IMPLEMENTATION MANUAL

REDUCING TRAUMA AMONG PSYCHIATRIC WORKERS



A step-by-step guide for assessing, implementing and evaluating trauma-prevention strategies in mental health care.

Waypoint
CENTRE for MENTAL HEALTH CARE
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traumaamongpsychiatricworkers.net

ABOUT THIS MANUAL

This manual aims to provide step-by-step instructions for healthcare clinical leaders and administrators on how to assess your hospital's stage of preparedness to prevent violence exposure and staff trauma, and how to plan, implement, and evaluate change in order to reduce occupational exposures to workplace violence and prevent and mitigate related psychological trauma.

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INTRODUCTION

This section includes:

- Manual Overview
- Project Background
- Recommendations Explored
- Identified Barriers

INTRODUCTION

MANUAL OVERVIEW

This manual includes two key components:

1. **What to implement:** Exploring the priority recommendations that were selected through a quantitative national survey identifying implementation gaps where improvements would be most beneficial; and

2**. How to implement**: This includes steps for planning change and addressing potential barriers, informed by research evidence and focus group feedback from clinical managers as well as hospital and union representatives.

Priority Recommendations

This manual is organized around the three priority recommendations identified by hospital leaders and staff in surveys and focus groups conducted in 2025:

1. Engage in primary prevention to reduce staff exposure to critical events
2. Increase staff's ability to prevent and safely respond to critical events
3. Improve organizational culture to create a psychologically healthy workplace emphasizing trauma prevention

MANUAL OVERVIEW

The Four-Step Method

Each priority consists of objectives identified through the focus groups, reflecting the needs, challenges, and opportunities for improvement described by participants.

Each objective is organized into four steps adapted from the Knowledge-to-Action Framework (Graham et al., 2026):

1. **Assess and Identify Gaps:** Includes a Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goal table, assessment scales, and notes section to support gap analysis.
2. **Plan and Improve:** Includes operational plan tables informed by focus-group findings and relevant best practices. Each Plan and Improve section concludes with a list of relevant tools and resources for further reference.
3. **Implement:** Includes a table outlining activities across the implementation phases.
4. **Monitor and Evaluate:** Provides relevant measures and indicators for evaluating implementation processes and outcomes.

You do not need to complete the priorities and objectives in the order they appear. Instead, you can begin with the objective that is most relevant to your organization's current needs and priorities. You may refer to the worked example provided for the first objective to understand how to complete each section. The tools and resources listed after each objective provide additional guidance and can be adapted to your organization's setting.

The accompanying **Workbook** can be used throughout the Manual to help guide your own implementation planning and includes additional tools related to organizational trauma support, cause-and-effect analysis, and the Plan-Do-Study-Act cycle to support the planning and evaluation of changes. **The Workbook can be accessed here** and through the links throughout the Manual.

PROJECT BACKGROUND

The Problem

Healthcare providers are at heightened risk for post-traumatic stress disorder (PTSD) and other mental health problems due to workplace violence exposure and other potentially traumatic events (Carleton et al., 2019; Stelnicki et al., 2020). In addition, healthcare workers still face the extraordinary stresses related to the ongoing post-pandemic healthcare workforce challenges (Galanis et al., 2021; Morgantini et al., 2020). Nearly two-thirds of healthcare workers (62%) report experiencing workplace violence (Liu et al., 2019), including 16% of psychiatric hospital workers experiencing post-traumatic stress disorder (PTSD; Seto et al., 2020). Evidence-based recommendations exist for preventing psychological injuries among healthcare workers (Hilton et al., 2020). The post-pandemic critical situation in healthcare (Ham et al., 2023) makes it imperative to implement these recommendations yet all the more challenging for organizations to adopt new research and translate it into policies and programs.

Statistics highlight the prevalence of psychological injuries in psychiatric healthcare workers.

Our previous research as part of the Trauma among Psychiatric Workers project (***https://www.traumaamongpsychiatricworkers.net/***) found that one in six people working in psychiatric hospitals in Ontario met the screening cut-off for probable PTSD (Seto et al., 2020). PTSD was uniquely related to exposure to workplace violence, which was directly experienced by two-thirds of staff (Hilton et al., 2020). Furthermore, both critical incidents of violence and chronic workplace stressors increased the risk of PTSD (Hilton et al., 2020). While individual burnout plays a mediating role in PTSD, chronic stress related to healthcare working conditions increases both burnout and PTSD (Ham et al., 2022). Organizational and managerial support are key components of workplace psychological injury prevention (Rodrigues et al., 2020, 2021).

PROJECT BACKGROUND

Healthcare workplaces across Canada currently face annual expenses exceeding $330 billion, with costs rising particularly in hospitals (CIHI, 2022). The increased reliance on overtime and agency staff, driven by absenteeism and the physical and psychological injuries contributing to it (CIHI, 2023), underscores the need for effective interventions and solutions.

Knowledge gaps exist in workplace injury prevention strategies in psychiatric healthcare.

There are few evidence-based interventions to prevent or reduce PTSD in healthcare settings. A scoping review of workplace interventions for hospital nurses found only six eligible studies, which focused on individual-level, educational, and therapeutic interventions (Liyanage et al., 2021). A broader scoping review of existing strategies to support the psychological health and safety of criminal justice and forensic healthcare workers found that most strategies again focused largely on training to reduce stigma, encourage help-seeking, and increase resilience (Canning et al., 2025), despite limited evidence of long-term effectiveness (Anderson et al., 2020; Vanhove et al., 2016). In contrast, a systematic review identified violence prevention and mental health care for healthcare workers exposed to violence as the most promising targets for PTSD prevention (Hilton et al., 2022). Further, there is limited attention to vulnerable populations such as women (Canning et al., 2025), despite the preponderance of women among healthcare workers and potential gender differences in workplace exposures, stressors, and PTSD risk and recovery (Hilton et al., 2022).

Recommendations for Reducing Trauma Among Psychiatric Workers

Twelve evidence-based recommendations for hospitals to undertake were initially developed, based on research (surveys, focus groups, interviews, and literature reviews) and interest-holder consultations (with employers, employee associations, government ministries and public service agencies). The recommendations (found ***here***) were posted on a public website in early 2020. In 2024, we began translating the recommendations into guidelines and steps to support implementation. This resulting manual considers post-pandemic demands on healthcare systems while also drawing upon current knowledge of the extent to which hospitals have accessed the recommendations, any successful strategies hospitals have implemented to reduce workplace violence and related trauma, and their current needs and priorities.

RECOMMENDATIONS EXPLORED

This implementation facilitation manual builds on work conducted through the Trauma Among Psychiatric Workers project. As a result of that project, 12 recommendations were produced, along with opportunities and suggested actions, to reduce workplace trauma and support the psychological well-being of staff working in psychiatric hospitals.

Summary of the 12 Recommendations

The first three recommendations identify opportunities that would allow employers to strengthen their capacity to support staff, both within existing or limited additional resources. These include expanding roles for regulated health professionals to support employee mental health, leveraging occupational health and safety specialists to provide trauma-informed leadership, and for hospitals, government ministries, employee associations, professional associations, and other interest-holders, to enhance partnerships and resources for solutions to address workplace PTSD.

Remaining recommendations are organized by categories of PTSD risk factors: pre-traumatic factors (risk factors existing prior to critical incident exposure; these recommendations address the environmental, educational, cultural, and other workplace factors that could enhance prevention and preparedness), peri-traumatic factors (critical events and immediate responses; these recommendations address trauma-informed debriefing and support) and post-traumatic factors (ongoing supports and after-effects; these recommendations address return-to-work and workers' compensation board procedures).

RECOMMENDATIONS EXPLORED

Current Implementation Status

Given that healthcare workplaces across Canada face escalating pressures, including absenteeism due to physical and psychological injuries, straining already limited resources, there is an urgent need for practical, prevention-focused approaches that can be feasibly implemented across diverse hospital contexts. Recognizing that evidence alone is insufficient to drive change, the current project examined the uptake of these recommendations, along with the barriers and facilitators to their implementation, in order to translate them into actionable guidance for practice.

To inform the development of this manual, a national, quantitative, cross-sectional survey was conducted with psychiatric hospitals and hospitals with adult psychiatric inpatient units across Canada. The survey collected information on hospital characteristics and assessed familiarity with, agreement with, perceived feasibility of, and extent of implementation of each of the 12 recommendations. Participants also identified their top four priority recommendations for psychiatric hospital environments, where staff are at heightened risk of exposure to violence, critical incidents, and cumulative psychological trauma.

Survey findings demonstrated clear consensus around the importance of primary prevention and preparedness

Four top-priority recommendations were selected from the pre-trauma stage, emphasizing the need to reduce exposure to critical events before harm occurs and to strengthen organizational capacity to respond effectively.

RECOMMENDATIONS EXPLORED

In a national survey, the following four recommendations were chosen as the highest priorities:

1. Engaging in primary prevention to reduce staff exposure to critical events;
2. Increasing staff capacity to prevent and safely respond to workplace critical events;
3. Strengthening collaboration between leaders and staff to improve organizational culture and reduce stigma related to workplace mental health; and
4. Creating psychologically healthy workplaces with a strong emphasis on trauma prevention.

Through further exploration during the focus groups, as well as the manual research and design phases, priorities 3 and 4 were combined into one priority: Improve organizational culture to create a psychologically healthy workplace emphasizing trauma prevention.

This manual exclusively focuses on these three priority recommendations.

It is designed as a practical, step-by-step implementation resource offering facilitation strategies, tools for overcoming barriers, and considerations that foster real-world uptake. By basing guidance in national data and implementation science, this manual aims to support meaningful, sustainable change aimed at preventing psychological injuries and promoting the mental health of staff in psychiatric hospitals across Canada.

Each of these priority recommendations includes specific opportunities and suggested actions, which are outlined further in this manual and accompanying **workbook**.

