Flagging Patient Records

Report on a Method of Communicating Risk

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Executive Summary

While the eight key informants for this study filled widely different roles in a broad range of organizations, several key themes emerged as issues or circumstances that need to be addressed when implementing a flagging system as part of a workplace safety strategy.

- **Education and training**. In order to avoid perpetuating stigma, there must be a clear understanding that the purpose of flagging is to identify *behaviors* that put staff at increased risk of experiencing harm. It is not punitive, it is not about labeling individual people or diagnoses, and it is not about identifying patients who have been flagged.
- **Complementary care plans**. Identification of risk is not enough to reduce violent incidents. Investment in working with patients to identify triggers and how staff can avoid those triggers while providing care is necessary. Care plans that address triggers and potential for violence may:
    - Increase staff safety
    - Improve quality of patient care
    - Decrease stigma by fostering understanding *and* making it clear that flags do not indicate patients are to be avoided
- **Clarification on requirements and limitations of patient confidentiality and privacy.** Legal definitions of what is confidential and what can be shared to protect staff safety varies by jurisdiction. Ethical assessments of what can be shared appropriately may vary even more widely. All organizations which implement flagging systems need to consider legal obligations as well as input from a variety of points of view to establish clear parameters of what information is shared, with whom, and how. It cannot be left open to individual interpretation.
- **Gaps in communication**. Communication between organizations within the health care system can be hampered by several factors:
    - Different electronic record keeping systems that cannot be integrated to share information easily
    - Lack of clear expectations, regulations, guidelines and/or enforcement mechanisms for communicating between organizations, such as acute care and long term care.
    - Divergent agendas. Four informants holding four different roles in two different jurisdictions suggested that information on violent histories or tendencies might be withheld in order to secure a spot for a patient in another institution/facility.
- **Ongoing identification of promising practices**. Most of the informants interviewed for this study are involved in organizations at the forefront of flagging practices in Canada. The complexity of the challenges involved in flagging systems are such that several identified that their organizations were reviewing or modifying their practices as they continue to strive to identify those most appropriate for their organizations. Evidence to support practices is not robust in general; many practices are still too novel to fully evaluate.

Introduction

NSHRF was contracted by the Nova Scotia Department of Health and Wellness on behalf of the Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors to provide synthesis on the topic of balancing worker safety and patient / client / resident (patient) confidentiality with respect to communicating risk posed by patients to staff.

Workplace violence in health care and community services settings impacts both staff and patients. Acts of aggression or violence enacted by patients or residents result in missed work, lower job satisfaction, and higher staff turnover. In addition, while suffering physical or psychological abuse or fear of it, care workers may not be able to devote full concentration to providing care, which means that patients suffer as well (Clarke, Brown, & Griffith, 2010; Ideker, Todicheeney-Mannes, & Kim, 2011; Lipscomb & El Ghaziri, 2013). Missed shifts resulting from staff experiencing harm from patients also increase the number of floater or short term staff who are less familiar with patients and care plans. These staff members are themselves at increased risk for suffering abuse and violence (Lipscomb & El Ghaziri, 2013).

Flagging systems have been developed to address this issue by alerting caregivers and other staff of the risk posed by a patient as well as protocols for approaching the patient to reduce the risk. Though use of flagging has been increasing in recent years, its effectiveness depends on a larger system of violence prediction and prevention, including comprehensive plans to address risk once it has been identified.

A detailed outline of the components of a flagging system is presented in a recent publication by Ontario's Public Services Health and Safety Association (PSHSA), "Communicating the risk of violence: A flagging program handbook for maximizing preventative care" (Public Services Health & Safety Association, 2016a). The publication includes a description of flagging practices, a list of privacy considerations, a step-by-step guide to implementing a flagging system, and a sample policy. This report is intended to provide a brief general overview of flagging practices as well as complement the information provided in the PSHSA document.

Methods

This report is supported by a synthesis of peer reviewed and grey literature as well as key informant interviews (See Appendix A for definitions).

Literature Searches

Peer reviewed literature was found through searches of the following sources: Academic Search Premier, PubMed, CINAHL, Embase, Scopus, PAIS International, and Google Scholar.

Search terms included: "workplace violence," "flagging," and "violent patients." Results were filtered to include only those published since 2005 in English.

Snowball sampling was also used, whereby the references of articles were consulted, sometimes resulting in the inclusion of publications prior to 2005.

Grey literature was sought using the TRIP database, OAIster, and the OPHLA list of organizations and resources with limited results. Google and DuckDuckGo searches were conducted using phrases such as, "flagging violent patients," and "identifying violent patients" which yielded a number of policy documents.

Appropriate results from each source were exported to Mendeley reference management software where duplicates were removed.

Key Informant Interviews

Open-ended, semi-structured telephone interviews were conducted to complement information found in the literature. The interview guide was developed in collaboration with members of the Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors' Project Team. Seven interviews were conducted with eight key informants. Key informants were sought to bring a variety of viewpoints from clinicians and administrators from different settings and were found from the literature search and professional networking. Snowball sampling (asking informants to recommend additional informants) expanded the number of key informants. Informants come from three provinces across Canada. The roles and institution types of key informants are included in Table 1.

Interviews were recorded and transcribed; the transcriptions were coded and analyzed using NVivo 11 (Version 11.2.1.616; QSR International 2016) qualitative analysis software and emerging themes were identified.

Table 1. The role and institutional affiliation of each key informant interviewed.

Role	Institution Type
Safety consultant	tertiary care facility
Program coordinator	small option home agency
Nursing administrator	tertiary care facility
Nursing administrator	tertiary care facility
Health information systems director	health authority
Health services programs director	provincial health and safety organization
Social worker	long term care provider
Occupational health and safety program leader	health authority

Use of Terms in This Report

While the term "flagging" is commonly used, it is also considered problematic and avoided by some organizations because it can easily be misunderstood as a derogatory label of an individual. Some organizations, such the tertiary care facility where one informant works, use flagging practices without calling them "flagging." The term is used in this report for convenience, and to represent the terminology commonly employed by key informants and the literature.

Likewise, the term "violent" or "violence" is sometimes rejected as representing a conscious or deliberate desire to harm. For many patients, assaultive behavior may instead stem from diminished cognitive function or otherwise be a symptom of a clinical condition. Nevertheless, the term "violence" is used in this context for clarity and consistency to make sure that such actions, their consequences, and preventive measures fall under the umbrella of "workplace violence." This report will use the term "violence" to refer to actions that cause physical or psychological harm, whatever the intention of the performer of that action.

