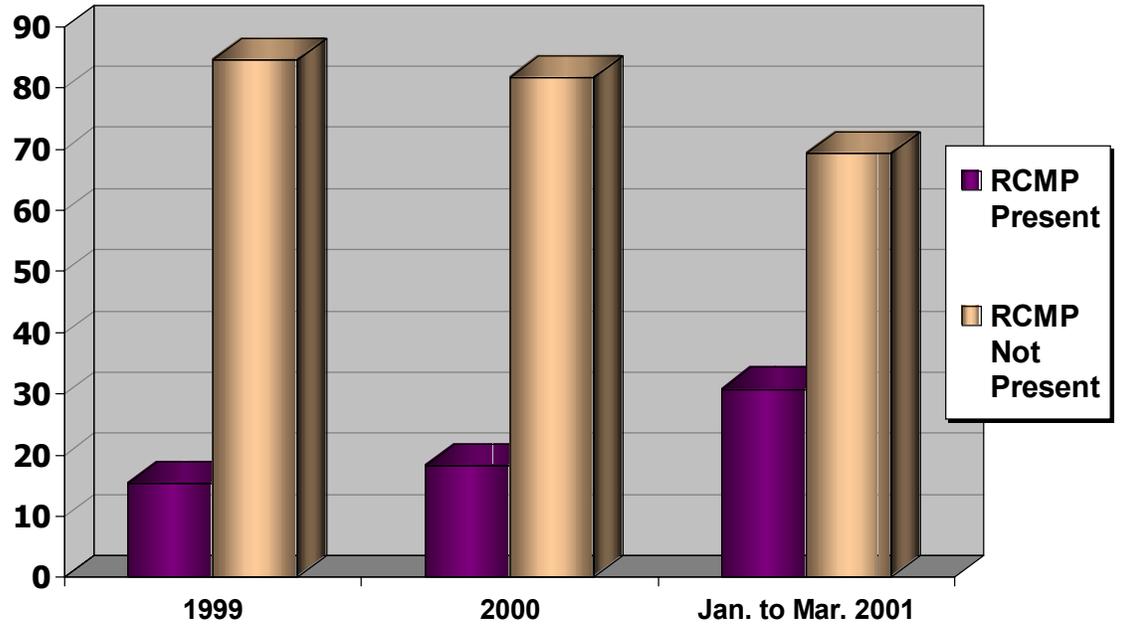
Chart J: RCMP Presence During Incidents

5.2 Analysis of Injury Data Related to Force or Violence

Our first step in analyzing Langley Memorial Hospital's injury experience was to consider the location of incidents which resulted in injury. At the same time we considered the job requirement which placed an employee at risk of injury.

The 1999 injury experience at LMH, noting location of incident and type of employee injured, is illustrated in Chart K. Facts of note are:

■ In 1999, LMH experienced 9 separate situations involving force or violence that resulted in 16 reported injuries or post-incident stress trauma;

■ Seven of the 16 reported injuries resulted from one incident in the Emergency Department; and

■ Three injuries occurred in 2 North, a unit that reports very few incidents.
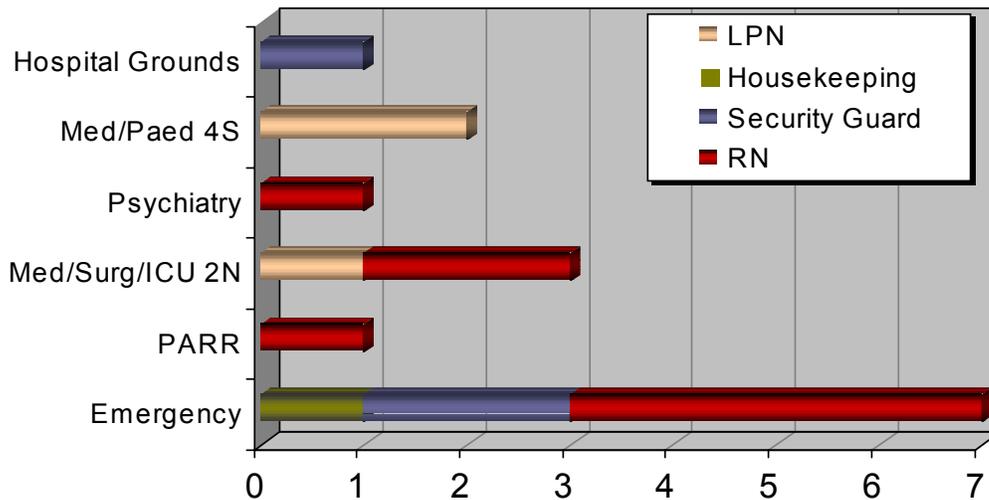
Chart K: Comparison of Injuries by Job Category and Location for 1999

The 2000 LMH injury experience due to force or violence is illustrated in Chart L. Facts of note here are:

■ In 2000, LMH experienced 18 injuries or trauma as a result of 14 acts of violence or aggression; and

■ Psychiatry experienced the largest number of injuries in 2000, a total of eight.
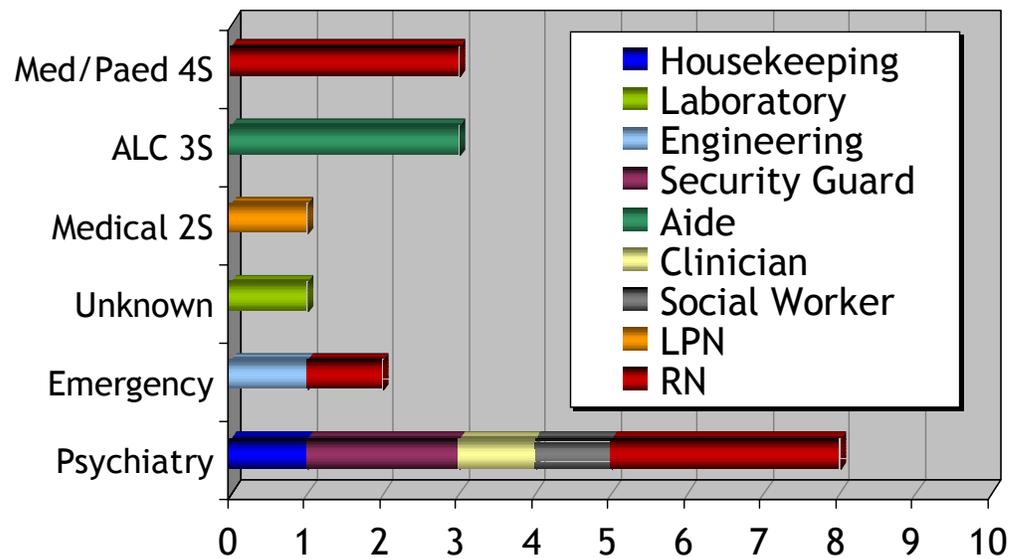
Chart L: Comparison of Injuries by Job Category and Location 2000

5.3   Analysis of Areas of Risk

It is when the injury statistics from these two years are combined, and incident data is also considered, that some useful conclusions can be drawn about the level of risk, as defined by the WCB[22], for categories of employees and departments within LMH.

For the purposes of this risk assessment an incident was considered to have a severe consequence if there was an injury resulting in lost work time or worse or an incident resulting in injuries to more than one person, regardless of whether there was lost work time. An incident was considered to have a moderate consequence if there was an injury, but did not result in lost work time. An incident was considered to have a minimal consequence if there was no documented injury to a worker.

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[22]   See Appendix K: Definitions

In conducting risk assessments, it is not unusual to assign 'risk scores' to identify job categories and locations most at risk of injury. Because of the variations in data available, our decision was that the probability of generating misleading results using this process was too high, and we have therefore omitted it from LMH's risk assessment report.

High risk job categories and departments

Staff having a high frequency of exposure to workplace violence are those who work, or are required to attend patients, in Emergency and Psychiatry. Additionally, those who respond to potential or actual incidents of violence throughout the Hospital, such as the Emergency Behavioural Response Team (Code White), and Security (Protection Services) are also at high risk of exposure to force or violence.

Incident Location	1999	2000	1st Quarter 2001
Emergency	43	53	26
Psychiatry (1S)	56	71	16
Emerg to Psych Escort	4	2	1
Medical (2S)	5	4	4
ALC (3S)	3	0	0
Med./Paed (4S)	6	4	2
Med/Surg/ICU (2N)	15	6	0
Maternity (3N)	0	1	0
Parking	2	4	1
Unknown	9	6	3
Other	2	2	0

Table 5: Location of Incidents

The highest risk occupational category of employee is RNs. There were 8 reported injuries to RNs in 1999 and 7 in 2000. In 1999, at least one RN had a lost work time injury relating to an incident in the Psychiatric Department. Another two RNs from the Psychiatric Department had lost work time injuries resulting from an incident occurring in the Emergency Department, reflecting employee vulnerability to severe injury consequences in both these departments. In 2000, there was at least one lost work time injury to an RN in the Psychiatric Department.

Injuries 1999	Psych 1S	Emerg	PARR	Med/Surg/ ICU 2N	Med/Paed 4S	Hospital Grounds
LPN				1	2	
Housekeeping		1				
Security		2				1
RN	1	4	1	2		

Table 6: Location of Injuries 1999

Injuries 2000	Psych 1S	Emerg	Unknown	Med 2S	Med/Paed 4S	ALC 3S
Housekeeping	1					
Laboratory			1			
Maintenance/ Engineering		1				
Security	2					
AIDE						3
Clinician	1					
Social Worker	1					
LPN				1		
RN	3	1			3	

Table 7: Location of Injuries 2000

Injuries that have been experienced by other categories of employees, i.e. Housekeeping, Maintenance/Engineering and Security staff, occurred during Code White team responses and did not result from exposure to force or violence within these departments.

Those who participate on the Code White team are considered to be at high risk of exposure to acts of force or violence because they are likely to be asked to respond to violent incidents. In both 1999 and 2000 there was one lost work time injury to Code White team members (not including the then-contract security guard experience where injuries to guards were noted on Security Incident reports, but not captured in LMH incident records).

Moderate risk job categories and departments

Nursing care staff on nursing units, other than Emergency and Psychiatry, are a moderate risk of exposure to workplace violence. However, due to our concern for anomalies in the incident and injury data for some nursing units indicating a number of staff injuries and correspondingly few or no incident reports, it is important that LMH carefully monitor incident/injury trends for patient care staff working on 3S (ALC), 4S (Med/Paediatrics), and 2N (Med/Surg/ICU). It is possible that incidents and injuries are underreported on

these nursing units and the actual incidence of violent encounters is much higher than recorded.

Other hospital departments providing diagnostic or other services to violent or potentially violent patients should also be considered to be a moderate risk and be included in general training programs for dealing with high-end violence.

Low risk job categories and departments

All other categories of employees and departments at LMH, based upon the incident history, can currently be considered to be low risk. However, vigilance is required because the ever-changing work environment can lead to changes in a department or occupation's exposure to workplace violence.

General observations

What this analysis brought to light is the need to differentiate between the location where an employee works and the place in the hospital the incident occurred. These are often not the same, and this is important information for trend monitoring and training assignments (e.g. a Psychiatry nurse injured when responding to an incident in the Emergency Department).

LMH's risk experience is consistent with the healthcare industry in general. As the WCB reports, "Emergency departments, care environments for patients/clients with psychiatric illnesses, and long-term care settings, particularly special care units, have been found to present the highest risk of violence."(Preventing Violence in Healthcare).

6.0 OVERVIEW OF OBSERVATIONAL RESEARCH

In addition to the quantitative research and analysis, a significant portion of this project involved interviews with key personnel, reviews of available documented information, an audit of the physical aspects of the worksite, as well as a thorough review of external resources[23].

LMH personnel provided extensive access to the documentation they considered relevant to this project, with the result that the Advance team looked at reports, guidelines, training materials, memos, e-mails, grievances, JOSHC minutes and manuals, etc. In addition, the Advance team was asked to review the comments provided by the Coroner's Court of BC following the shooting death of a patient in the Hospital's Emergency Department in December 1999.

6.1 Document Review

A wide range of LMH materials were reviewed as part of this project. A specific list of documents is provided in Appendix I.

As part of this review Advance team members prepared detailed comments on LMH's general workplace violence prevention policies and in particular the Psychiatric Manual Interdepartmental Policies and Procedures[24]. The main recommendations from this review have been incorporated into the general recommendations provided with this report.

6.2 Review of BC Coroner's Report 1999 on Shooting Death In Emergency

As part of this project the BC Coroner's report on a 1999 shooting death in Emergency was reviewed. Attached to this report is a commentary resulting from our examination of the details in the Coroner's findings.[25]

A more detailed commentary of observations, comments and suggestions may be accessed via Langley Memorial Hospital's quality improvement process.

