First Nations Health Authority
Health through wellness

Advanced Safety Training

Module 1

Workplace Violence Prevention

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Welcome to Advanced Safety Training module 1

- The material for this course has been developed based on risk assessments, staff interviews and the work the safety team has done with front line staff across the province.
- This module focuses on risks and safety measures related to preventing violence in the workplace.
- There are two parts to the module: this presentation pdf file and a quiz to evaluate your learning. We suggest you have both documents open as you go through the course and when you are prompted with questions in the presentation you can put your answers into the Quiz PDF.
- The questions have been designed to help you retain key messages from the module and ensure you know the location of information and physical resources for future reference.
- This course can be completed over several days, so make sure you regularly save your Quiz PDF so you do not lose any work you have done on it. Unfortunately this file does not automatically track how far along you are in the process, so if you shut down your computer you will have to remember how far you are when you re-open it and renew your studies.

DISCLAIMER: This module is required learning for those who work directly with clients, work alone or in isolation and/or travel for work. This includes contracted workers. However, it has not been customized for each occupational group so some of the information covered in this module may not seem relevant to the job you do within FNHA.

Why do we do this training?

To meet regulatory requirements of Workers Compensation Act Part 3 & OHS Regulation Part 3: Young or New Workers

FNHA's commitment to worker safety actively practices the six shared values and meets the seven directives.

A safe and secure workspace supports worker's wellness; protects them against injury and improves the quality of services we are able to deliver to our clients.

Learning Objectives

1. Explain how a commitment to cultural safety and humility can lead to better relationships with clients and improved health outcomes for First Nations peoples
2. Describe current leading practice approaches to the management of aggression in health care
3. Identify observable physical signs a client has been triggered
4. Develop an awareness of personal triggers and biases
5. Summarize the key steps to successful active listening and de-escalation
6. Identify the most effective approaches to development of safety measures
7. Describe the two-step procedure for reporting incidents of violence in nursing

Where to find resources

The resources mentioned in this training module can be found on the Bighouse OH&S team site.

Go to:

- Occupational Health and Safety team page
- OHS forms and shared documents

Cultural Safety and Humility

Cultural Safety and Humility

- Cultural Safety and Humility is the underlying skill set upon which the Violence Prevention program is based and which we incorporate into our violence prevention training.

- Employees with this skill set acknowledge the disruption of First Nations health and wellness through a process of colonization and oppression that has led to a legacy of trauma and health and social inequities.

- Cultural safety can be created when health care workers approach First Nations care with Cultural Humility while understanding that risks for aggression may occur in any health care setting.

Roots of Aggression

- Some of our clients have had negative experiences with a health care system that does not recognize the inter-generational trauma linked to the legacy of the residential schools and Indian Hospitals.

- When they experience a health crisis that forces them to seek care, clients may be triggered by behaviours that remind them of past experience.

- Sometimes clients may be angry about a situation unrelated to their care (e.g., a family situation, concern about their livelihood, or living standards) that contributes to feelings of hopelessness or powerlessness.

Cultural Safety and Humility – the how

- We demonstrate commitment to Cultural Humility by being open to learning and by integrating relationship-based care into our professional practice.

- We focus our intention on working with clients in a way that honours their cultural traditions and protocols and helps them achieve wellness in a safe environment.

- This requires developing communication skills that may be new to you while acknowledging that front-line health care workers everywhere face higher risks of violence than many other workers.

Preventing workplace violence

In accordance with the Occupational Health and Safety Regulation (OHSR) definition of violence/aggression, this module focuses on managing violent behaviour toward a worker from a non-worker such as a client, community member or member of the public.

*"The attempted or actual exercise by a person, **other than a worker**, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury."* (OHS Regulation part 4)

All violent acts (whether intentional or not) do not have to be tolerated and must be reported

What is violence and how do we prevent it?

Violent behaviour can be:

- Physical or sexual (e.g., beating, sexual assault, kicking, slapping, shooting, pushing, biting, pinching)
- Verbal or non-verbal (e.g., threatening, yelling, swearing, glaring)
- Psychological (e.g., intimidation, sabotaging work, gossip, backstabbing, put-downs, blaming, excluding a worker, trauma)

The key skill to preventing workplace violence incidents is to anticipate client triggers and to be aware of our own. Use crisis de-escalation and limit-setting communication strategies from this module when you notice a client becoming agitated or angry. If that is not successful, call for assistance or remove yourself from an escalating situation. Report the incident as soon as possible.

What do I report?

- These types of incidents *must* be reported: **minor injuries, serious injuries, time loss injuries, near miss incidents, psychological trauma incidents and workplace fatalities.**
- All incidents (including physical and verbal violence) must be reported so that the safety team can ensure an investigation is initiated by the manager, an investigation team is formed, and the proper analysis is done to determine corrective actions that will prevent similar incidents from happening again.
- WorkSafeBC requires that a preliminary investigation be done into certain types of incidents within 48 hours and a full investigation be done within 30 days.
- Remember: a near miss is defined as an incident that could have caused bodily harm but for a fortunate break in the chain of events. We may be able to prevent future incidents if we know the root causes of a near miss.

How do I report?

- Incidents must be reported on the **Worker Incident Report (WIR)** form found on the left sidebar of the OH&S main page on the Bighouse under LISTS. Worker Incident Report
- **Please note:** Nursing incidents must be reported on both the Nursing **Occurrence Report** and the **Worker Incident Report (WIR)** in order to gather all the information required in case a claim is filed for compensation (wage loss or health care costs due to injury). This includes all incidents of psychological stress where employees are referred to the Occupational Critical Incident Stress Management (OCISM) program.
- **Failing to complete the WIR may disqualify your claim.**

How do we report worker to worker violence?

