Continuing Care Safety Association

Emergency Response to Workplace Violence (Code White) in the Healthcare Sector Toolkit

CCSA and PSHSA License Agreement

CCSA has adapted these violence and aggression prevention tools and resources and we acknowledge the hard work he PSHSA has done in the development and sharing of these valuable resources for our members in the Alberta Continuing Care Industry. Accessing the PSHSA violence prevention materials for use in the Province of Alberta is with the agreement that the terms and conditions will be met under the license agreement between PSHSA and the CCSA.

These documents and resources may have references to the Ontario context and legislative requirements specific to the Province of Ontario. Though the CCSA has adapted these for use in Alberta, users of these resources are still advised to reference the Alberta OHS legislation.

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Introduction

About CCSA

The CCSA or Continuing Care Safety Association is a unique organization that provides industry-specific health and safety training to the Alberta continuing care sector. Taking an unbiased approach, we are able to give the industry and the public facts, data and safety alerts regarding employee health and safety. By assisting members in implementing health and safety training programs, we aim to lower incidences of workplace injury.

In recent years, the health care sector has witnessed an increase in the occurrence of violence and aggressive acts towards staff. In fact, over the last 5 years, "assaults/violent acts/harassment' remains one of the top 5 types of injuries reported to WCB in both long-term care and senior supportive living industries (WCB Industry Reports). We aim to reduce the violence injury rates in continuing care and senior supportive living industries by providing targeted resources to promote the adoption of effective violence prevention initiatives; prevent incidents or injuries caused by violence and acts of aggression and build a more robust culture of safety. The CCSA also aims to guide our members in building their organization's Violence and Harassment Prevention Program through focused consultations and collaboration.

About PSHSA

The Public Services Health & Safety Association (PSHSA) is funded by the Ministry of Labour, Training and Skills Development (MLTSD) and provides occupational health and safety training, resources, and consulting services to reduce workplace risks and prevent workplace injuries and illnesses.
PSHSA serves more than 10,000 organizations and over 1.6 million workers across the province's education and culture, community and healthcare, municipal and provincial government, and emergency services sectors.
The mission at PSHSA is to create safer workplaces through collaboration, innovation, and knowledge transfer. This is done by delivering solutions that address existing and emerging occupational hazards to support stakeholders in establishing and maintaining safe environments and healthy workers.

Making Violence Prevention a Priority in Ontario Healthcare Workplaces

Healthcare workers are a vital part of our health system. They are skilled, caring individuals, dedicated to their duty of care. However, too often they experience acts and threats of violence in the workplace that jeopardize their psychological and physical well-being. Whether violent events originate from care recipients, family members, friends, strangers, other staff, or is a cross over from domestic violence, the impact can be damaging and affect all involved. Violence in healthcare workplaces is further complicated by the varying types of healthcare workplaces (e.g., hospitals, long-term care homes, home and community care settings), each with a different mix of staffing, care recipient needs and workplace violence prevention approaches.
Violence against healthcare workers is a serious issue that demands system-wide attention and action. Provincial statistics suggest that although progress has been made to improve safety on the job, healthcare workers continue to experience one of the highest rates of workplace violence of all workers in Ontario (WSIB EI Database, 2018).
Workers should feel safe and secure at work. Violence must not be tolerated or accepted as part of the job.
In 2015, the Ministry of Labour (now called the Ministry of Labour, Training, and Skills Development) and the Ministry of Health and Long-Term Care (now separated into the Ministry of Health and the Ministry of Long-Term Care) made reducing workplace violence in healthcare organizations a priority. As a first step, a provincial Leadership Table was created to work in partnership with stakeholders

across the sector, including the PSHSA, to develop recommendations and resources to increase awareness of the issue and advance prevention outcomes.

About the VARB Toolkits

The Violence, Aggression, and Responsive Behaviour (VARB) Toolkits are evidence-informed toolkits developed by PSHSA, in collaboration with healthcare partners, to help address violence against healthcare workers. Each toolkit includes prevention strategies and a variety of support materials to help enable robust workplace violence program planning and implementation. The toolkits can be used as a comprehensive resource or accessed as stand-alone resources to address an immediate priority.

Why Focus on Code White

The *Occupational Health and Safety Code* in Alberta requires employers to develop and have in place as part of the workplace violence plan or program, (d) the procedure to be followed by a worker to obtain immediate assistance when an incident of violence occurs; (OHS Code Part 27 (390.2) (d). **One important measure is a formal emergency response to workplace violence, also known as "Code White".** Code White is used in many healthcare settings to alert workers to a real or perceived threat of violence, which includes aggressive or responsive behaviours, and ensures that there is consistency in the response from workers (who know how to respond). It is not the means to summon immediate assistance but rather the response that is triggered once the means to summon immediate assistance is activated.

Although Code White is a commonly used term across hospital and long-term care settings, some employers may be using a different term than Code White, such as *security assist*, *panic button procedure*, or *incident/crisis response team*. Employers may use varied control measures and procedures (for example, personal panic alarms linked to security with wireless or GPS locating type ability) to trigger an emergency (Code White) response for violent incidents.

Toolkit Purpose and Scope

The purpose of this toolkit is to provide information and guidance to assist healthcare employers and Joint Health and Safety Committees (JHSCs) or Health and Safety Representatives (HSRs) in planning and implementing emergency control measures and procedures to effectively respond to violence which includes aggressive or responsive behaviours at the workplace.

The toolkit provides resources and information on good practices that can be incorporated into employers' existing policies, control measures, or procedures used to create new ones where none exist.

The term "Code White" is commonly used in hospital and long-term care settings. Additional guidance and information have been provided in this document for home and community care settings to assist employers in planning and implementing emergency response measures and procedures.

Note: Throughout the toolkit, the term ***care recipient*** is used to refer to a patient, resident, or client who receives care from a healthcare provider in any setting such as hospital, long-term care, or home and community care. The terms *violence* and *violent behaviour* are used to mean violence which includes aggressive or responsive behaviours in the workplace.

To achieve and maintain a safe work environment, we must focus on the potential harm or injury (physical and psychological) to workers or others that a person's violent behaviours may cause, rather than a person's intentions to harm or injure. In the case of a violent care recipient, understanding the intentions behind the violent behaviours are important for developing and implementing an appropriate and fulsome behaviour care plan.

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Code White Basics

In this section Code White is defined. It also includes a discussion about how violence occurs along a continuum and the common risk factors and triggers of violent events.

Under the Emergency Management and Civil Protection Act (1990), healthcare organizations are required to prepare for emergencies, like violence incidents, to ensure **"24/7 timely, integrated, safe, and effective response to, and recovery from emergencies…"**[1]

Code White is a coordinated and trained emergency response to a care recipient, worker, or visitor displaying violent behaviours that may cause harm or injury to others, themselves, and/or is damaging to property.

The purpose of Code White is to:

1. Prevent or reduce harm or injury/illness to workers, others, and the violent person whenever possible.
2. De-escalate a person's violent behaviours and gain control of the situation.
3. Prevent damage to property.

DID YOU KNOW?

When the Ontario Hospital Association emergency colour codes were first standardized in 1993, violent situations were designated the colour *white* based on the common practice of white physical restraint use at that time.

Code White is one of several emergency colour codes standardized for Ontario hospitals by the Ontario Hospital Association (OHA).[2] The OHA recommends that hospitals align with the OHA standardized emergency colour codes to "promote a common language and response, to reduce the amount of information staff must learn and prevent alarming patients and visitors".[2] Implementing standardized emergency colour codes helps eliminate confusion during the response required from workers. Although use of a Code White emergency code may be standardized across healthcare sectors and organizations, the response should be based on leading practice and the organization's unique needs.

A Code White can escalate to a Code Purple, an emergency response to a hostage situation, or Code Silver, an emergency response to a weapons situation. It is important to distinguish these emergency responses from Code White as the policies, measures, and procedures and worker and police roles and responsibilities differ. In home and community care, other terminology may be used to identify Code Purple or Code Silver.

Code White Guiding Principles

Code White should be founded on the following principles:

1. Take prudent action in the face of potentially serious hazards without having to wait for complete scientific proof that a course of action is necessary (i.e., the precautionary principle).
2. Safety is prioritized in the following order: self and other workers, care recipient/visitor, environment.
3. Safe intervention requires organizational-wide and coordinated systems, structures, and resources.

4. Workers are appropriately trained in **Violence Management Techniques**: and the Code White policy before directly responding to violence emergencies.
5. Violent behaviour management and de-escalation techniques are implemented in a respectful, caring, and safe manner.
6. Workers' judgement to initiate a Code White is respected and supported.
7. Least restrictive measures are used, if possible, to ensure safety and security of all.
8. Workers do not intervene in any situation that may pose a risk beyond their resources to intervene safely.
9. Violent incidents, Code White responses, measures, and procedures are promptly, thoroughly, and unbiasedly reported, documented, reviewed, and investigated to prevent recurrences.
10. Workers have access to timely, comprehensive support and assistance whenever needed, including follow-up and referral.

Violence management techniques are the knowledge, skills, and abilities required to safely prevent and manage violence when it occurs or is likely to occur.

Refer to the Definitions section on page 81 for a full description.

Safety is compromised when

- ✘ Workers are not adequately trained in violence management techniques and the Code White policy.
- ✘ Workers are expected to respond to violent situations without appropriate training.
- ✘ Systemic issues exist such as overcrowding, hallway nursing, understaffing, and long wait times.
- ✘ Care recipients, family members, and visitors are not informed about their responsibility to respect workers and/or not held accountable for their violent behaviour.

Understanding Violence

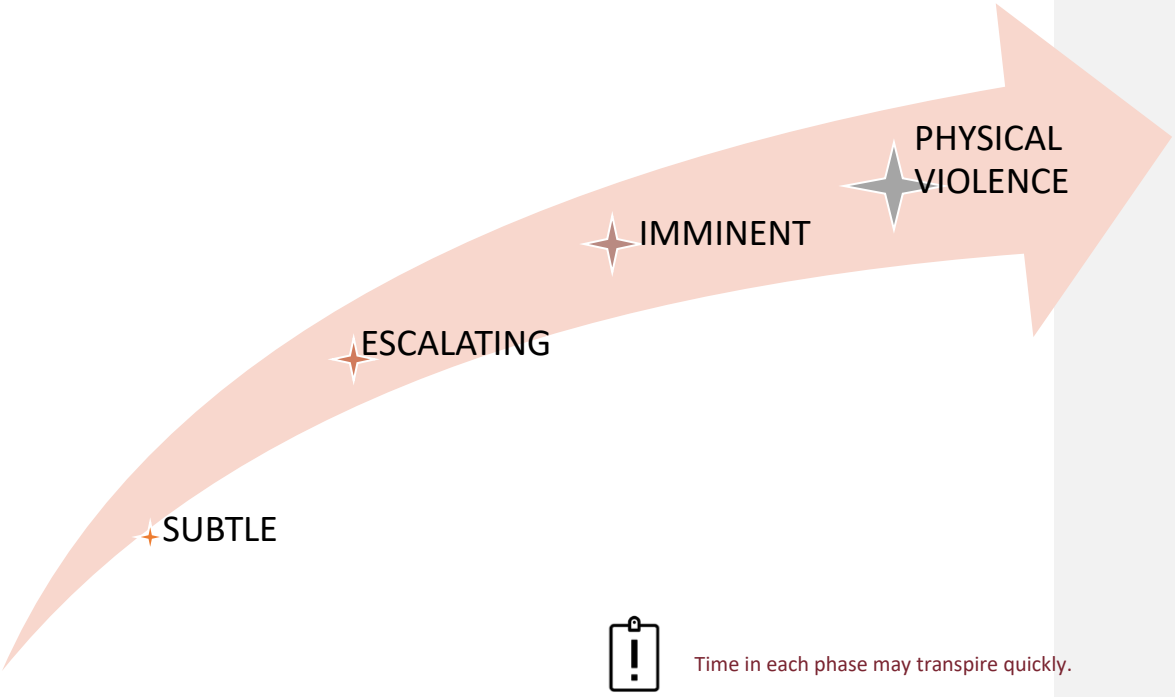
Violence Escalation Continuum

Violence functions along a continuum of behavioural changes. Figure 1 shows a continuum of four phases of violence from *subtle* to *physical violence* and examples of behaviours. This is known as the *Violence Escalation Continuum* (adopted from the Safe Management Group). By thinking about violence as a progression upwards like climbing a staircase, workers can anticipate the behaviours that a person may escalate to and mitigate or prevent physical violence and injury by implementing de-escalation skills or calling a Code White.

Violent behaviours can occur unexpectedly and may not follow the phases of violence progression, particularly with persons:

- Under the influence of alcohol or drugs
- Having a mental health crisis
- Who have a cognitive impairment

For examples of worker responses for each phase of violence, see Appendix A on page 39.



Time in each phase may transpire quickly.

Figure 1. Violence Escalation Continuum

Risk Factors and Triggers

Care recipient and workplace factors may contribute to the risk of violence. It is important to know what these factors are to develop effective violence prevention policies, control measures, and procedures.

The table below lists the common risk factors and triggers for the care recipient and the healthcare setting.[3] This is not an exhaustive list.

Table 1. Common Risk Factors and Triggers of Workplace Violence

	RISK FACTORS	TRIGGERS
	Circumstances or characteristics that predispose a care recipient or situation to the risk of violence, particularly if triggers are present.	***Circumstances or elements that may provoke or negatively impact care recipient behaviour by increasing the likelihood of a violent response.***
Care Recipient	History of violent behaviour Neurocognitive disorder (for example, dementia, delirium, intellectual disability, acquired brain injury, impulse control) High stress with limited supports or coping mechanisms Mental health detention Communication or language barrier Observed behaviours such as: • Physical threats • Attacking objects • Verbal threats • Boisterous • Irritable • Agitated or impulsive • Paranoid or suspicious • Confused • Socially inappropriate or disruptive behaviour • Substance intoxication or withdrawal • Body language • Resisting health care, suicidal ideation	Change of care providers or care plan Undertreated pain Hunger or thirst Physically intrusive care Peri-care Under stimulation Elopement prevention such as door alarms Having a request denied in absence of alternative Hearing unwelcome news related to status, condition, or discharge
Healthcare Setting	Crowding Long wait times Understaffing Sub-optimal staff mix (for example, ratio of experienced to inexperienced staff) Lack of stimulation Sub-optimal violence prevention program, training, and information Healthcare provider factors (for example, training and knowledge, nature of approach, previous interactions with care recipient) Workflow Patient acuity Patient surge Lack of mock drills to test procedures Lack of communication and knowledge transfer during change of care provider	Transition of care Change of shift Loss of care plan continuity Lack of care provider continuity

Adopted from the Workplace Violence Prevention Leadership Table

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Section References

[1] Ministry of Health and Long-Term Care. (2018). *Emergency management guideline, 2018*. http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Emergency_Management_Guideline_2018_en.pdf

[2] Ontario Hospital Association. (2008). *OHA emergency management toolkit: Developing a sustainable emergency management program for the hospital*. https://www.oha.com/Documents/Emergency%20Management%20Toolkit.pdf

[3] Workplace Violence Prevention in Health Care Leadership Table. (n.d.). *Triggers and care planning in workplace violence prevention*. Public Services Health & Safety Association. https://www.pshsa.ca/wp-content/uploads/2017/03/P7_VPRTLCEN0317-Triggers-and-Care-Planning.pdf.

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Code White Response

This section addressed important components of the Code White response including methods to summon immediate assistance.

Preventing Violent Situations

The leading practice is to prevent violent situations from escalating to physical violence and a Code White response. To prevent violence emergencies requiring a Code White response, adequate resources and system infrastructure must be in place. For example, employers should conduct risk assessments, train and share information with workers, and inform care recipients and visitors of their responsibility to respect workers.

Individual Client Risk Assessment

Care recipients can be proactively assessed for risk of violence:

- When they come to an emergency department
- After admission to a unit
- Before transition to another unit
- When violent behaviours are observed or a history of violent behavior is known to the employer or family
- In accordance with the employer's risk assessment policy

Information gathered from individual risk assessments is used for behaviour care planning. For example, the behaviour care plan should include information about what the care recipient's violent behaviours are, the things that trigger the behaviours, and the safety measures to prevent violence.

Organizational Risk Assessment

Organizational risk assessments identify resource need and availability for worker and care recipient safety and quality care delivery (for example, increase staffing on the night shift when more violent incidents occur). Organizational risk assessments should be conducted regularly, as often as necessary, and as part of the post-Code White investigation.

For information on risk assessments, refer to CCSA's Individual Client Risk Assessment (ICRA) and Workplace Violence Risk Assessment (WVRAT) toolkits.

Information, Instruction, and Training

Employers must provide all workers with information, instruction, and training (including refresher training) for two important reasons: (1) so that workers have the knowledge, skills, and abilities to prevent a situation from escalating to physical violence and (2) to safely manage violent incidents when they occur and mitigate injuries.

