PSHSA.ca Public Services Health & Safety Association

Workplace Violence Incident Investigations Toolkit

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Table of Contents

Terms of Use 3
Introduction 5
- About PSHSA 5
- Making Violence Prevention a Priority in Ontario Healthcare Workplaces 5
- About the VARB Toolkits 5
- Why Focus on Workplace Violence Incident Investigations? 5
- Toolkit Purpose and Scope 6

Legislative Responsibilities 7
About Incident Investigations 8
Principles of Incident Investigation and Best Practices 8
Management System Approach 9
Incident Investigations Authority and Jurisdiction 9
Investigator Competency 10
Level of Investigation and Team Composition 11
Understanding Incident Causation and the Hierarchy of Controls 14
Stages of Incident Investigations 16
Incident Investigation Tracking and Trending 40
Documentation and Record Keeping 41
Workplace Violence Prevention Checklist 41
APPENDIX A: Sample Incident Investigations Policy 43
APPENDIX B: Starbursting Questions and Data Collection Planning Tool 53
APPENDIX C: Investigator Kit Contents Checklist 55
APPENDIX D: Physical Data Collection Form 56
APPENDIX E: Witness Statement Form 57
APPENDIX F: Post-Incident Huddle Form 59
APPENDIX G: Paper and Electronic Data Collection Form 64
APPENDIX H: OHSA Compliance Checklist 66
APPENDIX I: Incident Investigation Information Mapping Tools 69
APPENDIX J: Incident Investigation Report Form 73
APPENDIX K: Recommended Corrective Actions and Implementation Planning Template 80
APPENDIX L: Workplace Violence Incident Investigation Tracking Tool 85
How the Toolkit Was Developed 89
Acknowledgements 90
Definitions 91
Resources and References 92

Introduction

About PSHSA

The Public Services Health & Safety Association (PSHSA) is funded by the Ministry of Labour, Immigration, Training and Skills Development (MLITSD) and provides occupational health and safety training, resources and consulting services to mitigate 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 from domestic violence, the impact can be damaging and affect all involved. Violence in healthcare workplaces is further complicated by the varying types of healthcare workplaces (e.g., hospitals, long-term care homes, home and community care settings), each with a different mix of staffing, care recipient needs and workplace violence prevention approaches.

Violence against healthcare workers is a serious issue that demands system-wide attention and action. Provincial statistics suggest that although progress has been made to improve safety on the job, healthcare workers continue to experience one of the highest rates of workplace violence of all workers in Ontario. Workers should feel safe and secure at work. Violence must not be tolerated or accepted as part of the job.

In 2015, the MLITSD 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. In 2019, the MLITSD also released a violence prevention guide called Workplace violence prevention in health care: A guide to the law for hospitals, long-term care homes and home care.

About the VARB Toolkits

The Violence, Aggression, and Responsive Behaviour (VARB) Toolkits are evidence-informed resources 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 series of toolkits are comprehensive resources but can be used as stand-alone documents to address an immediate or specific priority. For more information, visit www.workplace-violence.ca.

Why Focus on Workplace Violence Incident Investigations?

A thorough investigation of workplace violence and the implementation of corrective measures are critical for the prevention of future incidents. Frequent recurrences cause undue pain and suffering for workers and unnecessary losses to employers. It is important that community and healthcare organizations understand that workplace incident investigations are an opportunity for learning, understanding, making improvements, and preventing harm to workers and others.

Taking a more structured and comprehensive approach to investigations that focuses on identifying incident

root causes will assist organizations in developing effective recommendations to address (by eliminating or controlling risk) underlying causes and systemic issues.

Toolkit Purpose and Scope

This toolkit outlines incident investigation principles, a systematic approach to incident investigation, investigator and investigation considerations, and the basics for root cause analysis that can be applied to workplace violence investigations in hospital, long-term care, and home and community care settings. These investigation processes and principles may also be helpful for investigations involving work refusals.

Refer to the Workplace Violence in Healthcare Incident Reporting Toolkit for guidance about reporting the incidents and hazards that prompt these investigations.

Note: This toolkit provides guidance for investigating incidents and is not meant to be prescriptive. 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 care, long-term care, or community care. The terms violence and violent behaviour are used to represent violence, which includes aggressive or responsive behaviours in the workplace.

Legislative Responsibilities

Under the Occupational Health and Safety Act (OHSA), Ontario workplaces must protect workers from workplace injury and illness. Employers must consider how the OHSA and its regulations apply to their workplaces and what is required for workplace violence prevention and investigations. Key sections of the OHSA that workplaces need to consider regarding workplace violence investigations include, but are not limited to:

- General duty to establish measures and procedures to protect workers, which requires consultation with the Joint Health and Safety Committee or Health and Safety Representative (JHSC/HSR).
- Employer and supervisor duties to take every precaution reasonable under the circumstances to protect workers.
- Workplace violence program requirements, including how the employer will investigate and deal with incidents or complaints of workplace violence.
- Employer and supervisor duties, including the requirements to:
  - Provide to the JHSC/HSR the results of any health and safety reports (such as incident investigation reports).
  - Advise workers of the results of any health and safety reports.
- JHSC/HSR entitlement to investigate critical and fatal injuries and provide a report to the MLITSD of their findings.
- Assistance and cooperation the employer must afford to the JHSC/HSR in carrying out their investigation functions, and
- JHSC/HSR entitlement to obtain information from the employer respecting:
  - The identification of potential or existing hazards.
  - Health and safety experience and work practices and standards of other industries of which the employer has knowledge.

The OHSA and its regulations provide direction to employers regarding mandatory notices, including when and what information to report to the MLITSD, JHSC/HSR, and any applicable unions for different types of incidents, injuries, and illnesses. The OHSA does not explicitly use the term 'investigate' in the employer notice section. Instead, it mandates the employer, in accordance with Regulation 420/21, Notice and Reports Under Sections 51 to 53.2 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents, to provide a written report or written notice with particulars, including 'steps taken to prevent a reoccurrence'. To determine such steps implies that some type of investigation must be performed.

Similarly, the OHSA does not offer any specific direction for the investigation of near misses or no injury incidents; however, the OHSA general duty clause (as noted above) states that employers and supervisors must take every precaution reasonable in the circumstances to protect workers. Investigating potentially harmful incidents (including near misses) to prevent future workplace violence and injury may help meet this due diligence requirement for worker protection.

For healthcare workplaces governed by the Healthcare and Residential Facility Regulation (HCRFR), employers are mandated to establish written measures and procedures to protect workers. To identify the necessary steps for achieving this, an investigation would need to be conducted.

Before developing and implementing an incident investigation program, including investigations due to workplace violence, workplace parties

GOOD TO KNOW

Workplaces need to know how the sections of the OHSA apply to workplace investigations.

must understand the relevant sections of workplace health and safety legislation and regulations. This understanding, shaped through training and experience, is critical to ensure the program's effectiveness and ultimate success.

Also, see the Workplace Violence in Healthcare Incident Reporting Toolkit for additional information about reporting requirements.

About Incident Investigations

The purpose of conducting incident investigations is to assist with:

- Determining incident causes and corrective actions to prevent reoccurrence,
- Ensuring compliance with legal requirements, and
- Learning and making quality improvements.

Limited research has been done on workplace incident investigation; however, valuable lessons can be learned from the fields of patient safety, quality improvement, occupational health and safety, and high-risk industries such as aviation, nuclear power, oil and gas and chemical production.

Furthermore, the Canadian Standards Association has developed guidelines for implementing investigation programs. These guidelines support the management system approach and incorporate a plan-do-check-act continual quality improvement process.

CSA encourages system thinking and analysis when conducting investigations. This involves utilizing various investigation techniques, including root cause analysis, and other tools to support the process.

Whether workplace violence affects workers or care recipients, the consequences impact the entire healthcare system. Addressing workplace violence requires thorough analysis to determine the root cause(s) of incidents and effective corrective and preventative actions.

GOOD TO KNOW

'Root causes' are also referred to as basic or underlying causes, depending on the document source.

As incidents inherently vary in complexity, it is important to recognize that the intensity of the investigation will also vary accordingly. Evaluating the risk of harm (e.g., minimal, low, medium, or high risk) and the nature of the incident, will help workplaces determine the suitable scope of the investigation and guide the composition of the investigation team.

Principles of Incident Investigation and Best Practices

Guiding principles and best practices for workplaces to support the effective investigation of incidents include:

- Leadership support, commitment, and resources for the investigation of incidents, including support and resources for both employer/designate representative, and/or JHSC/HSR investigations.
- Safe and Just Culture promoting a fair and non-punitive environment.
- An objective, unbiased, and impartial approach.
- Use of an investigation team, including the right people who work collaboratively and demonstrate transparency.
- Participation by workers, JHSC/HSR worker members, and others (e.g., unions) as applicable.
- Confidentiality, including safe reporting and protecting identities, where required.
- Systems and a continuous quality improvement approach to enhance sustainability and learning from systemic problems.
- Consistent investigations with considerations for incident complexity.

- Timely and proactive action to prevent future incidents.
- Application of the precautionary principle to protect workers.

It is important that workplaces adopt a Just Culture approach so that root causes and/or systemic issues can be identified and addressed. Just culture promotes physical and psychologically safe workplaces by fostering an environment where individuals feel safe to speak up and transparent processes prioritize continual improvement through lessons learned.

Management System Approach

Workplaces are encouraged to take a systematic, iterative and structured approach to develop, implement and maintain the methods used for incident investigation. Policies and procedures for incident investigation should be part of a larger occupational health and safety management system (OHSMS) and integrate with their workplace violence prevention program. For context, the OHSA defines OHSMS as a coordinated system of procedures, processes and other measures designed to promote continual improvement in managing health and safety in the workplace.

A key benefit of developing a systematic and integrated approach to incident investigations is to help ensure senior management commitment, legislative compliance, incident investigation program sustainability, the promotion of quality improvement and reduction of risk for the protection of workplace parties.

Prior to developing incident investigation policies and procedures, workplaces may consider establishing a planning committee or working group that provides oversight. The committee composition should be multidisciplinary and could include JHSC/HSR union and non-union worker member(s), union leaders, and one or more leads or sponsors who have decision-making authority. Organizations may choose to use an existing workplace violence prevention committee or JHSC workplace violence subcommittee for this purpose.

GOOD TO KNOW

A systematic approach to developing and implementing an incident investigation program facilitates sustainability and quality improvement.

See Appendix A for sample incident investigation policy and procedures.

Incident Investigations Authority and Jurisdiction

The person(s) with the authority and jurisdiction to investigate incidents depends on many factors, including legislative requirements, the type of incident, organizational protocols for investigations and investigator competencies.

Note: OHSA does not prescribe who should investigate, how to investigate, or the defined steps in the investigation for reportable or non-reportable incidents or injuries, except for the requirements of JHSC/HSR investigations for critical or fatal injuries.

Investigations can be performed internally by employer designated personnel or teams, JHSC/HSR workers, and/or external authorities such as a MLITSD inspector and/or police. In fact, one incident may have multiple concurrent investigations and the authority having legal jurisdiction and control over an incident scene (e.g., police) will coordinate the release of the scene to the other parties (e.g., MLITSD or employer) once they have completed their initial onsite investigation. Investigations completed by each party may take varying lengths of time depending on the specific circumstances. Investigations often continue after the scene has been released. Organizations need to establish a process and procedure for the coordination of multiple investigations involving internal and external investigators (Canadian Standards Association, 2017) and work collaboratively with external investigators.

The employer and JHSC/HSR may complete their investigations separately or together if the JHSC/HSR

choose to do so. The employer must ensure that the JHSC/HSR are supported and not obstructed in exercising their power to investigate critical and fatal injuries, as outlined by the OHSA.

In the absence of information in the OHSA on conducting investigations, the CSA standard CSAZ1005-21 provides best practice guidance for the employer, investigator and related teams.

Joint Health and Safety Committee Worker Member or Health and Safety Representative

The OHSA entitles worker members of the JHSC/HSR to investigate critical and fatal injuries, separate from the employer's investigation, and provide a report to the JHSC and MLITSD Director on their findings. The JHSC/HSR may choose to investigate collaboratively with the employer and send either a separate or jointly signed report to the MLITSD. The JHSC/HSR worker member report does not have a specified deadline for submission; however, in the MLITSD Guide for health and safety committees and representatives, it states that findings must be reported "following the investigation", implying as soon as the investigation is completed.

It is important that supervisors and employers understand the JHSC/HSR's legal entitlement to investigate critical or fatal injuries and obtain information from the employer. The JHSC/HSR and employer will need to develop seamless processes to address these sections of the OHSA.

Ministry of Labour, Immigration, Training and Skills Development

MLITSD inspectors are entitled to investigate any workplace in response to workplace violence related complaints and contraventions of the OHSA. As outlined in the OHSA, the inspectors have broad powers for investigations to obtain warrants, enter workplaces, seize items, conduct tests, take measurements, and make inquiries of any person with or without expert help. Workplaces must cooperate with the investigation. A MLITSD inspector has jurisdiction over the scene of the incident once an investigation has been initiated. The employer can still initiate their investigation; however, the employer agents must operate within the constraints set by the MLITSD regarding the scene. The employer is still required to submit their report or notice within the legal time requirements.

Police

When workplace violence incidents involve potential criminal activities as outlined in the Criminal Code of Canada (e.g., assaults, homicide, etc.), the police will investigate to determine criminal wrongdoing and whether they will lay charges (Criminal Code R.S.C., 1985, c. C-46). They have jurisdiction over the incident scene until they have secured the information needed. For more information, see the Health Care Facility-Police Protocol developed by the Workplace Violence in Healthcare Leadership Response Working Group at https://workplace-violence.ca/wp-content/uploads/2023/11/pshsa-varb-violence-response-toolkit-03f-vhmmnben0619.pdf #page=40.

Investigator Competency

Individuals or teams conducting workplace violence investigations should have the competence through training and experience to carry out this responsibility.

Knowledge is required in:

- Occupational health and safety standards, codes and legislation including those related to investigations and workplace violence.
- OHSA and occupational health and safety principles and basics, including:
  - Internal and external responsibility systems.
  - Role and functions of the JHSC/HSR.
  - Worker rights and prohibition of reprisal.
  - Workplace violence risks and risk assessment.

  - Hazard recognition, assessment, risk control and evaluation of controls (RACE) as they relate to workplace violence.
- Investigation processes, techniques, and incident causation.
- Industry best practices, workplace practices, processes, procedures, evidence-based practice and/or technical information related to workplace violence.
- Documentation and report/record retention, dissemination, and control of internal policies and procedures.
- Confidentiality of information.
- Privacy Legislation e.g., Personal Health Information and Protection Act (PHIPA).

Skills and abilities are required in:

- Organization, prioritization, critical thinking, and analysis skills.
- Interpersonal, active listening and written and verbal communication skills.
- Conflict resolution skills.
- Ability to work independently, as well as in team environments.
- Remaining impartial in the situation, e.g., be objective, unbiased, fair-minded, just, unprejudiced, nonpartisan, non-discriminatory, open-minded.

GOOD TO KNOW

It is important that those investigating workplace violence incidents have knowledge, skills, and abilities and/or have access to those with the knowledge, skills, abilities and experience where gaps exist.

The CSA Z1005-21 incident investigation standard also suggests that where knowledge, skills, and ability gaps exist in an investigation team, the employer should develop a plan to remedy the gaps, e.g., develop a process for the investigators to acquire the knowledge, skills and abilities through education and training. Alternatively, external resources could be acquired, if needed.

Level of Investigation and Team Composition

Determining the scope of investigation required depends on a number of factors. Initial focus should be on assessing the severity the incident and identifying the necessary resources for the investigation. When evaluating the severity of risk, it is important to look beyond the immediate harm and consider the potential severity of what "could" have happened (worse case consequence) and the probability of recurrence. This relationship is represented below by the following formula:

Level of Investigation = Potential Severity of Incident x Probability of Recurrence

Far too often, incidents that could have been potentially fatal or cause major injury are not investigated or adequately investigated and corrective actions are not implemented or sufficient. Using the 'potential' severity of an incident in the level of investigation equation regardless of whether those consequences have occurred, is a proactive and preventative approach to implement.

In general, low and very low ranked risk incidents are less complex and may be investigated with fewer resources, less intensity, and over a short period of time. Whereas higher risk and more complex incidents may be investigated with additional resources and/or a team and may take longer to complete. The "Incident Investigation Decision Matrix" in Table 1, can assist organizations in determining the level of investigation for their incident circumstances. Table 2, "Incident Levels", provides some guidance on the resources needed for each level of investigation and can be adapted to meet an organization's needs. This may vary from hospitals, long-term care or home and community care. To reflect the needs of the organization and sector, organizations often define or use their own decision risk matrix and legends and alter their description of incident levels in Table 2.

Table 1: Incident investigation level decision matrix

Probability of recurrence	Potential severity or worst-case consequence of adverse event			
	Catastrophic	Critical	Minor	Negligible
Very likely	**High**	**High**	**Moderate**	**Low**
Likely	**High**	**High**	**Moderate**	**Low**
Possible	**High**	**High**	**Moderate**	**Low**
Unlikely	**High**	**Moderate**	**Low**	**Very Low**
Highly unlikely	**High**	**Moderate**	**Low**	**Very Low**

The colour code (i.e., heat map) identifies the level of investigation, e.g., High, Moderate, Low, Very Low

Probability Legend	
Catastrophic	Fatality, coma, severe emotional trauma
Critical	Debilitating injury, or significant emotional trauma (includes critical injury)
Minor	Minor injury, or moderate emotional trauma
Negligible	No injury, no emotional trauma
Very Likely	Very high probability of happening
Likely	High probability of happening
Possible	Moderate probability of happening
Unlikely	Low probability of happening
Highly unlikely	High probability it will not happen

Table 2: Investigation levels

Level	Suggested Investigation Level Activities
High	A team-based investigation involving a team leader, supervisor/manager, health and safety advisor, JHSC/HSR/worker representative, and experts as needed to conduct a comprehensive investigation under the direction of senior management. The team identifies immediate and root causes and makes recommendations to senior management. Once approved, management implements and monitors the corrective actions, and an assigned party will communicate changes to those affected or potentially affected in the organization.
Moderate	Supervisor/manager, health and safety advisor, JHSC/HSR/worker representative investigate to determine immediate and root causes and develop and recommend corrective actions. Supervisor implements and monitors corrective actions and communicates changes to those affected or potentially affected. Experts may also be included, as needed.
Low	Supervisor/manager to investigate to identify immediate and root causes of the incident, including speaking with staff, JHSC and others as needed; develop and implement corrective actions; and communicate changes to those affected or potentially affected. Ensure communications to the JHSC/HSR/worker representative as appropriate and communicate with staff. Seek health and safety advice as needed.
Very Low	Supervisor/manager to review the circumstances of the event including speaking with staff and learn lessons which will prevent future occurrences, implement and communicate changes to those affected. Ensure communications with JHSC/HSR/worker representative, as appropriate. Seek health and safety advice as needed.