- In the workplace, bullying (intentional use of power) or harassment (based on discriminatory grounds identified in the BC Human Rights Code) are the terms used when these behaviours are directed by one worker toward another worker
- Lateral violence (speaker may not be aware their words and actions are hurtful) is bullying type behaviour that may be accountable and correctable when confronted; true bullying is rarely admitted
- Bullying, lateral violence and harassment are covered in Basic Safety Training. Refer to the Respectful Workplace Policy Documents for reporting procedures and forms.

Reporting is key to improving both physical and psychological safety at FNHA

Remember if it's reported, FNHA can investigate for better solutions and prevention

Case Study

A nurse has come into the clinic after-hours by herself for a patient that was assaulted by her boyfriend. The patient arrives with 6 other family members. As the nurse is assessing the patient in the emergency bay, the family members waiting in the hallway continue to let more and more people into the clinic and soon the hallway and waiting area are full of concerned family.

The RCMP are not in the community at this time and the nurse sent the first responders home because it was after-hours and late; she felt bad that they were tired.

The nurse suddenly hears loud banging and screaming at the clinic doors – it is the patient's boyfriend at the door and he is demanding to be seen by a nurse. He appears intoxicated and is severely agitated. He has blood coming from a large laceration on his scalp with blood coming from his ears. The nurse knows that she needs to assess this patient for a potential head injury, but the only entrance to the clinic is surrounded by the family of the girlfriend who are all also agitated and are shouting threats at the injured man.

Case Study (cont'd)

The patient in the emergency bay has also become severely agitated and not responding to the nurses' request to lay flat and remain calm. She has removed her C-Spine collar despite repeated instruction to leave it on.

The second nurse is at her residence and can't make it to the clinic for another 10 minutes – she is a non-remote certified public health agency nurse that has never worked in a remote station in her career. The primary nurse knows that it will take the RCMP at least 4 hours to arrive to the community as the weather is poor and they cannot fly in. The nurse radios the first responders, but they have fallen asleep and are not answering.

Please reflect on these questions before advancing to the next slide:

1. How could the nurse respond in a way that provides cultural safety to all involved in this scenario?
2. If you were proactively assisting with creating a safety plan to address a situation like this what alternatives would you suggest for a nurse in this situation?
3. How should this situation be reported?

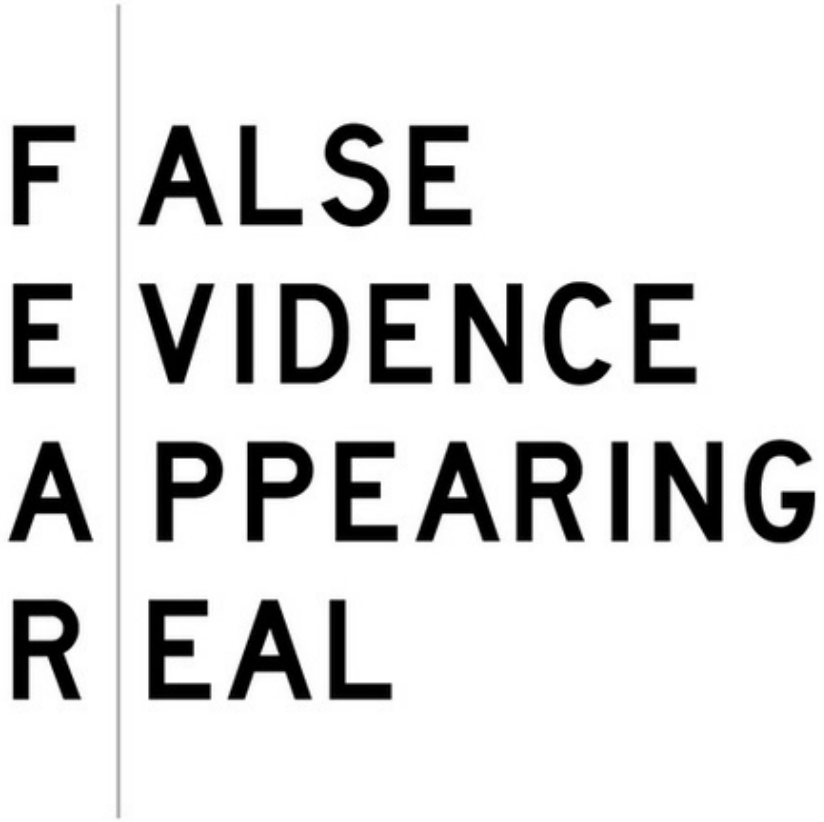
Nurse responses that help provide Cultural Safety

- The nurse understands that it is customary for the entire extended family to respond to the clinic when there is a family emergency. The nurse did not ask the family to leave and allowed a few family members in the treatment room to support the woman.
- The nurse understands that alcohol is a common coping substance used by people that have experienced a significant amount of trauma in their lives – the nurse takes a non-judgmental approach to dealing with the intoxicated boyfriend.
- The nurse offers all parties and their families follow-up from the community Traditional Healer.
- The nurse inquires about possible community supports available to initiate healing and reconciliation between the family and the boyfriend. With consent from the woman, the woman's family, and her boyfriend - the elders in the community could facilitate a healing circle.
- The RCMP are only involved at the request of the woman or boyfriend – the nurse listens to what her patients want and does not act for them. Unless the nurse feels her safety is at risk, he/she does not have to involve the RCMP if not asked to.

How was the Safety plan implemented?