IDENTIFIED BARRIERS

Overview of Barriers Identified in Focus Groups

While this manual focuses on facilitators and implementation strategies to prevent trauma among psychiatric workers, participants in our focus groups identified several barriers and challenges related to the implementation of prevention and safety strategies. Identifying these barriers five years after the initial recommendations were developed helped us to understand what has and has not changed and to frame barriers, facilitators and implementation strategies in light of current contexts- in particular, following the COVID-19 pandemic and subsequent strains on our healthcare system and resourcing.

During our focus groups, participants highlighted multiple barriers, including:

- Rising patient acuity and complexity
- Increased incidents of violence
- The need for risk assessment
- Resource constraints in multiple areas
- Patient and family involvement in care as both a barrier and facilitator
- Challenges and uncertainties with policy alignment and implementation
- Role- and team-based variation in response to incidents of violence, and
- A need for organizational cultures to support the psychological safety of staff

The priorities, objectives and strategies outlined throughout this manual aim to respond to these identified barriers, building up or building on facilitators to support trauma prevention for psychiatric workers.

PRIORITY 1

Engage in primary prevention to reduce staff exposure to critical events

Objectives include:

- Standardize individual-level risk management
- Develop infrastructure for trauma prevention
- Engage patients and families
- Optimize the physical environment
- Embed violence prevention in policies and procedures

PRIORITY 1

Engage in primary prevention to reduce staff exposure to critical events

Since the pandemic, individuals admitted to mental health care settings have presented with higher clinical acuity, increasing the risk of critical events and related harm to healthcare staff (Ham et al., 2023). Direct exposure to critical events, such as assaults and threats, is a key risk factor for post-traumatic stress disorder (PTSD) symptoms in staff working in healthcare settings (Hilton et al., 2020). This finding was also reflected in the pre-implementation survey (Ham et al., 2026) and focus groups conducted by our team, where workplace violence was identified as contributing to increased PTSD risk among psychiatric inpatient unit staff. This evidence highlights the need to prioritize primary prevention efforts to reduce critical events.

Priority 1 focuses on prevention strategies that reduce staff exposure to critical events.

Through our focus group sessions, we have identified five objectives involving multiple layers of action across patients, staff, physical environments, policies and procedures, and organizations. Patient-level actions include individual risk assessment and engagement with patients and families in violence prevention. Staff-level actions include risk assessment and risk management. Environmental actions include creating safer physical spaces and strengthening security design. Policy and procedure actions include identifying gaps in existing policies and developing standardized prevention practices. Organizational actions include building a stronger infrastructure for violence prevention through organizational survey and data-driven trends. These actions can be supported by baseline assessment, ongoing monitoring, and outcome evaluation to promote long-term sustainability.

OBJECTIVE 1

Standardize individual-level risk management

Worked Example

This objective focuses on supporting organizations to select, implement, and consistently use violence risk assessment tools. This may include identifying validated tools through a literature search, establishing time points for when risk assessment should occur, and defining clear processes for communicating and reporting risk information. Standardizing these processes helps ensure that patient risk information is identified and communicated across the organization.

Why it Matters

Consistent violence risk assessment is the foundation of effective safety planning and violence prevention in psychiatric settings. Standardizing assessment processes helps identify risks early, improves communication between staff, and reduces staff exposure to workplace violence.

Key Findings from Focus Groups

- Violence risk assessment practices vary considerably across organizations, with inconsistent use of screening tools.
- Risk assessments should be mandatory at patient admission and supported by standardized processes.
- Highly visible safety alerts should be integrated within the Electronic Medical Record (EMR) to ensure all healthcare workers are aware of potential risks.
- Psychological safety alerts should clearly identify known risk factors and recommend strategies to minimize staff exposure to violence.

OBJECTIVE 1

Standardize individual-level risk management

Worked Example

Evidence

Organizations using integrated EMR risk flagging systems have demonstrated improved communication and reduced incidents of workplace violence. The Centre for Addiction and Mental Health, for example, has implemented a risk flagging system within its electronic health record to help identify and communicate potential safety risks (Paterson et al., 2019). The flag appears immediately: when a healthcare professional opens the record, an alert communicates the nature of the risk. Flags include aggression, sexual aggression, weapons, arson, letter of trespass, and unauthorized leave of absence. Implementing the updated system reduced both the total number of incidents and the average number of incidents per patient with a risk flag (Paterson et al., 2019).

Timing matters as much as the tool. Screening instruments such as the Dynamic Appraisal of Situational Aggression (DASA) and the Brøset Violence Checklist (BVC) are designed to predict imminent violence, typically within 24 hours of assessment (Dickens et al., 2020). The Public Services Health and Safety Association (2017) recommends that violence risk assessment in mental health and addiction settings occur at the first point of contact with a healthcare worker, and be repeated each shift. Timing will vary with the tool selected and with local processes, so organizations should consult internal interest-holders and the original tool guidance before setting their own schedule.

Expected Outcomes

- More consistent identification and communication of violence risk
- Improved staff awareness and preparedness
- Stronger individualized safety planning
- Reduced workplace violence incidents and improved staff safety

Go to pages 6-16 in the Workbook to explore the planning resources for this objective.

Step 1: Assess and Identify Gaps

Task: Conduct a high-level gap analysis on the objectives below. We have provided an example **SMART goal** to illustrate this objective. This framework helps organizations and managers develop clear, practical, and meaningful goals (Doran, 1981). Rate the difference between the SMART goal and the existing state at your hospital or organization, from 0 (no gap) to 2 (major gap).

Use the **Notes section** to list specific gaps, such as areas where performance is lacking or where improvements are needed. You can also use the Notes section to identify where further assessment is needed. We will guide you through planning, implementation, and monitoring in the next steps.

We have provided a worked example for Objective 1 below.
Please refer to this when filling out your own tables.

SMART goal: *Within 12 months, the research lead will review the evidence for validated individual-level risk assessment tools, select one appropriate to our patient population and setting, and embed it in the admission workflow, with the evidence reviewed annually thereafter.*		
0	1	2
No gaps; goal achieved	Minor gaps: in progress but review or more work needed	Major gaps: goal not in sight
ex. Notes: Individual-level risk assessment is present in our unit, but it has not been updated for a long time and it is not a mandatory part of admission. Literature search and staff survey is needed to update and embed it into our system.		

Go to page 6 in the Workbook to access a blank fillable SMART goal template.

Step 2: Plan and Improve

Now that you have assessed your SMART goals, review the gaps you have identified. If both major and minor gaps are present, begin by prioritizing major gaps. You may also wish to consider whether any goals with gaps require priority escalation due to factors such as timeliness (e.g., temporary availability of funding or other resources, critical event review or inquest). Similarly, consider whether addressing a minor gap could have a significant impact on violence prevention or trauma reduction.

If no major gaps are identified, review the goals with minor gaps and proceed to the Planning and Improvement step for the remaining objectives. As you work your way through the manual and implement improvements, you will return to the Assessment step to reassess progress, identify new priorities and select the next objective to address. This cyclical process supports continuous quality improvement in preventing violence and reducing workplace-related psychological trauma.

This section will guide you through the tasks needed to make and implement your plans for violence prevention and trauma reduction. As you move your objectives from having gaps to having no gaps, re-assess the objectives in Step 1: Assessment, then return to this section to plan and implement your next cycle of improvements.

Task: Create an operational plan for each objective you are working on by going to the Workbook (**linked here**) and completing the table on **page 8**. In the Workbook, we have provided some specific suggestions of activities for each objective. These activities are based on data gathered from our focus groups, knowledge exchange events, and other interest-holder consultations. You may choose to use additional or alternative activities, being sure to check the evidence base for any activities you are considering.

Operational Plan Worked Example

If you identified gaps in your goal to *Complete validated tool(s) for assessing individuals' risk of violence in the healthcare setting at specified time points (e.g., intake, monthly, annually)*, and you noted that a literature review was needed, you might have a sub-goal of reviewing the evidence and current practices on individual level risk assessment. We have provided a worked example of an operational plan for this sub-goal below. Use the blank table in the workbook to develop an operational plan for your organization's goals.

Activity	**Definition**	**Actor** *Who will do this? (i.e., Team or person responsible)*	**Action** *What will they do?*	**Dose** *How much? (i.e., Number of staff reached, number of sessions)*	**Frequency** *How often? (i.e., once a month, annually)*	**Expected outcome** *Metrics (i.e. measures of what you hope to achieve)*	**Resources needed**	**Timeline** *Start - finish*
Sub-goal 1: Review evidence and current practices for individual-level risk assessment								
Review evidence on validated risk assessment tools for your setting	Identify tools that are evidence-based and appropriate for the care setting and patient population	Hospital research team, clinical managers, frontline staff	Conduct an environmental scan and literature search on validated violence screening tools that aligns with organization's patient population and setting	3–5 validated violence risk assessment tools identified and mapped to inpatient, outpatient, and/or community mental health settings	Once during the planning phase, then reviewed annually	Organization has an evidence-informed shortlist of risk assessment tools to support tool selection	Staff time; budget for tool access, licensing, or training; administrative support; clinical education/professional practice support	May - July 2026

Table adapted from Practicing Knowledge Translation Workbook from St. Michael's Unity Health Toronto.

