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Effective Workplace Safety Huddle Communication Tool

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Background

This tool was as part of the Workplace Violence Prevention in Health Care Leadership Table. It has been created for long-term care homes to address the needs of the sector, including the core resident population.

Long-term care homes are an environment where residents often feel vulnerable and anxious. This can include, for example, aging residents and their caregivers/care partners, individuals experiencing a physical or mental health crisis, those needing addiction support, and residents who have unmet needs they are unable to express. According to the Canadian Institute of Health Information (CIHI) (2015-16), fifty percent of residents with dementia in long-term care exhibit responsive behaviours. Some examples of responsive behaviours include: verbal or physical aggression (striking, self-harm), exit seeking, resistance to personal care, refusal to eat/take medication, etc. These behaviours may be due to a number of factors including an unmet need (e.g. pain, environment (hot/cold), feeling hemmed in, influences of other residents/staff and social history). Despite the fact that an aggressive action stemming from a responsive behaviour may be due to dementia or an unmet need, if it leads to an aggressive action against a worker in a workplace and meets the definition of workplace violence under the *Occupational Health and Safety Act*, (OHSA), it is considered workplace violence (herein referred to as workplace violence). Workplace violence in long-term care homes can originate from a number of sources, including from residents and their families and friends or other external people and/or from any employee associated or formerly associated with the workplace.

In order to prevent workplace violence, employers must implement workplace violence policies, measures, procedures and programs, conduct risk assessments and re-assessments for the risks of workplace violence, establish measures and procedures for: summoning immediate assistance when violence occurs or is likely to occur, reporting violent incidents and investigating incidents and complaints of violence, and providing information, education and training to workers so they may recognize and be protected from workplace violence. Employers, typically represented by senior management, hold the greatest responsibility with respect to worker health and safety within health care workplaces such as long term care homes.

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Safety Huddle Tool - Policy and Procedure

Contents

Overview

Safety Huddles can be utilized for all types of hazards including workplace violence. The focus of this huddle tool is to identify hazards related to workplace violence, sharing information and the implementation of control measures and procedures for prevention. Communicating risk information to workers is used in health care to provide workers with pertinent information related to the risk of violent, aggressive or responsive behaviour of residents in the workplace. (PSHSA, 2016). This is in keeping with the *Occupational Health and Safety Act (OHSA)* requirement for employers to provide information, including personal information, related to a risk of violence from a person with a history of violent behaviour if the worker can be expected to encounter that person in the course of his/her work, and the risk of workplace violence is likely to expose the worker to physical injury. Health care workers are very familiar with conducting shift reports to ensure information for the appropriate provision of resident care. Health care workers need to be supported on each shift to identify hazards and be provided information to help them to prevent workplace violence in order to protect themselves and those they work with. This enables them to protect their health and safety which results in resident safety in a long-term care home.

Purpose

This tool provides a guideline for the Safety Huddle process focusing on worker safety related to violence. It includes information on Daily Huddles and Weekly Huddles. This tool will address the fundamentals of communicating the risk of violence to all workers (clinical and non-clinical) during Safety Huddles to ensure they are included in and made aware of relevant information for violence prevention and protection. Workplace parties will then be able to identify, eliminate/minimize the hazards and risks. It should complement existing PSHSA toolkits on risk identification and communicating risk such as:

- Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventative Care
- Individual Client Risk Assessment (ICRA) and
- Long-Term Care Violence Assessment Tool (VAT).

While this tool was developed specifically for the long-term care sector, it can be modified to meet specific organizational needs related to safety huddles.

Policy Statement

<Name of Organization> understands the responsibilities to take every precaution reasonable under the circumstances to protect workers, comply with the health and safety legislation related to workplace violence, and to ensure the employer and supervisors meet their duties under the *Occupational Health and Safety Act* with respect to workplace violence. (*OHSA* 32.0.5 (1) and employer duties Section 25 and supervisor duties Section 27 and worker duties Section 28).

<Name of Organization> is committed to providing information and instruction that is appropriate for the worker on the contents of the policy and program with respect to workplace violence and any other prescribed information or instruction. The employer should consider the appropriate means by which information is provided to workers to ensure their health and safety. Under the provision of information, an employer's duty to provide information to a worker under clause 25 (2) (a) and a supervisor's duty to advise a worker under clause 27 (2) (a) include the duty to provide information, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour if,

(a) the worker can be expected to encounter that person in the course of his or her work; and

(b) (b) the risk of workplace violence is likely to expose the worker to physical injury. (*OHSA* s. 32.0.5(3)). This includes:

- Collecting the appropriate personal information related to a risk of violence from a person with a history of violent behaviour
- Limiting disclosure to personal information that is reasonably necessary to protect the worker from physical injury (*OHSA* 32.0.5 (4)).
- Establishing Safety Huddle measures, procedures and training
- Safety Huddle training will be provided to all workers on regular intervals, to new supervisors and workers at orientation and refreshers will be provided on an ongoing basis

<Name of Organization> is also committed to annual evaluation of the Safety Huddle policy and procedure in consultation with stakeholders, including the Joint Health and Safety Committee (JHSC)/Health and Safety Representative (HSR) (In workplaces with 6-19 workers). Approved quality improvements will be implemented and communicated to workplace parties. All workplace parties are required to follow the Safety Huddle policy, measures and procedures.