What is flagging?

Communication of Risk

Flagging is a system of communication of risk. It is intended to reduce incidents of staff suffering physical injury or psychological harm from patients by providing warnings that a patient carries increased risk of enacting harmful behavior. Protocols and care plans accompany the warnings to provide advanced preparation that serve to either prevent violent or harmful incidents or otherwise reduce risk. This communication of risk allows for a proactive approach to patient assault or violence, with the potential to prevent harm from ever happening.

What Flagging is Not

Several key informants emphasized that "flagging" is an indicator of potentially problematic behavior. It is not used to label individuals, and it is not used to indicate diagnoses. For example, while an individual with a dementia diagnosis may exhibit assaultive behavior stemming from his or her medical condition, all patients diagnosed with dementia are not flagged. The flag is used, for those who have them, to point caregivers to care plans designed to help them avoid triggers that might prompt behavior that puts staff at risk of harm.

As a system of communication, flagging is not itself a full solution to the problem of workplace violence enacted by patients. Key informants and the literature agree that information on the risk posed by a patient is generally insufficient to reduce that risk. Instead, flagging must be part of a larger, coordinated picture of violence prevention and harm reduction that includes education, training, and detailed planning as to how all the pieces work together to provide greater safety. There must be clear plans on what to do with the information communicated (Kling, Yassi, Smailes, Lovato, & Koehoorn, 2011; Public Services Health & Safety Association, 2016a). As Drummond et al. (1989) assert in their early study on flagging practices in the United States' Veterans Administration health care system, "the mere presence of security resources, training, etc., may be insufficient unless there is the actual development and implementation of a plan" (Drummond, Sparr, & Gordon, 1989).

The state of Minnesota's "Preventing violence in healthcare: Gap analysis" worksheet offers a detailed checklist of the components needed for a comprehensive workplace safety plan in healthcare that illustrates how flagging interconnects with other safety practices. It can also serve as a practical tool for organizations looking to implement promising practices in health workplace safety (Minnesota Department of Health, n.d.).

General Description of Flagging Practices

Flagging systems typically have three major components, though circumstances specific to different institutions result in variations as appropriate:

1) A process for identifying risk posed by a patient. This might come in response to an incident or as the result of a risk assessment on admission. Such risk assessments may be routine and follow a formal set of assessment criteria.
2) "Flagging" the patient i.e. communicating the increased risk when deemed appropriate. This may take multiple forms:
    a. In the patient's chart, whether paper or electronic, is something to grab attention such as a pop up warning, cover sheet, or tab that then directs the reader to more specific information such as details of the risk, triggers, care plan details, or security protocols, as appropriate.

b. An indicator on or associated with the body of the patient to warn anyone familiar with the indicator to consult the patient chart (or a clinician with access to the chart) for instructions on approaching and interacting with that patient. Such indicators might be wristbands of a particular color or printed with symbols, colored stickers on charts or doors, gowns of a particular color, and magnets or signs on the door or doorframe of the patient's room.

3) A background support system that determines plans and actions taken in response to the flag. This includes explicit detailing of which staff are responsible for which steps in the process.

Flagging can have both an immediate and long-term component. For instance, key informants from a tertiary care facility in Ontario described how their formal system of creating permanent flags involves creation of a formal electronic incident report and review by a supervisor to determine if the incident represents a repeatable pattern. At that point, formal flag indicators are added to the electronic system and the patient (or substitute decision maker for the patient) is notified. In addition, a formal risk assessment is conducted and a care plan is developed to address the risks and triggers associated with the patient. The formal process may take some time and requires the presence of management. Typically, managers are not available on weekends or holidays when there may be, nevertheless, the need to communicate an immediate risk. In such circumstances, an informal system communicates the risk to staff who care for the patient in the meantime. This communication would include use of a specific colored wristband, door signs, and indicators on white boards that notify staff with a glance that a patient poses a risk.

Similarly, an informant from British Columbia noted that clinicians can put immediate flags on patients in the emergency department when they are brought in, but a protocol is in place to determine whether or not it should stay. If the patient is not admitted, the protocol should still take place; however, the informant suggests there are instances in the busy environment of the emergency department where that flag would not be reviewed because it would be a low priority task. As a result, it would still be there the next time the individual showed up at the emergency department.

While the need for an immediate, less formal response to a risk is obvious, one key informant from Ontario did express some concern that it leaves open the possibility of a patient being informally tagged with a lasting flag without the checks observed in the formal process. This might happen when a patient comes to the emergency department but is not admitted, or is discharged quickly before the formal process is undertaken. Addressing that concern is part of an ongoing, active process of learning and improving practices at the informant's institution.

Who Should Be Flagged?

A successful flagging system requires a way to identify reliably those patients who pose risk. Sometimes flagging is done in response to an incident at the health care facility as part of a strategy to avoid having an assault repeated. Usually, the event and circumstances are evaluated to determine if the assault is an isolated event due to specific, atypical circumstances that are unlikely to be occur again (such as when a patient is coming off anesthesia) or if it should be understood as a demonstration of ongoing risk.

Routinely assessing new patients for risk may allow for assaults to be avoided in the first place. Policies and practices may vary widely depending on circumstances; facilities that care for patients experiencing mental illness or diminished cognitive functioning may have different tools and practices than acute care medical-surgical units, for example.

How to identify which patients may become violent can be a challenge, particularly in general tertiary or acute care settings. The Violence Risk Assessment Tool (M55) was developed as an assessment tool within the ALERT system in the Fraser Health Authority located in British Columbia to determine risk of violence in

an acute care medical-surgical setting. Kling et al., (2006) determined through a retrospective study that the tool offered moderate sensitivity (71%), which the authors found unexpectedly low but adequate (Kling et al., 2006). The tool was subsequently used in a prospective cohort study in California by Ideker et al. in 2009 and found to show lower sensitivity (41%) which the authors deemed insufficient to serve as a useful tool for identifying patients who will enact violence (Ideker et al., 2011).

For psychiatric patients, the Brøset Violence Checklist has been widely studied and found to have acceptable sensitivity and specificity (Abderhalden et al., 2004, 2006; Almvik, Woods, & Rasmussen, 2000; Hvidhjelm, Sestoft, Skovgaard, & Bjorner, 2014). It also has the advantage of focusing on six specific indicators and takes only a few minutes for the assessment to be made. There is some attempt to translate the Brøset Violence Checklist outside the strictly psychiatric context in a Canadian hospital; while study authors believe it shows promise, work remains to be done to prove its effectiveness there (Clarke et al., 2010).