Objective 1: Standardize individual-level risk management

Operational Plan Worked Example

Activity	Definition	Actor	Action	Dose	Frequency	Expected outcome	Resources needed	Timeline
Sub-goal 1: Review evidence and current practices for individual-level risk assessment								
Survey staff on their perception of current violence screening tools	Administer survey to staff on the risk assessment process	Professional Practice Department and leads, Learning and Development team	Administer surveys and conduct focus groups and interviews	Reach 100 staff in the hospital/ organization	Annually	Staff-reported strengths, barriers, and training needs related to violence screening tools	Survey tools; Data Analytics team	July - August 2026
Align tools and policies with accreditation standards	Compare current tools, policies, and documentation requirements with applicable accreditation standards and identify gaps	Quality Improvement lead, Accreditation lead	Complete a gap analysis comparing current violence risk assessment tools against relevant accreditation standards to identify areas that require updates	1 structured gap analysis completed with input from key clinical, policy, accreditation, and risk management stakeholders	Annually	Completed gap analysis identifies gaps between current tools, policies, documentation practices, and accreditation standards, with an action plan developed to address priority gaps	Administrative support; leadership support; budget for workflow updates	July-September 2026

Objective 1: Standardize individual-level risk management

Operational Plan Worked Example

Activity	Definition	Actor	Action	Dose	Frequency	Expected outcome	Resources needed	Timeline
Sub-goal 2: Select standardized tools								
Determine risk screening process and time points	Define when risk screening should occur	Clinical and professional practice leads	Conduct a targeted literature search to identify recommended violence risk screening time points, compare findings with staff surveys and identify points in the current workflow where risk screening is absent or unclear	1 workflow review completed to define when risk screening should occur	Biannually	Completed risk screening workflow with defined time points, staff responsibilities, and documentation requirements	Current clinical workflows; existing risk assessment policies; EMR or documentation templates; incident data; administrative and leadership support; staff time	September - October 2026
Embed admission screening tools and risk documentation in care plans	Develop a consistent process for completing risk screening and documenting results in care plans	IT team; Data Analytics team; Frontline staff representatives	Work with IT, data team, and end-users (frontline staff representatives) to embed violence screening tools in care plans	Care plan fields updated; number of units/programs included in workflow review; number of frontline staff representatives who tested or reviewed the process	Once during planning; reviewed annually or when documentation requirements change	Process is in place for completing admission risk screening and integrating risk findings into care plans	Staff time; current admission workflows, screening tools; care plan templates; EMR/document support	October-December 2026

Objective 1: Standardize individual-level risk management

Operational Plan Worked Example

Activity	Definition	Actor	Action	Dose	Frequency	Expected outcome	Resources needed	Timeline
Sub-goal 3: Strengthen communication and documentation processes								
Create risk communication plan	Define how risk information will be communicated between staff, teams, shifts, units, and departments	Clinical leadership; unit managers; frontline staff representatives	Use staff survey findings to identify gaps in current risk communication, develop a checklist for handoffs and unit transfers, and define the key risk information that must be communicated	Number of units/programs included in review, number of staff groups that provide feedback	Quarterly	Clear communication of violence risk information between staff, shifts, teams, units, and care settings	Staff time; handover and transfer workflows; risk communication template or checklist; EMR or documentation support; incident reporting procedures	November 2026-January 2027
Determine process for regularly reviewing risk scores	Establish who reviews risk scores, how often they are reviewed, and how changes are communicated and documented	Clinical managers; Professional Practice lead	Develop a streamlined process where staff surveys and literature searches were conducted annually and changes are communicated to affected staff	Number of units included, staff roles assigned, and review time points standardized	Annually	Consistent review schedule and documented roles/ responsibilities. Risk score changes are consistently communicated and updated in care plans.	Staff time; risk score review workflow	January-March 2027

Step 3: Implement

This section will guide you through the tasks needed to put your planned changes into practice. Focus on the goals that you identified as having a major or minor gap and for which an operational plan has been developed. Implementation may begin with piloting changes in selected units before broader roll-out. As you carry out your planned activities, you may need to adapt processes in response to staff feedback or implementation barriers.



Task: Document how each planned activity will be integrated into practice by completing the table **linked here** (on **page 11** of the Workbook). This includes activities such as piloting new processes, training staff, and embedding tools into the workflow. We have provided key implementation focus areas to support this work, but these can be adapted to fit your local context, resources, and workflow.

Implementation Plan Worked Example

We have provided a worked example of an implementation plan below. Use the blank table on the next pages to develop an implementation plan for your organization's goals.

Implementation goal	Strategies	Person(s) responsible	Unit or service area & target groups	Supports needed	Anticipated adaptive challenges	Timeline	Progress measures & data sources
Installation							
Pilot evidence-based violence risk assessment tools in one or two units	Identify staff groups and units that need to be informed. Provide drop-in sessions and provide presentations on the updated violence risk assessment tools	• Unit managers • Risk management team • Practice lead	Start with one unit (i.e., med-surg, inpatient, outpatient) Target all staff providing violence screening	Time and support to attend the sessions	• Staff may have limited availability • Staff may have negative perspectives on the updated assessment tools	April - June 2027	Feedback from staff
Gather feedback from staff who used the updated violence screening tool	Conduct staff focus groups. Engage staff in risk management team	• Data evaluation team • Research team	Staff on the pilot unit	Time needed to distribute and complete the focus groups	Staff have limited availability/ interest for focus group session	June - August 2027	Number of focus groups completed/ number of staff engaged
Use PDSA (Plan, Do, Study, Act) to assess pilot and improve implementation	Use the PDSA plan provided in this manual to try the pilot, observe the results, and act on the lessons learned	• Unit managers • Frontline staff representatives • Data evaluator	Pilot units	Time needed to complete PDSA form based on staff survey	• No meaningful information from the focus groups • Difficult to change certain aspects of the tool	September-October 2027	Completion of PDSA plan

Objective 1: Standardize individual-level risk management

Implementation Plan Worked Example

Implementation goal	Strategies	Person(s) responsible	Unit or service area & target groups	Supports needed	Anticipated adaptive challenges	Timeline	Progress measures & data sources
Initial Implementation							
Deliver staff training on screening, documenting, and incident reporting	Assess the current training on violence screening, review the staff survey findings, update training based on the pilot and staff survey	• Frontline staff representatives • Training department • Learning and Development • Occupational health department	Across the hospital to frontline staff	• Resources needed to update the training • Time needed for staff to complete the training	Limited time availability from staff	November-March 2028	• Number of staff trained • Number of new lessons and modules
Full Implementation							
Embed validated violence prevention screening tool	Work with IT team to embed the updated violence prevention tool into documentation, care planning, incident reporting, orientation, and Electronic Medical Record	• IT team • EMR team • Data analytics • Clinical managers	• Across the organization • All staff that conduct violence screening	Time, resources, and funding needed from the IT team	Capacity of the EMR system	October - March 2028	Violence screening tool embedded in the workflow

Table adapted from Implementation Plan Template and Examples by Collaborative for Implementation Practice.

Step 4: Monitor and Evaluate

Now that you have developed your operational plan and implementation strategies, it is important to consider evaluation throughout the implementation process. As you complete the first three steps, you can also begin planning how implementation will be monitored, evaluated, and sustained over time. This includes identifying metrics and indicators to assess implementation quality, track progress, and understand how well planned strategies were carried out.



Task: Identify the measures, indicators, and data sources you will use to monitor implementation, assess progress, and evaluate whether planned strategies were delivered as intended. Use the **Measurement Plan template** linked here (on **page 14** of the Workbook) to document how implementation quality, uptake, and outcomes will be reviewed over time, and how findings will be used to refine and sustain the work. A table of example indicators for each measure, specific to each objective, is included below. You may use these examples when completing your measurement plan.

Types of Measures

Outcome Measures This reflects the impact of the implementation on health status of patients (ultimate aim)	**Process Measures** This reflects the way your implementations work to deliver the desired outcome	**Structural Measures** This looks at whether the organization has the right foundation in place to support practice	**Balancing Measures** This looks at whether a change is creating unintended consequences elsewhere in the system
• Number of violent incidents or repeat incidents • Improved staff perceptions of safety	• Proportion of patients screened for violence risk • Number of policies updated and posted on the shared platform	• Staff to patient ratio • Access to staff training • Presence of EMR alerts or documentation templates	• Staff time required to complete screening or documentation • Perceived burden of new tools or procedures

This table was adapted from Healthcare Excellence Canada & Health Quality BC.



Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

We have provided a worked example of a measurement plan below.

Operational definition	Data sources & collection methods	Person(s) responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Outcome Measures: Main outcomes to improve						
Number of workplace violence incidents reported by hospital workers within a 12-month period (Health Quality Ontario, 2019)	The number of reported workplace violence incidents is available via your organization's internal reporting mechanisms	• Data Analytics team	120 incidents reported in the 12 months before implementation	10% reduction within 12 months, from 120 to 108 or fewer incidents	Quarterly, with annual review	102 incidents reported in the 12 months after implementation, representing a 15% reduction
Rates of injuries due to workplace violence that are reported to WSIB	• Provincial compensation board claim records • Human resources (HR) data	• Occupational Health & Safety team • Human Resources • Data Analytics team	6 WSIB-reported injuries per 100 FTE staff in the last 12 months before implementation	15% reduction, from 6.0 to 5.1 or fewer injuries per 100 FTE staff	Quarterly, with annual review	5.0 WSIB-reported injuries per 100 FTE staff
Percentage of Code Whites involving physical force toward healthcare professionals within the past calendar year (Sethi et al., 2024*)	• Code White reports • Workplace violence incident reports • Security logs	• Quality Improvement team • Data analyst • Occupational Health & Safety lead • Security lead	30% of Code White incidents in the past calendar year involved physical force toward healthcare professionals	Decrease from 30% to 25% within the next calendar year	Quarterly review, with annual summary	25% of Code White incidents involved physical force toward healthcare professionals after implementation