Scope

This policy applies to everyone in the organization that is:

- responsible for ensuring that workers are provided with information related to risk of workplace violence
- likely to encounter a person with a history of violent behaviour in the course of his/her work; and the risk of workplace violence is likely to expose them to physical injury.

Goals

- To ensure all workplace parties know and understand their Safety Huddle roles and responsibilities
- To ensure workers have up to date information related to residents with a history of violent behaviour
- To prevent and respond to violent incidents in a timely, efficient and safe manner
- To improve and protect worker safety which will improve resident care
- To implement enhanced prevention practices for at-risk residents that protect workers and which will improve resident care while maintaining routine prevention practices
- To comply with legislative requirements, and adopt evidence-based and best practices
- To discuss and address worker safety on a routine basis with an aim of creating a workplace with a culture of hazard prevention and safe work practices
- To collect information related to quality improvement indicators related to reporting incidents of violence as well as a check-in of staff physical and psychological safety

Objectives

- Appoint, maintain and coach a Safety Huddle Lead to implement the Safety Huddle at shift report
- Conduct and/or regularly review the Safety Huddle effectiveness in communication of the risk of violence considering the individual client risk assessment findings including information regarding a history of violent behavior that could lead to physical injury, violence legislated requirements, needs of workers and select appropriated measures and procedures as necessary
- Develop, implement and maintain written Safety Huddle policy, measures and procedures
- Develop, implement and maintain a Safety Huddle training program for all existing and newly hired workers
- Cross reference Safety Huddles into related policies, measures and/or programs, including but not limited to any transfer of accountability or shift handover policies

- Ensure ongoing Safety Huddle communications to workplace parties as needed
- Develop Safety Huddle indicators and evaluate, review and amend the Safety Huddle policy and procedure at least annually in consultation with JHSC/HSR and stakeholders, and provide recommendations to management for quality improvement

Measures and Procedures/Protocol

Daily (Shift Report) Safety Huddle

Prior to implementing Safety Huddles (Daily, Weekly, High Risk) staff will be surveyed on information they require to prevent workplace violence and what supports are required to create and implement measures to protect worker safety. The employer will develop and determine the huddle logistics, process and implementation plan in conjunction with health care workers who will be engaged in the huddle process and in consultation with the Joint Health and Safety Committee (JHSC)/Health and Safety Representative (HSR).

The Safety Huddle:

- Should be held for 10 minutes as part of shift to shift report when there is a transfer of accountability.
- Is a conversation that includes all unit staff.
- Is protected time to discuss resident information related to violent behaviour that could lead to incidents of physical, verbal or psychological violence toward staff.
- Is collaborative in its design and facilitation. It is time for staff to review or create a plan for worker safety. It assists the employer in tracking quality improvement indicators related to reporting incidents of violence.
- Acts as a check-in of staff physical and psychological safety.

The template below should be implemented at each shift report. The huddles should start on time and be orderly so communication is effective. This could be managed by going clockwise or having a “Talking Object”, meaning an object that is passed from person to person as they speak and only the person holding the object is allowed to speak during that time period.

Supervisors are part of the shift report and focus on communicating information related to resident(s) at-risk of violence.

Daily Safety Huddle Form (RN Charge Nurse to Complete)

Daily Safety Huddle Form (RN Charge Nurse to Complete) Include the same level of detail about your assessments, interventions and evaluations you would want to hear about a co-RN's resident in the daily safety huddle		
Verbal aggression	Physical aggression	Medical issues
Self-harm/suicide attempts	Smoking/ETOH/substance use	Elopement (and attempts)
Anticipated Triggers e.g. cleaning on unit, bath day	Refusing ADLs/care, or medication	Psychotropic PO PRNs
	Physical restraint	DOS (15 minute checks or 30 minute checks on resident)

Something positive from the shift	Other resident information the team should know

Daily Safety Huddle Form (RN Charge Nurse to Complete)		
Date:	**Shift:**	**CN:**
Unit/Floor/Area Census		
Residents Absent from the Home (e.g. visiting family)		**Anticipated Admissions**
Sitter/Security Guards on the unit, name and room number of resident being observed and reason		
Staffing issues		
Other Unit issues (e.g. facilities, plumbing)		
******At the end of safety huddle, Registered Nurse, Charge Nurse, ask Registered Practical Nurse's if there are any other resident or staff safety concerns raised during Behaviour Support Weekly Huddles.******		

**The Above Form was adapted from a form developed by The Ottawa Hospital for safety huddles*

All workers on a unit, floor or area attend the Daily Safety Huddle. This includes but is not limited to the supervisor, charge nurse (registered nurse), registered practical nurse, personal support workers, behaviour support workers, dietician, social worker, physiotherapist, housekeepers, maintenance workers, physicians, students and volunteers. The safety huddle is a shared responsibility of the interdisciplinary team.