A number of institutions in Ontario are now participating in a working group that is attempting to develop promising practices for quick and reliable assessment of risk posed by patients before they become violent. Determination and decisions about assessment have not been made. In addition, in May, 2017 the PSHSA is releasing its "Individual client risk assessment toolkit for health care settings," (Public Services Health & Safety Association, 2017a). It includes a Violence Assessment Tool for use in acute care, long-term care, community care, and emergency services settings. The tool was adapted from the Brøset Violence Checklist and the Dynamic Appraisal of Situational Aggression instrument (Public Services Health & Safety Association, 2017b).

In St. Cloud, Minnesota, at the St. Cloud Hospital, all patients are assessed for violence as part of the routine nursing assessment of all new adult patients. The assessment is electronic and tied to the patient's medical record. The assessment is repeated every twelve hours. The hospital's workplace violence committee created the assessment tool by modifying one originally designed to assess behavioral health to identify risk factors for perpetrating violence (Ocupational Safety and Health Administration, 2015). One of the key informants for this study found that while assessing all patients on check-in was the expectation at the informant's institution, in practice the assessments were often not completed for those patients who did not show obvious signs of potential violent behavior, such as agitation. Routine, systematic assessments for everyone is part of a proactive, rather than reactive strategy. Therefore, ensuring assessments are routinely done for all patients remains an important challenge.

How Does Flagging Impact Patient Care?

All key informants interviewed for this report argue that a system of clearly communicating risks, triggers, and appropriate mitigating actions positively impact patient care. This is based on the belief that information and clear communication remove stigma (Public Services Health & Safety Association, 2016a). One informant reinforced this thought by stating, "…it's really easy for people to judge… without any knowledge… and I think if you're educated and aware of the circumstances and the situation you have a better capacity for that empathy."

Several informants emphasized that flags are not warnings to avoid patients—rather, the reverse. Flags are an indication that care is required to devote extra time and attention to the patient and develop a detailed care plan that will allow for triggers to be identified and coping strategies developed.

One provided the example of a teenage girl acting out in an agitated and aggressive fashion after being brought to the emergency department on experiencing a sexual assault. For a male security officer to put that patient in a hold would be the worst possible response from a care perspective; by evaluating circumstances, the health care team is able to determine a course of action that keeps staff safe while

avoiding the exacerbation of trauma for the patient. This is part of "trauma-informed approach" to health care that seeks to help empower survivors of trauma.

Drummond et al.'s (1989) study asserted that flagging results in better and more complete medical care uncompromised by violent behavior. Key informants also suggested that the approach to potentially violent patients that involves flagging, education and training, and care plans designed to mitigate the risk posed by patients is also an approach that looks to reduce the use of physical restraints, chemical restraints, isolation or even refusal to provide care that typify more traditional approaches to patient-posed risk. This is an approach more focused on the well-being of the patient and therefore, informants suggest, represents an improvement in patient care.

Concerns and Resistance to Flagging

Confidentiality

A frequent concern mentioned by both key informants and the literature is that a flagging system has the potential to compromise patient confidentiality. The solution widely offered is to share only what is needed to take appropriate safety measures. For example, at one tertiary care facility, "Protection Services" are informed of where/when there is potential for assistance needed when caring for a patient. Information shared includes triggers, past and present behaviors, plans to mitigate the triggers, and a team intervention to promote safety. No diagnosis or additional health information is divulged. A similar level of as-needed communication is described in an example in PSHSA's flagging handbook (Public Services Health & Safety Association, 2016a).

Likewise, at another tertiary care facility, key informants explain that information is provided on a need to know basis. Symbols on doors indicate the patient records should be consulted before approaching the patient. Staff who do not have access to patient records, such as food services employees, ask at the nurses station if there are instructions that pertain to them. Unnecessary details, including diagnosis, are not provided. The informants said that because information disclosed was minimal and included no medical details, patient confidentiality concerns were not significant when the program was put in the place.

To ensure that patient confidentiality is maintained in the Fraser Health Authority, access to records is role-based, with stringent guidelines as to who has access to a record, when, and why. One informant described an auditing process as part of ensuring there is only appropriate access to electronic records.

While different colored bracelets might be generally visible on a patient's wrist, a key informant from a tertiary care facility in Ontario suggested that they do not result in a breach of confidentiality as several different colors are used for bracelets for a variety of alerts such as allergies or risk of falling; in addition, the significance of the specific colors is not widely known beyond staff members. The colors themselves are not thought to provide significant personal or confidential details about a patient.

The legal element to protect patient confidentiality involves observing provincial laws. Ontario's PSHSA provides a document to accompany its flagging handbook on confidentiality and the law in Ontario, "Communicating the risk of violence: What healthcare providers should know about privacy," (Public Services Health & Safety Association, 2016b). While Nova Scotia laws may differ from those in Ontario, the PSHSA document does provide a basis for considering how provincial law might address issues surrounding flagging and patient confidentiality. In British Columbia, a key informant indicated that clear policy from Work Safe BC states that considerations of worker safety trump issues of patient confidentiality when it comes to

communicating risk of violence. This gave the health authority confidence to proceed with the flagging system with due consideration to patient confidentiality.

Stigma

Key informants at multiple institutions asserted their belief that flagging reduced stigma, rather than promoting it. They indicated that the use of flagging and appropriate care plans address the risk of assault or violence by understanding the causes. It is their belief that the promotion of understanding is antithetical to stigmatization. While most key informants acknowledged that clinicians had voiced concerns about perpetrating stigma when flagging programs were first put in place, particularly with respect to mentally ill patients, informants indicated that education was able to relieve such concerns and they were not a major barrier to implementing flagging systems. One informant emphasized that education must clarify that flagging is not about diagnosis—those opposed to flagging fear that it is essentially labeling individuals with a disease—but instead part of a strategy of identifying behaviors that pose risk to staff so that the risk can be mitigated.

