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Communicating the Risk of Violence

A Flagging Program Handbook for Maximizing Preventative Care

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Public Services Health and Safety Association (PSHSA)
4950 Yonge Street, Suite 1800
Toronto, Ontario M2N 6K1
Canada
Telephone: 416-250-2131
Fax: 416-250-7484
Toll Free: 1-877-250-7444
Web site: www.pshsa.ca

Connect with us:
🐦 @PSHSAca

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Introduction

About PSHSA

Public Services Health & Safety Association (PSHSA) provides occupational health and safety training and consulting services to various Ontario public sectors. These include healthcare, education, municipalities, public safety and First Nations communities.

As a funded partner of the Ministry of Labour (MOL), we work to prevent and reduce workplace injuries and occupational diseases by helping organizations adopt best practices and meet legislative requirements. To create safer workplaces, employers and employees must work together to identify potential hazards and eliminate or control risks before injuries and illnesses occur.

Violence and Responsive Behaviours Project: Background and Project Scope

We recognize that violence in the workplace is a complex issue, and one of the top health and safety concerns facing Ontario's healthcare sector today. PSHSA, through multi-stakeholder and expert consultation, has developed five toolkits to help healthcare organizations protect staff from workplace violence, and meet legal responsibilities for ensuring healthy and safe workplaces. The toolkits are:

1. Workplace Violence Risk Assessment (WPVRA)
2. Individual Client Risk Assessment (ICRA)
3. Flagging
4. Security
5. Personal Safety Response System (PSRS)

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Working Group Members

Name	Organization
Anne Bell	Ontario Association of Community Care Access Centres
Becky Chiarot	Sault Area Hospital
Erna Bujna	Ontario Nurses' Association
Janice Ward	Toronto East General Hospital
Jonas Asare	McGarell Nursing Home
Kelly Quill	Niagara Health System
Mark Varga	Windsor Regional Hospital
Nancy Cooper	Ontario Long Term Care Association
Nancy Lew	Castleview Wychwood Towers
Patricia Leslie	Grand River Hospital
Stephanie Dowhan-Soltys	St. Joseph's Healthcare Hamilton
Tracy Kamino	John Paul II Care Center of Copernicus Lodge

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Workplace Violence in Healthcare

The prevention of workplace violence has become a top priority for Ontario workplaces. Despite improved working conditions and enhanced prevention and enforcement, Ontario workers remain vulnerable to the effects of this occupational health and safety hazard, with nearly one in five victimizations of violence occurring at work (Statistics Canada, 2007).

While the risk of exposure exists in every workplace, violence and aggression occur most frequently in healthcare settings, with as many as 30% of reported violent incidents in Ontario originating from this sector (Workplace Safety and Insurance Board, 2014). It is estimated that workplace violence is three times more likely to occur among healthcare workers than any other occupation, including police officers and prison guards (International Council of Nurses, 2001; Kingma, 2001).

These trends can be attributed to a variety of reasons. Perhaps the most significant is the proximity in which healthcare workers interact with patients and their families, often under difficult and stressful circumstances. Patients with certain medical conditions or taking certain medications can become violent, aggressive or responsive — 'responsive' referring to the fact that they may be responding to their environment and communicating feelings of helplessness and frustrated over unmet needs. Further, patients may also have a history of violence or aggression, or feel angry as a result of their current situation (Kling, Corbiere, & Milord, 2006).

Examples of violence include punching, choking, hitting, shoving, pushing, biting, spitting, groping, pinching, kicking, throwing objects, shaking fists, and threatening assault. In extreme cases, healthcare workers have been stabbed and even killed.

As these examples suggest, violence against healthcare workers, whether intentional or unintentional, often results in significant injuries. Many of these injuries require medical treatment and time away from work. Each year, Ontario's Workplace Safety & Insurance Board (WSIB) allows over 600 violence-related lost-time injury claims involving healthcare workers. While the numbers are alarming, many cases go unreported, dismissed instead as simply being part of the job. Beyond experiencing physical pain, many of the victims live with debilitating emotional and psychological effects, such as post-traumatic stress disorder (Erdos & Hughes, 2001; Shields & Wilkins, 2009). Being physically or psychologically assaulted at work also has repercussions for families and co-workers, not to mention the quality and productivity of healthcare overall (Shields & Wilkins, 2009; Sofield & Salmond, 2003). Healthcare staff work hard at keeping others healthy and safe, yet their work can put them at risk of serious harm.

Legislative changes in Ontario surrounding workplace violence have created new responsibilities and obligations for employers, and have given new rights to workers to refuse unsafe work. The changes have also broadened our awareness of the issue. Most importantly, they have strengthened our understanding that workplace violence is not acceptable. Under the Occupational Health and Safety Act (1990), employers and supervisors are required by law to take every precaution reasonable in the circumstances for the protection of a worker, including disclosure of information about a violent or potentially violent patient, to keep employees safe.

Employers, supervisors, staff — they all have a role to play in eliminating violence at work. Employers however have ultimate responsibility. They must also provide all workers at risk with information (including personal information) about a person with a history of violence. Workplaces, in turn, must adopt effective prevention / safety measures and procedures to keep workers and patients safe. One such approach is to implement a flagging alert program to communicate violence-related risks to healthcare teams. By taking this kind of proactive approach to managing violent, aggressive and responsive behaviours, we can reduce the risk of harm to workers while providing patients with the best possible care.

About the Flagging Handbook

This handbook provides practical tools and information that will help organizations develop a sustainable flagging alert program. The handbook includes:

1. A flagging overview on the purpose, benefits and types of flagging, and related legal and ethical responsibilities

2. The five key steps to developing a Flagging Program

3. Two appendices:
   - Appendix A — Workplace Violence and Health Information Privacy Fact Sheet
   - Appendix B — Sample Flagging Policy

Flagging Overview

What is Flagging?

Flagging is defined as a standardized method of communicating safety-related concerns to workers. Unlike code-white protocols that notify workers of violent situations, flagging draws attention to the *potential* of violence. It involves exchanges of information that consist of visual and / or electronic cues easily recognizable by the healthcare team.

While traditionally used to protect patients from risks such as severe allergic reactions, infection or falls, flagging is now also used to alert healthcare staff to the risk of violent, aggressive or responsive behaviour, and to signal that additional care is required (Kling, Yassi, Smailes, Lovato, & Koehoorn, 2011).

Good To Know

Effective violence prevention involves three critical components —assessing, communicating and controlling risks.

Put more simply, flagging is a proactive approach to communicating the risk of workplace violence, behaviours, triggers and prevention / safety measures and procedures that can protect workers and patients. It supports workers' 'right to know' about potential hazards, and ensures the employer and supervisor are protecting workers and that they have the appropriate information to take and/or seek preventive action.

Flagging should:

- Be a routine part of prevention and risk management planning
- Be used post-incident to prevent further occurrences
- Communicate early-warning information such as level of risk, behaviours, potential triggers, and prevention / safety measures and procedures to protect workers and patients.
- Be complimented by enhanced prevention practices for patients assessed as at-risk — see PSHSA's Individual Client Risk Assessment Toolkit
- Include procedures for identifying visitors who pose a risk — e.g., keeping logs of those who have been restricted from the premises or issued behavioural warnings
- Have an audit system in place to:
    - o systematically verify that flags are initiated appropriately
    - o ensure accountability and transparency
    - o proactively maintain quality control, rather than respond reactively to a dispute

- o provide a means of reporting — e.g., if a patient and / or family / substitute decision-maker requests that a flag be reviewed
  - Maintain a balance between the need for worker safety and patient privacy — see 'Flagging Legislation and Patient Privacy' on page 15.

It is important to remember that while flagging is an important part of managing workplace violence, it is not a stand-alone activity (Nachreiner, 2005). Effective violence prevention involves three components — risk assessment, flagging, and care planning — all of which must be fully developed and work together (Chrisfield, 2014; Derscheid & McKay, 2014; Kling et al., 2011).

Good To Know

Flagging should communicate early-warning information such as level of risk, behaviours, potential triggers, and prevention/safety measures and procedures.