Workers will huddle or congregate at the nursing station or designated location and review residents currently admitted who have a history of violent behaviour and their care plan **(consider sensitivities around disclosure of personal information)**, including triggers, behaviours and any safety measures already in place. Most importantly safety plan information will be discussed and provided to enable staff to implement or amend and follow an approach to care that protects worker safety during the provision of care and as a result improves resident care.

The Charge Nurse Will Lead the Huddle Using the Acronym

V.I.E.W.S which is based upon the principles of "Look Back (significant safety or quality issues from the last 24 hours), Look Ahead (anticipated safety or quality issues in the next 24 hours), Follow-Up (start-the-clock safety critical issues" with a resident. Safety Huddle information gathered through the conversation of the interdisciplinary team will be documented on the Safety Huddle form (see above form) by the charge nurse and posted in the nursing station. Copies of the forms will be stored in a secure area on the unit, floor, and area. V.I.E.W.S stands for sharing information and safety measures and procedures related to:

Violence, identification of a history of violence

Information, providing and communicating to workers

Equipment, condition

Watching at-risk residents

Staffing to reduce the risk of workplace violence

Under each of these areas the following questions will be considered and discussed with the interdisciplinary health care team:

Violence –

(a) Identify residents who have a history of violent behaviour or have a known history of violence based on their individual client risk assessment and ensure all staff are aware of the current risks in their risk identification (flagging system)

(b) Review relevant information in the care plan including resident triggers, behaviours and how care is to be provided safely and the safety measures and procedures to be taken during the provision of care to also protect worker health and safety.

PLEASE NOTE: Care plans document the care to be provided and are in the resident electronic medical record or paper chart. Each long-term care home must link the care plan and the safety plan and post the safety plan in the nursing station. A safety plan is the measures and procedures to be taken to protect worker health and safety during the provision of care. Examples include:

- Providing resident care with more than one person present at a given time
- Providing an object for the resident to hold rather than exhibiting escalating violent behaviours
- Playing a tape of a loved one's voice which soothes the resident
- Addressing the resident prior to entering their room and seeking permission to enter

It is important that if the care plan (should not be shared with non-clinical staff) includes the safety plan, it is the safety measures that are shared with all workers on a unit, floor or area and that the JHSC/HSR is consulted as required on the safety plan and interventions to be taken.

Information -

(a) Are there any new triggers? Is there any bad news or a situation that could cause resident aggression?

(b) What is the workplace context?

(c) How is the unit, floor, area functioning?

(d) Is there an outbreak? Are there residents that are agitated as a result of an infection control risk? E.g. confinement

(e) Are residents exhibiting irregular behaviours? e.g. spitting, scratching

(f) Do residents have any medical conditions that could increase aggressive behaviours?

(g) Are there admissions? Has there been an increase in the number of residents? E.g. interim care beds, short stay respite care

(h) Are there any resident to resident safety concerns or challenges?

(i) Do visitors have concerns regarding the environment or unmet care needs of residents? Are there any substitute decision makers or visitors that could impact worker safety?

(j) See Appendix A for information on triggers, violent, aggressive or responsive behaviours and interventions. The triggers, violent and aggressive and behaviours include:

- Verbal aggression
- Physical aggression
- Medical issues
- Self-harm
- Substance use
- Elopement
- Falls
- Refusing ADLs
- Psychotropic drugs
- Medications
- Restraints

Equipment –

(a) What equipment is working/not working that could have an impact on safety?

(b) Is there a means of summoning immediate assistance?

Watching –

(a) Who are workers watching?

(b) What has happened in the last 24 hours?

(c) What is happening today?

(d) Do we know of any resident triggers in advance?

(e) Is there a risk identified that needs to be elevated beyond the Safety Huddle?

Staffing –

(a) Do we have all of our staff?

(b) Are they regular care providers? E.g. agency

(c) Do we have the right staff to address the resident concern? E.g. activation staff

(d) Is there someone new on the unit, floor, area? Have all workers been trained in individual resident care needs?

(e) Are additional staff needed considering the risk state?

(f) Should security staff be hired? Should police be on standby?

(g) How are we going to decrease risk to any staff member because of the staffing mix and/or shortages?

(h) Are BSO staff available on-site or can they be called-in?

Weekly Safety Huddles

These Weekly Safety Huddles will differ from Daily (shift to shift) Safety Huddles in that they will be more comprehensive and develop different approaches to care planning which may change the care plan.

The safety plan, linked to the care plan, will be visible to all workers on the unit, floor or area. It will be accessible to all staff at the nursing station. The JHSC/HSR will be consulted as necessary on the safety plan.

These huddles will be 30 minutes each week and will include the supervisor, unit/floor/area staff, behaviour support staff/lead, physician, JHSC worker member or HSR.

The supervisor will facilitate the Weekly Safety Huddle.

The huddle will engage reporting of any existing new triggers and violent behaviours and successful interventions that reduce resident aggression. The V.I.E.W.S process can be used as a framework for conducting the weekly huddle, extending the timeframe from 24 hours to 7 days, where applicable.

Staff needs assessments will be done to identify training needs to address violent behaviour and the supervisor will follow-up in meeting those training needs. If BSO is on-site, these are also called quality huddles.

Issues will be identified and escalated that need action beyond the unit, floor or area that require management intervention. E.g. inappropriate behaviours of visitors/family members.

