Health & Safety in Action

Provincial Violence Prevention Initiative

Final Report

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Health & Safety in Action

*Appendices are in a separate document

Executive Summary

The Health and Safety in Action program included a Provincial Violence Prevention Initiative as one of four major health and safety initiatives targeted at system wide programs that would help to create safe and healthy workplaces in healthcare.

The initiative was organized and conducted by an initiative team comprised of representatives from each health authority. The main objectives of the initiative were to conduct a current state assessment and gap analysis of healthcare violence prevention programs and to implement and evaluate a new provincial violence prevention curriculum (PVPC).

The initiative team conducted the analysis and implemented the PVPC at 17 pilot sites across 7 health authorities and organizations from May 2011 to July 2012.

The initiative identified strengths in the level of support for violence prevention programs and some success in communicating violence risks but also identified deficiencies in violence prevention program requirements including education and training. The initiative also highlighted a high degree of support and engagement in the new provincial violence prevention curriculum.

Recommendations include; health authority specific plans to address gaps in programs, a specific budget for violence prevention education and training and expanding the PVPC to educational institutions that train healthcare workers as well as affiliates, contractors and other jurisdictions. Specific recommendations include; completion of violence prevention education as part of orientation, ongoing violence prevention education in a variety of settings and options and increasing capacity for violence prevention education by supporting a provincial violence prevention facilitator program.

The initiative team would like to acknowledge the Provincial Violence Prevention Steering Committee for creating the impetus for the development of the PVPC. We would also like to recognize the curriculum development team, whose hard work over several years resulted in a curriculum that is now an industry recognized practice for healthcare and a testament to their dedication and perseverance.

Introduction

The Provincial Violence Prevention Initiative was one of four major health and safety initiatives which were part of a provincial program called Health and Safety In Action (HSIA). HSIA was facilitated by the Health Employers Association of BC (HEABC) through a project management office (PMO), in partnership with WorkSafeBC, Healthcare Benefit Trust (HBT), the BC health authorities and Providence Healthcare.

Funding for HSIA came from an acute care contribution surplus identified by WorkSafeBC. Senior healthcare executives and health authority board chairs agreed to invest these funds in health and safety initiatives in the health authorities. The goal was to create safe and healthy workplaces and to realize a return on that investment.

The WorkSafeBC funding was to be targeted for system wide initiatives that would have the support of all key players and demonstrate positive changes within 12-18 months of implementation. The initiative activities included the development of industry best practices in four main areas; a provincial workplace health call centre, data collection and reporting, musculoskeletal injury prevention in residential care and violence prevention.

The intent of the HSIA projects was to lead to improvements in employee health and safety which will ultimately result in improvements in patient care and services. This provincial approach to violence prevention is an opportunity to standardize education and training, to improve violence prevention practices and to influence the culture of safety and mutual respect for both patients and health care workers.

Background

Violence is a leading cause of injury in healthcare. While healthcare workers make up approximately 10% of the workforce in BC, they account for approximately 40% of all violence related claims. This statistic does not reflect the actual number of violent incidents occurring in healthcare as many incidents go unreported. A 2009 BC violence survey completed by over 2500 healthcare workers

corroborated this finding. Survey results indicated that 80% of respondents reported that they had experienced violence in the workplace; however they reported that on average, only 28% of verbally violent incidents and 56% of physically violent incidents are formally reported.

Numerous studies have shown that exposure to violent behaviour is known to negatively affect healthcare workers' mental and physical health. Senior health care administrators report that this is an area of concern. When serious incidents occur anywhere in the BC Health system, they have dramatic implications, not only for the workers involved, but also for their co-workers and ultimately healthcare clients.

From 2009 to 2011 BC healthcare partners embarked on an ambitious and significant undertaking to address the issue of violence in the workplace and to promote a standard for violence prevention education and training. The health authorities, health care unions, WorkSafeBC and the former Occupational Agency for Healthcare in BC (OHSAH), collaborated to develop a "***made in BC***", provincial violence prevention curriculum (PVPC). The PVPC consists of online educational modules and supporting classroom modules. The online modules were completed in 2010 and the classroom modules in 2011.

Provincial Violence Prevention Curriculum Overview

The provincial violence prevention curriculum consists of 8 foundational online or e-learning modules. They are:

E-Learning Modules

1. Overview
2. Recognizing and Responding to Risk
3. Interventions in Acute, Residential and Community Care (3a, 3b and 3c)
4. Communication Basics
5. De-escalation Skills
6. Responding to Physical Violence
7. Post Incident Response
8. Behavioural Care Planning for Violence Prevention.

Four of these modules can be supplemented with interactive classroom-based training. Not all workers need every module. The provincial curriculum development team and initiative team have provided guidelines on which employees require which modules. One health authority, Fraser Health, has added a 9th module with health authority specific information.

Classroom Modules

1. Communication Basics for Health Care
2. De-escalation Skills for Health Care
3. Personal Safety Strategies for Violence Prevention
4. Behavioural Care Planning for Violence Prevention

A 5th module, Advanced Team Response (ATR) for Health Care was originally planned to be part of this initiative. Due to the scope, complexity and compressed timeline for the initiative the ATR and Code White team response were not included.