1. The nurse knew to triage after-hours calls and responding to violent incidents with another nurse.
2. The clinic had signage reminding staff and clients that respectful behaviour was expected and procedures were available for controlling groups of non-patients.
3. The second nurse was not fully trained. This was a staffing issue that impacted the effectiveness of the safety plan. The nurse radioed the first responders, but they didn't answer. The nurse finally sent one of the family members to retrieve the first responders. The first responders were able to alert the community safety officer who came to the clinic to disperse the crowd and assist with safely bringing the second patient into the clinic for assessment. Try to have several first responders if possible so they don't all tire at the same time.
4. This situation was not reported but should have been reported on both a Nursing Occurrence Report ***and*** worker Incident Report (2 reports)
5. The RCMP arrived at the community approximately 5 hours later

Understanding triggers for violence



Don’t take it personally

- Some client triggers are within your control; however, the patient may enter your worksite already upset about something totally different from their illness, their treatment or something within your control.
- Being aware that the client needs to vent may help us to be less reactive so we don’t take it personally.
- Anger is frequently a secondary emotion; when clients express anger it is usually in reaction to other emotions:
  - displaced anger
  - feeling powerless or treated unfairly
  - hurt pride
  - fear of losing face
  - lack of impulse control due to impairment or fatigue

Trigger examples

- A nurse treating a child and the parents are very stressed and become verbally abusive.
- A dental therapist treating a patient who has a fear of needles or who may have a severe toothache and be upset because they think they should have been seen sooner.
- A health benefits worker dealing with an emotional client on the phone who is upset with a patient travel claim being delayed or denied.
- Residents reacting with anger to an environmental health officer who wears a respirator to collect mould samples from their home.
- A regional engagement coordinator attending a meeting and a community member verbally abusing them due to a previous FNHA service delivery issue.

Providing Cultural Safety

- Your primary goal as a caregiver or service provider is to develop a relationship with the client based on trust. You do that by:
  - Practicing active listening to help your client feel heard, understood and respected.
  - Making sure you understand what your client is asking of you, and then doing your best to meet those expectations or provide alternatives.
- Feeling heard, understood, respected and accepted are basic human social needs and help your client develop trust in you.
- They are more apt to respect you if you apologize, explain or otherwise take corrective action when it is called for.
- Be aware of the attitudes, behaviours and judgments you may bring to the relationship.

Client triggers

Caregiver triggers

Caregiver triggers

Having an awareness of what triggers you can help you react with a respectful request to stop the behaviour rather than reacting in a negative way.

Activity: What triggers you?

- Do you feel defensive when someone calls you names?
- Do you feel annoyed when someone is slow and you are in a hurry? Do you let it show?

Take a few minutes to write down behaviours or words that trigger you.

Emotional Crisis – possible de-escalation

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Staring / facial expressions
Prolonged glaring, or avoiding eye contact

Tone and volume of voice
Put-downs, sarcasm, rude/disrespectful comments

Anxiety
Crying, jittery, wringing hands, excessive or minimal talking, flushed appearance

Mumbling
Talking under breath, criticizing just loud enough to be heard, repetition, slurring or incoherent speech

Pacing
Walking around confined areas such as waiting room, walking back and forth

Emotional Crisis – possible de-escalation

- When a client is having an **emotional crisis,** they are in distress and may display some of the physical signs or behaviours noted with the acronym STAMP.

- The specific cues of an emotional crisis will vary from person to person, but generally when a person is in emotional crisis you still have a possibility of de-escalating them.

- Be alert to these signs so you can attempt de-escalation early.

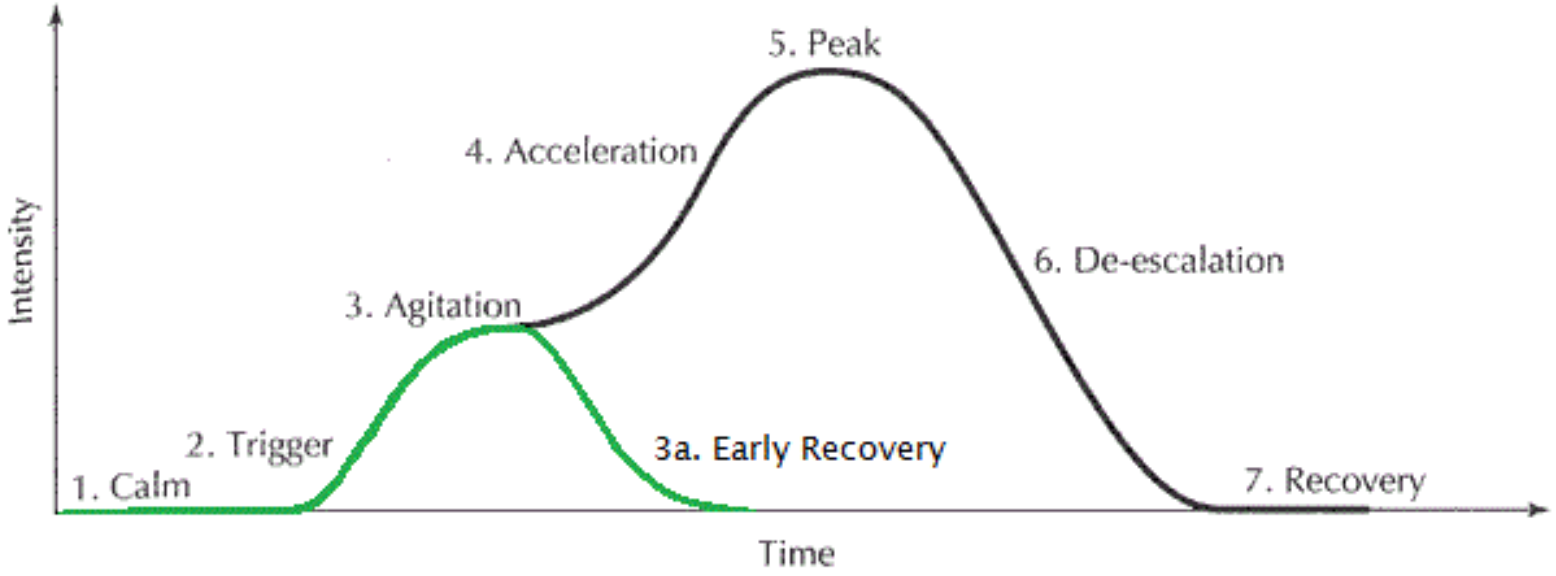
- Generally, you will notice a change in a person's behaviours when their emotions are escalating.