**Sethi et al., (2024) provide a list of evidence-based indicators that can be referred to when choosing measures.*

Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

Operational definition	Data sources & collection methods	Person(s) responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Process Measures: The activities you are doing to achieve your desired outcomes						
Number of completed violence risk screening tools	Number of EMR records with completed violence screening tool	• Data Analytics team • Implementation team • EMR team	355 completed screenings in the 12 months before implementation	20% increase within 12 months	Monthly for the first 6 months, then quarterly	500 completed screenings
Staff awareness and relevance ratings on a 10-point scale: How would you rate your awareness of the violence screening tools being used? How would you rate the relevance of the screening tool to the service you are providing? (Oussama & Makarem, 2020)	Staff survey	• Professional Practice team • Clinical managers • Data Analytics team	• Average awareness rating: 5.5/10 • Average relevance rating: 6.0/10	Increase awareness/ relevance scores to 8/10 within 12 months	Six months after implementation, then annually	• Average awareness rating: 8.2/10 • Average relevance rating: 8.0/10

Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

Operational definition	Data sources & collection methods	Person(s) responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Process Measures: The activities you are doing to achieve your desired outcomes						
Percentage of workplace violence incidents in which patient had a care plan and de-escalation methods were utilized (Lyver et al., 2024)	• Patient charts • EMR documentation • Nursing notes • Risk assessment forms	• Clinical documentation lead • Unit managers • Health records/EMR analyst	40% of reviewed workplace violence incidents had a documented care plan and documented use of de-escalation methods	Increase from 40% to 50% within 6 months	Quarterly, with annual review	52% of workplace violence incidents had a documented care plan and documented use of de-escalation methods after implementation
Percentage of eligible staff who received the updated violence reduction training	Number of training sessions delivered to staff based on the course website or facilitator	• Training and Education lead	Not applicable	Reach 70% of eligible staff	Monthly for the first 6 months, then quarterly	215 staff completed training, representing 75% of eligible staff
Structural Measures: Organizational foundations that support practice						
Percentage of staff aware of changes that have taken place (Lyver et al., 2024)	Post-implementation staff survey	• Data analytics team • Clinical managers	Not applicable	80% of staff aware of the change	Days after each change implementation	78% of staff aware of the change

Objective 1: Standardize individual-level risk management

Measurement Plan Worked Example

Operational definition	Data sources & collection methods	Person(s) responsible	Baseline data (If applicable)	Target/expected change	Review frequency	Post-implementation data
Balancing Measures: Used to assess any unintended consequences elsewhere in the system						
Staff time required to complete screening or documentation	Conduct time audits or ask staff to record estimated completion time during a trial period	• Data Analytics team • Clinical managers • Quality Improvement team	Not applicable	Maintain screening length of 15 minutes or less per patient	Monthly for first 3 months, then quarterly	14 minutes per patient
Delays in care because of added risk procedures	Review patient flow timestamps and staff-reported delays	• Quality Improvement team • Clinical managers • Data Analytics team	Not applicable	Keep delays at 30 minutes or less, while ensuring risk procedures are completed	Monthly for first 6 months, then quarterly	25-minute average delay

This table was adapted from Healthcare Excellence Canada & Health Quality BC.

OVERVIEW

Tools & Resources

The Tools & Resources sections throughout the manual provide a list of resources and tools to support implementation of the practices described in this objective. Where possible, this section highlights tools and approaches that are supported by available evidence and are commonly used in Canadian clinical or organizational settings.

In some areas, there may be limited evidence or no single validated tool that applies across all settings. In these cases, the section includes resources that may help organizations with planning, implementation, training, and evaluation. These resources may be adapted to fit your local context, patient population, staff roles, workflow, and organizational policies.

The resources included here are not intended to be exhaustive. Rather, they are meant to provide practical starting points for organizations as you assess your current practices, select appropriate tools, and strengthen trauma-informed, evidence-informed approaches to violence prevention and trauma reduction. When a tool or approach has limited validation or is based mainly on current practice rather than strong evidence, we recommend that you acknowledge its limitations during your review and implementation work.

In the upcoming sections, each objective will be followed by a list of tools and resources you can use to support your implementation planning and practice.

TOOLS & RESOURCES: OBJECTIVE 1

Engage in primary prevention to reduce staff exposure to critical events

Violence Risk Assessment Resources
The choice of violence risk assessment and screening tools should be based on: your target patient population and setting; your definition of violence; and the purpose of your evaluation (long-term or short-term, frequency of evaluation). Always choose tools that have been validated in outcome evaluation studies wherever possible and check to see whether they have been validated for populations similar to your patient population and setting.

The **Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Violence Risk Assessment**, by Canadian Academy of Psychiatry and the Law, has examples of risk assessment tools, examples of psychiatric interview content and questions for violence risk assessment, and template for violence risk assessment reporting.

- **The Brøset Violence Checklist (BVC)** has been found to have good predictive validity as a short-term structured risk assessment tool for events up to 72 hours after admission (Almvik & Woods, 2003; Kamarova et al., 2025; Kös et al., 2024).
  - The official page for BVS can be found here: **Risk Assessment - Broset Violence Checklist (BVC)**
  - You can view a version of the BVC here: **BVC English**

- **Dynamic Appraisal of Situational Aggression** (DASA) has been found to have good predictive validity as a short-term structured risk assessment tool to monitor patients before and after transitioning between settings (Kamarova et al., 2025; Ogloff & Daffern, 2006).
  - You can view a version of the DASA here: **DASA Rating Form**
  - Scoring guide for DASA form can be found here: **Dynamic Appraisal Of Situational Aggression | Swinburne**

- **Violence Risk Screening - 10 (V-RISK 10)** showed predictive validity for long-term violence with less frequent assessment (Bjørkly et al., 2009; Kamarova et al., 2025).
  - You can view a version of the V-RISK-10 here: **Violence Risk Screening - 10 (V-RISK 10)**

Violence Assessment in Community Care Settings
Public Services Health and Safety Association (PSHSA)'s **Assessing Violence in the Community: A Handbook for the Workplace** can be used as a guide to assessing violence in the community. It includes assessment tools to use before visit and when assessing environmental conditions.

Violence Assessment in Outpatient Settings
Risk Management Strategies for the Outpatient Setting, by the Canadian Nurses Association, provides a comprehensive overview of steps to identify risks across the outpatient setting. It includes risk identification, scoring of risks, risk responses, control and monitoring (Canadian Nurses Association et al., 2024).

Tools for Staff Survey
The Appendix A of Community Social Services Health and Safety Association of BC's **Violence Risk Assessment Standard** can be used to survey staff on the risk assessment process.

The SafeCare BC's **Violence Risk Assessment Staff Survey** includes a staff survey on risk assessment for non-clinical areas, long-term care, and home care and community health support.

Risk Communication
Communicating the Risk of Violence A Flagging Program Handbook for Maximizing Preventative Care, by Public Services Health and Safety Association, provides information and tools for organizations to build a flagging-alert program to provide preventative care. The handbook supports organizations in communicating risk more consistently and in real time to promote staff safety.

OBJECTIVE 2

Develop infrastructure for trauma prevention

This objective focuses on establishing stronger infrastructure for trauma prevention in organizations. This may involve conducting organizational assessment and developing data-informed actions through surveys and data collection.

Why it Matters

Preventing staff exposure to critical incidents requires more than individual-level risk assessment. Strong infrastructure for trauma prevention is the foundation for preventing and reducing critical incidents in psychiatric hospitals. Organizational assessments can help identify gaps in these systems, while routine collection and review of incident and staff-feedback data can help organizations select interventions and monitor whether staff exposure changes over time.

Key Findings from Focus Groups

- Embed national psychological health standards into organizational human resources strategies.
- Use data to identify trends and monitor changes in staff exposure to critical events.

OBJECTIVE 2

Develop infrastructure for trauma prevention

Evidence

Organizational assessment can support the successful implementation of trauma-informed care by helping organizations develop a clear implementation plan and establish goals for organizational change (Bryson et al., 2017). Regular staff self-assessments, checklists, and pulse surveys can support this process by providing ongoing feedback on organizational practices and implementation progress (Schulz-Quach et al., 2025). Tracking workplace violence data over time is important for understanding whether implementation efforts are making a difference, and clear quality indicators help ensure that organizations collect consistent data (Schulz-Quach et al., 2025).

Expected Outcomes

- Identify gaps in organizational trauma-informed practices
- Create data-informed prevention strategies based on incident report
- Conduct root cause analysis for each critical incident and address points of weaknesses

Go to pages 17-27 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 2

Develop infrastructure for trauma prevention

Tools for Organizational Assessment
Caring for Healthcare Workers – Assessment Tools is a set of assessment tools that evaluates 13 psychosocial factors relevant to healthcare workplaces. It includes two components: a psychosocial survey that allows healthcare staff to share their perspectives on the work environment, and an organizational review that helps healthcare organizations assess their current status in psychological health and safety.
Violence Prevention Risk Assessment Audit Tool provides audit tools on work environment, incident/injury information, resident data, and training. It is a great overview tool to look at current incident data in the organization.
Appendix A of **Organizational Trauma-Informed Practices Measure (O-TIPs)** provides a 31-item questionnaire for assessing and monitoring trauma-informed practices at the organizational level. The measure covers key areas such as staff development and support, safe and supportive environments, and organizational policies.
Guarding Minds at Work Organizational Review is a tool that can help leaders reflect on psychosocial factors such as psychological support and psychological protection in their organization. It may be useful as a starting point for discussion, planning, or identifying broad areas for improvement. Organizations should consider supplementing it with other data sources, such as staff surveys, interviews, incident trends, focus groups, or occupational health indicators.
Appendix A of Ontario Nurses' Association's **Workplace Violence and Harassment** has a general checklist on workplace violence prevention policy, risk assessment, and measure. This is a great resource for a checkpoint analysis on the current state of the organization.

Gap Analysis

Preventing Violence in Healthcare Gap Analysis provides specific actions and audit questions to help organizations assess current violence prevention practices and identify gaps. It would be a useful tool for the Assess and Identify stage of implementation.

Root Cause Analysis

RCA2: Improving Root Cause Analyses and Actions to Prevent Harm from the Institute for Healthcare Improvement provides instructions and best practices for conducting root cause analyses. The resource includes diagrams and charts to support the RCA process. Organizations can use this document to strengthen how they conduct root cause analyses and identify actions that help prevent similar incidents from happening again.