High Risk Huddle

When/if a resident exhibits violent behaviour or an incident of workplace violence has occurred involving a resident it is important to communicate that to the family. Please refer to the information found in Engaging Residents and Family in WVP tool.

When an incident of violent behaviour has occurred all of the staff in a unit, floor or area will immediately meet to assess why the violent behaviour occurred and how to prevent it from happening in the future. For example, some homes call this a Responsive Behaviour Huddle which is documented in electronic records e.g. Point Click Care.

Any member of the interdisciplinary team can request a High Risk Huddle from the supervisor. The supervisor will review the Individual Resident Risk Assessment, care plan and safety plan with the Charge Nurse (RN) and reference the criteria for a High Risk Safety Huddle and determine if the huddle should proceed. The supervisor will also review the risks, known history of violent behaviour, triggers and behaviours. The huddle will convene as soon as possible after the incident.

The supervisor, staff in the unit, floor, area and the charge nurse (RN), doctor, BSO lead, security where applicable and a worker member of the JHSC (or HSR) will attend the High Risk Huddle. All High Risk Huddle participants will have an opportunity to discuss the risks, triggers and behaviours and make recommendations for safety measures to protect staff.

The supervisor will document attendees, summary of the discussion, any concerns and recommendations and create or make amendments to the safety plan. A copy of this report will be provided to the JHSC/HSR and will be posted at the nursing station. The safety plan will be linked to the care plan and the care plan will be updated by the nurse providing care to the resident.

Communication

This policy and procedure will be communicated to all workers upon hire and made available for further reference in the health and safety manual. The employer shall ensure timely notice of changes to the existing policy as they arise.

Roles and Responsibilities

Board of Directors

- Ensures the organization complies with requirements under OHSA and the regulations, including the duty to warn and protect workers from workplace violence
- Ensures that Ministry of Labour orders and requirements related to violence towards workers are complied with
- Holds senior management accountable for the development of safety measures, procedures and training and the implementation of an effective violence prevention and flagging-alert program which will include effective communication strategies using Safety Huddles during shift to shift report and on a Weekly basis

Employer

- Takes every precaution reasonable in the circumstances to protect workers
- Appoints a competent person as supervisor as referenced under the OHSA 25 (2)(c)
- Assesses and manages the risks of workplace violence that may arise from the residents, nature of the workplace and the type or conditions of work, reassessing the risks as often as necessary
- Establishes and puts into effect written measures and procedures and training, in consultation with the JHSC/HSR, for a communication system that includes the requirement for a regular Safety Huddle for every shift and on a Weekly basis
- Provides to all workers at risk information (including personal information), with respect to persons with a history of or potential for violent behaviours
- Provides information, instruction, training, and education on this policy and its applicable procedures to all workers
- Designates an individual with the appropriate knowledge and experience to oversee the implementation, maintenance and evaluation of the Safety Huddles in accordance with the measures and procedure protocol. Holds that individual accountable for ensuring consistent application and implementation across the organization
- Allocates necessary resources for effective implementation of the Safety Huddle protocol
- Keeps and maintains training records related to the Safety Huddle protocol
- Ensures this policy and procedure is reviewed at least annually or as needed, and identifies policy and protocol gaps in order to make necessary changes to protect workers

Supervisor

- Takes every precaution reasonable in the circumstances to protect workers
- Advise a worker of the existence of any potential or actual workplace violence danger to the health and safety of the worker of which the supervisor is aware
- Communicate the risk of violence to workers and the measures to take to minimize/remove the risk
- Utilizes the Daily Safety Huddle at the start of each shift to communicate the hazards/risks that workers should be aware of or encounter on their shift
- The supervisor will review the current risk assessment, care plan and safety plan (triggers and measures and procedures to protect worker safety) of identified residents and will ensure both the care plan and safety plan are cross referenced
- Acting on behalf of the employer will ensure the Safety Huddle protocol regularly reviews every care plan to reflect on-going or new triggers that may arise from the nature of the workplace and type or conditions of work, reassessing the risk as often as necessary and communicating those risks and also communicating those risks at the Safety Huddle
- Determines where worker safety is a consideration, reflecting measures and procedures to be taken to protect worker safety are documented in the safety plan e.g. security is arranged because of a high risk resident
- Informs all workers (and security where applicable) about residents who have a history of violence or pose a risk of violent, as per *OHSA*
- Knows their duties under this policy
- Based on the Safety Huddle discussion ensures the resident care plan, worker safety plan and flag is updated to reflect any new triggers, violent behaviours and safety measures
- Assigns the Charge Nurse to make sure the Safety Huddle occurs if they are not available
- Ensures that staff receive appropriate training / education on this policy and its procedures, ensures that it is documented and consistently implemented
- Monitors and enforces compliance with this policy
- Reviews BSO requirements with staff
- Leads the Weekly Safety Huddle