Initiative Overview

The participating health authorities in the Provincial Violence Prevention Initiative included Fraser Health, Interior Health, Northern Health, Providence Health Care, Provincial Health, Vancouver Coastal Health and Vancouver Island Health. Three pilot sites were chosen from each health authority with the exception of Providence Healthcare and Provincial Health. These two organizations had one pilot site each. There were a total of 17 pilot sites involved in the initiative. The pilot sites were a mix of acute care, residential and community facilities.

The initiative team consisted of an Initiative Sponsor, Initiative Manager and 6 initiative leads. Initiative leads were chosen for Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health and Vancouver Island Health. Providence Healthcare and the Provincial Health Authority shared an initiative lead. Due to the magnitude and complexity of this initiative, the initiative team members were required to be experienced and knowledgeable about violence prevention programs and violence prevention education and training.

Scope

To achieve the goal of identifying, developing and implementing best practices for violence prevention the main objectives were to:

1. Evaluate the current state of violence prevention programs.
2. Identify gaps.
3. Identify health authority best practices and conduct a literature review.
4. Implement the Provincial Violence Prevention Curriculum at selected pilot sites.
5. Develop a Facilitator development and support program.
6. Evaluate the curriculum implementation and the initiative.

Initiative Methodology

The initiative team began with completing the current state assessment and gap analysis. The assessment format was based on the OHSAH document, *"Elements of a Best Practice Violence Prevention Program for BC Healthcare"*. The assessment and gap analysis provided the basis for identifying and sharing current health authority best practices in violence prevention and identifying gaps in health authority violence prevention programs. Once the assessment was completed, the initiative team focused on developing an evaluation framework for the components of the initiative. Considerable time was also spent developing a provincial violence prevention facilitator development and support program including a facilitator workshop, teaching plans and tools.

Next, initiative leads worked with their health authority partners to identify and choose pilot sites. Once pilot sites were confirmed the general plan was to complete an implementation plan, communicate the pilots, distribute the pre-pilot perception survey, schedule focus group sessions, identify facilitator recruits, hold facilitator workshops, schedule and conduct classroom sessions, distribute post pilot surveys, evaluate the results and report out.

The implementation plan and report included:

- A description of the pilot site.
- Why the site was chosen to participate.
- A statement of the pilot site's commitment to participate.
- A combined understanding of the deliverables and outcomes.

- A clear understanding of what the pilot site had committed to.

The overall work plan for the initiative included:

- Completion of the current state assessment and gap analysis - Appendix 1
- Development of communication and promotional materials - Appendix 2
- Development of an initiative evaluation framework – Appendix 3
- Development of pilot site selection criteria – Appendix 4
- Development of a pilot site communication package – Appendix 5
- Development of Facilitator selection criteria – Appendix 6
- Development of a Facilitator Development and Support Program – Appendix 7
- Completion of E-Learning and classroom modules.
- Initiative and pilot site evaluations – Appendix 8
- Best Practices and Literature Review – Appendix 9
- Code White Protocol and Reports, key components – Appendix 10

Initiative Evaluation Framework

Using fixed questions for the pilot focus group sessions and a standard pre and post perception survey, the initiative evaluation assessed the general awareness of violence prevention programs, perception of effectiveness of current violence prevention programs, and perception of the PVPC. Evaluation components included:

- focus group sessions
- employee perception survey, pre and post
- participant evaluations, e-learning, classroom, facilitator workshop
- management survey, pre and post

Pilot Site Implementation Steps:

1. Establishment of a site specific violence prevention curriculum steering committee.
2. Schedule Focus group session(s).
3. Dissemination of pre-pilot perception survey.
4. Identification of site supervisor group to:
    a. Ensure supervisor completion of perception survey.
    b. Ensure completion of e-learning.

c. Provide an initiative follow up checklist.

d. Provide an evaluation form to assess worker knowledge and competency post pilot.

5. Determination of which e-learning modules were applicable to site staff.
6. Identification of site staff to complete the modules.
7. Ensure staff participation in perception survey, e-learning and focus groups.
8. Identification of applicable classroom sessions and of site staff to complete them.
9. Identify potential facilitator recruits
10. Schedule facilitator workshops.
11. Support facilitators to facilitate or co-facilitate the classroom modules at the site.
12. Schedule and facilitate classroom sessions.
13. Analyze results.

Results

All of the perception survey questions with the exception of one, showed statistically significant improvements in employee responses. Respondents indicated that they felt their safety was as important as patient safety and that they were encouraged to work safely. Health authority leaders were seen as committed to safety. However in the pre-pilot survey only 49% indicated that they had used violence prevention policies and procedures, only 54% indicated they had received training in violence prevention and that they always checked for potential violence from clients. Just 55% indicated that they always follow violence prevention procedures. The post survey results were more encouraging with 95% reporting they had received training and 81% stating that they always follow violence prevention procedures. The top three strengths and opportunities from the pre and post pilot surveys plus the percent change in the responses are indicated below. The complete results from both the pre and post surveys are in Appendix 8.

