# 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

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|---|---|
| **Purpose** | • To promptly gather and document information following a workplace violence incident using a no fault, no blame approach.<br>• To encourage participation and problem solving for workers and care recipient safety against workplace violence.<br>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.<br>2. Keep the huddle brief (e.g., 15-20 minutes) and if needed, conduct more than one huddle.<br>3. Involve the staff, witnesses, and others (e.g., security, external experts), if possible.<br>4. Ask open-ended questions.<br>5. Document, "workplace violence post-incident huddle completed" in any required electronic reports.<br>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**<br>**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**<br>**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?<br><br>Substandard acts and conditions cause the "injury" but not the root cause of the incident. For example:<br><br>Substandard Acts — e.g., not reading care plan, de-escalation techniques not used, not calling for immediate assistance, history of violence not communicated.<br><br>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?<br><br>There is usually more than one root cause.<br><br>Root causes cause the "incident" and if corrected, will prevent future incidents.<br><br>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.<br><br>**PEOPLE**<br><br>☐ Care recipient behaviours / triggers<br><br>☐ Worker/Management – skills, knowledge, abilities, attitudes, compliance<br><br>ENVIRONMENT<br><br>☐ Lighting<br><br>☐ Workplace layout<br><br>☐ Sightlines<br><br>☐ Furniture<br><br>☐ Access, exits<br><br>☐ Temperature<br><br>☐ Noise<br><br>☐ Other<br><br>EQUIPMENT<br><br>☐ Alarms<br><br>☐ Personal Protective Equipment<br><br>☐ Surveillance Equipment<br><br>☐ Patient Related Equipment<br><br>☐ Other | |

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