Behavioural Emergency – too late for de-escalation

- Warning signs that the person may be escalating and possibly become physically violent are summarized by the acronym PAV which means:
  - **Personal space invaded**: Most cultures have a personal space (sometimes called a "bubble") understanding between two individuals – the more intimate/friendly you are with a person the closer you allow them to be and the less intimate/ friendly you are with a person the farther you want to position yourself from them.
    - When an angry person invades your intimate space this is a warning sign of escalation of anger, intimidation.
  - **Activity level increases**: Threatening movements, finger pointing, glaring, directs anger towards other inanimate items such as tables, chairs, walls.
    - Take a step back and stand at a 45 degree angle, far enough to be out of kicking or hitting distance
  - **Verbal violence**: threatening, swearing,
- These are signs the person may be past the point where they can be de-escalated and it may be best to leave.

Stay or leave?

Another way of understanding the difference between emotional crisis and behavioural emergency is with this graph.



Based on Phases of Acting-out Behaviour (Walker, Colvin, & Ramsey)

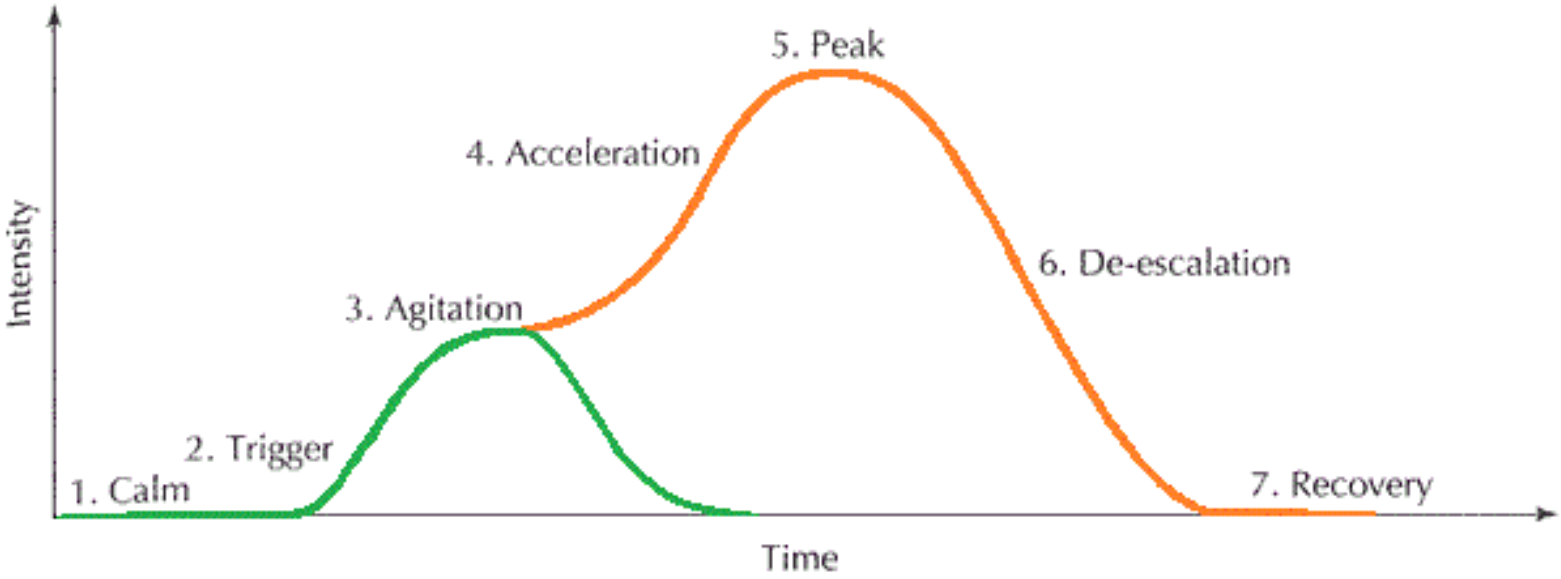
Stay or leave?

- Many times there is a predictable path from trigger to agitation through acceleration to peak; however the stages and length of each phase are impossible to predict. The good news is that anger comes in a cycle, and once it has peaked it starts to drop down.
- **Best practice in Violence Prevention is to use de-escalation communication skills which can interrupt the building intensity and keep a person from reaching the peak of the anger phase.**
- Your best chance to de-escalate a client is when you start using de-escalation communication skills with a client who has demonstrated signs of being triggered and acts a bit agitated. This is the emotional crisis (STAMP) phase.

  One of two things will occur:

  1. The person will respond well to your attempts to de-escalate and equilibrium will be restored (3. a. EARLY RECOVERY)
  2. If the emotional crisis continues without PAV signs, and you don't feel threatened, you may be comfortable to let the person vent. If given the chance to vent, the anger will peak and the person will de-escalate themselves. (7. Recovery)

Stay or leave?



Based on Phases of Acting-out Behaviour (Walker, Colvin, & Ramsey)

However, if your client passes Agitation and shows signs of Accelerating their behaviour, they are now in Behavioural Emergency. If you do not feel safe for any reason, you should leave the room, call for assistance and find a safe place away from the client.

In you planning for situations like this, you will want to make sure that you are always positioned between the client and the door so you can make your exit without being trapped in the room.

Fight, flight or freeze?

At this point, it's likely the client is in fight mode. But what about you? How do you respond to aggression?

These are some of the behaviours or physical changes you may experience when threatened. Everyone reacts in unique ways, sometimes responding a different way to the same threat depending on who the other person is.