Share Personal Information

When a worker is expected to encounter a person with (a) a history of violent behaviour during their work, and (b) the risk of workplace violence is likely to expose the worker to physical injury, the employer must

disclose as much information as possible, including personal information, to protect the worker from physical injury.

Personal information about a care recipient with risk of violence may be shared with workers via an organization-wide risk communication system (i.e., flagging). The 'flags' alert workers to implement the organization's safety procedures and to review the care recipient's behaviour care plan for triggers, observed behaviours, and safety measures that may reduce the risk of violent behaviours.

For more information on communicating the risk of violence, refer to the CCSA Toolkit, *Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventative Care*.

Care Recipient and Visitor Responsibilities

Care recipients and their family/visitors have the responsibility to respect healthcare workers. The experience of the illness and disease, treatment, pain, wait times, and the unknown may cause frustration, sadness, fear, or anger. However, these emotions do not give care recipients or their visitors permission to treat workers disrespectfully.

To prevent disrespectful behaviour, employers can put in place a **Code of Conduct** for care recipients and visitors with information about the consequences for non-compliance. Workers should get into the regular practice of proactively informing care recipients and visitors of their responsibilities and the consequences of breaking the code of conduct.

See Appendix B on page 41 for an example Code of Conduct.

When to Initiate a Code White

It is better to call for immediate assistance than to respond to a violence emergency alone.

A Code White is called in situations of real or perceived risk of harm to workers, others, or property. Workers who initiate a Code White should not be challenged as the decision to call for help is a subjective one. To call for immediate assistance, all workers should be given the means to call for immediate assistance (for example, a personal panic button). Figure 2 identifies the situations when a Code White is called.

Appendix C on page 42 illustrates a procedural flowchart for hospitals, long-term care homes, and the home and community care setting.

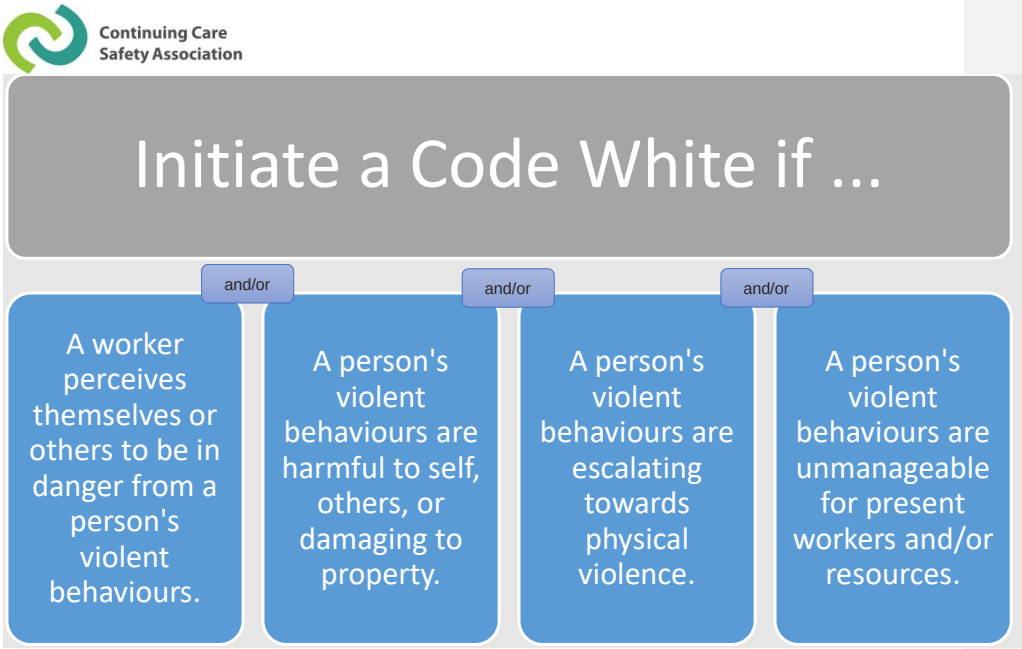

Figure 2. When to Initiate a Code White

When to Call 911/Police

911/police must also be called immediately if there is a real or perceived threat where lives are in danger such as a threat, attempt, or active use of a weapon is made (i.e., Code Silver) or a hostage situation (i.e., Code Purple). Other circumstances when 911/police must be called:

- When the violent behaviour occurs outside the employer's limits of pursuit
- For a hostage situation requiring a Code Purple emergency response
- When a person's violent behaviour escalates beyond security's resources or permitted role
- When there has been an assault (so police can lay charges)

Who Responds to a Code White

Frontline workers such as nurses and personal support workers are often the primary responders to violent situations. However, the expectation of healthcare workers to be regular responders of violent situations may interfere with their primary role to "promote health, prevent diseases and deliver health care services…"[1] For instance, a nurse's use of physical restraints on her care recipient may cause her care recipient to be very angry with her. This anger may lead the care recipient to lash out at the nurse during a later interaction.

On the other hand, the security guard's role (also referred to as security agent or protection agent) in healthcare settings is to guard or patrol for the purpose of protecting persons or property.[2] When working with clinical workers, security guards are the appropriate and recommended choice as primary responders of violent situations and the Code White emergency response.

It is strongly recommended that employers make every effort to use properly trained and qualified security guards as key responders of all violent situations, especially in hospitals. With appropriate training, security guards should have the authority to deal with any violent person in the healthcare facility. Security guards can determine the best course of action such as verbal de-escalation, restraint use, escorting off the property, or detaining for police.

Note: if an employer wants their healthcare workers to take on some of the functions of a security guard, they should be trained to the Canadian General Standard Board's security training standard with enhanced physical skills training.

Refer to the CCSA Security Toolkit for more information on the role security during violent situations.

How to Initiate a Code White

Employers must provide workers with devices that summon immediate assistance when violence occurs or is likely to occur. Methods to initiate a Code White can be structured around preexisting modes of communication, infrastructure, and technological capacity. An audit of the effectiveness of preexisting methods should be completed to ensure they are adequate. Systems for summoning immediate assistance must be developed in consultation with the JHSC/HSR and regularly tested with workers. Examples of devices and systems include:

- **Wireless internet-based communication technology** with two-way voice communication. This technology can determine the location of the person summoning immediate assistance in real-time. Vocera is one company with this technology currently used in some hospitals. *Applicable in hospital and long-term care settings.*
- **Alert button devices** with two-way communication between the person summoning immediate assistance and emergency personnel (for example, 911/police or a live monitoring centre). *Applicable in hospitals, long-term care, and home and community care settings.*

Refer to the CCSA Personal Safety Response System Toolkit for more information on communication and personal safety devices.

It's important that the methods to call for immediate assistance are:

- Consistently reliable and used by management and workers
- Simple and practical for workers to use (for example, not too heavy)
- Immediately accessible
- Immediately heard and responded to
- Directly connected to 911/police and others within response range if working in far proximity from other workers or if working alone
- Connected to wireless technology or satellite that can determine the physical location of the person summoning immediate assistance in real-time

In some sectors, devices should be linked to other workplace parties or emergency services. For example, in the home and community care sector, devices should be linked to emergency services and not to other workers because home and community care workers often work alone. If the current devices are not linked to any party to call for immediate help, employers should continue to use current or interim devices until more appropriate means of summoning immediate assistance are put in place.

Linked parties may include:

- Security guards or other comparably trained workers
- Other staff within response range of the device

- Switchboard/operator who implements an overhead page on a PA or intercom system heard facility-wide
- 911/police or a live monitoring centre in long-term care and home and community care settings

The worker(s) responsible for receiving Code White calls, summons the designated Code White Responders immediately.

Be aware of lack of wireless or satellite service in areas such as basements and rural areas. Make sure that the personal safety response device's GPS or *find* feature is always on. Always check for 'dead zones' and have a contingency plan in place.

Resources and Equipment for a Code White

During a Code White, resources or equipment may be needed to safely manage the situation including:

- Physical, chemical, or environmental restraints (for example, a stretcher with restraints, a padded seclusion room)
- Code White 'kits' that are easily accessible, replenished after use, and checked for expiry dates. They may include:
  - Physical, chemical, or environmental restraints
  - Standing orders for chemical restraints in case a psychiatrist is unavailable
  - Personal protective equipment (i.e., face masks and shields, gloves, gowns, arm guards in different sizes as needed)
  - Towels
  - Self-soothing items like music
  - Hair ties
  - Code White Team Leader vest

Components of a Code White Program

An effective Code White program is comprehensive and addresses:

- Triggers and risk factors
- Trauma-informed care
- Care and management of persons with suicidal and self-harm thoughts and behaviours
- Emergency use of restraints (i.e., physical, chemical, environmental)
- Diseases or illnesses linked to violent behaviours (for example, dementia, delirium, mental health illnesses)
- Chemical substance and/or alcohol intoxication, and withdrawal
- Injury management during Code White
- Behaviour care plans
- Post-Code White response
- Documentation and debriefing
- When Code White requires or becomes a 911/police call

- Systems issues such as long wait times, hallway nursing, and crowding
- Service Level Agreement with police, correctional officer, emergency medical service (EMS), etc. where a potential for violence is known and should be shared with healthcare workers
- Employer assistance for or support of workers filing criminal charges
- Limits of pursuit
- Relevant legislation such as the Mental Health Act and Criminal Code of Canada

Documentation after a Code White

Documentation should happen immediately after a Code White during an immediate debriefing procedure. The documented information will form part of the organizational incident reporting and investigation. See the Immediate Debrief section on page 35 for more information.

Documenting a violent incident, Code White response, and behaviour care plan is important for:

- Improving the Code White policy, measures, and procedures
- Preventing violent incident recurrence
- Communicating with workers about the risk of violence
- Providing a safe environment for workers
- Quality of care

All information about the violent care recipient goes into their medical record. Workers in the circle of care should have access to this information.

The employer must decide how and where violent incident and Code White information is documented, who has access to it, and how the information is communicated to workers. For instance, violent incident and Code White documentation may be managed by the security department because they have the primary role to deal with visitor behaviours.[3]

Documentation, whether in a care recipient's medical record, a worker's personnel file, or separate documentation procedures for visitors should include (but is not limited to):

- Violent person's demographics
- Names of all Code White responders including police
- When and where the incident occurred
- Time to respond to incident location
- Duration of Code White
- Behaviours before and during Code White
- Why the incident occurred i.e., risk factors, triggers (Table 1 on page 8)
- Strategies used to gain control of the person and situation
- Strategies used to prevent recurrences
- How the violent person responded to strategies (effective and ineffective)
- Injuries sustained by all involved

Note, serious incidents should be reported according to OHS Act Part 7 Section 33 (2). Written reports of a worker killed, critically injured, injured and unable to perform usual duties, requiring medical attention, reporting an occupational illness caused by workplace violence or filing a claim (whether allowed or not) with the Alberta Workers Compensation Board (WCB), must also be done.

On an ongoing basis, documentation should include:

- Safety measures to protect workers when providing care to the care recipient with a risk of violence (for example, whether a security guard or police presence is required)
- Implementation, effectiveness, and revisions to the behaviour care plan
- Root cause analysis and recommendations with a timeframe for implementation and person(s) responsible

Code White Quality Improvement

Quality improvement is a continual process that should be built into an organization's Code White policy and workplace violence program. Regularly improving the quality of the Code White response will make the workplace safer for workers and others.

Developing, implementing, and evaluating Code White policy, measures, and procedures must be done in consultation with the JHSC/HSR at least annually or more often if deemed necessary by the JHSC/HSR, or through a risk assessment. Code White policy, measures, and procedures can be evaluated separately or as part of an annual evaluation of the organization's workplace violence prevention program. Evaluation and improvement of the Code White response includes:

A. Monitoring performance and progress by:
   - Seeking input from supervisors, workers who have been involved in Code White events (either from the 'immediate debrief' or in other ways), JHSC/HSR, and union representatives
   - Tracking and analyzing indicators

B. Correcting identified program, policy, measures, procedures, training, or equipment gaps by:
   - Tracking performance metrics and indicators and by seeking input from supervisors, workers, JHSC/HSR, and union representatives
   - Updating program, measures, procedures, training, equipment, or other gaps based on the data

C. Verifying that the policy, measures, and procedures are consistently implemented, operating, and protecting workers by:
   - Consulting with supervisors and workers
   - Identifying gaps in resources

     For example, consider what policies, measures, and procedures would have been applicable in the situations and whether there were appropriate and clear instructions and training for workers to have dealt with the situations
   - Determining whether performance metrics, indicators, and goals are still relevant

See Appendix D on page 46 for a list of performance metrics and indictors.

Section References

[1] World Health Organization. (2021). *Health workforce*. https://www.who.int/teams/health-workforce/health-professions-networks/

[2] Private Security and Investigative Services Act, S.O. 2005, c. 34. https://www.canlii.org/en/on/laws/stat/so-2005-c-34/latest/so-2005-c-34.html

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This section describes roles and responsibilities for Code White responders and for developing, implementing, and sustaining a Code White policy.

Roles and Responsibilities

Employers must put in place formal and written roles and responsibilities for all workplace parties that may be involved in any part of the Code White response. Formal roles and responsibilities facilitate clear understanding of roles, responsibilities, and how to respond to a Code White call. If any worker is unaware of their role and responsibilities during Code White, control of the situation and safety of self and others may be compromised.

Code White responders can be:

- Security guards
- Nurses
- Physicians
- Supervisors/managers
- Clinical administrators
- Allied health workers (for example, personal support workers, social workers, medical technicians)
- Support workers (for example, administrative staff, housekeeping, maintenance, and porters)

WHEN RESPONDING TO A CODE WHITE, REMEMBER TO …

Be aware of surroundings when approaching the area

Secure or remove all loose articles of clothing and jewelry and tie up hair

Know locations of nearest exits

Remove objects that can be used as weapons

If weapons are known or assumed to be involved, call Code Silver and/or security/911/police

Tell the Code White Leader if you're unable to perform a task

Initiating a Code White

All workers must have the authority to initiate a Code White. Once trained by their employer or supervisor, workers are responsible for understanding their employer's Code White policy. They must also know

- How to call a Code White
- How to respond to a Code White
- Their role during and after a Code White
- How to use their personal safety response devise

Refer to Appendix E on page 47 for examples of policies on emergency response to workplace violence (i.e., Code White) for the hospital and long-term care sector, and the home and community care sector. Go to the section references for a list of the policies used to develop the policy templates in this toolkit. [1, 2, 3, 4 5, 6, 7, 8, 9]

Commented [EMF1]: @BOLD – can these endnotes be presented as 1-9 instead as 1,2,3,4, etc

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Code White Responder Roles

Violent or potentially violent situations require several roles to safely manage. The roles include:

☑ Code White Leader

☑ Code White De-escalation Leader

☑ Code White Back-Up for De-escalation Leader (2 suggested)

☑ Code White Responder for limbs if physical restraints are needed (4 required)

☑ Code White Responder to assist with crowd control, retrieving equipment, and administering medications

Code White Leader

The Code White Leader oversees the Code White intervention until completion by organizing, directing, and determining a plan of action. The Code White Leader role can delegate their role to another responder on a temporary or permanent basis during the Code. The Code White Leader can be chosen by a responder announcing their decision to take the Leader role or is preassigned and implemented on a rotation.

The Code White Leader also:

- Gets a verbal report from the first responder (if the Leader is not the first person on the scene)
- Briefs responders upon arrival
- Assigns roles and responsibilities to responders
- Directs responders to remove watches, pens, ties, stethoscopes, lanyards, name tags, glasses, etc. if possible
- Identifies room exit strategies
- Ensures personal protective equipment is available on scene
- Ensures responders are ready before action is taken (for example, seclusion room is available, medication is prepared, restraints are available and have not expired)
- Ensures restraints are applied safely and in accordance with training and organizational policy
- Requests attendance of most responsible physician or nurse practitioner to obtain orders as required
- Requests and communicates with police if required
- Conducts a debrief with responders and witnesses immediately after the Code White
- Participates in an organizational investigation
- Follows-up with care recipient's direct care nurse to assess effectiveness of behaviour care plan and ensures direct care nurse updates the flags in the medical record
- Encourages responders and workers to seek physical and psychological support or treatment as needed (for example, physician or nurse practitioner, peers, on-site psychological services, JHSC/HSR, union)
- Documents incident per organizational policy

Code White De-escalation Leader

The Code White De-escalation Leader uses de-escalation techniques and gives direction, explanation, and support to the violent person to de-escalate the situation. To preserve the rapport between the De-

escalation Leader and person, the De-escalation Leader is the only one who speaks to the person and does not apply restraints. Because of the De-escalation Leader's focus on the person, this role can best determine if or when restraints are needed and communicates this to the Code White Leader.

If the De-escalation Leader becomes the direct target of violence or de-escalation techniques no longer work, the role can be reassigned by the Code White Leader to a Code White Back-Up Responder. Alternatively, the De-escalation Leader can 'tag' themselves out of the role with a Code White Back-Up Responder.

The De-escalation Leader also monitors the person's airway and breathing status (particularly important during physical restraining) and stays with the person until the Code White is complete.