In training sessions, an informant who is an occupational health and safety program leader uses the example of a sweet-tempered and well-liked patient who had an extreme phobia of needles. When lab technicians approached the patient with a needle, the patient lashed out blindly in abject panic and twice unintentionally caused injury. Understanding the trigger allowed the patient's caregivers to come up with a plan for preparation and support when blood work was needed. The flag system was used to warn anyone who might need to approach the patient with a needle that a plan needed to be followed to ensure everyone's safety. The result was that staff safety was preserved while patient care remained uncompromised. The example is intended to demonstrate that flagging is not meant to label and shun individuals, but alert caregivers to the existence of a challenge and method for coping with it.

Cultural Sensitivity

According to two key informants, one facility in Toronto with a large number of staff who identify as Jewish experienced resistance to the use of symbols to identify potentially violent patients because the marking of individuals with a symbol was uncomfortably reminiscent of stigmatizing Jews with the Star of David during the Holocaust. The organization addressed this concern by avoiding the use of symbols (such as triangles which are sometimes employed by other organizations in their flagging programs) to refer to flagged patients. The organization also employed education to address the issue and other concerns, emphasizing that flagging is not a punitive measure or a personal label, but part of a system of alerts to allow health care workers to work safely, and thereby provide the best care for patients who pose safety challenges.

Barriers and Facilitators

Incident Reporting

One impediment to an effective flagging system is failure to report incidents. Those tasked with investigating the phenomenon of patient on staff aggression or violence have often been frustrated by the reluctance of staff to report incidents. That reluctance is often due, among other factors, to an understanding that some aggressive or violent behaviors that result in staff injury are unintentional or were enacted by patients who cannot be held wholly accountable for their actions due to mental illness or diminished cognitive function. Other considerations that inhibit reporting are expectations that experiencing violent incidents is normal in the course of duty, an unwillingness to take on the burdensome process of reporting, and concern that reporting will displease supervisors or result in blame to the staff member (Lipscomb & El Ghaziri, 2013). A

key informant from a long-term care facility, echoed by an informant from an assisted living agency, suggested that when reporting is burdensome and does not result in any discernable changes, staff regard reporting a waste of time.

Drummond et al. (1989) suggest that because the role of managing others' behavior is unfamiliar and uncomfortable for most clinicians, clear policies and supportive management are necessary for routine reporting. Diffuse responsibility and organizational ambiguity stymy the identification and communication of risk necessary for risk minimization. In order for workplace safety initiatives to be effective, reporting is essential to provide necessary data on what situations and circumstances carry risk in the future and to respond to existing risks.

Training and Education

Education focused on understanding the root causes of violence or assaults enacted by patients is considered an essential component of a successful workplace safety program as it helps to build support for new policies and practices. Several key informants noted that education was provided broadly throughout their organizations.

One informant noted that education at her facility included all staff, even housekeeping. Anyone who might come in contact with a patient would benefit from understanding of the nature of potentially violent behavior. This education is critical because, as noted above, flagging—communicating a warning about risk—is not a solution to the problem of workplace violence itself. Staff need to understand that acts of violence are not necessarily inevitable and it may be possible to prevent or diffuse situations that could descend into violence.

Flagging is not intended to be punitive and is not an indication that patients are to be avoided. However, that can be misunderstood without appropriate education on the purpose of flagging and how it can be beneficial to both staff and patients. Several key informants agreed that very open communication on the purpose of flagging is essential for appropriate use and to address any resistance to flagging that may be based on misperceptions or fears of misuse.

Another important component of education is ensuring that staff responsible for assigning flags are aware of the legal, ethical, and professional justifications and protections they have. One informant stressed that care workers need to understand that they are not breaching patient privacy by implementing flags.

Several informants suggest that training also is a companion feature of a flagging system. All staff need to be fully aware of policies, procedures and the meaning of symbols that might constitute part of the system. In addition, training on how to approach patients who pose risk with de-escalation techniques such as gentle persuasion or self-defense moves is critical. As an informant stated, "…it is about awareness, but it's also about competencies. So awareness only gets you so far. You have to know what to do in those circumstances."

Investment

Depending on the features of the flagging system and its supports, significant investment may be demanded. Hodgson et al. (2012) suggest that Disruptive Behavior Committees (DBCs) which review incidents and apply flags in the United States Veteran's Affairs (VA) healthcare system (see below) require about a half-day of work per week for the committee chair as well as staff support while committee members must dedicate several hours per month. In addition, the VA's nationwide electronic health record requires a significant investment in infrastructure (Hodgson, Mohr, Drummond, Bell, & Van Male, 2012).

An electronic system present at the tertiary care facility made flagging easier, according to key informants who work there, but the investment was part of an overall system improvement – it was not made for flagging alone. Nevertheless, several key informants agreed that while an electronic system is not essential for flagging, it does facilitate fast and reliable communication. An informant from a long-term care facility noted that switching to an electronic system of patient documentation made record keeping and communication dramatically easier. Communication between departments or from shift to shift is easily facilitated with electronic reports that can generate all the needed information.

An example of the advantages of an electronic system available from the Holy Cross Hospital in Fort Lauderdale, Florida. Medical record software is connected to a tracking board used in the emergency department. When a flagged patient checks in, staff are automatically alerted. In addition, a daily census scans for flagged patients and sends updates to key staff (Ocupational Safety and Health Administration, 2015).

While informants generally agreed that the electronic flagging system itself was not a significant financial cost since the flagging tools were part of the electronic patient record systems purchased anyway, informants noted that the training and education aspects of their program to address patient violence required considerable investment. Organizations have to allow time to employees for training and education programs. When all staff receive training, the amount of paid worktime is considerable. In some cases, allowing staff to receive training would require scheduling substitute coverage for shifts. In addition, maintaining the number of trainers available to provide training for new staff was a challenge that required attention and expenditure.

Balancing needs with expenses was also a theme mentioned by an informant from a for-profit assisted living agency. The informant describes the training provided as minimal – one hour for most staff with up to four hours for staff in homes with higher needs. He suggests that four hours is not necessarily enough, but the expense associated with training is an obstacle to providing more.

Culture

Reporting is also an outward manifestation of an institutional culture that prioritizes workplace safety. Throughout organizations, management can foster a culture that upholds safe work practices by acting consistently with policies. Key informants suggested that workers do not take the time to report incidents when they do not think anything is going to be done or when they fear reprisals. A willingness to allow staff at all levels to fulfill their roles in managing and responding to risk and in providing the necessary training and tools helps to facilitate the necessary policy compliance that promotes safety. This means not only providing one-time investments in electronic systems or training programs, but offering support to staff who have experienced or are at risk of experiencing violence, including the time needed to report.