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[23] See Appendix C: Report References

[24] See Appendix E: Review Psychiatric Interdepartmental Policies and Procedures

[25] See Appendix F: Review of Coroner's report

6.3   Worksite Audit

There were no departmental audits dealing with physical security available to review. Recorded incidents from 1999 and 2000 security logs associated with physical plant included:

- doors or windows left insecure,

- alarm system malfunction,

- building maintenance required, and

- improper parking.

In 2001 there were recorded incidents of vehicle break-ins in the staff parking lot.

Workplace design issues were not generally a factor in the most serious incidents recorded in security logs. The most serious incidents involved responding to incidents of force or violence, both involving patients and the visiting public.

Work site surveys were carried out for the following hospital areas:

- Emergency (ER),

- Psychiatry (Psych - 1S),

- Seclusions rooms (ER and Psych),

- A representative nursing unit – Medical/Surgical/ICU (2N),

- Cashier's office,

- Switchboard,

- Diagnostic Imaging,

- Admitting reception area.

In addition, Hospital entrances/exits, stairwells, main waiting room, overall grounds and parking areas were reviewed. General tours were conducted of the following areas:

- Maternity (3N),

- Alternate Level of Care (ALC - 3S),

- Medical Laboratory,

- Operating Room/Post Anaesthesia Recovery Room,

- Physiotherapy,

- Occupational Therapy/Rehabilitation,

- Ambulatory Care,

- Maintenance,

- Housekeeping,

- Food Services,

- Administration.

The specific identified risks from the worksite audit have been incorporated into the detailed recommendations of this report.

6.4 Comparisons of SFHR Hospitals' Injury Data

Table 8 documents WCB claims for acts of force or violence in the acute care units of the four hospitals within the South Fraser Region in the year 2000. The table indicates that given hospital size the incidence of violence claims in Langley Memorial's acute care units is no greater than the incidence of violence claims at other hospitals within the region.

It is also important to note that those who are injured or traumatized by acts of force or violence in health care settings may not make an official disability claim in response to their difficulties. Both decreased productivity and increased absenteeism are other, albeit less identifiable, employee responses to these incidents. Careful monitoring of absenteeism statistics can identify whether major incidents are followed by increased absenteeism among those staff or departments involved.

EAP utilization data, while available, was not segmented in a way which would indicate whether a relationship exists between EAP use and the aftermath of severe incidents.

The Regional report covers the year 2000. Table 8 compares each facility's acute care bed capacity and Emergency Department volume with its injury due to force or violence experience. Although we know that the data shown here for Langley Memorial is incomplete, and inconsistent with other information, this is the only data provided which allowed us to compare across facilities, with the assumption that the reporting process is consistent within the Region.

Facility	Number of Acute Care Beds	Emergency Department Volume	WCB Violence Claims	Claims/Acute Care Beds %
Delta Hospital	90	21,686	4	4.4%
Langley Memorial Hospital	200	39,036	10	5%
Peace Arch Hospital	178	31,616	11	6.2%
Surrey Memorial Hospital★	356	73,470	23	6.5%

★ we note that one incident seems to be recorded twice

Table 8: Regional Injury Data

It is important to remember here that these numbers do not include any injuries experienced by contract Security personnel. During the year 2000, contract personnel provided security services at all four facilities. As a result, their injury experience data was not included with hospital employee statistics.

7.0 EXTERNAL RESEARCH

7.1 Richmond General Hospital

A positive review of Richmond General Hospital's (RGH) Management of Aggressive Behaviour training program curriculum[26] prompted Advance to consult a number of this hospital's personnel to obtain more in-depth information about this program and their experiences. In general, these individuals reported that incidents involving injuries or damages are decreasing, although overall incidents have increased in number. However, many staff who are trained for Code White response do not, in fact, participate in actual situations, leaving this responsibility to be handled predominantly by Security personnel.

The RGH Code White training is a four-hour CPI-based introductory program. This is provided primarily to Building Services staff, porters, nurses in Psychiatry and night nurses from other units. Concerns were expressed regarding Building Services staff, whose participation in Code White Team is mandatory. However, many of these staff appear to be emotionally and physically unsuited for the Code White assignment. This typically means that the two on-duty Security guards, sometimes assisted by RCMP or BC Ambulance Services paramedics, handle most of the restraint duties during a Code White response.

As evidenced by the comments from Code White Team participants and in the opinion of our consulting team, CPI-based Management of Aggressive Behaviour training programs, such as the one offered at RGH, should be used as a foundation level of training and do not provide the skills necessary to respond to high-end violence in a behavioural emergency. At the same time, it would seem that selection of individuals to participate in Code White calls requires that individual attitudes and attributes be taken into account to a greater degree.

Security staff provided statistics for two months' experience at RGH. This is captured in Table 9:

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[26]   See Appendix C: Report References

Response to Behavioural Emergency	May 25/01-June 21/01	June 22/01 - July 19/01
Code White Stat (Usually involving physical restraint in ER)	0	12
Code White (Usually a standby)	2	1
Code White Meds (Either hands-on or standby for meds)	7	3
Psych patient restraint	0	4
Psych patient standby or escort (Non-compliant, verbally abusive, history of violence)	168	135
Total	179	155

Table 9: Response to Behavioural Emergency, Richmond General Hospital

The process for calling a Code White differs from LMH's in that the decision to call a Code is made by Security once they arrive at the scene of an incident in response to being paged.

One member of Security interviewed reported a number of injuries – a broken wrist, blood borne pathogens exposure and four pairs of broken glasses – in the past ten years. However, with an increase in training since 1996, incidents involving injuries or damages have decreased. The total number of calls, however, has been steadily increasing over the years.

7.2   Ridge Meadows Hospital

Another facility for which we were able to obtain some statistics was Ridge Meadows Hospital. This 92-bed (acute care) facility, with an Emergency Department volume of over 36,000 visits, in fiscal 2000/01 documented 125 "aggressive" acts. On three occasions, the incidents led to the RCMP being called to the hospital.

It is not possible to compare these statistics to LMH's experience because of variations in reporting and defining acts of force or violence.

7.3   Similar Training Programs

Our review of other training programs, along with team members' extensive experience in this area, led us to the conclusion that increased training does lead to eliminating or reducing the consequences of violent or aggressive behaviour. We also noted a correlation between the scope of training programs and positive results.

The April 2000, the KPMG Consulting Group LP report[27] for the provincial Ministry of Advanced Education, Training and Technology, WCB, Vancouver/Richmond Health Board and the Centre for Curriculum, Transfer and Technology includes a review of samples of available curricula relating to occupational health and safety within the Lower Mainland area of BC. The report singles out Richmond Health Services Management of Aggressive Behaviour (MOAB) curricula as noteworthy. It is important to note that the KPMG review related only to curriculum design and not program effectiveness. When this curriculum was reviewed in more detail, it did not appear to be suitable for Code White responders, offering only limited opportunities to develop the high-level skills necessary for direct involvement in violent incidents. This view is supported by interviews with Code White Team participants at Richmond General Hospital.

In their recommendations, KPMG note that "the development of consistent, quality resources will require much more work" with substantial input from content experts with experience in the health care setting. Future efforts would also, in our opinion, need input from experts in the prevention and management of aggressive behaviour, in addition to experts in educational processes.

External sources also confirm that there is a significant relationship between participating in training and not being assaulted. A study (Caramel & Hunter, 1988) comparing injuries among those who had or had not taken a 16-hour MOAB training program noted that non-participants were 65% more likely to be injured.

As a result of attending effective violence prevention training programs, participants verbalize and demonstrate increased confidence in managing assaultive behaviour, possess expanded objective knowledge about preventing potentially threatening situations, an increased sense of team morale, and have reduced rates of actual patient assaults (Fisher 1994).

7.4 Langley Crime Rate Statistics

Our examination of the community's experience in reported crimes showed no correlation with the hospital's experience with incidents of force or violence.

A common theme during this project was a perception that crime is on the increase in Langley, and this is spilling over into the hospital's experience. As a result, and to identify whether the immediate local environment does in fact present a risk factor to the hospital, the Advance team obtained crime statistics for both Langley City and Township for the last ten years. These statistics are not limited to violent crime, however. The reporting system includes all types of criminal activity occurring in the area.

Chart K captures the results of this analysis:

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[27] Ibid. See Appendix C
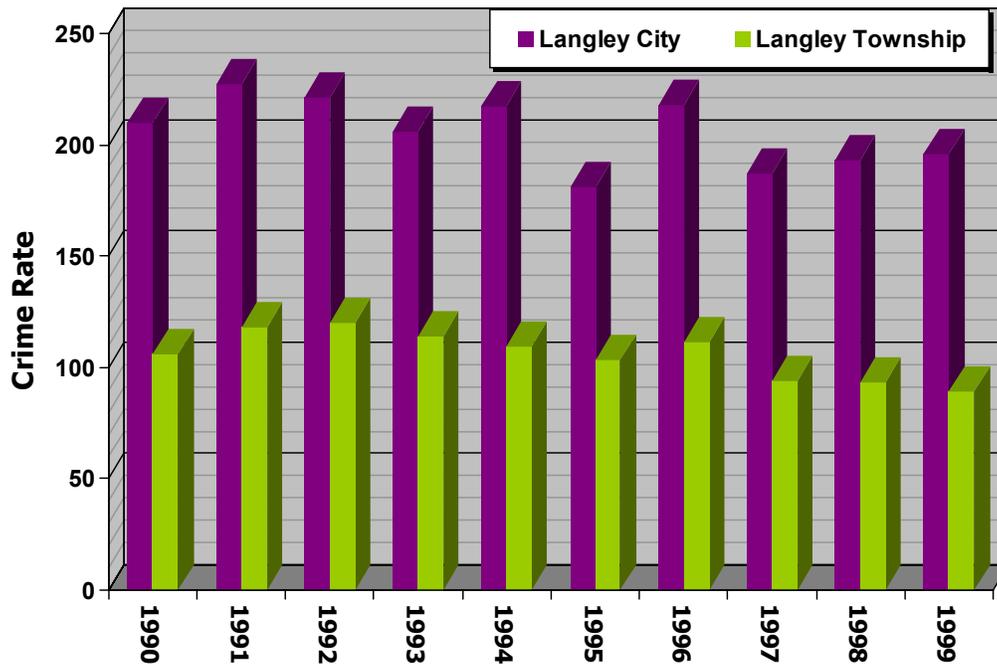
Chart K: Municipal Police Crime Statistics

It appears that the crime rate in both municipalities has shown no upward trend: indeed, the reverse is more the case. These crime rate statistics do not support employees' concerns about increased crime being reflected in the hospital's experience.

7.5   Relevant Case Law

Some Code White team members expressed concern that they might be held personally liable if a lawsuit were to result from an incident involving force or violence where the employee injured a patient in self-defence. In particular, staff members were concerned that this liability would occur if they used tactics not covered during training and therefore not "approved".

Although this is a possibility, we would note the following points:

■ Under the Criminal Code of Canada, as quoted in the WCB publication "Preventing Violence in Health Care", every individual has the right to "use as much force as is reasonably necessary to prevent an assault from occurring, or to defend himself or anyone under his protection as long as he uses no more force than is reasonably necessary to prevent the assault or repetition of it".

■ There is some case law that suggests the employer may be held liable in such incidents, if the law ruled in favour of the patient, because involvement in Code White response will be considered within the scope of employment.

P.A.B. v. Curry (1999)[28] is a possible precedent, in the event a patient was to sue the hospital as a result of injuries sustained during a Code White procedure. The case confirmed that employers are held vicariously liable for employees' torts falling within the "scope of employment". The Supreme Court held that an employer is vicariously liable for the wrongful act of its employee where (i) the employer's enterprise created or enhanced a risk, and (ii) there was a significant connection between that risk and the wrongful act. The Court also ruled that a non-profit employer is not relieved of liability.

A patient may be successful in a suit brought against the institution, even when an employee's act causing the injury was not authorized officially in the Code White procedures. The possibility of individual liability would depend on the facts and circumstances of the given case.

Because of the legal complexities of issues surrounding individual and institutional liability, we recommend that SFHR personnel seek legal counsel's opinion on this issue.

7.6 International Experience of Violence in the Healthcare Workplace

The Advance team researched the availability of relevant data from across Canada and internationally[29]. Two clear conclusions emerged from this extensive literature review:

- No national population-based epidemiological database covering workplace violence exists, with the result that broad conclusions are usually based on fragmented data; and

- Security personnel and healthcare professionals, particularly nurses, are the occupations most at risk of experiencing workplace abuse and violence.