The Code White Leader should facilitate a debrief immediately after a Code White to find out whether workers need physical or psychosocial support and to gather and document details of the violent incident and Code White response.

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Code White Back-Up Responders

At least two Code White Back-Up Responders attend each Code White to support the De-escalation Leader by forming a triangle position (Figure 3). The Back-Up Responder removes the De-escalation Leader from direct contact with the person if necessary, and the De-escalation Leader assumes the role of Back-up Responder.

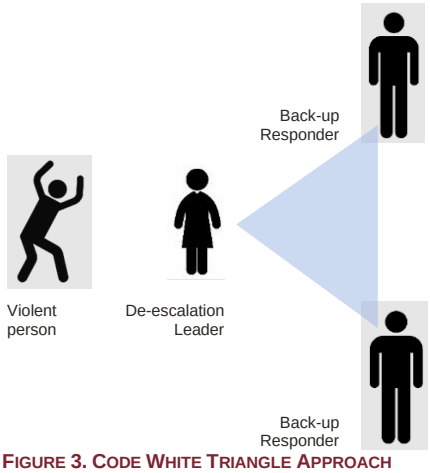

FIGURE 3. CODE WHITE TRIANGLE APPROACH

Other Code White Responders

Code White Responders function in any role including the Code White Leader, De-escalation Leader, Back-Up Responders, and Other Responders. Code White Responders have the following responsibilities:

- Follow instructions of the Code White Leader
- Control the crowd and restrict access to the area

- Retrieve and prepare resources and equipment including restraints and personal protective equipment
- Secure the person until instructed by the Code White Leader to release the person
- Hold limbs while other Responders apply physical restraints per the organizational policy
- Apply physical restraints per the organizational policy
- Escort the person to environmental restraints (i.e., seclusion room)
- Administer chemical restraints as ordered by physician or nurse practitioner
- Report to Code White Leader any injuries to self, co-workers, or person
- Document per organizational policy
- Participate in debrief, investigation, and worker supports

Note: If any Code White responder becomes the direct target of violence or needs to remove themselves for another reason, they can 'tag out' of their Code White role or out of the Code White response altogether. Once a Code White responder 'tag outs', the Code White Leader reassigns the team role to another responder.

Organizational Roles Directly Involved in Code White

Security Guard

The security guard attends all Code Whites and may function in any Code White responder role including the Code White Leader and De-escalation Leader. It's important to remember that the security guard's role (generally used in hospitals and long-term care homes) is to protect the safety and lives of others. When security guards are provided with training in violence management techniques and Code White, they can be experts in many areas such as de-escalation, applying restraints, appropriate use of force, and crisis intervention.

In addition to the responsibilities identified as part of the *Other Code White Responder* responsibilities, a security guard:

- Supports, protects, assists as requested or required
- Follows instructions of the Code White Leader
- Takes control of the situation when danger is imminent
- Physically restrains or applies physical restraints
- Provides support as required post-incident, for example, one-on-one monitoring
- Participates in a debrief, investigation, and worker supports
- Requests and communicates with switchboard/operator and 911/police, if required
- Determines the best course of action for violent visitors (for example, escorting off the property or detaining for police)

If an employer wants their healthcare workers to take on some functions of a security guard, workers should be trained to the Canadian General Standard Board's security training standard with enhanced physical skills.

Workers Directly Involved in a Code White

Workers who call a Code White or are on the scene may be asked by the Code White Leader to help. Properly trained workers should be prepared to take on any Code White responder role. Also, workers directly involved in a violence emergency will stay in self-defense mode and help to:

- Brief the Code White Leader by providing information about the person and situation

- Scan the immediate area for and remove objects that can be used as weapons (for example, chairs, IV poles)
- Locate the closest exits
- Use violence management techniques as needed until security arrives
- Maintain crowd control including restricting access to the area
- Administering medication and retrieving resources or equipment
- Help injured persons
- Participate in the immediate debrief, investigation, and worker supports
- Seek physical and psychological support as needed (for example, physician or nurse practitioner, peers, on-site psychological services, JHSC, union)

Most Responsible Provider—Physician or Nurse Practitioner

Physicians and/or nurse practitioners may take on any Code White responder role. They also respond to a Code White to assess the person's mental health status including the need for certification under the Mental Health Act, treat injuries, or order medications if standing orders do not exist. The responsible physician or nurse practitioner provides follow-up care if the violent person is a care recipient, participates in the immediate debrief and investigation, accesses worker supports if needed, and follows instructions of the Code White Leader. It's also important that the physician or nurse practitioner takes into consideration the safety of all workers at risk when prescribing treatment.

Direct Care Provider

The direct care provider (for example, primary care nurse or personal support worker) makes themselves available to the Code White Leader if or until dismissed from the scene. The direct care provider may take on the role of De-escalation Leader or Back-Up Responder.

Once the Code White is complete, the direct care provider conducts a follow-up assessment of the care recipient, paying attention to their behaviour status and how well the behaviour care plan is working. When any changes are made, the direct care provider updates the behaviour care plan.

The direct care provider communicates this information to the charge nurse, director of nursing, nurse manager, or other workers on the unit as appropriate. The direct care provider calls the Code White Leader, responsible physician, nurse practitioner, or charge nurse with any concerns or questions about the care recipient's behaviour or behaviour care plan.

Charge Nurse, Director of Nursing, or Nurse Manager

The charge nurse, director of nursing, or nurse manager can also function in any Code White responder role. The charge nurse in the hospital, the director of nursing in the long-term care, or the nurse manager in home and community care consults with the care recipient's physician or nurse practitioner to determine changes to the behaviour care plan (including measures to eliminate or minimize risk to workers, medications, and medical treatment). This role reviews the behaviour care plan with workers for understanding and implementation. They also ensure that all methods used (for example, electronic medical records and hardcopy chart, white boards, wristbands) communicate the risk.

Supervisors

Supervisors[10] (and managers, including the charge nurse, director of nursing, and nurse manager roles noted above) may function in any Code White responder role. They also implement, monitor, and evaluate the Code White policy, measures, and procedures, relevant legislation, and documents. In addition, the supervisor:

- Provides workers with written instructions on Code White measures and procedures
- Ensures Code White resources and equipment are always available and functional
- Conducts regular risk assessments to identify gaps in infrastructure, work practices, and system procedures; and makes recommendations to the employer
- Advises workers of any potential or actual risk of violence which workers are not aware of
- Implements and communicates to workers the controls and procedures
- Provides all workers with as much training needed, including refresher training, to respond to Code White safely and competently
- Shares with workers information, including personal information related to the risk of violence from a person with a history of violent behaviour whom workers may encounter
- Ensures documentation and flags of a care recipient's risk of violence including a history of violent behaviour, are in the medical record, white boards, on signage, wristbands, etc.
- Provides workers with a personal safety response system and device with capabilities to summon immediate assistance
- Uses or wears personal safety response device
- Provides physical and psychosocial support to workers exposed to violence and facilitates access to support whenever needed
- Encourages workers to contact their physician, nurse practitioner, mental health professional, JHSC/HSR, employer, or union if needed
- Follows-up with workers exposed to violence to support their psychological health
- Participates in or leads post-Code White debriefs and investigations
- Supports workers who wish to report a violent person to the police
- Informs workers who report violent incidents of the investigation outcome such as actions to be taken to prevent a recurrence, timelines for implementation, and most responsible person(s)

Workers in the Incident Area

Clinical, allied health, and support workers in the unit, department, or area of a Code White respond to the scene and wait for instructions from the Code White Leader. If a responding worker is not assigned a role, they are dismissed from the area. Dismissed workers return to their unit/department or area to care for and support other care recipients and family or return to their duties.

Workers not directly involved in the Code White continue to support care recipients while the Code White is in progress and until the post-Code White immediate debrief has been conducted.

Beyond the Code White roles listed on page 20, the Code White Leader determines who and how many workers stay to help or leave the scene. Workers in the incident area:

- Call a Code White if not called already
- Provide crowd control including removing other care recipients and bystanders
- Restrict access to the area
- Remove dangerous objects from the area
- Retrieve and/or prepare equipment (such as physical restraints)
- Retrieve and/or prepare medications (clinicians only)
- Document about the triggers, observed behaviours, care strategies, and safety measures in the behaviour care plan
- Applies flags per the organization's risk communication/flagging policy (if the violent person's direct care provider is not able to)
- Participate in debrief, investigation, and worker supports
- Seek physical and psychological support as needed

- Documents as required

Switchboard/Operator

The switchboard (i.e., operator or locating) or a front-desk worker in long-term care homes may be responsible for communicating over an organization-wide communication system, that a Code White has been called and when it is completed. The switchboard/operator contacts security, Code White responders, and 911/police as necessary.

In long-term care, if the front-desk worker has the role of operator, the employer must determine how to communicate a Code White when the worker is not at the front desk. For example, front-desk workers in long-term care often work daytime hours only.

Organizational Roles Indirectly Involved in Code White

Joint Health and Safety Committee or Health and Safety Representative

The JHSC/HSR, in consultation with the employer, develops, puts into effect, and evaluates the Code White policy, measures, and procedures including relevant training programs. The JHSC/HSR also helps conduct an annual review (at minimum) of the policy, measures, and procedures in consultation with the employer.

Depending on organizational policies, the JHSC/HSR may be responsible for monitoring implementation of the policy between reviews. The JHSC/HSR is provided appropriate notice about violent incidents that result in injury, illness, critical injury, or death within legislated timeframes. In addition, the JHSC/HSR:

- Reviews incident reports and statistical data
- Makes recommendations to the employer to eliminate and control the risk of violence to workers
- Monitors and ensures recommendations for prevention strategies are followed-up
- Inspects the workplace and considers Code White data
- Participates in investigations on Code White incidents

Employer

The employer oversees the development, implementation, training, evaluation, and sustainability of the Code White policy, measures, and procedures in consultation with the JHSC/HSR. The success of the Code White policy is best accomplished when leadership instills a culture of safety. The employer must appreciate that exposure to one incident of violence can have a psychological impact on workers. Therefore, employer actions should address this reality. Specific to Code White, the employer:

- Takes every precaution reasonable in the circumstances for the protection of workers
- Collects, understands, and evaluates data for policy, measures, procedures, and quality improvement
- Ensures supervisor competency in Code White policy, relevant legislations, investigation, and corrective action
- Provides all workers with training so they may competently and safely respond to Code White emergencies
- Consults stakeholders (for example, JHSC/HSR, risk management, care recipient relations) during appropriate processes and points of time, such as during the annual review, risk management, or incident investigation
- Ensures policy, procedures, and risk assessments are reviewed at least annually or as often as necessary and identifies gaps to make necessary changes to protect workers

- Designates resources for infrastructure to implement and sustain Code White policy [important components of Code White program include a personal safety response system, a communication system i.e. flagging, comprehensive training (including refreshers, mock drills, and evaluation)]
- Reviews and investigates all Code Whites including root cause analysis
- Implements measures and procedures to prevent a recurrence
- Informs workers of steps to prevent recurrence including triggers, observed behaviours, care strategies, measures, and procedures
- Informs workers who report violent incidents of the investigation outcome (for example, actions to be taken, implementation timelines, and most responsible person)
- Supports workers' psychosocial needs (for example, access to mental health specialists or programs, peer support, work accommodations)
- Supports workers who wish to report a violent person to the police
- Trains workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable (for more information about work refusals, refer to the CCSA Work Refusal Toolkit.

Other Departments

Departments such as Occupational Health and Safety, Human Resources, Education, Risk Management, Clinical or Professional Practice, Patient Relations, and Security Department may help to develop, implement, evaluate, or sustain the Code White policy, measures, and procedures. Other responsibilities are to:

- Develop training and evaluation in consultation with JHSC/HSR
- Ensure safety measures are implemented according to timelines and by responsible person(s)
- Investigate incidents and provide recommendations to prevent recurrence
- Provide physical and psychosocial supports to affected workers including work accommodations
- Implement systems for risk identification and communication and training on their purpose and function
- Implement or enhance security team training according to the Canadian General Standard Board's security training standard with enhanced physical skills
- Implement a personal panic alarm system linked to security with wireless or real-time locating technology (GPS)
- Evaluate effectiveness of policy, measures, and procedures

Approaches to Structure a Code White Team

There are two main ways that hospitals and long-term care organizations can put together their Code White team: A **Dedicated Team** or an **All-Worker Team**.

Because workers in home and community care settings are in the community, a team approach to violence emergencies is not appropriate. Go to page 28 on summoning immediate assistance in the community.

The Dedicated Team

A dedicated team approach is associated with positive outcomes including:

- Care recipient needs being met
- Reduced restraint use
- Fewer calls for security assistance

- Reduction in care recipients' violent behaviours
- Improved work satisfaction for nurses
- Improved worker confidence with identifying, managing, and de-escalating behaviours
- Enhanced collaboration among disciplines[11,12,13,14]

Studies show that a dedicated Code White team of primarily mental healthcare providers can effectively manage violent care recipients because of the workers' knowledge and experience of behavioural cognitive abnormalities, use of verbal de-escalation techniques, creation of a therapeutic milieu (i.e., healing atmosphere) and familiarity with medical treatments for violence emergencies.[12,13] On the other hand, some Ontario hospitals successfully use a security-centric approach where only security guards respond to a Code White along with the workers who called the Code White.

The All-Worker Team

The dedicated team approach may not be feasible for some workplaces or settings. For instance, a long-term care home may have too few staff for a dedicated team to be available during every night shift. Home and community care workers work alone and may not have access to co-workers while in the community. For these situations, an all-worker team can be used. With an all-worker team approach, all workers or a large subset of workers are trained to take on all Code White roles and responsibilities.

Whichever approach an employer takes, workers must be trained on how to protect themselves before responding.

Code White Team Examples

Example 1

In a large hospital, a **dedicated team** approach may be used and structured as follows:

SETTING	CODE WHITE TEAM ROLE	ORGANIZATIONAL ROLE
Large hospital	Code White Leader x 1	Security guard
	Code White De-Escalation Leader x 1	Charge nurse
	Back-Up for De-esclation Leader x 2	Security guard Registered nurse
	Code White Responder x 4	Security guard Registered nurse Nurse practitioner Porter
	Code White Responder x 1	Registered nurse

TABLE 1. EXAMPLE OF A DEDICATED CODE WHITE TEAM

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Example 2

In a long-term care home or a smaller hospital, an **all-worker team** approach may be used and structured as follows:

SETTING	CODE WHITE TEAM ROLE	ORGANIZATIONAL ROLE
Long-term care home	Code White Leader x 1	Security guard
	Code White De-Escalation Leader x 1	Registered nurse
	Back-Up for De-esclation Leader x 2	Registered practical nurse Director of nursing
	Code White Responder x 4	Registered practical nurse Personal support worker Personal support worker Occupational therapist
	Code White Responder x 1	Registered practical nurse

TABLE 2. EXAMPLE OF AN ALL-WORKER CODE WHITE TEAM

REMEMBER
CODE WHITE RESPONDER ROLES MAY INCLUDE…

1 x Code White Leader
1 x Code White De-escalation Leader
2 x Code White Back-Ups
4 x Code White Responder for limbs
1 x Code White Responder to help

Considerations for Home and Community Care

Home and community care workers often work and travel alone and do not have immediate access to other workers. Therefore, their Code White policy, measures, procedures, and roles and responsibilities differ than hospitals and long-term care homes.

In addition to the roles and responsibilities outlined above for employers, supervisors, JHSC/HSR, and other departments**, home and community care employers and supervisors**:

- Encourage workers to trust their intuition (refer to the CCSA Care Transition Toolkit which discusses situational awareness)
- Instruct workers not to engage with violent care recipients
- Instruct workers to leave the home or area when danger is perceived, imminent or present
- Train workers to recognize signs and symptoms of escalating and violent behaviours
- Implement technology capable of real-time updates on worker location (for example, a personal panic button that's linked to police and can determine the physical location of the worker)
- Equip workers with a personal safety response device with capabilities to call 911/police
- Ensure personal safety response devices are always functional
- Train workers on the violence emergency policy, measures, and procedures
- Share with workers information, including personal information, related to the risk of violence from a person with a history of violent behaviour
- Require workers to check-in and out-before and after each visit
- Provide workers with physical and psychosocial support and facilitate access whenever needed
- Investigate incidents and inform workers of the steps to prevent a recurrence
- Conduct a debrief with workers once the worker is in a safe place
- Support workers who wish to report a violent person to the police
- Have a **Competent Supervisor** available 24 hours a day, 7 days a week
- Train workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable (for more information about work refusals, refer to the CCSA Work Refusal Toolkit.

For the home and community care worker, the general rule is to be overly cautious, leave the immediate area if there is a risk of violence, and notify the supervisor for guidance on addressing any care recipient, family member, or worker safety concerns. Supervisors should take a no-reprisal approach when a worker determines they cannot safely enter a situation to provide care. For more information on work refusal and disciplinary action complaints see Alberta OHS Act Part 3.

