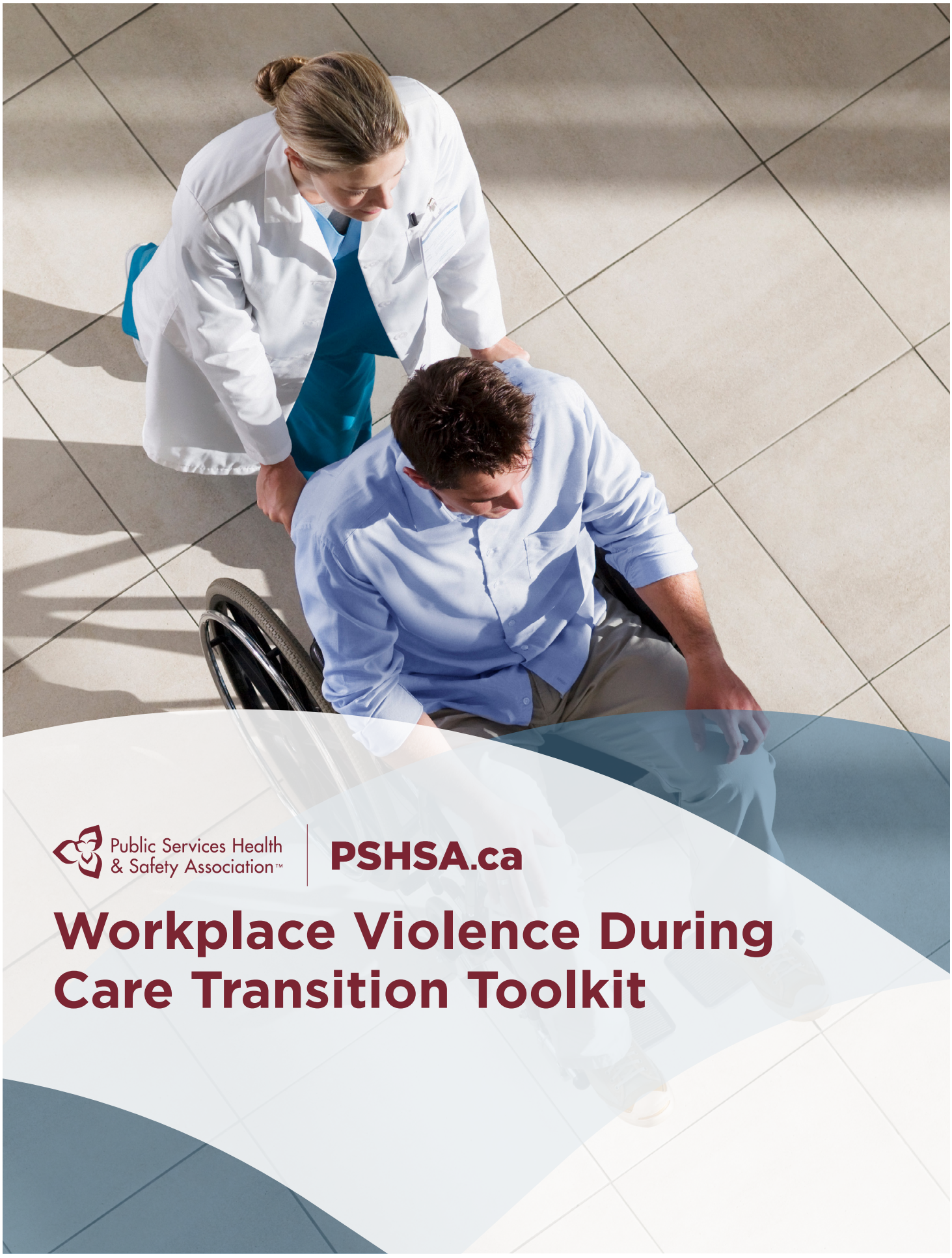

Public Services Health & Safety Association™

PSHSA.ca

Workplace Violence During Care Transition Toolkit

Workplace Violence During Care Transition Toolkit

Product Code: VTCTLAEN0321

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Introduction

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 continued 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. For more information, visit www.workplace-violence.ca.

Why Focus on the Care Transition of Care Recipients who Pose a Risk of Violence?

Care transition is an important part of the continuum of care. It involves moving care recipients between sectors, locations, and care providers to receive care and services or undergo tests and treatments.

Moving locations can be a stressful time for care recipients and a vulnerable time for workers. Fear, uncertainty, and loss of control can quickly lead to acts of violence towards healthcare workers which may result in psychological and/or physical injuries.

Toolkit Purpose and Scope

The purpose of this toolkit is to outline the planning, resources, collaborative efforts, and course of action needed to transition the care of care recipients with a risk of violence. Sharing information between sectors, locations, and workers is central to care transition and worker health and safety.

This toolkit provides information on good practices and resources that can be incorporated into an organization's existing policies, safety measures and procedures, or used to create new ones where none exist.

This toolkit addresses four (4) care transition situations with care recipients who pose a risk of violence. These include:

- Within a healthcare location (for example, emergency department to medical unit).
- Between healthcare locations (for example, hospital to home and community care, long-term care to hospital, or between sites belonging to the same organization).
- Between a healthcare location and a correctional facility/the courts/home or community care setting/ public setting.
- With an escort (for example, a healthcare worker, correctional officer, police officer, paramedic, transportation attendant, family).

The toolkit also addresses situations where a worker, such as a home and community care worker, moves between locations to provide care.

The toolkit does not address care transition as part of an individual's admission or discharge. For example, a care recipient leaves their home and goes to a hospital's diagnostic department for an x-ray test.

