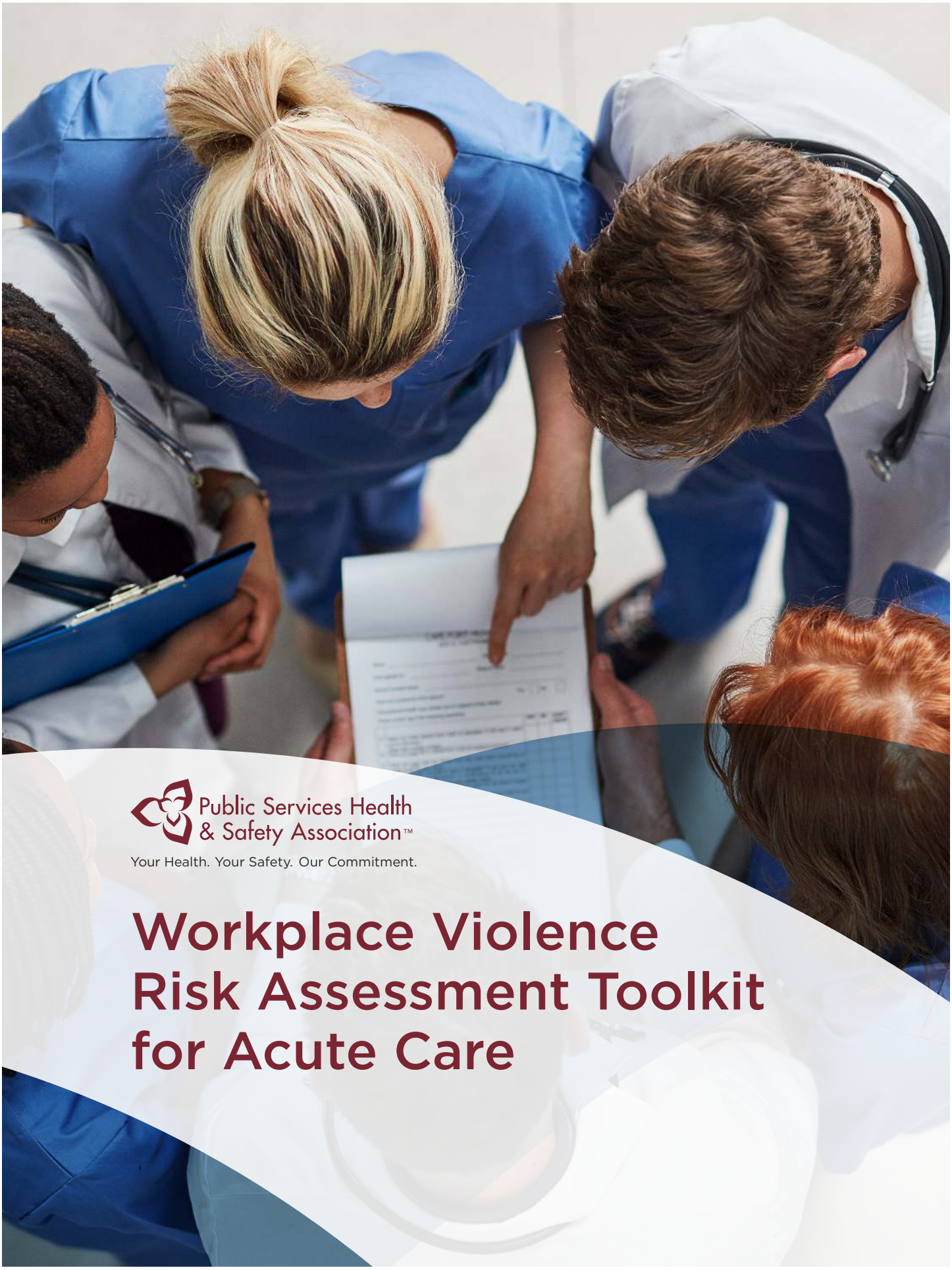

Public Services Health & Safety Association™

Your Health. Your Safety. Our Commitment.

Workplace Violence Risk Assessment Toolkit for Acute Care

Workplace Violence Risk Assessment Toolkit for Acute Care

Product Code: VPRASAEN0417

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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.

Workplace Violence in Healthcare

Violence in the workplace is a complex issue. It's also one of the top health and safety concerns facing Ontario's healthcare sector today. Research shows 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).

Each year, Ontario's Workplace Safety & Insurance Board (WSIB) allows more than 600 violence-related claims involving healthcare workers. While this number is alarming, many more cases are believed to go unreported (Findorff, Wall, & Gerberick, 2005). Healthcare staff work hard to keep others healthy and safe, yet their work can put them at risk and leave them with debilitating physical and psychological trauma.

Legislative changes in Ontario have broadened our awareness of workplace violence, and have strengthened our understanding that it cannot be considered part of the job. Under the law, everyone in the workplace has a role to play in eliminating violence at work.

The Five PSHSA toolkits

PSHSA has created 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)

Acknowledgements

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Toolkit development was led by Carolyn James, Henrietta Van hulle and supported by Kaiyan Fu, of PSHSA.

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About the WPVRA Toolkit

The Workplace Violence Risk Assessment Toolkit for Acute Care contains a detailed hazard assessment designed to help either the acute-care or long-term-care workplace:

- identify hazards
- establish their risk rating
- identify controls
- implement an action plan

The sections that follow provide more detail on how to complete the assessment.

The Need for Workplace Violence Risk Assessment

Workplace violence is defined by the *Occupational Health and Safety Act* as:

- the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
- an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or,
- 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.

Violence can happen in all workplaces. There are four types of violence organizations can encounter, and should consider when assessing and planning for risk:

- Type I — external perpetrator: The violent person has no relationship to the worker or workplace.
- Type II — client/customer: The violent person is a client at the workplace who becomes violent toward a worker or another client.
- Type III — employment-related: The violent person has / had some type of job-related involvement with the workplace.
- Type IV — domestic violence: The violent person has a personal relationship with an employee or a client.

Good to Know

Risk assessment —the process of collecting and analyzing data to identify what in the workplace can cause harm and to determine whether additional precautions are needed to control risks.

The *Occupational Health and Safety Act (OHSA)* states that employers must assess and control risks of workplace violence arising from the nature of the workplace,

type of work, and conditions of work. This needs to be done as often as necessary to ensure that organizational policies and programs continue to protect workers.

The Workplace Violence Risk Assessment (WPVRA) can be a valuable tool to identify such risks and determine whether existing controls are adequate. The WPVRA should be re-assessed at least annually, though each organization will need to establish and document its own processes for determining how often to complete an assessment, when to evaluate the effectiveness of the process, and what will be measured to ensure that the program is working. Generally speaking, revisions are needed when there is a change in the nature of the workplace, type of work, or conditions of work. Changes could include:

- facility layout or design
- work schedules and planning
- patient acuity
- surge capacity

A copy of the assessment must be provided to the Joint Health and Safety Committee (JHSC). As is the case with all H&S programs, the JHSC or Health and Safety Representative (HSR) must also be consulted on development of written WPV measures, procedures and training, as stated in the OSHA's Health Care and Residential Facilities Regulation (HCRFR). An annual review of the measures and procedures is required unless a more frequent review is requested by the JHSC or there is a change in circumstances that may affect the safety of workers.

Conducting a Risk Assessment

Risk perception and the impact of exposure

In health and safety, the term 'exposure' is used to refer to encounters with hazards or risks at work. Differences in exposure can have different consequences, as shown in the following table.

Daily exposure	Infrequent exposure
▪ Increases the chance of being injured ▪ Cumulative exposure to the hazard could result in a more severe outcome ▪ Complacency can occur	▪ Decreases awareness of the potential risks of the hazard ▪ Lack of awareness on how to control the risk ▪ Impact may be higher, even with less exposure

Risk perception is based on a person's understanding of the impact of exposure. Perceptions can be skewed by our experiences. Effective risk management requires a workplace to consider the influence of perception when assessing risk to ensure evidence is considered carefully and objectively.

Involving workers in risk assessment

Risk assessments are often done by employers and managers. While it is important that management take a leadership role in health and safety, they do not usually carry out day-to-day work, and so may not have a complete picture of the organization's functions and risks.

This is why it is important that workers, or the JHSC/ HSR and, if applicable, union representatives participate, review and/ or audit the risk assessment process. Together this broader representation will help increase the effectiveness of the risk assessment and controls measures.