In addition, **home and community care workers** should:

- Understand their employer's emergency response to workplace violence policy, measures, and procedures
- Be competent in violence management techniques
- Not enter home or area if danger is perceived, imminent, or present
- Leave home or area immediately if danger is perceived, imminent, or present
- Conduct and/or ensure assessments completed before visiting care recipient
- Not enter home or area alone if assessments have not been completed
- Know area and safest route out of the location
- Scan geographical area and parking location for hazards before entering home or area
- Identify exits and potential or actual hazards such as weapons and animals inside home or area
- Always carry a personal safety response device provided by the employer with capabilities to call 911/police or live monitoring centre (refer to the section, How to Initiate a Code White on page 14)
- Test personal safety response device before entering a home
- Call 911/police for immediate assistance when danger is perceived, imminent, or present
- Program emergency telephone numbers and alerts into cell phone
- Check-in and out-before with the office before and after each visit

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Training

This section includes suggestions for Code White training topics, examples of training methods, and a training program evaluation model.

The psychological and physical danger that violent situations pose means that all workers must be trained to protect themselves and others, and to safely deal with violent situations. The employer, in consultation with the JHSC/HSR, must develop, establish, and provide health and safety training. Failure to properly train workers places all workers at higher risks for workplace violence.[1]

Training Matrices for Hospitals[2], Long-Term Care[3], and Home Care[4] (on page 40 of the home care toolkit) can help employers assess risk and the associated training required for each workplace or area based on their unique setting, environment, care recipient population, and established training.

Training Methods

Simulation Training

In the training context, a simulation or mock is a near representation of a real scenario or event. Simulated Code White requires the worker to use a higher order cognition. It also requires fast and accurate decision-making and assessment and promotes co-worker dialogue. It provides a realistic, low-risk experience where:[5]

- Knowledge and skills can be practiced and tested
- Error can be committed without harm to self or others
- Deeper cognitive practice skills can improve knowledge retention

Simulated methods have many positive impacts on learners such as: better attitudes, increased knowledge, increased confidence in skills and role, clarity of roles, improved safety, enhanced teamwork, and decreased stress levels during a crisis.[6,7,8,9,10,11,12]

WHAT IS HIGHER-ORDER COGNITION?

Higher-order cognition is the more complex and challenging types of thinking.

Higher-order cognitive skills are more difficult to learn or teach but have more value because they are more likely to be used in a new situation.

Krathwohl (2002)

Commented [EMF3]: @BOLD – this should read 5-11 instead of 5,6,7,8,etc

Multi-modal Training

Although high engagement training methods like simulation give workers the opportunity to practice skills, they are not a substitute for instructional methods. Instruction can provide core information on topics such as policy, roles and responsibilities, and measures and procedures. Learning can be maximized when different methods (instruction and higher engagement training methods) are combined in a blended learning format.[5],[13]

Training Components

All Workers

All workers should receive training in Code White relevant topics. Core training components may include:

- Code White definition and guiding principles
- Code White policy, measures, and procedures
- Relevant policies (for example, emergency use of restraint and seclusion policies)
- Relevant legislation (for example, Mental Health Act, Criminal Code of Canada)
- Roles and responsibilities, including security guards
- Recognizing risk factors and triggers
- Crisis intervention
- Interpersonal skills including those based on an unmet needs model (for example, Gentle Persuasive Approach, Butterfly Model, and Green House Project model)
- Violence management techniques (if taking on some functions of a security guard, Canadian General Standard Board's security training standard with enhanced physical skills)
- Behaviour care planning and implementation
- Person-centred care, trauma-informed care, and emotional approaches to care and communication with persons displaying responsive behaviours
- Restraint use (physical, environmental, chemical), application, and condition of restraints if applicable (for example, expiry date for physical restraints)
- Personal safety response system and device
- Communicating the risk/flagging of violence policy and procedures
- Documenting and reporting incidents, illnesses, or injuries
- Debriefing
- Where and who to go to for support
- Stress prevention and management
- Coping and resilience

Note: workers with physical limitations or restrictions who cannot participate in physical skills must not be assigned hands-on tasks or responsibilities during a Code White that exceed their limitations or restrictions.

Code White Responders

In addition to the core training components listed above, Code White responders may need additional training in:

- Advanced violence management techniques including how to safely move a violent person
- Advanced knowledge in restraint use, such as: safe entry and exit into seclusion room with or without a care recipient, evaluating the condition of restraints (for example, expiry date for physical restraints that includes Velcro and restraint pins), and making sure restraint kit is complete
- Canadian General Standard Board's security training standard with enhanced physical skills if taking on some of functions of a security guard
- Crisis management principles
- Mock Code White scenarios with actors
- Team communication
- Rapid and accurate assessment and decision-making
- Accountability and responsibility
- Sensitive debriefing
- Legal and ethical responsibilities
- Relevant legislation

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Code White responders should train together. Team training has positive impacts like trust, confidence in team members, attitude, coordination, communication, and adaptability.[14] Team training helps to identify strengths and gaps in the team's knowledge and skills. This facilitates continuous improvement.

Training Frequency and Duration

A good practice is to provide initial training to all workers including new staff and then annual or regular refresher training. Refresher training should be delivered annually or as often as needed to ensure workers can competently and confidently implement the skills.

The duration of training sessions and frequency of refresher training should be based, in part, on the level of risk. A risk assessment will assist in decision-making.

Refer to these Training Matrices for Hospitals, Long-Term Care and Home Care to help assess risk and the associated training required for each work setting based its unique factors.

The Centre for Addiction and Mental Health (CAMH) provides Trauma-Informed De-escalation Education (TIDES) for safety and self-protection. It is a three-day training program provided to all new workers working in in-patient units and is provided to all these workers every other year with a one-day physical skills refresher training session in the off year.

They also have 'point of care' facilitators on each unit who, in addition to teaching crisis intervention/self-protection training to other workers on the unit, provide ongoing and regular coaching of taught skills to those workers.

They have found this training content, approach, and frequency to be very effective.

Training Evaluation

Training and evaluation are a time-consuming and resource intensive reality. However, the potentially life-threatening risk of any one violent situation warrants immediate focus on training. And training should occur alongside evaluation for constant quality improvement. Three important reasons for evaluating a Code White training program are to:[15]

- Improve the program
- Maximize transfer of learning to behaviour and subsequent organizational results
- Demonstrate the value of training to the organization

Training effectiveness can be evaluated by looking at the Code White knowledge that workers applied during actual Code White interventions. This information can be used to make improvements to the Code White training program with a goal of improving worker confidence responding to a Code White. This information can also be used to make improvements to the crisis intervention training program because it goes together with the Code White process.

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Post-Code White Response

This section presents intervention recommendations after a Code White is complete.

The purpose of a post-Code White response is to, at minimum:

- Support workers to prevent or reduce trauma-related symptoms
- Determine what caused the violent incident without blame, and implement corrective actions to prevent a recurrence
- Learn and make workplace violence program quality improvements

The post-Code White response includes collecting incident details immediately afterwards to support a root cause analysis and physical and psychological supports for workers.

Immediate Debrief

Debriefing is a routine review of the factual details to learn what happened for the historical record or planning process, improve future results in similar situations or events, and increase the readiness of those being debriefed for further action.[1]

An immediate debrief is conducted as soon as the Code White is complete. The first step in an immediate debrief is to ensure that workers are physically and emotionally okay and identify any worker injuries and supports needed. Once this is done, details, concerns, and recommendations are discussed and documented. Details that are gathered immediately after the Code White ensures that important information is collected while the incident remains clear in workers' minds. The person designated to conduct the debrief can be the Code White Leader or in accordance with organizational policy.

It may seem intuitive to ask workers to recount details with questions like *"What could you/we have done better?"* These types of questions are important to ask. However, they may be interpreted as unsupportive or blaming in nature. Those facilitating the immediate debrief must be sensitive when asking questions. For workers who may be traumatized, it is recommended to conduct the debrief with other witnesses. It is important not to re-victimize the victim.

The immediate debrief is one element of a formal incident investigation but should not be used in place of a formal incident investigation. Workplace violence incident investigation is a formal, organizational investigation of the factors that contributed to the violent incident and subsequent Code White response. Information from the investigation is used to implement solutions to prevent recurrence.

WORKERS AT HIGH RISK OF DEVELOPING ADJUSTMENT DIFFICULTIES AFTER A VIOLENT EVENT

Workers who have acute stress disorder or other clinically significant symptoms caused by trauma

Workers who are bereaved

Workers who have a pre-existing psychiatric disorder

Workers who require medical or surgical attention

Workers whose exposure to the violent event was particularly intense or of long duration

Everly et al. (2006)

In the home and community care sector, the immediate debrief may happen over the phone or have just a few people involved.

Refer to Appendix F of page 70 for an Immediate Debrief Form.

Individualized Worker Supports

Acute or frequent exposure to violent situations, whether direct or indirect, can be traumatic. The exposure to violent situations can have negative short or long-term physical and/or psychological outcomes without appropriate interventions. People exposed to traumatic events may be at risk for negative consequences including post-traumatic stress disorder (PTSD).

Workers with PTSD may experience a range of signs and symptoms associated with functional impairment including:[2]

- Re-experiencing
- Avoidance
- Hyperarousal (including hypervigilance, anger, irritability)
- Negative alterations in mood and thinking
- Emotional numbing
- Dissociation
- Emotional dysregulation
- Interpersonal difficulties or problems in relationships
- Negative self-perceptions including feeling diminished, defeated, or worthless

Refer to the Frontline Healthcare website for more information on PTSD.

DID YOU KNOW?

Psychologically focused debriefing interventions to prevent PTSD or trauma-related stress, whether delivered on an individual basis or in a group setting (models such as Critical Incident Stress Debriefing) do not effectively reduce PTSD and other trauma-related symptoms shortly after a traumatic event or in prevention of longer-term symptoms. There is some evidence that group psychological debriefing may have beneficial effects on alcohol consumption and overall quality of life.

Some experts have called to stop psychological debriefing as an intervention for PTSD prevention altogether.

(Foa et al., 2009; Rose et al., 2002; Tuckey & Scott, 2013; NICE, 2018)

Employer Strategies

Employers should offer supports tailored to workers' needs for as long as needed to reduce severity and duration of trauma reactions, and to feel safe, and regain health and well-being. Workers should not be forced to accept all, or any supports offered. However, employers should encourage workers to engage in support if trauma-related stress is suspected.

An employer can support their workers by:

A. Providing all exposed workers immediately after a violent incident with information about (at minimum)
   - Possible reactions
   - PTSD or trauma-related stress self-assessment tools
   - Who to see for support (for example, their primary care provider like their physician or nurse practitioner, mental health professional or psychological services, co-workers, their employer, JHSC, union, family, friends)
   - How to help themselves.[3,4]

B. Facilitating informal peer support or group debriefing by making a physical space within the facility available and coordinating meeting times. Support from colleagues helps one cope with the effects of violence.[5]

C. Actively monitoring and supporting workers for subthreshold symptoms of PTSD for at least one month after the violent incident. Follow-up contact should take place within one month. If a worker is showing PTSD or trauma-related stress symptoms, the employer should facilitate access to services, such as a mental health professional, and encourage using these services or a visit to their general practitioner. The mental healthcare professional may conduct a PTSD assessment. Follow-up is required if a worker suffers an injury from a violent incident or is distressed over the incident. Workers should also be monitored for cumulative effects if exposed to additional incidents of violence in the future.

> Active monitoring is known as watchful waiting. This means regularly monitoring a person who has some symptoms but who is not currently having clinical intervention for the condition. (NICE, 2018)

D. Flexibility in work accommodations for physically or psychologically injured workers. Recovery times differ for each worker. Therefore, accommodations, such as time away from work to attend treatment sessions must be flexible and supportive.

A good example of ongoing support currently provided in a hospital setting includes a hotline for workers to connect whenever needed in the way that works best for them (for example, by phone, online texting, or meeting in person). It also provides the option of in-person counselling and psychological services for every worker, physician, student, and volunteer.

Worker Strategies

Workers who notice a change in their health after a violent incident can complete a self-assessment tool. Self-assessment tools are not clinical diagnostic tools. Rather, they inform the user of the presence of psychological distress which tells the worker that they should seek help from a mental healthcare professional.

For PTSD or stress-related self-assessment tools, visit:

First Responders First

Canadian Institute for Public Safety Research and Treatment

PTSD Association of Canada

Section References

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Appendix A: Violence Escalation Continuum and Worker Responses to Violent Behaviour

Purpose of this Tool

The purpose of this tool is to provide a diagram of escalating behaviour from **subtle** to **physical violence**, common behaviours for each phase, and worker responses for their safety and the safety of others.

Who Uses this Tool

Hospital and long-term care workers who may encounter care recipients who pose a risk of violence.

How to Use this Tool

This tool can be used in several ways such as posted in nursing stations, break rooms, JHSC/HSR notice board, or other visible areas to workers; as part of worker training; or as a hardcopy available distributed to workers.

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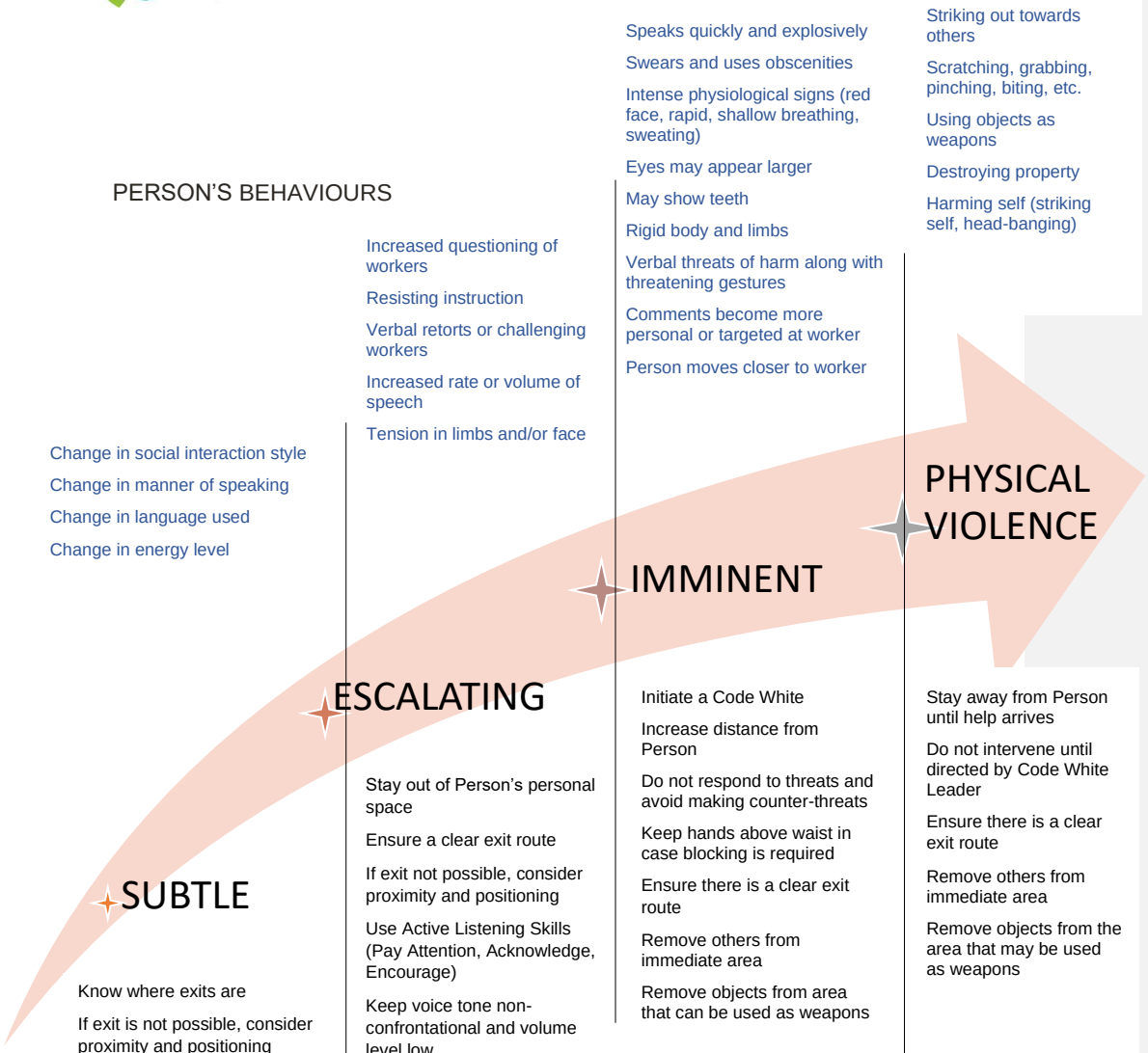

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Appendix B: Code of Conduct for Care Recipients, Families, and Visitors

Purpose of this Tool

The purpose of this tool is to provide a list of behaviours that are expected of care recipients, family, and visitors. All workplace parties should keep in mind that while their responsibilities are to provide quality care, poor behaviour displayed by their care recipients and others should not be tolerated.