The Benefits of Flagging

While the research on best practices for flagging is only now being explored, available studies have shown that that communication is critical in managing risk. Implementing a process for communicating the risk and signs (e.g. behaviours, triggers) of violence in the workplace and prevention / safety measures and procedures can offer many advantages for:

Patients:	Workers:	Employers:
- Safe and appropriate healthcare - Fairness and equity - Broadened self-awareness	- Improved awareness of known risks - Reduced violence-related incidents - Protection from harm / injury / illness	- Legislative compliance - Enhanced Prevention / Safety Planning to protect workers and patients - Enhanced health and safety management - Positive safety culture - Reduced injury and illness rates - Improved recruitment and retention

Types of Flagging

There are a variety of methods for flagging potentially violent, aggressive or responsive behaviours. The most common approach includes the use of electronic medical-record alerts and / or the application of labels and pull-tabs on paper-based charts. Other visual cues, such as wristbands, door / bedside signage, patient-assignment boards, graphical symbols, and coloured markers, can also help protect the health and safety of workers by calling attention to potential risks.

Since no single approach addresses all possible situations, progressive workplaces choose a combination of tools that best suit their operations and their prevention and risk management needs.

Medical-Record Flags

Health records, whether electronic or paper-based, are a means of communicating patient related information to authorized individuals about their health status and care needs. Flag-alerts are added to the records to ensure important information (e.g. behaviours, triggers, prevention/ safety measures and procedures to protect patients and workers) stands out. However, these alerts can be helpful only if they are easy for all relevant staff (including non –clinical staff who do not have access to the patient record) to spot and understand.

Electronic flags appear on the computer screen as abbreviations and / or symbols; however, their presentation and effectiveness may vary according to software and type of flag:

1. Active flags are displayed as pop-ups each time the file is opened. They require staff to acknowledge they've seen the flag before workflow can continue.

2. Passive flags are visible at all times in a prominent place on the screen, and do not require staff acknowledgement.

An organization may choose one type, or opt to use different types (Cranor, 2002; Wipfli & Lovis, 2010). Discuss the flagging options with your IT staff to ensure that the system architecture (e.g., Networking, Hardware and Applications) and applicable Information Security policies, procedures, guidelines are in place or under development to sustain the desired platform.

Flags for paper-based medical records are often colour-coded and used in conjunction with an alert notation on the 'face-sheet' at the front of the chart. One example is a pull-tab alert sheet that extends past the top edge of the chart. Another example is the placement of an adhesive dot or label on the spine of the chart, on relevant paper forms, and on transition-of-care documentation. Such stickers or labels must be updated based on level of risk

(risk state and status), well-maintained, and remain adhered to the correct medical record.

Additional Visual Cues

A number of other visual cues can be built into the care environment to facilitate quick recognition of risk without disclosing specific details to the general public. For example, if a wristband system is used, organizations may choose in the circumstance to add a defined colour to the patient's identification wristband (e.g. blue, yellow or red) to prompt staff that extra care is required. Similarly, standardized symbols, colours, shapes and icons on safety signage placed above the patient's bed, on the door, patient-assignment boards or mobility aids can also serve as safety reminders. These can relay safety concerns to members of the care team who do not have access to patient medical records (e.g. dietary, housekeeping, maintenance and volunteers, who then through training understand that they must speak to a clinical member of the team for prevention / safety information). At the same time, it is important to be mindful of visual clutter and 'sign fatigue'. Moreover, despite their communicative value, visual cues should not replace proper care-planning and implementation.

Flagging Legislation: Balancing Worker Safety with Patient Privacy

Worker Safety

Everyone has the right to a safe and respectful work environment. Under Ontario's Occupational Health and Safety Act (OHSA), employers and supervisors are required by law to "take every precaution reasonable in the circumstances to protect workers" against hazards such as workplace violence [25(2)(h); 27(2)(c)]. Taking precautions to control risks and informing workers about them is central to preventing unnecessary harm and injury and is a requirement under the OHSA.

The responsibility of employers to provide workers with information under OHSA section 25(2)(a), and the responsibility of supervisors to advise workers of hazards under section 27(2)(a), includes sharing personal information related to the risk of violence from a person with a history of violent behaviour. The OHSA is clear in stating that in instances when a worker is expected to encounter a person with a history of violent behaviour, the employer and supervisor must disclose as much information as needed to protect the worker from physical injury [32.0.5(3)], including enough personal information.

The Health Care and Residential Facilities Regulation 67/93 and due diligence standards also require the employer, in consultation with the joint health and safety committee, to develop, establish and implement written measures, procedures and training (e.g., flagging protocol) for the health and safety of workers [section 8 and section 9].

Patient Privacy

While the Occupational Health and Safety Act requires healthcare organizations to communicate necessary information to protect worker safety, there are sometimes concerns that flagging a patient as having a history of / potential for violence contravenes privacy legislation — e.g., the Personal Health Information Protection Act (PHIPA).

However, while PHIPA establishes specific privacy rights and responsibilities, it is not intended to discourage building safer workplaces. While it lays out and protects individuals' rights to privacy, it also allows for protection of workers' rights to safety.

Specifically, PHIPA allows the collection, use, and disclosure of risk / violence-related information by a 'health information custodian' – e.g., a hospital, long-term care home, or its authorized agents such as nurses and physicians:

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- When permitted or required by another statute (such as OHSA) [s. 37 (1)(k)];
- For planning or delivering programs or services [s. 37 (1)(c)];
- For the purpose of risk management or to increase quality of care [s. 37 (1)(d)]; and / or
- To eliminate or reduce significant risk of serious bodily harm to a person or group of persons [s.40 (1)];

The warning to workers and visitors needs to be specific enough to cover the risks however only to the degree necessary to protect worker safety [s. 30(2)].

Another concern among healthcare providers is that disclosure of violence-related information will result in stigmatization, which will impact the level of care provided to patients. However, as the real-life case study here suggests:

- Integrating worker safety measures into care-plans can lead to improved outcomes for patients; and
- Communicating details of specific medical information may not be necessary in order to advise workers of risks; rather, being aware of known behaviours, triggers, prevention / safety measures and procedures (e.g. de-escalation strategies) may be sufficient for workers to protect themselves

To prevent the breach of patients' rights, it is important for employers to fully comprehend their legal responsibilities and ensure that all their staff are adequately educated and trained.

For more information, see Appendix A: Workplace Violence and Health Information Privacy Fact Sheet.

Case Study

Challenge

Patient X is known to become aggressive when exposed to significant noise. This stems from a medical condition whereby loud noise causes extreme inner ear pain. Because the patient is non-communicative, he cannot ask healthcare workers to keep noise down.

Solution

Patient X is flagged as having a history of/ potential for violence. A note on the patient's door asks anyone about to enter the room to check with the nursing station before entering the room for important health and safety advice (without explaining specifically why). At the nursing station, workers and visitors are advised that the patient may become aggressive if exposed to loud noise. They are advised to work or visit quietly and avoid making loud noises in the patient's presence. If work is to be done that involves loud noise, provisions must be put in place to cover the patient's ears or remove him from the room.

Outcome

Without having to know the specifics of the medical condition causing the aggression, workers are able to comply with safety measures and keep themselves safe, while keeping the patient more comfortable.

Addressing Privacy Concerns

To adequately protect both safety and privacy, flagging should be implemented in conjunction with:

- A patient risk-assessment program (for example PSHSA's Individual Client Risk Assessment toolkit)
- Behavioural care-planning which includes tracking behaviours, triggers and prevention / safety measures and procedures to protect workers and patients
- An effective communication system among all staff, including physicians and volunteers; and

- Adequate staff training to tie all prevention components together

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Good To Know

Flagging needs to respect both worker safety and the need for patient privacy.

This kind of well-rounded program will ensure that patients' specific needs are identified, built into their care plan, and communicated among staff to support informed decision-making and the best possible care.

Ultimately, flagging is about communicating the information needed to promote a culture of safety. It is by no means intended to lay blame or compromise access to quality of care. In upholding the duty to warn workers and protect them from the risk of violence, organizations should be mindful of the following 10 nationally accepted privacy principles (Canadian Standards Association, 2003).