Employee Perception Survey

Top 3 strengths

Question and response scale: I strongly disagree, 2 disagree,3 neutral, 4 agree, 5 strongly agree (%agree and strongly agree)	Mean Pre	Mean Post	%	%
1. I feel my safety is as important as patient safety.	4.3	4.4	88	89

2. I feel encouraged to work safely and prevent work related injuries.	3.9	4.2	80	86
3. My health authority leaders are driving us to be a safety centred organization.	3.8	4.0	69%	79
3. Communication of potential violence from clients (alerts) is available.	3.8	4.0	69%	76

Top 3 opportunities

Question and response scale: 1-strongly disagree, 2-disagree,3-neutral, 4-agree, 5-strongly agree (%agree and strongly agree)	Mean Pre	Mean Post	%	%
1. I have accessed and used violence prevention policies and procedures.	3.3	3.9	49	76
2. I have been trained in violence prevention procedures.	3.4	4.4	54	95
2. How often do you check for potential violence from clients? Always?			54	64
3. I always follow violence prevention procedures.	3.6	4.0	55	81

The perception survey had 3 open ended questions and a thematic analysis of the responses identified some major themes. The top themes from the pre to post survey did not change significantly.

Question: If the necessary resources, equipment and/or education to work safely and prevent injuries are not available, what resources or training are needed?

1. Access to education and training
2. Adequate staffing, equipment and other resources.
3. Adequate security resources.

Question: What would you consider to be the greatest barrier to following violence prevention procedures?

1. Access to violence prevention education and training.

2. Lack of awareness or knowledge of violence prevention procedures.
3. Information and communication of violence risks.

Question: Do you have any other comments about the violence prevention program?

1. Very useful, appreciated, great.
2. Education and training is necessary and required.
3. Management support is required.

E-Learning

The pilot sites completed the e-learning modules in a variety of ways. Some participants were asked to do the modules at work. In some cases but not all, extra staff was brought in so participants could complete the modules. Other participants were asked to complete the modules when they had down time. Another method was to book a computer lab and have employees complete the modules in a group. Finally, some employees were asked to complete the modules at home or another time and location of their choice. The participants completed a time card to record the length of time it took per module as well as to document the hours they were to be paid for.

Summary of responses

Question and response scale: 1-strongly disagree, 2-disagree,3-neutral, 4-agree, 5-strongly agree (%agree and strongly agree)	**Percent Agree**	**Mean**
The information contained in the modules was relevant to my job.	87	4.2
The modules were easy to access.	71	3.8
The modules were easy to navigate	77	4.0
The modules were easy to complete.	82	4.1
I was able to complete the modules without technical (computer) support.	75	4.0
I was able to complete the modules without content support (assistance clarifying or understanding the material).	83	4.1

Question and response scale: 1-strongly disagree, 2-disagree,3-neutral, 4-agree, 5-strongly agree (%agree and strongly agree)	Percent Agree	Mean
I feel the best learning environment to complete online education is:		
▪ At work on my unit	35	2.9
▪ In a computer lab	40	3.2
▪ Away from work at a time of my convenience	45	3.3

Question: On average, how long did it take you to complete each module?	**Percent**
Less than 15 minutes	6
15 to 20 minutes	22
20 to 25 minutes	25
25 to 30 minutes	23
More than 30 minutes	21

The e-learning survey asked participants for any additional comments on the e-learning modules. A thematic analysis of the responses identified some major themes:

Major Themes

1. Easy to follow, enjoyed the modules.
2. Experienced computer or module issues.
3. The modules took longer than expected.
4. Instructions for accessing the modules, other logistical issues as well as requirements to complete quizzes need clarification.
5. Module quizzes were problematic.
6. Computer literacy is an issue.

Classroom training

The classroom modules were designed so they could be delivered individually or combined. Each of the modules were expected to take up to two hours but can take more or less depending on the needs of the participants. The classroom modules contain similar information to the e-learning modules and were planned to build on the knowledge gained with participatory exercises and various methods of facilitation such as videos, role plays, demonstrations and practice. The pilots differed in

their approach to delivering the classroom modules. One health authority, Fraser Health, delivered 3 modules in a four hour session; others delivered 4 modules over a 7.5 hour day or split up the modules and offered them in 2 to 4 hour time frames. The classroom modules were facilitated by the initiative leads, health authority violence prevention staff and by facilitators from the pilot sites who attended the facilitator workshop. The classroom evaluation focused on the learning objectives for each module as well as the facilitator's ability and relevance of the material. Some of the results are:

Question and response scale: 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree (% agree or strongly agree)	**Percent Agree**	Mean
The facilitators stimulated interest in the subject matter.	94%	4.6
The facilitators created an enjoyable learning atmosphere.	97%	4.7
The facilitators emphasized the principles of employing the least restrictive and most appropriate response to escalating and violent behaviour.	96%	4.6
This curriculum was relevant to my needs.	91%	4.5
How would you rate the overall program& (5 highest; 1 lowest)	95%	4.6

The classroom survey asked participants two additional open ended questions. A thematic analysis of the responses identified some major themes. They are:

Question: As a result of this program, I:

1. Learned skills and physical strategies to protect myself from violence from work or to remove myself from the situation.
2. Feel more prepared to prevent violence and to de-escalate potentially violent situations.
3. Am more aware of and will think more about my safety as well as be more aware of my reactions to violence.
4. Am more confident that I can respond to violence appropriately.
5. Feel the content was not necessarily new but was a good refresher.
6. Will be more attentive to body language, vocal and verbal communication.