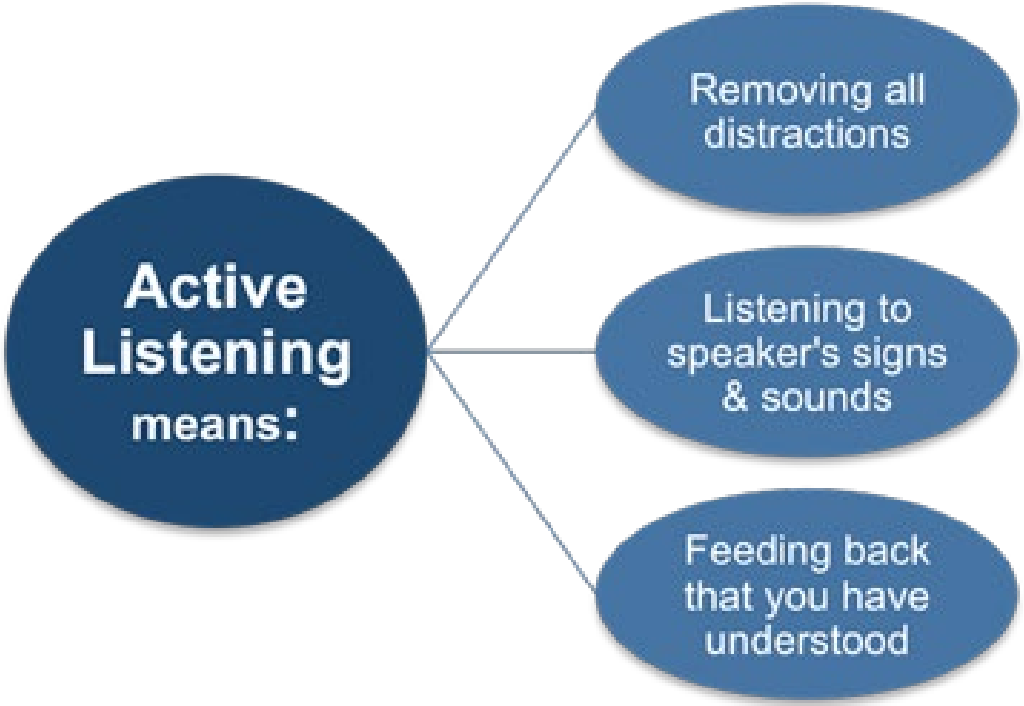
FIGHT	FLIGHT	FREEZE
Crying	Anxiety/shallow breathing	Feeling cold/frozen, numb, pale skin
Tight jaw, grinding teeth, snarl	Restlessness, fidgeting	Holding breath/restricted breathing
Raging	Feeling trapped, tense	Sense of dread, heart pounding
Homicidal/suicidal thoughts	Sense of running in life – one activity to the next	Decreased or increased heart rate

How do you respond to anger?

Take a moment to consider whether you identify with fight, flight or freeze.

- **ACTIVITY**: Imagine you are seeing a new client or meeting with a community member for the first time. You know none of the person's history but another staff member has mentioned she had a challenging situation with this person. What is your first behavioural response when the person says something to you in a threatening tone? Would the reaction be different if the other staff member reported having a friendly interaction with this person?

Communication skills



Navigating barriers to good communication

In normal conversations, a message is transmitted, received, understood and feedback is given. Then the cycle starts over. But when there is tension the following circumstances may create barriers to successful communication:

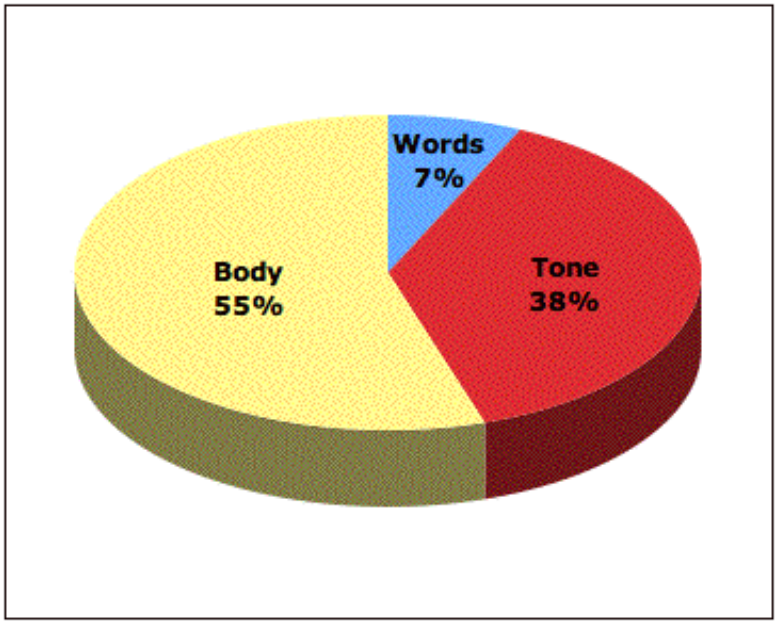
- Panic, complacency, negative non verbal communication – they may be so upset that they do not hear/comprehend the words you are saying
- Ambiguous language, assumptions or judgments
- Personal factors – difference in culture, beliefs, values, language, emotions, accent/dialect
- Illness/disability
- Fatigue, mental illness or impairment

- Think through what needs to be said, avoid slang, keep to the point and be prepared to repeat key points.
- Don't assume that your client has received your message in the way you intended. Confirm major points with them to make sure you understand each other.

Three components of communication

Have you ever finished a conversation with someone and realized you cannot remember a word they said? All you can remember is the disgusted look on their face (nonverbal) or that the person had a grating tone to their voice (paraverbal). This situation demonstrates the truth of the reasoning that we hear a message in three ways.