This toolkit is intended for use by employers, supervisors, workers, Joint Health and Safety Committees (JHSCs)/Health and Safety Representatives (HSRs), unions, safety professionals, police officers, correctional officers, transportation services, the courts, and regulators.

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.*

Care Transition Basics

In this section, care transition is defined and four (4) guiding principles are presented. The importance of a care transition policy, measures and procedures are also discussed.

Care transition is the process of reassigning the care of a care recipient from one service provider to another. It is part of a care recipient's continuum of care. Sharing information between sectors, locations, and workers is central to care transition and worker health and safety.

Care transition of care recipients with a risk of violence poses unique safety challenges for workers, such as attending to a care recipient's needs while moving them from one location to another. Therefore, it's important that organizations have a system in place for a safe and smooth process. This begins with having a care transition policy, measures and procedures that address both medical and behavioural needs. Also, a Service Level Agreement (SLA) between organizations will clarify the organization's roles, responsibilities, and accountabilities. SLAs are developed collaboratively and signed by leadership from both organizations.

Healthcare organizations can put in place SLAs with:

- Hospitals
- Long-term care homes
- Home and community care services
- Local Health Integration Networks (LHINs)
- Emergency medical services
- Police services (local and provincial)
- Correctional institutions
- Courts

Organizations should have mutual respect for limited resources by promptly acting on their responsibilities. For example, the receiving location will not delay in mobilizing their resources and assuming responsibility of the care recipient from the sending location.

Note: *Home and Community Care organizations may not have a care transition policy. Instead, they may have a referral of service policy that addresses information sharing between locations. It may not include procedures for physically moving a care recipient if outside their mandate.*

Care Transition Guiding Principles

Care transition of care recipients with a risk of violence is founded on the following principles:

1. **Worker Safety.** Workplace safety priority always occurs in the following order: self and other workers, care recipients/visitors, environment.
2. **Knowing is a Right.** Workers have the right to know about actual or potential hazards in their work tasks and workplace.
3. **Precautionary Principle.** Take prudent proactive action in the face of potentially serious hazards without having to wait for complete scientific proof that a course of action is necessary.
4. **Transparency.** Employers, supervisors, and workers of all organizations must be honest and open about any potential risk to worker safety.

Roles and Responsibilities

This section describes roles and responsibilities of workplace parties that may be involved in the care transition of a care recipient.

Employer

Under the Occupational Health and Safety Act (OHSA), the employer must take every precaution reasonable in the circumstances to prevent, assess, and control identified risks of workplace violence for the protection of workers. Employers who develop, implement, and evaluate a care transition policy, measures and procedures that address violent behaviours, assist to support these requirements. This work is done in consultation with the JHSC/HSR. **Specific to care transition, the employer also:**

- Develops roles and responsibilities including external escorts.
- Develops Service Level Agreements with external organizations.
- Identifies and communicates to workers the hazards and risks that may occur during care transition.
- Provides information and trains workers on topics relevant to care transition and **violence management techniques.**
- Provides workers with supportive systems (for example, a risk communication/flagging system, enough time allotted to plan for a care transition).
- Provides workers with a personal safety response device that is linked to workers trained in violence management techniques, such as security, emergency worker responders (i.e., code white responders), or 911/police.
- Ensures personal protective equipment and restraining devices are ready and available for care transition.
- Implements mechanisms to trigger information sharing (for example, a Care Transition Form and accompanying procedures).

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

Refer to the Definitions section beginning on page 33 for a full description.

For more information on the employer's responsibilities, see OHSA sections 32.0.3. and 32.0.5. For more information on developing measures, procedures, and training, go to sections 8 and 9 of the Health Care and Residential Facilities Regulation.

DID YOU KNOW

The OHSA defines a competent person as someone who:

a. **is qualified because of knowledge, training, and experience to organize the work and its performance,**

b. **is familiar with the OHSA 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.**

Supervisor

Like the employer, the supervisor must take every precaution reasonable in the circumstances to prevent and control identified risks of workplace violence for the protection of workers.

The supervisor must be a **competent person** (as appointed by an employer) who understands relevant legislations such as the Occupational Health and Safety Act and the Health Care and Residential Facilities Regulation. **Specific to care transition, the supervisor:**

- Proactively shares information about a care recipient's risk of violence including history of violent behaviour, safety measures and procedures with all workers who may encounter the care recipient during care transition where the risk of workplace violence is likely to expose the worker to physical injury.

- Provides workers with supportive systems (for example, allocates enough time for workers to plan and prepare for sending or receiving a care recipient).
- Provides workers with a working personal safety response device that's linked to security, 911/police, or workers trained to manage violence to call for immediate assistance.
- Ensures personal protective equipment and restraining devices (such as physical restraints) are ready and available.
- Trains workers on topics relevant to care transition and violence management techniques.
- If a supervisor's worker is going to be a care recipient's escort, informs the escort about the care transition logistics and violence risk related information.

Refer to the Training section on page 21 for a list of recommended training topics.

Worker

In care transition, a worker can take on one of many roles. For example, a worker may help plan the care transition logistics or escort a care recipient between locations. Or a worker may be assigned the primary care giver role of an incoming care recipient. **Specific to care transition, the worker:**

- Attends training offered by the employer or supervisor.
- Asks their supervisor for more instruction and training if needed.
- Carries out care transition policy requirements and procedures.
- Follows related policies and procedures (for example, a hospital's violence risk communication/flagging, Code White, and organizational risk assessment policies).
- Proactively shares care transition logistics and violence risk information with workers involved in the care transition.
- Seeks information from their supervisor or the sending location about the care recipient's risk of violence before moving them.
- Always wears their personal safety response device, checks that it's working, and reports any deficiencies to their supervisor.
- Documents per the organization's policy.