Clinical Health Care Worker

- Conducts individual resident risk assessments according to organizational policy; notes findings; checks for previous flag alerts, triggers and highlights these at the Safety Huddle
- Engages residents, families, and substitute decision-makers in identifying history of violent behaviour, behaviours, triggers, and prevention /safety measures and procedures for workers and shares all information at the Safety Huddle
- Flags any resident with a history of violent behaviour or assessed as at-risk of violent behaviour
- Ensures flag, including violent behaviours, triggers and prevention / safety measures and procedures and any risk identified at the Safety Huddle are noted on resident's electronic / paper record and / or transfer-of-accountability forms

- Engages BSO Lead in Weekly Safety Huddle
- Develops and implements resident care-plans and safety plans in consultation with the care team to address identified risks, violent behaviours, triggers and prevention / safety measures and procedures required to keep workers safe
- Immediately alerts the supervisor, and security, where applicable, if a flag is initiated when a resident with a history of violent behaviour is identified or if a resident's behavior escalates
- Participates in training provided by the employer
- Reports at the Safety Huddle and documents changes to resident behavior that can risk worker safety and violence-related incidents and injuries / illnesses promptly to supervisors and other staff according to organizational policy (*add link to policy*)
- Communicates any risk identified and safety precautions to workers without access to electronic/ paper resident records (e.g. alerts supervisor and security, where applicable, and other staff of escalated resident violent behaviours)
- Attends the unit, floor or area Safety Huddle on each shift and on a Weekly basis
- Contributes to the Safety Huddle, both Daily and Weekly, by identifying flags, violent behaviours, triggers, care plans, safety plans and measures and procedures to protect worker safety
- Documents using Safety Huddle form the flags, violent behaviours, triggers, care plans, safety plans and measures and procedures to protect worker safety (see the form on page 7 and 8)
- Ensures updated flag status, violent behaviours, triggers, and prevention / safety measures and procedures that protect workers and residents are communicated to workers and volunteers (may take resident to programs or outings)

Non-Clinical Health Care Worker

- Is familiar with and follows requirements / duties under this policy
- Requests High Risk Safety Huddle be initiated by clinical health care workers and/or security where applicable when escalating violent behaviours or new triggers have been identified
- Reports incidents of violent behaviours immediately to supervisor, clinical health care workers and security or police as required by organizational policy (add link to policy)
- Participates in training and education provided by employer
- Attends all unit, floor or area Workplace Violence Prevention (WVP) Safety Huddles
- Contributes to the WVP Safety Huddle by identifying flags, violent behaviours, triggers, care plans, safety plans and measures and procedures to protect worker safety

Joint Health and Safety Committee / Health and Safety Representative

- Reviews this policy at least annually or as needed
- Assists with developing control measures
- Provides written recommendations (e.g., measures, procedures, training, education) to employer where necessary to improve the policy and program, minimize identified risks and protect workers
- Is consulted in development of measures, procedures, training and education, and evaluates the effectiveness of training related to this policy
- Participates in Weekly Safety Huddle
- In consultation with the BSO Lead, discusses different approaches to controlling the risk to workers in the Weekly Safety Huddle which will enhance the care plan and safety measures that are already established for workers delivering care
- Ensures the safety plan, linked to the care plan, is visible to all workers on the unit, floor or area, and is posted in the nursing station
- Consulted on safety plans as required

Huddle Lead (Preferably RN Charge Nurse)

- Leads the Daily Safety Huddle
- Participates in training provided by the employer
- Reports and documents violent behaviours and violence related incidents and injuries / illnesses promptly to supervisors and other staff according to organizational policy (add link to policy)
- Communicates any risk identified and safety precautions to workers with or without access to electronic/ paper resident records (e.g. alerts supervisor and security and BSO Lead where applicable)
- Ensures care plan is updated based on new resident information from the Daily Safety Huddle including flag status, violent behaviours, triggers, and prevention / safety measures and procedures that protect workers and residents are communicated to transfer-of- accountability units, floors, areas or facilities
- Conducts Daily Safety Huddles in the absence of the supervisor at shift report/transfer-of-accountability and encourages feedback and discussion of worker regarding safety and safe resident care using the Daily Safety Huddle Form above.
- Attends Weekly Safety Huddle
- Contributes to the Safety Huddle by identifying flags, any known risks, history of violent behaviours, any other violent behaviours, triggers, care plans, safety plans and measures triggers, care plans, safety plans, measures and procedures to protect worker safety

Security (Where Applicable)

- Checks-in with Huddle Lead (RN Charge Nurse) at shift report and participates in the Safety Huddle unit at the start of each shift to receive report on risk of violence
- Alerts Huddle Lead (RN Charge Nurse) of any new resident, violent behaviour

Training

In consultation with the JHSC/HSR the employer will ensure supervisors and charge nurses will be trained on the Safety Huddle policy and procedure. This will include training on the procedure, template and skills necessary to facilitate the Safety Huddle. Training will include documentation requirements and record maintenance. Supervisors will act as coaches to the huddle leads and will ensure sustainability of the huddle and optimization.

The Employer will provide all staff with training on the policy and procedure and the requirement to participate in safety huddles. New employees will receive this training at orientation and when these policies and procedures are revised. Ongoing refresher training will be provided on a regular basis.

The employer will keep all documentation regarding staff who have been trained, their training dates, and material covered.