Good to Know

A comprehensive risk assessment should encompass all four types of violence:

Type I — external perpetrator

Type II — client/customer

Type III — employment-related

Type IV — domestic violence

The importance of risk training

In order to plan properly for risk, we need to be aware of it. We need some insight on the extent of the hazard, and the possible harm that could come from it.

That means training that takes into account all four types of workplace violence and, within that framework, looks at: past incidents of workplace violence — e.g., review all incident reports

- past incidents of workplace violence — e.g., review all incident reports
- workplace / sector-specific risks and the physical location of the unit and facility – e.g. high-crime area
- workplace stakeholder perception of workplace violence and harassment
- concerns about workplace violence and harassment that have been raised with supervisors and the JHSC
- environmental factors
- current controls
- work setting, clients, and work practices — e.g., patient population, acuity levels, workflow,
- staffing skill set and competencies and communication measures
- previous education/knowledge employees have received to determine additional or a review of educational options

Risk Rating

Risk rating involves defining the level of threat and priority arising from exposure to identified hazards in the workplace. Generally, hazards are classified as high, medium, or low risk based on the relationship between the following two factors:

- Probability — how likely the hazard is to cause injury or illness
- Impact — how serious the harm could be should the hazard cause injury / illness

Air travel provides a good example of how probability and impact work in risk rating. Air travel is considered safe because statistics show that an accident is unlikely. However, when planes do crash, it typically results in multiple deaths. In this case, although the probability rating is low, the overall risk level would be higher given the increased severity rating. Generally, the higher the probability and severity, the higher the overall risk rating.

Risk Rating Scale

The Risk Rating Scale provides defined criteria to help determine levels of risk which can then be plotted on a risk matrix to prioritize hazards. A sample scale is provided below.

Risk Rating Scale	
Probability Rating	**Impact Rating**
A – Highly likely	Catastrophic-fatality, coma, or severe emotional trauma
B – Likely	Critical- debilitating injury, or significant emotional trauma
C – Possible	Minor-minor injury, or moderate emotional trauma
D – Unlikely	Negligible- no injury, no emotional trauma
E – Highly unlikely	

The Five Steps of Workplace Violence Risk Assessment

The following diagram illustrates the five steps to completing a risk assessment:

Step 1: Plan assessment

Employers must proactively assess the risks of workplace violence. Participation and support of a competent team of individuals is vital throughout the process. To help decide who should be consulted, refer to the Hazard Consultation Table provided on page 6 keeping in mind what type of knowledge individual stakeholders should have in order to provide meaningful insight. To further engage frontline staff, it's advisable that a survey be conducted before the assessment to ensure a better understanding of risk including

- the nature of the work
- how frequently patient population and patient acuity changes
- patient risk levels
- current staffing skill set and competencies and skill mix
- processes around management of staff skill set and competencies and surge protocols

Hazard Consultation Table			
Hazard Category	**Category 1:** Physical environment, exterior and general worksite	**Category 2:** Work settings and conditions	**Category 3:** Direct patient care or interaction
Description	Assessment of risks related to the physical characteristics / nature of the general public areas of the facility — e.g., entrances, exits, stairwells and areas outside specific units or departments that may contribute to incidents of violence.	Assessment of risks related to the work activities, working conditions, and physical characteristics of a specific work area — e.g., a unit or department and its inherent attributes / challenges that may contribute to incidents of violence — e.g., interview / counselling / treatment rooms, working alone, ambulance bays etc. .	Assessment of risks related to the face-to-face care activities provided to, and intercommunication with, the patient that may contribute to incidents of violence.
Who should participate in the assessment	Any of the following: ▪ Security ▪ Environmental Services, Maintenance, Facilities ▪ JHSC Members ▪ Workplace Violence Prevention Committee ▪ OHS Professional	▪ Department / unit managers ▪ Frontline staff	▪ Managers of departments / units where patient care or services are provided ▪ Frontline staff

Step 2: Identify hazards and determine risk rating

In the Risk Assessment Matrix below, determine the risk rating (high, moderate, low or very low) for each hazard in the tool using the Risk Rating Scale on page 4 Keep in mind previously-noted factors such as patient population, changes in acuity, workflow, and staffing skill set and competencies. If the hazard does not apply/exist, check the N/A (not applicable) box.

Risk Assessment Matrix

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

(Adapted from NSAHO's Workplace Violence Risk Assessment Template for Adult Residential Centres/ Regional Rehabilitation Centres, 2007)

Step 3: Develop action plan to control risks

All hazards require corresponding control measures. The WPVRA tool provides best-practice examples. Some of the controls will be relevant to your workplace; others may not, and may instead be replaced by different controls. In addition, certain controls may require more detailed planning and assessment, particularly if during routine program audits they are not proving effective in protecting workers. It is recommended that the action plan be finalized with input from the JHSC; OHS; and security, maintenance and clinical staff (including management and front line). Each potential solution should be considered based on the associated risk. Consideration should be given to the Hierarchy of Controls when implementing solutions.

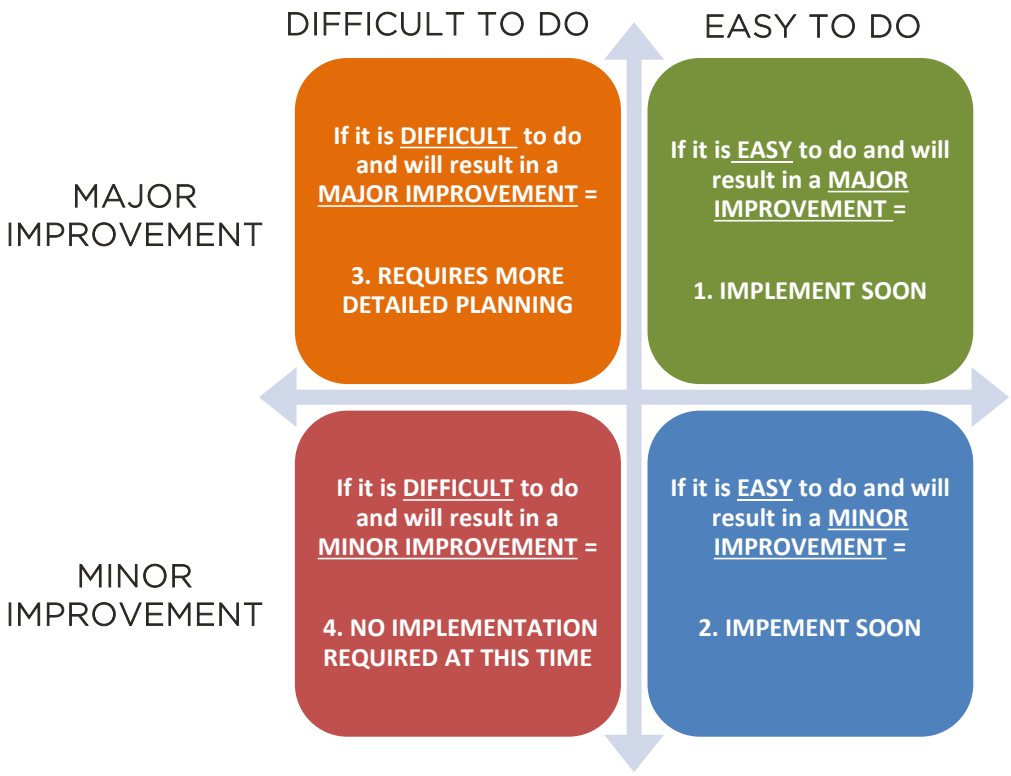
When identifying controls, decide what actions are necessary to eliminate or reduce hazards that could lead to a loss to people, equipment, materials, the environment or process. Usually when control measures are being considered, we look at the most effective strategies to control hazards:

- at the *source* (most effective)
- along the *path* (between the actual source of the hazard and the worker)
- at the *worker* (least effective and should only be applied after attempts have been made at the source and along the path)

Step 4: Implement action plan

Review the completed action plan and notify appropriate stakeholders to obtain assistance and assign responsibility for implementation. Determine timelines using the Effort vs. Impact Scale below. Share the final document with the JHSC / HSR.