Ten privacy principles to consider when introducing a flagging program:

	Privacy Principle	Requirement	Flagging consideration
1.	Accountability	Designate someone to be accountable for the management of personal information.	- Ensure flagging program leader receives privacy-awareness training. - Develop policies and procedures in consultation with privacy officer. - Establish protocols for flag monitoring and review to update triggers, behaviours and prevention / safety measures and procedures

	Privacy Principle	Requirement	Flagging consideration
			to protect workers and patients.
2	Identifying purpose	Clearly identify the purposes for which personal information is collected.	▪ Establish written standards for risk assessment. ▪ Define clear, objective flagging criteria.
3	Consent	Knowledge and consent of individuals are required when an organization collects, uses or discloses personal information.	▪ Develop protocols for informing patient of flag status, how information will be used or disclosed, and rights and obligations under PHIPA.
4	Limited collection	Personal information an organization collects should be limited only to the information necessary for the identified purpose.	▪ Use a reliable and valid risk assessment tool. ▪ Identify and document potential behaviours, triggers and prevention / safety measures and procedures to protect workers and patients.
5	Limited use and disclosure	Limit the ways an organization uses, discloses, and retains personal information.	▪ Select signage with symbols known only to those at risk where appropriate; if text is used the warning needs to be specific enough to cover the risks without disclosing more information than is necessary. E.g. sign pointing visitors to nursing station prior to entering a patient's room. ▪ Establish transfer-of-accountability / transition-of-care processes. ▪ Retain flag history for lessons learned and

	Privacy Principle	Requirement	Flagging consideration
			successes and completeness of the health record.
6	Accuracy	Ensure that personal information collected is accurate, complete, and up-to-date for the purposes for which it is being used.	▪ Establish protocols for flag appeals and care plan reviews and updates.
7	Safeguards	Protect personal informationwith security safeguards that are appropriate to its sensitivity.	▪ Ensure files containing risk assessment findings, flag status, and care plan strategies are secure and available only to authorized care providers.
8	Openness	Make policies and procedures on management of personal information readily available.	▪ Provide patients with information about the flagging program.
9	Access	Make known to the individual the existence, use, and disclosure of personal information, and provide access to it.	▪ Inform patients of the reasons for flags and how / with whom information will be shared.
10	Challenging compliance	Individuals may challenge an organization's compliance on any of the privacy principles.	▪ Establish and communicate a complaints management process. ▪ Establish a review board to hear all appeals.

Five Steps for Developing a Flagging Program

Following are the five steps to developing and maintaining a comprehensive flagging alert program:

Step 1:
Secure
Management
Commitment

Step 2:
Assess Program
Needs

Step 3:
Develop a
Flagging Policy
& Procedure

Step 4:
Implement the
Program

Step 5:
Evaluate the
Program

Step 1: Securing Management Commitment

Management commitment is vital for the success and sustainability of every health and safety program (Cooper, 2006). Leaders who are fully engaged inspire accountability and achieve better results. Prevention is powered by people, and people are powered by commitment. However, commitment to a flagging program must be supported by decisive action on the part of senior management. This involves taking time to:

A) Ask the Right Questions.

Asking questions requires and encourages active engagement. Collective inquiry builds capacity to solve problems — e.g., working together to challenge assumptions and reflect on where the organization is, where it wants to be, and what is needed to get there. Sample questions include:

- How do managers and staff on your unit communicate with other staff about the presence of a patient deemed at-risk for violent, aggressive, or responsive behaviours?
- Do you feel comfortable disclosing an at-risk patient's level of risk to clinical or non-clinical staff? If not, what would help?
- How effective is our current risk-communication strategy in alerting all workers at risk?
- What should we do differently?

B) Communicate the Right Message.

Regular program messaging from management about providing a safe environment for patients, staff, and visitors implies urgency and strategic priority. Taking prudent action for the protection of workers without compromising the duty to care requires talking openly about the challenges of

flagging, and setting clear policy direction for assessing, documenting, communicating, and controlling risks. Employers must also develop, establish and provide training and educational programs to ensure that staff are aware of workplace violence risks, the organization's plan to prevent risks posed, and how staff should respond in the event of an incident. Training methods should include both theoretical (e.g. lecture, webinars) and applied learning (e.g. hands-on practice, tests, and drills). Training should take place in an engaging learning environment and provide workers with an opportunity to apply the knowledge and ask questions. Consider delivering training on the unit or in a simulated work environment to enhance staff engagement.

C) Empower the Right People.

Delegating responsibility and authority to a flagging program leader helps demonstrate senior management's commitment to ensuring the program is implemented and maintained. However, the program will require ongoing support by all levels of the organization. It also may benefit from involvement of a multidisciplinary committee at various phases of program development. The program leader's membership on the workplace violence prevention committee will facilitate seamless liaising and transparency.

D) Allocate the Right Resources.

Adequate resources, financial and non-financial, must be allocated to ensure the flagging program is implemented and strategic objectives are met. Resources could include:

- Necessary training (e.g. training on individual client risk assessment and flagging procedures)
- An appropriate budget
- Time
- People
- Equipment
- Best-practice information
- Tools

Step 2: Assessing Program Needs

Assessing and documenting the potential for patient violence can provide valuable insight for optimizing care strategies and minimizing harm. Such assessment is critical to identifying the risks facing workers. It is important to consider:

- **Nature of the risk**. Start by defining the problem: What is patient-initiated violence? How is it a problem? Why does the problem exist?
- **Potential of risk**. Decide if risk exists: Which patients pose a risk? Who might be harmed? What activities or circumstances put workers at risk?

- **Extent of the risk**. Determine the scope of the situation: What is the current level of risk? What is the frequency and severity of past incidents?

Assessment begins with the selection of a screening tool that is easy to use and appropriate for the care setting. For more information, refer to <u>PSHSA's Individual Client Risk Assessment toolkit</u>.

It's then necessary to review the existing program and work processes to determine gaps and opportunities: How is risk communicated to all staff at risk? How *should* it be communicated? How would a flagging program improve processes? How would it align with strategic goals?

Finally, identify the interest and influence of key stakeholders and anticipate program constraints: How will key stakeholders be affected by the program? How should they be included? What are the challenges of communicating risk?

Step 3: Developing a Flagging Policy and Procedures

The flagging policy communicates the standards required to carry out the flagging program. The policy at a minimum should establish / include:

- A clear purpose
- A statement of expectation
- Roles and responsibilities
- An implementation plan — e.g., communication, training, and evaluation
- Provides instructions- e.g., procedures- on how to apply the policy.

Procedures describe specific tasks, processes, and the people responsible for them. For example, flagging procedures might explain how to initiate a new flag, or follow up on an incident. Flagging workflow and processes should be relevant and applicable to the organization's specific Health Record environment e.g. mixed paper/ electronic environment. Such procedures will include decisions or actions that can be summarized by algorithms or checklists, and be supplemented by template forms and resources — e.g., transfer-of-accountability / transition-of-care forms, flagging pamphlets, and notification letters. Organizations need to consider that sometimes a patient may be reacting in a distinct way because of circumstances beyond their control (e.g. they may present behaviours that are entirely out of character due to a reaction to a prescribed medication or a medication error.) There must be a mechanism to assess the risk of a recurrence in such situations and communicate a history of violence that is likely to expose a worker to physical injury.

The Health Care and Residential Facilities Regulation 67 / 93 requires the employer, in consultation with the Joint Health and Safety Committee, to develop, establish and put into effect written measures and procedures for the health and safety of workers, and review them at least annually, or more often

if required [s.8 and s.9]. For further information, refer to Appendix B: Sample Flagging Policy.

Step 4: Implementing the Program

Successful implementation depends on three key factors, as noted below.

A) Communication

Communication can include:

- Instructional handouts
- Newsletters or memos
- Posters
- Policy and procedure manuals
- Department staff meetings
- Safety huddles

B) Training

Training should be:

- Provided to all staff initially and to new staff at orientation and on an ongoing basis, at least annually
- Followed up by surveys / feedback to ensure comprehension

C) Compliance Monitoring
- To ensure the processes communicated during training are being followed

Step 5: Evaluating the Program

A flagging program should be monitored on a continual basis in consultation with the JHSC. Procedures should be evaluated at least annually to ensure the program is current and effective, and to identify areas needing improvement.

Evaluation should address qualitative indicators such as employee / patient satisfaction, as well as leading and lagging indicators that include but are not limited to:

- Number / type of flags initiated, and their risk level — e.g., low, moderate or high
- Number of flags permanently maintained on the patient's file at discharge
- Number of violent, aggressive, or responsive behaviour incidents
- Percentage of staff trained in flagging procedures
- Number of flag reviews / audits
- Number of incidents de-escalated or prevented because of known history
- Number of behaviour care plans developed to reduce/eliminate triggers
- Number of patient complaints and flags removed
- Patient satisfaction with quality of care through patient survey or interview process

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Appendix A: Workplace Violence and Health Information Privacy Fact Sheet

Under the Occupational Health and Safety Act (OHSA), employers are required to provide as much information as needed to keep workers safe. At the same time, the Personal Health Information Protection Act (PHIPA) sets requirements for healthcare providers and organizations when collecting, using and disclosure of such information.