Question: Additional comments on the program, teaching methods and or instructors?:

1. Thank you, the training was enjoyable, excellent, practical, awesome.
2. Good instructors.
3. Liked the presentation materials, videos, powerpoints and role play exercises.
4. Liked the hands on nature of the training.
5. Appreciated having my co-workers as facilitators.
6. Would like more time for practicing the physical skills and for care planning.

Facilitator Workshop

The facilitator workshop was a three day session. Facilitators were provided an overview of the provincial initiative, introduced to the curriculum and given an opportunity to present a portion of the curriculum and to lead small group sessions for the personal safety strategies. The participants were asked to evaluate each day of the workshop as well as each component of the curriculum. They were also asked to provide feedback on the materials, exercises and overall relevance of the PVPC and workshop. The participants varied in their experience, occupation and facilitation skills. Some participants were experienced facilitators and for some, it was their first time facilitating. Many of the new facilitators put a lot of effort into preparing and delivering the workshop material. Despite the appreciation the classroom participants had for their peers, it was evident that some facilitators would require a lot of support and practice to become proficient. Other facilitators did very well and were able to effectively facilitate. The workshop changed and evolved from the first session to the last. Participant feedback was a major driver of that evolution. The workshops were generally a very positive experience and were energetic, engaging and fun. Some of highlights and results are:

Question and response scale: 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree (% agree and strongly agree)	Percent Agree	**Mean**
The facilitators stimulated interest in the subject matter.	94	4.7
The facilitators created an enjoyable learning atmosphere.	95	4.7
The facilitators emphasized the importance of how violence prevention strategies result in the best outcomes for all in crisis situations.	94	4.7
The workshop content was relevant to my needs as a violence prevention facilitator.	93	4.6
I am confident I will be able to co-facilitate the violence prevention curriculum	86	4.1

I am confident I will be able to facilitate the violence prevention curriculum on my own	60	3.6
How would you rate the overall program& (5 highest; 1 lowest)	94	4.5

The facilitator workshop survey asked participants two additional open ended questions. A thematic analysis of the responses identified some major themes. They are:

Question: As a result of this workshop. I:

1. Have a better understanding of the materials and teaching methods.
2. Have more confidence in my ability to facilitate.
3. Gained new skills.
4. Felt this was a great workshop, enjoyed it.
5. Feel ready to teach.
6. Am more aware of staff safety.

Question: Additional comments about the facilitator workshop?:

1. Need more repetition and opportunities for practice, especially with physical skills.
2. The facilitation practice and small group sessions were very valuable.
3. It was great to have so many different facilitators.
4. There is a lot of information, it is very comprehensive.
5. Three days is too long.

Question: What additional/future supports do you suggest for VP facilitators?

- ATR curriculum developed ASAP with additional material like seclusion room policy and procedure and strong sheet or blanket methodology.
- Quarterly meetings.
- Video conferences.
- More scenarios, case studies including what worked, what didn`t.
- More drills and practice sessions for personal safety strategies.
- Provincial government and health authority support.
- Opportunities to facilitate and co-facilitate.
- Refreshers check in after 6 months.

- Care plan development, evaluation and adjustment.
- Online links.
- Facilitator prerequisites and requirements.
- Focus on presentation skills.
- Basic technology help with media and technical support.
- Access to ongoing education.
- Mentor support.

The feedback from the participants was very valuable in helping to evolve the workshop but some of the comments were especially positive. Here a just a few examples, all the responses can be found in Appendix 8.

> "Excellent workshop. Just the right amount of balance between lecture and hands on material. Loved having all the different presenters, all of you were awesome. Did not think I would laugh so much while learning so much."

> "Each and everyone of you was fantastic! You made a difficult topic interesting, educational, entertaining and fun!!! Thank you so much!"

> "This workshop was excellent. I can recognize how much work went into developing this program and am excited about this. It has always been a part of client care that was missing. Not everyone was on the same page."

Manager Survey

Managers of the pilot sites were asked to complete a pre and post pilot survey. They were asked 6 general questions about their perception of how the initiative would impact workers knowledge and skills around violence prevention as well as how it might impact workplace injuries. Managers were also asked about their perception of senior level support for violence prevention programs.

Question and response scale: 1 strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree (% agree or strongly agree)	Mean Pre	Mean Post	Percent Agree Pre	Percent Agree Post
1. Workers will be or are more knowledgeable about initiating violence prevention strategies after completing the e-learning modules.	4.1	4.3	85%	95%
2. Workers will be or are more confident in using violence prevention strategies after completing the classroom modules.	4.3	4.1	91%	86%
3. Workers with violence prevention training will be or are better equipped to improve patient care.	4.2	4.2	80%	87%
4. Violence Prevention training will or has enabled workers to be better prepared to prevent violent incidents from escalating to personal injuries.	4.3	4.3	93%	97%
5. As a result of violence prevention training, there will be or has been a reduction in the severity of workers' injuries.	3.7	3.4	63%	27%
6. The executive team supports the violence prevention program in my unit or department.	4.4	4.4	93%	95%

In addition to these 6 general questions, managers were asked about what barriers or challenges they anticipated for the e-learning, classroom session and facilitator recruits prior to the initiative, what the actual experience was like and how they overcame challenges.