Effort vs. Impact Scale



Step 5: Evaluation

Gathering ongoing information about risk management activities can help determine whether the program is operating as planned, achieving desired outcomes, and can help identify areas of improvement. Workplace violence risk assessments should be reviewed and updated at least annually. According to the information provided by routine audits, the risk assessment may need to be updated more frequent. These situations that may impact worker safety include:

- new leadership
- relocation of work sites / units / patients
- changes in equipment
- construction and temporary set-up
- changes in staffing skill set and competencies, workflow, or patient acuity and population
- changes in emergency preparedness and evacuation protocols

Good to Know

There should be a process to determine how often to complete an assessment, and when it requires evaluation.

Enabling and Reinforcing Factors

Several components are required to ensure that an organization's workplace violence prevention program functions efficiently and effectively. Three critical success factors are:

- the functioning of the Joint Health and Safety Committee (JHSC)
- the safety culture at the organization
- the degree to which the organization supports the psychological health and safety of its staff

While the Workplace Violence Risk Assessment Toolkit does not in itself address these factors, it's important they are considered before beginning a risk assessment and incorporated into the resulting action plan as required. The following resources can assist an organization in assessing these three components.

JHSC Functioning

1. The Centre for Research Expertise in Occupational Disease (CREOD) has created an evidence-driven assessment tool that JHSCs, employers and policy-makers can use to evaluate various JHSC functions and characteristics, and help improve JHSC effectiveness. The tool was developed based on the Safety Element Method and input from experts, and pilot tested in two stages by JHSC members at an urban, academic hospital. The final assessment tool, revised based on user feedback, is a 21-question survey that's easy to use and can be completed in less than one hour. The tool could be used regularly (i.e. annually) by JHSCs to ensure improvement objectives are met, new priorities are established and to sustain an effective JHSC. Although this study was focused on the health care system, the tool could have broad application across all Canadian workplaces. Read more about and download the tool here. (http://creod.on.ca/2015/new-tool-for-evaluating-jhscs/)
2. Effective Joint Health and Safety Committee (JHSC) Training. This PSHSA training program is designed to provide members of the joint health and safety committee with the necessary information to operate effectively and address workplace health and safety issues with knowledge and confidence. By the end of the course, participants will have the knowledge of their roles and responsibilities as committee members. (http://www.pshsa.ca/product/effective-joint-health-and-safety-committees/?pa_training-category=training-cat&pa_sector=health-community-services&pa_all-courses=health-safety-basics)

Safety Culture

1. Institute for Work & Health Organizational Performance Metric (IWH-OPM) is part of that research. The IWH-OPM is an eight-item questionnaire used to assess an organization's occupational health and safety performance. The IWH-OPM is a simple tool that will predict a firm's workplace injury experience based on an assessment of its health and safety policies and practices, and that can be used to benchmark organizations with others in their sector. (http://www.iwh.on.ca/opm)
2. PSHSA Climate Tool: A safety climate is a tangible output, or indicator, of an organization's health and safety culture as perceived by individuals or groups at a point in time. The project was implemented to test and validate a health and safety climate assessment tool in the Ontario healthcare setting and determine opportunities to improve the assessment's efficiency, effectiveness and scalability. (http://www.pshsa.ca/culture2/)

Psychological Health and Safety

1. Workplace Strategies for Mental Health: In his report Tracking the Perfect Legal Storm [PDF], Dr. Martin Shain suggests that providing a psychologically safe workplace is no longer something that is simply nice to do, it is increasingly becoming a legal imperative. Changes in labour law, occupational health and safety, employment standards, workers compensation, the contract of employment, tort law, and human rights decisions are all pointing to the need for employers to provide a psychologically safe workplace. In addition, human rights requires a duty to accommodate mental disabilities. These questions help review possible exposures to risk or potential for improvement. (https://www.workplacestrategiesformentalhealth.com/Psychological-Health-and-Safety/20-Questions-for-Leaders-About-Workplace-Psychological-Health-and-Safety)
2. PSHSA Healthy Work Environment Portal: Psychosocial environment refers to the culture and climate of the workplace. Examples of the psychosocial environment of a workplace include respect for work-life balance, mechanisms to recognize and reward good performance, valuing employee wellness, encourage employee feedback about organizational practices, zero tolerance for harassment, bullying and discrimination, ensuring employee psychological safety and health. (http://pshsavertical.businesscatalyst.com/psychosocial-environment)
3. Mental Injury Tools for Ontario Worker – A Worker's Guide for Addressing Workplace Causes of Mental Distress: The resource kit is an introduction and action guide created to provide workers basic understanding of workplace stress. The guide covers definitions, common causes of mental distress, legal frameworks, possible actions to take and additional available resources. (http://www.ohcow.on.ca/mit
4. CSA Z1003 Psychological health and safety in the workplace - prevention, promotion, and guidance to staged implementation: This national standard outlines requirements for the development, implementation, and continual improvement of psychologically safe and healthy workplaces. (http://shop.csa.ca)

Workplace Violence Risk Assessment Tool (AC)

Visit: **pshsa.ca/workplace-violence**

Workplace Violence Risk Assessment Tool

This is the Workplace Violence Risk Assessment (WPVRA) Tool. The WPVRA tool groups hazards into three categories:

- Hazard Category 1 – Physical environment risk assessment (completed for the organization as a whole including common areas)
- Hazard Category 2 – Department / unit-specific work settings / practices (completed for each unit/department)
- Hazard Category 3 – Direct care of potentially aggressive / responsive patients (completed in units/departments where client care is provided)

Review the examples in the Hazard column. Using the Risk Assessment Matrix on page 7 assign a Degree of Risk to each area. Review the Controls and Potential Solutions, using them as the basis for recommendations and action planning. Comment box may be used to document detailed information about action items and / or rationale behind control decisions (e.g., control already in place).

1.0 Physical Environment Risk Assessment

Completed by: _____

Signature: _____

Date:

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
1.1 Arriving / departing work				
Examples: ▪ Travelling alone to and from work, including using public transit ▪ Public transportation not close to facility ▪ Arriving / departing during off hours (e.g., on-call staff) ▪ Walking into facility via various entrances from street ▪ Building entrances and exits not clearly identified ▪ Doors / windows left unsecured ▪ Other: _____	☐ High (all) ☐ Moderate (all except 1a) ☐ Low (all except 1a, 1b, 3 e- f) ☐ Very Low(all except 1a, 1b, 2 e; 3 e-f) ☐ N/A	1. Safe travel into / out of / within / between buildings	a) Explore possibility of public transit or shuttle services made available at main entrance of building. b) Consider car pool opportunities. c) Maintain outdoor lighting for visibility of entrances/exits and walkways. d) Appropriately identify facility entrances, exits, and access parameters – e.g., staff only, restricted, etc. e) Monitor/inspect design features of entrances/exits and report deficiencies – e.g., lighting, lines of visibility, secured access, etc.	
		2. Safe travel practices	a) Establish travel-safety guidelines and ensure staff receive training (refer to PSHSA's 'Assessing Violence in the Community: a Handbook for the Workplace' as needed). b) Consider a safe-walk program — e.g., buddy system or security / safety escort. c) Ensure staff use designated walkways and single-point of entry. d) Ensure staff use access-controlled entrances / exits — e.g., using coded cards, keys, buzzers, etc.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			e) Consider priority parking or making other travel or parking arrangements for staff coming in or leaving during off hours.	
		3. Security / safety measures at entrances	a) Implement regular security patrols at high risk entrances. b) Ensure staff is aware of security staffed entrances in the event of an emergency. c) If alternative entrance is not available, install cameras / panic buttons at high-risk entrance points. d) Consider fixed CCTV camera placement at entry points and Pan, Tilt, Zoom camera (PTZ) programmed to randomly video a larger area including paths, walkways, parking, etc. e) Consider posting Video Surveillance signage at the perimeter of the property. f) Verify security systems are fully functioning on a regular basis. g) Install key-cards or biometric scanners at all staff entrances and exits. If code pads are used, ensure codes are changed regularly. h) Implement a sign-in / sign-out process. i) Monitor and enforce that staff wearing ID badges. Consider utilizing only first name on front of ID badge. j) Limit number of coded key cards. k) Consider implementing a key card authorization and agreement form l) Immediately replace lost or stolen coded key cards.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			m) Assess ability to electronically lockdown (with proper access control) corridors, department and units quickly and efficiently. n) Implement and enforce a "Tailgating" policy in all secure areas.	
1.2 Parking lots and grounds				
Examples: ▪ Inadequate or burnt-out lights ▪ Inadequate monitoring ▪ Parking on evening and night shifts ▪ Parking long distances from building ▪ Vehicle theft or damage in parking lot ▪ Workers not trained in safety procedures for leaving / returning to vehicles ▪ Parking lots that adjoin wooded areas, ravines, etc. and have or may be used as pathways.	☐ High (all) ☐ Moderate (all) ☐ Low (1,2, 3 a) ☐ Very Low (1,2, 3 a) ☐ N/A	1. Parking lot visibility & maintenance	a) Ensure adequate lighting in parking lots during all seasons and outside normal business hours. b) Implement a preventative-maintenance and inspection process for lighting in parking lots. c) Ensure clear visibility across parking lot (remove walls, trees and shrubbery where perpetrators could hide). d) Consider fencing the perimeter of the property and especially around parking lot that adjoin a ravine, wooded lot, or other areas that offer concealment. e) Designate a secure area close to building for workers' vehicles particularly for night shift workers.	
		2. Parking lot signage	a) Post clear and effective signage regarding: ▪ Expected behaviours by patrons ▪ Restricted access ▪ Location of emergency telephone and number ▪ Camera surveillance / security monitoring ▪ Hours of operation and visiting hours ▪ Safety tips — e.g., 'Lock your vehicle and take your valuables with you'	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
Check for signs of alcohol or illegal drug use, etc.			b) Clearly identify location of emergency call stations.	
		3. Parking lot security / safety measures and devices	a) Ensure a mechanism and training is in place for staff to report unusual activity or suspicious individuals. b) Monitor parking with surveillance cameras or security personnel / regular patrols. c) Make staff parking lots pass-card-accessible. d) Install panic buttons or pull stations in parking areas. e) Ensure that CCTV cameras monitor the pull stations and that Security and Switchboard are immediately notified of an alarm on their communications device.	
1.3 Building exterior and entrances (general appearance, grounds and common areas)				
Examples: ▪ Facility located in a high-crime area ▪ Facility located near high-potential crime area or generators such as liquor stores, bars, convenience stores, or vacant lots ▪ Worksite exteriors show lack of	☐ High (all) ☐ Moderate (all) ☐ Low (1,2) ☐ Very Low (1,2) ☐ N/A	1. Exterior building visibility and maintenance	a) Ensure facility exterior is well-maintained – e.g., landscaping, property maintenance and regular inspections. b) Ensure adequate lighting on facility grounds during all seasons and outside normal business hours. c) Implement a preventative maintenance and inspection process for lighting on facility grounds. d) Ensure that ground level windows are secure or windows are unable to be opened e) Ensure landscape and walls do not obstruct sight lines or offer possibilities for concealing perpetrators:	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
maintenance (e.g., graffiti / vandalism) ▪ Areas around building where a perpetrator could hide (shrubbery, walls, etc.) ▪ Inadequate lighting outside facility ▪ Staff required to walk outdoors to access other building areas			▪ Keep shrubbery on facility grounds to a minimum, particularly near entrances/exits ▪ Ensure planting / landscaping fosters open, clear sight lines f) Ensure garbage, external buildings and necessary equipment are in open areas in plain view.	
		2.Exterior building signage	a) Clearly indicate entrances and exits. b) Post clear and effective signage regarding: ▪ Property prohibitions e.g., unauthorized entry, firearm use ▪ Expected behaviours from patrons e.g. zero-tolerance for violence ▪ Restricted access ▪ Location of emergency telephone and number ▪ Camera surveillance / security monitoring ▪ Hours of operation and visiting hours	
		3.Exterior security / safety measures and devices	a) Implement regular security patrols. b) Implement risk-appropriate safety measures: ▪ Install security cameras at after-hour or high-risk entrances ▪ Install telephone / panic buttons in high- risk areas ▪ Assess need for additional telephone / panic buttons based on risk ▪ Assess need for security features that align with IAHSS security design guidelines c) Inform staff of emergency assistance procedures and security-staffed entrances.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
1.4 Building interior				