Observations from the research of note in light of SFHR's interest in workplace violence include:

- Healthcare generates the largest segment of WCB claims resulting from acts of violence or force (7% between 1994 and 1998), compared to 2% from all other BC industries. WCB also reports an 88% increase in wage loss claims by hospital workers due to acts of violence or force since 1988;

- Studies across Canada (Manitoba, Ontario, Saskatchewan, Nova Scotia, and Toronto) all confirm that nurses routinely experience aggression or actual physical assault from patients[30].

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[28] See Appendix C: Report References Filion Wakely Thorup Angeletti LLP (1999). P.A.B. v. Curry, (1999) S.C.J. No. 35. www.filion.on.ca/articles/caselaw9908g.html

[29] See Appendix C: Report References

[30] See Appendix C: Report References

8.0 OBSERVATIONS REGARDING LMH'S WORKPLACE VIOLENCE PREVENTION MEASURES

8.1 Workplace Violence Program Structure

During the course of our interviews, staff and managers were unable to describe the formal structure of Langley Memorial Hospital's violence prevention program.

At the Regional level, a Management of Aggressive Behaviour Training Program was in process of being developed and the Advance team was provided with a draft outline of the master program manual containing the following headings:

- Regional Management Philosophy and Responsibilities

- Risk Assessment Procedure

- Training and Orientation, Site specific, Code White

- Identification of Patients: Acute Care and Geriatric Services - i.e. flagging in computer and purple dot

- Aggressive Behaviour response

- Code White response

- Code White Intervention response

- Post Incident response

- Legal recourse for injured employees

- Reporting aggressive behaviour

- Patient care guidelines - screening and risk assessment, alcohol and drug dependant, elderly , application of restraints, visitor guidelines

- Working Alone - risk assessment, work procedures, training

- Hazard Prevention and Control

- Program Evaluation

- Appendices: Employee survey risk assessment questionnaire, Physical environment survey, Incident reporting flowchart, WCB regulations, Code White Team Profile (core competencies)

- Sample risk assessment checklist

Much of the material required to complete this draft had yet to be developed.

8.2 Workplace Wellness Organization Structure

The Workplace Wellness function is organized regionally, with Safety Advisors reporting to the Regional Human Resources/Labour Relations function. One Safety Advisor is physically located in each Health Service area. One Safety Advisor functions as the Team Leader. Safety Advisors have no authority for workplace violence program. They serve in an advisory capacity to line staff who bear the ultimate responsibility for ensuring that approved programs are implemented.

8.3 Data Collection

LMH has made considerable progress in the important priority of collecting consistent data. A standard form has been developed, with the contents being amalgamated into the Regional Employee Injury Exposure database. It is essential that all appropriate sources be asked to report using this form. For example, Code 33, Security Department reports, non-patient incidents, medication stand-by calls, and resolved incidents, when included in this database, can result in more effective trend and actionable analysis.

8.4 Patient Versus Staff Safety

Many healthcare policies have, to some degree, inadvertently implied that staff safety was of lower priority than patient safety. This is clearly not the intent of LMH's efforts in this area and current materials are now spelling out this balance more clearly.

8.5 Security Services

The decision to switch from contract to in-house Regional Security (Protection) services is viewed within the hospital as a positive step. In particular, this has resulted in a much higher level of confidence in Security personnel, particularly when staff must call upon them for assistance.

The selection standards have brought on board trained staff, with appropriate skills and experiences. Standardized violence prevention training needs to occur as a priority for those staff that come from various security backgrounds.

The planned new security co-coordinator position has significant potential for positive effect on managing incidents of force or violence. This position could be used to provide organizational support to the Code White team, and could play an important coordination role in incident investigation and reporting requirements.

8.6 Planned Management of Aggressive Behaviour Training

Advance was provided with an outline for the South Fraser Health Region's planned Management of Aggressive Behaviour (MOAB) training program.

The proposed training program[31] offers an appropriate foundation level of knowledge, skills and attitudes suitable for all staff who have direct patient contact including those who are at moderate or high risk for exposure to some level of patient violence. However, the Code White training provides little guidance for situations that escalate beyond a particular level of violent behaviour and should not be expected to meet the requirements of these situations.

Many hospitals in Canada experience episodes that fall beyond the scope of core training and have a need for more extensive or supplementary training programs to deal with these situations. The Health Care Health & Safety Association of Ontario, Workplace Violence Prevention Program Manual, 2001[32], notes that, "Employees should receive both general and job-specific training. Training should be part of the general orientation process for all new employees and refresher sessions should be conducted for all staff on a regular basis. Training should be mandatory." The WCB of BC states, "Workers with tasks or locations that place them at higher risk for violence incidents should receive specialized training in addition to the core education and training…"[33]

As the research for this project has shown, the location of incidents of force or violence at LMH is relatively unpredictable, so a core program will need to be offered for those staff having direct patient contact and all Code White responders.

During our interviews, a number of staff expressed concern that the training they previously received did not meet their needs for dealing with high-end violence, such as a Code White response. It is important to remember that CPI-based core training program is

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[31] See Appendix J: Planned SFHR Management of Aggressive Behaviour Training Program

[32] See Appendix C: References - Health Care H & S Association of Ontario, Workplace Violence Prevention Program Manual, 2001.

[33] See Appendix C: References - WCB of BC, Preventing Violence in Healthcare, 2000

a foundation program, and is an essential first step prior to taking any higher-level, risk-specific training programs. Core training is not intended to meet the needs of those encountering high-end violence. Training to deal with high-end violence, particularly for Code White responders, needs to be carefully designed and implemented as soon as possible.

8.7   Code White

Our review of Code White at LMH involved a number of steps. We conducted personal interviews with involved staff members, and reviewed the extensive documentation provided by the hospital[34]. The results of this research, combined with the expertise of Advance team members in this area, have been incorporated into the recommendations in this report.

Currently, participation on the Code White team is perceived to be mandatory for staff from Engineering/Maintenance and Housekeeping, as well as members of the Security department. Official Regional policies also indicate that members of the Nursing Department, in particular staff from Emergency and Psychiatry, are part of the Code White team. Concerns were expressed, primarily by Maintenance/Engineering and Housekeeping, that some staff members from these departments currently participating in Code White responses are unsuited for the task, by virtue of size, age, physical condition or personal inclination. In addition, the number of casual employees in Housekeeping has made it difficult for these staff members to gain the necessary skills and experience to become effective team members.

Because participation on the Code White team at LMH was, in practice, mandatory, no specific selection or exclusion criteria were being applied. In some instances, individuals with physical limitations could be excused on presentation of appropriate physicians' documentation.

All available staff respond when a Code White is called, with the result that sometimes a larger-than-necessary group is available, while at certain times such a small number of responders is available as to be considered inadequate to deal with what is usually an escalated incident.

Code White team members in general have a concern that their training is insufficient to resolve the situations they face, and on a number of occasions, the participation of the team has not prevented injuries to staff members.

In response to the widely-held view that Code White team members required additional training, an in-service was provided for the Team and conducted by their peers. This was intended to practice take-down techniques, using simulations. Following the practice, the

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[34]   See Appendix I: Documents Reviewed

team was to identify what techniques worked best for them. On the one occasion this training occurred, it resulted in an injury to a participant owing to the high level of aggression used during the simulation.

Anecdotal evidence indicates that those currently involved in Code White face situations that sometimes require them to act on their own initiative when an incident requires skills beyond those covered in core training. Once this occurs, each individual participating in a Code White episode may call upon prior skills and experiences to select a method for restraining the aggressive patient. In some instances, we have learned of control and restraint methods being used that could have serious risk management implications for the hospital.

In general, concerns about the Code White team and training have been noted for a number of years, and considerable effort has been given to moving towards a resolution of this issue.

Recent Joint Occupational Health and Safety committee agendas routinely include discussions of Code White concerns. It is important that this joint group be in a position to recommend solutions.

The current Code White team members are to be commended for their commitment to responding to calls and the contribution they make to preserving and improving patient and staff safety at Langley Memorial Hospital.

8.8   Alert/Flagging System

Langley Memorial currently uses a "purple dot" system to flag potentially violent individuals. Although well written policies covering this system are already in place, feedback from personnel interviewed identified the need to improve the practical implementation. Some departments do not appear to receive these alert flags, particularly those involved in diagnostic testing, and all patient notes require more specific information, such as details about risks and triggers.

This system has a role in protecting those in the Extended Care units at the hospital, when transfers occur from Acute Care, and vice versa. Interfacility transfers also have the same flagging requirements

9.0   RISK ASSESSMENT AND TACTICAL ANALYSIS

During the course of this project, many Langley Memorial Hospital staff expressed the belief that performing a risk assessment such as this one would provide a series of checklists or tools which could be applied to resolve workplace violence issues at other facilities. While a number of elements of a risk assessment can be handled in this manner, as clearly explained in the Workers' Compensation Board of British Columbia's excellent handbook "Preventing Violence in Healthcare", we are concerned that this perspective reveals a basic misunderstanding of how a risk tool is constructed. There is widespread agreement among experts in this field that developing a standard risk assessment tool requires analysis of multiple sites and input from a number of "content experts". It would be imprudent to develop and use risk assessment tools based on the results of analyzing a single site.

The risks of oversimplification and reliance on checklists lie also in the dynamic and unpredictable nature of violent incidents. Managing such incidents requires trained, skilled and experienced staff, capable of responding to the unpredictable nature of each unique situation to achieve the desired outcomes of patient safety and staff safety.

Four specific measures can be taken to achieve patient and staff safety:

- prevention of incidents;

- defusing hostile or angry individuals;

- disengaging from a hostile encounter; and

- the use of self-defence when all else fails.

These four measures are consistent with Health Care policy and with legal legislation, such as the Criminal Code of Canada. These measures are also logical and reasonable. They form not only a foundation for the physical safety of staff and patients, but also for the legal safety of staff, patients and the organization.

The other key factor in analyzing risk is an understanding of the types of force or violence that staff might encounter during their workday. Based on industry data, four types of hostile behaviour most experienced by those in the health care profession are:

- verbal abuse;

- passive resistance;

- active resistance, and

- assaultive behaviour.

A fifth type of aggression is called deadly force attack. However, the use of this level of attack against health care staff is extremely rare and has not been included in this analysis.

The four measures previously described when assessed against the four levels of aggression together form the basis of "Tactical Analysis". Tactical analysis is a "skill" as opposed to a "tool", and the skill must be applied when using any risk assessment tools, analyzing results or making recommendations.

Consider this example. In the Emergency Department there is a reception counter that patients or visitors must visit to gain access. The question of what makes the staff member safe at that location depends upon an analysis of the type of aggression anticipated coupled with the ability to prevent an assault, defuse an individual, or leave (disengage) should that become necessary.

If we assume that staff might experience assaultive behaviour, tactical analysis reveals that a fairly high and wide counter would be appropriate, as well as removing or securing all objects that could be used as weapons. The ability for a staff member to leave would next come into question. A tactical analysis would indicate that the reception area must have a ready and unobstructed escape route. Another component in this example would be training staff to verbally defuse a hostile individual, including how and when to disengage. Tactical analysis would move to the next logical step of staff training in recognizing cues to violence, defusing hostile individuals, use of alarms and other methods of summoning assistance.

10.0 RECOMMENDATIONS

In general, Langley Memorial Hospital and South Fraser Health Region management are firm in their commitment to the issues of preventing and managing workplace violence. To achieve their stated goals, the team must remain constantly vigilant to identify possible sources of violence and implement measures to eliminate or minimize risks and evaluate the effectiveness of risk control measures.

At the same time, the inevitability of those risks requires that staff be prepared to handle potential risks and consistently report those incidents they encounter.

To assist the LMH team develop a workplace violence management program that mitigates as much as is feasible the inevitable risks of a healthcare environment, the Advance team puts forward recommended future actions designed specifically to meet Langley Memorial's unique situation and needs. It is important to note that these recommendations form a multi-pronged and integrated approach. Success will be most likely through implementation of these interrelated steps.

10.1 Confirm the Commitment to Staff and Patient Safety

Management's philosophy and commitment to workplace violence prevention requires clear policies, procedures, and program organization. Combined with written policies, a regular awareness effort involving staff, physicians, volunteers, and appropriate external agencies, gives this commitment the visibility necessary to confirm its importance.

We understand that SFHR is currently engaged in this important first step and is developing a single master policy that spells out clearly the hospital and Region's position on this issue. The most useful master policy will include references to all subsidiary policies dealing with workplace violence.

Workplace violence prevention messages are now making it clear that the safety of those working at the hospital is at least of equal importance to the safety of those they serve.