(Adapted from HSE, 2004)

Examples: Determining incident investigation levels for workplace violence in healthcare settings

Incident	Incident investigation level
A worker's partner enters the workplace. The partner finds the worker and begins hitting the worker, then pushing them to the floor resulting in the worker fracturing their upper arm.	**Severity –** Critical **Probability for recurrence –** Possible or likely **Investigation Level =** HIGH
A worker is treating a very weak, frail, and confused 95-year-old care recipient who attempts to bite the worker, but the care recipient has no teeth, and the worker does not incur any injury or illness.	**Severity –** Minor **Probability for recurrence –** Moderate **Investigation Level =** LOW
A worker is pushed very hard into a door by an angry and frustrated family member of a care recipient. The worker sustains a concussion and is psychologically traumatized by the event and unable to work.	**Severity –** Critical **Probability for recurrence –** Possible **Investigation Level =** HIGH
A care recipient on new medication repeatedly slaps and scratches a worker's forearm very hard causing redness and a bruise.	**Severity –** Minor **Probability for recurrence –** Likely **Investigation Level =** MODERATE
A care recipient with a known long history of violence becomes extremely agitated in the emergency department when they learn they will be admitted to the hospital. The care recipient threatens a worker with a pen using a stabbing motion.	**Severity –** Critical **Probability for recurrence –** Likely **Investigation Level =** HIGH

Note: Where there is no consensus about the incident investigation level ratings, it is best to consider the precautionary principle and conduct an investigation that will be more detailed and protective of worker health and safety.

Understanding Incident Causation and the Hierarchy of Controls

It is important for those conducting incident investigations to understand incident (or accident) causation. This will help investigators work backwards from the injury and incident to identify the causes and preventive measures that can be implemented. Some theories are linear in nature and simple, while others are more complex (Health and Safety Professional Alliance, 2012).

There are many models and theories for incident causation, varying from the injury proneness theories of the 1930s where workers were blamed for workplace incidents due to personal attributes and hereditary predisposition, to more recent theories and models that take a more complex systems approach to incident causation.

The accident proneness theory of incident causation may be referred to as the person approach, which focuses on unsafe actions and mistakes of workers as the sole cause of incidents. We now know that the workplace's health and safety systems and controls play a key role in workplace injury prevention, including those related to workplace violence prevention. In many cases, what appears to be a worker's unsafe actions may be due to system inadequacies, such as a lack of leadership commitment, inadequate safety standards and processes, training, equipment, etc.

GOOD TO KNOW

Understanding how incidents occur can help investigators systematically work backwards from the incident occurrence to identify all the causes of an incident and prevent future incidents.

Two accident investigation models that provide useful insight while conducting investigations include the Loss Causation Model and the Swiss Cheese Model. These popular models provide investigators an understanding of how incident causation occurs and effective approaches to incident investigation. There are similarities between these incident causation models that are important for any investigation, including:

- Identifying local workplace, organizational and system factors that contribute to an incident,
- Determining root causes, and
- Identifying corrective actions using the hierarchy of health and safety controls, as seen in Figure 1 below.

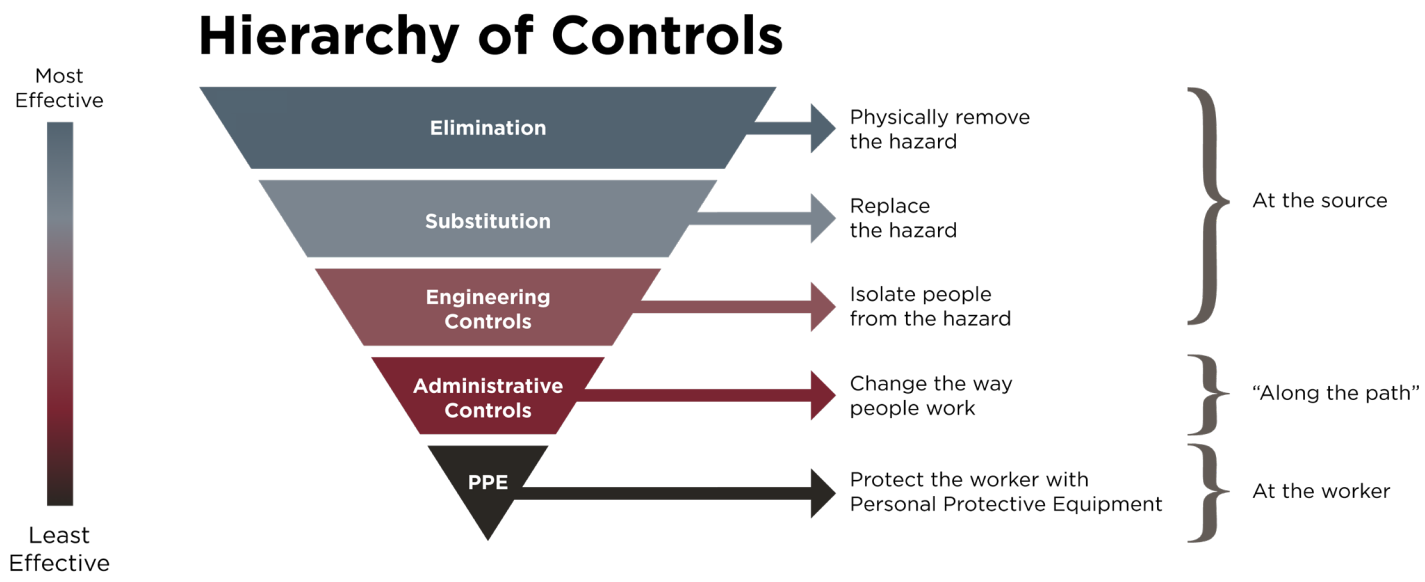


Figure 1: Hierarchy of Occupational Health and Safety Controls (Public Services Health and Safety Association)

In the hierarchy of controls eliminating or substituting hazards and implementing engineering controls are ranked higher. This is due to their effectiveness in designing out and/or reducing hazards, directly addressing risk at its source.

Administrative and personal protective equipment measures may also be used to help control hazards and protect workers but are less effective at eliminating hazards and minimizing risk. Control at the worker level such as personal protective equipment (PPE) is least desirable, as it depends on human behaviour and compliance, but often is still needed. Figure 1: Hierarchy of Occupational Health Safety Controls illustrates hazard control effectiveness from highest to lowest.

Sometimes a combination or three levels of controls are required.

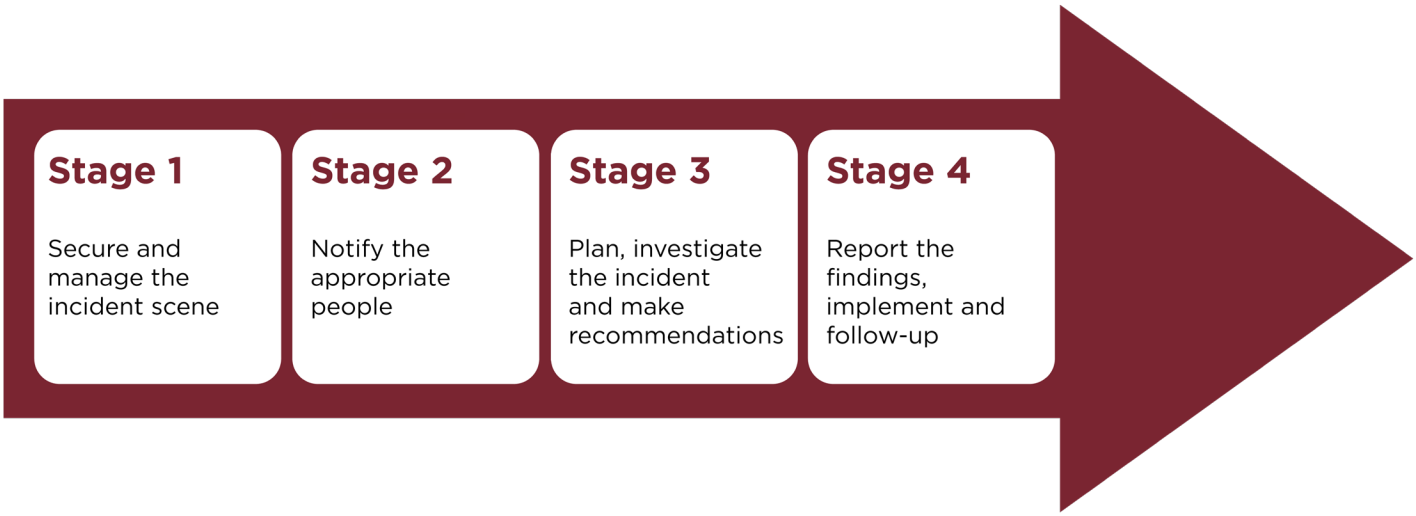
1. Controlling hazards at the source (e.g., elimination, substitution, engineering and ergonomics/human factor design)
2. Controlling hazards along the path (administrative controls such as policies, procedures, safe workplaces, processes, practices, training program), barriers, job organization, job/task design etc., and
3. Personal protective equipment (e.g., equipment that protects workers from direct exposure to potential hazards).

Refer to the Workplace Violence Risk Assessment Toolkits for additional information.

Understanding incident causation can help investigators develop more effective strategies to improve their health and safety system and reduce the risk of incidents.

Stages of Incident Investigations

There are four major stages to incident investigation:



Stage 1: Secure and Manage the Scene of the Incident

Where a critical or fatal injury has occurred, the priority is to provide care to the injured person. The organization must also take immediate steps to secure and preserve the scene of the incident, as required by the OHSA and detailed in Table 3 below. This task is typically assigned to initial responders, supervisors, security, and/or investigators.

Table 3: OHSA Section 51(2) Preservation of Wreckage (2) Where a person is killed or is critically injured at a workplace, no person shall, except for the purpose of,

(a) Saving life or relieving human suffering;

(b) maintaining an essential public utility service or a public transportation system; or

(c) preventing unnecessary damage to equipment or other property,

interfere with, disturb, destroy, alter or carry away any wreckage, article or thing at the scene of or connected with the occurrence until permission so to do has been given by an inspector.

All workplace parties, including those responsible for conducting the investigation, must adhere to the requirements of OHSA s.51(2) until the authority having jurisdiction — such as the police or MLITSD — releases the scene.

During this time, investigators may prepare for the investigation, provided that the scene remains undisturbed, and the integrity of the evidence is preserved. Even if a workplace violence incident does not result in a critical or fatal injury, securing the scene can provide more accurate information. It is important to investigate the scene of the incident in-person as soon as possible to prevent the loss of key evidence and to ensure witnesses' recall of the events remains clear.

After the scene is released, those responsible should conduct a hazard risk assessment to confirm the scene is safe to investigate and to implement any necessary safety precautions. If ongoing threats are present — such as the presence of a firearm, chemical spill, or uncontrolled fire — organizations must have a process in place to communicate and deal with these threats promptly and effectively. For more information, see the Emergency

Response to Workplace Violence (Code White) Toolkit for more information.

Stage 2: Notify the Appropriate People

After an incident occurs, but before initiating an investigation, it is important to notify all relevant internal and external parties, such as the MLITSD, JHSC/HSR, and union(s). Notifications must be made within the time limits established by the authority having jurisdiction.

The findings from a workplace violence incident investigation will form the basis for the OHSA notification reports in cases of:

- Critical or fatal injuries
- Disabling injuries where a worker is unable to perform their normal duties or requires medical attention
- Occupational illness

These reports must include all required details as specified in section 3 of O. Reg. 420/21, including the 'steps taken to prevent recurrence.

When an OHSA notification is not required, such as in cases of no harm or near miss incidents, notifying internal stakeholders may still be necessary according to the organization's reporting policy. This ensures that all incidents are documented and investigated to proactively identify risks and implement control measures to prevent future occurrences.

Refer to PSHSA's Workplace Violence in Healthcare Incident Reporting Toolkit for additional information about notification and reporting requirements.

Stage 3: Plan and Investigate

Planning the investigation

Prior to the investigation, consider:

- Identifying and notifying the lead investigator.
- Determining the scope and level of investigation required.
- Identifying required resources, such as:
  - Investigators or investigation team members (e.g., JHSC/HSR worker member, workers), and/or experts as needed based on the level of the investigation. Others may be added as the investigation progresses.
  - Investigation materials required.
- Confirming that the investigators are authorized to attend the scene of the incident.
- Coordinating how work activities, such as witness interviews, data collection, and root cause analysis will be performed.
- Reviewing relevant information from the incident report as outlined in the Workplace Violence in Healthcare Incident Reporting Toolkit.

Conducting the Investigation

To address the root causes of an incident and prevent recurrences, organizations must carry out a thorough investigation. This process involves gathering relevant information, objectively evaluating the evidence within the context of the organization's systems, and procedures and determining appropriate corrective actions. Depending on the complexity and/or urgency of the incident, a preliminary investigation may be necessary to implement immediate safety measures before a full investigation is conducted.

The investigation process consists of five main steps. Each step, along with relevant tools and examples, is detailed below.

Step 1 – Define the Incident Problem and Purpose

An effective investigation of workplace violence starts with a clear definition of the problem. This involves identifying the specific issue to be investigated and framing the key questions that need to be answered. Consider the who, what, when, where, how, and why of the incident, as well as how to prevent similar occurrences in the future. Formulating a focused investigation question can help guide the inquiry and ensure that all relevant aspects are addressed. A sample framework and example are provided below.

Question Framework: How and why did the [TYPE OF INCIDENT] incident occur to [WHO] on [WHEN] at [WHERE] that caused [TYPE OF INJURY OUTCOME e.g., physical/psychological injury/illness], and how can it be prevented?

Sample Investigation Question:

How and why did a patient-related critical workplace violence incident occur to a registered nurse on December 6, at 7 pm in the treatment clinic that caused a physical injury to their right lower arm and how can future incidents be prevented?

To guide the investigation further, organizations should also develop a strong purpose statement. The statement should explain why the investigation is necessary and outline the goals and objectives it aims to achieve. Well-defined purpose statements help maintain focus and ensure the investigation achieves its intended outcomes. Examples are shown in **Table 4**.

Table 4: Examples of investigation purpose statements

Investigator	Example Purpose Statements
HSR (worker)	• To investigate a workplace violence critical or fatal incident in compliance with section s. 8(14), identify root causes of the incident, and provide findings to a Director at the MLITSD. • To make recommendations as per OHSA s. 8(10) where a health and safety representative has the power to identify situations that may be a source of danger or hazard to workers and to make recommendations or report the findings thereon to the employer, the workers and the trade union or trade unions representing the workers.
JHSC worker member(s)	• To investigate workplace violence critical or fatal incident in compliance with s. 9(31), identify root causes and report findings to a Director at the MLITSD. • To make recommendations, as per OHSA s. 9(18) where the worker members of the JHSC have the power to identify situations that may be a source of danger or hazard to workers and make recommendations to the constructor or employer and the workers regarding the establishment, maintenance and monitoring of programs, measures and procedures respecting the health or safety of workers [s. 9(18(c)].
Employer	• To investigate workplace violence in compliance with OHSA s 51 and 52, identify root causes, develop steps to prevent the occurrence and protect workers, and provide notice/report to the MLITSD and/or JHSC/HSR and unions as per regulation 420/21 section 3. • To develop and implement quality improvement for worker and others' safety. • To communicate corrective actions and quality improvements to those affected or potentially affected by the incident or similar incident.

Step 2 – Collect Data

Competent investigators with the appropriate knowledge, skills, and abilities should gather all the necessary data. Collecting comprehensive facts and evidence related to the incident enables the investigators to answer the questions —who, what, where, when, how, and why —outlined in step 1.

To streamline data collection, investigators can incorporate tools such as the Starbursting Questions and Data Collection Planning tool in Appendix B and illustrated in figure 2. This tool can assist in:

- Identifying additional questions for each key category
- Planning the methods for collecting various types of data (e.g., interviews, physical evidence, paper/ electronic data)
- Assigning responsibilities for data collection, including who will collect the data and when

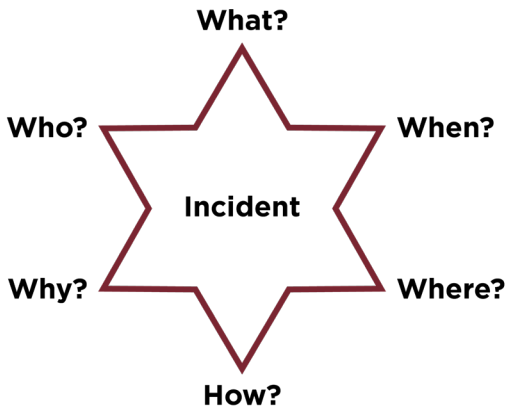


Figure 2. Starburst

Data collection must be objective, well planned and methodical. An investigation kit can help prepare and organize investigators for onsite investigations. For suggestions on what to include in the kit, refer to Appendix C: Investigator Kit Contents.