Joint Health and Safety Committee or Health and Safety Representative

The JHSC/HSR (as consulted by the employer) helps to develop, put in place, and evaluate the care transition policy, measures, procedures, and relevant training programs. The JHSC/HSR conducts, at minimum, an annual review of the policy, measures and procedures and reviews them more frequently if circumstances change that may affect the health and safety of the worker (for example, an increase in care recipient population or new knowledge around violence prevention interventions). Refer to sections 8 and 9 of the Health Care and Residential Facilities Regulation for more information about the employer's duty, in consultation with the JHSC/HSR, to establish measures and procedures.

In addition, the JHSC/HSR makes recommendations to the employer to eliminate and control the risk of violence to workers during care transition. The JHSC/HSR also monitors and ensures that recommended prevention strategies are followed-up.

The JHSC/HSR is provided appropriate notice about violent incidents, including those that occur during care transition and result in injury, illness, critical injury, or death (refer to the OHSA sections 51 and 52 and the Health Care and Residential Facilities Regulation section 5 for more information).

Sending Location

The sending location prepares the care recipient for the care transition. The sending location proactively shares information with all workers involved in care transition before the care recipient is moved. It is recommended that the sending and receiving locations have a phone meeting to carry out real-time information sharing.
Specific to care transition, the sending location:

- Proactively shares information.
- Organizes care transition logistics.
- Conducts violence risk assessments (initial and reassessment) for the most up-to-date violence risk information.
- Updates risk information in the behaviour care plan, documentation, and risk communication/flagging system.
- Sends at least one (1) informed and trained escort even when a transportation attendant is hired.
- Is responsible for the care recipient until the Transfer of Accountability with the receiving location is complete (when police are involved, this is called a transfer of custody).
- Informs the escort's supervisor of care transition logistics and violence risk information.
- Provides the sending escort with the care recipient's documents to give to the receiving location during the transfer of accountability.

It is important that a delegate from the sending location speaks with the escort before the escort moves the care recipient. The delegate tells the escort the care transition logistics, violence risk information, and safety measures and procedures.

Receiving Location

The receiving location gathers information from the sending location before the care recipient is moved. With this information, the receiving location prepares for the care recipient's behavioural and medical needs. This includes putting in place safety measures and procedures. For example, arranging for a security guard to be with the care recipient at all times. **Specific to care transition, the receiving location also:**

- Informs workers about the risk and the safety measures and procedures.
- Updates flags per the organization's risk communication/flagging policy.
- Only assigns workers who are informed and trained to manage the care recipient's behavioural needs.
- Becomes responsible for the care recipient after transfer of accountability with the receiving location is complete (when police are involved, this is called a transfer of custody).
- Conducts an individual client risk assessment as soon as possible (when police are involved, conduct the risk assessment with the police).

GOOD TO KNOW
When the sending and receiving locations proactively share information about the risk of violence, there is a better chance of preventing it.

Escort

An escort is a person who accompanies and can deliver the care needs of a care recipient. Escorts may move, monitor, support, and provide on-going care (or custody in the case of police and correctional officers) during the transportation.

Escorts can be security guards, nurses, physicians, personal support workers, allied health workers (for example, social workers), support workers (for example, porters), police officers (including hired police), correctional officers, paramedics, or transportation service attendants. **Specific to care transition, the escort:**

- Attends training offered by the employer or supervisor.
- Informs their supervisor if more training is needed.
- Understands the care transition logistics and violence risk information before moving the care recipient.
- Checks that transportation and restraint equipment are in good working order.
- Asks for care transition logistics and violence risk information from the sending location before moving the care recipient.
- Attends to the care recipient's behavioural and medical needs (if a clinician).

Figure 1. Questions the Escort Asks the Sending Location

- Takes their time and communicates clearly with the care recipient while transportingA
- Accompanies the care recipient in the hired transportation vehicle or ambulance as required.
- Tells the receiving location if there were any changes or notable events that happened during the transportation.
- Hands over any hardcopy documents to the receiving location that were provided by the sending location.
- Stays with the care recipient until the transfer of accountability with the receiving location is complete.
- Always carries a working personal safety response device.
- Knows how to call for immediate assistance if required.

It is important that escorts ask questions before they move a care recipient. See Figure 1 for some questions to ask the receiving location.

Security Guard as an Escort

Security guards may be the workers best suited to act as escorts. This is because of their trained occupational role to guard and patrol to protect people or property (Private Security and Investigative Services Act, 2005).

Police or Correctional Officer as an Escort

Sometimes a police officer brings a person with a risk of violence to the hospital (see section 17 of the Mental Health Act). In these situations, the police officer:

- Retains custody of the care recipient until a transfer of custody to the healthcare location is complete (refer to section 33 of the Mental Health Act for more information).
- Stays with the care recipient at all times until the transfer of custody is complete.
- Proactively shares information with healthcare workers about the incident that brought the care recipient to the hospital.

For more information about care transition involving officers, refer to:

- Mental Health Act
- Improving Police-Hospital Transitions: A Framework for Ontario
- Tools for Developing Police-Hospital Transitions in Ontario

- Collaborates with healthcare workers to assess the care recipient's risk of violence.
- Keeps on any handcuffs or other physical restraints being used on the care recipient until security guards or care providers are ready to take responsibility of the care recipient and a safety plan is in place.

In situations when a police officer or correctional officer brings an incarcerated person to the hospital, the police or correctional officer:

- Retains responsibility of the care recipient while they receive care.
- Stays with the care recipient at all times.
- Keeps physical restraints on the care recipient while they're receiving care or per police or corrections organizational policy (if they came to the healthcare facility with restraints on).