Specific recommendations include:

- Establish routine awareness programs that clearly convey that violence towards employees, physicians or volunteers is not acceptable, regardless of the source (not only from patients and residents, but also other health care and related personnel on site, visitors, suppliers, outside contractors, etc.)

- Ensure policies and procedures identify specific consequences of violent acts directed to LMH personnel, and ensure that everyone possible understands what will happen in cases of aggressive behaviour.

- Assign a team involving both management and unions to develop policies, as it is known that prevention and management of workplace violence will be most effective when they are a joint effort involving both management and unions.

Unfortunately, no public health care facility can adopt a "zero tolerance" position on violence. Risk identification, assessment and management is a process in which all staff have responsibilities and which benefits from a team approach. Health professionals in general accept that violent reactions are an inevitable response to the stress of illness, are inherent in certain conditions, or result from using drugs or excessive alcohol consumption and no system of rules and procedures can cover every possibility. Therefore, it is more important for LMH to understand the context in which violence occurs and to use this information to develop training programs and improve work practices to protect those staff who must deal with aggression and violence. A culture of "safe uncertainty" promotes:

- training in risk awareness, assessment and management;

- analysis of accidents and incidents; and

- regular team discussion of risk issues.

These steps allow staff to feel safer even though they cannot always predict what will happen.

In general terms, increased safety is the end result when vulnerable staff members have the skills necessary to successfully defuse as many incidents as possible.

10.2 Assign Overall Responsibility & Authority for the Workplace Violence Prevention Program

An important decision the South Fraser Health Region can make to turn its commitment into action is to identify a respected senior executive and assign him or her the power and resources to achieve the organization's goals for staff and patient safety.

While Safety Committees and Joint Occupational Safety and Health Committees have important roles, the key to moving these recommendations forward lies in giving one individual the overall responsibility and authority to eliminate duplicated efforts, to streamline the steps in the program and to make sure the considerable energy which is and will continue to be expended on this effort is as effective as possible.

An important element of this individual's responsibility will be to increase the visibility of the program and continually reinforce its importance to the organization as a whole.

While Langley Memorial Hospital's situation demonstrated the need for this single focal point for its efforts, this must be integrated into the overall Regional responsibility.

10.3 Create and Use Valuable Data

An essential element of risk reduction efforts at the hospital and throughout the Region is the availability of quality data.

Before the hospital can reap the benefits of a database, policies must clearly define what is a reportable incident, regardless of whether personnel have been injured, and provide clear guidelines on how to report such incidents. Employees must be encouraged to report incidents and must understand that the reporting effort is designed to eliminate or reduce their risk of injury.

There currently exists a comprehensive Employee Injury Exposure reporting form and Regional database. A process that includes rather than excludes reporting situations of potential threats or acts of force or violence will yield more valuable data. Both patient and non-patient incidents are relevant when assessing the risk of violence at the hospital, in particular experiences of Protection Services staff dealing with incidents involving visitors. Any call for assistance to an actual or potential behavioural emergency must be recorded so that data can be meaningful. If potentially violent incidents, that are successfully resolved, are not reported, the resulting data will be skewed and consequently of less value.

Using a common reporting form, regardless of code status, allows data to be more easily analyzed for trend monitoring, for learning and for injury prevention. Staff training programs must include reminders of the issue of underreporting, noting both the importance of the data for prevention measures and assuring staff that reporting will not result in reprisals. As important as the data collection is the timeliness of investigations and corrective actions. It is important that there be an agreed upon time deadline for reporting, investigating and following-up on violent incidents.

The contents of a valuable incident reporting form, in addition to basic general information, must include:

- Precipitating factors;
- Individuals responding;
- Actual location of incident/encounter;
- Home department of staff involved;
- Levels of control used;

- Outcomes;

- Follow-up planned and implemented;

- All aspects of injury claims or lost-work-time;

- Any involvement of individuals who are not hospital personnel, e.g. Police or Ambulance Services;

- Whether Police were involved in the incident at the request of a hospital staff member;

- Debriefing details; and

- "Timely" investigation and corrective action necessary and taken.

When all personnel use the same incident reporting form, consistent data can be generated to use in the analysis and reporting process. All reports, when centrally collated, will yield the data necessary for risk management. Incident reports and analysis must be a routine part of JOSH Committee meetings, along with the clear requirement that recommendations for action are followed up in a timely fashion.

It is particularly important for all Langley Memorial Hospital personnel to be aware that increasing the hospital's data collection activities will, in the near term, result in the appearance of an increase in violent incidents. However, the increase in available data will help the hospital analyse "what happened", and use this information to reduce vulnerability, adapt training programs and mitigate some areas of risk.

10.4 Reduce Workplace Design Risks

As a result of the worksite surveys and observational tours of the hospital departments and grounds (see details, 6.3 Worksite Audit), we identified a number of areas where physical changes can reduce staff vulnerability to injury. We also took into account feedback we received from staff during our interviews, and other comments made to us in the course of the project. The methodology for the worksite audit, with accompanying checklist, is included as Appendix G. This checklist is one component of a multidimensional tactical analysis conducted during this project with recommendations covering all aspects of workplace violence prevention program design.

The following sections include our recommendations for those areas where we identified opportunities to reduce the risks to which staff is exposed in those locations where there is a moderate or high risk of violent incidents.

Emergency Department

■ Redesign reception/triage areas so as to permit communication and reassurance to distressed patients or visitors, yet provide safety and security to staff;

■ Construct counters to sufficient height and depth to minimize the possibility of being jumped over or reached over to strike staff;

■ Raise floor to a height that permits staff to sit at eye level with standing patients or visitors;

■ Locate triage desk to allow unobstructed view of the waiting area;

■ Install covering on exterior windows to screen visibility of Triage reception/waiting area from potential aggressors;

■ Train all staff in the location and operation of alarms, particularly staff working alone or in isolation. Alarms are most useful when they are easily accessible and activate a visible or audible signal summoning the individual(s) providing aid. Routine testing of the alarms is an additional safeguard;

■ Install additional Closed Circuit TV (CCTV) cameras to watch key areas of the ED and Psychiatry, particularly the nursing stations, install monitor at Security desk;

■ Ensure staff are available to continuously monitor the CCTV;

■ Increase the level of staffing in the Fast Track area so that no-one works alone;

■ Locate sharps and medications so they are secure from patients/visitors;

■ Ensure a Security Guard is on duty in the Department as much as possible. When the Guard is called away, assign another member of staff to monitor the waiting area;

■ Add a lock system to the staff lounge to create a secure area for staff and their belongings;
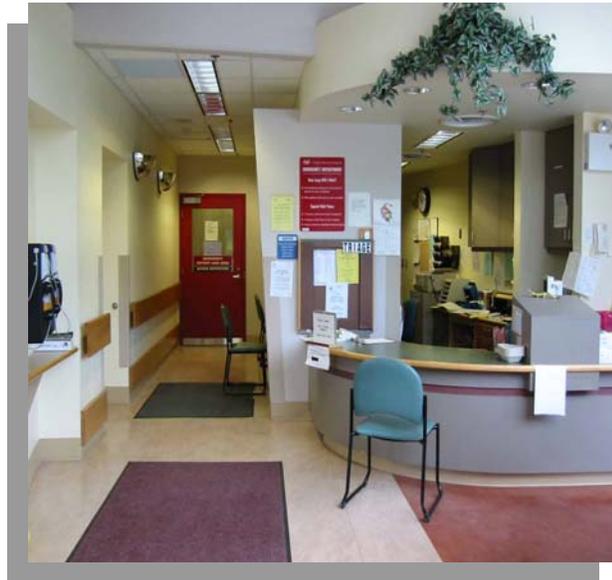
■ Modify public waiting area to decrease the frequently noisy and overcrowded surroundings;

■ Secure furniture and fixtures so they cannot be used as weapons of opportunity;

■ Provide a designated or "safe" room that can be locked from the inside, equipped with a telephone, be easily accessible and be used by staff, patients and even "visitors" to hide due to an immediate threat;

■ Renovate Acute Care area in ED to reduce overcrowding, install alarms or other assistance request devices, and improve quick access to escape routes;

■ Provide personal alarms or other assistance request devices for working alone or in isolation; and

■ Ensure all possible entrances to the Emergency Department have access controls and that the Emergency Department can be shut down, i.e. locked down, if necessary.

Seclusion Room Emergency Department

■ Relocate seclusion room so that it is close to a continuously staffed nursing station and separate enough from adjacent patient care areas to allow both privacy for the mental health patient and protection of other patients from potential disturbances. Acoustical and visual separation is desirable;

■ Make certain that all Seclusion related policies and practices meet Provincial Standards for Hospital-Based Psychiatric Emergency Services: Observation Units[35];

■ Ensure that physical, mechanical and chemical restraint policies and procedures are updated immediately and routinely;

■ Renovate doorway to allow easy simultaneous entry by two members of a Code White team;

■ Create a secure interview room near the Seclusion Room, again using the Provincial Standards for Hospital-Based Psychiatric Emergency Services: Observation Units as a guide for the construction; for example, the structure and covering of any observation windows in walls or doors, an

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[35] See Appendix C: Report References

intercom/monitoring system, and secured furniture and fixtures that may not be used as weapons, and a panic alarm;

■ Ensure Psychiatric RN's availability to the Emergency Department at all times to initiate emergency mental health consultation;

■ Reassess the location of psychiatric interviews or assessments in the Fast Track area, and consider creating an interview room.

Psychiatry Unit

■ Improve ability to differentiate between staff, patients and visitors by ensuring that staff ID tags are always worn and visible, since staff wear street clothes;

■ Provide panic alarms throughout the unit and personal alarms for any staff dealing with patients with a history of significant risk of violence;

■ Provide a designated or "safe" room that can be locked from the inside, equipped with a telephone, be easily accessible and be used by staff for safety due to an immediate threat;

■ Make sure all staff are familiar with the location and operation of alarms, particularly staff working alone or in isolation. Alarms are most useful when they are easily accessible and activate a visible or audible signal summoning the individual(s) providing aid. Routine testing of the alarms is an additional safeguard;

■ Install additional Closed Circuit TV (CCTV) cameras which observe key areas of the Emergency Department and Psychiatry, particularly the nursing stations, install monitors at Security desk;

■ Ensure staff are available to continuously monitor CCTVs;

■ Ensure that windows on patient rooms are constructed so they do not allow for exit and are not easily broken;

■ Prevent easy access by the public;

■ Provide timely emergency mental health response to the Emergency Department, with high priority for patients referred to Emergency by police.

Seclusion Room Psychiatry

■ Make certain that Seclusion facilities and all related policies and practices meet Provincial Standards for Hospital-Based Psychiatric Emergency Services: Observation Units [36].

■ Ensure that the seclusion room is directly adjacent to a staffed nursing station, and ensure limited public visibility;

■ Ensure that physical, mechanical and chemical restraint policies and procedures are updated immediately and routinely;

■ Create a secure interview room near the Seclusion Room, again using the Provincial Standards for Hospital-Based Psychiatric Emergency Services: Observation Units as a guide for the construction; for example, the structure and covering of any observation windows in walls or doors, an intercom/monitoring system, secured furniture and fixtures that may not be used as weapons, and a panic alarm.

Cashier's Office

There were no recorded incidents involving acts of force or violence, robbery or attempted robbery in Langley Memorial Hospital involving cash-handling locations. Nor have other hospitals in the Region reported such incidents. However in response to the concerns expressed to us by LMH staff we developed the following workplace design recommendations:

■ Limit amount of cash kept on hand;

■ Ensure main cashier area has an entry/exit separate from public access or regular walk-by traffic;

■ Install door with spring loaded closing with automatic lock, keyed entry or opened from inside only;

■ Make deposits randomly and ensure staff are accompanied by another staff member or Security;

■ Design cash handling areas to prevent unauthorized entry;

■ Ensure staff can clearly see all incoming visitors/clients;

■ Monitor cash handling area with Security staff through CCTV;

■ Install physical barriers at collections/reception counters/cash desks (Plexiglas, elevated counters, elevated floor, etc.);

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[36] See Appendix C: Report References

- Install an appropriate alarm for the cashier area;

- Provide adequate ventilation for work areas, as cashier's door is often propped open due to poor ventilation;

- Renovate surrounding area to provide increased visibility and security: for example, half-wall could easily be vaulted;

- Ensure an exit from the work area into a safe area or secure corridor.

Diagnostic Imaging

Department personnel expressed a level of concern regarding risks in this area. Our survey revealed no significant work site design risks.

The concerns for staff safety will be resolved by implementing a working alone policy (see Section 10.8), by enhancing the use of the flagging system, and by training the staff in workplace violence prevention.