Examples: Design & visibility: ▪ Inadequate or burned out lighting in general building areas ▪ Areas within the building where a perpetrator could hide ▪ Isolated areas of the building not well-lit ▪ Lack of signage ▪ Lack of emergency-exit signage Signage & way-finding: ▪ Lack of signage in areas indicating expected behaviour, code of conduct, restricted areas ▪ Lack of signage for way-finding and navigation (e.g. patients and visitors getting lost / into areas they're not supposed to be in)	☐ High (all) ☐ Moderate (all) ☐ Low (1,2, 3c) ☐ Very Low (1,2, 3c) ☐ N/A	1. Interior building visibility and maintenance	a) Ensure visibility to the end of each corridor or hallway. b) Install mirrors, angled corners and transparent materials in high-risk / recessed or hidden areas. c) Ensure there are no places of concealment in areas such as stairwells, recessed doorways, and elevators. d) Keep storage areas and unoccupied rooms locked. Ensure locking mechanism prevents entrapment. e) Identify the location and operational procedure for Safe Rooms. f) Ensure adequate lighting in all areas of the facility – e.g., meet the requirements of national standards and local building codes. g) Ensure adequate lighting on all shifts, particularly in common staff areas. h) Implement a preventive-maintenance and inspection process for lighting in all building areas. i) Implement panic bars on all emergency exit doors to allow prompt escape. j) Ensure video surveillance (CCTV) output is monitored by trained staff and that protocols are established for video surveillance and recording – including but not limited to timely access/viewing post incident and handling the storage, disclosure, and disposal of video tapes.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
Interior security / safety measures: ▪ No system to alert staff of intruders in their areas ▪ Lack of working relationship with local EMS/police		2. Interior signage & way-finding	a) Post floor plan showing exits, stairwells, elevators and restricted areas. b) Implement clear signage and evaluate effectiveness: ▪ All building areas / departments are well marked ▪ All exit routes are clearly marked ▪ Clear way-finding / directional signage (consider volunteers to assist) for patients and visitors ▪ Clear signage on: o Property prohibitions e.g., unauthorized entry, firearm use. o Expected behaviours from patrons (e.g. zero-tolerance for violence) o Restricted access o Location / number of emergency telephone o Camera surveillance / security monitoring o Hours of operation and visiting hours	
		3. Interior security / safety measures and devices	a) Implement regular security patrols. b) Implement risk-appropriate safety measures: ▪ Assess the need for security presence in designated high-risk areas ▪ Install security cameras, telephone / panic buttons in high-risk areas ▪ Assess need for additional telephone/panic buttons based on risk	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Ensure security personnel have appropriate training and equipment and able to intervene to protect patients and staff c) Clearly inform staff of: ▪ Emergency exits that will set off alarms ▪ Emergency assistance procedures ▪ Security-staffed areas ▪ Security roles and responsibilities d) Develop and test security plan for the workplace – e.g., locking of doors, installing panic buttons / alarms, accommodation, after – hours entrances, lockdown/ lockout policy and procedures etc.	
1.5 Access Control				
Examples: ▪ Lack of risk-appropriate access control (keys / cards) ▪ Lack of system to control / replace keys / cards ▪ Unauthorized persons present in patient or restricted areas ▪ Staff required to walk outdoors to access other building areas	☐ High (all) ☐ Moderate (1 a-g) ☐ Low (1 b-g) ☐ Very Low (1 b-g) ☐ N/A	1. Risk- appropriate and consistent control access to building and units	a) Implement consistent, risk-appropriate access-control to building and units – e.g., codes / pass-keys for doors; doors locked after hours. b) Enforce and monitor staff ID badges, including students, volunteers, contract workers and staff. Consider utilizing only first name on front of ID badge. c) Record and regularly review of the number of access cards / keys issued. Devices that are no longer required or reported lost or stolen should be immediately deactivated. d) Ensure access control procedures are established for external contractors such as providing proof of identification, signing key/card agreements	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			that lists e.g., terms of use and where/when devices should be returned. e) Allow access to work areas only through staffed reception areas. f) Minimize access to facility after hours. g) When renovating, design public and private spaces so that they are easily distinguished. h) Ensure a contingency protocol in the event of an emergency or power outage. i) Replace or deactivate key cards and codes when lost or stolen, and when employees leave the organization. j) Implement and monitor visitor sign-in process or the use of visitor badges after hours	
1.6 Stairwells and elevators				
Examples: ▪ Stairwells not well-lit, clearly marked or controlled by appropriate emergency measures ▪ Location of stairs makes it easy for someone to hide ▪ Stairwell doors lock behind people	☐ High (all) ☐ Moderate (all) ☐ Low (all) ☐ Very Low (all) ☐ N/A	1. Stairwell design and visibility	a) Regularly inspect all stairwells to ensure staff can escape an attacker: ▪ Clearly mark all exit routes ▪ Ensure exits from the building lock from the outside – e.g. they can be opened from the inside only, but require pass-card or key-code access to open from the outside ▪ Ensure stairwell exit doors have panic bars to allow prompt escape ▪ Ensure stairwell exits / entrances are secured appropriate to the risk – e.g., do not impede access to authorized persons ▪ Ensure all stairwell doors have windows	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Ensure stairwells and elevators are inspected regularly for adequate lighting ▪ Ensure stairwell lights cannot be turned off and that there is emergency lighting in the case of a power failure. Any power-dependant feature should have a power failure emergency backup system. ▪ Ensure wireless coverage for personal safety devices is adequate (e.g. no dead zones) in stairwells and personal areas	
		2. Security / safety measures and devices	a) Regularly inspect stairwells to ensure staff can escape an attacker: ▪ Test emergency call buttons or telephones to be sure they are operational ▪ Install phone / alarm system in elevators and test functionality on a regular basis ▪ Consider the use of surveillance cameras in elevators in high-risk areas b) Inform staff of emergency assistance procedures, and emergency exits that will set off alarms.	
1.7 Hallways / storage / common areas				
Examples: ▪ Areas within the building where an p could hide ▪ Barriers to quick entry/exit	☐ High (all) ☐ Moderate (all) ☐ Low (all) ☐ Very Low (all) ☐ N/A	1. Hallway / storage / common area visibility and maintenance	a) Ensure proper lighting and visibility b) Install convex mirrors as needed to minimize blind spots c) Assess storage for access, proper use and size: ▪ Control access to storage	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Minimize clutter — e.g., provide adequate shelving to properly house equipment / resources ▪ Consider use of dedicated storage options to secure patients' personal belongings – e.g., locked cabinets or locker in patient's room	
1.8 Staff washrooms				
Examples: ▪ Staff required to use public washrooms ▪ Potential for unauthorized persons found using staff washrooms	☐ High (all) ☐ Moderate (all) ☐ Low (1) ☐ Very Low (1) ☐ N/A	1. Staff washroom signage and visibility	Ensure that: a) Staff washrooms are separate from public washrooms and are controlled by locked doors (preferably key card access). If code access is used, codes should be changed on a regular basis. b) 'Staff Only' signage is installed on all staff washrooms. c) Lights are kept on at all times in washrooms.	
		2. Security / safety measures and devices	Ensure that: a) Staff can call for assistance if needed. b) Consider installing a peephole on inside of staff washroom and safe room doors c) Staff report suspicious activities and individuals. d) Staff check for unauthorized persons before entering washrooms.	