There were 53 pre pilot responses and 37 post pilot responses. Managers overwhelming stated that their executive team strongly supported violence prevention programs. However, most also stated that they did not have an assigned budget for violence prevention, that they had difficulty releasing or replacing staff for the training and that there were challenges scheduling workers for training. Other responses indicated that workload, both for staff and for managers, was an issue. According to the pre and post survey results, the time frame of the initiative was not long enough to assess whether there was or would be a reduction in the severity of worker injuries as a result of training. Finally, availability of computers and ease of obtaining records of training were additional challenges.

The comprehensive evaluation data from each of the surveys is in Appendix 8.

Successes

Current State Assessment

The current state assessment and gap analysis was a major accomplishment. This was the first time that such a comprehensive assessment and comparison of violence prevention programs has been conducted. The assessment illustrated the huge amount of work health authorities have put into violence prevention programs. It identified some great practices and some opportunities for improvement. Completing the assessment also illustrated the difficulties in gathering accurate information as each health authority has different means and abilities for data collection and reporting. The current state assessment and gap analysis provides an opportunity for each health authority to plan to address gaps and to further improve and standardize violence prevention programs.

Pilot site diversity

The initiative pilot sites represented each healthcare sector and included acute, residential and community sites. This diversity provided an opportunity to assess how the violence prevention curriculum applies in different settings. Facilitator recruits from each sector also had an opportunity to work together and gained an appreciation of the challenges in each sector. The pilot site selection criterion included input from regional violence prevention steering committees and was essential in choosing the pilot sites.

Pilot sites and Health Authority		
Acute	Residential	Community
Burnaby Hospital - FH	Cottage-Worthington - FH	Abbotsford Comm Dialysis - FH
Chetwynd Hospital - IH	Gorge Road - VIHA	Campbell River HS – VIHA
Fort Nelson Hospital - NH	Jubilee Manor - IH	Castlegar & District HC - IH
Mt. St. Joseph's - PHC	Stuart Nechako Manor - NH	Vernon Health Unit - IH
Richmond Hospital (2) - VCH		West Van Community - VCH
Women's Hospital - PHSA		

Communication Package

Communication materials were developed and professionally produced. The resulting package was an attractive and effective tool for promoting the provincial violence prevention curriculum. A formal

communication package was also prepared for the pilot sites. This material has potential to be used to communicate violence prevention program requirements to managers and supervisors on a go forward basis.

Pilot Participation.

The level of participation in the initiative was generally very good. Over 800 employees began the initiative and 734 completed the e-learning and 683 participated in the classroom sessions. Participants were asked to complete 4-6 evaluations and provided thoughtful and comprehensive feedback. The following table outlines the participation from each pilot site.

Health Authority	Facility	E-learning Participants	Classroom Participants
Fraser Health	Abbotsford Community Dialysis	12	12
	Burnaby Hospital	137	137
	Cottage Worthington	43	97
Interior Health	Castlegar and District Health Ctr	34	29
	Nelson Jubilee Manor	54	49
	Vernon Health Unit	35	33
Northern Health	Chetwynd	33	18
	Fort Nelson	44	25
	Stuart Nechako Manor	50	21
Providence Health	Mt. St. Joseph's, Geri Psych	52	52
Provincial Health	Women's Hospital, Fir Square	42	42
Vancouver Island	Campbell River Home Support	32	64
	Gorge Road Hospital	37	37
	West Coast General Hospital	45	39
Vancouver Coastal	Richmond Hospital, ER	38`	1
	Richmond Hospital, Psych	13	13
	West Van Community	33	14
Totals		**734**	**683**

E-learning

The evaluation results and feedback from pilot participants was very positive. Even with the reported frustrations related to the e-learning, 87% agreed or strongly agreed the modules were relevant and

useful. While there was not an overwhelming result for the best option for completing the modules, completing them at home or in a location and time of convenience was the most favourable option at 45%, in a scheduled computer lab was the next favourable at 40% and the least favourable option was at work on the unit at 35%. Over 75% of respondents were able to complete the modules in 30 minutes or less.

Classroom sessions

The classroom session evaluations were very positive. Over 91% agreed or strongly agreed the modules were relevant to their needs and over 95% rated the program very highly with a mean rating of 4.6 out of 5.0. The number of comments expressing thanks or calling the program excellent, practical and awesome was very unusual for an education and training program. There was a general theme of appreciation for the program and the opportunity to participate in the pilot.

Facilitator Workshop

The Facilitator workshops were very well received. Of the participants, 93% agreed or strongly agreed the workshop was relevant to their needs as violence prevention facilitators and 95% reported that the workshop was an enjoyable learning experience. Over 94% rated the overall workshop very highly with an average score of 4.5 out of 5.0. The Facilitator workshop materials are available as a complete package and are a valuable addition to the PVPC.