General Hospital Facility and Grounds

- Expand the system of Security escort, stand-by and support to cover a wider variety of risky situations, e.g., staff working alone and accessing remote storage areas within the hospital, staff arriving on-call after dark or staff handling cash or collections duties;

- Allow on-call staff and/or staff working at night to park in the visitors parking area, denote parking spots closest to hospital for use by staff after hours, i.e. on-call or after dark;

- Improve visibility to discourage vehicle break-ins, trim vegetation around staff parking lot perimeter, improve lighting, add signs reminding staff to lock doors and remove valuables, increase Security patrols;

- Promote the "buddy" system for staff leaving work after dark; and

- Improve assistance request alert system to include one-touch paging for all codes.

10.5 Modify Planned SFHR Management of Aggressive Behaviour Training Program

Before detailing our specific observations about the planned Management of Aggressive Behaviour training and education at Langley Memorial Hospital, the following outlines our recommendation of a hierarchy of general competency-based training geared for healthcare workplace violence prevention.
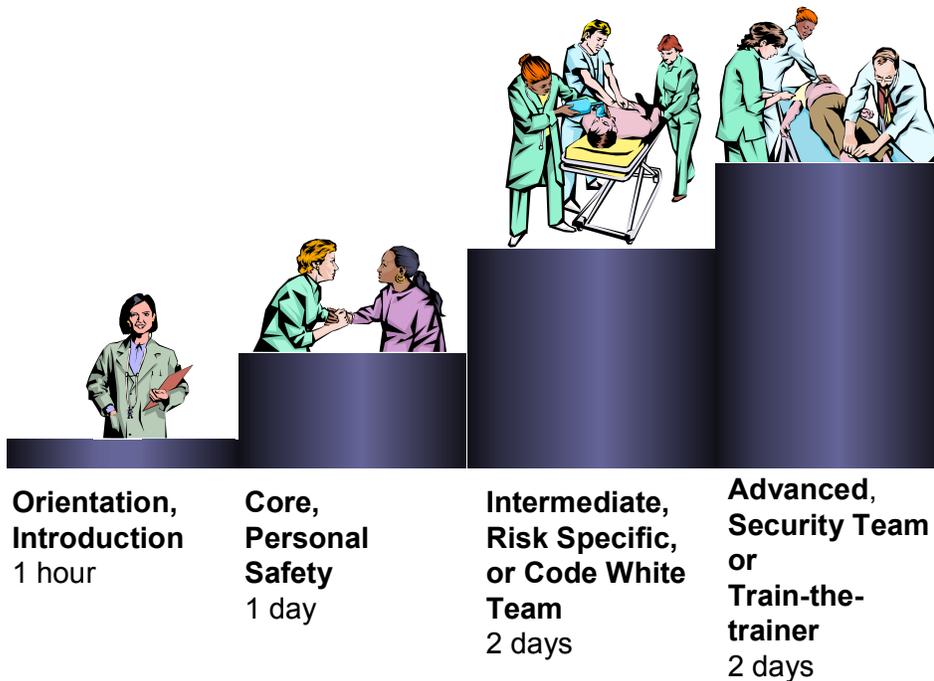
Chart M: Education and Training Module

Level I: Orientation or Introduction

This 1-1 ½ hour presentation is intended for the hospital's regular orientation of new employees. It provides a general overview of violence in healthcare, as well as legal rights and responsibilities. It also spells out the hospital's overall Workplace Violence Program, covers the policies and procedures used for preventing and avoiding aggression and violence, and outlines basic personal safety techniques.

Level II: Core Training

This one-day offering is designed for all employees who have direct contact with patients. It starts with a review of Level I, and then introduces participants to subjects including authority for the use of force, responsibility and liability, key concepts in managing aggressive behaviour, risk factors and triggers, crisis communication, the professional edge, debriefing and quality improvement, reporting requirements and processes, personal safety and break-away skills. It concludes with an exam, and is maintained with an annual minimum three-hour refresher.

Level III: Risk Specific Training

High Risk Response (Code White): This two-day risk-specific program is designed for employees working in high-risk situations and equips them with the skills necessary for responding to a behavioural emergency.

It reviews Level II, and moves on to address how to manage behavioural emergencies, covering personal safety skills (break-away techniques), self-protection skills, use of restraints, transport and escort techniques, and team control and restraint techniques. Reporting requirements and processes are also reviewed. Learning involves demonstrations and practice, and competency is tested with a concluding written and practical exam. This intermediate level program is supported by periodic in-services based on risk level and performance assessments. Annual recertification is required (2-day offering).

Level IV: Advanced Training

Security: This additional module is a tailored training module for security officers and security teams. Requires annual 1-2 day recertification.

Train-the-Trainer: This module is a two-day tailored session for those who will train at the Intermediate Level. Certification based on maintaining minimum training hours annually.

10.6   Refine General Training Practices

During the course of this project, the Advance team had many occasions to learn about the general training program offered to staff at Langley Memorial Hospital through the South Fraser Health Region. As a result, we offer the following general and specific observations to help the hospital more effectively achieve its risk management objectives.

- A simple introduction to Langley Memorial's position and policies on violent and aggressive behaviour must be included in staff orientation as a matter of routine. During orientation, each staff person should be informed of the level of training they will be required to obtain, based on the risks they will routinely face on the job. If physicians, volunteers and others who routinely visit the hospital are not exposed to general orientation, a separate process must be put in place to ensure these individuals have an appropriate level of awareness and training;

- The core general training program must be provided to all staff who during the course of their regular work have direct patient contact. This core training is essential to help them successfully defuse the majority of incidents they experience;

- Coupling the hospital's core program with an additional extensive, comprehensive two-day training course is necessary to properly prepare those responding to Code White incidents, as well as those involved in high-end violence;

- A clearly defined post-incident debriefing and analysis must be standard procedure. Interviewing staff involved in an incident will help them gain insight into how they respond and whether their behaviour has a calming effect or works as a trigger;

- Hospital personnel who receive only core training alone need to understand that this level of training does not qualify them to participate in Code White interventions;

- Access to critical incident stress management must be available;

- In instances where there is an immediate need to develop knowledge, skills and confidence in managing difficult situations, making trainers available for individual staff members or groups of staff will take advantage of a teachable moment; and

- Personnel acting as incident investigators to be more effective must be trained specifically for this role. In particular, they will gain the confidence of staff when they avoid the appearance of "blame-placing" and the results of the investigation are shown to have a positive impact on safety and managing behavioural incidents.

10.7 Fine-tune LMH's Code White System

The current core training program serves as the foundation element of a broader approach. Alone it is insufficient training to properly support a trained behavioural emergency response (Code White) team.

Langley Memorial Hospital must create a Code White system, not just a training program. Experienced personnel with expertise in this field note that it is not uncommon for Code White teams to require up to five years' experience before they gain optimum skills.

In general terms, an important priority for the Code White response is to upgrade policies and procedures, expand training, and improve data collection and analysis, and adapt procedures. These steps are necessary to more effectively monitor trends in potential and actual violent incidents and to follow up incidents in a timely way.

We recommend these practical steps be taken as the hospital moves ahead with its commitment to the Code White system:

- Clearly spell out definitions for incidents, violence, etc. in documentation and discuss these in training sessions;

- Review definitions on a regular basis and update based on insights gained during analysis of incidents;

- Develop guidelines that outline the criteria for staff selection for Code White training;

- Set a minimum criteria for Code White team members, in addition to understanding healthcare values, and successfully completing risk-specific training, that they will be individuals who demonstrate calmness under stress, willingness to engage an aggressive

or violent person, a track record as team players, and are physically fit enough to engage in somewhat strenuous activity;

■ Do not use physical size (small or large) and sex (male or female) as automatic characteristics that dictate whether an individual can be an effective Code White team member;

■ Establish that Code White team participation is voluntary for non-Security personnel and requires a supervisor's recommendation prior to training;

■ Designate Security staff as automatic members of Code White teams;

■ Give all members of staff the option of withdrawing from Code White responsibilities, with the exception of Security staff. In addition, give supervisors the option to withdraw a member of their department from the Code White team;

■ Instruct all potential Code White team members in healthcare "values" prior to giving any training in hands-on intervention, including the fact that prevention and defusing take priority over the last resort of physical restraint;

■ Establish the appropriate physical techniques that are sufficient to resolve all but the most extreme incidents;

■ Clearly spell out in all Code White documentation and training which physical techniques the Code White team should or should not use;

■ Use only trainers with experience in use-of-force methods when training team members on take-down techniques;

■ Assign a Code White leader for each shift who functions as team leader for each response. This individual identifies which trained personnel are available for that shift and assigns each one a pager;

■ Assign the team leader role to a member of Security staff. However, each individual should be assessed for suitability before being assigned to the leadership role;

■ Designate a set number of individuals who respond to each Code White;

■ Include crowd control instructions for Code White incidents;

■ Spell out the process and responsibility for appropriately to securing the area in which a Code White incident is occurring;

■ Do not designate the nurse on the scene to act as the Code White team leader. A nurse's priority is maintaining a trust relationship with each patient. The negative impact on the patient of experiencing the nurse leading the Code White team may very likely damage the future of the relationship. It also interferes with the nurse's many other responsibilities during an incident;

- Set up a collaborative process between the individual with overall responsibility for Code White and the local RCMP detachment to establish how the two would work together in instances when the RCMP are called or are already at the hospital;

- Call upon law enforcement officers in all incidents involving weapons;

- Establish strict protocols for use of physical and mechanical restraint and for seclusion.

We also draw attention to Appendix E: Review of Psychiatric Manual. This document contains many additional detailed comments relevant to current standards and procedures relevant to Code White.

10.8 Develop and Implement Policies for Working Alone and General Safety

In addition to the specific policies and procedures regarding workplace violence, employees need to be protected in two additional specific situations:

- When they encounter a more general situation which causes them to be concerned about their personal safety; and

- When their job requires them to work alone.

The policy dealing with general safety concerns should include options such as:

- Security escort on request; (e.g. to parking lot during darkness hours);

- Visible emergency phone numbers throughout the facility;

- Information included in all employee orientation sessions;

- Regular communication in employee information materials.

The policy dealing with working alone is being developed and should include the following procedures:

- Establishing regular phone contact at predetermined times, including the feature that if an employee doesn't check in at a set time, the lack of contact will be investigated;

- Including areas where employees regularly work alone on routine security patrols;

- Initiating security standby when dealing with a patient or client who has been identified a potentially violent (particularly for Diagnostic Imaging or Laboratory Departments);

- Prominently posted emergency phone numbers;

■ Video surveillance in appropriate departments, activated when an individual is alone in the area.

10.9 Conduct Ongoing Evaluations

Langley Memorial Hospital and the South Fraser Health Region should give priority to implementing the main recommendations of this report, particularly those dealing with collecting consistent data, doing appropriate follow-up after major incidents, and providing training appropriate to each employee's level of risk.

However, when sufficient time has passed to generate a meaningful database, using the updated incident reporting form and consistently gathering data from all reportable incidents, the hospital will be in a position to initiate periodic evaluations. These should include:

■ Analyzing the data to determine if any trends are evident;

■ Reviewing the actions resulting from any incident investigations to ensure recommended remedial actions have been implemented;

■ Adapting policies, training or other elements of the program to eliminate or reduce as far as possible the risks brought to light by analysis of the available data; and

■ Collecting and using feedback from Code White team members and others involved in major workplace violent incidents.

11.0 CONCLUSION

We want to end by thanking the many people at Langley Memorial Hospital who helped us throughout this project. In the face of many competing demands, so many people made the time to be interviewed, provide background information, gather data, and generally facilitate our work, and we really appreciate these efforts.

As a conclusion, we would have to say that competing demands for time and resources are significant challenges at Langley Memorial Hospital, as it strives to deal with the sensitive issue of workplace violence. These issues are not unique to Langley, but rather inherent in BC and Canada's healthcare situation.

What we have provided here is a prescription for action: as with all prescriptions, "patient compliance" is the key to success. So the decision to bring together determination and resources is key to moving ahead with the recommendations we have made. Resources are only part of the solution. The determination factor is also critical. This will come about when the organization focuses on the assignment of implementing the necessary long-term systematic approach to keeping the risks faced by Langley Memorial Hospital personnel to a minimum.

Respectfully submitted,

Advance Workplace Management Inc.

September 2001

APPENDIX A:
THE ADVANCE TEAM

Diane Brinton RT

- ❑ Diane is the principal of Advance Workplace Management Inc. Advance provides consulting and training to keep people legally and physically safe at work. Courses are offered primarily in the areas of dealing with co-worker conflict, harassment and violence; helping managers avert employer-directed violence; assisting executives to build protective profiles for their homes, families and offices; and preventing workplace violence for those who are at risk from clients and the public.