Workers need to be safe; privacy must be respected. Can they co-exist?

This fact sheet was developed in collaboration with Hicks Morley Hamilton Stewart Storie LLP, and is designed to answer common questions about communicating the risk of violence without compromising oblication to protect privacy. It is intended for general use only. If you require specific advice on application of privacy law, healthcare providers are encouraged to contact their privacy officer, legal representative, or the **Information and Privacy Commissioner of Ontario**.

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COMMUNICATING THE RISK OF VIOLENCE:
What Healthcare Providers Should Know About Privacy

Under the Occupational Health and Safety Act (OHSA), employers are required to provide as much information as needed to keep workers safe. At the same time, the Personal Health Information Protection Act (PHIPA) sets requirements for healthcare providers and organizations for the collection, use and disclosure of such information.

Workers need to be safe; privacy must be respected. Can they co-exist?

This fact sheet was designed to answer common questions about communicating patient risk of violence without comprising obligations to protect privacy. It is intended for general use only. If you require specific advice on application of privacy law, healthcare providers are encouraged to contact their privacy officer, legal representative, or the Information and Privacy Commissioner of Ontario.

Q: What information must an employer provide to employees to protect their health and safety?

A: In Ontario, employers must provide information, instruction, (e.g., training) and supervision to protect worker health and safety. If an employee can expect to encounter a person with a history of violent behaviour, and the risk of workplace violence is likely to expose the worker to physical injury, the employer must provide the employee with information, including personal information, related to the risk. The employer must not disclose any more information than is reasonably necessary to protect the worker from physical injury.

The OHSA also requires supervisors to advise employees of known dangers to worker health and safety. In a healthcare context, this can include information about a patient who may not have a history of violent behaviour, but has an increased risk of engaging in such behaviour given existing medical and non-medical conditions and circumstances. Only information necessary to address the risk of violence should be disclosed. As the case study at the end of this fact sheet indicates, it usually is possible to provide workers with enough information to protect them without sharing personal health information.

Disclosures to address the risk of violence have some similarity to workplace accommodation disclosures made in respect to a person with a disability: usually, it is not necessary to disclose personal health information, in order to achieve the desired outcome. Rather, the focus of disclosure is on possible behaviours, and factors that may trigger or enable those behaviours.

Q: What privacy legislation applies to information about an individual with a history of or potential for violent, aggressive or responsive behaviour?

A: The collection, use, disclosure, and management of "personal health information" (PHI) by healthcare providers is governed by the Personal Health Information Protection Act (PHIPA). This includes information in healthcare records that identifies a patient as having a history of or potential for violent, aggressive or responsive

behaviour. In particular, care plans, flags on files, and warning markers – e.g., wristbands or notices on the door, related to a history of or potential for violent, aggressive or responsive behaviour are likely to be considered personal health information to which PHIPA applies.

For certain organizations in the healthcare sector — e.g., hospitals and municipally-owned long-term care facilities — the collection, use, and disclosure of "personal information" (PI) is governed by the Freedom of Information and Protection of Privacy Act (FIPPA) and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA). However, where personal health information is subject to PHIPA, the provisions of PHIPA will apply and those of FIPPA or MFIPPA will not.

Q: What is personal health information?

A: Section 4 of PHIPA defines 'personal health information' as:

Information about an individual in oral or recorded form, if the information,

a. relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,

b. relates to the provision of health care to the individual, including the identification of a person as a provider of health care to the individual,

c. is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual,

d. relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,

e. relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,

f. is the individual's health number

g. identifies an individual's substitute decision-maker

This definition has been broadly interpreted, and can include a wide range of information about an individual's healthcare, including:

• Information relating to a medical condition that may manifest itself in violent behaviour — for an example, see the case study at the end of this fact sheet

• Risk assessment findings (e.g. low, moderate or high risk); identifying flags and markers (e.g. wristbands;

warning signs); triggers (e.g., food, noise); and care plans designed to help healthcare workers safely treat/support individuals where such treatment or dealings may involve a risk of physical violence

Q: Does PHIPA limit an employer's duty to warn employees under OHSA?

A: PHIPA allows healthcare providers to use and disclose personal health information where permitted or required by another statute. Therefore, where the OHSA requires an employer to provide an employee with personal information, PHIPA does not prohibit such use or disclosure.

However, the OHSA restricts such disclosure to no more information than is necessary to protect worker safety.

Q: Can a healthcare provider disclose information about an individual with a history of violent behaviour to individuals a) other than workers, or b) outside the healthcare facility?

A: In limited circumstances, yes.

PHIPA permits the disclosure of personal health information to prevent serious and imminent physical harm. More specifically, it allows healthcare providers to disclose personal health information where the provider reasonably believes that such disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm.

In such circumstances, PHIPA places no restrictions on the type of persons to whom the information may be disclosed. Practically speaking, for example, it may make sense to share this information with volunteers, visitors, and other individuals expected to come in contact with the patient.

Q: Does PHIPA allow healthcare providers to flag potential for violent behaviour to other healthcare providers where there is a transfer of accountability / transition of care?

Yes. PHIPA allows one healthcare provider to disclose personal health information to another provider if at least one of the following is true:

• the disclosure is to improve or maintain the quality of care provided by the receiving provider / organization; or

• there are reasonable grounds to conclude such disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm

Q: Is patient consent required to disclose to a worker information relating to a person with a history of violent behaviour?

A: No, though in some cases (e.g., where obtaining consent does not pose a risk to worker safety), healthcare providers may still wish to ask for it. Legally, consent is not required to allow an organization or its authorized agents to use or disclose to a worker information, including personal health information, relating to a risk of violence. However, it should be noted that patient consent may be required for information that does not pertain to the risk of violence.

Q: Do professional codes of conduct impose rules about information sharing for health and safety purposes that are inconsistent with PHIPA or OHSA?

A: No. While healthcare workers must comply with their respective codes of professional conduct as established by the Regulated Health Professions Act, such codes must comply with and give precedence to statutory requirements, including the requirements established by the OHSA. In any event, use or disclosure under the OHSA normally is consistent with professional codes, and practice standards that typically impose a duty to take steps to eliminate or reduce a significant risk of serious bodily harm.

Q: Does the Resident's Bill of Rights establish different rules for long-term care homes?

A: No. Long-term care facilities are governed by the Long-Term Care Homes Act (2007), which contains a Bill of Rights protecting the residents of such facilities. This Bill of Rights provides that residents are entitled to have their personal health information treated in accordance with PHIPA. By incorporating PHIPA into its provisions, the Bill of Rights allows long-term care facilities to disclose personal health information where doing so is required to protect a worker from a person with a history of violent behaviour in accordance with the OHSA. This also means that long-term care facilities must respect the rules set out in PHIPA, including establishing policies and principles to prevent misuse or over-disclosure of personal health information.

Respecting Both Patient Privacy with Worker Safety: A Case Study

Challenge

Patient X is known to become aggressive when exposed to significant noise. This stems from a medical condition whereby loud noise causes extreme inner ear pain. Because the patient is non-communicative, he cannot ask healthcare workers to keep noise down.

Solution

Patient X is flagged as having a history of/ potential for violence. A note on the patient's door asks anyone who enters the room to check with the nursing station before entering the room for important health and safety advice (without explaining specifically why). At the nursing station, workers and visitors are advised that the patient may become aggressive if exposed to loud noise. They are advised to work and visit quietly and avoid making loud noises in the patient's presence. If work is to be done that involves loud noise, provisions must be put in place to cover the patient's ears or remove him from the room.

Outcome

Without having to know the specifics of the medical condition causing the aggression, workers are able to comply with safety measures and keep themselves safe, while keeping the patient more comfortable.

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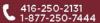PSHSA.ca | 416-250-2131 1-877-250-7444

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Appendix B: Sample Flagging Policy

This Appendix provides a sample flagging policy which can be customized for various work environments.