To gather and document the required facts or evidence, investigators should draw from three primary data sources:

- Physical evidence data
- People data - interviews
- Paper and electronic data

Physical Evidence

Physical evidence in a workplace investigation refers to tangible objects, tools, materials or other items, present at the scene of the incident. Timely identification, documentation and careful handling of these items can help minimize the risk of the evidence being lost or altered. This ensures that evidence remains reliable and can offer more accurate insights into what occurred or caused the event.

When assessing the scene for physical evidence, also consider environmental factors that may have influenced the incident. These factors provide important context for analyzing the physical evidence once all data collection is complete:

- Equipment, devices, materials, objects, things and their condition, position, accessibility (e.g., alarms, furniture, weapons or potential weapons).
- Workplace layout, including windows, doors, exits, access points, emergency exits, physical barriers, or obstructions.
- Sightlines for staff, patients and visitors e.g., visual obstructions.
- Lighting condition and direction.
- Flooring and its condition.
- Air quality, temperature, noise, weather conditions, odors.
- Housekeeping and general condition of the scene.
- The location of the people involved in the incident and their physical relationship and distance to other people and/or objects at the scene.
- Time of day or other conditions in the workplace that may have provided opportunity for workplace

violence incidents, or trigger behaviours.

Maintain a detailed log of all evidence collected, including the time and date of collection, the exact location where each item was found, and thorough description of its nature and condition. Where relevant, include supporting photographs, sketches and measurements. For example, take clear photos from multiple angles and close-ups of specific details; create a sketch showing the layout and position of key items; and measure distance or sizes using a tape measure or laser measure.

For more detailed instructions on collecting and documenting physical evidence, refer to Appendix D: Physical Data Collection Form.

People data

People data refers to information collected from individuals directly involved in or connected to the workplace violence incident. This includes the affected worker, the perpetrator, witnesses, and experts who may offer further context or insights. The aim is to identify the root causes of the incident by gathering objective facts rather than subjective opinions and assumptions.

Common methods for collecting this data include:

- Interviews: Verbal conversations with key individuals identified from the incident report and other relevant sources. During the interview, the investigator asks pre-defined questions and takes detailed notes or may record the conversation (with consent) for later transcription. See Table 5 below for tips on conducting effective interviews.
- Witness Statements: Detailed descriptions of the incident from individuals who observed it or were first on the scene. Statements can be provided in writing or verbally. If given verbally, the investigator transcribes the statement and has the witness sign to confirm its accuracy. For a sample documentation form, refer to Appendix E: Witness Statement Form.

Regardless of the methods used to gather people data, special consideration and care should be given to maintain the psychological safety and well-being of those who may be traumatized by the event.

Table 5: Interviewing tips

Interviewing tips
• Use a quiet location for the interviews • Schedule the interviews allowing for flexibility • Consider interviewing one person at a time • Ensure a consistent approach with all interviewees • Prepare by developing interview questions and reviewing relevant documents, e.g., policies • Introduce yourself as the interviewer and thank them for attending • Develop a positive rapport with the interviewee • Tell the interviewee the purpose of the interview, – That their help is needed to gather information to understand the incident so that future incidents are prevented; and – That the aim is to obtain facts and not find fault, blame, or judge • Let the interviewee know that you will be taking notes and possibly verbatim • Use open-ended, fact-finding questions such as "What did you see or hear?" and avoid leading questions • Some closed-ended questions may be appropriate e.g., "Do you have a standard operating procedure in these situations?" • Encourage objective observations and, where available, concrete, corroborating evidence, e.g., memo, communiques, documents • Listen carefully for the objective facts and encourage the interviewee to speak • Avoid interrupting interviewee and encourage detailed information • Summarize witness statements and repeat them back to clarify the information • Ask if interviewee is comfortable with the information being shared in the future and ask permission to follow-up with more questions if needed, or let them know that they can reach out if they have any questions or additional information to provide • Communicate confidentiality and/or privacy rules • Document the information from the interview, e.g., name of interviewee, date, time, questions, interview answers. • Make notes of any follow-up action items (Awareness, n.d.; CCOHS, n.d.; PSHSA, 2017; Vanden Heuval et al, 2008)

Paper and electronic data

This type of information provides valuable insights and can help investigators get a better understanding of processes, activities, and any concerns. Records and documents may include:

- Policies and procedures (e.g., behavioural risk assessments and care planning, communicating risk of violence).
- Safe work practices and safe operating procedures (e.g., codes, alarms, personal safety response systems)
- Workplace violence risk assessments
- Inspection reports
- Code white reports and debriefing notes
- Post-incident code white "Immediate Debrief Form for Hospital and Long-Term Care Settings" document – debriefing session with all responders and workers affected by the incident, documenting immediate threats and actions taken during the response

- Post-Incident Huddle Form (see Appendix F for sample huddle form) – debriefing session with affected team and witnesses to determine root causes
- Health and safety reports, including incident and hazard reports
- Orientation and training records (e.g., workplace violence prevention, non-violent crisis intervention, personal safety response system, behaviour risk assessment, code white, specialized training such as restraints, competent supervisor training)
- Equipment selection, purchasing, and maintenance records (e.g., personal safety response system devices, other personal protective equipment, closed-circuit television and surveillance)
- Communications (e.g., care plan, emails, notifications, posters, newsletters, staff meeting minutes, huddles, patient/family/workplace parties' code of conduct and responsibilities)
- JHSC committee meetings minutes and recommendations
- Workplace violence work refusals
- Behavioural risk assessments and care plans
- Security logs or reports
- Police reports, if available
- Established floor plans and workplace layout

Both paper and electronic data can enhance the investigation by providing additional context and information beyond what was gathered from people to the investigatory questions previously mentioned. For example, comparing procedures to actual practices can help identify factors that contributed to or caused an incident. Additional questions that need to be answered may arise after this data is reviewed.

Investigators must adhere to organizational policies and/or legislation regarding record retention, record access, privacy and confidentiality. Ensure that the documents and records that are reviewed are those that were in place at the time of the incident. See Appendix G for a sample Paper and Electronic Data Form.

Step 3 – Understand Processes

This step involves expanding data collection to include a comprehensive review of the processes in place at the time of the incident. While gathering details about the incident itself is important, understanding the context in which it occurred is equally necessary. This approach helps identify deviations from established practices and areas for improvement. This is particularly relevant for workplace violence prevention and control, as it is process-oriented and relies heavily on adherence to well-defined processes and procedures.

Processes to review may include:

- **Work processes** - e.g., care recipient care / treatment, intra/inter facility movement or transition, non-patient care activities..
- **Organizational processes -** e.g., purchasing equipment, workplace violence risk assessment.
- **Interaction processes -** e.g., interactions that occur between worker(s) and others (patients, clients, residents, family, public, visitors or unknown individuals)
- **Individual Risk Assessment and Care Planning Processes** - e.g., processes related to:
  - Identifying care recipient triggers
  - Development of care plans to minimize triggers
  - Transitions of care
  - Intra and inter facility transportation and movement
- **Workplace violence prevention processes** - e.g., process related to:
  - Communication of risk for those with a history of violence
  - Summoning immediate assistance where workplace violence occurs or is likely to occur
  - Personal safety response system processes

  - De-escalation and non-violent crisis intervention
  - Security
  - Emergency measures and codes
  - Working alone
  - Workplace violence program orientation and training
  - Oher workplace violence prevention processes
- **Other** processes and procedures that are deemed to be important

Consider the following questions to guide the review:

- Do written or verbal standards, training programs, documentation, communication exist for the processes?
- What type of evidence (e.g., documents, records, observations) are required?
- Are written standards consistently followed and enforced?
- Were the standards being followed at the time of the incident?
- Did any deviations from normal practices occur on the day of the incidents?
- Are the processes and standards appropriate, adequate, and effective?
- Do applicable processes meet legal requirements, including roles, responsibilities and rights of workplace parties involved?

Investigators should ensure they are familiar with the specific requirements and roles and responsibilities outlined in the OHSA, as they will impact the thoroughness of the investigation. For detailed examples of requirements to consider, refer to Appendix H: OHSA Compliance Checklist.

Step 4 – Analysis

Analysis is the next step in the investigation. This involves reviewing, synthesizing and interpreting all the data and evidence collected to:

- Develop a comprehensive summary of events that occurred before, during and after the incident.
- Identify causes and contributing factors related to the incident.
- Uncover root causes to inform recommendations for preventing or reducing the risk of recurrence.

GOOD TO KNOW

Finding effective solutions lies in understanding the incident first.

Various theoretical models offer perspectives on how incidents occur. The model guiding the investigation will influence the choice of analytical methods used to establish causation. For example, Bird and Germain's Loss Causation Model (see Figure 3) suggests that incidents and subsequent losses, result from immediate causes (unsafe acts and conditions) which are directly linked to underlying basic causes (personal and job factors). These basic causes, in turn, stem from deficiencies in safety systems, standards and/or compliance, which ultimately arise from a lack of effective management control.

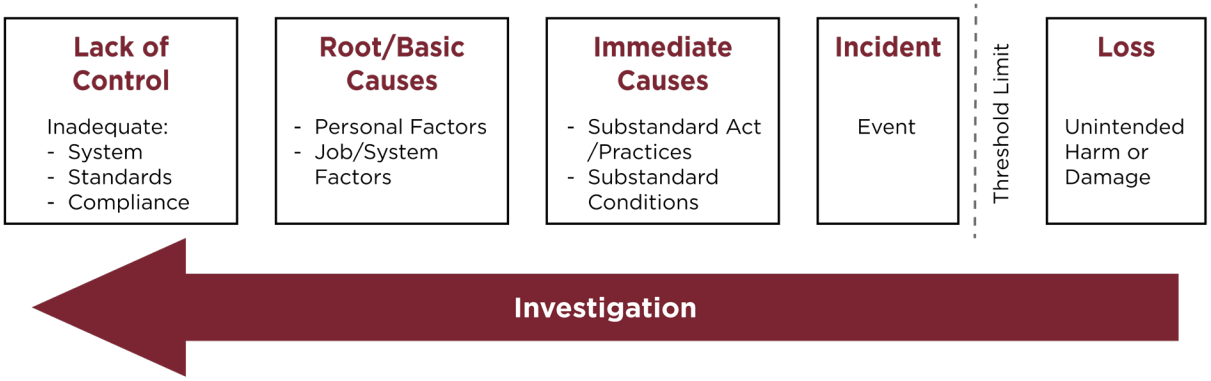


Figure 3. The Loss Causation Model

The assumptions of such models can significantly influence the choice of analytical methods that will be used. For instance, a model that emphasizes systemic issues, such as the Loss Causation Model, will guide analysis towards tracing the sequence of events to ensure root causes are identified. This ensures that the analysis is focused on long-term solutions to effectively prevent future incidents.

Data analysis methods offer practical action-oriented approaches designed to achieve specific objectives. There are many methods available, and the choice should align with the needs and nature of the incident. This toolkit highlights three methods particularly relevant to workplace violence, given these incidents involve people and are time sensitive. These methods include:

- Timeline Analysis
- Causal Factor Analysis
- Root Causes Analysis

Organizations that have had success using their own methods, whether proprietary or not, are encouraged to continue using them. The following information provides additional options to analyze the data collected or to complement existing processes.

Timeline Analysis (Information Mapping)

Incidents unfold much like a story. It is important to establish the storyline to obtain a better understanding of what led up to the incident, including who was present, how and when the incident occurred, and so on. Information mapping is a method that can be used to develop a timeline of the events, including the people involved. Investigators should review the collected evidence and arrange it to understand the sequence of events. There are several options for information mapping. Common tools include:

- Narrative chronology
- Tabular timeline; and
- Time-person grid.

Each tool has value depending on the nature of the incident can be particularly effective for incidents involving workplace violence. After selecting and developing a timeline using one of the proposed mapping tools, investigators may identify any remaining gaps in the timeline and additional information. The tools can be adapted to meet an organization's specific needs.

Narrative Chronology – is a documented account of events in the order they occurred, e.g., date, time, events and activities that occurred. This approach is very common and less complicated than other mapping tools. Table 6 provides an example of a completed narrative chronology information mapping tool.

Table 6: Narrative chronology information mapping tool

Date of incident: January 10, 2020

Time	Event or Activity	Evidence source	Immediate Cause / Causal Factor
9:05	Janet, an RPN on a medical unit, has reviewed the patient's chart. The patient is a 74-year-old man who needs assistance to stand but can use a walker with supervision. The man lives with his daughter in a house. Janet notes that there is no history of violence in emergency documentation or on admission to the unit. She noted that the patient arrived in the evening from emergency with low grade fever, increasing confusion with intermittent agitation, general weakness and poor appetite. The patient experienced a recent fall the day prior during a confused moment but with no apparent injury.	Interview with Janet Paper Review	Causal Factor #1 No patient behavioural risk assessment or history of violence information in chart upon admission
9:20	Janet requests assistance from colleague Kamil, an RPN, and they together enter the patient's room. The patient is lying in the bed with the rails up.	Interviews with Janet & Kamil	
9:21	Kamil asks the patient how he is feeling and whether he knows the date and where he is. The patient is slow to respond but smiles and says the date, location and expresses the need to go to the washroom and it hurts.	Interviews with Janet & Kamil	
9:22	Janet and Kamil tidy the room, moving clutter and chairs out of the way in preparation to get the patient up.	Interview with Janet	
9:25	The patient becomes more alert and agitated about the staff moving his magazines on the table. Staff reassure the patient, and he settles down but is restless.	Interviews with Janet & Kamil	
9:28	Janet asks the patient for consent to help him get up and walk to go to the washroom with a walker. The patient nods.	Interviews with Janet	Causal Factor #2 Patient behavioural risk assessment not completed, and plan not communicated.
9:30	The RPNs lower the bed rails on both sides and lower the bed. Janet asks the patient to roll towards her and she helps the patient roll to his right side. Kamil moves to the same side of the bed as Janet. Janet asks the patient to sit up on the edge of the bed.	Interview with Janet	
9:31	Kamil starts to help the patient lower their legs. Janet starts to help the patient sit by steadying their shoulders. As the patient starts to sit upright, they start to scream and hit Janet about the head and right eye area, causing her right cheek to bleed. Janet and Kamil lower the patient quickly back into bed and raise the bed rails. Janet is dazed and does not have a communication device to call for immediate assistance. After a delay, Kamil realizes this, so he uses his badge to call for help. The patient continues to lash out at Janet but stops screaming.	Interviews with Janet & Kamil	Causal Factor #3 RPN Janet unable to summon immediate assistance herself.
9:32	The patient's daughter rushes into the room upset and starts shouting 'what are you doing?" She also communicates that her father started hitting people when he was confused, but not very hard.	Interviews with Janet & Kamil	
9:33	The supervisor and staff respond to the communication badge alert. Janet rushes from the room covering her right eye area and she is taken immediately to Emergency by another colleague, Sariah.	Interview with Sariah	
9:33	Kamil attends to the patient with the responding team. Another staff attends to the patient's daughter.	Interview with Kamil	

Time	Event or Activity	Evidence source	Immediate Cause / Causal Factor
9:40	Supervisor conducts investigation with staff.	Supervisor and Staff	
10:00	Supervisor conducts a debrief with staff.	Interview with Kamil	

Tabular Timeline – is a table format document that allows each activity or event to be recorded (one subject and one active verb, along with the date, time), and additional information can be added. Good practices can be identified, in addition to problems or causal factors which are discussed in the next section. Table 7 provides an example of a completed Tabular Timeline information mapping tool.

Table 7: Tabular timeline information mapping

Date Time	Event/ Condition	Additional information	Good practice identified	Immediate causes (causal factors)
Jan 10 9:05	RPN checks patient chart	No history of violence documented. There was a history of recent sporadic confusion and agitation.	Worker checked for history of violence.	Causal factor #1 No patient behavioural risk assessment information in chart or emergency department documents.
9:20	RPN requests help from co-worker		RPN requested assistance.	
9:21	Co-worker checks patient's orientation	Client responds and appears oriented. Patient experiencing discomfort and pain and need to go to the washroom.	RPN briefly assessed patient's mental status.	
9:22	RPNs tidy room		Preparing room for patient mobility and removing hazards.	
9:25	Client becomes agitated	Workers able to calm client. Client has unknown triggers.	Workers provided reassurance to patient.	
9:28	Co-workers try to sit patient up	Patient cooperates initially.	Coworkers work together to get client up.	Causal Factor #2 Patient behavioural risk assessment not completed on the floor and plan not communicated.
9:30	Patient hits worker	Sitting up triggers the patient to scream and flail arms. RPN does not have a communication badge to call for help. Patient hits RPN in the right eye. Workers put patient back into bed.	Co-worker uses his communication badge to summon immediate assistance.	Causal Factor #3 RPN Janet unable to call summon immediate assistance herself.
9:33	Responders arrive at the scene	A co-worker takes Injured RPN to Emergency.	Quick response to call for help.	

Date Time	Event/ Condition	Additional information	Good practice identified	Immediate causes (causal factors)
9:33	Responders attend to patient	Responders de-escalate situation. Supervisor takes part and prepares debrief.	Responders are well trained. Formal debrief process in place.	
10:00	Supervisor conduct debrief	Supervisor waits until staff are back from break to complete debrief to ensure as many staff as possible are available. Supervisor debriefs family.	Supervisor conducts debrief as soon as possible after the event with all staff and family.	

Time-Person Grid – is a table that outlines all the people involved in the incident in addition to the event sequence. It is best used when closely tracking the activities of more than one person immediately before, during and immediately following the incident. It is useful for short time frames where there is a lot happening. It is sometimes used in combination with other mapping tools, especially to detail a particularly complex sequence of events. Table 8 provides an example of a completed Time-Person Grid information mapping tool.

Table 8: Time-person grid information mapping tool

Time Frame	Janet	Kamil	Patient	Responders	Supervisor
9:05	Janet checks patient chart and no behaviour alerts or history of violence.				
9:20	Janet requests Kamil's assistance with patient.	Kamil agrees to assist Janet with a patient.			
9:21	Janet goes to patient room with Kamil.	Kamil goes to the patient room and checks the patient's orientation to time and place.	Patient is slow to respond but is oriented to place and time. Needs to go to washroom and complains it hurts.		
9:22	Janet tidies the room and prepares to get the patient up.	Kamil tidies the room move and prepares to get the patient up.			
9:25	Janet moves magazines on the table.	Kamil reassures the patient about magazines and he settles down but is restless.	Patient is alert but agitated by the movement of his magazines.		
9:28	Janet asks patient for consent for them to help him up to the washroom.		The patient provides consent to some help to get up and go to washroom.		