- ❑ Prior to forming Advance her experience has been in the Medical Laboratory field. She held senior management roles in community-based clinics, at Foothills hospital in Calgary and at Metropolitan Clinical Laboratories, one of the largest independent laboratory organizations in BC.

- ❑ Diane was the Director of Operations for Metropolitan Clinical Laboratories Ltd. and its affiliates for 10 years. In addition to her operations management role, she was responsible for the corporation's programs in education & training, and health & safety, for over 1,000 employees throughout British Columbia.

- ❑ She has served on the Board of international business and professional associations.

- ❑ She writes for a variety of health care, education, human resources, finance and industrial security publications both in Canada and the U.S.

Anne Logie RN, DOHN

- ❑ Anne is an occupational health consultant with over 20 years experience working with corporate clients in a variety of high-risk occupational groups including emergency responders, in health, marine, and aviation sectors, nationally and internationally.

- ❑ She has extensive experience in workplace health program design, implementation, evaluation and case management.

- ❑ Anne owns her own workplace health management firm that provides organizations with assistance in dealing with 'high maintenance' employee issues.

Neil Boyd LL.M

- Neil, is a lawyer, with a focus on criminal justice and criminal law, and was the Director of the School of Criminology at Simon Fraser University, where he is still based as a Professor of Criminology.

- Neil provided initial studies on workplace violence, which preceded the WCB's regulations, and is currently doing further research for the WCB and other groups on workplace violence in Long Term Care.

- He consults, lectures and writes, and is frequently interviewed on a variety of criminology subjects.

- Neil has produced three television documentaries and has received the Award of Excellence from AMTEC for his educational video "The Last Dance, Murder in Canada".

- He has written several books. His latest is: "The Beast Within: Why Men are Violent". Greystone Books, 2000.

Mario Govorchin BA

- Mario is a psychiatric social worker by training.

- He is currently a trainer in conflict resolution, anger management, and negotiation. He has provided this training at the Justice Institute of BC for the past 10 years, where he instructs in all academies.

- Additionally, Mario is an organizational consultant and human resources trainer for a variety of public and private sector agencies.

- He develops and implements programs in the areas of communication, negotiation and mediation skills, conflict resolution and crisis intervention.

- He is also a certified trainer in CPI techniques.

Carol Cheveldave B Comm

- Carol is a consultant with a Risk Management diploma from Simon Fraser University. She has worked most recently on projects involving research and policy development services for emergency preparedness, public safety, dangerous goods control, environmental protection and technological risk.

- She provided the statistical analysis in a workplace violence risk assessment for the Office of the Chief Judge, and has developed a number of policy manuals and instructional handbooks for various clients.

- Carol was a volunteer trainer on risk management for the BC Children's Hospital.

John McKay BA

- John is an Inspector with Vancouver Police Department (VPD). His responsibilities include the Division for downtown Vancouver, Watch Commander and Training and Development at the VPD.

- He formerly headed an ERT (SWAT) team where he led 300 critical operations.

- John has been a police officer for over 25 years, both with the RCMP and the VPD.

- He is recognized across North America as a liabilities specialist, defensive tactics instructor & assault prevention trainer.

- John introduced the "use-of-force" training now used throughout the Province and has trained over 40,000 people from all industry sectors in workplace violence prevention.

- He is an expert witness in the use-of-force, certified in the Supreme Court of BC, Provincial court of BC, BC Coroner's courts, Office of the Chief Judge, Attorney General's ministry, and BC Human Rights Commission, where he has testified successfully on behalf of employees in over 400 cases across Canada involving workplace related violence.

Joe Noone LRCP & SI, FRCP (C)

- Joe is a forensic psychiatrist who specializes in clinical aspects of violent behaviour.

- Joe has a unique ability to combine tactical skills with his understanding of human behavioural issues, resulting from his British Army service and his psychiatric training.

- In addition to a private practice in criminal forensic psychiatry and in trauma psychotherapy, Joe is a Clinical Professor of Psychiatry at UBC; heads the Workplace Violence Prevention Committee at VGH, and chairs the Committee on Violence for the BCMA.

- He consults to the Parole Board of Canada, Federal and Provincial Corrections, the BC Coroner's Service, police forces and to Emergency Mental Health Programs.

- Joe is a Master Level Crisis Prevention Institute (CPI) trainer. Additionally, he has developed a specialized 'Code White' team model for emergency response to violent incidents at VGH & UBC hospitals.

- He trains physicians and others in the management of aggressive behaviour and provides debriefing in the aftermath of violent incidents, using the Mitchell model.

Sheree Hudson RN, BSc

- Sheree is a registered nurse and trainer in aggression management for health care providers.

- She is a Master Level CPI trainer and has participated in the development and training of emergency response teams at VGH and UBC sites.

- She has assisted clinical teams to develop specific care plans for the management of disruptive patients.

- Sheree is currently working as a Clinical Educator in the Downtown Eastside for the Vancouver/Richmond Health Board providing education to both staff and clients.

Lin Perceval, MBA, APR

- Lin is a Public Relations consultant, specializing in health service organizations.

- Clients use Lin's experience to provide them with strategic communications consultation, communication project management, event coordination and general corporate and promotional writing services.

- Prior to starting her consulting business in 1989, Lin worked in senior communications positions in health care in BC, as well as in the oil and gas business in Alberta.

- Her volunteer roles include a number of years as board member for both the Canadian Public Relations Society in Vancouver and the Surrey Memorial Hospital Foundation

APPENDIX B:
PROJECT METHODOLOGY

Review Information, Practices, and Procedures

- Review current related internal materials and policies (past 24 months) including:

- workplace violence policies, guidelines and violence-related codes

- violence prevention program materials

- incident and security reports and communications

- JOHSC minutes: relevant to workplace violence incidents

- WCB inspection, police, and coroner's reports

- Comparative review based on readily available information: Langley Memorial vs. similar B.C. hospitals

- Review current workplace violence practices and procedures, including interviews with workers and department heads

- Review current workplace violence data collection and distribution procedures

- Collate and analyze data, identify risk areas, make recommendations

Worker Survey Using Focus Group Methodology

- Design format tailored to LMH for focus groups & interviews

- Conduct approximately 10-15 focus groups with a maximum of 25 participants each over 5 separate days, goal is to survey 150 - 170 staff (10% of 1500 – 1700 staff to provide a statistically significant sample) including a representative sample of people from each job category, unit and shift (availability of LMH staff will be essential to the timely completion of the focus groups and interviews)

- Interview selected senior management, department heads, union representatives and staff members

- Efficient scheduling will be required to optimize the use of facilitators' time during these days.

- Should it be necessary to schedule additional time for focus groups and interviews due to LMH staff unavailability, additional fees will be required

- Advance will offer confidential (toll-free) call-in line for those staff who are not included in focus group selection and wish to provide input to the risk assessment

- Collate and analyze data, identify perceptions and risks, make recommendations

Work Site Audit

- Review physical facilities: engineering controls, physical security and specific risk areas including summoning assistance, access control, perimeter controls, environmental issues and high risk units

- Collate and analyze data, identify risk areas, make recommendations

General Training Program Review

- Review current overall workplace violence training program, including training materials

- Collate, analyze data, identify gaps, make recommendations

- Code White Team: Organization and Training Review

- Meet with key stakeholders

- Attend one training session

- Examine criteria for selection of Code White Team members, role and mandate of Code White Team, etc.

- Interview representative sample of participants, look at past experiences/incidents, identify dynamics that may hinder or enable the training program

- Look at training requirements for in-house security staff in the violence prevention program and/or Code White Team

- Determine proportion of lectures to physical/team training based on participants skill level and level of training required

- Review related training that has been received or is currently being developed to ensure that Code White Training content is not being duplicated elsewhere

- Collate and analyze data, identify gaps, make recommendations

Risk Assessment Report

- Develop report on workplace violence risk assessment conducted, including separate executive summary

Contents:

- ☐ summary of process used to conduct risk assessment;

- ☐ details of all data and materials reviewed;

- ☐ results of all reviews conducted;

- ☐ summary of information gathered in each component of the risk assessment including focus group and worksite audit surveys;

- ☐ assessment of current training approach;

- ☐ assessment of policies and procedures;

- ☐ assessment of staff awareness and communications effectiveness;

- ☐ identification/analysis of risk factors;

- ☐ additional relevant commentary;

- ☐ recommendations to address identified risks and areas of potential improvement covering all key components reviewed in risk assessment;

- ☐ samples of tools used to conduct survey portions of this risk assessment.

Present Risk Assessment Results

- ☐ Develop presentation, including overhead visual materials

- ☐ Present the report's findings and recommendations at a meeting of the Steering Committee and senior management.

APPENDIX C:
REPORT REFERENCES

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APPENDIX D:
EMPLOYEE SURVEY

Date   **Position**
Unit/Department   **Years of Service**
Gender   F   M

1.   Do you think that violence or aggression, as defined by the WCB (see definition), is a problem at Langley Memorial?   Yes   No

2.   Regarding reporting incidents of acts of force or violence, (or threats) that you encounter on the job:
       I report all incidents   I report some incidents   I do not report incidents

If you report only some incidents or do not report incidents at all, please explain:

3.   Have threats or violent incidents increased or decreased during the time that you have worked at Langley Memorial?
       Increased   Decreased   No change

In your opinion what is the reason:

4.   What factors do you think contribute to the problem or threat of violence, or aggression?

5.   What steps do you take to protect yourself from this potential for harm? What steps do others take to respond to this problem?

6.   How could you improve the way that you respond to violence?

7.   What steps could Langley Memorial take to help you to respond more effectively to this problem of violence, or the threat of violence?

APPENDIX E:
REVIEW OF PSYCHIATRIC MANUAL

Interdepartmental Standards and Procedures

General comment:

Ensure that all policies and procedures follow the Standards for Hospital-based Psychiatric Emergency Services, March 2000, available from the Government of BC, Ministry of Health, see Appendix C: Report References.

PSY.12.021 – Criteria for calling on security guard coverage

Comment/Suggestions:

- This seems to refer to accessing additional security staff for constant observation purposes.

- In the indication re suicide "and is an elopement risk" should be added.

- With the advent of a new in house and regional security department this guideline should perhaps be reviewed as a priority.

- It may well be that clinical staff should be used for constant observation, not security staff.

- In any case the patient should be assessed by a physician and an appropriate care plan and order be written within a given time frame to maintain staff and patient safety.

PSY.12.060 - Code White: Acute Care

General Comment/Suggestions:

- Whilst education regarding CPI will be made available on an annual basis there appears to be no mention of the additional training required by certified Code White responders.

- Suggest modify "wielding any sort of weapon" be narrowed to edged weapons or serious threat with a potential weapon of opportunity. Need for some flexibility to allow for common sense.

- "All appropriate intervention to control patient behaviour will be attempted" before a Code White is initiated. This is too restrictive. After "attempted" suggest insert "or deemed unworkable."

- "Member of the Code White team who have completed the CPI training." Add "plus Code White training."

■ "All available Code White team members will respond to the identified area immediately." This should be changed to designated Code White responders. You don't want more than 5 trained responders at a Code White.

Specific Suggestions:

1.4 Code White team leader needs to have Code White team training. Criteria to identify team leader need to be outlined.

■ Attends Code White team training;

■ Knows the strengths and limitations of the team responding;

■ Has achieved grading on Code White training that was of a team leader level.

1.5 Any staff can call the RCMP when a non-patient is aggressive. Security should also be called to attend, secure and clear the area.

1.7 Appropriate interventions need to be defined. Staff should not attempt to physically restrain patients without Code White training. Physical restraint should only be done by a trained team i.e. all appropriate verbal intervention to de-escalate the patient should be attempted first.

1.8 Code White calls should summon a dedicated team by pager so that a set number of staff always shows up.

1.9 Streamline documentation to avoid unnecessary repetition, which lends to poor compliance.

2.1 See prior comments on numbers and how team is called.

2.2 Should not be all available Code White members, for reasons stated above

2.5 Team members should always remove keys, pens, jewellery, stethoscopes, neckties, scarves or any object that could be used as a weapon.

2.7 The team leader can delegate who talks to the acting out person (AOP).

2.8 It is unsafe to attempt to hold onto an upright person's legs

2.9 You need a more subtle message to signal the team to employ a hands-on move.

2.10-2.12 This seems too rigid. Variations would be covered in Code White

Training

Debriefing: Sequence suggested:

- Is anyone hurt?

- What went well?

- What didn't go so well?

- What can be done so we improve the next time?

PSY.12.061 - Intervention for an employee following an assault

Comment:

This seems quite well written.