2.0 Department or Unit-Specific Work Settings and/or Practices

Completed by: _____

Signature: _____

Date:

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
2.1 Reception / inter-disciplinary team station / waiting area				
Examples: ▪ Open access by public ▪ Staff working directly with the public (whose history of violence is not known to staff, and who may be in stressful situations that trigger violence, aggression, responsive behaviour) ▪ Lack of response mechanisms at reception desks ▪ Lack of suitable furniture for various populations — e.g. psychiatric, bariatric ▪ Unattended reception area ▪ Lack of available distractions in public or private waiting areas - e.g. magazines,	☐ High (all) ☐ Moderate (1, 2, 3 c-d) ☐ Low (1 a-c, 3 c-d) ☐ Very Low (1 a-c, 3c-d) ☐ N/A	1. Reception / interdisciplinary team station / waiting area design, visibility and signage	a) Implement safety principles for reception, interdisciplinary team station and waiting areas: ▪ Prevent unauthorized entry where possible and have a secondary entry/exit point that is key card access controlled. ▪ Implement layout giving staff direct line of sight/clear observation of patients, visitors and public ▪ Ensure height and depth of desk / counter provide adequate physical barrier between staff and public. Depending on level of risk identified additional enclosure options (e.g., Plexiglas) may be required. ▪ Restrict access to worker-only work areas. ▪ Provide adequate work space for staff to help patients, greet visitors, etc. ▪ Provide a comfortable environment — e.g., sufficient space, reading materials, posters, comfortable seating, and reduced noise level — to minimize personal interference, tension, and other potential irritants.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
brochures, posters – which may lead to patient / public frustration or impatience ▪ Absence of personal safety response systems – e.g., panic buttons and code words (e.g. “grab me the yellow card”) to summon help			▪ Ensure washrooms, food-service areas and public telephones have proper signage, easy access and regular maintenance. b) Remove all objects — e.g., electronic devices, tools, equipment — that could be used as weapons. c) Post signage clearly stating: ▪ Code of conduct and expected behaviours (make staff aware of sanctions) ▪ Organizational policy on workplace violence d) Ensure safe and secure furniture: ▪ Furniture arrangement should prevent entrapment of staff ▪ Heavy furniture should be movable and light furniture should be secured to the floor. ▪ Ensure furniture does not have sharp edges or corners that could be used as weapons ▪ Provide furniture suitable for special populations — e.g., psychiatric patients may feel anxious sitting in chairs that do not move	
		2. Effective management of area for safety	a) Implement quality- improvement strategies to reduce wait times for admissions and responding to care needs. b) Provide excellent customer service: ▪ Train staff in customer service, and provide sensitivity training where appropriate ▪ Ensure reception staff understand their role as key people in receiving and reading patients and visitors ▪ Ensure staff are sufficiently trained to answer questions	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Inform people how long they will be waiting ▪ Designate a point-of-contact for patients and visitors, and regularly provide updates to alleviate anxiety. ▪ Provide effective and timely communication to patients and visitors. ▪ Minimize patient / visitor boredom through activities — e.g., reading materials, television, and recreational games c) Ensure adequate staffing: ▪ Increase staff in main reception areas and on units during peak times ▪ Provide extra staffing in high-risk public lounges — e.g., possibly with volunteers	
		3. Security / safety measures and devices	a) Implement regular security patrols. b) Implement risk-appropriate safety measures ▪ Implement a sign-in process for visitors ▪ Minimize staff working alone, and if they must, implement a personal alarm system ▪ Implement protective barriers for workers at higher-risk, and to separate dangerous patients from other patients and the public ▪ Ensure staff are aware of any restraining orders or visitation restrictions for patients, family members or visitors ▪ Make copies available at interdisciplinary team stations and visitor sign-in areas ▪ Ensure a security presence in high-risk areas	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Assess the need to install an alarm system — e.g., personal or panic buttons c) Educate staff and provide practice opportunities around: ▪ Patient-centred care ▪ Recognizing triggers that escalate behaviours ▪ De-escalation and communication techniques d) Educate staff on Code White and other relevant emergency procedures (e.g. lock down) and implement regular mock Code Drills.	
2.2 Interview/ counselling / treatment rooms				
Examples: ▪ Working in isolated areas / locked rooms with patients, relatives or visitors ▪ Working in areas with patients at risk for workplace violence ▪ Rooms are not private enough to reduce patient stimulation / agitation	☐ High (all) ☐ Moderate (all) ☐ Low (1, 2 a-c, 3 a-d) ☐ Very Low (1, 2 a-c, 3 a-d) ☐ N/A	1. Interview / counselling / treatment room design	a) Provide adequate work space for staff to help patients, greet visitors, etc. b) Ensure maximum visibility while allowing for patient privacy and confidentiality (e.g., install windows in doors). c) Establish protocol for requesting security backup as needed. d) Ensure furniture is arranged to prevent entrapment of staff. e) Furniture should be: ▪ Minimal ▪ If lightweight should be attached to a surface ▪ Without sharp corners or edges ▪ Affixed to the floor where appropriate f) Treatment rooms should have two exits or be arrange to allow easy exit.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			g) Staff should be placed closest to an exit or escape route. h) Ensure door locking mechanisms prevent staff entrapment. i) In emergency services, separate treatment rooms from public areas and provide a separate room for high risk patients j) Post clear signage for: ▪ Code of conduct and expected behaviours (make staff aware of sanctions) ▪ Organizational policy on workplace violence	
		2.Management of area for safety	a) Implement a screening process to assess and identify risk for workplace violence – refer to the PSHSA Individual Client Risk Assessment Toolkit as needed. b) Ensure space is suitable for patient needs and staff safety – e.g., staffing skill set and competencies, patient flow, etc. c) Ensure adequate staffing skill set and competencies when a risk of violence is identified – e.g., buddy system, security escort. d) Implement a sign-in / sign-out process.	
		3.Security / safety measures and devices	a) Educate and train staff on: ▪ Patient-centred care ▪ Recognizing and documenting triggers that escalate behaviours ▪ De-escalation and communication techniques ▪ Personal safety training including but not limited to behaviour management, holds, and releases based on circumstance.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Restraints practice standards (e.g., use of pinel restraints, seclusion, replenishing restraint kits) ▪ Personal protective equipment and written procedures for summoning immediate help b) Provide opportunities for regular practice of learned skills. c) Educate and train staff on personal safety measures including safe positioning in room for easy access / departure. d) Educate and train staff on Code White (including the role of security) and other relevant emergency procedures (e.g. lock down), and implement regular mock Code Drills. e) Implement protective barriers for at-risk workers to separate dangerous patients from other patients and the public. f) Implement a personal alarm system. g) Consider fixed or personal safety alarms with secondary notification features such as audible alarms that also initiate flashing light on outside of patient room. h) Implement a check-in / check-out as well as buddy system for co-worker safety awareness.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
2.3 Working with objects of value (cash, drugs, syringes / needles, expensive equipment, potential weapons)				
Examples: ▪ Risk of crime and increasingly violent crime wherever valuables are or seem to be within "easy reach" ▪ Handling objects of value, especially in an area open to the public ▪ Transporting objects of value, especially to remote or isolated locations ▪ Intervening in a situation to prevent theft or loss ▪ Patrolling alone or at night, especially in remote or isolated locations	☐ High (all) ☐ Moderate (all) ☐ Low (1 a, 2, 3 a-c) ☐ Very Low (1 a, 2, 3 a-c) ☐ N/A	1. Design for safety	a) Deter theft by impeding identification, access and removal of valuables – e.g., ensuring they're not within 'easy reach'. b) Use engineering controls to prevent theft and protect staff – e.g., locked doors without windows; glass barriers; counters; and pneumatic conveyors. ▪ Ensure staff have exit / escape routes and aware of their locations.	
		2.Management of area	a) Implement practices for safe handling cash: ▪ Limit amounts of cash on hand ▪ Ensure deposits are made according to a random schedule and staff is accompanied by co-workers or security / an armoured car b) Develop and implement security measures for medication procurement, preparation, storage, distribution and control. c) Develop and implement organizational policy on patient personal property and valuables: ▪ Inform patients, visitors and staff that they're not to bring or keep valuables at the facility, and that the organization will not assume responsibility for such valuables ▪ For valuables that must remain on-site, place them in a locked cabinet with items properly identified	
		3.Security / safety measures and devices	a) Implement a risk-appropriate personal safety response system (PSRS) in case of emergency – refer to the PSHSA PSRS Toolkit as needed.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			b) Ensure staff are reporting all suspicious persons and activities. c) Educate and train staff on Code White and other relevant emergency procedures (e.g. lock down), and implement regular mock Code Drills. d) Ensure that cash-handling areas are monitored by appropriate security personnel or other surveillance mechanisms. e) Encourage staff to access security personnel or implement buddy system protocol when they believe they are at risk	
2.4 Working alone / in isolated locations / individual office areas				
Examples: ▪ Staff working in isolated areas within the facility ▪ Staff working alone without close proximity to other staff ▪ Staff working with patients alone ▪ Lack of security system ▪ History of unauthorized persons found in unauthorized / remote locations	☐ High (all) ☐ Moderate (1, 2, 3 a-c) ☐ Low (1, 2 a-b, 3 a-b) ☐ Very Low (1, 2 a-b, 3 a-b) ☐ N/A	1. Management of area for safety	a) Develop and implement policies and procedures on working-alone safety: ▪ Educate and train staff on working-alone safety procedures and provide opportunities for regular practice ▪ Conduct regular reviews of policy and procedure ▪ Ensure sufficient lighting and visibility in staff work areas	
		2.Security / safety measures and devices	a) Educate and train staff on: ▪ Patient-centred care ▪ Recognizing and documenting triggers that escalate behaviours ▪ De-escalation and other safety measures to protect patients and staff b) Provide opportunities for regular practice of learned skills.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			c) Ensure staff in high-risk areas are equipped with personal safety training including but not limited to behaviour management, holds, and releases based on circumstance. d) Implement regular security patrols or camera surveillance. e) Implement a check-in / check-out system that is tested and documented regularly. f) Implement a buddy system.	
		3.Emergency response measures	a) Implement an Emergency Code / communication system – e.g., an internal emergency number linked to 24-hour reception; alerts linked to staffs' personal phones; or a departmental code that can be announced over the PA system. b) Educate and train staff on Code White and other relevant emergency procedures (e.g. lock down), and implement regular mock Codes Drills – refer to the PSHSA PSRS Toolkit as needed. c) Encourage the use of security back-up and escorts. d) Implement a personal alarm system that provides an audible alarm to scare off an attacker and notify staff in surrounding areas. e) Implement a panic-button alarm system that summons aid to a specific location such as emergency department admitting desk. f) Implement a personal alarm system that tracks employee location within the unit/building; which includes but not limited to mandatory use for staff working alone in remote areas of the facility, or with high-risk patients in closed rooms.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