Setting-Specific Considerations

While individuals might naturally pass to different forms of care—from acute to long term care or home care, for example—information about past histories of violence or problematic behavior does not necessarily pass with them. The segmentation of the health care system also segments bodies of information, and though details relevant to patient/client/resident care and worker safety might be expected to be communicated, lack of regulation or specific mechanisms may pose significant obstacles.

Long Term Care

Key informants from the Fraser Health Authority in British Columbia noted that the information transferred to long term care facilities from acute care facilities would vary depending on whether the long term care is offered by the health authority directly or a private agency. Though different record keeping systems are used by different sectors within the health authority, communication of basic information, including patient flags, is possible. However, the same automatic and consistent communication is not possible for external, private agencies.

In situations where an electronic system to transfer information is not in place, communication may be at the discretion of the staff involved in transfer. Informants from a tertiary care facility in Ontario admitted that while that information pertaining to risk of violence, triggers and related information should be transferred with the patient as s/he moves to a different institution as part of the patient care plan, information may still be mislaid in the transition.

A key informant who works at a private long term care facility in Ontario explained that there are limited reasons why a patient may be denied a place in the facility: lack of nursing expertise or lack of physical facilities to meet the need of a prospective resident. While the law limits the discretion of the facility to reject the application of a prospective resident, the two reasons that can be invoked by facilities are sufficiently broad that they can sometimes apply to residents with behavioral challenges. Someone working elsewhere in the health system may be trying to get a resident placed in a home and want to avoid providing unnecessary information that could jeopardize that placement or else avoid doing extra paperwork to include more detail; at the same time, those working in the long term care home are concerned that they not take on residents who pose an undue risk to staff, other residents, or themselves in the given circumstances of their facility. Their information needs or information wants may often exceed what is made available to them.

The same informant suggested the frequent need to “read between the lines” to identify prospective residents who pose safety risks or other challenges with which her facility may not be well prepared to cope. She can ask for a behavior assessment to accompany a prospective resident’s application, but she has to provide justification from the application if she hopes to have that request filled. The behavior assessment is typically five pages long and the work to complete it is generally avoided if a clear justification for completing one is not presented. While the behavior assessment includes a wide range of behaviors, the time frame it covers is also limited to one year. Criminal records are not provided, yet the informant notes that conditions like dementia can see residents revert to tendencies and behaviors from far in their past. So, someone who was violent or demonstrated anti-social tendencies at age 22 may see a return of those behaviors when experiencing dementia later in life. In one example, the informant discovered only by chance that a short-term resident with a disclosed diagnosis of schizophrenia had an extensive, extremely violent criminal history. It just so happened that a staff member at her facility realized she was speaking on the phone about the patient with a forensic nurse and understood the implications.

Aside from reviewing information provided with the resident when he or she joins the facility, the key informant from a long term care facility characterized flagging of residents as reactive. There is no general assessment of potential risk; instead, when incidents are reported they are analyzed for triggers and safety measures are developed to address them in the resident’s care plan. Care plans are reviewed quarterly at minimum, and revised as needed. However, the informant also noted that daily reports generated by the electronic record system do include reported changes in behavior, such as increased agitation which is then acted upon to identify the trigger and attempt to reduce the risk of assault or incident before the situation escalates. All personal support workers carry a tablet which is used to document details of care and behavior, including a range of criteria used to assess potential for violent behavior.

The transfer of information outside of the long term care facility can also be incomplete. When a resident transfers to another facility, the informant completes a behavior assessment with all relevant information within a one year time frame, as required by law. However, if a resident were to become a patient at an acute care facility, details about risk, triggers, and other information from the resident's care plan might not be transferred with the patient.

The culture of care in long term care also offers flagging challenges. Such facilities are considered the homes of the individuals who live there; those individuals are called residents by key informants for this study, not patients. As homes, there is resistance to signs or labels and the informant from a long term care facility explained that their use contravenes Ontario's Bill of Rights for residents in long term care. Flagging that involves signage or identifying symbols such as magnets are not permissible in long term care facilities in that province as they are thought to breach patient confidentiality and distress visiting family. The informant mentioned proposed compromises like putting signs inside wardrobes or hiding the nature of the flag in an "all about me" tree by a resident's bed, but those were not considered acceptable. Instead, the informant explained, employees who do not have access to patient records or care plans, such as housekeeping or dietary services, are given instructions from their managers who attend daily meetings in which any new instructions or warning are disseminated. The expectation is that such information will be passed down to the appropriate staff members.

While similar cultural resistance is present in British Columbia, the law worked to the opposite effect and physical signs such as purple stickers can be used on doors, for example, as part of the flagging system within long term care facilities. Another informant indicates that sometimes creative compromises are made between the need to use the flagging system as part of a workplace safety strategy and cultural sensitivities. One facility in British Columbia uses colored flowers on the doors of residents and when a purple flagging indicator is needed, the flower is purple.

Community Services

One key informant works as a program coordinator for a private agency that provides assisted living services in small option homes or apartments. The informant identified poor communication between external organizations in the health care system and the agency as a significant challenge to providing a safe workplace for staff. Approaches to a client's violent behavior is typically a reactive response. Generally, the informant and agency staff are able to determine protocols for caring for potentially assaultive clients only after an incident had happened in one of their facilities.

When arrangements for taking in a new client are made, communication about the client comes from two sources: a meeting between agency staff and the client's support team at the client's current institution, and from a report that includes details of life history, diagnosis, injuries, medications and other details deemed relevant for appropriate care. The reports are routinely updated every three to four years which means at the time they transfer to one of the informant's homes they may be lacking information from the last several years of the client's life. Whether or not such reports might contain details of aggressive episodes is mixed. The informant suggests that very serious incidents are included, but tendencies to aggression that have not resulted in major injuries are not routinely mentioned. There is no regulation to indicate what kinds of behaviors or incidents need to be in the report, according to the informant.

Likewise, the same informant suggests that client support teams will answer questions honestly about a new client's behavioral history, but tend not to volunteer information. The onus is therefore on the agency's employees to ask the right questions to ensure full disclosure of risks that come with a new client. There are

no standard questions asked at such meetings, and since every client's circumstances and care needs are different, the question of risk for assault on staff may not arise.