OBJECTIVE 3

Engage patients and families

This objective focuses on engaging patients and families when they get admitted to hospital. It may involve surveying patients and families to identify gaps, engage patients and families in a streamlined process, and invite patients and families to an advisory team. This objective will guide you through working with patients and families to support violence prevention and trauma reduction.

Why it Matters

Strong relationships between staff and patients can help staff recognize changes in behavior, distress, cues, and potential triggers. Patients and families may also be more comfortable sharing concerns and preferences with staff when communication is open, respectful, and consistent.

Key Findings from Focus Groups

- A rise in patient acuity contributing to the increased risk of violence to staff. They noted that more patients are behaving in extreme ways toward healthcare workers.
- Open and genuine communication with patients, family members, and the care team are important facilitators to ensure that "all services across the continuum of care are stepping up to the max of their ability."
- Treat patients with respect and humility and have staff engage more with patients, and "see patients as people".
- Support patient involvement in and ownership of care.

OBJECTIVE 3

Engage patients and families

Evidence

Evidence shows that greater service user involvement helps psychiatric services respond more effectively to patient needs. Managers and staff emphasized the importance of creating greater openness to service user participation and increasing staff visibility on the ward (Pelto-Piri and Kjellin, 2021). Patients have also highlighted the need to be involved in care planning, including decisions about post-discharge supports such as housing and employment assistance (Pelto-Piri & Kjellin, 2021).
Family members can provide important information about a patient's history of aggression, early warning signs, triggers, and strategies that have helped prevent escalation in the past (Onwumere et al., 2014). Engaging families can help care teams develop a more complete understanding of risk and tailor prevention strategies to the patient's needs.

Expected Outcomes

- Identify gaps in patient and family engagement
- Create streamlined processes to embed patient preferences into care plan
- Establish a patient and family advisory board to provide input on care planning and treatment processes

Go to pages 28-39 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 3

Engage patients and families

Objective 3: Engage patients and families

Surveys of Patients and Families
Ontario Adult Inpatient Mental Health and Addictions (OA-IMHA) survey, created by The Ontario Hospital Association (OHA) and the Centre for Addictions and Mental Health (CAMH), is a tool designed to collect feedback from patients during an inpatient mental health and addiction stay and post-discharge.
Mental Health Carer Experience Survey (CES), developed by the Australian Mental Health Outcomes and Classification Network, is a survey designed to capture carers' experiences with the mental health care received by the person they support, including how services engage, communicate, and work with families and carers.
Establishing a Patient and Family Council
Working With Patients and Families as Advisors (Implementation Handbook) is a step-by-step guide for implementing patient and family advisor roles within healthcare organizations. It outlines key stages, including identifying a staff liaison, creating opportunities for patient advisor involvement, preparing hospital leadership to work with patient advisors, recruiting and training patient advisors, and implementing advisor activities. This resource provides a useful overview for organizations seeking to implement patient and family advisor roles.
A Patient And Family Advisory Council Workplan: Getting Started by the Institute for Patient- and Family-Centered Care provides a fillable work plan for steps to establish a patient and family advisory council. Organizations can use this as an initial guide for starting an advisory council.

Objective 3: Engage patients and families

Best Practices for Patient and Family/Caregiver Engagement
Engaging Patients And Families In Workplace Violence Prevention: A Handbook For Organizational Leaders In Healthcare, created by the Public Services Health and Safety Association, provides strategies for partnering with patients and families to prevent workplace violence. This serves as a foundational guide for organizations seeking to engage patients and families and incorporate their perspectives into violence prevention programs.
Promising practices guide: Engaging caregivers in mental health and addiction services in Canada, developed by the Mental Health Commission of Canada, provides a comprehensive overview of promising practices for caregiver engagement. It outlines key steps for getting started, including when, where, and how to engage caregivers, and includes case studies and examples of successful programs. This guide is a useful resource for organizations beginning or strengthening caregiver and family engagement efforts.
PHSA Patient and Family Engagement Framework provides a step-by-step guide for engaging patients and families, from initiation and planning to partnering, connecting, involving, and concluding the engagement process. It is a useful resource for organizations seeking to invite patient partners and families to inform violence prevention programs and projects.

OBJECTIVE 4

Optimize the physical environment

This objective focuses on optimizing the physical environment within a hospital, which may include environmental assessment, identify environmental risks, and raise solutions for improvement.

Why it Matters

The physical environment of a hospital can influence patients' emotional responses. For example, crowded, enclosed, or poorly lit areas may contribute to distress, while open and well-lit spaces may help patients feel calmer. It is important to include the experience of patients and carers in the physical environment design process, as their perspective will be different from designers and architects.

Key Findings from Focus Groups

- Participants noted that clear signage communicating that violence is not tolerated and that the hospital is a respectful environment should be visible the moment patients enter the hospital.
- Participants mentioned the importance of having a separate admission area where staff can explain expectations to patients joining the unit.
- Preferences for private or low-stimulation spaces, which give patients greater control over their environment and help them feel safer and less at risk.

OBJECTIVE 4

Optimize the physical environment

Evidence

Hospital environments were found to have a significant influence on the risk of violence. Research suggests that implementing clear signage may help reduce the rate of violent incidents by improving navigation and reducing confusion (Kim et al., 2024). Patients prefer physical environments that allow for personal space, while crowded environments can contribute to feelings of anxiety and stress (Sui et al., 2023). Studies also emphasize the importance of giving patients greater control over their room environment, such as access to adjustable windows, heating, lighting, and acoustics (Rodríguez-Labajos et al., 2024).

Expected Outcomes

- Complete an environmental assessment and identify gaps and points of weaknesses
- Identify the teams and departments needed to support environmental changes
- Integrate assessment of environmental spaces into routine practice

Go to pages 40-50 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 4

Optimize the physical environment

Objective 4: Optimize the physical environment

Survey of Physical Environments
The Appendix D of the **Violence Risk Assessment Standard** provides an environmental walk-through checklist to direct attention to hazards and control measures in the workplace. It is a useful tool for conducting an initial environmental assessment and guiding a structured walk-through of the physical space.
Page 14 of the **Workplace Violence Risk Assessment Toolkit for Acute Care** provides a table for documenting hazards, associated risks, and guidance on controls and potential solutions. This tool can support organizations in identifying environmental safety concerns and planning practical improvements to reduce environment-based violence risks.
The **Violence Risk Assessment Environmental Survey**, developed by SafeCare BC, has environmental surveys for community care, long-term care homes, and non-clinical areas. It is a great tool for outpatient and non-clinical environmental assessments.
The **Developing Workplace Violence and Harassment Policies and Programs Toolkit**, developed by the Occupational Health and Safety Council of Ontario, includes a General Physical Environment Assessment on page 18. The tool provides space to document existing controls and identify recommended controls, making it a useful resource for organizations assessing environmental risks and planning improvements to workplace violence prevention practices.

Objective 4: Optimize the physical environment

Best Practices for Space Design
The **Behavioral Health Design Guide**, developed by Behavioral Health Facility Consulting, LLC, provides detailed best practice guidance for behavioural health space design, including construction, materials, doorways, admission areas, and seclusion rooms. This resource can support organizations in comparing their current physical environment against recommended design practices and identifying opportunities for improvement.
Exploring environmental design attributes impacting staff perceptions of safety in a complex hospital system: implications for healthcare design noted environmental design as a predictor of staff satisfaction with patient or visitor safety, including clear signage, cleanliness, security measures, and team visibility. This article may be a useful reference for organizations considering how physical design features can support staff, patient, and visitor perceptions of safety and satisfaction.

OBJECTIVE 5

Embed violence prevention in policies and procedures

This objective focuses on embedding violence prevention in policies and procedures to create a safer workplace. It may involve identifying all the existing policies in your organization, gathering staff surveys, and addressing any gaps.

Why it Matters

Policies and procedures matter because they give staff clear guidance on how to respond to and report violence. They clarify roles and responsibilities and ensure that incidents are handled consistently. Effective policies and procedures also support accountability, staff training, post-incident review, and identify areas for improvement, helping to create a safer environment for staff and patients.

Key Findings from Focus Groups

- Violence prevention policies are often too lengthy, lack a clear scope, and are not tailored to specific settings, such as outpatient and community care.
- Leadership restructuring can lead to existing policies being shifted or recreated, even when relevant policies are already in place. This can result in "reinventing the wheel" and increase staff unfamiliarity with current processes.
- Participants suggested identifying all the existing policies, assessing their usability, and addressing any gaps as solutions.
- Formalizing support, including clear standards for what should happen after an incident, who is responsible for each policy, and where policies are stored.
- Creating an online platform to keep all policies, procedures, and training materials could help avoid creation of multiple versions.
- Making policies and procedures more accessible through technologies such as screen reading.

OBJECTIVE 5

Embed violence prevention in policies and procedures

Evidence

Policies and procedures can support violence prevention by requiring psychiatric hospitals to establish consistent processes for identifying risks, reviewing incidents, and training staff. Lipscomb et al., (2006) assessed the impact of implementing a policy that requires psychiatric facilities to establish violence-prevention programs and found an improvement in staff perceptions of environmental safety, teamwork, and access to training. However, this study did not find a statistically significant reduction in staff assaults, suggesting that policies may strengthen the organizational practices needed for prevention but may not reduce violence unless they are consistently implemented alongside clinical, environmental, and organizational interventions (Lipscomb et al., 2006).