1. VERBAL – words
2. PARA-VERBAL –tone of voice
3. NON-VERBAL – body language



What did you actually hear?

- It also underscores the importance of considering all three components when we engage others in conversation:
  1. Do I take the time to organize my thoughts in clear, concise messages, avoiding ambiguous terms (e.g., the word “it”)?
  2. Is there something about my body language that is distracting to others when I speak? Ask someone you trust.
  3. Is my speaking voice pleasing or irritating? Do I sound condescending to others when I ask a question? Impatient? Ask someone you trust.
- The goal is to work past the para-verbal and non-verbal distractions so we convey our message in a way that is most likely to be received the way we intended it.
- And when we are the listeners, we may need to work a little harder to give our full attention to others when they speak so they feel heard and understood. In other words, active listening.

De-escalation begins with Active Listening

- De-escalation is reducing a client's stress/frustration levels so that you can have a successful interaction that benefits both of you.
- Your first step in de-escalation is active listening.
  - Active listening takes work but it is key to establishing trusting relationships.
  - It takes concentration to focus completely on what the other person is saying without distractions. Take the person to a quieter place if necessary.
  - Listen to words, listen for emotion and listen also for what is not said.
  - Give your full physical attention to the speaker and demonstrate your openness to listening by keeping your hands open and your body relaxed.
  - Move your body in response to the speaker, i.e., appropriate head nodding, facial expressions.

De-escalation begins with Active Listening

- Observe your own behaviour and defer judgment.
  - The individual may not tell you directly what the issue is, possibly due to fear or embarrassment, so look for hidden messages or what really is the source of the problem.
- Ignore challenging questions (e.g., “why did you …”?). Aim for open–ended questions (“Can you tell me more about that?”) rather than questions that can be answered “yes” or “no”.
  - Redirect the person’s attention to the issue at hand when necessary.

How active listening works

1. Devote your undivided attention

Face the person you are listening to, and make eye contact. Show him or her that you are listening by nodding and make the person feel like you are genuinely interested in what he or she has to say. Periodically say acknowledging words like, “Ok”, “I see”, “Uh-huh” and so on. This doesn’t mean that you are agreeing or in support of what is being said, it just means that you are taking in what’s being said.

2. Listen with the intent to restate what’s being said

In many cases you start listening fully focused, but then something the person says triggers thoughts that lead back to yourself. Instead of thinking about your own situation or what you are going to say to the person who is talking, listen to the person with the intent of restating what is being said. If this is your focus, than you will be a much better listener because this forces you to fully concentrate on what the person is actually saying.

3. Be patient and constrain your own impulses

When you are actively listening to someone else you need to be patient and give the other person “air time”. Don’t interrupt. Don’t finish sentences or jump to conclusions. It’s okay to leave room for silence. Even if you have a very strong point of view about what is being said, constrain your immediate impulse of objecting or agreeing. Active listening is not about sharing your thoughts on the matter, but fully capturing what the other person is saying.

Active listening cont'd

4. Ask questions to confirm and deepen understanding

Many times our own background, experience, and beliefs distort what we hear. We interpret what is being said based on our own views. To avoid jumping to inaccurate conclusions ask open-ended questions to clarify what the person really means. For example:

When you say "poor management", what do you mean? What examples can you give me?

What do you consider to be "unacceptable behavior"?

If you are uncertain about stated facts, confirm that you have understood by asking:

Is it correct that in your opinion the project was late due to a change in project management?

So, in your view, the biggest challenge was lack of leadership?

5. Pick up on and affirm emotions

In addition to listening to the words that are being said, it's important that you pay attention to the non-verbal communication – body language, facial expression, tone of voice, etc. To fully understand someone else you need empathy, the ability to see things from the other person's perspective. Just like you should confirm that you have understood what is being said, it's important that you show that you are able to pick up on emotions, for example:

You seem really happy / It sounds to me that you are extremely shaken by this / I can see that you're really frustrated

Active listening cont'd

6. Restate in your own words

The final step in actively listening is to restate what you have heard in a summarized way using your own words, also referred to as paraphrasing. You can see this as a "receipt" of your understanding of what has been said.

> *So in other words, you believe that a change of management during the project is a huge risk and you recommend that we delay the start of the project. Is that correct?*

Not listening becomes a vicious spiral

We all want to be heard. There is nothing more frustrating than speaking to someone who is distracted with something else, or speaking to someone who keeps interrupting, or someone who starts talking about his or her own experiences (that by the way always outweighs your story).

"You were given two ears and one mouth, make sure to listen before you talk." Again, the theory of active listening is very straight forward – it's putting it into practice that is the challenging part.

Reflective listening skills defined

- **Paraphrasing -** brief, succinct, and focusing on the facts or ideas of the message rather than the feeling and using the listener's own words rather than "parroting back".

- **Reflecting Feeling -** The listener asks herself, "How would I be feeling if I was having that experience?" and then restates or paraphrases the feeling of what she has heard in a manner that conveys understanding.

- **Summarizing -** The listener pulls together the main ideas and feelings of the speaker to demonstrate understanding.

How to set limits

- Always give face-saving choices when setting limits:
  - Agitated individuals are very sensitive to feeling ashamed or disrespected.
  - Use polite phrases (“Please sit down”, “Please lower your voice”, “Please put that object down”).
- Speak in a confident voice. Be respectful and use a firm tone.
  - Validate person’s concerns
  - Describe the behaviour you want them to change
  - Explain why you want the behaviour to change
  - Describe the consequences of not changing the behaviour
  - Follow through on the consequences in a realistic timeframe
- If it feels safe to do so, explain to them that FNHA has a zero tolerance policy for abusive behaviour and what the consequence is in your facility (e.g., calling for assistance from another staff member or the Health Director, end session or reschedule).