MANUAL: *Health and Safety*	SUBJECT: Workplace Violence Prevention	POLICY NUMBER: XX-XXX-XX
EFFECTIVE DATE: XX-XX-XXXX	DATE REVISED: XX-XX-XXXX	DATE of NEXT REVIEW: XX-XX-XXXX
POLICY REVIEWERS:		
SENIOR LEADERSHIP SIGNATURE:		JHSC SIGNATURE:

Policy Title:

Workplace Violence Prevention — Flagging Patients Who Pose a Risk of Violent, Aggressive or Responsive Behaviours

Under Ontario's Occupational Health and Safety Act (OHSA), the employer [*Organization*] and its supervisors must take every precaution reasonable in the circumstances for the protection of a worker against workplace violence [25(2)(h); 27(2)(c)]. As well, under clause 25 (2)(a), the employer has a duty to provide information to workers, and under s. 27(2)(a) a supervisor must advise workers of actual / potential workplace hazards. If a worker is expected to encounter a person with a history of violent behaviour in the course of their work, the employer and supervisor must disclose as much information as needed, including personal information, to protect the worker from physical injury while respecting patient privacy as much as possible [32.0.5(3) and (4)]. This is an extension of the employer and supervisor's duty to warn and protect.

The Health Care and Residential Facilities Regulation 67 / 93 requires the employer, in consultation with the joint health and safety committee, to develop, establish and put into effect written measures and procedures for the health and safety of workers [s.8 and s.9]. Workplace violence prevention is of primary importance and a continuing objective. All [*Organization*] workers are expected to work in compliance with OHS laws and with safe work practices and procedures established by the organization.

Policy Purpose

The purpose of this policy is to provide a safe environment by communicating the necessary information and preventive measures to staff regarding patients who present a history and / or risk of violent, aggressive or responsive behaviour in the workplace. The policy outlines *[Organization]*'s expectations with regard to establishing and maintaining a flag-alert system for at-risk patients. It also aims, in accordance with legislative and regulatory requirements, to prevent occupational injury / illnesses and to ensure that safe patient care and dignity are maintained.

Policy Statement

[Organization] is committed to identifying and addressing occupational health and safety hazards. This includes providing workers with information related to the risk of violence from a person with a history and / or potential of violent, aggressive or responsive behaviours.

All patients presenting for admission or treatment will be screened using a valid and reliable tool, and necessary flags will be initiated to alert staff of at-risk patients. Results of the risk assessment, including behaviours, potential triggers and prevention /safety measures and procedures that protect workers and patients, shall be placed in a prominent location in the chart and communicated to all appropriate staff.

Incidents and past history of violent behaviour will be retained in the patient's chart/electronic record. Flagging activities are not intended to stigmatize at-risk patients, and will be conducted in a manner that respects ethical principles and aligns with the organization's duty to care (e.g. is mindful of clients who have a history of trauma with safety plans that will support the philosophy of trauma informed care while also protecting workers).

Patients with a known history of violence that may put workers at risk of physical injury, will have a flag initiated and maintained in their file and will be screened using a valid and reliable tool to document current risk state / status, behaviours, triggers and prevention / safety measures and procedures to protect workers and the patient. If in doubt- apply the precautionary principle and initiate the flagging process.

> **Note:**
>
> Patients with a history of violence must be assessed to determine which workers would be likely to encounter this patient in the course of their work and whether the person poses a risk of physical injury to those workers.

[Organization] recognizes that everyone must work together to identify at-risk patients and ensure appropriate flags are in place and communicated to all workers at risk. The organization will, in consultation with the joint health and safety committee, take every precaution reasonable in the circumstances to protect workers and minimize risks in a proactive and timely manner.
[Organization] will ensure that elements of the flagging program meet all requirements under the OHSA and its regulations.

Policy Scope

All staff, students, volunteers, contractors, and agents of *[Organization]* are required to comply with this policy and related procedures.

Policy Principles

[*Organization*] is committed to providing a safe and respectful environment, and implementing measures and procedures to prevent, control and minimize the risk of violence.

[Organization] considers any violent behaviour unacceptable, and will provide the necessary measures to protect staff, along with the training they require to understand and completely implement this flagging protocol and to prevent and respond to incidents in a timely, efficient and safe manner.

[Organization] acknowledges various circumstances such as medical conditions or cognitive illness that may cause a patient to be violent. *[Organization]* seeks to use information about violent incidents to improve patient care while protecting staff safety.

[*Organization*] supports the application of the precautionary principle when taking all reasonable steps to prevent and manage workplace violence.

[Organization] takes seriously its responsibility for personal health information under its control, and shall limit the collection, use, and disclosure of such information to that which is necessary to protect the safety of workers and provide safe, competent, ethical care.

[Organization] supports the use of routine prevention practices for all patients, and enhanced prevention practices for at-risk patients. Enhanced prevention practices shall be risk-based and patient-centred while ensuring the protection of workers.

Definitions

At-risk patient: A patient who poses a risk for violent or response behaviours.

Behaviour care plan: A written plan that details the care to be provided to prevent or control violent, aggressive or responsive behaviours. It is developed by a clinical healthcare worker or team in collaboration with (when possible) the patient and / or substitute decision-maker (SDM).

Clinical healthcare worker: A clinical staff member who provides preventive, curative, promotional or rehabilitative healthcare services to patients.

Complaints management/ Requesting for reconsideration process: In the context of flagging, the complaints management/ reconsideration process is the act of addressing a patient's and / or substitute decision maker's concern with a flagging-alert decision. The process involves:
- Open communication and sharing of information
- Explanations of flagging policies and procedures
- Decisions and rationales

The complaints management/ request for reconsideration process shall align with the organization's regulatory requirements for addressing patient complaints.

Enhanced prevention practices: These are heightened measures used to prevent violent, aggressive or responsive behaviours in at-risk patients and protect staff based on care needs and risk assessment.

Flag: A visual and / or electronic alert used to:
- inform staff of a risk of violent, aggressive or responsive behaviours
- signal additional and individualized care-needs and preventive measures

Flagging: A standardized method to communicate safety concerns to workers.

Individual client risk assessment: A systematic process used by clinical healthcare workers for evaluating a patient's likelihood of violent, aggressive or responsive behaviour.

Non-clinical healthcare worker: Any staff member who is not a clinical healthcare worker and is carrying on work activities in an acute-care setting.

Patient: For the purpose of this policy, a patient is any recipient of care.

Precautionary principle: An approach for "protecting workers in circumstances of scientific uncertainty, reflecting the need to take prudent action in the face of potentially serious hazards without having to await complete scientific proof that a course of action is necessary." (Ontario Health Care Health and Safety Committee under Section 21 of the Occupational Health and Safety Act, 2011).

Responsive Behaviours: A protective means by which persons with dementia or other conditions may communicate an unmet need (e.g., pain, cold, hunger, constipation, boredom) or reaction to their environment (e.g., lighting, noise, invasion of space).

Routine prevention practices: Violence-prevention strategies such as active listening and empathy that are used with all patients to prevent violent, aggressive or responsive behaviours.

Staff: Staff members can be:
- Clinical healthcare workers
- Non-clinical healthcare workers
- Managers
- Administrative personnel
- Physicians
- Students
- Security guards
- Any individual who has a working relationship with the healthcare organization

In this policy, the terms 'worker' and 'staff' are used interchangeably, and extend to volunteers of the organization.

Transfer of accountability / transition of care (TOA / TOC): An interactive process for transferring patient information from one healthcare worker / team to another in order to ensure continuity of care, as well as staff and patient safety. Examples of TOA / TOC include:
- Nurse-to-nurse at change of shift
- Nurse-to-nurse when care is temporarily assigned to another nurse on a short-term basis
- Transfer from one patient-care area to another
- Transfer to a different patient-care unit within the organization
- Transfer to an outside organization

Trigger: A circumstance or situation that may initiate, provoke or impact patient behaviour. Triggers may be physical, psychological or activity-related.

Violent behaviour: Acts of violence such as but not limited to choking, punching, hitting, shoving, pushing, biting, spitting, shouting, swearing, verbal threats, groping, pinching, kicking, throwing objects, shaking fists, and threatening assault.

Violent behaviour — early signs: Overt signs of escalating violent, aggressive or responsive behaviours such as:
- Changes in autonomic nervous system — e.g., sweating, flushed face, changes in pupil size, increased muscle tension
- Rapid, loud, or profane speech

- Sudden changes in level of consciousness — e.g., increased disorientation and confusion
- Motor agitation — e.g., agitated pacing and inability to remain still
- Hallucinations, which can be auditory or visual and may be benign or command-orientated
- Sudden changes in extremes or affect — e.g., exhilaration, grandiosity
- Sudden lack of affect in someone who was previously very agitated and threatening, which may indicate a decision to take violent action
- Use of alcohol or drugs

Visitor: Any person who enters the workplace who is neither a patient nor a worker.