Time Frame	Janet	Kamil	Patient	Responders	Supervisor
9:30	Janet lowers the bed rail on the patient's right side of the patient. Janet asks the patient to roll forward and helps him. Asks the patient to sit up on the edge of the bed.	Kamil lowers the bed rail on the patient's left side and lowers the bed. Kamil moves to the same side of the bed as Janet.	Patient rolls toward Janet and starts to sit up.		
9:31	Janet helps the patient sit by steadying their shoulders.	Kamil helps the patient lower their legs.	Patient moves to upright sitting then starts to scream. Patient hits Janet about the head and right eye causing bleeding.		
9:31	Janet lowers the patient quickly back into bed and raises the right bed rail. Janet does not have a communication badge to summon immediate help.	Kamil lowers the patient quickly back into bed and raises the left bed rails. Patient realizes Janet does not have badge and uses own badge to summon immediate assistance.			
9:32			The patient's daughter walks in upset and starts shouting 'what are you doing?"		
9:33	Janet rushes from the room covering the affected eye and goes to emergency accompanied by Sariah.	Kamil attends to the patient with the responding team.	Patient lies back in bed in lessened discomfort and agitation.	Staff respond to the communication alert and assess the patient. One responder attends to the patient's daughter.	Supervisor(s) responds to communication alert with the responders.
10:00					Supervisor conducts a debrief with all staff after the break.
	Causal factor #1	No patient behavioural risk assessment information in chart or emergency department documents			
	Causal factor #2	Patient behavioural risk assessment not completed on the floor and plan not communicated. Worker Janet not trained on Behavioural Risk Assessment.			
	Causal factor #3	RPN Janet unable to call summon immediate assistance herself.			

See Appendix I: Information Mapping Analysis Tools for each type of mapping tool.

Identifying Immediate Causes / Causal Factors and Contributing Causes

Once the timeline is completed, investigators need to identify causal factors. These factors are condition(s), event(s), omission(s), deficiency or deficiencies, or action(s) that contributed directly to the incident. These are also called substandard acts and substandard conditions.

One or more causal factors may occur prior to the violent incident. It is the job of the investigator to search for and identify these factors. Investigators will need to review the timeline and fill in gaps with their collected data to identify causal factors. To do this the investigators must have a good understanding of workplace processes.

Table 9 below demonstrates how causal factor(s) can be documented in a separate document/log. Some investigators place a star on the timeline where a causal factor exists, as shown in Tables 6,7 and 8 above. Causal factors can also be numbered to make ongoing analysis easier.

Many times, omissions, deficiencies, substandard acts and substandard conditions are not intentional. For instance, a worker may not use an available personal safety communications device because they are not aware of its availability of the policies, procedures; and they may not have been trained on the use, limitations and care. It is important to objectively identify these factors and remember not to assign blame or place judgement.

Table 9: Examples of immediate causes/causal factors for workplace violence incidents.

Item	Causal factors/immediate causes	Description
1.	No risk assessment information in chart or department documents	Substandard condition
2.	Patient behavioural risk assessment not completed by Janet before helping client to the washroom.	Omission or substandard act
3.	Not carrying available panic alarm to call for immediate assistance	Substandard act

Identifying the substandard acts, substandard conditions, deficiencies, etc. does not, however, explain why and how it happened. The next step involves finding out why and how it happened, to identify the root causes.

According to the CSA Group, contributing factors are those condition(s), event(s), omission(s), deficiency or deficiencies, or action(s) that contributed indirectly to the incident but are not root causes. If these factors are eliminated or corrected, they may or may not help prevent future incidents. They may include conditions that increase the likelihood or affect the severity of the consequences, or accelerate the risk, etc. Organizations may choose to correct or eliminate contributing factors if they are identified.

Identifying Root Causes

Once immediate causes or causal factors have been identified, root causes can be determined. A root cause is the most basic factor responsible for the incident. The question to ask when determining the root cause is: if this were corrected, would future incidents be prevented?

The source of root causes can be:

- People
- Equipment
- Materials
- Environment
- Processes (e.g., procedures, practices, operating procedures)
- Other factors such as internal or external system factors (e.g., organizational factors)

Table 10 provides general examples of potential root causes. There is no assignment of blame but rather identification of the root cause(s) that need to be remedied to prevent the incident from recurring.

Table 10. Examples of Root Causes

Root Cause Source	General root cause examples
People	Worker • Inadequate knowledge, training, skills or abilities for task • Non-compliance with known rules (intentional or not intentional) Management/Supervisor • Inadequate occupational health and safety (OHS) prevention and/or competent supervisor training • Lack of supervision or performance monitoring • Inadequate occupational health and safety OHS rule enforcement (intentional or not intentional) Employer • Inadequate OHS knowledge of legislation or OHS roles and responsibilities • Inadequate OHS rule enforcement Board of Directors • Inadequate knowledge regarding OHS fiduciary responsibility Contractors • Lack of OHS knowledge, training and/or OHS standards expectation Care Recipient • Uncontrolled behaviours that can be triggered
Equipment	• Equipment available is not appropriate for the work being performed • Equipment required to do job safety is not maintained
Materials	• Materials required not available or not available in quantity needed • Materials for the job are not appropriate or inadequate • Materials are poorly designed and difficult to use
Environment	• Inadequate workplace layout, design, working heights, space, sight lines • Lighting not sufficient or does not meet standards • Temperature not meeting standard or not optimal for the task or activity • Flooring or surfaces not appropriate for the activity • Noise levels exceed standards or interfere with work activities or patient population
Process, Procedures	• Lack of OHS standards, processes, safe work practices or safe operating procedures • Inadequate alignment of standards and actual practices • Inadequate training programs
Other e.g., internal/external organization or system factors	• Inadequate commitment to OHS prevention priorities • Inadequate occupational health and safety management system • Inadequate internal system resources for OHS prevention • Inadequate OHS internal responsibility system and accountability for OHS • Inadequate external system funding

Many times, organizational investigations stop investigating after identifying the causal factors only and then fix them instead of identifying and correcting root causes.

Using the examples of immediate cause/causal factors in Table 9, the initial questions investigators might start with to find the root causes are outlined in Table 11. It may take many times asking "why" to determine the root causes for each causal factor.

For each answer to the initial question, there can be several more questions asked, and multiple intermediate causes identified.

Table 11: Examples of initial root cause questions

Item	Question	Immediate Cause Type
1.	Why were no behavioural risk assessment or history of violence information not in the chart or ER documents?	Substandard condition
2.	Why did Janet not assess the patient's risk for violence before helping him to the washroom?	Omission or substandard act
3.	Why was the panic alarm not used to summon immediate assistance during the workplace violence event?	Substandard act

There are two common methods and tools to determine root causes:

- Tree Diagram
- Cause and Effect Diagram

Tree diagram

Figure 4 demonstrates the use of a tree diagram to identify root causes by repeatedly asking 'why' causal factors happened. This example uses three identified causal factors. For any given incident, there could be any number of causal factors that caused the incident. Investigators should continue to ask why the causal factors occurred to identify intermediate causes until the final root cause is identified.

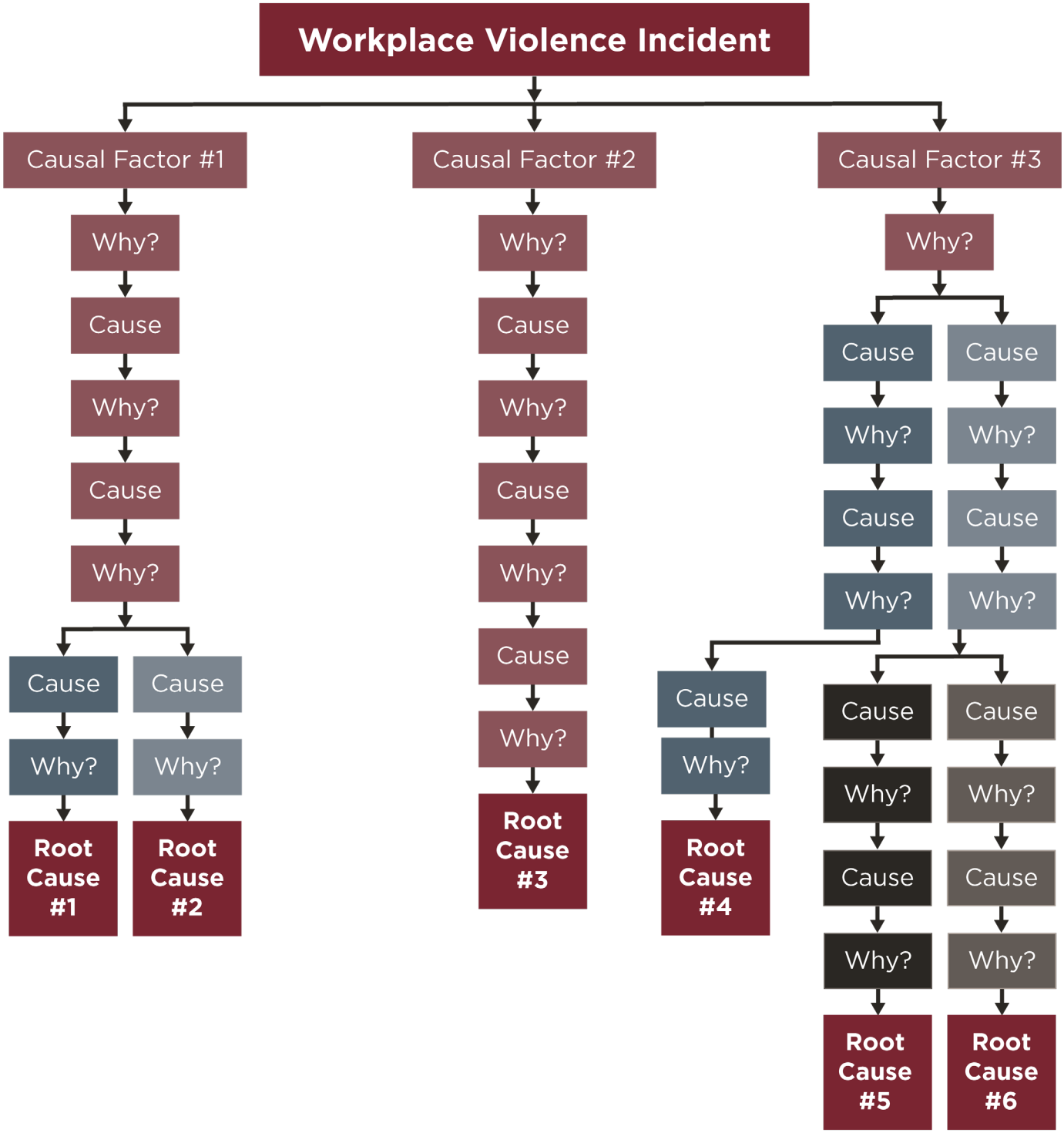


Figure 4. Tree Diagram to Identify Root Causes

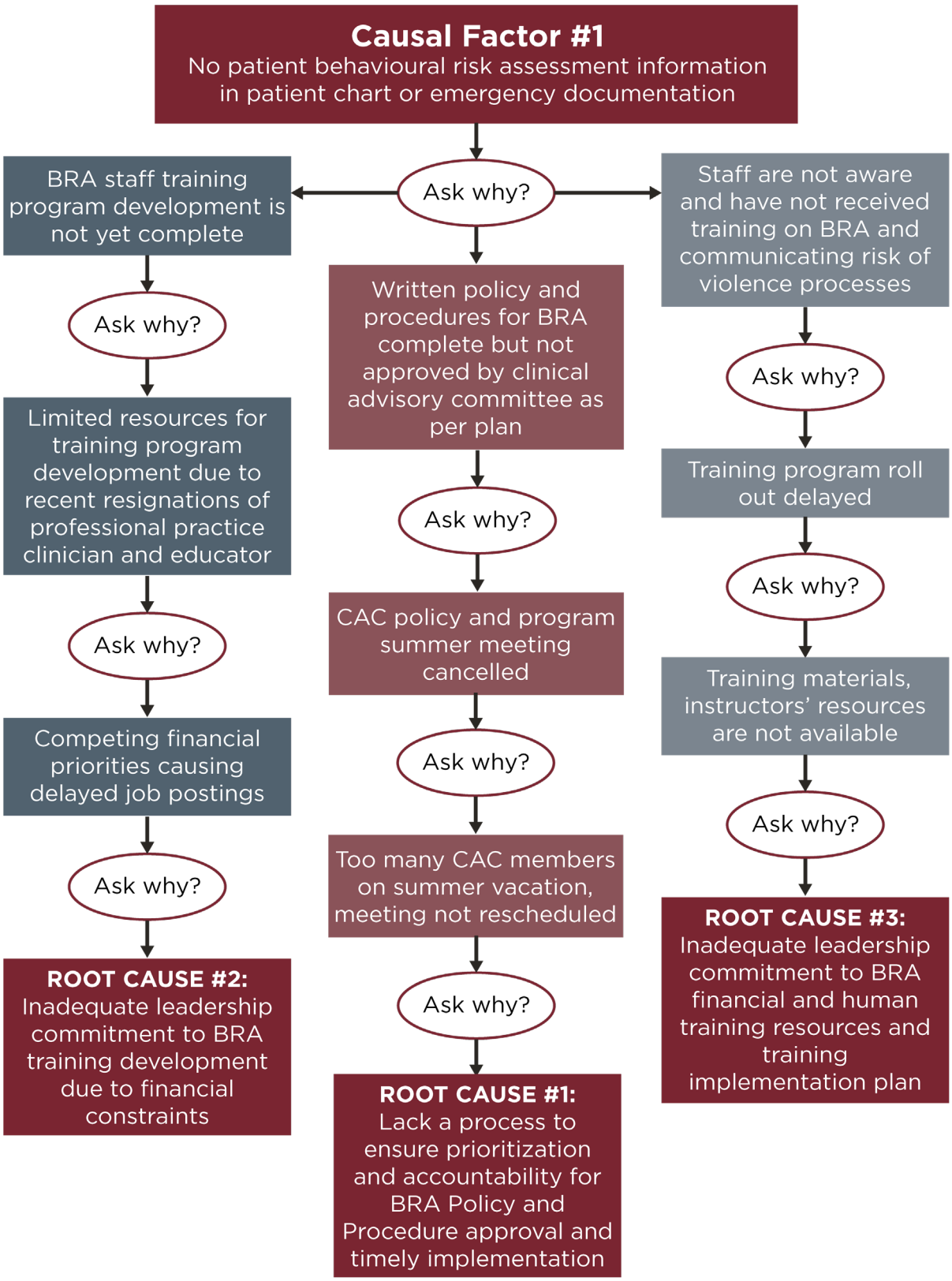


Figure 5. Sample Root Cause Tree Diagram.

Cause and Effect Diagram

Another tool that can be used in the analysis of the root causes of an incident is the "Cause and Effect" diagram, also called the Ishikawa or Fishbone diagram. The main categories of root causes form the bones of the diagram. Additional root cause categories could be added to the diagram. The resultant effect of the root causes is the workplace violence incident. Investigators review data, group causal factors, and brainstorm root causes.

Figure 6 provides a sample cause and effect diagram in progress. Investigators may choose to review the causal factors and brainstorm root causes using a white board and/or sticky notes before clustering and formalizing them into the diagram.

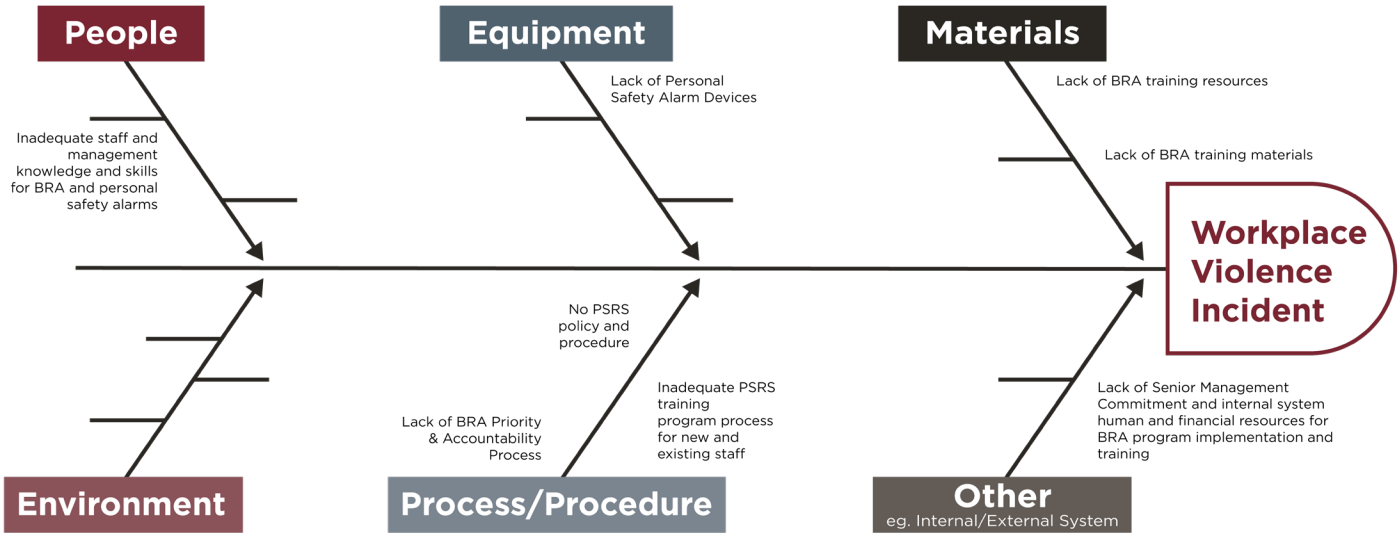


Figure 6. Sample Cause and Effect Diagram

Organizations may select one or multiple methods to identify root causes.