If the officer must leave the person for any length of time and another officer isn't available to take their place, the healthcare organization's security guards must stay with the care recipient and be allowed by their employer to use physical force as needed.

GOOD TO KNOW
Correctional officers are governed by the Corrections and Conditional Release Act. Restraints application and removal are covered in the Act. Therefore, removing restraints from an inmate receiving care at a healthcare facility is at the discretion of the correctional officer, which may include input from the healthcare team

Paramedic as an Escort

A paramedic may transport a care recipient with a risk of violence from the community (like their home) to a healthcare facility or between healthcare facilities. Specific to care transition, the paramedic:

- Provides care to the care recipient until transfer of accountability with the healthcare facility is complete.
- Asks the sending location for violence risk information before moving the care recipient.
- Shares medical and behavioural information with the receiving location.
- Has violence management skills.

Transportation Attendant as an Escort

Non-emergency transportation services are used when transportation by ambulance is not needed. Although transportation attendants may be trained by their employer in basic skills like standard first aid, they do not carry out safety interventions to manage violent behaviours. To protect the transportation attendant from harm, the sending location should send a properly trained escort to go with the care recipient in the vehicle.

If a care recipient needs physical or chemical restraints, transportation services are not appropriate.

Phases of Care Transition

In this section, the phases of care transition and the activities for each are described.

Care transition of a care recipient with a risk of violence between locations involves three (3) phases. Each phase requires policies, measures, procedures, training, and resources. The phases are:

1. Pre-care transition
2. During care transition
3. Post-care transition

Phase 1: Pre-Care Transition

During the pre-care transition phase, the sending and receiving locations plan, coordinate, and prepare before the care recipient is moved. That's why the pre-care transition phase has the most components to consider, including integrating relevant policies such as the organization's individual client risk assessment and risk communication/flagging policies. **Components specific to care transition include:**

1. Knowing the level of risk.
2. Sharing information.
3. Choosing the right escorts.
4. Preparing resources and equipment.
5. Assembling important documentation.

1. Know the Level of Risk

Before a care recipient is moved, know the level of violence risk. This is done in a few ways:

- The sending location conducts an individual client risk assessment right before the care recipient is moved.
- The receiving location conducts an individual client risk assessment as soon as the care recipient arrives.
- Both the sending and receiving locations assess the physical environment, especially if it hasn't been done in a while or changes in the environment have recently occurred. This includes assessing the risks along the travel route, staffing level and skill mix to address care recipient acuity, and workflow.

Organizations may also want to get information about the care recipient's history of violent behaviour from the family. This includes violence against non-healthcare workers. To encourage transparency, employers can develop formal procedures on how to respectfully ask for sensitive information and train workers on these procedures.

To learn more about how to conduct risk assessments, refer to PSHSA's toolkits, Individual Client Risk Assessment and Workplace Violence Risk Assessment.

2. Share Information

Before a care recipient is moved, care transition logistics and violence risk information are shared between locations (i.e., sectors, organizations, and internal locations), with workers involved in the transition, with workers who may encounter the care recipient in their work, and with the care recipient or family.

For more information on sharing information, refer to the OHSA sections 25, 27, 32.0.5 and the Health Care and Residential Facilities Regulation section 9.

What Information Is Shared?

Any information related to a risk of violence such as:

- A history of violent behaviour (against family, the public, or healthcare workers).
- Observed behaviours (for example, shouting, throwing objects, escape attempts from an institution, weapon making, fire starting).
- Level of violence risk (identified in an individual client risk assessment).
- Common triggers and risk factors.
- Worker safety measures and procedures.

The care transition logistics that are shared include:

- Pick-up and appointment time.
- Contact information of both sending and receiving locations.
- Number of escorts.
- Type of equipment needed.
- Special considerations for route such as routes with less visitor traffic and less travelled roads.

Who Shares the Information?

Sectors, organizations, and workers involved in sending a care recipient share information with sectors, organizations, and workers involved in receiving a care recipient. To facilitate consistent information sharing, sending organizations can adopt formal procedures so that their delegates, like charge nurses, security guards, porters, or paramedics know when, how, and with whom to proactively share care transition logistics and violence risk information.

Who Receives the Information?

Workers who receive information about care transition logistics and violence risk information are:

- Workers acting in the capacity of an escort (for example, nurses, porters, or security guards).
- Escorts external to the healthcare facility (such as police officers, correctional officers, paramedics, or transportation service attendants).
- Receiving locations, including a care recipient's residence if care is being provided there (for example, a long-term care home).
- Workers who may encounter the care recipient during their work.
- Workers sent to an external location to provide care.

As soon as healthcare providers know that a care recipient will be moved, a good practice is to tell the care recipient or their family right away. This gives the care recipient or their family enough time to accept that the transition needs to happen, to understand what's going to happen, to ask questions [1] , and to mentally prepare for the move. The worker who informs

DID YOU KNOW

The Personal Health Information Protection Act (PHIPA) does not prohibit use or disclosure of personal health information when the OHSA requires employers to provide workers with as much information necessary to keep them safe.

If there is conflict between the PHIPA and the OHSA, an employer's duties under the OHSA prevail over the PHIPA or any other Act. See OHSA section 2(2).

Information to Share With Escorts:

- **Level of risk of violence**
- **History of violent behaviour**
- **Observed behaviours**
- **Triggers and risk factors**
- **Behavioural care needs**
- **Safety measures and procedures**
- **Pick-up and appointment times**
- **Special considerations for route**
- **Transportation and mobility devices needed**
- **Receiving location details (e.g., organization/unit, most responsible worker's name)**

1. The exception to this is with corrections and police, where for security reasons, care recipients and their families may not be told about transfers or medical appointments.

the care recipient should be someone who the care recipient trusts whenever possible. The sending location can plan for this worker to be available to the care recipient during all transition phases.