2.5 Working in areas separate from security monitored facilities – e.g. ambulance transport, home or community setting				
Examples: ▪ Inadequate security system ▪ Inadequate alarm system ▪ Lack of adherence to security protocols ▪ Lack of effective code-white responses ▪ Frontline staff are responding to violent situations ▪ Lack of understanding of emergency response measures ▪ Ineffective emergency response measures	☐ High (all) ☐ Moderate (1,2, 3a) ☐ Low (1, 2 a-b) ☐ Very Low (1, 2 a-b) ☐ N/A	1. Community violence risk assessment & safety plan	a) Complete PSHSA's Assessing Violence in the Community: A Handbook for the Workplace. This resource includes a Pre-visit and Pre-travel assessments, which identify potential hazards related to patients and to visiting them – e.g., driving, parking, physical hazards, phone access, etc. b) Implement safety plans based on risk assessment results – e.g. home-visit check-in / check-out procedures; transfer of care reporting and documentation protocols related to risk and history of violence. c) Conduct regular reassessment of safety plans.	
		2. Security / safety measures and devices	a) Equip staff with knowledge and skills for safe working in the community: ▪ Educate and train staff on safe travel and work in the community, covering topics such as: o Planning travel o Travelling by public transit o Walking in the community o Travelling by car* o History of violence in patient / family o Behaviours, triggers and safety measures and procedures for violence o Recent threats of violence o Pets / animals in the home	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Educate and train staff on: o Patient-centred care o Recognizing triggers that escalate behaviours ▪ De-escalation and communication techniques ▪ Provide opportunities for regular practice of learned skills ▪ Educate and train staff on how to handle personal threats in the community, providing tips on: o Personal attacks o Weapons in the home* b) Implement a process for employee tracking in the event staff don't arrive / call-in. c) Ensure there is adequate staff to allow working in pairs when high risk-patients are identified, or when visiting clients in public settings. d) Establish protocol for contacting police and arranging police escort as needed. e) Arrange to meet patients in safe environment or public location * Refer to PSHSA's 'Assessing Violence in the Community: A Handbook for the Workplace as needed	
		3.Emergency response measures	a) Provide staff with personal safety training including but not limited to behaviour management, holds, and releases based on circumstance and opportunities for regular practice. b) Implement a mechanism for staff to summon immediate response in case of emergency: ▪ Use a smartphone or similar device equipped with global positioning system (GPS) capabilities. Enable GPS when the employee is working, and	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			ensure the device is on and with the employee for every visit ▪ If device is a smart phone consider an app that provides a loud audible alarm and automatically notifies a number of emergency contacts when activated (e.g. which is a free app activated by a large red button which initiates a loud sound while sending an SOS message to two previously-selected contacts) ▪ Investigate availability of personal safety response system or smartphone apps that alerts appropriate personnel if worker is injured or unconscious (e.g., man-down system). ▪ Implement a procedure where staff call in to central office before and after each appointment. Central office immediately contacts employees who fail to call within 15 minutes of visit end-time. If employee does not respond, central office contacts emergency services and provides most recent appointment location. For details refer to the PSHSA PSRS Toolkit as needed.	
2.6 Emergency response and security system				
Examples: ▪ Inadequate security system ▪ Inadequate alarm system ▪ Lack of adherence to security protocols	☐ High (all) ☐ Moderate (all) ☐ Low (1, 2 a-g, 3a-c) ☐ Very Low (1, 2 a-g, 3a-c) ☐ ☐ N/A	1. Security program	a) Complete PSHSA's Security Toolkit as needed to identify gaps and areas for improvement. b) Adopt a continuous quality improvement (CQI) approach to systematically implement actions in order to address gaps — refer to PSHSA's Security self-assessment Checklist. c) Implement a program to integrate the security functions and roles into interdisciplinary care teams working with violent patients	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
▪ Lack of effective Code-White responses ▪ Frontline staff are responding to violent situations ▪ Lack of understanding of emergency response measures ▪ Ineffective emergency response measures		2. Security /safety measures & devices	a) Conduct a thorough assessment of needs for personal safety response systems based on workplace risks — refer to PSHSA's PSRS Toolkit. b) Implement a preventive maintenance mechanism to regularly inspect and maintain alarm systems and security equipment. c) Educate all staff on patient-centred care and the Gentle Persuasive Approach (GPA). d) Ensure all staff are aware of: ▪ Code White procedures ▪ Designated safe areas ▪ Use and location of alarms, cameras and panic buttons e) Ensure all staff are able to identify escalating behaviour and use effective communication skills to de-escalate behaviours. f) Educate all staff on PSRS and conduct regular mock Code Drills — to PSHSA's PSRS Toolkit. g) Ensure staff responding to Code White receive training and practice opportunities on the following: ▪ De-escalation and communication techniques ▪ Non-violent holds and approaches ▪ Conflict resolution ▪ Dealing with pressure / harassment / bullying ▪ Use of personal protective equipment ▪ Infection prevention and control h) Implement two-way communication devices for Code White responders	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
		3. Emergency response measures	a) Implement risk-appropriate PSRS to ensure staff can summon immediate response in case of emergency. b) Establish protocol for summoning emergency-response team. c) Adopt a CQI approach to evaluate the Code White response — e.g., adequate staffing skill set and competencies / timeliness / outcome. d) Develop and implement a two-stage debriefing process post violent/aggressive event: ▪ Immediate post-incident — caregivers and patient ▪ Investigative — formal problem / root cause analysis	
2.7 Performing security or emergency response functions				
Examples: ▪ Untrained staff are responding to violent situations ▪ Lack of understanding of emergency response measures ▪ Ineffective emergency response measures	☐ High (all) ☐ Moderate (all) ☐ Low (all) ☐ Very Low (all) ☐ N/A	1. Staff response effectively / safely to emergencies	a) If security guards are used, ensure they are licensed and have training that includes: ▪ De-escalation and communication techniques ▪ Appropriate use of force ▪ Conflict resolution ▪ Dealing with pressure / bullying ▪ Use of personal protective equipment b) Orient staff and other responder with organizational procedures around de-escalation of violence. c) Implement emergency communication for responders.	
		2.Timely and effective response to Code White	a) Implement a CQI system to evaluate emergency response — e.g., timeliness, outcome, adequate staff.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
		and other Emergency protocols	b) Provide specialized regular education / training / resources for staff – e.g., protective positions and managing physical aggression. c) Implement post-violent/aggressive event follow-up including: ▪ Immediate post-incident debrief for those affected in the workplace ▪ Emotional/psychological support for staff involved such as critical incident stress management, and the employee assistance program ▪ Investigate all incidents and implement preventive controls — e.g. complete root-cause analysis d) Reassess risk and provide a copy of the risk assessment to the JHSC.	
2.8 Workplace harassment / bullying				
Examples: ▪ Absence of a workplace harassment (including sexual harassment) policy ▪ Absence of protocol to assess risks of workplace harassment/ bullying ▪ Absence of a code-of-conduct policy	☐ High (all) ☐ Moderate (all) ☐ Low (1, 3) ☐ Very Low (1,3) ☐ N/A	1. Workplace harassment / bullying policies	a) Implement and communicate workplace harassment / bullying policies, and review them annually. They should cover: ▪ Organizational commitment ▪ Clear definitions, roles and responsibilities ▪ Reporting processes ▪ Investigation procedures ▪ Code of conduct ▪ Employee complaint resolution procedure	
		2. Conduct a harassment /	a) Conduct a corporate workplace violence and harassment survey of staff.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
▪ Lack of mechanisms to report workplace harassment / reporting not encouraged ▪ Reports of repeated verbal and / or physical aggression from coworkers ▪ Grievances ▪ Complaints of harassment and discrimination ▪ Poor morale ▪ High absenteeism / sickness rates ▪ High staff turn-over		bullying risk assessment	b) Implement a unit assessment tool for harassment and bullying such as the MIT for psychosocial hazards, which include bullying, harassment, and many other offensive behaviours. c) Implement a process to complete annual unit assessments of workplace harassment / bullying – refer to PSHSA's Bullying in the Workplace: A Handbook for the Workplace as needed. d) Maintain accurate and complete records of absences, sick leaves, and turnover. Monitor scheduling changes and attendance patterns for signs of potential difficulties (e.g. staff cancelling or refusing shifts related to bullying/ harassment).	
		3. Staff education / training related to harassment / bullying	a) Implement a process to provide bullying / harassment-related support and resources to staff. b) Implement an awareness-training program on workplace harassment/bullying and its consequences. c) Educate and train staff on reporting processes and what to do if they have been / are being bullied / harassed. d) Educate perpetrators – e.g., anger management. e) Ensure managers are provided with education / training on how to respond to / eliminate harassment / bullying. f) Develop a process for providing physician training and accountability on harassment / bullying.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
2.9 Domestic violence				
Examples: ▪ Domestic violence is seen as personal and not a workplace issue ▪ Victims of domestic violence do not feel supported by their workplace / managers / supervisors ▪ Supervisors are unaware of the steps to take once they become aware of domestic violence ▪ There is no program for domestic violence	☐ High (all) ☐ Moderate (all) ☐ Low (1,2 a-f) ☐ Very Low (1, 2 a-f) ☐ N/A	1. Awareness	a) Display public education materials and resources in accessible areas such as lunch rooms, washrooms and on the company website. b) Provide domestic-violence awareness-training to all staff. c) Educate and train staff on signs of domestic violence and supports / resources available for victims d) Ensure managers know the signs of domestic violence and take reasonable precautions to protect workers who may be at risk e) Refer to PSHSA's Domestic Violence: A Handbook for the Workplace as needed and www.makeitourbusiness.ca	
		2.Domestic violence program	a) Develop a policy and program for dealing with a perpetrator potentially or actually entering into the workplace. b) Develop a security plan for the workplace – e.g., notifying and / or removing targeted staff, locking of doors, installing panic buttons / alarms, accommodation, after – hours entrances, etc. c) Ensure there is an education program for staff regarding work / family issues. d) Implement a reporting procedure for domestic violence and ensure confidentiality is maintained. e) Ensure employees understand reporting obligations of abuse and any other information that may be useful in preventing future workplace violence.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			f) Provide resources / brochures / hotline and EAP assistance numbers to all staff. g) Develop a process or tool – e.g., a hotline – for reporting witnessed or experienced threats.	
		3.Security / safety measures and response	a) Implement a safety plan for victims that includes safety / security measures such as: ▪ Personal escort to vehicle ▪ Providing a physical description or photograph of abuser to security / reception staff b) Accommodate staff scheduling and work re-assignments / transfers in situations involving domestic / workplace violence – refer to PSHSA's 'Domestic Violence: A Handbook for the Workplace' and www.makeitourbusiness.ca as needed. c) Conduct a reassessment of parking lots when risk of domestic violence is identified. d) Implement security measures including screening of calls, and using code words or phrases to indicate an escalating situation.	