Workplace violence: Under the OHSA, workplace violence means:
   a. the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
   b. an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or,
   c. a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Roles and Responsibilities

Board of Directors
- Ensures the organization complies with requirements under OHSA, including the duty to warn and protect workers from workplace violence
- Verifies that Ministry of Labour orders and requirements related to violence towards staff are addressed
- Holds senior management accountable for the development and implementation of an effective violence-prevention and flagging-alert program

Employer
- Takes every precaution reasonable in the circumstances to protect workers
- Assesses and manages the risks of workplace violence that may arise from the nature of the workplace and the type or conditions of work, reassessing the risks as often as necessary
- Establishes and puts into effect written measures and procedures and training for the early recognition, identification (electronic and visual) and flagging of patients with a history of or potential for violent, aggressive or responsive behaviour, in consultation with the joint health and safety committee
- Provides to all workers at risk information (including personal information), with respect to persons with a history of or potential for violent, aggressive or responsive behaviours

- Provides information, instruction, training, and education on this policy and its applicable procedures to all staff
- Designates an individual with the appropriate knowledge and experience to oversee the implementation and maintenance of the flagging program. Holds that individual accountable for ensuring consistent application and implementation
- Identifies and allocates necessary resources for effective implementation of the flagging program
- Provides all required equipment, materials, and devices, and keeps them in good working order
- Keeps and maintains training records related to workplace violence and flagging
- Ensures policy, procedures and risk assessments are reviewed at least annually or as needed, and identifies policy and program gaps in order to make necessary changes to protect workers

Supervisor

- Takes every precaution reasonable in the circumstances to protect workers
- Advise a worker of the existence of any potential or actual workplace violence danger to the health and safety of the worker of which the supervisor is aware
- Acting on behalf of the employer will assess and manage the risks of workplace violence that may arise from the nature of the workplace and type or conditions of work, reassessing the risks as often as necessary
- Informs workers and security about patients who have a history of violence or pose a risk of violent, aggressive or responsive behaviour
- Is familiar with flagging requirements and their duties under this policy
- Ensures that staff receive appropriate training / education on this policy and its procedures and ensures that it is documented
- Monitors and enforces compliance with this policy
- Communicates the flagging process to staff
- Responds to all known or reported incidents of violent, aggressive or responsive behaviours and   / or risks to workers within care-area, and ensures workers are protected
- Calls Security or code white when assistance is required
- Ensures flagging status is updated after an incident and prior to discharge or transfer-of- accountability in order to:
- document the history of violent or responsive behavior
- alert workers who might encounter the patient in the future
- Helps inform at-risk patients of flagging status, and oversees complaints management/reconsideration

Clinical Healthcare Worker (CHW)

- Is familiar / complies with flagging requirements and duties under this policy

- Conducts individual client risk assessments according to organizational policy; notes findings; and checks for previous flag alert
- Engages patient, families, and substitute decision-makers in identifying history of violence, behaviours, triggers, and prevention /safety measures and procedures for workers and patients
- Flags any patient with a history of violent behaviour or assessed as moderate/high risk
- Ensures flag, including behaviours, triggers and prevention / safety measures and procedures are noted on patient's electronic / paper record and / or transfer-of-accountability forms; and initiates visual alert indicators as required by this policy
- Develops and implement patient-centered care-plans to address identified risks, behaviours, triggers and prevention / safety measures and procedures required to keep workers and patients safe.
- Immediately alerts security and manager/supervisors when flag is initiated or when a patient with a history of violent, aggressive or responsive behaviour is identified
- Informs at-risk patients of flagging status, triggers, and care-plans
- Participates in training provided by the employer
- Reports and documents violent, aggressive and responsive behaviours and violence-related incidents and injuries / illnesses promptly to supervisors and other staff according to organizational policy (*add link to policy*)
- Calls Security or code white when assistance is required
- Communicates flag and safety precautions to staff without access to electronic / paper patient records (e.g. alerts security, advises manager who will alert all other nonclinical departments, advises during patient and safety huddles, advises verbally when they are approached in response to signage)
- Ensures updated flag status, behaviours, triggers, and prevention / safety measures and procedures that protect workers and patients are communicated to transfer-of- accountability units / facilities
- Participates in complaints-management process

Non-Clinical Healthcare Worker

- Is familiar with and follows requirements / duties under this policy
- Takes notice of visual-alert indicators such as signage, symbols, and wristbands
- Verifies triggers and safe work practices with CHW or supervisor before entering a room / approaching a patient
- Notifies clinical healthcare workers and / or Security regarding signs of escalating behaviour and / or additional triggers
- Calls Security / code white when assistance is required
- Reports incidents of violent, aggressive or responsive behaviour immediately to supervisor, clinical healthcare workers and Security as required by organizational policy (*add link to policy*)
- Participates in training and education provided by employer

Security

- Is on standby as a safety precaution when at-risk patients are identified / flagged
- Checks-in with clinical healthcare unit at start of each shift to receive report on risk of violence
- Provides assistance as needed when flags are initiated
- Patrols areas regularly / as needed where a flagged patient is receiving care
- Provides security escorts requested by staff including for planned interventions that are known to trigger a patient
- Calls, attends, and participates in code-white situations (refer to PSHSA "Security Tool" for more details)

Registration Staff

- Immediately contacts Security / requests standby support when a patient presents to the registration desk with a flag on their record
- Verifies and advises area manager / supervisor / or charge nurse of the arrival of a flagged patient
- Ensure flag-alerts are activated:
    - o Display in electronic and/ or paper health record
    - o Highlight on face-sheet and place in front of chart
    - o Gather alert signage and relevant visual cues
- Regularly checks the security log of flagged visitors

Joint Health and Safety Committee (JHSC)

- Reviews this policy at least annually / as needed
- Assists with hazard identification and control
- Provides written recommendations (e.g., measures, procedures, training, education) to employer where necessary to improve the policy and program, minimize identified risks and protect workers
- Is consulted in development of measures, procedures, training and education, and evaluates the effectiveness of training related to this policy
- Reviews and analyzes reported incidents / injuries of violence towards staff, as well as relevant OHS reports to help determine corrective actions

Procedures

This section will need to be customized based on decisions made by the employer as to the procedures that will support their flagging policy.

Equipment / Tools

Each employer must decide which of the following equipment / tools best suits their operational and risk management needs to best protect workers and patients.

This list is not exhaustive, nor is the organization required to use all items listed.

- Individual client risk assessment tool — see PSHSA's Individual Client Risk Assessment toolkit
- Violence behaviour care-plan
- Electronic information / medical record system (e.g., Cerner, McKesson, Meditech)
- Electronic flagging system
- Medical record labels/ pull-tabs for paper charts
- Electronic or magnetic bedboard
- Whiteboard
- Flagging pamphlet and notification letter for patients / families / visitors — see Example A
- Comprehensive written violence-prevention program
- Violence incident / investigation report / form (determined by the organization) that includes speaking to the patient and family about behaviours, triggers and prevention / safety measures and procedures
- Transfer-of-accountability form
- Safety indicator symbols (determine by organization) — See Example B
- Door / bedside signage — see Example C
- Patient wristband (colour determined by organization, keeping in mind the possible cultural context of different colours)
- Coloured markers / stickers / dots / tags

Flag-Alerts

Flag-Alert Criteria

Establish flag-alert criteria and communicate this criteria to all staff.

- Flag alerts are not intended for all patients
- Decisions for flag-alerts must be based on objective, clearly defined criteria as follows:
  - A known, disclosed or documented history of violence and / or
  - Violent behaviour is either intentional or unintentional
  - The individual is a recipient of care / services
  - The risk-assessment rating is moderate or high

Initiating Flag Alert

Triage/Emergency Department

- Triage nurse will check for previous flag alert (on patient record / security log of flagged visitors) and conduct an individual client risk assessment using a violence risk assessment form chosen by the organization to determine risk of

> violence— e.g., the Violence Assessment Tool (VAT) in <u>PSHSA's Individual Client Risk Assessment toolkit</u>.
>
> > o If no flag is present and VAT risk rating is low, no further action in required
> >
> > o If no flag is present and VAT risk rating is either moderate or higher, enter alert in the electronic / paper record — a yellow flag for moderate risk; a red flag for high risk. Update record to include behaviours, triggers, and prevention / safety measures and procedures to keep workers and patients safe.
> >
> > o If flag is present, note history on VAT and update alert rating if indicated by new risk assessment. Update record to include additional behaviours, triggers, and prevention / safety measures and procedures to keep workers and patients safe.