Expected Outcomes

- Review current policy content and use policy survey and checklist to assess gaps
- Standardize violence prevention language and response processes across policies and procedures
- Keep all policies in one single platform and assign a most responsible person for maintaining the policies

Go to pages 51-61 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 5

Embed violence prevention in policies and procedures

Objective 5: Embed violence prevention in policies and procedures

Policy and Procedure Review
Appendix C of the Community Social Services Health and Safety Association of BC's **Violence Risk Assessment Standard** has a checklist for documentation. This is a great starting point to assess all the policies, standards, and procedures in your organization and identify gaps.
The **Violence Risk Assessment Policy and Procedure Review** provides policy and procedure review checklists and tables for long-term care, home care and community health, and non-clinical areas.
Best Practices for Policies and Procedures
Public Services Health and Safety Association (PSHSA) has a **sample violence prevention policy** that provides standardized language for identifying behaviours, triggers, prevention strategies, safety measures, and control interventions for moderate- and high-risk clients. This is a useful resource for organizations developing or updating policies related to patient violence prevention.
PSHSA has a **code white policy template** that provides template wording for responding to a violent care recipient, visitor, or worker. It includes language on de-escalation, reducing harm, emergency response activation, and response procedures. A great resource for organizations to create or update the code white policies.

PRIORITY 2

Increase staff's ability to prevent and safely respond to critical events

Objectives include:

- Provide comprehensive, skills-based safety training
- Develop team-based response procedures
- Practice and maintain competencies

PRIORITY 2

Increase staff's ability to prevent and safely respond to critical events

Only 30% of psychiatric staff in a survey conducted by our team at Waypoint and The Royal said they felt very or extremely prepared to prevent or respond to physical violence and other workplace critical events (Hilton et al., 2020). Training programs that teach practitioners how to prevent, de-escalate, or safely intervene in critical and potentially harmful behaviors on healthcare units are widely used, and some evidence suggests that these programs can improve staff confidence in managing patient aggression (Almulla et al., 2026; Recsky et al., 2023). However, evidence on the effectiveness of de-escalation training for psychiatric healthcare workers on the rate of violent incidents remains limited, highlighting the need for organizations to select training approaches carefully, tailor them to local context, and monitor whether they are lowering rate of violent incidents (Brenig et al., 2023)

Priority 2 focuses on increasing staff's ability to prevent and safely respond to critical events.

Through our focus group sessions, we have identified three objectives involving actions around providing skill-based safety training, practicing and maintaining competencies, and developing team-based responses during a critical incident. These actions are supported by baseline assessment, ongoing monitoring, and outcome evaluation to promote sustainability.

OBJECTIVE 1

Provide comprehensive, skills-based safety training

This objective focuses on providing comprehensive, skills-based safety training for staff at psychiatric hospitals. This may involve assessing current training, conducting staff surveys to identify gaps, planning for practical learning opportunities, and creating ongoing processes to boost staff confidence in violence prevention and lower the rate of violent incidents.

Why it Matters

Training is an important part of violence risk reduction because it helps staff recognize early warning signs and respond before situations escalate. Effective training can improve staff skills in risk assessment, communication, and de-escalation. It also improves staff confidence and ensures that staff understand their roles and follow consistent procedures during a violent incident. Regular refreshers and scenario-based training can help staff apply these skills in real-life situations.

Key Findings from Focus Groups

- Training needs to be designed with the learner in mind.
- Prioritize soft skills and non-verbal communication training before heavy restrictive interventions.
- To maintain staff confidence and competency over time, participants suggested that de-escalation training should be offered annually or biannually.
- Increased training should be required for security staff, especially in mental health settings.
- Training should be in-person, interactive and engaging.
- Training needs to be available as new initiatives are introduced, with instructions being provided on the clinical units when a new intervention is introduced.
- Incorporate experiential, scenario-based training using real staff experiences for role-play learning activities.

OBJECTIVE 1

Provide comprehensive, skills-based safety training

Evidence

Implementing training in verbal and non-verbal de-escalation techniques has been found to reduce the risk of aggression by half compared with the control group (Celofiga et al., 2022). A significant reduction in the use of physical restraint was also observed (Celofiga et al., 2022). In addition, the severity of aggressive behaviours among patients decreased significantly on wards where staff received de-escalation training, highlighting the importance of training in reducing critical incidents (Celofiga et al., 2022).

Training is most likely to reduce violence when it includes practical and scenario-based learning. Duncan et al., (2023) found that embedding simulation in training significantly reduced restraint use six months after implementation. Other studies have found that immersive simulation training for mental health professionals increased self-efficacy in teamwork and confidence when responding to aggression (Young et al., 2022).

Expected Outcomes

- Assess current training and conduct staff survey on confidence in de-escalation
- Review current training content and format
- Implement violence prevention training that prioritize prevention and de-escalation
- Develop interactive materials like role-play, mock Code Whites, and simulation activities

Go to pages 62-75 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 1

Provide comprehensive, skills-based safety training

Objective 1: Provide comprehensive, skills-based safety training

Training Content Checklist
Appendix B13 of Worksafe BC's **Preventing Violence in Health Care** is a sample training and education content checklist. It has training and education guidelines for both managers and workers. This is a great starting point to check if training in your organization meets the required standards of violence prevention.
Page 14 of PSHSA's **Workplace Violence Prevention Checklist** provides an overview of relevant violence prevention training and education for workers, along with a checklist that organizations can use to assess their current training practices.
Appendix A (Page 13) of the **Individual Client Risk Assessment Toolkit for Health Care Settings** provides a list of recommended training when assessing and responding to violence. Organizations can refer to this list to assess which part of training is present or missing.
Restraint Reduction Training Guidelines
Violence Assessment in Outpatient Settings The **Restraint Reduction Network Training Standards 2021** provide standards, best practices, and recommended curriculum content to support restraint reduction and humanized care. Organizations can use this resource to compare their current training against recognized criteria, identify gaps, and assess whether their training prioritizes de-escalation while preparing staff to use restrictive interventions safely when necessary.

Objective 1: Provide comprehensive, skills-based safety training

Simulations and Mock Code White Training Resources
Page 30 of the **Emergency Response to Workplace Violence (Code White) in the Healthcare Sector Toolkit** from Public Services Health and Safety Association provides guidelines on code white simulation training and core training components for Code Whites. Organizations can refer to this when assessing their current code white training or coming up with their own training and assess for any areas of improvement.
The **Code White - Violence/Aggression Exercise Catalogue** from Continuing Care Safety Association provides a series of Code White scenarios in different settings with purpose, scope, objectives, and narratives for each. Organizations can use this as an example when developing their own Code White scenarios.
Alberta Health Services' **Patient-to-Worker Table Top Exercise Facilitator's Guide** provides instructions for facilitating tabletop exercises with staff using workplace violence scenarios. The guide outlines a four-step process: knowing what to do, choosing what to do, taking action, and reporting. Appendix A includes Code White scenarios that organizations can adapt or use when conducting these exercises.
The **Simulation Training Sample Scenarios** provide sample scenarios across different hospital settings. It includes a specific section on a behavioural health de-escalation scenario, with details on the scenario setup, step-by-step actions, and a checklist for each step. Although this resource may not be evidence-based, it can still provide useful examples for developing simulation activities. Organizations should use it alongside evidence-informed guidelines or standards to ensure the training content aligns with best practices.

OBJECTIVE 2

Develop team-based response procedures

This objective focuses on building team-based responses during critical incidents. This may involve assessing current team-based practices, identifying gaps in staffing and coordination, and defining clear expectations for who leads, supports, communicates, and documents during and following an incident.

Why it Matters

Team-based responses allow staff to coordinate their actions and respond consistently during escalating situations. It can also reduce pressure on the staff members involved and help the team respond before the situation escalates.

Key Findings from Focus Groups

- Working together can make responses more efficient and help staff feel safer.
- Staff feel more confident when they know who is supporting them during a shift and can see that action is being taken based on their feedback.

OBJECTIVE 2

Develop team-based response procedures

Evidence

The findings from the focus groups align with the literature; previous research conducted by our team found that team dynamics can become strained when staff morale is low, highlighting the importance of respectful and coordinated team responses (Ham et al., 2022). Other research has shown that team-based care can improve patient safety and staff communication while reducing provider burnout (Weller et al., 2014).

Expected Outcomes

- Assess current team response practices
- Complete a skills assessment of staff that will support the critical incident team
- Define the roles (support, communication, documentation) during an incident

Go to pages 76-85 in the Workbook to explore the planning resources for this objective.

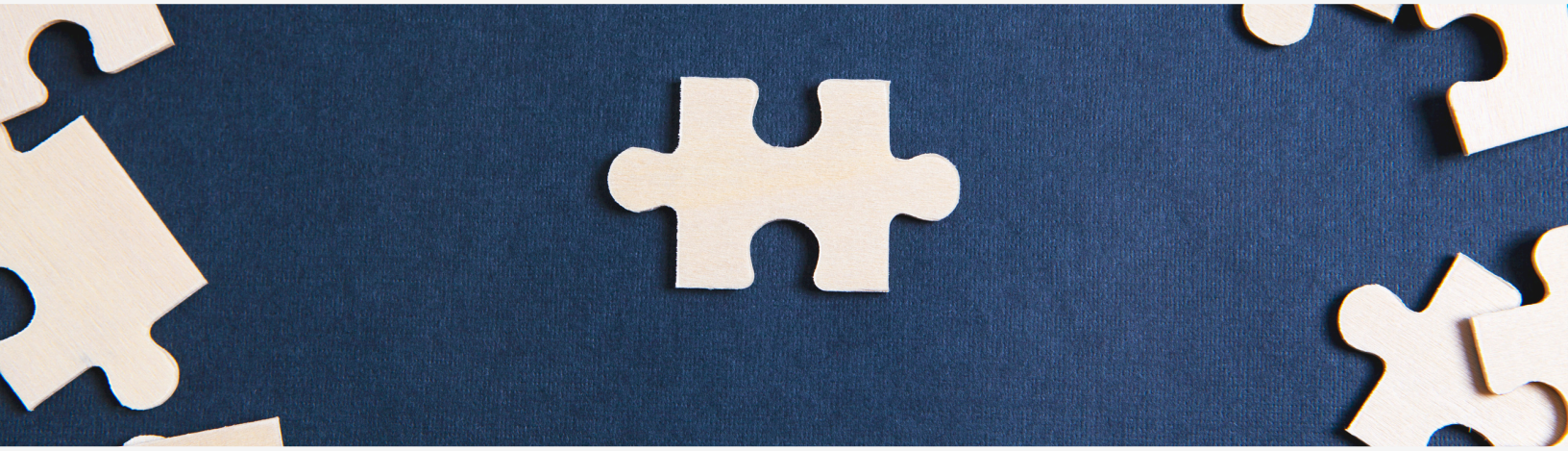
TOOLS & RESOURCES: OBJECTIVE 2

Develop team-based response procedures

Objective 2: Develop team-based response procedures

Employee Survey on Team-Based Responses

The **AHRQ SOPS Hospital Survey 2.0** is a healthcare staff survey that assesses employee perceptions of patient safety culture, including supervisor support, hospital management support, response to error, teamwork, and work pace. Section A of the survey contains the teamwork and workflow piece. Survey findings can help units understand whether staff feel prepared to work together, communicate concerns, and rely on leadership support during and after critical events.