The initiative had a lot of other positive benefits. Not least among them was increased awareness of violence and prevention program requirements. The PVPC meets the requirements of the Recommended Operating Procedures (ROP) for violence prevention education from Accreditation Canada. It provides a platform for increased awareness of the issue of horizontal violence and bullying in the workplace. Vancouver Coastal Health was able to follow up after a critical incident by using the PVPC to train staff. Lastly, the initiative team was able to be responsive to issues that arose during the pilot, such as commissioning a technical review of the e-learning quizzes or opening up facilitator workshops to other partners. VIHA held an additional 7 facilitator workshops using the material developed by the team and have been able to increase the capacity of their health authority to sustain violence prevention education and training.

Challenges

The project charter identified potential risks and strategies to overcome them but despite this preparation, the initiative still faced some major challenges. Challenges included:

Initiative Design, Project Management.

While health authorities have received funding in the past for projects and have successfully managed them, this HSIA initiative was larger in scope. This initiative was also the first time all the health authorities had collaborated to implement a provincial violence prevention program. It was a change to have an external company, not related to healthcare, provide project management. The HSIA committee structure added another layer of complexity to the initiative. When the initiative began, there was a learning curve for all involved and the meeting and reporting requirements were considerable. This put a strain on resources and relationships but things did improve over time. Over the initiative term, there were also 5 Project Directors. This impacted the continuity of the initiative and required communication to bring them up to speed.

Communication

A major challenge throughout the initiative was a lack of awareness about the initiative. Even with senior health authority representation on the HSIA steering committee, information and communication bulletins prepared by the PMO, communications materials developed and distributed by the initiative team, health authority level communication through regional violence prevention steering committees, joint occupational health and safety committees and articles in health authority newsletters, the initiative leads still encountered a general lack of knowledge about the violence prevention initiative. This lack of communication impacted the selection of pilot sites and the willingness of departments to participate in the initiative.

Pilot Site Selection

The pilot site selection process was impacted and delayed in 3 of the health authorities, Interior Health, Northern Health and Vancouver Coastal Health. One of the pilot site selection criteria was to have sites that were receptive and willing to participate. Some sites that originally agreed to be a pilot backed out due to many competing priorities and a perceived lack of capacity to participate.

Geography

The project charter called for consideration of geography when choosing pilot sites to address the potential travel costs. Due to the difficulty in confirming pilot sites, particularly in Northern and Interior Health, some of sites were quite distant and did require considerable travel. This impacted the initiative leads as well as facilitator recruits from those sites.

Facilitator Recruitment

The project charter called for up to 5 facilitator recruits from each pilot site or up to 85 total facilitator trainees. With the difficulty in confirming pilot sites as well as lack of commitment by some health authorities for future implementation of the provincial curriculum, recruitment was an issue. Eight facilitator workshops were originally planned but one was cancelled in February due to a lack of registration. Due to the delays that were experienced the initiative team decided to open up the workshops to other sites and departments and an additional workshop was held in VIHA. At the conclusion of the initiative there were 114 facilitators trained as part of the initiative.

E-Learning

Some of the pilot sites experienced significant issues with the online learning. Two health authorities, Northern Health and Vancouver Island Health, did not have access to the online modules through their health authority learning management systems. A separate process to access the online modules through OHS Connect had to be developed for Vancouver Island and Northern Health. This additional requirement for pilot participants caused some difficulties. In addition, at some sites, the level of computer literacy was very low. For these pilot participants, accessing and completing the online modules was a frustrating experience. In these situations, the site manager, supervisor, champion or initiative lead had to provide a lot of hands on assistance. As a result, the time to complete the modules was in excess of what was anticipated. Modules that were expected to take 25-30 minutes to complete sometimes took over 60 minutes or more. Some participants expressed their dissatisfaction with online learning and their preference for alternate forms of education.

Classroom Modules

Classroom sessions were originally scheduled to be completed by the end of May. Due to the late start in some health authorities classroom sessions continued until late June. One health authority,

Vancouver Coastal Health, was not able to confirm classroom dates and sessions were planned up to July 12, 2012. Unfortunately low registration caused the cancellation of the two last sessions.

Health Authority Differences

As was stated in the charter, the health authorities had violence prevention programs that differed in their scope, methods, policies and procedures. Some health authority violence prevention programs were well established and making the change from their education and training program to the provincial curriculum was not a universal understanding. Other health authorities did not have a plan in place to implement the provincial curriculum. Due to these innate differences, the ability of the initiative lead to ensure pilot site selection and compliance as well as recruiting potential facilitators was difficult.

Pilot site challenges

Pilot sites were challenged in committing to the pilot due to many competing priorities such as undergoing accreditation and integration. All the sites had challenges with staffing, some had no ability to backfill shifts and others did not have casual staff to provide coverage for staff to attend the training. Other site challenges included a lack of computers for the e-learning and a lack of suitable spaces to hold classroom sessions.