A third, informal channel of communication comes from casual conversations with family or physicians who might reveal a past history of aggression or assault not recorded in the documents available to the agency. The result of the current state of communication between institutions and the agency providing assisted living care is fragmented and information is incomplete. The informant finds that plans to address patients who pose risk are reactive and come as a consequence of an incident, rather than a pro-active approach.

Home Care

For home visits provided by clinicians based out of an informant's tertiary care facility, a pro-active approach is taken to remove potential hazards in patients' homes before the visit. A preliminary telephone call with the patient or the patient's family goes through a checklist of items or issues to be addressed. These include no smoking in the home, no animals roaming free, all weapons must be locked up. Any incidents in the home must be reported and go in the patient file so that other clinicians who might go to the house are aware of potential problems. That information would also be available if the patient were to be admitted to the informant's facility. If, however, patients transfer to the facility from another part of the province, file information related to home visits are unlikely to accompany the patient.

Byon et al.'s (2016) study of two American agencies that provide home care found that home care workers typically have little or no knowledge of a client's history of violent behaviors. In light of the study's finding that caring for a client with a previous history of violence was positively associated with increased risk of experiencing violence acts or threats of violence, Byon et al. recommend policies that support the communication of risk posed by clients to home care workers, including historical and clinical factors.

While key informants and Byon et al. (2016) note the importance of communication of risk as a precondition of effective planning to keep home health care workers safe, the flow of communication is challenged by the fragmentation of health care sectors and the different types of professionals who provide care. Agencies that provide home care or assisted living care in facilities typically do not have access to patient records and the information transferred comes according to the judgement and discretion of health care professionals. These professionals are often concerned to respect patient confidentiality and avoid disclosure of unnecessary information as well as help to ensure a placement in circumstances where spaces for residential or home care services might be limited and in high demand.

Inter-Institutional Communication

Transferring the existence of a patient's flag from one health care institution to another presents a number of significant challenges:

- The use of different electronic record keeping systems by different organizations combined with different kinds of alerts within systems to convey flags and associated information
- Different standards, definitions, criteria for assessing risk and assigning flags
- Privacy concerns that would limit the transfer of the type of information conveyed and the type of personnel who should have access to it
- Concerns that non-essential information might jeopardize placement in a different kind of facility (such as residential care or other type of assisted living accommodation)

The lack of integrated electronic communication between health care institutions or sectors means that the communication that accompanies a patient through his experiences within the health care system may be fragmented. In some cases, a legal obligation to provide information relevant to workplace safety is hampered by ambiguity as to the specific details of needs to be disclosed, which bodies (if any) have any obligation to disclose anything, a cumbersome reporting process, fear of violating patient privacy, or concern of jeopardizing an individual's placement in a new setting (such as a long term care facility), among other barriers.

Nevertheless, a few examples are available of larger systems facilitating the spread of flagging information from health care site to health care site, discussed below.

The VA Health System Example

The United States Veterans Health Administration has worked for decades to address the challenge of maintaining a safe workplace for staff without compromising the quality of care to patients prone to violence. Drummond et al. (1989) considered an early experiment with flagging patient records to communicate risk and appropriate responses to it.

The VA health system has in place an example of a flagging system that operates throughout the VA health care system nationwide. Disruptive Behavior Committees (DBC) at VA facilities, headed by a senior clinician and composed of stakeholders from a range of expertise and interests including mental health, safety, General Counsel, security, ethics, and patient representatives evaluate and manage the risk posed by patients who may be prone to assault (Hodgson et al., 2012; United States Department of Veterans Affairs, 2016). The DCBs incorporate reviews of medical records, interviews with patients, care providers, families and victims in order to develop recommendations for patient treatment plans specific to each patient. Plans may include such information as known triggers or mandates for police accompaniment. These recommendations are noted in a Category I Patient Record Flag in an electronic patient record system that services all VA facilities nationwide. As a result, risks and recommendations follow patients throughout the VA health system (Blake, 2011; Hodgson et al., 2012; Veterans Health Administration, 2010). Hodgson et al.'s (2012) survey of Chiefs of Staff at 140 VA hospitals found that respondents were generally satisfied with the system and that higher levels of satisfaction were associated with reduction in assaults at those facilities.

Joint Centres for Transformative Healthcare Innovation

Six hospitals in the Toronto area have created a collaborating partnership to share promising practices. Among the projects undertaken by the collaboration is Workplace Violence Prevention ("Joint Centres Transformative Healthcare Innovation," n.d.). One of the key informants is familiar with the collaboration and explained that the institutions are not only sharing their practices related to flagging with one another but committed to 80% standardization of the process among themselves to facilitate the transfer of information from one participating institution to another. This system, which would allow for the sharing of flags and associated information through electronic record systems, is still in the planning stages.

Fraser Health Authority

The Fraser Health Authority in British Columbia is a body responsible for a range of health services from acute care to residential facilities and home care. All institutions and organizations under the umbrella of the health authority have basic electronic connectivity that allows for information such as patient flags to be communicated as the patient moves through the health care system for different needs. Key informants familiar with the flagging policy and technical details of the system indicate that such extensive

communication is challenging given the different needs of different health care settings and the use of different electronic record keeping systems by different organizations within the health authority.

It is worth noting that the flow of communication does not extend in the same way to private agencies which provide residential or other kinds of assisted living care to patients coming from facilities operated by the Fraser Health Authority. In those circumstances, information related to risk of violence is expected to be communicated with care plans, but is not regulated or standardized.

Impacts on Rate of Violent Incidents

Evidence from Academic Studies

Published studies in academic journals that consider the efficacy of flagging systems on rates of violence are limited as well as divided on the degree of success that they report.

Studies of the Veteran's Administration health care system flagging practices have reported mixed success. Drummond et al.'s early study (1989) found that a sample of fifty patients at a general VA hospital at risk for repeated violence, primarily in an ambulatory care setting, saw a reduction in violent behaviors after flagging. A later, larger scale study of the VA Workplace Violence Prevention Program (WVP) in 138 VA facilities found mixed results (Mohr, Warren, Hodgson, & Drummond, 2011). While the number of reported incidents only marginally decreased, the study authors suggest their results need to be interpreted in light of several factors:

- Some facilities did observe large assault reduction rates while others saw large increases, minimizing the effects of the WVP program in the study's regression model and suggestive of a need for further analysis
- The WVP program may have had the intended result of encouraging employees to report assaults, leading to an increase of *reported* incidents, but not actual levels of violence experienced.
- Assaults are associated with certain patient areas: long term care, emergency department, and inpatient psychiatric units. This study focused on facilities and not specific departments, again suggesting need for further analysis of specific circumstances (Mohr et al., 2011).