3.0 Direct care of potentially aggressive / responsive patients

Completed by: _____

Signature: _____

Date:

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
3.1 Patient risk assessment & communication				
Examples: ▪ Unit has significant patient populations of the following: o Patients with cognitive disorder, acquired brain injury, dual diagnosis, mental and psychological conditions and / or addictions o Patients with medical conditions that may predispose / trigger aggressive or responsive behaviours such as acute disease, pain, impaired mobility	☐ High (all) ☐ Moderate (1 a-d, 2, 3) ☐ Low (1 a, 2 a-e) ☐ Very Low (1 a, 2 a-e) ☐ N/A	1. Patient assessment	a) Ensure that the admission history includes observed behaviours indicating a potential for violence and information about the context in which they are presented. This may include but not be limited to: ▪ History, diagnosis, medications ▪ Symptom patterns (agitation, excitement, hostility frequency / intensity of behaviours) ▪ Demographic characteristics ▪ Triggers for agitation, aggression and violence ▪ Factors / interventions that decrease the risk of agitation, aggression and violence b) Implement a process to assess all patients for violence / aggression immediately upon entering the facility. c) Implement a patient assessment process – e.g., using an aggression rating scale – to identify aggressive behaviours d) Implement an 'Aggression Control Behaviour' tool that helps staff assess and distinguish between patient behaviours – e.g., agitated, disruptive, destructive, dangerous, lethal – to support decision-making around use of restraints/seclusion. Refer to the PSHSA Individual Client Risk Assessment Toolkit as needed.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
and ADL function, impaired sleep, delirium, and post-surgery) o Patients during period of transition (e.g., new admission, unit transfer, level-of-care transfer) o Patients with complex bio-psycho-social presentation ▪ Families with a heavy caregiver burden ▪ Families who have experienced violence and aggression ▪ Lack of a patient assessment protocol to identify risk for workplace violence ▪ Lack of mechanisms to communicate patient risks among care team members ▪ Environment not conducive to staff safety caring for patients at risk for workplace violence		2.Care planning and flagging	a) Develop a flagging and communication system for patients with a history of violence or who at risk for violence- refer to the PSHSA Flagging Toolkit as needed. b) Implement a process to ensure staff design flexible, patient-centred care plans designed to meet patient needs and protects staff. Connect with your Behavioural Supports Ontario (BSO) resources for additional support as needed. c) Ensure there is a process to: ▪ Document all observed behaviours, known violence triggers ▪ Communicate risks and safety measures and procedures this to all relevant staff ▪ Alert security personnel d) Ensure patient-care planning takes into account known violence, aggressive, or responsive behaviours, calming techniques, early warning signs, mobility levels, handling aids, presence of infectious diseases, social situations. e) Develop safety plans for patients, families and staff.	
		3.Environmental control	a) Implement a unit environmental audit tool to assess environmental hazards related to violence. The audit should include assessment of: ▪ All rooms to ensure furniture is arranged to prevent entrapment of staff ▪ Unit furniture to ensure it is lightweight and without sharp corners ▪ All rooms to ensure they are free from clutter, weapons, and items that may potentially be used to injure others	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			b) .Assess counselling/interview/triage areas to ensure there is a secondary exit in case the main door is blocked by a patient	
3.2 Patient care strategies				
Examples: ▪ Inappropriate patient care practices for patients at risk of or demonstrating aggressive / responsive behaviours	☐ High (all) ☐ Moderate (all) ☐ Low (1 a-d, 2) ☐ Very Low (1a-d, 2) ☐ N/A	1. Patient care strategies	a) Implement appropriate patient-centred care – e.g.: ▪ Dementia patients – PIECES, Gentle Persuasive Approach ▪ Mental health patients – Collaborative Recovery Model, Therapeutic Alliance; RNAO Best Practice Guidelines ▪ Safewards conflict and containment model of care. b) Perform risk assessment to ensure staffing skill set and competencies aligns with unit fluctuations in workload / high- risk patients. c) Ensure patients are appropriately aligned with services and activities / programs within services. d) Implement a transition of care and transition-support process to ensure risk are communicated to staff and that patients and their families are: ▪ Oriented within the unit ▪ Familiar with assigned clinicians and provided information (unit pamphlet, Bill of Patient Rights, code of conduct, workplace violence prevention program brochure, and zero tolerance signage etc.) to assist with transition e) Investigate staff break times to ensure appropriate staffing skill set and competencies are maintained during patient meal-times when patient needs are high.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			f) Develop communication strategies to support families and link them to external resources as required.	
		2. Least Restraint practice	a) Implement alternative care strategies such as de-escalation to enhance comfort, safety and well-being before considering restraint. b) Develop and implement a Least Restraint policy, including a process for safe application of seclusion and restraint measures as a last resort. c) Ensure policy includes worker safety measures (e.g., checking flagging system, calling for security backup) and use of appropriate PPE (e.g., Kevlar gloves, spit shield, etc.) d) Consider use of trained security staff to assist with restraint practices as needed. e) Prior to the implementation of the Least Restraint policy, conduct a unit assessment to address caregiver, staffing skill set and competencies and patient issues. f) Develop and implement a process to conduct a thorough analysis of all events related to restraint use – e.g.: ▪ Identifying antecedent factors that led to restraint use ▪ Applying this information to care-planning and risk-reduction strategies g) Implement a documented process, investigative tool, and communication process to inform staff / patients / family of investigative findings. h) Educate and train staff and provide practice opportunities around: ▪ Containing aggressive behaviours before application of restraints ▪ Appropriate application of restraints	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Different levels of physical interventions i) Ensure restraint equipment and supplies are available and replenished on a regular basis as per written organizational policy and procedure.	
3.3 Staffing / staff support				
Examples: ▪ Inappropriate staffing skill set and competencies ▪ Staff not equipped with knowledge and skills to care for aggressive / responsive patients	☐ High (all) ☐ Moderate (all) ☐ Low (1 a-c, 2 a-b, 3) ☐ Very Low (1 a-c, 2 a-b, 3) ☐ N/A	1. Staffing	a) Ensure staffing, including security personnel, levels appropriate to the risk level of predominant patient populations, taking into account: ▪ Surge protocol ▪ Staff skill set and competencies and experience level b) Implement a process for reviewing staffing skill set and competencies / staff assignments on an ongoing basis, and adjust as needed. c) Develop a process to ensure staff caring for high- risk patients have are appropriately trained / equipped to provide safe care. E.g., ability to identify escalating behaviour cues, de-escalation skills, and physical defensive options etc. d) Implement a buddy system for staff caring for high-risk patients.	
		2.Staff training and education	a) Implement training that enables staff to identify situations where patients may exhibit responsive behaviours. b) Train staff on recognizing aggressive behaviours and appropriate communication and care strategies.	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			c) Implement education / training on specialized patient care curricula for dementia, mental health, and patient-centred care strategies. d) Implement training on personal safety including but not limited to behaviour management, holds, and releases based on circumstances, including but not limited to holds and releases etc. e) Provide training in team settings, and ensure regular opportunities for practice.	
		3.Staff support	a) Develop and implement a two-stage debriefing process post violent / aggressive event: ▪ Immediate post-incident – caregivers and patient ▪ Investigative – formal problem / root-cause analysis which includes asking staff about factors that could have prevented the assault b) Implement regular unit staff meetings, ensuring that safety is a standard agenda item, and that minutes are made available to all staff. c) Encourage staff self- reflection on their own behaviours and responses.	
3.4 Security / safety measures				
Examples: ▪ Insufficient security measures for management of patient population at risk for workplace violence	☐ High (all) ☐ Moderate (all) ☐ Low (2) ☐ Very Low (2) ☐ N/A	1. Security / safety measures and devices	a) Perform risk assessment to determine the need for a security presence in high risk units or when high risk patients are on the units. b) Implement a program that: ▪ Integrates security plan into interdisciplinary care teams working with violent patients ▪ Assigns clear security roles and responsibilities	

Hazard	Degree of Risk	Controls	Potential Solutions	Comments
			▪ Ensures security personnel have appropriate level of training to intervene when necessary to protect staff and patients ▪ Includes a process to audit the program for effectiveness c) Refer to the PSHSA Security and PSRS Toolkits as needed.	
		2.Emergency response measures	a) Ensure staff are trained in all emergency-response mechanisms. b) Implement regular drills in areas such as Code White, use of alarms / panic buttons, etc. c) Ensure all team members know their roles and responsibilities in emergency response to workplace violence.	

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