ToolKit: Case Example

At the start of the work shift, Care Worker "A" noticed a strong smell associated with a resident. The worker spoke with the resident and suggested that he take a shower. The resident was resistant to taking a shower and agitated, so the worker left the resident alone and decided instead to just change the linens on the bed. The worker then entered the laundry room to launder the linens.

Subsequently, Care Worker "B" noticed the smell associated with the resident and directed him to have a shower and change into clean clothes.

While Care Worker "A" was in the laundry room, the resident entered and threw his soiled clothes at the worker and then choked the worker, repeatedly punched her in the face, and trapped her in the laundry room. The commotion was heard by two Nurses in the nurses' station who entered the laundry room and initiated a code white while intervening to remove the resident from the worker.

This scenario was loosely based on an incident that occurred at the Vancouver Coastal Health Authority. The following link details the exact facts of the investigation that was conducted by Work Safe BC: https://www.documentcloud.org/documents/1277243-detwiller-pavillion-incident-investigation.html

An investigation seeks to find the cause of an incident by asking a series of questions. Here are some examples of questions to be asked based on the scenario above. If the answer to any of the questions is "no" then the next question should be "why".

Human Behaviours:

- Did Care Worker "A" read the kardex or progress notes at the start of the shift related to the resident?
- Was there any information about this resident's past behaviour when agitated?
- Was the Resident's agitated behaviour that was observed by Care Worker "A" documented and/or shared with Care Worker "B"?
- Were there other interactions related to the Resident that were observed but not documented/communicated by other workers?

Organizational Factors:

- Was the Worker's response to change the bed linens consistent with the policies and procedures?
- Was the training received by the Care Workers sufficient to understand the potential risks of an agitated resident?
- Was training received by workers to respond to aggressive behaviour?
- Was this resident in the appropriate facility/wing?
- Was the Worker to Resident staffing ratio appropriate? Were there any Supervisors' on duty during the shift?
- Are the Workers involved with reviews of the care plan?
- What controls are in place to minimize incidents of violence?
- Are there policies/procedures implemented to respond to emergency situations of workplace violence?

Materials / Equipment:

- Did the Care Worker have the ability to call for assistance?
- What mechanism was available to receive support/assistance in an emergency?
- Were panic alarms available? How is code white initiated?

Environment:

- How did the resident have access to the laundry room? Was the egress, access to exit appropriate?
- Was the laundry room in direct line of sight to the nurses' station?
- Did the organization have a violence risk assessment that was up to date determine the nature and type of occurrences of violence that could be anticipated?
- Was assistance for Care Worker "A" provided in a timely manner?

Conclusions:

Incomplete Investigation	
Cause(s)	**Corrective action(s)**
Care Worker "A" should have left the resident alone and not changed his linens and communicated the decision with Care Worker "B" and documented the behaviour in the progress notes.	Provide additional training on documenting, communicating and recognizing escalating behaviours and communication techniques.
Thorough Investigation	
Cause(s)	**Corrective action(s)**
Experienced workers assigned to the residents with a known history of violence were not sufficient. Workers need to be trained and accountable to check the progress notes at the beginning of each shift and appropriately document and communicate behaviour changes.	The resident should be re-assessed to identify any risks, changes to care/medication etc. Staffing allocation should be evaluated and the credentials of the appropriate staff for the nature of the residents considered. Assess how information about residents is communicated and shared.
Laundry room should not be accessible to residents and should have a separate access to egress for emergency situations and be in a clear line of sight.	A risk assessment should be conducted to minimize the potential for injuries in the event of workplace violence – the assessment needs to consider the physical environment and tasks associated with the job.
Workers did not have access to panic alarms that were working or other emergency communication devices.	Emergency protocols should be established and practice emergency code white situations. Evaluate educational needs of workers on violence prevention.