Examples of limit setting

- Examples of limit-setting statements:
  - I can see that has been very frustrating for you, but I can't help you if you continue to raise your voice.
  - I will do what I can to help you; please lower your voice.
  - If you continue to yell, I will have to ask you to leave.
  - If you continue to swear, I will have to ask you to leave.

Activity: Imagine for a few moments a situation where you might have used a limit-setting statement. What would you have said?

De-escalation summary

- While engaging with your client remember these options:
  1. **Call for assistance** (co-worker, medical professional, security, police). Rely on your site safety plan for how to call for assistance, e.g., phoning a co-worker and use pre-arranged code word ("bring me the red file please") that signals the need for one or two people to assist you.
  2. **Run if you have to leave** the situation to protect yourself. As Health Care professionals this may go against your instinct to help, but you must put your own safety first so that you are not hurt and become unable to perform your duties.
  3. **Hide if you can** find a secured environment like a designated shelter-in-place. Again, procedures for shelter-in-place should be developed and communicated before they are needed.
  4. **Fight back** – this is the **last option**, and is only recommended if you cannot escape to protect yourself.

Removing Yourself / Leaving

- Use pre-planned strategies to leave (site safety plan) which may include:
  - Saying you have to go get a file or check with a co-worker
  - Use a panic alarm if available
  - Leave the area and retreat to a position of safety
- It is your responsibility to recognize when the situation is no longer safe and make plans to leave according to the safety procedures outlined in the OH&S Procedures and customized for your team/site by your team and your manager and/or Health Director.
- Remember that always placing yourself between the client and the exit gives you the best chance of leaving safely.
- Make sure you report the incident to your supervisor so that follow up actions can be taken by a supervisor (and Health Director if in a health care facility) and the incident can be tracked.

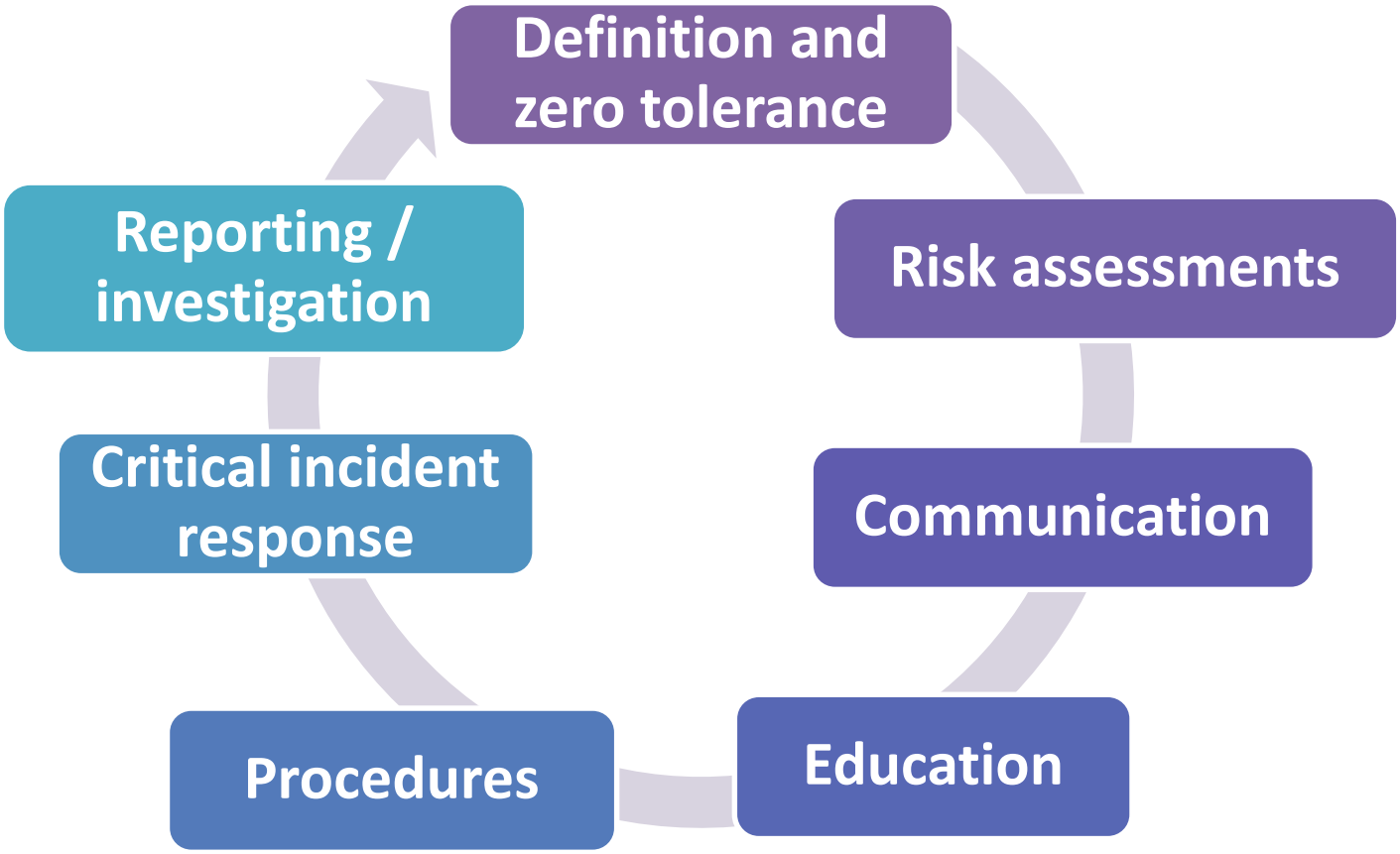
After the incident is over

- Once the incident has been reported to the manager, reports filed and an investigation planned, the affected worker and witness need to make themselves available to liaise with local police and community leaders if needed and to contribute to the incident investigation.
- The investigation is NOT supposed to be an opportunity to blame the worker.
- The investigation will determine if new safety measures are required, or more training, and the results should be shared with all staff so that they are aware of how they can deal with or prevent similar incidents from reoccurring.
- Not everyone handles stress and confrontation the same way. What may be a simple verbal disagreement or yelling match to one person could have been a very painful experience to another. Plus, repeated incidents may build up stress and pain and can have a significant impact on staff morale, performance and attendance.