Step 5 – Develop and Select Solutions

The next critical step after identifying root causes is to develop and select solutions that will prevent or reduce the risk of the recurrence of workplace violence incidents. Where possible, consider solutions that are evidence-based, best or leading practices. The PSHSA Workplace Violence Risk Assessment Toolkit also provides sample solutions and controls for many workplace violence risks. When selecting solutions, consider information from 'understanding processes' in Step 3 above and legislative gaps identified during the initial data collection.

Recall, controlling hazards at the source is most desirable and effective, followed by controlling hazards along the path and at the worker. It is not uncommon to develop multiple solutions for root causes and these may include a combination of controls from more than one level or a combination from all levels.

Table 12 provides some examples of solutions for workplace violence based on the hierarchy of controls. Solutions and controls should be tailored to mitigate the root causes of the incident.

Table 12: Example of workplace violence controls

Level	Controls
At the Source	Access control – automated doors, access badges
	Surveillance cameras
	Site and environment design and layout – clear sight lines, safety exits
	Seclusion suite
Along the Path	Plexiglas barrier
	Domestic violence safety procedure and plans
	Client behavioural risk assessment policy, procedure and training program
	De-escalation and non-violent crisis intervention training
	Personal safety response system policy, procedures and training
	Workplace violence communication poster
	Workplace violence program and training
	Mandatory workplace violence reporting policy and procedure
	Communicating risk of violence protocol
	Resident/patient/client inter/intra-facility transport checklist
	Workplace violence situational awareness training
	Emergency response planning and protocols for workplace violence
At the worker	Protective Kevlar or leather sleeves, gloves, spit shields
	Personal safety response system device e.g., panic alarms, communication badges
	Security guard shield and/or baton

When identifying solutions, investigators should also focus on improvements at various levels in the organization, for example:

- System and organizational levels requiring enhancement
  - Health and safety system processes and accountabilities
  - Internal responsibility system (shared responsibility for health and safety)
- Local/department level e.g., purchasing, training
- Work tasks and conditions level e.g., work practices

Under OHSA, employers have the greatest responsibility for workplace health and safety. Regardless, preventing incidents from recurring requires commitment and action from all workplace parties, e.g., the employer, supervisor, workers, and others. When identifying and selecting solutions, consider what the employer can do, what the supervisor can do, and what workers can do to prevent incident recurrence. For example:

How can the **employer** control workplace violence incidents?

- Remain current and compliant with legislative changes.
- Demonstrate commitment and ensure workplace violence prevention is a priority and part of the organization's health and safety management system/program.

- Communicate messaging that workplace violence is not acceptable nor tolerated.
- Ensure workplace violence risk assessments are current and preventative measures/procedures/training to protect workers are implemented.
- Identify and communicate workplace violence hazards to supervisors and workers.
- Ensure human and financial resources for workplace violence prevention.
- Provide necessary devices and procedures to summon immediate assistance when violence is to occur or likely to occur.
- Provide and maintain safety equipment e.g., personal safety response system devices.
- Encourage reporting of all violent workplace incidents to supervisors and/or employer.
- Promote and foster a positive health and safety culture.

What can **supervisors** do?

- Stay current with workplace violence legislation and organizational policies and procedures.
- Identify workplace violence hazards in their area of authority and identify workplace violence root causes identified during incident investigations.
- Actively participate in workplace violence investigations and development of corrective actions.
- Implement timely workplace violence corrective actions in areas under their authority.
- Ensure timely orientation and ongoing workplace violence prevention training for workers.
- Communicate workplace violence health and safety controls or changes in a timely manner to workers.
- Communicate messaging that workplace violence is not acceptable or tolerated.
- Monitor safety performance and practices.
- Enforce workplace violence prevention policies and procedures.
- Encourage workers to report workplace violence hazards and incidents.
- Where workplace violence challenges are beyond the scope of the supervisor, ensure they are reported to a level of management that can address the challenge in a timely manner.
- Promote and foster a positive health and safety culture.

What can **workers** do?

- Promptly report workplace violence hazards and incidents to the supervisor or employer.
- Follow workplace violence prevention rules, policies and procedures.
- Attend required workplace violence training.
- Participate in opportunities for health and safety improvement.

Stage 4: Report, Implement Solutions and Follow-Up

The final phase of the investigation process comprises four additional steps outlined in the next following pages. These include reporting the investigation findings to those who can make the necessary changes in a timely manner, implementing the recommendations, evaluating the changes made, and communicating lessons learned and following up on areas for improvement. Unlike many investigation frameworks, communication and follow-up steps are heavily emphasized to ensure information is fully disseminated to those affected or potentially affected and to the JHSC/HSR.

Note that delivery of final reports to internal and external authorities may vary depending on the incident. Refer to Appendix J: Workplace Violence Incident Investigation Report Form, for a sample report template.

Step 6 - Make Recommendations

The next step in the investigation process is to take the suggested solutions and develop recommendations. The purpose of recommendations is to communicate the required corrective actions to be taken to prevent recurrence. This means that the recommendations must address each root cause identified and therefore alleviate the causal factors leading to the incident. Recommendations should consider legislative requirements. It is useful to highlight instances where a recommendation is linked to a legislated requirement.

Target Audience

For successful remediation and results, it is important that recommendations are developed and presented to the appropriate level(s) or target audience(s) within the organization and, if applicable, to external stakeholder to who the investigators are accountable. Investigators must reflect on the original purpose of the investigation to confirm who the target audience of a recommendation is, for example:

- JHSC/HSR worker investigation of a critical or fatal injury/illness will target the MLITSD who requires the findings and share the findings with the JHSC who may in turn make recommendations to the employer.
- Employer appointed investigation team for a critical or fatal injury/illness will report recommendations to the employer who will then provide reports and steps to prevent recurrence to the MLITSD and JHSC/HSR and trade union, if any.

SMART Format

Recommendations should be written using the SMART format, which means they should be specific, measurable, attainable, realistic, and timely.

Priority

Recommendations should also address the level of priority, if necessary, and consider the solution's effectiveness, sustainability, and risk reduction (severity and probability of recurrence). The investigator(s), with worker involvement, may want to prioritize the recommendations (or groupings of controls that work together to address the problem) by ranking them as high, medium and low priority. In some cases, the priority may be indicated in terms of risk where timing and urgency are critical. Effectiveness and sustainability are often reflected in the hierarchy of controls. Investigator(s) may want to indicate that the preferred solution or recommendation is based on effectiveness and need for sustainability.

Recommendation Term

Some recommendations may be complicated and more difficult to implement. To ensure a positive outcome and to reduce the risk of harm, some recommendations may include short term, medium term, and/or long-term solutions that can be implemented in phases, especially when there may be funding and budgetary restraints.

For example, in a workplace that does not have the needed personal safety alarm system devices to summon immediate assistance where workplace violence is a threat, and recommendations may include::

- A short-term solution of purchasing inexpensive "screamer noise" devices and implementation of procedural training; and
- A medium to long-term solution of purchasing electronic communication badges and implementation of training in a phased approach in the next budget year.

Recommendation Summary

In summary, recommendations need to:

- Meet the purpose of the investigation
- Align with legislated requirements
- Address all the root causes identified in the investigation
- Outline actions to be taken using a SMART format and consider people, equipment, materials,

environment, process and other solutions as outlined in Step 5
- Communicate the level or priority and/or urgency as appropriate
- Indicate short, medium and long-term recommendations as appropriate
- Be directed to the key target audiences and the level(s) of the organization and/or system that is most appropriate to ensure they are enacted

Table 13 below provides examples of recommendations for two root causes using the example from Step 4.

Table 13: Examples of recommendations for root causes.

Root Cause	Recommended Actions	Priority Hi/Med/Lo	Term if required Short	Med.	Long	Time Frame
#1	1. Clinical Advisory Committee to meet, review and approve Behavioural Risk Assessment policy and procedures, as soon as possible.	High	X			5 days
	2. Clinical Advisory Committee to revise committee terms of reference (TOR) to ensure prompt review and approval of time sensitive policies and procedures including the Behaviour Risk Assessment policy and procedure. TOR to include a contingency plan that includes the rescheduling of cancelled in-person meetings due to vacations and unexpected absences. This may include but is not limited to teleconference meetings and assignment of alternate members.	High	X			14 days
	3. Clinical Advisory Committee through the committee chair to provide monthly quality report to senior leadership with a schedule of clinical and/or health & safety policy & procedure reviews/approvals and implementation plans including any deviations from the scheduled plan, reasons for deviation and remedial action and/or plan. The committee to also rank the priority of the policy and procedure approval as high, medium or low.	Medium	x			14 days
#2	1. Assignment of a management leader to provide oversight and be accountable for the Behaviour Risk Assessment program, implementation and quality monitoring.	High	X		X	5 days
	2. Seek senior leadership approval and commitment to provide fiscal and human resources for the development and sustainability of the Behavioural Risk Assessment program, training materials as soon as possible.	High	X			0-3 months
	3. Seek senior leadership approval for fiscal and human resources to develop behavioural risk assessment awareness communications; and schedule, implement and monitor (using quality indicators) the Behaviour Risk Assessment training program as soon as it has been developed. Suggest a phased in approach starting with areas of high risk followed by an ongoing program.	High	X	X	X	3 to 24 months

Investigators or lead investigator should sign the document if required by the employer. See Appendix K: Recommendation and Implementation Planning Template.

Where recommendations from the HSR or JHSC are made to the employer after an investigation, the employer must respond to the JHSC/HSR within 21 days ..

Step 7 – Implement Solutions and Recommendations

It is important for organizations to develop an implementation action plan for each of the recommendations. This may be completed by a person, or a team given responsibility for developing the implementation plan, and it is important that management demonstrate commitment and provide support for the plan. In some cases, those developing the implementation plan may or may not be the investigators.

The implementation plan includes the::

- Assignment of responsibilities to individuals or teams.
- Establishment of target dates, tracking completion dates.
- Time, human and fiscal resources required and,
- Determination of how the recommendation will be measured.
  - Measurement ensures there is accountability of the plan. The implemented changes can be viewed as quality improvements to improve workers' and others' health and safety.

In preparation for implementation, organizations may also consider change management processes, for example:

- Evaluate workplace readiness for the change.
- Understand the current environment.
- Create a vision for the change.
- Communicate upcoming changes and provide opportunity for feedback.
- Identify and mitigate barriers.
- Identify leads, champions and other facilitators and, if required, change teams.
- Encourage participation, where appropriate.

It is important to develop a well-planned documented action plan. The extent of the action plan will depend on the complexity and level of the investigation.

For a sample implementation template, see Appendix K: Recommendation and Implementation Planning Templates.

Step 8 – Evaluation

Organizations that investigate workplace violence and implement corrective actions need to plan and evaluate the corrective actions to ensure effectiveness. The timing of the evaluation or frequency of re-evaluations of the corrective actions should be determined in advance and may depend on the risk e.g., potential severity and probability.

Evaluation can be achieved by:

- Assessing the risk of workplace violence for the incident situation or similar situation, once the corrective actions have been implemented, e.g., evaluating the potential severity and probability of workplace violence recurring with the new controls, and make necessary improvements, if any.

GOOD TO KNOW

Evaluating implemented corrective actions helps ensure controls are effective in protecting workers against violence.

- Discussing or seeking feedback on the new controls and corrective action with managers, frontline workers, and JHSC/HSR and incorporate any additional improvements.
- Conducting a mock exercise or role play with the new controls, evaluating the controls, and making additional improvements.
- Reviewing any incident, hazard identification reports, or JHSC/HSR inspection reports since the incident to determine whether ongoing hazards exist, or injuries have been occurring and implement necessary improvements.
- Assessing whether the implemented recommendations meet relevant standards and/or legislative requirements.

Where workplace violence hazards have been identified that caused an incident, it is important that the employer ensure there is a process to update the workplace violence risk assessment and the new controls. It is important to keep the workplace violence risk assessment current so that workers and others are protected from harm. This ongoing evaluation is also a vital component for ensuring the continual improvement and effectiveness of the organization's overarching occupational health and safety management system.

Step 9 – Communication and Follow-Up

An essential step in the investigation process is communicating awareness, corrective actions and changes resulting from the investigation to others in the organization. There must be processes to provide feedback for:

- Those involved in the incident or potentially exposed to the workplace violence situation
- Others that may encounter similar situations elsewhere in the organizations
- JHSC/HSR/union members

Sharing the results of an investigation also supports the concept of a learning organization. Sharing what is learned helps close the investigation loop and is fundamental to organizational continuous quality improvement. Organizations may also choose to share their information with system partners external to their organization.

Incorporating processes for communication into investigation policies, procedures, forms, checklists, and/or action plans, can help ensure follow-up communications occur. See Appendix J: Workplace Violence Incident Investigation Report Form as an example.

Incident Investigation Tracking and Trending

As part of incident investigation quality improvement, healthcare workplaces may want to track and review their workplace violence incidents and conduct an analysis to determine workplace violence root cause trends and opportunities for preventing future incidents. Organizations may track this data manually or electronically. Some caution should be taken with electronic programs that provide limited information in dropdown menus where the root causes and corrective actions may be too general.

Appendix L: Workplace Violence Incident Investigation Tracking Tool provides examples of topics and topic descriptions that organizations may want to consider when collecting and analyzing incident investigations. Quality improvement initiatives can be developed for workplace violence based on root cause trends for violent incidents encountered in the workplace. Work completed for corrective action can have a positive impact on areas not previously considered.

However, it is important to recognize that the data gathered from incident investigation quality improvement not only enhances the investigation program but also refines the organization's occupational health and safety management system (OHSMS). Similarly, routine OHSMS monitoring data informs the investigation program, creating a feedback loop for continual improvement in both, thereby contributing to overall success of prevention efforts.

Documentation and Record Keeping

Employers and supervisors are required to demonstrate due diligence to protect workers. Maintaining and retaining incident investigation records can provide evidence that they have taken every necessary precaution in the circumstances for the protection of workers from harm. Regulations under OHSA provide a minimal standard for general record keeping and for mandatory notices. Table 14 below outlines excerpts from the Health Care and Residential Facility Regulation 67/93 and Regulation 420/21. Notices, including steps taken to prevent recurrence, must be submitted to the MLITSD, JHSC/HSR, and unions for various injuries/illness. Documents and records may also be requested by the MLITSD upon request during an inspection or investigation.

Table 14 Regulations and Recording Keeping

Health Care and Residential Facility Regulation 67/93
Retention of Reports and Records s.4. The employer shall keep on file all records or reports that are required to be kept under this Regulation for a period of at least one year or such longer period as is necessary to ensure that the two most recent reports or records are on file.
Regulation 420/21 Notices and Reports under Section 51 to 53.1 of the Act
Records.6. The employer or constructor shall retain a copy of a written notice or report require under sections 51 to 53.1 of the Act for at least three years after the date the notice or report is made.

Examples of incident and investigation documents and records for retention include, but are not limited to:

- Workplace violence incident reports and summaries
- Workplace violence investigation reports and summaries
- Investigation communications to workplace parties including JHSC/HSR/unions
- Notices with steps to prevent recurrences required under the legislation and proof of submission to the MLITSD, JHSC/HSR/union, and
- Workplace violence investigation reports completed by the MLITSD, e.g., work refusal, reprisal investigations, work stoppages, complaint investigations

Workplace violence analysis reports and quality improvement plans are also important to retain and may be required in some healthcare workplaces where required organizational practices or indicators are mandated by external parties such as Accreditation Canada and/or Health Quality Ontario.

Workplace Violence Prevention Checklist

Healthcare organizations should assess their activities and programs related to workplace violence incident investigation to identify good practices in place and any program gaps. The Workplace Violence Prevention in Health Care Leadership Table supports healthcare organizations to use the Workplace Violence Prevention Checklist and Action Plan as a best practice guide.

The key sections of the checklist that organizations should review and self-assess for incident investigation practices or gaps include:

- Leadership Support and Worker Participation – Items 7, and 12 to 23
- Education and Training – Items 1, 6, 7, 9 and

- Performance Reporting and Evaluation – Items 2 to 8

Once a self-assessment is complete, incident investigation gaps and an action plan can be developed. It is recommended that the multidisciplinary workplace violence or similar committee which includes JHSC/HSR worker representation conduct the self- assessment.

APPENDIX A: Sample Incident Investigations Policy

Purpose of This Tool

The purpose of this tool is to provide hospital, long-term care, and home and community care workplaces with a sample incident investigation policy. The sample document can be used to create a policy at a workplace where one does not exist or to update an existing policy to ensure it includes information about workplace violence.

Who Uses This Tool

Any workplace party involved in incident investigation policy and procedure development, revisions, and evaluation. All workers to whom the policy pertains, are required to read, understand, and implement the policy and its procedures as required.

How to Use This Tool

This is a sample policy. Use whole parts, revise, or customize as required to meet your workplace needs. The policy must be developed in consultation with the Joint Health and Safety Committee or the health and safety representative. Revisions and customization should be done with careful consideration. Significant changes or removal of important sections may negatively impact worker safety.

Incident Investigations Policy

MANUAL: Health and Safety	**SUBJECT:** Incident Investigations	**POLICY NUMBER:**
EFFECTIVE DATE:	**REVISED DATE:**	**NEXT REVIEW DATE:**
POLICY REVIEWERS:		
APPROVED BY:		
SENIOR LEADERSHIP SIGNATURE (e.g., CEO or Executive Director):		**JHSC/HSR SIGNATURE:**

Purpose

The purpose of this policy is to provide direction and guidance to all workplace parties regarding organizational and legal requirements for incident investigation, including those related to workplace violence. It offers a systematic approach for identifying root causes and implementing measures and procedures to promote the physical and psychological health and safety of the workplace.