The impact of the ALERT system was studied at one acute care hospital in British Columbia by Kling et al. (2011) and found to have mixed results. A reduction in violence rates during the implementation phase of the system was not sustained. It is not clear what was the cause of that result. The authors speculate it could be due to lack of use of the system or increased reporting of incidents, among other possibilities. In addition, the authors did not find that use of flags combined with worker training was associated with successful avoidance of violence by flagged patients. That result, too, can stem from many possible causes. The authors conclude that more study is needed (Kling et al., 2011).

Information from Key Informants

Key informants were also mixed in what they were able to state about the impact of flagging practices on the rate of violent episodes experienced by staff at the hands of patients. One informant asserted that her institution's plan lead to a significantly reduced number of worker injuries resulting from patient on staff violence, on the basis of the number of incidents before and after the plan was put into action.

Two informants from a different facility, noted that they did not have enough data to speak definitively about the impact of flagging, and that the answer was further complicated by the fact that flagging is one piece of a much larger program of violence prevention. In addition, one element of that program is encouragement to

employees to report incidents. As a consequence, increased numbers of *reported* incidents cannot be interpreted as an increase in the number of actual incidents experienced, a caveat noted by Mohr et al. (2011) above.

Other informants were also reluctant to make definitive statements, citing the relative newness of programs and the number of variables. There is also the challenge of attempting to capture the number of events *that did not happen*. One informant further noted that at the same time flagging and other violent prevention measures are in place, changes in patient care that avoid the use of physical or chemical restraints on patients who pose risk my also impact the number of experiences of violence as staff adjust to new ways of managing risk. Another informant found that in a preliminary evaluation the system was being used properly and supported by staff, but also mentioned formal evaluation would follow a current revision of policy and procedures.

References

Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Haug, H.-J., & Fischer, J. (2006). Predicting inpatient violence using an extended version of the Brøset-Violence-Checklist: Instrument development and clinical application. *BMC Psychiatry*, *6*, 17. http://doi.org/10.1186/1471-244X-6-17

Abderhalden, C., Needham, I., Miserez, B., Almvik, K., Dassen, T., Haug, H.-J., & Fischer, J. E. (2004). Predicting inpatient violence in acute psychiatric wards using the Broset-Violence-Checklist: A multicentre prospective cohort study. *Journal of Psychiatric and Mental Health Nursing*, (11), 422–427. http://doi.org/10.1111/j.1365-2850.2004.00733.x

Almvik, R., Woods, P., & Rasmussen, K. (2000). The Broset violence checklist: Sensitivity, specificity, and interrater reliability. *Journal of Interpersonal Violence*, *15*(12), 1284–1296. http://doi.org/10.1177/088626000015012003

Blake, J. (2011). Prevening patient violence in VA health care. *VAnguard*, (May/June), 14–15. Retrieved from https://www.va.gov/opa/publications/vanguard/vanguard_11_mayjun.pdf

Clarke, D. E., Brown, A. M., & Griffith, P. (2010). The Brøset Violence Checklist: Clinical utility in a secure psychiatric intensive care setting. *Journal of Psychiatric and Mental Health Nursing*, *17*(7), 614–620. http://doi.org/10.1111/j.1365-2850.2010.01558.x

Drummond, D. J., Sparr, L. F., & Gordon, G. H. (1989). Hospital violence reduction among high-risk patients. *Jama*, *261*(17), 2531–2534. http://doi.org/10.1001/jama.1989.03420170075033

Hodgson, M. J., Mohr, D. C., Drummond, D. J., Bell, M., & Van Male, L. (2012). Managing disruptive patients in health care: Necessary solutions to a difficult problem. *American Journal of Industrial Medicine*, *55*(11), 1009–17. http://doi.org/10.1002/ajim.22104

Hvidhjelm, J., Sestoft, D., Skovgaard, L. T., & Bjorner, J. B. (2014). Sensitivity and specificity of the Broset Violence Checklist as predictor of violence in forensic psychiatry. *Nordic Journal of Psychiatry*, *68*(8), 536–542. http://doi.org/10.3109/08039488.2014.880942

Ideker, K., Todicheeney-Mannes, D., & Kim, S. C. (2011). A confirmatory study of violence risk assessment tool (M55) and demographic predictors of patient violence. *Journal of Advanced Nursing*, *67*(11). http://doi.org/10.1111/j.1365-2648.2011.05667.x

Joint Centres Transformative Healthcare Innovation. (n.d.). Retrieved April 27, 2017, from http://innovationex.ca/

Kling, R., Corbière, M., Milord, R., Morrison, J. G., Craib, K., Yassi, A., … Saunders, S. (2006). Use of a violence risk assessment tool in an acute care hospital: Effectiveness in identifying violent patients. *AAOHN Journal*,

54(11), 481–487. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17124966

Kling, R., Yassi, A., Smailes, E., Lovato, C. Y., & Koehoorn, M. (2011). Evaluation of a violence risk assessment system (the Alert System) for reducing violence in an acute hospital: A before and after study. *International Journal of Nursing Studies*, *48*(5), 534–539. http://doi.org/10.1016/j.ijnurstu.2010.10.006

Lipscomb, J. A., & El Ghaziri, M. (2013). Workplace violence prevention: Improving front-line health-care worker and patient safety. *New Solutions : A Journal of Environmental and Occupational Health Policy*, *23*(2), 297–313. http://doi.org/10.2190/NS.23.2.f

Minnesota Department of Health. (n.d.). *Preventing violence in healthcare: Gap analysis*. Retrieved from http://www.health.state.mn.us/patientsafety/preventionofviolence/preventingviolenceinhealthcaregapanalysis.pdf

Mohr, D. C., Warren, N., Hodgson, M. J., & Drummond, D. J. (2011). Assault rates and implementation of a workplace violence prevention program in the Veterans Health Care Administration. *Journal of Occupational and Environmental Medicine*, *53*(5), 511–6. http://doi.org/10.1097/JOM.0b013e31820d101e

Ocupational Safety and Health Administration. (2015). *Caring for our caregivers preventing workplace violence: A road map for healthcare facilities*. Retrieved from https://www.osha.gov/Publications/OSHA3826.pdf

Public Services Health & Safety Association. (2016a). *Communicating the risk of violence: A flagging program handbook for maximizing preventative care*. Toronto. Retrieved from https://www.pshsa.ca/wp-content/uploads/2016/07/VWVMNAEN0616-Communicating-Risk-of-Violence-Flagging-Program-Prevention-final.pdf

Public Services Health & Safety Association. (2016b). *Communicating the risk of violence: What healthcare providers should know about privacy*. Toronto. Retrieved from http://www.pshsa.ca/wp-content/uploads/2016/07/PSHSA_Flagging-Workplace-Violence-and-Health-Information-Privacy-Fact-Sheet_VWVFCFEN0616.pdf

Public Services Health & Safety Association. (2017a). *Individual client risk assessment toolkit for health care settings*. Toronto.