Information to communicate to the care recipient before they're moved includes:

- Why the care transition is happening.
- What to expect before, during, and after transition.
- How long the transition will take.
- Who the escort is (if applicable).
- The mode of transportation (if applicable).
- Who to ask questions or raise concerns to.

When and How is the Information Shared?

Information about care transition logistics and violence risk information can be shared in different ways. All approaches should include oral communication. This is because speaking with others directly allows for real-time information sharing. Organizations may have as many meetings needed so that all important information is shared with all the right people.

The table below lists different approaches to sharing violence risk information and care transition logistics.

Table 1. Approaches to Sharing Information

APPROACH	CONSIDERATIONS
Phone meeting	The sending location initiates a phone meeting with the receiving location. The sending location initiates the meeting far in advance to give the receiving location enough time to prepare resources and put in place safety measures and procedures.
Shift report	One-to-one sharing at every shift.
Safety huddle	A conversation led by the charge nurse with all unit staff at every shift. For more information on safety huddles, go to the PSHSA Toolkit, Effective Workplace Safety Huddle Communication Tool.
High-risk huddle	When a violent incident occurs, a high-risk huddle takes place immediately to discuss what happened and how to prevent it from happening in the future. This is an interdisciplinary meeting including security (where applicable) and the JHSC/HSR (if available).
When an escort arrives	A delegate from the sending location speaks with the escort once the escort arrives to move the care recipient. During this meeting, the delegate shares information about the care recipient's risk of violence, the safety measures and procedures, and transition logistics. This conversation is a review of the information the escort should have already received from their supervisor.
In writing	Written communication may not be as effective as oral communication. However, written communication may be the only feasible approach in some circumstances (for example, written communication is typical between a home and community care support service or a care funder and home and community care agencies). In these circumstances, violence related information should be written in a way so that it cannot be missed by the receiving location. Methods may include use of brightly coloured forms/paper; text at the top of the form; large, bold, or highlighted text.

How is the Information Used?

The receiving location uses the information shared by the sending location to prepare for the care recipient. The escort taking the care recipient from one location to another uses the information to be vigilant and to follow the safety protocols. Preparations may include:

- Mapping out and organizing the flow of care for the care recipient's arrival (including from a waiting or assigned room or area).
- Clearing the care recipient room of objects that could be used as weapons.
- Implementing flags per the organization's risk communication/flagging policy.
- Developing a behaviour care plan.
- Informing workers on the unit about the risk and safety plan.
- Assigning only trained workers (in violence management techniques for example) to care for the care recipient.
- Having enough staff to manage the level of risk.
- Preparing restraints.
- Being extra attentive.

Refer to PSHSA's toolkit on risk communication, Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventative Care

It is recommended that sharing information about a care recipient's assessed risk of violence is a standard practice.

3. Choose Escorts

Workers who are trained to function as an escort can transport care recipients with a risk of violence. More escorts are likely required as the risk increases. For example, if two escorts transport a care recipient, then one can summon immediate assistance if the other escort is hurt or being attacked.

For a list of possible training topics, go to the Training section beginning on page 21.

A worker shouldn't escort a care recipient without getting all important information about the risk of violence first!

4. Prepare Resources and Equipment

Resources and equipment are gathered and examined for good working condition before moving the care recipient. These may include:

- Personal safety response device for escorts to call for immediate assistance (from security guards, 911/ police, or trained responders) during transport.
- Personal protective equipment (i.e., Kevlar gloves, face mask, and shield).
- Restraints (physical, chemical, and environmental).
- Care recipient's personal belongings for comfort (for example, slippers, blanket, family picture).
- Transportation equipment (stretcher, wheelchair including dynamic tilt wheelchairs e.g., Broda wheelchair).
- Mobility aides (walker, cane).

Ambulatory care recipients with a risk of violence who can walk themselves to the receiving location pose a safety risk. Canes, walkers, or other equipment like IV poles can be used as a weapon. Therefore, it is recommended that ambulatory care recipients who pose a risk of violence are accompanied by an informed and trained escort.

For more information on equipment, see OHSA section 25 and the Health Care and Residential Facilities Regulation sections 8-10.

5. Assemble Documents

Care Transition Form

Organizations can document the care recipient's care transition logistics and violence risk information on a standard form, like the Care Transition Form found in Appendix A on page 22.

A Care Transition Form should include information about a care recipient's care transition logistics, history of violent behaviour, observed behaviours, triggers and risk factors, and safety measures and procedures. If an organization already uses a care transition form that addresses medical needs, it can incorporate the behavioural components from our care transition form into their existing one.

Care Transition Package

Organizations can adopt a standard Care Transition Package. The package is assembled by the sending location to give to the receiving location. The package contains a copy of the following:

- Care Transition Form (Appendix A)
- Individual client risk assessment (initial assessment and reassessments)
- Information about transportation booking (if applicable)
- Service Level Agreement document (if applicable)
- Hardcopy medical record (or per organization's policy)

The Care Transition Package is handed over to the escort once the escort arrives to pick-up the care recipient.

Refer to the PSHSA's toolkit, Workplace Violence Prevention Toolkit for Home Care, for more information on preventing violence and staying safe while providing care in the community.

Special Considerations

Home and Community Care

Workers in home and community care settings often work alone. When transporting a care recipient with a risk of violence in the home and community setting, the worker must carefully consider whether it's safe to drive the care recipient. If the worker is attacked while driving, they may not be able protect themselves or call for help.