Policy statement

<Name of Organization> understands the organization's responsibility under the Occupational Health and Safety Act (OHSA) to take every precaution reasonable in the circumstances to protect workers from

workplace hazards (s.25(2)(h) and the duty to investigate and manage incidents of workplace violence in accordance s.32.0.2(2).

Keeping with these responsibilities, <Name of Organization> is committed to developing, implementing, and maintaining `an incident investigation process for all reported workplace incidents and/or complaints. This will support the effective application of preventive and corrective actions.

All workers will be provided with training and education on this policy and associated procedure. An annual evaluation of the policy will also be conducted in consultation with stakeholders, including the Joint Health & Safety Committee (JHSC) and/or health and safety representative (HSR). Approved quality and program improvements will be implemented and promptly communicated to workplace parties.

Scope

This policy applies to everyone in the organization.

Investigations will be conducted for:

- Fatalities
- Critical injuries
- Lost-time injuries
- No lost-time injuries (i.e. medical aid)
- First Aid and near misses
- Occupational Illnesses
- Property Damage
- Fires
- Environmental Releases
- Workplace Violence and harassment
- Incidents with potential for psychological injury

Definitions

- Cause: A person, thing or factor that gives rise to an action, phenomenon, or condition or other effect.
- Immediate cause: Substandard or unsafe acts and conditions or deviations from an accepted practice that immediately precede the incident that results in a hazardous event that caused the injury.
- Root cause (also called basic cause): A factor that caused a non-conformance or incident and should be permanently eliminated through process improvement. The highest-level cause of a problem or incident. There may be many root causes to an incident. It is a condition or factor that produces an effect or incident; eliminating a root cause(s) will eliminate the effect or incident. Root causes are generally management, planning and organizational failings. Root causes can be personal factors or job/system factors.
- Causal factors: Condition(s), event(s), omission(s), deficiency or deficiencies, or action(s) that occur before the incident and contributed directly to the incident.
- Contributing factors: Condition(s), event(s), omission(s), deficiency or deficiencies, or action(s) that contributed indirectly to the incident. If these factors are eliminated, they may not or would not necessarily prevent the incident but may or could help prevent incidents in the future. They are also conditions that may increase the likelihood, accelerate the effect in time, affect severity of the consequences etc. and by eliminating a contributing factor(s) it may not eliminate the effect.
- Critical injury: An occupational injury of a serious nature that:
  - Places life in jeopardy.
  - Produces unconsciousness.

  - Results in substantial loss of blood.
  - Involves a fracture or a leg or arm, but not finger or toe.
  - Involves the amputation of a leg, arm, hand or foot but not finger or toe.
  - Consists of burns to a major portion of the body.
  - Causes loss of sight in an eye.
- Fatality: Death due to causes in the workplace. Also called fatal injury.
- 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 circumstance, agent or action with the potential to cause harm.
- Incident: An occurrence, condition, or situation arising in the course of work that resulted in, or could have resulted injuries, illnesses, damage to health or fatalities.
- Near miss incident: An incident that does not reach or make contact with a worker and does not result in harm to worker's health and safety.
- No harm incident: An incident that reaches or makes contact with a worker but does not result in harm to a worker's health and safety
- Harmful incident: An incident that reaches or makes contact with a worker and results in harm to a worker's health and safety.
- Occupational injury: An occurrence which is neither expected nor planned, resulting in a worker's injury due to an exposure or conditions at the workplace.
- Occupational illness: A condition that results from a workplace exposure to a psychological trauma or a physical, chemical or biological agent to the extent that normal physiological mechanisms are affected and the health of the worker is impaired.
- Physical injury: Bodily harm because of an incident.
- Psychological injury or illness: Mental harm as a result of an incident.
- Responsive behaviours: Actions, words and gestures that are a response, often unintentional, that express something important about their personal, social or physical environment.

Roles and Responsibilities

Board of Directors

- Take all reasonable care to ensure that the organization complies with the occupational health and safety act and regulations and with any orders and requirement from the MLITSD inspectors, Directors, and Minister.

Employer

- Ensure the provision of human and fiscal resources for the development, implementation and maintenance of a workplace violence incident and complaint investigation policy, measures and procedures as part of the workplace violence prevention program; and appoint a leader to oversee the process and evaluation.
- Ensure the development of investigation steps including the identification of root causes and their remediation to prevent future incidents and protect workers and others.
- Ensure all workers are aware of the workplace incident investigation policy measures and procedures.
- Develop and implement a process to appoint lead investigator and, if required, a team for high level and more complex workplace investigations. Delegate authority for the lead and team to investigate.
- Ensure investigators are competent to perform workplace investigations, e.g., possess the skills, knowledge and abilities.
- Provide support to the worker JHSC/HSR for their legislated investigations for critical and fatal workplace violence incidents.

- Ensure legislative requirements are met for:
  - Workplace reporting.
  - Internal and external notifications to the JHSC and/or HSR, trade union and if required MLITSD for injuries and illness.
  - Managing the scene of a critical and fatal incident and preservation of the wreckage.
  - Ontario Regulation 420/21 s. 3 Notice of Accident Reports, specifically steps to be taken to prevent recurrence.
  - Worker HSR/JHSC member conducting critical/fatal injury/illness investigation - section 8(14) and 9(31)
  - Employer provision of occupational health and safety reports to JHSC and/or HSR including those related to workplace violence hazards or incidents.
  - Health and safety consultations with the JHSC and/or HSR, as per OHSA section 25(2) and HCRFR section 8 and 9.
  - Responding to JHSC and/or HSR recommendations OHSA section 9(20) within 21 days including those related to workplace violence.
- Annually review and evaluate the workplace investigation processes in consultation with the JHSC, HSR and stakeholders.
- Ensure workplace incidents are investigated in a timely manner that protects workers and others.
- Ensure quality improvements are implemented as required and communicate any changes and improvements to those that are affected or those who could be potentially affected in the organization.
- Enforcement of the workplace investigation policy and procedures.
- Promote and encourage a culture of safety and workplace prevention quality improvement.
- Take every precaution reasonable in the circumstances, for the protection of the workers.

Supervisor

- Ensure the policy, measures and procedures are implemented in the areas under their authority.
- Be familiar and comply with applicable health and safety legislation and demonstrate occupational health and safety supervisor competency.
- Attend the necessary training to ensure competencies to investigate workplace incidents.
- Ensure workers under their authority are aware of the investigation policy and procedure and understand they may be asked to participate and cooperate in an investigation and quality improvements.
- Communicate any changes in policy, measures, procedures and quality improvement to those affected under their authority.
- Ensure workers attend training.
- Ensure injured workers are provided immediate care, if needed post incident.
- In the case of a critical or fatal injury, ensure the scene of the scene of the incident is preserved and not disturbed.
- Investigate incidents in the areas under their authority and complete the necessary documents required.
- Review the incident report in a timely manner; investigate the incident as per investigation policy and procedure to identify root causes; and implement and communicate corrective and preventative actions that are appropriate for incident, e.g., address the behaviour, whether responsive non-intentional or intentional behaviours, related the workplace violence incident.
- Participate in the workplace investigation team, if required.
- Where workplace incident requires a team to investigate, participate on the team.
- Implement corrective actions in a timely manner.
- Promote and encourage a culture of safety and workplace prevention quality improvement.
- Take every precaution reasonable in the circumstances for the protection of workers.

Worker

- Attend required reporting training.
- Follow the workplace prevention policies and procedures.
- Report all workplace hazards and incidents promptly to their supervisor so that they may be investigated in a timely manner.
- Participate in workplace investigation, on request.

Joint Health and Safety Committee/Health and Safety Representative

- Be consulted in the policy and training.
- Receive accident/illness notifications as prescribed in OHSA and Regulation 420/21, e.g., be notified of critical injuries immediately, be notified of disabling injuries within four days and receive notices or reports as required.
- HSR/JHSC worker member conduct critical /fatal workplace injury investigations and provide the findings to the MLITSD.
- Participate in non-fatal or critical injuries/illness investigations, on request.
- Communicate complaints from JHSC/HSR investigations and worker reports to management.
- Make recommendations for improvement in writing to management as needed.

Occupational Health and Safety Administrator or Delegate(s)

- Responsible for oversight, coordination and monitoring of the workplace investigation process.
- Develop and revise the workplace investigation, measures and procedures as needed and submit to senior management for approval.
- Ensure internal and external notifications are conducted, completed and documented on behalf of the employer (e.g., management, MLITSD, JHSC/HSR, trade unions).
- Oversee and monitor the workplace investigation program evaluation and develop recommendations for improvement as required for senior management.
- Develop and distribute workplace health and safety reports to management and JHSC/HSR.
- Communicate with management, workers and JHSC/HSR regarding quality improvement changes.
- Maintain investigation reports and corrective actions.

Procedures

Investigation

Organizations will be required to develop and customize investigation procedures to administer the investigation program. The following provides guidance for key procedural steps in an investigation.

1. Outline steps to be taken to ensure the injured worker receives immediate care post incident. Also, refer to the incident reporting policy and procedure.
2. Outline the steps to manage the scene of the incident and who in the organization will manage the scene for:
   - Incidents of critical and fatal injury, as per legislation (e.g., preserve and not disturb the scene).
   - Non-critical and fatal injury.
3. Outline the process to ensure internal notifications and legislated notifications depending on the type of

incident. There is a legal requirement to provide 'steps to prevent recurrence' to the MLITSD, JHSC/HSR and unions in some instances, hence the need for an investigation. See chart below.

Legislated Notifications under OHSA

Type of Notice	Description	Required Notification	Content of Notice or Report
Death or critical injury.	Person is killed or critically injured (see definition).	Employer shall notify immediately the: • Ministry of Labour, Immigration, Training and Skills Development • JHSC/HSR, and • Trade union if any. • Provide a written report within 48 hours to the parties OHSA Section 51(1)	O. Reg. 420/21: Notices and Reports Under Sections 51 TO 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents. • The name, address and type of business of the employer. • The name of the worker. • The nature of the bodily injury or occupational illness. • The name and address of the constructor if the occurrence is at a project, • The address of the worker. • The nature and circumstances of the occurrence, including a description of any machinery, equipment or procedure involved. • The time, date and place of the occurrence. • The name and address of the legally qualified medical practitioner, registered nurse who holds an extended certificate of registration under the Nursing Act, 1991 or medical facility that is attending to or attended to the worker. • The names and addresses or other contact information of any witnesses to the occurrence. • The steps taken to prevent a recurrence or further illness.

Type of Notice	Description	Required Notification	Content of Notice or Report
Accident, explosion fire or incident of workplace violence causing Injury.	Person is disabled from performing his or her usual work or requires medical attention because of an accident, explosion fire or incident of workplace violence at a workplace but no one dies or is critically injured because of the occurrence.	Employer shall report within 4 days of the occurrence, give written notice of the occurrence to the: • JHSC/HSR • Trade union, if any • MLITSD Director if an inspector requires notification of the Director OHSA Section 52(1)	O. Reg. 420/21: Notices and Reports Under Sections 51 TO 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents. (2) If an accident, explosion or fire causes injury to a worker at a facility that disables the worker from performing his or her usual work, the written notice required by subsection 52 (1) of the Act shall include, • The name, address and type of business of the employer. • The name of the worker. • The nature of the bodily injury or occupational illness. • the nature and circumstances of the occurrence, including a description of any machinery, equipment or procedure involved. • the time, date and place of the occurrence. • The names and addresses or other contact information of any witnesses to the occurrence. • The steps taken to prevent a recurrence or further illness.
Note of Occupational Illness e.g., post-traumatic stress disorder.	If an employer is advised by or on behalf of a worker that the worker has an occupational illness or that a claim in respect of an occupational illness has been filed with Workplace Safety and Insurance Board by or on behalf of a worker.	Employer shall notify in writing within 4 days of being advised, to: • MLITSD Director • JHSC/HSR, and • Trade union OHSA Section 52(2)	O. Reg. 420/21: Notices and Reports Under Sections 51 TO 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents. (5) The written notice required under subsection 52 (2) of the Act if an employer is advised that a worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the Workplace Safety and Insurance Board shall include, • The name, address and type of business of the employer. • The name of the worker. • The nature of the bodily injury or occupational illness. • A description of the cause or suspected cause of the occupational illness. • The names and addresses or other contact information of any witnesses to the occurrence. • The steps taken to prevent a recurrence or further illness.

4. Develop steps for the launch of the investigation process after an incident (harm, no harm, near miss) or complaint is reported to the supervisor or employer. Consider the timeliness of the investigation and possible use of immediate post-incident investigation huddles to identify immediate and/or ongoing threats and immediate actions.
5. Develop a process to be used to determine the level of the investigation and investigator(s) and/or team

required, e.g., low and medium level investigation to be conducted.

6. Identify the documents and forms that the organization requires to be completed. Outline the steps for the investigation, for example:
   - Define the workplace incident problem and purpose
   - Collect Data – survey scene, collect data, interviews
   - Understand processes – workplace prevention, work processes etc.
   - Analysis including root cause analysis
   - Develop and select solutions – workplace controls
   - Make recommendations and reporting findings
   - Implementing solutions and recommendations – action plan and completion
   - Evaluation of corrective actions, and
   - Communication and follow-up

Administration of Workplace Incident Reports

7. The occupational health and safety administrator or delegate will ensure incident reports are completed and inform investigation personnel and/or team.
8. Incident reports will be tracked and reviewed for trends and where appropriate for the development of recommendations and quality improvements. Information of the review will be shared with stakeholders including the JHSC/HSR and others. Sample tracking/trending topics and indicators for e.g., workplace violence, include but not limited to the following.

Potential Workplace Violence Tracking/Trending Topics and Indicators	
1	Number of workplace violence Incidents: • # workplace violence incident causing injury (contact occurred), e.g., physical / psychological harm (injury/illness), • # workplace violence incidents with no injury/illness, e.g., near misses (no contact occurred) and no harm (contact occurred)
2	Source of workplace violence • # Type 1 – External Perpetrator • # Type 2 – Patient/resident/client/visitor • # Type 3 – Employment/Employee Related • # Type 4 – Domestic Violence
3	Summary of incident demographics – location and department, time of incidents, work activities at the time of the incident, worker's job position/title
4	Type of behaviour causing injury • # intentional violence • # non-intentional responsive behaviour

Potential Workplace Violence Tracking/Trending Topics and Indicators	
5	Workplace violence or responsive behaviour present: • # verbal threat • # written threat • # weapon threat • # threatening gestures • # kicking • # spitting • # choking • # grabbing and pinching • # hitting, slapping and punching • # pushing / pulling • # throwing objects • # scratching • # head butting • # sexual assaults • # weapon assaults • # Other, specify
6	Summary of common causal factors and root cause factors that lead to the workplace violence incident
7	Summary of corrective actions.

Communication

The employer, supervisor and occupational health and safety administrator will communicate the workplace investigation policy, measures, procedures and any changes to workers using:

- Staff meeting
- Posters
- Newsletters
- Email notifications

Ongoing communication about workplace hazards and incidents will be promoted to raise awareness and encourage ongoing reporting.

Training

All staff will be provided workplace incident investigation policy and procedure training at the time of new hire orientation. Regular reviews will be provided during departmental training sessions. Training records will be maintained by Human Resources and/or supervisor.

General training for all staff will include:

- Policy, measures and procedures
- Roles and responsibilities
- Care of worker and managing the scene
- Promotion of a positive safety culture
- Completion of report forms and documentation requirement e.g., online reporting and/or written

Investigator competency training for supervisors, lead investigators and investigating teams will include:

- Information above
- Investigator competency
- Review of emergency response to workplace incidents
- Managing the scene
- Authority and jurisdiction over the workplace incident scene
- Notifications and when to call the police
- Levels of investigation
- Steps to the investigations including root causing analysis (causal factors, contributing causes, root causes etc.)

- Documents and forms and their use
- Confidentiality
- Importance of clear and timely communication and follow-up with workers, others affect and JHSC/HSR/union
- Investigation document and record retention

Program Evaluation

The employer will evaluate and review this policy, measures and procedures annually and if necessary, revise it in consultation with stakeholders and JHSC/HSR. Approved quality improvements will be implemented according to an implementation plan and communicated to management and workers in a timely manner.

Related Policies and Procedures

- Hazard reporting policy and procedure
- Incident reporting policy and procedures
- Critical and Fatal injury procedures
- JHSC/HSR terms of reference
- Code White procedures
- Security procedures

Signature: _____

(President, CEO, Administrator, Executive Director)

Date: _____

Date of JHSC Consultation: _____

References:

Occupational Health and Safety Act R.S.O. 1990

Healthcare and Residential Facility Regulation Ontario Regulation 67/93

CSA Z1005-21

APPENDIX B: Starbursting Questions and Data Collection Planning Tool

Purpose of this Tool

Investigators often develop questions and then determine a plan to obtain the needed information to answer those questions. Starbursting is a "form of brainstorming used to generate questions in a systematic and comprehensive way. It is a useful tool to support problem-solving or decision-making processes by helping to understand all aspects and options more fully."

This Starbursting tool can assist investigators to systematically:

- Brainstorm the investigation problem and develop questions they need to answer; and
- Determine methods and a plan to answer those questions e.g., interviews, review of physical evidence, review of paper/electronic records and processes.

This is an optional tool and may not always be needed. The tool may be most useful for moderately complex to very complex investigations, especially when there is a team of investigators involved. A key goal of this tool is to capitalize on an opportunity to obtain the information needed.

Who uses this tool

- Incident investigator(s)
- Any additional workers involved in an incident investigation

How to use this tool

1. Review the incident report.
2. Using the tool, brainstorm questions that need answers for each of the general question categories (i.e., who, what, where, when, why, how).

The table below lists the question categories and provides examples of questions to answer. More questions may be added to the investigation as it proceeds.

Questions	Examples
Who?	Who was injured? Who was involved? Who was impacted? Who are the witnesses?
What?	What happened? What were people doing?
Where?	Where did the incident happen?
When?	When did it happen – day, time, shift?
Why?	Why did it happen? Why was the care recipient agitated?
How?	How did it happen? How did the worker get injured?