Evaluation

The key indicators for effectiveness of Safety Huddles in providing information to identify, eliminate/minimize the hazards and risks of violence are:

- ✓ Communication of information
- ✓ Efficient operations
- ✓ Maximum staff participation
- ✓ Sustainable prevention measures
- ✓ Reduction of violent incidents involving staff
- ✓ Perceptions and experiences of staff related to physical and psychological safety

Safety Huddles (Daily and Weekly) will be evaluated by the interdisciplinary team at least every three months and at one year post implementation of the huddle itself. The evaluation will be based on the questions outlined below. Case studies could be utilized. Three month and one year evaluations will be documented by the supervisor answering the questions outlined below. Documentation will be maintained on the unit, floor or area.

In addition, huddles will be evaluated based on staff experience by including questions regarding huddle communication, operations, participation, implementation of safety measures, perception and experience of staff related to physical and psychological safety on a post implementation survey at three months and one year post implementation. There will be specific survey questions to evaluate the experience of the huddle lead (charge nurse) and the role of the supervisor as coach.

An indicator of effectiveness would be a reduction in violent incidents involving staff. The evaluation will also include a review of violent incident reports at three months and one year post implementation. The employer will want to see a reduction in violent behaviour based on reports from BSO staff.

The JHSC/HSR will be provided reports on the three month and one year evaluations done in the huddles, results of the data from the surveys completed at these intervals and the metrics on violent incident reporting in these same time frames.

The effectiveness of huddles in care planning will be measured through improved resident/family experience with questions on the annual resident/family satisfaction surveys.

The following questions will be considered and discussed in the huddle evaluation:

(a) Did staff receive the information necessary to prevent violence?

(b) Did the huddles happen? Daily? Weekly?

(c) If not, why not? Were there staffing shortages?

(d) If not, what can be done differently?

(e) Did they start on time?

(f) If not, why not?

(g) Did all staff participate? Attendance? Contribute to the conversations?

(h) At Daily huddles could all risks be identified in 10 minutes? Does the physician attend safety huddles if on site?

(i) At Weekly huddles could the review of the safety plan and care plan be done in 30 minutes?

(j) What else could be done?

(k) Did huddles result in measures to protect worker safety? Were they sustained by staff?

(l) Do staff feel their physical and psychological safety needs are being addressed? Do they feel safer?

The supervisor, in conjunction with the multidisciplinary team, will utilize the evaluation data to make process improvements to the Safety Huddle.

The actions will be documented in an evaluation report and time lines will be assigned for process improvements with persons responsible for implementation.

Prior to implementation the JHSC/HSR will be provided with the evaluation report and consulted on the actions.

The improvements will be implemented immediately following the evaluation where possible. The evaluation report will be stored in the unit, floor or area with the evaluation data.

Applicable Legislation

Occupational Health and Safety Act, 2009

Resources and References

The Ottawa Hospital Bedside Shift Report Poster, Mental Health Safety Huddle Pocket Card

MENTAL HEALTH SAFETY HUDDLE POCKET CARD

ELEMENTS:	
Violence Risk	Security Alerts
Code Whites	Med Assist
Suicide Risk	AWOL
Medical Risk	Fall Risk
Admissions	Transfers

GUIDELINES:
1-2 minutes per nurse
Discuss priority issues for patients
Only patients that require discussion
Team approach for overall unit safety

PROMOTES:

- Critical thinking
- Teamwork
- Information sharing
- Shared accountability
- Communication re: safety risks/priorities
- Mentoring new staff
- Collaborative Care Plans

The Beside Shift Report Poster outlines the goals, guidelines and elements of the shift report and outlines the content of the verbal report at the shift report and the safety check. The Mental Health Safety Huddle Pocket Card outlines the elements and guidelines of the safety huddle.

Institute for Healthcare Improvement Daily Huddles

http://www.ihi.org/resources/Pages/Tools/Huddles.aspx

This document outlines the definition of a huddle, tips for running a huddle, implementation of a huddle using Plan-Do-Study-Act, suggested huddle agenda,

Baycrest Transfer of Accountability at Shift Handover Policy

Title: Transfer of Accountability at Shift Handover		
Date first created:	**Revised: April 20, 2015**	**Approved By: NPAPD**

1.0 Policy:

Effective communication has been identified as a critical element in improving client safety, particularly with regard to shift handover. The purpose of the Transfer of Accountability at Shift Handover policy is to facilitate a standardized approach to:

1. Understanding the roles and responsibilities of staff involved in shift handover process;
2. The use of shift report templates during shift handover;
3. Ensuring that the narcotic/ controlled drug count is a part of the shift handover process.

This policy directly affects all interdisciplinary staff involved with clients at shift handover.

2.0 Procedure:

Transfer of Accountability: giving professional responsibility for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis[1]

Shift handover: the process in which transfer of accountability occurs between outgoing staff and oncoming staff from shift to shift

Team Members: Roles and Responsibilities

The interdisciplinary team plays a significant role in shift handover.

Clinical Managers/Unit Directors/Director(s) of Care facilitates that the direct care team:

- Has access to the policy and associated teaching materials.

[1] Jorm, C.M., White, S. & Kaneen, T. (2009). Clinical handover: critical communications. *Medical Journal of Australia, 190 (11),* s108-s109.