Public Services Health & Safety Association. (2017b). Violence, aggression & responsive behaviour (VARB) project. Retrieved April 27, 2017, from http://www.pshsa.ca/products/flagging-resources/

United States Department of Veterans Affairs. (2016). Workplace violence prevention in health care facilities. Retrieved March 30, 2017, from https://www.publichealth.va.gov/employeehealth/threat_management/index.asp

Veterans Health Administration. Patient Record Flags (2010). Washington D.C.: Department of Veterans Affairs.

Appendix A: Operating Definitions Used by the NSHRF

Peer-reviewed literature is evaluated by experts in a field in order to determine the quality of articles submitted for publication in a scholarly journal. Articles are evaluated for their validity and contribution to the field. The peer review process seeks to maintain standards of quality and provide credibility.

Grey literature is published material which contributes to the evidence base but is not peer-reviewed, and can include articles, reports, brochures, newsletters, theses, dissertations, conference proceedings, working papers, patents, databases, websites, legislation, and policy documents. These materials can be produced by government, non-profit organizations, health research institutes, professional organizations, universities, international organizations, media, and others. Grey literature can be very useful in informing decision making as it is helpful for understanding new and emerging opinions and issues, for understanding processes of individual programs and approaches, and for planning purposes. The inclusion of grey literature can help to broaden the scope of and provide a more comprehensive review by including evidence from a wider variety of sources and reducing publication bias. However, grey literature has not been exposed to a rigorous systematic review process to assess its quality, reliability and validity which means that the quality of grey literature can be quite varied. Grey literature and media coverage play a particularly important role in providing evidence on topics which are contemporary, continually evolving and where there is limited evidence available in the peer-reviewed literature.

Key Informant Interviews involve conducting in-depth interviews with individuals who are able to provide insights into a particular topic. In addition to their knowledge, experience with and understanding of the topic, these individuals may initiate access to other sources of evidence, such as published or unpublished materials, and other key informants. Key informant interviews, are particularly useful when the researcher wishes to gather evidence on a pressing or contemporary and continually evolving topic from well-informed invididuals with diverse backgrounds and opinions. In-depth interviews allow the researcher to establish rapport with the respondent and clarify questions, which results in detailed and rich qualitative data on the topic[1].

[1] Sources: UCLA Center for Health Policy Research. Health DATA Program. Section 4: Key Informant Interviews; Yin, R. K. (2009). *Case study research: Design and methods*. Los Angeles, Calif: Sage Publications

Appendix B: Key Informant Interview Guide

Introduction

Thank you for agreeing to participate in this interview. The Nova Scotia Health Research Foundation (NSHRF) is conducting interviews on behalf of the Project Team for the "Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors," and the Nova Scotia Department of Health and Wellness. These interviews are intended to gather evidence for the development of policy and practice on the topic of addressing patient violence on health care staff. The objective is to reduce incidents that result in physical or psychological injuries at the workplace.

Our areas of interest are:

- Policies and procedures for flagging the records of violent or potentially violent patients
- Challenges and facilitators associated with the use of flagging
- Preservation of patient confidentiality of avoidance of stigma, particularly for those patients whose violent behaviors stem from clinical mental health conditions
- Issues surrounding sharing or communicating flags with other institutions/settings within the healthcare system

You've been identified as someone with expertise on this topic who would have valuable insights, information, and comments that could benefit this investigation. We appreciate any and all information you are able to share with us.

Privacy and Confidentiality

Our discussion will be audio recorded and transcribed to ensure accuracy during the analysis and write-up of the interview findings. The audio recording will not be shared with anyone outside the project team, which consists of employees and representatives of NSHRF. The audio files and transcripts will be stored on a limited access folder on the Nova Scotia Government's internal network. This folder is only accessible by NSHRF employees. The interview findings will be summarized and used to inform the development.

Interview Questions

1) Please provide a brief description of your organization and your role within it?
2) Please tell me about your experience as it relates to flagging practices?
    a. Can you briefly describe how flagging works at your institution? (i.e. from the time a patient presents until discharge)
        Who can flag a patient?
        Is it an immediate response to an incident or assessment?
            If based on an incident – what is the threshold?
            If based on an assessment, how is the threat level assessed?
        Is it a short or long term response?
3) What are the elements of a successful flagging system?
4) What conditions need to be in place for a flagging system to be successful?
    a. training? leadership? culture?
5) What are the challenges of putting in place a flagging system?

6) Are you aware of any resistance to flagging?
    a. By whom (i.e. what role)?
    b. Why?
    c. Were measures taken to address the cause/s of resistance?
        i. Were they successful?
        ii. Why/why not?
7) Is patient confidentiality a concern since the policy/practice has been in place?
8) What is the potential for the flagging to cause unnecessary harm/distress to patients?
9) How does flagging impact patient care?
10) Stigma surrounding mental illness is a concern for some clinicians, patient advocates, and others. What are your thoughts on the risk that the use of flags might perpetuate stigma?
11) Does concern about stigma dissuade clinicians from flagging patients?
12) Can flags follow a patient through different institutions/settings within the health care system?
    a. What are the challenges of doing that?
    b. Are there advantages/disadvantages?
13) Are patient flags removable?
    a. If yes, what is the process?
    b. Is there a routine review to do so?
14) How do flagging systems evolve or change, in your experience?
    a. In what circumstances?
15) What are the financial costs associated with a flagging system?
16) Has the flagging policy of your institution been formally evaluated?
    a. What are the key indicators of success?
        i. Has it reduced incidents of worker injury?
17) How do/should systems (risk assessments, procedures, etc.) vary depending on the setting (acute care, long term care)?
18) Is there anything else you'd like to mention that you think would be useful before we close?

Thank you for taking the time to talk with me today!