Financial Process

The initiative required health authorities to submit invoices to the PMO for the initiative lead's time, travel and accommodation as well as for employee participation. A letter was sent to each financial contact outlining the initiative and what was expected to be invoiced. The letter included a request for period billing. Despite this and other follow up communication, most health authorities did not submit timely invoices. This impacted the ability of the initiative manager to oversee the budget. In an effort to simplify the billing requirements a Transfer of Funds agreement was drawn up to enable the full amount of funding for pilot site education to be given directly to the health authorities. All the provisions of the agreement were not clear to all parties and this caused additional work for the initiative team, PMO and health authority finance contacts.

Leadership engagement

Pilot site leadership (managers, supervisors, patient care coordinators and clinical educators) and engagement at the pilot sites varied. The intent was to have supervisors and managers also participate in the education but with a few exceptions, this did not occur. Management support, including communication of commitment to violence prevention and performance expectations for employees are key to developing and maintaining a culture of safety. Pilot participants frequently stressed management support as a requirement for effective violence prevention programs.

Data Management and Reporting

Tracking completion of the online and classroom modules was made difficult by limitations in the learning management systems used by the health authorities. Some of the initiative leads were unable to easily run a report of attendance and have confidence in the results. Northern Health and Vancouver Island Health authorities had to request records of training from OHS Connect. The WHITE data system does have capability for training records but it requires additional data entry.

Summary

The Provincial Violence Prevention Initiative was largely successful in meeting the goals outlined in the charter. The current state assessment and gap analysis was completed; the education modules received a good trial and were very well received. Best practices were shared and a literature review conducted. A violence prevention facilitator program was developed and 114 facilitators trained. A generic Code White policy, protocol and report form is also completed.

A highlight of the initiative was the very positive feedback about the Provincial Violence Prevention curriculum. The majority of the participants liked the e-learning and completed the modules within expected time frames. However, there were many employees who did not have computer skills and e-learning was not a good option for them. The classroom sessions were appreciated but still pose considerable logistical challenges such as scheduling and facilitation for health authorities. The facilitator program was also appreciated by those who attended but inexperienced facilitators need ongoing support and development. The entire facilitator program requires provincial coordination with continued communication and mentoring plus opportunities for skill maintenance and growth.

Health authorities always struggle with staffing and once a new employee starts work, it is difficult to release them for education and training. The best option would be to have employees come into healthcare already having had violence prevention education. Health authorities could then focus their attention on ensuring employees are provided with adequate orientation and department specific education. Educational facilities that provide healthcare programs are interested in incorporating the PVPC into their programs. This is an opportunity that could increase capacity for healthcare.

The Provincial Violence Prevention curriculum was deliberately developed in a modular fashion to make it very flexible in application. While classroom sessions still have relevance, especially for physical skills, applying learning directly to the care environment may have more relevance and impact. There are many ways the curriculum could be offered in addition to classroom sessions, for example, one module per quarter, one topic in a mini session or safety huddle, personal safety practice sessions, etc. Trained violence prevention facilitators could support violence prevention programs and maintain their skills by facilitating these sessions and/or other activities. This would increase capacity and improve sustainability of violence prevention in healthcare.

Advanced Team Response

The Advanced Team Response Module was not part of this initiative but there is an imperative to have it incorporated into the PVPC. The initiative survey results indicate that healthcare workers are responding to Code White calls and some have not been trained. This is a risk to workers, healthcare clients and health authorities. The ATR was completed as part of the curriculum development but it did not receive a comprehensive trial. There was some disagreement on the initiative team as to whether the ATR module was complete and ready to be used.

BC Healthcare has created a unique violence prevention education and training program. There are opportunities to expand the use of the PVPC to educational institutions, healthcare affiliates, contractors and other jurisdictions. The violence prevention initiative has demonstrated that commitment and support of violence prevention programs including the PVPC is valued by employees and does have the potential to help make positive changes in the workplace.

A provincial violence prevention program can contribute to a culture of safety in healthcare by improving reporting of violence and increasing awareness of the issue. A provincial program however, needs continued coordination and support and development.

Recommendations

Recommendations from this initiative fall into 3 major categories, provincial oversight and/or potential future HSIA projects, health authority recommendations and health and safety directors and department recommendations. The following table outlines the major recommendations.

Recommendation		Responsibility
1. Curriculum Development & Review		
▪ E-Learning Modules	Revise online modules	HSIA/OHS
▪ E-learning Modules	Repost modules and quizzes	Health Authorities/OHS
▪ Classroom Modules	Review and revise materials	HSIA
▪ Advanced Team Response	Trial and evaluation	HSIA/OHS departments
▪ Supplementary Materials	Development (expert input)	HSIA/OHS departments
▪ Provincial review	Oversight body	OHS Departments
2. Curriculum Implementation		
▪ E-learning	Part of orientation	Health Authorities
▪ E-learning	Review certificate process	Health Authorities and OHS
▪ E-learning	Healthcare worker training	HSIA/Provincial Coordination
▪ Classroom modules	Guidelines for completion	Health Authorities and OHS
▪ Classroom modules	Options for delivery	Health Authorities and OHS
3. Facilitator Development and Support		
	Maintain central registry	OHS/Provincial Coordination
	Prerequisites	OHS/Provincial Coordination
	Competency requirements	OHS/Provincial Coordination
	Development opportunities	OHS/Provincial Coordination
	Certification Program	HSIA
4. Provincial Violence Prevention Programs		
▪ Data Management	Training records	HSIA/OHS/Health Authorities
	Code White Report	HSIA/OHS/Health Authorities
▪ Financial Support	Dedicated Budget	Health Authorities

A more detailed overview of the recommendations is outlined in the following section.