- Follows a standard protocol for shift handover through an accountability framework.
- Understand their accountability and responsibility according to the policy.

Nurses (Registered Nurses and Registered Practical Nurses)

- Understand the importance of both verbal and written communication at shift handover.
- Incorporate both written and verbal communication into the shift handover process.
- Utilize forms/guidelines and procedure as outlined below for nurse to nurse shift handover.
- Follow up on any significant client issues reported by personal support workers during the shift.
- Include any pertinent information observed and/or reported by personal support workers into shift report documentation.
- Remain on duty until the oncoming nurse (or delegate) arrives and transfer of accountability shift report has been completed.
  Note: nurses have a professional responsibility to continue care for their clients until they have arranged a suitable alternative or replacement. According to the College of Nurses of Ontario (CNO), a nurse who discontinues services without meeting the above condition may be liable for professional misconduct. [2] Managers will follow up with the staff as per the attendance and code of conduct policies
- Where applicable: Include and complete the transfer of accountability of the code blue/medical alert/ white pager. Ensure that the code pagers are transferred to the assigned nurses on the oncoming shift.
- Include and complete narcotic/benzodiazepine/controlled and targeted drug counts with the oncoming nurse as a part of the shift report and transfer of accountability handover process. Complete narcotic/benzodiazepine/controlled and targeted drug counts as per policy, please refer to policies: Narcotic and Controlled Drugs Policy
  Note: in the event of a count discrepancy, the nurse must report it immediately to their clinical manager/unit director (or delegate).

Personal Support Workers (PSW)

- Is required to verbally report to the most responsible nurse any client changes; client or family concerns and action taken to address throughout the shift and at the end of shift.
- Handover should not begin their client care assignment before receiving report from the nurse in charge

[2] College of Nurses of Ontario. (2009). *Practice guidelines: refusing assignments and discontinuing nursing services*. Toronto, Ontario: College of Nurses of Ontario.

- Organize their time and care activities in order to participate in the nurse shift handover process.
- Remain on the unit until the oncoming PSW(s) arrives and transfer of care has been completed. When a personal support worker is late for a scheduled shift, managers will address concerns of lateness as outlined in lateness policy.

Unit Clerks (Apotex)

- Populate and updates shift handover report forms for nurses with clients' names according to the updated bed roster
- Print out copies of shift handover report forms

Procedure

Shift report handover should be completed on the unit. Specific location (ie: nursing station, staff room, etc) can vary from unit to unit. To ensure client safety, the charge nurse must ensure there is adequate staff coverage on the unit during the shift handover and transfer of accountability transfer to the oncoming staff

Nurses (Registered Nurses and Registered Practical Nurses)

1. All nurses will use a shift report form/guideline at change of shift to guide the transfer of pertinent client information to staff on the following shift.
2. Shift handover will include: a written report form and verbal report. Please see Appendix A for: Shift report guideline, Hospital, Appendix B for: Shift report, Apotex, and Appendix C: Shift report, Transitional Behavioral support unit (Apotex).
3. Transfer of accountability for code white/ medical alert/code blue pagers to be completed as a part of the transfer of accountability between the assigned outgoing and oncoming nurses where applicable.
4. Narcotic/benzodiazepines/ controlled and targeted drug counts should be completed with outgoing and oncoming nurse as part of transfer of accountability process.

Personal Support Workers

1. All personal support workers will verbally report to the most responsible nurse of any client issues observed during the shift and prior to the end of the shift. Acute changes in clients' conditions should be reported immediately as they occur.
2. Should not begin their client care assignment before receiving report from the nurse in charge.
3. Personal support workers will be present and participate in nursing shift handovers.

3.0 Cross Reference Policies/Documents

Lateness Policy
Narcotic and Controlled Drugs Policy

Transfer of information at Client Transition Points Policy
Attendance management program policy

4.0 Appendix

Appendix A: Shift Report Guidelines, Hospital
Appendix B: Shift Report, Apotex
Appendix C: Shift Report, Behavioral Support (Apotex)

This policy facilitates a standard approach to understanding the roles and responsibilities of staff involved in the shift handover, uses shift report templates during shift handover and ensures the narcotic controlled drug count is part of the shift handover process.

- PSHSA Toolkit on Communicating the Risk of Violence, A flagging Handbook here
- PSHSA Toolkit on Individual Client Risk Assessment here
- PSHSA Long Term Care Violence Assessment Tool (VAT) here

Using a potentially aggressive/violent patient huddle to improve health care safety: https://psnet.ahrq.gov/resources/resource/32792/Using-a-potentially-aggressiveviolent-patient-huddle-to-improve-health-care-safety

Appendices

Appendix A –Definitions

At-risk Resident: A resident who poses a risk for violent behaviours.

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 health care worker or team in collaboration with (when possible) the resident and / or substitute decision-maker (SDM).

Behaviour Support Lead: The Behavioural Supports Ontario (BSO) Long-Term Care (LTC) Lead will serve as an in-house expert on identification and management of violent behaviours, which includes responsive behaviours. This dedicated lead will function in a specialty role providing behavioural support expertise to older adults presenting with or at risk for violent behaviours that may be associated with dementia, complex mental health, substance use and/or other neurological conditions.