3. Determine what information/data will be collected for each question category. Check all methods that will be used. Refer to the tool on the following page for a list of data collection methods.
4. Develop a plan to collect information/data using the chosen data collection methods and determine who will handle each part of the data collection and when.

For example, to answer the What questions such as "What happened?" and "What were people doing?", the investigators may plan to do the following:

- Investigator 1 – Observe the incident scene to collect physical evidence and interview witnesses.
- Investigator 2 – Review paper/electronic data and workplace processes.

Starbursting Questions and Data Collection Planning

What?
List questions

Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other

Why?
List questions

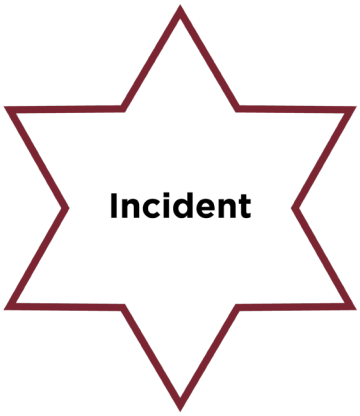
Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other

Were?
List questions

Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other



Why?
List questions

Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other

How?
List questions

Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other

Why?
List questions

Data Collection Plan

- ☐ Physical evidence
- ☐ Interviews
- ☐ Review of paper/electronic data
- ☐ Review of processes
- ☐ Other

Adapted from Mind Tool, n.d.

APPENDIX C: Investigator Kit Contents Checklist

Purpose of this tool

This tool is designed as a checklist to ensure that the investigator's 'kit' contains all the necessary materials. It aims to gather all required documentation and resources in one place, so they are ready and available when needed.

Who Uses this tool

- Incident investigator(s)
- Any additional workers involved in an incident investigation

How to Use this tool

Use this checklist when creating or checking the contents of the investigator's kit.

Investigator Kit Contents Checklist

☐ Investigation policy and procedures

☐ Investigation forms (paper or electronic)

☐ Note taking materials e.g., paper, pens, pencil, computer, tablet

☐ Witness forms and/or computer template

☐ Clip board as needed

☐ Camera

☐ Tape measure / ruler

☐ DO NOT ENTER tape and/or signage for securing the scene if required

☐ Masking or scotch tape to tape DO NOT ENTER sign

☐ Flashlight or cell phone flashlight

☐ Plastic bags or containers

☐ Personal protective equipment e.g., disposable gloves

☐ Communications checklist

- Whom to notify regarding not to disturb the scene e.g., security, supervisor, workers, visitors etc.
- Other required notifications

☐ Investigation carrying case, bag or backpack (yellow/orange may be a preferred colour)

☐ Access to a phone and key contacts

APPENDIX D: Physical Data Collection Form

Purpose of this tool

This form can be used to collect and track physical data to inform the investigation.

Who Uses this tool

- Incident investigator(s)
- Any additional workers involved in an incident investigation

How to Use this tool

Use this form to record and track the collection of physical data informing the investigation.

Physical Data Collection Form

INCIDENT DATE:	DATE OF COLLECTION:	TIME:
INVESTIGATOR(S) NAME:		
CHECK ALL THAT APPLY: ☐ Description of scene and evidence (including positional data – relative location of people & items) ☐ Equipment ☐ Materials ☐ Environment ☐ Other, describe: ☐ Other, describe: ☐ Photographs ☐ Sketches ☐ Measurements		
FINDINGS:		
FOLLOW-UP ACTIVITIES AND QUESTIONS, IF ANY:		

APPENDIX E: Witness Statement Form

Purpose of this tool

This form can be used to collect and track witness statements to inform the investigation.

Who Uses this tool

- Incident investigator(s)
- Any additional workers involved in an incident investigation

How to Use this tool

Use this form to document and track the collection of witness statements informing the investigation.

Witness Statement Form

WITNESS NAME:		**TODAY'S DATE:**
TELEPHONE NUMBER:		
(Home)	(Work)	(Mobile)
ADDRESS:		
INCIDENT LOCATION:		
INCIDENT DATE:	**TIME WITNESS ARRIVED AT SCENE:**	**TIME WITNESS LEFT SCENE:**
INCIDENT LOCATION:		
WITNESS DETAILS ABOUT INCIDENT:		

_____ _____

Print Witness Name **Date**

_____ _____

Witness Signature **Date**

APPENDIX F: Post-Incident Huddle Form

Purpose of This Tool

This tool was designed to collect details about a workplace violence incident. It aims to identify the root causes so that corrective actions can be developed and implemented to prevent recurrences and protect workers.

Sample Questions:

- Who was at the scene?
- Where were they located at the scene?
- What was happening at the scene?
- What were the interactions amongst people there?
- What did you see, hear, feel, smell (consider senses)?
- What were the environmental and work conditions?
- Was there anything unusual that you noticed?
- What was your role and what did you do?
- Why do you think this happened?
- How do you think the incident could have been prevented?
- Do you have anything more to add?

Who Completes This Tool

- Huddle lead, e.g., manager/supervisor, charge nurse, worker designated the role
- Worker(s) affected by a workplace violence incident
- Worker(s) witness to a workplace violence incident

How to Use This Tool

After an incident has occurred and is under control:

1. The huddle lead gathers workers involved in or who witnessed the incident.
2. The huddle lead uses the workplace violence post-incident investigation huddle form as a guide and asks workers a series of questions about the incident.
3. The huddle lead or other designated worker documents incident details on the workplace violence post-incident investigation huddle form.
4. Once the form is complete, it is given to the unit/department/area manager/supervisor to file in a designated location.

Workplace Violence Post-Incident Huddle Form

Purpose	• To promptly gather and document information following a workplace violence incident using a no fault, no blame approach. • To encourage participation and problem solving for workers and care recipient safety against workplace violence. It is strongly recommended that staff conduct a post-incident huddle as soon as possible to facilitate more accurate information recall, including for minimal or low risk workplace violence incidents. More complex incidents may require a more robust investigation approach.
Guidelines	1. Hold the workplace violence post-incident huddle as soon as possible after the incident. 2. Keep the huddle brief (e.g., 15-20 minutes) and if needed, conduct more than one huddle. 3. Involve the staff, witnesses, and others (e.g., security, external experts), if possible. 4. Ask open-ended questions. 5. Document, "workplace violence post-incident huddle completed" in any required electronic reports. 6. Huddle lead provides completed form to the manager/supervisor, if the lead is not a manager/supervisor.

POST-INCIDENT INVESTIGATION DATE:	**INCIDENT DATE:**	**INCIDENT TIME:**
HUDDLE LEADER:		**UNIT:**
HUDDLE ATTENDEES:		

QUESTIONS **Who, Where, What, How?**	**ANSWERS**
Who was involved?	
Where did it happen?	
When did it happen?	
What happened? Describe in detail the sequence of events leading up to the incident.	
How did it happen? What did you see and hear? What was the worker(s) doing? What was the person/care recipient doing? What were others present doing?	

QUESTIONS **Why did this happen? What are the causes?**	
What were the immediate causes? E.g., substandard act(s)/ practice(s) or condition(s) leading to the incident event? Substandard acts and conditions cause the "injury" but not the root cause of the incident. For example: Substandard Acts — e.g., not reading care plan, de-escalation techniques not used, not calling for immediate assistance, history of violence not communicated. Substandard Conditions — e.g., noise that triggered a care recipient, shrubs blocking the view of parking lot, door propped, panic alarm failure, poor lighting, personal safety response system or device not available.	
What were the root causes? There is usually more than one root cause. Root causes cause the "incident" and if corrected, will prevent future incidents. For each category listed below, check off all contributing factors that may be root causes of the incident. In the column to the right, provide details about each suspected root cause. **PEOPLE** ☐ Care recipient behaviours / triggers ☐ Worker/Management – skills, knowledge, abilities, attitudes, compliance ENVIRONMENT ☐ Lighting ☐ Workplace layout ☐ Sightlines ☐ Furniture ☐ Access, exits ☐ Temperature ☐ Noise ☐ Other EQUIPMENT ☐ Alarms ☐ Personal Protective Equipment ☐ Surveillance Equipment ☐ Patient Related Equipment ☐ Other	

QUESTIONS **Why did this happen? What are the causes?**	
MATERIALS ☐ Forms and checklists, e.g., assessment, communications, documentation ☐ Other PROCESS (policy, procedure, practice) ☐ Available ☐ Followed ☐ Training Program ☐ Other ORGANIZATION ☐ Internal Responsibility System ☐ Positive Safety Culture ☐ Other	

After the root causes have been identified:

1. Develop recommendations for corrective actions for each of the identified root causes (see table above).
2. Designate staff to implement recommended corrective actions within an established timeframe.
3. Evaluate the effectiveness of corrective actions; revise corrective actions as required.
4. Reassess the risk of workplace violence.

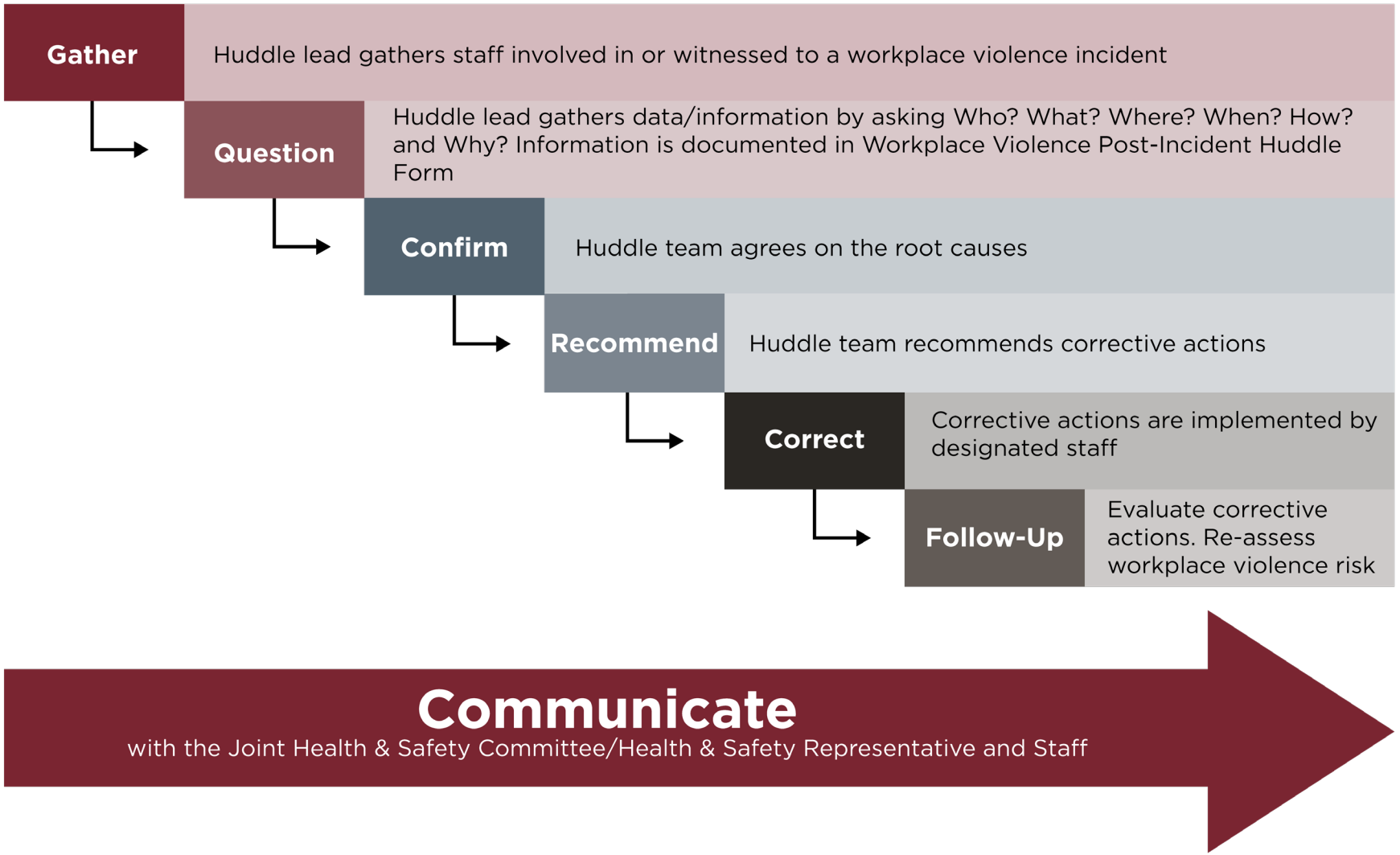
Through-out the post-incident investigation, **always** communicate updates to the JHSC/HSR on the:

- Incident
- Findings
- Corrective actions

Throughout the post-incident investigation, **always** communicate the changes and improvements to:

- Staff who reported the incident
- Staff who were affected or may be potentially affected

Workplace Violence Post-Incident Investigation Huddle



APPENDIX G: Paper and Electronic Data Collection Form

Purpose of this tool

This tool was designed to summarize and record paper and electronic data reviewed throughout the investigation.

Who Uses this tool

- Incident investigator(s)
- Any additional workers involved in an incident investigation

How to Use this tool

Use this tool for each paper and electronic data reviewed throughout the investigation. Summarize the findings and relevance of the data and record any follow-up activities or questions.

Data Collection Form

INCIDENT DATE:
INCIDENT LOCATION:

PAPER AND ELECTRONIC DATA COLLECTION		
INVESTIGATOR(S) NAME:		
DOCUMENT/RECORD NAME:	**DEVELOPED/PRODUCED BY:**	
DATE OF REVIEW:	**DATE OF DOCUMENT:**	**TYPE:** ☐ Paper Data ☐ Electronic Data
PERMISSION REQUIRED: ☐ Yes ☐ No	**DATE:**	**PERSON GRANTING PERMISSION:**
FINDINGS AND RELEVANCE TO INVESTIGATION:		
FOLLOW-UP ACTIVITIES AND QUESTIONS, IF ANY:		

APPENDIX H: OHSA Compliance Checklist

Purpose of this tool

This tool was designed to assist organizations to assess and verify compliance with relevant legislative requirements.

Who Uses this tool

- Employer
- Incident investigator(s) / Investigation team
- Any additional individuals responsible for legal compliance within the organization

How to Use this tool

Review the legislative requirements in the table below. Check off the corresponding boxes to confirm that the organization has achieved compliance; leave the boxes unchecked if not in compliance.

OHSA Compliance Checklist

Key OHSA Duties (applied to the workplace violence hazard)

☐ Employer shall ensure that:

- The equipment, materials and protective devices as prescribed are provided;
- The equipment, materials and protective devices provided by employer are kept in good condition; and
- The measures and procedures prescribed are carried out in the workplace OHSA s. 25(1)(a)(b)(c)

e.g., workers have the alarms required for workplace violence protection and it is in good condition and used as intended.

☐ Employer shall provide, information, instruction and supervision to a worker to protect the health and safety of the worker OHSA s.25(2)(a) e.g., workplace violence program training on policy and necessary workplace violence procedures, workplace violence equipment education and training, emergency response etc.

☐ Employer shall acquaint a worker or a person in authority over a worker with any hazard in the work s. 25(2)(d) e.g., supervisors/managers and workers are acquainted with workplace violence hazards.

☐ Employer and supervisor shall take every precaution reasonable in the circumstances for the protection of a worker [s. 25(2)(h)].

e.g., workplace violence program and preventive measures and procedures in place, worker and manager training, personal safety response system and devices and communication of the risk of violence.

☐ Ensure supervisors appointed are competent persons which are defined as:

- Qualified because of knowledge, training and experience to organize the work and its performance
- Familiar with OSHA and the regulations that apply to the work e.g. workplace violence requirements, how to protect workers
- Has knowledge of any potential or actual dangers to health or safety in the workplace e.g. workplace violence in the areas under their authority
- OHSA s. 25(2)(c) and s. 1

e.g., OHS competent supervisor training program that includes understanding OHS responsibilities and accountabilities, competence regarding workplace violence hazards and controls including the workplace violence program.

☐ Supervisor shall ensure that a worker,

- Works in the manner and with the protective devices, measures and procedures required by the Act and regulations.

e.g., *follows workplace violence prevention policy, procedures, rules etc.; and*

- Uses or wears equipment, protective devices or clothing that the worker's employer requires to be used or worn, e.g. personal safety response system devices etc. s.27(1)(a)(b)

e.g., supervisor enforces workplace violence prevention program requirements and rules in the work areas under their authority.

☐ Supervisor shall

- Advise a worker of the existence of any potential or actual danger to the health and safety of the worker of which the supervisor is aware.

e.g., supervisor ensures workers are aware of potential or actual workplace violence that may affect the worker's health and safety.

Key OHSA Duties (applied to the workplace violence hazard)

OHSA workplace violence

☐ Workplace violence program to include measures and procedures:

- To control the risk identified in the workplace violence risk assessment required in the act OHSA s. 32.0.2(2)(a)
- In place to summon immediate assistance where workplace violence is to occur or likely to occur s.32.0.2(2)(b)
- For workers to report incidents of workplace violence to the employer or supervisor s.32.0.2(2)(c)

e.g., workplace violence program protects workers and includes the noted requirements.

☐ Employer shall assess the risks of violence that may arise from the nature of the workplace, type of work or the conditions of work OHSA 32.0.3(1)

e.g., current and updated risk assessment is available and adequately protects workers.

☐ Employer shall reassess the risks of workplace violence as often as necessary to ensure that the related workplace violence policy and related program continue to protect workers from workplace violence OHSA s.32.0.3(4)

e.g., workplace violence reassessments are conducted regularly and when there are changes so that workers are protected.