Who Uses this Tool

All workplace parties, care recipients, their family, and visitors.

How to Use this Tool

Employers, supervisors, and decision-makers use this tool to add to or combine with their organization's Code of Conduct in its entirety or where one doesn't exist. All workplace parties use this tool for their own knowledge and as a reminder to their care recipients and their care recipients' family or visitors.

The tool can be used in several ways such as being posted in areas visible to care recipients and others (e.g., hospital main entrance, visitor waiting rooms), in care recipient treatment or admissions packages, and part of worker training.

This tool is an example and can be modified to meet the needs of the organization.

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Hospital and Long-term Care Settings

Patient/Resident, Family, and Visitor Code of Conduct

As a Patient/Resident receiving services from [*Organization's name*] you have the responsibility to:

1. Treat your healthcare professionals with respect.
2. Ensure your family members and visitors treat your healthcare professionals with respect.
3. Never abuse your healthcare professionals. Abuse includes threats, yelling, hitting, or making sexual or humiliating remarks. Do not allow any family member or visitor to abuse your healthcare professionals.
4. Participate in your care.

Home and Community Care Settings

Client, Family, and Visitor Code of Conduct

As a Client receiving services from [*Organization's name*] you have the responsibility to:

1. Treat your healthcare professionals with respect.
2. Ensure your family members and visitors treat your healthcare professionals with respect.
3. Never abuse your healthcare professionals. Abuse includes threats, yelling, hitting, or making sexual or humiliating remarks. Do not allow any family member or visitor to abuse your healthcare professionals.
4. Participate in your care.
5. Refrain from smoking tobacco or any other substance while [*Organization's name*] healthcare professionals are in your home.
6. Put all pets in another room behind a closed door while [*Organization's name*] healthcare professionals are in your home.
7. Ensure your driveway, walkway, and stairs are safe and free of snow or ice.
8. Be available at the scheduled time or notify [*Organization's name*] of your need for an alternate visit time.
9. Always obtain the consent of your healthcare professional before photographing or videotaping.

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Appendix C: Flowchart of Emergency Response to Workplace Violence (Code White) Example

Purpose of this Tool

The purpose of this tool is to provide a diagram that represents the process of an emergency response to workplace violence (Code White) in the hospital, long-term care, and home and community care settings.

Who Uses this Tool

All workplace parties.

How to Use this Tool

These flowcharts can be placed in locations visible to workers such as nursing stations and break rooms. They can be included in training materials and made available in hardcopy for workers to take.

The tool is not intended as a training tool by itself. Workers must be trained in several topics so that they are properly prepared to respond to violent incidents. This tool can be used as one component of a training program.

It is recommended that modifying this tool is limited or done only with careful consideration to the organization's workflow operations and in consultation with the Joint Health and Safety Committee or Health and Safety Representative.

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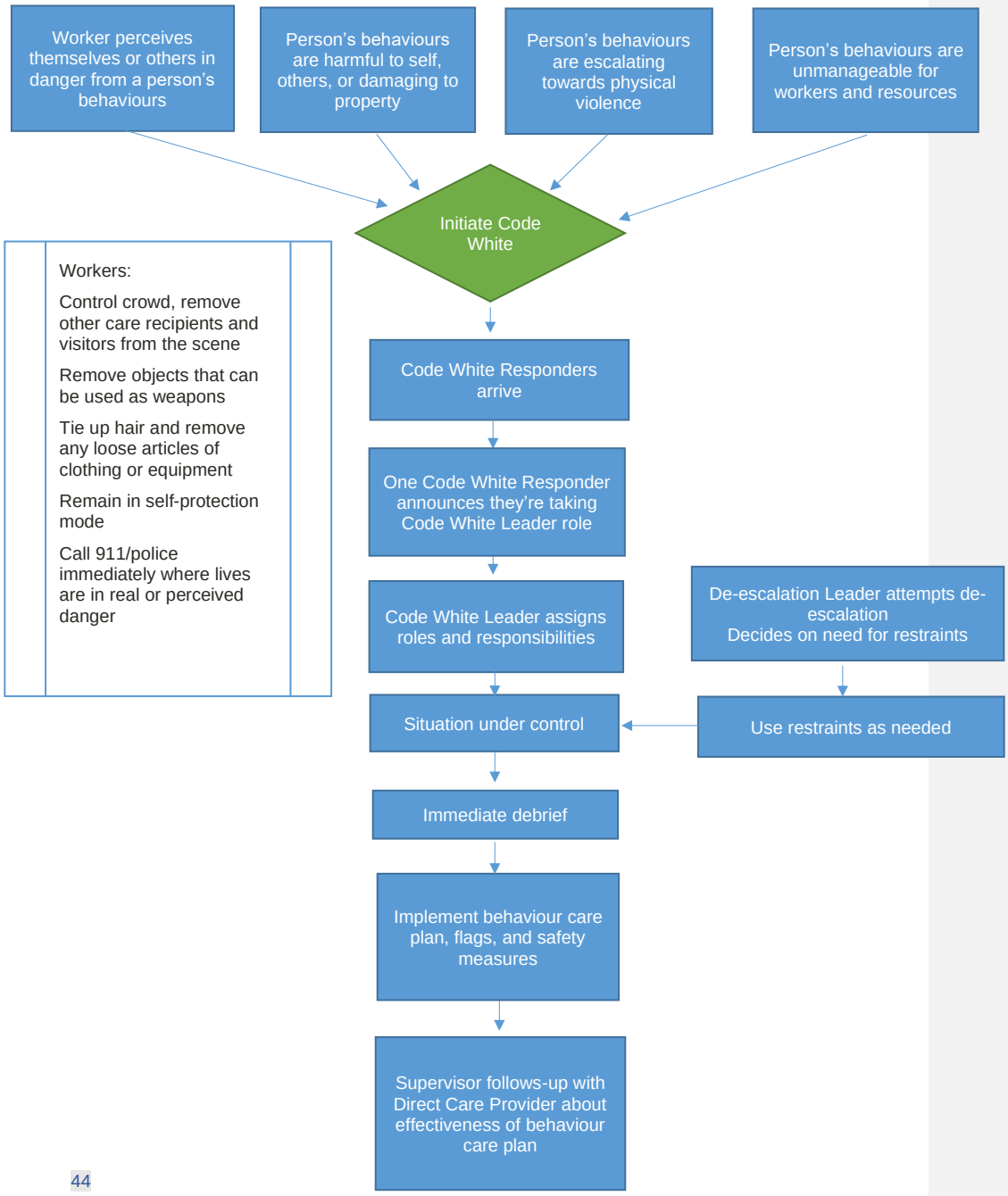
Flowchart for Hospital and Long-Term Care Settings



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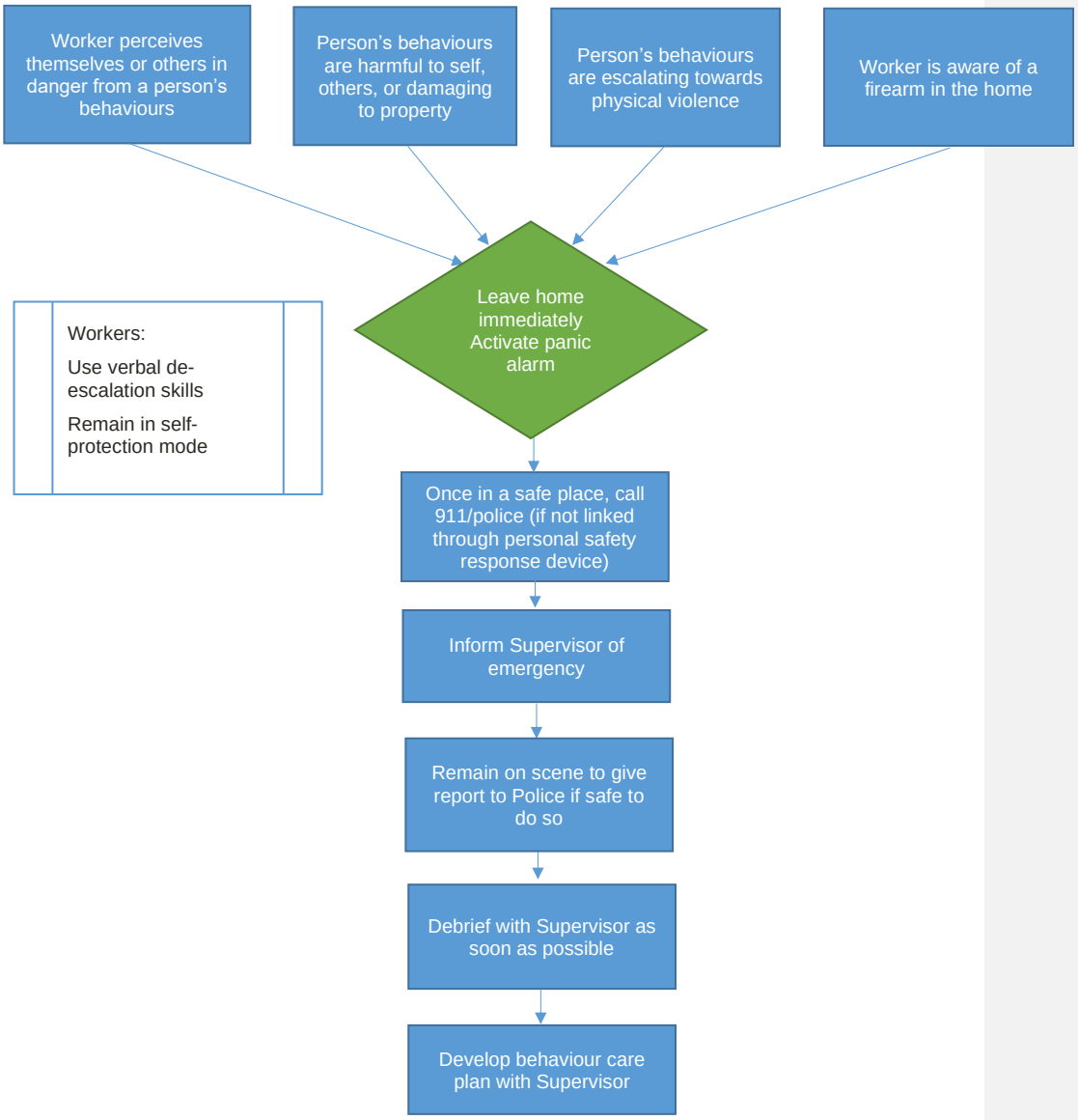
Flowchart for Home and Community Care Setting



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Appendix D: Quality Indicators of Emergency Response to Workplace Violence (Code White)

Purpose of this Tool

The purpose of this tool is to list important indicators of an organization's emergency response to workplace violence (Code White).

Who Uses this Tool

Employers, supervisors, and other decision-makers.

How to Use this Tool

Use this tool to know which indicators to track, monitor, and analyze to reduce violent events and injuries to workers, and to improve your Emergency Response to Workplace Violence (Code White) program.

As part of an organization's evaluation and quality improvement of their emergency response (Code White), track, monitor, and analyze indicators such as the ones below. This is not an exhaustive list.

INDICATOR	CONSIDERATIONS
Types of interventions used during Code White and percentage use of each	For example, verbal de-escalation, security guard presence, physical restraints, chemical restraints, seclusion.
Types of interventions implemented after Code White and percentage use of each	For example, updated or established behaviour care plan (including triggers, observed behaviours, safety measures to protect workers) in the medical record.
Percentage of workers who completed annual Code White training	
Percentage of workers who completed refresher training	
Workers' perceptions of Code White training	For example, after receiving training, ask workers if they know the Code White roles and responsibilities, know how to initiate a Code White, feel confident responding to a Code White, can demonstrate violence management techniques. Surveys can be conducted during JHSC/HSR monthly inspections.
Number of mock Code Whites and percentage of workers who participated	
Percentage of Code Whites that were followed by an immediate debrief	
Percentage of immediate debrief reports that are completed fully and accurately	Quality of reports may indicate effectiveness of system procedures, training, level of knowledge, level of competence.
Percentage of injured workers who were offered support	
Percentage of Code Whites that were formally investigated	Include root cause analysis of supporting factors contributing to violence and the steps to prevent recurrence.
Workers' evaluation of supervisor actions	For example, workers feedback on whether their supervisor conducted a debrief with staff immediately after Code White; communicated the safety measures, timeline for implementing the safety measures, and the person responsible for implementation. Anonymous surveys can be conducted during JHSC monthly inspections.

Appendix E: Emergency Response to Workplace Violence (Code White) Policy Templates

Purpose of this Tool

The purpose of this tool is to provide hospital, long-term care, and home and community care workplaces with an Emergency Response to Workplace Violence (i.e., Code White) Policy template. The policy

should be put in place immediately where one doesn't exist or combined with a policy that's already in place.

Who Uses this Tool

Any workplace party involved in their workplace's the Emergency Response to Workplace Violence (Code White) policy development, implementation, and evaluation.

How to Use this Tool

Customize the template as required to meet your organizational needs. The policy must be developed in consultation with the Joint Health and Safety Committee or Health and Safety Representative. Revisions and customization to this template should be done with careful consideration. Significant changes or removal of important sections may negatively impact worker safety.

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Emergency Response to Workplace Violence (Code White) Policy for Hospital and Long-Term Care Settings

MANUAL: Health and Safety	**SUBJECT:** Emergency Response to a Violent Person	**POLICY NUMBER:** #####
EFFECTIVE DATE: ##-##-####	**REVISED DATE:** ##-##-####	**NEXT REVIEW DATE:** ##-##-####
POLICY REVIEWERS:		
APPROVED BY:		
SENIOR LEADESHIP SIGNATURE:		**JHSC SIGNATURE:**

Table of Contents

Insert here.

Policy Title

Emergency Response to Workplace Violence (Code White) Policy

Policy Purpose

The purpose of this policy is to outline expectations and procedures to (1) respond to a violent care recipient, visitor, or worker on facility property; (2) de-escalate a person's violent behaviours and gain control of the situation; (3) prevent or reduce harm or injury to workers, others, and the violent person whenever possible; (4) prevent damage to property; and (5) provide post-incident support to workers.

Policy Statement

[Organization name] is committed to a safe and healthy workplace for all workers including students, volunteers, care recipients, and others.

[Organization name] understands its obligation to have a workplace violence prevention program, policies, measures, procedures, and training in accordance with the AlbertA *Occupational Health and Safety Act , Regulation and Code* if the organization is a long-term care facility. One of the components of a workplace violence prevention program is to have a means to summon immediate assistance when violence occurs or is likely to occur. This policy outlines the means for summoning immediate assistance and the measures, procedures, and planned response to a situation where a care recipient, family member, visitor, or worker is behaving in a potentially dangerous manner towards themselves or others beyond the abilities of present workers to control the situation.

[Organization name] will ensure that components of the Code White policy meet all requirements under the OHSA and its applicable regulations.

Policy Scope

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

Policy Principles

The *[Organization name]* Code White policy and procedures are founded on the following principles:

1. Take prudent action in the face of potentially serious hazards without having to wait for complete scientific proof that a course of action is necessary (i.e., the precautionary principle).
2. Safety is prioritized in the following order: self and other workers, care recipient/visitor, environment.
3. Safe intervention requires organizational-wide and coordinated systems, structures, and resources.
4. Workers are appropriately trained in **Violence Management Techniques**: and the Code White policy before directly responding to violence emergencies.
5. Violent behaviour management and de-escalation techniques are implemented in a respectful, caring, and safe manner.
6. Workers' judgement to initiate a Code White is respected and supported.
7. Least restrictive measures are used, if possible, to ensure safety and security of all.
8. Workers do not intervene in any situation that may pose a risk beyond their resources to intervene safely.
9. Violent incidents, Code White responses, measures, and procedures are promptly, thoroughly, and unbiasedly reported, documented, reviewed, and investigated to prevent recurrences.
10. Workers have access to timely, comprehensive support and assistance whenever needed, including follow-up and referral.

Note: There are some populations, such as pediatrics, that may require population specific interventions.