- Registration staff will highlight flag alerts on patient's face sheet and / or Electronic Patient Record (EPR) and notify security and area manager/supervisor of flag status

- Security will assist or remain on stand-by as required

- Area manager/supervisors will communicate the presence of a flag to relevant staff and ensure electronic patient tracking board is current.

- Clinical team will ensure visual indicators (e.g. coloured wristband/ symbol etc.) are in place and develop a behavioural care-plan to manage risks and identify prevention / safety measures and procedures to protect workers and patients. Include the reason for the flag, behaviours, triggers, and specific care-strategies — e.g. additional staffing, engagement and distraction techniques, and use de-escalation and other crisis-prevention skills as necessary.

- Clinical healthcare worker from emergency department will provide the flagging pamphlet and notification letter to the patient or SDM when safe to do so. If factors exist that prevent disclosure (e.g., imminent safety concerns, or a patient's inability to comprehend materials), document the decision in the patient's chart and report it to the manager/supervisor and flagging program coordinator.

- Patient's status and response to care-plan interventions will be re-assessed at least once per shift and at discharge.

- When at-risk patient is transferred to another unit or discharged to an external facility, emergency department nurse or manager will provide the receiving party with copy of VAT and TOA outlining the circumstances surrounding the flag — e.g., types of behaviours, triggers, plan of care.

- Clinical healthcare workers that are approached by non-clinical staff, porters, EMS personnel and volunteers (as directed by flag signage) are to verbally inform them of the flag prior to their coming in contact with the patient.

In-Patient Unit – New Admission

- Clinical healthcare worker from receiving unit will:
  - o Check patient face sheet and TOA for flag alert and conduct an individual client risk assessment using a violence risk assessment form chosen by the organization to determine risk of violence— e.g., the

Violence Assessment Tool (VAT) in <u>PSHSA's Individual Client Risk Assessment toolkit</u>.

- If no flag is present and VAT risk rating is low, no further action in required
- If no flag is present and VAT risk rating is either moderate or higher, enter alert in the electronic / paper record and ensure alert is added to bedboard system.
- If flag is present, note history, behaviours, triggers, prevention / safety measures and procedures and update alert rating if indicated by admission VAT, and confirm bedboard shows flag

o Notify Security of the flag status and request Security presence / have on standby as required.

o Promptly inform the manager/ supervisor of flag so they can inform porters, non- clinical staff and volunteers verbally of the flag prior to contact with the patient

o Supervisors will immediately communicate the presence of a flag to relevant staff and report flag alert status' including behaviours, triggers and prevention / safety measures and procedures for workers and patients during shift change.

o Ensure visual indicators (e.g. bedside signage/ armband) are in place.

o Develop a behavioural care-plan to manage risks. Include the reason for the flag, triggers, and specific care-strategies — e.g. additional staffing, engagement and distraction techniques, and use de-escalation and other crisis prevention skills as necessary.

o Provide the flagging pamphlet and notification letter to the patient or SDM when safe to do so. If factors exist that prevent disclosure (e.g., imminent safety concerns, or a patient's inability to comprehend materials), document the decision in the patient's chart and report it to the manager/supervisor and flagging program coordinator.

o Reassess the patient's status and response to care-plan interventions at least once per shift and at discharge.

o When a flagged patient is transferred to another unit or discharged to an external facility, provide the receiving party with copy of VAT and TOA outlining the circumstances surrounding the flag — e.g., types of behaviours, triggers, plan of care and safety precautions used for workers and patients.

o Clinical healthcare workers that are approached by non-clinical staff, porters, EMS personnel and volunteers (as directed by flag signage) are to verbally inform them of the flag prior to their coming in contact with the patient.

Outpatient Clinics

- Before patient's arrival clinical healthcare worker from outpatient unit will:
  o Check patient schedule list for active flag alerts/notes and notify security and area manager/supervisor accordingly
  o Security will assist or be on standby as required

- o Manager/supervisor will communicate the presence of the flag and safe work practices to relevant staff and volunteers
- Upon patient's arrival clinical healthcare worker will
  - o Conduct an individual client risk assessment using a violence risk assessment form chosen by the organization to determine risk of violence— e.g., the Violence Assessment Tool (VAT) in <u>PSHSA's Individual Client Risk Assessment toolkit</u>.
    - If patient has a known, disclosed or documented history of violence
    - If flag is present on patient schedule list
    - If patient is demonstrating behaviours associated with increased risk of violence
    - If clinic/unit is high risk as identified by the organizations/departmental risk assessment
  - o Promptly inform security and area manager/ supervisor of additional flag. The supervisor / manager will ensure non-clinical staff, porters and volunteers are aware of the flag prior to their coming in contact with the patient.
  - o Ensure necessary visual indicators (e.g. colour markers) are in place.
  - o Develop a behavioural care-plan to manage risks. Include the reason for the flag, triggers, and specific care-strategies — e.g. additional staffing, engagement and distraction techniques, and use de-escalation and other crisis prevention skills as necessary.
  - o Provide the flagging pamphlet and notification letter to the patient or SDM when safe to do so. If factors exist that prevent disclosure (e.g., imminent safety concerns, or a patient's inability to comprehend materials), document the decision in the patient's chart and report it to the manager/supervisor and flagging program coordinator.
  - o Reassess the patient's status and response to care-plan interventions as often as necessary and at discharge.
  - o If a flagged patient is transferred to another unit or discharged to an external facility, provide the receiving party with copy of VAT and TOA outlining the circumstances surrounding the flag — e.g., types of behaviours, triggers, plan of care and safety precautions used for workers and patients.
  - o Clinical healthcare workers that are approached by non-clinical staff, porters, and volunteers (as directed by flag signage) are to verbally inform them of the flag prior to their coming in contact with the patient.

Violent Incidents Involving Patient – All Departments

- Call Security / code white as needed; if workers are unable to remove themselves or believe behaviours will escalate, such as when the patient is aware Security is being contacted, they might use a code phrase established by the organization to signal distress — e.g., requesting a 'yellow card'.
- Notify the supervisor.

Communicating the Risk of Violence

- Use de-escalation and other crisis-prevention skills and recommended approaches as needed.
- Advise clinical healthcare worker and supervisor of any change in behaviours, triggers or violent incidents
- Complete or repeat an <u>individual client risk assessment</u>. Enter the alert, behaviours, triggers, and prevention / safety measures and procedures to protect workers and patient in the electronic / paper record if not already flagged — yellow flag for moderate risk; red flag for high risk.
- Ensure electronic / magnetic bedboard / whiteboard and all visual indicators are in place.
- Develop / update behavioural care-plans to manage risks and identify all prevention / safety measures and procedures to protect workers and patients.
- Flag any patient with a known history of violent behaviour.
- Supervisors should immediately communicate flags to at-risk workers.
- Staff / volunteers who do not have access to the patient's electronic record / paper chart should check for visual indicators. If a flag is present, they should consult with a clinical healthcare worker prior to contact with the patient regarding behaviour, triggers, and applicable prevention / safety measures and procedures.
- Provide the flagging pamphlet and notification letter to the patient when safe to do so. If factors exists that prevent disclosure (e.g., imminent safety concerns or the patient's inability to comprehend materials), document the decision in the patient's chart and report it to the supervisor and flagging program coordinator.
- Provide a report on patient status and the response to care-plan interventions at least once per shift and as necessary.
- When a patient whose chart has been flagged is transferred to another unit or discharged to an external facility, provide the receiving party with verbal and written reports outlining the circumstances surrounding the flag — e.g., types of behaviours, triggers, and any prevention / safety measures and procedures to protect workers and patients etc.
- Inform relevant staff, porters and EMS personnel verbally of the flag prior to their coming in contact with the patient.
- Complete an incident-report form.

Violent Incidents Involving Visitors

- Call Security / code white if necessary.
- Inform the supervisor and clinical healthcare worker of the risk.
- Document the incident per organizational policy (*add link to policy*).
- Alert workers per organizational policy.
- Document the incident in the progress notes as it applies to the patient.
- Update the log report for visitors who are restricted from the premises or have been issued a behavioural warning.
- Develop a searchable security log of flagged visitors for registration / triage staff.