Clinical Health Care Worker: A clinical staff member who provides preventive, curative, promotional or rehabilitative healthcare services to residents.

Daily Safety Huddle: Is a conversation including all unit staff. They are held for 10 minutes as part of shift to shift report when there is a transfer of accountability. It is protected time to discuss resident information related to violent behaviour that could lead to incidents of physical, verbal or psychological violence toward staff. The safety huddle is collaborative in their design and facilitation. It is time for staff to review or create a plan for worker safety.

Enhanced Prevention Practices: These are heightened measures used to prevent violent behaviours in at-risk residents and protect staff based on care needs and risk assessment.

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

- inform staff of a risk of violent, behaviours
- signal additional and individualized care-needs and preventive measures

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

Hazard: According to the Canadian Center for Occupational Health and Safety, a hazard can be a chemical, ergonomic, physical, or psychosocial agent which can cause harm or adverse effects in the workplace.

High Risk Huddle: When an incident of violent behaviour has occurred all of the workers in a unit, floor or area will immediately meet to assess why the violent behaviour occurred (being sensitive during the discussions to not ask questions in a way that may lay blame to any worker) and how to prevent it from happening in the future.

Individual Client Risk Assessment: A systematic process used by clinical Health care workers for evaluating a resident's likelihood of violent, violent behaviour.

Non-clinical Health Care Worker: Any staff member who is not a clinical Health care worker and is carrying on work activities in the long term care home setting.

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

Protocol: A system of rules that explain the correct conduct and procedures to be followed in formal situations.

Resident: For the purpose of this policy, a resident is any recipient of care.

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

Risk: Is 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 harm could be should the hazard cause injury or illness.

Routine Prevention Practices: Violence prevention strategies such as active listening and empathy that are used with all residents to prevent violent behaviours.

Staff: Staff members can be:

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

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

Supervisor: One that directs or oversees a person, group, department, organization, or operation; may be called a manager in a LTC setting. The Occupational Health and Safety Act (OHSA) defines a supervisor as a person who has charge of a workplace or authority over a worker. This is a broad definition that can apply to many different people in a workplace, including people in management, on the shop floor, in a bargaining unit, and individuals whose job title does not include the word "supervisor". E.g. In health care institutions like hospitals or nursing homes, an employer may assign responsibilities to a nurse that could make him or her a supervisor under the OHSA, depending on the circumstances. For example, a nurse acting in the capacity of a charge nurse may be considered a supervisor under the OHSA if the manager is not present on the unit or in the hospital or nursing home, and s/he has the following responsibilities:

- giving directions to other healthcare workers,
- monitoring how other healthcare co-workers carry out directions,
- reassigning duties, calling in extra staff when short staffed, and/or
- being in charge of the building.

In such a case, the employer would be obligated to train this nurse to the same competency level as any other supervisor (Who is a Supervisor under the Occupational Health and Safety Act).

Transfer of Accountability / Transition of Care (TOA / TOC): An interactive process for transferring resident information from one health care worker / team to another in order to ensure continuity of care, as well as staff and resident safety. Examples of TOA / TOC include:

- Nurse-to-nurse at change of shift
- Nurse-to-nurse when care is temporarily assigned to another nurse on a short-term basis
- Transfer from one resident-care area to another
- Transfer to an outside organization

Trigger: A circumstance or situation that may initiate, provoke or impact resident/visitor/family member behaviour. Triggers may be physical, psychological or activity-related.

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

Violent Behaviour — Early Signs: Overt signs of escalating violent behaviours such as:

- Changes in autonomic nervous system — e.g., sweating, flushed face, changes in pupil size, increased muscle tension
- Rapid, loud, or profane speech
- Sudden changes in level of consciousness — e.g., increased disorientation and confusion

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

Weekly Safety Huddle: Weekly Safety Huddles develop different approaches to care planning which may change the care plan and safety plan.

Workplace Violence is defined under the *Occupational Health and Safety Act* as:

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

Categories of Violence

- Type I. External perpetrator (thefts, vandalism, assaults by a person with no relationship to the workplace)
- Type II. Resident /Customer/Resident (physical or verbal assault of an employee by a resident/family member) someone who receives service from the organization
- Type III. Employment related. The violent person (physical or verbal) has or had some type of job-related involvement with the workplace.
- Type IV. Domestic violence (personal relationship)

Examples of Type II workplace violence may include:

  - Verbally threatening to attack a worker
  - Leaving threatening notes, emails, calls to workplace
  - Shaking a fist at a worker
  - Wielding a weapon at work
  - Punching, hitting or trying to
  - Throwing an object at a worker
  - Sexual violence against a worker
  - Spitting at a worker
  - Stabbing a worker
  - Responsive behaviour

Although the OHSA does not address psychological violence, as a best practice this policy and procedure includes it in the prevention effort. Therefore, “workplace violence” is any actual, attempted or threatened behaviour of a person that causes or is likely to cause psychological harm/injury/illness or that gives a person reason to believe that s/he or another person is at risk of psychological harm/injury/illnes

Public Services Health & Safety Association™

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Effective Workplace Safety Huddle Communication Tool

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