Roles and Responsibilities

Code White Leader

- Oversees Code White response
- Organizes, directs, determines plan of action
- Gets verbal report from first Responder (if Leader is not first person on scene)
- Briefs Responders upon arrival
- Assigns roles and responsibilities to Responders
- Directs Responders to remove watches, pens, ties, stethoscopes, lanyards, name tags, glasses, etc. if possible
- Identifies room exit strategies
- Ensures personal protective equipment is available on scene (e.g., Kevlar gloves, spit shields)
- Ensures Responders are ready before action taken (e.g., seclusion room is available, medication is prepared, restraints are available and have not expired)
- Ensures restraints applied safely and in accordance with training and organizational policy
- Requests attendance of most responsible physician or nurse practitioner to obtain orders as required
- Requests and communicates with police if required
- Conducts debrief with Responders and witnesses immediately after Code White
- Documents incident per organizational policy
- Participates in an organizational investigation
- Follows-up with violent person's direct care provider (if a care recipient) to assess effectiveness of behaviour care plan
- Ensures direct care provider updates flags in medical record
- Encourages Responders and exposed workers to seek physical and psychological support or treatment as needed
- Delegates their role to another Responder on a temporary or permanent basis if needed

Code White De-escalation Leader

- Uses de-escalation techniques to try to de-escalate situation
- Gives direction, explanation, and support to violent person
- Only person who speaks to violent person
- Does not apply or administer restraints

- Determines if or when restraints are needed and communicates this decision to the Code White Leader
- Monitors violent person's airway and breathing status (particularly important during physical restraining)
- Remains with violent person at all times until the Code White is complete
- If necessary, assumes the role of Back-up Responder
- 'Tags' out of role if they become direct subject of violent behaviours

Code White Back-Up Responder

- Follows instructions of Code White Leader
- Supports De-escalation Leader by forming a triangle position
- Removes De-escalation Leader from direct contact with violent person

Other Code White Responder

- Functions in any Code White Responder role
- Follows instructions of Code White Leader
- Controls crowd and restricts access to area
- Retrieves and prepares resources and equipment including restraints and personal protective equipment
- Secures violent person until instructed by Code White Leader to release the person
- Holds limbs while other Responders apply physical restraints per organizational policy
- Applies physical restraints per organizational policy
- Escorts violent person to environmental restraints (i.e., seclusion room)
- Administers chemical restraints as ordered by physician or nurse practitioner
- Reports to Code White Leader any injuries to self, co-workers, or person
- Participates in debrief, investigation, and worker supports
- Seeks physical and psychological support as needed
- 'Tags' out of role if they become direct subject of violent behaviours

Security Guard

- Attends all Code White calls
- Functions in any Code White Responder role if trained
- Follows instructions of Code White Leader
- Supports, protects, assists as requested or required
- Takes control of the situation in the event of imminent danger or harm
- Physically restrains or applies physical restraints
- Provides support as required post-incident e.g., one-on-one monitoring
- Participates in a debrief, investigation, and worker supports
- Requests and communicates with switchboard/operator and 911/police if required
- Determines best course of action for violent visitors e.g., escorting off the property, detaining for police

Physician or Nurse Practitioner

- Attends Code White calls
- Takes into consideration the safety of all workers at risk when prescribing treatment
- Follows instructions of Code White Leader
- Assesses violent person's mental health status, including need for certification under Mental Health Act
- Treats injuries
- Applies physical restraints as needed
- Orders medications if standing orders do not exist
- Provides follow-up care to violent person if a care recipient

- Participates in debrief, investigation, and worker supports

Switchboard/Operator or Front Desk Worker (in Long-Term Care)

- Announces Code White over organization-wide communication system or per organizational policy
- Announces Code White response completion over organization-wide communication system or per organizational policy
- Summons security, Code White Responders, 911/police as necessary

Worker in Incident Area

- Responds to scene and follows instructions of Code White Leader
- Initiates Code White if not called already
- Follows instructions of Code White Leader
- Provides crowd control, including removing other care recipients and bystanders
- Restricts access to the area
- Removes dangerous objects from area
- Retrieves and/or prepares equipment (e.g., physical restraints)
- Retrieves and/or prepares medications (clinicians only)
- Applies flag per organizational flagging policy (if direct care provider unable to)
- Participates in debrief, investigation, and worker supports
- Seeks physical and psychological support as needed
- Returns to unit/department to care for and support other care recipients and family or returns to their duties (if not assigned a role)
- Supports care recipients or continues duties while Code White in progress until post-Code White debrief is complete (if not assigned a role)
- Documents triggers, observed behaviours, care strategies, and safety measures to protect workers in behaviour care plan (if direct care provider unable to)

Direct Care Provider (primary care nurse or personal support worker)

- Functions as De-escalation Leader or Back-up Responder roles if trained
- Follows instructions of Code White Leader
- Remains on scene until dismissed by Code White Leader
- Conducts follow-up assessment of violent person (if a care recipient) as soon as possible after Code White
- Communicates information about assessment, triggers, observed behaviours, care strategies, and safety measures in place for workers to Charge Nurse, Director of Nursing, Nurse Manager, or other workers
- Calls Code White Leader, responsible physician, nurse practitioner or Charge Nurse with any concerns or questions about care recipient's behaviour or behaviour care plan

Charge Nurse/Director of Nursing/Nurse Manager

- Functions in any Responder role if trained
- Consults care recipient's most responsible provider about changes to behaviour care plan
- Reviews behaviour care plan with workers
- Communicates risk and flagging information to all workers who may encounter care recipient
- Ensures all relevant methods (e.g., electronic medical records, hardcopy chart, white boards, wristbands, etc.) communicate the risk

Supervisor (including Manager, Charge Nurse, Director of Nursing, Nurse Manager)

- Takes every precaution reasonable in the circumstances to protect workers
- Informs workers of any potential or actual risk of violence of which they are aware
- Develops, implements, monitors, evaluates Code White policy, measures, and procedures
- Understands Code White policy, measures, procedures, relevant legislation, and documents

- Provides workers with written instructions on Code White measures and procedures
- Shares information with worker, including personal information, related to the risk of violence from a person with a history of violent behaviour whom workers may encounter
- Conducts regular risk assessments and makes recommendations to the employer
- Provides workers with a personal safety response device with capabilities to summon immediate assistance
- Ensures personal safety response devices are always functional
- Uses/wears personal safety response device
- Ensures Code White resources and equipment are always available and functional
- Ensures documentation and flags of care recipient's risk of violence included in medical record chart, white boards, care recipient rooms, wristbands, etc.
- Trains workers how to respond safely and competently to potentially violent situations and Code White calls
- Trains workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable
- Informs workers of the steps to prevent a recurrence including triggers, behaviours, care strategies, and safety measures for workers
- Participates and/or leads post-Code White debriefs and investigations
- Informs workers who report violent incidents of investigation outcome
- Provides physical and psychosocial support to workers and facilitates access to support whenever needed
- Encourages workers to get support if needed
- Follows-up with workers to support their psychological health
- Supports workers who wish to report a violent person to the police

Joint Health and Safety Committee/Health and Safety Representative

- Develops, establishes, implements, evaluates Code White policy, measures, procedures, and training (as consulted by employer)
- Reviews annually (at minimum) Code White policy, measures, and procedures
- Monitors policy implementation in between reviews
- Reviews incident reports and statistical data
- Makes recommendations to employer to eliminate and control risk of violence to workers
- Monitors and ensures recommendations for prevention strategies are followed-up
- Conducts workplace inspection and considers Code White data when conducting inspections
- Participates in investigations on Code White incidents

Other Departments (e.g., Occupational Health and Safety, Human Resources, Education, Risk Management, Clinical or Professional Practice, Patient Relations, Security Department)

- Develops, implements, evaluates, and sustains policy, measures, procedures, and training
- Ensures safety measures and procedures are implemented according to timelines and by responsible person(s)
- Investigates incidents and provides recommendations to prevent recurrence
- Provides physical and psychosocial supports to affected workers including work accommodations
- Implements system for risk identification and communication
- Evaluates policy, measures, and procedures for effectiveness

Employer

- Takes every precaution reasonable in the circumstances to protect workers
- Oversees, develops, implements, evaluates, and sustains Code White policy, measures, procedures, and training
- Ensures supervisor competency in Code White and relevant legislations, policies, safety measures, procedures, investigation, and corrective action
- Collects, understands, and evaluates statistical data for policy, measures, procedures, and quality improvement

- Provides all workers with as much training needed to respond safely and competently to Code White
- Consults stakeholders (e.g., JHSC/HSR, risk management, care recipient relations, etc.) during appropriate processes and points of time (e.g., annual review, risk management, incident investigation)
- Ensures policy, procedures, and risk assessments are reviewed at least annually or as often as necessary
- Identifies policy and program gaps to make necessary changes to protect workers
- Builds infrastructure to support Code White policy, measures, and procedure implementation and sustainability (e.g., personal safety response system, seamless reporting system, risk of communication/flagging system for in- and out-patient units)
- Designates resources for infrastructure to implement and sustain Code White policy (important components of Code White program include a personal safety response system, a risk communication/flagging system, comprehensive training including refreshers, mock drills, and Code White policy evaluation)
- Reviews and investigates all Code Whites including root cause analysis
- Implements control measures and procedures to prevent recurrence
- Informs workers of steps to prevent a recurrence including triggers, behaviours, care strategies, measures, and procedures put in place to protect their safety
- Informs workers who report violent incidents of the investigation outcome such as actions to be taken, timelines for implementation, and most responsible person(s)
- Supports psychosocial needs of exposed workers
- Supports workers who wish to report a violent care recipient to the police
- Trains workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable

Procedures

This section provides examples of Code White procedures. Customize this section based on your organizational operations and to support an effective response to Code White calls.

Guidelines for Maintaining Safety for All	a. Any worker can initiate a Code White. b. Do not delay in calling for help. c. Scan area and remove objects that can be used as weapons. d. Remove other care recipients and visitors from the area. e. Approach the violent person only if there is enough help. Do not approach the person alone. f. Contain or isolate the violent person where the behaviour occurs to reduce the risk of injury to others and the person. g. Do not attempt to move or sedate a struggling person without adequate personnel. Clinical discretion should be used to determine when to move the violent person and when sedation is required.
Who Responds to a Code White	*The Employer decides which workers are trained to respond to a Code White. If security guards are employed, they should always respond to Code White emergencies given their primary occupational role to protect the safety of others and property. Clinical, allied health, and support workers acting in the capacity of security guards should also be trained to the same level as security guards (Canadian General Standards Board for security plus physical skills) if the Employer requires them to respond to Code White emergencies.*

When to Call Code White	• A worker perceives themselves or others to be in danger from a person's behaviours that are violent (e.g., verbally or physically disturbing, hostile, threatening) ***AND/OR*** • A person is behaving in violent ways that are harmful to self, others or damaging to property ***AND/OR*** • A person displays violent behaviours that are escalating towards physical violence ***AND/OR*** • A person displays violent behaviours that are unmanageable for present workers and/or resources.
When to Call Code White Assist	• A person is verbally agitated or hostile, a worker calls a Code White Assist to request assistance from security • The situation is escalating or perceived to be escalating
When to Call 911	• There is a real or perceived threat that lives are in danger • A weapon or hostage is involved • A violent person is beyond Code White responders' abilities to control
Activate a Code White	Code White is called by using one of the following mechanisms: A. **Dial [O*rganization's phone number*] for direct access to Switchboard**. Give the following information: i. Violent care recipient/visitor/worker ii. Exact location (unit, floor, details on area) Switchboard calls a Code White overhead. **B. Personal Safety Response Device** Activate distress feature to summon immediate assistance when violence occurs or is likely to occur from the linked workplace party(s) (e.g., security department). The device should enable two-way communication between the person summoning immediate assistance and emergency personnel with capability to inform the worker that help has been notified and is on the way. **C. Activate (Silent) Alarm** Alarm buttons (which may or may not be silent) are located in various departments/areas. They are used when it is difficult to access a phone. The (silent) alarm is linked to Switchboard/Operator who will initiate a Code White overhead.
During Code White Response Procedures	*Populate this section with the Roles and Responsibilities from this document. Customize as required. See example below.* CODE WHITE LEADER • Oversees Code White intervention • Organizes, directs, determines plan of action

	• Gets verbal report from first responder (if Leader is not first person on scene) • Briefs Responders upon arrival • Assigns roles and responsibilities to Responders • Directs Responders to remove watches, pens, ties, stethoscopes, lanyards, name tags, glasses, etc. if possible • Identifies room exit strategies • Ensures personal protective equipment is available on scene (e.g., Kevlar gloves, spit shields) • Ensures Responders are ready before action taken (e.g., seclusion room is available, medication is prepared, restraints are available and have not expired) • Ensures restraints applied safely and in accordance with training and organizational policy • Requests attendance of most responsible physician or nurse practitioner to obtain orders as required • Requests and communicates with police if required
After Code White Response Procedures	*Populate this section with the Roles and Responsibilities from this document. Customize as required. See example below.* CODE WHITE LEADER • Conducts debrief with Responders and witnesses immediately after Code White • Participates in an organizational investigation • Follows-up with care recipient's direct care provider to assess effectiveness of behaviour care plan • Ensures direct care provider updates flag alert in medical record • Encourages Responders and exposed workers to seek physical and psychological support or treatment as needed (e.g., physician, nurse practitioner, peers, on-site psychological services, JHSC, union) • Documents incident per organizational policy • Can delegate their role to another Responder on a temporary or permanent basis

Equipment

List all equipment needed during Code White and the location in the facility where they are located. See example below.

Equipment needed to safely manage a Code White situation include:

- Physical, chemical, or environmental restraints (e.g., stretcher with restraints ready when needed, padded seclusion room)
- Code White 'kits' are easily accessible, replenished as needed, checked for expiry dates, and may include:
  - Physical or chemical restraints
  - Standing orders for chemical restraints in case a psychiatrist is not available
  - Personal protective equipment (face masks and shields, protective gloves, gowns, arm guards in different sizes as needed)
  - Towels
  - Self-soothing items like music
  - Hair ties

- Code White Team Leader vest

Documentation

Indicate person(s) responsible for completing the Immediate Debrief Form (Appendix F on page 70) and who receives the documentation.

Communication

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

Training

[Organization], in consultation with the JHSC/HSR, will develop, establish, and provide violence emergency proficiency-based training to all workers. New employees will receive this training at orientation. Workers will receive refresher training when changes (new or revisions) to the Code White policy, measures, or procedures are put in place. Ongoing refresher training will be provided on a regular basis. Supervisors are required to participate in training appropriate to their assigned duties. *[Organization]* will keep training records which will include names of workers trained, training received, topics covered, and training dates.

Evaluation

A review of this policy, related procedures, and data collected will be completed in consultation with the JHSC/HSR at least annually or more often if deemed necessary by the JHSC/HSR or through a reassessment of risk. The review will evaluate policy content, application, and performance outcomes. Senior management will consider recommendations when setting subsequent goals and objectives, coordinating training, and allocating program resources. *See Appendix D on page 46 for a list of possible metrics.*

Related Documents

Customize this section to include the applicable organizational documents such as policies, procedures, forms, legislations, and references. Example documents are:

- Emergency use of restraints and maintenance of restraints
- Criteria for environmental restraints (i.e., seclusion)
- Medication administration
- Presence of weapons
- Staffing protocols
- Post-incident response policies and procedures including safety plans
- Documentation requirements and responsibilities
- Investigation recommendations for control measures and procedures
- Protocols for alcohol withdrawal, chemical substance intoxication, dementia protocols, prisoner protocols, psychiatric clients (including observation levels), suicidal/self-harming clients
- Transfer protocols with EMS, corrections, and police
- Triage and admission of violent care recipients to the Emergency Department
- Emergency Codes e.g., Code Purple, Code Silver, Lockdown
- Formal care recipient or visitor complaint process
- Employer assistance for workers when filing criminal charges
- Risk identification/tracking and risk communication/flagging system
- Limits of pursuit

Definitions

Aggression: hostile or violent behaviour or attitudes.

Behaviour Care Plan: a written plan that details the care to be provided to prevent or control violent behaviours. It is developed by a clinical healthcare worker or team in collaboration with the care recipient and/or substitute decision-maker when possible.

Breakaway: strategies to remove oneself safely from various holds, grabs, and pulls while at the same time not physically compromising the aggressor.

Care Recipient: a general term used for a patient, resident, or client who receives care from a healthcare provider.

Chemical Restraint: medications used to modify or restrict behaviour.

Code White: a coordinated and trained emergency response to a care recipient, visitor, worker, physician, contractor, or student displaying violent behaviours that may cause harm or injury to others, themselves, and/or is damaging to property.

Code Purple: a coordinated and trained emergency response to a hostage situation involving a care recipient, worker, or visitor where enhanced police response is required.

Code Silver: a coordinated and trained emergency response to care recipient, visitor, or worker in possession of a weapon where enhanced police response is required.

Competent Supervisor: a supervisor, as appointed by an employer, who:

a. is qualified because of knowledge, training, and experience to organize the work and its performance,
b. is familiar with the Occupational Health and Safety Act and the regulations that apply to the work, and
c. has knowledge of any potential or actual danger to health or safety in the workplace.

De-escalation: interventions and techniques to reduce or eliminate violence during a period of escalation. Interventions can include the following:

a. Engaging persons who are displaying violent behaviours by establishing a bond with them and maintaining a rapport and connection.
b. Decision-making about the optimal time to intervene based on knowledge of the violent person, the meaning and danger of the violent behaviour, and the resources available in the setting.
c. Assessing safety of the area and the situation.
d. Using verbal and non-verbal skills (e.g., using a calm and gentle tone of voice, body language, posture, eye contact and active listening) to de-escalate the person.

Emergency: a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.

Emergency Restraint Use: use of restraints without consent in the event of a serious threat of harm to the person or others and only after all alternative interventions are unsuccessful.

Environmental Restraint: limiting a person's surroundings to restrict or control movement (i.e., seclusion).

Escalation: violent behaviour that is increasing in intensity and/or magnitude.