Reporting and Documentation

- Document assessment details in the care-plan, including behaviours, potential triggers, recommended risk management strategies, worker and patient prevention / safety measures and procedures, and any other pertinent information.
- Display the flag status on the electronic or magnetic bedboard / whiteboard and report it to the supervisor.
- Communicate risk-assessment findings to other staff during shift change, transfer-of- accountability, and as required.
- Use visual cues such as wristbands; door / bedside signage / symbols; coloured markers on chart spines and mobility aids to communicate risk with staff without access to patients' charts.
- Report all incidents of violence as per organizational policy (*add link to policy*) and to the JHSC and trade union (if any) as per the OHSA and all applicable information required under the Health Care and Residential Facilities Regulation, within 4 days of the occurrence if incident causes injury that prevents performance of usual duties, requires medical attention, or as per collective agreement.

Reviews and investigations

- Clinical staff should conduct regular reviews of flag-alerts to update behaviours, triggers and prevention / safety measures and procedures to protect workers and patients.
- In addition to legislated reporting obligations listed above, responsible department leadership should summarize and report violence-related incidents to the JHSC.
- All incidents should be promptly investigated, and root causes identified and corrective actions documented.

Complaints management/ Reconsideration process

- The person to contact related to the complaints/ reconsideration process should be outlined in the flagging pamphlet and patient-notification letter.
- Questions regarding the flagging -alert program should be directed to the responsible clinical healthcare worker and / or supervisor for follow-up.
- Complaints or requests for removal of flags should be in writing and directed to the program leader. The review should be conducted by a multidisciplinary team including clinical staff, patient advocate, safety professional and privacy officer. The following should be discussed as part of the review:
  - o The history of violent behaviour
  - o The nature of the risk
  - o The potential for and extent of future risk
- Decisions and rationales will be communicated in writing to the patient and relevant clinical team.

- All decisions must consider objective findings and exercise a precautionary approach.

Communication

This policy will be communicated to all staff upon hire and made available for further reference in the health and safety manual. (*Organization*) shall ensure timely notice of changes to the existing policy as they arise.

Training

(*Organization*), in consultation with the JHSC, will develop, establish and provide flagging-alert proficiency-based training for all employees. New employees will receive this training at orientation, and when new flagging procedures are developed and / or revised. Ongoing refresher training will be provided on a regular basis. Supervisors are required to participate in violence-prevention and flagging training appropriate to their assigned duties. (*Organization*) will keep all documentation regarding staff who have been trained, their training dates, and material covered.

Evaluation

Evaluation will include the following data:
- Number / type of flags initiated, and their risk level – e.g. low, moderate, or high
- Number of permanently maintained on the patient's file at discharge
- Number of violent, aggressive or responsive behaviour incidents
- Percentage of staff trained in flagging procedures
- Number of incidents de-escalated or prevented because of known history
- Number of behaviour care plans developed to reduce / eliminate the triggers
- Number of patient complaints and flags removed
- Patient satisfaction with quality of care through patient survey or interview process

A review of this policy and related procedures and data collected will be completed in consultation with the JHSC at least annually or more often if deemed necessary by the JHSC and / or through a reassessment of risk. The review will evaluate program content, application, and performance outcomes. Senior management will consider recommendations when setting subsequent goals and objectives; coordinating training; and allocating program resources.

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Example A: Patient and Family / Visitor Brochure

Q: What do you mean by violent behaviour?

A: Some people react to stress, anger, fear or pain with violence. Medication, anaesthesia or medical conditions like dementia also can cause violent behaviour. This can include hitting, shoving, pushing, punching, biting, spitting, groping, pinching, kicking, throwing objects, shaking fists, & attempts and threats of assault.

Q: How did you decide that I may be at risk of becoming violent?

A: We carry out a detailed assessment on each patient. This tells us if they have been or could become violent.

What if I have more questions?
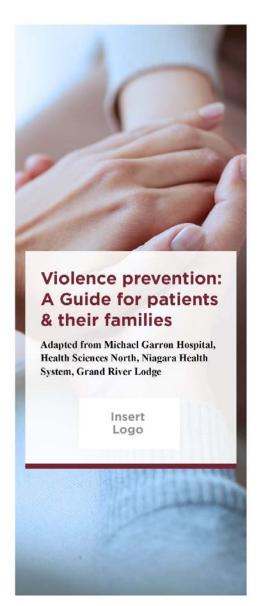
You are welcome to speak to:

[Insert Contact Title/Info]

If you have questions, concerns or would like to submit a written request for reconsideration.

4950 Yonge Street
18th floor, Suite 1800
Toronto, Ontario
Canada
M2N 6K1

Tel: 416-250-2131
Toll free: 1-877-250-7444

Insert Logo

Violence prevention: A Guide for patients & their families

Adapted from Michael Garron Hospital, Health Sciences North, Niagara Health System, Grand River Lodge
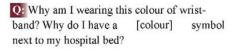
Insert Logo

At [Organization Name]
we work hard to provide a safe
environment for all our patients, visitors
and staff. For the protection of everyone,
we have a violence-prevention program.

Our program does not allow any kind of
violent behaviour. That means:

- If someone becomes aggressive or
  violent, they may be asked to leave.

- We need to let staff know when there
  is a risk of violence or abuse.

- Our goal is to provide the best possible
  care. By keeping our staff safe and
  informed, we help ensure they can
  meet the needs of all our patients and
  their families.

Q: Why am I wearing this colour of wrist-
band? Why do I have a   [colour]   symbol
next to my hospital bed?

A: The   [colour]   wristband and
   [colour]   symbol is a way to communicate
so everyone is safe. It lets staff know about the
potential for violence, and helps them prevent
violent behaviours from being triggered. The
wristband and signage also helps remind you
of our violence prevention policy.

Q: Are people going to treat me differently?
Will I always wear it when I am at
[Organization Name]   ?

A: The alert markers (e.g. your wristband and
bedside signage) are necessary for alerting

staff so they can find out more about what you
specifically need. It will not affect the care you
receive — you will always get the best care we
can give. We will review your needs regularly
and update your care-plan so that we can help
where and how it's needed.

Q: Would other health organizations do the
same thing?

A: All healthcare organizations must follow the
Occupational Health & Safety Act (OHSA).
Under the OHSA, we all must take necessary
steps to provide a healthy and safe workplace.
Practices may vary a little from one facility to
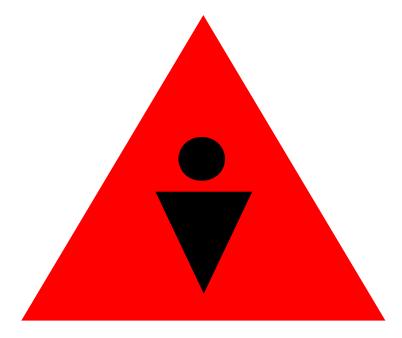another, but the basic steps are the same.

Example B: Flag Symbols

(implemented in response to individual client risk assessment)

MODERATE RISK OF VIOLENCE
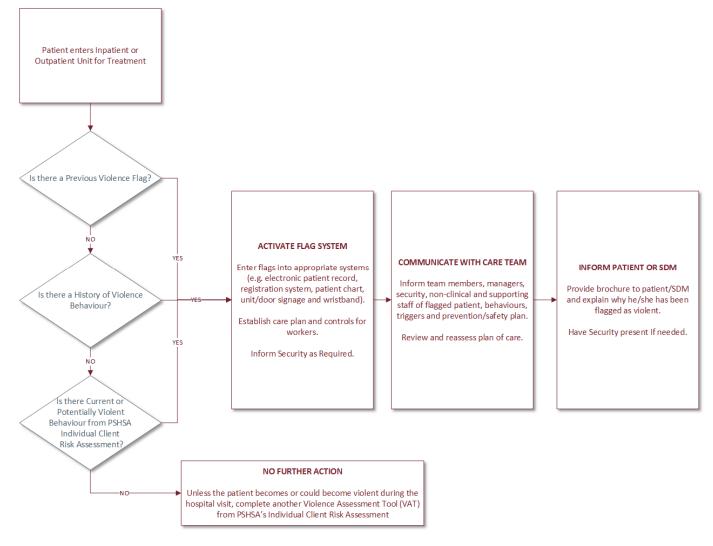

HIGH OR IMMINENT RISK OF VIOLENCE

Example C: Door / Unit Signage

PLEASE CHECK
WITH
NURSE BEFORE
ENTERING

PLEASE CHECK IN WITH NURSE/ COMMUNICATION DESK BEFORE ENTERING

STOP

Example D: Flagging Algorithm

Any nurse or clinical healthcare worker familiar with the patient can start the flagging process. Patients should be screened when they are presenting to the Inpatient or Outpatient Unit for treatment, and are either exhibiting violent behaviour or have a history of violence.

Communicating the Risk of Violence
A Flagging Program Handbook for Maximizing Preventative Care