OBJECTIVE 3

Practice and maintain competencies

This objective focuses on practicing and maintaining competencies in psychiatric hospitals. This may involve assessing how staff currently respond to workplace critical events, clarifying roles, identifying what should be consistent across staff groups and improving how incidents and near misses are reported.

Why it Matters

Staff may vary in how they assess risk, communicate, de-escalate, respond, and report events afterwards. Clear role expectations are essential when responding to workplace critical incidents.

Key Findings from Focus Groups

- Different professionals (e.g., registered nurse, registered practical nurse, personal support workers) may have different approaches and training in violence prevention and de-escalation, resulting in a lack of consistency in staff response despite the training the organization provides.
- Differences in organizational composition and how different generations or newer vs. more experienced staff react and respond were noted, with newer staff seeming to be less confident in assessing risks and longer-term staff more reluctant to adopt new practices.
- Staff may not have sufficient time or adequate training in using the incident reporting system and may not be reporting 'near misses' – incidents that could have but did not result in harm.
- The fear of reprisal or being investigated may inhibit staff reporting.

OBJECTIVE 3

Practice and maintain competencies

Evidence

Maintaining staff competencies requires organizations to assess how violence-prevention skills are applied in practice, rather than relying on whether staff have completed training. McNiel et al. (2011) found that structured clinical scenarios and standardized assessment criteria could be used to assess competency in violence-risk assessment and management. This allowed supervisors to observe performance, identify differences in skill level, and provide more targeted feedback.

Maintaining staff competency also involves reviewing incidents and near misses to identify gaps in practice. Research has found that a stronger patient safety culture is associated with greater willingness among nurses to report near misses, suggesting that organizations need clear reporting expectations and a supportive, non-blaming response to reported events (Yang & Lui, 2021).

Expected Outcomes

- Assess staff competency in violence-risk management through Staff Competency Assessment
- Clarify role and responsibilities for staff during assessment and response
- Clarify expectations for reporting and follow-up

Go to pages 86-97 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 3

Practice and maintain competencies

Objective 3: Practice and maintain competencies

Roles and Responsibilities

Page 19 of the **Emergency Response to Workplace Violence (Code White) in the Healthcare Sector Toolkit** provides guidance on the number of staff needed and their responsibilities during a Code White response. It includes a list of staff who may respond directly or indirectly during a Code White. Organizations can use this resource to review the composition of their Code White team and identify whether any roles or personnel are missing.

Reporting Incidents and Near Misses

The **Workplace Violence Incident Reporting Toolkit** provides practical tools to support workplace violence reporting, including hazard and incident reporting forms, guidance on staff communication and training, and strategies for monitoring reporting trends and identifying gaps. Organizations can use this resource to strengthen staff reporting processes and improve how workplace violence incidents are communicated and addressed. Appendix A includes a sample policy that outlines the roles and responsibilities for each staff member.



PRIORITY 3

Improve organizational culture to create a psychologically healthy workplace emphasizing trauma prevention

Objectives include:

- Strengthen leadership communication and trust with staff
- Conduct evidence-based post-incident debriefing and learning
- Improve access to timely and appropriate psychological support for staff after critical incidents

PRIORITY 3

Improve organizational culture to create a psychologically healthy workplace emphasizing trauma prevention

In a survey conducted by our team, 30% of psychiatric staff who met the screening cutoffs for PTSD, depression, or anxiety were concerned that getting treatment or counselling might have a negative effect on their job (Seto et al., 2020). Staff who reported less manager-employee trust were at increased risk of PTSD (Ham et al., 2021). Interview participants were concerned about anonymity and potential breaches of confidentiality when accessing services or taking time off work to do so (Rodrigues et al., 2021). Many of our interview and focus group participants highly valued the role of peer support, especially from other staff who understand their workplace culture and challenges. Many wished to share their stories of trauma and recovery to benefit their colleagues. Other research shows that staff's sense of support affects how they cope with workplace critical events (Huang et al., 2024) and their level of trust in their organization after such events (Rodrigues et al., 2021).

Priority 3 focuses on strengthening communication and relationships between leaders and employees, providing immediate post-incident debriefing and establishing ongoing psychological support.

These actions can be supported by baseline assessment, ongoing monitoring and evaluation of outcomes.

OBJECTIVE 1

Strengthen leadership communication and trust with staff

This objective focuses on strengthening relationships between leadership and staff in psychiatric hospitals. This may include improving communication from senior leaders, creating clear feedback loops, and building trust through open and consistent engagement with staff.

Why it Matters

Strong relationships between leadership and staff can help build trust and make staff feel supported. When leaders are visible, listen to concerns, and follow up on feedback, staff are more likely to speak openly about safety risks and areas that need improvement. Clear feedback loops also show staff that their concerns are being taken seriously, which can support a more positive workplace culture.

Key Findings from Focus Groups

- Leaders' attention focused on the process, not the person, leaving a gap in staff support if there is no follow-up from leadership.
- Face-to-face connection with leadership and open, genuine communication as important facilitators of trust and communication.
- More collaborative relationships between leaders and clinical teams, where communication flows both ways and staff feel heard.
- Formal feedback loops with senior managers, including follow-up after critical incidents.
- Leaders with mental health expertise who can better support employees in these settings.
- A psychology associate or other mental health professional with relevant expertise to support staff.

OBJECTIVE 1

Strengthen leadership communication and trust with staff

Evidence

Previous research conducted by our team found that organizations may view psychological support for workers as less important than maintaining patient care delivery or evaluating staff behavior during workplace incidents (Ham et al., 2022). This can leave staff feeling that their well-being is not being treated as an organizational priority. Gillespie & Leming-Lee (2019) similarly found that staff may be reluctant to report workplace violence when they believe leadership will not respond or take meaningful action. These findings highlight the importance of keeping staff well-being at the centre of violence-prevention efforts and ensuring that leaders communicate openly and close the feedback loop. Leadership engagement has also been associated with greater staff trust and stronger perceptions of workplace safety (Green et al., 2025).

Expected Outcomes

- Assess leadership competencies
- Build leadership-employee relationships
- Establish leadership-employee feedback loops
- Strengthen leadership training in psychological safety
- Update supervisor competency indicators

Go to pages 98-109 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 1

Strengthen leadership communication and trust with staff

Objective 1: Strengthen leadership communication and trust with staff

Guidelines and Expectations from Leadership
The **Critical Incident Stress Response (CiSR) - Guide for Leaders** by Shared Health Manitoba provides instructions and guidelines on how leaders can support their employees as well as a template for activities that leadership can coordinate for staff following a critical incident.
The **Critical Incidents in the Workplace: Management Guide** from the City of Toronto provides guidance to help managers respond to critical incidents in the workplace. It outlines strategies for supporting staff during the incident, in the days and weeks that follow, and through ongoing recovery. Managers can use this guide to understand how to support employees, recognize when assistance may be needed, and connect staff with appropriate resources.
The **Trauma Response Tool Kit for People Leaders** provides support resources for leaders, including recommended actions and tips for managers when speaking with employees after a critical incident. It includes conversation prompts and ways to be attentive and vulnerable in front of colleagues and employees. This is a helpful guide for leaders to understand what trauma can do and provide guidance and counselling to employees.
The **Conversation Guide for Managers: Employees and Mental Health** from the Saskatchewan Public Service Commission contains actions and example conversation starters that managers can use when talking about employees' mental health to show empathy and care.
The **Critical Incident Stress Management Guidelines for Ministries and Employees** from the Public Service Commission of Saskatchewan provides guidance on preparing for critical incidents, establishing a peer support team, and responding to workplace critical incidents. It outlines processes that organizations can use to support employees before, during, and after a critical event.

Objective 1: Strengthen leadership communication and trust with staff

Leadership Competency Survey
The **Psychologically safe leader survey** by Workplace Strategies for Mental Health provides a leadership self-assessment tool focused on communication and collaboration, social intelligence, problem solving and conflict management, security and safety, and fairness and integrity. Organizations can use this tool to assess whether leaders have the competencies needed to support staff psychological safety, communicate effectively, respond to conflict, and follow up on staff concerns.
The **AHRQ SOPS Hospital Survey 2.0** is a healthcare staff survey that assesses employee perceptions of patient safety culture, including supervisor support, hospital management support, response to error, teamwork, and work pace. Sections B and F of the survey contain surveys on supervisor and the hospital management's response. Survey findings can help organizations identify gaps in leadership support, communication, and responsiveness.
Leadership WalkRounds
The **Patient Safety Leadership WalkRounds | Institute for Healthcare Improvement** tool provides instructions and sample scripts for weekly WalkRounds to units to have conversations with frontline staff. Although this tool is not specific to violence prevention, some of the questions and scripts can be adapted to align with the organization's workplace violence prevention goals.