Family: individuals who are related biologically, emotionally, or legally to and/or have close bonds (friendships, commitments, shared households and child-rearing responsibilities, and romantic attachments) with the care recipient. A care recipient's family may include all those whom the care recipient identifies as significant in their life. The care recipient determines the importance and level of involvement of any of these individuals in their care based on their capacity.

Flag: a visual and/or electronic alert used to:

- Inform workers of a risk of violent behaviours
- Signal additional and individualized care needs and preventive measures

Flagging: see definition of Risk Communication System.

Harm: an impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and/or death.

Health and Safety Culture: the collective individual and group values, attitudes, beliefs, perceptions, and behaviour that determine the organization's commitment to health and safety. These values, ideas, and beliefs affect the mental and physical wellbeing of all workers.

Hospital Setting: healthcare facilities that provide a range of care such as acute care (e.g., emergency or surgical care), specialized treatment (e.g., trauma centres, treatment centres for chronic treatment, birthing centres), and hospice care.

Immediate Debrief: an immediate collection and review of details of a violent incident and Code White intervention.

Incident: an occurrence, condition, or situation arising in the course of work that resulted in, or could have resulted injuries, illnesses, damage to health or fatalities.

Incident Investigation: a collection, review, and analysis of incident details and contributing factors by the employer in collaboration with workers to determine root causes, and develop and implement control measures and procedures to mitigate risk and prevent recurrence.

Individual Client Risk Assessment: a systematic process used by clinical healthcare workers to evaluate a care recipient's likelihood of violent behaviour.

Injury: with respect to occupation, an occurrence, which is neither expected nor planned, resulting in personal injury and/or property damage due to an exposure or conditions at the workplace.

Least Restraint: a restraint intervention used with a violent care recipient which is the least restrictive possible yet will allow Code White responders to regain control of the situation.

Limits of Pursuit: limits set by the employer as to how far outside of the facility workers are authorized to respond to a violent person before it becomes a police response.

Near Miss: an act of striking out, which misses the target.

Physical Restraint: a device that restricts or controls movement or behaviour. They may be attached to a person's body or create physical barriers.

Precautionary Principle: an approach for "protecting workers in circumstances of scientific uncertainty, reflecting the need to take prudent action in the face of potentially serious hazards without having to await complete scientific proof that a course of action is necessary."

Post-Traumatic Stress Disorder: a trauma and stressor-related disorder that can occur in people who have experienced or witnessed a traumatic event.

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

Risk Communication System: a standardized method to communicate safety concerns to workers.

Risk Factor: circumstance or characteristic that may increase the likelihood that violence may occur, particularly if triggers are also present. It predisposes a person or situation to the risk of violence. Examples might include a history of violence or delirium with paranoia.

Root Cause Analysis: a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it.

Self-Defence: self-defence is the use or threat of force in the defence of oneself or a third party to the criminal offence of assault. Refer to section 34 of the Criminal Code for explanation of the three required elements of self-defence.

Situational Awareness: the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning, and the projection of their status in the near future. It describes a person's awareness and understanding of "what is happening" around them and "what could happen" if hazards and risk are not addressed.

Trauma-Informed Care: a strengths-based framework grounded in the understanding of and responsiveness to the impact of trauma. The framework emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Trigger: a circumstance or element that may provoke or negatively impact care recipient behaviour by increasing the likelihood of a violent response or reaction. It precipitates violence. Examples might include undertreated pain, loud alarms, care to a sensitive part of the body, requests that can't be accommodated or behaviours of care recipients or visitors in close proximity.

Use of Force: the amount of effort needed to compel compliance by a violent person.

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

Violence Management Techniques: the knowledge, skills, and abilities required to safely prevent and manage violence when it occurs or is likely to occur. The techniques include (but are not limited to) de-escalation, self-defense, self-protection, breakaway, detaining and holding, use of force, restraint use, and situational awareness. These techniques are learned through appropriate and repeated training provided by the employer.

Violent Person: a person who displays behaviours that are verbally or physically aggressive, and intentional or unintentional in nature that may or may not harm or injure others.

Visitor: any person who enters the workplace who is not a care recipient, worker, contractor, or student.

Weapon: any object that could cause harm used in a threatening manner towards another person or self.

Worker: an employee of a healthcare organization. They can be a clinical healthcare worker, allied healthcare worker, manager, administrative personnel, physician, student, security guard, or any individual who has a working relationship with the healthcare organization.

Workplace Violence: under the OHSA section 1, workplace violence means:

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

b. an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,

c. a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker

Continuing Care Safety Association

Emergency Response to Workplace Violence Policy for Home and Community Care Settings

MANUAL: Health and Safety	**SUBJECT:** Emergency Response to a Violent Person	**POLICY NUMBER:** #####
EFFECTIVE DATE: ##-##-####	**REVISED DATE:** ##-##-####	**NEXT REVIEW DATE:** ##-##-####
POLICY REVIEWERS:		
APPROVED BY:		
SENIOR LEADESHIP SIGNATURE:		**JHSC SIGNATURE:**

Table of Contents

Insert here

Policy Title

Emergency Response to a Violent Person in their Home or Community

Policy Purpose

The purpose of this policy is to outline expectations and procedures to (1) respond to a violent care recipient, family, or visitor in the home or community setting; (2) de-escalate a person's violent behaviours and gain control of the situation; (3) prevent or reduce harm or injury to workers, others, and the violent person whenever possible; and (4) provide post-incident support to workers.

Policy Statement

[Organization name] is committed to a safe and healthy workplace for all workers including students, volunteers, care recipients, and others.

[Organization name] understands its obligation to have a workplace violence prevention program, policies, measures, procedures, and training in accordance with the *Occupational Health and Safety Act (OHSA)* and the *Health Care Residential Facilities Regulation 67/93*. One of the components of a workplace violence prevention program is to have a means to summon immediate assistance when violence occurs or is likely to occur. This policy outlines the means for summoning immediate assistance and the measures, procedures, and planned response to a situation where a care recipient, family member, visitor, or worker is behaving in a potentially dangerous manner towards themselves or others beyond the abilities of present workers to control the situation.

[Organization name] will ensure that components of the Emergency Response to Workplace Violence policy meet all requirements under the OHSA and its applicable regulations.

Policy Scope

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

Continuing Care Safety Association

Policy Principles

The *[Organization's]* violence emergency response policy and procedures are founded on the following principles:

1. Take prudent action in the face of potentially serious hazards without having to wait for complete scientific proof that a course of action is necessary (i.e., the precautionary principle).
2. Safety is prioritized in the following order: self and other workers, care recipient/visitor, environment.
3. Safe intervention requires organizational-wide and coordinated systems, structures, and resources.
4. Workers are appropriately trained in **Violence Management Techniques**: and the Code White policy before directly responding to violence emergencies.
5. Violent behaviour management and de-escalation techniques are implemented in a respectful, caring, and safe manner.
6. Workers' judgement to initiate a Code White is respected and supported.
7. Least restrictive measures are used, if possible, to ensure safety and security of all.
8. Workers do not intervene in any situation that may pose a risk beyond their resources to intervene safely.
9. Violent incidents, Code White responses, measures, and procedures are promptly, thoroughly, and unbiasedly reported, documented, reviewed, and investigated to prevent recurrences.
10. Workers have access to timely, comprehensive support and assistance whenever needed, including follow-up and referral.

Roles and Responsibilities

Home and Community Care Worker

- Understands employer's violence emergency to workplace violence policy, relevant policies, measures, and procedures
- Competent in violence management techniques
- Conducts and/or ensures risk assessment completed prior to visiting care recipient
- Always carries personal safety response device provided by employer with capabilities to call 911/police or a live monitoring centre
- Tests alarm prior to entering home
- Programs emergency telephone numbers and alerts into cell phone
- Checks in and out before with the office before and after each visit
- Does not enter home or area alone if assessments haven't been completed
- Knows area and safest route out of care location
- Scans geographical area and parking location for hazards before entering home or area
- Does not enter home or area if danger is perceived, imminent, or present
- Identifies exits and potential or actual hazards such as weapons and animals inside home or area
- Leaves home or area immediately if danger is imminent or present
- Once in a safe place (e.g., worker's car), calls 911/police for immediate assistance when danger is perceived or imminent
- Activates personal panic alarm when danger is perceived or imminent
- Stays in a safe place until police arrive
- Be available to police should police have questions
- Calls supervisor to inform them of violent incident
- Participates in a debrief with supervisor soon after incident
- Documents incident in care recipient's medical record
- Participates with supervisor and JHSC/HSR in developing behaviour care plan
- Ensures risk of violence is flagged in medical record or per organizational policy

- Informs supervisor of any physical or psychological injuries
- Seeks treatment for any physical or psychological injuries

Intake/Office Worker

- Conducts risk assessments prior to visit
- Provides worker with risk assessments prior to visit
- Manages workers' arrival and departure procedures
- Requires care recipient sign a contract stating their understanding that care will be terminated if a visiting worker experiences violent behaviours in the care recipient's home

Supervisor

- Takes every precaution reasonable in the circumstances to protect workers
- Informs workers of any potential or actual risk of violence of which they are aware
- Understands emergency response to workplace violence policy, measures, procedures, relevant legislation, and documents
- Provides workers with written instructions on emergency response to workplace violence measures and procedures
- Develops, implements, monitors, evaluates emergency response to workplace violence policy, measures, and procedures
- Develops, implements, monitors, and evaluates worker safety procedures specifically designed for lone workers
- Conducts regular risk assessments and makes recommendations to the employer
- Shares information with worker including personal information, related to the risk of violence from a person with a history of violent behaviour whom workers may encounter
- Provides workers with a personal safety response device with capabilities to summon immediate assistance from 911/police or live monitoring centre, and real-time updates on worker location
- Ensures personal safety response devices are always functional
- Ensures documentation and flags of care recipient's risk of violence included in medical record chart before worker visits care recipient's home
- Trains workers how to respond safely and competently to potentially violent situations
- Encourages workers to trust their intuition
- Requires workers to check in and out before and after each visit
- Instructs workers to not engage with violent care recipients and leave the home or area when danger is perceived, imminent, or present
- Trains workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable
- Informs workers of the steps to prevent a recurrence including triggers, behaviours, care strategies, and safety measures for workers
- Investigates incidents
- Informs workers who report violent incidents of investigation outcome
- Conducts debrief with worker once the worker is in a safe place
- Provides physical and psychosocial support to workers and facilitates access to support whenever needed
- Encourages workers to get support if needed
- Follows-up with workers to support their psychological health
- Supports workers who wish to report a violent person to the police
- Have a **Competent Supervisor** available 24 hours a day, 7 days a week

Joint Health and Safety Committee/Health and Safety Representative

- Develops, establishes, implements, evaluates emergency response to workplace violence policy, measures, procedures, and training (as consulted by employer)
- Reviews annually (at minimum), policy, measures, and procedures
- Monitors policy implementation in between reviews
- Reviews incident reports and statistical data
- Makes recommendations to the employer to eliminate and control the risk of violence to workers
- Monitors and ensures recommendations for prevention strategies are followed-up
- Conducts workplace inspection and considers Code White data when conducting inspections
- Participates in investigations on violent incidents

Employer

- Takes every precaution reasonable in the circumstances to protect workers
- Oversees, develops, implements, evaluates, and sustains emergency response to workplace violence policy, measures, procedures, and training
- Ensures supervisor competency in emergency response to a violent person and relevant legislations, policies, safety measures, procedures, investigation, and corrective action
- Collects, understands, and evaluates statistical data for policy, measures and procedures, and quality improvement
- Provides all workers with training relevant to their work and in response to a violent person to demonstrate and maintain competence for safety
- Consults stakeholders (e.g., JHSC/HSR, risk management, care recipient relations, etc.) during appropriate processes and points of time (e.g., annual review, risk management, incident investigation)
- Ensures policy, procedures, and risk assessments are reviewed at least annually or often as necessary
- Identifies policy and program gaps to make necessary changes to protect workers
- Develops check-in procedures, and co-worker buddy procedures (or per organizational policy)
- Builds infrastructure to support emergency response to workplace violence policy, measures, and procedure implementation and sustainability (e.g., personal safety response system, seamless reporting system, risk communication system for in- and out-patient units)
- Designates resources for:
    - Infrastructure (e.g., personal alarm system linked to security with wireless or GPS type locating, reporting system, data collection, risk communication system)
    - Communication devices and alerts
    - Information, training, and mock drills, including refreshers
    - Evaluating emergency response to workplace violence training program effectiveness
- Reviews and investigates all violent incidents including root cause analysis
- Implements control measures and procedures to prevent recurrence
- Informs workers of steps to prevent recurrence including triggers, behaviours, care strategies, measures, and procedures put in place to protect their safety
- Informs workers who report violent incidents of investigation outcome such as actions to be taken, timelines for implementation, and most responsible person(s)
- Supports psychosocial needs of exposed workers (e.g., access to mental health specialists or programs, peer support, work accommodations)
- Supports workers who wish to report violent care recipient to police
- Trains workers about the right to refuse unsafe work while being mindful of their professional college standards, if applicable

Continuing Care Safety Association

Procedures

This section provides examples of violence emergency procedures. Customize this section based on your organizational operations and to support effective responses to violence emergencies.

Guidelines for Maintaining Safety for All	a. Conduct risk assessments prior to home visit. b. Do not delay in calling 911/police. c. Do not enter the home/area if feeling unsafe. d. Ensure personal safety response device is in working order and has cell tower service.
Who Responds to a Violence Emergency	911/police are called to respond to all violence emergencies in the home and community care setting.
When to Call 911/Police	• A worker perceives themselves or others to be in danger from a person's behaviours that are violent (e.g., verbally or physically disturbing, hostile, threatening) ***AND/OR*** • A person is behaving in violent ways that are harmful to self, others or damaging to property ***AND/OR*** • A person displays violent behaviours that are escalating towards physical violence ***AND/OR*** • A worker is aware of a firearm in the home
Calling for Immediate Assistance When Violence Occurs or is Likely to Occur	*Populate this section with the Roles and Responsibilities from this document. Customize as required. See example below.* WORKER • Activate personal safety response system or device linked to police/911 • If the care recipient is displaying violent behaviours, leave the home or area • Once in a safe place (e.g., worker's car), call 911/police • Remain in a safe place until police arrive • Remain available to police should they have questions • Call supervisor to inform them of violent incident
After Violent Incident Procedures	*Populate this section with the Roles and Responsibilities from this document. Customize as required. See example below.* WORKER • Participates in a debrief with supervisor soon after incident • Documents incident in care recipient's medical record • Participates with supervisor and JHSC/HSR in developing behaviour care plan • Ensures risk of violence is flagged in medical record or per organizational policy • Informs supervisor of any physical or psychological injuries • Seeks treatment for any physical or psychological injuries

Equipment

A list of equipment and resources needed during violence emergency procedures are listed here.

Documentation

Indicate person(s) responsible for completing the Immediate Debrief Form (Appendix F on page 70) and who receives the documentation.

Communication

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

Training

[Organization name] in consultation with the JHSC/HSR will develop, establish, and provide violence emergency proficiency-based training for all workers. New employees will receive this training at orientation. Workers will receive refresher training when changes (new or revisions) to the emergency response to workplace violence policy, measures, or procedures are put in place. Ongoing refresher training will be provided on a regular basis. Supervisors are required to participate in training appropriate to their assigned duties. *[Organization]* will keep training records which will include names of workers trained, training received, topics covered, and training dates.

Evaluation

A review of this policy, related procedures, and data collected will be completed in consultation with the JHSC/HSR at least annually or more often if deemed necessary by the JHSC/HSR or through a reassessment of risk. The review will evaluate program content, application, and performance outcomes. Senior management will consider recommendations when setting subsequent goals and objectives, coordinating training, and allocating program resources. *See Appendix D on page 46 for a list of possible metrics.*

Related Documents

Customize this section to include the applicable organizational documents, such as policies, procedures, forms, legislations, and references. Example documents are:

- Emergency use of restraints and maintenance of restraints
- Criteria for environmental restraints (i.e., seclusion)
- Medication administration
- Presence of weapons
- Staffing protocols
- Post-incident response policies and procedures including safety plans
- Documentation requirements and responsibilities
- Investigation recommendations for control measures and procedures
- Employer assistance for workers when filing criminal charges
- Risk identification/tracking and risk communication system

Definitions

Aggression: hostile or violent behaviour or attitudes.

Behaviour Care Plan: a written plan that details the care to be provided to prevent or control violent behaviours. It is developed by a clinical healthcare worker or team in collaboration with the care recipient and/or substitute decision-maker when possible.

Breakaway: strategies to remove oneself safely from various holds, grabs, and pulls while at the same time not physically compromising the aggressor.

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Code White: a coordinated and trained emergency response to a care recipient, visitor, worker, physician, contractor, or student displaying violent behaviours that may cause harm or injury to others, themselves, and/or is damaging to property.

Code Purple: a coordinated and trained emergency response to a hostage situation involving a care recipient, worker, or visitor where enhanced police response is required.