PSY.12.062 - Assessment and Management of the Aggressive patient/resident

Comments:

1.2.3 Insert "Dementia" instead of "Alzheimer's Disease."

1.2.4-1.2.5 Condense to add "withdrawal" to 1.2.4. and renumber.

1.2.6 Add "Paranoid" to list of personality disorders.

1.4.3 Add "threats."

2.0 What is under aggression does not match with potential aggression. The table needs to be redone.

Haldol 5mg should not be given if the patient is not psychotic.

2.4.7. Always obtain and confirm consent to procedures. Remember silence is not consent. Clarify if in doubt.

PSY.12.063 – Levels of Intervention

Comment:

2.2 "begins" not "beings"

2.3 delete "total"

PSY.12.064 – Code 33: Acute Care

Comment:

Code 33 should always be used when a patient is in seclusion, also when restraints need to be removed. Staff should not remove restraints without a security standby or a set number of persons (so as not to agitate the patient).

PSY.12.065 – Initiation of Seclusion

Comment/Suggestions:

This covers more than just "initiation of seclusion." Would "use of seclusion" be more apt? No reference is made to restraint (physical or mechanical). Is there a separate policy in that area?

2.4 "A second Certification Form must be obtained within 48 hours."
Only if you wish to continue to detain the patient.

3.3 After "TWO staff members" insert "available."

3.9 After "as quickly" add "and safely."

6.1 This may be problematic for some RCMP. Can be sorted out in the regular liaison meetings with RCMP.

8.1 You need to document the termination of seclusion.

PSY.12.067 – Code White Team Report

Comment/Suggestions:

2.1 Need to review the issue of team leader selection.

3.1 The focus may need more timely review than monthly, perhaps by the Coordinator of Code White training.

PSY.12.070 – Guidelines for crisis calls to RCMP/911 requesting assistance

Comment:

This appears quite complete and can be modified via the liaison meetings with RCMP when necessary.

PSY.12.071 – Behaviour Alert Procedure

Comment:

This appears adequate.

Code White Team Report

Suggestions:

- Re – status. "Visitors" should be dealt with as necessary by security, not by a Code White response.

- Any weapon involved should be described.

- Part I has room for 5 names and at some time, more may respond.

- Suggest you list risk factors i.e. drugs, alcohol, dementia, etc separate from reason for call i.e. verbal or physical aggression, need to medicate, etc.

APPENDIX F:
CORONER'S REPORT

Re: 17 Dec 1999 A Review

Observations

- It is unclear what the standards were regarding psychiatrist supervision (direct/indirect) of the primary emergency mental health clinician;

- Suggest no discharge from Emergency Room without documentation of psychiatrist supervision;

- Patient was left unassessed in a seclusion room. For seclusion, there needed to be a medical certificate completed. No indication given that this occurred;

- Psychiatrist who attended indicated he was not aware that his patient had not received ordered medication, or any food or water during the preceding seven hours;

- Psychiatrist and nurse entered seclusion room apparently without any Security standby;

- When patient barricaded himself in an office, psychiatrist asked a nurse to unlock door. No indication of security or Code White standby in place at this juncture;

- Location of seclusion room problematic as apparently not immediately adjacent to a staffed nursing station;

- Staff members who responded to Code White were not aware of Code White policy or procedures. There were several people talking to the acting-out patient. No identified Team leader was in charge of the Code White response. Some staff entered the area of the critical incident without direction of Code White leader;

- The patient had been placed from seclusion into an unsecured and unsafe office setting where there were many potential weapons of opportunity. The patient was known to be suicidal and homicidal at the time;

- There was no seclusion room policy /procedure in place.

APPENDIX G:
WORKSITE AUDIT

Worksite Audit Considerations

Understanding the desired outcomes for workplace violence risk management is fundamental to utilizing this risk assessment tool. It is generally accepted that the desired outcomes are: patient safety and staff safety.

The risk control measures that can be taken to achieve these general desired outcomes are: prevention of incidents, defusing hostile or angry individuals, disengaging (escaping) from a hostile encounter and the use of self-defence when all else fails.

The other key factor in analyzing risk is an understanding of the types of force or violence that staff are expected to encounter during the work day. The types of hostile behaviour most experienced by those in the health care profession are: verbal abuse, passive resistance, active resistance, and assaultive behaviour. A fifth type of aggression is called deadly force attack, however, the use of this level of attack against health care staff is extremely rare and has not been included in this analysis.

"Tactical Analysis" is a key analytical skill required when using any risk assessment tools; it requires consideration of the desired outcomes, assessing the four risk control measures previously described against the four levels of aggression.

As an example: In the Emergency Department there is a reception counter that patients or visitors must visit to gain access. The question of what makes the staff member safe at that location depends upon an analysis of the type of aggression anticipated coupled with the ability to prevent an assault, defuse an individual, or leave (disengage) should that become necessary.

If we assume that staff might experience assaultive behaviour, using tactical analysis would reveal that a fairly high and wide counter would be appropriate, as well as, removing or securing all objects that could be used as weapons. The ability for a staff member to leave would next come into question. A tactical analysis would indicate that the reception area must have a ready and unobstructed escape route. Another component in this example would be training staff to verbally defuse a hostile individual, including how and when to disengage. Tactical analysis would move to the next logical step of staff training in recognizing cues to violence, defusing hostile individuals, use of alarms or other methods of summoning assistance, etc.

There are many questions and considerations when performing a worksite audit, the following are examples of the some of the questions which should be asked when conducting an audit of the physical facility, furniture, fixtures and equipment. Worksite

audits cannot be analyzed in isolation from the administrative policies, operational requirements and environmental conditions when identifying risks and implementing risk control measures. Putting in place a risk control measure in one area may in fact create a risk in another. Appendix C provides a number of reference documents for conducting worksite audits and designing physical space.

Always keep in mind the overall goals of keeping staff, patients and visitors physically and legally safe.

Access control

Nursing stations, Patient area, Hallways, stairwells, Entrance/Exit, Hospital grounds, parking, Staff-only areas

- Is access to work areas only through staffed reception area?

- Are reception and work areas designed to prevent unauthorized entry?

- What are the access controls - coded cards, keys, buzzers?

- Is there controlled access to any other connected buildings?

- Are employee-only work areas separate from public areas?

- Are entrances and exits well marked?

- Is there a system to alert employees of intruders?

- Where are the places of concealment – stairwells, recessed doorways, elevators, unlocked storage areas, unoccupied rooms?

- Can lights be turned off in the stairwell?

- Do any of the areas inspected feel isolated?

- Is it possible to see what is at the end of each corridor or hallway?

- Is there an emergency call button or telephone in each elevator?

Escape opportunities

Safe rooms, Escape routes

- Are there enough exits and adequate routes of escape?

- Are work areas, treatment rooms, reception areas organized to prevent employees from being trapped?

- Are interview rooms designed to ensure unimpeded exit by both staff and patient/visitor?

- Are private, locked restrooms available for staff?

- Are there places where workers can go to for protection in an emergency?

❏ Do operational requirements create an isolated work area, i.e. working alone at night?

Contact between staff and patients/public

Reception areas, Service/treatment areas, Interview rooms, General waiting areas

❏ Are there employee work areas that are always separate from public areas?

❏ Are reception areas designed to prevent unauthorized entry?

❏ Can reception staff clearly see all incoming visitors?

❏ Can reception staff clearly see all waiting areas?

❏ Is the reception area/Security desk staffed at all times?

❏ Are there times when there is no staff at the reception area?

❏ Are waiting and work areas free of objects that could be used as weapons?

❏ Are chairs and furniture secured to prevent use a weapons?

❏ Are waiting areas designed to maximize comfort and minimize stress? Note: people experiencing high tension require more interpersonal distance from others.[37]

❏ Are there physical barriers in reception areas (Plexiglas, elevated counters, etc.)?

❏ Are there uncontrolled access points to the facility?

❏ Are patients/visitors frequently updated on waiting times, etc. to prevent frustration?

❏ Are public contact areas well ventilated and temperature controlled?

❏ Do interview/seclusion rooms meet the BC Ministry of Health Standards for Hospital-based Psychiatric Emergency Services?

Visibility

❏ Is lighting inside and outside the facility adequate to see clearly at all times?

❏ Do workers feel safe walking from the workplace?

❏ Are the entrances to the building clearly visible from the street or from the Security station?

❏ Is the area surrounding the facility free of places of concealment, i.e. bushes?

❏ Is video surveillance provided outside the building?

❏ Do interview rooms have windows?

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[37] See Appendix C: Report References

Locked cupboards/storage areas

Medication, Personal belongings, Weapons

- ❏ Is a secure place available for employees to store personal belongings?

- ❏ Area there weapons storage facilities?

Cash handling

- ❏ Are limited amounts of cash kept on hand?

- ❏ Is there a safe for large amounts of cash?

- ❏ Does main cashier area have entry/exit separate from public access?

- ❏ Does cash handling area have silent alarm?

- ❏ Does door have spring loaded closing with automatic lock, keyed entry or opened from inside only?

- ❏ Are deposits made randomly and accompanied by another staff member or Security?

- ❏ Is cash collected by armoured car company?

- ❏ Are cash handling areas designed to prevent unauthorized entry?

- ❏ Can staff clearly see all incoming visitors?

- ❏ Can other staff clearly see cash handling/collections areas?

- ❏ Is the cash handling area monitored by Security staff through CCTV?

- ❏ Are there times when there is no staff at the cash handling area?

- ❏ Are reception areas free of objects that could be used as weapons?

- ❏ Are chairs and furniture secured to prevent use a weapons?

- ❏ Are there physical barriers at collections/ reception counters/cash desks (Plexiglas, elevated counters, elevated floor, etc.)?

- ❏ Are there uncontrolled access points to the cash handling area?

Security and Surveillance systems/equipment

CCTV, Alarms – panic, Alarms – personal, Two-way radios, cell phones, pagers

- ❏ Are trained security personnel available to staff in a timely manner?

- ❏ Are security personnel provided outside the facility?

- ❏ Are floor plans posted showing building entrances, exits and location of security alarms? Are alarm locations well marked?

- ❏ Is other emergency information posted, such as telephone numbers?

❏ Are special security measures in place to protect staff who work late at night or alone?

❏ Are all security devices tested on a regular basis?

❏ Are lights, broken windows, door locks, etc. maintained regularly?

❏ Are there regular checks made on staff working alone?

❏ Are workers required to carry/use items that may be used as weapons against them?

❏ When staff are working off-site, is there someone who knows where each worker is located?

Identification of staff and visitors

Staff ID nametags, photo ID, Visitor ID – tags, sign-in

❏ Are visitors required to sign in?

❏ Are authorized visitors required to wear ID badges?

❏ Are visitors escorted to offices for appointments?

❏ Do staff wear photo ID?

❏ Are workers regularly notified of the presence/ location of patients or visitors with a history of violent behaviour?

Parking Areas, Exterior and Building Perimeter

❏ Are parking lots attended or have secure access?

❏ Are security escorts available to and from parking lot?

❏ Are employee parking lots visible from the Security station?

❏ Could someone hear a worker call for help?

❏ Is parking lot free from places of concealment?

❏ Are there panic alarms in the staff parking lot?

❏ Are there emergency telephones in the staff parking lot?

❏ Is the parking lot frequently patrolled by Security staff?

❏ Are there signs of vandalism?

❏ Are building entrances and exits clearly marked?

❏ Does outside lighting automatically go on after dusk?

❏ Are garbage disposal areas well lit with no areas of concealment?

❏ Is the facility isolated from other businesses?

- Is the building located near any organizations at risk for violent crime?

- Is the building located in a high crime area?

- Are notices posted regarding special precautions working alone, late at night or after dark?

- Do Security staff regularly patrol the grounds?

Dedicated Observation/Seclusion Rooms

Selected excerpts from the Standards for Hospital-based Psychiatric Emergency Services, Observation Units, BC Ministry of Health, March 2000

- Located in close proximity to nursing station?

- Fixed/mobile alarm systems for immediate response when activated that directly alerts Security/Code White Team?

- Video monitoring, CCTV?

- Staff available to monitor CCTV?

- Seclusion room is in addition to bed count?

- At least one single bedroom available for decompression?

- Secure ventilated smoking area for involuntary patients?

- Exterior windows: obscure glass block, reinforced at mortar joints to prevent collapse in repeated impact?

- Interior windows: protected with steel-framed security window?

- Interior walls, new facilities: concrete block, with every core reinforced and filled with grout, joints are flush?

- Interior walls, existing facilities: heavy duty steel studs with batt insulation, plywood and abuse-resistant gypsum board? Clay tile walls: in good condition?