☐ Employer to provide information to a worker with information and instruction for the worker on the contents of the policy and program with respect to workplace violence and any other prescribed information or instruction OHSA s.32.0.5(1)(2).

e.g., workers receive all the necessary and adequate information and instruction on workplace violence *policy, program and preventive measures such as a policy, procedures for emergency response, when to call the police, information on all types of workplace violence summoning immediate assistance, workplace security, communicating workplace violence risk, how to protect themselves de-escalation and non-violent crisis intervention, mandatory reporting, requirement to follow safety rules.*

☐ Employer to provide information to a worker and a supervisor to advise a worker and provide information including personal information, related to a risk of workplace violence from a person with a history of violent behaviour if,

a) A worker can expect to encounter that person in the course of his or her work; and

b) The risk of workplace violence is likely to expose the worker to physical injury OHSA s. 32.0.5(3) and where NO employer or supervisor shall disclose more personal information in the circumstances than reasonably necessary to protect the worker from physical injury s. 32.0.5(4)

e.g., communicating workplace risk especially for those who have a history of violence.

☐ Other

Worker Right to Refuse

☐ Workers have the right to refuse unsafe work respective of the limitations to refuse as outlined in the act.

e.g., workers know their right to refuse unsafe work including workplace violence; and employer/supervisor, workers and JHSC/HSR understand the work refusal process and how it related to workplace violence.

APPENDIX I: Incident Investigation Information Mapping Tools

Purpose of this tool

Workplace Violence investigators need to know the sequence of events leading up to an incident, the people involved, and the activities that occurred. This information is needed for both identifying causal factors and conducting a root cause analysis.

Information Mapping is a simple way of organizing information. The purpose of the Information Mapping Tool is to help investigators:

- Interpret the data they have collected
- Identify and investigate gaps in the incident timelines

An Information Mapping tool prompts the investigator to gather and document incident-related information such as timing of events and immediate causes (e.g., substandard acts and conditions) before exploring root causes (Vanden Heuvel, 2008).

There are different information mapping methods. Common ones include:

- Narrative Chronology – An account of what happened in the order of date and time. It is developed by using information collected from various sources into one account. This is a very common tool.
- Tabular Timeline – Allows the opportunity to record the date, time, event or situation, good practices, and problems or issues for each activity or event. The advantage is that the tool provides more information about what went well and what did not.
- Time-Person Grid – Outlines all the people involved in the incident and what they were doing throughout the event sequence. It is best used when the investigator needs to precisely understand the activities of more than one person immediately before, during, and immediately following the incident. It is useful for short time frames where there is a lot happening or for complex incidents. It is sometimes used in combination with other mapping tools, especially to detail a particular sequence of events.

Who Completes the Tool

- Investigator(s)

What is needed to complete the tool

Before completing this tool, the investigator(s) should collect and review the investigation evidence and put the information in order to develop a timeline.

How to Use this tool

Select an Information Mapping method that works best for the incident scenario. Sample mapping tools are located on the next few pages. You can modify the tools to meet your organization's needs. For workplace violence examples using the mapping tools, refer back to pages 25 to 30 of this toolkit.

- Narrative Chronology – Is a documented account of what happened in the order of occurrence. For instance, date, time, events and activities, and people involved. There is a section to include the evidence source, e.g., interview, paper/electronic data, physical data etc.
- Tabular Timeline – Is a table format document that allows each activity or event to be recorded (date, time), one subject and one active verb (e.g., nurse gets help). Additional information, such as the conditions or situation, good practices, and problems or issues. The advantage is that the table can provide more information about what went well and what did not. Identifying problems supplements the root cause analysis.
- Time-Person Grid – Is a table that outlines all the people involved in the incident and what they were doing throughout the event sequence. It is best used when closely tracking the activities of more than

one person immediately before, during, and immediately following the incident. It is useful for short time frames where there is a lot happening or for complex incidents. It is sometimes used in combination with other mapping tools, especially to detail a particular sequence of events.

Narrative Chronology Information Mapping Tool

DATE OF COMPLETION:
INVESTIGATORS:

Date/Time	Event or Activity in Chronological Order	Comments, Causal Factors	Evidence Source

Tabular Timeline Information Mapping Tool

DATE OF COMPLETION:
INVESTIGATORS:

Date/Time	Event or Condition	Additional Information or Contributing Factors	Good Practices	Problem Factors

Time-Person Grid Information Mapping Analysis Tool

DATE OF COMPLETION:
INVESTIGATORS:

Time Frame	Event and Activities				
	Person 1	Person 2	Person 3	Person 4	Comments, Causal Factors

APPENDIX J: Incident Investigation Report Form

Purpose of this tool

To provide a sample of an incident investigation report form. The information on the Workplace Violence Investigation Report Form may be used for tracking and trending purposes for the workplace violence investigation programs

What is needed to complete the tool

Prior to completing this tool, collect and analyze incident-related information and documents.

How to Use this tool

1. Complete this form using incident-related data already collected and analyzed data.
2. Review the completed form to verify that the details are accurate.
3. Lead investigator signs the document and ensures submission to the required parties.

Workplace Violence Investigation (WPV) Report Form

Part A: Workplace Violence Investigator

Names of Investigators

Lead Investigator: _____ Position: _____ Department: _____

Investigating Team: Yes ☐ No ☐ (If yes, complete the list of additional investigators)

Names of Additional Investigators

Name:_____ Position: _____ Department:_____

Name:_____ Position: _____ Department:_____

Name:_____ Position: _____ Department:_____

Name:_____ Position: _____ Department:_____

Name:_____ Position: _____ Department:_____

Name:_____ Position: _____ Department:_____

Purpose of Investigation

Date(s) of Investigation

Part B: Workplace Violence Incident Information and Demographics
Injury Notification Category (Occupational Health and Safety Act sections 51 and 52)
☐ Critical/fatal injury ☐ Disabled from performing regular duties or requires medical attention ☐ Occupational Illness ☐ Other
Required Notifications Completed (Occupational Health and Safety Regulations)
☐ JHSC/HSR/Unions Date: _____ Time: _____ ☐ MLITSD Date: _____ Time: _____ ☐ Police Date: _____ Time:: _____
Investigation Jurisdiction. *Check all that apply*.
☐ Internal Organizational Investigation ☐ MLITSD Investigation ☐ Police Investigation ☐ Other

Injured Persons

Name and Contact

First Name: _____ Last Name: _____ Phone Number:_____

Employee Number: _____ Department/Unit:_____ Job Position: _____

Date of Incident: _____ Time of Incident: _____

Name and Contact

First Name: _____ Last Name: _____ Phone Number:_____

Employee Number: _____ Department/Unit:_____ Job Position: _____

Date of Incident: _____ Time of Incident: _____

Other:

Type of Workplace Violence Incident. Check √ one.

☐ WPV Near Miss (incident occurred but WPV did not reach the employee – no injury/illness)
☐ WPV Not Causing Harm (incident occurred - WPV reached employee – no apparent injury/illness)
☐ WPV Causing Harm (incident occurred - WPV reached employee - causing injury/illness)

Nature of Workplace Violence Incident. Check all that apply.

- ☐ Threat to exercise physical force that could have caused physical injury
- ☐ Attempt to exercise physical force that could have caused physical injury
- ☐ Physical force that caused or could cause physical injury
- ☐ Other. Specify: _____

Source of Workplace Violence Incident. Check all that apply.

- ☐ External Perpetrator (typically unknown)
- ☐ Care Recipient/Family/Visitor
- ☐ Employment Related (e.g., employee, supervisor, contract employee etc.)
- ☐ Domestic (e.g., spouse or relative of an employee)
- ☐ Uncertain
- ☐ Other

Person identified by employee as the source of the workplace violence incident

☐ Known	First Name: _____Last Name: _____ or Subject Identifier: _____ How is the person known? _____ Address of person if known? _____
☐ Unknown	If unknown, describe the person: gender, height, weight, features, hair/eye colour etc.

Location of the Incident

Location was on workplace grounds/premises: Yes ☐ No ☐

Describe the specific location of WPV incident, e.g., address, building, room, area in room or public place:

Witnesses and Contact Information
Immediate and Preventive Actions Taken Before the Investigation

Part C: Investigation
Summary of Findings
☐ See attached physical evidence ☐ See attached information data – source paper/electronic data ☐ See attached interview data
Summary of Root Causes

Recommendations

See Appendix K for recommendations and implementation plan template

Communication and Follow-up of Report Findings			
Person Contacted	**Date**	**Investigator**	**Comments**
☐ Injured Person ☐ JHSC/HSR/Union ☐ Worker ☐ Other Departments Potentially Affected ☐ Family ☐ Alleged Perpetrator ☐ MLITSD ☐ Other			

_____ _____

Lead Investigator Signature **Date**

APPENDIX K: Recommended Corrective Actions and Implementation Planning Template

Purpose of this tool

The purpose of the tool is to provide organizations with a document to record recommendations for corrective actions, along with their implementation plan in response to a workplace violence incident. This also serves as valuable evidence, demonstrating the organization's commitment to meeting due diligence documentation and record keeping requirements. The tool can be modified to meet the organization's needs. For example, organizations may increase or decrease the number of recommendations for each root cause as needed. It is necessary for management to be committed and support the recommended corrective actions.

Who Completes the Tool

- Investigator(s)
- Workplace party(s) who develops corrective actions
- Workplace party(s) who implements corrective actions
- Workplace party(s) who evaluates corrective actions

What is Needed to Use the Tool

Prior to using the tool, the incident's root causes should be identified and investigated.

How to Use the Tool

The tool is divided into two parts – Part A and Part B. Complete the tool in this order.

Part A: Recommended Corrective Actions

1. Recommended corrective action(s) for each root cause are entered into Recommended Actions column.
2. For each recommendation, assign a priority level e.g., high, medium, low – where high is more urgent and low is less urgent.
3. Suggest short-, medium-, and long-term solutions for corrective actions that need comprehensive planning and resources.
4. Provide a suggested time frame in which the recommendations should be implemented.
5. Sign the document and provide it to relevant stakeholders and those in authority to implement the recommended corrective actions.

Workplace Violence Incident Investigation	
Lead Investigator:	
Prepared by:	**Date:**

Part A Recommendations

Root Cause #	Recommended Actions	Priority	Time Demand if required			Time Frame
		High/Med/Low	Short	Med	Long	

_____ _____

Lead Investigator Signature **Date**

Part B: Recommended Corrective Actions Implementation Plan

Prior to completing Part B, a person(s) is assigned the role of developing and implementing a plan to carry out the recommended corrective actions.

1. In the first column, insert the root cause number that corresponds with the root cause number in Part A table.
2. For each root cause, document the recommended steps to be taken in the corresponding column
3. For each step to be taken, insert the name of the person most responsible for overseeing the implementation of the recommendation. The person(s) selected must possess the authority, ability and resources to carry out the recommendation.
4. Identify resources required in terms of time, human, and financial.
5. Identify reasonable target dates for completion.
6. Enter the target dates in the completion data column, once the recommended actions are complete.
7. Identify in the measurement column, how you will know the recommended corrective actions are complete e.g., policy and procedure has been developed and approved.
8. Report progress to management that approved the recommendations.
9. Sign and date the completed document.

Form:

Root Cause #	Steps to be Taken to Address Root Cause	Person(s) Assigned to	Resources Required (Time, human, financial)	Target Date	Completion Date	Measurement e.g., outcome

_____ _____

Lead Investigator Signature **Date**

APPENDIX L: Workplace Violence Incident Investigation Tracking Tool

Purpose of this tool

The purpose of this tool is to provide a template for collectively tracking WPV incident investigation data and corrective actions in one central location. This will make it easier to analyze incidents at an aggregate level, help determine root cause trends and support ongoing efforts for quality and continual improvement.

Who Completes the Tool

- Workplace party(s) designated the role of tracking WPV incident data. This may be the same person(s) responsible for overseeing incident and hazard reporting activities and documentation.

How to Use the Tool

For each incident:

1. Track by number.
2. Enter the date, time and location.
3. Describe the task or situation. Examples are provided in the legend below.
4. Identify the type/source of the WPV (e.g., workplace violence type i-iv).
5. Identify whether it is an incident with injury, incident with no injury or hazard.
6. Describe the WPV incident (e.g., threat of physical force, attempt of physical force or physical force as per OHSA definition, or whether it was just a hazard with no incident).
7. Identify the WPV behaviour exhibited e.g., aggressive (intentional), responsive behaviour (non-intentional), or unknown.
8. Describe the behaviour. Sample behaviours are provided in the legend. Select those that were most predominant.
9. Identify whether there was physical harm, psychological harm, both or unknown.
10. Provide a brief list of root causes for the incident identified in the investigation.
11. Provide a summary list of corrective actions.
12. Conduct an analysis to identify any trends in the root causes of incidents and identify opportunities for organizational quality improvements.
13. Summarize the findings and provide a report to management, JHSC and/or HSR. Where appropriate make recommendations for Workplace Violence and Investigation program improvements.

Note: *Analysis should be conducted at least annually or more often if necessary.*

WPV Incident Investigation Tracking Tool

#	Date	Time	Dept.	Incident	Describe Task / Situation	WPV Type 1-4	Incident / Hazard Type	WPV Description	Description of Behaviour	Psychological / Physical Harm	Key Root Causes (People, Equipment, Materials, Environment, Process, Other)	Corrective Actions
1												
2												
3												
4												
5												
6												

WPV Incident Investigation Tracking Tool

WPV Incident Investigation Tracking Tool Legend:

Describe task/situation: • Patient care or treatments • Transition of care – receiving, escort, moving, sending • Patient interventions • Redirection patient • Non-patient care • Other – describe	Incident Hazard/type: • Hazard – potential for incident • No-injury incident – no harm incidents, and near misses • Injury incident – Harmful incident	WPV description (based on OHS act descriptions): • Hazard – Potential of Physical Force • Threat of Physical Force • Attempt of Physical Force • Physical Force
Psychological/physical harm: • Psychological harm • Physical harm • Both	WPV type: I External Perpetrator II Client/visitor III Employment/Employee-related IV Domestic	Key root causes • Examples can be found in the table below
Description of behaviour: • Verbal threat • Written threat • Weapon threat • Behaviour threat (e.g., fists) • Kicking • Spitting	• Biting • Hitting/slapping • Punching • Pushing/pulling • Grabbing and pinching • Choking	• Scratching • Head butting • Sexual assault • Weapons use (e.g., stab, shoot) • Other
Corrective actions: • Describe controls used to address the root causes such as management commitment, resource policy, procedures, protocol, worker/management training, equipment, maintenance, environmental design, engineering controls • Tailor corrective actions to each situation • Note effectiveness of corrective action		

Examples of key root causes can be found in the table below.

Root Cause Source	General root cause examples
People	Worker: • Inadequate knowledge, training, skills or abilities for the task • Non-compliance with known rules (intentional or not intentional) Management/Supervisor: • Inadequate OHS prevention and/or competent supervisor training • Lack of supervision or performance monitoring • Inadequate OHS rule enforcement (intentional or not intentional) Employer: • Inadequate OHS knowledge of legislation or OHS roles and responsibilities • Inadequate OHS rule enforcement Board of Directors: • Inadequate knowledge regarding OHS fiduciary responsibility Contractors • Lack of OHS knowledge, training and/or OHS standards expectations Care Recipient: • Uncontrolled behaviours that can be triggered
Equipment	• Required equipment to do job safety is not available or not available when needed • Equipment available is not appropriate • Equipment needed is not maintained
Materials	• Materials needed not available or not available in quantity needed • Materials for the job are not appropriate or inadequate • Materials are poorly designed and difficult to use
Environment	• Inadequate workplace layout, design, working heights, space, sight lines • Lighting not sufficient or does not meet standards • Temperature not meeting standard or not optimal for the task or activity • Flooring or surfaces not appropriate for the activity • Noise levels exceed standards or interfere with work activities or patient population
Process, Procedures	• Lack of OHS standards, processes, safe work practices or safe operating procedures • Inadequate alignment of standards and actual practices • Inadequate training programs
Other e.g., internal/ external organization or system factors	• Inadequate commitment to OHS prevention priorities • Inadequate occupational health and safety management system • Inadequate internal system resources for OHS prevention e.g., funding, equipment, human resources • Inadequate OHS internal responsibility system and accountability for OHS • Inadequate external system funding

How the Toolkit Was Developed

This toolkit was developed and informed by:

- Scientific and grey literature
- Advice and input from the project's Steering Committee (see acknowledgements section below for the list of organizational contributors)
- Expertise 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)
- Expertise of PSHSA's occupational health and safety consultants.

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We could not have developed this toolkit without the Steering Committee's commitment, leadership, expertise, and input.

Organizations Represented on VARB Steering Committee

Addictions & Mental Health Ontario (AMHO) / Ontario Federation of Community Mental Health and Addiction Programs

AdvantAge Ontario

Canadian Union of Public Employees (CUPE)

Guelph General Hospital (GGH)

Health Shared Services Ontario (HSSO)

Home Care Ontario (HCO)

Institute for Work and Health (IWH)

Ministry of Health (MOH)

Ministry of Labour, Immigration, Training and Skills Development (MLITSD)

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.

Control Measures: Measures and procedures used to address workplace health and safety hazards and risks.

Employer: Means a person who employs one or more workers or contracts for the services of one or more workers to perform work or supply services (OHSA).

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

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

Long-Term Care Setting: Healthcare facilitates where adults can live and receive help with most or all daily activities and access to 24-hour nursing and personal 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, invasion of space) (PSHSA).

Supervisor: A person who has charge of a workplace or authority over a worker (OHSA).

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.

Worker: Staff members who can be clinical healthcare workers, allied healthcare workers, managers, administrative personnel, physicians, students, security guards, or any individual who has a working relationship with the healthcare organization (PSHSA).

Worker Safety Representative: A Joint Health and Safety Committee (JHSC) worker member, Health and Safety Representative, or another worker who because of their knowledge, experience and training is selected by the union that represents the worker, or if there is no union, is selected by the workers to be a representative during a work refusal (OHSA).

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.

Workplace Violence: Under the OHSA, workplace violence means:

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

Resources and References

Additional Resources

Ontario's Occupational Health and Safety Act (OHSA)

Workplace violence prevention in health care: A guide to the law for hospitals, long-term care homes and home care

PSHSA's Workplace Violence website – www.workplace-violence.ca

#frontlinehealthcare PTSD Resource Toolkit

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Workplace Violence Incident Investigations Toolkit

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