Post-incident emotional support

- Managers are required by law to offer counselling resources to staff.
- Staff need the opportunity to share the experience with others in a supportive, non-blaming way.
- Debriefing can deepen the level of trust among staff members.
- Follow up support is available to everyone.
  - Nurses - from the Health Canada Office of Occupational Critical Incident Stress Management (OCISM) in Winnipeg
  - All staff – our Employee Assistance provider can provide assistance to employees one-on-one or can be called in to do Critical Incident Stress response with groups of staff on a fee-for-service basis. ***Speak with your manager if you require more information.***

Planning for violence prevention



Safety planning starts with assessing risk

- You may be required to facilitate or participate in a workplace risk assessment or Job Hazard Analysis for your job to periodically inform the site safety plan.
- Using a risk matrix tool allows us to prioritize safety risks and develop an action plan with safety measures to mitigate or control those risks to prevent injuries.
- Managers work with OH&S to develop safety plans with worker input.
- Safety measures or controls are implemented using the hierarchy of controls. The most effective control is the first one that should be considered.

Hierarchy of controls

In order of best to least effective control:

1. **Eliminating** the hazard e.g., enlisting the help of a family member or community first responder to remove the client from the room
2. **Substituting** one hazard for another e.g., asking for another worker to provide service to a client if the client reacts negatively to the original care provider.
3. **Engineering controls** are physical changes to the workplace or devices that put a barrier between the worker and the patient. Examples include:
    - Physical barriers (such as enclosures or guards)
    - Access control (doors, security cameras) to reduce worker exposure to the hazard
    - More exits built into a receptionist workstation e.g., one way in, another way out
    - Arranging furniture so the worker is always between the client and the exit
4. **Administrative controls** are things like:
    - Policies and procedures
    - Training in communication (e.g. Trauma-Informed care, Non-violent Crisis Intervention)
    - Safe work procedures e.g., working alone check-ins, communicating risk, shelter-in-place
    - Changes to scheduling to allow for extra workers e.g., use of buddy system when working with patients with a history of violent behaviour

Managing workplace violence

The Occupational Health and Safety policy documents, available online or by emailing safetymatters@fnha.ca, have been created to give workers a foundation upon which to create site safety plans, which may be customized to honour community traditions/protocols. The policy documents contain a commitment to the health and safety of workers and include:

- Definition of violence in the workplace
- How to conduct Risk Assessments. This includes formal assessments for individual workplaces, informal assessments for clients who require home visits, and Job Hazard Analyses for each job.
- Formalized communication procedures (i.e., flagging) for risk of violence so client and community risks are shared with other workers

Managing workplace violence cont'd

- Availability of education/training relating to violence prevention and worker safety in general. This includes Basic and Advanced Safety Training, Respect in the Workplace training, Nurse Safety and Awareness training, Provincial Violence Prevention Curriculum, and Lateral Violence / Lateral Kindness training (for client-facing positions), and Keep Calm violence prevention training for reception workers.
- Procedures for responding to violence from clients and the requirement for staff to report to managers when they experience domestic violence (so procedures can be put in place in case the perpetrator spouse enters the worksite)
- Critical incident stress management response
- Reporting and investigation

Site safety plans

- Clinical managers/supervisors develop and implement safety plans in consultation with the Health Care team and JOHSC representatives.
- Workers have access to the site Violence Prevention safety plan that includes:
  - Access to a site risk assessment and required training and equipment.
  - Current notifications of significant violent activity identified in the surrounding community (including gang activity) that may affect staff safety and safety procedures for staff (e.g., to home visit, to nurse residence or home).
  - Communication of client history of violence and information on safety measures to be used (e.g., attend with another nurse or designated family member in the room), documented only when clients have demonstrated violent or threatening behaviour or if worker has any reason to feel threatened (e.g., stalking). Workers will flag client history of violence according to procedures. Staff coming into community are required to review the Communication binder or speak with nurses or Health Director.

Site safety plans cont'd

- Procedures and forms are available for reporting all incidents, including violent incidents.
- Guidelines are available for conducting Point-of-care client risk assessments.
- Facility worker telephone (work and home) numbers and community responder telephone / radio frequency contact lists are included in the plans
- Procedures for summoning assistance in the event of a threat that may include:
  - phoning designated co-worker and using code word to initiate a show of presence,
  - use of personal safety strategies like deflecting advances or retreating to a designated shelter-in-place room,
  - calling contracted security services where available at a workplace, or
  - calling 911/community first responders/RCMP.
- Procedures for shelter-in-place

Activity: Please bookmark these resources

FNHA

- OH&S team site home page
  - My Health at Work
  - My Safety at Work
  - My Return to Work
  - Occupational Health and Safety policy documents
- Respectful Workplace Policy – under Resources & Tools

External resources

- WorkSafeBC health care sector resource list
- Preventing violence in Health Care

Thank You!

Thank you for completing this Advanced Safety Orientation module 1 -- Workplace Violence Prevention.

Please make sure you complete the accompanying quiz document so we have a record of your successful completion.

Please proceed to modules 2 and 3 of Advanced Safety Orientation. Once you have submitted all 3 quizzes you will have completed the safety orientation required for all workers by part 3 of the Occupational Health and Safety Regulation.

We wish you all the best in your work at FNHA and hope that you have a safe and enjoyable experience. If you have questions or comments on this training or any other workplace safety topics please contact safetymatters@fnha.ca.

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