- Door: 42" wide, flush painted 12 gauge steel, insulated, 1 ¾″ thick, all-welded construction with painted 12 gauge all-welded frames having strike bucket that will accept a 1″ throw deadbolt? Door swings outward? Observation window in door: 1/8″ smoked polycarbonate laminated between two layers of 1/4″ heat strengthened glass? Electromechanical lock, keying and hinges: Folger-Adam or Adtec, locks open remotely from nursing station?

- Flooring: slip resistant solvent-free epoxy polymer coating with quartz granules or non-skid, glue-down sheet vinyl, all joints heat welded?

- Ceiling: height 10′, concrete/cement plaster/abuse-resistant gypsum board?

- Fixtures and fittings: secure, hinged, lockable metal cover over existing wall-mounted medical services outlets?

- Heating: separately zoned hydronic or electric under-floor radiant heating or radiant heating in plaster ceiling, temperature reset at nurses' station?

- Ventilation: six air changes per hour, security type ventilation grills with 12 gauge faceplate with 1/8″ holes at 3/16″ centres, smoke/heat detectors in return air ducts, background noise does not exceed 35 NC?

- Sprinkler heads: security type sprinkler head to prevent suicide attempts?

- Plumbing: floor mounted/wall mounted stainless steel combined sink/toilet fixture with rounded corners, single push button water supply, secure water shut off valve located outside room, floor drain with self priming trap and tamper proof screws?

- Lighting: two-level lighting (normal and night) maximum security corner mounted luminaire with polycarbonate lens, light switches outside the room?

- Electrical: no electrical receptacles in the room, with secure cover-plate?

- Intercom/Monitoring system: stand-alone, two-way intercom system between nurses' station and secure room, console in secure room flush mounted, impact and tamper resistant, voice-activated, hands free feature?

- CCTV: stand-alone system, camera in secure room – compact, high resolution, 180° wide angle, pan tilt and rotation controller, auto-electric iris, high quality imaging at low light levels, ceiling mounted?

- Bed and mattress: hospital bed and mattress used, has bed been removed to maintain patient safety, thick floor mat used where a mattress is deemed inappropriate?

- Bedding: strong sheets, six to seven layers of material sewn together?

APPENDIX H:
PROJECT ANNOUNCEMENT

Workplace Violence Risk Assessment at Langley Memorial Hospital

As part of our focus on health and safety in the workplace and in keeping with the Workers' Compensation Board regulations to prevent the incidents of violence towards health care workers, Langley Memorial Hospital is starting a project to assess the risk of violence towards all employees. It is being performed with the support of the BCNU, HEU, and HSA, as well as, a steering committee from the South Fraser Health Region.

The risk assessment results will identify those work-related situations which hold the potential for the risk of violence toward employees.

With your cooperation, the Workplace Violence Risk Assessment will help us reduce or, where possible, eliminate the risk of violence to employees throughout the South Fraser Health Region.

To assist us in performing this important first step to implementing the most effective violence prevention program and training possible, we are working with an independent consulting firm, Advance Workplace Management.

On-Site Visits

During May and June, professionals from Advance will be at Langley Memorial Hospital to examine a cross-section of work positions, shifts and typical activities. They will look at the physical environment and gather information about actual or potential incidents throughout a series of focus groups and interviews with employees.

Information obtained from employees during this process will remain confidential and will be used only by Advance's independent health and safety professionals and researchers in determining the risk assessment results and recommendations

Toll-Free Line

Risk assessment is an ongoing process. While our on-site assessments may only include a statistical sampling of employees, shifts, work locations and activities, we would like to gather information about the relevant experiences of others who may not have had a chance to participate in a focus group or an interview. So that all employees will have an opportunity to participate in the risk assessment, Advance will have a confidential toll-free call in line available during May and June. This will allow you to speak directly to an Advance health and safety professional in confidence about any violent incident you may have experienced.

APPENDIX I:
DOCUMENTS REVIEWED

1. South Fraser Region, Planned Policy for Management of Aggressive Behaviour

2. (MOAB) Langley Memorial Hospital

3. Oct 20 1999 Workplace Health Services

4. South Fraser Region, MOAB, General principles and guidelines

5. MOAB Instructors Guide to 4 hour session

6. Jan 1999 – April 1 2001 Incident reports

7. Training log re attendance and evaluations

8. July 12 1999 - memo from Workplace Health and Safety advisors (Surrey, Delta) on management of aggressive behaviour in the Workplace. With attached procedures.

9. Nov 23 1999 - email from Lois Shoebridge re Code White (CW) training

10. Nov 24 1999 - email reply to Lois Shoebridge re Code White training plan

11. Jan 18 2000 - email from Lori Howell (Diagnostic Imaging) re Code White concerns

12. Feb 2 2000 - email from Jan de Boekhorst

13. Feb 2 2000 - email to Jan de Boekhorst

14. Feb 2 2000 - email from Dave Keen re Code White training

15. Hospital Employees Union Grievance, Mar 30 2000

16. Apr 6 2000 - emails Rempy Lidder and Dave Keen re CW

17. British Columbia Nurses' Union Grievance, Apr 7 2000

18. Jul 14 2000 - emails from Alison Hutchinson, Dave Keen, and Carol Needham

19. HEU Bulletin on Code White, Jul 17 2000

20. South Fraser region, Update on status of Mandatory Safety Education, Jul 2000

21. Oct 6 2000 - Coroners Report re death of D. Mayer on Dec 17 1999

22. Oct 12 2000 - email from Catherine Kidd re CPI education

23. South Fraser Health Region, Update on status of mandatory safety training and education Oct 2000. Revised Oct 13 2000

24. Joint Occupational Health and Safety Committee (JOHS) Recommendation to senior leadership LMH Mar 20 2001

25. Letter from Martin Donaldson to Rafael Verdejo, chair OH+S cte. LMH, dated Mar 26 2001

26. Letter from Martin Davidson to Lois Shoebridge, chairperson Code White Task Force, Mar 26 2001

27. Email from Alison Hutchison re One Day CPI schedule, with attachment ("Manager's Guide and FAQ"), Apr 6 2001

APPENDIX J:
PLANNED SFHR MANAGEMENT OF AGGRESSIVE BEHAVIOUR TRAINING PROGRAM

Overview

The South Fraser Health Region is committed to a safe non-harmful behaviour management system designed to help staff provide for the best possible care and welfare of aggressive patients, residents, visitors and family members.

The Region will ensure that an appropriate assessment process is in place to identify potential risks to staff. It will provide appropriate control measures to address potential risks as well as education related to the assessment, prevention and management of violence and aggression.

Requirements

- Management of Aggressive Behaviour training is required for all staff.

- Departments designated as "High risk" require annual training: Emergency, Psychiatry, Mental Health.

- Code White Team members require annual training.

- All other staff require semi-annual refreshers or a situations require (serious incidents, change of location, etc.)

"High Risk" Departments, CPI (8 hour)

Target Audience

- Clinical staff who work in departments deemed to be "High Risk": Emergency, Psychiatry, Mental Health and Code White Team members

Content

- This training course is intended to provide staff with the confidence to recognize and prevent aggressive behaviour before it escalates. The session emphasizes early intervention and non-physical methods for preventing or controlling disruptive behaviour.

- The training will provide an introduction to safe and non-harmful control and restrain techniques to safely intervene when disruptive behaviour has gone too far.

❑ Participants will also receive demonstration in basic personal safety techniques and knowledge in site-specific procedures for calling for assistance during an aggressive incident (Code White).

This course is intended to be of a generic nature for South Fraser Health Region employees and does not provide for specific information on dementia, clinical profiles, ethical/legal questions or detailed methods of control and restraint (Code White response). Specific sessions are available for the above.

Training Prerequisites

Participants should have reviewed their site's specific Code White policies and procedures.

"High Risk" Departments Clinical Portion (4 hour)

Target Audience

Clinical staff who work in departments deemed to be "High Risk": Emergency, Psychiatry and Mental Health

To be completed within 3 month of initial 8 hours "CPI" course

Content

This training course is intended to provide an understanding of clinical issues and practices as they relate to the Management of Aggressive Behaviour (MOAB) for patients and clients. Common curriculum will include:

❑ Assessment (risk assessment for violence)

❑ Clinical Profiles (Dual Diagnosis, Geriatrics, Drug and Alcohol, ER/Psychiatry)

❑ Ethical/legal considerations

Specific curriculum will include:

Acute Care Practitioners

❑ Chemical management of aggression (45 minutes - taught by a pharmacist)

❑ Policies and procedures, including use of restraints, seclusion rooms, weapons

Community Practitioners

❑ Policies and procedures as related to the community scenarios

Training Prerequisites

Participants should have participated in, and successfully completed, the 8 hour CPI course and be involved in direct patient care or clinical practices within their department.

"Code White Team Response" (4 Hour)

Target Audience

Code White Team members

Content

This training course is intended to provide staff with the confidence to safely control and restrain physically aggressive patients and residents. The session emphasizes safe and non-harmful control and restrain techniques to safely intervene when disruptive behaviour has gone too far.

This course is intended to be of a specific nature for South Fraser Health Region Code White Team members and does not provide for specific information on dementia and clinical profiles. Specific sessions are available for the above.

Training Prerequisites

Participants should have participated in, and successfully completed, the 8 hour CPI course and be involved in Code White response at their specific site.

"Moderate Risk Groups" (4 Hour)

Target Audience

Staff who have regular, direct contact with patients, residents, clients and the general public

Content

This training course is intended to provide an understanding of workplace Health & Safety requirements as they relate to the MOAB for patients, clients and visitors. Participants are also required to demonstrate basic personal safety techniques and knowledge in site-specific procedures for calling for assistance during an aggressive incident (Code White).

Training Prerequisites

Participants should have reviewed their site's specific Code White policies and procedures.

APPENDIX K:
DEFINITIONS

For the purposes of this risk assessment we are concerned only with Workplace Violence:

Assault

An intent to inflict injury on another, coupled with an apparent ability to do so; any intentional display of force that causes the victim to fear immediate bodily harm. Examples of assault include:

- Kicking, hitting, biting, grabbing, pinching, scratching, or spitting;

- Injuring a person by using an object (such as a chair, cane, or sharps container), or a weapon such as a knife, gun or blunt instrument;

- Verbal hostility and abuse.

Code 33

Langley Memorial Hospital, Psychiatric Manual, PSY 12.064, "When patients are being managed in the ER or 1 South (Psychiatry) security room, ongoing treatment with medication is usually prescribed. If the nurse determines the patient behaviour may potentially escalate or elope when the door is opened, he/she may call a Code 33 in order to summon additional help prior to entering the security room.

Code White

Langley Memorial Hospital, Psychiatric Manual, PSY 12.060, "When assaultive or aggressive behaviour has not been controlled and where staff, patients, or visitors are in physical danger, then assistance is required immediately.

Crisis Prevention Institute (CPI)Training

Crisis Prevention Institute, Inc. Brookfield, Wisconsin, USA, provides training programs in non-violent crisis intervention. CPI training programs are used at various hospitals throughout B.C. as a foundation level of training workplace violence prevention. This document does not purport to comment on nor to promote CPI training programs.

Incident

An occurrence from an act of force or violence. Incidents are considered workplace violence if they arise out of the worker's employment and may not necessarily occur at the job site.

Injury

Damage or harm done to or suffered by a person due to an act of force or violence.

Risk

The following definitions are reprinted here for readers' convenience, and are taken from page 23 of Preventing Violence in Healthcare, WCB of BC.

High risk: Workplace factors frequently place workers at risk, the consequences may be severe, and it is *likely* that the workers will be exposed to workplace violence.

Moderate risk: Workplace factors place workers at risk less often, the consequences may be less than severe, and it is *possible* that the worker will be exposed to violence.

Low risk: Workers are rarely or never exposed to risk, the consequences may be minimal, and it is *unlikely* that the worker will be exposed to violence.

Situation

A threatening condition, such as Code 33, which is not necessarily recorded as an incident of force or violence, but requires the presence of assistance to manage the potentially aggressive behaviour of a client/patient.

Threat (verbal or written)

A communicated intent to inflict physical or other harm on a person or to property by some unlawful act, that gives a worker reasonable cause to believe there is a risk of injury. A threat against a worker's family arising from the workers' employment is considered a threat against the worker. Examples of threats:

- Threats, direct or indirect, delivered in person or through letters, phone calls, or electronic mail
- Intimidating gestures
- Throwing or striking objects
- Stalking
- Wielding a weapon
- Not controlling a dog, menacing a worker

Violence

Occupational Health and Safety Regulation, section 4.27, "the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker." Violence also includes, "any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury."

Incidents of violence may not necessarily occur on the job site. Incidents are considered workplace violence if they arise out of the workers' employment.

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