Worker Moving between Locations to Provide Care

Workers may be required to move between locations to provide care to a care recipient rather than the care recipient being moved. Before seeing the care recipient, the worker should receive information from the receiving location about the care recipient's risk of violence, behaviour care plan, and safety measures and procedures. The worker should also ask questions so that they're clear about violence related and safety information before they provide care.

The Court System

There are situations where a judge orders a person with a history of violent behaviour to have a psychiatric assessment at a hospital, but the courts don't provide this information to the hospital. The person then goes to the hospital for their assessment and is treated as a new admission rather than a care transition.

This gap in information sharing is a safety hazard for workers. Treating situations involving the courts like a care transition rather than an admission can close the care and safety gap between healthcare and non-healthcare organizations that are providing service to the same person.

It is recommended that a standard process is put in place for the courts to share violence risk information with healthcare facilities. Important information that courts should share include verbal or physical violence against anyone, fire starting, weapons possession or use, attempts to escape, or self-harm.

Transition to Seclusion

At times, it may be necessary to move a care recipient temporarily to a seclusion room to de-escalate the situation. This requires an up-close, hands-on intervention to restrain the care recipient and move them from one location to a seclusion room. Workers who are involved in this kind of violence management must be well trained in violence management techniques.

Other things to consider when transitioning to seclusion include wearing personal protective equipment, clearing hallways, locking doors, and getting assistance from security guards.

Phase 2: During Care Transition

The during care transition phase involves procedures for picking up a care recipient from the sending location. It also involves en-route procedures to the receiving location.

Before the escort arrives at the sending location, the location has already done the following:

- Assembled the Care Transition Package (see page 18 for a list of suggested contents).
- Informed the care recipient or family of the move.
- Provided the care recipient with personal items.
- Put in place safety measures and procedures.

When the escort arrives at the sending location, they come prepared with:

- Transportation equipment such as a wheelchair or stretcher.
- Their personal safety response device in working order.
- Knowledge about the care transition logistics.
- Knowledge and skills provided through training in the care transition policy, safety measures and procedures, and violence management techniques.

Before moving the care recipient, the escort and sending location delegate (for example, the care recipient's primary care nurse) have a meeting. During the meeting, the delegate and escort review the care transition logistics, violence risk information (for example, history of violent behaviour, observed behaviours, triggers), and the safety measures and procedures.

The escort moves the care recipient at a relaxed pace to help keep the care recipient calm. Chatting with the care recipient during the move may also help them feel at ease. During the move, the escort provides help when needed.

Phase 3: Post-Care Transition

It's important that the receiving location is ready for the arrival of the care recipient who poses a risk of violence by having safety measures and procedures in place. For example, this may include having flags in place (per the organization's policy) and security guards or other support staff on the unit, ready to help. Also, the receiving location:

- Has a healthcare provider available to receive the Care Transition Package and any important details about what happened en-route from the escort.
- Is ready to conduct an individual client risk assessment.
- Has transportation and mobility device(s) ready.
- Has the care recipient room/procedural room ready.
- Has comfort items available.
- Communicates with the care recipient about next steps in their care, including wait times.
- Confirms that the care recipient's belongings have arrived from the sending location and returns them to the care recipient.
- Completes the transfer of accountability process with the escort before the escort leaves.

Transfer of Accountability or giving "report" or "handover" is an interactive process of transferring care recipient information between workers, teams, or organizations to ensure continuity of care and worker and care recipient safety. It's a crucial component of the care transition process (College of Nurses of Ontario, 2018).

The escort is responsible for the care recipient until the transfer of accountability is complete. The transfer of accountability is complete when the receiving location confirms to the sending location escort that they're accepting responsibility of the care recipient.

Training

This section lists suggested training topics important for the safe care transition of care recipients who pose a risk of violence.

Workers involved in transporting care recipients need a unique skill set. For example, a nurse acting in the role of an escort needs to know the care recipient's likely and potential medical and behavioural needs, how to protect themselves while in an elevator with the care recipient, ways to put the care recipient at ease, and how to de-escalate the care recipient's behaviours while on the move.

Specific to care transition, workers may be trained in (but not limited to) the following topics:

- Care transition policy, measures, and procedures
- Roles and responsibilities
- Violence management techniques (including in an enclosed space such as an elevator and when in a seated position)
- Risk assessments
- Information sharing and seeking (including from family and supervisors)
- Care of persons under the influence of drugs or alcohol
- Transfer of accountability
- Transfer of custody (from police)
- Restraint use (physical, chemical, and environmental)
- Moving someone into a seclusion room
- Personal safety response device
- Personal protective equipment
- Transportation equipment
- Relevant organizational policies (for example, risk communication/flagging, Code White, restraint use)
- Canadian General Standards Board security guard training with enhanced physical skills as required
- Empathy and communication techniques (for example, using small talk to put the care recipient at ease)
- Situational awareness

The Importance of Being Situationally Aware

Things can go wrong even when the best plan is in place. That's why situational awareness is important, particularly during care transition.

Situational awareness is about being aware of what is going on around you at any given time. It's about seeing, understanding, and analyzing your surroundings in the context of what you're trying to do. Situational awareness skills can enable workers to manage different situations as they happen.

Refer to Appendix B on page 27 to learn more.

Appendix A: Care Transition Form

Purpose of this Tool

The purpose of this tool is to document information about the care transition of a care recipient with a risk of violence. Both the sending and receiving locations should have a copy of the completed form before the care recipient is moved.

Who Uses this Tool

Delegates from healthcare sending and receiving locations. Non-healthcare sending locations such as correctional or police services, may have their own care transition form to complete as required by their employer.