Code Silver: a coordinated and trained emergency response to care recipient, visitor, or worker in possession of a weapon where enhanced police response is required.

Competent Supervisor: a supervisor, as appointed by an employer, who:

a. is qualified because of knowledge, training, and experience to organize the work and its performance,
b. is familiar with the Occupational Health and Safety Act and the regulations that apply to the work, and
c. has knowledge of any potential or actual danger to health or safety in the workplace.

De-escalation: interventions and techniques to reduce or eliminate violence during a period of escalation. Interventions can include the following:

a. Engaging persons who are displaying violent behaviours by establishing a bond with them and maintaining a rapport and connection.
b. Decision-making about the optimal time to intervene based on knowledge of the violent person, the meaning and danger of the violent behaviour, and the resources available in the setting.
c. Assessing safety of the area and the situation.
d. Using verbal and non-verbal skills (e.g., using a calm and gentle tone of voice, body language, posture, eye contact and active listening) to de-escalate the person.

Emergency: a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.

Emergency Restraint Use: use of restraints without consent in the event of a serious threat of harm to the person or others and only after all alternative interventions are unsuccessful.

Environmental Restraint: limiting a person's surroundings to restrict or control movement (i.e., seclusion).

Escalation: violent behaviour that is increasing in intensity and/or magnitude.

Family: individuals who are related biologically, emotionally, or legally to and/or have close bonds (friendships, commitments, shared households and child-rearing responsibilities, and romantic attachments) with the care recipient. A care recipient's family may include all those whom the care recipient identifies as significant in their life. The care recipient determines the importance and level of involvement of any of these individuals in their care based on their capacity.

Flag: a visual and/or electronic alert used to:

- Inform workers of a risk of violent behaviours
- Signal additional and individualized care needs and preventive measures

Flagging: see definition of Risk Communication System.

Harm: an impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and/or death.

Health and Safety Culture: the collective individual and group values, attitudes, beliefs, perceptions, and behaviour that determine the organization's commitment to health and safety. These values, ideas, and beliefs affect the mental and physical wellbeing of all workers.

Home and Community Care Setting: care provided in home and community settings and includes care in these settings provided by public health.

Immediate Debrief: an immediate collection and review of details of a violent incident and Code White intervention.

Incident: an occurrence, condition, or situation arising in the course of work that resulted in, or could have resulted injuries, illnesses, damage to health or fatalities.

Incident Investigation: a collection, review, and analysis of incident details and contributing factors by the employer in collaboration with workers to determine root causes, and develop and implement control measures and procedures to mitigate risk and prevent recurrence.

Individual Client Risk Assessment: a systematic process used by clinical healthcare workers to evaluate a care recipient's likelihood of violent behaviour.

Injury: with respect to occupation, an occurrence, which is neither expected nor planned, resulting in personal injury and/or property damage due to an exposure or conditions at the workplace.

Least Restraint: a restraint intervention used with a violent care recipient which is the least restrictive possible yet will allow Code White responders to regain control of the situation.

Limits of Pursuit: limits set by the employer as to how far outside of the facility workers are authorized to respond to a violent person before it becomes a police response.

Near Miss: an act of striking out, which misses the target.

Physical Restraint: a device that restricts or controls movement or behaviour. They may be attached to a person's body or create physical barriers.

Precautionary Principle: an approach for "protecting workers in circumstances of scientific uncertainty, reflecting the need to take prudent action in the face of potentially serious hazards without having to await complete scientific proof that a course of action is necessary."

Post-Traumatic Stress Disorder: a trauma and stressor-related disorder that can occur in people who have experienced or witnessed a traumatic event.

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

Risk Communication System: a standardized method to communicate safety concerns to workers.

Risk Factor: circumstance or characteristic that may increase the likelihood that violence may occur, particularly if triggers are also present. It predisposes a person or situation to the risk of violence. Examples might include a history of violence or delirium with paranoia.

Root Cause Analysis: a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it.

Self-Defence: self-defence is the use or threat of force in the defence of oneself or a third party to the criminal offence of assault. Refer to section 34 of the Criminal Code for explanation of the three required elements of self-defence.

Situational Awareness: the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning, and the projection of their status in the near future. It describes a person's awareness and understanding of "what is happening" around them and "what could happen" if hazards and risk are not addressed.

Trauma-Informed Care: a strengths-based framework grounded in the understanding of and responsiveness to the impact of trauma. The framework emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Trigger: a circumstance or element that may provoke or negatively impact care recipient behaviour by increasing the likelihood of a violent response or reaction. It precipitates violence. Examples might include undertreated pain, loud alarms, care to a sensitive part of the body, requests that can't be accommodated or behaviours of care recipients or visitors in close proximity.

Use of Force: the amount of effort needed to compel compliance by a violent person.

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

Violence Management Techniques: the knowledge, skills, and abilities required to safely prevent and manage violence when it occurs or is likely to occur. The techniques include (but are not limited to) de-escalation, self-defense, self-protection, breakaway, detaining and holding, use of force, restraint use, and situational awareness. These techniques are learned through appropriate and repeated training provided by the employer.

Violent Person: a person who displays behaviours that are verbally or physically aggressive, and intentional or unintentional in nature that may or may not harm or injure others.

Visitor: any person who enters the workplace who is not a care recipient, worker, contractor, or student.

Weapon: any object that could cause harm used in a threatening manner towards another person or self.

Worker: an employee of a healthcare organization. They can be a clinical healthcare worker, allied healthcare worker, manager, administrative personnel, physician, student, security guard, or any individual who has a working relationship with the healthcare organization.

Workplace Violence: under the OHSA section 1, workplace violence means:

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

e. an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,

f. 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

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Appendix F: Immediate Debrief Form

Purpose of this Tool

The purpose of this tool is to collect and document information about the response to a violent person in a healthcare workplace.

Who Uses this Tool

The worker designated the responsibility to facilitate the immediate debrief.

How to Use this Tool

This tool is completed immediately after an emergency response to a violent person (Code White) has ended. One responder (e.g., Code White Leader, Charge Nurse) facilitates a debrief with all responders and workers affected by the incident. This form should be included as an element of the organization's formal incident investigation of the incident.

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Immediate Debrief Form for Hospitals and Long-term Care Homes

File #:

Date:

Time Code Called:

Time Code Ended:

Time first Code White Responder Arrived on Scene:

Specific Location:

Name of Person involved in Incident:

Person is a … (*Check ☑ one)*

- ☐ Care recipient
- ☐ Visitor of Care Recipient
- ☐ Worker
- ☐ Known to Worker
- ☐ Other – Specify

Names and Occupational Role of Responders:

1. What behaviours did the Person display? *Check ☑ all that apply*.

- ☐ Verbal (threats or harassment)
- ☐ Physical
- ☐ Self-harm
- ☐ Exit seeking
- ☐ Property destruction
- ☐ Other – *Describe*

2. What interventions were used *before* Code White Responders arrived? *Check ☑ all that apply*.

- ☐ Verbal de-escalation

- ☐ **Environmental restraints (i.e., seclusion)**
- ☐ **Chemical restraints (i.e., medication)**
- ☐ **Physical restraints**
- ☐ **Hands-on**
- ☐ **Other – *Describe***

3. What interventions were used *during* the Code White? *Check ☑ all that apply*.

- ☐ **Verbal de-escalation**
- ☐ **Environmental restraints (i.e., seclusion)**
- ☐ **Chemical restraints (i.e., medication)**
- ☐ **Physical restraints**
- ☐ **Hands-on**
- ☐ **Other – *Describe***

4. Was a Physician or Nurse Practitioner called to attend the Code White?

- ☐ **Yes ——————▶ Physician/Nurse Practitioner Name: _____**
- ☐ **No**

5. Were Police called to attend the Code White?

- ☐ **Yes**
- ☐ **No**

If *Yes*, what are the names of the Police officers who attended?

If *No*, will Police be contacted and informed of the incident?

- ☐ **Yes**
- ☐ **No**

6. Was anybody injured?

- ☐ **Yes**
- ☐ **No**

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If *Yes*, who was injured? *Check ☑ all that apply*.

- ☐ **Worker** → **How many?**
- ☐ **Violent person**
- ☐ **Other care recipient** → **How many?**
- ☐ **Other** → **How many?**

7. Did the Code White response work well?

- ☐ **Yes**
- ☐ **No**
- ☐ **Somewhat**

If *No* or *Somewhat*, what could have been done differently?

8. What was the first sign of escalation?

9. Is there anything that could have prevented the incident?

10. Was a Worker Safety Plan (for example, flags/communication of risk plan) in place for the Person prior to the incident?

- ☐ **Yes**
- ☐ **No**

If *Yes*, what are the safety strategies?

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11. ***Answer if Violent Person was a Care Recipient.***

Was the Care Recipient prescribed PRN medication for agitation prior to the incident?

- ☐ **Yes**
- ☐ **No**

If *Yes*, date and time last administered:

12. What new or revised worker safety strategies will be implemented as part of the Behaviour Care Plan?

Think about proactive steps to prevent violent behaviour escalation.

Strategies must be recorded in the Behaviour Care Plan and communicated to Workers who may encounter the Person.

13. A Code White requires flags to be implemented. If flags will not be implemented, why not?

14. Were supports or resources requested by any Worker?

- ☐ **Yes**
- ☐ **No**

If *Yes*, what was requested?

15. Were supports or resources offered to any Worker (for example, first aid, peer support, professional mental health services)?

- ☐ **Yes**
- ☐ **No**

If *Yes*, what was offered?

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Name of Worker responsible for filing this Debrief form (hardcopy and/or electronically):	
Name of Worker who conducted Debrief:	

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Immediate Debrief Form for Home and Community Care Settings

File #:	
Date:	
Time Worker called for assistance:	
Time Emergency Response ended:	
Time first Responder arrived on scene:	
Specific Location:	
Name of Person involved in Incident:	
Person is a … (*Check ☑ one*)	☐ **Care recipient** ☐ **Visitor of Care Recipient** ☐ **Worker** ☐ **Known to Worker** ☐ **Other – Specify**

1. What behaviours did the Person display? *Check ☑ all that apply*.

- ☐ Verbal (threats or harassment)
- ☐ Physical
- ☐ Self-harm
- ☐ Exit seeking
- ☐ Property destruction
- ☐ Using animal or pet as a threat
- ☐ Talking about or showing a firearm

2. What was the first sign of escalation?

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3. Were Police called to attend the scene?

☐ Yes

☐ No

If *Yes*, what are the names of the Police officers who attended?

If *No*, will Police be contacted and informed of the incident?

☐ **Yes**

☐ **No**

4. Was anybody injured?

☐ **Yes**

☐ **No**

If *Yes*, who was injured? *Check ☑ all that apply*.

☐ **Worker**

☐ **Care recipient**

☐ **Other**

5. Is there anything that could have prevented the incident?

6. Was a Worker Safety Plan (for example, flags/communication of risk plan) in place for the Person prior to the incident?

☐ **Yes**

☐ **No**

If *Yes*, what are the safety strategies?

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7. What new or revised worker safety strategies will be implemented as part of the Behaviour Care Plan?

Think about proactive steps to prevent violent behaviour escalation.

Strategies must be recorded in the Behaviour Care Plan and communicated to Workers who may encounter the Person.

8. Were supports or resources requested by the Worker?

☐ **Yes**

☐ **No**

If *Yes*, what was requested?

9. Were supports or resources offered to the Worker (for example, first aid, peer support, professional mental health services)?

☐ **Yes**

☐ **No**

If *Yes*, what was offered?

Name of Worker responsible for filing this Debrief form (hardcopy and/or electronically):	
Name of Worker who conducted Debrief:	

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How the Toolkit was Developed

This toolkit was developed and informed by the following information and evidence:

- scientific and grey literature;
- advice and input from the project's Steering Committee (see acknowledgements section for the list of organizational contributors);
- expertise of and input from the project Design and Development Consultation Forum, a group that was assembled for the purpose of this project and represented a broad range of individuals working in different healthcare settings (acute, long-term care, community care, employer associations, labour unions) and organizational levels in a variety of roles (frontline care providers, union representatives, supervisors, health and safety professionals, Joint Health and Safety Committee members, and Co-Chairs);
- practices used in jurisdictions or by employers across Canada (the scan was focused on Canadian provinces and employers in Ontario identified by Steering Committee members, other research, or through participation on the Design and Development Consultation Forum and having done notable work in these areas); and
- expertise of PSHSA's occupational health and safety consultants

The project team used the information collected from the above sources to develop this toolkit.

Acknowledgements

PSHSA would like to acknowledge and thank everyone who participated in the process – including the VARB Steering Committee who guided the process and informed the development of this toolkit. We could not have developed this toolkit without the Steering Committee's commitment, leadership, expertise, and input.

Organizations Represented on VARB Steering Committee

Addictions & Mental Health Ontario (AMHO) / Ontario Federation of Community Mental Health and Addiction Programs
AdvantAge Ontario
Canadian Union of Public Employees (CUPE)
Guelph General Hospital (GGH)
Health Shared Services Ontario (HSSO)
Home Care Ontario (HCO)
Institute for Work and Health (IWH)
Ministry of Health (MOH)
Ministry of Labour, Training and Skills Development (MLTSD)
Ontario Community Support Association (OCSA) / Personal Support Network of Ontario
Ontario Hospital Association (OHA)
Ontario Long-Term Care Association (OLTCA)
Ontario Nurses' Association (ONA)
Ontario Personal Support Workers Association (OPSWA)
Ontario Public Service Employees Union (OPSEU)
Registered Nurses' Association of Ontario (RNAO)
Registered Practical Nurses Association of Ontario (WeRPN)
Service Employees International Union (SEIU)
Unifor

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Definitions

Aggression: hostile or violent behaviour or attitudes.

Behaviour Care Plan: a written plan that details the care to be provided to prevent or control violent behaviours. It is developed by a clinical healthcare worker or team in collaboration with the care recipient and/or substitute decision-maker when possible.

Breakaway: strategies to remove oneself safely from various holds, grabs, and pulls while at the same time not physically compromising the aggressor.

Care Recipient: a general term used for a patient, resident, or client who receives care from a healthcare provider.

Chemical Restraint: medications used to modify or restrict behaviour.

Code White: a coordinated and trained emergency response to a care recipient, visitor, worker, physician, contractor, or student displaying violent behaviours that may cause harm or injury to others, themselves, and/or is damaging to property.

Code Purple: a coordinated and trained emergency response to a hostage situation involving a care recipient, worker, or visitor where enhanced police response is required.

Code Silver: a coordinated and trained emergency response to care recipient, visitor, or worker in possession of a weapon where enhanced police response is required.

Competent Supervisor: a supervisor, as appointed by an employer, who:

a. is qualified because of knowledge, training, and experience to organize the work and its performance,
b. is familiar with the Occupational Health and Safety Act and the regulations that apply to the work, and
c. has knowledge of any potential or actual danger to health or safety in the workplace. (OHSA section 25)

De-escalation: interventions and techniques to reduce or eliminate violence during a period of escalation. Interventions can include the following:

a. Engaging persons who are displaying violent behaviours by establishing a bond with them and maintaining a rapport and connection.
b. Decision-making about the optimal time to intervene based on knowledge of the violent person, the meaning and danger of the violent behaviour, and the resources available in the setting.
c. Assessing safety of the area and the situation.
d. Using verbal and non-verbal skills (e.g., using a calm and gentle tone of voice, body language, posture, eye contact and active listening) to de-escalate the person.

Emergency: a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.

Emergency Response to Workplace Violence: *see the definition of Code White.*

Environmental Restraint: limiting a person's surroundings to restrict or control movement (i.e., seclusion).

Escalation: violent behaviour that is increasing in intensity and/or magnitude.

Family: individuals who are related biologically, emotionally, or legally to and/or have close bonds (friendships, commitments, shared households and child-rearing responsibilities, and romantic

attachments) with the care recipient. A care recipient's family may include all those whom the care recipient identifies as significant in their life. The care recipient determines the importance and level of involvement of any of these individuals in their care based on their capacity.

Flag: a visual and/or electronic alert used to:

- Inform workers of a risk of violent behaviours
- Signal additional and individualized care needs and preventive measures

Flagging: see definition of Risk Communication System.

Harm: an impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and/or death.

Health and Safety Culture: the collective individual and group values, attitudes, beliefs, perceptions, and behaviour that determine the organization's commitment to health and safety. These values, ideas, and beliefs affect the mental and physical wellbeing of all workers.

Home and Community Care Setting: care provided in home and community settings and includes care in these settings provided by public health.

Hospital Setting: healthcare facilities that provide a range of care such as acute care (e.g., emergency or surgical care), specialized treatment (e.g., trauma centres, treatment centres for chronic treatment, birthing centres), and hospice care.

Immediate Debrief: an immediate collection and review of details of a violent incident and Code White intervention.

Incident: an occurrence, condition, or situation arising in the course of work that resulted in, or could have resulted injuries, illnesses, damage to health or fatalities.

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

b. an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker, or;

c. a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

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