Provincial Oversight and Coordination (Potential HSIA projects)

1. **Curriculum review and revisions**

a) E-Learning

During the course of the initiative, some suggestions were made to improve the quality and clarity of the curriculum material. Feedback from participants indicated the e-learning quizzes were difficult and the initiative team commissioned a technical review of the quiz questions. The technical writer hired to complete the review has made revisions that meet best practices for quiz design. In addition, the writer recommended a light rewrite and revision of the online modules to make the text clear and easy to read. This would include changes to:

- Simply wording
- Shorten sentences
- Use the active voice
- Improve logic and flow
- Eliminate inconsistencies
- Clarify difficult or confusing sections
- Fill in any gaps.

The writer would also look for ways to simplify the within-module quizzes, and would assess the clarity of graphics and illustrations.

b) Classroom Modules

The classroom modules would also benefit from a light rewrite and review, including updating the power point presentations. Participants and facilitator recruits expressed some issues with the flow of the presentations and these could be improved.

c) Advanced Team Response Module

i) Review and update of ATR materials (by subject matter experts).

ii) Review recommendations from the curriculum committee for ATR.

iii) Tie in ATR Facilitator Requirements with Facilitator program.

iv) Complete a literature review of physical restraint techniques.

v) Review and reach consensus on controversial techniques (standing containment, transition to floor, entry for physical restraint).

2. Data management and reporting

a) Investigate options to improve ability to collect, maintain and communicate training records.

b) Investigate the use of WHITE to collect and record Code White reports.

3. Facilitator Development and Support and Potential Certification program.

One of the goals of the initiative was to develop a Facilitator Development and Support program including facilitator prerequisites and maintenance of competency requirements. In addition a facilitator team site was created as a central place for the provincial curriculum materials to be housed and accessed. The team site also serves as a communication conduit for all the facilitators to notify them of updated or changed materials. Facilitators also expressed a desire for ongoing opportunities for skill maintenance and improvement. A major concern of the initiative team was how to ensure quality instruction, especially if other agencies are using the PVPC. One way to maintain the quality of the program would be to have a provincial facilitator certification process.

a) Maintain a central registry of facilitators

b) Confirm facilitator prerequisite requirements

c) Confirm facilitator competency requirements

d) Confirm facilitator development process (from facilitator trainee to master facilitator)

e) Provide opportunities for ongoing skill development (webinars, practice sessions, conferences, etc)

f) Investigate a provincial violence prevention certification program.

4. Future modules or supplementary material development

a) Convene subject matter expert groups on a time limited basis to develop supplementary materials.

b) Prepare options for delivering classroom materials, i.e. mini safety sessions, safety huddle topics, etc

Health Authority Recommendations

1. Establish a designated budget for violence prevention programs, including education and training.

A major barrier to ensuring violence prevention programs is maintained is a lack of dedicated funds. Health Authorities should provide a budget for violence prevention programs including education and training, risk assessments, code white response teams and facilitator support and development.

2. E – learning recommendations

Online learning is not for everyone however new hires generally apply on line and some complete orientation online so it is a reasonable assumption that they will have computer skills. While violence prevention education is valuable for all new hires, targeting clinical staff who provide client care would be more fiscally prudent. Educational institutions that provide healthcare training have requested to add the provincial violence prevention curriculum as part of their programs. If all new employees had completed the online learning before they are hired this would benefit both the employees and employers. Until this can occur ensure:

1. new hires complete designated e-learning modules. (designation based on recommendations from curriculum development team and initiative team).
2. all direct care employees as well as clinical managers and directors are included.
3. completion of VP education a condition of employment.
4. paid options for completing the modules (at work, at home).
5. employees provide evidence that they have completed the modules.
6. the process for Certificates of completion (e.g. one certificate only that list the modules that were completed) is simplified. For existing staff, e-learning modules can be an option for those staff who do not require classroom training

Classroom Module recommendations

1. Provide instruction on optimum time to deliver the modules in the form of guidelines based on learning objectives and desired outcomes.
2. Delivery of classroom sessions are based on assessment and risk levels.

3. Provide options on how to provide classroom sessions, e.g. schedule of sessions, departments and units provide the training, offer mini sessions, i.e. set up a quarterly schedule and cover one topic at a time, etc.

OHS Directors and Occupational Health and Safety Departments

1. Establish a provincial review process for the PVPC. (Individual health authorities or other agencies should not be able to make changes with out provincial consensus.)
2. Establish an oversight body for the provincial curriculum, e.g. PVPSC
3. Further education (i.e. classroom sessions) based on organization, site specific risk levels.