How to Use this Tool

This tool is completed during a phone meeting, when possible, between the sending and receiving locations. The sending location initiates the meeting and documents the information. Once the document is complete, the sending location shares the completed document with the receiving location using a method that allows for real-time sharing such as fax or email.

Care Transition Form for Hospital, Long-Term Care, and Home & Community Care Settings

Purpose:	This tool is intended for the healthcare sending location to share information with the healthcare or non-healthcare receiving location about a. a care recipient's risk of violence b. the behaviour related interventions used to prevent or reduce the risk of violence
Instructions:	The sending or receiving location can initiate the use of this form. Care teams from the sending and receiving locations meet on the phone when possible. The form is completed by a healthcare provider from the sending location and shared with the receiving location.

Care Recipient Name: _____ **Date:** _____

Sending Location: _____ **Time of Meeting:** _____

(name, address) _____

Receiving Location: _____

(name, address) _____

RISK OF VIOLENCE INFORMATION (check ☑ all that apply)

N.B. This is NOT a client violence risk assessment. Information from the care recipient's violence risk assessment is entered into this form to share and be transparent with the receiving location.

☐ No Known History of Violent Behaviour

☐ History of Violent Behaviour

☐ No Observed Behaviours

☐ Observed Behaviours. Check ☑ all that apply and describe.

LEVEL OF RISK

☐ Low

☐ Moderate

☐ High

☐ Physical Threats: _____
(e.g., choking, punching, hitting, pushing, biting, spitting, groping, pinching, kicking, shaking fists, moves or lunges towards others, or banging own head or body)

☐ Attacking Objects: _____
(e.g., throws objects; bangs or breaks windows; kicks objects; smashes furniture)

☐ Verbal Threats: _____
(e.g., raises voice in intimidating or threatening way; shouts angrily, insulting others or swearing; makes aggressive sounds)

TRIGGERS

Describe.

_____

_____

_____

_____

_____

_____

☐ Boisterous: _____
(e.g., overtly loud or noisy such as slamming doors, shouting, etc.)

☐ Irritable: _____
(e.g., easily annoyed or angered; unable to tolerate the presence of others; Unwilling to follow instructions)

☐ Agitated/Impulsive: _____
(e.g., unable to remain composed; quick to overreact to real and imagined disappointments; troubled, nervous, restless or upset; spontaneous, hasty or emotional)

☐ Paranoid/Suspicious: _____
(e.g., unreasonable or obsessively anxious; overly suspicious or mistrustful e.g., belief of being spied on or someone conspiring to hurt them)

☐ Confused: _____
(e.g., disoriented – e.g., unaware of time place, or person)

☐ Socially Inappropriate/Disruptive Behaviour: _____
(e.g., screams; engages in self-abusive acts, sexual behaviour or inappropriate behaviour)

☐ Substance Intoxication/Withdrawal: _____

☐ Body Language: _____
(e.g., puffed up chest; deep breathing; arms spread or behind head; dilated pupils)

☐ Other: _____
(resisting healthcare, suicidal ideation)

_____
_____
_____
_____
_____
_____
_____
_____
_____

SAFETY INTERVENTIONS USED IN SENDING LOCATION (check ☑ all that apply)

Safety	Medications Given & Administration Times
☐ Personal belongings kept separate from care recipient	☐ Anxiolytics (name): _____ Admin times: _____
☐ Restraints	☐ Antipsychotics (name): _____ Admin times: _____
☐ Security presence	☐ Sedation (name): _____ Admin times: _____
☐ 72 hr. hold in place	☐ Other: _____ Admin times: _____

☐ Other: _____

INTERVENTIONS REQUIRED DURING TRANSITION (check ☑ all that apply)

- ☐ Attendance of family/friend/substitute decision-maker
- ☐ Personal belonging(s) known to prevent behaviours
- ☐ Restraints _____
- ☐ Other _____

METHODS OF TRANSITION (check ☑ all that apply)

- ☐ Assisted Walking
- ☐ Wheelchair
- ☐ Stretcher
- ☐ Ambulance
- ☐ Hired Transportation Service
- ☐ Taxi
- ☐ Police/Corrections
- ☐ Air

TASKS TO COMPLETE BEFORE SENDING (check ☑ all that apply)

Sending Location

- ☐ Communicate risk of violence to workers
- ☐ Perform client risk assessment
- ☐ Confirm that Escort competencies are appropriate for level of risk

Recieving Location

- ☐ Clear room of non-essential items
- ☐ Communicate risk of violence to workers
- ☐ Have medications available
- ☐ Request healthcare provider(s) be present upon arrival

MEETING ATTENDEES

SENDING LOCATION

_____ Name	_____ Designation (e.g., primary care nurse, charge nurse)
_____ Name	_____ Designation

RECEIVING LOCATION

_____ Name	_____ Designation (e.g., primary care nurse, charge nurse)
_____ Name	_____ Designation

Person Who Completed this form:

Name	Designation
Signature	

Appendix B: Situational Awareness Fast Fact

Purpose of this Tool

The purpose of this tool is to provide information on the importance of situational awareness and to help improve situational awareness in the healthcare setting.

Who Uses this Tool

Any worker who directly cares for or who may encounter in their work a care recipient with a risk of violence.

How to Use this Tool

This tool can be printed or distributed electronically and can be used in worker training.

Situational Awareness: A Building Block for Safer Workplaces

Situational Awareness is a critical, but often neglected dimension of workplace safety. It is a term commonly used to describe our awareness and understanding of what is happening around us and what could happen if hazards and risk are not addressed. It is based on the belief that everything we do is influenced by the dynamic relationship we have with our environment and is a mental model or mindset that results in us being fully alert and engaged with the factors and conditions in our workplace.