Objective 1: Strengthen leadership communication and trust with staff

Manager Training on Mental Health
The **Psychologically safe leader aligns with the National Standard** by Workplace Strategies for Mental Health outlines key leadership competencies and skills needed to support a psychologically safe workplace. Organizations can use this resource to guide leadership training and help leaders build the skills needed to communicate effectively, manage conflict, and create a more supportive work environment.
Workplace Psychological Health and Safety: A guide to support worker well-being by Public Services Health and Safety Association has a section on leadership training in psychological safety in the workplace and provide a list of recommended training for leaders.
The **Mental Health and Wellness: Managers & Leaders Training** from St. John's Ambulance is a course on mental health training for leadership and managers. Course can be taken in-person or virtually.
Not Myself Today is a course developed by the Canadian Mental Health Association that helps managers support staff mental health and well-being at work. There are interactive materials, tools and resources, and data to support learning.

OBJECTIVE 2

Conduct evidence-based post-incident debriefing and learning

This objective focuses on post-incident debriefing and learning after a critical incident. This section will walk you through the steps for developing a clear, supportive, and psychologically safe debriefing process specific to your organization.

Why it Matters

Post-incident debriefing gives staff an opportunity to reflect on what happened, identify what went well and discuss what could be improved. Debriefing also shows staff that their experiences are being acknowledged and can help connect those who need additional support with appropriate resources.

Key Findings from Focus Groups

- Immediate, trauma-informed debriefing following a critical event.
- Debriefs offered to all staff involved in the incident directly or indirectly, including non-clinical team members on the unit at the time of an incident.
- Clinical leaders who recognize when staff support is required. Staff trained in psychological health and safety involved in debriefs.
- Follow-up that extends beyond the initial event through support services accessed through occupational health departments or employee unions.

OBJECTIVE 2

Conduct evidence-based post-incident debriefing and learning

Evidence

There is evidence in the research literature that some critical incident debriefing techniques can have adverse effects (Evans et al., 2023). For example, Critical Incident Stress Management and single-session psychological debriefing have been found to be ineffective and may even worsen symptoms of trauma-related distress among affected staff (Evans et al., 2023). Educational methods, peer support, and debriefing in which participants are not required to talk through details of the critical event may be more favourable techniques (Evans et al., 2023).

Below are some evidence-based practices to consider when planning and conducting debrief sessions:

- Offer trauma-informed debriefing/support to staff following events they identify as potentially traumatic, not necessarily only those with serious physical assaults (Burman, 2018).
- Include facilitators who have a good relationship with staff or a senior member of the team (Burman, 2018).
- Provide training to facilitators in seclusion and restraint procedures, therapeutic communication, and steps to conduct root cause analysis (Sutton et al. 2014).
- Clearly define the purpose of each debriefing and communicate plans and purposes in advance of the meeting. Note that the timing of the debriefing is important and can serve different purposes; for example, immediate post-incident debriefing during the same shift to identify staff's immediate needs versus formal analysis of the incident days later (Sutton et al. 2014).
- When analyzing events, avoid using clinical jargon, use specific descriptive language (e.g., "Bill hit Joe" instead of "aggressive behaviour") for clearer communication and more accurate analysis (Sutton et al., 2014).
- Do not ask staff to share more details than they are comfortable providing during the session (Stileman & Jones, 2023).
- Include peer support facilitators trained in promising practices such as Psychological First Aid (Sammut et al., 2025)
- Use a 'just culture" or a no-blame approach to reviewing events (Brown et al., 2026; Cribb et al., 2022).

OBJECTIVE 2

Conduct evidence-based post-incident debriefing and learning

Expected Outcomes

- Define debriefing, identify when a debriefing should occur
- Develop a structured debriefing process
- Clarify who should attend, facilitate, and how to support participation
- Develop tools and guide for consistent debriefing practice



Go to pages 110-120 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 2

Conduct evidence-based post-incident debriefing and learning

Objective 2: Conduct evidence-based post-incident debriefing and learning

Debriefing Guides and Resources

The **Critical Incident Group Debriefing** resource from the Crisis & Trauma Resource Institute provides a structured approach for conducting a critical incident debriefing. The resource acknowledges the limitations of existing evidence and outlines the key stages of the debriefing process, including introduction, exploration, teaching, and closing. It also includes facilitation guidance and considerations for supporting participants throughout the discussion.

Well-Being Debriefings for Health Care Workers is a guide for debriefing facilitators on how to conduct supportive debriefing sessions. The guide covers how to set expectations, maintain appropriate boundaries, and use cues to support discussion. Organizations can use this resource when developing facilitator guides or defining roles and responsibilities for staff who lead debriefings.

Psychological First Aid Training Courses

- **Psychological First Aid Courses - Canadian Red Cross**
- **Psychological First Aid (PFA) Online | The National Child Traumatic Stress Network**

OBJECTIVE 3

Improve access to timely and appropriate psychological support for staff after critical incidents

This objective will guide you through the steps to improve organizational psychological support for staff. These actions can be supported by baseline assessment, ongoing monitoring and evaluation of outcomes.

Why it Matters

Timely and appropriate psychological support can help staff cope with the emotional impact of workplace critical incidents. It also shows that the organization takes staff well-being seriously, which can strengthen trust and support recovery after a difficult event.

Key Findings from Focus Groups

- Lack of employer support for staff mental health as a key barrier to feeling safe and supported at work.
- Organizational benefits and internal support systems that are inadequate in meeting staff mental health needs.
- Many staff mental health referrals and assessments are inconsistent. PTSD-related workplace compensation board claims are often denied.
- People as the pillar of hospitals' strategic plans, with increased organizational buy-in, more collaborative work across employees, and greater focus on staff psychological safety.
- Integration of national psychological health standards into organizational human resources strategies.

OBJECTIVE 3

Improve access to timely and appropriate psychological support for staff after critical incidents

Evidence

The literature suggests that implementing national standards may improve job satisfaction and employee retention (Sheikh et al., 2018). However, barriers to implementation include limited resources and a lack of recognition of psychological health as an organizational priority (Sheikh et al., 2018).

In addition to broader changes, organizations can introduce approaches to support staff following critical incidents. One example is the implementation of Psychological First Aid (PFA), a structured support approach consisting of eight core actions (Sutton et al., 2014). PFA helps staff connect with others, access social support, and feel supported after a stressful or traumatic event (Sutton et al., 2014).

Organizations should also establish processes to identify staff who may require further assessment or treatment. A "screen and treat" approach can be used to identify staff who may be at higher risk of developing PTSD and connect them to timely support (Sutton et al., 2014). Staff facilitating this process should have the knowledge and skills to recognize early signs of acute stress (Sutton et al., 2014). Organizations should also provide access to a range of treatment options, including trauma-focused cognitive behavioural therapy, which have shown to be a recommended evidence-based treatment for PTSD (Sutton et al., 2014).

Expected Outcomes

- Assess current psychological support by conducting a needs assessment to identify gaps in staff expectation
- Improve psychological safety by creating clear pathways to connect staff with required services
- Establish a process for ongoing follow-up and support after the initial event

Go to pages 121-132 in the Workbook to explore the planning resources for this objective.

TOOLS & RESOURCES: OBJECTIVE 3

Improve access to timely and appropriate psychological support for staff after critical incidents

Objective 3: Improve access to timely and appropriate psychological support for staff after critical incidents

Psychological Health Risk Assessment
The **Psychological Harm Risk Assessment Tool | PSHSA** provides a set of tools to assess the risk of psychological harm within specific job roles and identify actionable solutions. It supports organizations in reducing harm through recommendations related to job design, work planning, and risk mitigation. Organizations can use this resource to assess whether roles are psychologically safe and to identify strategies for addressing psychological hazards.
The **Psychologically Safe Team Assessment** is a tool to capture the current experiences of team members to help leaders understand team strengths and areas for improvement. Organizations can use this assessment to gather employee feedback on psychological safety and identify areas for improving team support.
Safety Huddles
The **Safety huddle: Debriefing critical incidents** resource provides guiding questions that can be asked during a safety huddle. It provides recommendations for huddle leaders, such as being curious, confidential, and vulnerable. A huddle attendance sheet is provided to track participation.
The **Safety Huddle: Psychological and social support for healthcare workers** resource from SafeCare BC provide instructions for safety huddles that provide resources and instructions on psychological and social support for staff.

Objective 3: Improve access to timely and appropriate psychological support for staff after critical incidents

Peer Support
The **Creating a Safe Space: Psychological Safety of Healthcare Workers (Peer-to-Peer Support)** resource includes a section on Canadian best practices for peer-to-peer support programs. It provides recommendations on building the program by assessing needs and identifying a goal. Organizations can use this resource to explore how to set up a peer-to-peer program.
The **Guidelines for the Practice and Training of Peer Support** resource explores the skills, training and best practices related to peer support. The guidelines provide training and skill development recommendations. Organizations can use this resource when designing training and setting up their peer support group.
The **CISM Peer Support Team Selection Criteria and Training Guideline for Executive Government** from Saskatchewan provide instructions for how to set up a peer support team. They share guidance on roles and responsibilities, how to select roles, and engage with the peer supporter. The guide also provides competencies and training options for peer supporter members. Organizations can use this resource if they want to select and set up their own critical incident peer supporter team for psychological safety.



NEXT STEPS

We hope this manual provides additional information and resources to support your organization's efforts in preventing trauma among psychiatric workers. To get started on planning for implementation, next steps include:

- Exploring the accompanying **Workbook**. Identify the priorities your organization would benefit from further developing and work through the implementation steps.
- Seeking out additional resources or connecting with our team through our project website, linked here: **https://www.traumaamongpsychiatricworkers.net/**



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