Situational Awareness helps healthcare workers, teams, and organizations focus on the bigger picture and determine what actions need to be taken in each situation to be safer. Situational Awareness is a tool for making the right decisions, at the right time, for the right reasons.

Why is Situational Awareness Important?

Healthcare workers face many challenges in their workplaces. These challenges come from multiple sources that include, but are not limited to, exposures to occupational hazards and increasingly complex clinical care settings. Being aware of the interdependent elements of an unfolding situation or work environment and understanding their meaning and potential impact is crucial to reducing negative outcomes.

Situational Awareness is an important skill to develop and maintain to:

- Identify and report hazards proactively
- Solve problems and make decisions quickly
- Respond to incidents faster and more adaptively
- Protect workers and care recipients from harm, injury, and illness

What are the Levels of Situational Awareness?

The most well-known model of Situational Awareness was proposed by Mica Endsley in 1995.

The model outlines three (3) levels of awareness needed to recognize and effectively respond to situations that may affect the safety and well-being of individuals in each environment. By keeping the three levels of Situational Awareness in mind, individuals, teams, and organizations will be more adept to make good decisions and act accordingly.

What I see
What is available?
What is happening?

Perception is the most basic level of situational awareness. A healthcare worker with this level of awareness is consciously aware of the people, objects, and conditions around them; however, the observations in themselves have no meaning.

For example, a crowded emergency room, a 4 p.m. transition departure time, and a care recipient's facial tension without context, have no meaning.

What I understand
Is this important?
Why is this relevant?

Comprehension is the next level of situational awareness. At this point, the perceived information becomes more meaningful. Patterns of relationships between perceived information are more structured. The healthcare worker—in the context of experience, learning, and sharing—now connects the dots and interprets what seems to be going on.

Adding to the example, when the cues are analyzed and integrated as a whole, the healthcare worker can recognize that the care recipient's aggression is escalating.

What could happen
What will be the outcome?
How will the situation develop?

Projection is the highest level of situational awareness. The healthcare worker anticipates what might happen next by using their understanding of the current situation.

Adding to the example, the healthcare worker predicts that a violent event is possible. Given their current and projected awareness of the situation, the healthcare worker uses preventive and protective measures (such as administrating pain meds, using active listening, increasing their distance from the care recipient's hands and feet) to manage the care recipient's aggression and reduce the risk of a violent event.

5 Helpful Tips to Increase Your Situational Awareness

Be Alert

Situational awareness is developed and maintained by gathering information. Make sure that your senses are fully turned on and tuned in to your environment.

Keep Looking

Remember that behaviours and elements in the environment can change at any time. Don't limit your answers to "what is happening" or "what could happen" to one assessment. Reassess the situation as often as needed to make sure the information you have is as accurate and as complete as possible.

Be Wise

Be aware and plan for factors that can divert your attention and thinking. Common examples include:

- **Task or Senses Fixation.** Narrowed attention or focus to one task or place in the situation.
- **Complacency.** Assuming that a situation is routine and predictable.
- **Distractions or Unrealistic Expectations.** External interfering factors or the belief that the job can be done faster and with less effort than possible.
- **Inexperience or Low Self-Efficacy.** Lack of training, experience, or confidence to understand the meaning of environmental cues.
- **Time or Fatigue.** Short notices, urgency, fatigue.

Plan Ahead

Be proactive—review and get familiar with what needs to be done and the plan to get there. Take time to ask the right action-provoking questions—so what? and what if?

Keep Practicing

Use it so you don't lose it! Take advantage of opportunities to learn more about and refine your situational awareness skills. Some examples include:

- **Mock Exercises** – practical exercises to deal with situations such as Code White and Code Silver.
- **Briefings and Debriefings** – reports and safety huddles to provide and discuss key information with the team.
- **Analysis of Previous Incidents** – formal reviews to identify root cause.

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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 below 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.

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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

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 (when possible) the care recipient and/or substitute decision-maker.

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.

Care Transition: the process of reassigning the care of a care recipient from one service provider to another.

Chemical Restraint: medications used to modify or restrict behaviour.

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 and aggression 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.

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

Escort: a person who accompanies and can deliver the care needs of the care recipient during transport. Escorts are typically responsible for moving, monitoring, supporting, and providing on-going care (or custody in the case of police and correctional officers) during the transportation.

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.

Hazard: a hazard can be a chemical, ergonomic, physical, or psychosocial agent which can cause harm or adverse effects in the workplace.

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 such 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.

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

I**ndividual 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.

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." (Ontario Health Care Health and Safety Committee under Section 21 of the Occupational Health and Safety Act)

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 a reaction to their environment (e.g., lighting, noise, invasion of space).

Risk: the chance of being harmed or experiencing an adverse health effect from exposure to identified hazards in the workplace. Generally, hazards are classified as high, medium, or low risk based on the relationship between the following two factors: probability—how likely the hazard is to cause injury or illness and impact—how serious the hard could be should the hazard cause injury or illness.

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. Risk factors do not make violence a certainty—many people with risk factors will not demonstrate violent behaviour.

Self-Defense: self-defense is the use or threat of force in the defense 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-defense.

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.

Transfer of Accountability: an interactive process of transferring care recipient-specific information between locations or workers to ensure the continuity of care and the safety of the client and worker. It's also referred to as giving "report" or "handover". When police are involved, the process is called transfer of custody.

Transfer of Custody: the process of reassigning the care of a care recipient from a police officer(s) to a healthcare provider(s).

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 include undertreated pain, loud alarms, care to a sensitive part of the body, requests that can't be accommodated or behaviours of patients 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 attitudes 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 can 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; 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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